T.Y.B.A.

SEMESTER - VI (CBCS)

PSYCHOLOGY PAPER - V

ABNORMAL PSYCHOLOGY

SUBJECT CODE : UAPS602

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Prof. (Dr.) D. T. Shirke
Offg. Vice Chancellor
University of Mumbai, Mumbai.

Prin. Dr. Ajay Bhamare
Offg. Pro Vice-Chancellor,
University of Mumbai.

Prof. Prakash Mahanwar
Director
IDOL, University of Mumbai.

Programe Co-ordinator : **Prof. Anil R. Bankar**
Head, Faculty of Humanities and Social Sciences,
IDOL, University of Mumbai

Course Co-ordinator : **Dr. Naresh Tambe**
Assistant Professor (Psychology), IDOL,
University of Mumbai.

Editor: : **Ms. Trupti Mohan Nawar**
Assistant Professor,
Ramnarain Ruia College, Matunga, Mumbai-400019.

Course Writer: : **Dr. Vipan Kumar**
R.D. National College,
Bandra West, Mumbai-400050.

: **Prof. Archana Ambore**
Mithibai College of Arts,
Vile Parle West Mumbai-400056.

: **Dr. Babita Sinha**
SPDT College or Arts, Science and Commerce,
Andheri East, Mumbai-400069.

: **Prof. Vimal Ambre**
Gonsalo Garsia College, Vasai, Dist. Thane.

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Choice Based Credit System (CBCS)

T.Y.B.A. Abnormal Psychology Syllabus to be implemented from 2022-2023

Paper V: Abnormal Psychology Part II

Code	Sem	Course Title	Credits	Marks
UAPS602	6	Abnormal Psychology	4	100

Learning Objectives:

1) To have students build knowledge and understanding of the basic concepts in Abnormal Psychology and the theories of Abnormality.

2) To have students build knowledge and understanding of the different Psychological Disorder– their symptoms, diagnosis, causes and treatment.

3) To create awareness among students about Mental Health problems in society

4) To create a foundation in students for higher education and a professional career in Clinical Psychology.

Semester 6

Abnormal Psychology Part II (Credits = 4) 4 lectures per week

Unit 1: Schizophrenia and other Psychotic Disorders

a) Clinical Picture and Subtypes of Schizophrenia.

b) Other Psychotic Disorders: Schizoaffective Disorder, Schizophreniform Disorder, Delusional disorder and Brief Psychotic Disorder.

c) Risk and Causal factors: Genetic Factors, Neurodevelopmental Perspective, Neurochemistry, Psychosocial and Cultural Factors.

Unit 2: Mood Disorders and Suicide

a) Unipolar Depressive Disorders: Dysthymia Disorder, Major Depressive Disorder.

b) Causal Factors in Unipolar Mood Disorders - Biological Causal Factors, Psychological Causal Disorders

c) Bipolar and Related Disorders: Cyclothymic Disorder, Bipolar Disorder (I and II) and Causal Factors in Bipolar Disorders: Biological and Psychological Causal Factors.

d) Sociocultural Factors Affecting Unipolar and Bipolar Disorders, Treatment and Outcomes.

e) Suicide: The Clinical Picture and the Causal Pattern.

Unit 3: Personality Disorders

a) Clinical features of Personality Disorders.

b) Cluster A, Cluster B and Cluster C Personality Disorders.

c) General Sociocultural Causal factors, Treatments for Personality Disorders.

Unit 4: Sexual Variants, Abuse and Dysfunctions

a) Sociocultural Influence on Sexual Practices and Standards.

b) The Paraphilias: Causal Factors and Treatment for Paraphilias.

c) Gender Dysphoria, Sexual Abuse.

d) Sexual Dysfunctions: Forms and Treatment.

Book for study:

- Egan,G.& Reese,R.J. (2019).The Skilled Helper: A Problem-Management and Opportunity-Development Approach to Helping.(11th Edition) Cengage Learning.
- Gladding,S. T. (2014). Counselling: A Comprehensive Profession. (7thEd.). Pearson Education. New Delhi: Indian subcontinent version by Dorling Kindersley India

Books for reference:

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1

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS - I

Unit Structure

1.0 Objectives

1.1 Introduction

1.2 Characteristics of Schizophrenia – positive, negative and other Symptoms

1.3 Other Psychotic Disorders

1.4 Summary

1.5 Questions

1.6 References

1.0 OBJECTIVES

After reading this unit, you will the able to know:

- About one of the major psychotic disorder: schizophrenia.
- About the positive, negative and other symptoms of schizophrenia.
- The other psychotic disorders related to schizophrenia – schizophreniform disorder, brief psychotic disorder, schizoaffective disorder, delusional disorder.

1.1 INTRODUCTION

Schizophrenia is one of the most common psychotic disorders. It is a puzzling disorder wherein sometimes patient thinks and communicates clearly and is related with reality. And, sometimes the same individual's thinking and speech is disorganized and is not in touch with reality. Process disrupted by schizophrenia include those that involve an individual's thought, perception, emotions, motor functions etc.

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 recognizes 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.

1.2 CHARACTERISTICS OF SCHIZOPHRENIA

The term psychotic has been used to characterize much unusual behaviour where an individual seems to not be in touch with reality. Although in its strictest sense it usually involves delusions (which involve irrational

beliefs) and / or hallucination (experiencing things through the scenes in the absence of any external events such as hearing voices). Schizophrenia is just one of the disorders that involve psychotic behavior. This is a disorder that affects a person's thought, feeling, behavior, perception, motor functioning, motivation, judgment, insight and overall intrapersonal and interpersonal functioning. It is more common in men than women.

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 of distortion of normal behaviors. The positive symptoms include delusions, hallucinations and disorganized thought, disorganized speech and catatonic behavior. Negative symptoms involve deficit in normal behaviour or normal functioning. A negative symptom of schizophrenia affects an individual's speech, emotion and motivation. Examples of negative symptoms are avolition, alogia, restricted affect etc.

In order to diagnose an individual with schizophrenia, an individual should experience two or more of the positive symptoms and/or negative symptoms for at least one month.

Positive Symptoms of Schizophrenia:

a. Delusions:

Delusions are a misrepresentation of reality in an individual's content of thought. Delusions are difficult to believe. For example, an individual might believe that squirrels are aliens sent to earth on a reconnaissance mission. It is a fixed false belief that an individual holds. They will not give upon their belief in spite they are been presented with the evidence against their belief. Individual experiencing delusion are preoccupied with them.

Common types of delusions are:

i. **Persecutory Delusions:** Individual suffering from these delusions constantly feel that others intends to harm them or their loved ones. They are being watched or tormented by people whom they know.

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 think that they are great historical characters.

iv. **Delusion of Thought Insertions:** Individual suffering from this delusion feel that their thoughts are being controlled by outside forces

An intriguing view of delusion is that they may serve a purpose for people with schizophrenia, who are otherwise quite upset by the changes, taking

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:** In auditory hallucinations individuals hear heavy voices, music, different type of noises, in its absence.

ii. **Visual Hallucinations:** An individual suffering from this may see a stimuli in its absence.

iii. **Tactile Hallucinations:** It involves a feeling that some odd is happening to one's body. E.g., insects are crawling all over the 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 tomographty (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 involves understanding the speech of others, you might expect more activity in the area of the brain that involves language comprehension, on 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. Disorganized 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 disorganized 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 the

person with schizophrenia is questioned then they may give a totally unrelated reply.

At times, an individual with schizophrenia may use a word in a conversation which has no meaning in any dictionary. It has meaning only to them. This is 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. This is known as perseveration.

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.

People with schizophrenia are unpredictable and 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 carelerneres in eating, dressing, oral hygiene, etc.

Catatonic behaviour too can been seen in patients of schizophrenia. Catatonia referred to as a group of disorganised behaviours that reflect an extreme lack of responsiveness to the outside world. Catatonia involves a spectrum of motor dysfunctions from wild agitation to immobility. Catatonic excitement involves extreme uncontrollable agitation expressing a number of delusions and hallucinations.

Negative Symptoms of Schizophrenia:

In contrast to the active presentations that characterize 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 effect, apathy, and poverty of thought or speech.

a. Flat Affect:

Approximately two thirds of the people with schizophrenia exhibit what is called as flat affect. They do not show emotions. They may stare at you with vacant eyes, speak in a flat and toneless manner and seems to be unaffected by things going on around them. This condition in also known as blunted affect. The person remains in a freeze 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:

Avolition is an individual’s inability to initiate and persist in many important activities. It is also referred to as apathy. Avolition is an inability to be committed to a common goal directed activity. People with this symptom show little interest in most of the basic day-to-day activities, including personal hygiene. People with schizophrenia are unmotivated, disorganized and careless in the task that they undertake.

c. Alogia:

It refers to as poverty of speech. It is relative absence in either the amount or the content of speech. A person suffering with alogia may respond the question with very brief replies that have little content and many appear disinterested in the conversation. Or may not reply at all. Sometimes alogia takes the form a delayed comments or slow response to the questions. This deficiency in communication by some people with schizophrenia is believed to reflect a negative thought disorder rather than an in adequacy in communication skills.

Other Symptoms of Schizothrenia:

Some symptoms of schizophrenia are not prominently seen in all cases but they do frequently occur in schizophrenic as follows-

a. Inappropriate Affect:

An individual with schizophrenia 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 bedonic, pertaining to pleasure. It refers to the lack of pleasure experienced by people with schizophrenia. Individuals with anhedonia report no interest in an activities that they would typically be considered pleasurable, including eating, social relations, sexual interactions, etc.

c. Impaired Social Skills:

Most of the schizophrenic patients show poor social skills, such as difficulty in maintaning conversation, job and relationship.

Sub-Types of Schizophrenia:

DSM-IV-TR describes five major sub-types of Schizophernia - Paranoid schizophrenia, Disorganised schizophrenia, Catatonic schizophrenia, Undifferentiated schizophrenia and Residual schizophrenia.

- **Paranoid schizophrenia:** wherein the prominent feature is delusion and hallucination. The clinical picture is dominated by absurd and illogical beliefs.

- **Disorganized schizophrenia:** which is characterized by disorganized speech, disorganized behavior, and flat or inappropriate affect
- **Catatonic schizophrenia:** which involves pronounced motor signs that reflect great excitement or stupor.
- **Undifferentiated schizophrenia:** wherein an individual present the symptoms of two or more subtypes of schizophrenia.
- **Residual schizophrenia:** wherein individual experiences only negative symptoms of schizophrenia and absence of positive symptoms.

Unfortunately, research using the subtyping approach did not yielded major insights into the etiology or treatment of the disorder. Reflecting this, subtypes of schizophrenia are no longer included in DSM-5.

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.
4. Explain the subtypes of schizophrenia

1.3 OTHER PSYCHOTIC DISORDERS (THE SCHIZOPHRENIA SRECTRUM DISORDERS)

a. Brief Psychotic Disorder:

This disorder shows the sudden onset of one or more "positive" symptoms such as delusions, hallucinations, or disorganised speech or behaviour for the period of less than a month. The symptoms are not seen beyond one month.

b. Schizophreniform Disorder:

Some people experience the psychotic symptoms similar to schizophrenia, but for limited period, usually last from one month to six months. If the symptom seen beyond six months then the diagnosis of schizophrenia is given to that person. These symptoms disappear quickly, often for unknown reasons, and the person can usually resume his or her life as before. 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).

c. 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 with no signs or symptoms of depression or mania.

d. Delusional Disorder:

The major feature of delusional disorder is a persistent delusion or belief that is contrary to reality. These individual appears to be very normal until the point they talk about their delusion. This persistent delusion is not the result of an organic factor such as brain seizures or any severe psychotic disorder. Individual 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. The different types of delusional disorder are –

i. **Persecutory Delusion:** False belief that they or their loved ones are treated in a wrong or unkind manner.

ii. **Grandiose Delusion:** False belief that one has great, knowledge, or talent.

iii. **Jealous type of Delusion:** False belief, without any strong reason, that their partner is being unfaithful towards them.

iv. **Erotomanic type of Delusion:** False belief that another person is in love with them.

v. **Somatic Delusion:** False belief that one's has some diseased or some medical condition.

e. 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.

1.4 SUMMARY

Schizophrenia is a type of psychosis which is very common. 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. Hallucination

Is the experience of sensory events without any input from surrounding environment. The types of hallucination are visual, auditory, tactile and somatic. The individual suffering from schizophrenia also have disorganised speech and disorganized thought process due to which it become difficult to have a smooth conversation with them. They also display maladaptive behavior or catatonic behavior wherein they either have excessive motor movements or no movements at all.

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.

The other psychotic disorders are brief psychotic disorder, schizophreniform disorder, schizoaffective disorder, delusional disorder and shared psychotic disorder which falls on the same continuum of schizophrenia.

1.5 QUESTIONS

1. Discuss the various characteristics, positive and negative symptoms of schizophrerina.
2. Discuss the different types of psychotic disorders.
3. Write notes on the following.
    a. Hallucinations and its types.
    b. Types of Delusions.
    c. Subtypes of Schizophrenia

1.6 REFERENCES

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2

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS - II

Unit Structure

2.0 Objectives

2.1 Risk and Causal factors of Schizophrenia

2.2 Summary

2.3 Questions

2.4 References

2.0 OBJECTIVES

- After reading this unit, you will the able to know about various factors contributing to development of schizophrenia and other psychotic disorders.

2.1 RISK AND CASUAL FACTORS

Despite enormous efforts by researchers, this question still defies a simple answer. What is clear is that no one factor can fully explain why schizophrenia develops. Psychiatric disorders are not the result of a single genetic switch being flipped. Rather, a complex interplay between genetic and environmental factors is responsible.

Genetic factors:

- Genetic factors are clearly implicated in schizophrenia. It has long been known that disorders of the schizophrenia type are "familial" and tend to "run in families

- Having a relative with the disorder significantly raises a person's risk of developing schizophrenia. For example, the prevalence of schizophrenia in the first-degree relatives (parents, siblings, and offspring) of a patient with schizophrenia is about 10 percent. For second-degree relatives who share only 25 percent of their genes with the patient (e.g., half-siblings, aunts, uncles, nieces, nephews, and grandchildren), the lifetime prevalence of schizophrenia is closer to 3 percent.

- Study after study has shown a higher concordance for schizophrenia among identical, or monozygotic (MZ), twins than among people related in any other way, including fraternal, or dizygotic (DZ), twins.

- Concordance rates for schizophrenia are compared for the biological and the adoptive relatives of people who have been adopted out of their biological families at an early age (preferably at birth) and have subsequently developed schizophrenia. If concordance is greater

among the patients' biological than adoptive relatives, a hereditary influence is strongly suggested

- Having high heritability, researchers are attempting to locate the specific genes involved and to understand the factors that increase the genetically vulnerable a chances of developing the disorder. Combination of neuroimaging and genomics of the siblings show fMRI abnormalities less severe than those that appear in the brains of affected indi (Gur & Gur, 2010)
- At present, researchers have identified at least 19 possible genes discrete over chromosomes 1,2,5,6,8,11,13,14,19,22. Some of the functions of these chromosomes involve the neurotransmitters including dopamine and GABA, as well as serotonin and glutamate.
- Other factors that have been implicated in the development of schizophrenia include prenatal exposure to the influenza virus, early nutritional deficiencies, rhesus incompatibility, maternal stress, and perinatal birth complications.
- Urban living, immigration, and cannabis use during adolescence have also been shown to increase the risk of developing schizophrenia.
- Current thinking about schizophrenia emphasizes the interplay between genetic and environmental factors

Neurodevelopmental Perspective:

- According to neurodevelopmental perspective, schizophrenia is a disorder of development that arises during the years of adolescence or early adulthood due to alterations in the genetic control of brain maturation.
- Genetic vulnerability becomes evident if an individual is exposed to certain risks during early brain development.
- These risks can occur during the prenatal period in the form of viral infections, malnurition or exposure to toxins or during/shortly after birth if they exposed to injuries or viral infections, or if their mothers suffer birth complications.
- Harm to their developing brains may show up early in life in the form of decreased head size motor impairments in cognition and social functioning
- Support to the neurodevelopmental hypothesis also comes from the fact that an individual having their first psychotic episodes have a number of incomprehensible brain abnormalities as the result of the illness. As their illness proceeds they may show continued harmful changes through a process of "neuroprogression" in which the effects of schi interact with brain changes caused by normal aging

Neurochemistry:

- Based on the observation of the effect of drug to relax surgical patients, French physicians began to experiment these drug to treat an individual with psychotic disorders.
- Chlorpromazine was found to be effective to deal the psychotic symptoms. Chlorpromazine had its effect by blocking dopamine receptors. This gave rise to the idea that dopamine, more specifically, the d2 receptor, plays a role in development schizophrenia
- Gamma-aminobutyric acid (GABA) also appears to be involved in development of schizophrenia.
- Changes in the n-methyl-d-aspartate (NMDA) receptors also seem to play a role in development of psychotic symptoms. NMDA help to promote new learning in the brain by helping to build synapses. So, alternations in NMDA may, in turn, be related to changes in the neurons that make them less capable of supporting memory and learning.
- Symptoms of schizophrenia related to increase excitation, decreased inhibition and altered cognitive functioning would thus correspond to these changes in the neurotransmitters

Structural Abnormality:

- One of the earliest discoveries from neuroimaging methods was that the brain of an individual with schizophrenia have enlarged ventricles, the cavities within the brain that hold cerebrospinal fluid. This condition is called as Ventricular Enlargement, often occurs along side cortical atrophy, i.e. a wasting away of brain tissue.
- The loss of brain volume is particularly found in the prefrontal lobes, which is an area responsible for planning, inhibiting thoughts and behavior.
- Over the course of the illness, the cortex shows marked thinning throughout the brain, but particularly in the frontal lobes and temporal lobes, parts of the brain that process auditory info

Psychological Theories:

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.

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.

Psychosocial and Cultural Factors:

- Disturbed pattern of communication in a child's family environment could precipitate factor for development of schizophrenia.
- Researchers tried to study the modes of communication and behavior within families with schizophrenia member. Researchers attempted to document deviant patterns of communication and inappropriate ways that parents interacted with their children could be the factors playing role in development of schizophrenia.
- Clinicians thought these disturbances results in the development of defective emotional responsiveness and cognitive distortions which are fundamental to the psychological symptoms.
- Contemporary researchers approached the issues by trying to predict outcome or recovery in adults hospitalized for schizophrenia. According to them, instead of disturbed family as the cause, they view the family as a potential source of stress in the environment of the person who is trying to recover from a schizophrenia episode
- They explained the above with the help of an index which termed as Index of expressed emotion (EE) i.e. stress that family members create. This provides a measure of the degree to which family

members speak in ways that reflect criticism, hostile feelings and emotional overinvolvement or overconcern

- Researchers found that people living in families high in EE are more likely to suffer a relapse, particularly if they are exposed to high levels of criticism

- One fMRI study showed that people with schizophrenia experiences higher activation of brain regions involved in self-reflection and sensitivity to social situations when hearing speech high in EE compared to neural speech

- EE could never employ an experimental design as a result researchers can never draw casual links between EE and schizophrenia

- It is also very likely that the presence of an individual with schizophrenia creates stress within the family.

- Broader social factors such as social class and income can also contribute to the development of schizophrenia.

- In the first epidemiological study of mental illness in the US, Hollinshead and Redlich (1958) observed that schizophrenia was far more prevalent in the lowest socio-economic classes. Number of reserchers have since replicated this findings.

- Possible interpretation could be the individual with schizophrenia may be experiencing "downward drift". That is their disorder drives them into poverty, which interferes with their ability to work and earn a living

- Stress of living in isolation and poverty in urban areas contributes to the risk of developing of schizophrenia.

- Rates of schizophrenia is higher in individual who were born or raised in urban areas, not just those who moved there as adults.

- People living in other country - (i.e. Those who have "migrant" status) have higher rates of schizophrenia. Those who migrate to lower-status jobs and urban areas are more likely to suffer from schizophrenia.

- Other risk factors in sociocultural background include adversity in childhood including parental loss or separation, abuse and a target of bullying. In adulthood they are more vulnerable to first or subsequent episodes of psychosis.

- Individual with high genetic risk who are exposed to environmental stressors are more likely than others to develop schizophrenia.

- Recognizing that the cause of schizophrenia is multifaceted and develop over time, Stilo and Murray (2010) proposed a

"developmental cascade" hypothesis that integrates genetic vulnerabilities, damage occurring in the prenatal and early childhood periods adversity and drug abuse as leading, ultimately to change in dopamine expressed in psychosis

2.2 SUMMARY

Schizophrenia is a disorder that is result of interaction between biological factors, psychological factors and social factors, wherein biological factors play an important role.

2.3 QUESTIONS

Q.1 Discuss various risk and causal factors of schizophrenia.

2.4 REFERENCES

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3

MOOD DISORDER AND SUICIDE - I

Unit Structures

3.0 Objectives
3.1 Introduction
3.2 General Characteristics of Mood Disorder
3.3 Depressive Disorders
    3.3.1 Major Depressive Disorder
    3.3.2 Types of Depression
    3.3.3 Dysthymic Disorder
3.4 Disorders Involving Alterations of Mood
    3.4.1 Bipolar disorder
    3.4.2 Cyclothymic disorder
3.5 Summary
3.6 Questions
3.7 References

3.0 OBJECTIVES

After studying this unit you should:

- Comprehend the general characteristics of mood disorder.
- Know the various types of mood disorders.

3.1 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 emotions 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.

3.2 THE GENERAL CHARACTERISTICS OF MOOD DISORDERS

1. Individual feels overwhelming sadness or dysphoria.
2. Some may have 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 occurance 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.

3.3 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.

3.3.1 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 internal 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. Person experiences 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 moments.

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 moments 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 and 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.

3.3.2 Types of Depression:

A. Depressive episodes involving melancholic features.

B. Depressive episodes involving seasonal patterns.

A. Depressive episodes involving melancholic features:

Persons loose 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 at 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).

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 be early 20’s. D.N. Klein Taylor Dickstein and Harding found the three characterstics 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 Kersler 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 peaks by 45 to 59 years. Adults usually report the physical symptoms of depression. Finally, hospitalization is very rarely required except in the cases where depression leads to suicidal attempts

3.3.3 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 (1 year for children and adolescence). 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 differ from major depressive episode only on the basis of its course, i.e., chronic in nature and severity of the symptom. 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 even develop major depressive episode. Some of them may engage into substances abuse. Hence, clinicians may diagnose wrongly, and attempts may be done to reduce feelings of hopelessness and worthlessness.

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.

3.4 DISORDERS INVOLVING ALTERATIONS OF MOOD

There are two types of disorder involving mood alterations.

1) Bipolar disorder 2) Cyclothymic disorder

3.4.1 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 obsessively.

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 I:** 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 disorder II:** 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.

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 and 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.

3.4.2 Cyclothymic disorder:

It is similar in many ways to dysthymic disorder in its severity and duration of symptoms. People with cyclothymic disorder experience alterations between dysphoric and hypomanic episode for over the span of 2 years (1 year for children and adolescene). Hypomanic episodes are the less intense and less disruptive euphoric state. They display unusually dramatic and recurrent mood shifts. The elation may not be severe enough to be diagnosed as manic episode and 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. The behaviour is not severe enough to require hospitalisation or immediate intervention.

The average onset of this disorder in between 19 to 22 years. This disorder begins with minor mood changes or minor cyclothymic mood swings.

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.

3.5 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 briefy explained. Two types of disorder involving mood alteration was also discussed, which included bipolar disorder and cyclothymc disorder. Types of bipolar disorder, its prevalence and course was also discussed.

3.6 QUESTIONS

1. Discuss the general characteristics of mood disorders.
2. Explain the various characteristics of major depressive episodes.

3. Discuss :

   a. Depressive episodes involving melancholic features.

   b. Depressive episodes involving seasonal patterns.

   c. Dysthmic Disorder

4. Discuss Bipolar and Cyclothymic disorder.

3.7 REFERENCES

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4

MOOD DISORDER AND SUICIDE - II

Unit Structures

4.0 Objectives

4.1 Casual factors in Unipolar and Bipolar Disorders

4.1.1 Biological Perspectives

4.1.2 Psychological Perspectives

4.1.3 Behavioural and Cognitive Perspective

4.1.4 Socio Cultural and Interpersonal Perspectives

4.2 Treatment of Mood Disorders

4.2.1 Biological Treatment

4.2.2 Psychological Treatment

4.3 Suicide

4.3.1 Causes of Suicide

4.3.2 Assessment and Treatment

4.4 Summary

4.5 Questions

4.6 References

4.0 OBJECTIVES

After studying this unit you should:

- Understand the theories and treatment of Mood disorders.
- Became aware about suicide its causes, assessment and treatment.

4.1 CAUSAL FACTORS IN UNIPOLAR AND BIPOLAR 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.

4.1.1 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, Neak & Kender 2006) The risk in higher for the first degree relatives of children of depressed individuals (Lieb et al 2002) The studies of three generation of children, parents and grandparents, show that this disorder tend to run in families. If major depressive disorder is present in parents and grandparents, children are more likely to show symptoms of psychopathology.

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 close relative who has disorder out of them approximately 30 to 40 of them have a major likelihood of having major depression (Sullivan, Neals & Kendler 2009).

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

4.1.2 Psychological Perspectives:

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

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.

4.1.3 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 in 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 a 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 consequences women are more likely to experience depression.

These individuals are convinced of facture 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".

4.1.4 Socio Cultural and Interpersonal Perspectives:

Interpersonal model of mood disorder: (Myrna Werssman, 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).

4.2 TREATMENT OF MOOD DISORDERS

4.2.1 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 Reputake Inhibitors (SSRIS).

Tricyclic antidepressants (TCAS): these chemicals have three ring structures. They are available in the market with trade names like Elavit, 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 Reputake Inhibitors – (SSRIS): It is generally used as an alternative to tricylic and MAIOS. They block the uptake of serotonin, so that more of serotonin in 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.

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

Lithium carbonate in 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 maintance 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 anasthesia 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) in 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.

4.2.2 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 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 in 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 summarize, 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):

This therapy is especially seem to be effective to deal with relapse episode of Bipolar disorder. 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.

4.3 SUICIDE

Suicide is one of the most common causes of death among youngsters and elderly members of society. Suicide in often associated with depression, it is a way a escaping from hard realities of life. There seem to be 4 phases of suicide: Suicidal Ideation, Suicide Planning, Suicide Attempt and Suicide.

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 in 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 in 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 then men. The study found that suicide rate for women in the age group of 19-29 years in 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).

4.3.1 Causes of Suicide:

i. Biological perspective:

In one 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 risks 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 in 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 succeptible 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 in 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, then any one disorder alone. Hawton & Colleagues (2003) found that prevalence of previous attempts and repeated attempts doubled if a combination of disorder in 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 risks 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 national 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.

iii. 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.

4.3.2 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.

4.4 SUMMARY

In this unit we had discussed the 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.

4.5 QUESTIONS

1. Discuss the various causal factors or theories of mood disorders.
2. Explain the various treatments of mood disorder.
3. Explain Suicide its causes, assessment and treatment.

4.6 REFERENCES

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5

PERSONALITY DISORDERS - I

Unit Structure

5.0 Objectives
5.1 Introduction
5.2 Nature or Clinical Feature of Personality Disorder
5.3 Classification of Personality Disorders:
  5.3.1 Paranoid Personality Disorder
  5.3.2 Schizoid Personality Disorder
  5.3.3 Schizotypal Personality Disorder
5.4 Summary
5.5 Questions
5.6 References

5.0 OBJECTIVES

After studying this unit you should be able to:

- Understand the nature, definition and features of Personality disorders.
- Know the classification of Personality Disorders.
- Comprehend the characteristics as well as theories and treatment of Paranoid Personality Disorder, Schizoid Personality Disorder, Schizotypal Personality Disorder.

5.1 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 into 10 different types and classifies understand 3 clusters: Cluster A, Cluster B and Cluster C. We will discuss the characteristic features, theories as well as treatment of the various personality disorder listed in DSM 5.

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

5.2 NATURE OF PERSONALITY DISORDERS

Individuals who have maladaptive personality traits can be called as having 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. So, when an individual have maladaptive way of perceiving, relating to and thinking about the environment and others then he/she is said to be having personality disorder.

Personality Disorders are patterns of behavior that are deeply ingrained and are manifested primarily as exaggerations. The category of Personality Disorder 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 defined Personality Disorder as "those characteristics that are inflexible and maladaptive and cause either significant functional impairment or subjective distress”. It is 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. Generally, these are life-long patterns often recognizable by the time of adolescence or earlier. Although these persons cause themselves and others much unhappiness, their behavior is usually Egosyntonic and there is little motivation for change (Arkem 1981).

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. The 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.

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.

5.3 CLASSIFICATION OF PERSONALITY DISORDERS:

DSM – IV – TR has classified personality disorders in to three categories covering a total of 10 personality disorders which are listed in the following table.

We will discuss each of these Clusters in detail.

Cluster A:

Cluster A of personality disorder is characterized as having odd and eccentric behavior. Paranoid Personality Disorder, Schizoid Personality Disorder and Schizotypal Personality Disorder are the Cluster A disorder. An individual having any of the disorder from this Cluster seem to be having a very strange and unusual personality trait. People around them might perceive this individual odd, usual and peculiar.

5.3.1 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.

5.3.2 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 as like with other personality disorder even they do not acknowledge that they are having any problem.

5.3.3 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

Very few controlled studies concerning the treatment of this disorder is available. 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.

Cluster A personality disorder, particularly, Schizoid personality disorder and Schizotypal personality disorder are consider to be falling on the continuum of schizophrenia wherein schizophrenia is the extreme condition. Individuals with this disorder tend not to improve over time and some move on to develop schizophrenia.

5.4 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.

5.5 QUESTIONS

1) Define Personality Disorders and discuss the various features of Personality Disorders.

2) Discuss the Classification of Personality Disorders.

3) Write short notes on the following:

    a) Paranoid Personality Disorder

    b) Schizoid Personality Disorder

    c) Schizotypal Personality Disorder

5.6 REFERENCES

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6

PERSONALITY DISORDERS - II

Unit Structure

6.0 Objectives
6.1 Cluster B Disorders
    6.1.1 Antisocial Personality Disorder
    6.1.2 Borderline Personality Disorder
    6.1.3 Histrionic Personality Disorder
    6.1.4 Narcissistic Personality Disorder
6.2 Cluster C Disorder
    6.2.1 Avoidant Personality Disorder
    6.2.2 Dependent Personality Disorder
    6.2.3 Obsessive-Compulsive Personality Disorder
6.3 Personality Disorder: The Bio-psychosocial Perspective
6.4 Summary
6.5 Questions
6.6 References

6.0 OBJECTIVES

After studying this unit you should be able to comprehend the characteristics as well as theories and treatment of Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic and Narcissistic Personality disorders, Avoidant Personality Disorder, Dependent Personality Disorder and Obsessive Compulsive Personality Disorder.

6.1 CLUSTER B DISORDERS

Individuals having this cluster of disorders have in common a tendency to be dramatic, emotional and erratic. Antisocial personality disorder, Borderline personality disorder, Narcissistic personality disorder and Histronic personality disorder are Cluster B disorders. Individual having a disorder from this Cluster tend to be very much unpredictable and unreliable.

6.1.1 Antisocial Personality Disorder:

Antisocial personality disorder has been known since a long time, but different labels were used to refer to this disorder like sociopaths or psychopaths. 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.

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 characteristics of this disorder are as follows:

1. People with this disorder wreak havoc in society and for this reason they have been the focus of great deal of research.
2. The lifetime 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 disoreder). 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. Inadequate motivated antisocial behavior.

ii. Unreliability.

iii. Untruthfulness and insincerity.

iv. Superficial charm of good intelligence

v. Absence of "Nervousness" or Psychoneurotic manifestations.

vi. Lack of remorse or shame.

vii. Poor judgment and failure to learn from experiences.

viii. Pathological egocentricity and incapacity for love.

ix. Specific loss of insight.

x. Unresponsiveness in general interpersonal relations.

xi. Sex life impersonal, trivial and poorly integrated.

xii. 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-wroth, 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 characteristic 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 diagnostic criteria for this disorder also include 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 can 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 behaivours as they age.

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 off spring 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 noriton 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 whey 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 nor 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 emphasizes 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.

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 guild 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

6.1.2 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.

Characteristics of Borderline Personality Disorder:

Some important characteristic features of Borderline Personality Disorder are as follows:

i. Individuals with borderline personalities are frequently impulsive and unpredictable, angry, empty, and unstable.

ii. 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.

iii. 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.

iv. The inappropriate intensity of their relationship results in recurrent experiences of distress and rage. People with this disorder experience anger and hostility. Their interpersonal relationships are always disturbed and unstable. They commonly have a history of intense but stormy relationship, typically involving over idealization of friends or lovers that later end in bitter disillusionment and disappointment (Gunderson & Singer, 1986). They often explode in rage when they experience neglect and abandonment by their lover or some important person in their life.

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 have chronic feeling of boredom and a low tolerance for frustration. The chronic feelings of boredom 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. self- mutilation is one of the most discriminating signs for borderline personality (Widiger et al, 1986).

viii. 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.

ix. 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 mutilitation.

x. They are highly sensitive to stress and often break down displaying brief psychotic reactions in the presence of intense stressful situations. 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).

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.

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:

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.

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

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 dictomise 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.

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

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.

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

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.

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: sucidial behaviour, attempts or threats, psychotic like episodes, threat or harm to others, etc.

6.1.3 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.

9. Their cognitive style is impressionistic. They view situations in a very global, black and white term.

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.

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.

6.1.4 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.

6.2 CLUSTER C DISORDER

Cluster C is characterized as anxious and fearful. Avoidant personality disorder, Dependent personality disorder and Obsessive Compulsive personality disorder are Cluster C disorders.

6.2.1 Avoidant Personality Disorder:

Individuals having avoidant personality disorder refrain form 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

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 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.

6.2.2 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.

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.

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.

6.2.3 Obsessive-Compulsive Personality Disorder:

Individuals with obsessive- compulsive personality disorder are too preoccupied with concern about neatness and to be perfect. 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. And so they are unable to take decisions.
- People with this disorder have a poor ability to express emotions and they have few intimate emotions.
- They have a preoccupation with details and perfection that very often interferes with their normal functioning. So they are often 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 are very moralistic. 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.
- 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. This is commonly found among men than women.

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.

6.3 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.

6.4 SUMMARY

DSM V TR has classified personality disorders in to three categories covering a total of 10 personality disorders which were discussed in detail. After discussing the characteristics symptoms, theories and treatment it can be concluded that the prognosis of most of these disorders is difficult as personality traits are very much ingrained in the person and most them do not acknowledge that they are having defective personality traits.

6.5 QUESTIONS

1. Explain the Characteristic features of Antisocial Personality Disorder
2. Discuss the various Theories and Treatment of Antisocial Personality Disorder
3. Discuss the characteristic features of Borderline Personality Disorder
4. Discuss the various Theories and Treatment of Borderline Personality Disorder
5. Write short notes on the following:
    a) Histrionic Personality Disorder
    b) Narcissistic Personality Disorder
    c) Avoidant Personality Disorder
    d) Dependent Personality Disorder
    e) Obsessive-Compulsive Personality Disorder

6.6 REFERENCES

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7

SEXUAL VARIANTS, ABUSE AND DYSFUNCTIONS - I

Unit Structure

7.0 Objectives

7.1 Introduction

7.2 Abnormal Sexual Behaviour

7.3 Sociocultural Influence on Sexual Practices and Standards

7.4 Sexual Abuse

7.5 Paraphilias

 7.5.1 Causes of Paraphilias

 7.5.2 Treatment of Paraphilias

7.6 Summary

7.7 Questions

7.8 References

7.0 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.

7.1 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.

7.2 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, pedophlia, etc., include inflicting pain to sexual partners.

7.3 SOCIOCULTURAL INFLUENCE ON SEXUAL PRACTICES AND STANDARD

Although some aspects of sexuality and mating, such as men's greater emphasis on their partner's attractiveness, are cross culturally universal (Buss, 1989, 2012), others are quite variable. For example, all known cultures have taboos against sex between close relatives, but attitudes toward premarital sex have varied considerably across history and around the world.

Ideas about acceptable sexual behavior also change over time. Less than 100 years ago, for example, sexual modesty in Western cultures was such that women's arms and legs were always hidden in public. Although this is by no means the case in Western cultures today, it remains true in many Muslim countries.

Despite the substantial variability in sexual attitudes and behavior in different times and places, people typically behave as though the sexual standards of their own time and place are obviously correct, and they tend to be intolerant of sexual nonconformity. Sexual nonconformists are often considered evil or sick. We do not mean to suggest that such judgments are always arbitrary. There has probably never existed a society in which Jeffrey Dahmer, who was sexually aroused by killing men, having sex with them, storing their corpses, and sometimes eating them, would be considered psychologically normal. Nevertheless, it is useful to be aware of historical and cultural influences on sexuality. When the expression or the acceptance of a certain behavior varies considerably across eras and cultures, we should at least pause to consider the possibility that our own stance is not the only appropriate one.

7.4 SEXUAL ABUSE

Sexual abuse is sexual contact that involves physical or psychological coercion or at least one individual who cannot reasonably consent to the contact (e.g., a child). Such abuse includes pedophilia, incest, and rape, and it concerns society much more than any other sexual problem. It is somewhat ironic, then, that of these three forms of abuse, only pedophilia is included in DSM-5. This partly reflects the seriousness with which the society views these offenses and its preference for treating coercive sex offenders as criminals rather than as having a mental disorder (although obviously many criminals also have mental disorders)

Childhood Sexual Abuse:

The past few decades have seen intense concern about childhood sexual abuse, with an accompanying increase in relevant research. There are at least three reasons for including some discussion of this here. First, there are possible links between childhood sexual abuse and some mental disorders, so such abuse may be important in the etiology of some disorders. Second, much evidence suggests that, broadly defined, childhood sexual abuse is more common than was once assumed, and it is important to understand some of its causes. Third, some dramatic and well-publicized cases involving allegations of childhood sexual abuse have raised very controversial issues such as the validity of children's testimony and the accuracy of recovered memories of sexual abuse.

The prevalence of childhood sexual abuse depends on its definition, which has varied substantially across studies. For example, different studies use different definitions of "childhood," with the upper age limit ranging from 12 to as high as 19 years. Some studies have counted any kind of sexual interaction, even that which does not include physical contact (e.g., exhibitionism); others have counted only physical contact; others have counted only genital contact; and still others have counted consensual sexual contact with a minor. A recent review of data from 22 countries estimated that 7.9 percent of men and 19.7 percent of women had suffered sexual abuse prior to age 18. The highest rates were from African countries, and the lowest rates were from Europe; U.S. figures were intermediate. Obviously "prior to age 18" comprises a wide range of ages, and, for example, age 17 is not always viewed as part of childhood.

Consequences of Childhood Sexual Abuse:

Childhood sexual abuse may have both short-term and long-term consequences. The most common short-term consequences are fears, posttraumatic stress disorder (PTSD), sexual inappropriateness (e.g., touching others' genitals or talking about sexual acts), and poor self-esteem, but approximately one-third of sexually abused children show no symptoms (e.g., Kendall-Tackett et al., 1993; McConaghy, 1998).

Associations between reports of childhood sexual abuse and adult psychopathology have been commonly reported (Maniglio, 2009). Specific examples include borderline personality disorder (Bandelow et al., 2005; Battle et al., 2004), somatization disorder with dissociative symptoms (Sar et al., 2004), and dissociative identity disorder (Maldonado & Spiegel, 2007; Ross, 1999). A wide variety of sexual symptoms have also been alleged to result from early sexual abuse (e.g., Leonard & Follette, 2002; Loeb et al., 2002; see review in Maniglio, 2009), ranging, for example, from sexual aversion to sexual promiscuity.

7.5 PARAPHILIAS

1. Pedophilia and Incest:

The most tragic deviant pattern of arousal is a sexual attraction to children called pedophilia. The 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 alteast 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 penetrates 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. If the children are from pedophilics own family, such as daughters or son, then it is called incest. Victims of insects 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.

2. 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. 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.

3. Transvestic Disorder:

An elaborate form of fetishism is Transvestism, also referred as cross - dressing, in which hetro sexual 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.

4. 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. They get excited to see fear and disgust on the partner's face. Sometimes the activities can go out of control, for example, Autoerotic asphyxiation. In this activity, sexual arousal in gained by oxygen deprivation caused by hanging or chest compression.

5. Frotteurism:

It is another paraphilia wherein an individual 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.

6. Voyeurism and Exhibitionism:

Voyeurism refers to the practice of observing an unsuspecting person undressing or naked in order to experience sexual aorousal. This type of paraphilia involves secretly watching another individuals nude, bathing in sexual positions. Most pedophilics are hetrosexual males abusing young girls. Homosexual pedophilics typically abuse young boys. Women can be pedophilics but it is rare.

7. Exhibitionism:

It 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.

7.5.1 Causes of Paraphilias Biological Causes:

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. Some studies have found links between endocrine abnormalities and paraphilia. Some studies suggest a relationship between testosterone abnormalities and sexually aggressive paraphilias.

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. Psychodynamic Theory:

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

b. Behavioural Theory:

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.

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.

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:

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.

7.5.2 Treatment of Paraphilias:

Biological Treatment:

a. Certain drugs are sometimes used to treat paraphilias, the most popular drug is an anti- androgen drug called, Medroxy proqesterone acetate. This drug eliminates the person's sexual desire and fantasy by reducing his testoterone levels. But fantasies and arousal soon returns as soon as the drug is removed. This drug is useful for dangrous 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 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?
3. Write a Short Note on Sociocultural influence on Sexual practices and standards.

7.6 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.

7.7 QUESTIONS

Q1. Discuss the different types of paraphilias.

Q2. Explain the various causes and treatment of paraphilias.

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8

SEXUAL VARIANTS, ABUSE AND DYSFUNCTIONS - II

Unit Structure

8.0 Objectives

8.1 Sexual Dysfunctions

8.1.1 Sexual Desire Disorders

8.1.2 Sexual Arousal Disorders

8.1.3 Orgasmic Disorders

8.1.4 Sexual Pain Disorders

8.1.5 Causes of Sexual Dysfunction

8.1.6 Treatments Suggested for Sexual Dysfunctions

8.2 Gender Dysphoria / Gender Identity Disorder

8.2.1 Symptoms

8.2.2 Causes of GID

8.2.3 Treatment of GID

8.3 Sexual Disorders: The Bio psychosocial Perspective

8.4 Summary

8.5 Questions

8.6 References

8.0 OBJECTIVES

After reading this unit you will be able to know :

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

8.1 SEXUAL DYSFUNCTIONS

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

8.1.1 Sexual Desire Disorders:

a. Hypoactive Sexual Desire Disorder:

The person seems to have no interest in any type of sexual activity. It is absence of sexual fantasies and thought. This can be a lifelong problem or it can happen over the period of time.

b. Sexual Aversion Disorder:

In this, the individual not only have 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.

8.1.2 Sexual Arousal Disorders:

Disorders of arousal refers to male erectile disorder and female sexual arousal disorder. Individuals with arousal disorders have frequent sexual urgers and fantasies and strong desire to have sex. The individual having erectile disorder have difficulty becoming aroused, that is, a male has difficulty achieving 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 in present during a person's entire sexual life. Acquired arousal disorder being 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 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.

8.1.3 Orgasmic Disorders:

a. Inhibited Orgasm (Female Orgasmic Disorder and Male Orgasmic Disorder):

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.

8.1.4 Sexual Pain Disorders:

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

a. Dyspareunia:

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

It may also be experienced by an individual before or after the intercourse. The disorder may occur both in male as well as a female.

b. Vaginismus:

More common than dyspareunia is vaginismus. In this condition, occurring in women, the pelvic muscles located in the outer third of the vagina under go involuntary spasms where intercourse is attempted. Women report sensation of "ripping, burning or tearing during attempted intercourse". In some females, even the thought of vaginal insertion may result in muscle spasm.

8.1.5 Causes of Sexual Dysfunction:

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 chord 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.

c. **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

b. **Attitude and Cognition about Sex:** 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.

c. **Performance anxiety:** This is yet another blockade for people to enjoy sex. There in 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. 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.

8.1.6 Treatments Suggested for Sexual Dysfunctions:

1. Biological Therapy:

Certain medical conditions like diabetes automatically lead to sexual dysfunctionality. 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 in 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 complement 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.

8.2 GENDER DYSPHORIA / GENDER IDENTITY 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.

DSM 5 renamed the diagnostic label of gender identity disorder to Gender Dysphoria to remove the stigma associated with the term disorder.

8.2.1 Symptoms:

1. Strong and persistent identification with the other sex:

I. In children, this is manifested by repeatedly stated desire to be or insistence that he or she is the other sex.

II. In boys, preference for cross dressing or stimulating female dress. In girls, insistence on wearing only masculine clothing.

III. Strong and persistant preference for cross sex roles in play and in fantasies.

IV. Strong preference for playmates of the other sex.

V. 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 in appropriateness 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. 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.

8.2.2 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 masculisation 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.

8.2.3 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?

8.3 SEXUAL DISORDERS: 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.

8.4 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.

8.5 QUESTIONS

Q1. Write a note on Gender Identity Disorder.

Q2. Discuss the different types of sexual dysfunction and its causes.

Q3. Discuss various treatment options for sexual dysfunctions.

8.6 REFERENCES

- Oltmanns, T.F., Emery, R.E. (2010). Abnormal Psychology 6th ed., New Jersy : Pearson Prentice Hall
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