



T.Y.B.A.
Psychology Paper -V
Abnormal Psychology

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T.Y.B.A. Paper V

Abnormal Psychology

Objectives :

- 1) To impart knowledge and understanding of the basic concepts in Abnormal Psychology and the theories about Abnormality.
- 2) To impart knowledge and understanding of the different Psychological Disorders – their symptoms, diagnosis, causes and treatment.
- 3) To create awareness about Mental Health problems in society.
- 4) To create a foundation for higher education and a professional career in Clinical Psychology.

(4 lectures per week; 48 lectures per tem; 9 lectures per topic and 6 lectures for Orientation to the Paper)

Topic I : Understanding Abnormality; Definition, Classification, and Assessment

- a) What is Abnormal Behaviour?
- b) The Diagnostic and Statistical Manual of Mental Disorders
- c) Psychological Assessment – Clinical Interviews and Mental Status Examination
- d) Behavioural, Multicultural, Environmental, and Physiological Assessment

Topic II : Theoretical Perspectives

- a) The purpose of Theoretical Perspectives in Abnormal Psychology
- b) Psychodynamic Perspective
- c) Humanistic Perspective
- d) Socio cultural Perspective
- e) Behavioral and Cognitively based Perspectives
- f) Biological Perspective
- g) Bio-psychosocial Perspectives on theories and treatments: An Integrative Approach

II

Topic III : Anxiety Disorders

- a) The Nature of Anxiety Disorders
- b) Panic Disorder and Agoraphobia
- c) Specific Phobias
- d) Social Phobia
- e) Generalized Anxiety Disorder
- f) Obsessive – Compulsive Disorder
- g) Acute Stress Disorder and Post Traumatic Stress Disorder
- h) Anxiety Disorders : The Bio-psychosocial Perspective

Topic IV : Somatoform Disorders, Psychological Factors Affecting Medical Conditions and Dissociative Disorders

- a) Somatoform Disorders
- b) Psychological Factors Affecting Medical Conditions
- c) Dissociative disorders
- d) Somatoform disorders, Psychological Factors affecting medical conditions and Dissociative disorders : The Bio-psychosocial perspective

Topic V : Sexual Disorders

- a) What is Abnormal Sexual Behaviour?
- b) Paraphilias
- c) Gender Identity Disorder
- d) Sexual Dysfunctions
- e) Sexual Disorders : The Bio-psychosocial Perspective

Topic VI : Mood Disorders

- a) General Characteristics of Mood Disorders
- b) Depressive Disorders
- c) Disorders involving alterations in Mood
- d) Theories and Treatments of Mood Disorders
- e) Suicide – who and why
- f) Mood Disorders : The Bio-psychosocial Perspective

III

Topic VII : Schizophrenia and Related Disorders

- a) Characteristics of Schizophrenia
- b) Other Psychotic Disorders
- c) Theories and Treatment of Schizophrenia
- d) Schizophrenia : The Bio-psychosocial Perspective

Topic VIII : Personality Disorders

- a) The Nature of Personality Disorders
- b) Antisocial Personality Disorder
- c) Borderline Personality Disorder
- d) Histrionic, Narcissistic, Paranoid, Schizoid, Schizotypal, Avoidant, Dependant, and Obsessive – Compulsive Personality Disorders
- e) Personality Disorders : The Bio-psychosocial Perspective.

Topic IX : Development – Related, Aging-Related and Cognitive Disorders

- a) Introductory Issues
- b) Mental Retardation
- c) Pervasive Development Disorders
- d) Attention Deficit and Disruptive Behaviour Disorders
- e) Learning, Communication and Motor Skills Disorder
- f) Separation Anxiety Disorder
- g) Other Disorders that Originate in Childhood
- h) Development – Related Disorders : The Bio-psychosocial Perspective
- i) The Nature of Cognitive Disorders
- j) Delirium, Amnestic Disorders, Traumatic Brain Injury, Dementia
- k) Cognitive Disorders: The Bio-psychosocial Perspective

Topic X : Eating Disorders and Impulse Control Disorders

- a) Eating Disorders
- b) Impulse Control Disorders
- c) Internet Addiction
- d) Self Injurious Behaviors
- e) Eating Disorders and Impulse Control Disorders: The Bio-Psychosocial Perspective

IV

Note : As an Orientation to this paper, the following sub-topics should be taught in brief (questions will not be set on these sub-topics)

- a) Abnormal Psychology throughout History; Research Methods in Abnormal Psychology; Impact of Psychological Disorders on the individual, family, community and society; Reducing stigma.
- b) Experiences of client and clinician; The diagnostic process; Treatment Planning and Implementation.
- c) Some Ethical and Legal Issues relevant in India.

Book for study

Halgin, R. P., Whitbourne, S. K. (2010). Abnormal Psychology: Clinical Perspectives on Psychological disorders. (6th ed.) McGraw-Hill

Book for Reference :

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2. Beidel, D. C., Bulik, C. M., & Stanley, M. A. (2010). Abnormal Psychology. New Jersey : Pearson Prentice Hall
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UNDERSTANDING ABNORMALITY: DEFINITION, CLASSIFICATION AND ASSESSMENT

Unit Structure

- 1.0 Objectives
- 1.1 Introduction
- 1.2 What is Abnormal Behaviour
 - 1.2.1 Defining Abnormality
 - 1.2.2 Challenges Involved in Characterising Abnormal Behaviour
 - 1.2.3 What causes Abnormality
- 1.3 The Diagnostic and Statistical Manual of Mental Disorders
 - 1.3.1 How the DSM Developed
 - 1.3.2 Controversial Issues Pertaining to the DSM
 - 1.3.3 Definition of Mental Disorder
 - 1.3.4 Assumptions of the DSM-IV-TR
- 1.4 Psychological Assessment
 - 1.4.1 Clinical Interview
 - 1.4.2 Mental Status Examination
- 1.5 Behavioural Assessment
- 1.6 Multicultural Assessment
- 1.7 Environmental Assessment
- 1.8 Physiological Assessment
- 1.9 Summary
- 1.10 Questions
- 1.11 Suggested Readings

1.0 OBJECTIVES :

After reading this unit you will be able to:

- Understand what is meant by abnormality and the difficulties in defining it.
- Discuss the factors involved in the development of abnormality.

- Describe the development and use of the Diagnostic and Statistical Manual of Mental Disorders.
- Explain how Psychological Assessment is carried out with the help of Clinical interviews and Mental Status Examination.
- Understand Behavioural, Multicultural, Environmental and Physiological assessment.

1.1 INTRODUCTION :

Efforts to understand, explain and control problematic behaviours can be traced back to several years. Abnormal Psychology is the systematic study of abnormal behaviour - it is a branch of psychology that is concerned with the etiology, symptomatology and the process of mental illnesses. In this chapter we will examine what is meant by deviant or 'abnormal' behaviour?

After defining abnormality we will discuss the challenges involved in characterising abnormal behaviour as well as the causes of abnormality. Following this we will discuss the Diagnostic and Statistical Manual of Metal Disorders and related topics.

The concept of psychological assessment, behavioural assessment, multicultural assessment, environmental assessment and physiological assessment would be discussed with relevant examples.

1.2 WHAT IS ABNORMAL BEHAVIOUR?

Let's consider the following case.

Raju, 26 year old, was laughing when he was brought to the ward by the nurse - looked like he was having a good time. Before the nurse could introduce him to the staff, he said, "Cricket, I love cricket! I have never played cricket in my life but that is what I am going to do while I am here. I am going to become the world's best cricket player! He then went on to talk about his mother and then suddenly described what he had for dinner the previous night. Few days back, Raju had spent all his money and that of his elderly parents and bought an expensive professional camera. Without any formal training in photography, he thought he could set up the best studio in the city and make lot of money.

Does anything about Raju seem strange? How would you feel if you were to see someone like Raju walking in your neighborhood? You could be surprised or scared or may even laugh. You may think there is something abnormal about this person. On what basis is Raju judged to be abnormal? Is it because the way he is talking is odd? Or since he is making tall claims? Or because one cannot anticipate how he may behave after a while?

Anything that deviates from the normal or differs from the usual or typical is called abnormal. However there can be exceptions and certain very unusual behaviours may also be considered normal in the given cultural/social context.

Thus, there are certain criteria that help us define abnormality and also distinguish between what is normal and abnormal.

1.2.1 Defining Abnormality

The current diagnostic procedures used in the mental health community rely on four important ways in which abnormality can be defined.

Impairment: According to this criterion, maladaptive behaviours that prevent an individual from functioning in daily life can be considered abnormal. Impairment refers to a reduction in a person's ability to function at an optimal or average level. For example, when a woman consumes psychoactive substances (drugs), her cognitive and perceptual abilities are impaired and she would be at risk if she drives in this state. In certain situations, the person may report feeling great and describe oneself in positive terms but those around may suggest that s/he is functioning inadequately in her/his personal or work life. In the case mentioned earlier, Raju spent all his savings to set up a studio due to impaired judgement.

Distress: This criterion suggests that behaviours should be considered abnormal if the individual suffers discomfort as a result of the behaviours and wish to get rid of them. The experience of distress - emotional or physical pain is common in life. However, here the intensity of pain is so high that it interferes with the person's daily living. For example, a victim of an extremely traumatic event may experience unrelenting pain or emotional turmoil and may not be able to cope in daily life.

Risk to Self or Other People: When an individual's actions pose a threat to one's own life or to the life of others, the behaviour is considered to be abnormal. A severely depressed individual is at risk for committing suicide and therefore the condition is referred to as abnormal. Similarly, a person suffering from Schizophrenia is out of touch with reality and may put oneself and/ or others at risk. In

some situations, a person's thoughts and behaviours threaten the physical or psychological wellbeing of others and are therefore, considered abnormal such as the act of abusing children or exploiting others.

Socially and Culturally Unacceptable Behaviour: Behaviours that are not in line with the social or cultural norms are considered abnormal. Certain behaviours may be acceptable in some cultures but considered odd in certain others. For e.g., In India, the phenomenon of being possessed by God is a common practice during Navratri or other festivals, but the same behaviour would be considered abnormal in most of the other countries. Thus, the social context needs to be taken into account while judging behaviour as normal or abnormal.

1.2.2 Challenges Involved in Characterising Abnormal Behaviour

Although there are clear criteria for defining abnormality, diagnosing abnormal conditions is not as straightforward as it may seem. In 1973, David Rosenhan conducted a classic study that threw light on the difficulties involved in this process - 8 sane individuals were able to trick the staff of 12 psychiatric hospitals across the United States. Each of them was gainfully employed and presented oneself at these hospital reporting hearing voices such as "Empty", "Hollow," and "Thud." These kind of psychotic symptoms were chosen because they had never been reported in the history of psychiatric literature.

Except their names and employment, none of their other details were changed and thus their history and present behaviour (except for the symptoms) could not be considered abnormal in any way. Interestingly, all the hospitals admitted these pseudopatients and although they stopped producing the symptoms immediately following the admission, none of the staff members noticed it. On the contrary, their ordinary actions were taken as additional evidence of their abnormality.

What was most striking was the inhuman approach of the staff - the pseudopatients felt as if nobody from the staff was concerned about their needs. Also, the staff didn't believe them when they tried to convince them that they were actually normal. The pseudopatients were released in 7 to 52 days and at discharge, each of them had received a diagnosis of 'schizophrenia in remission', which meant that their symptoms were not present, at least during that time.

Rosenhan (1973) concluded that what prevented the hospital staff from detecting the pseudopatient's normality is the general bias to call a healthy person sick. Since this study involved

deception of the mental health professionals, it was criticised for ethical reasons. Questions pertaining to why a control group was not used for comparison were raised. It was also said that since the symptoms reported (hallucinations) were of a serious nature, most clinicians would have done what the hospital staff did.

Scribner (2001) found that Rosenhan's controversial study had led to an extreme change in the mental health field where now patients with diagnosable psychotic symptoms had difficulty receiving mental health services. He reported 7 cases with documented history of chronic Schizophrenia, 6 of which were not treated even while they were in the active phase of symptoms.

Lauren Slater (2004) attempted to replicate Rosenhan's study - she went to several clinicians complaining hearing "thud" and no other symptom. She was denied admission everywhere and at the most, diagnosed with depression with psychotic symptoms, prescribed some medication and sent away. She also reported that as opposed to the pseudopatient's experience in the Rosenhan study, she was treated very kindly by every mental health staff.

Thus, inspite of the criticisms, Rosenhan's study proved to be crucial in pointing out that the attitudes towards diagnosing and admitting individuals with psychological difficulties need to change.

1.2.3 What causes Abnormality?

There are certain assumptions about the causes of abnormality - if one considers the biological approach, one might think that the abnormal behaviours are caused by a biological factor such as genetic vulnerability to a disorder, inherited from a parent.

If one takes the psychological approach, one might assume that the early childhood experiences or the self concept are responsible for the symptoms. Looking at it from the social perspective, one might think that the symptoms stem from the interpersonal relationships or the social environment in which an individual lives.

What is often asked is whether the cause is biological or psychological or social? This is referred to as the nature-nurture question - is the abnormality caused by something in the nature or biology of the person or due to nurturing factors like life experiences.

Social scientists are of the view that there is an interaction between these factors and have used the term '**biopsychosocial**' to denote the same. The **diathesis-stress model** suggests that a person must carry some risk to the disorder in order to develop it. This vulnerability can be biological - inheriting disordered genes, it

may be psychological - a faulty personality trait, or social - a history of abuse or poor interpersonal relations. In addition to this, for the disorder to develop, one must experience some kind of stress or trigger. This stress could be biological - an accident or illness that changes the neurotransmitter balance, psychological - perceived loss of control, or social - a traumatic event.

The full-blown disorder can develop only when the vulnerability combines with the stress. Also, a feedback loop tends to develop, such that, changes in one system lead to changes in the second and then the changes in the second system bring about changes in the first. For example, an increase in a certain neurotransmitter (biological factor) may make an individual angry and irritable (psychological factor). This may cause the person to react angrily towards his friends, who may begin avoiding him (social factor) due to this behaviour. The rejection from friends (social factor) may make the person even more agitated, which may cause further changes in the neurotransmitters (biological factor).

Although the theoretical approaches are discussed in detail in topic 2, let's have a brief look at the biopsychosocial factors involved in the development of abnormality.

Biological causes:

- In understanding what causes abnormality from the biological perspective, mental health professionals focus on the processes in a person's body, such as genetic inheritance or physical disturbances.
- Many disorders run in the family. For example, the chances of the son or daughter developing schizophrenia are greater if either of their parents is suffering from it as compared to children of parents who do not have the disorder.
- Other factors such as medical conditions (thyroid), brain damage (head trauma), exposure to certain environmental stimuli (toxic substances, allergens), ingestion of certain medicines, illicit drugs, etc., can cause disturbances in the physical functioning that cause emotional or behavioural disturbances.

Psychological causes:

- Traumatic life experiences that have an impact on the individual's personality constitute the psychological factors in the development of abnormality. For example, an irrational fear of the marketplace may be caused due to a childhood experience of having been lost in the market.

- Early interpersonal relationships may lead to distortions in perception and faulty thought processes. For example, a boy who is very upset because his girlfriend didn't call back may realise that his reaction stems from his history of being disappointed by his unreliable parents, and having internalised the idea that important people tend to disappoint.
- Unrealistic expectations, learned helplessness, focussing on the negative, blaming, dichotomous thinking (seeing things as black or white), catastrophising (exaggerating) etc., can trigger psychological difficulties.

Sociocultural causes:

- The term sociocultural refers to the sources of social influence in one's life. The most immediate circle that has an impact on a person comprises of the family members and friends - troubled relationships can make one feel depressed. Similarly, a failed lover may become suicidal.
- The next circle involves extended family, neighbours with whom there is less interaction. Nonetheless their behaviours, standards, attitudes and expectations do influence individuals.
- The society plays a decisive role in most people's lives. Political turmoil, even at the local level can leave one feeling anxious or fearful. Discrimination on the basis of gender, caste, sexual orientation, disability can have an impact on individuals. As seen earlier, social and cultural norms determine what would be called abnormal, to a large extent.

1.3 THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS :

- Mental health professionals refer to the Diagnostic and Statistical Manual of Mental Disorders (DSM) for standard terms and definitions of various forms of abnormality. It is a classification system that includes descriptions of all psychological disorders, which are also known as mental disorders.
- The DSM, published by the American Psychiatric Association (APA), is periodically revised to incorporate the latest information related to psychological disorders. The DSM was first published in 1952 and since then has gone through several changes with its latest version being DSM-IV-TR (text revision).
- To develop revised editions of the DSM, task forces are appointed which comprise of clinicians and researchers with expertise in specific disorders. On the basis of their research, a

list of several disorders ranging from mild adjustment problems to severe disorders has been developed.

- The DSM ensures standardised interpretation of the diagnostic labels and also provides a common language and format for communication between clinicians and researchers.

Its multi-axial format (explained later in the chapter) also allows thorough evaluation of cases with attention to the mental disorders, general medical conditions, psychosocial problems and the level of functioning, which might get ignored if the focus were on evaluating only the presenting complaints.

- The recent editions of the DSM follow an atheoretical approach, that is, they try to present psychological disorders in a manner that reflects observable phenomena rather than what caused it. For example, anxiety disorders are described in terms of the associated psychological and physical symptoms associated with no reference to what caused these symptoms.
- The DSM classification system also helps in treatment planning. For example, a clinician would choose very different treatment plans for individuals with anxiety disorders as compared to those with psychotic illnesses. Also, every DSM-IV diagnosis has specific numerical code, which helps individuals acquire health insurance to manage the treatment cost.
- The authors of the DSM have tried to develop a reliable and scientifically and clinically sound system such that anyone showing a specific set of symptoms receives the same diagnosis across clinicians, irrespective of their theoretical orientation.
- Emphasis has also been on ensuring its validity - the extent to which the diagnostic criteria measure a specific disorder and how well the disorders can be distinguished from each other. For this, the experts have been required to take into account the base rate of a disorder - that is, the frequency with which a disorder is found among the general population. Low base rate means fewer cases and therefore establishing the reliability of the disorder becomes difficult.

1.3.1 How the DSM Developed

The DSM was the first official classification system that was developed exclusively for diagnosing mental disorders. Let's look at the history of the DSM - the initial editions of this manual were not as precise and reliable as the recent ones.

- The DSM-I, the first edition published in 1952, followed a theoretical approach where mental disorders were seen as an individual's 'emotional reactions' to his problems.

- The DSM-II which was published in 1968, tried to introduce explicit definitions and diagnostic terms that would reduce reliance on theoretical assumptions.
- In 1974, the APA appointed a team of scholars and practitioners to develop a manual that would be based on observable phenomena and acceptable to clinicians irrespective of their theoretical orientation. This led to the DSM-III, published in 1980.
- Although the DSM-III was a refined edition, it had instances in which the diagnostic criteria were not entirely clear. Due to this, the DSM-III-R was published in 1987 as an interim manual till a more complete edition was developed.
- Around the same time, the APA once again set up a task force that worked towards improving the reliability and validity of the diagnoses, in stages. In stage 1, its members reviewed the relevant research published which was then carefully analysed in stage 2. The next stage involved field trials in which several thousand individuals with diagnosed psychological disorders were interviewed. Consistency in diagnosis was assessed by having pairs of clinicians independently rate clients through videotaped interviews. To establish the validity of the diagnosis, clinicians evaluated individuals diagnosed with specific psychological disorders, with the number and nature of symptoms needed to diagnose specific conditions. These field trials helped to empirically decide the specific kind and number of symptoms that would make a diagnostic criteria. For example, to diagnose Major Depressive Disorder, a person has to have at least five out of the nine listed symptoms which include lack of interest, sad mood, disturbed sleep, disturbed appetite, feelings of worthlessness, etc.
- Thus, the DSM-IV was published in 1994. A major feature of this version was that it included 'the symptoms cause clinically significant distress or impairment in social, occupational or other areas of functioning' as one criterion for almost half of all the disorders.
- The DSM-IV with updated information, known as DSM-IV-TR (text revised) was published by 2013.

Researchers have begun working on the DSM-V which may be published in the coming years.

1.3.2 Controversial Issues Pertaining to the DSM

- For many years, critics of the DSM have argued that it tends to unfairly label people and is not a very reliable and valid tool. It is also suggested that politics and culture have influenced the definitions of disorders from time to time. For example,

homosexuality was included as a diagnostic category in the DSM-II and was removed following protests from gay activists at the APA annual conferences from 1970 to 1973. Also, pressure from the Vietnam War veterans forced the authors of DSM-III to recognise that a group of symptoms experienced by survivors of traumatic events represented a disorder and thus post-traumatic stress disorder was introduced. This demonstrates the biased processes involved in defining mental disorders.

- In addition to this, the DSM classification system is criticised for being prejudiced against women, in that women are more likely to be diagnosed with personality or mood disorders because feminine personality characteristics are perceived as being pathological. As a result of this, the authors of the DSM-IV have been particularly careful about basing their decisions on fair interpretation of the research data (Kirk & Kutchins, 1992; Kutchins & Kirk, 1997).

1.3.3 Definition of Mental Disorder

The concept of mental disorders is fundamental to the processes of diagnoses and treatment. The authors of the DSM define a mental disorder as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual that is associated with present distress (e.g., painful symptom) or disability (i.e., impairment in one or more areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom and it is not typical or culturally expected.”

Let's understand this definition.

- **A mental disorder is clinically significant** - this implies that the symptoms have to be present for a specified period of time and should have a major effect on the person's life. Thus, an occasional low mood or strange behaviour or a sense of instability are common experiences and do not represent a mental disorder.
- **A mental disorder is behavioral or psychological syndrome or pattern** - a syndrome is a collection of defined symptoms. A behavioural or psychological syndrome indicates a set of observable actions and the thoughts and feelings reported by the individual. Accordingly a random thought or behaviour does not constitute a mental disorder. A person has to experience a wide range of defined thoughts, feelings and behaviours in order to be called as having a psychological disorder.

- Further, it is **associated with present distress, disability, impairment or serious risk**. This means that the syndrome sufficiently interferes with the individual's everyday functioning. For example, a woman who compulsively washes hands may be very disturbed by her actions and may not be able to overcome the behaviour. Her productivity at work and social life may also be severely affected by this.

In certain mental disorders the person may not experience any distress but there may be a serious risk to life. For example, a person in a hyperexcited state of mania, having a good time, may believe he can fly and is thus at risk.

- Finally, **the disorder is not a culturally expected or sanctioned pattern**. For example, a woman feeling sad, having difficulty eating, sleeping, concentrating, etc., for few days, following the death of her husband, will not be called as suffering from Major Depressive Disorder because it is an expected reaction to this event.

1.3.4 Assumptions of the DSM-IV-TR

The DSM is based on some assumptions:

- 1.) **Medical Model:** The DSM follows a medical model which means that every physical and psychological disorder is regarded as a disease. In this sense the DSM is similar to the ICD, the International Classification of Diseases (ICD), developed by the World Health Organisation, and ensures uniformity in the usage of medical terms. Thus, according to this view, Schizophrenia is a *disease* and the individual suffering from it is referred to as *patient*. The use of the term *mental disorder* is also in line with this view. Although the term mental disorder implies a distinction between 'mental' disorders and 'physical' disorders, it is important to recognise that there aren't any fundamental differences between mental disorders and general medical conditions. Mental disorders tend to involve biological factors and similarly physical disorders have psychological components.

The term 'general medical conditions' (Axis III) is used only as a convenient format to refer to illnesses that are not listed under mental disorders.

- 2.) **Atheoretical Orientation:** The authors of the DSM have tried to develop a descriptive rather than explanatory classification system, that is, a psychological disorder is presented as an observable phenomenon rather than in terms of what caused it.

The DSM is neutral with respect to the theories of causality. For example, the DSM-IV-TR classifies social phobia as an anxiety disorder in which the person has persistent fear of social or performance situations, without any reference to whether the anxiety is caused due to a childhood trauma or an unconscious conflict or any other factor.

The early editions of the DSM were based on the psychoanalytical tradition in which mental disorders were seen as 'neurosis' or an 'emotional reaction' to one's problems and were thought to be a result of unconscious conflicts. The term neurosis is not a part of the DSM anymore but is still commonly used to describe symptoms that are distressing and do not have a physiological basis. The term is also used to refer to excessive anxiety or worry and to distinguish the condition from psychosis.

Psychosis involves the presence of hallucinations (false perceptions) and delusions (false beliefs). It is a condition in which the person is not in touch with reality and shows grossly disturbed and bizarre behaviour. Psychosis is not a diagnostic category but used as a descriptive term in the DSM-IV-TR.

3.) Categorical Approach: The DSM-IV-TR classifies the disorders into separate categories. For instance, conditions which involve excessive anxiety or worry are categorised as anxiety disorders, those which affect the mood are referred to as mood disorders. Although systematic, this approach has a limitation - psychological disorders cannot be very neatly separated from one another. For example, it is difficult to distinguish between sad mood and clinical depression (severe enough to receive a diagnosis of depression). Also, some cases involve a mixed presentation such a person experiencing anxiety and sad mood or mood symptoms with psychosis.

Due to this, a dimensional approach is being considered, that is, instead of fitting an individual's symptoms into some category s/he would receive a numerical rating on his symptoms indicating the severity of each. The dimensional model is thought to give a better picture of the individual's condition.

There are two issues related to the categorical approach. One is comorbidity, that is, conditions in which a person has two or more disorders that co-exist. For instance, negative emotional states are common in anxiety disorders, mood disorders and some personality disorders. The second is that of boundaries - some disorders have overlapping symptoms, such as conduct disorder, oppositional defiant disorder and attention-deficit/hyperactivity disorder (Widiger & Samuel, 2005).

4.) Multiaxial system: This system involves assessing five areas of an individual's functioning so that the treatment can be planned accordingly and the course of the disorder can be predicted. The DSM comprises of five axes:

Axis I: Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention

This axis is used for listing the various forms of abnormality, that is, the clinical syndromes or disorders with the exception of the Personality Disorders and Mental Retardation, such as schizophrenia, the different types of anxiety disorders, such as social phobia, specific phobia, generalised anxiety disorder, obsessive compulsive disorder, etc., mood disorders such as major depressive disorder, bipolar disorder, etc., adjustment disorders, cognitive disorders like delirium, dementia, amnestic disorder, etc. If an individual has more than one Axis I disorder, all should be reported with the primary reason for the visit being listed first.

Axis II: Personality Disorders and Mental Retardation

All the Personality Disorders like Paranoid personality disorder, Schizoid personality disorder, Schizotypal personality disorder, Antisocial personality disorder, Narcissistic personality disorder, etc., and Mental Retardation are reported on Axis II. Maladaptive personality features or excessive use of defense mechanisms can also be mentioned here. This axis ensures that the unhealthy personality characteristics and mental retardation will be taken into account while attending to the primary complaint.

Axis III: General Medical Conditions

This axis is for reporting the general medical conditions that are important in understanding an individual's mental disorder. General medical conditions may be related to the mental disorders in several ways. In some cases they may play a role in the development of an Axis I disorder, for example, Hypothyroidism may lead to depressive symptoms in some or an individual may develop an Adjustment disorder as a reaction to the diagnosis of Brain tumour. In certain cases medical conditions may influence the treatment of the Axis I disorder, for instance, a person's heart disease may influence the clinician's choice of medicines for this patient's depression.

Axis IV: Psychosocial and Environmental Problems

The psychosocial and environmental problems that influence the diagnosis, treatment and prognosis (future course) of mental disorders listed on Axis I and/or II are reported on this axis. This includes a negative life event, interpersonal stresses, lack of social support, etc. These problems may influence the development or treatment of mental disorders or may develop as a result of the Axis I/II condition.

Axis V: Global Assessment of Functioning

This axis is for reporting the clinician's judgement of the individual's overall functioning, which is useful in treatment planning or predicting its outcome. The Global Assessment of Functioning (GAF) scale is used to rate the individual's psychological, social and occupational functioning. For example, score of 100 means superior functioning with no symptoms while a score of 50 indicates serious symptoms.

91-100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
81-90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
71-80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
61-70	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupational, or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
41-50	Severe symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).
31-40	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
21-30	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

11-20	Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
1-10	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.0 Inadequate information.

1.4 PSYCHOLOGICAL ASSESSMENT - CLINICAL INTERVIEWS AND MENTAL STATUS EXAMINATION :

Psychological assessment refers to gathering and integration of psychological data for the purpose of a psychological evaluation through the use of tests, interview, observation, etc.

This kind of an assessment is carried out in order to arrive at a diagnosis for an individual with a mental disorder, to determine the individual's intellectual capacity, to predict how suitable a person is for a job and to assess if a person is competent to stand trial.

There are various techniques used in assessment of which we will discuss two - the clinical interview and the mental status examination.

1.4.1 Clinical Interview:

This is the most common method used to understand the client, his presenting problem, history and future goals. The interview involves asking questions in a face-to-face interaction. The clinician may audiotape or videotape the details or note them down during or after the interview. There are two kinds of clinical interviews:

Unstructured Interview:

- In this type of an interview, the client is asked open-ended questions related to his or her presenting problem, the family background and life history.
- The term 'unstructured' is used to indicate that the interviewer is free to ask questions in any order and frames them in a manner that he prefers. The client's response to the previous question and nonverbal cues such eye-contact, posture, tone of voice, etc., guide the interviewer in this process.

- The interviewer's approach is influenced by the purpose of the interview. A clinician who wants to arrive at a diagnosis would ask questions related to the client's symptoms, such as changes in mood, sleep pattern, disturbance in appetite, nature of thoughts, etc., their onset, duration and progress, medical or psychiatric history if any, etc.
- Some clients seek help for personal issues such as disturbed relationships and may not have a diagnosable psychological disorder. In such cases the interviewer would try to enquire about the reasons for the client's distress.
- A significant part of an unstructured interview is history taking, which involves asking questions related to personal history such as major life events since childhood, academic interest and performance, number of friends and leisure activities, work life, marriage, habits, etc., and family history such as numbers of family members, close relatives and relationships with them, atmosphere at home, history of illnesses in the family, etc.
- This gives the clinician a picture of the client's world and may also help draw connections between the client's current problem and a traumatic event in early life.

Structured and Semistructured Interviews:

- The structured interview gives less freedom to the clinician as it involves asking a set of predetermined questions in a fixed order. The semistructured interview also has a standardised set of questions but the interviewer can ask follow up questions to clarify the client's responses, if needed.
- The advantage of structured and semistructured interviews is that they help make accurate diagnosis. Some of these are designed to cover a wide range of psychological disorders while others are meant to diagnose specific conditions such as a Schizophrenia or Mood or Anxiety disorder.
- The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) is a commonly used structured interview while the Structured Clinical Interview for DSM-IV-TR Axis I disorders (SCID-I) and the Structured Clinical Interview for DSM-IV Personality disorders (SCID-II) are examples of semistructured interviews (despite the word structured).
- The World Health Organisation (WHO) and the U.S. Alcohol, Drug and Mental Health Administration (ADAMHA) have developed the Composite International Diagnostic Interview (CIDI), which is an assessment tool that has been translated in many languages and can be used with people from different cultures.

1.4.2 Mental Status Examination:

The mental status means what the client thinks, feels and how the client thinks, speaks and behaves. The mental status examination or the MSE is used to assess the client's thoughts, feelings and behaviour and identify symptoms. An example of a structured MSE is the mini-mental status examination (MMSE) which is very useful in assessing patients with cognitive disorders such as Alzheimer's disease. The MSE report is based on the client's responses and the clinician's objective observations of the client's appearance, speech and behaviour. Following are the components of the MSE:

- 1.) **Appearance and Behaviour:** The clinician carefully looks for any peculiarities in the client's appearance and overall behaviour as this can give an insight into her/her mental state. Clinician's are interested in the client's motor behaviour, that is, the movements. Anxious patients tend to fidget or pace around while some others tend to move about in a sluggish manner. Overactivity can be seen in the form of **hyperactivity** which refers to increased physical activity and quick movements or **psychomotor agitation** which is characterised by agitation and excessive motor and cognitive activity. Some patients show **psychomotor retardation**, that is, visible slowing of thoughts, speech and movements. Strange mannerisms, stereotyped movements and vocal or motor tics (involuntary muscular movements) are seen in some others.

In extreme cases, motor abnormalities may manifest as **catatonia** which is seen in psychotic patients. Some of these patients constantly maintain an immobile position (catalepsy) or assume bizarre postures or can be moulded into a position that is then maintained (waxy flexibility).

Compulsion is a form of motor disturbance in which there is an uncontrollable impulse to perform an act repeatedly. For example, counting the fingers or scratching one's nose before answering every question, chanting a particular mantra every few minutes, etc.

- 2.) **Orientation:** This refers to one's awareness of time, place and person. In some disorders the patient's sense of themselves and the surrounding is disturbed. This is important in diagnosing cognitive disorders such as Delirium, Dementia, Amnesia and also psychotic disorders like Schizophrenia.
- 3.) **Content of Thought:** Disturbances in the thought process occurs in various forms. Some patients have an **obsession**, which means an intrusive, repetitive, thought, image or impulse which causes distress. For example, thoughts of being unclean

or contaminated, that is often accompanied by the compulsion of washing hands.

Another form of disturbance in thought content is **delusions**. These are unshakable, false beliefs which cannot be corrected through logical reasoning, for example, a man may believe that he is a messenger of God who has been sent on Earth for a special mission. Delusions can be of different types:

- **Grandeur:** A person's exaggerated conception of one's importance, power, beauty or identity.
- **Control:** False feeling that a person's will, thoughts or feelings are being controlled by external forces. One form of this delusion is **thought broadcasting** in which the person believes that his/her thoughts can be heard by others as if they were being broadcast over the air. Likewise, **thought insertion** is a delusional belief that others are implanting thoughts in a person's mind.
- **Reference:** False belief that other's actions refer to oneself or that others are talking about him/her.
- **Persecution:** False belief that the person him/herself or a loved one is being harassed, cheated or mistreated by someone.
- **Self-blame:** False feeling of regret or guilt in which the person holds him/herself responsible for some wrongdoing.
- **Somatic:** False belief involving body functions such the belief that the brain is rotting or melting.
- **Infidelity:** False belief associated with pathological jealousy about a person's lover being unfaithful.

There are **overvalued ideas** which refer to unusual thoughts of a bizarre nature but they are not as rigid as delusions. For example, a man who believes that his credit card number should end with the digit 6 and refuses to accept a new credit card with a different last number. **Magical thinking** involves seeing a connection between two events which would seem unrelated to most people. For example, a woman may believe that every time she buys things from a particular shop her husband loses a contract.

Overvalued ideas and magical thinking do not indicate that the person has a mental disorder but suggests some psychological decline. Violent thoughts such suicidal ideas or thoughts of harming or killing another person also need to be assessed.

4.) Thinking Style and Language: An individual's style of thinking is manifested through his or her speech. For example, speaking to person with Schizophrenia or other forms of psychosis can be difficult because their language may be illogical. Examples of thought disorder:

- **Incoherence:** The speech is not clear and understandable. For example, "the ice-cream threw the poodle that is not here."
- **Loosening of associations:** Ideas expressed are unrelated. For example, "Suma is nice person but there is lot of poverty in the world and I am going to cut my hair tomorrow."
- **Illogical thinking:** Thoughts that has wrong conclusions. For example, a person who likes milk thinks she must be a cat.
- **Neologisms:** New words created, often by combining syllables of other words. For example, "I saw some "snarks" today that were "boredomly bad."
- **Blocking:** Sudden interruption in the train of thought before the idea is finished.
- **Circumstantiality:** Indirect speech that is delayed in reaching the point by bringing in lot of irrelevant details.
- **Tangentiality:** Going off on a different point without coming to the original idea.
- **Clanging:** Association of words similar in sound but not in meaning. For example, "That is Ross, there is so much moss, the coin will toss."
- **Confabulation:** Making up ideas to fill in gaps in memory. This is not an attempt to lie but to give the most possible answer. For example, when one is not very sure if he has had breakfast and is asked what he had eaten, he may give an elaborate account of a typical breakfast.
- **Echolalia:** Pathological repeating of words or phrases of one person by another.
- **Flight of ideas:** Rapid, continuous shifting from one idea to another in which ideas tend to be connected.
- **Pressure of speech:** Rapid speech as if the person feels forced to speak continuously.
- **Perseveration:** Continuing with a response to a previous question or stimulus after a new question or stimulus is presented.

5.) **Affect and Mood**: Emotion is a complex feeling state with somatic, cognitive and behavioural components. **Affect** refers to an observed expression of emotion. While assessing the affect, the clinician checks if it is **appropriate** (condition in which emotional tone is in harmony with the accompanying idea) or **inappropriate** (disharmony between the feeling tone and the thought or idea accompanying it).

The **intensity of affect**, that is, its strength is also noted. The affect is described as **blunted affect** when there is a severe reduction in the intensity of externalised feeling tone and as **flat affect** when signs of affective expression are absent or nearly absent, the face is immobile and voice is monotonous. On the other hand, **exaggerated** or **heightened** or **overdramatic affect** is reported when the emotional expression is very strong. The range of affect in terms of the variety of emotional expressions noted is also taken into account.

Mood is a pervasive and sustained state of emotion that one feels inside. Mood may be described as **dysphoric** (unpleasant feelings such as sadness or irritability), **euphoric** (very cheerful with feelings of grandeur), **euthymic** (normal range of mood; absence of depressed or elevated mood), angry, anxious, etc.

6.) **Perceptual Experiences**: Some psychological disorders are characterised by disturbances in perception. The clinician enquires about these by asking whether the patient hears voices or sees things that others are unaware of. Hallucinations are false sensory perceptions in the absence of real external stimuli. These are different from illusions in which there is distortion of a real stimulus such as misperceiving a rope as a snake. Hallucinations can involve any of the five senses:

- **Auditory hallucinations** are the most common and involve hearing sounds or voices (usually insulting comments such as “you are dumb”) or conversations. **Command hallucinations** are those in which one hears instruction to act in a certain way.
- **Visual hallucinations** involve seeing images of objects or persons. For example, a person may claim to see God or one’s spouse who has passed away.
- **Olfactory hallucinations** are uncommon and refer to false perception of smells such as unpleasant odours.
- **Gustatory hallucinations** are false perceptions of taste usually unpleasant in nature.

- **Somatic hallucinations** involve false sensations pertaining to the body, usually tactile such as crawling sensation on or under the skin.

7.) **Sense of Self**: Some psychological disorders affect the person's identity or the sense of 'who am I.' **Depersonalisation** is a phenomenon in which the person feels he is unreal, strange or unfamiliar with himself. For example, one may feel that his mind and body are not connected. One may also experience **identity confusion** which involve a lack of clear sense of who one is, what one's role is, etc.

8.) **Motivation**: In some psychological disorders, the patients lose interest in all activities to the extent that even ordinary tasks such as having a bath or dressing may seem difficult. Some may not be willing to put in any effort to change and might find their familiar state of distress better than the uncertainty of facing new challenges.

9.) **Cognitive Functioning**: During the MSE, the clinician attempts to judge the client's general intellectual capacity from the answers given by the client, on questions related to attention and concentration, memory, ability to think in an abstract manner, etc. For instance, in case a client's memory is severely impaired, the clinician might suspect a neurological condition such Alzheimer's disease. Here, the clinician doesn't administer an IQ test but rather gets a general idea about the client's cognitive abilities.

10.) **Insight and Judgement**: The clinician is also interested in seeing whether the client understands one's own difficulties. Insight refers to a person's ability to understand the true cause and meaning of a situation. For example, a person who has paranoid delusions may be very defensive and unable to see things objectively, showing poor insight.

Judgment is the ability to assess a situation correctly and to act appropriately in the situation. Clients who are severely impaired may not be in a position to make correct decisions and this may result in harm to self or others. Thus, checking the client's judgment gives the clinician an idea of protective measures that may have to be initiated.

1.5 BEHAVIOURAL ASSESSMENT :

Behavioural assessment involves systematic recording of an individual's behaviour in order to identify problem behaviours, the factors that help maintain these behaviours and decide techniques

to modify the undesirable behaviours. Clinicians use various methods such as behavioral interviews, observational methods - naturalistic observation/ controlled observation, self-monitoring, role-playing, inventories, checklists, etc., of which behavioural self-report and observation are most common.

Behavioural Self-Report:

- This is a method in which the client provides information about how frequently certain behaviours occur, either through an interview or by monitoring oneself and filling up checklists or inventories developed for this purpose.
- The advantage of self-report is that it helps obtain critical information about the client's behaviours which others would not have access to.
- Behavioural interviews involve a detailed enquiry into what happens before, during and after the behaviour in question. In understanding the 'before' factors, the clinician may ask questions such as when and where does the behaviour occur, does the behaviour occur in presence of any particular person or stimulus, etc.
- Particulars of the 'during' phase may be found out with the help of questions such as how many times and for how long does the problem behaviour occur, what happens first, what follows that, etc.
- The client is also asked about the consequence of the behaviour in terms of what effect does it have or how does it benefit him or her. For example, in case of a client who wants to give up smoking, the clinician may be interested in knowing how frequently the person smokes in a day, any specific time and place at which he smokes, does he smoke in the company of certain people, what triggers the smoking behaviour, what the client thinks and feels after smoking, etc.
- Thus, the extensive information obtained helps set realistic goals and devise strategies to change the undesirable behaviour.
- Another behavioural self report technique is self monitoring, which involves keeping a record of the frequency of the problem behaviour such as, number of cigarettes or calories consumed, number of times the client bit her nails or had unwanted thoughts or got angry.
- The client is trained to note the time, place and relevant information pertaining to the target behaviour. Self-monitoring is a very useful technique because it may lead to important insights, for example, a woman may realise that she tends to eat more while watching the television or when she is distracted.

- Behavioural checklists or inventories help to find whether certain events or experiences have occurred. For example, the Conners Ratings Scales-Revised uses self and observer ratings to assess attention deficit hyperactivity disorder and determine the number and nature of undesirable behaviours present. Checklists and inventories are quite commonly used in the clinical set up because they are easy to use and economical.

Behavioural Observation:

- In this method, the clinician observes and records the frequency of the behaviour in question, including any other relevant situational variables. For example, a nurse may be asked to observe the number of times a patient washes her hands and also her reactions when she is prevented from doing that. Or a trained observer may record the number of times a child leaves his place or speaks out of turn.
- In observing the clients, the clinician first selects the problem behaviour on the basis of an interview, direct observation or using behavioural checklists or inventories. The problem behaviour is then broken down into behavioural terms, that is, it is defined. For example, temper tantrum would be defined in terms of crying and shouting.
- Selecting vague target behaviours is inappropriate in behavioural observation because it makes measurement difficult. For example, violent behaviour cannot be measured unless specified as breaking things around or whichever is the behaviour exhibited.
- It is best to observe the target behaviour in the natural setting and this kind of behavioural observation is known as in vivo observation. In assessing a child with attention deficit hyperactivity disorder, a clinician is likely to get an accurate picture of the child's problem behaviours if he is observed in the classroom or at home rather than in the lab or clinic.
- While using this method the clinician has to be careful about the client's reactivity - the knowledge of being observed can influence the target behaviours. In order to avoid these problems, the client may be observed through a one-way mirror. In some situations, others may be included and the client's interaction with them may be observed with focus on the target behaviours.

1.6 MULTICULTURAL ASSESSMENT :

In the process of assessment, the clinician needs to be sensitive to the cultural, racial and ethnic background of the client.

There is a growing emphasis on developing culture fair tests and being careful while administering and interpreting psychological tests as the background from which the client comes can seriously influence the test performance. For example, while assessing a client whose mother-tongue is not English, the clinician needs to ensure that the instructions are followed and that the client's scores are interpreted on the basis of norms developed for that specific group. Also, certain phrases or behaviours may have multiple meanings and are likely to be misunderstood by the clients. Thus, the clinicians are required to have sufficient knowledge of the client's cultural background and critically evaluate the tests to see if they are designed for use with the specific group to which the client belongs.

1.7 ENVIRONMENTAL ASSESSMENT :

As seen earlier, the environment that surrounds a person has a tremendous impact on his/her life. Psychologist Rudolf Moos has developed Environmental **assessment scales** in which individuals provide ratings on aspects of the environment that are thought to influence behaviour. This includes the various circles of social influence in one's life such as the family, the neighbourhood, the school and the society at large. For example, in the Family Environment Scale is used to assess aspects of the client's family such as the nature of relationships between the family members. Nature of relations, such as cohesiveness and identification with family members, expression of emotions, etc; the activities that the family engages such as what do the members do for recreation or how are responsibilities shared, attitudes / beliefs of the family members, etc.

Another example is the Global Family Environment Scale, a cross-cultural tool that measures factors such as the extent to which the family provides good physical and emotional care, secure attachments, consistency and discipline.

These scales can be used to assess the home environment of children / adolescents with behavioural disorders, excessive anxiety, etc., and thus help clinicians get insight into the family dynamics of the client and understand its impact on the client's condition.

1.8 PHYSIOLOGICAL ASSESSMENT :

It is important to understand the biological basis of behaviour as all psychological problems are manifested in the body. Due to this physiological assessment becomes a part of the evaluative process.

Psychophysiological Assessment

- Psychophysiological assessment involves the use of instrumentation to monitor psychophysiological processes, based on the idea that psychological experiences are associated with definite physiological components such as changes in heart functioning, muscles, skin, brain, etc.
- The electroencephalogram (ECG) is used to monitor whether the heart is functioning normally. A measure of the blood pressure gives an estimate of any excessive or damaging pressure of the blood against the walls of the blood vessels. This helps to assess the risk for developing any stress-related heart conditions.
- The electromyography (EMG) is an instrument which is used to measure muscle tensing/contraction associated with stress and to rule out conditions such as headaches.
- Individuals tend to sweat excessively when they are tensed - this leads to changes in the electrical properties of the skin and can be measured with the help of the galvanic skin response (GSR).

Brain Imaging Techniques

Various techniques that construct pictures of the structure and function of the brain have been developed since the 1970s:

The Electroencephalogram (EEG):

- The EEG measures the electrical activity in the brain that indicates one's level of arousal, that is, whether one is alert, resting, sleeping or dreaming.

The procedure involves pasting electrodes onto the scalp with an electricity-conducting gel. The machine picks up the brain activity and a device called the galvanometer, which has an ink pen attached to it, writes continuously creating wave-like patterns on moving paper strip.
- The EEG shows a distinct pattern of brain waves depending on the mental activity one engages in. Thus, the EEG recording helps in assessing conditions such as epilepsy in which convulsions are caused by disturbed neural activity, sleep disorders, brain tumors, etc.
- An abnormality in the EEG patterns is used as a basis for further investigations. In recent years computerised interpretations of the EEG have made objective evaluation possible. The computer can convert specific EEG patterns into colour-coded plots.

- For example, low amplitude areas are shown in black or blue while high amplitude areas are highlighted in yellow and red. These colourful images help understand the patterns of electrical activity throughout the surface of the brain and are useful for diagnosis.

Computerised Axial Tomography (CAT CT scans):

- This is a technique in which one lies down with the head in a large X-ray tube. Highly focused beam of X-rays is then passed through the brain from many different angles. Differing densities of the different brain regions result in different deflections (bending) of the X-rays.
- The deflection is greater in case of dense tissue such as bones and it is least in case of fluid. The X-ray detectors gather the readings taken from multiple angles and a computerised program constructs an image of the brain in the form of slices (tomo means 'slice' in Greek).
- This method helps obtain a cross sectional slice of the brain from a specific angle or level. For example, CT scans can provide images such as the fluid filled ventricles in the brain, showing differences in the brains of people with and without Schizophrenia.

Magnetic Resonance Imaging (MRI):

- This technique uses magnetic fields and radio waves to produce high quality two or three dimensional images, based in the water content of the different tissues. The person undergoing an MRI lies inside a tunnel-like structure that surrounds the person with a strong magnetic field.
- The activity of the electromagnetic energy from several angles, through a computer program is converted into a high resolution image of the scanned region. The MRI images are quite detailed and can detect tiny changes of structures within the body.
- Using the MRI, trauma to the brain can be seen as bleeding or swelling. Sometimes tumours that go undetected in CT scans can be seen in MRI. It is also used in identifying brain dysfunction in specific disorders.
- For example, one study compared the MRIs of women with Major Depressive Disorder (MDD) and controls on a task in which they had to learn objects paired with faces displaying six emotions. It was seen that women with MDD had difficulty learning the pairs and also showed larger amygdala (part of the limbic system that is involved in emotional responsiveness).

However, when both the above factors were taken together, only women with MDD and larger amygdala were found to do poorly on the learning task. This suggests that the memory

deficit may have resulted from changes in the brain triggered by MDD (Weniger, Lange & Irle, 2006).

Functional Magnetic Resonance Imaging (fMRI):

- This is a new technique and a specialised MRI which relies on the idea that when an area of the brain becomes active due to mental processing, the blood flow to that region increases.
- This scan is called 'functional' MRI because it shows the brain as it is functioning while performing a mental task and is therefore very useful in psychological assessment.
- The fMRI produces images of the active brain regions when one processes information. This is done by showing regions with increased activity in different colours reflecting high and low levels of blood flow. The advantage of this technique is that it shows the brain in action rather than just its physical structures.

Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT):

- This is another brain imaging technique that involves injecting a radioactively labelled compound into the person's veins which binds itself to the oxygen in the blood.
- This compound travels to the brain through the blood and emits positively charged electrons (positrons), which are detected by the scanner. A computer program then converts this into images showing the structure and function of organs and tissue.
- Bright colours at the red end indicate greater activity in the brain while colours at the blue-green-violet end suggest lower activity. Thus, any kind of mental activity will result in lighting up a region of the brain.

Neuropsychological Assessment

- Neuropsychological assessment involves assessing brain functioning from how an individual performs on certain psychological tests.
- Two best known test batteries that are used for neuropsychological evaluation are the Halstead-Reitan Battery and the Luria-Nebraska Neuropsychological Battery.
- The Halstead-Reitan is used to differentiate between the brain damaged individuals and the neurologically intact and comprises of subtests such as category test, tactual performance test, rhythm test, speech-sounds perception test, time sense test, aphasia screening test, finger-oscillation test, etc. This may often be combined with the MMPI-2 to get a measure of the individual's personality and the WAIS-III to assess cognitive functioning.

- The Luria-Nebraska test assesses a wide range of cognitive functions such as memory; motor functions; rhythm; tactile, auditory and visual functions; receptive and expressive speech; writing; spelling; reading and arithmetic.

This test is extremely sensitive for identifying specific types of problems such as dyslexia and dyscalculia rather giving global impressions of brain dysfunction. Also as compared to the Halstead-Reitan battery, this test is administered faster and is more standardised.

- The Neuropsychological Assessment Battery (NAB) is another instrument that can be administered within 4 hours and includes modules on attention, language, memory, spatial functions, executive functions, etc.
- The reliability and validity of neuropsychological tests may be affected by mood states (anxiety and depression), motivation and also effects of medication.

1.9 SUMMARY :

In this unit we had defined abnormality and discussed the four important ways in which abnormality can be defined. Changes involved in characterising abnormal behaviour were also discussed. Following this we had discussed the various causes of abnormality. The concept of Diagnostic and Statistical Manual of Mental Disorders was also discussed along with various controversial issues pertaining to the DSM. The concept of psychological assessment was discussed. The important instruments of psychological assessment, i.e., clinical interview as well as mental status examination were discussed. Various types of assessment such as multicultural assessment, environmental assessment, physiological assessment were also discussed.

1.10 QUESTIONS :

- Q.1 Discuss the various ways in which abnormality can be defined.
- Q.2 Discuss the Diagnostic and Statistical Manual of Mental Disorders.
- Q.3 Write short notes on –
- a) Definition of Mental Disorder
 - b) Assumptions of DSM-IV-TR
 - c) Five Axis of DSM
- Q.4 Explain Clinical Interview and its types.
- Q.5 Write a detailed note on Mental Status Examination.

Q.6 Write short notes on the following.

- a) Behavioural Assessment
- b) Multicultural Assessment
- c) Environmental Assessment

Q.7 Discuss the different types of Physiological Assessment.

1.11 SUGGESTED READINGS :

1. Barlow David H and Durand M.V. Abnormal Psychology, (2005), New Delhi.
2. Halgin R.P. and Whitbourne S.K. (2010) Abnormal Psychology, Clinical Perspectives on Psychological Disorders, (6th Ed.), McGraw Hill.



THEORETICAL PERSPECTIVES

Unit Structure

- 2.0 Objectives
- 2.1 Introduction
- 2.2 The Purpose of Theoretical Perspectives in Abnormal Psychology
- 2.3 Psychodynamic Perspective
- 2.4 Humanistic Perspective
- 2.5 Sociocultural Perspective
- 2.6 Behavioural and Cognitively Based Perspectives
- 2.7 Biological Perspective
- 2.8 Biopsychosocial Perspective on Theories and Treatment : An Integrative Approach
- 2.9 Summary
- 2.10 Questions
- 2.11 Suggested Readings

2.0 OBJECTIVES :

After reading this topic you will be able to:

- Explain how theoretical orientation of the clinicians and researchers determines the way they perceive abnormal behaviour.
- Critically evaluate the psychodynamic, humanistic, sociocultural, behavioural and cognitively based and biological perspectives of Abnormal Psychology.
- Understand the integrative biopsychosocial approach to the theories and treatment of psychological disorders.

2.1 INTRODUCTION :

Causation of abnormal behaviour is one important areas of psychopathology. Many different theoretical perspectives have been developed to conceptualise and explain the various causes of abnormal behavior. In this unit we will discuss the most prominent

theoretical perspectives. We will begin with the purpose of theoretical perspectives and then discuss the psychodynamic perspective. Some important concepts of psychodynamic perspectives would be discussed. We will also study about post Freudian scholars and evaluate the psychodynamic perspective.

Humanistic perspective developed in 1950s out of works of Carl Rogers, Abraham Maslow and others. Person centered and self actualisation theories as well as treatment based on it would be examined. We will also evaluate the humanistic theories.

Socio-cultural factors are also taken in to consideration while understanding and assessing abnormal behaviour. Among the socio-cultural perspectives family perspective on psychopathology would be discussed. Similarly, Social discrimination and Social influences and historical events would be studied. Treatment based on socio-cultural perspective such as family therapy, group therapy, multicultural approach, milieu therapy would also be briefly discussed. Following this socio-cultural perspective will be evaluated.

Behavioral and cognitively based perspective is an important theoretical view point expressed in writings of Ivan P. Pavlov in his classical conditioning, B.F. Skinner in his operant conditioning, etc. Social learning and social cognition developed late in 1960s and grew out of behavioral perspective. It was developed by Albert Bandura. Cognitive based theory developed out of the work of Aaron Beck and Albert Ellis. Treatment approaches based on cognitive perspective include conditioning techniques, contingency management techniques, modeling and self efficacy training and cognitive therapies.

Biological perspectives include the nervous system and its role in the development of abnormal behavior. Under this we will discuss the role of genetics, models of genetic transmission and the treatments based on biological perspectives such as Psychosurgery, Electroconvulsive therapy, TMS, DBS, Medication, etc. All these, including evaluation of biological perspective, would be discussed.

Towards the end of this unit we will discuss the biopsychological perspective on theories and treatment.

2.2 THE PURPOSE OF THEORETICAL PERSPECTIVES IN ABNORMAL PSYCHOLOGY :

This chapter focuses on what causes abnormality. There are different schools of thought that vary in their beliefs and

assumptions about what leads to abnormal behaviours and how they can be treated. In this chapter we will critically evaluate five major theoretical perspectives that are influential in this field.

The theoretical orientation of the clinicians and researchers determine how they perceive abnormal behaviour. In practice, most experienced clinicians follow an eclectic approach, that is, they put together concepts and techniques from several theoretical perspectives.

2.3 PSYCHODYNAMIC PERSPECTIVE :

The psychodynamic view emphasises on the idea that behaviour is primarily influenced by unconscious factors. The term 'psychoanalytical' is used to refer to Freud's ideas while the term 'psychodynamic' covers a broader perspective that focuses on unconscious processes as well as various other factors that are thought to influence behaviour.

Freud's Psychoanalytic theory

- Freud was a neurologist from Vienna who became interested in unconscious processes while working with Jean Charcot. Freud's theory was controversial because he wrote extensively about the role of sexual instincts during a period when sex was not discussed openly.
- He was of the opinion that early childhood experiences are the most influential in determining one's personality. He believed that events that occur in childhood deeply impact the unconscious mind and these experiences continue to influence an individual in his adulthood.
- This idea was based on Freud's analysis of his own dreams, thoughts and early childhood memories. He also realised that by recollecting the memory of his traumatic train ride at the age of 4, he was relieved from some very disturbing symptoms.
- Being a medical student he was convinced that disorders of the mind could be studied scientifically and that they are caused by physiological processes.

Structure of Personality: Id, Ego and Superego

According to Freud, the psyche comprises of three structures - the id, ego and the superego and used the term *psychodynamics* to explain that our behaviour is the result of a complex interaction between these structures.

Id: The id is the most primitive part of the unconscious mind and contains sexual and aggressive instincts. It is based on the 'pleasure principle' and needs immediate satisfaction of its desires.

- An unfulfilled desire or impulse creates tension and only when it is satisfied that one experiences pleasure. The id tries to achieve pleasure from the actual gratification of needs as well as wishful thinking.
- Freud uses the term primary process thinking to indicate id's attempts to satisfy needs by forming wish-fulfilling mental images of the desired objects. In other words, primary process thinking satisfies motives in imagination rather than reality. Fantasising about your enemy, being beaten up or having your favourite desert is an instance of primary process thinking.

Ego: This part of the personality has conscious awareness and enables the individual to perceive, use judgment, memory and make decisions necessary to adapt to the environment.

- It also helps to transform the wishes and fantasies of the id into reality. It works on the 'reality principle' which makes the individual face the constraints and difficulties of the external world.
- The ego engages in secondary process thinking, a more logical and rational way of solving problems. For example, suppose a man has an argument with his wife and as a result gets delayed and misses his bus. In this case primary process thinking would probably make him curse wife whereas secondary process thinking would help him look for a solution such as finding an alternate way of reaching his destination.
- According to Freud, the ego doesn't have a motivating force and draws its energy from id's energy that is the libido. He also believed that although the ego reflects conscious awareness, one is unaware of certain aspects of the ego. This includes, memories of events in which one has been self centered or cruel or aggressive or behaved in sexually unacceptable ways.

Superego: This refers to one's conscience and is the part of the psyche that guides the ego's efforts of gratifying the impulses and desires of the id. The superego represents the do's and don'ts of the society that one has internalised. Freud was of the opinion that if it weren't for the superego, man would have tried to seek inappropriate and unacceptable forms of pleasure such as rape, murder, etc.

Defense Mechanisms: Defenses are strategies to protect oneself from unpleasant and disturbing emotions. For example, if one is feeling guilty about getting poor marks in the exam, blaming the teacher for being partial may make him feel better. Defense mechanism can be healthy if used in moderation. The problem arises when they are used rigidly and in excess, so much so that it can give rise to psychological disorders.

Adaptive Defenses: These are healthy ways of coping with stress. Some of the healthy and adaptive defenses include the following.

a.) **Humor**: Focusing on the funny / lighter aspects of a situation.

Example: Mohan joked about how he slipped and fell down during the conference.

b.) **Self-assertion**: Dealing with distress by expressing one's thoughts, feelings directly. **Example:** Asha told her husband that she was let down when he cancelled their dinner plan at the last moment.

c.) **Suppression**: A conscious attempt to avoid unpleasant or disturbing thoughts or ideas. **Example:** Sheena decided to avoid thinking about her recent break up so that she could concentrate on her studies.

d.) **Sublimation**: Channelising one's energies in socially desirable ways.

Example: Betrayed in love, Mona decided to do her PhD on the dynamics of romantic relationships.

Mental Inhibition: These are unconscious strategies to keep unwanted thoughts, feelings, memories, desires, out of conscious awareness.

a.) **Displacement**: Transferring an unpleasant emotion onto a non-threatening stimulus. **Example:** Being scolded her mom, Rita slaps her doll.

b.) **Dissociation**: Withdrawing or distancing oneself from the unpleasant memories, aspects of self or the environment. **Example:** While being shouted at by the teacher, Gopal withdrew into his fantasy world thinking about his favourite dinner being cooked at home.

c.) **Intellectualisation**: Excessive emphasis on external reality or irrelevant details to avoid expression or experience of emotion. **Example:** Sumit who is getting divorced talks excessively about the validity of marriage as a social institution.

- d.) **Reaction formation**: Changing an unacceptable feeling or desire into the opposite. **Example**: Roma who feels jealous of her younger brother showers him with lot of gifts.
- e.) **Repression**: An unconscious attempt to push disturbing thoughts or ideas out of awareness. **Example**: Jay can not recollect the traumatic death of his friend.

Minor Image-Distorting Defenses: These are tactics in which an individual derives his self-esteem by altering or misrepresenting the image of self, the body or others.

- a.) **Devaluation**: Dealing with distress by assigning negative characteristics to oneself or others. **Example**: Roshan feels that she doesn't get good marks because of low intelligence and lack of proper guidance.
- b.) **Idealisation**: Seeing others in unrealistically positive light. **Example**: Sita ignores her husband's dominance by thinking that he is a man of high self-belief.
- c.) **Omnipotence**: Dealing with stress by thinking that one is superior to others. **Example**: Prakash behaves arrogantly with others especially during exams.

Major Image-Distorting Defenses:

- a.) **Splitting**: Disintegrating the positives and negatives feelings or aspects of self and others. Seeing things as all or none. **Example**: Mr. Ramesh was Sneha's favourite uncle whom she idealised. But ever since he spoke against her, she began viewing him as mean and evil.

Disavowal Defenses: Here, the individual disclaims responsibility in an attempt to keep unpleasant thoughts, feelings, desires, and impulses out of conscious awareness.

- a.) **Denial**: Refusing to accept disturbing aspects of reality. **Example**: Reema refused to acknowledge the news of her brother's accidental death.
- b.) **Projection**: Seeing one's own unacceptable characteristics or thoughts, feelings, impulses as someone else's. **Example**: Satish is attracted to other women and accuses his wife for being interested in other men.
- c.) **Rationalisation**: Giving logical but false explanations to cover up one's real thoughts/ideas. **Example**: Rekha who's upset

because her friend didn't invite her to a party said that she wasn't interested in it in the first place.

Defenses Involving Action: These are strategies in which the individual deals with stress by acting or withdrawing.

- a.) **Acting out:** Dealing with distress with actions instead of thoughts or feelings. **Example:** Children throw temper tantrums when they are annoyed.
- b.) **Passive aggression:** Expressing anger, disappointment or opposition indirectly.

Example: Nita stops talking to her husband when she is angry about something he has done.

- c.) **Regression:** Dealing with distress by reverting to an earlier age level. **Example:** Tushar began thumb sucking after the birth of his younger sibling.

Defenses Involving Breaks with Reality: These are coping techniques that involve the use of bizarre thoughts or behaviour.

- a.) **Delusional Projection:** Delusionally seeing one's own unacceptable characteristics or thoughts, feelings, impulses as someone else's. **Example:** Kiran who's attracted to other women thinks that his wife is interested in other men and is convinced that she is having an affair with someone.
- b.) **Psychotic distortion:** Dealing with distress by delusional misrepresentation of reality. **Example:** Geeta developed the belief that she is an adopted child because her father scolded her for overspending.

Psychosexual Development: Freud's theory of personality is a developmental theory - he believed that our personality is formed as we pass through a series of stages from infancy to adulthood and that the events which occur during these stages are especially significant. He put forth the idea that every stage is characterised by a body part that is found pleasurable (erogenous zone) and how the child learns to satisfy the sexual desire associated with each stage is crucial in determining the personality.

Freud developed this theory on the basis of the reports of his own patients. He was convinced that their problems were caused by repressed sexual desires of early life. He spoke of two forms of disturbances, regression, in which a person reverts back to a previous level, and fixation, in which the person remains, stuck or fixed at a particular psychosexual stage.

- 1.) **Oral stage:** In this stage which lasts from birth to 18 months, the mouth and the lips are the primary source of pleasure for the infant. This stage is divided into the oral-passive or receptive phase in which the child gains pleasure from nursing or eating, and the oral-aggressive phase in which the child enjoys chewing, spitting and tries to bite anything that is around. In Freud's view, regression or fixation at the oral passive phase would result in an adult who depends excessively on oral gratification such as overeating, cigarette smoking, etc. Those who are regressed or fixated at the oral-aggressive phase tend to be unfriendly and critical of others.
- 2.) **Anal stage:** In this stage the toddler (18 months to 3 years) derives pleasure from holding on to and expelling feces. Fixation at this stage may result in an anal retentive personality, that is, an adult who is a control freak and obsessed about hoarding things. On the other hand, fixation at this stage may also result in an anal expulsive character, that is, an adult who is sloppy, disorganised and uncontrolled.
- 3.) **Phallic stage:** According to Freud, the child faces a significant crisis in this stage of development (3 to 5 years) in which the erogenous zone is the genitals. Here, the child develops sexual attraction towards the opposite sex parent (Freud referred to this as the Oedipus complex in boys and Electra complex in girls, based on Greek mythology).

The young boy wishes to unconsciously kill his father and sexually possess the mother. However, he fears that the father will punish him by cutting off his genitals (castration anxiety) for having sexual feelings for the mother. This crisis is resolved when the child represses his feelings for his mother and identifies with the father.

In case of the girl, she discovers that she doesn't possess a penis and comes to blame her mother for the same. She also hopes to share her father's penis and becomes sexually and emotionally attracted towards him. This crisis gets resolved when the girl identifies with the mother and incorporates her values.

Thus, in this stage the children's superego begins to develop and prepares them for dealing with unacceptable sexual urges. Freud believed that neurosis results from an inability to resolve the Oedipus/Electra complex.

- 4.) **Latency stage:** This is the phase (5 to 12 years) in which the sexual energies take a backstage. During this phase, children channelise their energies into school work and play. They interact and imitate parents and others of the same sex.

- 5.) **Genital stage:** in this stage, there is renewed interest in deriving sexual pleasure through the genitals. Masturbation begins and since parents are ruled out as sex objects through the resolution of the phallic stage, one starts looking out for opposite sex partners. Any unresolved issues from the earlier stages interfere with one's ability to successfully pass through this stage.

Post-Freudian Psychodynamic Views: The post-Freudian theorists believed in the unconscious aspects of personality but criticised Freud for overemphasising on sexual and aggressive instincts. They considered socio-cultural influences such as interpersonal and social needs to also play an important role in shaping one's personality.

- Carl Jung (1875-1961) felt that Freud took a one-sided view of the human condition. Jung believed that although the unconscious mind contained selfish and hostile forces, it also contained positive, even spiritual motives. He put forth the concept of 'archetypes', that is, certain images which are commonly held by all human beings. For example, the good or evil, self, hero, etc. Jung believed that characters like superman are popular because they evoke the hero archetype.

His original and lasting contribution is the idea of introversion extroversion. He modified Freud's view of the unconscious and said that we have a personal unconscious that consists of our unknown impulses, desires, thoughts, etc., and a collective unconscious, whose contents are the same for all humans.

He also said that healthy personality development involves harmony between the conscious and unconscious elements of the personality and imbalance between these results in psychological disorders.

- Alfred Adler (1870-1937) and Karen Horney (1885-1952) have both focused on the ego and self-concept. They put forth the idea that we all wish to see ourselves in positive light and use defenses in order to maintain this positive image.

They asserted that neurosis develops in people who see themselves as inferior and these feelings emerge in childhood. Adler believed that as children we are small and dependent on adults for protection, due to which we begin life with feelings of inferiority. Healthy personality development depends on outgrowing the inferiority of childhood and seeing ourselves as competent adults.

Karen Horney believed that conflicts don't develop as a result of inborn motives but because of inadequate child-rearing experiences. If a child feels loved and secure no conflict will develop and positive aspects of personality will dominate.

Both of them also emphasised on the role of social and interpersonal factors in shaping the personality and believed that close relationships are very satisfying in themselves and are not sought to fulfill sexual or aggressive desires.

- Erik Erikson (1902-1994) formulated a theory of human development that covers the entire life span. He described eight stages of the life cycle. At each stage individuals face some crisis that increases their vulnerability. When they successfully master a particular stage, they gain strength and move on to the next stage.

Stage	Approximate age	Positive Outcomes	Negative Outcomes
1.Trust versus mistrust	Birth – 1.5 years.	Feelings of trust from others' support.	Fear and concern regarding others.
2. Autonomy versus shame and doubt	1.5 – 3 years.	Self-sufficiency if exploration is encouraged.	Doubts about self; lack of independence.
3.Initiative versus guilt	3 – 6 years.	Discovery of ways to initiate action.	Guilt from actions and thoughts.
4.Industry versus inferiority	6 – 12 years.	Development of sense of competence.	Feelings of inferiority; little sense of mastery.
5.Identity versus identity confusion	Adolescence	Awareness of uniqueness of self; knowledge of roles.	Inability to identify appropriate roles in life.
6.Intimacy versus isolation	Early adulthood	Development of loving, sexual relationships and close friendships.	Fear of relationships with others.
7.Generativity versus stagnation	Middle adulthood	Sense of contribution to continuity of life.	Trivialisation of one's activities.
8.Ego-integrity versus despair	Late adulthood	Sense of unity in life's accomplishments.	Regret over lost opportunities.

- Object relations theorists such as Melanie Klein (1882-1960), Margaret Mahler (1897-1985), D.W.Winnicott (1896-1971) and Heinz Kohut (1913-1981) suggested that we create images or representations of ourselves and others, on the basis of our early relationships, and these are carried throughout adulthood and influence subsequent relationships. They suggested that self concept develops in 4 stages:
 - i) **Undifferentiated stage**: In this stage there is no sense of self
 - ii) **Symbiosis**: Here, the newborn doesn't distinguish between self and others but has images of good self / bad self and good others/bad others. In this stage, the child perceives things as all good or all bad.
 - iii) **Separation-individuation**: In this stage, the child begins to distinguish between self and others but the images of good me-bad me and good other-bad other are not integrated. For example, a child who is annoyed with a parent, sees only the bad image of the parent and says 'I hate you' with all his heart.
 - iv) **Integration stage**: By this stage the child understands complex representations that include both good and bad aspects of self and others. For example, the child who is annoyed with a parent now might say 'I am mad at you but I still love you.'
- Mary Salter Ainsworth (1913-1999) and others developed characterisations of infants depending on the way they relate to the caregiver. They described four attachment styles:
 - a.) Fearful, in which the child desires emotional closeness but is uncomfortable becoming close due to lack of trust or the fear of getting hurt.
 - b.) Preoccupied, in which the child wants to be emotionally close and uncomfortable without close relationships. The child is dependent and believes that others don't value him as much as he does.
 - c.) Dismissing, in which the child is self-sufficient and prefers not be emotionally close to anyone or have others depend on him.
 - d.) Secure, in which the child is comfortable depending on others and letting others depend on him. The child also doesn't worry about being left alone or rejected.

Treatment

- According to Freud, the goal of psychoanalytical treatment is to become consciously aware of the repressed material. This is achieved through techniques like free association, in which the client is encouraged to feel free and speak about anything that comes to his mind, and dream analysis, in which the client relates details of a dream and freely associates them while the psychoanalyst gives meaning to the dreams on the basis of its content and the associations.
- The essence of psychoanalysis is the systematic analysis of transference and resistance. Transference is the process in which, while interacting with the therapist, the client relives conflictual relationships shared with one's parents and transfers them onto the therapist. Often clients resist or hold back in therapy which blocks the process. Dealing with unconscious fears and conflicts is painful and as a result the client might forget (unconsciously block) important information, may not be able to freely associate, postpone appointments or discontinue therapy altogether.
- The therapist uses interpretation, a technique in which client's resistance is analysed and then he or she is helped to work through the conflictual issues by resolving them in a healthy manner as compared to what had occurred in the childhood.
- The post-Freudian therapists developed new theories of personality and methods of treatment but the reliance on Freudian concepts to explore the unconscious continued.

Evaluation of Psychodynamic Theories

- Freud is credited for developing the first extensive theory of psychology and an organised approach to therapy. Although the role of instincts and the unconscious continues to be debated on, the idea that early childhood is crucial in shaping one's personality and that the therapist plays a significant role in facilitating the process of change, are popular among clinicians irrespective of their theoretical orientation.
- There is lot of evidence in support of the idea of the importance of early life and that attachment styles are related to psychological disorders. For example, one study found that adolescents with an insecure attachment style are more likely to develop anxiety disorders as compared to those with a secure attachment style (Warren et al., 1997). Another study found that those with an insecure style, receive higher scores on depression and experience depressive symptoms - it is suggested these individuals selectively focus on the negative information and hold themselves responsible for the negative events (Shaver, Schachner, & Mkulincer, 2005; Reis & Grenyer, 2004).

One study also showed that infant attachment style can predict relationship with one's romantic partner - those with a secure attachment style comfortably relate to others and enjoy close relationships and interdependence; ambivalent or preoccupied individuals want and seek emotionally close relationships but worry that others won't value them as much; those with fearful style experience conflicts because they feel others will reject or be disloyal to them; while those with a dismissive style are self-sufficient and not very interested in close relationships.

- Freud's theory did change the conceptualisation of psychological disorders, but a major criticism in this regard is that Freudian concepts such as the unconscious material, repression, dreams, etc., cannot be empirically tested. However, the concept of unconscious does find wide acceptance in other areas of Psychology, for example, implicit memory, where the person may not remember details of an event but the performance clearly seems to be influenced by it is an instance of an unconscious process.
- Interestingly certain aspects of Freud's theory cannot be adequately tested and challenged. For example, if one refutes the idea that the defense mechanisms are used to protect oneself from anxiety aroused by unconscious sexual impulses, Freud would suggest that it is one's anxiety about coming to terms with this fact that prevents him acknowledging it.

Feminist have criticised Freud for being biased against women and emphasising on male development. Karen Horney rejected his concept of penis envy as the central factor that determines their personality. She suggested that women don't envy the penis or masculinity per se but the power and privileges they enjoy in society.

- Traditional psychoanalysis is criticised for being lengthy. However, there are newer brief forms of therapy that use transference-based interpretations and focus on the current problems of the client. Brief psychodynamic therapy (BPT), developed by McCullough and associates (2003) is based on the idea that the client's problem stems from the excessive use of dysfunctional defense mechanisms. BPT involves increasing the clients' awareness of their defenses and encouraging them to drop the defenses and experience the unpleasant emotions. The therapists then help the clients come to terms with these distressing thoughts and impulses and develop healthy ways of expressing them. Finally, the clients, especially those with personality disorders are helped to build a positive self image and rewarding relationships with others.

2.4 HUMANISTIC PERSPECTIVE :

The humanistic perspective emerged as the 'third force' in psychology to emphasise on the 'human' behind the cognitions, behaviours and feelings, which seemed to be largely ignored by psychoanalysis and behaviourism. According to this psychological view, human beings possess an innate tendency to improve and to determine their lives by the decisions they make.

Existential views have also influenced the humanistic perspective. Existentialists believe that human beings try to seek the meaning of their existence and those who appreciate each moment and live as fully as possible in each moment are mentally healthy. The important founders of humanistic psychology include Carl Rogers and Abraham Maslow.

Person-Centered Theory

- The person-centered or client-centered theory has been developed by Carl Rogers, who considered every human being as unique. He believed that individuals naturally move towards self-actualisation, that is, fulfillment of their potential for love, creativity and meaning. The term 'client-centered' suggests the idea that the focus is on the client and not on the therapist or therapeutic techniques.
- The concepts of 'self' and 'self-concept', one's subjective perception of who one is and what one is like are central to Rogers's theory. He said there is the self – the person one thinks he is and the ideal self - the person one wishes to be. For example, I am an average student (self) but I would like to get a distinction in my exams (ideal self).
- According to Rogers, a person is said to be fully functional or well-adjusted when there is a match between the real and ideal self and between one's self-image and his experiences. The term 'fully' implies that the individual is utilising his psychological resources effectively. Thus, a psychological disorder results from an inability to use one's full potential that leads to an inconsistency between how one perceives oneself and reality.
- Due to stress from parents and the society, individuals develop rigid, distorted perspectives of self and lose touch with their values and needs. Consider the case of Sohan, who believes he is unpopular when in fact most of his classmates are fond of him. This creates a mismatch between reality and Sohan's perception of it. Others may try to interact with him but his ignorance would cause him to avoid them. According to Rogers, this leads to emotional distress, unhealthy behaviours and in extreme cases, psychosis.

- Rogers viewed a fully functioning individual as steadily moving towards his own growth. He also suggested that psychological problems result in children who have critical and harsh parents. Messages such as 'you are a good boy only if you listen to me' create 'conditions of worth' which make the child insecure and anxious that he might do something that would disappoint his parents. Conditional love on part of the parents is responsible for the child's low self-esteem and the difficulties that follow.

Self-Actualisation Theory

- Abraham Maslow, best known for his hierarchy of needs suggested that the source of motivation is certain needs. He proposed five types of needs - at the base of the hierarchy are the basic biological needs for hunger, thirst, etc., followed by the safety needs, the need for belongingness, esteem needs and at the top of the hierarchy is the need for self-actualisation.
- Maslow defined self-actualisation as the inner directed drive in human beings to reach their highest potential. He described self-actualised people as those who are more concerned about the welfare of others than themselves, they usually work for some cause or task than for fame or money, they enjoy the company of their friends but are not dependent on their approval, they have an accurate view of life and are yet positive about life etc.
- Maslow was of the opinion that there are very few self-actualising individuals in this world and that many are partially actualised who get to experience self-actualisation in what he referred to as the 'peak experience' - intensely moving experiences in which one is completely immersed and feels a sense of unity with the world.
- He also said that behaviour is dominated and determined by needs that are unfulfilled. When an individual attempts to satisfy his needs he does it very systematically by beginning with the most basic needs and then gradually working up the hierarchy.
- Both Maslow and Rogers were of the view that psychological disorders are caused by a movement away from the ideal state and had similar ideas about the conditions that hinder self-actualisation.

Treatment

- Rogers firmly believed that the focus on therapy should be the client and his needs. The clinician's role is to help the client realise that he is innately good and enhance his understanding of himself.

- To deal with the difficulties caused by the conditions of worth, Rogers suggested that the therapist provides the client with what he called as the core conditions necessary for therapeutic change - positive regards, empathy and genuineness. He believed it is important for the therapist to have unconditional positive regard for the client, that is, a non-judgmental acceptance of what the client thinks, feels and says. He defined empathy as the therapist's ability to enter the client's phenomenal world - to experience the client's world as if it were your own without ever losing the 'as if' quality. The term genuineness refers to being honest and suggests that the therapist behaves in ways that are congruent with his self-concept and thus consistent across time.
- Therapists following the Rogerian approach use the techniques of reflection and clarification. Reflection involves rephrasing and mirroring back what the client has just said. For example, a client might say, "I feel terrible about having fought with mom." The therapist's reflection of this statement could be, "So you feel very bad when you have a fight with your mom." Clarification involves throwing light on or making clear a vague statement made by the client about how he feels. For example, if the client says, "I am mad at my friend for not returning my call", to which the therapist might say, "And may be slightly hurt as well."
- Rogers also said that the therapist needs to avoid making suggestions to the client as this lowers the dignity of the client and his capacity to be self-directing.
- Maslow did not put forth a model of therapy to treat psychological disorders but rather provided theoretical guidelines for the most favourable form of human development.
- In recent times, theorists have come up with techniques like motivational interviewing (MI) which involves using the core therapeutic conditions suggested by Rogers in an attempt to encourage changes from within and make the client independent.

Evaluation of Humanistic Theories

- One criticism against the humanistic theories is that its concepts cannot be scientifically tested. There has been some research on the effectiveness of this approach but the measurement was based on self-report techniques rather than objective evaluation.
- The humanistic theories are not very useful in explaining psychological disorders. Nonetheless, Maslow's principles are very popular and widely used in industry to enhance employee motivation.

2.5 SOCIOCULTURAL PERSPECTIVE :

This perspective focuses on how social and cultural agents or external factors such as other people, social institutions and events in the social context, influence the individual. The term sociocultural refers to all the circles of social influence that surround the individual that is the family, neighbourhood and society.

Family Perspective of Psychopathology

According to the family perspective, psychopathology or dysfunction in an individual reflects psychopathology or dysfunction in the family members. There are four approaches under this perspective:

- 1.) Intergenerational, given by Murray Bowen, suggests that how parents interact with their children is influenced by how they were treated as children.
- 2.) Salvador Minuchin gave the Structural approach which puts forth the idea that in normal families every individual has specific functions and the relationship boundaries are fixed and that troubles occur if family members are too close or too distant.
- 3.) In the Strategic approach, proposed by Jay Haley, the therapist influences the client with direct instructions about how to resolve issues within the family, especially power relationships.
- 4.) In the Experiential approach, Carl Whitaker suggests that the family dysfunctions are caused by obstacles in one's personal development. Virginia Satir's sculpting techniques involves making clients role-play difficulties in interaction. John Gottman found that characteristics such as contempt, criticism, defensiveness and stonewalling are related to difficulties in a marriage.

Family theorists have provided insights that help explain and treat psychological disorders. For example, Eating disorders may be found in families with disturbed relationships and starving oneself is seen as an adolescent's attempt to demonstrate one's control over one's body and life.

Social Discrimination

- Sociocultural theorists suggest that discrimination on the grounds of gender, race, religion, social class, age, sexual orientation, etc., can also cause psychological disorders.
- Due to stressors such as poverty, unemployment, lack of education, nutrition, access to health care systems, etc., many

psychological difficulties are commonly found among those from the lower socio-economic strata.

- In addition to this, the rates of crime and substance abuse are high and poor physical and mental health often results in premature death (Khaw et al., 2008). Age and gender bias can cause tremendous frustration and emotional difficulties giving rise to psychological symptoms, especially since these characteristics are fixed.

Social Influences and Historical Events

- Theodore Millon (1988), a personality psychologist suggested that changing societal values has led to a rise in psychological disorders in the West. Social instability makes children perceive the world as threatening and unpredictable and thus increase the risk of developing disorders later in life.
- The rates of mental disorders are higher in societies that go through significant social change. Reorganisation in the society, such as industrialisation, changing people's roles and relationships to the society from a worker to an unemployed person or in a situation like India-Pakistan partition, from a majority culture to a minority or multicultural society.
- Traumatic events of historical or political significance or natural disasters such as the earthquakes, floods, famines also adversely affect mental health. American psychologists, studying the effects of war have found that it negatively affects psychological functioning. Also, the possibility of developing serious anxiety disorders is greater among those who have been disturbed by terrorist attacks, harassment, imprisonment or experienced war.

Treatment

Therapists play a significant role in helping individuals cope with the stresses within the family, immediate environment or the society at large, especially since the world cannot be changed.

Family Therapy

- Family therapy focuses on helping the family members relate to each other and communicate in healthy ways. The therapist often spends time talking to every family member so as to build rapport, especially with those who seem to resist therapy.
- To improve communication, the therapist may initiate a conversation, observe the dynamics of their relationship and then guide the two members as they proceed. Sometimes these sessions are videotaped or held in rooms with one-way mirrors.

- Family therapy is different from individual psychotherapy, that is, here the therapist works on disturbed relationship patterns in the family as a whole rather than the individual issues of family members.
- Also, family therapists believe that harmonious relationships among family members are more beneficial to treatment than the client-therapist relationship.
- Various techniques are used by family therapists, for example, an intergenerational therapist may use a genogram, which is a diagrammatic representation of all relatives in the recent past. This information gives the therapist an idea of the nature of relationships shared by the family members, which is then used to bring about desirable changes.

Strategic family therapists work on finding solutions to issues within the family by making the members role-play conflicting views; while an experiential family therapist focuses on helping the family members develop a better understanding of their relationships.

Group Therapy

- In this method people having similar problems share their experiences with each other. Irvin Yalom (1995) suggested that this technique is effective for various reasons - it relieves the individuals and gives them hope as they realise that their problems are not exceptional; they receive useful information and suggestions from others who share how they dealt with their issues and the feeling of being of help to someone makes them feel better about themselves.
- The evidence for the effectiveness of group therapy comes from Alcoholics Anonymous, in which individuals with alcohol-related problems and their families share their stories and the techniques they successfully used to stay away from it.
- Group therapy also helps individuals with pedophilias, who have sexually abused children, to drop their defenses by providing a very supportive environment to share their concerns (Berlin, 1998).
- Studies have shown that group therapy is effective for individuals with depression, especially when combined with individual therapy or medication (Kasters et al., 2006).

Multicultural Approach

- The therapists need to be sensitive to the cultural background of the clients. When dealing with clients from different backgrounds, treatment should incorporate three components: awareness, knowledge and skills.

- Awareness refers to the idea that the therapist needs to be familiar with how the cultural context influences the client's experience or the way he relates to others.
- Knowledge relates to taking the responsibility of finding out about the client's cultural background and its effect on assessment, diagnosis and treatment.
- Skills refer to expertise in the specific therapy techniques that would work with the clients of a particular culture.

Milieu Therapy

- The term milieu implies the surrounding or the environment. This form of therapy involves scientific structuring of the environment by the staff - therapist, nurse or the paramedical professional, and clients as a team, to enhance the client's functioning.
- It focuses on improving social interaction, the physical structure of the setting and scheduling activities such as group therapy session, occupational therapy, physiotherapy, etc.
- The goal of milieu therapy is to provide a supportive environment that encourages socially desirable behaviour and to keep as many links as possible to the client's life, beyond the family.

Evaluation of Sociocultural Perspective

- Clinicians acknowledge the role of the environment in causing or maintaining psychological symptoms, with the understanding that not much can be changed in the surrounding. For example, discrimination has adverse effects on one's mental health but putting a stop to it is difficult. Similarly, the client's family may have a clear role in his psychological problems but the family members may be uncooperative or unavailable.
- Though group therapy can be very effective, several clients are shy or ashamed of sharing their concerns in front of others who are seen as strangers. These issues can be dealt with in individual therapy by focusing on how the cultural background of the client influences the way he relates to others.
- In certain cases biological theories provide better explanations of disorders than the sociocultural ones. For example, Schizophrenia cannot be accounted for by dysfunctional family patterns. However, disturbed communication within the family is known to increase the severity of Schizophrenia or cause relapse.

- Thus, though the sociocultural perspective throws light on the psychological disorders, they are better explained when the biological and psychological perspectives are combined with it.

2.6 BEHAVIOURAL AND COGNITIVELY BASED PERSPECTIVES :

According to the behavioural and cognitively based perspectives, abnormality results from faulty ways of thinking which are learned, and lead to maladaptive behaviours.

Classical Conditioning

Classical conditioning is a type of learning which was studied experimentally by Ivan Pavlov. It refers to the formation of an association between a conditioned stimulus and response through repeated presentation of the conditioned stimulus with the unconditioned stimulus that originally produced the response.

For example: Sharda feels sad every time she sees the sari gifted by her husband, who passed away recently. Here, sari is initially a neutral stimulus because it doesn't evoke any response by itself. But after becoming associated with her husband (a naturally evoking stimulus) seeing the sari (now, a conditioned stimulus) evokes the emotion of sadness (conditioned response) .

Some crucial elements in classical conditioning:

- The stimulus which naturally evokes a reflex-like response is called the unconditioned stimulus.
- The reflex-like response produced by the unconditioned stimulus is called the unconditioned response.
- The stimulus which is neutral in the beginning and begins evoking a response after being paired with unconditioned stimulus is called the conditioned stimulus.
- The response produced by the conditioned stimulus after pairing it with the unconditioned stimulus is called the conditioned response.
- In stimulus generalisation, an individual responds in the same way to different stimuli that have common properties.
- In stimulus discrimination, an organism learns to differentiate among different stimuli and restricts its responding to one stimulus rather than the other.

- The gradual reduction in the frequency of the conditioned response and its eventual disappearance is called extinction.
- Spontaneous recovery refers to the reappearance of a previously extinguished response after sometime has gone without exposure to the conditioned stimulus.

John Watson (1878-1958) demonstrated how conditioned fear developed through an experiment conducted on an 11 month old infant 'Little Albert'. In the experiment, Albert was playing with white rats when Watson with his associate exposed him to a loud noise. Following this incident Albert developed a fear for rats. This process is called aversive conditioning in which an aversive/painful stimulus (noise) becomes associated with a neutral stimulus (rats). Through stimulus generalisation, Albert began fearing other white objects too. Although experiments of this sort are not conducted anymore due to ethical restrictions, Watson's work helped explain the development of phobias (irrational fears).

Counterconditioning, a process of eliminating the classically conditioned response by pairing the conditioned stimulus with an unconditioned stimulus to elicit a response that is stronger than the conditioned response and that cannot occur at the same time as the conditioned response, is used to treat phobias.

Operant Conditioning

- Operant or Instrumental conditioning is a type of learning in which a voluntary response is strengthened or weakened depending on its positive or negative consequences. Skinner, the father of operant conditioning, was influenced by Thorndike's law of effect which states that responses that satisfy some motive are repeated.
- Operant conditioning is based on the concept of reinforcement, a process by which a stimulus increases the probability that an earlier behaviour will be repeated. Reinforcers are of several kinds: a primary reinforcer satisfies some biological need and work naturally without any prior experience. For example, food and water are primary reinforcers.
- A secondary reinforcer is a stimulus that becomes reinforcing because of its association with a primary reinforcer. Money is a secondary reinforcer because it helps obtain primary reinforcers. Attention, recognition and praise are secondary reinforcers and often play a role in the maintenance of psychological symptoms. For example, the aches and pains reported individuals with somatoform disorders are often reinforced due to the attention they get from family members.

- Reinforcement can be positive or negative. In positive reinforcement, behaviour is repeating because of the reward that follows. In negative reinforcement, the behaviour is repeated because it removes something unpleasant from the environment.
- Negative reinforcement is often confused with punishment. In negative reinforcement the frequency of the behaviour increases whereas punishment involves an unpleasant or painful stimulus that decreases the probability that an earlier behaviour will be repeated.
- For example, a mischievous child may be told that he won't be allowed to go out to play in the evening if he misbehaves. This is an instance of negative reinforcement because withdrawing the pleasant stimulus (play) would encourage the child to behave (increase in frequency). On the other hand, beating the child for misbehaving is an instance of punishment because that is expected to reduce his disobedience (decrease in frequency).
- Shaping is a technique based on the principles of reinforcement in which every step towards the desired goal is reinforced. For example, while teaching a child to write alphabets, they are first encouraged to draw a standing line, a sleeping line, then a slanting line and then finally an A.

This is a very commonly used behavioural technique. For example, a shy person who has difficulty communicating may be encouraged to look at others and smile, then the next step would involve greeting them, still later speaking one line, then holding a conversation for two minutes and so on.

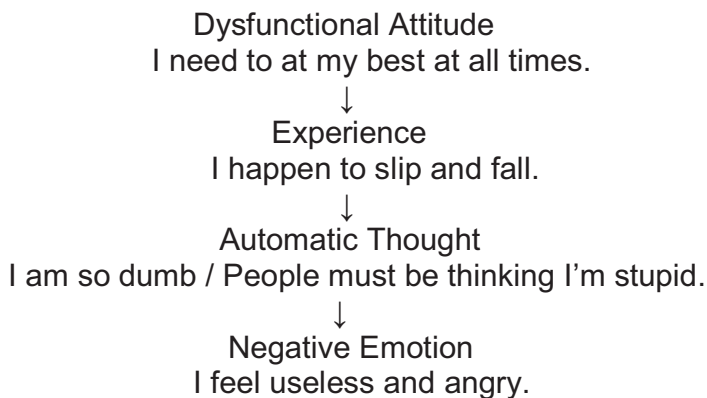
Social Learning and Social Cognition

- The social learning view is given by Albert Bandura who argued that people also learn by observing the behaviour of other people. Modeling is the process in which people acquire new behaviours by imitating the behaviour of important people in their lives.
- Social learning theorists study the influence of modeling and one's relationships with others on the development of psychological disorders. They are also interested in social cognition, that is, the manner in which we interpret, analyse, remember and use information about the social world.
- Bandura said that observational learning (vicarious reinforcement) takes place when a person observes the rewards and punishments that another person receives for his behaviours and behaves accordingly.

- He also put forth the concept of self-efficacy, that is, the belief that one can successfully execute behaviours necessary to control desired outcome ('I think I can'). Self-efficacy is found to be related to motivation, self-esteem, interpersonal relationships, health behaviours, addictions, etc. (Bandura et al., 2004).

Cognitively Based Theory

- The cognitively based theories believe that cognitions, that is, thoughts or beliefs, shape behaviours. Aaron Beck and Albert Ellis are two well-known cognitive theorists who have contributed to the understanding of several psychological disorders, especially depression.
- Beck spoke about automatic thoughts - ideas that are so deep-rooted that the individual is often not aware of them, which come to mind spontaneously and cannot be neglected. For example, if one slips and fall one might think "how stupid am I," "others must be thinking I am so dumb," etc. These automatic thoughts are usually of a self-defeating nature and are followed by the experience of negative emotions.
- Automatic thoughts arise from faulty attitudes. These attitudes make a person interpret situations in a biased manner as shown below:



- Albert Ellis gave the A-B-C model which suggests that how one feels is determined by the way one thinks about the events in his life. A refers to the 'activating event', B to the 'beliefs' and C is the 'consequences'. According to him, irrational beliefs, that is, unrealistic and exaggerated views about self and the world are the cause of several psychological disorders. Conforming rigidly to these irrational beliefs using 'should/must/ought' makes one feel miserable and results in emotional disturbances.
- David Barlow gave a model that explains the impact of a combination of physiological, cognitive and behavioural factors

on the development of anxiety disorders. For example, a panic attack may be triggered when a person who hyperventilates (physiological factor) after climbing up stairs, misinterprets (cognitive factor) the physiological signs as an indication of an impending heart attack and forms associations between some stimuli and the experience of panic, consequently avoiding that situation (behavioural factor).

Treatment

The behavioural and cognitively based approach asserts that abnormality results from faulty thought processes which are learned and can be unlearned.

Conditioning Techniques

- Using principles of classical conditioning and operant conditioning such as positive and negative reinforcement, counterconditioning, aversive conditioning, extinction, etc behaviour therapists help client change faulty behavioural patterns and substitute them with healthy behaviours.
- Joseph Wolpe used counterconditioning to treat phobias or irrational fears. For example, he taught cats who were classically conditioned to experience anxiety in a room in which they were administered shocks, to associate the room with eating, which reduced their anxiety.
- Counterconditioning is effective when the new stimulus used is able to evoke a response that is stronger and cannot exist at the same time as the conditioned response. For example, to help little Albert get rid of his fear of white rats, one needs to pair white rats with a stimulus such as chocolates or his favourite toy. Fear (evoked by the rats) and joy (evoked by the chocolate/toy) being contradictory states cannot co-exist and repeated pairing of this nature would gradually help to reduce his fear.
- Another form of counterconditioning is systematic desensitisation in which the therapist attempts to reduce the client's anxiety by combining relaxation techniques and progressive or graded exposure to the phobic stimulus. For example, to treat a client with dog phobia, the therapist may gradually expose him to the concept of dog in a hierarchical order. The first step would involve helping the client enter a relaxed state following which the therapist would speak about the feared stimulus (the dog), the next step would involve watching pictures of a dog, next watching a live dog outside from the window and so on till the client is comfortable with the idea of being close to a dog without anxiety.

- Also often used is the technique of flooding, which is the opposite of systematic desensitisation and involves intensely exposing the client to the feared object. For example, instead of gradually desensitising a person who has bat phobia he may be exposed to a bunch of bats in entirety.
- Wolpe developed one more form of counterconditioning - assertiveness training, which involves expressing oneself and satisfying one's own needs and feeling good about it without hurting others in the process. In this technique, the aim is to learn to communicate the desired emotion (anger) effectively so that the opposing emotion (anxiety) gets weakened. As a result the client is able to express one's needs and deal with the challenging situation effectively.

Contingency Management Techniques

- These set of techniques are based on the idea that any behaviour that is followed by a positive consequence (reward) is repeated and undesirable behaviours can be unlearned by taking away the rewards. Accordingly, contingency management involves helping a client connect the outcome of the behaviour with the behaviour itself. This technique is effective in reducing disruptive behaviours such as temper tantrums, in disciplining children, developing good habits, reducing smoking, weight management, etc.
- Token economy is a form of contingency management in which clients earn tokens or points showing desirable behaviour which can be later exchanged for some concrete reward. For example: In 1970s, at a mental health centre in Illinois, researchers designed an environment for Schizophrenia inpatients that encouraged appropriate socialisation, participation in group activities, self-care such as bed-making, and discouraging violent behaviours. They then set up a token economy in which patient could earn small luxuries such as buy cigarettes with the tokens earned for keeping the room clean or be fined (lose tokens) for behaving inappropriately. This technique can also be used to manage behavioural disorders in children.

Modeling and Self-Efficacy Training

- Bandura believed in observational learning (vicarious reinforcement) and used this understanding in treating phobias by showing clients video-tapes or real-life model. For example, a boy who has developed the fear of white rats may be shown a video in which a boy is enjoying playing with a rat. This helps the boys to understand that rats need not be dangerous and dealing with them can be fun.

- Another form of this technique is participant modeling, in which the therapist first demonstrates the desired behaviour to the client and then helps him do the same. For instance, in the earlier example, the therapist might first play with the rat and then support the client in doing so.
- Bandura is also credited for his theory of self-efficacy. According to this theory, people's beliefs about their capacities are better predictors of their accomplishments than their actual skills. He said that fears develop because the person believes that he doesn't have the resources needed to deal with the phobic stimulus and thus by improving self-efficacy, the fear can be eliminated. Bandura describes four ways of improving self-efficacy:
 - 1.) **Performance attainment:** The best way to enhance self-efficacy is to successfully carry out the desired task.
 - 2.) **Vicarious experience:** By observing someone similar overcome a problem, one is likely to believe or have greater confidence that one can also overcome a similar problem.
 - 3.) **Verbal persuasion:** Encouragement by saying 'you can do it' can increase confidence and reassure a person of his capabilities.
 - 4.) **Physiological state:** one is not likely to feel confident about doing well when one is sweating excessively. By learning to relax and consciously changing the physiological arousal one can reduce stress and improve self-efficacy.

Thus, self-efficacy training can be useful in overcoming problems such as smoking, obesity, undesirable health habits, etc.

Cognitive Therapies

- According to the cognitive and cognitive-behavioural therapies, the way we think determines the way we feel. Based on this principle is the technique of cognitive restructuring in which the therapist helps the client change the way he thinks about himself, others and the future. The therapist does this by encouraging the client to identify maladaptive attitudes and irrational beliefs, challenge them and replace them with ideas that can be checked in real life.
- Panic control therapy (PCT) is a form of cognitive-behavioural therapy that is used to treat panic disorder which is a type of anxiety disorder in which the person experiences recurrent and unexpected panic attacks. PCT combines cognitive

restructuring, exposing the client to the bodily sensations associated with panic attacks and breathing retraining. Here, the client is taught to identify how faulty cognitive judgments are contributing to the experience of anxiety, examine their reactions and change them with appropriate breathing techniques and recognise places, persons and behaviours that make them feel safe.

- Acceptance and Commitment Therapy (ACT) is also a cognitively based form of therapy in which the client is encouraged to acknowledge and accept all the distressing thoughts, feelings and behaviours and thereby gain a sense of control that helps them in their commitment to overcome them.

Evaluation of Behavioural and Cognitively Based Perspective

- The cognitive - behavioural perspective is credited for its simple approach that emphasises on the use of objective/empirical procedures.
- According to the humanists, the behavioural perspective limits the scope of Psychology because it doesn't take into account the active choices that individuals make (free will) in dealing with the environment.
- The Psychoanalysts have criticised the behaviourists for ignoring the fascinating unconscious influences on behaviour.
- However, the cognitive theories acknowledge that thought processes need to be studied and that implicit ideas about the self do influence behaviours.
- Behavioural and cognitive theories have a wide application and are useful in explaining and treating a variety of disorders including anxiety disorders, mood disorders, eating disorders, sexual dysfunctions, etc.

2.7 BIOLOGICAL PERSPECTIVE :

The biological perspective focuses on how certain abnormalities in the activities of the brain and the nervous system affect behavioural, cognitive and emotional functioning.

The Nervous System and Behaviour

The nervous system is a complex structure that regulates our thoughts, behaviours and emotions. The central nervous system's function is to transmit messages from different parts of the body to the higher decision making centre and then send their messages back to body. These messages are relayed by the neurons, which are specialised cells for receiving, moving and processing information.

Neurons, Synapses and Neurotransmitters:

- There are over 100 billion neurons in the human body which carry messages between the brain and the body. These neurons form an interconnected pathway and pass the messages through neural transmission and synaptic transmission.
- In neural transmission the information within the neuron moves in the form of an electrochemical impulse and is called an action potential, while synaptic transmission is the process by which information is transmitted from one neuron to another neuron.
- Neurons are arranged in the form of chains but they do not touch each other. The space between the axon of one neuron and the dendrite of another is a gap called the synapse.
- When the neuron is stimulated, the resting potential changes and activates an action potential which travels along the axon to its tip, that is, the synaptic knobs which have tiny vessels called synaptic vesicles that contain neurotransmitters.
- Neurotransmitters are chemical substances which carry information across the synapse and can have two effects on the receiving neuron - inhibitory (turn off) or excitatory (turn on).
- If the effect is excitatory in nature then there is a change in the resting potential of the receiving neuron and the process of neural transmission occurs in this neuron. On the other hand, if the effect of the neurotransmitter is inhibitory, no action potential is generated in the receiving neuron and the message is not transmitted.
- For some neurotransmitters there is a reuptake – the neurotransmitters are reabsorbed by the synaptic terminals from which they were released. Reuptake prevents the action of the neurotransmitter and the further production of the chemical.
- Whether a neuron will generate an action potential and pass the message to other neurons in its pathway depends on the balance between the excitatory and inhibitory synapses. Thus, the neuron integrates all the signals it receives and responds to the stronger signal.
- Scientists have found several types of neurotransmitters which operate in the brain and carry out different functions. Synaptic transmission in the brain can be altered through the use of drugs that increase or decrease the effectiveness of the neurotransmitter.
- Acetylcholine (ACh) usually has an excitatory effect, is present mainly in the hippocampus and plays an important role in the formation of new memories. Less amount of ACh caused by the

degeneration of the neurons that produce it is associated with Alzheimer's disease.

- Gamma-aminobutyric acid (GABA) is a major inhibitory neurotransmitter. Antianxiety drugs work by activating the action of GABA, which slows down the nervous system.
- Serotonin plays a crucial role in the regulation of mood, appetite and sleep. Low levels of serotonin are associated with depression. Antidepressants work by inhibiting the reuptake of serotonin that increases the amount of serotonin in the brain.
- Norepinephrine is an excitatory neurotransmitter and influences mood states. Drugs like cocaine/amphetamines have their psychological effects by prolonging the action of norepinephrine and slowing its reuptake. Its insufficiency causes depression.
- Dopamine when released in the brain produces intense feelings of pleasure. An excess of dopamine is thought to cause Schizophrenia while its deficit leads to Parkinson's disease.

Genetic Influences on Behaviour

Genetics or heredity is what one gets from one's parents.

Basic concepts in Genetics

- The basic unit of genetics is the genome which is the complete set of instructions for the development of every cell in the body. The human genome is present in the nucleus of the trillions of cells in one's body and consists of long molecules of deoxyribonucleic acid (DNA). Phenotype refers to the expression of the genes as a result of their interaction with the environment.
- Strands of the DNA have the information needed by the cells to produce the protein which is the primary component of all organisms. An important function of the DNA is to replicate itself before cell division begins so that every new cell has a copy of the instructions required for manufacturing the protein.
- There are 32000 thousand genes in the human body, which are functional units of the DNA and carry the precise instructions for manufacturing a specific protein. Genes are microscopic bags of chemicals found on the chromosomes.
- Human beings have 23 pairs of chromosomes, one in each set from each of the parents. Of the 23 single chromosomes in each cell, 22 are called autosomes and carry non-sex-related information. The 23rd one is the X or Y sex chromosome. In normal females the combination of chromosomes is XX while it is XY in normal males.

- The arrangement of genes on the chromosomes has no logical reason - a gene that determines the eye colour may be next to the gene that influences the height.
- Genes go through mutations, that is, alterations or changes caused from incorrect copying of instructions during cell replication and this may be inherited or acquired. Inherited mutations are caused due to mutations in the DNA of the reproductive cells (sperm and ovum) - when these mutated cells get passed to the child, the mutations would be found in all the cells in the child's body. Acquired mutations are changes in the DNA that occur throughout one's life due to sunlight or carcinogens. Inherited mutations play a role in diseases such as cystic fibrosis and sickle anemia and may predispose a person to cancer, mental illnesses, etc. However, our cells have the ability to repair many of these mutations. If the cells fail to do so, the mutations are passed to the future copies of the affected cell.

Models of Genetic Transmission

- The chromosomes operate in pairs and each set has the same genes on it but in different combinations called alleles. Alleles refer to whether the combination of genes is dominant or recessive. The hair colour, texture, eye colour, etc., are decided by the combination of alleles inherited by the individual. A dominant allele always shows its effect irrespective of what the other allele in the pair is whereas a recessive allele expresses its effect only if it paired with another allele of its own kind.

Genetic disorders have a dominant-recessive pattern of transmission. In dominant pattern of disease inheritance, if the person has a normal allele and a disease allele, he is likely to develop the disease because the disease allele is dominant. Since, this person carries a normal and a disease allele, his/her child has a 50 percent chance of inheriting the disease allele and thus a 50 percent chance of having the disease.

In recessive pattern of disease inheritance where both parents carry one normal allele (N) and one disease allele (D), neither of them have the disease but both are carriers of it. The combination of alleles that they are likely to pass on to their children are NN, ND, DN or DD. Thus, each of their children has $1/4^{\text{th}}$ chances of being normal (NN), $1/4^{\text{th}}$ chances of developed the disease (DD) and $2/4^{\text{th}}$ chances of being carriers of the disease (ND, DN).

- Disease inheritance sometimes is much complex and cannot be explained through the dominant-recessive pattern of

transmission. In such cases the pattern is likely to be polygenic, that is, multiple genes may play a role in the expression of a characteristic. Diabetes, coronary heart disease, epilepsy, etc., are a result of such polygenic processes.

It is suggested that genetic factors are involved in the manifestation of several traits such as subjective wellbeing, political views, job satisfaction, religiosity etc. (Plomin & Caspi, 1999).

Genes, Environment and Psychological Disorders

- Researchers believe that an important aspect of genetic transmission is that what is inherited is only the predisposition and not the inevitability of the disorder. It is the mutual influences of nature (biology) and the nurture (environment) on each other that determine most psychological disorders.

For instance, the trait of extraversion is thought to be partially inherited (Loehlin, McCrae, Costa & John, 1998).

A child born with extraversion genes may generate positive reactions in people in her environment, which further strengthen this personality trait. It is also suggested that people tend to select environments that are consistent with their inherited interests and capabilities and these environments in turn facilitate the expression of these characteristics.

- The diathesis-stress model suggests that a person must carry some risk to the disorder in order to develop it. This vulnerability can be biological - inheriting disordered genes, it may be psychological - a faulty personality trait, or social - a history of abuse or poor interpersonal relations. In addition to this, for the disorder to develop, one must experience some kind of stress or trigger. This stress could be biological - an accident or illness that changes the neurotransmitter balance, psychological - perceived loss of control, or social - a traumatic event. The full-blown disorder can develop only when the vulnerability combines with the stress.

A large study which demonstrates the diathesis-stress model involved biological parents with and without psychiatric disorders and their children. They were interviewed and ratings were obtained to determine the child's chances of developing psychiatric disorders (Johnson et al., 2001). A significant factor here was the presence of maladaptive parental behaviour. It was found that children who developed psychiatric disorders tended to come from homes with maladaptive parental behaviours, irrespective of whether their parents had psychiatric disorders or not. Similarly, children of parents who had psychiatric disorders were found to develop the disorders only

when there was a history of disturbed parental behaviour. Thus, the diathesis of parental psychiatric disorders produced a full blown illness only when combined with the stress of living with parents having maladaptive behaviours.

Thus, a genome may not always express itself in the phenotype. A phenomenon called incomplete penetrance occurs when the genotype that predisposes a person to a disorder doesn't get manifested.

- According to the multifactorial polygenic threshold several genes of varying influence are involved in the transmission of a disorder or characteristic. The specific combination of inherited genes decides whether the vulnerability or risk is high, low or moderate. The symptoms of the disorder are thought to develop when the combined effect of genetic and environmental factors exceeds a certain threshold (Moldin & Gottesman, 1997). This model is more popular than the single-gene explanations of genetic transmission.

Treatment

Biological therapies work on reducing symptoms of a disorder by focusing on the physiological abnormalities.

Psychosurgery: This is a surgical intervention on the brain and typically involves cutting off the frontal lobe from the rest of the brain. This technique was developed by Egas Moniz to treat people with severe psychosis in 1935 and won the Nobel Prize in 1949 for the same. The negative side-effects of this technique included loss of motivation and emotional dullness. Psychosurgery is not used anymore but yet recommended by some to manage some forms of obsessive compulsive disorder (Woerdeman et al., 2006).

Electroconvulsive Therapy (ECT): The ECT was developed by Ugo Cerletti in 1937 as a treatment for psychosis based on his observation that dogs that underwent convulsions induced through electric shocks appeared much calmer later. Although the technique didn't work to reduce psychotic symptoms it did help reduce severe depression.

The procedure for ECT involves giving the patients anesthesia so that they aren't conscious and muscle relaxants so that their muscle don't jerk violently. Metal electrodes are then taped to the head and a current of 70-130 volts is passed through one or both sides of the brain for about half a second. As a result the patient goes into a convulsion which lasts for about a minute.

ECTs are often given to depressive patients who haven't responded to medication. However, how the technique helps relieve depression is not clearly known.

ECTs are controversial for several reasons. First, there were reports about it being inappropriately used to punish patients who seemed out of control. Second, ECT can result in memory loss and difficulties in learning new material. Third, though it is very effective in relieving depression, the relapse rate is 85 percent. And finally, the idea of passing electric current through a person's body is very frightening and seems like a very primitive form of treatment.

Transcranial Magnetic Stimulation (TMS): This method involves placing an electromagnet on the scalp and passing electric current through the cortex to increase or decrease the excitability of neurons in a given region. The effect is not restricted only to the cortex but spreads to the subcortical areas of the brain. It is suggested that TMS is likely to replace ECT as a treatment for depression (Couturier, 2005) and is quite effective when given in combination with medication (Rumi et al., 2005).

Deep Brain Stimulation (DBS): In DBS an electrical conductor is planted in the brain, which provides continuous low electrical stimulation to a small area of the brain. The procedure involves inserting a thin insulated wire in the brain and connecting it through an extension of the insulated wire passed under the skin of the head, neck and shoulder to a neurostimulator (battery) which is placed under the skin near the collar bone. The DBS was developed with the aim of increasing activity in certain brain regions, for instance, the basal ganglia which is less active in patients with Parkinson's disease. The technique is also being considered for treating obsessive compulsive disorder and depression.

Medication: This is the most commonly used form of biological treatment. Medications work by altering the activity and amount of neurotransmitters.

- Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine and setraline, block the reuptake of serotonin thus increasing the amount of this neurotransmitter in the synapse. SSRIs are effective in treating several disorders such as depression, obsessive compulsive disorder, eating disorders, borderline personality disorder, etc.
- Tricyclic Antidepressants such as clomipramine and desipramine, work by blocking the reuptake of norepinephrine and serotonin and are used in treating depression and obsessive compulsive disorder.

- Benzodiazepines like clonazepam and diazepam are antianxiety drugs which increase the activity of GABA and thus inhibit the brain regions that produce anxiety and panic.
- Atypical Antipsychotics such as clozapine and olanzapine block the serotonin and dopamine receptors in the limbic system and are effective in treating Schizophrenia and Alzheimer's disease.
- Mood stabilisers such as lithium and valproate work by decreasing levels of catecholamines and increasing release of GABA to manage Mania and Bipolar disorder.
- Neuroleptics like chlorpromazine and haloperidol are antipsychotic medicines that block the dopamine receptors and are effective in treating Schizophrenia and Alzheimer's disease.

Biofeedback: Biofeedback involves the use of instrumentation to monitor psychophysiological processes, combined with behavioural principles to bring these functions under voluntary control. The technique is based on the idea that autonomic functions such as heart rate, blood pressure, galvanic skin response, etc., can be voluntarily altered through the use of reinforcement. It is suggested that some physiological symptoms are caused due to misinterpretation of bodily cues (Miller & Dworkin, 1977). In biofeedback, patients are taught to identify their bodily sensations through sophisticated instruments and then are encouraged to change these functions by providing a reward. For instance, one may learn to recognise muscle tension followed by techniques to relax them. When the person is able to reduce muscle tension through relaxation then some lights or music is put on which acts as reinforcement. This is often combined with shaping in such a way that the initial goals are within the person's reach and then are gradually made difficult.

Evaluation of the Biological Perspective

- It is important to understand the biological basis of behaviour as all psychological problems are manifested in the body. Also there is a reciprocal relationship between biological and psychological factors explained as the concept of feedback loop in the earlier chapter. For instance, exam anxiety raises the heart beat, sweating, etc. and these bodily sensations interfere with the ability to concentrate. The thought that one is not able to focus makes one even more anxious which further leads to physical changes.
- In the development of some psychological disorders such as Schizophrenia and Depression, biological factors like genetic involvement play a crucial role and accordingly biological therapy, that is, medication becomes the primary treatment.

- Researchers have also found that the experience of traumatic events or chronic stress affects the brain's structure and functions. It is suggested that with each traumatic incident the neurotransmitter systems become more easily dysregulated - the first episode may take a strong stressor to cause the dysregulation but later mild stressors can also initiate the dysregulation.
- Finally, the biological perspective helps understand genetic contributions to psychological disorders and traits, and the patterns of genetic transmission. The advancements in genetic technology provide improved solutions for genetically based disorders.

2.8 BIOPSYCHOSOCIAL PERSPECTIVE ON THEORIES AND TREATMENT: AN INTEGRATIVE APPROACH :

There are five major schools of thought discussed in this chapter. In actual practice, most clinicians prefer an eclectic approach that integrates concepts and multiple perspectives.

There are three ways in which clinicians combine the different therapeutic models (Goldfried & Norcross, 1995): technical eclecticism, theoretical integration and the common factors approach. Those who follow technical eclecticism acknowledge that particular techniques across theoretical perspectives are effective in treating a particular problem, irrespective of their own theoretical orientation. For example, a psychoanalyst may value the use of graded exposure in treating a patient with phobia.

Theoretical integration comprises of developing one's own theory about the patient's presenting problem by incorporating principles from different theoretical models. For instance, a therapist may believe that maladaptive family system and faulty cognitions have contributed to the client's condition and accordingly develop an intervention plan by combining these two approaches.

The common factors approach involves using the core principles shared by the different theoretical models and those which have been proven to effective in clinical practice such as the counselor-client relationship (O'Leary & Murphy, 2006). Some clinicians follow a mixed model of integration which combines aspects of all the three integrative approaches.

In understanding the psychological disorders in the following chapters it is important to take into account the various biological, psychological and social factors that may contribute to its development and treatment.

2.9 SUMMARY :

In this unit we have discussed the various theoretical perspectives. The first perspective was the psychodynamic perspective developed by Sigmund Freud. We discussed the structure of personality and the concept of defense mechanism. We also discussed the psychosexual stages of development. Post Freudian Psychodynamic writers were also discussed. Psychodynamic theory was evaluated. The next perspective that we discussed was the Humanistic perspective. The person-centered theory as well as self-actualisation theory was discussed.

Sociocultural perspective was the next perspective which we discussed. We discussed the family perspective of psychopathology, social discrimination and related concepts. Family therapy, group theory, milieu therapy was also discussed.

Behavioural and cognitive based perspective is one of the most dominant current perspectives. The behavioural perspective includes classical conditioning, operant conditioning as well as social learning. Cognitive based theories as well as treatment based on cognitive and behavioural approaches were also discussed. These treatment approaches include conditioning techniques, contingency management techniques, modeling and self-efficacy training, etc.

Following this we had discussed the biological perspective and concepts related to it such as neurons, synapse, neurotransmitters, basic concepts of genetics, models of genetic transmission, etc. Treatment based on biological perspectives were also discussed.

Towards the end of the unit we had discussed the concept of biopsychosocial perspective.

2.10 QUESTIONS :

- Q.1 Discuss the concepts of Id, Ego and Superego as given by Sigmund Freud.
- Q.2 Discuss the various Adaptive Defenses.
- Q.3 Explain the psychosexual stages of development as outlined by Sigmund Freud.
- Q.4 Write notes on the following
 - a) Person centered theory
 - b) Self actualisation theory

- Q.5 Discuss the sociocultural perspective in detail.
- Q.6 Discuss the behavioural and cognitive perspective.
- Q.7 Write short notes on the following.
- a) Conditioning Techniques
 - b) Contingency Management Techniques
- Q.8 Discuss the biological treatment approaches.

2.11 SUGGESTED READINGS :

1. Halgin R. P. and Whitbourne S.K. (2010) Abnormal Psychology : Clinical Perspectives on Psychological Disorders, (6th Ed.), McGraw Hill.
2. Nolen – Hoeksema S. (2008) Abnormal Psychology (4th Ed.), New York McGraw Hill.



ANXIETY DISORDERS

Unit Structure

- 3.0 Objectives
- 3.1 Introduction
- 3.2 Anxiety Disorders
- 3.3 Panic Disorder and Phobias
- 3.4 Generalised Anxiety Disorder
- 3.5 Obsessive Compulsive Disorder
- 3.6 Post Traumatic Stress Disorder
- 3.7 The Bio psychosocial Perspective of Anxiety Disorder
- 3.8 Summary
- 3.9 Glossary
- 3.10 Questions
- 3.11 Suggested Reading

3.0 OBJECTIVES :

After reading this unit you will get to know

- About the nature of anxiety disorders.
- About the causes and treatments of panic disorder and phobias.
- About symptoms, causes and treatments of GAD and OCD.
- What is the bio-psychosocial perspective of anxiety disorders.

3.1 INTRODUCTION :

Anxiety is a complex and mysterious type of disorder in psychopathology. It is a subjective sense of unease, a set of behaviours or a physiological response originating in the brain. It is a mood state characterised by marked negative affect and somatic symptoms. A panic attack represents the alarm response of real fear but without any actual danger. Panic and anxiety combine to create different anxiety disorders. There is no simple one dimensional cause of excessive emotional reactions such as anxiety or panic. Causes come from different sources. There is

strong evidence that a tendency to the tensed is inherited. Behaviorists view anxiety as a product of early classical conditioning. Different anxiety disorders such as GAD, OCD, PTSD, Phobias, etc., can be treated by different approaches such as biological, psychological, cognitive therapies, counseling, etc.

3.2 ANXIETY DISORDERS :

Most of the people have grown out of our childhood fears and our adulthood fears are mild, short-term, or reasonable. The fears of people with anxiety disorder are severe and lower the quality of their lives. Their fear are chronic and frequent enough to interfere with their functioning. Their fears are out of proportion to dangers that they truly face. Once this anxiety starts, it tends to feed on itself so that it might not stop even if the particular life stressor has long since passed.

Four types of symptoms determine the presence of anxiety-

1. ***Somatic symptoms*** – muscle tension, heart palpitation, stomach pain etc.
2. ***Emotional symptoms*** – restlessness, fearfulness, irritability and constant watchfulness.
3. ***Cognitive symptoms*** – problems in taking decisions and concentration, fear of dying, loosing control, etc.
4. ***Behavioural symptoms*** – escapism in behaviour, aggressiveness, avoidance, etc.

There are different types of disorders where the main cause is anxiety and panic. Anxieties are consciously expressed or take some maladaptive forms like phobia, GAD, PTSD, etc.

3.3 PANIC DISORDER AND PHOBIAS :

Symptoms of Panic Attacks

Panic attacks, are short but intense periods in which individual experiences many symptoms of anxiety. Heart palpitations, trembling, a feeling of choking, dizziness, intense dread, and so on. Panic attacks may occur in the absence of any environmental triggers on in some people panic attacks are situationally predisposed. The person is more likely to have them in certain situation but does not always have them when in those situations. In all cases, however, the panic attack is a terrifying experience, causing a person intense fear or discomfort. The physiological symptoms of anxiety, the feeling of loosing control, going crazy, or dying when panic attacks become a common

occurrence. When the panic attacks are usually not provoked by any particular situation, and when a person begins to worry about having attacks and changes behaviours as a result of this worry, a diagnosis of panic disorder is made. Some people with panic disorder have many attacks in a short period of time. Less frequently, people who have panic disorder often fear that they have life – threatening illnesses. E.g., thyroid disorders, or with a cardiac disorder called mitral value prelate. Between 1.5 and 4 percent of people will develop panic disorder at some time in their lives. Most people who develop panic disorder usually do so sometime between late adolescence and their mid thirties. Many people with panic disorder also suffer from chronic generalised anxiety, depression, and alcohol abuse.

Bio psychosocial Perspective

One biological theory of panic disorder is that these people have over reactive autonomic nervous systems, which put them into a full flight-or-fight suspense with little provocation. This may be the result of imbalances in norepinephrine or serotonin or in hyper sensitivity to feelings of suffocation. There also is some evidence that panic disorder may be transmitted genetically.

Psychological theories of panic suggest that people who suffer from panic disorder pay very close attention to their bodily sensations, misinterpret bodily sensations in a negative way, and engage in snowballing, catastrophic thinking. This thinking then increases physiological activation, and a full panic attack starts.

Antidepressants and benzodiazepines have been effective in reducing panic attack and agoraphobic behaviour, but people tend to relapse into these disorders when they discontinue these drugs.

An effective cognitive – behavioural therapy has been developed for panic disorders. Clients are taught relaxation exercises and then learn to identify and challenge their catastrophic styles of thinking, often while having panic attacks induced in the therapy sessions. Systematic desensitisation techniques are used to reduce agoraphobic behaviour.

Phobias

Agoraphobia :-

The term agoraphobia is from the Greek for “fear of the market place”. People with agoraphobia fear crowded, bustling places, such as the market place or in our times, the shopping mall. They also fear enclosed space, such as buses, subways, or elevators. Finally, they fear wide open spaces, such as open fields, particularly if they are alone. In general, they fear any place that

they might have trouble escaping or getting help in an emergency i.e., panic attack. People with agoraphobia also often fear that they will embarrass themselves if others see their symptoms of panic attack. In most cases, agoraphobia begins within one year after a person begins experiencing frequent anxiety symptoms. People with agoraphobia are unable to often get to the point, where they will not leave their own homes.

Agoraphobia strikes people in their youth. In one large study, more than 70 percent of the people who developed agoraphobia did so before the age of 25, and 50 percent developed the disorder before the age of 15 (Bourden et al. 1988).

Specific Phobias :-

Most specific phobias fall into one of four categories, (APA, 2000) animal type, natural environment type, situational type, and blood – injection – injury type. When people with these phobias encounter their feared objects or situation, their anxiety is immediate and intense, and they may even have full panic attacks. Most phobias develop during childhood. Adults with phobias recognise that their anxieties are illogical and unreasonable, however children may not have his insight and just have the anxiety. Although as many as 04 in 10 people will have a specific phobia at some time, making it one of the most common disorders.

- a) **Animals type phobias** are focused on specific animal or insets, such as dogs, cats, snakes, or spiders. A snake phobia appears to be the most common type of animal phobia in the United States. People with phobias go to great lengths to avoid the objects of their fears.
- b) **Natural environment type phobia** are focused on events or situations in the natural environment, such as storms, heights, or water.
- c) **Situational type phobias** usually involve fear of public transportation, tunnels, bridges, elevators, flying, and driving. Claustrophobia, or fear of enclosed spaces, is common situational phobia. People with situational phobias believe they might have panic attacks in their phobic situations.
- d) The final type, **blood-injection-injury type phobias**, was first recognised in DSM IV. People with this type of phobia, fear seeing blood or an injury, receiving an injection, or experiencing any other medical procedure.

Social Phobia

People with social phobia fear being judged on embarrassing themselves in front of other people. Social phobia creates severe disruption in a person's daily life. People with a social phobia may avoid eating or drinking in public, for fear they will make noises when they eat, drop food, or otherwise embarrass themselves. They may avoid writing in public, including signing their names, for fear that others see their hands tremble. Men with social phobia will often avoid urinating in public bathrooms for fear of embarrassing themselves. People with social phobia tend to fall into three groups (Eng et al 2000) some people with social phobia fear only public speaking. Others have moderate anxiety about a variety of social situations finally, who have severe fear of many social situations, from speaking in public to just having a conversation with another person, are said to have a generalised type of social phobia.

Social phobia is relatively common, with about 8 percent of the U.S. adult population qualifying for the diagnosis in a 12 month period and one in eight people experiencing the disorder at some time in their lives (Kessler et. al., 1998, Schneier et. al, 1992) Women are somewhat more likely than men to develop this disorder.

Once it develops, social phobia tends to be a chronic problem if untreated. Most people with a social phobia do not seek treatment for their symptoms.

3.4 GENERALISED ANXIETY DISORDER (GAD) :

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

GAD is a relatively common type of anxiety disorder, with about 4 percent of the U.S. population experiencing it in any six-month period. The majority of people with GAD also develop another anxiety disorder, such as phobias or panic disorder and many experience depression as well.

Theories of Generalised Anxiety Disorder

1. Psychodynamic Theories :-

Freud (1917) developed the first psychological theory of generalised anxiety. He distinguished among three kinds of anxiety : realistic, neurotic, and moral. Realistic anxiety occurs when we face a real danger or threat, such as an oncoming tornado. Neurotic anxiety occurs when we are repeatedly prevented from expressing our id impulses, it causes anxiety. Moral anxiety occurs when we have been punished for expressing our id impulses, and we come to associate those impulses with punishment, causing anxiety. Generalised anxiety occurs when our defense mechanisms can no longer contain either the id impulses or the neurotic or moral anxiety that arises from these impulses.

More recent psychodynamic theories attribute generalised anxiety to poor upbringing, which results in fragile and conflicted images of the self and others. Children whose parents were not sufficiently warm and nurturing, and many have been overly strict or critical, may develop images of the self as vulnerable and images of others as hostile. As adults, their lives are filled with frantic attempts to overcome or hide their vulnerability, but stressors often overwhelm their coping capacities, causing frequent bouts of anxiety.

2. Humanistic and Existential Theories :-

Carl Roger's humanistic explanation of generalised anxiety suggests that children who do not receive unconditional positive regard from significant others become overly critical of themselves and develop conditions of worth, harsh self-standards they feel they must meet in order to be acceptable. Throughout their lives, these people, then, strive to meet these conditions of worth by denying their true selves and remaining constantly vigilant for the approval of others. They typically fail to meet their self-standards, causing them to feel chronically anxious or depressed.

Existential theorists attribute generalised anxiety disorder to existential anxiety, a universal human fear of the limits and responsibilities of one's existence. Existential anxiety arises when we face the finality of death, the fact that we may unintentionally hurt someone, or the prospect that our lives have no meaning. We can avoid existential anxiety by accepting our limits and striving to make our lives meaningful, or we can try to silence that anxiety by avoiding responsibility or by conforming to other's rules. Failing to confront life's existential issues only leaves the anxiety in place, however, and leads us to "inauthentic lives".

3. Cognitive Theories :-

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

Their maladaptive assumptions lead people with GAD to responds to situations with automatic thoughts, which directly stir up anxiety, cause them to be hyper vigilant, and lead them to overreact to situations.

Check Your Progress:-

1. What do you mean by GAD?
2. Discuss the different theories of GAD?

3.5 OBSESSIVE COMPULSIVE DISORDER (OCD) :

OCD is a type of anxiety disorder but differs from other anxiety disorders. The person shows either obsessions or compulsion, which are excessive and unreasonable.

Obsessions

They are recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause anxiety or distress.

Compulsions

They are repetitive behaviours (such as hand washing, checking, etc.) or mental acts (such as praying, repeating words, etc.) that the person feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

People with obsessive compulsive disorder experience anxiety when they have obsessions and when they cannot carry out their compulsions.

Common obsessions one focused on contamination, sex, violence and repeated doubts.

THEORIES OF OCD –

Biological theories of OCD speculate that areas of the brain involved in the execution of primitive patterns of behaviour, such as washing rituals, may be impaired in people with OCD. These areas of the brain are rich in the neurotransmitter serotonin and drugs that regulate serotonin have proven helpful in the treatment of OCD.

Psychodynamic theories of OCD suggest that the obsessions and compulsions symbolises unconscious conflict or impulses and that the proper therapy for OCD involves uncovering these unconscious thoughts.

Cognitive behavioral theories suggest that people with OCD are chronically distressed, think in rigid and moralistic ways, judge negative thoughts as more acceptable than other people do, and feel more responsible for their thoughts and behaviours. This makes them unable to turn off the negative, intrusive thoughts that most people have occasionally. Compulsive behaviours develop through operant conditioning, people are reinforced for compulsive behaviours by the fact that they reduce anxiety.

TREATMENTS OF OCD –

Drug Therapy : The most effective drug therapies for OCD are the antidepressants known as selective – serotonin reuptake inhibitors.

Cognitive Behavioural Therapies : They have also proven helpful for OCD. These therapies expose OCD client to the content of their obsessions while preventing compulsive behaviour, the anxiety over the obsessions and the compulsions to do the behaviours are extinguished.

Unfortunately neither the drug therapies nor the cognitive behavioural therapies tend to eliminate the obsessions and compulsions completely. The relapse rate with the drug therapies is high once the drugs are discontinued. Cognitive behavioural therapies help prevent relapse.

3.6 POSTTRAUMATIC STRESS DISORDER (PTSD) :

PTSD is an anxiety disorder which occurs after a person experiences a severe trauma. It is a set of symptoms including hyper vigilance, re-experiencing of the trauma, emotional numbing experienced by trauma survivors.

People who experience severe and long lasting traumas, who have lower levels of social support, who experience socially stigmatising traumas, who were already depressed or anxious before the trauma, or who have maladaptive coping styles may be at increased risk for PTSD.

The three main categories of symptoms of PTSD are –

- 1. Re – experiencing of the traumatic event –**
Frequent nightmares, flashbacks of the event, other stimulus remind the event, etc.
- 2. Emotional numbing and detachment -**
Avoidance of anything which reminds of the event, restricted emotional responses, no reaction to any kind of emotional provocation, sometimes unable to remember certain aspects of the event, etc.
- 3. Hyper vigilance and chronic arousal -**
Constantly alertness for the traumatic event, panic and flight, chronically over aroused, easily startled, quick to anger, etc.

Four types of events are seen to result in PTSD –

- 1. Natural disasters –** Floods, earthquakes, fires, tornadoes, etc.
- 2. Abuse –** Physical abuse like beating, sexual abuse like rape, emotional abuse like critical parents, etc.
- 3. Combat and War related traumas -** War prisoners witnessing deaths, war zone stress etc.
- 4. Common traumatic events -** Accidents, sudden death of loved ones, drowning, heart break, etc.

CAUSES OF PTSD

1. Psychological Causes –

- a) Human beings live with many assumptions about themselves and others, this keeps the person's faith and trust intact. But if these assumptions, one shattered because of the trauma, may result in PTSD.
- b) People already suffering from depression and anxiety are more vulnerable to develop PTSD.
- c) The onset of PTSD also depends on the person's coping styles and adjustments. People using self-destructive styles such as taking alcohol, drugs, isolation are more vulnerable to PTSD.

2. Biological Causes -

- a) Lower level of the hormone cortisol can result in PTSD, as it prolongs the activity of the sympathetic nervous system. PTSD people show increased blood flow in the amygdala area of the brain.
- b) Twin and family studies shows that PTSD can be inherited, it runs in the family.

3. Social and Cultural Causes -

People with strong social and supportive social group are less likely to develop PTSD after a trauma.

TREATMENT OF PTSD

1. Cognitive Treatment

- a) Behavioural therapy –
Systematic desensitisation helps the patient to identify the stimulus and rank the fear ascendingly. Positive imagery training helps the victims of rape to recover from PTSD.
- b) Stress management methods helps to develop skills to overcome stressful issues.

2. Biological therapy –

Selective Serotonin Reuptake Inhibitors (SSRI) and Benzodiazepines are helpful in treating PTSD symptoms.

3. Social – Cultural Help –

Community level interventions helps the people with PTSD caused by natural disasters, etc.

Check Your Progress –

1. What are the causes of PTSD?
2. What are the treatments of PTSD?

3.7 BIOPSYCHOSOCIAL PERSPECTIVE OF ANXIETY DISORDERS :

Biology is clearly involved in the experience of anxiety disorders. Evolution has prepared our bodies to respond to threatening situations with physiological changes that make it easier for a person to flee or fight an attacker. In few persons this reaction leads to chronic arousal, to over actively or poorly regulated arousal. These people are more prone to severe anxiety reactions to threatening stimuli and to the anxiety disorders.

Social perspective focus on differences between groups in the rates and expression of anxiety disorders. Women have higher rates of almost all the anxiety disorders than do men. Women may have more genetic vulnerability to anxiety disorders because of changes in their hormonal levels.

Culture may differ in their expression of this disorder. Psychological perspective focus on the upbringing of an individual e.g., specific traumatic experiences that some have suffered.

3.8 SUMMARY :

Anxiety disorders are complex and most common form of mental disorder. Anxiety is a future oriented state where a person focuses on the possibility of experiencing danger. Panic and anxiety creates different anxiety disorders.

In phobia, the person avoids situations that produce severe anxiety or panic disorders. PTSD focuses on avoiding thoughts or images of past traumatic experiences.

OCD disorder focuses on repulsive intrusive thoughts and the use of ritualistic behaviours.

Specific genetic vulnerability seem to put person at risk for anxiety disorder. Psychological and social causes can result in anxiety disorders.

Psychological, social and biological treatments helps a patient with anxiety disorder.

3.9 GLOSARY :

1. **Animal Phobia** – unreasonable fear of animals or insects.
2. **Serotonin** – Neurotransmitter involved in processing information and co ordination of movements as well as inhibition.

3.10 QUESTIONS :

- Q.1 Define Anxiety and Panic Disorders and discuss their symptoms.
- Q.2 Write notes on the following.
 - a) Agoraphobia
 - b) Specific Phobia
 - c) Social Phobia
- Q.3 What is Generalised Anxiety Disorder. Discuss the various theories of Generdised Anxiety Disorder.
- Q.4 Define Obsessive Compulsive Disorder. Discuss its theories and treatment.
- Q.5 Define Post Traumatic Disorders and discuss its causes and treatment.
- Q.6 Write a note on Biopsychosocial perspective of Anxiety Disorders.

3.11 SUGGESTED READINGS :

1. Abnormal psychology by David H. Barlow & V. Mark Durand, 1995, 2005, New Delhi.
2. Dhanda, Amrta (2000) Legal order and mental disorder, New Delhi. Sage Publications Pvt Ltd.



SOMATOFORM DISORDERS, PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITIONS AND DISSOCIATIVE DISORDERS - I

Unit Structure

- 4.0 Objectives
- 4.1 Introduction
- 4.2 Somatoform Disorders
- 4.3 Psychological Factors Affecting Medical Conditions
- 4.4 Summary
- 4.5 Questions
- 4.6 Reference

4.0 OBJECTIVES

After studying this unit you should:

- Know the concept of somatoform disorders.
- Understand conversion disorder.
- Comprehend somatisation disorder and related conditions.
- Know body dysmorphic disorder and hypochondriasis.
- Understand conditions related to somatoform disorders.
- Know theories and treatment of somatoform disorders.
- Understand Psychological Factors Affecting Medical Conditions and associated topics such as coping, stress and the immune system, etc.

4.1 INTRODUCTION

In this unit we will discuss the concept of somatoform disorders. The concept of conversion disorder, somatisation disorder and related conditions, dysmorphic disorder as well as hypochondriasis will also be discussed. Following this we will discuss the various conditions related to somatoform disorders, such as malingering, factitious disorder and Munchausen's syndrome. Theories and treatment of somatoform disorder would also be discussed.

Many medical conditions are influenced by psychological factors. DSM IV TR category of psychological factors affecting medical conditions includes situations in which psychological or behavioural factors have an adverse effect on a medical conditions. Theories and treatment of these conditions would also be discussed.

4.2 SOMATOFORM DISORDERS

Somatoform disorders are those disorders in which an individual complains of bodily symptoms but for which there is no clear-cut identifiable physical cause. Somatoform disorders include a variety of conditions in which conflict becomes translated in to physical problems or complaints that cause distress or impairment in a person's life. Psychologists have known Somatoform disorders since a long time. The term "soma" refers to body and somatoform disorders are those bodily disorders for which there is no biological basis for physical complaints and the cause is largely a result of psychological factors. Somatoform disorders can be defined as an anxiety based pattern in which an individual complains of bodily symptoms that suggest the presence of a physical problem, but for which no organic basis can be found. Health professionals find it difficult distinguishing between a physical cause and a psychological cause when it comes to understanding bodily symptoms. DSM-IV has identified many different forms of somatoform disorders. These include: Conversion disorder, Somatisation disorder and related conditions, Body dysmorphic disorder, Hypochondriasis, etc.

4.2.1 Conversion Disorder: Conversion disorder involves a translation of unacceptable drives or troubling conflicts in to bodily motor or sensory symptoms that suggest neurological or other kinds of medical conditions. The essential feature of this disorder is an involuntary loss or alteration of a bodily function due to psychological conflict or need, causing the individual to feel seriously distressed or to be impaired in social, occupational or other important areas of life. It should be remembered that the person is not intentionally producing the symptoms. Clinicians cannot establish a medical basis for the symptoms and it appears that the person is converting the psychological conflict or need in to a physical problem.

This disorder was earlier called as hysteria and it involves a neurotic pattern in which symptoms of some physical malfunctioning or loss of control appear without any underlying organic pathology. In 1850s a French physician Paul Briquet systematically described and categorized various symptoms of hysteria based on his review of about 400 patients. Jean Martin

Charcot used the technique of hypnosis to show that psychological factors played a role in the physical symptoms of hysteria. Pierre Janet and Hyppolyte Marie Bernheim did considerable work on hysteria and enhanced our understanding about it. Sigmund Freud developed a radically different theory of hysteria. He called it as hysterical neurosis.

According to Barlow and Durand (2000) conversion disorder can be defined as physical malfunctioning such as blindness or paralysis suggesting neurological impairment but with no organic pathology to account for it.

Conversion disorders were once relatively common in civilian and especially in military life. In World War I, conversion disorders were the most frequently diagnosed psychiatric syndrome among soldiers. It was also relatively common during World War II.

Statistical details reveal that conversion disorder may occur in conjunction with other disorder particularly Somatisation disorder. This disorder is common among women and generally develops during adolescence. These disorders are common among soldiers exposed to combat.

Conversion disorders typically occurred under highly stressful combat conditions and involved men who would ordinarily be considered stable.

Conversion disorder is a rare phenomenon affecting about 1 to 3 % of those referred for mental health care. The disorder often runs in families. It generally appears between the ages of 10 and 35 Years and is more frequently observed among women and in people with less education.

The symptoms of conversion disorder are multiple. All these symptoms of conversion disorder can be grouped into three broad categories. These are as follows:

A) Sensory Symptoms: Some of the sensory symptoms involved in conversion disorder are as follows:

- Anesthesia: loss of sensitivity.
- Analgesia: loss of sensitivity to pain.
- Hypesthesia: partial loss of sensitivity.
- Hyperaesthesia: excessive sensitivity.

Ironside and Bachelor (1945) found the following sensory symptoms among conversion disorders. These are blurred vision, photophobia, double vision, night blindness, jumping of print during attempts to read, etc. These researchers also found that the symptoms of each airman (whom they studied) were closely related

to his performance duties. Night fliers were more subject to night blindness, while day fliers more often developed failing day vision.

B) *Motor Symptoms:* Some common motor symptoms found among conversion disorder are as follows:

- i. **Paralysis:** Such a behavior is usually confined to only one arm or leg and the loss of function is usually selective for e.g. writer's cramp, ticks (localized muscular twitches).
- ii. **Contractors:** Such a behavior involves flexing a finger and toes or rigidity of the larger joints such as elbows and knees. Paralysis and contractors frequently lead to walking disturbances.
- iii. **Aphonia:** is a most common speech disturbance. In this disorder an individual is able to talk only in whispers and mutism.
- iv. **Convulsion:** This is an occasional motor symptom. However, people with hysterical convulsion show features or the usual characteristics of true epileptics.

C) *Visceral Symptoms:* Visceral conversion reactions also cover a wide range of symptoms, including headaches "lump in the throat" (formerly known as globus hystericus) and choking sensations, coughing spells, difficulty in breathing, cold and clammy extremities, bleaching, nausea, vomiting, and so on. Occasionally, persistent hiccupping or sneezing occurs.

Accurate diagnosis of conversion disorder is a difficult task because conversion disorder can stimulate every known disease. Conversion disorder can be distinguished from organic disorder on the basis of the following points.

1. ***La Belle Indifference:*** This means that those who have conversion disorder are unconcerned about the long-range effects of their disabilities. Individuals with organic disorder are very much concerned about the long-range effect of their symptoms.
2. ***Selective nature of the dysfunctioning:*** Individuals who have conversion disorder are highly selective with respect to symptom pathology. For example, in conversion blindness, an individual does not usually bump into people or objects; "paralyzed", muscles can be used for some activities but not others; and controlled contractors usually disappear during sleep.
3. ***Under hypnosis or narcosis:*** The interesting fact that under hypnosis or narcosis (a sleep like state induced by drugs) the symptoms can usually be removed, shifted, or

reinduced by the suggestion of the therapist. Similarly, if the individual is suddenly awakened from a sound sleep, he or she may be tricked into using a “paralyzed” limb.

In the development of a conversion disorder, the following chain of events typically occurs:

- a. A desire to escape from some unpleasant situation.
- b. A feeling or a wish to be sick in order to avoid the situation (this wish, however is suppressed as unfeasible or unworthy); and under additional or continued stress.
- c. The appearance of the symptoms of some physical ailment. The individual sees no relation between the symptoms and the stress situation. The particular symptoms that occur are usually those of a previous illness or are copied from other sources, such as symptoms observed among relatives, seen on television, or read about in magazines.

Conversion disorders seem to stem from feelings of guilt and the necessity for self-punishment. Those who suffer from conversion disorder also suffer from a dissociative disorder. It is difficult to diagnose conversion disorder. Individuals suspected of conversion disorder must be given a thorough neurological examination in addition to follow up to determine whether a client’s symptoms represent an underlying medical condition.

4.2.2 Somatisation Disorder and Related Conditions:

Somatisation disorder involves the expression of psychological issues through bodily problems that cannot be explained by any known medical condition or as being due to the effects of a substance.

The difference between somatization disorder and conversion disorder is that somatisation disorder involves multiple and recurrent bodily symptoms rather than a single physical complaint.

This condition generally, which is relatively rare, first appears before the age of 30 years and leads to problems in the areas of social, occupational and interpersonal functioning. Individuals suffering from this disorder generally tend to be from lower socioeconomic classes.

This disorder was earlier called as Briquet’s Syndrome, after the famous French physician, Pierre Briquet who in 1859 described patients who has multiple somatic complaints for which he could not find any medical cause. Somatisation disorder was known as

Briquet's syndrome for more than 100 years and was called as somatisation disorder for the first time only in 1980s in the DSM- III. In this disorder there are repeated and multiple vague somatic complaints for which there is no physiological cause. This is a very rare disorder and occurs on a continuum.

Two important points with respect to somatisation disorder are as follows:

- Majority of the individuals with somatisation disorder tend to be women, unmarried and from lower socioeconomic groups.
- In addition to a variety of somatic complaints, individuals may also have psychological complaints, usually anxiety or mood disorders.

Clinical Description: The common complaints in this disorder are pseudoneurological
i. e. neurological disorder without organic neurological causes like double vision, or headache, allergies, nausea, stomach problem, and menstrual and sexual difficulties.

Such people experience pain and sickness in exaggerated manner. It has been demonstrated that individuals with somatisation disorder tend to be women, unmatured and from lower socio economic status.

This disorder shares a number of features with Antisocial Personality Disorder. These are as follows:

- Both these disorders begin early in life.
- They both run a typical chronic course.
- They both predominate among lower socioeconomic classes.
- Both are difficult to treat.
- Both these disorders are associated with marital discord, drug and alcohol abuse and suicide attempts.

Causes: Some important causes of this disorder are as follows:

1. *Genetic factors:* Early studies of possible genetic contributions have had shown mixed results. For e.g. Torgerson (1986) found no increased prevalence of somatisation disorder in monozygotic pairs. However, most recent studies have found that this disorder run in families and may have a heritable basis. It has also been observed that Somatisation Disorder is strongly linked in family and genetic studies to Antisocial Personality Disorder.

2. *Early Learning:* Somatisation disorder is a learned disorder. Individuals learn from significant others, and through role modeling, significant somatic symptoms that are characteristic of these disorders.

3. *Neurobiological Factors*: Jeffrey Gray and his associates (1985) have implicated neurophysiological factors in the development of somatisation disorder. According to him Somatisation Disorder and Antisocial Personality Disorder share a neurobiological based disinhibition syndrome. A variety of neurophysiological evidence suggests a dysfunction in the brain circuit in somatisation disorder.

According to Widom (1984) and Colniger (1987) in the occurrence of somatisation disorder, social and cultural factors too play an important role. Gender roles encourage development of somatisation disorder in women in many cultures.

Treatment: Treatment of somatisation disorder is exceedingly difficult and there are no treatments with proven effectiveness that seem to cure the syndrome. Barlow et al (1992) have pointed out that somatisation disorder can be better managed by providing patients with the following:

- Providing reassurance.
- Reducing stress.
- Reducing the frequency of help-seeking behavior.

People with somatisation disorder do not voluntarily seek psychotherapy. They seek psychotherapy only on the insistence from their physician. The prognosis of this disorder is generally poor.

4.2.3 Pain Disorder : It is one variant of somatisation disorder in which instead of the multiple somatic complaints, individual demonstrates only one symptom, i.e. pain. The pain causes intense personal distress or impairment. The client is not faking pain. In some cases of pain disorder there may be a diagnosable medical condition but the reported experience of pain is more than what can be normally seen.

In pain disorder there may have been a clear physical reason for pain at least initially, but psychological factors play a role in maintaining it. An important feature of pain disorder is that the pain is real and it hurts regardless of the cause. Since it is a new and a separate category more research on it is needed to increase our understanding of this disorder.

People with pain disorder are likely to become dependent on substances, either illicit drugs or prescription medications, in their effort to alleviate their discomfort.

4.2.4 Body Dysmorphic Disorder: Individuals having this disorder have distorted negative concerns about their bodies. They are preoccupied, almost to the point of being delusional, with the

idea that a part of their body is ugly or defective. They are so concerned with distress about their bodily problem that their work, social life and relationships are impaired. They may be abnormally worried about the texture of their skin, too little facial hair, or they feel that there is deformity in the shape of their nose, mouth, jaw or eyebrow.

This is an imaginative disorder. This disorder is also called as “imagined ugliness” (Phillips, 1991). It is a somatoform disorder in which there is an excessive preoccupation with some imagined defect in appearance by some one who actually looks reasonably normal.

The prevalence of this disorder is hard to estimate since by its very nature it tends to be kept a secret. This disorder is more commonly found among females; however, in Japan more males experience this disorder. This disorder occurs in adolescence and peaks at the age of 18 or 19 years.

Clinical Description: Individuals with this disorder show the following symptoms:

- People with this disorder become fixated on mirrors. They often view themselves in a mirror to check as if any change is taking place in them.
- As a result of this disorder, individuals indulge in suicidal ideation as well as suicidal attempt and even actual suicide.
- They have “ideas of reference”, i.e. they think that everything that goes on in their world is somehow related to them.
- Their psychopathology lies in their reacting to a deformity that others cannot perceive.
- They are also concerned with the width of their face
- Individuals having this disorder are the one’s who do not conform to the current cultural practices of their bodily features.

Causes: The etiology of this disorder is not well known. There is no data available to indicate whether this disorder run in families or whether there is biological or psychological predisposition to this disorder.

The pattern of comorbidity with other disorders does give us some indication about the etiology of this disorder. This disorder co-occurs with hypochondriasis, however it does not co-occur with other somatoform disorders, nor does it occur in family members of patients with other disorders. A disorder that has been frequently found to co-occur with Body Dysmorphic Disorder is the Obsessive Compulsive Disorder.

Body Dysmorphic Disorder has considerable degree of similarity with Obsessive Compulsive Disorder. Some important points are as follows:

- i) Individuals with Body Dysmorphic Disorder often complain of persistent, intrusive and horrible thoughts about their appearances, and they engage in such compulsive behaviours as repeatedly looking in mirrors to check their physical features.
- ii) Body Dysmorphic Disorder and Obsessive Compulsive Disorder also have approximately the same age of onset and run the same course.
- iii) The treatment of these two disorders is also the same. Medically the drug that block the reuptake of serotonin, such as Clomipramine (Anafranil) and fluoxetine (Prozac) are useful in both these disorders. Similarly, exposure and response prevention, the type of cognitive behavior therapy that is effective with Obsessive Compulsive Disorder, has also been successful with Body Dysmorphic Disorder.

Treatment: Psychological treatment of this disorder consists of bringing about a cognitive change in the individual. Among the medical treatment Plastic surgery is the most common. Preliminary research suggests that as many as 2% of all the patients who request plastic surgery may have this disorder. It has also been noted that surgery on people with Body Dysmorphic Disorder seldom produced the desired results and these people return for additional surgery on the same defect, or concentrate on some new defect.

Recent research (1993) has revealed that preoccupation with imagined ugliness actually increased in people who had plastic surgery, dental procedures or special skin treatments for their perceived problems.

4.2.5 Hypochondriasis: Those suffering from hypochondriasis believe or fear that they have a serious illness, when in fact they are merely experiencing normal bodily reactions. Unlike conversion disorder or somatisation disorder, hypochondriasis does not involve extreme bodily dysfunction or unexplainable medical symptoms.

It is one type of somatoform disorder, which is characterized by multiple complaints about possible physical illness where no evidence for such illness can be found. In hypochondriasis anxiety is a result on one's preoccupation with bodily symptoms misinterpreting them as indicative of illness or disease, etc. Since the preliminary symptoms of this disorder are generally of health

concerns, an individual with this disorder is likely to visit a family physician.

In hypochondriasis an individual has a severe anxiety, which is focused on the possibility of having a serious disease.

Clinical Description: Those who suffer from hypochondriasis show the following symptoms:

- i. They have an unrealistic interpretation of relatively common physical complaint.
- ii. Their complaints are not restricted to any logical symptoms.
- iii. They have trouble in giving precise description of their symptoms.
- iv. They read a lot on medical topics and feel certain that they are suffering from every new disease they read or hear about.
- v. They believe that they are seriously ill and cannot recover. As their symptoms have no physical causes, no treatment is possible. Hence, they keep on changing their physician until the physician treats the disorder, which does not exist at all.
- vi. These patients are so preoccupied with their health, that many of them keep detailed information about diet, functioning of body, etc. Besides, they also keep themselves well informed about the latest medical treatments by reading popular newspaper and magazines.
- vii. Usually this disorder occurs after the age of thirty.
- viii. Hypochondriacal individuals show a morbid preoccupation with digestive and excretory functions. These individuals have an abnormal preoccupation with disease.

Hypochondriasis differs from somatisation disorder on the following grounds.

- a. It occurs after the age of 30 years.
- b. The abnormal concerns of hypochondriacal individuals are vague, general, and do not focus on particular set of symptoms.
- c. Hypochondriacal persons have a belief that they have a serious disorder, which is unique.

Since in this disorder there is preoccupation with physical symptoms, individuals are more likely to visit family physicians.

They come to the attention of mental health experts only when all relevant medical conditions concerned with the presenting physical complaints are ruled out.

Research studies indicate that hypochondriasis shares many features with anxiety disorders, particularly panic disorders. These two disorders are frequently comorbid i.e. individuals with a hypochondriacal disorder have an additional diagnosis of anxiety disorder.

In hypochondriacal disorder an individual is preoccupied with bodily symptoms, misrepresenting them as indicative of illness or disease. Any physical sensation, experienced by such individuals can become a basis of concern for individuals.

In spite of best efforts by the doctors to convince the individual that nothing is medically wrong with him and the disorder is more psychological in nature; the patient is not able to understand this.

Patients having hypochondriasis are distinguished from those having illness Phobia. Illness Phobia is future oriented, i.e. individuals who fear developing a disease is said to have illness Phobia. On the other hand hypochondriasis is a current anxiety about a presumed illness. In other words, individuals who mistakenly believe they currently have a disease are diagnosed as having hypochondriasis.

Statistics: The prevalence of hypochondriasis in general population is not well known. It is estimated that anywhere between 1% to 14% of the medical patients has hypochondriasis. The sex ratio of this disorder is 50-50. Once it was believed that hypochondriasis was most common among elderly population. However this is not so. It is estimated that hypochondriasis can develop at any time of life, with peak age period found in adolescence, middle age (40s and 50s) and ages 60 years.

Hypochondriasis is a culture specific disorder. Its manifestation is considerably influenced by sociocultural factors. Two important culture specific syndromes are as follows:

- a) Koro
- b) Dhat

Koro: This syndrome is generally found among Chinese males, though it is also found among western women to a lesser extent. In this syndrome there is a belief accompanied by severe anxiety and sometimes panic that genitals are retracting into the abdomen. Koro occurs in Chinese males because of the central importance given to sexual functioning among Chinese males. In this syndrome

an individual feels guilty about excessive masturbation, unsatisfactory intercourse or promiscuity. These events generally predispose men to focus their attention on their sexual organs, which generally increases anxiety and arousal leading to hypochondrical symptoms.

Dhat: This is another culture specific syndrome, most common among Indians. It is an anxious concern about losing one's semen. The loss of semen is associated with a vague mix of physical symptoms including dizziness, weakness and fatigue that are not so specific as in Koro.

The various somatic symptoms present in hypochondriasis poses diagnostic problem for a clinician and hence the clinician must remember the following points:

- a) First, the clinician must be accurately aware of the specific culture or subculture of a patient in order to understand the cultural manifestation of this disorder.
- b) A clinician must rule out the physical cause of somatic complaints before referring the patient to a mental health professional.
- c) The mental health professional must determine the nature of somatic complaints in order to know whether they are associated with a somatoform or are a part of other psychopathological syndrome such as panic attack.

Causes of Hypochondriasis: Some important causes of hypochondriasis are as follows:

- *Disorder of Cognition and Perception:* Hypochondriasis is a disorder of cognition and perception with strong emotional contributions. Individuals with hypochondriasis pay undue attention to physical sensations that are common to all normal individuals. They quickly focus their attention on these sensations. The very fact of focusing attention of their self increases their arousal and makes physical sensations seem more intense than they actually are. For e.g. a minor headache may be interpreted as a sign of brain tumor.
- *Increased Perceptual Sensitivity:* Experiments using the stroop test has revealed that individuals having hypochondriasis show enhanced perceptual sensitivity to illness cues. They also tend to interpret ambiguous stimuli as threatening.
- *Integrated Approach:* It should be remembered that no single biological or psychological cause can be implicated in this

disorder. Researchers have pointed out that the fundamental causes of hypochondriasis are similar to those implicated in the anxiety disorder.

According to Cote et al (1996) three important factors related to the etiology process of this disorder are as follows:

- i. Hypochondriasis seems to develop in the context of stressful life events. Such events often involve death or illness.
- ii. People who develop hypochondriasis tend to have had a disproportionate incidence of disease in their family when they were children.
- iii. Important interpersonal and social influence also plays an important role in the development of hypochondriasis. For e.g. some people who come from families where illness is a major issue seem to have learned that an ill person is often paid increased attention. Hence, they develop illness.

Treatment: Some important points related to treatment of this disorder are as follows:

- i) Our knowledge about the treatment of this disorder is limited. Scientifically controlled studies are very rare.
- ii) Treatment of this disorder consists of identifying and challenging illness related misinterpretation of physical sensations and on showing the patient how to create “symptoms” by focusing attention on certain body areas.
- iii) Psychoanalysis has been found to be less effective with this type of disorder. Ladee (1966) found that only four out of the 23 patients with this type of treatment improved.
- iv) Kellner (1992) found that reassurance seems to be effective in some cases, especially when it is given by a medically trained person such as a family physician.
- v) Participation in support groups (i.e. group therapy or counselling) can also be of considerable benefit for such patients.

4.2.6 Conditions Related to Somatoform Disorders: Some important conditions related to somatoform disorders that we will discuss in this section are as follows:

- i. **Malingering (*Faking*):** It involves deliberately feigning the symptoms of physical illness or psychological disorder for an ulterior motive. A person may feign physical problem to either obtain financial gain, avoid punishment or to fulfill some other motive. Malingering is deliberate faking of a physical or

psychological disorder motivated by gain. It is difficult to distinguish between malingering and conversion disorder. In the former the person is consciously aware that he is faking a disorder, whereas, in conversion disorder the individual is not aware, it occurs unconsciously. Three important points that can help one to distinguish between conversion disorder and malingering are as follows:

- An individual with conversion disorder is indifferent to the symptoms as compared to other disorders, i.e., they show “la belle indifference”.
- Conversion symptoms are often precipitated by marked stress.
- Individuals with conversion symptoms can usually function normally and that they seem to be really unaware either of this ability or of sensory input.

Psychologists have developed psychological instruments to determine whether a patient is malingering or not. One type of scale is the validity scales found in the MMPI or EPQ. Another instrument is the Validity Indicator Profile (Frederick, 1998) which consists of verbal and nonverbal tasks designed to determine whether a subject is responding legitimately or is trying to look impaired.

ii. Factitious Disorder: This disorder falls between malingering and conversion disorder. It refers to non-existent physical or psychological disorder deliberately faked for no apparent gain except possibly sympathy and attention. In factitious disorders the symptoms are feigned and under voluntary control, but unlike malingering there is no good reason for voluntarily producing the symptoms except, possibly to assume the sick role and receive increased attention. In factitious disorder, people fake symptoms or disorders, not for the purpose of any particular gain but because of an inner need to maintain a sick role. The symptoms may be either physical or psychological or they may be a combination of both. In some cases, individual fabricates a problem, such as excruciating headaches. These individuals relish the notion of being ill and may go to great lengths either to appear ill or to make themselves ill

iii. Munchausen’s Syndrome: It is a type of factitious disorder, named after Baron von Munchausen, a retired German cavalry officer known for his tall tales. Munchausen’s Syndrome involves chronic cases in which the individual’s whole life revolves with the pursuit of medical care. Munchausen syndrome is a type of factitious disorder, or mental illness, in which a person repeatedly acts as if he or she has a physical or mental disorder when, in truth, he or she has caused the symptoms. People with factitious

disorders act this way because of an inner need to be seen as ill or injured, not to achieve a concrete benefit, such as financial gain. They are even willing to undergo painful or risky tests and operations in order to get the sympathy and special attention given to people who are truly ill. Some will secretly injure themselves to cause signs like blood in the urine or cyanosis of a limb. Munchausen syndrome is a mental illness associated with severe emotional difficulties.

Persons with Munchausen syndrome intentionally cause signs and symptoms of an illness or injury by inflicting medical harm to their body, often to the point of having to be hospitalized. These persons are sometimes eager to undergo invasive medical interventions. They are also known to move from doctor to doctor, hospital to hospital, or town to town to find a new audience once they have exhausted the workup and treatment options available in a given medical setting. Persons with Munchausen syndrome may also make false claims about their accomplishments, credentials, relations to famous persons, etc.

A related condition, called Munchausen by proxy syndrome, refers to a caregiver who fakes symptoms by causing injury to someone else, often a child, and then wants to be with that person in a hospital or similar medical setting.

The exact cause of Munchausen syndrome is not known, but researchers believe both biological and psychological factors play a role in the development of this syndrome. Some theories suggest that a history of abuse or neglect as a child, or a history of frequent illnesses requiring hospitalization, might be factors associated with the development of this syndrome. Researchers also are studying the possible link with personality disorders, which are common in individuals with Munchausen syndrome.

4.2.7 Theories and Treatment of Somatoform Disorder:

Causes and treatment of each of the somatoform disorder has been discussed above. However it is important to understand as to what motivates people to appear sick. Psychologists explain motives with the help of primary gain and secondary gain. Primary gain is avoidance of burdensome responsibilities because one is "disabled". Secondary gain is the sympathy and attention the sick person receives from other people.

Somatoform disorders can best be explained as interplay of biological factors, learning experiences, emotional factors and faulty cognitions. According to this integrative approach, childhood events set the stage for the later development of symptoms.

Most contemporary approaches to treating somatoform disorders involve exploring a person's need to play the sick role, evaluating the contribution of stress in the person's life and providing clients with cognitive behavioural techniques to control their symptoms. Medication can also be used in certain cases. For some patients with somatisation disorder, antidepressant medications can serve an important role in treatment.

4.3 PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITIONS

Bodily conditions can be adversely affected by psychological factors. For example, intense emotional stress can increase one's vulnerability to getting sick and can seem to slow down recovery from an ailment. This is a special diagnostic category in DSM IV TR.

Psychological factors can influence physical health either indirectly, by changing behaviors that affect your health, such as eating, sleeping and socializing, or directly, by producing changes in your hormones and/or heart rate. Additionally, the mind can interact with the benefits of a medicine, reducing the effectiveness of a certain drug or worsening the negative symptoms associated with certain medical conditions. Therefore, you should monitor your thoughts towards your health and psychological well-being when coping with any medical condition.

The diagnosis of "Psychological Factors Affecting Medical Conditions", is given to those individuals who suffer from a recognised medical condition that is adversely affected by emotional factors that influence the course of the medical condition or interfere with treatment, create additional health risk or aggravate its symptoms. Emotional and psychological factors can aggravate any physical problem.

4.3.1 Theories and Treatment of Psychological Factors Affecting Medical Conditions: Researchers who study the mind body relationship attempt to determine why some people develop physiological or medical problems, when their lives become busy, complicated or filled with pleasant events. Some important factors worth noting are as follows:

1. **Stress:** Stress refers to unpleasant emotional reaction a person has when he or she perceives an event as threatening. The emotional reaction to stress may include heightened physiological arousal due to increased reactivity of the sympathetic nervous system. The term stressor is used to refer to any event that leads to stress. Holmes and Rahe (1967) developed the Social

Readjustment Rating Scale to assess life stress in terms of life change units. They identified individuals who are prone to stress and likely to develop physical problems and illnesses as a result of constant exposure to stress. In recent years cognitive model of stress has been put forward which emphasizes the fact that it is not the event itself but the ways in which it is interpreted that determines its impact.

2. Coping: Another important factor that is related to Psychological Factors Affecting Medical Conditions is coping mechanisms that is used by an individual. Coping can be defined as active efforts to master, reduce or tolerate the demands created by stress. Coping is the process of managing taxing circumstance, expending effort to solve personal and interpersonal problems, and seeking to master, minimize, reduce, or tolerate stress. Coping can be defined as facing and finding effective means of overcoming problems and difficulties. "Coping consists of efforts, both action-oriented and intrapsychic, to manage (i.e. master, tolerate, reduce, minimize) environmental and internal demands and conflicts among them". Coping strategies are also defined as actions that people take to master, tolerate, reduce or minimize the effects of stressors and they can include both behavioural and psychological strategies. Coping efforts can be either adaptive or effective (healthy) or unadaptive and ineffective (unhealthy). Effective methods of coping with stress help to remove the source of stress or control our reactions to it. Ineffective coping techniques are those techniques that can come in the way of our adaptation or that can create more problems for us in the long run.

There are two types of coping: Problem Focused Coping and Emotion Focused Coping. Problem Focused Coping is a type of coping that is basically concerned with alleviating the problem, trying to change the situation so that the problem is eliminated or to avoid the occurrence of the same or similar problem in the future. Problem focused coping is concerned with direct efforts to deal with, understand and overcome current causes of stress. Problem focused coping is generally superior in reducing the adverse effects of stress. Emotion Focused Coping is a form of coping an individual makes attempt to manage and deal with negative emotions and feelings that may develop with stressful situation. Emotion focused coping also involves learning to handle one's emotions in an appropriate manner so that we can face and adjust to situations where we find the problem to be uncontrollable. Emotion focused coping centers around efforts to reduce or manage the emotional distress resulting from stress and often involves strategies such as refusing to recognise painful realities concluding oneself that things could be worse, masking the stress with alcohol or other drugs.

3. Stress and the Immune System: Immune system is an important system of our body that consists of cells, organs and chemicals in the body that responds to attacks on the body from diseases and injuries. Immune system protects us from onslaught. Immune system is the body's means of identifying and eliminating any foreign materials (e.g. bacteria, parasites or even transplanted organs, etc.,) that enter our body. A new subject which studies as to how stress influences our body's immune system is called as ***Psychoneuroimmunology***. It is more specifically defined as the study of the effects of psychological factors such as stress, emotions, thoughts and behaviour on the immune system. The field of *psychoneuroimmunology* focuses on the relationship between psychological influences (such as stress), the nervous system, and the immune system.

Stress appears to depress immune function in two main ways. First, when people experience stress, they more often engage in behaviors that have adverse effects on their health: cigarette smoking, using more alcohol or drugs, sleeping less, exercising less, and eating poorly. In addition, stress may alter the immune system directly through hormonal changes. Research indicates that glucocorticoids—hormones that are secreted by the adrenal glands during the stress response—actively suppress the body's immune system.

Two important points with respect to immune system and stress that are worth noting are as follows:

- Stress triggers the same response in the immune system that infection triggers.
- Positive effects of stress on the immune system only seem to work when the stress is not continuous and acchronic condition. Prolonged stress has detrimental effect on our immune system functioning.

A large number of research studies have revealed that stress considerably influences the immune system's abilities to defend the body.

A large number of studies, both laboratory as well as field, have been carried out to demonstrate how immune system functioning is influenced by stress and related variables.

Emotional Expression: When emotional expression is inhibited, health problems arise. Research studies have demonstrated that expressing emotions is beneficial to one's physical health and mental well-being. Inability to express one's emotions appropriately – either emotional outburst or its suppression is unhealthy and can lead to wide variety of problems – both physical as well as psychological. Research studies by James Pennebaker (1997)

have observed that actively confronting emotions that arise from an upsetting or a traumatic event can have long-term health benefits. For example writing about a distressing experience facilitates coping and contributes to physical health.

Personality Style: One's personality style is also closely associated with development of physical and mental health problems. One type of personality style that has been extensively studied is the "Type A" personality pattern. Type A people who are impatient, irritable, and aggressive and are always in a pressure to get something done is more prone to develop cardiovascular disorders such as heart attacks. Type A individuals react explosively to stressful situations. The sympathetic system of Type A individual is always alert and at its peak. Type A individuals with high levels of hostility, commonly engage in unhealthy behaviours, such as smoking and consuming large amounts of alcohol.

A new personality type that has been identified by some researchers (Sher, 2005, Pedersen and Denollet, 2003) is the "Type D" (Distressed) personality. These individual are at increased risk for heart disease due to their tendency to experience negative emotions while inhibiting the expression of these emotions when they are in social situations. These individual also have a reduced quality of life and they benefit less from medical treatment.

Sociocultural factors: Sociocultural factors play an important role in causing and aggravating stress-related disorders. Living in a harsh social environment threatens a person's safety, interferes with the establishment of social relationships and involves a high level of conflict, abuse and violence. Chronic exposure to stressful environment can lead to higher cortisol levels resulting in disturbances in the immune system.

Treatment: Treatment of problems associated with the condition called "Psychological factors affecting medical conditions" requires a multidimensional approach. Medical treatment alone is insufficient. People must be taught to change their lifestyle, develop certain behaviours and changes in attitude that can go a long way in altering their lifestyle and consequently gain control over their health and problems. One interdisciplinary approach that has been developed is called as **behavioural medicine**, which makes use of behavioural techniques and learning approaches. In this approach they are taught to learn about unhealthy bodily processes and to take action to avoid or modify circumstances in which they are likely to become sick. Individuals learn to monitor early signs of mounting tension and to initiate steps to avert the further development of pain.

4.4 SUMMARY

In this unit we have discussed the concept of somatoform disorders and the various types of somatoform disorders which include conversion disorder, Somatisation disorder and related conditions, Pain disorder, Body dysmorphic disorder and Hypochondriasis. Clinical symptoms, causes and treatment of each of these disorders were briefly explained.

Three conditions related to Somatoform Disorders were discussed in brief. These include: Malingering (*Faking*), Factitious Disorder and Munchausen's Syndrome. Theories and Treatment of somatoform disorders were also discussed in brief.

Psychological Factors Affecting Medical Conditions as well as its theories and treatment were discussed.

4.5 QUESTIONS

- Q1. What are somatoform disorders.
- Q2. Write short notes on the following:
- Conversion disorder
 - Somatisation Disorder and Related Conditions
 - Pain Disorder Body Dysmorphic Disorder:
 - Hypochondriasis:
 - Conditions Related to Somatoform Disorders
 - Theories and Treatment of Somatoform Disorder
- Q3. Discuss the Theories and Treatment of Psychological Factors Affecting Medical Conditions:

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SOMATOFORM DISORDERS, PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITIONS AND DISSOCIATIVE DISORDERS - II

Unit Structure

- 5.0 Objectives
- 5.1 Introduction
- 5.2 Dissociative Disorders
- 5.3 Somatoform Disorders, Psychological Factors Affecting Medical Conditions and Dissociative Disorders: The Biopsychosocial Perspective
- 5.4 Summary
- 5.5 Questions
- 5.6 Reference

5.0 OBJECTIVES

After studying this unit you should be able to:

- Understand the concept of Dissociative Disorders
- Know the details about Dissociative Identity Disorder
- Comprehend other Dissociative Disorders
- Know the biopsychosocial perspective of various Somatoform Disorder, Psychological Factors Affecting Medical Conditions and Dissociative Disorders.

5.1 INTRODUCTION

Dissociative disorders are an extreme form of psychological disturbance involving anxiety and conflict in which part of an individual's personality actually separates from the rest of his or her conscious functioning. One type of dissociative disorder is the Dissociative Identity Disorder. Characteristics of Dissociative Identity Disorder as well as its theories and treatment would be discussed in brief. Some other dissociative disorders that we would discuss in brief include Dissociative Amnesia and its variants,

Dissociative Fugue, Depersonalisation Disorder. Theories and treatment of these various dissociative disorders will be discussed. Towards the end of the unit we will discuss the biopsychosocial perspective of various Somatoform Disorder, Psychological Factors Affecting Medical Conditions and Dissociative Disorders.

5.2 DISSOCIATIVE DISORDERS

Dissociative disorders are one of the most attractive disorders that have received considerable media attention. Dr. Sigmund Freud and Morton Prince carried out some pioneering studies on this disorder. The dissociative disorder refers to a group of related disorders in which there is certain altered states of consciousness. The dissociative disorder are described in DSM-IV as sudden temporary alterations in the normally integrative functioning of consciousness, identity or motor behavior. Dissociative disorders are characterised by alterations in perceptions: a sense of detachment from one's self from the world or from memories.

Dissociative disorders are an extreme form of psychological disturbance involving anxiety and conflict in which part of an individual's personality actually separates from the rest of his or her conscious functioning. An individual with dissociative disorder experiences a temporary alteration in consciousness involving a loss of personal identity, decreased awareness of immediate surroundings and odd bodily movements. Once the dissociation has occurred, the content of the dissociated part becomes inaccessible to the rest of the client's conscious mind.

Some of the most common types of dissociative disorders include: Dissociative Identity Disorder, Dissociative Amnesia, Dissociative Fugue, Depersonalization Disorder, Dissociative Trance Disorder, etc. We would discuss the different variants of dissociative disorders.

5.2.1 Dissociative Identity Disorder (DID):

It is the most interesting and dramatic of all the dissociative disorder and was earlier called as multiple personality disorder. In Dissociative Identity Disorder a person develops more than one self or personality. These personalities are referred to as alters, in contrast to the core personality, the host. In this disorder many, say more than 100 personalities or fragments of personality coexist within one body and mind. In some cases the identities are complete, each with its own behavior, tone of voice and physical gestures. In other cases, only a few characteristics are distinct, because the identities are only partially independent.

The disorder was made famous in novels and movies, such as “Sybil” and “The Three Faces of Eve”. In Dissociative Identity Disorder, each alter is understood to be a consistent and enduring pattern of perceiving, relating to and thinking about the environment and the self.

Characteristics of Dissociative Identity Disorder: According to DSM-IV the major characteristics of this disorder are as follows:

- i) Amnesia is the most important characteristic feature of this disorder.
- ii) The identity of this disorder is fragmented.
- iii) Many personalities live inside one body. These can be anywhere from 3 to 4 to 100.
- iv) Certain important aspects of person’s identity are dissociated.

A person who comes for treatment with a DID is called as a host personality. The host personality tends to hold many different identities together. The transition from one personality to another is called as a “switch”. During a switch physical transformation may occur. Posture, facial expressions, pattern of facial wrinkling and even physical disabilities may occur. One of the most important debatable issue is whether the DID can be faked or whether it is real. Some important points with respect to this disorder are as follows:

- Individuals with DID are very suggestible and the alternative personalities that these individuals manifest are actually created as a reaction to leading questions suggested by therapists during psychotherapy or in a state of hypnosis.
- Some investigators have studied the ability of individuals to fake dissociative experiences. According to them it is possible to stimulate dissociative disorder. Various experiments conducted by Spanos et al (1994) have suggested that the symptoms of DID could be faked. They found that in one experiment 80 percent of the individuals could successfully fake an alternative personality.
- Objective tests suggest that many people with fragmented identities are not consciously and voluntarily simulating
- DID is more common among females. The ratio of females to males is as high as 9 is to 1.
- The onset of this disorder is always in childhood, often as young as 4 years of age, although it is usually identified approximately at the age of 7 years.
- The prevalence rate of this disorder has been found to be between 3% to 6 %.

- It has also been found that large percentage of DID patients have simultaneous psychological disorders that may include substance abuse, depression, somatisation disorder, borderline personality disorder, panic attacks and eating disorders.
- It has also been noted that there is a high degree of comorbidity of DID with other disorders. This high rate of comorbidity may reflect the fact that certain disorders, such as Borderline personality disorder share many features of DID.
- DID is often misdiagnosed as a psychotic disorder.
- DID occur in a variety of cultures across the world.
- People with DID also experiences a form of amnesia, in which they have gaps in their memory about some aspects of their personal history.

Richard Kluft (2005) has done considerable research in this area. Putnam et al (1986) have noted that, in the 50 years prior to 1970s, only a handful of cases had been reported, but since 1970s, the number of reports increased astronomically, in to thousands. In fact, more cases of this disorder were reported during one 05 – year period in the 1980s than had been documented in the preceding two centuries.

Causes of Dissociative Identity Disorder (DID): Some important causes of DID are as follows:

- i. **Childhood Traumatic Events:** Many surveys have reported that DID is a result of traumatic life events. Putnam et al (1986) examined 100 cases and found that 97 % of the patients had experienced significant trauma, usually sexual or physical abuse and 68 % had reported incest. Similarly, Ross et al (1990) had reported that, of the 97 % of the cases, 95 percent reported physical or sexual abuse. Often the abuse is bizarre and sadistic. Traumatized individuals fail to develop an integrated and continuous sense of self
- ii. **Lack of Social Support:** It has also been found that a lack of social support during or after the abuse also seems implicated. A recent study of 428 adolescent twins has demonstrated that in 33% to 50% of the cases dissociative disorder could be attributed to chaotic, nonsupportive family environment.
- iii. **Sociocognitive Model of DID:** This model was presented by Lilienfeld et al (1999). According to this model, clients enact the roles that they feel (consciously or unconsciously) are demanded by the situation. Social attention to the condition of DID, along with unintentional prompting by

therapist, can lead to the development of this disorder in vulnerable individuals. According to Sociocognitive Model, these individuals may in fact have suffered abuse as children, but many other factors, socially determined, operate to create the dissociative symptoms in adulthood

- iv. **Subtype of Post Traumatic Stress Disorder:** DID is very similar in etiology to Post Traumatic Stress Disorder. Both conditions feature strong emotional reactions to experiencing a severe trauma. There are some researchers who are of the opinion that DID is an extreme subtype of Post Traumatic Stress Disorder, with a much greater emphasis on the process of dissociation than on symptoms of anxiety, although both are present in each disorder.
- v. **Biological Contributions:** Some researchers have implicated biological contributions in the development of DID. It has been reported that individuals with certain neurological disorders, particularly seizure disorders, experience many dissociative symptoms. Devinsky et al (1989) reported that approximately 6 % of the patients with temporal lobe epilepsy reported “out of body” experiences. Similarly, another groups of researchers (Schenk and Bear, 1981) have found that about 50 % of the patients with temporal lobe epilepsy displayed some kinds of dissociative symptoms.

Treatment of Dissociative Disorder: Some important points with respect to the treatment of this disorder are as follows:

- i. Generally individuals who experience dissociative amnesia or a fugue state usually get better on his or her own and remember what they have forgotten.
- ii. The therapy focuses on recalling what happened during the amnesia or fugue states, often with help of friends or family who know what happened, so patients can confront the information and integrate it into their conscious experience.
- iii. The treatment of DID is much more difficult as compared to other dissociative disorders. Not much controlled research has been done on the effects of treatment, though there are many documented successes of attempts to reintegrate identities through long-term psychotherapy.
- iv. The strategies that therapist use today in treating DID are based on accumulated clinical wisdom as well as procedures that have been successful with posttraumatic stress disorder.

- v. The major goal in treating DID is to identify cues or triggers that provoke memories of trauma and/or dissociation and to neutralize them. Most important in the treatment process is that the patient is taught to confront and relieve the early trauma and gain control over the horrible events, at least as they recur in the patient's mind
- vi. In the treatment of DID hypnosis is often used to gain access to unconscious memories and bring various alters into awareness.
- vii. Treatment of dissociative disorders involves helping the patient re-experience the traumatic events in a controlled therapeutic manner in order to develop better coping skills. In the case of dissociative identity disorder, therapy is often long term, and may include antidepressant drugs. Particularly essential with this disorder is a sense of trust between therapist and patient.
- viii. Some clinicians have used cognitive-behavioural techniques in the treatment of DID instead of or in addition to hypnotherapy in an effort to change the client's dysfunctional attitudes. These attitudes arise from the client's history of abuse and includes the following core beliefs:
 - That it is wrong to show anger or defiance
 - That one cannot handle painful memories
 - That one unconsciously hates the parents or experiences conflicting attitudes towards one or both the parents
 - That one must be punished
 - That one cannot be trusted, etc.

According to Ross (1997) these core beliefs need to be changed. Kluft (1989) has used cognitive-behavioural techniques to bolster an individual's sense of self-efficacy through a process called temporizing, in which the client controls the way that the alters make their appearance. This may be accomplished through hypnosis in an effort to help the client develop coping skills that can be used when dealing with stress.

5.2.2 Dissociative Identity Disorder and the Legal System:

Forensic psychologists and other legal experts have been concerned with the legal aspects of DID. Legal Defendants have used this diagnostic category as a defense for their offences. Forensic psychologists and other members of the judicial system are faced with the difficult task of differentiating a true dissociative disorder from instances of malingering. Kenneth Bianchi, a serial murderer also known as the Hillside Strangler, faked multiple personality disorder defense. Individuals who seek to explain their

crimes as products of alter personalities typically invoke an insanity defense or claim that they are not competent to stand trial (Slovenko, 1993). Accused undertake the defense that they have committed the crime under the control of an alter personality. They may further claim that the offense was committed in a state of dissociation and that they have no recall of what happened. Steinberg et al (2001) developed criteria for assessing the validity of dissociative symptoms within the context of clinical and forensic evaluations. They recommended the use of Structured Clinical Interviews for DSM IV Dissociative Disorders – Revised (SCID – D – R).

5.2.3 Other Dissociative Disorders: Many other dissociative disorders have also received considerable research attention and have come to the attention of the clinicians in their routine practice. Some important dissociative disorders that we will briefly discuss are as follows:

a. Dissociative Amnesia: Dissociative Amnesia was earlier called as psychogenic amnesia. In this disorder an individual is unable to remember important personal details and experiences usually associated with traumatic or very stressful events. This memory loss is not attributable to brain dysfunction, brain disorder or drugs. In this disorder an individual forgets his personal information in totality or is unable to remember some specific personal details. Dissociative Amnesia is common during the time of war or similar stressful events. It should be remembered that in most cases of Dissociative Amnesia, the forgetting is very selective for traumatic events or memories rather than generalized. Dissociative Amnesia is found to be common during war. There are four forms of dissociative amnesia, each associated with the nature of a person's memory loss. The four forms of dissociative amnesia are as follows:

- i. **Generalized Amnesia:** In this type of amnesia an individual is unable to remember personal information, including one's identity. The duration of this disorder may range from being a life long or may last for about 6 months or a year.
- ii. **Localized or Selective Amnesia:** In this type of amnesia there is a failure to recall specific events. These specific events, which are difficult to remember, are related to specific period of time. This amnesia is more common as compared to generalized amnesia.
- iii. **Selective Amnesia:** The individual fails to recall some, but not all details of events that have occurred during a given period of time. For example, the survivor of fire may remember the ambulance ride to the hospital, but not having been rescued from the burning house.

- iv. **Continuous Amnesia:** It involves a failure to recall events from a particular date up to and including the present time. For example a soldier may remember his childhood and youth until the time he entered the armed services, but he may have forgotten everything that took place after his first tour of combat duty.

Dissociative Amnesia is very difficult for clinicians to diagnose, because there are so many possible causes of memory loss. Amnesia can also result from physical dysfunction due to brain injury, epilepsy, substance abuse, etc. Some individuals also fake symptoms of dissociative amnesia to gain certain benefits or advantages. For example, a man who has committed a serious crime may claim that he remembers nothing of the incident or even who is.

b. Dissociative Fugue: It was formerly called as psychogenic fugue. The term Fugue means flight and this disorder is very much similar to amnesia. In this disorder individuals take off from one place and move to another place without their conscious awareness and may be further confused, on gaining awareness, as to how they arrived at this new place. In this disorder a person is confused about personal identity suddenly and unexpectedly travels to another place. People in a fugue state are unable to recall their history or identity and a few may even assume a new identity. A fugue is rare and usually passes quickly. The disorder is more likely to occur at certain times, such as during a war or following a natural disaster. Personal crises or extreme stress, such as financial problems the desire to escape punishment or the experience of a trauma can also precipitate fugue states. Some other important features of this disorder are as follows:

- This disorder usually occurs in adulthood and never before adolescence. It rarely occurs after the person has crossed the age of 50.
- Dissociative Fugue is such a rare disorder that virtually no controlled research has been carried out on it.
- Fugue state end rather abruptly and the individual returns home recalling most if not all of what happened. In this disorder, the disintegrated experience is more than memory loss, involving atleast some disintegration of identity if not the complete adaptation of a new role.
- One type of distinct dissociative disorder not found among western cultures is “Amok”, which is very similar to the term “running amok”. In this state an individual is in a trance like state and often brutally assaults and sometimes kills persons or animals and acquires a mysterious source of energy, runs or

flees for a long time, etc. This disorder is most common among males.

- A still another type of dissociative disorder found among the native people of Aartic which is similar to “Amok” is called “Pivloktoq” and the same disorder amongst the Navajo tribe is called “Frenzy Witchcraft”.

c. Depersonalization Disorder: It is a dissociative disorder, usually occurring in adolescence, in which individuals lose their sense of self and feel unreal or displaced to a different location. Depersonalization involves a sense of thing or experiences as being “unreal” and a feeling of estrangement from oneself or one’s surrounding, both feelings have an unpleasant quality and are experienced as a distinct change from one’s usual mode of functioning.

Individuals with this disorder feel that they are, all of a sudden different, for example, that they are other people or that their bodies have drastically changed and hence, become very much different.

Individuals with this disorder have an out-of-body experience in which they feel that they are, for time, floating above their physical bodies and observing what is going on below.

The phenomenon of depersonalization includes alterations of mind-body perception, ranging from detachment from one’s experiences to the feeling that one has stepped out of one’s body. Depersonalisation experiences also occur in normal people when they are placed under great stress or when they use mind-altering drugs, such as marijuana or LSD. In depersonalization disorder, however, distortions of mind-body perceptions happen repeatedly without provocation by drugs. Periods of extreme stress, such as the time immediately following an accident can also precipitate an episode of Depersonalisation in a vulnerable individual

This disorder is often precipitated by acute stress resulting from an infectious illness, an accident, or some other traumatic event. Individuals who experience depersonalized state are usually able to function entirely normally between episodes.

This disorder is episodic by nature and lasts for few minutes or hours. This is the most frequent disorder of dissociative type, so it is thought that it must be mildest form of dissociation and must be more easily curable. It is assumed that depersonalization must be an attempt to escape from a stressful situation. However, the data about the disorder is not very clear. Some important features of this disorder are as follows:

- Depersonalisation is a psychological mechanism whereby one “dissociates” from reality. Depersonalisation is often a part of a serious set of conditions where reality experience and even one’s identity seem to disintegrate.
- This is the most frequent disorder of dissociative type, so it is thought that it must be the mildest form of dissociation and must be more easily curable.
- Most frequent disorder found among normal individuals.
- It involves feelings that are extremely unpleasant and result in anxiety and feeling of lack of control.
- In this disorder an individual feels that he is out of his body and the body is distorted. Sometimes, people also report that they were dead and floating above the body.
- This disorder is episodic by nature and lasts for few minutes or hours.

5.2.4 Theories and Treatment of Dissociative Amnesia, Dissociative Fugue and Depersonalisation Disorder: Most experts agree that dissociative disorders are the end product of intensely traumatic experiences during childhood, especially those involving abuse or other forms of emotional maltreatment. Other forms of traumatic experiences, which can be transient or long lasting may also lead to dissociative disorders. Current views with regard to causation of dissociative disorder is largely based on psychological perspectives. Our knowledge of biological factors involved in causation of these conditions is highly limited.

5.3 SOMATOFORM DISORDERS, PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITIONS AND DISSOCIATIVE DISORDERS: THE BIOPSYCHOSOCIAL PERSPECTIVE

Historically these disorders were regarded as neurosis rather than psychosis. People with these disorders have experienced conflict or trauma during their lives and circumstances have created strong emotional reactions that they could not integrate in to their memory, personality and self-concept. The symptoms seen in somatisation disorder and dissociative states represent not a loss of contact with reality but a translation of various emotions in to terms that are less painful to acknowledge than is the original conflict or trauma.

Stressful events in many individuals trigger maladaptive responses in physical functioning, ranging from variety of physical conditions to sleep dysfunctions and various somatic complaints

which are often vague. Currently the most prevalent view is that stress related factors and not repressed sexuality is central to understanding somatoform disorders. Besides stress, learning seems to play a strong role, especially in cases where individuals have developed secondary gains from their symptoms.

With regard to dissociative disorders, researchers believe that, actual, rather than imagined trauma is the source of such symptoms as amnesia, fugue and multiple identities.

Cognitive behavioural therapists have also offered their perspective on this group of disorders. According to them low feelings of self-efficacy, lack of assertiveness and faulty ideas about the self can all be contributing factors to somatoform and dissociative disorders. For example believing that one must be sick to be worthy of attention is a dysfunctional attitude that underlie the development of somatoform disorders. Similarly faulty beliefs about the self and the role of the self in past experiences of trauma seem to be important cognitive factors that may contribute to an individual's vulnerability to developing these maladaptive thoughts or susceptibility to trauma.

5.4 SUMMARY

In this unit we have discussed the concept of Dissociative disorders. We have attempted to understand as to how these group of disorders are an extreme form of psychological disturbance involving anxiety and conflict in which part of an individual's personality actually separates from the rest of his or her conscious functioning. One type of dissociative that we discussed in detail was the Dissociative Identity Disorder (DID). The various characteristics of Dissociative Identity Disorders as well as its theories and treatment were discussed.

Many different types of dissociative disorders that we would discuss in brief include Dissociative Amnesia and its variants, Dissociative Fugue, Depersonalisation Disorder. Theories and treatment of these various dissociative disorders were also briefly discussed. Towards the end of the unit we have discussed the biopsychosocial perspective of various Somatoform Disorder, Psychological Factors Affecting Medical Conditions and Dissociative Disorders.

5.5 QUESTIONS

- Q1. What are Dissociative disorders? Discuss Dissociative Identity Disorder (DID), its Characteristics, Causes and treatment.
- Q2. Write a note on Dissociative Identity Disorder and the Legal System.
- Q3. Discuss Dissociative Amnesia, Dissociative Fugue and Depersonalization Disorder.
- Q4. Write a note on The Biopsychosocial Perspective of Somatoform Disorders, Psychological Factors Affecting Medical Conditions and Dissociative Disorders.

5.6 REFERENCE

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SEXUAL DISORDERS

Unit Structure

- 6.0 Objectives
- 6.1 Introduction
- 6.2 Abnormal Sexual Behaviour
- 6.3 Paraphilias
- 6.4 Gender Identity Disorder
- 6.5 Sexual Dysfunctions
- 6.6 Sexual Disorders :The Bio psychosocial Perspective
- 6.7 Summary
- 6.8 Glossary
- 6.9 Questions
- 6.10 Suggested Readings

6.0 OBJECTIVES :

After reading this unit you will be able to know :

- About abnormal sexual behaviours.
- What are the different types of paraphilias, its causes and treatment.
- About gender identity disorder, its causes and treatment.
- What are the types, causes of sexual dysfunctions.
- The different perspectives of sexual disorders.

6.1 INTRODUCTION :

The inability to enjoy sexual relationship and experience distress and difficulty while engaging in sexual acts is referred to as sexual disorder. In this unit we will discuss about the concept of sexual disorder, its types and treatments. First one is paraphilias or sexual deviation, second is sexual dysfunction and third is gender identity disorder. There are different theories of the causes of these disorders. Different treatments such as biological therapies, psychological approaches and cognitive therapies, etc., are successful to great extent to help the people suffering from these disorders.

6.2 ABNORMAL SEXUAL BEHAVIOUR :

Normal sexual response cycle has five stages – sexual desire, arousal, plateau, orgasm and resolution state. But inability to enjoy sexual relationship and experiencing difficulty at any stage is considered sexual disorder. For example, complete lack of sexual desire, active avoidance of sexual activity, inability to be aroused or maintaining erections or absence of orgasm are few sexual disorders. Paraphilias are disorders that involve non-human objects, non-consenting adults, children, etc. Gender Identity disorder is wrong perception of one's own gender resulting in transsexual or transgender individuals. Sexual sadism, pedophilia, etc., include inflicting pain to sexual partners.

6.3 PARAPHILIAS :

1. Fetishism :-

Fetishism involves the use of inanimate objects as the preferred source of sexual arousal or gratification. There are different types of fetishism. The most popular are women's under garment, according to DSM – IV criteria. Fetishistic arousal can be associated with different classes of objects or activities.

- a) An inanimate object.
- b) A source of specific tactile stimulation such as rubber, etc.
- c) Part of the body such as toe, buttocks, etc.

Soft fetishes are soft, furry, lacy or frilly panties, stocking, etc., Hard fetishes objects are smooth, harsh objects, such as spied shoes, gloves, etc.

An elaborate form of fetishism is Transvestism, also referred as cross - dressing, in which heterosexual men dress in women's clothing as their primary means of becoming sexually aroused. Some use only one garment such as women's panty, under their business suits. The complete cross dresser, fully clothes himself in women's garments, applies make up and a wig, etc. Few engage cross dressing alone, others participate in groups.

2. Sexual Sadism and Sexual Masochism :-

Sexual sadism and sexual masochism are two separate diagnoses, although sadistic and masochism sexual practices are considered together as a pattern of sadomasochism. Both are associated with either inflicting pain or humiliation (Sadism) or being made to suffer pain or humiliation (masochism). Some people occasionally engage in modestly sadistic or masochistic behaviours

during sex or stimulate such behaviours without actually inflicting pain or suffering.

They follow the rituals of practising of bondage and domination. One partner is bound, gagged and immobilised and is subjected to sexual acts of other partner. Apart from sexual, acts, beating, whippings, electrical shock, burning, cutting, stabbing, strangulation, torture or even death. Different props such as feather garments, chains, shackles, whips, ropes, etc. are used by the sadistic partner to inflict pain on the other partner. Few other partners can find it exciting, many give their consent to please their partner, few do because they are paid for it and few are unconsenting victims. Almost all voyeurs are men who watch women. They typically masturbate while watching or shortly after watching women. They get excited to see fear and disgust on the women's face if they know that they are being watched. The danger of being caught gives them thrill and excitement.

3. Frotteurism :-

It is another paraphilia that often occurs with voyeurism and exhibitionism. The frotteuist gains sexual pleasure by rubbing against and fondling parts of the body of a non-consenting person. They engage in this behaviour in public places such as on a bus, subway, market place, etc., Most of the frotteurists are young males between 15 and 25 years of age.

4. Pedophilia and Incest

The most tragic deviant pattern of arousal is a sexual attraction to children called pedophilia. The DSM – IV diagnostic criteria for pedophilia are-

- a) Intense sexually arousing fantasies, sexual urges with a child or children (over a period of at least 6 months).
- b) The person is atleast 16 years and at least 5 years older than the child or children.
- c) Sexual encounters between pedophilic and their child victims are often brief but they may reoccur frequently.
- d) The contact often consists of the pedophilic exposing and touching the child's genitals or perform fellatio (oral stimulation of the penis) or cunnilingus (oral stimulation of the female genitals) on children.
- e) Some pedophilic penetrate, children's vagina, mouth, or anus with their fingers, foreign objects or their penis. Pedophilics often threaten children, harm them physically, restrain them or tell them that they will punish them or their loved one's if the

children do not obey the pedophilics order. But most of them are not physically abusive because there is no harm or threats from their victims. Children may participate in the molestation without seeming to protest, yet, they may be scared and unwilling without expressing it. Most Pedophilics are family members or acquaintances of the children. Some develop elaborate plans for gaining access to the children, such as winning the trust of their mothers, marrying their mothers, or in rare cases abducting children or adopting children from other countries.

Sometimes the activities can go out of control, for example, Autoerotic asphyxiation. In this activity, sexual arousal is gained by oxygen deprivation caused by hanging or chest compression.

5. Voyeurism and Exhibitionism :-

Voyeurism refers to the practice of observing an unsuspecting person undressing or naked in order to experience sexual arousal. Exhibitionism refers to sexual arousal and gratification associated with exposing one's genitals to unsuspecting strangers.

A vast majority of cases, the exhibitionists are men who bares all to surprise women at public places such as parks, roads, etc. His behaviour is impulsive and compulsive. He experiences excitement, fear, restlessness and sexual arousal and feels compelled to get relief by masturbating himself. Because of the public nature of their behavior, they get caught but they are likely to continue their behaviour after having been caught. The danger of being caught increases their arousal. The element of risk or thrill seems to be important part of this sexual disorder. The fear and disgust on victims face gives them sexual pleasure. Exhibitionisms in same way is the mirror image of voyeurism.

Voyeurism – This type of paraphilia involves secretly watching another individuals nude, bathing in sexual positions. Most pedophilics are heterosexual males abusing young girls. Homosexual pedophilics typically abuse young boys. Women can be pedophilics but it is rare.

If the children are from pedophilics own family, such as daughters or son, then it is called incest. Victims of incests tend to be daughters who are beginning to mature physically. Incestors relation may have more to do with availability and other inter personal ongoing issues in the family.

Causes of Paraphilias

Biological Causes :-

- a) Most of the paraphilics are male (over 90 percent). This may be because paraphilic behaviour often involves hostile or aggressive impulses, which may be more common in males than in females.
- b) Some studies have found links between endocrine abnormalities and paraphilia.
- c) Some studies suggest a relationship between testosterone abnormalities and sexually aggressive paraphilias.
- d) Alcohol and other drug abuse is common in paraphilias because these substances, may disinhibit the paraphilic and so he acts out his fantasy.

Psychological Causes :

- a) Freud viewed paraphilias as a result of arrested psychological development or regression to childhood forms of sexual arousal.
- b) Robert Stoller (1975) argued that the paraphilias are symbolic re-enactments of childhood traumas in which the paraphilics is unconsciously taking revenge on adults who inflicted harm on him as a child.

Behavioural Causes :

- a) Behavioural theories view them as the result of chance classical conditioning. An adolescent male might be masturbating and notice a panty kept on the chair in the room. He thinks of the panty and becomes more aroused. Next time he masturbates, he might be more drawn to the panty because it aroused him a day before. If this fantasy becomes strongly associated with sexual arousal for him, he may develop a fetish for panties.
- b) Paraphilias may be developed by social learning. Children whose parents engaged in aggressive, sexual behaviours with them learn to engage in impulsive, aggressive, sexualised acts towards others.
- c) Many pedophilics have poor interpersonal skills and feel intimidated when interacting sexually with adults. Others have strong hostility toward women and carry out this hostile antisocial acts towards children,

Cognitive Causes :-

- a) Cognitive theories says that a number of distortions and assumptions that paraphilics have about their behaviours and the behaviours of their victims. These distortions may have been learned from parent's deviant messages about sexuality.

Treatment of Paraphilias

Biological Treatment

- a) Drug Treatment
Certain drugs are sometimes used to treat paraphilias, the most popular drug is an anti- androgen drug called, Medroxy progesterone acetate. This drug eliminates the person's sexual desire and fantasy by reducing his testosterone levels. But fantasies and arousal soon returns as soon as the drug is removed. This drug is useful for dangerous sexual offenders who do not respond to alternative treatments.
- b) Drastic biological interventions for pedophilics and men who commit rape have been tried. These includes surgery on the centers of the brain. Castration lowers sexual rates of paraphilias who have committed sexual crimes.

Psychosocial Treatments :-

- a) Actually touching objects that arouses them.
- b) De- Aversion Therapy –
During this therapy paraphilics might receive painful but harmless electric shocks while viewing photographs of what arouse them or while Sensitisation
This therapy helps to reduce the anxiety of the paraphilics about getting involved in normal sexual activities with other normal adults. Relaxation exercises overcomes their faulty association regarding sexual behaviour.
- c) Cognitive Therapy :-
This therapy encourages the paraphilics to identify and challenge thought and situations that arouses them sexually. They are not asked to justify their behaviours.
- d) Empathy training makes paraphilics to think about their victims condition and understand their situations when they are attacked.

- e) Role play and Group therapy -
These two therapy helps parapilic to interact, share and gain insight about their own behaviours.

Check Your Progress –

1. What are the different types of paraphilias?
2. What are the different causes and treatments of paraphilias?

6.4 GENDER INDENTITY DISORDER (GID) :

Gender identity is the perception of a person about themselves as male or female. It is a fundamental component of their self-concept.

Gender identity disorder is diagnosed when a person believes that they are born with the wrong sex's genitals and are fundamentally person of the opposite sex. Person feels that they are trapped in the body of the opposite gender.

Symptoms

1. Strong and persistent identification with the other sex

- a) In children, this is manifested by repeatedly stated desire to be or insistence that he or she is the other sex.
- b) In boys, preference for cross dressing or stimulating female dress. In girls, insistence on wearing only masculine clothing.
- c) Strong and persistant preference for cross sex roles in play and in fantasies.
- d) Strong preference for playmates of the other sex.
- e) In adolescents or adults, identification with the other sex is seen by symptoms such as desire to be with the other sex, desire to live or to be treated as the other sex, conviction that he/she has the typical feeling or reactions of the other sex.

2. Discomfort

Persistent discomfort with his/her sex and sense of inappropriateness in the gender role of that sex.

3. Disinterest in Opposite Sex

He/she is not interested in sexual relation with opposite sex. They experience distress or problem in sexual interaction with the opposite sex, if forced.

4. Confusion

Adults with gender identity disorder is also referred as transsexual or transgender individuals. They wear dress of opposite sex. Some go for sex change operation, some of them are asexual, some are heterosexual and some are homosexual.

5. Disturbed Mental State

To relieve themselves from the tension and confusion, some go for alcohol and drugs. Because of rejection from others they experience frustration, low self-esteem and distress.

Causes of GID**1. Biological Causes –**

- a) Biological theories have emphasised the effects of prenatal hormones on brain development. The excessive exposure to unusual levels of hormones affects the hypothalamus and other important brain structures that controls sexual identity and sexual orientation. But these theories are not well investigated.
- b) Few studies focus on a cluster of cells in the hypothalamus called the “bed nucleus of stria terminalis”. It plays an important role in sexual behaviour. The size of this cell cluster plays an important role in GID. This cell cluster are found to be half of the size in transsexual as compared to non-transsexuals.
- c) Another study suggested that prenatal hormones play an important role in GID. In an experiment, girls were exposed to elevated levels of testosterone in utero. Most of these girls were born with some degree of masculinisation of their genitalia and have more masculine behaviour than other girls.

2. Psychological Causes-

- a) Psychological theories focuses on the prenatal nurturing dimension. How the parents share the child's gender related norms will decide the vulnerability of the child to develop GID later as adult. Usually parents encourage their children to show gender appropriate behaviour, for example, girls playing with

dolls, boy acting as fathers, etc. Boys showing feminine tendencies had mothers who desired girls rather than boys, so pampering their sons with dolls, frocks, kitchen set, etc., Absence of father figure at home and overprotection of mother also leads to feminine tendencies in boys.

- b) Parental psychopathology also determines the development of GID in individuals. It is seen that parents of GID individuals had history of depression, severe anxiety and personality disorder issues. This type of environment may create anxiety and confusion in children. It makes the child unsure about him or herself. A child may adopt a cross gendered identity as a way of pleasing the parent and reducing his/her own anxiety.

Treatment of GID

- a) The therapist tries to help these individuals to clarify their gender identity and sexual orientation.
- b) Some individuals undergo gender reassignment procedures by taking hormone therapy through sex change operation. Before surgery they are asked to groom themselves by cross dressing and interact in society for one or two years. They are given life time hormone therapy in which estrogen is given to a male to develop female secondary sexual trait (breast, etc.,) and testosterone is given to females to develop male secondary sexual trait (beard, etc.). Artificial genitals are created, person can get sexual pleasure but reaching orgasm is not possible. The change and adaptation may cause stress which is managed by the help of counselors and therapists.

Check Your Progress-

1. What are the symptoms of gender identity disorder?
2. How an individual with gender identity disorder can be helped out?
3. What are the biological and psychological causes of gender identity disorder?

6.5 SEXUAL DYSFUNCTIONS :

Three stages of sexuality - desire, arousal and orgasm – each associated with specific dysfunctions. A sexual dysfunction is an impairment in one of these stages. In addition pain can become associated with sexual functioning, leading to additional sexual dysfunctions.

1. Sexual Desire Disorders

a) Hypoactive Sexual Desire Disorder

The person seems to have no interest in any type of sexual activity. The individual might have no desire whatsoever despite having frequent sex.

b) Sexual Aversion Disorder

In this situation the individual not only has no interest in sex, but even the thought of sex or a brief touch, such as someone's taking the person's hand to assist him or her in getting out of a car may evoke fear, panic or disgust. In some cases of sexual aversion disorder, the principal problem might actually be panic disorder, when the fear or alarm response has become associated with the physical sensation of sex.

c) Sexual Arousal Disorders

Disorders of arousal refer to male erectile disorder and female sexual arousal disorder. Individuals with arousal disorders have frequent sexual urges and fantasies and strong desire to have sex. Their problem is difficulty becoming aroused, that is, a male has difficulty achieving and maintaining an erection and a female cannot achieve or maintain adequate lubrication.

Arousal disorders can be either lifelong or acquired. Lifelong refers to a chronic condition that is present during a person's entire sexual life. Acquired arousal disorder is one that begins at a specific time before which sexual activity was relatively normal. In addition arousal disorders can either be generalised, in which case they occur every time an individual attempts sex or they can be situational, occurring only with some partners or at certain times, but not with other partners or at other times.

2. Orgasm Disorders

a) Inhibited Orgasm

It is inability to achieve an orgasm despite adequate sexual desire and arousal, commonly seen in women but rarely seen in men. Five to ten percent of the females may experience female orgasmic disorder in which they never or almost never reach orgasm (Wincze & Carey, 1991).

b) Premature Ejaculation

A far more common disorder of orgasm experienced by males is premature ejaculation, which refers to ejaculation occurring well before the partner wishes it to.

3. Sexual Pain Disorders

In sexual pain disorders marked pain is associated with sexual intercourse. Two subtypes have been identified-

- Dyspareunia
- Vaginismus

For some males and females sexual desire is present and arousal and orgasm are easily attained, but the pain of intercourse is so severe that sexual behaviour is disrupted. This disorder is named dyspareunia which, in its original Greek, means “unhappily mated as bedfellows” (Wince & Carey 1991).

More common than dyspareunia is vaginismus. In this condition, occurring in women, the pelvic muscles located in the outer third of the vagina undergo involuntary spasms where intercourse is attempted. Women report sensation of “ripping, burning or tearing during attempted intercourse”.

CAUSES OF SEXUAL DYSFUNCTION

1. Biological Causes
2. Psychological Causes
3. Socio Cultural Causes

1. Biological Causes

a) Disease

Diabetes has been linked to sexual dysfunction. Diabetes can lower the sexual drive, arousal, pleasure and satisfaction, especially in men. Cardiovascular disease, multiple sclerosis, renal failure, vascular disease, spinal cord injury and injury to automatic neurons system due to surgery or radiation have also been linked to causes of sexual dysfunction. Males are more prone to get affected.

b) Hormones

Low level of androgen hormones in men, especially. Testosterone, and high/level of estrogen and prolactin hormone have been linked to cause sexual dysfunction. Menopausal women have low sexual desire and arousal because of no estrogen secretion in the body. Ovarian cancer, vaginal surgery and sexual self image problem can bring sexual dysfunction among women.

Prescribed Drugs

Antihypertensive drugs (for high blood pressure), antipsychotic drugs, anti depressants, tranquillisers, etc, are medical drugs that cause sexual dysfunction.

Marijuana, cocaine, amphetamine and nicotine can impair sexual functioning. Alcohol intake too is linked to sexual dysfunctioning.

2. Psychological Causes

a) Psychological disorder

Depression is one such cause of sexual dysfunction. Besides this, the individual suffering from anxiety disorder, panic disorder, obsessive compulsive disorder, schizophrenia too have reported no or little desire for having sex. They lack feelings of sexual arousal and have problems in sexual functioning.

Attitudes and cognition about sex – some people have negative attitudes about sex. They may consider it dirty, sinful and disgusting and may avoid involving themselves in any kind of sexual activity.

Performance anxiety is yet another blockade for people to enjoy sex. There is so much worry and apprehension about their sexual performance that it psychologically hinders the pleasure of sexual acts among individuals.

3. Social and Inter personal Causes

a) Problems in Relationship

People suffering from sexual dysfunction are also seen to be struggling with maintaining intimate relationship. Differences in opinion about conducting sexual activities may be the main reason for conflicts between couples. Lack of communication about sexual preferences and arousal to each other trigger more interpersonal conflicts. Besides this, the male arousal pattern differs from female patterns. Non assertiveness in communicating one's sexual desires and stimulation to the partner can cause dissatisfaction in sexual life leading to frustration. Behaviour conflicts also influences sexual relationship. Disrespect towards one's partner, bitterness, anger, frustration among couples block sexual desire and healthy sexual functioning.

b) Trauma

Death of loved one, job loss, diagnosis of a serious disease unemployment in men, etc., leads to lower self esteem and distorts the self concept. Trauma also leads to depression and reduces desire for sex.

4. Cross Cultural Differences

Ancient Chinese and Indian medical system consider male masturbation as uncommendable.

Malaysians, Southeast Asian and Southern Chinese male population has shown a depersonalisation syndrome known as 'koro'. This syndrome involves acute anxiety state, panic and fear of dying, delusional feeling that the penis is shrinking in the body and will eventually, disappear.

5. Sexual Problems across life span

As age declines, the biological changes occurring in the body influences one's sexual functioning. Adequate level of testosterone are essential for proper sexual arousal in both men and women. Testosterone levels start declining around age of fifty in men. Inadequate erections and sexual dysfunction increases with age.

TREATMENTS SUGGESTED FOR SEXUAL DYSFUNCTIONS

1. Biological Therapy
2. Sex Therapy
3. Couple Therapy
4. Individual Psychotherapy
5. Treatment approach towards homosexual and bisexual issue

1. Biological Therapy

Certain medical conditions like diabetes, etc., automatically leads to sexual dysfunctioning. Regulating dosage of drugs helps in regulating/curing sexual dysfunction.

Special drugs too are available that can treat sexual dysfunction. Viagra is one such drug.

- Some drugs are also injected in the penis to gain penile erections.
- Hormone therapy too is administered among men and women, who are suffering from sexual dysfunctions.

2. Sex Therapy

Sex therapy is recommended to couples. The major focus of therapy is on training the couples on various sexual practices that can be beneficial to keep them aroused and compliment each other sexual preferences.

3. Couple Therapy

Many times couples do not give enough attention to foreplay and seduction prior to sexual intercourse. They just rush to experience the sexual pleasure through the sexual act. This can be problematic for couple later in life, when the biological level of testosterone and estrogen starts diminishing it result in inadequate arousal and displeasurable experience while having sex.

4. Individual Psychotherapy

Cognitive behaviour therapy is conducted to reshape sexual attitudes and script between couples (Rosen and Leiblum 1995). The reasoning behind sexual fears are confronted to form fresh perspective and positive cognitions. Psychodynamic therapies too are used to find clues from the past to the current sexual problems.

5. Approach towards Homosexual and Bisexual Issues : Gay, lesbians and bisexuals too experience sexual dysfunctions similar to heterosexuals. Societal attitude towards gay, lesbians and bisexuals is the most important factor negatively influencing their sexual problems.

6.6 BIOPSYCHOSOCIAL PERSPECTIVE :

Patterns of sexual behaviour vary widely across different cultures around the world. Although most individuals around the world, especially in western cultures, practice safe sex, approximately 20% of individuals engage in sex with multiple partners. Studies show that no gender differences are apparent in attitudes about sexual satisfaction, masturbation or homosexuality. In western cultures premarital sex is common as compared to Sweden where attitudes, are more permissive. What is normal sexual behaviour in one culture may not necessarily be normal in another culture. Report says that homosexuality runs in families. The environment and experience play very powerful role in sexual behaviour. Sometimes negative attitudes or experiences associated with sexual interactions may contribute to sexual determination. Cultures with very restrictive attitudes towards sex can influence sexual behaviour. For example. Vaginismns is rare in North America but is most common in Ireland.

6.7 SUMMARY :

Three types of sexual disorders are gender identity disorder , sexual dysfunction and paraphilias. GID is dissatisfactions with one's biological sex. Sexual dysfunctions such as disorders of sexual desire, arousal, orgasmic disorder, inadequate penile

erection, etc., are related to different stages of normal sexual cycle. Paraphilias is sexual attractions to inappropriate people such as children, or objects such as clothes, etc.

The causes are socially transmitted negative attitudes towards sex, biological and psychological causes.

Treatments for sexual disorders include biological and psychosocial approaches. Treatments for paraphilias are highly successful but available only in specialised clinics. Treatments for sexual dysfunctions is successful but not readily available.

6.8 GLOSSARY :

1. **Exhibitionism** - sexual gratification associated with exposing one's genitals to unsuspecting strangers.
2. **Fetishism** - sexual attraction to non-living objects, such as clothes, shoes.
3. **Pedophilia** - sexual attraction to children.

6.9 QUESTIONS :

- Q.1 Discuss the different types of paraphilias.
- Q.2 Explain the various causes and treatment of paraphilias.
- Q.3 Write a note on Gender Identity Disorder.
- Q.4 Discuss the different types of sexual dysfunction and its causes.
- Q.5 Discuss various treatment options for sexual dysfunctions.

6.10 SUGGESTED READINGS :

1. Oltmanns, T.F., Emery, R.E. (2010). Abnormal Psychology 6th ed., New Jersey : Pearson Prentice Hall
2. Nolen – Hoeksema, S. (2008). Abnormal Psychology. 4th ed. New York : McGraw – Hill



MOOD DISORDER

Unit Structures :

- 7.0 Objectives
- 7.1 Introduction
- 7.2 General Characteristics of Mood Disorder
- 7.3 Depressive Disorders
 - 7.3.1 Major Depressive Disorder
 - 7.3.2 Types of Depression
 - 7.3.3 Dysthymic Disorder
- 7.4 Disorders Involving Alterations of Mood
 - 7.4.1 Cyclothymic Disorder
- 7.5 Theories of Mood Disorders
 - 7.5.1 Biological Perspectives
 - 7.5.2 Psychological Perspectives
 - 7.5.3 Socio Cultural And Interpersonal Perspectives
- 7.6 Treatment of Mood Disorders.
- 7.7 Suicide.
- 7.8 Summary
- 7.9 Questions
- 7.10 References

7.0 OBJECTIVES

After studying this unit you should-

- Comprehend the general characteristics of mood disorder.
- Know the various types of mood disorders.
- Understand the theories and treatment of Mood disorders.
- Became aware about suicide its causes, assessment and treatment.

7.1 INTRODUCTION

We do feel happy and energetic and sometimes sad and depressed. These are commonly experienced mood changes. The mood disorders explained in this unit are more serious and disruptive in nature.

Mood disorder is one of the group of disorders involving severe and enduring disturbances in emotionality ranging from elation to severe depression. Mood disorder involves disturbances in person's emotional state or mood. People can experience extreme depression or alternate between elation and depression.

7.2 THE GENERAL CHARACTERISTICS OF MOOD DISORDERS

1. Individual feels overwhelming sadness or dysphoria.
2. In another variety of mood disorder, individual has experiences that are opposite of depression, feelings of happiness called as euphoria.
3. Mood disorder has a time limit period during which specific symptoms of disorders are seen. The time limited period of intense symptoms of disorder is called as an episode. The episode of disorder may be very lengthy extending up to 2 or 3 years .
4. Mood disorders are classified as mild, moderate and severe depending on the severity of episode.
5. Every clinician documents whether the disorder is first occurrence or if there is recurrence of symptoms. If it is a recurrent episode, clinician tries to find out if the client has fully recovered or not.
6. Some people may display even bizarre and unusual behaviors, such as odd bodily postures or movements or excessive purposeless motor activity.
7. The clinician also tries to determine if there is a postpartum disorder. A disorder that is seen in women after giving birth to baby is called postpartum disorder.

7.3 DEPRESSIVE DISORDERS

The person experiencing depressive disorder, usually experiences feelings that follow a tragic loss or grief. People do get back to day-to-day affairs and come to terms with tragic loss and grief. Individuals suffering from depression, continue to experience

feelings of hopelessness, fatigue, and worthlessness and show suicidal tendencies even when there is no apparent cause.

I Major Depressive Disorder

- i) The following are the characteristics of major depressive episodes:-
 1. It involves an intense dysphoric mood that is much more serious than ordinary sad moments of day-to-day life. The dysphoria may be found in the form of excessive dejection or sudden loss of interest in the activities that were previously pleasurable.
 2. If intense depression continues after death of loved one for more than 2 months, then it is a major depressive disorder.
 3. The depressive disorders may not always have a precipitating event. Onset may be without any known cause.
 4. Persons experience impairment at home and work due to depression.
 5. The physical signs of depressive episode are manifested as somatic symptoms like :-
 - a) Lethargy and listlessness.
 - b) Psychomotor retardation involving slowing down of body movements.
 - c) Some people may show extreme psychomotor agitation. These behaviors may be bizarre and extreme, sometimes may be even categorised as catatonic.
 6. Eating disturbances are more common, people may not have appetite and may even avoid food. Some others may overeat, or overindulge in sweet and carbohydrates.
 7. Dramatic changes in sleep patterns are observed. People may show insomnia or engage in excessive sleeping. The EEG sleep patterns show that clients show disturbances in sleep continuity, intermittent wakefulness and early morning awakening. Disturbances in REM sleep are evident; there are more eye movements and increased duration of REM sleep. Such major REM abnormalities are seen before the major depressive episode.
8. The cognitive symptoms are :
 - i) Intensely negative self –concept, low self-esteem followed by a strong need to be punished.
 - ii) Intense guilt feelings and persistent thinking about the past mistakes is common.
 - iii) Difficulty in thinking, concentration and decision making.

9. Loss of interest in the activities that were considered as interesting in the past. Person is overcome by feelings of negativity and hopelessness and thinks that death is the only way of escaping and may actually commit suicide.

The symptoms of depression may continue from 2 weeks to period of two months. If untreated, symptoms may continue for another six months. The symptoms of major depressive episode occur gradually, they are not shown over night.

II) Types of Depression

- A) Depressive episodes involving melancholic features.
- B) Depressive episodes involving seasonal patterns.

A) Depressive episodes involving melancholic features:-

Persons lose interest in most of the activities. They find it difficult to react to events that require pleasurable reactions. Morning is very difficult for these people. They may wake up early in the morning and continue the day with sad and gloomy feelings and other major symptoms of depression.

B) Depressive episodes involving Seasonal Patterns:-

People with seasonal patterns of depression develop disorder almost at the same time each year or may be about 2 months during winter, but then, they come back to normal life. During episode they lack energy, interest, may sleep excessively, and overeat more carbohydrates. Some researchers propose that seasonal depression is linked with changes in biological rhythms. It is found that people with seasonal depression are found more in states where there is less temperature.

The onset and the course of disorder:- The average age for major depressive disorder is 30 years.(Hasin et al 2005) A study performed Cross National Collaboration Group 1992, (Kessler et al 2003) showed that incidence of depression and consequent suicide is steadily increasing over the years. The national morbidity study has shown that increasing younger groups called as cohorts have higher prevalence rates than older people. Individuals aged 18-29 years are more likely to become depressed at the earlier ages than the people in the age group 30-44 years. In short, depression has started surfacing at an early age with greater frequency.

The length of depressive episode is variable. Some episode may last for two weeks and in more severe cases it may last for several years. If untreated the first episode of depression may last for 4 to 9 months (Eaton et al 1997). The diagnosis of depressive episode becomes completed, especially when person also has a

personality disorder. Some may attempt to reduce depression by resorting to drug or alcohol addiction. Depressive episodes may be found in children and adolescents. The typical age of onset has been estimated to be early 20's. D.N. Klein, Taylor, Dickstein and Harding found the three characteristics of the onset of disorder before 21.

1) It lasts longer 2) It shows relatively poor response for treatment. 3) The chances are stronger that the disorder may run in the family of affected persons. Study done by Kessler et al (2005) show that approximately 2.5 percent of adult population develop this disorder in the course of their life. This disorder reaches its peak by 45 to 59 years.

Adults usually take on the physical symptoms of dysthymia. Finally, hospitalisation is very rarely required except in the cases where depression leads to suicidal attempts.

III) Dysthymic Disorder :

Some people experience depression involving sadness, but sadness is not so intense to be described as major depressive episode. But such depression is very often long lasting. This does not refer to the mood changes that we do experience in day-to-day life. People with dysthymic disorder show the symptoms of major depressive disorder for at least 2 years. These symptoms may include appetite disorder, sleep disturbances, low energy, fatigue, low self esteem, poor concentration, difficulty in decision making and feelings of hopelessness. Dysthymic disorder differs from major depressive episode only on the basis of its course, i.e., chronic in nature. People with dysthymic disorder are never symptom free for more than two months. They may withdraw from social interactions and react with anger and irritability towards others. Many a times dysthymic disorder may be accompanied by other serious psychological disorder. In some instances dysthymia may be accompanied by personality disorder, some of them may go for major depressive episode. Some of them may go for substance abuse. Hence, clinicians may diagnose wrongly, and attempts may be done to reduce feelings of hopelessness and worthlessness. Hospitalisation may not occur in such cases except in the cases of suicidal behaviour. Dysthymia may be diagnosed in children and adolescents.

The Prevalence and Occurrence of the Disorder:- It is observed that 2.5 percent of adult population will develop this disorder in the course of life and the disorder reaches its peak from 45 to 59 years (Kessler et al 2005). In the older patients the disorder may take physical form rather than psychological disturbance.

7.4 DISORDERS INVOLVING ALTERATIONS OF MOOD

There are two types of disorder involving mood alterations.

1) Bipolar disorder 2) Cyclothymic disorder

1) Bipolar disorder :

It involves an intense and disruptive experience of elations or euphoria alternating with major depressive episode.

Bipolar disorder may occur in two forms. Individuals may experience manic episode or may experience mixed episode.

Cyclothymic disorder involves alteration between dysphoria and less intense type of euphoria called hypomaniac disorder.

Manic episode ;- Any manic episode, even if it is not followed by depressive episode is described as bipolar disorder. Previously bipolar disorders were described as manic depressive disorder. The term bipolar implies two poles or extremes, mania and depression. People with bipolar disorder may not always show symptoms of depression. It is assumed that people with bipolar disorder will experience depression at some time in later months or years.

Person experiencing manic episode may appear to be outgoing, talkative, creative, witty and self confident. The expansiveness and feelings of energy can cause serious problems in their day-to-day functioning. Self-esteem of these individuals may be grossly inflated. Their thinking may be grandiose and even may have psychotic quality.

Most people in manic episode may have bizarre thoughts, They may show unusual ideas and swings of unusual creativity. There is a rapid change in thoughts and ideas; they may jump from one activity to another. They are easily distracted and continually require stimulation. They may speak rapidly to others with a such a speed that others find it difficult to interpret. People experiencing manic episode may seek out pleasurable activities that may be impulsive in nature. He or she may engage in ill advised sexual relationships or spending sprees. Often person has grand plans and goals which he pursues fanatically.

Manic episode may appear and diminish suddenly. The depressive episode may appear gradually and diminish with same speed. The duration of manic episode depends on the treatment taken by the individual.

Types of Bipolar disorder :

Bipolar disorder is of two types:- Bipolar disorder-I and Bipolar disorder – II. Bipolar I disorder is diagnosed when individuals experience one or more manic disorder, with the possibility of experiencing one or more depressive disorder. But it is always not necessary that person experience one or more depressive episode.

Bipolar II is a disorder in which major depressive episode alternates with hypomania episode i.e., individual has one or more major depressive episode and at least one hypomanic episode. hypomania episode are of lesser severity.

Prevalence and course of the disorder :

It is relatively very rare for someone to develop bipolar disorder after the age of 40. But once it appears it tends to be chronic, where manic and depression keep on recurring indefinitely. Bipolar disorder is less commonly seen as compared with major depressive disorder. The incidence of bipolar disorder is equally found in both males and females (Kessler of et al 1994). There are gender differences in the onset of the disorder.

The first episode for men is more likely to be major manic episode, for women it is more likely to be major depressive episode.

Bipolar disorder has been reported in psychiatric literature, it has been found in children as young as 3 years. There is lack of consistency in the diagnostic criteria and methods of assessment for young children. Psychologically disturbed children display wide range of symptoms.

II) Cyclothymic disorder :

It is similar in many ways to dysthymic disorder. Like dysthymic disorder, cyclothymic disorder is chronic alteration of mood elevation and depression. People with cyclothymic disorder display unusually dramatic and recurrent mood shifts. The symptoms may not be as severe as with people with bipolar disorder. The elation may not be severe enough to be diagnosed as manic episode, depression is never severe enough to be diagnosed as depressive episode. It is the effects of the disorder that disrupts the life of an individual.

Persons with cyclothymic disorder tend to be in one mood state or other with relatively few periods of neutral mood. This pattern must last for 2 years (1 year for children and adolescent). People with cyclothymic disorder alternate between the kinds of mild depressive symptoms. The behaviour is not severe enough to

require hospitalisation or immediate intervention. In many cases such people are only regarded as moody. Sometimes, individual with this disorder is actually more likely to experience some impairment in interpersonal dealings as people may consider them unreliable because of their mood changes.

The problem of diagnosis becomes complicated among children because the symptoms of bipolar disorder may co-exist with already present disorders like conduct disorder, hyperactivity, attention deficit disorder (Shapiro 2005). Lot of research needs to be done in area of diagnostics for judging bipolar disorder in children.

Kindling is a phenomena indicating that individuals who have experienced manic episode are at greater risks of experiencing another episode, even if they are taking medicines for controlling it. Manic depressive episode may occur just before or so on after major depressive episode. The frequency of manic depressive episode is on an average 4 episodes within a span of decade, for those who do not under go any treatment or medication. Not more than 15% people experience four to eight episodes of mood disorder. These individuals are described as rapid cyclers. Majority of women are likely to become rapid cyclers, Hyperthyroidism, use of antidepressant drugs increase the chances of reducing the time gap between episodes.

Most individuals with bipolar disorder feel normal between the episodes. But one forth of them may continue to feel depressed and have difficulty in dealing with people at home or at work, problems are especially likely for individuals who struggle with unpredictable mood changes that occur in rapid cycles because other people consider them to be moody and unreliable.

Onset and duration :- The average onset of this disorder is between 19 to 22 years. This disorder begins with minor mood changes or minor cyclothymic mood swings.

7.5 THEORIES OF MOOD DISORDERS:

There are different perspectives towards mood disorders. They explain the causes of mood disorders. Researchers have identified biological, psychological and social factors that seem to play an important role in the etiology of mood disorders.

7.5.1 Biological Perspectives:

The Twin studies and family studies indicate the role of biological factors in mood disorders.

Genetics:-

Studies on genetics suggest that bipolar disorder is seen in families. Research has shown that the first degree relatives of people with major depression are twice likely to develop disorder as compared with individuals from general population (Sullivan, Neale & Kendler 2006) The risk is higher for the first degree relatives of children of depressed individuals (Lewinsohn et al 2002) The studies of three generations of children, parents and grandparents, show that this disorder tends to run in families. If major depressive disorder is present in parents and grandparents, children are more likely to show symptoms of psychopathology. This psychopathology takes the form of a disorder. A child with anxiety disorder who comes from a family with major depressive disorder is more likely to suffer from depressive disorder later in life.

The five large scale studies observed inheritance patterns in families. They found that the heritability of 31 to 42 percent, meaning among 100 individuals who have a close relative who has a disorder, out of them approximately 30 to 40 of them have a major likelihood of having major depression (Sullivan, Neale & Kendler 2009).

NIMH carried out a major study on bipolar disorder at 5 major research centers. They carried out genetic linkage analysis of 500 individuals diagnosed with bipolar disorder. (Faraone, Glatt, Su & Tsuang, 2004) This is the largest study that offered evidence for genetic linkage. The available evidence does not clearly indicate the role of specific genes (De Paul 2004).

In the development of mood disorders, gender also plays an important role. In a study of over 1000 pairs of opposite sex twins who were interviewed 2 years apart, to study the effect of receiving social support on the development of depressive symptoms. It was found that both men and women of twin pairs had more chances of developing major depression when social support is very low, as compared with men and women who had more social support. The study indicated that even powerful genetic risk factors can be influenced by environmental conditions.

Biochemical factors – The biological theories emphasise the altered neurotransmitter functioning as a cause of mood disorder. It is not possible to observe neurotransmitter substances in human brain.

Following are two explanations given that suggest the role of deficiency of neurotransmitter substances.

- 1) Catecholamine hypothesis, suggests that, the shortage of norepinephrine (a catecholamine) causes depression and excess causes mania.
- 2) Indolemine hypothesis (Glassman, 1969) suggests that deficiency of serotonin produces behavioural symptoms of depression.

The above two hypothesis regarding the role of deficient neurotransmitter substances in mood disorder, is called as Monoamine Depletion Model. All the antidepressants currently used attempt to increase the availability of these neurotransmitter substances. Studies have pointed out the relationship between hormonal activity and depression. Researchers are focusing on the role of Cortisol. It is a hormone that mobilises body's resources during stress.

The research findings in the area of genetics imply the role of biological factors in the causation and symptomatology of mood disorder.

7.5.2 Psychological Perspectives :

The review of genetic contribution to the causes of depression could be attributed to psychological factors.

7.5.3 Psychodynamics Theories :

- 1) The earlier theories emphasised upon the loss and feelings of rejection as a cause of mood disorders. The later psychodynamic theories emphasised the inner psychic processes as the basis of mood disorders.
- 2) British psychoanalyst, John Bowlby proposed that people can become depressed as adults, if they were raised by parents who failed to provide them with secure and stable relationship.

Similar theory was proposed by Jules Bempoard (1985). He emphasised the role of deficient parenting in mood disorders. Children of such parents become preoccupied by being loved by others. As adults they form relationship where they overvalue the support of their partners. End of such relationship may make depressed person experience feelings of inadequacy and loss.

- 3) Psychoanalytic theory of personality suggests that mania is a defensive response adopted by an individual to deal with feelings of inadequacy and loss. People become hyperenergetic as a defense against becoming gloomy and depressed.

7.5.4 Behavioural and Cognitive Perspective :

- 1) Lazarus and Skinner (1968, 1953) proposed that depression is the consequence of reduction of positive reinforcement. Depressed people withdraw from life because they do not have an incentive to remain active.
- 2) The contemporary perspective on depression is (Kanter et al 2004), based on Lewinshon's theory, maintaining that low rate of response contingent positive reinforcement is the cause of depression.

Behavioural approaches have been integrated into cognitive approaches. Cognitive approaches propose that serious mood changes can result from events in our lives or from our perception of events.

Cognitive perspectives suggest that people experience depression as their earlier experiences sensitise, them to react in certain ways to stressful events. People react to stressful events, with a set of thoughts involving negative view of self, world and future. Beck in 1967, described this negative view of self world and future as cognitive triad, he further proposed that if this view is activated once, it continues further in a cyclical manner.

Cyclical thinking is maintained by cognitive distortions. They are the errors that depressed people make while drawing conclusions. The cognitive distortions include applying illogical rules, jumping to conclusions, over generalising and taking detail out of context. As a consequence of this, depressed people give negative meaning to past and future events. They may have pessimistic expectations from future. Such persons may not be even aware of such negativity in their thinking.

Beck proposes that depressed people feel sad because they are deprived of something that threatens their self esteem. It represents an individual's misguided attempts to adapt to psychological environment.

Harry Stack Sullivan proposed that abnormal behaviour is a consequence of impaired interpersonal relationships, including deficiencies in communication.

Bowlby proposed that, a disturbed attachment pattern in the childhood in the cause of depression is later years.

Interpersonal theory of depression connects this ideas and gives behavioural and cognitively oriented theory of depression. It explains the steps in the development of depression.

i) Failure to develop social skills in childhood. The skills required for developing relationship.

ii) This leads to sense of despair and solution resulting in depression.

iii) Once depression is established it is further enhanced by poor social skills and communication. This invites rejection from others. The depression that develops in adulthood may arise when person experiences an event like a death or loss of loved one. Depression continues because of a vicious cycle.

Poor communications skills keep people away; poor interactions make person experience feelings of loneliness and worthlessness still more intensely. Women are more exposed to stressful events as compared to men. As a consequence women are more likely to experience depression.

These individuals are convinced of failure in their efforts. The positive experience also may be distorted to fit in their negative framework. The cognitive distortions make depressed individuals to experience low feelings of well being, energy and desire to be with others and lack of interest in the environment. For e.g., one may find them making statements like "If a person like me contests for election, no one will really vote for me because I know people do not like me".

7.5.5 Socio Cultural and Interpersonal Perspectives :

Interpersonal model of mood disorder:– (Myrna Weissman, Gerald Klerman & associates) – This model emphasises disturbed social functioning. The interpersonal therapy (IPT) follows from this model. It is a time limited form of therapy for treating depressed persons. This – therapy assumes that individuals are genetically vulnerable to interpersonal stress and hence they are more likely to experience depressive episode. The interpersonal therapy focuses on both poor social skills and origin of depressed person's problem.

Adolph Meyer (1957), An interpersonal theorist with psychobiological approach to abnormal behaviour emphasised that, psychological problems are diagnosed with depression. (Hammen 2005).

7.6 TREATMENT OF MOOD DISORDERS

A) Biological Treatment :

The most common treatment for mood disorder is antidepressants. People with bipolar disorder are treated with

lithium carbonate. The most common medication used to treat depressions are:

- i) Tricyclic Antidepressants. (TCAS)
- ii) Monoamine Oxidase Inhibitor (MAOIS).
- iii) Selective Serotonin Reuptake Inhibitors (SSRIS).

Tricyclic antidepressants (TCAS) – these chemicals have three ring structures. They are available in the market with trade names like Elavil, Endep, Norpramin, Tofranil, Aventyl and Pamelor. These medications are effective with people who have disturbed appetite and sleep. These tricyclic antidepressant increase the excitatory effect of postsynaptic neurons.

Monoamine Oxidase Inhibitions (MAOIS)–These drugs are available with trade names Nardil and tranlcypromine (Parnate) – It is effective in treatment of chronic depression. These chemicals function by prolonging the effects of neurotransmitter substances. MAOIS are not frequently prescribed as they can lead to serious complications. People taking MAOIS are not able to take allergy medications or not able to ingest food containing tyramine, e.g., beer, Cheese and Chocolate. The combination of this with MAOIS can rise blood pressure dramatically.

Selective Serotonin Reuptake Inhibitors – (SSRIS) – It is generally used as an alternative to tricyclic and MAIOS. They block the uptake of serotonin, so that more of serotonin is made available to action at receptor sites. SSRIS are different from other antidepressants as they do not block many receptor sites at a moment; that can cause sedation, weight gain, constipation and rise in the blood pressure and dry mouth. The new SSRI medications also have side effects such as feelings of nausea, agitation and sexual dysfunction.

Studies during past two decades suggest the effectiveness of SSRIS. The result of these studies should be viewed with caution. These studies fail to indicate the effectiveness of medication. Most studies done in this area have not been published.

There are reports of higher suicide risk with SSRI medication. But the investigation during 1996 to 1998 showed that the rate of suicide is much lower among people treated with SSRI as compared with other antidepressants.

The higher suicide rate among SSRIS prescribed persons made clinicians to focus attention on the number of related variables such as comorbid psychological disorder, gender and geographic location and role of psychotherapy. Antidepressants,

are frequently prescribed to patients with severe symptoms by nature. They are at the higher risk of suicide (Rosack 2005). Therefore, precaution has to be exercised by administering to children and adolescents. Several studies have shown a link between suicidal behaviour and antidepressants.

Antidepressant medications are commonly used for relieving symptoms. But many people are not eligible for this medication, especially women of child bearing age.

Lithium carbonate is a common salt found in the natural environment. It is used as an antidepressant. Dosage has to be carefully monitored to prevent toxicity, and low thyroid functioning, which might intensify lack of energy associated with depression. Lithium carbonate has side effects such as mild central nervous system disturbances, gastrointestinal upsets or even cardiac effects.

Lithium interferes with the high associated with the bipolar disorder. Persons with bipolar disorder actually enjoy the pleasurable feelings associated with mania. By the time full blown mania is developed, individuals may not accept that they have any problem. If side effects are considered, then person is at risk of developing another episode. Therefore, therapists encourage the clients to remain on the maintenance dose of lithium.

The variable nature of bipolar disorder makes it necessary to have an additional antidepressant along with lithium. Persons prone to mania may develop mania after medication. Persons with psychotic symptoms, may benefit from antipsychotic medications. Clinicians may also prescribe ECT, for clients with mood disorders for whom medication may be ineffective or slow in alleviating the symptoms. People have negative attitude towards ECT, as it is more likely to be misused. This method has been used for punishment in the past rather than for treatment.

ECT - (Electro Convulsive Therapy) – Lisanby (2007) has demonstrated that ECT is life saving treatment for severely depressed people. Clients are usually given anesthesia to reduce discomfort, and are given muscle relaxing drugs to prevent breaking of bones from convulsions during seizures. Electric shock is directly administered through the brain for less than a second. This produces seizures and brief convulsions. In current practice ECT is administered 6 to 8 times, once every other day, until the person's mood returns to normal. The side effects are few. Person has short term memory loss and confusion that disappears within one or two weeks. Some clients may show long term memory problems. It is not clear as to why ECT works. One explanation is

that induces changes in neurotransmitter receptors and body's neural opiates.

TMS - Transcranial Magnetic Stimulation (TMS) is an alternative to traditional ECT. TMS combined with medications have been found to be more effective with persons who do not respond to medications.

Light therapy is another treatment offered for seasonal depression. Depressed individuals are especially exposed to special light during winter season. Another less well known method of the treatment is sleep deprivation. Both the methods are effective when combined with medication.

B) Psychological Treatment –

Cognitive Behavioural approach and interpersonal psychotherapy are the most commonly adopted approaches for treatment of depression.

Behavioural Approach :

The major features of this approach in dealing with depression are :

1. Careful assessment of frequency, quality and range of activities and social interactions in client's life.
2. Helping client change his or her social environment along with teaching of social skills.
3. Encouraging clients to seek activities that restore mood balance, helping clients to seek reinforcement in activities.
4. Educating client in settling realistic goals because depressed clients often set unrealistic goals for themselves. Therapist may give homework to clients in this area.
5. Therapist focuses on self-reinforcement procedures such as self congratulations like rewarding one self with some pleasurable activity.
6. If these procedures do not succeed then therapist may engage in more extensive programme like instructions. Modeling and coaching, role playing, rehearsals at real world trials, etc.

Cognitive based approach :

Short time structured approach- It focuses on our negative thoughts and it includes activities that will improve client's daily life.

1. Clients are taught to examine carefully their thought processes while they are depressed. They are made to recognise depressive errors in thinking.

2. Client is taught that errors in thinking can directly cause depression.
3. It involves correcting cognitive errors and substituting more realistic thoughts and appraisals.
4. Later in therapy underlying negative cognitive schemes (characteristic ways of viewing the world) that trigger the cognitive errors are targeted.
5. Therapist makes it clear to the client that both of them together will be working as a team to uncover faulty thinking patterns.

To summarise, cognitive approach incorporates didactic work, i.e., cognitive restructuring and behavioural techniques. It involves explaining theory to client, teaching the client how depression results from faulty thinking and cognitive restructuring. Clients are instructed to monitor their thought processes carefully, especially in situations where client might feel depressed. Client is required to plan activity for a week, it may involve graded task assignment. It may involve pleasure prediction experiments like how much pleasure will be produced by a given activity and how much pleasure is produced in reality. This pleasure production experiments help therapist in demonstrating to client how gloomy predictions are inaccurate. Client is asked to rate the pleasure of each activity. If patient is inactive, then activities are planned on the hour by hour basis. Thus, helping clients to experience success of accomplishing something.

Cognitive behavioural therapy is a short term method. It requires generally 10 to 12 sessions. People with chronic major depressive disorder may require long term cognitive behaviour therapy.

Psychodynamic approaches involve short terms focused treatment combined with medication. Clinicians treating bipolar disorder, begin with medication, incorporated by psychological intervention.

Interpersonal Psychotherapy :

It is observed that problems in personal relationships, absence of relationship, etc is a major stressful event, and it can lead to relapse of the bipolar disorder.

Interpersonal and social rhythm therapy (IPSRT) – According to this model mood, episodes are likely to emerge from:

- a) Non adherence to medication
- b) Stressful life events
- c) Disruption in social rhythms.

Clinicians, who follow IPSRT model, focus on educating clients, about medication adherence, helping them to understand their feelings about the disorder and how it has changed their lives.

Clinicians emphasise the reduction of interpersonal stress in client's life, especially one who is suffering from bipolar disorder for following reasons.

1. Stressful life events affect circadian rhythm, i.e., sleep wake cycles, appetite energy levels.
2. Stressful life events change the daily routine.
3. This may affect person's mood and may bring about changes in social, rhythms. (Frank 2007).

Researchers have found this programme to be very effective in improving relationships.

Socio cultural and interpersonal therapy – The family members of the client are involved in treatment. They can understand the experiences of the person with mood disorder and help him or her in dealing with the symptoms. Interpersonal therapy may last from 12 to 16 weeks. This theory is divided into three broad phases.

- 1) Assessing the nature of depression by using quantities measurement.
Interviews are carried and to determine exactly what triggered the present episode.
- 2) Therapist and patient together formulate a treatment plan focusing on primary problems like grief, interpersonal disputes and problems faced due to inadequate social sketch.
- 3) Third phase treatment plans are carried out depending on the nature of client's problem.

7.7 SUICIDE

Suicide is one of the most common causes of death among youngsters and elderly members of society. Suicide is often associated with depression, it is a way of escaping from hard realities of life. Suicide attempts are usually desperate efforts at getting attention from concerned people. These are the people who communicate about their suicide intentions rather than actually doing it.

American studies and statistics shows that men are likely to commit suicide than women. Women may attempt suicide but their attempts may not be completed as compared to men. Generally 90% adults who commit suicide have some diagnosable

psychological disorder. Disorders like alcohol abuse, dependence or Schizophrenia are associated with suicide. (Duberstein & Conwell 2000). Similarly, people with borderline personality disorder also make suicide attempts.

The statistics of suicide in India is different. According to WHO, India has a highest suicide rates in the world. The country's health ministry estimates that 1,20,000 people kill themselves every year and among these 40% of them are below 30 years.

South India is considered as world's suicide capital. Kerala, has highest suicide rate, 32 people commit suicide almost every day. In India it is observed that women are more likely to commit suicide than men.

The study found that suicide rate for women in the age group of 19-29 years is 148 per 1,00,000 and for men it is 58 per 1,00,000.

There are international variations in suicide rates. The highest rates of suicide are found in Eastern Europe and lowest in Latin America. (WHO 2004).

1) Causes of Suicide –

i) Biological perspective –

In one of the largest investigations of family patterns of suicide, 250 relatives of 25 people who committed suicide were compared with 171 relatives of men who did not commit or attempt suicide. The results of the study showed that relatives of suicide completers had 10 times more chances of committing suicide.

Baud (2005) showed that tendency to commit suicide is associated with genetic vulnerability involving serotonin related genes. Thus, vulnerability leads to certain personality traits which interact with life events, thus making a person more prone to committing suicide. Similarly, low alcohol tolerance combined with genetic vulnerability increases the risks of committing suicide (Marusie 2005).

ii) Psychological perspective –

If one of the family member commits suicide then there is an increased risk that someone else in the family will also follow. Brent and colleagues observed a six fold increased risk of suicide attempts in the offspring of the family members who had attempted suicide compared to the offspring of persons who had not attempted suicide. If sibling was a suicide attempter then the risk

increased even more (Brent et al 2003). The question is people who kill themselves, do they simply adopt a solution that is familiar to them? or is it impulsivity that is inherited as a family trait that is responsible?

Studies show that early onset of mood disorder, as well as aggressive and impulsive traits, make such persons susceptible to suicidal behaviour (Mann et al 2005).

Existing psychological disorders such as mood disorder may become a precipitating cause of suicidal behaviour. Many people who commit suicide do have mood disorders.

Similarly, alcohol use and abuse is also associated with suicides, particularly in adolescent suicides. Combination of disorders such as substance abuse and mood disorder in adults and mood disorder and conduct disorder in children seem to create a stronger vulnerability, than any one disorder alone. Hawton & Colleagues (2003) found that prevalence of previous attempts and repeated attempts doubled if a combination of disorder is present. Esposito and Clum (2003) also noted that presence of anxiety and mood disorder predicated suicide attempts in adolescents. J. Cooper and Colleagues (2005) followed almost 8,000 individuals who were treated in emergency room for deliberate self harm for 4 years. Sixty of these people killed themselves, a 30 fold increase in risk compared to population statistics.

The important risk factor in suicidal behaviour is stressful life event which are experienced as shameful or humiliating, such as failure that may be real or imagined. The stress and disruption of natural disasters increase the likelihood of suicide.

The psychological factors that predispose individuals to committing suicide are explained by Edwin Shneidman (1984). He suggests that act of taking one's life is an attempt of interpersonal communication. Through suicidal attempts people try to communicate frustrated psychological needs to significant people in life.

Beck explains suicide from cognitive perspective. He suggests that suicide is an expression of feelings of hopelessness triggered by preception that stress is beyond control. Beck (1996) has used the concept of suicidal mode to describe the frame of mind of person who has made multiple suicidal attempts.

Impaired decision making and altered Serotonin pathways in the parts of the brain involved in making complex choices also predisposes an individual towards suicidal behaviour.

Socio cultural perspective :

Emile Durkheim, a French sociologist, suggest that a feeling of alienation from society can become a cause of suicidal behaviour, Media also plays an important role in propogating suicide, especially among teenagers. Media accounts often describe in detail the methods used for suicide, thus they provide guidelines to potential victims.

There are racial and age related differences in suicide. Whites are more likely to commit suicide followed by African Americans. The age at which a member of a given race will commit suicide also varies e.g., for blacks suicide may occur at an average age of 32 whereas for whites it may be 44 years.

iii) Assessment and Treatment :

Clinicians can assess suicidal intent in the client. The suicidal intent refers to how person in committed to dying. Secondly, the suicidal lethality in also judged. The suicidal lethality refers to the dangerousness of the method adopted for dying. Suicidal intent and lethality are always connected.

Many people are willing to discuss their suicidal intentions. Many people may prefer avoiding warning signs of suicide, by thinking that asking about intention may provoke a person. Even a trained clinician may find it difficult to judge the suicidal intentions of person. Client may deny the suicidal thought, but his behaviour may give clue about the suicidal intention, Changes in mood, declining grades, recklessness, substance abuse, giving up of former interests, stormy relationships are considered as suicidal signs. The potential factors involved in suicide may differ from individual to individual.

Suicidability is assessed through hotlines, hospital emergency rooms, mental health clinic and inpatient psychiatric departments.

Professionals help the person with suicidal intention, by providing support and by regaining sense of control in the life of the individual.

The clinician can have a two way agreement, where client promises to contact clinician when he experiences such ideas and clinician promises client that he will be available whenever the crisis is experienced.

Therapist may use cognitive techniques and help an individual to get control over the suicidal intentions by thinking about alternative ways of dealing with the problem.

Brent (2001) suggested a comprehensive model of treatment for adolescence that include :

- 1) Treatment of psychopathology.
- 2) Reduction of cognitive distortion.
- 3) Work improvement of social skills.
- 4) Encouragement of problem solving.
- 5) Regulation of affect and family intervention.

7.8 SUMMARY :

In this unit we had discussed the general characteristics of mood disorder. Following this we had discussed the different types of mood disorders. The characteristics of major depressive episode and various types of depression were discussed. One of the most common types of depression is Dysthymic disorder, which was briefly explained. Two types of disorder involving mood alteration was also discussed, which included bipolar disorder and cyclothymic disorder. Types of bipolar disorder, its prevalence and course was also discussed.

There are various causes of mood disorders such as biological perspective, psychological perspective, psychodynamic theories, behavioral and cognitive perspective, etc.

Various treatments of mood disorder was also discussed. Towards the end of the unit the concept of suicide, its cause, assessment and treatment were discussed.

7.9 QUESTIONS :

- Q. 1. Discuss the general characteristics of mood disorders.
- Q.2. Explain the various characteristics of major depressive episodes.
- Q.3. Discuss :
 - a) Depressive episodes involving melancholic features.
 - b) Depressive episodes involving seasonal patterns.
 - c) Dysthymic Disorder

- Q.4. Discuss Bipolar and Cyclothymic disorder.
- Q.5. Discuss the various theories of mood disorders.
- Q.6. Explain the various treatments of mood disorder.
- Q.7. Explain Suicide its causes, assessment and treatment.

7.10 REFERENCES :

- 1. Richard P. Halgin and Susan Krauss Whitbourne, (2010) Abnormal Psychology, Clinical Perspectives or Psychological disorders. (6th Ed).
- 2. V. Mark Durand and David-H-Barlow (2010, 2006, Essentials of Abnormal Psychology. Wadsworth, Cengage learning.



SCHIZOPHRENIA AND RELATED DISORDERS – I

Unit Structure

- 8.0 Objectives
- 8.1 Introduction
- 8.2 Characteristics of Schizophrenia – positive, negative and other Symptoms
- 8.3 Other Psychotic Disorders
- 8.4 Summary
- 8.5 Glossary
- 8.6 Questions
- 8.7 Suggested readings

8.0 OBJECTIVES :

After reading this unit, you will be able to know –

- About major psychosis, schizophrenia.
- About the positive, negative and other symptoms of schizophrenia.
- The other psychotic disorders related to schizophrenia – schizophreniform disorder, schizoaffective disorder, delusional disorder and grandiose delusion.

8.1 INTRODUCTION :

One of the common psychotic disorders is schizophrenia, more common in men than women. It is a puzzling disorder where sometimes patients think and communicate clearly and is related with reality. Sometimes thinking and speech are disorganised and there is no touch of reality. It is more common in men than women and there is a strong evidence for a genetic transmission of this disorder. Structure of brain, prenatal environment and birth complications may result in this disorder. DSM-IV recognises two main symptoms of schizophrenia- positive and negative. Type I symptoms (positive) include unusual perceptions, thoughts and behaviours. Type II symptoms (negative) represent loss or absence

of behaviours. As this disorder is a complex one, psychologists believe that there are different types of schizophrenias. Five major types of Schizophrenia include are – paranoid schizophrenia, disorganised schizophrenia, catatonic schizophrenia, undifferentiated schizophrenia and residual schizophrenia.

8.2 CHARACTERISTICS OF SCHIZOPHRENIA :

The term psychotic has been used to characterise many unusual behaviours, although in its strictest sense it usually involves delusions (which involve irrational beliefs) and / or hallucination (experiencing things through the senses in the absence of any external events such as hearing voices). Schizophrenia is just one of the disorders that involve psychotic behaviour .

Processes disrupted by schizophrenia include those that involve thought, our perception of the world, our emotions and even how we move.

DSM- IV has a multiple part process for determining whether someone does or does not have schizophrenia.

Psychologists in this field typically distinguish between what are called positive and negative symptoms of schizophrenia. Positive symptoms refer to more active manifestations of abnormal behaviour or an excess or distortion of normal behaviours, these include delusions, hallucinations and disorganised speech. Negative symptoms involve deficit in normal behaviour or such dimensions as affect speech and motivation. A diagnosis of schizophrenia requires that two or more of these positive and/or negative symptoms are present for at least one month.

POSITIVE SYMPTOMS OF SCHIZOPHRENIA

(a) Delusions

A belief that would be seen by most members of a society as a misrepresentation of reality is called a disorder of thought, content as a delusion. Because of its importance in schizophrenia delusions have been called as basic characteristic of madness. If for example, you believe that squirrels really are aliens sent to earth on a reconnaissance mission, this belief would be considered a delusion.

Delusions are difficult to believe (like house will fall resulting in death of person). Individuals experiencing it are preoccupied with them.

Common types of delusions are –

- i) Persecutory delusions
- ii) Delusions of reference
- iii) Grandiose delusions
- iv) Delusions of thought insertions

i) Persecutory Delusions :- Individual suffering from these delusions constantly feel that they are being watched or tormented by people whom they know such as professors (in case of students), CBI who are involved in hard core crime or any other authoritative figure.

ii) Delusions Reference :- Individual suffering from this type of delusion believe that random events, comments passed by others are aimed at them. People with delusion of reference may feel that a politician is trying to harm him personally through speech.

iii) Grandiose Delusions :- Individual suffering from this delusion feel that they are special person and have magic powers. They may consider them selves as the most intelligent, insightful and creative person on planet earth. They may think that they are great historical characters and think they have discovered the cure of an incurable disease.

iv) Delusion of Thought Insertions :- Individual suffering from this delusion feel that their thoughts are being controlled by out side forces (e.g., serial killers or terrorists).

An intriguing view of delusion in that they may serve a purpose for people with schizophrenia, who are otherwise quite upset by the changes, talking place within themselves. The delusions may serve as adaptive function for delusional individuals is at present just a theory with little support, but it may help us understand this phenomenon and the reactions to it expressed by those experiencing the delusions.

b) Hallucinations

The experience of sensory events without any input from surrounding environment is called hallucination. Hallucination can involve any of the senses, although hearing things that are not there or auditory hallucination in the most common form experienced by person with schizophrenia.

Types of Hallucinations :-

- i) Auditory Hallucinations
- ii) Visual Hallucinations
- iii) Tactile Hallucinations
- iv) Somatic Hallucinations

i) Auditory Hallucinations :-

In auditory hallucinations individuals hear heavy voices, music, different type of noises, which are imaginary and not existing. Women are more prone to it than men. The schizophrenic answer the voice back even when in the middle of conversations with a real person.

ii) Visual Hallucinations :-

An individual suffering from this may see a ghost coming out of T.V. and talking to him.

iii) Tactile Hallucinations :-

It involves a feeling that some weird thing is happening to one's body. E.g., insects are crawling all over his body.

iv) Somatic Hallucinations :- It involves feeling that something is happening inside one's body and they are tickling him from within.

Research on hallucinations suggests that people tend to experience hallucination more frequently when they are unoccupied or restricted from sensory input. By studying cerebral blood flow using single photon emission computed tomography (SPECT), scientists of London have discovered that the part of the brain most active during hallucinations was the area called Broca's area. Broca's area is involved in speech production.

If hallucinations involve understanding the speech of others, you might expect more activity in the area of the brain that involves language comprehension, an area called Wernick's area. Research establishes that during hallucination Broca's is more active than Wernick's area. This observation of brain activity during hallucinations supports a theory that the people who are hallucinating are in fact not hearing the voices of others but instead are listening to their own thoughts or voice and can not recognise the difference.

c) Disorganised speech :-

People with schizophrenia often lack insight that they have disease. They experience associative splitting and cognitive slippage. DSM – IV has used the term disorganised speech to describe these problems with communications.

The most commonly found disorganised tendency is to slip from one topic to a totally unrelated topic. There is no association between topics discussed by them. This is also known as derailment of thought. When questioned the schizophrenic person may give a totally unrelated reply. At times schizophrenic quote

words that have some meaning only to them. Such words are known as neologisms. They also associate the words on the basis of its sounds rather than meaning. Such associations are known as clangs. e.g., dog may be called “spog” and cat as “meaw”.

Sometimes the person may repeat the same word again and again by stressing on particular word.

Men with schizophrenia show greater tendency of language deficit as compared to women. Men have limited linguistic resources to overcome their problems.

Grossly Disorganised or Catatonic Behaviour :-

People with schizophrenia engage in a number of other active behaviours that might be considered positive symptoms. For example, catatonia is one of the symptoms present in some individual with schizophrenia. It involves a spectrum of motor dysfunctions from wild agitation to immobility.

Schizophrenic are unpredictable, suddenly react in an agitated manner. They may suddenly shout, swear and wander about up and down the street alone. They may tend to engage in an embarrassing behaviour by acting in a socially disapproved manner, like publicly masturbating. Their daily routines are disturbed, where they do not care for themselves, showing carelessness in eating, dressing, oral hygiene, etc.

Catatonic behaviour too is seen in patients of schizophrenia. Catatonia is referred to as a group of disorganised behaviours that reflect an extreme lack of responsiveness to the outside world. Catatonic excitement involves extreme uncontrollable agitation expressing a number of delusions and hallucinations.

NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

In contrast to the active presentations that characterise the positive symptoms of schizophrenia, the negative symptoms usually refer to the absence or insufficiency of normal behaviour and include emotional and social withdrawal, blunted affect, apathy, and poverty of thought or speech.

(a) Flat Affect :- Approximately two thirds of the people with schizophrenia exhibit what is called flat affect. They do not show emotions. They may stare at you with vacant eyes, speak in a flat and toneless manner and seem to be unaffected by things going on around them. This condition is also known as blunted affect. The person remains in a frozen condition most of the time. They are extremely unresponsive to the events around them. The flat affect

in schizophrenia may represent the person's difficulty with expressing emotion and an inability to feel the emotion.

(b) Avolition :-

Derived from the prefix a meaning "Without" and volitions which mean "an act of willing, choosing or deciding." Avolition is an inability to initiate and persist in many important activities. It is also referred to as apathy, people with this symptom show little interest in even the most basic day-to-day activities, including personal hygiene. Avolition is an inability to be committed to a common goal directed activity. Schizophrenic are unmotivated, disorganised and careless in the task that they undertake.

(C) Alogia :-

It refers to the relative absence in either the amount or the content of speech. The word derives from the combination of a (without) and logos (word). A person suffering with alogia may respond to the question with very brief replies that have little content and many appear disinterested in the conversation.

This deficiency in communication by some people with schizophrenia is believed to reflect a negative thought disorder rather than an inadequacy in communication skills. Some times alogia takes the form of delayed comments or slow response to the questions. Trying to talk to people suffering with alogia is very frustrating.

OTHER SYMPTOMS OF SCHIZOPHRENIA

Some symptoms of schizophrenia are not prominently seen in all cases but they do frequently occur in schizophrenic as follows-

(a) Inappropriate Affect :- The schizophrenic patients may react with an inappropriate emotion to a particular action, e.g., individual may cry when it is time to laugh and vice-versa.

(b) Anhedonia:- It is derived from the word hedonic, pertaining to pleasure. It refers to the presumed lack of pleasure experienced by some people with schizophrenia. Individuals with anhedonia report loss of enjoyment for activities that would typically be considered pleasurable, including eating, social relations, sexual interactions, etc. Anhedonia is the inability to experience emotions. They lack feeling of both happy and sad emotions.

(c) Impaired Social Skills :- Most of the schizophrenic patients show poor social skills, such as difficulty in maintaining conversation, job and relationship.

CHECK YOUR PROGRESS -

1. Discuss the positive symptoms of schizophrenia.
2. Explain the negative symptoms of schizophrenia.
3. What are the other symptoms of schizophrenia.

8.3 OTHER PSYCHOTIC DISORDERS (THE SCHIZOPHRENIA SPECTRUM DISORDERS)

(a) Schizophreniform Disorder- Some people experience the symptoms of schizophrenia, but for only a few months. These symptoms disappear quickly, often for unknown reasons, and the person can usually resume his or her life as before. Such symptoms would be classified under the label “Schizophreniform disorder.” There are few studies on this disorder, therefore, data on important aspects of it are sparse. It appears, however, that the lifetime prevalence is approximately 0.2% (American Psychiatric Association, DSM – IV, 1994).

(b) Schizoaffective Disorder –The symptoms of schizophrenia coincides with symptoms of depression or mania, but there is at least a two week period when only symptoms of schizophrenia are present. The person exhibits symptoms of both schizophrenia and mood disorders and this mixed bag of symptoms is now diagnosed as schizoaffective disorder. These individuals tend not to get better on their own and are likely to continue experiencing major life difficulties for many years.

(c) Delusional Disorder - The major feature of delusional disorder is a persistent delusion or belief that is contrary to reality. These persistent delusions are not the result of an organic factor such as brain seizures or any severe psychotic disorder. Individuals with these delusions tend not to have most of the other problems associated with schizophrenia. They may become socially isolated because of their suspicion of others. DSM – IV divides the delusions in different types –

i) Persecutory Delusion - False belief that oneself or one's loved ones are being persecuted watched, or conspired against by others.

ii) Grandiose Delusion - False belief that one has great power, knowledge, or talent or that one is a famous and powerful person.

iii) Delusion of Reference - Belief that random events are directed at oneself.

iv) Delusions of being Controlled – Belief that one's thoughts, feelings, or behaviours are being imposed or controlled by an external force.

v) Thought Broadcasting – Belief that one's thoughts are being broadcast from one's mind for others to learn.

vi) Thought Insertion – Belief that another person or object is inserting thoughts into one's head.

vii) Thought Withdawal – Belief that thoughts are being removed from one's head by another person or an object.

viii) Delusion of Guilt or Sin – False belief that one has committed a terrible act or is responsible for a terrible event.

ix) Somatic Delusion – False belief that one's appearance or part of one's body is diseased or altered.

(d) Brief Psychotic Disorder - This disorder shows the presence of one or more "positive" symptoms such as delusions, hallucinations, or disorganised speech or behaviour over the course of less than a month. This disorder is precipitated by extremely stressful situations.

(c) Shared Psychotic Disorder – It is a name given to a condition in which an individual develops delusions simply as a result of a close relationship with a delusional individual. The content and nature of the delusion depends on the delusion of the partner and can range from the relatively bizarre, such as believing that enemies are sending gamma rays through your house to less bizarre, such as believing that you are about to receive a major promotion.

CHECK YOUR PROGRSS –

1. Explain any two other Psychotic Disorders.
2. Discuss Schizophreniform Disorders.
3. Explain different types of delusions found in delusional disorder.

8.4 SUMMARY

Schizophrenia is a type of psychosis which is very common. It is more common in men than in women.

There are mainly two types of clinical symptoms of this disorder – negative and positive symptoms.

Positive symptoms include delusions, hallucinations, disorganised thought and speech, disorganised or catatonic behaviour.

Delusions are ideas that an individual believes are true but are highly unlikely and often simply impossible. There are different types of delusions – Persecutory delusions, delusions of reference, grandiose delusions and delusions of thought insertion. People with persecutory delusion may believe they are being watched or tormented by people they know. People with delusion of reference believe that random events or comments by others are directed at them. People with delusions of thought believe that their thought are controlled by others. People with grandiose delusions believe that they are special person with special powers. Negative symptoms of schizophrenia are affect flattening alogia and avolition. Affect flattening is a severe reduction or absence of affective responses to the environment. Alogia is reduction in speaking. Avolition is an inability to persist at common, goal directed activities.

Other symptoms are inappropriate affect, anhedonia and impaired social skills. Other types of schizophrenia are – paranoid schizophrenia, disorganised schizophrenia, catatonic schizophrenia, undifferentiated schizophrenia, residual schizophrenia.

8.5 GLOSSARY

1. **Affect** – subjective aspect of an emotion that accompanies an action at a given time.
2. **Anhedonia** – inability to experience pleasure.
3. **Catatonia** – immobility or excited agitation.
4. **Paranoia** – person's belief that he/she is especially important or other people are seeking to harm him/her.

8.6 QUESTIONS

- Q.1. Discuss the various characteristics, positive and negative symptoms of schizophrenia.
- Q.2. Discuss the different types of psychotic disorders.
- Q.3. Write notes on the following
 - a) Hallucinations and its types.
 - b) Types of Delusions.

8.7 SUGGESTED READINGS

1. Oltmanns, T.F. & Emery, R. E. (2010). Abnormal Psychology, 6th ed., New Jersey : Pearson Prentice Hall.
2. Bennet, P. (2003). Abnormal and Clinical Psychology : An Introductory Textbook – Open University Press.



SCHIZOPHRENIA AND RELATED DISORDERS- II

UNIT STRUCTURE

- 9.0 Objectives
- 9.1 Introduction
- 9.2 Theories of Schizophrenia
- 9.3 Treatments of Schizophrenia
- 9.4 The Bio psychosocial perspective
- 9.5 Summary
- 9.6 Glossary
- 9.7 Suggested Readings

9.0 OBJECTIVES

After reading this unit you will know

- About different theories or causes of schizophrenia.
- About the various treatments available for schizophrenia.
- About the bio psychosocial perspective of schizophrenia

9.1 INTRODUCTION

Schizophrenia is characterised by a broad spectrum of cognitive and emotional dysfunctions that include symptoms of delusions, hallucinations, disorganised speech and behaviour and inappropriate emotions. A number of causative factors have been implicated for schizophrenia including genetic, neurotransmitters imbalances, structural damage to the brain and psychological stressors.

Different biological theories such as Dopamine theory, structural abnormality, etc, proves the genetic causes of this disorder Psychological theories such as psychodynamic, expressed emotions, etc, gives the causes of this disorder. Social and cross cultural theories proves the social factors as the causes of schizophrenia. Two approaches to treatments – biological and psychosocial are recommended for this disorder. But these treatments have limited effects as schizophrenia is a chronic disorder.

9.2 THEORIES OF SCHIZOPHRENIA

Many people studied this disorder and have given their analysis and interpretation. All these theories are classified into two broad categories –

1. Biological Theories
2. Psycho – social Theories

Biological theories are sub – divided into several categories –

1. Genetic Influences on Schizophrenia.
2. Neurotransmitters
3. Structural Brain Abnormality
4. Birth complications
5. Prenatal Viral Exposure

1) Genetic Influences on Schizophrenia

Genes are responsible for making some persons vulnerable to schizophrenia. To examine the evidence of genetic vulnerability many studies on family, twin, adoption, linkages has been done.

a) Family Studies –

Franz Kallmann (1938) in his research showed that severity of the parent's disorder influenced the likelihood of the child's having schizophrenia. All forms of schizophrenia (for example, catatonic paranoid) were seen within the families. A person may inherit a general predisposition for schizophrenia that may be same or different from that of his parent.

The risk of having this disorder varies according to how many genes a person shares with some one who has the disorder. For example a person will have the greatest chance ((approx 48%) of having this disorder if he has an identical twin who has schizophrenia. The risk drops to about 17% in case of fraternal twins.

b) Twin Studies –

Gottesman (1991) has reported that monozygotic twins have higher possibility of suffering from schizophrenia as compared to dizygotic twins. 46% of monozygotic twins have concordance rate where as 14% was found for dizygotic twins.

c) Adoption Studies –

A study carried out by Leonard Heston (1966) on adoption, found that 17% of the adopted children of parents with schizophrenia developed the disorder in their adulthood. Kety (1994) found that biological relative of adoptees were 10 times

more likely to have a diagnosis of schizophrenia as compared to biological relatives of adoptees who did not have this disorder.

2) **Neurotransmitters –**

Various theories have studied the interlink between schizophrenia and the neurotransmitter dopamine. Davis, Kahn, Ko, and Davidson (1991) found that there is a strong relation between dopamine and schizophrenia. The dopamine system is too active in person with this disorder. The drug phenothiazines or neuroleptics reduces the dopamine levels and calms down the symptoms accordingly. High number of neuronal receptors for dopamine in certain brain areas and high level of a by product of dopamine named homovanillic acid (HVA) in the blood and cerebrospinal fluid is reported to be the cause of schizophrenia.

But recent studies suggest that neurotransmitters other than dopamine are instrumental in causing this disorder. New theories suggest that excess dopamine activity in the mesolimbic system, the area which controls human cognition and emotions, has a major role in determining schizophrenia. Other studies suggest that deficiencies in neurotransmitters named Glutamate and GABA, widely spread in the nervous system are suspected to cause schizophrenia, thus leading to severe cognitive and emotional malfunctioning.

3) **Structural Brain Abnormality**

There are some structural brain abnormalities which lead to schizophrenia. Modern medical equipments like PET, CAT scans, MRI scans, etc, shows that structural abnormalities of brain can result in this disorder.

Enlarged Ventricles

The ventricles are fluid-filled space in the brain. When the ventricles are enlarged the blood tissues starts deteriorating. It has been seen that schizophrenics having enlarged ventricles also show deterioration of the whole matter, i.e., prefrontal areas of the brain and abnormal link between the pre-frontal cortex and the amygdala and hippocampus. The patients having enlarged ventricles show poor tendencies of social, emotional and other behavioural issues even before the full onset of schizophrenia.

Brain areas such as frontal cortex, temporal lobe, basal ganglia, limbic system, thalamus, amygdala are vital in determining schizophrenia. Studies shows that if the volume, density and metabolic rate in the neurons of these areas follow an abnormal pattern then the person may suffer from this disorder.

Lower level of frontal cortex activity is mostly found in schizophrenics with negative symptoms.

3) **Birth Complications -**

Prenatal development and complications during birth also influences the possibilities of schizophrenia due to neurological damage and dysfunction. Delivery complications and oxygen deprivation to the baby, during labour and delivery, can give rise to neurological vulnerability, thus further leading to schizophrenic tendencies. Study show that 39% of people with schizophrenia reported to have a history of prenatal hypoxia. (deprivation of oxygen at birth).

4) **Prenatal Viral Exposure –**

There are evidences that a virus like disease may account for some cases of this disorder (Kirch, 1993). Studies have shown that persons whose mothers were exposed to influenza during the time of pregnancy were much likely to have schizophrenia than others (Cannon, Barr & Mednick, 1991). Influenza affects the fetal brains in this way that this damage causes the behaviours that characterize people with schizophrenia. Disruption of brain cells and malformation of central nervous system of the unborn baby may result in major structural deficits that are similar to the brains of people with schizophrenia.

2) **Psycho- Social Theories**

There are many perspectives which throws light on the psychosocial aspects in the development of schizophrenia. Few of them are-

- a) Psychodynamic Perspective
- b) Communication Patterns
- c) Expressed Emotions
- d) Stress and Relapse
- e) Behavioural and Cognitive Perspective
- f) Cross – Cultural Perspective

a) **Psychodynamic Perspective**

Sigmund Freud (1924) in his psychodynamic theory suggested that negative childhood experiences may result in schizophrenia in a person. Poor parenting may place additional strain on a vulnerable person already at risk for schizophrenia. Freud said that when mothers behave extremely harsh towards their child and when they do not express love to their child then the child regresses and shows infantile tendencies while carrying out the daily functioning. This becomes unhealthy for the Ego to discriminate between reality and unreality. Freida Formm Reichmann (1948) pointed out that poor parenting can affect the mental state of a child. Two contrasting situation were a mother is over protective on one side and at the same time questioning the child about his well-worth. This leads the child in state of confusion, worthlessness and despair. It may lead to disturbed and illogical ego that may result in tendencies of schizophrenia.

b) Communication Patterns

Bateson (1959) introduced the term “double bind” which portrays a type of communication style that produces conflicting messages, which in turn, causes schizophrenia to develop. If the parent communicates messages that have two conflicting meanings (for example, a mother responding coolly to her child’s embrace, but saying “Don’t you love me anymore?” when the child withdraws. Such children get sensitive to the contrasting remarks and distrust their own feelings and perceptions of the world. It may result in developing fake views of themselves, of others and of the environment, which may contribute to schizophrenia.

A higher level of communication deviance was found in families with schizophrenia. If children having a family history of schizophrenia are exposed to communication deviance patterns they face more risk to develop schizophrenia (Goldstein 1987).

c) Expressed Emotions

One area researchers have focused on a particular emotional communication style of few families which is referred to as “Expressed Emotions” (E E). This concept was given by George W. Brown and his colleagues in London. The researchers studied a sample of people discharged from the hospital after an episode of schizophrenia. They found that former patients with less family contact did better than the patients who spent long periods of time with their families (Brown, 1959). The cause was that the level of criticism (expressing disapproval), hostility (expressing animosity), and emotional overinvolvement (being intrusive) by the families was high, patients tended to relapse (Brown Monck & Wing 1962). Jill Hooley (1985) have found that ratings of high expressed emotion in a family are a good predictor of relapse among people with schizophrenia (almost 3.7 times more likely to relapse). An analysis of 27 Studies reveals the fact that the relapse rate of schizophrenia in “high expressed emotion” families were 70% as compared to 31% of relapse cases in patients from “low expressed emotion” families.

d) Social Circumstances

According to Dohrenmed et al (1987), people suffering from this disorder are more likely to be exposed to chronically stressful circumstances. They may live in low income and low status occupations neighborhood.

The social selection explanation states that schizophrenic people are unable to continue education or job and so automatically slides down the economic ladder. Lewis et. al (1992) stated that there is a link between “Urban lifestyle” and this disorder. Schizophrenia and other psychosis are seen to be prevailing largely in big cities than small towns.

e) **Stress and Relapse**

Researchers have studied the effects of a variety of stressors on schizophrenia. Dohrenwend and Egri (1981) observed that otherwise healthy people who engage in combat during a war (an extremely stressful situation) often display temporary symptoms resembling schizophrenia. Brown and Birley (1968, 1970) found that people showing early symptoms of this disorder tended to have a high number of stressful life events in the 3 weeks just before they started showing the signs of the disorder.

Ventura, Lukoff and Hardesty (1989) studied 30 people who has onsets of schizophrenia. 11 of the 30 people had significant relapse in which the symptoms returned or worsened. It was found that people who had relapsed experienced an increase in stressful life events in the month before their relapse. Social withdrawal is one of the prominent causes of schizophrenic relapse. Job loss, relationship problems, etc; are caused because of this disorder. These things may lead to social withdrawal, which can result in relapse.

f) **Behavioural and Cognitive Causes**

Belcher (1988) studied that schizophrenia can develop through operant conditioning under normal circumstances. In case of people with schizophrenia, the basic training for operating over environment is missing. Because of inadequate parenting or due to some unfortunate circumstance they learn irrelevant, inappropriate and socially unacceptable responses towards others around them.

According to Belcher (1988) if the family members ignore reacting to illogical and inappropriate behaviour that the schizophrenic people show, then he develops operant conditioning.

Cognitive theorists considered that schizophrenia in caused because of lack of basic perceptual and intentional skills. Delusions are formed due to irrelevant misinterpretation of the information attended and perceived in a distorted manner. For example, if a schizophrenic person report his hallucination to which his family members may neglect or reject. This in turn can, be misinterpreted by the patient that his family members have teamed up with invisible force to harm him. This may give rise to paranoid beliefs in the person with schizophrenia.

g) **Cross Cultural causes**

Different cultures and societies have different viewpoint related to this disorder. Most cultures explain this disorder as a biological issue, a disorder which runs in the families. Sometimes lack of spiritual inclination and family interactions can also cause the symptoms of this disorder. Living in more critical and hostile cultures may provide additional stressors that can in turn lead to more relapses.

Check Your Progress-

1. Explain the different causes of schizophrenia?
2. What are the biological causes of schizophrenia?
3. How the socio cultural environment affects the symptoms of schizophrenia?

9.3 TREATMENT OF SCHIZOPHRENIA

1. BIOLOGICAL TREATMENT :

DRUG THERAPY –

Over the centuries, many treatments for this disorder have been developed, based on the scientific theories of the time.

During the 1930s, one approach used massive doses of insulin – the drug used to treat diabetes – to induce coma deliberately in people suffering from schizophrenia. It was called Insulin coma therapy, which has great risk of serious illness and death. During this time, Psychosurgery, including prefrontal lobotomies, was introduced, and in the late 1930s, electroconvulsive therapy (ECT) was used as a treatment for this disorder. A break through in this field came in 1950 with the introduction of many drugs called “neuroleptics”. It helped the patient to think clearly, reduce or eliminate the hallucinations and delusions and was effective on the positive symptoms. Because of the side effects of this drug such as grogginess, blurred vision, dryness of the mouth, slow motor activities, etc., most of the patients refuse to take it. New medicines, such as, “Clozapine” is widely used and results in fewer negative side effects.

2. PSYCHO – SOCIAL TREATMENTS OF SCHIZOPHRENIA

Psychological and social interventions helps them to cope more effectively with their families, job and medical aspects.

1. Behavioural Cognitive and Social interventions -

Behavioural interventions includes social learning theory, operant conditioning and modeling. It teaches the patients essential skills such as initiating and maintaining conversations with others, asking for help or information from the doctor, etc . The therapist and family members can reinforce socially appropriate behaviour by giving attention and positive emotional responses. Sometimes “token economy” is used in hospitals, based on the principles of operant conditioning. Patients earn tokens, which they can exchange for privileges, such as time for watching television, walks, etc.

Cognitive interventions includes helping the patients to recognise demoralising attitudes and change them. This helps the patients to mix in society and learn new life skills for healthy functioning and adaptations in one’s environment.

Social interventions include increasing the social interaction between patients and supportive others or self-help support groups. These groups meet to discuss the impact of the disorder on their lives, frustration, fears of relapse, experiences and other concerns of daily life. They help each other by giving feedback, solving problems, etc.

2. Family therapy -

Family members are trained to deal with the patient in the family. They are made aware of the causes of this disorder, symptoms and the side effect of the drug therapy. This helps the family members to reduce self – blame and tolerate while adjusting with the patient. Rash, unhealthy and rude interactions are reduced and good communication skills are taught.

3. Assertive Community Treatment Programs

Many people with schizophrenia do not have families who can care for them. Even those who do have families have such a wide array of needs – for the monitoring and adjustment of their medications, occupational training, assistance in getting financial resources (such as social security and medications), social skills training, emotional support, and some times basic housing that comprehensive community – based treatment programs are necessary. Assertive community treatment programs provide comprehensive services to people with schizophrenia, using the expertise of medical professionals, psychologists to meet the variety of patient’s needs 24 hours a day.

Other comprehensive treatment programs provide skills training, vocational rehabilitation and social support to people with schizophrenia who are living at home. Studies of these programs find that they reduce the amount of time spent in the hospital by people with schizophrenia and as a result, can be cost effective. (Bastille et al, 2001). In a model program established in Madison, Wisconsin, by founders of the assertive community program movement (Test & Stein, 1980), mental – health professionals worked with chronically disabled schizophrenics.

1. To help them gain material resources for food shelter, clothing and medical care.
2. To help them gain coping skills to meet the demands of community life, such as using public transportation, preparing simple but nutritious meals and budgeting money.
3. To lessen their dependency on family members.
4. To educate family and community members about the kind of support they need.

4. Cross – Cultural treatments -

Traditional Healers

The symptoms of schizophrenia are sometimes treated by folk or religious healers, according to the cultural beliefs about the meaning and causes of these symptoms.

Anthropologists and cultural psychiatrists have described four models that traditional healers tend to follow in treating schizophrenic symptoms.

1. According to the structural model, there are interrelated levels of experience, such as the body, emotion cognition, as well as the person, society and culture. Symptoms arise when the integration of these levels is lost. Healing thus involves reintegrating these levels, through changes in the client, or environment, or both and / or the prescription of herbal medicines, or rituals.
2. The social support model holds that symptoms arise from conflictual social relationships and that healing involve mobilising a patient's kin to support him or her through this crisis and reintegrating the patient into a positive social support network.
3. The persuasive model suggests that rituals can transform the meaning of symptoms for the patient, diminishing the pain of the symptoms.
4. Clinical model, it is simply the faith that the patients puts in the traditional healer to provide a cure for the symptoms.

Check Your Progress-

1. Discuss the Assertive Training Programs to help a patient?
2. What are the psycho social treatment of schizophrenia?

9.4 THE BIOPSYCHOSOCIAL PERSPECTIVE

The biological theories believes that there are genetic basis of this disorder. Family, twin, adoption studies shows the genetic cause of this disorder. Brain abnormality, prenatal environment and neurotransmitters, etc., also play an important role. Psychodynamic perspective stresses on negative childhood experiences and faulty parenting. Faulty communication patterns, over expressed emotions, stress and relapse can result in schizophrenia. Age, gender and cross cultural or social factors plays an influencing role. Poor neighborhood, lower socioeconomic status, social withdrawal, etc., can be the causes of this psychosis. Cross-cultural pererspective explains that in majority of the cultures, this disorder is considered biological or genetic. This perspective also emphasises on spiritual indignation and family interaction.

9.5 SUMMARY

Schizophrenia is characterized by a broad spectrum of cognitive and emotional functions, that include delusions, hallucinations, disorganised speech and behaviour and inappropriate emotions.

The symptoms are divided into three categories positive, negative and others. DSM – IV divides this disorder into five subtypes – paranoid type, disorganised type, catatonic type, undifferentiated type and residual type of schizophrenia. Genetic influences, neurotransmitter imbalances, structural damage, viral infections can be the biological causes of the disorder. Relapse appears as a result of hostile and critical family environment .

Treatment includes drug therapy, family therapy, community help and social interventions.

9.6 GLOSSARY

1. **Alogia** – Deficiency in the amount or content of speech.
2. **Anhedonia** – inability to experience pleasure.
3. **Delusion** – disorder of thought content and presence of strong belief that one misrepresentations of reality.

9.7 SUGGESTED READINGS

1. Balow, D. H. & Durand, V. M. (2005) Abnormal Psychology – An integrative approach, New Delhi.
2. Bennet, P. (2003). Abnormal and Clinical Psychology An Introduction Textbook. Open university Press.



PERSONALITY DISORDERS – I

Unit Structure :

- 10.0 Objectives
- 10.1 Introduction
- 10.2 Nature of Personality Disorder
- 10.3 Antisocial Personality Disorder
- 10.4 Borderline Personality Disorder
- 10.5 Histrionic Personality Disorder
- 10.6 Narcissistic Personality Disorder
- 10.7 Summary
- 10.8 Questions
- 10.9 References

10.0 OBJECTIVES

After studying this unit you should be able to:

- a) Understand the nature, definition and features of Personality disorders.
- b) Know the classification of Personality Disorders.
- c) Comprehend the characteristics of Antisocial Personality Disorder as well as Theories and Treatment of Antisocial Personality Disorder.
- d) Know the Characteristics of Borderline Personality Disorder as well as Theories and Treatment of Borderline Personality Disorder.
- e) Explain histrionic and narcissistic personality disorders.

10.1 INTRODUCTION

In this unit we will first define personality disorder and discuss its nature, characteristics as well as classification of personality disorders. Personality Disorder, initially called as character disorders, is defined as "those characteristics that are inflexible and maladaptive and cause either significant functional impairment or subjective distress". Personality disorders are classified in to 10 different types. In this unit we will discuss cluster

B disorders. The two most important of these disorders include the Antisocial Personality Disorder and the Borderline Personality Disorder. We will also discuss its characteristic features, theories as well as treatment. Following this we will discuss the histrionic personality disorder as well as narcissistic personality disorder.

10.2 NATURE OF PERSONALITY DISORDERS

Personality disorders are a separate group of disorders which are completely different from major disorders, anxiety disorders and other related disorders. Individuals who have maladaptive personality traits are said to possess personality disorders. A **personality trait** can be defined as an enduring pattern of perceiving, relating to and thinking about the environment and others, a pattern that is ingrained in the matrix of the individual's psychological makeup.

Personality Disorders: Personality Disorders are patterns of behavior that are deeply ingrained and are manifested primarily as exaggerations. The category of Personality Disorder is relatively new. It was introduced by the American Psychiatric Association's Classification in its first Diagnostic and Statistical Manual (DSM-I) (1952). Before the publication of this manual, personality disorders were largely termed as "Character Disorders".

DSM-IV- has defined Personality Disorder as "those characteristics that are inflexible and maladaptive and cause either significant functional impairment or subjective distress". Generally these are life long patterns often recognizable by the time of adolescence or earlier. Personality Disorders were classified on a separate Axis. i. e., Axis II for the first time in DSM-III. Personality Disorders are a heterogeneous group of deeply ingrained, usually life-long, maladaptive patterns of behavior in which there was an absence of true neurotic or psychotic symptoms. Although these persons cause themselves and others much unhappiness, their behavior is usually Egosyntonic and there is little motivation for change (Arkem 1981).

In conclusion, we can say that Personality Disorders are learned life-long consistent patterns of characteristic behavior which impair an individual's occupational, interpersonal and social functioning, and which lead to problematic behavior both for the individual and for those around him.

Personality disorders involves a long-lasting maladaptive pattern of inner experience and behaviour dating back to adolescence or young adulthood that is manifested in atleast two of

the following areas: (i) Cognition, (ii) Affectivity, (iii) Interpersonal functioning, (iv) Impulse control. Some important features of personality disorders are as follows:

1. They have an inflexible pattern of interaction with others that causes considerable distress and impairment either to themselves or to others.
2. Their problems involve excessive dependency, overwhelming fear of intimacy, intense worry, exploitative behaviour or uncontrollable rage. These individuals are usually unhappy and maladjusted.
3. It is the most challenging of the psychological disorders to treat.
4. The lifetime prevalence of personality disorders in the population ranges from 1-3 Percent, with higher prevalence seen in people with clinical settings. Estimates of prevalence vary according to age and socio-demographic factors.
5. Personality disorders are most commonly diagnosed among younger individuals, students and unemployed homemakers.
6. The prevalence of personality disorders is higher among individuals who have alcohol and drug abuse disorders.
7. Diagnosis of personality disorders is difficult because many personality disorders have similar features.

10.2.1 Classification of Personality Disorders: DSM –IV – TR has classified personality disorders into three categories covering a total of 10 personality disorders which are listed in the following table.

<p style="text-align: center;">Cluster B Disorders</p> <ul style="list-style-type: none"> • Antisocial Personality Disorder • Borderline Personality Disorder • Histrionic Personality Disorder • Narcissistic Personality Disorder <p style="text-align: center;">Cluster A Disorders</p> <ul style="list-style-type: none"> • Paranoid Personality Disorder • Schizoid Personality Disorder • Schizotypal Personality Disorder <p style="text-align: center;">Cluster C Disorders</p> <ul style="list-style-type: none"> • Avoidant Personality Disorder • Dependent Personality Disorder • Obsessive Compulsive Personality Disorder
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In this unit we will discuss Cluster B disorders. Individuals having this cluster of disorders have in common a tendency to be

dramatic, emotional and erratic. Their impulsive behavior often involving antisocial activities is more colorful, more forceful and more likely to get them into contact with mental health or legal authorities than the behavior characterizing disorders in either Cluster A or Cluster C disorders.

10.3 ANTISOCIAL PERSONALITY DISORDER

This disorder has been known since a long time but different labels were used to refer to this disorder. This is relatively one of the most studied and researched disorders. In this disorder the rights of others are violated. Individuals with this disorder find themselves in confrontation with the laws and norms of society. This disorder was earlier called as Sociopath or Psychopath.

10.3.1 Characteristics of Antisocial Personality Disorder:

This disorder was first recognized by Philippe Pinel as a form of madness in which individuals exhibited impulsiveness and destructive behaviour disorder while maintaining rational thought. Some important characteristic of this disorder are as follows:

1. People with this disorder wreck havoc in society and for this reason they have been the focus of great deal of research.
2. The life time prevalence of this disorder is 4.5 percent of the adult males and 0.8 percent of the adult females (Robins and Regier, 1991).
3. Hervey Cleckley (1941) in his work "The Mask of Sanity", made the first scientific attempt to list and categorise the behaviour of "psychopathic" personality. Cleckley developed a set of criteria for Psychopathy (which is today called as antisocial personality disorder). He identified more than a dozen criteria which constitutes the core of antisocial personality disorder. Harvey Cleckly identified 16 traits that he found was common in these individuals. These are as follows:
 - i. Superficial charm of good intelligence
 - ii. Absence of delusions and other signs of irrational thinking.
 - iii. Absence of "Nervousness" or psychoneurotic manifestations.
 - iv. Unreliability.
 - v. Untruthfulness and insincerity.
 - vi. Lack of remorse or shame.
 - vii. Inadequate motivated antisocial behavior.
 - viii. Poor judgment and failure to learn from experiences.
 - ix. Pathological egocentricity and incapacity for love.

- x. General poverty in major effective reactions.
 - xi. Specific loss of insight.
 - xii. Unresponsiveness in general interpersonal relations.
 - xiii. Fanatic and uninviting behavior with drink and some times without.
 - xiv. Suicide rarely carried out.
 - xv. Sex life impersonal, trivial and poorly integrated.
 - xvi. Failure to follow any life plan.
4. Cleckley used the term Semantic Dementia to capture the psychopath's inability to react appropriately to expressions of emotionality. Cleckley's notion of psychopathy remains a key concept in descriptions of antisocial personality disorder.
 5. Building on Cleckley's work Canadian psychologist Robert D Hare (1997) developed an assessment instrument known as the Psychopathy Checklist – Revised (PCL – R) which has two factors: a) Core Psychopathic Personality Traits and b) Antisocial Lifestyle. The core personality traits include glibness and superficial charm, a grandiose sense of self-worth, a tendency towards pathological lying, a lack of empathy for others, a lack of remorse and unwillingness to accept responsibility for one's action. The antisocial lifestyle traits revolve around impulsivity, a characteristics that can lead to behaviours expressed in an unstable lifestyle, juvenile delinquency, early behavioural problems, lack of realistic long-term goals and a need for constant stimulation. Robert Hare et al (1989), elaborated on the work of Cleckly and developed a 20-item checklist that serves as an assessment tool. Six of the criteria that Hare (1991) included in his Revised Psychopathy checklist are as follows:
 - Grandiose sense of self-worth
 - Lack of remorse
 - Glibness/superficial charm
 - Proneness to boredom/need for stimulation
 - Pathological lying
 - Conning/manipulative
 6. The DSM IV – TR diagnostic criteria for this disorder also includes behavioural aspects of the disorder such as disreputable or manipulative behaviours. There is a difference between the DSM-IV criteria of Antisocial Personality Disorder and the Cleckley/Hare criteria. While the former focuses on observable behavior the latter focuses primarily on the underlying personality traits.
 7. Individual having antisocial personality disorder show a pervasive disregard for the rights of others as shown by such

behaviours as lawlessness, deceitfulness and impulsivity. They do not show any signs of remorse when they behave impulsively, recklessly and aggressively. Occasionally they may demonstrate feign remorse with the intention of coming out of the difficult situation.

8. These individuals are smooth talkers who are able to get what they want by presenting themselves in a favourable light.
9. It should be remembered that not all individuals having antisocial personality disorder are criminals. The term criminal is a legal connotation. Many qualities of the antisocial personality disorder are reflected in acts that would not be considered as violations of the law, such as job problem, promiscuity and aggressiveness.
10. Research studies have shown that under controlled young children i.e., children who are impulsive, restless and distractible are more likely to meet the diagnostic criteria for antisocial personality disorder and to be involved in crime as adults.
11. Though, today we have a good understanding of the predisposing factors that lead to antisocial personality disorder, we have less knowledge about the long-term prospects of individuals having antisocial personality disorder.
12. Personality disorder, especially antisocial personality disorder reduces as one reaches middle adulthood years and beyond. This is called a ***maturation hypothesis***, which means that individuals having this disorder are better able to manage their behaviours as they age.

10.3.2 Theories and Treatment of Antisocial Personality Disorder: Wide varieties of theories have been developed to explain the causation of Antisocial Personality Disorder. Some of the most important theories are discussed below.

Biological Perspectives: Biological perspectives emphasis on the role of brain pathology, genetic factors and related cause. Brief descriptions of biological causes are as follows:

Brain abnormalities: Individuals having antisocial personality disorder have certain brain abnormalities. MRI studies have revealed that they have difficulty processing conceptually abstract verbal information (Kiehl et al 2004). They also show deficits in emotional processing during juvenile years. It has also been observed (Goethals et al 2005) that individuals having antisocial personality disorder have deficits in prefrontal lobes of the cerebral cortex – an area of the brain involved in planning future activities and in considering the moral implications of one's actions.

Individuals having antisocial personality disorder also show amygdala dysfunction as well as have dysfunction in the hippocampus regions.

Genetic Causes: Genetic influences have been found to play an important role in the development of this disorder. Family, twin, and adoption studies all suggest a genetic influence on both Antisocial Personality Disorder and criminality. A comparison of the adopted children of Felons along with the adoptive children of normal parents, carried out by Crowe (1974) revealed that adopted offspring of felons had significantly higher rates of arrests, conviction and Antisocial Personality than did the adoptive offspring of normal mothers. This suggests that in the development of Antisocial Personality Disorder and criminality genetic influences play a dominant role. Crowe (1974) also pointed out that genetic influence is more likely to act when certain type of environment is available. Though genetic factors provide vulnerability, actual development of criminality will depend upon a particular type of environment.

In a similar study Cadoret et al (1995) found that if the children's biological parents had a history of Antisocial Personality Disorder and their adoptive families exposed them to chronic stress through marital, legal or psychiatric problems, the children were at greater risk for conduct problems.

Twin studies also strongly support the view that genetic influence plays an important role in the development of criminality. Eysenck and Eysenck (1978) found that the average concordance rate for criminality among Monozygotic (MZ) twins was 55%, whereas, among Dizygotic it was only 13 %.

Strong evidence in favour of inheritance of antisocial personality disorder comes from a study of more than 3200 male twin pairs (Lyons et al, 1995). Recently Button et al (2005) have pointed out that those individuals who are genetically predisposed to antisocial personality disorder may be particularly vulnerable to family dysfunction, supporting the notion of gene-environment interaction.

Psychological Perspectives: According to this perspective Antisocial personality disorder is a result of neuropsychological deficits reflected in abnormal patterns of learning and attention. According to David Lykken (1957), psychopathic individuals failed to show the normal response of anxiety when they are subjected to aversive stimuli. Psychopathic individuals are unable to feel fear or anxiety.

Deficient emotional arousal: Research evidence indicates that a primary reaction tendency typically found in antisocial

individuals is a deficient emotional arousal; this condition presumably renders them less prone to fear and anxiety in stressful situations and less prone to normal conscience development and socialization. In an early study, for example, Lykken (1957) concluded that anti-social individuals have fewer inhibitions about committing antisocial acts because they suffer little anxiety.

Response Modulation Hypothesis: This hypothesis proposes that psychopaths are not able to process any information that is not relevant to their primary goals. Individuals having antisocial personality are unable to think about someone else's needs when focused on one's personal needs. The "response modulation" hypothesis, postulates that psychopaths have difficulty shifting their attention from the performance of a behavior to an evaluation of its consequences

Social Cognitive theory is another psychological perspective which emphasizes that low self esteem is a causal factor in antisocial personality disorder.

Socio-cultural Perspectives: Social cultural factors emphasize on the role of family, early environment and socialization experiences that lead individuals to develop psychopathic lifestyle. Anti-social personality is thought to be more common in lower socioeconomic groups. Lee Robins (1966) found that children of divorce generally develop antisocial personality disorder. Research studies have revealed that disharmony between parents lead to development of antisocial personality disorder. Poor child rearing practices and inconsistent discipline also contribute to development of antisocial personality disorder. Luntz and Wisdom (1994) found that abused and neglected children often develop antisocial personality disorder when they grow up. These individuals have 50 % more arrests for violent crimes as compared to control group individuals. Strangely research studies have also found that malnutrition in early life may serve as another risk factor for the development of antisocial personality disorder. Children who between the ages of 03 years and 17 years experienced poor nutrition showed more aggressiveness and motor activity as they grew up.

10.3.3 Treatment of Antisocial Personality Disorder: Antisocial behavior is difficult to treat. People with this disorder do not change easily. They are unlikely to seek professional help voluntarily, because they see no reason to change. If they do see a clinician, it is often because treatment is mandated by a court order. The prognosis of this disorder is highly poor. This disorder can be prevented during childhood if certain steps are taken. One such step is Parent Training. In this type of training parents are taught to recognize behavior problems early and how to use praise and

privileges to reduce problem behavior and encourage prosocial behavior. A good parenting skill is one of the prerequisites for effectively retarding the development of antisocial personality disorder. The client should be taught to feel remorse and guilt for their behaviour, when they learn these, they start showing change in behaviour. Psychotherapy for people with Antisocial Personality Disorder should focus on helping the individual understand the nature and consequences of his disorder so he can be helped to control his behavior. Exploratory or insight-oriented forms of psychotherapy are generally not helpful to people with Antisocial Personality Disorder

10.4 BORDERLINE PERSONALITY DISORDER

Borderline personality disorder is characterized by a pervasive pattern of instability, most evident in relationships, mood and sense of identity. The term borderline has been in use in the psychiatric literature since a long time, but it was only with the DSM –III that this term received official recognition for the first time. Stern (1938) used it as a catchall term to refer to treatment-resistant clients. Knight (1953) regarded such individuals to be functioning somewhere between border of neurosis and psychosis, on the edge of schizophrenia. Many scholars regard it as a variant of schizophrenia or mood disorder or possibly a hybrid.

10.4.1 Characteristics of Borderline Personality Disorder:

Some important characteristic features of Borderline Personality Disorder are as follows:

- i. Individuals with this disorder often experience a distinct kind of depression that is characterized by feeling of emptiness. They often vacillate between extreme emotional states, one day feeling on the top of the world and the next moment feeling depressed, anxious or irritable.
- ii. People with this disorder suddenly form intense demanding relationships with others and to perceive other people as being all good or all bad – a phenomenon called as splitting.
- iii. The inappropriate intensity of their relationship results in recurrent experiences of distress and rage. People with this disorder experience anger and hostility.
- iv. Their interpersonal relationships are always disturbed
- v. They also experience identity problems. They are often confused about their identity as to who they are. They are unsure of what they want out of life and lack a firm grasp of their sense of self. Their uncertainty about who they are may be expressed in sudden shifts in life choices such as career plans, values, goals and types of friends.

- vi. They experience chronic feelings of boredom, which make them seek stimulation. In order to overcome boredom they may indulge in impulsive behaviour such as promiscuity, careless spending, reckless driving, binge eating, substance abuse, shoplifting, etc.
- vii. They often indulge in suicidal thinking and self-injurious behaviour. They indulge in suicide behaviour only to get attention from others – a phenomenon called parasuicide.
- viii. They often explode in rage when they experience neglect and abandonment by their lover or some important person in their life.
- ix. They are highly sensitive to stress and often break down displaying brief psychotic reactions in the presence of intense stressful situations.
- x. Individuals with borderline personality disorder show a pattern of behaviour that resembles features of both the personality disorder and some of the more severe psychological disorder, particularly the affective disorders and schizophrenia.
- xi. People with borderline personality disorder suddenly move from anger to deep depression. They are also characterized by impulsivity, which can be seen in their drug abuse and self mutilation.
- xii. Mood disorder is common among individuals having borderline personality disorder, about 24% to 74 % of the individual having this disorder also has major depression and about 4 % to 20 % have bipolar disorder. About 25% of the bulimics also has this disorder.
- xiii. Although they are usually aware of their circumstances, and surroundings, borderline personalities may have short episodes in which they appear to be out of contact with reality and experience delusions or other psychotic-like symptoms, such as recurrent illusions, magical thinking, and paranoid beliefs (O'Connell et al, 1989).
- xiv. Individuals with borderline personalities are frequently impulsive and unpredictable, angry, empty, and unstable.
- xv. They typically display intense anger outbursts with little provocation, and they may show disturbance in basic identity that preoccupy them and produce a basically negative outlook.
- xvi. They have chronic feeling of boredom and a low tolerance for frustration. Their extreme instability is reflected in drastic mood shifts and erratic self- destructive behaviours, such as binges of gambling, sex, alcohol use, eating, or shoplifting. They commonly have a history of intense but stormy relationship, typically involving over idealisation of friends or

lovers that later end in bitter disillusionment and disappointment (Gunderson & Singer, 1986).

- xvii. Feeling slighted, they might, for example, become verbally abusive towards loved ones or might threaten suicide over minor setbacks.
- xviii. Suicide attempts, often are often manipulative, are frequently part of the clinical picture (Fine & Sansone, 1990), and self-mutilation is one of the most discriminating signs for borderline personality (Widiger et al, 1986).
- xix. Clinical observation of people whose behaviour meets the criteria of borderline personality disorder points strongly to a problem of achieving a coherent sense of self as a key predisposing causal factor.
- xx. These people somehow fail to complete the process of achieving an articulated self-identity and hence do not really become individual. This lack of individualisation leads to complication in interpersonal relationships.

10.4.2 Theories and Treatment of Borderline Personality Disorder:

This is one of the most challenging disorders as individuals suffering from it create chaos in their lives as well as those of others with whom they interact. This disorder evolves as a result of combination of vulnerable temperament, traumatic early experiences in early childhood and certain triggering events in early adulthood

Biologic al Perspectives: Most theories regarding causation of this disorder is psychological in nature, though psychologists have attempted to identify biological correlates of psychological factors thought to be involved in the development of this disorder. One set of biological factors involved in the causation of this disorder is **neurotransmitter dysregulation**. For Example sexual abuse in the childhood influences the noradrenergic (sympathetic nervous system \) pathways and makes them hypersensitive, so that an individual is primed to overreact to experiences of any kind later in childhood. This altered sympathetic system functioning predisposes an individual towards impulsivity, due to abnormalities in the serotonergic receptors in the brain.

MRI studies (Driessen at al 2000) comparing the brains of women having Borderline Personality Disorder with control subjects have revealed that the hippocampus was 16 percent smaller and amygdala was 08 percent smaller among women suffering from Borderline Personality Disorder as compared to normal healthy control subjects.

Psychological Perspectives: Most adults with Borderline Personality Disorder show a family history of extreme negative experiences within the family. Three important factors that have emerged as important in the development of Borderline Personality Disorder are as follows:

- a) Disturbed childhood family environment
- b) Parental psychopathology
- c) Child abuse

It has been observed that child sexual abuse is the most important significant predictor of Borderline symptomatology. Early child abuse experiences cause children to expect that others will harm them. Zanarini et al (1997) found that people with Borderline Personality Disorder reported that their caretakers withdrew from them emotionally, treated them inconsistently, denied the validity of their thoughts and feelings and did not carry out their roles as parents in terms of providing them with protection from abuse. It has also been found that individuals with Borderline Personality Disorder experience:

- a. Deficits in the formation of self
- b. Have a mother who is uninvolved with her child and inconsistent in her emotional responsiveness.
- c. Parents do not bolster the child's independent sense of self.
- d. As children such individual perceive other people in a distorted way and builds a false self that is fused with distorted perceptions of the self.

Beck and other cognitive theorists have observed that people having Borderline Personality Disorder have a tendency to dichotomise their thinking about themselves and other people, they think in terms of "all or nothing". Such type of thinking leads to shift in moods. For example, individuals with Borderline Personality Disorder display "splitting", which means that if individuals with this disorder originally perceive someone as all good, and that person fails to follow through on a promise, the person immediately is perceived as all bad.

People with Borderline Personality Disorder are not realistic while evaluating themselves. Even on minor ground their entire self-evaluation becomes negative. A low sense of self-efficacy related to their weak identity causes a lack of confidence in their decisions, low motivation and an inability to seek long-term goals.

Socio-cultural Perspectives: According to Millon and Davis (1996) pressures of the contemporary society have placed a strain on families and individuals which in turn has exacerbated the deficient parenting that has given rise to this disorder.

Individuals with Borderline Personality Disorder are highly vulnerable to reduced cohesion in society that is a result of urbanization and modernization in the contemporary society. Their lack of psychic cohesion is a reflection of instability within society and lack of clearly defined cultural norms and cohesion. According to Goldman et al, 1993, family difficulties, including depression, substance abuse and antisocial behaviour lead to development of this disorder. According to Stone (1990) an adult with Borderline Personality Disorder who was abused as a child, passes on this pattern of parenting to the next generation, who then become vulnerable to developing this disorder.

10.4.3 Treatment of Borderline Personality Disorder: Treatment of Borderline Personality Disorder poses number of challenges to the clinicians. Some of the important points to be noted with respect to the treatment of this disorder are as follows:

1. The treatment of this disorder is highly difficult as, according to Million, (2000) these individuals “often appear to be more healthy at first glance than they really are”.
2. These individuals do not remain in therapy for a long time and they often drop out of therapy due to their volatility, inconsistency and intensity.
3. Individuals with this disorder commonly become pathologically dependent upon their therapist, as a result they may feel uncontrollably enraged when the therapist fails to live up to their idealization.
4. According to Goin (2001) in the treatment of the clients with this disorder it is important to establish clear treatment framework by discussing and clarifying treatment goals as well as the roles that the clients and therapists are expected to play.
5. Therapist must also determine the extent to which these patients need support and confrontation
6. One of the most systematically developed therapeutic approach to treat individuals having this disorder is the Dialectical Behaviour Therapy developed by Marsha Linehan. This approach integrates supportive and cognitive behavioural treatments to reduce the frequency of self-destructive acts and to improve the client's ability to handle disturbing emotions, such as anger and dependency. The term dialectical refers to systematically combining opposed ideas with the goal of reconciling them. The therapist's strategy is to alternate between accepting clients as they are and confronting their disturbing behaviour to help them to change. Some specific aim of this therapy includes:

- i. Regulating emotions
- ii. Developing interpersonal effectiveness
- iii. Learning to tolerate emotional distress
- iv. Developing self-management skills

One technique used by therapists practicing Dialectical Behaviour Therapy is called as core mindfulness in which the clients are taught to balance emotions, reason and intuition in their approach to life's problems.

- vii. Another approach to treat individuals having Borderline Personality Disorder is called as Transference Focused Psychotherapy. In this approach the therapist deals with dominant affect laden themes that emerge in relationship between the client and therapist. In this approach the therapist uses techniques of clarification, confrontation and interpretations of the transference in the here and now of the therapeutic relationship
- viii. Medication is often used as an adjunct to therapy. Some medication has been found to be effective in treating specific symptoms. Wide ranges of medications have been used and these include: antidepressants, antipsychotics, anticonvulsants, lithium and minor tranquilizers. When ever these medications are used, they should be prescribed with careful assessment of specific symptoms.
- ix. In severe cases of Borderline Personality Disorder, effective treatment can only be given in an inpatient or partial hospitalization setting. This approach is more appropriate when the patient displays: suicidal behaviour, attempts or threats, psychotic like episodes, threat or harm to others, etc.

10.5 HISTRIONIC PERSONALITY DISORDER

The term histrionic is derived from the latin word meaning "actor". People with this disorder display theatrical qualities in their everyday behaviour. One important characteristic that differentiates individuals with this disorder from those who show appropriate emotionality is the fleeting nature of their emotional states and their use of excessive emotions to manipulate others rather than to express their genuine feelings.

This disorder is more commonly diagnosed among women. Some important characteristics of this disorder are as follows:

- 1. Individuals with this disorder enjoy being the centre of attention and behave in whatever way necessary to ensure that this happens.

2. They are very much concerned with their physical appearances, often trying to draw attention to themselves in extreme ways.
3. These individuals are likely to be seen as flirtatious and seductive, demanding the reassurance, praise and approval of others and they become furious if they do not get it.
4. These individuals seek immediate gratification of their wishes and overreact to minor provocations, usually in exaggerated ways, such as weeping or fainting.
5. Their relationships are superficial. They are easily influenced by others, lack analytical ability and often see the world in broad impressionistic ways.
6. People who are in relationships with individuals having this disorder often feel frustrated and unsatisfied.
7. Individuals having this disorder have an insecure attachment type style.
8. These individuals often exhibit dependence and helplessness and are quite gullible. Their sexual adjustment is usually poor and interpersonal relationships are stormy. In their interpersonal relationships they are over concerned about approval from others. Their cognitive style is impressionistic. They view situations in a very global, black and white term.
9. Not much research has been done with respect to causes or treatment of histrionic personality disorder. This disorder co-occurs with antisocial personality disorder. This association has led to the suggestion that Histrionic Personality Disorder and Antisocial Personality Disorder may be sex typed alternative expressions of the same unidentified underlying conditions.
10. Not much work has been done with respect to the treatment of this disorder. It has been pointed out that modifying attention-seeking behavior will help to reduce this disorder. A large part of therapy for these individuals usually focuses on the problematic interpersonal relationships. These individuals need to be taught how the short term gains derived from their faulty interaction can create problems for them.

10.6 NARCISSISTIC PERSONALITY DISORDER

Sigmund Freud described narcissistic Individuals as one who shows an exaggerated sense of self- importance and a preoccupation with receiving attention. It has been pointed out that grandiosity was the most stable and generalizable orientation for diagnosing narcissistic patterns. The narcissistic personality disorder is more frequently observed in men than in women.

People with this disorder expect others to compliment them and gratify all their wishes and demands. They lack sensitivity to the needs of others. They are preoccupied with and driven to achieve their own goals, even to the extent of exploiting others. These individuals often experience self-doubt inspite of grandiosity. Million and his colleagues (2000) identified four subtypes of this disorder:

- *Elitist Narcissistic*: These individuals feel privileged and empowered and tend to flaunt their status and achievements. They are upwardly mobile, they engage in self-promotion and tries to cultivate special status and any opportunity to be recognized.
- *Amorous Narcissistic*: These individuals are sexually seductive, but they avoid real intimacy. Such individuals are especially drawn to tempting, naïve and emotionally needy people.
- *Unprincipled Narcissistic*: These individuals are very much like antisocial individuals. They are unscrupulous, deceptive, arrogant and exploitative.
- *Compensatory Narcissistic*: These individuals tend to be negativistic. They often create an illusions of being superior and exceptional.

The traditional psychoanalytic approach regards narcissism as failure to progress beyond the early stages of psychosexual development. Object relations approach views this disorder to be a result of disturbances in parent-child relationships. Disturbed parent-child relationship leads to faulty development of sense of self. Every child needs parents to provide reassurance and positive response to accomplishments. In the absence of these, the child becomes insecure and this insecurity is expressed, paradoxically as an inflated sense of self-importance that can be understood as an individual's attempt to makeup for what was missing early in life. Narcissistic personality disorder is viewed as the adult's expression of childhood insecurity and the need for attention.

10.7 SUMMARY

Personality disorder is a separate group of disorders. In DSM IV these disorders are coded on a separate Axis II. They are regarded as being different enough from the standard psychiatric syndromes to warrant separate classification. Personality Disorders are learned life-long consistent patterns of characteristic behavior which impair an individual's occupational, interpersonal and social functioning, and which lead to problematic behavior both for the individual and for those around him. After defining personality disorders, some important features of this group of disorders were discussed in brief.

DSM –IV – TR has classified personality disorders in to three categories covering a total of 10 personality disorders. In this unit we had briefly discussed Cluster B Disorders, which included Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder and Narcissistic Personality Disorder.

Theories and Treatment of Antisocial Personality Disorder as well as Theories and Treatment of Borderline Personality Disorder were discussed in detail.

10.8 QUESTIONS

1. Define Personality Disorders and discuss the various features of Personality Disorders.
2. Discuss the Classification of Personality Disorders.
3. Explain the Characteristic features of Antisocial Personality Disorder
4. Discuss the various Theories and Treatment of Antisocial Personality Disorder
5. Discuss the characteristic features of Borderline Personality Disorder
6. Discuss the various Theories and Treatment of Borderline Personality Disorder
7. Write short notes on the following:
 - a. Histrionic Personality Disorder
 - b. Narcissistic Personality Disorder

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PERSONALITY DISORDERS – II

Unit Structure:

- 11.0 Objectives
- 11.1 Introduction
- 11.2 Paranoid Personality Disorder
- 11.3 Schizoid Personality Disorder
- 11.4 Schizotypal Personality Disorder
- 11.5 Avoidant Personality Disorder
- 11.6 Dependent Personality Disorder
- 11.7 Obsessive-Compulsive Personality Disorder
- 11.8 Personality Disorder: The Biopsychosocial Perspective
- 11.9 Summary
- 11.10 Questions
- 11.11 References

11.0 OBJECTIVES

After studying this unit you should be able to:

- understand the various personality disorders such as Paranoid Personality Disorder, Schizoid Personality Disorder, Schizotypal Personality Disorder, Avoidant Personality Disorder, Dependent Personality Disorder and Obsessive-Compulsive Personality Disorder
- Comprehend the biopsychosocial perspective of personality disorder.

11.1 INTRODUCTION

In this unit we will discuss the paranoid personality disorder. Individuals with this disorder are extremely suspicious of others and are always on the guard against potential danger or harm. Following this we will discuss the Schizoid Personality Disorder as

well as the Schizotypal Personality Disorder. These two disorders involve disturbances in personality that have schizophrenia-like qualities but do not take on the psychotic form seen in schizophrenia. It is a part of the schizophrenia spectrum disorders implying that these two disorders are related to schizophrenia.

The next disorder that we would discuss includes the Avoidant Personality Disorder as well as the Dependent Personality Disorder. People having avoidant personality disorder are shy and are often worried about committing some social blunder and appearing foolish in front of others. They are also terrified by the prospect of being publicly embarrassed. On the other hand individuals with dependent personality disorder are strongly drawn to others. They have a strong need that others should take responsibility for them and are unable to decide for themselves.

Lastly, we would discuss obsessive compulsive personality disorder. Individuals having this disorder are overwhelmingly concerned about neatness and the minor details of everyday life.

Towards the end of this unit we will discuss the biopsychosocial perspective. This perspective, as discussed in an earlier chapter, takes in to account the biological, psychological and social factors in the development of a given disorder. According to this perspective any disorder is a combination of and integration of many causes and no one cause can explain the causation of a given disorder.

11.2 PARANOID PERSONALITY DISORDER

Individuals with paranoid personality disorder are extremely suspicious of others and are always on the guard against potential danger or harm. Their world view is very narrow and they are always on the look for confirmation that others are taking advantage of them. They may accuse a partner or spouse of being unfaithful, even when there is no evidence for the same. They are hostile to those who criticize them. They misconstrue innocent comments and minor events as having threatening contents. They draw wrong inferences. Their emotional life is constrained and isolated. Individuals having this disorder have problematic relationships. They generally keep other people at a distance because of irrational fears that others will harm them. They are particularly sensitive to people in position of power. They have a fearful attachment style. They think and behave in ways that are unrelated to their environment. They refuse to seek professional help as they don't acknowledge the nature of their problems.

According to Psychodynamic theorists, individuals having paranoid personality disorder heavily uses defense mechanisms of projection. They consider that other people rather than they themselves have negative or damaging motives.

According to Cognitive Behavioural theorists, such as Beck (2004) individuals with paranoid personality disorder suffers from mistaken assumptions about the world. They attribute personal problems and mistakes to others. According to Cognitive Behavioural theorists three basic mistaken assumptions that individuals with this disorder have are as follows:

- People are malevolent and deceptive
- They will attack you if they get the chance
- You can be OK only if you stay on your toes

The treatment of Paranoid Personality Disorder is the most difficult one. These individuals are highly resistant to change, as they cannot form any trusting relationship even with a therapist. The dropout rate, for such disorder, in treatment is very high and the prognosis for this disorder is poor. Some recent research has suggested that cognitive therapy to overcome an individual's mistaken assumptions is of considerable help. The cognitive behavioural therapist attempts to increase the client's feelings of self-efficacy, so that the client feels able to handle situations without resorting to a defensive and vigilant stance. It should be remembered that direct confrontation with the paranoid client usually backfires, because the client is likely to construe this as yet another attack.

11.3 SCHIZOID PERSONALITY DISORDER

Schizoid personality disorder is characterized by an indifference to social and sexual relationships, as well as a very limited range of emotional experience and expressions. Individuals with this disorder prefer to be with themselves rather than with others. They lack desire to be accepted or loved even by their family members. They are not interested in sex. They are basically insensitive to feelings and thoughts of others. They are cold, reserved, withdrawn and seclusive. They seek out situations in which there is minimal interaction with others. They have problems in employment and they do not retain jobs for a long period of time. They generally do not seek psychotherapy.

According to some experts nutritional deficiency during the prenatal period is one of the risk factors leading to development of schizoid personality disorder by age 18 years.

Treating people with schizoid personality disorder is extremely difficult because they lack the normal patterns of emotional responsiveness that play a role in human communication. Individuals with this disorder do not on their own seek treatment except when they are facing a crisis situation. Therapeutic efforts, with this disorder consist in teaching them the following skills:

- i) Importance of social relationship as well as developing and or maintaining good social relationships.
- ii) Teaching them certain skills of empathy.
- iii) Developing social skills in them.
- iv) Therapist should teach certain skills to these individuals through role-playing.

The prognosis of this disorder is not good.

11.4 SCHIZOTYPAL PERSONALITY DISORDER

Individuals having schizotypal personality disorder are peculiar eccentric and oddly bizarre in the way they think, behave and relate to others, even in how they dress. Their peculiar ideas include magical thinking and belief in psychic phenomenon such as clairvoyance and telepathy. They have unusual perceptual experiences in the form of illusions. Their speech is coherent, but the contents of speech are strange to others. Their affect is constricted and inappropriate. They are often suspicious of other people and may have ideas of reference. They are unable to experience pleasure and their lives are characterized by blandness that robs them of the capacity for enthusiasm. These individuals find it difficult to form close relationships with others.

The most important characteristics of these individuals include social isolation, eccentricity, peculiar communication and poor social adaptation. The symptoms of schizotypal personality disorder represent a latent form of schizophrenia. People with schizotypal personality disorder are vulnerable to developing a full blown psychosis .if exposed to difficult circumstances that challenge their ability to maintain contact with reality

Medical treatment of this disorder is very similar to that of schizophrenia. The most commonly used drug in the treatment of this disorder is Haloperidol. Individuals, when put on this drug show improvement with ideas of reference, odd communication and social isolation.

The psychosocial treatment consists of teaching these individuals social skills to help them and reduce their isolation from others.

Very few controlled studies concerning the treatment of this disorder is available.

Individuals with this disorder tend not to improve over time and some move on to develop schizophrenia.

11.5 AVOIDANT PERSONALITY DISORDER

Individuals having avoidant personality disorder refrain from social encounters, especially avoiding situations in which there is a potential for personal harm or embarrassment. Individuals with this disorder are extremely sensitive to the opinion of others and therefore avoid them. Some important characteristic features of individuals having this disorder are as follows:

- These individuals are hypersensitive to rejection and apprehension of any sign of social derogation. Their sensitivity to rejection causes them to misinterpret even neutral and positive remarks in a different manner.
- Individuals having this disorder readily see ridicule or disparagement where none was intended.
- These individuals are too fearful of criticism. They view even a slight remark or personal comment as a form of extreme criticism.
- Their self-esteem is very low and their fear of social rejection makes them less friendly to others.

This disorder shares some characteristics with schizoid personality disorder. In both disorders, the person tends to stay away from intimate relationships. However persons with avoidant personality disorder truly desires closeness and feels a great deal of emotional pain about the seeming inability to make connections with others. According to some scholars avoidant personality disorder is a more severe form of social phobia

Causes: Millon (1981) has pointed out one psychosocial theory of the development of this disorder. According to him individuals with this disorder may be born with a difficult temperament or personality characteristic, as a result their parent's may reject them or at least not provide them with enough early uncritical love. This rejection in turn, may result in low self-esteem and social alienation. Another group of researcher found that individuals having this

disorder had parents who were more rejecting, more, more guilt engendering and less affectionate than the control group. According to psychodynamic writers individuals having this disorder have a fear of attachment in relationships. Cognitive behavioural approaches regard this disorder as hypersensitive to rejection due to childhood experiences of extreme parental criticism. These individuals have dysfunctional attitudes that they are unworthy of other people's regard. As a result of this attitude they view themselves as unworthy and they expect that other people will not like them and as a result they avoid getting close to other people.

Treatment: As compared to other personality disorders, there are a number of well-controlled studies on approaches to therapy for people with this disorder. Behavioral intervention techniques for anxiety and social skills problems have had some success. Since the problems experienced by people with avoidant personality disorder resemble those of people with social Phobia, many of the same treatments are used for both the groups. It has also been found that systematic desensitization as well as behavioral rehearsal works better with this group of individuals. The prognosis for this disorder is generally poor. Therapist treating this personality disorder must have considerable patience and attempt to build a strong therapeutic relationship.

11.6 DEPENDENT PERSONALITY DISORDER

These individuals are highly dependent on others even for making ordinary day-to-day decisions. Individuals having this disorder are perceived to be "clingy"

Some important characteristic features of this disorder are as follows:

- These individuals show extreme dependence on other people and acute discomfort on being alone. Without others near them they feel abandoned and despondent. They often have the fear that close ones will leave them.
- In their interpersonal relationship they are timid, submissive and passive.
- These individuals usually build their lives around other people and subordinate their own needs to keep these people involved with them.
- They lack self-confidence and feel helpless even when they have actually developed good work or other competencies.
- These individuals typically appear selfless and bland, since they usually feel they have no rights to express even mild individuality.

- Individuals with this disorder are very much similar to those having avoidant personality disorder with respect to their feelings of inadequacy, sensitivity to criticism and need for reassurance.
- Their extreme dependence upon others causes them to urgently seek another relationship, when one breaks, to fill the void.

Causes and Treatment: Early socializing experiences and child rearing practices contribute towards the development of this disorder. According to psychodynamic writers individuals with this personality disorder have regressed to or have become fixated at oral stage of development because of parental overindulgence or neglect of dependency needs. According to Object Relations theorists such individuals are insecurely attached and constantly fear abandonment. According to them, individuals having this personality disorder have low self esteem and rely on others for guidance and support.

The treatment literature on this disorder is largely descriptive. Very little research is available as to whether a particular treatment is effective or not. A therapist should take care to see to it that the patient does not become overly dependent on him or her. Unlike most other personality disorder, the prognosis of this disorder is more optimistic and hopeful. Most people with this condition are motivated to change. Structured approach and guidance to become more independent has been found to be beneficial. Clients must be taught to identify skill deficits and work on improving those skills.

11.7 OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

This is the most common personality disorder, commonly found among men than women. Individuals with obsessive-compulsive personality disorder are too preoccupied with concern about neatness. They are unable to take decisions. These individuals show the following other features:

- They are intensely perfectionists and inflexible
- They have an inordinate concern with neatness and detail, often to the point of losing perspective on what is important and what is not.
- People with this disorder have a poor ability to express emotions and they have few intimate emotions.
- People with this disorder are unproductive and their pursuit of perfection becomes self -defeating rather than constructive.

These individuals have a fixation on things being done “the right way”. They have a preoccupation with details and perfection that very often interferes with their normal functioning. Individuals with obsessive-compulsive personality disorder show excessive concern for rules, orders, efficiency and work, coupled with an insistence that everyone do things their ways.

Individuals having this disorder are unable to, express warm feelings. Such individuals tend to be over inhibited, over conscious, over dutiful and rigid and to have difficulty relaxing or doing anything just for fun. They are usually preoccupied with trivial details and poor allocation of time.

Obsessive-compulsive personalities have whole lifestyles characterized by obstinacy and compulsive orderliness. Although they may be anxious about getting all their work done in keeping with their exacting standards, they are not anxious about their compulsive self.

Causes and Treatment: Some researchers have pointed out that there may be a weak genetic contribution to this disorder. Freud believed that the obsessive-compulsive style represented fixation at or regression to the anal stage of psychosexual development. According to cognitive behavioural therapy people with this disorder have unrealistic expectations about being perfect and avoiding mistakes. Their feelings of self worth depend on their behaving in ways that conform to an abstract ideal of perfectionism. If they fail to achieve that ideal they regard themselves as worthless.

Not much information is available with respect to the treatment of this disorder. Behavioral techniques including systematic desensitization and behavioral rehearsal and some conditioning reinforcement techniques work better with them. Therapists must help these individuals to relax or use distraction techniques to redirect their compulsive thoughts. Some therapists use more traditional behavioural techniques, such as thought stopping – instructing the client to reduce the amount of time spent in ruminative worry.

11.8 PERSONALITY DISORDER: THE BIOPSYCHOSOCIAL PERSPECTIVE

This perspective views a given disorder to be a combination of biological, psychological and social perspective. People who have a borderline personality disorder require a combination of treatment approaches which includes biological, psychological and social interventions. Biopsychosocial perspective views personality disorder to evolve over a period of adulthood and tend to remain

challenging for clinicians and researchers. In the understanding and treatment of personality disorders integrative view combining the various perspectives must be taken in to consideration.

11.9 SUMMARY

In this unit we have discussed the various types of personality disorders listed in “cluster A” as well as “cluster C” Disorders. Some of these disorders include Paranoid Personality Disorder, Schizoid Personality Disorder, Schizotypal Personality Disorder, Avoidant Personality Disorder, Dependent Personality Disorder and Obsessive-Compulsive Personality Disorder. Towards the end of the unit we have made a mention of Biopsychosocial perspective. The prognosis of most of these disorders is difficult.

11.10 QUESTIONS

Q.1 Write short notes on the following:

- a. Paranoid Personality Disorder
- b.. Schizoid Personality Disorder
- c. Schizotypal Personality Disorder
- d. Avoidant Personality Disorder
- e. Dependent Personality Disorder
- f. Obsessive-Compulsive Personality Disorder

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DEVELOPMENT-RELATED, AGING-RELATED AND COGNITIVE DISORDERS - I

Unit Structure

- 12.0 Objectives
- 12.1 Introduction
- 12.2 Introductory Issues
- 12.3 Mental Retardation
- 12.4 Pervasive Developmental Disorders
- 12.5 Attention Deficit and Disruptive Behavior Disorders
- 12.6 Learning, Communication and Motor Skills Disorder
- 12.7 Summary
- 12.8 Questions
- 12.9 References

12.0 OBJECTIVES

After studying this unit you should be able to understand:

- The concept of mental retardation its types, characteristics and treatment.
- Know the pervasive developmental disorders, such as autistic disorders, Rett's disorder, asperger's disorders, etc.
- Understand Attention Deficit and Disruptive Behavior Disorders, its theories and treatment
- Comprehend Learning, Communication and Motor Skills Disorder as well as its theories and treatment

12.1 INTRODUCTION

In this unit we will begin with some introductory issues and then discuss the concept of mental retardation and the various types of mental retardation. We will also discuss the characteristics of mental retardation, its theories and treatment.

Pervasive developmental disorders are another group of disorders that leads to severe disorder in the area of development. It influences the social interaction or communication patterns and leads to odd behaviour, interests and activities. The most common pervasive developmental disorder is the autistic disorder. We will discuss the characteristics, theories and treatment of this disorder. Another group of disorder that has attracted the attention of psychologists as well as educationists and parents is the Attention-Deficit and Disruptive Behaviour Disorders. This group of disorders includes Attention-Deficit and Hyperactivity Disorder, conduct disorder and oppositional defiant disorder. We would discuss the theories and treatment of these groups of disorders. Towards the end of this unit we will discuss the motor skills disorders.

12.2 INTRODUCTORY ISSUES

In this unit we will be discussing some conditions that would surprise you as to why they are considered as psychological disorders. Some of you will contend that it is not appropriate to classify these disorders in the category of psychological disorders. Some of these disorders that we will discuss in these units actually represent developmental aberrations rather than psychiatric abnormalities. For example oppositional defiant disorder that we will be discussing towards the end of this unit, is often questioned for being included in the category of psychiatric diagnosis. Since many of these conditions lead to maladjustment or experiences of stress it is included in DSM IV as a diagnostic category.

12.3 MENTAL RETARDATION

Mental retardation is one of the common problems of development. It has not received much attention in India. It is a condition present from childhood and is characterized by significantly below average general intellectual functioning (an IQ of 70 and below). Mental retardation is considered to be a specific disorder, but it may occur in combination with other disorders. In fact, other psychiatric disorders, especially psychoses (Jacobson, 1990), occur at a markedly higher rate among retarded individuals than in the general population. It is estimated that approximately 1 % of the population has mental retardation and it is more common in males. The American Association on Mental Deficiency (AAMD) has defined mental retardation as "significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period." (AAMD, 1973, p.11).

The incidence of mental retardation seems to increase markedly at ages 5 to 6, to peak at age 15, and to drop off sharply

after that. According to DSM-IV there are three groups of criteria for defining mental retardation:

1. An individual must have significantly sub average intellectual functioning. On any standard Intelligence test their IQ must be below 70. It is estimated that roughly about 3% of the population have low I.Q.
2. Along with low intelligence there must be deficits or impairments in adaptive functioning.
3. The third most important criteria is the age of onset. That is low IQ and deficits in adaptive behavior must occur before the age of 18 years in order to call it mental retardation.

Individuals with mental retardation differ significantly among themselves. Four different levels of mental retardation have been identified.

12.3.1 Classification of Mental Retardation by IQ Scores and Behavioural Competencies: These are four levels of mental retardation. These are as follows:

1. Mild Mental Retardation
2. Moderate Mental Retardation.
3. Severe Mental Retardation.
4. Profound Mental Retardation.

We would discuss each of them in detail:

1. *Mild Mental Retardation:*

- Large numbers of individuals who suffer from mental retardation fall into this group.
- Mildly retarded individuals have an IQ between 50-70.
- They are educable and they can learn academic skills or study up to 6th or 7th standard.
- These individuals can develop social and communication skills. They have minimal retardation in sensory-motor areas, often not distinguished until later areas
- Their intellectual levels as adults are comparable with those of average 8 to 11 year old children.
- Social adjustment of such people often approximates that of adolescents. However, they tend to lack normal adolescent's imagination inventiveness and judgment.
- Such individuals can be guided towards social conformity.

- Such individuals have no brain pathology or other physical anomalies. Their retardation is largely due to cultural-familial factors.
- Occupationally, they are independent. They can work and be financially independent to a limited extent. But in some cases especially under stress, they require supervised guidance.
- With early diagnosis, parental assistance and special educational programs, the great majority of borderline and mildly retarded individuals can adjust socially, master simple academic tasks and occupational skills and become self-supporting citizens.

2. *Moderate Mental Retardation:*

Individuals having Moderate Mental retardation have an IQ between 35-50

- 3 to 4 percent of individuals suffering from mental retardation fall in this group.
- Individuals belonging to this group are likely to fall in the educational category of trainable. They are likely to study only up to 2nd or 3rd standard.
- They can talk or learn to communicate. They have poor social awareness, fair motor skills. They often benefit from self-help skills training and require some supervision.
- In adult life, individuals classified as moderately retarded attain intellectual levels similar to those of average 4 to 7 year old children.
- Physically such individuals appear clumsy and ungainly and they suffer from bodily deformities and poor motor coordination.
- Some of these individuals are aggressive and hostile.
- These individuals are semi-independent in their occupational life. With great deal of practice they can be taught semiskilled manual work like tailoring, carpentry, etc.
- Such retardation is also due to cultural familial factors.

3. *Severe Mental Retardation:*

- These individuals are also called as dependent retarded.
- Their IQ is within the range of 20-35.
- They cannot study at all. They have to be sent to special schools or given specialised coaching even to learn self-help skills.

- Among these individuals, motor and speech development is severely retarded. They have sensory defects and motor handicaps. Thus, they have poor motor development and minimal language skills. They learn little communication skills. They can learn only to talk or communicate using bare language.
- They have limited levels of personal hygiene and self-help skills. They can profit from systematic habit skills.
- Such individuals generally require institutionalisation.
- Such individuals can perform simple occupational tasks under supervision.

4. *Profound Mental Retardation:*

- This is the most severely retarded group.
- 1% of all the retarded individuals belong to this group.
- These individuals have an IQ below 20.
- The term “life support retarded” is sometimes used to refer to profoundly retarded individuals.
- Most of these people are severely deficient in adaptive behaviour and unable to master any but the simple tasks.
- Their speech is rudimentary. They have minimal capacity for functioning in sensory-motor areas.
- These individuals have physical deformities and Central Nervous System pathology. They also have convulsive seizures, mutism, etc.
- These category of individuals may respond to very limited range of training in self-help.
- Such individuals require permanent custodial care.
- They have low life expectancy due to low resistance to disease and poor physical health.

12.3.2 Theories and Treatment of Mental Retardation: Mental retardation results from inherited conditions or an event or an illness. Some of the important causes of mental retardation are as follows:

Inherited Causes: Many inherited factors contribute to development of mental retardation, some of which are as follows:

- Phenylketonuria:*** This is another disorder that leads to mental retardation. It is a rare genetically related metabolic disorder that occurs in about 1 in 20,000 births. Dr. Asbjorn Folling

identified PKU in 1934. PKU occurs due to recessive gene. As a result of this genetic abnormality liver does not produce an enzyme, which is required to decompose Phenylalanine, an amino acid found in many foods. As a result the amount of Phenylalanine increases in blood and leads to brain damage.

- ii. Tay-Sachs disease:** It is a metabolic disorder caused by the absence of a vital enzyme (hexosaminidase A or Hex – A), which lead to accumulation of lipid in the nerve cells, leading to neural degeneration and early death, usually before the age of 05. This disorder is most commonly found among the descendants of Eastern European Jews.
- iii. Fragile X Syndrome:** It is another common chromosomal related cause of mental retardation, especially among the males. This disorder is caused by an abnormality on the X chromosome.
- iv. Down's Syndrome:** It is a chromosomal disorder, which was first described by Langdan Down in 1866; Down syndrome is the most common of the clinical conditions associated with moderate and several mental retardation. A person with the Down's syndrome has the following characteristics:
 - Severe to moderate mental retardation (I.Q. is within the range of 20 to 69 where 100 is the normal)
 - Obliquely slanted eyes with an extra fold of skin over the eyelids (hence the name Mongolism)
 - A round face and short stature
 - Abnormalities of the skull bones and the jaw and
 - Short little fingers and other abnormalities of hand and feet.

Down's Babies are usually quiet and placid and their mortality rate during infancy is high because so many of them succumb to respiratory infection and heart malformation. Chromosomal analysis of individuals with Down's syndrome has shown that many of them have an extra chromosome in the 21st pair of the chromosome, i.e. in the twenty first pair instead of two; there are three chromosomes (thus it is also called as Trisomy-21). More than 50 percent of people with Down's syndrome have cataracts, which are not congenital but tend to make their appearance when a child is about 7 or 8 (Fall, 1970).

Occurrence of Down's syndrome is correlated with mother's age. It is one birth in 2000 among 25 years old mothers and one in 40 for women over 45. It has been found that the risk also rises with father's age, especially among men over 50 (Abroms and Benneerr, 1981). DNA analysis has revealed that the extra

chromosome seems to come from the mother's ovum in 95 percent of the cases (Antonarakis 1991).

Children suffering from Down's syndrome are usually able to learn self-help skills, acceptable social behaviour, and routine manual skills that enable them to be of assistance in a family or institutional setting. Many individuals with Down's syndrome are able to support themselves and do well in structured job situations. Down Syndrome babies, today, can live up to 60 years also.

Down's Syndrome children show their greatest deficit in verbal and language related skills. Their ability in spatial relationship and visual motor co-ordination is relatively unimpaired. They are at special risk of developing Alzheimer's disease.

Environmental Causes: Many environmental causes lead to mental retardation. Some of these causes include:

- Exposure to certain drugs
- Toxic chemicals
- Maternal malnutrition
- Infections in the mother during critical phases of fetal development (For example it has been observed that mothers who developed rubella (German Measles) during the first three months of pregnancy are likely to have child with mental retardation.
- Problems (such as infections, anoxia – lack of oxygen, and injury to the brain) during baby's delivery can cause mental retardation.
- Premature birth
- After birth and during childhood mental retardation can be due to diseases, head injuries caused by accident/s or child abuse and exposure to toxic substance such as carbon monoxide, lead, etc.

Fetal Alcohol Syndrome: It is one type of disorder that occurs when a pregnant woman consumes alcohol. About one in 750 individual suffers from FAS. Individuals having this defect have the following characteristics.

- Slowed prenatal and postnatal growth.
- Facial and bodily malformations.
- Their IQ is in the mildly retarded range.

- Disorders of central nervous system such as poor sucking response, brain-wave abnormalities and sleep disturbance in infancy, slow information processing, short attention span, irritability, hyperactivity, motor impairments, learning disabilities, etc.
- It has also been found that individuals in some cases show fetal alcohol effects. It is a milder form of FAS in which individual shows mental retardation, retardation of uterine growth and minor congenital abnormalities.
- They show motor and Cognitive deficits as mentioned above.
- Their internal organs may also be affected, particularly the cardiovascular system.
- There appears to be a direct connection between the amount of alcohol ingested by the mother and the degree of physical and behavioural problems in the child.
- Heavy alcohol intake during pregnancy can also cause a wide range of neuropsychological deficits, including dysfunction in visuospatial processing, verbal and non-verbal learning, attention and executive control processes.

Treatment: There is no cure for mental retardation. Early intervention can enrich the intellectual and physical development of the child. Some individuals with mental retardation can be taught necessary skills which are required to live as a productive member of society. With educative intervention early in life children can be taught to develop better motor abilities, coordination, language usage and social skills.

Mainstreaming: It refers to an approach in which individuals with cognitive and physical disabilities are integrated with nondisabled individuals. Such individuals participate in ordinary schools and ordinary environment, but provided with assistance to cope with any difficulties.

Behavioural Interventions: Behavioural interventions are used to bring about changes in motor, language, social and cognitive skills. Parents are taught as to when and how to reward the child if he displays appropriate and crucial behaviours.

Family Based Interventions: In this approach family issues related to mental retardation are sorted out. Such interventions provide support to family members who have to deal with issues of mental retardation

Public Awareness: Public awareness is required to deal with mental retardation. One aspect of such awareness is early detection and guidance to the parents and care givers. For example

early detection of PKU can help to overcome the damaging effects of mental retardation and in few cases to completely avoid mental retardation. Early prevention and public awareness also includes improving the conditions of prenatal development and making the birth process safer and simpler. Similarly, community education programs within specific populations can be influential in changing alcohol-related behaviours among pregnant women in high risk groups. Counseling pregnant women who abuse or are dependent on alcohol or other substances can also help limit the damage to the developing fetus. Parents should also be made aware as to how head injuries, high fever during childhood, ingestion of certain poisonous or toxic substance such as lead, carbon monoxide, mercury, etc., can lead to mental retardation among children.

12.4 PERVASIVE DEVELOPMENTAL DISORDERS

Pervasive developmental disorders are another group of disorders that leads to severe disorder in the area of development. It influences the social interaction or communication patterns and leads to odd behaviour, interests and activities. 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 socialize 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 development 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. One important category of pervasive development disorders is Autism which we would discuss.

12.4.1 Autism and Characteristics of Autistic Disorder: 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. It has been found that in 20 % of the cases autistic disturbance is not evident during the first or even second year of life. Some important characteristics of Autistic disorders are as follows:

- 1. Impairment in Social Interaction:** Individuals having autistic disorder show impaired social interaction in many ways. Their non-verbal behaviour reveals emotional distancing. They

- Avoid eye contact,
- Make odd facial expressions, postures, etc.
- Use gestures as a way of controlling interactions
- Refrain from peer relationships
- They lack the ability to share thoughts feeling and interests with others.
- Their world is characterized by preference for isolation. They lack an awareness of others, including, even their parents and siblings.
- As infants they resist the cuddling and tickling of a parent.
- Autistic children do not smile or response to adult's laughter. They remain aloof and unresponsive. They lack emotion and sensitivity in their interactions with others.

2. Impairment in Communication: The communication patterns of individuals having this disorder is abnormal. These individuals either are unable to speak or show serious delay in language acquisition. Those who are able to speak generally do not initiate a conversation or remain involved in one. Their language and style of speech is strange. Their tone, pitch, rate and rhythm are unusual. They may speak in a monotone voice and end sentences with a questionable rise. They often repeat word and phrases and their use of grammar is very poor. They may confuse pronouns such as I and you. Their speech is characterized by echolalia or the repetition of words or phrases that they hear.

3. Oddities of Behaviour, Interests and Activities: Individuals having autistic disorder display several behavioural oddities:

- They may be particularly interested in the parts of the objects, such as buttons on sweaters, moving objects, such as rotating blades of an electric fan, etc.
- Many adhere to rituals and rigid daily routines and they may become very distracted at the slightest change.
- Their bodily movements are often bizarre and include repetitive mannerism.
- People with autism may shake their arms, spin around repetitively, rock back and forth or engage in harmful, self-damaging behaviour such as head-banging.
- Regressive behaviours are very common, such as temper tantrums, childish expression of anger and the soiling of clothes by defecating or urinating.

An unusual variant of this disorder is what is called as **Autistic Savant Syndrome**, which occurs in people with autism who possess an extraordinary skill, such as the ability to perform extremely complicated numerical operations – for example – correctly naming the day of the week on which a date thousands of years away would fall. The autistic savant syndrome typically appears at an early age, when the young child with autistic disorder appears to have exceptional musical skill or artistic talent or the ability to solve extremely challenging puzzle.

12.4.2 Theories of Autistic Disorder:

Biological Factors: Autistic Disorder is attributed to biological factors, especially familial inheritance. Heritability of autistic disorder is estimated to be approximately 90 %. It is estimated that this disorder is due to genetic abnormality especially on chromosome No. 7, 2 and 15.

There is no clear evidence regarding the involvement of deficit brain structures. However, researchers have focused their studies on the following four factors:

- Cerebellum
- Frontal Cortex,
- Hippocampus and amygdale

There is some research evidence pointing to the fact that overall brain size is increased in some individuals with autistic disorders.

Research studies have also revealed that there exists abnormalities in the neural circuitry of people with this disorder.

Psychological Factors: Earliest psychological explanations of causation of this disorder focused on psychodynamic processes. Autistic disorder was attributed to disturbances in the child's attachment patterns to the parents. Mother of such children were found to be cold and detached and were referred to as "refrigerated mother". In recent years cognitive explanation of this disorder is emphasized which regards this disorder to be a result of problems in the areas of language, attention and perception.

12.4.3 Treatment of Autistic Disorder: Treatment picture of this disorder is not so good. Medication and behavioural treatment programs are used to help children deal with severe and broad range of deficits. Teaching children with these disorders will help to reduce disruptive and self-stimulatory behaviours. It has been observed that when children with autistic disorder are given reinforcement for appropriate behaviours, such as asking for help

or feedback, then they are less likely to engage in self-injurious or aggressive behaviours. Autistic children can also be taught:

- New learning skills that help them in problem solving behaviours.
- To communicate more effectively.
- To regulate and initiate behaviours on their own.
- Adaptive skills
- Interactive skills

Self control procedures such as self-monitoring of language, relaxation training and covert conditioning have been found to be useful.

Ivar Lovaas (2003) developed behavioural treatment to eliminate all odd behaviours such as self-harm. Clinicians teach children with autistic disorder appropriate eye contact and responsiveness to instructions as necessary preconditions for other therapeutic and educational interventions. This program targets undesirable behaviours and then reduces them through operant conditioning methods of positive reinforcement, extinction, negative reinforcement and in some cases punishment. It has been observed that the principles and techniques of Lovaas's method can be applied in a variety of settings in addition to the laboratory, including the home and the school.

Behavioural program to be successful must be carried out over a long period of time, beginning early in the child's life.

Treatment of autistic children involve comprehensive program of intervention and requires therapist who is experienced, dedicated and perseverant and has considerable patience.

12.4.4 Other Pervasive Developmental Disorders: Some other pervasive development disorders are as follows:

1. Rett's Disorder: It is also called as Rett syndrome, which is a brain disorder that occurs almost exclusively in girls. The child develops normally through the first 05 months of life. However, between 05 months and 04 years, some changes indicative of neurological and cognitive impairments occur. They tend to grow more slowly than other children and have a small head size (microcephaly). There is loss of hand skills, followed by odd hand movements (hand-wringing), poorly co-ordinated walking and bodily movements, psychomotor retardation and severely impaired language.

2. Asperger's Disorder: Asperger's Disorder is the term for a specific type of pervasive developmental disorder which is characterized by problems in development of social skills and behavior. In the past, many children with Asperger's Disorder were diagnosed as having autism.

While autism and Asperger's have certain similarities, there are also important differences. For this reason, children suspected of having these conditions require careful evaluation.

In general, a child with Asperger's Disorder functions at a higher level than the typical child with autism. For example, many children with Asperger's Disorder have normal intelligence. While most children with autism fail to develop language or have language delays, children with Asperger's Disorder are usually using words by the age of two, although their speech patterns may be somewhat odd.

Most children with Asperger's Disorder have difficulty interacting with their peers. They tend to be loners and may display eccentric behaviors. A child with Asperger's, for example, may spend hours each day preoccupied with counting cars passing on the street or watching only the weather channel on television. Coordination difficulties are also common with this disorder. These children often have special educational needs.

Although the cause of Asperger's Disorder is not yet known, current research suggests that a tendency toward the condition may run in families. Children with Asperger's Disorder are also at risk for other psychiatric problems including depression, attention deficit disorder, schizophrenia, and obsessive-compulsive disorder.

The outcome for children with Asperger's Disorder is generally more promising than for those with autism. Due to their higher level of intellectual functioning, many of these children successfully finish high school and attend college. Although problems with social interaction and awareness persist, they can also develop lasting relationships with family and friends.

12.5 ATTENTION DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS

Attention deficit and disruptive behaviour disorder has received increasing attention in recent years. Children with these disorders commonly act in ways that are so disruptive and provocative that caretakers and peers respond with anger, impatience, punishment and avoidance.

12.5.1 Attention-Deficit / Hyperactivity Disorder (ADHD): It is a disorder involving inattentiveness and hyperactivity-impulsivity. Inattentiveness is characterized by such behaviours as:

- Carelessness
- Forgetfulness in daily activities. Inattentive children commonly lose their belongings.
- Easily distracted
- Cannot follow through on instructions
- Difficulty organising tasks
-

Hyperactivity is characterized by fidgeting, restlessness, running about inappropriately, difficulty in playing quietly and talking excessively. Impulsivity is seen in individuals who blurt out answers, cannot wait their turn, interrupt or intrude on others, etc.

It can be detected early in the child's life as to whether he/she is hyperactive or not. Children with ADHD are regarded as difficult by their parents, relatives and friends. In primary classes children with ADHD show deficits in educational performance, have repeated discipline problems and are commonly held back and require tutoring and placement in special classes.

The view that ADHD subsides by adolescence has been discarded. It is now held that ADHD is also seen in adolescence and adulthood. As ADHD children grow, they display problems in executive functions, which include tasks involving self-reflection, self-control, planning, forethought, delay of gratification, affect regulation and resistance to distraction. Adults with ADHD are more likely to have deficits in working memory, sustained attention, verbal fluency and processing speed.

Teenagers with ADHD have a wide range of behavioural, academic and interpersonal problems that create emotional havoc for them and serious difficulties in their relationships with family, friends and educators. They tend to be especially immature, likely to engage in conflict with their parents, have poor social skills and engage in more high-risk activities such as substance abuse, unprotected sex and reckless driving (Resnick, 2005). In the case of young girls the diagnosis of ADHD is likely to be ignored or missed because their symptoms tend to be less overt than those seen among boys. Their symptoms take the form of forgetfulness, disorganization, low self-esteem and demoralization. Their tendency to internalize symptoms may cause them to become anxious, depressed and socially withdrawn. Some teenage girls are hyper talkative and emotionally over reactive.

12.5.2 ADHD in Adults: Considerable amount of research has been conducted to assess the specific ways in which ADHD is manifested in adulthood. ADHD does not emerge in adulthood, but there are cases where it is first diagnosed in adulthood because in few cases childhood symptoms of this disorder were overlooked or misdiagnosed. It is estimated that about 4 % of the American adults meet the diagnostic criteria for his disorder. Adults with ADHD tend to be:

- Chronic procrastinators who repeatedly forget things
- They are grossly disorganized regardless of the task, even for activities that they enjoy.
- They tend to be intolerant of stress, emotionally volatile and almost incapable of meeting deadlines.
- Adults with ADHD has tremendous difficulties with routines, they are haphazard with management of time and money and have a very hard time completing academic work or holding down jobs.
- They miss appointments, even dates with their own partners and they forget to pay bills or follow through on commitments.
- They crave for adventure and excitement and hence are likely to indulge in risk-taking behaviour.
- Some ADHD adults are able to manage their excessive energy and restlessness in to creative endeavours, such as entrepreneurial ventures.
- Adult women with ADHD are more likely to experience dysphoria, organization problems, impulsivity and inattention.
- When ADHD adults have interpersonal problems either with their partner or colleague, it is likely to be severe as such individuals are seeking stimulation. They may provoke conflict in their interactions with others by starting an argument, refusing to end arguments or insisting that they have the last word. They are high-strung as they tend to be hypersensitive and impulsive. They may hear only parts of the conversation and are prone to interpreting resulting in conflicts during arguments/conversations.

12.5.3 Conduct Disorders: It is a condition characterised by the repetitive and persistent violation of the rights of others. Conduct disorder is defined as a repetitive and persistent pattern of behavior in which the basic rights of others and major-age appropriate societal norms are violated. It is chronic pattern of behavior that causes harm to others. It is a chronic pattern of behavior that

violates societal rules. It was previously called as Juvenile Delinquency. Their delinquent behaviour includes:

- Stealing
- Truancy
- Running away from home,
- Lying
- Fire setting
- Breaking
- Physical cruelty to people and animals,
- Sexual assault and
- mugging

These individuals, many of whom abuse drugs or alcohol, may act alone or in groups. When caught, they deny their guilt, shift blame onto others and lack remorse about the consequences of their actions. Some important symptoms of conduct disorders are as follows:

(A) *Aggression towards people & animals*

- Bullies or threatens others or often gets into physical fights
- Uses weapons that can cause serious harm to others
- Physical cruelty towards people and animals
- Has forced another into sexual activity
- Stealing after threatening (e.g., mugging, etc)

(B) *Destruction of property*

- Deliberate fire setting or destroying others' property

(C) *Deceitfulness or theft*

- Stealing or breaking into others' house or car
- Lying or conning others

(D) *Serious violation of rules*

- Staying out at night repeatedly despite parental prohibition
- Running away from home
- Truancy from school

Conduct disorders are of two types: a) Conduct disorder with childhood onset (prior to age 10), b) Conduct disorder with adolescent onset. It is one of the most frequently diagnosed disorders in both outpatient and inpatient treatment programs. It is prevalent among males and estimated to range between 1% to 10% of the general population.

Causes of Conduct focuses on Gene-environment interaction. Conduct disorder is generally associated with the person's environment:

1. Poverty / disorganized neighborhood.
2. Violence within the home / neighborhood.
3. Abuse / neglect / inadequate supervision.
4. poor quality schools.

Treatment of Conduct Disorder: The following important points with regard to treatment of this disorder are worth noting:

- Treatment is difficult.
- Poor prognosis for children with many symptoms or those who develop symptoms at an early age.
- Medications to control aggression, mood disorders, hyperactivity, drug abuse, impulse control problems, psychotic behaviors, or if there is associated epilepsy.
- Behavior modification techniques with structured environment and consistent rules.
- Psychiatric evaluation of parents with counseling.
- Individual psychotherapy aimed at improving problem solving skills.

12.5.4 Oppositional Defiant Disorder: Individuals having this disorder show a pattern of negative, hostile and defiant behaviour that results in significant family or school problems. This disorder is much more extreme than the typical childhood or adolescent rebelliousness. Youths with this disorder repeatedly loose temper, refuse to do what they are told to do, argue and deliberately annoy others. They are touchy, resentful, belligerent, spiteful and self-righteousness. Rather than seeing themselves as the cause of problems, they blame other people or insist that they are a victim of circumstances. Some young people who behave in this way are more oppositional with their parents than with outsiders. This disorder typically becomes evident between the ages of 08 years and 12 years. Preadolescent boys are more likely to develop this disorder than are girls of the same age.

12.5.5 Theories and Treatment of ADHD and Disruptive Behaviour Disorders: The understanding of causation of this disorder and its treatment is not so simple.

1. This disorder is caused by abnormality in brain functioning. Family, twin and molecular genetic studies indicate the role of genetic factors in the causation of this disorder. The heritability of this disorder is approximately 70 % and is among the highest rates of all psychiatric disorders. It has been observed that interrelated brain areas is involved in impairment of attentional-executive functions of these individuals.
2. Neuroimaging studies have found structural brain abnormalities such as smaller volumes in the frontal cortex, the cerebellum and subcortical structures. Functional imaging studies have pointed out that this disorder is a result of abnormal functioning in the circuits that provide feedback of the cortex for regulation of behaviour.

3. Researchers are uncertain about the causal factors other than genetics. Researchers continue to focus on other biological factors such as birth complications, acquired brain damage, exposure to toxic substances and infectious diseases.
4. psychological factors also play an important role in the causation of this disorder. Barkley (1998) focuses on impaired self-control. The impairment is evidenced in four realms:
 - non-verbal working memory
 - the internalization of self-directed speech
 - the self-regulation of mood and level of arousal
 - reconstitution – the ability to break down observed behaviours in to component parts that can be recombined in to new behaviours directed towards a goal.
5. Sociological factors also play an important role in the causation of this disorder. Many children with this disorder have grown up in a disturbed family environment and have had failure experiences in school.

Treatment of this disorder typically includes medications which are effective in helping a large proportion of people with ADHD. Most medication is based on methylphenidate (Ritalin). Besides this, antidepressant medications are sometimes prescribed, some of which includes:

- i) Bupropion (Wellbutrin SR)
- ii) Pemoline (Cylert)
- iii) Atomoxetine (Strattera) and
- iv) Imipramine

The above medications are used to treat mild to moderate ADHD. Most of these medications are not without any sideeffects.

6. Besides medication, Murphy has emphasized multi prolonged approach to psychosocial treatment. Some of these include as follows:
 - a. Psychoeducation is used frequently. It instills hope and optimism
 - b. Psychological therapies such as individual therapy provides a context in which treatment goals can be set and co-existing problems such as depression and anxiety can be solved.
 - c. Cognitive behaviour therapy helps the client change maladaptive behaviour and thought patterns that interfere with daily functioning.

- d. Compensatory behavioural and self management training provides the opportunity to build skills by incorporating more structure and routine in to one's life.
- e. Marital counseling, family therapy, career counseling, group therapy and other similar techniques are of considerable benefit.
- f. Coaching, that involves consulting with a professional helps in assisting the individual with ADHD to focus on practical implementation of goals. The coach helps the person find ways to get things done through a pragmatic, behavioural, result oriented approach.
- g. Technology can be used to help individuals with ADHD access tools and devices that helps them to communicate effectively, remember and organize one's one's activities in a much better manner.
- h. School and workplace accommodation can be sought that facilitate productivity and minimize distraction. Students and employees with ADHD work better in a quiet non-distracting environment.
- i. Advocacy. Meaning advocating oneself and one's limitations to other can help improve situation and help others to understand the individual better.
- j. Self reinforcement can be used to encourage the child to regulate behaviours such as settling into a task, delaying gratification, maintaining self-motivation and monitoring progress towards a goal
- k. A combination of behavioural, cognitive and social learning approaches appears to be the most useful strategy in working with youths with disruptive behaviour disorders.

12.6 LEARNING, COMMUNICATION AND MOTOR SKILLS DISORDER

Disorders in the areas of learning, communication and motor skills are considered as specific developmental disorder. They cause delay or deficit in a specific area of functioning, such as academic skills, language and speech or motor coordination. Many scholars object to the use of learning difficulties in a classification system designed for the diagnosis of psychological disorders. One reason as to why these difficulties are included in the diagnostic classification is because they are often associated with emotional distress and may seriously interfere with person's everyday life and social relationships.

12.6.1 Learning Disorders: A learning disorder is a delay or deficit in an academic skill that is evident when an individual's achievement or standardized tests is substantially below what could be expected for others of comparable age, education and level of intelligence. These disorders cause significant impairment in functioning and are estimated to affect about 2 to 10 percent of the population. Learning disorders are evident in three areas:

- i. **Mathematics – called as mathematics disorder:*** Individuals having difficulty in this area has difficulties with mathematical tasks and concepts. Impairment may be evident in linguistic skills, such as understanding mathematical terms, symbols or concepts, perceptual skills such as reading arithmetic signs, attention skills such as copying numbers correctly and mathematical skills such as learning multiplication tables.
- ii. **Writing – Disorder of Written Expression:*** Disturbances in these areas are expressed in the form of poor spelling, grammatical or punctuation errors and disorganization of paragraphs which creates serious problems for children in many academic subjects.
- iv. **Reading – Reading disorder commonly called as dyslexia:*** It is a learning disorder in which the individual omits, distorts or substitutes words when reading and reads in a slow, halting fashion. This inability to read inhibits the child's progress in a variety of school subjects. Individuals with learning disorders have low self-esteem and feelings of incompetence and shame. It is well known fact that some of the great scientists had learning disorders. Some of these include – Isaac Newton, Albert Einstein, Thomas Edison, Charles Darwin, etc.

12.6.2 Communication Disorders: Communication disorders refer to conditions characterised by impairment in the expression and understanding of language. Some common types of Communication disorders are discussed below:

- i. **Expressive Language Disorder:*** It is a developmental disorder characterized by obvious problems of verbal expression. Children with this disorder do not have the ability to express themselves in ways appropriate to their age group. Their language style consists of the following:

Faulty vocabulary, Speaking in short sentences with simplified grammatical structures, Omitting critical words or phrases and Putting words together in a peculiar order

For some children expressive language disorders are developmental conditions in which speaking abilities occur at a later

age than average and progress more slowly than the average. Others acquire this disorder as a result of medical illness or a neurological problem resulting from a head trauma.

ii. *Mixed Receptive-Expressive Language Disorder:*

Children with this disorder have difficulty in both expressing and understanding certain kinds of words or phrases, such as directions or even in more severe form basic vocabulary or entire sentences. An individual with this disorder gets confused even with simple directions. While speaking children with this disorder show some of the same communication problems as children with expressive language disorder. This disorder can be developmental or acquired.

iii. *Phonological Disorder:* This disorder results in difficulties which are specific to speech. A person with phonological disorder substitutes, omits, or incorrectly articulates speech sounds. Mispronunciation among children may appear cute, but if it persists for a long time it can create academic difficulties and a child can become a target of ridicule.

iv. *Stuttering:* It involves a disturbance in the normal fluency and patterning of speech that is characterized by verbalizations such as sound repetitions and prolongations, broken words, the blocking out of sounds, word substitutions to avoid problematic words and words expressed with an excess of tension.

12.6.3 Motor Skills Disorders: Motor skills disorder is primarily a developmental coordination disorder which is characterized by marked impairment in the development of motor coordination. Children with this disorder encounter problems in academic achievement and daily living because of their severe lack of coordination, unassociated with another developmental disability. In the earlier stages of this disorder children have trouble crawling, walking and sitting. Many children acquire age related tasks below their average age level. These individuals may be unable to tie their shoelace, play ball, complete a puzzle or even write legibly. Six percent of the children between the ages of 5 years and 11 years experience this disorder.

12.6.4 Theories and Treatment of Learning, Communication

and Motor Skills Disorders: Learning, communication and motor skills disorders are generally a result of neurological abnormalities. These can occur either during the stage of fetal development, during the birth process or as a result of neurological condition caused by physical trauma or a medical disorder.

One explanation for this disorder is that the brain areas involved in vision, speech and language comprehension cannot integrate information. For example a child whose ability to

remember a sequence of letters or words is impaired may have difficulty in comprehending speech.

These disorders can best be treated in school or atleast treatment can start from school. A treatment plan should be designed that would take a holistic and integrated approach. School psychologists, school counselors, a speech therapist, special education teacher, neurologist, a general physician and a class teacher is all required to treat the child in an integrated and coordinated manner. Parental awareness, education and their cooperation is required.

12.7 SUMMARY:

In this unit after a brief mention of introductory issues we have discussed the concept of mental retardation and have classified Mental Retardation by IQ Scores and Behavioural Competencies. We discussed the four types of mental retardation – mild, moderate, severe and profound. We then discussed the various theories and treatment of mental retardation including some genetic disorders such as Down's Syndrome and Fetal Alcohol Syndrome. Various treatment options and preventive aspects of mental retardation were also discussed.

Pervasive Developmental Disorders **were discussed, which refers to** group of disorders that leads to severe disturbances in the different areas of development, especially, social interaction, communication patterns and odd behaviour, interests and activities. Some important pervasive developmental disorders that were discussed were Autism, Rett's Disorder and Asperger's Disorder. The concept of autism and its characteristic features as well as its theories and treatment were discussed.

Following this we discussed the Attention Deficit and Disruptive Behavior Disorders. It is a disorder involving inattentiveness and hyperactivity-impulsivity. This disorder is most commonly found among school going children and adolescents. In recent years this disorder has been diagnosed among adults also. ADHD in adults has been discussed in brief. Related to ADHD are two disorders called as conduct disorder and Oppositional Defiant Disorder. We would discuss their symptomatology and treatment. Theories and Treatment of ADHD and Disruptive Behaviour Disorders has also been discussed at length.

Another category of disorders is in the area of learning, communication and motor skills. These groups of disorders are considered as specific developmental disorders. They cause delay or deficit in a specific area of functioning, such as academic skills,

language and speech or motor coordination. Different types of learning and communication disorders were discussed. Theories and Treatment of Learning, Communication and Motor Skills Disorders were also briefly discussed towards the end of the unit.

12.8 QUESTIONS:

- Q1. Define Mental Retardation and discuss the classification of mental disorders
- Q2. Discuss the different theories and treatment of mental disorders.
- Q3. Write a note on Pervasive developmental disorders.
- Q4. Explain Autism and discuss the Characteristics of Autistic Disorder.
- Q5. Discuss the Theories and Treatment of Autistic Disorder.
- Q6. Write short notes on the following:
 Rett's Disorder
 Asperger's Disorder
 ADHD in Adults
 Oppositional Defiant Disorder
- Q7. Discuss Attention-Deficit / Hyperactivity Disorder (ADHD)
- Q8. Discuss Conduct Disorders and its treatment.
- Q9. Write a note on Theories and Treatment of ADHD and Disruptive Behaviour Disorders.
- Q10. Discuss learning, communication and motor skills disorders.

12.9 REFERENCES:

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DEVELOPMENT-RELATED, AGING-RELATED AND COGNITIVE DISORDERS – II

Unit Structure

- 13.0 Objectives
- 13.1 Introduction
- 13.2 Separation Anxiety Disorder
- 13.3 Other Disorders that Originate in Childhood
- 13.4 Development - Related Disorders: The Biopsychosocial Perspective
- 13.5 The Nature of Cognitive Disorders
- 13.6 Delirium, Amnestic Disorders, Traumatic Brain Injury, Dementia
- 13.7 Cognitive Disorders: The Biopsychosocial Perspective
- 13.8 Summary
- 13.9 Questions
- 13.10 References

13.0 OBJECTIVES

After studying this unit you should be able to:

- Understand the concept of Separation Anxiety Disorder
- Explain Other Disorders that Originate in Childhood
- Comprehend the Biopsychosocial Perspective of Development - Related Disorders.
- Know the Nature of Cognitive Disorders
- Understand the different types of cognitive disorders such as Delirium, Amnestic Disorders, Traumatic Brain Injury and Dementia
- Comprehend the The Biopsychosocial Perspective of Cognitive Disorders.

13.1 INTRODUCTION

In this we would discuss the concept of Separation Anxiety Disorder and its characteristics features as well as its theories and treatment. Following this we would discuss “Other Disorders that Originate in Childhood”. Some of these disorders that we would briefly discuss under this category includes: Childhood Eating Disorders, Tic Disorders, Elimination Disorders, Reactive Attachment Disorder, Stereotypic Movement Disorder, Selective Mutism, etc.

The biopsychosocial perspective of development-related disorders as well as, towards the end of the chapter, cognitive disorders, would be discussed.

We would also discuss the nature of cognitive disorders and different types of cognitive disorders, such as, delirium; amnesic disorders; traumatic brain injury and dementia. The characteristics of Dementia as well as the concept of Alzheimer’s Disease, its Alzheimer’s Disease, Theories and Treatment of Alzheimer’s Disease would also be discussed in this unit.

13.2 SEPARATION ANXIETY DISORDER

Separation anxiety disorder can be defined as a condition involving excessive, prolonged anxiety, concerning separation from home or from people to whom a child is attached. Children with separation anxiety disorder have intense and inappropriate anxiety concerning separation from home or caregivers. **Separation anxiety disorder** is a psychological condition in which an individual experiences excessive anxiety regarding separation from home or from people to whom the individual has a strong emotional attachment (like a father, mother, grandparents, and brothers or sisters). Separation Anxiety Disorder (SAD), is characterized by significant and recurrent amounts of worry upon (or anticipation of) separation from a child or adolescent’s home or from those to whom the child or adolescent is attached.

Characteristics of Separation Anxiety Disorder: Some important characteristics of separation anxiety disorder are as follows:

- They experience severe reactions when confronted with the prospect of being apart from their parents.
- They become upset and often physically ill when facing a normal separation, such as when parent leaves for work or when they go to a relative’s house for a visit. Some may refuse to sleep overnight at a friend’s house or go to camp or school.

- They fear that something terrible will happen to them or to their parents or themselves.
- When separated from their caretakers they are likely to complain of physical complaints such as headache or stomach aches. They may insist that apparent stays with them till they fall asleep.
- When not with an attachment figure, they become panicky, miserable, homesick, socially withdrawn and sad.
- They are also intrusive, demanding and in need of constant attention.

Theories and Treatment of Separation Anxiety Disorder:

Anxiety evolves as a result of Psychological and physiological factors. Among the biological factors involved in anxiety, the study of familial patterns and to determine the genetic basis has been more useful.

Some children with separation anxiety disorder have found to have a family history of anxiety. A large study by Cronk et al (2004) found strong evidence for heritability. It was observed that temperamental differences rooted in biology causes some children to respond with heightened anxiety to certain environmental factors discussed below.

They also found that along with strong heritability there are also environmental factors that contribute to development of this disorder. Some important environmental factors that result in anxiety disorder include:

- Loss of threat
- Loss of father from the home
- Natural or man made disasters

According to psychodynamic writers separation anxiety disorders in children results from failing to learn how to negotiate the normal developmental tasks of separating from parents.

Large number of children diagnosed with this disorder experience remission and are completely free from this disorder in a period of about 18 months or so. The clinicians main task while treating these children is to help them to gain control over anxiety-provoking situations. Behavioural treatment has been found to be highly effective for this disorder. Some important behavioural techniques for treating this disorder include:

- Systematic desensitization,
- Prolonged exposure to a certain situation so as to develop immunity
- Modeling

- Relaxation techniques and cognitive strategies are highly useful.
- Contingency Management and self management are useful in teaching the child to react more positively and competently to a fear provoking situation.

Behavioural techniques can be applied either individually or in groups.

Medications are also used to treat separation anxiety disorder among children. SSRI's, such as fluoxetine is the most commonly used drug to treat this disorder. These medications should be used cautiously as they lead to extreme impulsive reactions in the children including suicidal attempts.

13.3 OTHER DISORDERS THAT ORIGINATE IN CHILDHOOD

A few rare and unusual disorders are limited to childhood years. These disorders include the following:

1. Childhood Eating Disorders: One type of childhood disorder is called as *Pica*, commonly found among mentally retarded children. In this disorder children eat inedible substances, such as paint, string, hair, animal droppings, paper, etc. Another eating disorder of childhood is *Feeding disorder of infancy or early childhood*. In this disorder the child fails to eat leading to loss of weight/failure to gain weight. Still another type of eating disorder is rumination disorder in which infant or child regurgitates and rechews food after it has been swallowed. Each of these disorders lasts for a month and is not associated with transient stomach distress.

2. Tic Disorders: Tic is defined as a rapid, recurring involuntary movement or vocalization. Some important tics include motor ticks such as eye blinking, facial twitches and shoulder shrugging. Besides motor movements, tics can also involve vocal tics such as coughing, grunting, snorting, coprolalia (uttering of obscenities) and tongue clicking. One type of tic disorder is *Tourette's Disorder*, a combination of movement and vocal tics, commonly found among males. People with Tourette's Disorder usually make uncontrollable movements of the head and sometimes parts of the upper body. In some cases individuals engage in complex bodily movements involving touching, squatting, twirling or retracing steps. At the same time they utter vocalizations that sound very odd to others. Individuals with this disorder also have obsessive-compulsive symptoms, speech difficulties and attentional problems. According to some experts Tourette's Disorder

is a result of deficits in brain inhibitory mechanisms in the prefrontal cortex.

3. Elimination Disorders: In this disorder children have difficulties in gaining control over their toilet. There are two types of elimination disorder.

a) Encopresis: Repeated bowel movements either in clothes or at inappropriate places.

b) Enuresis: Children with this disorder urinate in clothes or in bed after their age when they are expected to be in control of urination.

4. Reactive Attachment Disorder: It is a severe disturbance in the child's ability to relate to others. Some children with this disorder do not initiate social interactions or respond when it is inappropriate. They may act extremely inhibited or avoidant. Some children show inappropriate familiarity with strangers. This disorder is a result of pathological care giving or child rearing practices adopted by the parent in which, the child's physical or emotional needs are not satisfied. Frequent changes in the caregiver, such as frequent parental divorce followed by remarriages or change in the care giver, etc., can also lead to lack of formation of a stable identity which may result in this disorder.

5. Stereotypic Movement Disorder: Children with this disorder engage in repetitive behaviours such as waving, body rocking, head banging, self-biting, etc. These behaviours interfere with normal functioning and cause bodily injury.

6. Selective Mutism: In selective mutism, the child consciously refuses to talk in certain situations, usually when there is an expectation for interaction such as at school.

13.4 DEVELOPMENT-RELATED DISORDERS: THE BIOPSYCHOSOCIAL PERSPECTIVE

Diagnosing and treating individuals with this disorder is not an easy task. It requires considerable skills and a multiple approaches which takes in to account, biological, psychological and social factors.

There is considerable debate among researchers and clinicians as to whether separate diagnostic categories should exist for children for development-related disorders or other disorders. Another issue that has been debated is, are there overlap between childhood and adult disorders? Is there continuity between them or are they different disorders?

Another question that is raised is that of origin of child's referral for psychological evaluation or treatment. A parent may report child's symptoms as a cry for help from an overburdened parent of a normal but difficult child or it may be the reflection of a disturbance that lies outside the child but within the parent, the family, school or a larger social milieu.

The biopsychosocial perspective takes in to consideration the totality of the child's environment and multiple causes that can result in to and sustain the various development-related disorders discussed above.

13.5 THE NATURE OF COGNITIVE DISORDERS

Cognition has received considerable attention in psychology during the last two decades. Cognitive functions include processing of thought, memory capacity and ability to pay attention. The cognitive disorders that we will discuss in the following pages have following three central characteristics:

- It involves impairment of thoughts
- Loss of or problems in memory
- Difficulties in attention

Impairment can result due to brain trauma, disease or exposure to toxic substances (including drugs). DSM IV TR uses the term "delirium, dementia, amnestic and other cognitive disorders" to refer to cognitive disorders. Cognitive disorders is a comprehensive term.

Impairment of cognitions can be assessed through neurophysiological testing and through development of new neuroimaging technologies. However inspite of advancements in sophisticated diagnostic tools, neuropsychological assessment has assumed greater importance to determine as to whether cognitive disorder is a result of organic impairment or whether it is a result of psychological factors.

13.6 DELIRIUM; AMNESTIC DISORDERS; TRAUMATIC BRAIN INJURY; DEMENTIA

13.6.1 Delirium: It is a temporary state in which individual experiences a clouding of consciousness, in which they are unaware of what is happening around them and are unable to focus or pay attention. In delirium individual experiences cognitive changes in which their memory is foggy and they are disoriented. A person in a state of delirium may forget what he or she had eaten for lunch only an hour earlier or be unaware of the day of the week

or even the season of the year. The speech of the individual experiencing delirium may be rambling or incoherent as they shift from one topic to another. Some other major characteristics of delirium are as follows:

- Individuals having delirium may experience delusion, hallucinations or illusions as well as emotional disturbances such as anxiety, euphoria or irritability.
- Delirious individuals may do things that are physically dangerous, such as walking in to traffic or falling down the stairs.
- Delirium is caused by changes in the brain's metabolism and usually reflects something that is happening in the brain. Delirium can be caused by substance intoxication or withdrawal, head injury, high fever, vitamin deficiency, etc.
- Delirium can occur at any age but it is more common among medically or psychiatrically hospitalized older adult patients, particularly among surgical patients with pre-existing cognitive impairment and depressive symptoms.
- Certain medications and/or drugs can also give rise to delirium.
- Psychomotor disturbances related to delirium can be either hyperactive or hypoactive. Hyperactive individuals are restless and agitated. Hypoactive individuals are slowed down, acting in ways that reflect their feelings of lethargy and stupor. Hallucinations, delusions and agitation are more likely to occur in the hyperactive phase.

Multi dimensional approach can be of help in treating delirium. Patients and their relatives must be educated about its symptomatology, early prevention and diagnosis. Awareness about delirium and early intervention can help the patients to overcome many negative consequences.

13.6.2 Amnestic Disorders: Amnestic disorders refer to loss of memory. People with amnestic disorders are unable to recall previously learned information or to register new memories. The inability to incorporate recent events into memory or to recall important information can be very disturbing, because an individual loses a sense of personal identity. In amnestic disorder an individual may try to cover up social problems caused by memory loss through denial or confabulation, the fabrication of facts or events to fill a memory void. According to DSM – IV – TR there are two major categories of amnestic disorders:

- a) One due to medical conditions.
- b) Those that are a result of substance- induced.

Wide variety of medical conditions such as head trauma, loss of oxygen, or herpes simplex or environmental toxins like lead, mercury, pesticides, industrial toxins, etc. The most common cause of amnesic disorder is chronic alcohol use. Memory loss, due to any reason in this disorder can result from damage to subcortical regions of the brain responsible for consolidating and retrieving memory

13.6.3 Traumatic Brain Injury: Traumatic Brain Injury results from exposure to trauma resulting in damage to the brain. Intense pressure to head as a result of fall, automobile accident sports injury, combat, etc., may lead to brain injury. It is estimated that in war, such as Afghanistan War and Iran War about 22 % of the soldiers suffered from brain injury. Some important brain injuries that result due to brain trauma include:

- Concussions - It is caused by a blow to the head.
- Contusions
- Cereberal infarcations (cutting off of blood)
- Intrusion in to brain by fragments of bullets, instruments, iron rods,e tc.

Some important symptoms of Traumatic Brain Injury include: headaches, sleep disturbances, sensitivity to light and noise and diminished cognitive performance on tests of attention, memory, language and reaction time. Symptoms also include depression, anxiety, emotional outbursts, mood changes or inappropriate affect.

Individuals suffering from Traumatic Brain Injury often experience subtle changes that are note easily observable to themselves or to others.

Post-Concussion Syndrome: It is a disorder arising out of concussions in which a constellation of physical, cognitive or emotional symptoms persists from weeks to years. These symptoms are summarised in the following table.

Physical Symptoms	Cognitive Symptoms	Emotional Symptoms
<ul style="list-style-type: none">• Headaches• Dizziness• Sleep disturbance• Sensitivity to light and noise	<ul style="list-style-type: none">• Confusion• Concentration difficulties• Impaired judgment• Amnesia	<ul style="list-style-type: none">• Irritability• Mood swings• Depression

13.6.4 Characteristics of Dementia: Dementia is a form of cognitive impairment involving generalised progressive deficits in a person's memory and learning of new information, ability to communicate, judgment and motor coordination. Besides cognitive changes people with dementia experience changes in personality and emotional state. The main cause of dementia is profuse and progressive brain damage. Other physical conditions that can cause dementia include vascular (circulatory) diseases, AIDS, head trauma, psychoactive substances and various neurological disorders. Dementia is found among people of all ages including children. Dementia is generally found among people who have Alzheimer's Disease. Some important characteristics of dementia are as follows:

- Initially in the earlier stages the disorder may begin with mild forgetfulness that is only slightly noticeable and annoying.
- Gradually their symptoms become increasingly obvious and severe
- As their condition worsens, they gradually lose their capacity to care for themselves.

Memory Loss: Initially there is slight memory impairment. The person is incapable of retaining any new information. Gradually the symptoms worsen between one to ten years. As their conditions worsen they are unable to remember even the basic facts about themselves and their lives.

Aphasia, Apraxia and Agnosia: Aphasia is the loss of ability to use language. It is caused by the damage to the brain's speech and language area and this damage influences the production and understanding of a language. There are two types of aphasia.

- a) **Wernike's aphasia:** In this an individual is able to produce words but has lost the ability to comprehend it so that these verbalizations have no meanings.
- b) **Broca's aphasia:** They have disturbance in the area of language production, but comprehension abilities are intact. The individual knows the rules of sentence construction and can grasp the meaning of language, but he/she is unable to produce complete sentences

In Apraxia a person has lost the ability carry out coordinated bodily movements that he or she could previously perform without difficulty. This is not due to physical weakness or decreased muscle tone, but due to brain deterioration.

Agnosia is the inability to recognize familiar objects or experiences, despite the ability to perceive their basic elements.

Disturbances in Executive Functioning: Dementia also leads to disturbances in executive functioning, which includes cognitive abilities, such as abstract thinking, planning, organizing or carrying out behaviours. Executive dysfunction is seen in many everyday activities

13.6.5 Alzheimer's Disease: Dementia seen among individuals with Alzheimer's disease is called as "Dementia of the Alzheimer's type". The term senile is sometime, mistakenly, used to refer to this disorder, or more generally to the process of growing old. Alzheimer's disease is a brain disorder named for German physician Alois Alzheimer who first described it in 1906. It is estimated that about 3.5 to 4 million Indians suffer from this disorder. In Mumbai alone there are an estimated of about 40,000 individuals having this disorder.

Alzheimer's destroys brain cells, causing problems with memory, thinking and behavior severe enough to affect work, lifelong hobbies or social life. Alzheimer's gets worse over time, and it is fatal. Currently there is no cure for Alzheimer's disease though with love and care the suffering that the patient undergoes can be considerably reduced.



Alois Alzheimer

At a scientific meeting in November 1906, German physician Alois Alzheimer presented the case of "Frau Auguste D.," a 51-year-old woman brought to see him in 1901 by her family. Auguste had developed problems with memory, unfounded suspicions that her husband was unfaithful, and difficulty speaking and understanding what was said to her. Her symptoms rapidly grew worse, and within a few years she was bedridden. She died in 1906, of overwhelming infections from bedsores and pneumonia.

Dr. Alzheimer had never before seen anyone like Auguste D., and he gained the family's permission to perform an autopsy. In Auguste's brain, he saw dramatic shrinkage, especially of the cortex, the outer layer involved in memory, thinking, judgment and speech. Under the microscope, he also saw widespread fatty

deposits in small blood vessels, dead and dying brain cells, and abnormal deposits in and around cells.

The condition entered the medical literature in 1907, when Alzheimer published his observations about Auguste D. In 1910, Emil Kraepelin, a psychiatrist noted for his work in naming and classifying brain disorders, proposed that the disease be named after Alzheimer.

13.6.6 Symptoms of the Alzheimer's disease: People with Alzheimer's experience difficulties communicating, learning, thinking and reasoning. Alzheimer's disease is a progressive fatal illness that causes areas of the brain to shrink. The resulting symptoms start with memory loss and other cognitive deficits, advancing to major personality changes and eventual loss of control over bodily functions. Some common symptoms of Alzheimer's disease are as follows:

- General confusion, disorientation to date, time or place
- Apathy, irritability, depression, anxiety
- Problems with language, math, abstract thinking, and judgment
- Personality changes with strange quirks or inappropriate behaviors
- Wandering, hiding objects, problems with eating and sleeping
- Late in the disease, paranoia and delusions may occur
- Toward the end, total loss of self, and inability to control bodily functions

Some of the most common warning signs of Alzheimer's disease are as follows:

1. Memory loss. Forgetting recently learned information is one of the most common early signs of dementia. A person begins to forget more often and is unable to recall the information later.

2. Difficulty performing familiar tasks. People with dementia often find it hard to plan or complete everyday tasks. Individuals may lose track of the steps involved in preparing a meal, placing a telephone call or playing a game.

3. Problems with language. People with Alzheimer's disease often forget simple words or substitute unusual words, making their speech or writing hard to understand. They may be unable to find the toothbrush, for example, and instead ask for "that thing for my mouth."

4. Disorientation to time and place. People with Alzheimer's disease can become lost in their own neighborhood, forget where they are and how they got there, and not know how to get back home.

5. Poor or decreased judgment. Those with Alzheimer's may dress inappropriately, wearing several layers on a warm day or little clothing in the cold. They may show poor judgment, like giving away large sums of money to telemarketers.

6. Problems with abstract thinking. Someone with Alzheimer's disease may have unusual difficulty performing complex mental tasks, like forgetting what numbers are for and how they should be used.

7. Misplacing things. A person with Alzheimer's disease may put things in unusual places: an iron in the freezer or a wristwatch in the sugar bowl.

8. Changes in mood or behavior. Someone with Alzheimer's disease may show rapid mood swings – from calm to tears to anger – for no apparent reason.

9. Changes in personality. The personalities of people with dementia can change dramatically. They may become extremely confused, suspicious, fearful or dependent on a family member.

10. Loss of initiative. A person with Alzheimer's disease may become very passive, sitting in front of the TV for hours, sleeping more than usual or not wanting to do usual activities.

13.6.7 Dementia Caused by other Conditions: Many different conditions can also result in dementia. Physical conditions such as infectious diseases such as neurosyphilis, encephalitis, tuberculosis, meningitis or localized infections in the brain can result in dementia. People who experience kidney failure may have symptoms of dementia as a result of toxic accumulation of substances that the kidneys cannot cleanse from the blood. People with certain types of brain tumors also experience cognitive impairments and symptoms of dementia. Environmental toxins or ingestion of substances such as drugs can also lead to dementia, such dementia is called as *Substance-induced persisting dementia*. Dementia can also result from severe nutritional deficiencies. People who are severely undernourished are prone to develop a deficiency of folate, a critical nutrient, which can lead to progressive cerebral atrophy. Dementia can also result from the following diseases:

i. **Pick's Disease:** It is a relatively rare progressive degenerative disease that affects the frontal and temporal lobes of the cerebral cortex. It is caused by the accumulation in neurons of unusual proteins deposits called pick bodies. Individuals with this disease are socially inhibited, have memory loss, they act impulsively or inappropriately. They also appear unmotivated or apathetic.

ii. **Parkinson's Disease:** It involves neuronal degeneration of the basal ganglia, the sub-cortical structures that control motor movements. Not all individuals with parkinson's disease experience dementia. About 60 % of the individuals who are older and are in the advanced stage of the disease experience dementia. This is basically a disease involving disorder of motor disturbances. The person's muscle becomes rigid and it is difficult for him to initiate movement, a symptom called as *akinesia*. They also have general slowing of motor activity, known as *bradykinesia*. Besides motor disturbances, individuals having parkinson's disease show cognitive deterioration such as slowed scanning on visual recognition task, diminished conceptual flexibility and slowing of motor response tests. The individual's face appears expressionless and speech becomes stilted, losing its normal rhythmic quality. They also have difficulty producing words on tests that demand word fluency. Individuals with this disorder have Lewy body Dementia

Lewy body Dementia: It is similar to Alzheimer's Disease resulting in progressive loss of memory, language, calculation, reasoning as well as other higher mental functions. The progress of illness is more rapid than what is seen in Alzheimer's Disease. Lewy bodies are tiny spherical structures consisting of deposits of protein in dying nerve cells found in damaged regions deep with in the brains of people, especially having parkinson's disease. Lewy body Dementia is diagnosed when lewy bodies are found more diffusely dispersed throughout the brain. It is not clear whether Lewy body Dementia is a variant of either Alzheimer's Disease or Parkinson's Disease.

Frontal-Temporal Dementia: This form of dementia is commonly found among individuals having Alzheimer's Disease or Parkinson's Disease. The onset of this dementia is slow and insidious.

iii. **Huntington's Disease:** It is a degenerative neurological disorder that can also affect personality and cognitive functioning. It is a result of abnormality on chromosome 4 that causes a protein, known as huntingtin, to accumulate and reach toxic levels. The symptoms first appear in adult hood between 30 years to 50 years. The disease results in the death of neurons in sub-cortical

structures that control motor behaviour. The disease is associated with following:

- Mood disturbances
- Changes in personality
- Irritability and Explosiveness
- Suicidal behaviour
- Changes in sexuality and
- Cognitive deficits

iv Creutzfeldt-Jacob Disease: It is a rare neurological disorder caused by an infectious agent that results in abnormal protein accumulations in the brain. Initial symptoms of this disease includes:

- Fatigue
- Appetite disturbances
- Sleep problems and concentration difficulties

As the disease progresses individual shows increasing signs of dementia and eventually dies.

Underlying these symptoms is widespread damage known as spongiform encephalopathy, meaning that large holes develop in brain tissues.

v. Cardiovascular Disease: Cardiovascular disease affecting the supply of blood to the brain is another cause of dementia. Dementia arising from this condition is called as *vascular dementia*. The damage to the artery deprives the surrounding neurons of blood and oxygen which causes the neurons to die. Vascular dementia resembles the dementia due to Alzheimer's disease. People with vascular dementia experiences:

- Memory impairment
- They may also experience any one of the following: apraxia, agnosia or disturbance in executive functioning.
- People with vascular dementia also show a particular set of physical abnormalities such as walking difficulties and weakness in the arms and legs.

The cognitive impairment in this disease is slightly different from that occurring in Alzheimer's disease. In a typical vascular dementia certain cognitive functions remain intact and others show significant loss, a pattern called patchy deterioration. Individuals with vascular dementia also show a stepwise deterioration in cognitive functioning, for e.g., a function that was relatively unimpaired is suddenly lost or severely deteriorates.

13.6.8 Pseudodementia: It is also called as false dementia. It is generally found among people who are severely depressed. People

with Pseudodementia generally have a history of prior depressive episodes that may have been undiagnosed. Their memory problems and other cognitive complaints have a very abrupt onset, compared with those of people with dementia, who experience a slowly developing downward course. Some important points of difference between depression and Alzheimer's disease are as follows:

Depression	Alzheimer's Disease
Depressed individuals are more keenly aware of their impaired cognition and frequently complain of their faulty memory.	Individuals with Alzheimer's Disease usually try to hide or minimize the extent of impairment or to explain it away when the loss cannot be concealed.
In depressed elderly people, mood changes precede, memory loss	Opposite is the case in Alzheimer's Disease.
Individuals with depression are generally anxious, have difficulty sleeping, show disturbed appetite patterns, experience suicidal thoughts, low self-esteem, guilt and lack of motivation	Individuals with dementia, in contrast experience unsociability, uncooperativeness, hostility, emotional instability, confusion, disorientation and reduced alertness.

13.6.9 Diagnosis of Alzheimer's Disease: It is very important to diagnose Alzheimer's Disease in its earlier stages so that appropriate management strategies can be applied to deal with it as well as to rule out treatable dementia. Brain imaging techniques are being increasingly used to diagnose Alzheimer's Disease. The clinical tool used to diagnose Alzheimer's Disease is a specialized form of mental status examination known as Mini-Mental State Examination (MMSE). People with Alzheimer's Disease respond in particular ways to several of the items on this instruments. They tend to be circumstantial, repeat themselves and lack richness of detail when describing people, objects and events.

13.6.10 Theories and Treatment of Alzheimer's Disease: Treatment of Alzheimer's disease requires a multidisciplinary approach that involves a comprehensive evaluation of the patient's disease and associated symptoms. The specialists who treat Alzheimer's disease include neurologists, neuropsychologists, neuroradiologists, psychiatrists, sleep medicine, and physical medicine specialists.

The first step in treating Alzheimer's is an accurate diagnosis. It's important to rule out other causes of dementia,

particularly conditions that can be treated and potentially reversed. If Alzheimer's is diagnosed early, medications and other care may improve the patient's daily functioning and quality of life, as well as potentially slow disease progression. The second step in treating Alzheimer's is for the patient, and family, to prepare for and manage the disease as it progresses.

There is no cure for Alzheimer's Disease but prospects for management have improved. New drugs are being developed which seek to slow down the rate of mental decline. These are promising in the early stages of the disease, although it is unclear for how long they can help and they are not yet widely available. In April 1997, donepezil (Aricept) became the first drug to be licensed for Alzheimer's in Britain.

Affected people should live as normal a life for as long as they can. Memory aids and familiar routines are helpful. As the disease progresses, people need more support and may need close supervision and eventually nursing care. In India Rivastigmine (Exelon) is being marketed by Novartis since 1999.

13.7 COGNITIVE DISORDERS: THE BIOPSYCHOSOCIAL PERSPECTIVE

Cognitive impairments associated with various disorders discussed in this unit generally result from biological causes. However, medical experts have still not developed biological treatment for successfully treating or managing these groups of disorders. Individuals suffering from dementia are generally treated with a combination of various approaches to alleviate their sufferings. Experts have also given due attention to manage caregivers who experience considerable stress and strain when dealing with individuals having dementia especially Alzheimer's Disease. Emphasis is laid on improving the quality of life of these individuals. Traditional as well as technology based approaches have been used to deal with various aspects of the problems encountered while dealing with these individuals.

13.8 SUMMARY

In this unit we have discussed the Separation anxiety disorder which is a psychological condition in which an individual experiences excessive anxiety regarding separation from home or from people to whom the individual has a strong emotional attachment. The various Characteristics of Separation Anxiety Disorder were also discussed followed by Theories and Treatment of Separation Anxiety Disorder.

Some disorders that specifically originate in childhood were discussed. These included, Childhood Eating Disorders, Tic Disorders, such as Tourette's Disorder, Elimination Disorders, such as Encopresis and Enuresis, Reactive Attachment Disorder, Stereotypic Movement Disorders and Selective Mutism.

The biopsychosocial perspective of development-related disorders as well as Nature of Cognitive Disorders were discussed. Following this concepts such as Delirium, Amnestic Disorders, Traumatic Brain Injury were discussed.

Characteristics of Dementia as well as Alzheimer's Disease were discussed in detail. Many different types of dementia caused by other conditions were discussed. Some of these disorders/disease include: Pick's Disease, Parkinson's Disease, Huntington's Disease, Creutzfeldt-Jacob Disease, Cardiovascular Disease etc. Towards the end of this unit we have discussed the Biopsychosocial Perspective of Cognitive Disorders.

13.9 QUESTIONS

1. Define Separation Anxiety Disorder and discuss its characteristics.
2. Explain the Theories and Treatment of Separation Anxiety Disorder.
3. Discuss some Disorders that Originate in Childhood.
4. Write short notes on the following:
 - Biopsychosocial perspective of development-related disorders
 - Nature of Cognitive Disorders
 - Delirium
 - Amnestic Disorders
 - Traumatic Brain Injury
 - Characteristics of Dementia
 - Alzheimer's Disease
5. Discuss the different types of Dementia Caused by other Conditions
6. Explain Biopsychosocial Perspective of Cognitive Disorders.

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EATING DISORDERS AND IMPULSE CONTROL DISORDERS – I

Unit Structure

- 14.0 Objectives
- 14.1 Introduction
- 14.2 Anorexia Nervosa
- 14.3 Bulimia Nervosa
- 14.4 Theories and Treatment of Eating Disorders
- 14.5 Summary
- 14.6 Questions
- 14.7 Reference

14.0 OBJECTIVES

After studying this unit you should be able to:

- Understand as to what eating disorders are.
- Know the characteristics of Anorexia Nervosa
- Comprehend Bulimia Nervosa
- Appreciate the theories and treatment of eating disorders

14.1 INTRODUCTION

Eating disorders refer to a group of conditions defined by abnormal eating habits that may involve either insufficient or excessive food intake to the detriment of an individual's physical and mental health. Eating disorders are serious behavior problems. They include

- Anorexia nervosa, in which you become too thin, but you don't eat enough because you think you are fat
- Bulimia nervosa, involving periods of overeating followed by purging, sometimes through self-induced vomiting or using laxatives
- Binge-eating, which is out-of-control eating

Women are more likely than men to have eating disorders. They usually start in the teenage years and often occur along with depression, anxiety disorders and substance abuse.

Eating disorders can cause heart and kidney problems and even death. Getting help early is important. Treatment involves monitoring, mental health therapy, nutritional counseling and sometimes medicines.

In this unit we will discuss Anorexia Nervosa, Bulimia Nervosa and the Theories and Treatment of Eating Disorders

14.2 ANOREXIA NERVOSA

The term anorexia literally means “without appetite” and is a misleading term as far as this disorder is concerned. Anorexia nervosa is an eating disorder affecting mainly girls or women, although boys or men can also suffer from it. It usually starts in the teenage years. Anorexia Nervosa is an eating disorder, which is characterized by extreme, self, imposed weight loss. In anorexia nervosa an individual loses at least 15% of his weight from the normally required weight as per his weight and body constitution. It is also defined as an eating disorder diagnosed when an otherwise healthy person refuses to maintain a normal weight level because of an intense fear of being overweight. Individuals who have anorexia nervosa also have a distorted body image. Some other important characteristics of this disorder are as follows:

- It is relatively a rare disorder beginning typically in teenage years.
- About 20 times more females than males have anorexia nervosa.
- Most anorexics are adult females from well-educated middle and upper income families that are competitive and high achieving.
- They are highly obsessed with food and weight gain.

Individuals having anorexia nervosa has the following characteristics:

- They are unwilling or unable to maintain minimally normal weight, which is about 85 percent of the weight that is expected of a person of given height and body frame.
- These individuals have an intense fear of gaining weight or becoming fat, even if they are grossly underweight
- They have a distorted perception of the weight or shape of their body, possibly denying the seriousness of abnormally low body weight

- Postpubescent females with anorexia nervosa experience amenorrhea, the absence of at least three consecutive menstrual cycles.

Anorexic individuals also display the following characteristics:

- Some individuals engage in various behaviours geared towards weight loss such as abusing laxatives, taking diet pills or indulging in compulsive exercises. These individuals are also called as “restricting type”
- There are another group of individuals who are called as “Binge eating or purging type”. These individuals first overeat and then force themselves to purge or get rid of whatever they have eaten by inducing vomiting
- Anorexia nervosa is associated with many physical complaints and problems such as: menstrual disturbance, dry and cracking skin, slowed heart beat, gastrointestinal disturbance, etc.
- Those who induce vomiting commonly experience abnormalities of the salivary glands, erosion of dental enamel and scarring of hand skin from contact with the teeth.
- Extreme starvation among anorexics can lead to anemia, impaired kidney functioning, heart problems and bone deterioration.
- It has been observed that people with this disorder generally have normal appetite and are interested in eating, however they have difficulty reading their hunger cues.

Psychological and Behavioural Symptomatology: Some important psychological and behavioural symptoms found among anorexia nervosa individuals are as follows

- The individual can become seriously underweight, which can lead to depression and social withdrawal.
- The individual can become irritable and easily upset and have difficulty interacting with others.
- Sleep can become disrupted and lead to fatigue during the day.
- Attention and concentration can decrease.
- Most individuals with anorexia become obsessed with food and thoughts of food. They think about it constantly and become compulsive about eating rituals. They may collect recipes, cut their food into tiny pieces, prepare elaborate calorie-laden meals for other people, or hoard food. Additionally, they may exhibit other obsessions and/or compulsions related to food, weight, or body shape that meet the diagnostic criteria for an obsessive compulsive disorder.

- Other psychiatric problems are also common in people with anorexia nervosa, including affective (mood) disorders, anxiety disorders, and personality disorders.
- Generally, individuals with anorexia are compliant in every other aspect of their life except for their relationship with food. Sometimes, they are overly compliant, to the extent that they lack adequate self-perception. They are eager to please and strive for perfection. They usually do well in school and may often overextend themselves in a variety of activities. The families of anorexics often appear to be "perfect." Physical appearances are important to the anorexia sufferer. Performance in other areas is stressed as well, and they are often high achievers in many areas.
- While control and perfection are critical issues for individuals with anorexia, aspects of their life other than their eating habits are often found to be out of control as well. Many have, or have had at some point in their lives, addictions to alcohol, drugs, or gambling. Compulsions involving sex, exercising, housework, and shopping are not uncommon. In particular, people with anorexia often exercise compulsively to speed the weight-loss process.
- Body image disturbance is one of the core features of anorexia nervosa. Individuals having anorexia often feel that they are gaining weight and are obsessed with weight reduction and staying slim.

Prevalence of Anorexia Nervosa: Prevalence of this disorder range between 1 and 4 percent among women. Approximately 95% of those affected by anorexia are female, most often teenage girls, but males can develop the disorder as well. While anorexia typically begins to manifest itself during early adolescence, it is also seen in young children and adults. In the U.S. and other countries with high economic status, it is estimated that about one out of every 100 adolescent girls has the disorder. Caucasians are more often affected than people of other racial backgrounds, and anorexia is more common in middle and upper socioeconomic groups. According to the U.S. National Institute of Mental Health (NIMH), other statistics about this disorder include the fact that an estimated 0.5%-3.7% of women will suffer from this disorder at some point in their lives. About 0.3% of men are thought to develop anorexia in their lifetimes.

Diagnosis of Anorexia Nervosa: Anorexia nervosa can be a difficult disorder to diagnose, since individuals with anorexia often attempt to hide the disorder. Denial and secrecy frequently accompany other symptoms. It is unusual for an individual with anorexia to seek professional help because the individual typically does not accept that she or he has a problem (denial). In many

cases, the actual diagnosis is not made until medical complications have developed. The individual is often brought to the attention of a professional by family members only after marked weight loss has occurred. When anorexics finally come to the attention of the health-care professional, they often lack insight into their problem despite being severely malnourished and may be unreliable in terms of providing accurate information. Therefore, it is often necessary to obtain information from parents, a spouse, or other family members in order to evaluate the degree of weight loss and extent of the disorder. Health professionals will sometimes administer questionnaires for anorexia as part of screening for the disorder.

One instrument that has been used extensively in research to study eating disorder is The Eating Attitudes Test, which provides a measure of preoccupation with dieting and food, bulimic behaviour and the ability to control eating.

The actual criteria for anorexia nervosa are found in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*.

There are four basic criteria for the diagnosis of anorexia nervosa that are characteristic:

1. The refusal to maintain body weight at or above a minimally normal weight for age and height (maintaining a body weight less than 85% of the expected weight)
2. An intense fear of gaining weight or becoming fat, even though the person is underweight
3. Self-perception that is grossly distorted, excessive emphasis on body weight in self-assessment, and weight loss that is either minimized or not acknowledged completely
4. In women who have already begun their menstrual cycle, at least three consecutive periods are missed (amenorrhea), or menstrual periods occur only after a hormone is administered.

The *DSM-IV-TR* further identifies two subtypes of anorexia nervosa. In the binge-eating/purging type, the individual regularly engages in binge eating or purging behavior which involves self-induced vomiting or the misuse of laxatives, diuretics, or enemas during the current episode of anorexia. In the restricting type, the individual severely restricts food intake but does not regularly engage in the behaviors seen in the binge-eating type.

The cause of anorexia nervosa is unknown, although it is likely that both inherent biological factors and factors in the patient's

social environment play a part. The disease is mainly encountered in the western world and is more common among women in certain professions, such as models and ballet dancers. One reason younger women are particularly vulnerable to eating disorders is their tendency to go on strict diets to achieve an "ideal" figure. This obsessive dieting behavior reflects today's societal pressure to be thin, which is seen in advertising and the media. Others especially at risk for eating disorders include athletes, actors, dancers, models, and TV personalities for whom thinness has become a professional requirement. The causes of anorexia are multiple some of them are as follows:-

- a. One of the chief causes is the growing concern with beauty. Adolescent girls want to look attractive and beautiful. Excessive concern with their body makes them obsessive about weight gain and diet. Hence, anorexia nervosa is a reaction towards slimness.
- b. Anorexia nervosa may also be a result of psychological disturbances related to the fear of growing up and a fear of one's own sexuality.
- c. One's family also contributes towards the development of anorexia nervosa. Anorexic girls describe their mothers as excessively dominant, intrusive, over bearing and markedly ambivalent.
- d. According to some researchers, anorexia may result due to physical disorder caused by deficiency of a crucial chemical in the brain or by disturbance of the hypothalamus.

14.3 BULIMIA NERVOSA

Bulimia nervosa is an eating disorder characterised by frequent episodes of binge eating, followed by frantic efforts to avoid gaining weight. The person may eat a lot of food at once and then try to get rid of the food by vomiting, using laxatives, or sometimes over-exercising. People with bulimia are preoccupied with their weight and body image. Bulimia is associated with depression and other psychiatric disorders. It shares some symptoms with anorexia nervosa, another major eating disorder. Because many people with bulimia can maintain a normal weight, they may be able to keep their condition a secret for years. If not treated, bulimia can lead to nutritional deficiencies and even fatal complications.

Bulimia is characterised by overeating also known as "binges". They may over eat more than 2000 calories in a two hour period. They display lack of control over eating. They then indulge in inappropriate behaviours that are intended to prevent weight gain. They then indulge in what is called as "purging", i.e. indulge in

induced vomiting to get rid of what they have eaten. They may do this in any one of the following ways:

- Induced vomiting
- Administer an enema
- Take laxatives or diuretics

Bulimia can also be of “non-purging type” in which an individual try to compensate for what they have eaten by fasting or engaging in excessive exercise.

Symptomatology: People with bulimia may have the following signs and symptoms:

- Binge eating of high-carbohydrate foods, usually in secret
- Exercising for hours
- Eating until painfully full
- Going to the bathroom during meals
- Loss of control over eating, with guilt and shame
- Body weight that goes up and down
- Constipation, diarrhea, nausea, gas, abdominal pain
- Dehydration
- Missed periods or lack of menstrual periods
- Damaged tooth enamel
- Bad breath
- Sore throat or mouth sores
- Depression

Binge eating signs and symptoms

- **Lack of control over eating** – Inability to stop eating. Eating until the point of physical discomfort and pain.
- **Secrecy surrounding eating** – Going to the kitchen after everyone else has gone to bed. Going out alone on unexpected food runs. Wanting to eat in privacy.
- **Eating unusually large amounts of food** with no obvious change in weight.
- **Disappearance of food**, numerous empty wrappers or food containers in the garbage, or hidden stashes of junk food.
- **Alternating between overeating and fasting** – Rarely eats normal meals. It’s all-or-nothing when it comes to food.

Purging signs and symptoms

- **Going to the bathroom after meals** – Frequently disappears after meals or takes a trip to the bathroom to throw up. May run the water to disguise sounds of vomiting.
- **Using laxatives, diuretics, or enemas** after eating. May also take diet pills to curb appetite or use the sauna to “sweat out” water weight.

- **Smell of vomit** – The bathroom or the person may smell like vomit. They may try to cover up the smell with mouthwash, perfume, air freshener, gum, or mints.
- **Excessive exercising** – Works out strenuously, especially after eating. Typical activities include high-intensity calorie burners such as running or aerobics.

Physical signs and symptoms of bulimia

- **Calluses or scars on the knuckles or hands** from sticking fingers down the throat to induce vomiting.
- **Puffy “chipmunk” cheeks** caused by repeated vomiting.
- **Discolored teeth** from exposure to stomach acid when throwing up. May look yellow, ragged, or clear.
- **Not underweight** – Men and women with bulimia are usually normal weight or slightly overweight. Being underweight while purging might indicate a purging type of anorexia.
- **Frequent fluctuations in weight** – Weight may fluctuate by 10 pounds or more due to alternating episodes of bingeing and purging.

Distinction between Anorexia Nervosa and Bulimia Nervosa:
Some people have both Anorexia Nervosa and Bulimia Nervosa. Clinicians often have to distinguish between the two disorders. The following table will help you to distinguish between the two:

Criteria of difference between the two	Anorexia Nervosa	Bulimia Nervosa
Body Image	People with Anorexia Nervosa have distorted perceptions of their body image/size. Even when close to a chronic stage of starvation, anorexics perceive them selves as overweight	Individuals with bulimia nervosa have an accurate body perception about but still worry about weight gain
Perception concerning the amount of weight lost	People with Anorexia Nervosa weigh significantly below the norm for height and body build.	Many Individuals with bulimia nervosa have weight that is average or above average.

Medical Complications: Individuals having Bulimia Nervosa experience many medical complications. Most of these are life threatening complications associated with purging.

- i. Ipecac syrup, the medication that is used to induce vomiting in people who have consumed poisonous substances, has severe toxic effects when taken regularly and in large doses by people who have eating disorders.
- ii. Dental decay which results from frequent vomiting is common as cavities develop and teeth take on ragged appearance.
- iii. The salivary gland becomes enlarged.
- iv. Skin calluses develop on hands that brush against teeth in the vomiting process.
- v. Menstrual irregularity among women.
- vi. Toxic effects can also occur from the laxatives, diuretics and diet pills that bulimics use to induce weight loss.
- vii. Some individuals with bulimia nervosa engage in harmful behaviours such as using enemas, regurgitating and then re-chewing the food or overusing saunas in efforts to lose weight.
- viii. These individuals develop problems of the gastrointestinal, cardiovascular and nervous systems. In addition to the effects of dehydration caused by bingeing and purging, the bulimic individual runs the risk of permanent gastrointestinal damage. Fluid retention in the hands and feet and destruction of the heart muscles or collapse of the heart valves.

Prevalence: This disorder is more prevalent among girls, especially those who are between the ages of 16 to 18. The onset of bulimia nervosa is often during adolescence, between 13 and 20 years of age, and many cases have previously suffered obesity, with many sufferers relapsing in adulthood into episodic bingeing and purging even after initially successful treatment and remission. There is little data on the prevalence of bulimia nervosa in-the-large, on general populations. Most studies conducted thus far have been on convenience samples from hospital patients, high school or university students. These have yielded a wide range of results: between 0.1% and 1.4% of males, and between 0.3% and 9.4% of females. The lifetime prevalence of Bulimia Nervosa among women is approximately 1%-3%; the rate of occurrence of this disorder in males is approximately one-tenth of that in females. Bulimia Nervosa has been reported to occur with roughly similar frequencies in most industrialized countries, including the United States, Canada, Europe, Australia, Japan, New Zealand, and South Africa. Few studies have examined the prevalence of Bulimia Nervosa in other cultures. In clinical studies of Bulimia Nervosa in the United States, individuals presenting with this disorder are

primarily white, but the disorder has also been reported among other ethnic groups.

14.4 Theories and Treatment of Eating Disorders: Many varied perspectives on causation and treatment of eating disorders have been developed.

People with eating disorder have altered dopamine and serotonin neurotransmitter substances. People with eating disorder have abnormalities in the dopamine receptors reflecting inherited vulnerability. It is also suggested that deficiency of serotonin is related to feelings of hunger (leading to binging) and an excess is related to feelings of fullness.

Psychological perspective holds the view that eating disorder develop in young people who suffer a great deal of inner turmoil and pain and become obsessed with bodily issues, often turning to food for feelings of comfort and nurturance. Individuals suffering from eating disorder tend to have difficulty understanding and labeling their emotions and over time they learn that eating can provide a means of dealing with unpleasant and unclear emotional states. Some women with eating disorder, especially bulimia nervosa have a history of sexual abuse during childhood. According to cognitive behavioural perspective, people with eating disorders become trapped in their pathological patterns because of a resistance to change that commonly characterizes their thought process. They avoid problems rather than resolve them, they resort to wishful thinking rather than realistic appraisal; they do not seek social support even when they are in serious trouble.

Sociocultural perspective views society's attitude as primarily responsible for the development of eating disorders. Society's idealization of thinness leads adolescent girls to equate beauty with a slim figure. As she matures, she reads magazines, hears other people, views television and films which all depict and glamorize thinness and equates it with beauty.

Some experts also hold the view that these eating disorders develop as a result of complex interaction among biological, psychological and sociological factors. IN the case of anorexia nervosa biological factors, dieting and psychosocial influences come together and set the stage for development of this disorder. Once the stage is set the individual becomes trapped in a cycle of physiological changes that leads to disorder.

Since multiple causes are responsible for the development of eating disorder, its treatment also requires a combination of approaches. Psychotherapy is very essential for trating people with eating disorder. Fairburn (1997) observed that cognitive

behavioural therapy and interpersonal therapy were found to be highly effective in the treatment of eating disorders. Therapeutic alliance is an important factor that helps to bring about therapeutic change. Fairburn (1997) found that following factors associated with cognitive behavioural therapy plays an important role in the treatment of eating disorders:

- Building of a good therapeutic relationship
- Teaching the client Self monitoring techniques
- Helping the clients to develop an understanding of the cognitive model, the importance of weekly weighing and regular eating patterns and other techniques designed to bring about healthy eating habits.

Interpersonal therapy uses techniques similar to those used for treating depression, with a focus on helping client cope with stress in interpersonal situations and with feelings of low self-esteem. The clients learn to recognize emotions as triggers of disordered eating, particularly binge eating.

Group therapy may also be helpful in the treatment of eating disorders. However, the success rate with group therapy is far below than what it is for individual therapy. Multifamily therapy group is much better than ordinary group therapy.

Treatment plans often are tailored to individual needs and may include one or more of the following:

- Individual, group, and/or family psychotherapy
- Medical care and monitoring
- Nutritional counseling
- Medications.

Some patients may also need to be hospitalized to treat problems caused by malnutrition or to ensure they eat enough if they are very underweight.

Treating Anorexia Nervosa: Treating anorexia nervosa involves three components:

- Restoring the person to a healthy weight
- Treating the psychological issues related to the eating disorder
- Reducing or eliminating behaviors or thoughts that lead to insufficient eating and preventing relapse.

Some research suggests that the use of medications, such as antidepressants, antipsychotics, or mood stabilizers, may be modestly effective in treating patients with anorexia nervosa. These medications may help resolve mood and anxiety symptoms that

often occur along with anorexia nervosa. It is not clear whether antidepressants can prevent some weight-restored patients with anorexia nervosa from relapsing.

Treating Bulimia Nervosa: As with anorexia nervosa, treatment for bulimia nervosa often involves a combination of options and depends upon the needs of the individual. To reduce or eliminate binge-eating and purging behaviors, a patient may undergo nutritional counseling and psychotherapy, especially cognitive behavioral therapy (CBT), or be prescribed medication. CBT helps a person focus on his or her current problems and how to solve them. The therapist helps the patient learn how to identify distorted or unhelpful thinking patterns, recognize, and change inaccurate beliefs, relate to others in more positive ways, and change behaviors accordingly.

CBT that is tailored to treat bulimia nervosa is effective in changing binge-eating and purging behaviors and eating attitudes. Therapy may be individual or group-based.

Some antidepressants, such as fluoxetine (Prozac), which is the only medication approved by the U.S. Food and Drug Administration (FDA) for treating bulimia nervosa, may help patients who also have depression or anxiety. Fluoxetine also appears to help reduce binge-eating and purging behaviors, reduce the chance of relapse, and improve eating attitudes.

14.5 SUMMARY

In this unit we have first defined eating disorders as a group of conditions involving abnormal eating habits that includes either insufficient or excessive food intake to the detriment of an individual's physical and mental health. Eating disorders lead to serious behavior problems. Symptoms of various eating disorders were discussed. We defined anorexia nervosa and discussed its various symptoms including Psychological and Behavioural Symptomatology. Following this we discussed the Prevalence of Anorexia Nervosa and the Diagnosis of Anorexia Nervosa.

Bulimia Nervosa was the next eating disorder discussed in detail. Bulimia nervosa was defined as an eating disorder characterised by frequent episodes of binge eating, followed by frantic efforts to avoid gaining weight. Symptomatology of Bulimia Nervosa was discussed. We also distinguished between Anorexia Nervosa and Bulimia Nervosa, especially with respect to Body Image and Perception concerning the amount of weight lost.

Various medical complications arising as a result of Bulimia Nervosa was discussed. Following this we discussed the prevalence of this disorder.

Towards the end of this unit we discussed the Theories and Treatment of Eating Disorders, especially with reference to Anorexia Nervosa and Bulimia Nervosa.

14.6 QUESTIONS

- Q1. What are eating disorders. Discuss the symptomatology of Anorexia Nervosa.
- Q2. Discuss Bulimia Nervosa as an eating disorder.
- Q3. Discuss the Theories and Treatment of Eating Disorders.

14.7 REFERENCE

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EATING DISORDERS AND IMPULSE CONTROL DISORDERS – II

Unit Structure

- 15.0 Objectives
- 15.1 Introduction
- 15.2 Definition of Impulse Control Disorders
- 15.3 Kleptomania
- 15.4 Pathological Gambling
- 15.5 Pyromania
- 15.6 Sexual Impulsivity
- 15.7 Trichotillomania
- 15.8 Intermittent Explosive Disorder
- 15.9 Internet Addiction
- 15.10 Self-injurious Behaviour
- 15.11 Summary
- 15.12 Questions
- 15.13 Reference

15.0 OBJECTIVES

After studying this unit you should be able to:

- Understand the concept of impulse control disorders
- Know what is Kleptomania, its characteristics, theories and treatment?
- Comprehend Pathological Gambling and know its characteristics, theories and treatment.
- Know the concept of Pyromania as well as its characteristics, theories and treatment.
- Understand Sexual Impulsivity and Trichotillomania.
- vi Know what is Intermittent Explosive Disorder and Internet Addiction?
- Understand Self-injurious Behaviour

15.1 INTRODUCTION

In this unit we will first discuss the concept of impulse control disorder, which refers to urges to act in ways that are destructive or detrimental to their well-being. Some of the impulse control behaviours are not problematic when indulged in moderation. Some of the most important impulse control disorders that we will discuss in this unit along with their characteristics, theories and treatment include the following: Kleptomania, Pathological Gambling, Pyromania, Sexual Impulsivity, Trichotillomania, Intermittent Explosive Disorder, Internet Addiction and Self-injurious Behaviour.

15.2 DEFINITION OF IMPULSE CONTROL DISORDERS

Impulse Control Disorders are a specific group of impulsive behaviours that have been accepted as psychiatric disorders under the DSM – IV - TR . Although they have been grouped together in this diagnostic category, there are striking differences as well as similarities between these disorders.

An Impulse Control Disorder can be loosely defined as the *failure to resist an impulsive act or behaviour that may be harmful to self or others*. For purposes of this definition, an impulsive behaviour or act is considered to be one that is not premeditated or not considered in advance and one over which the individual has little or no control.

While anyone can be capable of impulsive behaviours and/or actions at any given point, this particular diagnosis is used when there is a mental health issue present. In many cases, the individual may have more than one formal psychiatric diagnosis.

The impulsive behaviours or actions refer to violent behavior, sexual behavior, gambling behaviour, fire starting, stealing, and self-abusive behaviors.

Impulse-control disorders are psychological disorders characterized by the repeated inability to refrain from performing a particular action that is harmful either to oneself or others. Impulse-control disorders are thought to have both neurological and environmental causes and are known to be exacerbated by stress. Some mental health professionals regard several of these disorders, such as compulsive gambling or shopping, as addictions. In impulse-control disorder, the impulse action is typically preceded by feelings of tension and excitement and followed by a sense of relief and gratification, often—but not always— accompanied by guilt or remorse.

15.3 KLEPTOMANIA

Kleptomania is one form of impulse control disorder in which an individual is driven by a persistent urge to steal, although their theft is not motivated by a wish to own the object or by the monetary value of the item they have stolen.

Characteristics of Kleptomania: Some important characteristics of kleptomania are as follows:

- It is wrongly believed that they are driven by the wish to acquire possessions, infact that is not the case.
- They are more influenced by the excitement of engaging in the act of stealing the object. In the process of stealing, they experience a release of tension that is gratifying as they experience a temporary thrill.
- People with Kleptomania steal just anything, though the most common objects are food, clothes, jewellery, cosmetics, compact disc, toys, pens, paper, money, etc. Most people with Kleptomania steal from a store or workplace. In few cases, stealing is limited only to certain particular person.
- It is not the intrinsic value of these objects that motivates the person with Kleptomania to steal, but, rather the urge to release tension
- Most people with Kleptomania are perplexed about what to do with their acquired items. Some hoard the objects; others give away or throw the objects. This lack of interest in the stolen items is the main feature that distinguishes between a typical shoplifter or the thief from a person with Kleptomania.

Theories and Treatment of Kleptomania: Very few cases of Kleptomania come to the attention of clinicians, but only when they are directed by the court. Clinician usually becomes aware that a person has Kleptomania only when he or she is in treatment for another psychological problem, such as an anxiety, psychoactive substance abuse, eating or mood disorder. One important question is that is Kleptomania a symptom of some underlying disorder. Some researchers are of the view that Kleptomania constitutes a variant of obsessive-compulsive disorder.

Biological and pharmacological treatment approaches for Kleptomania has been developed. It has been observed that Kleptomania responds to SSRIs. Besides pharmacological interventions clinicians also employ behavioural treatments to help individuals control their urge to steal.

15.4 PATHOLOGICAL GAMBLING

Individuals with pathological gambling have an urge to gamble that is much stronger than that of the average person, and they often end up spending their entire lives in pursuit of big wins

People with pathological gambling often feel ashamed and try to avoid letting others know of their problem. A person may be diagnosed with a pathological gambling habit if they fit more than five of the following criteria; the criteria were published in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders:

- Preoccupation: the individual constantly thinks about gambling.
- Tolerance: the individual becomes increasingly tolerant to gambling and starts to spend more money and take more risks to get the same 'rush'; this is similar to someone with alcohol dependency.
- Withdrawal: the individual suffers withdrawal symptoms if they go for a while without gambling; commonly, people with gambling problems get irritable and restless when they don't gamble on a regular basis.
- Escape: the individual uses gambling as a means of escaping the real world.
- Chasing: the individual will continue to gamble if they have lost money to try and win it back.
- Lying: the individual lies about the gravity of their gambling habit to loved ones and tries to disguise their addiction.
- Loss of control: the individual cannot cut down on gambling, even if they want to.
- Illegal acts: the individual breaks the law to get money to gamble or make money back following a loss; these acts may include theft and fraud.
- Risked significant relationship: the individual continues to gamble even though they know a significant relationship is at risk.
- Bailout: an individual asks friends, family or a third party for help with repaying gambling debts.

Pathological gambling is currently the only behavioural addiction included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and is classified as an "Impulse Control Disorder," where the "essential feature is the failure to resist an impulse, drive or temptation to perform an act that is harmful to the person or to others" (p. 609, DSM-IV, American Psychiatric Association, 1994).

Characteristics of Pathological Gambling: Some important characteristics of pathological gambling are as follows:

- It is estimated that lifetime prevalence of this disorder is slightly less than 01 percent. Pathological gamblers are likely to be males, non-white and unmarried. They are likely to have co-morbid disorders, including mood, alcohol abuse and substance abuse disorders. Those with middle income levels and low education levels are also at risk for pathological gambling. Pathological gambling usually begins in early adolescence in men, and between ages 20 and 40 in women.
- Pathological gamblers are preoccupied with gambling to such an extent that it is difficult for them to get the idea of being out of their mind. Repeated efforts to control their gambling are usually unsuccessful.
- Gambling progresses through a series of stages. In the first stage the individual is simply a recreational gambler who enjoys gambling as a social activity. The next stage is the beginning of pathological gambling pattern, it occurs when the individual begins to win. At this point of time individual gains the identity as a winner and now he/she strives to achieve more and more wins, most probably a big win.

Theories and Treatment of Pathological Gambling: Pathological gambling is an addiction which is similar to drug or alcohol addiction. From a biological perspective, the gambler's perceptual pursuit of the big win can be seen as similar to the alcohol-dependent person's search for stimulation and pleasurable feelings through alcohol use. Some researchers have opined that people with pathological gambling have abnormalities in the brain that lead them to seek excess stimulation, be it through drugs, food or gambling. Few researchers have pointed out that those who indulge in pathological gambling have abnormalities affecting neurotransmitters including dopamine, serotonin and MAO. Researchers believe that dopamine abnormalities, in particular, affect the reward system of the brain that leads pathological gamblers to seek excessive stimulation.

Cognitive factors may also play a role in transmission of pathological gambling. Another factor that contributes to a person's likelihood of becoming a pathological gambler is the experience of gambling during childhood and adolescence. Some individuals suggest that individuals with certain personality characteristics may have a predisposition to developing the disorder.

Socio-cultural factors are also involved in the acquisition and maintenance of pathological gambling. Exposure to a culture of

gambling, in which parents and peers are heavily engaged in gambling activities themselves, can also increase the individual's chances of developing this disorder.

It has been observed that treatment methods that combine elements of the various perspectives seem to have the greatest chance of success. Serotonin reuptake inhibitors such as Clomipramine and fluvoxamine are effective in treatment of this disorder. Cognitive behavioural methods such as correcting the gambler's inaccurate perceptions of gambling, providing training in problem solving and social skills and incorporating elements of motivational interviewing techniques are highly useful in the treatment of this disorder.

Treatment for people with pathological gambling begins with recognizing the problem. Pathological gambling is often associated with denial. People with the illness often refuse to accept that they are ill or need treatment. Most people with pathological gambling enter treatment under pressure from others, rather than voluntarily accepting the need for treatment. Treatment options include:

- Cognitive behavioral therapy has been found to be effective.
- Self-help support groups, such as Gamblers Anonymous. Gamblers Anonymous is a 12-step program similar to Alcoholics Anonymous. Principles related to stopping the habit (abstinence) for other types of addiction, such as substance abuse and alcohol dependence, can also be helpful in the treatment of pathological gambling.
- A few studies have been done on medications for the treatment of pathological gambling. Early results suggest that antidepressants and opioid antagonists (Naltrexone) may help treat the symptoms of pathological gambling. However, it is not yet clear which people will respond to medications.

15.5 PYROMANIA

Pyromania is an impulse control disorder in which an individual indulges in setting fire and gets fascinated by fire. People with this condition show evidence of the following characteristics:

- They deliberately and repeatedly set fires
- They experience a sense of tension or affective arousal before the fire setting.
- They are fascinated with, interested in, curious about or attracted to fire and things associated with fire.

- They feel pleasure, gratification or relief when setting fires or when watching or participating in the events following a fire.
- Their fire setting is not done for ulterior motives, such as monetary gain, an expression of political ideology, the concealment of criminal activity or an expression of anger or vengeance.

Those individuals who suffer from pyromania have a history of childhood problems. These individuals have learned the curiosity and attraction for fire through observation and modeling of adult fire setting behaviour. Parents of such children are found to be uninterested and ineffective in disciplining them. These individuals tend to be highly aggressive and have higher levels of psychopathology. They also show evidence of antisocial and other pathological behaviours. As adults those who indulge in pyromania have other coexisting disorder such as schizophrenia, bipolar disorder or substance abuse disorder.

Individuals with this disorder have a low level of education. Among the biological factors low level of serotonin have been identified in individuals who indulge in pyromania

15.6 SEXUAL IMPULSIVITY

Individuals who suffer from sexual impulsivity are unable to control their sexual behaviour and they feel driven to engage in frequent and indiscriminate sexual activity. Although this condition is not a DSM IV TR diagnosis, the symptoms and behaviours of people with sexual impulsivity are very much similar to those generally associated with impulse control disorders. Terms such as “sexual addiction”, “sexual compulsivity”, and “sexual dependency” are often used to refer to this disorder.

Characteristics of sexual impulsivity: Some important characteristic features of sexual impulsivity are as follows:

- These individuals are preoccupied with sex, feeling uncontrollably driven to seek out sexual encounters, which they later regret.
- People with sexual impulsivity feel that they cannot control either the number of their sexual encounters or the contexts in which they are likely to initiate sexual behaviour.
- The uncontrollable behaviour of people with sexual impulsivity interferes with their ability to carry out normal social and occupational responsibilities and can place their social status in jeopardy.

- They feel a great deal of distress about their behaviour after the sexual encounter. They also are likely to feel dejected, hopeless and ashamed.
- People with this condition are unable to control their sexual behaviour, and they feel driven to engage in frequent and indiscriminate sexual activity.
- They experience an increasing sense of tension prior to engaging in a sexual act.
- They feel a great deal of distress about their behaviour and following sexual encounters, are likely to feel depressed.
- Their compulsive pursuit of sexual encounters interferes with their ability to carry out normal social and occupational responsibilities
- This disorder is generally more common in men but its manifestation in women tends to be more passive.
- Individuals with sexual impulsivity commonly have a co-existing condition, such as depression, substance abuse or anxiety. It has been observed that episodes of strong sexual interest seem to occur when these individuals are feeling depressed or anxious.
- Some individuals with sexual impulsivity experience dissociative symptoms.

Theories and Treatment of sexual impulsivity: Comprehensive approach to understanding and treatment is required for sexual impulsivity. Biopsychosocial perspective provides an excellent starting point for an integrated approach for management and treatment of sexual impulsivity. Experts have suggested that sexual impulsivity is comparable to other addictions with a similar biochemical basis.

Psychodynamic theorists view sexually addictive behaviour as intimacy disorder rooted in early attachment experiences. According to this view impaired bonding between infant and caregiver can cause some individuals to experience difficulties regulating their affect as adults. Consequently, they get caught in compulsive cycle in which they try to soothe themselves and regulate internal struggles by engaging in sexual behaviours.

Exposure to abusive family environment is one of the key factors thought to predispose an individual toward this behaviour.

It has been observed that sexual impulsivity responds to SSRIs. Besides, treatment for sexual impulsivity involves a combination of insight oriented, behavioural and family systems approach.

Insight oriented therapy focuses on bringing to the surface the individual's underlying conflicts that motivate the behaviour. These conflicts include resolving nonsexual problems through sexual means, needing reassurance and feeling insecure about one's sex role. The therapist also helps the client to learn how to regulate affect and establish adaptive sexual boundaries.

Behavioural techniques include aversive covert conditioning, imaginable desensitization and behavioural contracting.

Where sexual impulsivity is associated with other disorder such as mood disorder or obsessive compulsive disorder, the treatment of these conditions also require administration of medicines.

Family and couples therapy is also an important component of therapy for clients whose excessive sexual behaviour occur in the context of long term close relationship.

15.7 TRICHOTILLOMANIA

It is one type of impulse control disorder in which there is an urge to pull out one's hair becomes a compulsion. It is estimated that this disorder is prevalent in about 1 to 2 % of the population. This disorder is common among female adolescent and young adults. In some cases the condition is transient where as in some other cases it can last for even a decade.

Characteristics of Trichotillomania: Some important characteristics of this disorder are as follows:

- Like other impulse control disorder, persons with Trichotillomania experience an increasing sense of tension immediately prior to pulling out the hair or when trying to resist the urge to pull.
- The experience of hair-pulling results in feelings of relief, pleasure or gratification.
- The disturbance is not accounted for by another mental disorder and is not due to a general medical condition (i.e., dermatological condition)
- The disturbance causes significant distress or impairment in social, occupational, or other important areas of functioning.
- In extreme cases, some individuals swallow the hair after they have pulled it out, risking the danger that it will solidify in the stomach or intestine (a condition referred to as a Trichobezoar or Rapunzel syndrome).

- People with this disorder are secretive about what they are doing and tend to engage in hair pulling only when they are alone. For some the interest goes beyond their hair and may involve pulling the hair from another person, or even pets, dolls and materials such as carpets and sweaters. People with this disorder deny that they are pulling the hair.
- This disorder often coexists with other disorders including depression, obsessive compulsive disorder, substance abuse or an eating disorder.

Theories and Treatment of Trichotillomania: This is not a well understood disorder. There is no certain cause of trichotillomania, but the current way of looking at trichotillomania is as a medical illness. One theory on a biological level is that there is some disruption in the system involving one of the chemical messengers between the nerve cells in parts of the brain. There may be also a combination of factors such as a genetic predisposition and an aggravating stress or circumstance; as with many other illnesses. Further, trichotillomania could be a symptom caused by different factors in different individuals just as a cough can be produced by a multitude of different medical problems. Finding the cause(s) will take more research.

From a biological perspective Trichotillomania is seen as sharing the characteristics of obsessive-compulsive disorder because people with both these disorders respond well to medication. Some important medications that are used in the treatment of this disorder include paroxetine (Paxil), Venlafaxine (Effexor), Fluvoxamine (Luvox) and Olanzapine, which is an atypical antipsychotic.

Behavioural theorists regard this disorder as a complex interaction among environmental cues, hair pulling and consequences of pulling. Individuals with this disorder learn to associate hair-pulling behaviour with relief from tension. Thus, a young girl who becomes anxious while studying may experience transient relief when she tugs on her hair. Overtime, she may return to the hair-pulling behaviour in an effort to gain the sense of relief she experienced before. In behavioral therapy, people learn a structured method of keeping track of the symptoms and associated behaviors, increasing awareness of pulling, substituting incompatible behaviors and several other techniques aimed at reversing the “habit” of pulling.

Sociocultural perspective states that Trichotillomania affects an individual’s social relationship. The disorder is associated with feelings of shame and unattractiveness and in disturbed interactions with others.

15.8 INTERMITTENT EXPLOSIVE DISORDER

People with Intermittent explosive disorder feel a recurrent inability to resist assaultive or destructive acts of aggression. Intermittent explosive disorder is characterized by repeated episodes of aggressive, violent behavior in which you react grossly out of proportion to the situation. Road rage, domestic abuse, and angry outbursts or temper tantrums that involve throwing or breaking objects may be signs of intermittent explosive disorder (IED).

People with intermittent explosive disorder may attack others and their possessions, causing bodily injury and property damage. Later, people with intermittent explosive disorder may feel remorse, regret or embarrassment. People with this condition show evidence of the following characteristics:

- During several separate episodes, they are unable to resist aggressive impulses, which result in serious acts of assault or destruction
- Their level of aggressiveness during these episodes is grossly out of proportion to any precipitating stressors.
- Their aggressive episodes are not associated with another mental or physical disorder.

Characteristics of Intermittent Explosive Disorder: Some important characteristics of this disorder are as follows:

- Individuals with intermittent explosive disorder display occasional bouts of extreme rage, in which they become assaultive or destructive without serious provocation or verbally threaten to physically assault another individual. During these episodes these individuals can cause serious physical harm to themselves, other people and property that suggest that it is like a seizure state.
- In some individuals the aggressive episodes are often preceded or accompanied by symptoms such as tingling, tremor, heart palpitations, head pressure or even hearing echoes.
- The disorder is most commonly found among men.
- This disorder is also commonly associated with clinical disorders such as mood disorders, substance abuse disorder and anxiety disorders
- Explosive eruptions, usually lasting 10 to 20 minutes, often result in injuries and the deliberate destruction of property.

These episodes may occur in clusters or be separated by weeks or months of nonaggression. Aggressive episodes may be preceded or accompanied by:

- a. Irritability
- b. Increased energy
- c. Rage
- d. Tingling
- e. Tremors
- f. Palpitations
- g. Chest tightness
- h. Headache or a feeling of pressure in the head

Theories and Treatment of Intermittent Explosive Disorder:

The exact cause of intermittent explosive disorder is unknown, but the disorder is probably caused by a number of environmental and biological factors.

Most people with this disorder grew up in families where explosive behavior and verbal and physical abuse were common. Being exposed to this type of violence at an early age makes it more likely for these children to exhibit these same traits as they mature.

There may also be a genetic component, causing the disorder to be passed down from parents to children.

Additionally, there may be differences in the way serotonin, an important chemical messenger in the brain, works in people with intermittent explosive disorder. Higher levels of the hormone testosterone have been associated with intermittent explosive disorder.

Researchers have observed that abnormalities in brain circuits are involved in impulsive aggressiveness.

Learning theorists have pointed out that concepts of operant conditioning are involved in the causation of this disorder.

15.9 INTERNET ADDICTION

Internet addiction is an impulse-control condition in which an individual feels an irresistible need to be involved in internet-based activities. Internet addiction is not included in DSM – IV – TR, but shares many of the characteristics of the impulse-control disorders and creates substantial intrapsychic and interpersonal turmoil for people with this uncontrollable condition.

Characteristics of Internet Addiction: Internet addiction is described as an impulse control disorder, which does not involve use of an intoxicating drug and is very similar to pathological gambling. Similar to other addictions, those suffering from Internet addiction use the virtual fantasy world to connect with real people through the Internet, as a substitution for real-life human connection, which they are unable to achieve normally. Some important symptoms of internet addiction are as follows

- Preoccupation with the Internet. (Thoughts about previous on-line activity or anticipation of the next on-line session.)
- Use of the Internet in increasing amounts of time in order to achieve satisfaction.
- Repeated, unsuccessful efforts to control, cut back or stop Internet use.
- Feelings of restlessness, moodiness, depression, or irritability when attempting to cut down use of the Internet.
- On-line longer than originally intended.
- Jeopardized or risked loss of significant relationships, job, educational or career opportunities because of Internet use.
- Lies to family members, therapists, or others to conceal the extent of involvement with the Internet.
- Use of the Internet is a way to escape from problems or to relieve a dysphoric mood. (e.g. Feelings of hopelessness, guilt, anxiety, depression.).
- The term cyber-disorder is also used to refer to internet addiction.
- Some important variants of internet addiction are as follows:
 - a) Cyber-sexual addiction, involving the compulsive use of sexually oriented websites,
 - b) cyber-relationship addiction, characterized by over involvement in online relationships,
 - c) net compulsions such as online gambling, shopping or trading,
 - 4) information overload which involves compulsive web-surfing or database searches and
 - 5) computer addiction which consists of compulsive addiction in online game playing.

Internet addiction results in personal, family, academic, financial, and occupational problems that are characteristic of other addictions. Impairments of real life relationships are disrupted as a result of excessive use of the Internet. Individuals suffering from Internet addiction spend more time in solitary seclusion, spend less time with real people in their lives, and are often viewed as socially awkward. Arguments may result due to the volume of time spent on-line. Those suffering from Internet addiction may attempt to

conceal the amount of time spent on-line, which results in distrust and the disturbance of quality in once stable relationships.

Theories and Treatment of Internet Addiction: Biopsychosocial model is used to conceptualise internet addiction. Internet addiction is explained on the basis of classical conditioning and operant conditioning. Sociocultural perspective emphasizes on the familial, social and cultural dynamics. Many people turn to the Internet in order to manage unpleasant feelings such as stress, loneliness, depression, and anxiety. When you have a bad day and are looking for a way to escape your problems or to quickly relieve stress or self-soothe, the Internet can be an easily accessible outlet.

People who are addicted to internet usually resist treatment. It is only at the insistence of the loved one that they seek assistance. Therapy can give you a tremendous boost in controlling Internet use. Cognitive-behavioral therapy provides step-by-step ways to stop compulsive Internet behaviors and change your perceptions regarding Internet and computer use. Therapy can also help you learn healthier ways of coping with uncomfortable emotions, such as stress, anxiety, or depression.

15.10 SELF-INJURIOUS BEHAVIOUR

Self injurious behaviours are acts that are not socially sanctioned involving deliberate self-harm, self-injury, self-mutilation and cutting. Self injurious behaviours are not included in DSM - IV – TR but often are the basis of clinical attention and share many of the characteristics of impulse-control disorders. Self-injurious behaviour (SIB) has been defined as: “Any behaviour, initiated by the individual, which directly results in physical harm to that individual. Physical harm will be considered to include bruising, laceration, bleeding, bone fractures and breakages and other tissue damage” (Murphy and Wilson, 1985). The behavior is defined as the deliberate, repetitive, impulsive, non-lethal harming of oneself. Self-injury includes:

- . Cutting
- . Scratching
- . Picking scabs or interfering with wound healing
- . Burning
- . Punching self or objects
- . Infecting oneself
- . Inserting objects in body opening
- . Bruising or breaking bones
- . Some forms of hair pulling
- . Other various forms of bodily harm

Experts estimate the incidence of habitual self-injurers is nearly 1% of the population with a higher proportion of females than males. The typical onset of self-harming acts is at puberty. The behaviors often last 5-10 years but can persist much longer without appropriate treatment.

Theories and Treatment of Self-injurious behaviour: Many factors are associated in the causation of these behaviours. Childhood maltreatment and emotional in expressivity is the main cause of these behaviours. Many individuals who display such behaviour may also have some forms of organic pathology, brain disorders, concurrent psychiatric diagnosis such as borderline personality disorder or antisocial personality disorder, schizophrenia, etc. Self-injury treatment options include:

- . Outpatient therapy, partial (6-12 hours a day)
- . Inpatient hospitalization

When the behaviors interfere with daily living, such as employment and relationships, and are health or life threatening, a specialized self-injury hospital program with an experienced staff is recommended. The effective treatment of self-injury is most often: a combination of medication, cognitive/behavioral therapy, and interpersonal therapy, supplemented by other treatment services as needed.

Medication is often useful in the management of depression, anxiety, obsessive-compulsive behaviors, and the racing thoughts that may accompany self-injury.

Cognitive/behavioral therapy helps individuals understand and manage their destructive thoughts and behaviors. Contracts, journals, and behavior logs are useful tools for regaining self-control. Interpersonal therapy assists individuals in gaining insight and skills for the development and maintenance of relationships. Services for eating disorders, alcohol/substance abuse, trauma abuse, and family therapy should be readily available and integrated into treatment, depending on individual needs.

15.11 SUMMARY

We began this unit by discussing the concept of impulse control disorder, which refers to urges to act in ways that are destructive or detrimental to their well-being. Some of the impulse control behaviours are not problematic when indulged in moderation. Some of the most important impulse control disorders that we discussed in this unit along with their characteristics, theories and treatment include the following: Kleptomania,

Pathological Gambling, Pyromania, Sexual Impulsivity, Trichotillomania, Intermittent Explosive Disorder, Internet Addiction and Self-injurious Behaviour.

15.12 QUESTIONS

- Q1. What is Kleptomania? Discuss its characteristics, theories and treatment?
- Q2. Define Pathological Gambling and explain its characteristics, theories and treatment.
- Q3. Explain the concept of Pyromania as well as its characteristics, theories and treatment.
- Q4. Write notes on the following:
- Sexual Impulsivity
 - Trichotillomania.
 - Intermittent Explosive Disorder
 - Internet Addiction?
 - Self-injurious Behaviour

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