PSYCHOPATHOLOGY

M.A. Psychology, Final, PAPER I

Lesson Writers

Prof.Shanti V.Prasad
Department of Psychology
Andhra University
Visakhapatnam.

B.Nalini
Department of Psychology
Andhra University
Visakhapatnam.

N.Sucharita
Department of Psychology
Andhra Pradesh
Visakhapatnam

A.Mrudula
Department of Psychology
Andhra University
Visakhapatnam

Editor:
Prof. Shanti V.Prasad
Department of Psychology
Andhra University, Visakhapatnam

Academic Advisor for the Course
Prof.U.Vindhya
Department of Psychology
Andhra University, Visakhapatnam

Director
Prof. V.Chandrasekhara Rao

CENTRE FOR DISTANCE EDUCATION

Acharya Nagarjuna University
Nagarjuna Nagar – 522 510.

Ph: 0863 – 229399, (08645) 261023, 261024
Cell : 98482 85518
e-mail: anucde@yahoo.com
Website:www.nagarjunauniversity.ac.in

PAPER – I : PSYCHOPATHOLOGY

SYLLABUS

Unit I

Abnormal Psychology : What is Abnormal Psychology ? The epidemiology of Maladaptive Behaviour – The Historical Background of Abnormal Psychology – Physiological and Organic Behaviour – seeking help for Abnormal Behaviour – Research in Abnormal Psychology.

Theoretical Perspective on Maladaptive Behaviour: The role of the Theory in Abnormal Psychology – The Biological Perspective – The Behavioral Perspective – The Community – Cultural Perspective – An integral approach.

Classification and Assessment: Classification: Categories of Maladaptive Behaviour – Advantages and Disadvantages – Vulnerability, Resiliency and coping – The Multiaxial approach – DSM IV – the major diagnostic categories – Evaluation of DSM Multiaxial Approach – Research on classification – assessment: The basis of classification – ICD – 10 classification.

Unit II

Stress, coping and Maladaptive Behaviour: Stress and Coping – Social Support – Stressful situation and life Transitions – Clinical Reactions to stress – Treating stress – Related Problems.

Psychological Factors and Physical Symptoms: Psychological, Social and Bodily Interactions – Psychophysiological Disorders – Somatoform disorders – Factitious Disorders and Malingering.

Anxiety Disorders: Generalized Anxiety Disorder – Panic Disorder – Obsessive Compulsive Disorder – interpreting and treating anxiety Disorders.

Sexual Varations and Disorders: Changing views of sexual Behaviour – Homosexuality – Sexual Dysfunctions – Gender identify Disorder – The paraphilias – Sexual Victimizations.

UNIT III

Personality Disorders: Classifications – Odd or Eccentric Behaviours – Dramatic, Emotional or Erratic Behaviour – Anxious or Fearful Behaviours – Treatment of Personality Disorders.

Mood Disorders: Depression – Depressive Disorders – Theoretical Perspectives on Depression – Bipolar Disorders – Suicide.

Schizophrenic Disorders: Characteristics and probable causes – Major subtypes of schizophrenia – What causes schizophrenic Disorder? – Methods of Studying Genetic and Environmental Factors – Psychological Research – Treatment, and Outcome Attention, Cognition and the Schizophrenic process – Therapeutic Approaches.

UNIT IV

Cognitive Imairment Disorders: The Brain – An interactional Perspective – Delirium – Dementia – Amnestic Disorders – An Integrative Approach to Brain Disorders.

Substance Related Disorders: Substance use Disorders – Substance Induced Disorders – Alcohol – related Disorders – Eating Disorder – Therapy for Children and Adolescents.

Development Disorders: Autistic Disorder – Mental Retardation.

UNIT V

Therapies and their outcomes: Psychotherapy – Cognitive Behavioural therapies – Group Therapy – Research on the Psychological therapies – Integration of Psychologically based therapeutic approaches – Biological Therapies – Hospitalizations.

Society's Response to Maladaptive Behaviour: Types of prevention – Sites of prevention – The Challenge of prevention – Treatment in the community – Legal Aspects of Treatment and prevention.

References

Sarason I.G. & Sarason, B.R. (1998). Abnormal Psychology. The problem of maladaptive behavior VIII edition, prentice Hall of India Private Limited, New Delhi.

Ronald F.Comer (1996). Fundamentals of Abnormal Psychology: Edition, W.H.Freeman and Company, New York.

PAPER – I : PSYCHOPATHOLOGY

MODEL QUESTION PAPER

Marks : 100 Time:3 Hours

*Answer any **five** questions*
All questions carry equal marks.

1. Trace the historical background of Abnormal Psychology.

2. Describe the classification system; what are its advantages and disadvantages.

3. Describe some of the major Psychophycological disorders.

4. What are anxiety disorders? Briefly explain the various types and how they can be treated.

5. Explain symptoms, etiology and treatment of any two personality dis orders.

6. Explain briefly the symptomatology, types and cansative factors of Schizophremo.

7. The Common disorders of Childhood and adolescence?

8. Write about notes on

    1. Amnestic disorder.
    2. Substance related disorders
    3. Cognitive – Behavioral therapies
    4. Societies response to maladaptive behaviour.

LESSON 1

ABNORMAL PSYCHOLOGY

1.1. Objectives

- To know the definition of abnormal psychology.
- To have an idea of the epidemiology of maladaptive behaviour.
- To understand the historical background of abnormal psychology.
- To know about physiological and organic aspects of maladaptive behaviour.
- To understand the importance of seeking help for abnormal behaviour.
- To know about the fundamentals of research in abnormal psychology.

1.2 Structure

1.2.1. What is abnormal psychology?

1.2.2. The epidemiology of maladaptive behaviour.

1.2.3. The historical background of abnormal psychology.

1.2.4. Physiological and Organic behaviour.

1.2.5. Research in Abnormal Psychology.

1.3. What is abnormal psychology?

Ideas about acceptable behaviour change over time, sometimes slowly, sometimes more rapidly. Similarly, ideas about psychological abnormality change from century to century and from society to society. Abnormality is a relative concept.

1.3.1. Norms

When we ask how a society defines psychological abnormality, what we are asking is where that society draws the line between acceptable and unacceptable patterns of thought and behaviour. Acceptability is gauged by a variety of measuring sticks, but perhaps the most commonly used is the society's norms.

Every human group lives by a set of norms – rules that tell us what is right and wrong to do, and when and where and with whom. Such rules circumscribe every aspect of our existence, from our most far-reaching decisions to our most prosaic daily routines. To outsiders, such norms may seem odd and unnecessarily complicated, but adults who have been raised in the culture and who have assimilated its norms through the process of socialization simply take them for granted. Far from regarding them as folkways, they regard them as what is right and proper. And consequently they will tend to label as abnormal any one who violates these norms. In a small, highly

integrated society, there will be little disagreement over norms. In a large, complex society, on the other hand, there may be considerable friction among different groups over the question of what is right and proper.

The use of norms as a standard for judging mental health may seem inappropriate. Norms are not universal and eternal, truths; on the contrary they vary across time and across cultures. Therefore, they seem a weak basis for applying the label abnormal to anyone. Furthermore, whether or not adherence to norms is an appropriate criterion for mental health, it may be called an oppressive criterion. It enthrones conformity as the ideal pattern of behaviour and it stigmatizes the nonconformist. For norms contain value judgments. People who violate them are not just doing something unusual; they are doing something wrong. Yet despite these objections, norms remain a very important standard for defining abnormality. Though they may be relative to time and place, they are nevertheless so deeply ingrained that they seem absolute, and hence anyone who violates them appears abnormal. Important as norms are, they are not the only standard for defining abnormal behaviour.

1.3.2. Statistical Rarity

From a statistical point of view, abnormality is any substantial deviation from a statistically calculated average. Those who fall within the "golden mean" – those, in short, who do what most other people do – are normal, while those whose behaviour differs from that of the majority are abnormal.

This criterion is used in some evaluations of psychological abnormality. The diagnosis of mental retardation, for instance, is based in large part on statistical accounting. Those whose tested intelligence falls below an average range for the population and who also have problems coping with life – which, with intelligence far lower than the average, is likely to be the case are labeled retarded. However, careful statistical calculations are not always considered necessary in order to establish deviance. In the extreme version of the statistical approach, any behaviour that is simply unusual would be judged abnormal.

The statistical-rarity approach makes defining abnormality a simple task. One has only to measure the individual's performance against the average performance; if it falls outside the average range, it is abnormal. However, there are obvious difficulties with this approach. It has no values; it lacks any system for differentiating between desirable and undesirable behaviour. Such a point of view is potentially very dangerous, since it discourages and denigrates even valuable deviations from the norm.

1.3.3. Personal Discomfort

An alternative criterion for defining abnormality is personal discomfort. If people are content with their lives, then their lives are of no concern to the mental health establishment. If on the other hand, they are distressed over their thoughts or behaviour, then they require treatment. This is a more liberal approach in that it makes people the judges of their own normality, rather than subjecting them to the judgment of the society or the diagnostician. And this is the approach that is probably the most widely used in the case of the less severe psychological disorders. Most people in psychotherapy are there not because anyone has declared their behaviour abnormal but because they themselves are unhappy.

Reasonable as it may be in such cases, the personal discomfort criterion has obvious weaknesses as a comprehensive standard for defining abnormal behaviour. The same behaviour pattern may cause very different degrees of dissatisfaction in different people. If we focus on dissatisfaction, we are left with no stable criterion for evaluating the behaviour itself. The lack of an objective standard is especially problematic in the case of behaviours that cause serious harm or are socially disruptive. Furthermore, even if a behaviour pattern is not necessarily harmful, it may still merit psychological attention in the absence of personal distress. People who believe that their brains are receiving messages from outer space may inflict no great pain on others and may report no unhappiness with their lives, yet in the eyes of most people they would appear to be in need of psychological treatment.

1.3.4. Maladaptive Behaviour

A fourth criterion for defining behaviour as abnormal is maladaptiveness. Here the question is whether the person, given that behaviour pattern, is able to meet the demands of his or her life – hold down a job, deal with friends and family, pay the bills on time, and the like. If not, the pattern is abnormal. This standard overlaps somewhat with that of norm violation. After all, many norms are rules for adapting our behaviour to our own and our society's requirements.

The maladaptiveness standard is also connected to that of personal discomfort, for it is often the consequence of maladaptive behaviour that cause us discomfort. At the same time, the maladaptiveness standard is unique in that it concentrates on the practical matter of getting through life with some measure of success.

This practical approach makes the maladaptiveness standard a useful one. Those whose behaviour makes them unable to cope with the everyday demands of life would seem obvious candidates for psychological help. Furthermore, the maladaptiveness standard is favoured by many professionals for its elasticity – because it focuses on behaviour relative to life circumstances, it can accommodate many different styles of living. But as with the personal-discomfort criterion, this liberalism is purchased at the cost of values, and it raises certain moral questions. Like the norm-violation standard, it does seem to favour conformity, since, in general, those who adapt well are those who "fit in".

1.3.5. Deviation from an Ideal

Several psychological theories describe an ideally well-adjusted personality, any deviation from which is interpreted as abnormal to a greater or lesser degree. Since the ideal is difficult to achieve, most people are seen as being poorly adjusted at least part of the time. One may strive to achieve the ideal, but one seldom makes it.

In light of such theories, many people may judge themselves to be abnormal, or at least in need of psychological treatment, even though they have no particularly troubling behavioural symptoms. For example, a woman may have a number of friends and a reasonably satisfying job and yet consider herself a candidate for psychotherapy because she lacks some thing – an intimate relationship with another person, a sense of realizing her full potential – that is held up as a criterion for mental health by one or another theory. This standard is obviously related to the personal-discomfort standard; the source of the personal discomfort – and hence of the presumed need for treatment – may be a failure to achieve an ideal.

The shortcomings of the deviation-from-an-ideal approach are again obvious. First, a person who falls short of an ideal does not necessarily merit the label "abnormal" or require treatment. The pursuit of ideal adjustment can add to people's troubles, making them feel seriously inadequate, whereas they may simply be imperfect, like all human beings. Second, psychological theories are as relative to time and place as social norms, and they change even more quickly. Thus, if norms are a weak foundation for the evaluation of mental health, theoretical ideas are even weaker. Nevertheless, the need to achieve something more than ordinary adjustment has propelled many people into psychotherapy in recent years – and especially into group therapies oriented toward what is called "personal growth".

In sum, behaviour may be identified as abnormal in a variety of ways, no one of which is foolproof. In practice, the judgment of abnormality, whether by professional diagnosticians or by family and neighbours, is usually based on a combination of standards. The person's happiness, relation to social norms, and ability to cope – and also the society's ability to cope with him or her – are all taken into account in varying degrees.

1.4. The epidemiology of maladaptive behaviour

Epidemiological studies on mental health problems conducted in different parts of the country, using different criteria for "caseness", and different methodologies, have revealed the magnitude of the problem. A consensus between these studies has revealed an 11% prevalence rate in the general population (Davar, 1995).

Surya, Datta, Gopalakrishna, Sundaram and Kutty (1964) found 1% of the population in Kurchikuppam of Pondicherry to be in need of neuro-psychiatric help. A total morbidity of 1.6% was reported from Sakalawara village near Bangalore (Gopinath, 1968).

A prevalence rate of 23.79% was reported in Agra town (Dube, 1970). 2.7% of the population of a village in Hoogly District of West Bengal was found to be morbid (Elnagar, Maitra & Rao, 1971). In four villages near Lucknow, a prevalence of 3.9% was reported (Sethi, Gupta, Kumar & Kumari, 1972). A prevalence rate of 6.62% in adults and 6.68% in children was reported from Vellore (Verghese, Beig, Senseman, Rao & Benjamin, 1973). The prevalence rate in Lucknow city was reported to be 7.2% in 1967 (Sethi, 1967) and 6.7% in 1974 (Sethi, Gupta, Mahendru, & Kumari, 1974). A one-year prevalence rate of 8.1% was later reported from Lucknow (Thacore, Gupta & Suraiya, 1975).

The prevalence of psychiatric morbidity in rural communities has been reported at 102.12/1,000 in 1972 and 107.61/1000 in 1973 (Nandi et al., 1976); 37% in Kota village (Carstairs & Kapur, 1976); 3.7% in tribal groups (Nandi et al., 1977); 9/2,500 and 11/1000 cases of neuroses (Murty, Kala & Wig, 1978); 60.3% and 31% in two uprooted communities (Nandi et al., 1978); 14.2% and 4.3% in two rural groups (Nandi et al., 1980); 33% of the subjects over 60 years of age manifested psychiatric symptoms (Ramachandran, Menon & Ramamurthi, 1981); 3.7% cases of possession syndrome (Venkataramiah, Mallikarjuniah, Chandrasekhar, Rao & Reddy, 1981); and 17/100 in a geriatric population (Rao, Vasudevan & Madhavan, 1982).

In a population of rural Punjab (Kapoor & Singh, 1983) the rate of affective disorders was 49.1/1000. This was the highest figure reported in India. Mehta, Joseph and Verghese (1985) reported a rate of 14.1/1000 for psychiatric problems. Nandi et al., (1986) adopting the same methodology as they had used 10 years earlier, in the same rural area of West Bengal found that though the total morbidity did not change between 1982 and 1992, an upward trend was apparent

in the case of hysteria and a downward trend for anxiety. Sachdeva, Singh, Sidhu, Goyal, & Singh, (1986) conducted an epidemiological study of priority psychiatric disorders in a rural area, where the prevalence of psychiatric disorders was 22.12/1000.

On the basis of epidemiological studies on urban communities, the prevalence rate was 12.5% in a group of industrial workers (Ganguli, 1968); the incidence rate of psychiatric morbidity was observed to be 0.32% in a group of persons covered by the ESI scheme and their family members (Singh, 1977); 13.9% and the majority of this group was neurotic (Harding et al., 1980); 22% in parents of schizophrenics and 20.7% in an urban group (Nandi et al., 1980); 4.7% (Shah, Goswami, Maniar, Hajariwala & Sinha, 1980); 16-30% in the general population and 10-15% in medical clinics of which nearly 25% followed a chronic course (Wig & Murthy, 1981); and 36.1% in general practice (Krishnamurthy, Shamasundar, Omprakash & Prabhakar, 1981).

A prevalence of 4.7% was reported from Ahmedabad (Shah et al., 1980). A study in Bombay (Bagadia, Ayyar, Dhawale and Pradhan 1983) noted an overall psychiatric morbidity of 26.4%. Satija, Patni & Nathawat (1984) used the General Health Questionnaire to identify cases among a group of workers at a copper mining complex. The prevalence of mental disturbance was 186.66/1,000. Sriram, Shamasundar, Mohan & Shanmugham (1986) reported that there was a prevalence of 51.3% of psychiatric disturbance in Bangalore.

Psychiatric morbidity was also reportedly detected in up to half of adult primary care attenders in India (Shamasundar et al. 1986; Sen, 1987). For the first time in the country, ICMR and DST sponsored a multi-centered, collaborative study on prevalence of severe mental morbidity in 4 centres - Bangalore, Baroda, Calcutta and Patiala. The prevalence rate was 0.9%. But it was different from center to center, lowest in Baroda and highest in Patiala (Isaac, 1987). Chakraborty (1990) from a social psychiatric field study of Calcutta reported a prevalence rate of mental distress at 129/1000.

Four more studies were conducted to find out the prevalence of severe mental morbidity by Mehta et al., (1985) in Tamil Nadu, Sachdeva, et al., (1986) in Punjab, Premrajan, Danabalan, Chandrashekar and Srinivasa (1993) in Pondicherry and Shaji, Verghese, Promodu, George and Shibu (1995) in Kerala. They reported prevalence rates of 1.4%, 2.2%, 9.9% and 1.46% respectively. A meta-analysis of 13 studies reveals that prevalence rate of total morbidity is 58.2 /1000 population (Chandrashekar & Isaac, 1999). Nadkarni & Dhavale (1999) studied the psychiatric aspects of patients suffering from chronic musculoskeletal pain in a government hospital in Mumbai, and reported that more than half the patients satisfied the criteria for a depressive disorder.

Changes in the mental health status of a community were compared after 20 years. Total morbidity per 1,000 fell from 116.8 to 105.2. Morbidity in men fell from 86.9 to 73.5 per 1,000 and in women from 146.8 to 138.3 per 1,000. Rates of anxiety, hysteria, and phobia fell dramatically and those of depression and mania rose significantly (Nandi et al., 2000). Khess, Kumar, Basu and Akhtar (2000) determined the frequency of psychiatric morbidity, especially depression, in patients attending a headache clinic. Migraine was the commonest diagnosis (36.2%) followed by depression (23.2%). Patel & Prince (2001) investigated the status of older people and concepts of late-life mental health conditions in Goa and observed that fear for the future, and "dependency anxiety" was commonplace among older Goans.

Patel, Rodrigues and DeSouza, (2002) described the natural history of depression in mothers who recently gave birth in Goa. Depressive disorder was detected in 59 (23%) of the

mothers at 6 weeks after childbirth; 78% of these patients had had clinically substantial psychological morbidity during the antenatal period.

Epidemiological studies of general psychiatric morbidity in India revealed a wide range of prevalence rates from as low as 0.32% to as high as 60.3%. Such wide variations in epidemiological studies may be due to different definitions of caseness, different methods used to detect caseness and also due to the varied nature of the population studied. The types of disorders that were reported also ranged from neurotic disorders like anxiety and phobias to the more severe disorders like antenatal depression, affective disorders, hysteria and also neuro-psychiatric problems. The studies were also reportedly conducted in the general hospital as well as in the community settings with the hospital based studies showing slightly higher prevalence rates than the community based studies, with important exceptions.

1.5. The historical background of abnormal psychology

The earliest societies seem to have regarded abnormal behaviour as the product of supernatural forces. An accepted method of dealing with disturbing behaviour was to drive out evil spirits by various forms of exorcism, although much abnormality was probably treated in less dramatic ways. A more scientific approach to abnormality evolved in ancient Greece; the physician Hippocrates observed and recorded cases of mental disturbance, developed an organic theory of abnormal behaviour, attempted to classify abnormal mental states, and adopted humane methods of treatment. His approach survived until the fall of the Roman Empire in the fifth century A.D.

In the Middle Ages, abnormal behaviour was often attributed to demonic possession, and cures ranged from prayers and other gentle measures to starvation and flogging. However, abnormality was often regarded as a naturally caused phenomenon. In the Renaissance, thousands of people – many of whom exhibited abnormal behaviour – were executed as witches. But most of the deranged were probably of no interest to the witch hunters; they were kept in hospitals or institutions for the poor, generally under horrible conditions.

Though hospitalization of the insane became more common in the eighteenth and nineteenth centuries, little effort was made to improve treatment until the reforms of Vincenzo Chiarugi in Florence and of the better-known Frenchmen Jean-Baptiste Pussin and Philippe Pinel at La Bicetre, a Paris asylum, in the late eighteenth century. The leaders of this reform movement in nineteenth-century America were Benjamin Rush and Dorothea Dix. These reformers advocated moral therapy, or improving the morals of the mentally ill through peaceful living, useful employment, and dignified treatment.

Although remarkably successful, moral therapy declined in the late nineteenth century, partly because of the rise of the medical model. Wilhelm Wundt and his student Emil Kraepelin were pioneers in applying scientific methods to the study of human thought and behaviour, and the work of Kraepelin and others brought the medical model to the forefront. At the same time, psychogenic theories, which attribute mental disorder to emotional stress, also began to gain prominence. The controversial work of Franz Anton Mesmer, who discovered the power of suggestion to cure some mental disorders, laid the groundwork for psychogenic theory.

Member's efforts were expanded upon by the members of the Nancy School, notably Ambrose-Auguste Liebeault and Hippolyte-Marie Bernheim, and later the rival Paris School,

under Jean-Martin Charcot, and Josef Breuer became convinced that mental disorders were caused by unconscious conflicts that once revealed under hypnosis, could be resolved. But Freud later abandoned hypnosis, replacing it with his technique of free association and developed his pioneering theory of psychoanalysis.

1.6. Physiological and Organic Behaviour

The neuroscience perspective believes that physical and mental functions cannot be separated. Genetic factors, the central and peripheral nervous systems, and the endocrine system are all biological functions that interact with each other and with environmental influences to determine behaviour.

Behaviour genetics is a sub field of psychology that attempts to determine the degree to which specific disorders are inherited. Although only a few disorders such as Down's syndrome, have a clear-cut genetic cause, many disorders, including schizophrenia, result from the interaction of environmental stressors and an inherited diathesis, or predisposition, to the disorder. Through family, twin and adoption studies, behaviour geneticists try to assess heritability. An individual's observable characteristics, or phenotype, show the combined results of experience and underlying genotype. Family studies help to determine the degree of influence of the genotype by comparing percentages of genes shared by family members – for example, siblings share about 50 per cent – with percentages of shared disorder, or concordance.

Although family studies suggest that closer relatives of the index, or proband, case are more likely than more distant relatives to be predisposed to schizophrenia, these correlational studies do not prove heritability. Twin studies give stronger evidence that schizophrenia is inherited. Although monozygotic (MZ) or dizygotic (DZ) or fraternal, twins generally share the same environment. MZ twins, who share all their genes, are more than twice as likely (three to five times as likely) as DZ twins, who share half their genes, to share the disorder of schizophrenia. Adoption studies attempt to separate and weigh the relative influence of environment and genetic predisposition. It is thought that similarities between related individuals reared in different environments may be caused by genetic predisposition. Small samples of MZ twins reared apart along with larger mother-child samples offer the best evidence for the genetic transmission of schizophrenia.

The Central Nervous System (CNS) consisting of the brain and spinal cord, controls behaviour by processing, transmitting, and storing information. Nerve cells, or neurons, which consist of the cell body, dendrites, axon and axon terminals, receive and transmit electrical impulses along the neural pathway. The neuron receives the impulse through the dendrites, passes it down the axon to the terminals, then sends it across the synapse lying between the terminal and the dendrites of another nerve cell. Neurotransmitters are the critical chemical links between neurons and effect the transmission of impulses across the synapse. Among at least fifty neurotransmitters that are thought to operate along neural pathways, nine are implicated in various psychological disorders and four play a critical role in psychopathology: acetylcholine, dopamine, norepinephrine, and serotonin. Neurotransmitters begin as amino acids in the bloodstream and are converted at the axon terminals just before the impulse is fired across the synapse. Drugs used to correct a suspected malfunction of the body's neurotransmitters operate by increasing amino acid levels, facilitating conversion, or prolonging the action of neurotransmitters at the synapse.

The external surface of the cerebral cortex – the intricate gray matter covering the brain – is formed of fissures and ridges. The longitudinal fissure divides the brain along the midline into two symmetrical hemispheres, each containing four lobes with differentiated functions. Regulatory structures include the hypothalamus, thalamus, cerebellum, and brainstem, a structure containing the pons, medulla and reticular formation. Ventricles filled with cerebrospinal fluid occur throughout the brain. Psychological disorders have been traced to dysfunctions in many of these structures as well as to dysfunctions related to brain lateralization. Aphasias are organically based language disorders; some researchers suspect that schizophrenia, which is characterized by disordered speech, may be partly explained by left-hemisphere dysfunction. It is also suspected that right-hemisphere dysfunction may contribute to such emotional disturbances as anxiety and depression.

The peripheral nervous system consists of the somatic nervous system and the autonomic nervous system (ANS). The somatic division activates skeletal muscles and controls such purposeful behaviour as crossing a street on the green signal. The ANS activates smooth muscles, glands, and internal organs and controls such automatic responses as heart rate, respiration, and the release of adrenaline. The ANS functions to adjust the body to changing environmental demands through its sympathetic and parasympathetic branches. Sympathetic arousal prepares us for quick action in emergencies – for example, increasing heart rate, respiration, and blood sugar (through the release of adrenaline). The parasympathetic division slows metabolism and helps to restore the system to equilibrium. The ANS is associated with such stress-related disorders as hypertension, ulcers and insomnia.

The endocrine system influences emotional states, sexual functioning, physical development, and level of available energy by releasing hormones into the bloodstream from the hypothalamus, pituitary gland, and other endocrine glands. Glandular dysfunction may be partly responsible for severe depressive disorders.

The neuroscience perspective presents problems of both causality and ethics. Finding that a genetic predisposition or chemical imbalance accompanies a given disorder does not mean that the organic factor is the only or even the principal cause of the disorder. Ethical concerns include questions of prevention (in genetic counseling) and of intervention (in genetic engineering), as well as concerns that the neuroscience approach could lead to a medicalized psychology that treats only symptoms. The strongest argument in favour of the neuroscience perspective is the hope it holds for people with severe depression, schizophrenia and other disabling disorders. Even for these disorders, however, researchers favour the diathesis-stress model, which studies the combined influences of environmental stress and biochemical factors.

1.7. Research in Abnormal Psychology

The scientific method provides a basis for developing theories of abnormal behaviour as well as a means to test those theories. It is also used to determine whether particular therapeutic approaches are effective in treating clients. The scientific method is characterized by the skeptical attitude of those who use it, by the objectives it is intended to meet (description, prediction, and understanding), and by the specific procedures used to meet those objectives (hypothesis testing, definition formulation and methods of control). Careful description of phenomena often serves as the basis of prediction, which is an essential part of psychological assessment.

The most difficult objective of scientific research is understanding what causes a phenomenon. Understanding is achieved only when three conditions have been demonstrated:

covariation of events, a time-order relationship, and the elimination of plausible alternative causes. People often think that causality has been established when only one condition has been met – for example, covariation of events. Research that fails to eliminate alternative explanations is said to be confounded. Only when no confounding is present is a study internally valid.

The external **validity** of research depends on our ability to generalize, or apply, the findings to different populations, settings, and conditions. External validity increases as the representativeness of a sample increases. The best way to achieve a representative sample is to use a random sampling procedure.

Research often begins with the development of a testable, or falsifiable, **hypothesis**. Generally, a hypothesis is tested in an experiment that uses three control techniques: manipulating the independent variable, holding all other variables constant, and balancing uncontrollable factors – the personal characteristics of the subjects being tested – among all conditions. Holding conditions constant rules out the effect of those conditions, but balancing through random assignment may still produce some error variation. Special problems of control also arise from expectations on the part of subjects (demand characteristics) and researchers (experimenter effects). Placebo control groups and double blind procedures may help avoid these problems.

Research results are often evaluated through statistical inference. The null hypothesis is assumed and is rejected only if there is a statistically significant likelihood that the independent variable had an effect. In the context of therapy, however, clinical significance (the effectiveness of a treatment outside the laboratory) is more important than statistical significance.

Many different research designs are used to investigate abnormal behaviour. **Correlational** or natural group designs examine whether systematic differences exist between groups of people who have been treated naturally. A serious problem in evaluating the results of correlational studies is to determine the direction of the causal relationship and to eliminate possible third variables that may cause differences between groups. Longitudinal, or developmental, studies examine the behaviour of an individual over time. Although this design does not solve the problem of causality, it is more powerful than a correlational design because assumptions of covariation and time-order relationships can be more easily tested.

Epidemiological studies examine the incidence and prevalence of a behavioural disorder in a population. Such studies can help to determine whether the frequency of a particular disorder is related to other variables, including the demographic characteristics of the population and the prevalence of other disorders in that population. Major concerns in population surveys are the representativeness of the sample and the fact that survey responses are affected by social desirability and selective memory.

The **case study** method is the intensive description and analysis of a single individual. Case studies offer an opportunity for clinical innovation and can provide either a counter instance that disconfirms a general scientific principle or tentative support for a psychological theory. The usefulness of the case study is limited because investigators can usually not draw cause-and-effect conclusions from it or apply their findings to other individuals.

Analogue experiments attempt to reproduce under controlled conditions the essential features of naturally occurring psychopathology or its treatment. They allow the kind of control that is generally prohibited for ethical or practical reasons but that often enables researchers to establish causal relationships. Analogue experiments with animal subjects can closely approximate natural treatments, and they allow the use of intrusive behavioural and physiological

measures; moreover, data can be obtained in a relatively brief period because of the short life span of many animals. The emphasis on internal validity in analogue or laboratory experiments, however, often leads to the criticism that they are low in external validity.

Single-case experimental designs monitor behaviour change following an intervention that was introduced after a baseline (no-treatment) observation. Evidence for a causal relationship is obtained if the person's behaviour changes systematically with the introduction of the treatment. The ABAB, or reversal, design seeks to confirm a treatment effect by showing that behaviour changes systematically with alternating conditions of no treatment (A), treatment (B), a return to baseline (A), and another treatment (B). Because improvement in behaviour may be reversed when treatment is withdrawn at the second A stage, ethical considerations frequently suggest a multiple-baseline procedure, in which a treatment is introduced at different intervals across subjects, behaviours, or situations. Two or more multiple-baseline procedures used in combination can establish causal relationships in single-case design, and external validity can be improved by the use of a group rather than a single subject; conclusions can then be drawn from the group about the population it represents.

1.8. Summary

Abnormality is a relative concept. It can be defined in terms of deviation from norms, statistical rarity, personal discomfort, maladaptive behaviour, or deviation from an ideal. Epidemiological studies on mental health problems conducted in different parts of the country, using different criteria for "caseness", and different methodologies, have revealed the magnitude of the problem. A consensus between these studies has revealed an 11% prevalence rate in the general population. The earliest societies seem to have regarded abnormal behaviour as the product of supernatural forces. In the Middle Ages, abnormal behaviour was often attributed to demonic possession, until reformers advocated moral treatment. The neuroscience perspective believes that physical and mental functions cannot be separated. Genetic factors, the central and peripheral nervous systems, and the endocrine system are all biological functions that interact with each other and with environmental influences to determine behaviour. Many different research designs are used to investigate abnormal behaviour – correlational, epidemiological, case studies, analogue experiments and single-case experimental designs.

1.9. Technical Terms

Norms– Rules that tell us what is right and what is wrong.

Exorcism – a way of driving out evil spirits.

Moral therapy - improving the morals of the mentally ill through peaceful living, useful employment, and dignified treatment.

Neuroscience perspective – It believes that physical and mental functions cannot be separated.

Behaviour genetics - is a sub field of psychology that attempts to determine the degree to which specific disorders are inherited.

1.10. References

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1.11. Model Questions

1.11.1. What is abnormal psychology? What are the various criteria for understanding abnormality?

1.11.2. What is the epidemiology of maladaptive behaviour in India?

1.11.3. Give a brief account of the historical background of abnormal psychology.

1.11.4. What are the various research methods in psychopathology?

LESSON 2

THEORETICAL PERSPECTIVES ON MALADAPTIVE BEHAVIOUR

2.0 Objectives

1. To understand how modern views of abnormal behaviour have originated
2. To understand maladaptive behaviour through various theoretical perspectives

Structure

Introduction

Abnormal Behaviour in Ancient Times

Biological or Organic Perspective

Psychodynamic Perspective

Behavioural Perspective

Cognitive-behavioural Perspective

Humanistic Perspective

Sociocultural Perspective

2.1 Introduction

With the development of modern research methods, psychotherapeutic drugs, techniques of psychotherapy, and community mental health concepts and facilities, we may say with some confidence that we have come a long way from the superstitious and often cruel treatment of persons with mental disorders characteristic of earlier times. The story of this journey is fascinating, one that will help us understand how modern views of abnormal behaviour have come about.

2.2 Abnormal behaviour in ancient times

2.2.1 Demonology among the ancients

The earliest treatment of mental disorders of which we have any knowledge was that practiced by Stone Age cave dwellers some half million years ago. For certain forms of mental disorders, especially those in which the individual complained of severe headaches and developed convulsive attacks, the early *shaman*, or medicine man, treated the disorder by means of an operation called **trephining**. This operation was performed with crude stone instruments and consisted of chipping away one area of the skull in the form of a circle until the skull was cut through. This opening, called a trephine, was thought

to permit the evil spirit causing all the trouble, to escape – which may have relieved a certain amount of pressure on the brain.

References to mental disorders in the early writings show that such disorders were attributed to demons that had taken 'possession' of the individual. The primary type of treatment for demoniacal possession was **exorcism**, which included various techniques for casting the evil spirit out of the body of the afflicted one.

2.2.2 Early philosophical and medical concepts

During the Golden Age of Greece considerable progress was made in the understanding and treatment of mental disorders. Significant contributions to the understanding of abnormal behavior were made by many Greek philosophers such as:

- **Hippocrates** (460-377). Called the "Father of Modern Medicine", he insisted that mental disorders had natural causes and required treatment like other diseases. He emphasized the view that the brain was the central organ of intellectual activity and that mental disorders were due to brain pathology. Hippocrates also stressed the importance of *heredity* and *predisposition* and pointed out that injuries to the head could cause sensory and motor disorders. Hippocrates' emphasis on natural causes, clinical observations, and brain pathology in relation to mental disorders was revolutionary. Hippocrates' scant knowledge of physiology is reflected in his concept of the "four humors" – **blood, black bile, yellow bile,** and **phlegm**. Hippocrates apparently conceived the notion of a balance of physiological processes as essential to normal brain functioning and mental health. He stated that physical or mental disease resulted when the humors were adversely mixed or disturbed. Although this concept was a far cry from demonology, it was too crude physiologically to be of any great value.

- **Plato and Aristotle.** In addition to the emphasis on the more humane treatment of the mentally disturbed, Plato contributed to a better understanding of human behaviour by pointing out that all forms of life, human included, were motivated by physiological needs or "natural appetites." In his *Republic*, Plato emphasized the importance of individual differences in intellectual and other abilities, and pointed out the role of socio-cultural influences in shaping the thinking and behaviour of the individual. Despite these modern ideas, however, Plato shared the belief of his time that mental disorders were partly organic, partly moral, and partly divine. The question of whether mental disorders could be caused by psychological factors like frustration and conflict was discussed and rejected by the celebrated systematist Aristotle (384-322 B.C). In his extensive writings on mental disorders, Aristotle generally followed the Hippocratic theory of disturbances in the bile. For example, he believed that very hot bile

generated amorous desires and loquacity, and was responsible for suicidal impulses.

2.2.3 Demonology in the Middle Ages

With the collapse of the Greek and Roman civilizations, medicine as well as other scientific pursuits suffered an almost complete eclipse in Europe. There was a tremendous revival of the most ancient superstition and demonology, with only a slight modification to conform to current theological demands.

In the Middle Ages in Europe, management of the mentally disturbed was left largely to the clergy. During the early part of the medieval period, the mentally disturbed were treated with considerable kindness. "Treatment" consisted of prayer, holy water, sanctified ointments, the breath or spittle of the priests, the touching of relics, visits to holy places, and mild forms of **exorcism**.

2.2.4 Toward Humanitarian Approaches

During the latter part of the Middle Ages and the early Renaissance, scientific questioning reemerged and a movement emphasizing the importance of human interests and concerns began – a movement loosely referred to as **humanism**.

- **Establishment of early asylums and shrines**

From the sixteenth century onwards, **asylums,** meant solely for the care of the mentally ill, grew in number. In 1547, the monastery of St. Mary of Bethlehem at London was officially made into a mental hospital by Henry VII and soon came to be known as "Bedlam". It became widely known for the deplorable conditions and practices that prevailed.

- **Humanitarian reform**

Although scientific skepticism had undermined the belief that mental disturbance was the devil's work, most early asylums were no better than concentration camps. Humanitarian reform of mental hospitals received its first great impetus from the work of Philippe Pinel (1745-1826) in France, Tuke in England, and Rush and Dix in America.

(i) Pinel's experiment

In 1792, shortly after the first phase of the French Revolution ended, Pinel was given charge of La Bicetre hospital. In this capacity, he received permission, though not without hesitation, from the Revolutionary Commune to remove the chains of some of the inmates as an experiment to test his views that mental patients should be treated with kindness and consideration – as sick people and not as vicious beasts or criminals. The effect was almost miraculous. The previous noise, filth, and abuse were replaced by order and peace.

(ii) Tuke's work in England

At about the same time that Pinel was reforming the Bicetre Hospital, an English Quaker named William Tuke established the "York Retreat," a pleasant country house where mental patients lived, worked, and rested in a kindly religious atmosphere. This represented the culmination of a noble battle against the brutality, ignorance, and indifference of his time.

(iii) Rush and Dix in America.

Benjamin Rush, the founder of American Psychiatry, encouraged more humane treatment of the mentally ill. The early work of Benjamin Rush was followed through by an energetic New England schoolteacher, Dorothea Dix (1802-1887). Dix carried on a zealous campaign between 1841 and 1981, which aroused the people, and the legislatures to an awareness of the inhuman treatment accorded the mentally ill.

2.3 The organic viewpoint and the medical model

The first systematic presentation of the organic viewpoint was made by the German psychiatrist, William Griesinger (1817-1868). The organic viewpoint or medical model emphasizes that all mental disorders can be explained in terms of brain pathology. This model represents the first great advance of modern science toward the understanding and treatment of mental disorders.

2.3.1 Systematic classification of mental disorders

Although the work of Griesinger received considerable attention, it was his follower, Emil Kraepelin who played the dominant role in the early development of the organic viewpoint. Kraepelin noted that certain symptom patterns occurred with sufficient regularity to be regarded as specific types of mental disease. He then proceeded to describe and clarify these types of mental disorders, working out the scheme of classification that is the basis of our present categories.

2.3.2 Advances achieved by the medical model

1. The early concepts of demonology were finally destroyed, and the organic viewpoint of mental disorder as based on brain pathology was well established.

2. For general paresis and certain other mental disorders, definite underlying brain pathology had been discovered and appropriate methods of treatment developed.

3. A workable, though not yet completely satisfactory, scheme of classification had been set up.
4. Mental disorders had finally been put on an equal footing with physical illness, at least in medical circles, and for the first time mental patients were receiving humane treatment based on scientific findings.

5. A great deal of research was under way in anatomy, physiology, biochemistry, and other allied medical sciences, in an attempt to ascertain the brain pathology (or other bodily pathology that might be affecting the brain) in other types of mental disorders, and to clarify the role of organic processes in all behaviour.

2.4 Psychosocial Perspectives

Despite the great advances in the understanding and treatment of mental disorders achieved by the organic viewpoint and medical model, many puzzling and important questions remained unanswered. There was a new school of thought emerging that questioned the dominant belief that brain pathology was the sole cause of mental disorders. This was the "revolutionary" view that certain types of mental disorders may be caused by psychological rather than organic factors.

2.4.1 The Psychodynamic Perspective

The first systematic steps toward understanding psychological factors in mental disorders came about through the significant contributions of Sigmund Freud. The major principles of his psychoanalytic model were based on the clinical study of individual patients – mostly neurotic – who were undergoing treatment for their problems.

- **Basic principles of the psychoanalytic model.**

The psychoanalytic model is both highly systematized and complex. Its basic principles are explained below:

1. **Id, ego, and superego.** The individual's behaviour is assumed to result from the interaction of three key subsystems within the personality: the id, ego, and superego.
   The ***id*** operates in terms of the *pleasure principle.* The id is the source of instinctual drives, which are of two types:

   (a) Constructive drives, primarily of a sexual nature, which constitute the libido, or basic energy of life, and

   (b) Destructive drives which tend toward aggression, destruction and eventual death.

   The **ego** mediates between the demands of the id and the realities of the external world. The basic purpose of the ego is to meet the demands of the id, but in such a way as to ensure the well-being and survival of the individual. The ego operates in terms of the *reality principle*.

The **superego** is the outgrowth of learning the moral values of society. It is essentially what we refer to as conscience, and is concerned with right and wrong. Parental and societal values are internalized as the superego develops, and an additional inner control system comes into operation to cope with uninhibited desires of the id. Superego also operates through the ego system and strives to compel the ego to inhibit desires that are considered wrong or immoral.

2. **Anxiety, defense mechanisms, and the unconscious.** The concept of anxiety is prominent in the psychoanalytic model. Freud distinguished among three types of anxiety that people can suffer from:

   (a) reality anxiety, arising from dangers or threats in the external world

   (b) neurotic anxiety, caused by the id's impulses threatening to break through ego controls, resulting in behaviour that will be punished in some way and

   (c) moral anxiety, arising from a real or contemplated action in conflict with the individual's superego or moral values, and arousing feelings of guilt.

   Anxiety is a warning of impending danger as well as a painful experience, so it forces the individual to undertake corrective action. Often the ego can cope with the anxiety by rational measures – such as rationalization or repression – which are referred to as **ego-defense mechanisms.** These defense mechanisms alleviate the painful anxiety, but they do so by distorting reality instead of dealing directly with the problem. This creates a schism between actual reality and the way the individual sees reality.

3. **Psychosexual development.**

   Freud viewed personality development as a succession of stages, each characterized by a dominant mode of achieving libidinal (sexual) pleasure. These five stages are oral stage, anal stage, phallic stage, latency stage, genital stage. Freud believed that gratification during each stage is important for the individual not to be fixated at that level.

2.4.2 Impact on our views of psychopathology

According to the psychoanalytic model, people are dominated by instinctual biological drives, as well as by unconscious desires and motives. Although there is a constructive libidinal side in each individual, there are also the darker forces of aggression leading toward destruction and death. Though the ego tends toward rationality, the counterforces of intra-psychic conflict, defense mechanisms, and the unconscious all tend toward a high degree of irrationality and maladaptive behaviour.

The psychoanalytic model presents a negativistic and **deterministic view** of human behaviour that minimizes rationality and freedom for self-determination.

Many of Freud's ideas have been revised or discarded because of subsequent research findings. However, two of Freud's contributions stand out as particularly noteworthy.

1. The development of psychoanalytical techniques – free association and dream analysis – for becoming acquainted with both the conscious and unconscious aspects of the mental life of the individual. The data thus obtained led Freud to emphasize (a) the dynamic role of unconscious motives and ego-defense processes, (b) the importance of early childhood experiences in later personality adjustment and maladjustment, and (c) the importance of sexual factors in human behaviour and mental disorders.

2. The demonstrations that certain abnormal mental phenomena – such as the repression of traumatic experiences and irrational fears – occurred as a result of attempts to cope with difficult problems and were simply exaggerations of normal ego-defense mechanisms. With the realization that the same psychological principles apply to both normal and abnormal behaviour, much of the mystery and fear surrounding mental disorders was dispelled and mental patients were helped to regain their dignity as human beings.

2.5 The Behaviouristic Model

While psychoanalysis largely dominated psychological thought about abnormal behaviour in the early part of this century, a new school – behaviourism – was emerging to challenge its supremacy. According to the behaviorists point of view, only the study of directly observable behaviour and the stimulus and reinforcing conditions that "control" it could serve as a basis for formulating scientific principles of human behaviour.

2.5.1 Principles of Conditioning

Classical Conditioning. In classical conditioning, a formerly neutral stimulus – the conditioned stimulus (CS) – acquires the capacity to elicit biologically adaptive responses through repeated pairing with the unconditioned stimulus (UCS).

Instrumental (Operant) Conditioning. Reinforcement of a subject for making a correct response that either leads to receipt of something that is rewarding or escape from something that is unpleasant.

Generalization and Discrimination. **Generalization** is the tendency of a response that has been conditioned to one stimulus to become associated with other similar stimuli. A process complementary to generalization is **discrimination**, which occurs when a person learns to distinguish between similar stimuli and to respond differently to them.

Modeling, shaping, and learned drives. **Modeling** involves precisely what the term implies – the demonstration of desired response patterns by parents or

others and the systematic reinforcement of the subject's imitation of such responses.

Often an appropriate response is not available in a person's behaviour repertoire, a matter that presents problems for the behaviour therapist, who cannot reinforce a response until it occurs. In such cases, it is often possible to **shape** the response by reinforcing successive approximations of the desired behaviour.

Behaviourists view motivation as based on a limited number of primary biological drives, such as hunger and thirst that are directly related to meeting bodily needs. The many different motives in everyday life are seen as **learned extensions** of these primary drives. For example, an infant soon learns that parental approval leads to the gratification of bodily needs and thus learns to seek parental approval.

2.5.2 Impact on our views of psychopathology.

Maladaptive behaviour is defined in terms of specific responses – undesirable reactions resulting from faulty learning and/or excessive stress.

Maladaptive behaviour is viewed as essentially the result of (a) failure to learn necessary adaptive behaviours or competencies, such as how to establish satisfying personal relationships; (b) learning ineffective or maladaptive responses, (c) stress situations that the individual feels incapable of dealing with.

2.6 Cognitive-Behavioural Perspective

The cognitive-behavioural perspective on abnormal behaviour focuses on how thoughts and information processing can become distorted and lead to maladaptive emotions and behaviour. Unlike behaviourism's focus on overt behaviour, the cognitive view treats thoughts as "behaviours" that can be studied empirically and that can become the focus of attention in therapy.

2.7 The Humanistic Model

The humanistic model has been heavily influenced by such outstanding psychologists as William James, Gordon Allport, Abraham Maslow , Carl Rogers and Fritz Perls. As an important new "third force" in contemporary psychology, the humanistic model is concerned not only with the characteristics we share in common as human beings but also with the uniqueness of each individual.

2.7.1 Impact on our views of psychopathology.

According to the humanistic model, psychopathology is essentially the blocking or distortion of personal growth. This is generally the result of one or

more of these causal factors: (a) the exaggerated use of ego defense mechanisms so that the individual becomes increasing out of touch with reality; (b) unfavourable social conditions and faulty learning; and (c) excessive stress.

2.8 The Sociocultural Perspective

By the beginning of the twentieth century, sociology and anthropology had emerged as independent scientific disciplines and were making rapid strides toward understanding the role of sociocultural factors in human development and behaviour.

The investigations and writing of early sociocultural theorists like Ruth Benedict, Ralph Linton, and others showed that individual personality development reflected the large society – its institutions, norms, values, ideas, and – as well as the immediate family and other groups. Studies also made clear the relationship between sociocultural conditions and mental disorders – between the particular stressors in a society and the types of mental disorders that typically occur in it.

2.8.1 Uncovering Sociocultural Factors through Cross-Cultural Studies

The sociocultural viewpoint is concerned with the impact of the social environment on mental disorder. Human biology does not operate in a vacuum; cultural demands serve as causal factors and modifying influences in psychopathology. For example, sociocultural factors often create stress for an individual. Children growing up in an oppressive society that offer few rewards and many hassles are likely to experience more stress and thus be more vulnerable to disorder than children growing up in a society that offers ample rewards and considerable social support. In addition, growing up during a period of great fear, such as during a war, a famine, or a period of persecution, can make a child vulnerable to psychological problems.

2.8.2 Cultural Differences in the development and experience of disorders

Sociocultural factors also appear to influence which disorders develop, the forms that they take, and their courses. For example, Kleinman (1986, 1988) traced the different ways that Chinese people deal with stress compared with Westerners. He found that in Western societies depression was a frequent reaction to individual stress. In China, on the other hand, he noted a relatively low rate of reported depression. Kleinman and Good (1985) surveyed the experience of depression across cultures. Their data show that important elements of depression in Western societies – for example, the acute sense of guilt typically experienced – do not appear in other cultures. They also point out that the symptoms of depression, such as sadness, hopelessness, unhappiness, lack of pleasure in the things of the world and in social relationships, have dramatically different meanings in different societies. For Buddhists, seeking pleasure from things of the world

and social relationships is the basis of all suffering; a wilful disengagement is thus the first step on the road to salvation.

2.7 Toward a Unified Viewpoint

The interdisciplinary approach has led to the integration of research findings from such varied disciplines as genetics, biochemistry, neurophysiology, psychology, sociology, anthropology, and ecology in efforts to understand and cope with abnormal behaviour. On a practical level, it has led to the meaningful coordination of medical, psychological, and other mental health personnel in the assessment, treatment, and prevention of mental disorders. It has become increasingly apparent to workers in these fields that maladaptive behaviour can only be fully understood and effectively dealt with in this comprehensive way.

2.8 Summary

Great strides have been made in our understanding of abnormal behaviour in the twentieth century, and we can trace a general movement away from superstitions and "magic" toward reasoned, scientific studies.

In the nineteenth century, great technological discoveries and scientific advancements made in the biological sciences aided in the understanding and treatment of disturbed individuals.

The psychosocial viewpoints on abnormal behaviour, which deal with human psychology rather that biology, necessarily are more varied than the biological perspective.

The oldest of these perspectives is Freudian psychoanalytic theory.

The behavioural perspective on abnormal behaviour focuses on the role of learning in human behaviour.

The cognitive-behavioural perspective attempts to incorporate the complexities of human cognition in a rigorous, information-processing framework.

The humanistic model views psychopathology as essentially the blocking or distortion of personal growth.

The sociocultural viewpoint is concerned with the social environment as a contributor to mental disorders.

To obtain a more comprehensive understanding of mental disorder, we must draw on a variety of sources, including the findings of genetics, biochemistry, psychology, sociology and so forth.

The biopsychosocial approach comes closes, but in many ways it is merely a descriptive acknowledgment of these complex interactions rather than a clearly articulated theory of how they interact.

2.9 Technical Terms

Intra-psychic conflict	Inner mental struggles resulting from the interplay of the id, ego and superego when the three subsystems are striving for different goals.
Ego- defense mechanisms	Psychic mechanisms that discharge or soothe anxiety rather than coping directly with an anxiety-provoking situation; usually unconscious reality-distorting.
Psychosexual development	Freudian view of development in a succession of stages, each characterized by a dominant mode of achieving libidinal pleasure
Cultural relativism	Position that one cannot apply universal standards of normality or abnormality to all societies
culture-bound syndromes	syndromes that usually occur only in specific societies or cultural areas e.g., Dhat syndrome

2.10 Model Questions

1. Explain the psychosocial viewpoints on maladaptive behaviour.
2. Explain how the modern views of abnormal behaviour originated?
3. Bring out the differences between the various perspectives on maladaptive behaviour.

2.11 Reference Books

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LESSON 3

CLASSIFICATION AND ASSESSMENT

3.0 Objectives

1. To describe the various categories of maladaptive behaviour
2. To understand the advantages and disadvantages of the classification system
3. To introduce the two diagnostic classification systems of nosology

Structure of the lesson

3.1 Introduction

3.2 Categories of Maladaptive Behaviour

3.3 Vulnerability, resilience and coping

3.4 Advantages and Disadvantages

3.5 The Multiaxial approach

3.6 DSM-IV

3.7 Research on classification

3.8 ICD-10 classification

3.1 Introduction

Any system of classification is an attempt to understand human behaviour by sorting it into categories. The purpose of classification is to identify groups of patients who share similar clinical features so that suitable treatment can be planned and the likely outcome predicted. When certain symptoms regularly occur together (a cluster of symptoms called a **syndrome**) and follow a particular course, clinicians agree that those symptoms constitute a particular mental disorder and are assigned to that category. A comprehensive list of such categories with the description of symptoms characteristic of each and guidelines assigning to categories is known as a ***classification system.***

3.1.1Ancient systems

The recognition of mental disorders was first recorded by the Egyptians in 3000 BC and was later advanced by the Sumerians. By 1400 BC India had developed its own classification (within its medical classification, the Ayur Veda). In this system there were seven kinds of demonic possession, each

corresponding to an observed human trait. The next major development in classification occurred in 5th century Greece. Hippo crates (460-377 BC) classified mental disorders into three categories: mania, melancholy, and phrenitis, or brain fever. His system of classification was based on empirical observation. During the succeeding Roman period, classificatory attempts by Galen (AD. 130-200) were based on the three souls in the human psyche, the vegetative, the animal and the rational. The most seminal era for modern classification was perhaps the eighteenth century. With the growth of science came an increased interest in sophistication of classifying abnormal behaviour. Thomas Sydenham (1624- 1663) emphasized on careful observation of data and sorting of abnormal behaviour by patterns of occurrence than using speculative theories. Emil Kraeplin developed the first influential classification system for abnormal behaviour in 1883. The categories of disorders established by him have formed the foundation for the classification system used by the World Health Organization, called the **International Classification of Diseases (ICD).** It has also been incorporated in the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** developed by the American Psychiatric Association.

3.2 Categories of Maladaptive Behaviour

Before we proceed to categories of maladaptive behaviours it is essential to define what are the features of maladaptive behaviours. Maladaptive behaviours or disorders generate distress, and are thought to be atypical or undesirable within a given culture. They also interfere with the individual's ability to function normally and to meet the demands of daily life. Maladaptive behaviours should be ideally categorized based on etiology. For most mental disorders no distinct etiology is known, although there are many attractive probabilities for each. Hence the only rational way to classify them is as syndromes. Maladaptive behaviours were traditionally categorized into a number of separate and mutually

exclusive categories like schizophrenia, mania, and Alzheimer's disease. The reason for this categorization was unknown. The earlier classification was done as either organic mental syndromes or non-organic (also called as functional). Organic syndromes included those that have a *brain dysfunction*. The term organic mental disorder was eliminated from DSM-IV because it incorrectly implied that other mental disorders do not have a biological component. Non-organic or functional disorders were traditional classified into ***psychosis*** and ***neurosis***. The term psychosis emphasized *loss of reality testing* and impairment of mental functioning manifested by hallucinations and delusions, confusion and impaired memory. Psychotic features also include severe impairment of social and personal functioning. Neurosis is *a chronic* or *recurrent non-psychotic disorder* characterized mainly by *anxiety* and it appears as symptom such as an obsession, a compulsion, a phobia or asexual dysfunction. Although there is no diagnostic category called neurosis in DSM-IV as it has lost the degree of precision, it is found in literature and in ICD-10. The term encompasses a broad range of disorders with various signs and symptoms that signify that a person's gross reality testing and personality organization are in tact.

An alternative way of expressing the relationship between heterogeneous disorders would be to simply assign each on one or more axes or dimensions. This would convey more information because finer distinctions are possible and are not imposed by boundaries of a particular category. Patients exhibiting a combination of typical schizophrenic and affective symptoms illustrate this problem clearly.

3.3 Advantages and Disadvantages

The advantages of classification system are that it enables clinicians to diagnose and know the probable future course of the problem and what treatment strategies are likely to be helpful. Clinicians believe that classification and diagnosis can yield valuable information that can advance the understanding and treatment of people in distress. Classification also provides description of disorders and enables acquisition of knowledge in that category from clinical practice and research. Classification is of most use to clinicians when they

demonstrate predictive and concurrent validity. It also enables communication regarding the diagnosis and facilitates comprehension of the underlying causes.

Despite its advantages classification system can have unintended consequences. Clinicians do not always arrive at the correct conclusion and as some theorists believe diagnosis may be self-fulfilling prophecies. In this sense when persons are diagnosed as mentally disturbed they are viewed and treated in a stereotyped way, especially in our society that attaches a stigma to abnormality. Consequently they are labeled as mentally ill even after disorder has been successfully treated. This hinders their prospects in occupational, social and interpersonal relationships.

However classification is not a bad idea. It is important that diagnosis is the beginning, not the end of psychological evaluation. It is used for planning treatment that goes beyond diagnosis alone. To take an example, a form of mental retardation, phenylketonuria, is caused by deficiency in the metabolism of the protein phenylalanine, resulting in the release of incomplete metabolites that injure the brain. A diet reduced in phenylalanine prevents this injury. In this case the diagnositic label distinguishes this particular form of mental retardation made effective treatment possible.

3.4 Vulnerability, resilience and coping

At this point it should be mentioned that each individual is born with certain ***vulnerabilities***, such as difficult temperament, a physical abnormality, allergies or a

genetic tendency toward alcoholism. Similarly every individual has some ***protective factors***, such as high intelligence, good coordination, an easy temperament, which tend to make them more ***resilient*** in the face of stress. These vulnerabilities and protective factors then interact with the environment. The same environment can have different effects depending on the qualities the child brings to the interaction. In the interaction between the qualities of the child and the environment comes the coping strategy that shows the individual's vulnerability or resilience. The facilitativeness of the environment is an important ingredient in the development of coping mechanisms. A highly facilitative environment is one in which the child id reared by responsive parents and is provided by rich array of stimulation. Horowitz, a developmental psychologist, proposes that a resilient child in a poor environment may do quite well, since a child can take advantage of all the stimulation and opportunities available. Similarly a vulnerable child may do well in a highly facilitative environment. According to this model only the **double whammy**- the vulnerable child in poor environment – that leads to really poor outcomes and coping.

3.5 The Multiaxial approach

Clinicians are now adapting for achieving a more comprehensive diagnosis by using the multiaxial system that helps in amore holistic assessment of an individual patient. In depth assessment of a patient goes beyond diagnosis alone and takes into account the patient's circumastances.

The Multiaxial system is used to evaluate the patient along several variables and the DSM-III employed it for the first time. The multi axis system forces the diagnositician to consider a broad range of information, including the environment in which the patient lives. The DSM-IV classification contains five axes. Axis I and Axis II comprise the entire classification of mental disorders – 17 major classification and more than 300 specific disorders. In many instances the patient has a disorder on both axes.

- **Axis I** consists of clinical disorders and other conditions that may be of clinical attention
- **Axis II** consists of personality disorders and mental retardation. The habitual use of a particular defense mechanism can be indicated on Axis II
- **Axis III** lists any physical disorder or general medical condition that is present in addition to the mental disorder. The causative (for example, kidney failure, causing delirium), the result of a mental disorder
- **Axis IV** is used to code the psychosocial and environmental problems that contribute to the development or the exacerbation of the current disorder. The evaluation of stressors is based on the clinician's assessment of the stress that an average person with similar socio-cultural values and circumstances would experience from the psychosocial stressors.
- **Axis V** is the **Global Assessment of Functioning (GAF**) scale with which the clinician judges the patient's overall level of functioning during particular time

period. Functioning is conceptualized as a composite of three major areas: social functioning, occupational functioning and psychosocial functioning. The GAF scale is based on a continuum of mental health and mental illness is a 100- point scale, 100 representing the highest level of functioning in al areas.

The World Health Organization also initiated the multiaxial presentation of disorders in the ICD 10. The multiaxial presentation of the ICD-10 is composed of three axes

- **Axis I Clinical Diagnoses** - this axis accommodates both mental and general medical disorders
- **Axis II Disablements** - this axis appraises the consequences of illness in terms of social impairment (this includes personal care, occupational functioning, functioning with family and social behaviours
- **Axis III contextual factors -** this axis attempts to portray ecological domains (includes problems related to the family, general social environment , economic circumstances, legal issues, family history and life-style)

3.6 DSM-IV

The fourth edition of *Diagnostic and Stastical Manual of Mental Disorders* (DSM-IV) published in 1994, is the latest and most up to date classification of mental disorders. DSM- IV is a multiaxial system that is used by mental health professionals. In 1952 the American Psychiatric Association published the first edition of DSM. Four editions have been published since then. DSM –IV systematically describes each disorder in terms of its

- **Clinical features, associated features** (specific age –culture, and gender related feature),
- **Epidemiology (**prevalence, incidence, and risk),
- **Course the disorder is likely to take**, **prognosis** (the chances for recovery)
- **Etiology** (causal factors, complications, predisposing factors, familial patterns) and
- **Differential diagnosis**.

No mention is made of theories of causes, management and treatment. The organizational plan of DSM-IV is described as follows

Disorders usually First diagnosed in Infancy, Childhood, or Adolescence
Delirium, Dementia and other cognitive disorders
Mental Disorders Due to a General Medical Condition are described
Substance-Related Disorders
Schizophrenia
Mood disorders
Anxiety disorders

Somatoform disorders
Factitious disorders
Dissociative disorders
Sexual and gender identity disorders
Eating disorders
Sleep disorders
Impulse control disorder snot else where classified
Adjustment disorders
Personality disorders
Other conditions that may be a focus of clinical attention

The DSM-IV indicates the severity and course of the disorders as Mild, Moderate, Severe, In Partial remission, In full remission and Prior History.
A Case Illustration of the DSM-IV MultiAxial Daignosis is given below

3.7 Research on classification

The DSM's have been published since 1952 with the intention to provide a system whereby mental disorders can be classified into nosological categories. As knowledge about mental disorders increased the DSM nomenclature expanded. DSM-IV made nosological revolution. It had modernized the diagnostic system and updated and integrated many advances in mental health nomenclature. The preparation involved a three-stage process in order to assure good reliability and validity status to the manual. The first stage involved conducting comprehensive reviews of published research, the second stage involved a thorough analysis of research data for including and excluding criteria and the third stage involved field trails in which interviews were taken with thousands of people with diagnosed problems to ensure the reliability and validity of the new diagnostic criteria.

By the late 1980's clinicians and researchers realized the need for a consistent worldwide system of classification so the currently used ICD-10 was published in 1993 in consultation with those working on DSM-IV at that time. Since the United States of America was required to use ICD-10 codes in all matters related to health, and to make DSM as compatible as possible with ICD-10, work on both proceeded at the same time. Concerted efforts were made to work together in order to produce an empirically based worldwide system of classification for psychological disorders.

3.8 ICD-10 classification

The roots of the ICD can be traced to the inspirational work of Swedish biologist Carolous Linnaeus in the18th century. The first International Classification of Causes of Death has been prepared and adopted at the International Statistical Congress of 1893. Since then there have been revisions of the ICD approximately every ten years. The World Health Organization, created in 1948, assumed from its inception the preparation of these revisions as a constitutional responsibility.

In the 10th revision of the ICD the classification of mental disorders are listed in the chapter V where all conditions are coded with the letter F (the first character). The first digit (second character) of the chapter V diagnostic codes denoted 10 major classes of mental and behavioural disorders: F0 through F9. The second and third digits (third and fourth characters) identify progressively finer categories. For example the code F30.2 sequentially denotes the mental chapter, mood disorders class, manic episode, and the presence of psychotic symptoms. In this way 1,000 four-character mental disorders categorical slots are available in ICD-10. ICD-10 classification of disorders re categorized as follows

F00-09 Organic, including symptomatic, mental disorders

F10-19 Mental and behavioural disorders due to psychoactive substance use

F20-29 Schizophrenia, schizotypal and delusional disorders

F30-39 Mood (affective) disorders

F40-48 Neurotic stress-related and somatoform disorders

F50-59 Behavioural syndromes associated with physiological disturbances

F60-69 Disorders of adult personality and behaviour

F70-79 Mental retardation

F80-89 Disorders of psychological development

F90-98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F99 Mental disorder, not otherwise specified

3.9 Summary

Clinicians use assessment information to diagnose a psychological disorder. Historically classification of abnormal behaviour was vague.

Classification system enables professional to communicate about the disorder and also helps to plan the treatment. Classifying also has its disadvantages as it may stigmatize a person affecting the person's life. Also classification would overlook some of the uniqueness of the person.

Recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American psychiatric Association and the International Classification of Disorders (ICD) by the World Health Organization represent efforts to make diagnostic criteria clearer. DSM-IV and ICD-10 are the leading classification systems used by clinicians world over.

Clinicians who use these systems to make diagnosis must evaluate a client's condition on several axes. This system is called the multiaxial system.

Every time a diagnosis is made based on DSM-IV, the clinician is to describe the patient's condition according to each of the five axes, or dimensions. Axes I and II encompass the mental disorders and Axis II covers specifically personality disorders and mental retardation. Any physical disorder leading to a mental disorder is listed on Axis III. Axis IV is used to indicate the psychosocial and environmental problems that the person has been experiencing and Axis V rated current level of adaptive functioning.

The ICD the classification of mental disorders are listed in the chapter V where all conditions are coded with the letter F (the first character). The first digit (second character) of the chapter V diagnostic codes denoted 10 major classes of mental and behavioural disorders: F0 through F9.

3.10 Technical Terms

Classification system	***A comprehensive list of categories of mental dysfunctions, including a description of that symptoms that characterize each category and guidelines for assigning people to the categories***
Diagnosis	The process of determining whether a person's dysfunction constitutes a particular psychological disorder
DSM –IV	The fourth edition of *Diagnostic and Stastical Manual of Mental Disorders* published in 1994, by the American Psychiatric Association is the latest and most up to date classification of mental disorders
ICD	The classification system used by the World Health Organization is called the International Classification of Diseases (ICD).
Multi axial system	***System used to evaluate the patient along several variables and the DSM-IV classification contains five axes. The multiaxial presentation of the ICD-10 is composed of three axes***
Neurosis	is a chronic or recurrent non-psychotic disorder characterized mainly by anxiety
Psychosis	Psychosis is emphasized loss of reality testing and impairment of mental functioning manifested by hallucinations and delusions, confusion and impaired memory. Psychotic features also include

	severe impairment of social and personal functioning.
Syndrome	A cluster of symptoms is called a syndrome

3.11 Model Questions

1. Describe the purpose of the classification system and what are its advantages and disadvantages
2. Explain the content and structure of DSM-IV
3. Bring out the salient features of ICD-10

3.12 References

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LESSON 4
STRESS COPING AND MALADAPTIVE BEHAVIOUR

4.1. Objectives

- To understand the concepts of stress and coping.
- To know about the importance of social support in coping with stress.
- To have an idea about stressful situations and life transitions.
- To understand clinical reactions to stress.
- To know the various methods of treating stress.
- To understand stress related problems.

4.2. Structure

4.2.1. Stress and Coping.

4.2.2. Social support

4.2.3. Stressful situations and life transitions.

4.2.4. Clinical reactions to stress.

4.2.5. Treating stress

4.2.6. Related Problems.

4.3. Stress and Coping

Stress is the process of appraising events as threatening, challenging, or harmful, and responding to such events on a physiological, emotional, cognitive or behavioural level. The triggering events themselves may be negative in nature, such a physician confronted with a series of life-threatening crises, or they may be positive, such as a bride faced with a series of important, although desirable changes in her life. What defines events as stressful is the response that is made to them.

No one's life is totally free of stress – and, if it were, we would likely wish for something to happen that would relieve the consistency of a stress free existence. Indeed, the only way in

which life could hold no stress is if the environment would place no demands whatsoever upon us and if we had no needs of our own to fulfill.

Generally, stress occurs when cognitive appraisal – the process by which people define and interpret events, occurrences, and other stimuli in their environment – reveals some kind of threat or challenge. The stimuli producing stress vary not only from one individual to another, but even within the same person from day to day. You might find that getting a low grade on a test does not evoke stress if you attribute your failure to the difficulty of the test – especially if most of your classmates also do poorly. On the other hand, you likely will experience stress if you consider your poor performance a reflection of your intellectual shortcomings.

Despite the personal nature of the factors that produce stress in a given individual, stressors fall into several broad categories. These include cataclysmic events, personal stressors, and background stressors or minimum hassles.

4.3.1. Cataclysmic Events

Cataclysmic events are stressors that occur suddenly and that affect many people simultaneously. Natural disasters, such as hurricanes and floods, nuclear accidents and plane crashes fit into this category.

Although it may seem that cataclysmic events would produce the longer-lasting effects of any type of stressor, they actually may produce lower levels of long-term stress than do events and circumstances that are initially less intense. One reason is that they affect many people at the same time, so the difficulties a person encounters may be shared with others who can provide social support. Cataclysmic events typically have a clear end point; and once they are over, people can begin to rebuild their lives with the knowledge that the worst is behind them.

On the other hand, some victims of major catastrophes can experience posttraumatic stress syndrome, in which the original events and the feelings associated with them are reexperienced in vivid flashbacks or dreams. Many veterans of war suffer from posttraumatic stress syndrome, which leads to sleep difficulties, problems in relating to others, and alcohol and drug abuse.

4.3.2. Background Stressors

For most people it may be life's minor day-to-day hassles that are the source of most stress. Background stressors, or more informally, daily hassles, are minor irritations we face as we proceed trough life. They may be inconsistent, one-time inconveniences or frustrations, or they may be longer-term in nature, such as dissatisfaction with a relationship, school or job; a lack of privacy; or a fear of crime. By itself, no single hassle is sufficient to produce much stress, but when hassles add up, they may be enough to tip the balance toward a strong, stress-related reaction.

There is a clear linkage between the number of daily hassles one experiences and the appearance of psychological symptoms such as depression and anxiety. Most people's hassles are relatively inconsequential – the most common being concern about one's weight. The act that such hassles are associated with psychological health suggests that the minor annoyances of life do add up.

On the flip side of hassles are uplifts; those minor positive events that make one feel good – even if it is only temporarily. Uplifts range from relating well to a companion to finding one's environs pleasing. What is more intriguing about these uplifts is that they are associated with people's psychological health in just the opposite way that hassles are: The greater number of uplifts experienced, the fewer the negative psychological symptoms experienced.

Yet, just as stress may appear in several guises, there are many ways in which coping, efforts to control, reduce or learn to tolerate the threats that lead to stress, may take place. One mechanism of coping with stress, is to attempt to take control of the body's physiological reactions.

4.3.3. Meditation

Meditation is a learned technique for refocusing attention that brings about an altered state of consciousness. In most forms of meditation, people repeat a mantra – a sound, word, or syllable such as the ones above – or focus their attention on a particular picture, a part of the body, a plant, or some other stimulus such as a flame. The meditator's key to the procedure is to concentrate so thoroughly on the stimulus that he or she becomes unaware of outside stimulation, focusing entirely on the inner experience. If meditation is carried out effectively, it brings about a decline in heart rate and blood pressure. Oxygen usage decreases, and even brain-wave patterns are altered. People typically feel refreshed, relaxed and less stressed. Enthusiasts of a popular variant of meditation, called transcendental meditation claim that it also leads to better scholastic performance and decreased aggression, as well as several other benefits. While such claims have yet to be verified, it is clear that meditation is an effective technique for inducing relaxation and reducing stress.

4.3.4. Progressive relaxation

A technique that focuses on the relaxation of specific muscle groups, as well as relaxation of the body as a whole, progressive relaxation is a coping technique that is more specific than meditation. In the procedure, various muscle groups are alternately tensed and then relaxed, allowing people to experience and learn what relaxation feels like. Once our muscles are relaxed, we will interpret the physiological experience as one of tranquility. In turn, this leads to a reduction in the perception of stress. But more takes place than just a reduction in the sense of stress. Research has found that the use of progressive relaxation procedures leads to such benefits as a reduction in high blood pressure and other ailments such as headaches – even during periods when relaxation procedures are not being actively employed.

4.3.5. Biofeedback

Biofeedback is a procedure in which a person learns to control internal physiological processes through the use of electronic monitoring devices that provide continuous feedback on a given physiological response. For instance, a person concerned about headaches produced by muscle tension in her neck might have sensors connected to her neck muscles. By willfully trying to alter the tension, then receiving immediate and precise feedback from the electrical apparatus, she will learn to control the constriction and relaxation of the muscles.

The significance of biofeedback for reducing the experience of stress is clear, since it allows people direct control of their physiological reactions to stress. Moreover, it can act as a preventive measure: By teaching people to reduce physiological tension in situations in which they normally would be expected to experience stress, they may be able to avoid the stress altogether.

4.3.6. Exercise

A technique that is quite effective in dealing with stress is one that initially increases physiological arousal: exercise. Heart beat, respiration rate and blood pressure – physiological responses sensitive to stress – tend to be lower in people who regularly exercise. Moreover, exercise gives people a sense of control over their bodies, plus a feeling of accomplishment. It even provides a temporary respite from the environment that is causing the stress in the first place, and it causes people to sleep better at night.

Vigorous exercise releases endorphins, a natural painkilling chemicals in the brain that may result in feelings of happiness and even euphoria. Endorphins may be responsible for the "runner's high", the positive feelings sometimes reported by long-distance runners following a long run. In sum, exercising may produce a naturalistic coping response in the body.

4.3.7. Diet

Sometimes a change in diet is helpful in coping with stress. For instance, people who drink large quantities of caffeine are susceptible to feeling jittery and anxious; simply decreasing the amount they consume may be sufficient to reduce the experience of stress. Similarly, being overweight may itself be a stressor, and losing excess weight may be an effective measure for reducing stress.

4.3.8. Stress inoculation

The identification of irrational beliefs suggests a means for coping with stress through an approach known as stress-inoculation training. It is a three-stage method for coping with and modifying people's thoughts about the stress and tension in their lives.

The first step in the procedure is to develop a greater awareness of one's behaviour and thoughts. A daily log helps here; through it, a person can identify the specific circumstances that produce stress, learning the kinds of stimuli that bring about and maintain stress. Moreover, this process in and of itself can lead to a greater sense of control, as the person comes to understand the specific cause of his or her negative feelings.

In the second stage, a person mentally rehearses and begins to initiate behaviour that is incompatible with any earlier irrational thoughts. Using self-statements a person can learn the habit of coping with stress in a rational and constructive manner.

In the last stage, a person is taught to apply the skills that have been learned. The skills are employed in increasingly stressful situations until the person is comfortable with the procedures. At this point, people can employ reinforcing self-statements.

4.4. Social Support

Our relationships with others may provide an important means of coping with stress. Researchers found that social support, the knowledge that we are part of a mutual network of caring, interested others, enables us to experience lower levels of stress and to be better able to cope with the stress we do undergo.

There are several ways in which others can provide the social support that helps in dealing with stress. For instance, others can provide emotional support by demonstrating that the person in need of their support is an important and valued member of a social network. Similarly, other people can provide information and advice about appropriate ways of dealing with stress – and they can be available as a sounding board.

Finally, people who are part of our social support network can provide us with tangible goods and services. For instance, they can supply a person whose house has burned down with temporary living quarters, or they can help a student who is experiencing stress due to academic performance to study for a test.

Relying on the social support of others, then, seems to be a reasonable strategy for dealing with stress. Not only does social support diminish the experience of stress, but increases our ability to cope with it.

4.4. Stressful situations and life transitions

The death of a friend, starting college, moving. Although normal parts of life, each of these changes can bring stress. Personal stressors represent major events in one's life that can produce an immediate stress reaction. Although the stress typically tapers off after sufficient time has passed, there can be lingering long-term effects.

Which of life's many events can be considered stressful? In an attempt to answer this question, researchers developed the Social Readjustment Rating Scale (SRRS), a questionnaire for rating the number of life events – both negative and positive that a person has experienced during the past year. Because a large set of judges determined the typical importance of each event – starting with marriage, which was rated at an arbitrary 50 on the scale – during the development of the scale, it is possible to derive a total score for "life-change" events.

Several studies have found that high scores on the SRRS are linked to subsequent illness or injury, and that – in general – stressful events are a factor in ensuing physical illness. For instance, high levels of life events have been found to be associated with heart attacks, tuberculosis, diabetes, leukemia and even accidents. Of course, we cannot necessarily assume that having many changes in one's life actually produces illness; there is merely an association between life changes and illness. It is possible for instance, those people who experience significant life changes are also those who are more apt to be ill in the first place, or that being ill – one of the life events measured by the scale – causes one to experience more life changes. Similarly, because the experience of stress is based on the appraisal of the individual, we cannot assume that everyone reacts to a particular life change in the same way. Hence, the death of a disliked, quarrelsome spouse may be welcomed and ultimately produce less stress than if the spouse had continued to live.

Despite the deficiencies of the SRRS, it does provide a list of the major patent kinds of life events. Given that such events require both major and minor adjustments, their potential for causing stress is real.

4.5. Clinical Reactions to Stress

Stress can produce a variety of extreme biological outcomes according to Hans Selye, a pioneering figure in research on the physiological characteristics of stress. Selye developed the general adaptation syndrome (GAS), a model of the stages through which one's body passes as it attempts to ward off the effects of environmental stressors. We move through three major phases: alarm and mobilization, resistance and exhaustion.

The alarm and mobilization stage represents the body's first line of defense against a stressor. When an organism is threatened by some stressor, it first prepares itself for battle. Regardless of whether the stressor is physical or psychological, the body's reaction is similar: heartbeat and blood pressure increase, muscles tense, sweating increases, production of the hormone adrenalin increases and the organism attempts to meet the challenge of the stressor. In physiological terms, there is activation of the sympathetic nervous system responsible for physiological responses to emergency situations.

If the stressor continues, the next phase of the GAS is reached. In the resistance stage, people prepare to fight the stressor, and they are generally able to cope with the stress-producing situation. But their physiological and psychological – preoccupation with the specific original stressor makes them more vulnerable to other stressors. For example, if you are primarily concerned with meeting the demands of a difficult semester and concentrate your efforts on studying, you may be particularly irritable and unusually susceptible to illness. In fact, during the resistance stage, you are particularly prone to diseases of adaptation, or psychosomatic disorders – physical disorders in which emotions and thoughts play an important role. Psychosomatic disorders, which may include ulcers, high blood pressure, asthma, and skin problems, or more subtle problems such as insomnia or sexual problems, originate from people's attempts to adapt to stressors.

If attempts to meet the demands of a stress-provoking situation are inadequate, or if they continue for too long, the final stage of the GAS is reached: exhaustion. In the exhaustion stage, a person's ability to cope with stress declines to a point where the stressor is overwhelming. Almost no one is able to maintain a normal existence under continued high levels of stress. If the stressor continues unabated, the resultant stress leads ultimately to total exhaustion – and to the eventuality of death.

Anxiety is a emotional response characterized by feelings of fear, apprehension, and physiological tension. Anxiety is a common response to stress. A stressor may lead us to be worried, frightened, or unable to think clearly. We experience obvious internal physiological reactions as well: a knot in the stomach, an increased heart rate, or muscle tightness. There may be outward physical signs of anxiety, obvious to observers, in which a person under stress sweats, trembles, or breathes heavily.

Typically, there is a clear source of stress that produces anxiety. In some cases, however, anxiety is more generalized, occurring when there is no clear-cut, obvious stressor present. In

such cases, the presence of anxiety can itself produce stress, as the individual tries, sometimes unsuccessfully, to determine why the anxiety is present. Anxiety, then, can occur as a result of stress, and it can also act as a cause of future stress.

Some people are more anxious than others, regardless of the nature of stress in their lives, while others experience relatively little anxiety, even in situations that would typically produce anxiety in others. People also have characteristic ways of experiencing and displaying anxiety due to stress; one person might, for instance, stutter when experiencing unusually high anxiety, while another's hands might shake.

4.6. Treating Stress

The relatively recent identification of acute and posttraumatic stress disorders as specific diagnostic categories has spurred the development of numerous treatment programs for the psychologically troubled survivors of traumatic events. Although the specific features of these treatment programs vary from trauma to trauma, all the programs share basic goals; they try to help survivors reduce or overcome their lingering symptoms, gain perspective on their traumatic experiences, and return to constructive living. Treatment programs for war veterans who suffer from posttraumatic stress disorder demonstrate how these issues may be addressed.

Therapists have used a combination of techniques to alleviate the posttraumatic symptoms of veterans. Anti anxiety drugs have reduced the tension, hyper alertness, and exaggerated startle responses that many veterans experience. In addition, antidepressant medications have sometimes lessened nightmares, flashbacks, intrusive recollections, and feelings of depression.

Behavioural exposure techniques have also been employed. For example, flooding along with relaxation training helped reduce frightening combat flashbacks and nightmares. The therapist and client first singled out combat scenes that the veteran had been reexperiencing frequently. The therapist then helped the client to imagine one of these scenes in great detail and urged him to retain the image until his anxiety subsided. After each of these flooding exercises, the therapist switched to positive imagery and led the client through relaxation exercises. In response to this treatment, the man's flashbacks and nightmares diminished.

Although symptomatic relief of this kind is useful, most clinicians believe that veterans with posttraumatic stress disorder cannot fully recover until they also develop insight and perspective in regard to their combat experiences and the impact those experiences continue to have on them. Sometimes clinicians help clients to bring out deep-seated feelings, accept what they have done and experienced, become less judgmental of themselves, and learn to trust others once again.

Attempts at expressing feelings and developing insight are often undertaken in group therapy, or rap groups, in which veterans meet to share experiences and give mutual emotional support. In an atmosphere of group trust, social support and common experience, many individuals find it easier to recall events and confront feelings they have been trying to avoid for a number of years.

One of the major issues dealt with in rap groups is guilt – guilt about things the members may have done to survive or about the very fact that they did survive while close friends died.

Once the veterans are finally able to talk candidly about their combat experiences and guilt feelings, they may start to recover from them and guage their responsibility for past actions more accurately. Another important issue addressed in rap groups is the rage that many veterans feel. Many veterans of the Vietnam War, for example, are intensely angry that they had to fight for a questionable cause, face unbearable conditions and tensions in Vietnam, and deal with an accusing society upon their return.

Rap groups originated in 1971, when an organization called Vietnam Veterans Against the War decided that there was a pressing need for a forum in which veterans could discuss their experiences with other veterans and together heal their psychological wounds. Today, more than 150 small counseling centers across America, as well as numerous treatment programs in Veterans Administration hospitals, specialize in rap groups. In addition, these agencies offer individual therapy, counseling for the spouses and children of troubled veterans, family therapy, and assistance in securing employment, education and benefits.

Because most Veteran Outreach Centres have existed only a relatively short time, research into their effectiveness is just beginning. So far, clinical reports and empirical studies suggest that they offer an important, sometimes life-saving treatment opportunity.

4.7. Related Problems

4.7.1. Acute reactions to stress

This category is for immediate and brief responses to sudden intense stressors in a person who does not have another psychiatric disorder at the time. The ICD-10 definition of acute stress reaction requires that the response should start within an hour of exposure to the stressor and begins to diminish after not more than 48 hours. The DSM-IV definition of acute stress disorder states that the onset should be while of after experiencing the distressing event and requires that the condition lasts for at least 2 days and for no more than 4 weeks.

The core symptoms of an acute psychological response to stress are anxiety or depression. Anxiety is the response to threatening experiences; depression is the response to loss. Anxiety and depression often occur together, because stressful events often combine danger and loss; an extreme example is a road accident in which a companion is killed. Other symptoms include feelings of being numb or dazed, difficulty in remembering the whole sequence of the traumatic event, insomnia, restlessness, poor concentration, and physical symptoms of autonomic arousal, especially sweating, palpitations and tremor. Anger or histrionic behaviour may be part of the response. Occasionally there is a flight reaction, for example, when a driver runs away from the scene of a road accident.

Coping strategies and defence mechanisms are also part of the acute response to stressful events. Avoidance is the most frequent coping strategy; the person avoids talking or thinking about the stressful events, and avoids reminders of them. The most frequent defence mechanism is denial, which is experienced as a feeling that the events have not really happened, or as inability to remember them. Usually avoidance and denial recede as anxiety diminishes: memories of the events return and the person is able to think or talk about them with less distress. This sequence allows working through and coming to terms with the stressful experience, though there may be continuing difficulty in recalling details of highly stressful events.

4.7.2. Posttraumatic stress disorder

This term denotes an intense, prolonged, and sometimes delayed reaction to an intensely stressful event. The essential features of a post-traumatic stress reaction are hyper arousal, re-experiencing of aspects of the stressful events, and avoidance of reminders. Examples of extreme stressors that may cause this disorder are natural disasters such as floods and earthquakes, man-made calamities such as major fires, serious transport accidents, or the circumstances of war, and rape or serious physical assault on the person. The original concept of posttraumatic stress disorder was of a reaction to such an extreme stressor that any person would be affected. Epidemiological studies have shown that not everyone exposed to the same extreme stressor develops post-traumatic stress disorder; hence personal predisposition plays a part. In many disasters the victims suffer not only psychological distress but also physical injury, which may increase the likelihood of a posttraumatic stress disorder.

The condition now known as posttraumatic stress disorder has been recognized for many years though under other names. The term posttraumatic stress disorder originated in the study of American servicemen returning from the Vietnam War. The diagnosis meant that affected servicemen could be given medical and social help without being diagnosed as suffering from another psychiatric disorder. Similar psychological effects have been reported among servicemen in both world wars, and amongst survivors of peacetime disasters.

4.7.3. Other reactions to severe stress

Posttraumatic stress disorder occurs only after exceptionally stressful events, but not every response to such events is a posttraumatic stress disorder. Combat veterans have high rates of depression, somatization disorder, and alcohol and drug abuse as well as post-traumatic stress disorder. After road accidents, anxiety disorders are actually more frequent than posttraumatic stress disorder. Survivors of concentration camps may develop marital problems. These other conditions may occur instead of, but also as well as, posttraumatic stress disorder. The most frequent were atypical depression, alcohol dependence, anxiety disorder, substance abuse, and somatization disorder.

4.7.4. Response to special kinds of severe stress: Rape and Physical assault

Victims of rape or physical assault experience acute reactions to stress, posttraumatic stress disorder, anxiety and depressive disorders, and psychosexual dysfunction. Posttraumatic stress disorder is the most frequent of these consequences. As well as experiencing symptoms of posttraumatic stress disorder, victims of rape and assault feel humiliated, ashamed, and vulnerable to further attack. They lose confidence and self-esteem, question why they were chosen as victims, and blame themselves for putting themselves in unnecessary danger. To these problems are added issues of betrayal and secrecy when the rapist is a family member or a friend. The victims may have problems in trusting, persistent anger and irritability, and excessive dependence. These problems were described first among women victims of rape but similar difficulties have been described among victims of male sexual assault.

Problems are more likely to persist when there has been an actual or perceived threat to life, previous psychological and social problems, past victimization, particularly abuse in childhood, past psychiatric illness or substance abuse, or a lack of social support.

4.7.5. Response to special kinds of severe stress: War and other armed conflict

Shellshock, battle fatigue, or war neurosis are terms used during the First World War, to describe psychological reactions to battle in British and American servicemen. Most of the reactions appear to resemble cases now diagnosed as posttraumatic stress disorder; others seem to have resembled panic disorder or depressive disorders. Cases with panic attacks and concerns about the heart, now diagnosed as panic disorder were known then as Da Costa's syndrome or disorderly action of the heart.

4.7.6. Response to special kinds of severe stress: Problems of refugees and victims of torture

Refugees may have experienced a wide range of traumatic events, including: the conditions of war, loss of home and possessions, loss by death or separation of relatives and friends, physical injury, either from the actions of war or from assault, rape or torture and the witnessing of violence to others. Those involved may develop any of the reactions to stressful events especially posttraumatic stress disorder and depressive disorders. These conditions have been identified in refugees from many cultures, though the presenting complaints may differ somewhat in people from different cultures, with more emphasis on physical than on psychological symptoms among people from non-Western countries. Victims of torture often experience posttraumatic stress disorder as well as the physical consequences of the experience. Factors increasing a person's resistance to the psychological effects of torture are said to be strong political convictions, and strong religious faith.

4.8. Summary

Stress is the process of appraising events as threatening, challenging, or harmful, and responding to such events on a physiological, emotional, cognitive or behavioural level. Just as stress may appear in several guises, there are many ways in which coping, efforts to control, reduce or learn to tolerate the threats that lead to stress, may take place. Our relationships with others too may provide an important means of coping with stress. The death of a friend, starting college, moving. Although normal parts of life, each of these changes can bring stress. Personal stressors represent major events in one's life that can produce an immediate stress reaction. Stress can produce a variety of extreme biological outcomes called the general adaptation syndrome, a model of the stages through which one's body passes as it attempts to ward off the effects of environmental stressors. Although the specific features of treatment programs for stress vary from trauma to trauma, all the programs share basic goals; they try to help survivors reduce or overcome their lingering symptoms, gain perspective on their traumatic experiences, and return to constructive living.

4.9. Technical Terms

Stress - is the process of appraising events as threatening, challenging, or harmful, and responding to such events on a physiological, emotional, cognitive or behavioural level.

Cataclysmic events - are stressors that occur suddenly and that affect many people simultaneously.

Meditation - is a learned technique for refocusing attention that brings about an altered state of consciousness.

Progressive Relaxation - A technique that focuses on the relaxation of specific muscle groups, as well as relaxation of the body as a whole.

Biofeedback - is a procedure in which a person learns to control internal physiological processes through the use of electronic monitoring devices that provide continuous feedback on a given physiological response.

Stress inoculation - It is a three-stage method for coping with and modifying people's thoughts about the stress and tension in their lives.

GAS - a model of the stages through which one's body passes as it attempts to ward off the effects of environmental stressors.

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4.11. Model Questions

4.11.1. What is Stress? What are the various coping mechanisms of Stress?

4.11.2. How is Social Support helpful in tackling Stress?

4.11.3. What is the role of life changes in leading to Stress?

4.11.4. What are the clinical reactions to Stress?

4.11.5. What are the various Stress related problems? How can they be treated?

LESSON 5

PSYCHOLOGICAL FACTORS AND PHYSICAL SYMPTOMS

5.1. Objectives

- To understand the interactions of psychological, social and bodily processes.
- To know about Psychophysiological disorders.
- To know about Somatoform Disorders.
- To understand Factitious Disorders.
- To know the disorder of Malingering

5.2. Structure

5.2.1. Psychological, Social and Bodily interactions.

5.2.2. Psychophysiological Disorders.

5.2.3. Somatoform Disorders.

5.2.4. Factitious Disorders

5.2.5. Malingering

5.3. Psychological, Social and Bodily interactions

Advocates of the psychosomatic approach to medicine maintain – as Galen and others did many centuries ago – that it is unrealistic to compartmentalize "mind", "body" and "environment" when assessing and treating maladaptive patterns, whether such patterns are primarily physical or psychological in nature. This view is supported by the striking correlations, which a number of investigators have found between the incidence of physical illness and emotional disturbances.

In their pioneering study of illness in relatively healthy populations, for example, Hinkle and Wolff (1957) found that persons who had the greatest number of physical illnesses, regardless of kind, were also the ones who experienced the greatest number of disturbances in mood, thought, and behaviour. Similarly, in a study of almost 400 subjects in a 10-year period, Rahe and Holmes (1966) found that major health changes were evidenced by 70 per cent of those who experienced severe life crises, while the figure was only 37 per cent for those who experienced moderate crises. In fact, Matarazzo, Matarazzo, and Saslow (1961) concluded that the incidence of physical illness in a population is a good predictor of mental disturbances, and vice versa.

The correlation between physical and emotional disturbances is well brought out in the reports of Jacobs et al., (1970, 1971) of their initial and follow-up evaluations of 179 college students in the Boston area – 106 of whom sought medical help for respiratory infections. The ill

subjects were significantly more likely than the "normals" to perceive the year preceding their illness as one characterized by failure and disappointment; and the more severely ill they were, the more frequent and intense were their reports of unpleasant and stressful events and emotions. A follow-up study revealed recurrences of illness and repetition of treatment-seeking behaviour, while the healthy controls tended to stay healthy. Finding that the chief point of difference between the ill and healthy subjects was the style and intensity of the formers' maladaptive coping behaviour, the investigators concluded that a direct association could be made between maladaptive coping styles and physical illness, as well as psychiatric complaints.

An explanation for such concurrences in physical and emotional disturbances may be found in Schwab's (1970) observation that there is often a vicious circle in which emotional disturbances adversely affect the body's functioning and lower its resistance to disease; and disease, in turn, tends to elicit and exacerbate feelings of anxiety, depression, and, often, hopelessness. Thus, Schwab did not find reports of both physical and mental distress by emotionally disturbed persons surprising – noting that the concurrence of mental and physical symptomatology should be regarded as natural when we view man as a biosocial organism whose nervous system functions as the central integrating medium. Each highly stressful experience leaves a person with an indelible scar to the extent that it uses up bodily reserves that cannot be entirely replaced and contributes to the process we call "aging".

5.4. Psychophysiological Disorders

Earlier in this century clinicians identified a group of physical illnesses that seemed to result from an interaction of psychological and physical factors. These illnesses differed from somatoform disorders in that both psychological and physical factors played significant causal roles and the illnesses themselves brought about actual medical damage. Whereas early versions of the DSM labeled these illnesses psychosomatic or psychophysiological disorders, DSM-IV uses the label psychological factors affecting medical condition and further clarifies that the factors at work may be psychological symptoms, personality traits, coping styles, or another such factor.

At first clinicians believed that only a limited number of illneses were psychophysiological. In recent years, however, researchers have learned that many kinds of illnesses – including bacterial and viral infections – may be caused by an interaction of psychological and physical factors.

During the first seventy years of the last century, clinicians identified several disorders that they believed were psychophysiological. The best known and most prevalent were ulcers, asthma, chronic headaches, hypertension, and coronary heart disease.

Ulcers are lesions, or holes, that form in the wall of the stomach (gastric ulcers) or of the duodenum (peptic ulcers), resulting in burning sensations or pain in the stomach, occasional vomiting, and stomach bleeding. Ulcers are apparently caused by an interaction of psychological factors, such as environmental stress, intense feelings of anger or anxiety, or a dependent personality, and physiological factors, such as excessive secretions of the gastric juices or a weak lining of the stomach or duodenum.

Asthma causes the body's airways (the trachea and bronchi) to constrict periodically, so that it is hard for air to pass to and from the lungs. The resulting symptoms are shortness of breath, wheezing, coughing, and a terrifying choking sensation. Approximately 70 per cent of all

cases appear to be caused by an interaction of such psychological factors as anxiety, heightened dependency needs, environmental stress, and troubled family relationships and such physiological factors as allergies to specific substances, a slow-acting sympathetic nervous system, and a weakness of the respiratory system traceable to respiratory infections or biological inheritance.

Chronic headaches are frequent intense aches of the head or neck that are not caused exclusively by a physical disorder. There are of two types. **Muscle contraction headaches** (also called tension headaches) bring pain at the back or front of the head or at the back of the neck. These headaches occur when the muscles surrounding the skull contract, constricting the blood vessels. **Migraine headaches** are extremely severe and often immobilizing aches located on one side of the head, often preceded by a warning sensation called an aura, and sometimes accompanied by dizziness, nausea, or vomiting. Migraine headaches develop in two phases: (1) blood vessels in the brain constrict, so that the flow of blood to parts of the brain is reduced, and (2) the same blood vessels later dilate, so that blood flows through them rapidly, stimulating numerous neuron endings and causing pain. Research suggests that chronic headaches are caused by an interaction of psychological factors, such as environmental stress, general feelings of helplessness, feelings of hostility, compulsiveness, or a passive or depressive personality style, and such physiological factors as serotonin dysfunction, vascular weakness, or musculoskeletal deficiencies.

Hypertension is a state of chronic high blood pressure. That is, the blood pumped through the body's arteries by the heart produces too much pressure against the artery walls. Only 5 to 10 per cent of all cases of hypertension are caused exclusively by physiological abnormalities; the vast majority are brought about by a combination of psychological and physiological factors and are often designated essential hypertension. Some of the leading psychological causes of **essential hypertension** are constant environmental danger, chronic feelings of anger or its inhibition, and an unexpressed need for power. Leading physiological causes include a diet high in salt and dysfunctional baroreceptors – sensitive nerves in the blood vessels responsible for signaling the brain that blood pressure is becoming too high.

Coronary heart disease is caused by a blocking of the coronary arteries – the blood vessels that surround the heart and are responsible for providing oxygen to the heart muscle. The term actually refers to any of several specific problems, including myocardial infarction and blockages of coronary arteries. More than half of all cases of coronary heart disease are related to an interaction of such psychological factors as job stress and the so-called Type A personality style of high levels of hostility, impatience, frustration and competitiveness and constant striving for control and success and such physiological factors as a high level of serum cholesterol, obesity, hypertension, the effects of smoking and lack of exercise.

5.5. Somatoform Disorders

When a physical illness eludes medical assessment, physicians may alternatively suspect that the patient has a somatoform disorder. Such patients have physical complaints that are again rooted exclusively in psychological causes. However, in contrast to people with factitious disorders, patients with somatoform disorders experience no sense of willing their symptoms or having

control over them. Indeed, they rarely believe that the problems are anything but organic.

Some somatoform disorders, known as hysterical disorders, involve an actual loss o change of physical functioning. People with a conversion disorder, for instance, develop dramatic physical symptoms or deficits affecting voluntary motor or sensory functioning; those with a somatization disorder experience multiple physical symptoms; and those with a pain disorder experience pain that is not predominantly attributable to a medical cause.

In another group of somatoform disorders, the preoccupation disorders, physical functioning is at most minimally lost or changed, but people with these disorders become preoccupied with the notion that something is wrong with them physically. Those who experience hypochondriasis mistakenly and repeatedly fear that fluctuations in their physical functioning indicate a serious disease. Those with a body dysmorphic disorder worry excessively that some aspect of their physical appearance is defective.

5.5.1. Hysterical Somatoform Disorders

Hysterical disorders, the somatoform disorders that involve altered or lost physical functioning, are often difficult to distinguish from problems with a medical base. The symptoms of these disorders take many forms and typically have a major impact on patients' lives.

A **conversion disorder** is characterized by one or more physical symptoms or deficits affecting voluntary motor or sensory function that are actually expressions of a psychological problem, such as a conflict or need: the psychological problem is converted to a physical symptom. The symptoms often suggest a neurological dysfunction, such as paralysis, seizures, blindness, loss of feeling, or loss of speech, and are thus often called pseudoneurological. Most conversion disorders emerge between late childhood and young adulthood; they are diagnosed at least twice as often in women as in men. They usually appear suddenly, at times of extreme psychological stress, and last a matter of weeks. Conversion disorders are thought to be quite rare.

People who have numerous physical ailments without an organic basis, and whose difficulties continue or recur for several years, are likely to receive a diagnosis of **somatization disorder**. This pattern, first described by Pierre Briquet in 1859, is also known as Briquet's syndrome. To receive a diagnosis of somatization disorder, the person's multiple ailments must include pains symptoms, gastrointestinal symptoms (such as nausea or diarrhea), a sexual symptom (such as erectile or menstrual difficulties), and a psuedoneurologic symptom (such as double vision or paralysis).

Patients with a somatization disorder usually go from doctor to doctor in search of relief. They often describe their many symptoms in dramatic terms.

Most also feel anxious and depressed. The disorder often runs in families; 10 to 20 per cent of the close female relatives of women with the disorder also develop it. It usually begins between adolescence and young adulthood with no identifiable precipitating event. A somatization disorder lasts considerably longer than a conversion disorder, typically for many years. The symptoms may fluctuate over time but rarely disappear completely without psychotherapy.

When people experience severe of prolonged pain and psychological factors play a significant role in the onset, severity, exacerbation, or maintenance of the pain they may receive a diagnosis of **pain disorder**. The psychological factors at work may be the exclusive cause of the pain, or may join with an actual medical problem to cause the pain. The pain may occur in any part of the body. Patients with conversion or somatization disorders may also experience pain without a dominant medical cause, but in a pain disorder the pain is the central symptom. Researchers have not been able to determine the precise prevalence of pain disorders, but they appear to be relatively common, and women seem to experience them more often than men. The disorder may begin at any age and in some cases continues for years.

5.5.2. Preoccupation Somatoform Disorders

People who have hypochondriasis and body dysmorphic disorder, both characterized as preoccupation somatoform disorders, misinterpret physical symptoms as signs of serious physical problems. Friends, relatives, and physicians may try to dissuade them from this notion but usually without success. Although often these kinds of somatoform disorders cause considerable distress, they do not affect a person's social or occupational functioning so profoundly as hysterical disorders do.

People who suffer from **hypochondriasis** unrealistically and fearfully interpret bodily signs or symptoms as signs of serious illness. Often the reported ailments are merely normal fluctuations in physical functioning, such as occasional coughing, sores, or sweating. Despite repeated diagnostic tests, patients with hypochondriasis are not reassured. Some patients actually recognize that their concern is excessive; others do not.

Hypochondriasis can present a picture very similar to that of a somatization disorder. Each typically involves numerous physical symptoms and frequent visits to doctors, and each causes patients great concern. Diagnosticians try to distinguish between the two on the basis of the following criteria: if the anxiety level is significant and the bodily symptoms are relatively minor, a diagnosis of hypochondriasis is in order; if the bodily symptoms are

more significant and overshadow the patient's anxiety, they probably indicate a somatization disorder.

Although hypochondriasis can begin at any age, it emerges most commonly in early adulthood. Some patients eventually overcome their preoccupation, but for most the symptoms wax and wane over the years. Like pain disorders, hypochondriasis is reportedly very familiar to physicians, but its exact prevalence is unknown. Men and women are equally likely to receive this diagnosis.

People who experience a **body dysmorphic disorder** also known as dysmorphophobia, become preoccupied with some imagined or exaggerated defect in their appearance. Most commonly they worry about facial flaws such as wrinkles, spots on the skin, excessive facial hair, swelling of the face, or a misshapen nose, mouth, jaw of eyebrow. Some worry about the appearance of their feet, hands, breasts, penis, or another body part. Others are concerned about bad odors coming from sweat, the breath, the genitals, or the rectum. Some people are distressed by several body features.

It is common for people in our society to be somewhat concerned about their appearance. Adolescents and young adults in particular often worry about such things as acne. The concerns of people with a body dysmorphic disorder, however, are extreme and disruptive. Sufferers may even have difficulty looking others in the eye, convinced that their flaws are on display. They may also to go great lengths to conceal the defect – always wearing sunglasses to hide the shape of their supposedly misshapen eyes, for example, or even seeking plastic surgery to correct the problem. Most cases begin during adolescence and persist for an extended period. Often, however, they are not diagnosed for many years because individuals with the disorder are reluctant to reveal their concerns.

5.6. Factitious Disorders

People who become physically sick usually go to a physician. Sometimes, however, an illness defies medical assessment, and physicians may suspect some causes other than the physical factors they have been seeking. They may conclude, for instance, that the patient is malingering – intentionally feigning illness to achieve some external gains, such as financial compensation.

Alternatively, physicians may suspect that the patient is manifesting a factitious disorder, more precisely, a factitious disorder with predominantly physical signs and symptoms. People with this disorder intentionally produce or feign physical symptoms, but, unlike the malingerers, their motivation for assuming the sick role is the role itself. They have no external incentives for developing the symptoms.

The physical symptoms of a factitious disorder may be a total fabrication, self-inflicted, or an exaggeration of a preexisting physical condition. People with the disorder usually describe their medical history dramatically, but become

vague when pressed for details. Their knowledge of medical terminology and hospital routine is often extensive. Many eagerly undergo painful testing or treatment, even surgery. If physicians confront them with evidence that their symptoms are factitious, they typically deny the charges and rapidly discharge themselves from the hospital; they are quite likely to enter another hospital the same day.

Munchausen syndrome is the chronic form of this disorder. People with this syndrome travel from hospital to hospital reciting their symptoms, gaining admission, and receiving treatment. In a related but apparently rare form of factitious disorder, **Munchausen syndrome by proxy**, parents fabricate or induce physical illnesses in their children in order to get attention from physicians. When these children are removed from their parents and placed in the care of others, their symptoms disappear.

The syndrome is more common in men than women. Cases usually begin during early adulthood and often develop into a pattern that greatly impairs the person's ability to hold a steady job, maintain family ties, or form enduring social relationships. The disorder seems to be most common among people who (1) received extensive medical treatment and hospitalization as children for a true physical disorder, (2) carry a grudge against the medical profession, (3) have worked as a nurse, laboratory technician or medical paraprofessional, (4) had a significant relationship with a physician in the past, or (5) have underlying dependent, exploitative, or self-defeating personality traits.

The precise cause of factitious disorders are not really understood. These disorders have received little systematic study, and clinicians have not been able to develop standard effective treatments for them. Some success has been reported in individual cases with the use of a flexible, multidisciplinary treatment team.

5.7. Malingering

Malingering is the fraudulent stimulation or exaggeration of symptoms. In DSM-IV it is said to differ from factitious disorder in that the production of symptoms is motivated by external incentives, whereas in factitious disorder there are no external incentives but a psychological need for the sick role. This distinction as well as the distinction from somatoform disorder can be difficult.

Malingering occurs most often among prisoners, the military, and people seeking compensation for accidents. Numerous types of clinical picture have been described:

- Malingered psychosis, seen in those wishing to obtain admission to hospital for shelter, previously psychotic patients whose discharge is imminent or in criminal defendants trying to avoid standing trial or influence sentencing;

- Ganser's syndrome with four features: giving approximate answers, to questions designed to test intellectual functions, psychogenic physical symptoms, hallucinations and apparent clouding of consciousness;
- Malingered or exaggerated post-traumatic stress disorder;
- Malingered cognitive-deficit;
- Malingered physical disease and disability.

Before malingering is diagnosed, there should always be a full medical examination. DSM-IV suggests that malingering should be strongly suspected if the following are observed:

- Marked discrepancy between the person's claimed stress or disability and the objective findings;
- Lack of cooperation during the diagnostic evaluation and treatment;
- The presence of antisocial personality disorder; and
- The medico legal context.

When the diagnosis is certain, the patient should be informed tactfully. He should be encouraged to deal more appropriately with any problems that led to the symptoms, and in appropriate cases offered a face-saving way to give up the symptoms. It is always necessary to remember that people who are known to malinger also suffer genuine physical illness.

Surveillance by video or other means is used by lawyers or insurers, although seldom by clinicians for ethical reasons. Psychological tests and a number of specialist instruments have been suggested as aids in diagnosis. Careful and cautious interpretation is appropriate within consideration of the whole clinical picture.

5.8. Summary

Advocates of the psychosomatic approach to medicine maintain – as Galen and others did many centuries ago – that it is unrealistic to compartmentalize "mind", "body" and "environment" when assessing and treating maladaptive patterns. Psychophysiological disorders are those in which both psychological and physiological factors interact to cause a medical problem. Patients with a somatoform disorder have physical complaints whose causes are almost exclusively psychological. Patients with a factitious disorder fake physical disorders in order to assume the role of a person with an illness. Malingering is the production of symptoms motivated by external incentives.

5.9. Technical Terms

Psychophysiological disorders – are those in which both psychological and physiological factors interact to cause a medical problem.

Somatoform disorders – are physical complaints whose causes are almost exclusively psychological.

Hysterical Somatoform disorders – involve the actual loss or alteration of physical functioning.
Preoccupation somatoform disorders – involves preoccupation with the notion that something is wrong physically.

Factitious disorders – involve faking physical disorders for assuming the role of a person with illness.

Malingering – is the production of symptoms motivated by external incentives.

5.10. References

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5.11. Model Questions

5.11.1. Explain the interrelationship between mind, body and the environment in causing
psychopathology.

5.11.2. What are psychophysiological disorders?

5.11.3. Describe the various Somatoform disorders with illustrations.

5.11.4. What are factitious disorders? How are they different from somatoform disorders?

5.11.5. What is Malingering? How is it different from factitious disorder?

LESSON 6
ANXIETY DISORDERS

6.1. Objectives

- To know about generalized anxiety disorder.
- To understand panic disorder.
- To have an idea about obsessive-compulsive disorder.
- To understand the interpretation and treatment methods of anxiety disorders.

6.2. Structure

6.2.1. Generalized Anxiety Disorder

6.2.2. Panic Disorder

6.2.3. Obsessive-Compulsive Disorder

6.2.4. Interpretation and Treatment of Anxiety Disorders

6.3. Generalized Anxiety Disorder

People sometimes tend to experience excessive anxiety and worry about numerous events or activities. Given the scope of their worries, their problem is often described as free-floating anxiety.

Generalized Anxiety Disorder is relatively common in our society. Although the disorder may emerge at any age, it most commonly first appears in childhood or adolescence. Women diagnosed with this disorder outnumber men 2 to 1.

People with a generalized anxiety disorder typically feel restless, keyed up, or on edge, are easily fatigued, have difficulty concentrating, act irritable, experience muscle tension, and have sleep problems. The symptoms last at least six months. Nevertheless, most people with the disorder are able, with some difficulty, to maintain adequate social relationships and occupational activities.

A variety of factors have been cited to explain the development of generalized anxiety disorder. Proponents of the various models have focused on different factors and offered different explanations and treatments for generalized anxiety disorder. These explanations and treatments have received only limited research support to date, although recent cognitive and biological efforts seem to be promising.

According to the sociocultural view, increases in societal dangers and pressures may establish a climate in which generalized anxiety disorder is more likely to develop. Freud, the initial formulator of the psychodynamic view, said that a generalized anxiety disorder develops when defense mechanisms break down and function poorly. Carl Rogers, the leading humanistic theorist, believed that people with generalized anxiety disorder fail to receive unconditional positive regard from significant others during their childhood and so become overly critical of themselves. Existentialists believe that generalized anxiety disorder results from the existential

anxiety people experience because they know that life is finite and suspect that it may have no meaning. Cognitive theorists believe that generalized anxiety disorder is caused by maladaptive assumptions that lead people to view mot life situations as dangerous. Biological theorists argue that generalized anxiety disorder results from deficient activity of the neurotransmitter GABA. Behaviourists believe that anxiety is learned from the environment through classical conditioning or modelling and then maintained because of avoidance behaviour.

6.4. Panic Disorder

Sometimes an anxiety reaction accelerates into a smothering, nightmarish panic. When that happens to people, they lose control of their behaviour, are practically unaware of what they are doing, and feel a sense of imminent doom. Anyone can react with panic if a situation is provocative enough. Some people, however, experience panic attacks – periodic, discrete bouts of panic that occur abruptly and reach a peak within ten minutes. Such attacks consist of at least four symptoms of panic, the most common of which are palpitations of the heart, tingling in the hands or feet, shortness of breath, sweating, hot and cold flashes, trembling, chest pains, choking sensations, faintness, dizziness, and a feeling of unreality. Small wonder that during a panic attack many people fear they will die, go crazy, or lose control.

People suffering from any of the anxiety disorders may experience a panic attack when they confront one of the objects or situations they dread. Some people, however, experience panic attacks without apparent provocation, and do so recurrently and unpredictably. They may receive a diagnosis of panic disorder.

According to DSM-IV, a diagnosis of panic disorder is warranted if after one or more unexpected panic attacks a person spends a month or more worrying persistently about having another attack, worrying about the implications or consequences of the attack, or changing his or her behaviour markedly in response to the attack.

Most people develop the disorder between late adolescence and the mid-thirties, and the diagnosis is at least twice as common among women as among men. Many other people experience panic attacks that are not severe or frequent enough to be diagnosed as a panic disorder. Many people mistakenly believe that they have a general medical problem when they first experience panic attacks. Conversely, certain medical problems, such as mitral valve prolapse, a cardiac malfunction marked by periodic episodes of heart palpitations, and thyroid disease, may initially be misdiagnosed as panic disorder and nothing else.

A panic disorder is often accompanied by agoraphobia or fear of venturing into public places, a pattern that DSM-IV terms panic disorder with agoraphobia. In such cases, the agoraphobic pattern usually seems to emerge from the panic attacks. After experiencing unpredictable and recurrent panic attacks, people become fearful of having one someplace where help is unavailable or escape difficult.

Biological theorists believe that abnormal norepinephrine activity in the locus coeruleus is a key factor in panic disorders. The Cognitive position is that panic-prone people become preoccupied wit some of their bodily sensations and mental states and often misinterpret them as indicative of imminent catastrophe.

6.5. Obsessive-Compulsive Disorder

Obsessions are persistent thoughts, ideas, impulses, or images that seem to invade a person's consciousness. Compulsions are repetitive and rigid behaviours or mental acts that a person feels compelled to perform in order to prevent or reduce anxiety or distress. Minor obsessions and compulsions are familiar to almost everyone. We may find ourselves preoccupied with thoughts about an upcoming performance, date, examination, or vacation; worry that we forgot to turn off the stove or lock the door; or be haunted for days by the same song, melody, or poem. Similarly, we may feel better when we avoid stepping on cracks, turn away from black cats, follow a strict routine every morning, or arrange our closets in a carefully prescribed manner.

Minor obsessions and compulsions can play a helpful role in life. Distracting tunes or little rituals often calm us during times of stress. A man who repeatedly clicks his pen or taps his finger during a test may be releasing tension and thus improving his performance. Many people find it comforting to repeat religious or cultural rituals, such as sprinkling holy water, or fingering rosary beads.

According to DSM-IV, a diagnosis of obsessive-compulsive disorder is appropriate when a person's obsessions or compulsions feel excessive, unreasonable, intrusive and inappropriate; are hard to dismiss; cause significant distress; are very time-consuming; or interfere with daily functions.

It is equally common in males and females and usually begins in childhood, adolescence, or the early 20s. The disorder typically persists for many years, and the symptoms and their severity fluctuate over time. Many people with an obsessive-compulsive disorder are also depressed.

Obsessions are not the same as excessive worries about real problems. They are thoughts that feel both intrusive and foreign to the people who experience them. Attempts to ignore or resist these thoughts may arouse even more anxiety, and before long they come back more strongly than ever. People with obsessions are usually quite aware that their cognitions are excessive, inappropriate, and in fact products of their own mind, and many experience them as disgusting and torturous.

Clinicians have found it useful to distinguish various kinds of obsessions, although a single person may have several kinds. Obsessions often take the form of obsessive wishes, impulses, images, ideas, or doubts. Certain basic themes permeate the thoughts of most people troubled by obsessive thinking. The most common theme appears to be dirt or contamination. Other common ones are violence and aggression, orderliness, religion and sexuality.

Although compulsive behaviours are technically under voluntary control, the people compelled to do them have little sense of choice in the matter. They believe something terrible, often unspecified, will happen if they do not act on their compulsion. Many, but not all, such people recognize at the same time that their behaviour is excessive and unreasonable.

Some people develop the act into a compulsive ritual, performed in a detailed and often elaborate manner. They must go through the ritual in exactly the same way every time, according to certain carefully observed rules. Failure to complete it properly will generate further anxiety and often call for the ritual to be repeated from the beginning.

Like obsessions, compulsions take various forms and center on a variety of themes. A cleaning compulsion is very common. People with these compulsions feel compelled to keep cleaning themselves, their clothing, or their homes. The cleaning may follow ritualistic rules and be repeated dozens of hundreds of times a day. People with checking compulsions check the same things over and over, such as appliances, door locks, gas taps, ashtrays or important papers. Another common compulsion is displayed by people who repeatedly seek symmetry, order, or balance in their actions and surroundings. They must place certain items in perfect order in accordance with strict rules. Still other common compulsions involve touching, verbal rituals, or counting.

Although some people with an obsessive-compulsive disorder experience obsessions only or compulsions only, most of them experience both. In fact, their compulsive acts are often a response to their obsessive thoughts. A man who keeps doubting that his house is secure may yield to that obsessive doubt by repeatedly checking locks and gas jets. Or a man who obsessively fears contamination may yield to that fear by performing cleaning rituals. In some cases the compulsions seemed to serve to control obsessions. A girl may try to control her obsessive fears of contamination by performing counting and verbal rituals.

Many people with obsessive-compulsive disorder worry that they will act out their obsessions. A man with obsessive images of mutilated loved ones may worry that he is but a step away from committing murder; or a woman with obsessive urges to yell out in church may worry that she will one day give in to them and embarrass herself. Most of these concerns are unfounded. Although many obsessions lead to compulsive acts – particularly to cleaning and checking compulsions – they do not usually lead to acts of violence, immorality or the like.

Obsessive-compulsive disorder was once among the least understood of the psychological disorders. In recent years, however, researchers particularly in the biological realm have begun to learn more about it. The most influential explanations and treatments come from the psychodynamic, behavioural, cognitive and biological models. According to the psychodynamic view, obsessive-compulsive disorder arises out of a battle between id impulses, which appear as obsessive thoughts, and ego defense mechanisms, which take the form of counter thoughts or compulsive actions. Behaviourists suggest that compulsive behaviours often develop through chance associations and operant conditioning. Cognitive theorists suggest that obsessive-compulsive disorder grows from a normal human tendency to have unwanted and unpleasant thoughts – a tendency that some persons misinterpret as dangerous, reprehensible and controllable. Their efforts to eliminate or avoid such thoughts inadvertently lead to the development of obsessions and compulsions. Biological researchers have identified two biological factors that may contribute to this disorder: low activity of the neurotransmitter serotonin and abnormal functioning in key regions of the brain, including the caudate nuclei.

6.6. Interpretation and Treatment of Anxiety Disorders

The symptoms of anxiety disorders are persistent and are not restricted to, or markedly increased in, any particular set of circumstances. Characteristic pattern of symptoms comprise of the following features:

- Worry and apprehension, which are difficult to control and more prolonged than the ordinary worries and concerns of healthy people. The worries are widespread and not focused on a specific issue such as the possibility of having a panic attack or of being embarrassed or contaminated.

- Psychological arousal, which may be evident as irritability, poor concentration, and sensitivity to noise. Some patients complain of poor memory but this is due to poor concentration. If true memory impairment is found, a careful search should be made for a cause other than anxiety.
- Autonomic over reactivity, which is experienced most often as sweating, palpitations, dry mouth, epigastric discomfort, and dizziness. However, patients may complain of any of the symptoms. Some patients ask for help with any of these symptoms without mentioning spontaneously the psychological symptoms of anxiety.
- Muscle tension, which may be experienced as restlessness, trembling, inability to relax, headache and aching in the shoulders and back.
- Hyperventilation, which may lead to dizziness, tingling in the extremities and, paradoxically a feeling of shortness of breath.
- Sleep disturbances, which include difficulty in falling asleep and persistent worrying thoughts. Sleep is often intermittent, unrefreshing, and accompanied by unpleasant dreams. Some patients have night terrors in which they wake suddenly feeling intensely anxious. Early morning waking is not a feature of anxiety disorder and its presence strongly suggests a depressive disorder.
- Other features include tiredness, depressive symptoms, obsessional symptoms, and depersonalization.

6.6.1. Counselling

In the absence of a sufficient number of satisfactory controlled trials carried out with formally diagnosed anxiety disorders, guidance has to be based on clinical experience. In the early stages of the disorder, simple methods of counseling are often effective. Some patients with more severe or persistent generalized anxiety disorders respond to counseling, but others need either cognitive-behavioural therapy or medication. Counselling follows the general lines emphasizing the following:

- A clear plan of management agreed with the patient, and when appropriate, a relative or partners.
- An explanation of the nature of the disorder and reassurance that any physical symptoms of anxiety are not caused by physical disease.
- Problem solving or help in adjusting to problems.
- Advice about the use of caffeine. Patients with anxiety disorder are more sensitive than normal subjects to the anxiogenic effects of caffeine. Although many patients discover this for themselves and reduce their caffeine intake, those who have not done so may be helped by avoiding excessive caffeine intake.

6.6.2. Relaxation Training

If practiced regularly, relaxation can reduce anxiety in all the less severe disorders. However, many patients fail to persevere with the relaxation exercises. Practice in a group sometimes improves motivation, and some patients do better when relaxation is part of a programme of yoga exercises, which engage their interest.

6.6.3. Cognitive-Behavioural Therapy

The treatment combines relaxation with cognitive procedures designed to help patients to control worrying thoughts. Cognitive techniques are combined with exposure. The importance of exposure varies with the amount of avoidance behaviour, being greater in phobic disorders and less important in generalized anxiety disorders.

Three kinds of cognition are considered in treatment: general concerns about the effects of being anxious; concerns about specific symptoms, for example, fears that palpitations are a sign of heart disease, and concerns that other people will react unfavourably to the patient. The balance of these cognitions varies in the different anxiety disorders. Such cognitions are modified by giving information about the physiology of anxiety, and by questioning their logical basis. Information about the physiology of anxiety helps patients to attribute symptoms such as dizziness and palpitations to the correct cause, instead to physical illness such as heart disease. The logical basis of the fears is questioned by reviewing the patient's own evidence for the beliefs and suggesting ways in which he can test these and alternative explanations.

For panic disorder treatment is focused on the characteristic fears that physical symptoms of anxiety are evidence of serious physical disease. These fears, which often relate to heart disease, create a vicious circle in which anxiety symptoms such as tachycardia generate more anxiety, which further increases the physical symptoms. Vigorous heart action and other symptoms feared by the patient may be induced by voluntary hyperventilation or by strenuous exercise. Symptoms produced in these ways usually trigger the anxious thoughts, and thereby lead to anxiety. This demonstration that physical symptoms lead to anxious thoughts, which in turn lead to anxiety, helps patients to understand how a vicious circle of anxiety can lead to a panic attack. Patients then monitor the thoughts that precede naturally occurring panic attacks, to find out whether these attacks arise through the same mechanism. Attention is also given to safety behaviours and to any dysfunctional beliefs, which make ordinary situations stressful.

6.6.4. Medication

Medication should be used selectively for anxiety disorders. It can be used to bring symptoms under control quickly, while the effects of psychological treatment are awaited. Medication is helpful also in the minority of patients who do not improve with psychological measures. However, there is a general tendency to prescribe drugs too often and for too long. There have been many clinical trials of the various anxiolytic drugs but few with patients meeting present criteria for generalized anxiety disorder.

6.7. Summary

People with a generalized anxiety disorder typically feel restless, keyed up, or on edge, are easily fatigued, have difficulty concentrating, act irritable, experience muscle tension, and have sleep problems. Sometimes an anxiety reaction accelerates into a smothering, nightmarish panic. When that happens to people, they lose control of their behaviour, are practically unaware of what they are doing, and feel a sense of imminent doom. Some people, however, experience panic attacks – periodic, discrete bouts of panic that occur abruptly and reach a peak within ten minutes. Obsessions are persistent thoughts, ideas, impulses, or images that seem to invade a person's consciousness. Compulsions are repetitive and rigid behaviours or mental acts that a person feels compelled to perform in order to prevent or reduce anxiety or distress. a diagnosis of

obsessive-compulsive disorder is appropriate when a person's obsessions or compulsions feel excessive, unreasonable, intrusive and inappropriate; are hard to dismiss; cause significant distress; are very time-consuming; or interfere with daily functions. Counselling, relaxation training, cognitive-behavioural therapy and sometimes medication are useful treatment methods of anxiety disorders.

6.8. Technical Terms

Generalized anxiety disorder – involves typically feeling of restlessness, being keyed up, or on edge, becoming easily fatigued, having difficulty concentrating, acting irritable, experiencing muscle tension, and having sleep problems.

Panic disorder – involves panic attacks - periodic, discrete bouts of panic that occur abruptly and reach a peak within ten minutes. Such attacks consist of at least four symptoms of panic, the most common of which are palpitations of the heart, tingling in the hands or feet, shortness of breath, sweating, hot and cold flashes, trembling, chest pains, choking sensations, faintness, dizziness, and a feeling of unreality.

Obsessions - are persistent thoughts, ideas, impulses, or images that seem to invade a person's consciousness.

Compulsions - are repetitive and rigid behaviours or mental acts that a person feels compelled to perform in order to prevent or reduce anxiety or distress.

Cognitive-Behavioural Therapy - combines relaxation with cognitive procedures designed to help patients to control worrying thoughts.

6.9. References

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6.10. Model Questions

6.10.1. Describe the clinical picture of Generalized Anxiety Disorder and give a brief account of the various perspectives of Generalized Anxiety.

6.10.2. What is Panic Disorder? Describe the onset and course of the Panic Attack?

6.10.3. What are obsessions and compulsions? Describe the clinical picture of obsessive-compulsive disorder.

6.10.4. What are the various methods of treating anxiety disorders?

LESSON-7

SEXUAL VARIATIONS AND DISORDERS

7.0 Objectives

1. To have an overview of the various sexual variations
2. To understand sexual paraphilias and gender identity disorders

Structure of the lesson

7.1 Introduction

7.2 Changing views of Sexual Behaviour

7.3 Sexual dysfunctions

7.4 Paraphilias

7.5 Gender identity disorders

7.6 Sexual victimizations

7.1 Introduction

Sexual feelings are central to the development of intimate relationships in any adult's life. Sexual activity is related to satisfaction of basic needs, and therefore sexual performance is linked to self-esteem. The study of human sexuality deals with everything that is affected by sex; the sex impulses, instincts and drives; all thoughts, feelings, and behaviors connected to sexual gratification and reproduction, including interpersonal attraction; and the organs of sex and their functions. A person's sexuality is enmeshed with other personality factors, with his or her biological makeup, perception of being male or female and developmental experiences with sex throughout the life cycle. It is easier to define abnormal sexuality – sexual behavior that is destructive to self and others and is inappropriately associated with guilt and anxiety.

This lesson is concerned with two topics related to abnormal sexuality: sexual dysfunctions and paraphilias. Majority of sexual problems are presented in heterosexual relationships, but other types of sexual difficulty include preferential homosexuality and gender identity disorder.

7.2 Changing views of Sexual Behaviour

Homosexuality for long was considered a paraphilia. Before 1973, the DSM listed homosexuality as a sexual disorder. Until a few decades age there were rigid sexual norms imposed by the society and when people differed from the conventional norms of

sexuality it prosecuted and humiliated them. The gay rights movement, revolutionized society's understanding of and attitudes towards homosexuality. Homosexuality is now accepted as a variant of normal sexual behaviour and not a disorder. Homosexuality is accepted as life-style that some people adopt through choice, environment, genetics, physiological predisposition or psychosocial development. Sexual preference is the only behavioural variable that consistently distinguishes homosexual from heterosexual couples.

7.3 Sexual Dysfunctions

Sexual dysfunctions are disorders that make it impossible for an individual to enjoy coitus. The dysfunction is very distressing to the one experiencing it and often leads to sexual frustration, guilt about failure, loss of self-esteem and interpersonal problems with the sex partner.

Seven major categories of sexual dysfunctions are listed in DSM-1V:

- Sexual desire disorders
- Sexual arousal disorders
- Orgasm disorders
- Sexual pain disorders
- Sexual dysfunction due to general medical condition
- Substance-induced sexual dysfunction
- Sexual dysfunction not otherwise specified.

There are four phases of human sexual response: **the desire, excitement, orgasm, and resolution phases**. Sexual dysfunctions affect one or more of the first three phases of the cycle and the resolution phase is not associated with any dysfunction as it consists of relaxation and decline in arousal that follows orgasm.

7.3.1 Disorders of the Desire Phase

The desire phase of the sexual response cycle consists of feeling an urge to have sex and feeling sexually attracted to others. Two dysfunctions- ***hypoactive sexual desire disorder and sexual aversion disorder*** are associated with the desire phase. **Hypoactive sexual desire disorder** is characterized by lack of interest in sex resulting in low level of sexual activity. Age, duration of married life, education and social-class are some of the factors that influence the frequency of sex.

Sexual aversion disorder is related to finding sexual activity as unpleasant accompanied by feelings of revulsion, disgust, anxiety and fear. Aversion to sex seems to be quite rare in men and somewhat more common in women. A person's sex drive is determined by a combination of socio-cultural and psychological factors although biological factors to some extent can also lower sex drive. **Biological Causes** can be due to hormonal imbalances, use of drugs or chronic illness. Low levels of the male sex

hormone ***testosterone*** and high or low levels of the female sex hormone ***estrogen*** can result in low sex drive in men and women respectively. Drugs containing high levels of estrogen (certain oral contraceptives) may also suppress sex drive. Pain reducing medications, medications for certain medical disorders, some psychotropic drugs and illicit drugs such as cocaine, marijuana, amphetamines and heroin also lead to low sex drive. A low sex drive can be the result of an illness, an effect of medication or the result of the stress, pain or depression that may accompany a chronic illness.

Socio-cultural and psychological causes such as death in the family, job stress or having a baby often lead to hypoactive sexual desire. Relationship problems that include living in an unhappy, conflicted relationship may suppress sex drive or make sex unpleasant. People who feel powerless in their relationship and are very dominated by their partner lose sexual interest. Culture's double standard concerning the sexuality of women, the value placed on sexual attractiveness and youth also contributes to hypoactive sexual desire. Psychological factors such as personal beliefs and fears about sex are also factors for low sexual desire. People with extreme antisexual religious beliefs, those with hardworking and serious approach to life and those with fear of pregnancy also tend to have hypoactive sexual desire and sexual aversion. The trauma of being molested, or assaulted is likely to result in sexual aversion. Such individuals may experience vivid flashbacks during sexual activity and visual memories of the assault overwhelm them.

7.3.2 Disorders of the Excitement Phase

The excitement phase of the sexual response cycle is marked by a sense of sexual pleasure and general physical arousal. Dysfunctions affecting this phase are ***female sexual arousal disorder*** and ***male erectile disorder.*** Women with a sexual arousal disorder are unable to attain or maintain sexual excitement, including adequate lubrication or genital swelling during sexual activity. Consequently many also experience an orgasmic sexual dysfunction along with this disorder. Men with erectile disorder experience a persistent inability to attain or maintain an adequate erection during sexual activity. Erectile problems are most often seen in men over the age of 50. Erectile problems are often caused by a combination of organic impairments and psychological factors. Hormonal abnormalities that cause hypoactive sexual desire can also produce erectile problems. Abnormal levels of testosterone, estrogen, prolactin or thyroid hormones are found to be some of the **Biological Causes** seen in few cases while vascular abnormalities are much more common causes for male erectile disorder. Evaluation of ***nocturnal penile tumescence*** *(NPT),* or erections during sleep is useful in assessing organic basis for erectile difficulties. The **socio-cultural and psychological** causes of hypoactive sexual desire such as marital conflict or fear of closeness can also interfere with arousal and lead to an erectile disorder. Masters and Johnson proposed the cognitive theory that highlights the mechanisms of ***performance anxiety*** and the ***spectator role***. When an individual experiences erectile problem, he becomes fearful about having erection and worries during each sexual encounter and watches himself focusing on the goal of reaching erection. Instead of relaxing he becomes self-evaluative spectator.

7.3.3 Disorders of the Orgasm Phase

During the orgasm phase of the sexual response cycle an individual's sexual pleasure peaks and the sexual tension is released as the muscles of the pelvic region contract rhythmically. In men semen is ejaculated and in women the vaginal walls contract. Dysfunctions of this phase are ***premature ejaculation, male orgasmic disorder*** and ***female orgasmic disorder***.

In the dysfunction of ***premature ejaculation***, a man reaches orgasm and ejaculates with minimal sexual stimulation before, on, or after penetration and before he wishes it. This dysfunction seems to be typical of young, sexually inexperienced men who simply have not learned to modulate their arousal. This dysfunction is also related to heightened anxiety, rapid masturbation experiences during adolescence or inaccurate perceptions of one's own sexual arousal.

In ***male orgasmic disorder*** a man repeatedly is unable to reach orgasm or is delayed significantly in reaching orgasm following normal sexual excitement. This disorder is also referred to as ***inhibited male orgasm, inhibited ejaculation, ejaculatory incompetence*** or ***retarded ejaculation***, which is relatively uncommon. A number of biological factors can inhibit ejaculation. A low testosterone level, certain neurological diseases, head injuries and drugs such as alcohol, medications for high blood pressure and antidepressants can also inhibit ejaculation. The psychological cause of male orgasmic disorder may arise from hypoactive sexual desire where a man is not aroused enough to reach orgasm.

In ***female orgasmic disorder,*** also called ***inhibited female orgasm***, a woman repeatedly fails to experience an orgasm or repeatedly experiences a very delayed orgasm following normal sexual excitement. A number of physiological conditions affect woman's arousal and orgasm. Lack of orgasm can be a result of diabetes, multiple sclerosis and other neurological diseases. Medications and drugs can also inhibit orgasm. Postmenopausal changes in skin sensitivity and in the structure of the clitoris and the vaginal walls also have an effect on the arousal and orgasm in women. The various factors that cause hypoactive sexual desire and sexual aversion may also contribute to female arousal and orgasmic disorders. For example being raised in a sexually restrictive manner, lack of preparedness for the onset of menstruation, negative cultural message about female sexuality and sexual abuse in childhood may be some contributory factors for arousal and orgasmic disorders. The quality of woman's intimate relationship, her attraction to her partner and marital happiness can be linked to orgasmic behaviour.

7.3.4 Sexual Pain Disorders

Two sexual dysfunctions do not fit into the specific phase of the sexual response cycle. These are the sexual pain disorders, ***vaginismus*** and ***dyspareunia***, in which sexual activity cause extreme physical dysfunction or discomfort. In ***vaginismus***, involuntary

contractions of the muscles around the outer third of the vagina prevent the entry of the penis and women experience pain during intercourse. Most clinicians are of the view that vaginismus is a conditioned fear response set off by anticipation that vaginal penetration will be painful and damaging. Anxiety and ignorance of sexual intercourse, trauma caused before the woman is aroused and the trauma caused by childhood sexual abuse or adult rape are some cause for vaginismus. Some women experience painful intercourse because of an infection of the vagina or urinary tract or a gynaecological disease such as herpes simplex, or after menopause. In ***dyspareunia*** the person experiences severe pain in the genital during sexual activity. Dyspareunia occasionally occurs in men but it is much more common in women chiefly because of a physical cause such as an injury during childbirth to the vagina, cervix, uterus or pelvic ligaments. Also the scar left by episiotomy can be a source of pain. Though women who suffer from organically caused dyspareunia enjoy sex and get aroused, their sexual enjoyment is severely hindered by the pain

7.4 Paraphilias

These are disorders characterized by recurrent and intense sexual urges, fantasies or behaviors involving either nonhuman objects, children, nonconsenting adults or experiences of suffering or humiliation. Paraphilias are sexual deviations or perversions in which sexual arousal occurs persistently in response to objects which are not a part of normal sexual arousal. Few people receive a formal diagnosis of paraphilia but the large advertising of pornography leads clinician to suspect that the disorder may be quite prevalent. People whose paraphilias involve children or nonconsenting adults are often wrapped up in legal trouble and come to the attention of professionals for treatment. There is however less evidence about the causes and possible treatment to most of these disorders.

7.4.1 Fetishism

The key feature of ***fetishism*** is recurrent and intense sexual urges, fantasies, or behaviors that involve the use of a non-living object, which is intimately associated with the human body. This disorder is seen mostly in males. The fetish object may include shoes, gloves, lingerie, stockings and wigs. Some people with fetishism commit petty theft for the purpose of collecting as many of the objects of desire. The objects may be touched, smelled, or worn while the person masturbates, or the individual may ask the partner to wear the object when they have sex. Psychodynamic theorists proposed that fetishes are defenses to help the person avoid the anxiety associated with normal sexual contact. Behaviorists explain fetishes as acquired through classical conditioning and are treated with aversion therapy such as covert sensitization or masturbatory satiation.

7.4.2 Transvestism

This disorder occurs in heterosexual males. The person actually or in fantasy wears clothes of the opposite sex (cross dressing) for sexual arousal. This may be

associated with fantasies of other males approaching the person who is in female dress. Masturbation or coitus though rarely is associated with cross-dressing to achieve orgasm. To be called a disorder, this should be a persistent and significant mode of sexual arousal in the person. The persons with transvestism involve their partners in their cross-dressing behaviour. The development of transvestic behaviour can be explained through principles of operant conditioning.

7.3.3 Exhibitionism

A person with exhibitionism has recurrent sexually arousing urges or fantasies of exposing his genitals to another person, always a member of the opposite sex and may carry out the fantasies or urges. Sexuality is not attempted and what is often desired is a reaction of shock or surprise. Persons with these urges expose themselves when they have free time or are under significant stress. Usually this disorder begins before age 18 and is seen typically in males. Persons with exhibitionism are immature in their approaches to the opposite sex and have difficulty in interpersonal relationships. They have doubts about their masculinity and do not have satisfying relationships with their wives. Treatment includes aversion therapy and social skills training.

7.4.4 Voyeurism

This is a persistent and significant performance of the act of observing an unsuspecting person usually of the other sex, naked, disrobing or engaged in sexual activity. The risk of being discovered often adds to the person's excitement. The individual does not seek to have sex with the person being spied on. Voyeurism usually begins before the age of 15. Again this is mostly seen in males who masturbate either during the act or when thinking about it afterwards. Voyeurism is marked by the repeated invasion of another person's privacy. These actions are interpreted as exercising power over others by sexually inhibited persons. Psychodynamic dynamic theorists attribute this behaviour to an attempt to reduce castration anxiety while behaviourists explain the disorder as learned behaviour that can be traced to a chance and secret observations of a sexually arousing scene.

7.4.5 Frotteurism

This is a persistent and significant involvement in the act of touching and rubbing against an unsuspecting, non-consenting person usually of the other sex. Frotteurism is always committed by a male. This act is often employed in crowded places such as buses and market places where the victim does not protest because she cannot suspect that frottage can be committed there. Frotteurism begins in adolescence often after the person observes others committing an act of frottage. After the person reaches the age of 25 the act gradually decreases and often disappears.

7.4.6 Pedophilia

Pedophilia is a persistent and significant involvement of an adult (age> 16 years and at least 5 years older than the child) in sexual activity with pre-pubertal children, either heterosexual or homosexual. This may be associated with sexual sadism. Pedophilic behaviour may be limited to incest or is spread to children outside the family. People with pedophilia usually develop this sexual disorder during adolescence. Research suggests that many who develop this disorder were sexually abused as children. Pedophilia is an offence and pedophiles could be imprisoned and forced into treatment as it involves child sexual abuse. Treatments include aversion therapy.

7.4.7 Sexual Masochism

In this disorder the person (masochist) is persistently and significantly sexually aroused by physical and / or psychological humiliation, suffering or injury inflicted on self by others. People suffering from this disorder often derive sexual pleasure by having fantasies of being forced into reluctant sexual acts while they masturbate or have intercourse. Some of the acts involve being tied and whipped, spanked or verbally abused.

7.4.8 Sexual Sadism

In this disorder the person (sadist) persistently is sexually aroused by physical and /or psychological humiliation, suffering or injury of the sexual partner. Often the person inflicting the suffering is a male. The methods used range from beating, burning, cutting, stabbing, restraining to rape and killing. The term sadism is derived from the name of Maquis de Sade (1740-1814), who indulged in brutal violence on other people for his sexual gratification.

7.5 Gender Identity Disorder

Gender identity disorder or Transsexualism is characterized by persistent feelings of having been assigned to the wrong sex. Persons afflicted with this disorder are preoccupied with acquiring the primary or secondary sex characteristics of the other sex. They feel discomfort in clothes of their sex and therefore dress in the clothes of the opposite sex. Transsexualism is different from transvestism (cross dressing). In transvestism people dress in order to become sexually aroused while in transsexualism it involves deeper reasons for cross-dressing, reasons of sexual identity. Males outnumber females with this disorder by approximately 3 to 1. Furthermore individuals with transsexualism often engage in activities that are traditionally associated with the other sex. Treatment for this disorder includes hormone therapy as well as psychotherapy. Sex reassignment surgery has been controversial and transformation includes surgery and hormone therapy. In men it involves amputation of the penis, creation of an artificial vagina and face plastic surgery. For women surgery includes bilateral mastectomy and hysterectomy. The procedure for creating a functioning penis, called phalloplasty gives the appearance of having male genitals.

7.6 Sexual victimization

Sexual victimization or rape as it is commonly called is an antisocial act involving sexual intercourse with an unwilling partner. Rape is primarily an act of men against women. Forcible rape is considered an act of violence that includes any act of sexual domination. The definition of rape includes not only vaginal penetration but oral and anal entry as well. Another category called statutory rape refers to sexual intercourse between an adult male and child under the age of consent (typically eighteen years). The majority of sexual assaults are not reported. Rape victims are often traumatized by the experience, both physically and mentally. The physical violation of her body and ripping away the freedom of choice are enraging to the woman who is victimized. The victim also feels her vulnerability in not being able to fight off her stronger attacker and usually finds her capacity for resistance seriously compromised by her terror. Following an assault posttraumatic symptoms of anxiety and depression persist in the victim for years and such an individual is also at a high-risk foe suicide. Another source of stress is the societal pressure to prove their moral purity to husbands, friends, police and even to themselves.

Rape is not a spontaneous act of a man whose sexual impulses have gone out of control but is usually a planned one. The rapist may have a sadistic streak and exposure to certain forms of pornography may dispose men to act aggressively towards women in sexual situations. Rape between two people who know each other and are dating is called acquaintance rape or date rape. Faulty communication, alcohol consumption are some of the causes for acts of rape.

Attempts to prevent recurrence among rapists include a) group therapies aimed at changing attitudes toward women and teaching other ways to deal with anger, b) biological interventions such as chemical lowering of testosterone are used to some extent. Evidence for the effectiveness of such interventions is limited. Therapy for rape victim includes encouraging the victim to discuss her feelings about the trauma and to report the crime as well as helping her cope with the legal system and get medical attention. Long term therapy focuses on relationship problems that may have resulted from the rape, re-exposure in imagination to the trauma so as to lower anxiety and any guilt the victim may feel about her own role in the attack.

7.7 Summary

Sexual disorders are categorized into two broad areas, sexual dysfunctions and paraphilias.

Sexual dysfunctions are disorders that make it difficult or impossible for a person to have or enjoy coitus because of disturbances in the sexual desire and in the physiological changes that feature in the sexual response cycle and cause noticeable suffering and conflict in inter personal relations.

The sexual response cycle comprises of four stages namely, desire, excitement orgasm and resolution. In the resolution stag there are no dysfunctions. The two disorders related to the desire phase are Hypoactive sexual desire and sexual aversion. Dysfunctions in the excitement phase are female sexual arousal disorder and male erectile disorder. Dysfunctions in the orgasmic phase are premature ejaculation, male orgasmic disorder and female orgasmic disorder.

Two more sexual dysfunctions include sexual pain disorders that occur during the phase of sexual response cycle, vaginismus and dyspareunia where sexual activity causes a lot of pain and severe physical distress.

Biological causes for sexual dysfunctions include abnormality in the levels of hormones that control sex drive. Other common causes of sexual dysfunctions are due to vascular abnormalities, medications for chronic medical problems and use of illicit drugs. The socio-cultural and psychological factors that affect sexual activity include divorce, loss of a family member, childbirth, financial stress, unhappy relationship, disinterest in the partner and desire for personal space. Cultural standards also contribute to the disorder.

Paraphilias are frequent, forceful sexual urges, desires, fantasies or behaviours, which involve unusual objects, activities or situations and result in noteworthy anguish. Paraphilias are rarely diagnosed in clinical settings with the prevalence more common among men. Treatment of Paraphilias involves behavioural techniques such as aversion therapy, masturbatory satiation and orgasmic reorientation.

Gender identity disorder or transsexualism is characterized by persistent feelings of having been assigned to the wrong sex. Persons with this disorder have profound reasons for their sexual identity and cross-dressing, and involve themselves in the activities associated with the opposite sex. Treatment includes hormone therapy to alter secondary sex characteristics and in some cases sex-change surgery or sex-reassignment surgery.

Sexual victimization or rape is an antisocial act involving sexual intercourse with an unwilling partner. Rape is primarily an act of men against women. Faulty communication, alcohol consumption are some of the causes for acts of rape.

7.8 Technical Terms

Dyspareunia	A disorder in which a person experiences severe pain in the genitals during sexual activity
Exhibitionism	A paraphilias in which persons have sexually arousing urges to expose their genitals to another person, and may act upon those urges or fantasies

Female orgasmic disorder	A female dysfunction characterized by a repeated absence of or a long delay in reaching orgasm following normal sexual excitement.
Female sexual arousal disorder	A female dysfunction characterized by a persistent inability to attain or maintain sexual excitement
Fetishism	A paraphilia consisting intense sexual urges that involve the use of non living object, often to the exclusion of all other stimuli
Frotteurism	A paraphilia consisting of recurrent and intense sexual urges, fantasies, or behaviours that involve touching and rubbing against a non consenting person
Gender identity disorders	A disorder in which a person persistently feels uncomfortable about his or her assigned sex and strongly wishes to be a member of the opposite sex
Male erectile disorder	A disorder characterized by persistent inability to attain erection during sexual activity
Male orgasmic disorder	A disorder characterized by a lack of interest in sex
Masochism	A paraphilia characterized by repeated and intense sexual urges and behaviours that involve being humiliated, beaten, bound or otherwise made to suffer
Nocturnal penile tumescence	Erections during sleep
Paraphilias	Disorders characterized by recurrent and intense sexual urges and fantasies or behaviours involving nonhuman objects, children, nonconsenting adults or experiences of suffering or humiliation

Pedophilia	A paraphilia in which a person has intense sexual urges about touching or engaging in sexual act with prepubescent children
Premature ejaculation	A dysfunction in which a man reaches orgasm and ejaculates before, on or shortly after penetration ad before he wishes it
Sadism	A paraphilia characterized by intense sexual urges or behaviours that involve inflicting physical or psychological suffering on others
Sexual aversion disorder	A disorder characterized by an aversion to and active avoidance of genital sexual contact with sexual partner
Sexual dysfunction	A disorder in which a person is unable to function normally in some areas of the human sexual response cycle
Transvestism	A paraphilia consisting of intense sexual urges and behaviours that involve dressing in clothes of the opposite sex
Vaginismus	*A condition marked by involuntary contractions of the muscles around the outer third of the vagina, preventing entry of the penis*
Voyeurism	A paraphilia in which a person has recurrent and intense sexual desires to observe unsuspecting people in secret as they undress or to spy on couples engaged in intercourse, and may involve acting upon these desires

7.9 Model questions

1. Explain sexual dysfunctions that are associated with the different phases of the sexual response cycle?
2. Distinguish transvestism from transsexualism
3. Describe and explain sexual pain disorders

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LESSON 8

PERSONALITY DISORDERS

8.0 Objectives

1. To explain the major categories of personality disorders
2. To describe the treatment approaches to personality disorders

Structure of the lesson

8.1 Introduction

8.2 Classification

8.3 Odd or eccentric behaviours

8.4 Dramatic, emotional or erratic Behaviours

8.5 Anxious or Fearful Behaviours

8.6 Treatment of Personality Disorders

8.1 Introduction

Successful adjustment through the life cycle is mostly adapting to the changing demands and limitations involved at different stages of life. However a person's characteristic traits, coping styles and ways of interacting to the social environment emerge during childhood and fortify into established patterns by early adulthood. These patterns constitute the individual's personality. Most individuals comply with the social expectations while some are ill equipped to become fully functioning members of society. For these individuals personality formation has led to some traits that are maladaptive. These people are unable to perform some of the roles expected of them by their society. Such people are diagnosed as having personality disorders**.**

A **Personality disorder** is an enduring pattern of inner experiences and behaviour that deviates markedly from the expectation of the individual's culture. These disorders are pervasive across a broad range of personal and social situations. The enduring pattern leads to distress or impairment in social, occupational or other important areas of functioning.

8.2 Classification

The DSM-IV personality disorders are grouped into three clusters on the basis of similarities among the disorders. Cluster A includes paranoid, schizoid and schizotypal personality disorders. People with these disorders seem ***odd or eccentric*** with unusual behaviour ranging from distrust to suspiciousness to social detachment. Cluster B includes histrionic, narcissistic, anti-social and borderline personality disorders. Individuals with these disorders have in common a tendency to be ***dramatic, emotional and erratic.*** Their impulsive behaviour involves antisocial activities, is colourful, more

forceful and likely to bring them into contact with mental health or legal authorities. Cluster C includes avoidant, dependant and obsessive-compulsive personality disorders. In contrast to the other clusters, ***anxiety and fearfulness*** are often part of these disorders. It is difficult to distinguish them from anxiety-based disorders. Two additional personality disorders– depressive and passive aggressive personality disorders are listed in DSM-IV.

8.3 Odd or eccentric Behaviours

Cluster A consists of those personality disorders, which are thought to be on a 'schizophrenic continuum'. These are paranoid, schizoid and schizotypal disorders.

8.3.1Paranoid personality disorder

People with **paranoid personality disorder** have pervasive suspiciousness and distrust of others. They tend to see themselves as blameless, instead finding fault for their own mistakes and failures in others such that their motives are interpreted as malevolent. Such peoples are constantly expecting trickery and looking for clues to validate their experiences. They are often preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates leading to reluctance to confide in others because of unwarranted fear that the information will be used maliciously against him or her. They are also hypersensitive and have a tendency to read hidden demeaning or threatening meanings into benign remarks or events. They also commonly bear grudges and are unwilling to forgive perceived insults and slights. This pervasive suspiciousness and mistrust of other people leave a paranoid personality prone to numerous difficulties and hurts in interpersonal relationships. These people perceive attacks on their character or reputation that are not apparent to others and are quick to react angrily or to counterattack. They also have recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

8.3.2 Schizoid personality disorder

Individuals with schizoid personality disorder show an inability to form social relationships and lack of interest in doing so. They do not have good friends and are unable to express their feelings and are seen by others as cold and distant. As a result of such behaviours they are classified as loners, with solitary interests and occupations. They lack social skills and do not take any pleasure in many activities, including sexual activity. They may appear indifferent to praise or criticism and are not emotionally reactive. The central problem of the schizoid personality is an inability to form attachments to other people. The need for love, belonging and approval seem to have failed to develop in these people, leading to paucity of interpersonal experience.

8.3.3 Schizotypal Personality Disorder

Individuals with schizotypal disorder not only have pervasive pattern of social and interpersonal deficits, they also have cognitive and perceptual

distortions and eccentricities in communication and behaviour. Although both schizotypal and schizoid personalities are characterized by social isolation and withdrawal the two can be distinguished as schizotypal personality which is characterized by oddities of thought such as personalized and superstitious thinking, and idiosyncratic perception or speech even while reality contact is maintained. Under extreme stress they may experience transient psychotic symptoms. They often believe that they have magical powers and engage in magical rituals. Their oddities in thinking and talking, and other behaviours are similar to those seen in severe forms in schizophrenic patients. The distinguishing features of a schizotypal person are indicated by the following symptoms.

- Ideas of reference (excluding delusion of reference)
- Odd beliefs or magical thinking that influences behaviour and is inconsistent with sub cultural norms
- Unusual perceptual experience, including bodily illusions, aphorical, over elaborate or stereotyped
- Suspiciousness or paranoid ideation
- Inappropriate or constricted affect
- Lack of close friends or confidants other than first-degree relatives
- Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

8.4 Dramatic, Emotional or Erratic Behaviours

Cluster B consists of those personality disorders, which are thought to be on a psychopathic continuum. These are antisocial, histrionic, narcissistic and borderline personality disorders.

8.4.1 Antisocial personality

Individuals with anti-social personality disorder have a pervasive pattern of violation of the rights of others occurring since the age of 15 years. They continually show disregard for the rights of others through deceitful, aggressive or anti-social behaviour, without any remorse or loyalty to anyone. They tend to be impulsive, irritable and aggressive and show a pattern of generally irresponsible behaviour. According to DSM-IV this pattern of behaviour must have been occurring since the age of 15 years and before the age 15, the person must have had symptoms of Conduct Disorder. Some people with anti-social personalities have enough intelligence and social charm to devise and carry out elaborate schemes for conning large numbers of people. Imposters frequently fit into this category.

8.4.2 Borderline personality disorder

Persons with borderline personality disorder show a pattern of behaviour characterized by impulsivity and instability in interpersonal relationships, self-image and moods. The term borderline was originally used to refer to a condition that was thought to occupy the border between neurotic and psychotic disorders. Later the term has been used for people who have enduring personality features of instability and vulnerability. Individuals with borderline personalities show serious disturbances in basic identity or sense of self, which is highly unstable characterized by alternating between extremes of idealization and devaluation.

Given this extremely unstable self-image, they also have unstable interpersonal relationships. Feeling slighted they become verbally abusive toward loved ones or might even threaten suicide over minor setbacks. Given such behaviours it is not unusual that they have intense and stormy relationships that entail overidealizations of friends or lovers that later end in bitter disillusionment and disappointment. Their mood is also slightly unstable as they may display intense anger outbursts with little provocation and have difficulty controlling their anger.

They also tend to have a low tolerance for frustration, as well as chronic feelings of emptiness. Associated with the sense of emptiness is a common intolerance for being alone. Their extreme affective instability is reflected in drastic mood shifts and impulsive or erratic self-destructive behaviours, such as binges of gambling, sex, substance abuse, binge eating or reckless driving. Suicide attempts often manipulative are part of the clinical picture and self-mutilation is one of the most discriminating signs of borderline personality. Self injurious behaviour is associated with relief from anxiety or dysphoria.

The distinguishing feature of people with borderline personality is that failing to achieve a coherent sense of self. These people fail to complete the process of achieving an articulated self-identity and this failure leads to complications in interpersonal relationships.

8.4.3 Histrionic Personality Disorder

Persons with histrionic personality disorder typically show excessive attention-seeking behaviour and emotionality. They tend to feel unappreciated if not in the center of attention and their lively and dramatic styles often assure that they can charm others into attending to them. But these qualities do not lead to stable and satisfying relationships because tire of providing this level of attention. In seeking attention their appearance and behaviour are quite theatrical and emotional as well as sexually provocative and seductive. Their style of speech may be dramatic but also quite impressionistic and lacking in detail. They are often highly suggestible and consider relationships to be closer than they are. Their sexual adjustment is usually poor and their interpersonal relationships are stormy because they may attempt to control their partner through seductive behaviour and emotional manipulation, but they may also show a good deal of dependence. They are considered to be self-centered, vain, and over concerned

about the approval of others who see them as overly reactive, shallow and insincere.

8.4.4 Narcissistic Personality Disorder

Individuals with narcissistic personality disorder show an exaggerated sense of self-importance, a preoccupation with being admired and a lack of empathy for the feelings of others. The most stable and generalized criteria for diagnosing narcissistic person are a pervasive pattern of grandiosity and lack of empathy. Their grandiosity is manifested by a strong tendency to overestimate their abilities and accomplishments, while concurrently underestimating the abilities and accomplishments of others. Their sense of self-importance is a source of astonishment to others as the person expects to be recognized as superior without commensurate achievements. They are preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love. Because they believe they are so special they often associate with other high status people and make excessive efforts to look good. Narcissistic personalities believe that he or she is “special” and unique and can only be understood by other special or high-status people. People with narcissistic personality disorder have a very fragile sense of self-esteem under all their grandiosity. Probably this could be the reason why they are often preoccupied with what others think and show a great need for admiration. They are also sensitive to criticism, which leave them feeling humiliated, or empty. They show arrogant, haughty behaviours or attitudes and are often envious of others. They also have unreasonable expectations of favourable treatment or automatic compliance with theirr expectations. Most often they are interpersonally exploitative to achieve their own needs.

8.5 Anxious or Fearful Behaviours

Cluster C consists of those personality disorders which are characterized by ‘introversion’. These include Avoidant, Dependent, Obsessive-Compulsive and Passive-Aggressive personality disorders.

8.5.1 Avoidant Personality Disorder

Individuals with avoidant personality disorder have a pattern of extreme social inhibition leading to a lifelong pattern of limited social interactions. Because of their hypersensitivity and fear of criticism they do not seek other people, yet they desire affection and are often lonely and bored. Unlike schizoid personality they do not enjoy their aloneness; their inability to relate comfortably to other people causes acute distress and is accompanied by low self-esteem. Because of their hypersensitivity to any sign of rejection or social derogation they may readily see ridicule where none was intended. People with avoidant personality disorder avoid occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval or rejection. They

are unwilling to get involved with people unless certain of being liked. Such people also show restrain within intimate relationships because of the fear of being shamed or ridiculed. Often they suffer from feelings of inadequacy leading to inhibited behaviour in new interpersonal situations. They are usually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing. They want guarantees of success before they will participate and are not willing to face the slightest risk.

8.5.2 Dependent Personality Disorder

People with dependent personality disorder show extreme dependence on other people. A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation is characteristic of this disorder. They show acute difficulty in making everyday decisions without an excessive amount of advice and reassurance from others. These individuals usually build their lives around other people and need others to assume responsibility for most major areas of their life. They have difficulty expressing disagreement with others because of fear of loss of support or approval. They subordinate their own needs and views to keep the people involved with them. They have a great difficulty initiating projects or doing things on their own because of lack of self-confidence in judgment or abilities rather than lack of motivation or energy. They feel helpless and uncomfortable when alone because of exaggerated fears of being unable to take care of themselves. They urgently seek another relationship as a source of care and support when a close relationship ends. As a result dependent personalities passively allow other people to take over the major decisions in their lives. These individuals appear selfless and bland and feel that they have no right to express even mild individuality. They are often preoccupied with fears of being left to take care of themselves.

8.5.3 Obsessive-Compulsive Personality Disorder

Individuals with obsessive-compulsive personality disorder show an excessive concern with maintaining order and are very perfectionistic. They are also preoccupied with maintaining mental and interpersonal control through careful attention to rules and scheduled. They are very careful in what they do and repeatedly check for possible mistakes. They are preoccupied with details that are often trivial that consumes their time. Their perfectionism is dysfunctional in that it can result in their never finishing projects. They are devoted to work that necessitates ruling out leisure activities and may have difficulty in relaxing or doing anything just for fun.

People with obsessive-compulsive personality are excessively conscientious and are inflexible about moral and ethical issues. They also have difficulty getting rid of old and worn out household items and are quite stingy or miserly. At the interpersonal level, they have difficulty in delegating work to others and are rigid and stubborn. Others may view them as being cold and emotionally constricted.

8.5.4 Passive-Aggressive Personality Disorder

This disorder is characterized by a pervasive pattern of passive resistance to demands in social or occupational performance. They also show a strong pattern of negativistic attitudes unrelated to depressive or dysthymic disorders. Their passive resistance to demands is shown in many ways ranging from simple resistance to fulfilling routine tasks, to being sullen or argumentative, or alternating between defiance and submission. They complain of being misunderstood and unappreciated and at the same time are critical or scornful of authority. Intentional inefficiency, procrastination, forgetfulness are also used to achieve their purpose. Passive resistance can be viewed as covert anger or retroflexed anger. This behaviour is chosen in spite of the fact that a more direct and active way of showing an opinion or resisting is possible. Passive aggressive ways of reacting to problems are frustrating to others, who must deal with the inefficient behaviour and frustrating for the individual also because such behaviour typically does not productively resolve problems.

8.6 Treatment of Personality Disorders

Personality disorders are resistant to therapy and they do not respond to treatment. Due to defects in genes, socialization or maturation personality–disordered individuals have difficulty learning what society wishes to teach them. Valliant had reasoned that these individuals are similar to 'adolescents who need opportunities to internalize fresh role models and to make peace with the imperfect familial figures who are already within'. Treatment of personality disorders in Cluster A and Cluster B involves extensive cognitive therapy, individual psychotherapy, psychoanalysis and supportive therapy. Occasionally behavioural therapy such as social skills training and group therapy has been tried with this population. There is no known specific intervention that appears to be effective. Often response to treatment has limited impact on them. Behaviour therapy is effective for the Cluster –C (Anxious or Fearful) that includes Avoidant Personality Disorder and Dependent Personality Disorder. Social skills training and assertiveness training are useful and response to treatment is usually good. Table below provides the treatment of personality disorder and responsiveness to treatment

	DSM-IV Cluster	Treatment	Responsiveness to treatment
Paranoid	Odd	Individual psychotherapy, Supportive therapy	Modest
Schizoid	Odd	Individual psychotherapy, Psychoanalysis	Modest
Schizotypal	Odd	Psychoanalysis, Individual	Modest

		psychotherapy	
Anti-social	Dramatic	Individual psychotherapy	Poor
Borderline	Dramatic	Supportive psychotherapy and Psychoanalysis	Modest
Histrionic	Dramatic	Psychoanalysis and Individual therapy	Modest
Narcissistic	Dramatic	Individual therapy	Poor
Avoidant	Anxious	Cognitive – behavioural, group therapies	Moderate
Dependent	Anxious	Group therapy, Cognitive therapy and Assertiveness training	Moderate
Obsessive-compulsive	Anxious	Psychoanalysis, group therapy	Moderate
Passive-aggressive	Anxious	Supportive therapy, Behaviour therapy and Group therapy	Moderate

8.7 Summary

A personality disorder is a pervasive enduring and inflexible pattern of inner experience and outward behaviour that deviates markedly from the expectations of one's culture and leads to distress or impairment.

The DSM –IV distinguishes ten personality disorders and separates them into three clusters.

Three personality disorders are characterized by the kinds of odd or eccentric behaviours. Those with Paranoid personality disorder display a pattern of pervasive distrust and suspiciousness of others. Those with schizoid personality disorder display a pattern of detachment from social relationship and a restricted range of emotional expression. Individuals with schizotypal personality disorder display a pattern of interpersonal deficits marked by acute discomfort in close relationships, cognitive or perceptual distortions, and behavioural eccentricities.

Four personality disorders are marked by highly dramatic and emotional symptoms. Persons with antisocial personality disorder display a pervasive pattern of disregard for and violation of rights of others. Individuals with borderline personality disorder display a pervasive pattern of instability in interpersonal relationships, self-image, and mood, along with marked impulsivity. Histrionic personality disorder display a pattern of excessive emotionality and attention seeking. People with narcissistic personality disorder display a chronic and pervasive pattern of grandiosity, need for admiration, and lack of empathy.

Three of the personality disorders are marked by the kinds of symptoms exhibited in anxious personality disorders. People with avoidant personality disorder display a chronic and pervasive pattern of inhibition in social situations, feelings of inadequacy and extreme sensitivity. Individuals with dependent personality disorder display a pattern of submissive and clinging behaviour, fears of separation and a need to be taken care of. Individuals with obsessive-compulsive personality disorder display a pattern of preoccupation with orderliness, perfectionism and interpersonal control.

Personality disorders are usually resistant to treatment. The treatment gains tend to be modest in people with odd personality disorders. Antisocial personality disorder and narcissistic personality disorder are chronic and have been characterized as difficult disorder to treat. Psychotherapy, though limited in its effectiveness is often used with borderline and histrionic personality disorders.

8.8 Technical Terms

Antisocial personality disorder	***People with this disorder display a pervasive pattern of disregard for and violation of the rights of others***
Avoidant personality disorder	People with this disorder display a chronic and pervasive pattern of inhibition in social situations, feelings of inadequacy and extreme sensitivity to negative criticism
Borderline personality disorder	In this disorder people exhibit a pervasive pattern of instability in interpersonal relationships, self-image, and mood, along with marked impulsivity
Dependent personality disorder	People with this disorder display a pattern of submissive and clinging behaviour, fears of separation, and a pervasive and excessive need to be taken care of
Histrionic personality disorder	***People with this disorder display a pattern of excessive emotionality and attention seeking.***
Narcissistic personality disorder	Persons with this disorder display a pervasive need for admiration, and show a lack of empathy
Obsessive personality disorder	Individuals with this disorder display a pattern of preoccupation with orderliness,

	perfectionism and mental and interpersonal control, at the expense of openness and efficiency
Paranoid personality disorder	***People with this disorder display a pattern of distrust and suspiciousness of others.***
Passive personality disorder	Individuals with this disorder are characterized with stubbornness, intentional inefficiency, and procrastination.
Schizoid personality disorder	Individuals with this disorder display a pattern of detachment from social relationships and a restricted range of emotional expression
Schizotypal personality disorder	***People with this disorder display a pattern of interpersonal deficits marked by acute discomfort in close relationships, cognitive or perceptual distortions and behavioural eccentricities***

8.9 Model Questions

1. What is a personality disorder and briefly describe the various types listed in DSM-IV?
2. What are the "dramatic personality disorders" and what are the symptoms of each?
3. Describe different personality disorders and discuss some effective treatments methods

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LESSON 9

MOOD DISORDERS

9.0 Objectives

1. To understand the different perspectives on depression
2. To describe the two major mood disorders

Structure of the lesson

9.1 Introduction

9.2 Depression

9.3 Depressive disorders

9.4 Theoretical perspectives on depression

9.5 Bipolar disorders

9.6 Suicide

9.1 Introduction

Most individuals experience a wide variety of moods and have a range of affective expressions. They feel in control of their moods (the internal emotional state of a person) and affects (the external expression of emotional content). Mood disorders are a group of clinical conditions characterized by a loss of that sense of control and a subjective experience of great distress. Depression and mania are the dominating emotions in mood disorders. Patients who are afflicted with only major depressive episodes are said to have major depressive disorder or unipolar depression. Patients with both manic and depressive episodes or patients with manic episodes alone are said to have bipolar disorder. Bipolar disorder occurs less often than major depressive disorders. Three additional categories of mood disorders are hypomania, cyclothymic and dysthymia. **Hypomania** is an episode of manic symptoms that does not meet the full DSM-IV criteria for manic episode. **Cyclothymia** and **dysthymia** are defined as disorders that represent less severe forms of bipolar and major depression respectively.

9.2 Depression

Depression is a low, sad state in which life seems bleak and its challenges overwhelming. Mania, the extreme opposite of depression, is a state of breathless euphoria, or intense energy, associated with grandiose feelings and excessive involvement in pleasurable activities. Most people with a mood disorder suffer exclusively from depression, a pattern often called as ***unipolar depression*** or ***major depressive disorder***. They have no history of mania and

return to normal mood state when their depression lifts. Most of us experience dejection or the ups and downs in our mood, or the every day blues, which we label as depression, this state of mood, however is not the same as clinical depression. This dysfunctional clinical syndrome, which only a few experience, is called as unipolar depression or an episode of major depressive disorder. DSM- IV describes several different patterns of major depressive disorder. The depressive disorders are – major depressive disorder, Dysthymic disorder and depressive disorder not otherwise specified which are distinguished from the bipolar disorders by the fact that there is no history of ever having had a manic or hypo manic episode.

9.2.1 Clinical Picture of Depression

The DSM-IV diagnosis of a major depressive episode requires that a person exhibit at least five of the following symptoms nearly everyday for at east two weeks. Either depressed mood or loss of interest and pleasure must be one of the five symptoms.

- Sad, depressed mood
- Loss of interest and pleasure in usual activities
- Difficulties in sleeping
- Shifting in activity level, becoming lethargic or agitated
- Poor appetite and weight loss or increased appetite and weight gain
- Loss of energy and great fatigue
- Negative self-concept, self-blame, feelings of worthlessness and guilt
- Complaints or evidence of difficulty in concentrating such as slowed thinking and indecisiveness
- Recurrent thoughts of death or suicide

The symptoms associated with depression span five areas of functioning: the emotional, motivational, behavioural, cognitive and somatic. Persons with depression feel intensely sad and dejected. They tend to loose pleasure from anything and also experience anxiety, anger or agitation. The sea of misery finds expression in crying spells. Depressed people lose their desire to participate in their accustomed activities. They lack drive, initiative and spontaneity and find it difficult to go to work, eat meals or have sex. The activity of depressed people decreases and they do less productive work and prefer to spend time alone. Depressed people also move and speak slowly with reluctance and lack of energy. At the cognitive level depressed people hold negative views and consider themselves to be inadequate, undesirable and inferior people. A significant feature of depression is a negative view of the future and they are convinced that nothing will ever improve and they feel helpless. Depression is accompanied by physical ailments as headaches, indigestion, constipation unpleasant sensations in the chest and generalized pain.

9.3 Depressive Disorders

People experience major depressive disorder when their depression is significantly disabling. Major depressive disorder is a common recurrent disorder affecting about twice as many women as men. In few cases, episodes of depression include psychotic symptoms such as loss of reality, experiencing delusions (bizarre ideas without foundation) or hallucinations (perceptions of things that are not actually present). A major depressive disorder is described as ***recurrent*** if it is preceded by previous depressive episodes, ***seasonal*** if it fluctuates with seasonal changes or ***postpartum*** if it occurs within four weeks of giving birth. ***Dysthymic*** disorder is less severe but chronic that is long lasting but not severe enough for the diagnosis of major depressive disorder. Stressful life events can also trigger depressive episodes. Depression following a precipitating event is called as reactive or ***exogenous depression*** that is different from ***endogenous depression***, which unfolds without antecedents and seems to be caused by internal factors.

9.4 Theoretical perspectives on Depression

Several theories have been developed to explain the onset of depression. All the perspectives accept the vulnerability-stress model that indicates the relevance of stressful life events in causing mood disorders. The perspectives differ with respect to what vulnerabilities make some people more susceptible than others to becoming depressed after such events. ***Psychodynamic perspectives*** explain depression as resulting from anger turned inward against the self in response to loss of a loved one with whom the depressed person identifies. This process is believed to be likely if one's needs were insufficiently or excessively gratified during the oral stage, resulting in fixation and excessive dependency on others for maintaining self-esteem. Interpersonal researchers shift the focus from how depression prone people have internalized past relationships to the nature of the actual relationships in which they find themselves today. Depressed people show a range of social skill deficits, which may result in others rejecting them. This rejection in turn is depressing. Psychoanalytic therapy help depressed patients gain insight into their loss and repressed anger. Interpersonal therapy focuses on the current social interactions and relationships.

The ***behaviourists*** believe that depression results from significant changes in the rewards and punishments people receive in their lives, and the treatment includes reestablishing more favourable reinforcement patterns. Social reinforcements are important, as depressed people tend to experience fewer positive social reinforcements and lack social skills.

There are two theories which explain depression in terms of faulty cognitions. The ***Hopelessness theory*** developed from animal research by Seligman was derived from his theory , the ***learned helplessness theory, cognitive, attributional version*** and its ***transformation into the hopelessness***

theory. The basic premise of the learned helplessness theory is that depression is caused by a feeling of hopelessness, which arises when negative events happen to someone with one or more of the following tendencies: (a) to attribute negative events to stable, global causes, (b) to infer that negative events will have severe consequences, (c) to draw negative inferences about the self from the occurrences of negative events. ***Beck's cognitive theory*** explains depression in terms of unstated dysfunctional beliefs or schemata (such as a belief that one is unworthy and defective). When triggered by relevant stressful events (as in failure) these schemata fuel biased perceptions such as over generalizing the implications of a setback. This results in sustaining the individual's *negative outlook on self, the future and the environment*, (**the cognitive triad**) which in turn maintains the depressed mood. ***Cognitive therapy*** is based on Beck's theory of depression and teaches patients how to question and evaluate, rather than automatically accept, their depressing negative thoughts. It appears to be as effective as standard antidepressant medications in the maintenance of improvement.

Biological perspectives indicate that vulnerability to the major mood disorders is in part genetically transmitted. Theories involving the neurochemistry of mood disorders implicate low level of ***norepinephrine*** in depression and a high level in mania. it has also been found that a low level of ***serotonin*** allows wild fluctuations in the activity of other neurotransmitters, thereby producing both mania and depression. These theories are supported by the diverse lines of research on drug therapy for mood disorders. The hypothalamic –pituitary – adrenal cortical axis seems to be overactive in depression whereas disorders of thyroid function may play a role in bipolar disorder. Biological interventions include medications such as tricyclic antidepressants for major depressive disorders and lithium carbonate for bipolar disorder. Electro convulsive therapy is a controversial treatment although an effective and fast-acting intervention for unipolar depression. Combination of psychotherapy and drug therapy has tended to be successful than any one approach in the treatment of depression.

9.5 Bipolar Disorder

People with bipolar disorders experience both the lows of depression and the highs of mania. Their life is described as an emotional roller coaster as they shift back and forth between extreme moods, which affect relatives and friends.

9.5.1Clinical picture of mania

In contrast to unrelieved gloom of depression, a person in a state of mania is governed by a dramatic and inappropriate elevation of mood. The symptoms of mania encompass the same areas of functioning- emotional, motivational, behavioural, cognitive and physical- as those of depression but in a diametrically opposite way. Mania is characterized by active emotions that seem to be looking

for an outlet. The mood of euphoric joy and well being is out of proportion to the actual happening in the person's life. Some can also become irritable and angry when others get in the way of their ambitions, activities and plans. The DSM-IV diagnosis of a manic episode requires that a person exhibit a distinct period of abnormally and persistently elevated expansive or irritable mood, lasting at least 1 week during which three of the following symptoms have been present to a significant degree

- Inflated self-esteem or grandiosity
- Decreased need for sleep (feels rested after only 3 hours of sleep)
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience that thoughts are racing
- Distractibility (attention is too easily drawn to unimportant or irrelevant external stimuli
- Increase in goal directed activity (either socially, at work or sexually) or psychomotor retardation
- Excessive involvement in pleasurable activities (engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

The elevated mood is often infectious in nature. Manic patients often drink alcohol excessively in an attempt to self-medicate. The manic stream of remarks is loud and incessant, full of puns, jokes, play on words and rhyming. This speech is difficult to interrupt and reveals a manic's so called flight of ideas. They are disinhibited and exhibit a tendency to disrobe in public places and clothing and flaunting jewellery of bright colours in unusual combination. The manic need for activity may cause the individual to be social to the point of being intrusive. Any attempt to curb this momentum can bring quick anger and even rage. The patient is preoccupied by religious, political, financial, sexual or persecutory ideas that can evolve into complex delusional system. Mania usually comes on suddenly, over a period of a day or two. Untreated episodes may last from a few days to several months. Bipolar disorder occurs less often than major depressive disorder.

Mania has been related to high norepinehrine activity. Moreover, bipolar disorders have been linked to improper transportation of sodium ions back and forth between the outside and the inside of the nerve cell's membrane. Some genetic studies have suggested that people may inherit a predisposition to the biological abnormalities underlying bipolar disorders. Lithium has proved to be effective in alleviating and preventing both the manic and depressive episodes of bipolar disorders. Drug therapy supported by psychotherapy is found to be effective in the treatment of bipolar disorders.

9.6 Suicide

The word suicide conveys the meaning of self-destruction, self-killing or self-murder. Suicide has been defined variously for psychological, legal and social purposes.

Edwin Shneidman defines suicide as an intentional death- "***a self-inflicted death in which one makes an intentional, direct and conscious effort to end one's life***". The risk of suicide is elevated in mood disorders than in other disorders such as alcohol dependence, schizophrenia and panic disorder. Suicide rates vary with age and sex. The rate rises in old age although the rates of suicide for adolescents are also increasing. Men are three to four times more likely to kill themselves than are women. However about three times as many women as men attempt to kill themselves but they do not die. The sex difference may be related to the means of attempting suicide; while men usually choose jumping off a building, shooting or hanging which is fatal more often women use sleeping pills.

9.6.1 Causes of Suicide

The leading theories about suicide come from psychodynamic, biological and socio-cultural perspectives. However these theories have limited empirical support and fail to address all kinds of suicidal acts. Thus it would be inaccurate to conclude that the causes of suicide can be completely understood. ***The Psychodynamic*** theorists believe that suicide results mainly from depression and self-directed anger. The first important insight into suicide came from Sigmund Freud. In his *Mourning and Melancholia* Freud stated that suicide represented aggression turned inward against an introjected, ambivalently, cathected love object. Freud further explained suicide by proposing that human beings have a basic "death instinct," which he called *Thanatos,* that functions in opposition to their life instinct. Building on Freud's concepts Karl Meninger in *Man against Himself* was convinced that suicide is inverted homicide and that it is a result of patient's anger toward another person, which is turned inward or used as an excuse for punishment. He described three components of hostility in suicide: *the wish to kill, the wish to be killed and the wish to die*. Contemporary suicidologists suggested that patients having suicidal ideas have several reasons. There may be a wish to seek revenge, power, control, punishment; some may wish for atonement, sacrifice or restitution; others for escape or for rescue, and rebirth, or even reunion with dead or a new life. The preoccupation with suicide in many suicide patients is a way of fighting off intolerable depression and a sense of hopelessness. In fact, hopelessness was found to be one of the most accurate indicators of suicidal risks.

The French sociologist **Emile Durkheim** made major contribution to the study of the ***Socio-cultural influences*** on suicide**.** He divided suicides into three social categories: egoistic, altruistic and anomic. ***Egoistic suicide*** applies to those who are not strongly included into any social group. Lack of family integration can be considered why unmarried people are vulnerable to suicide than are the married. ***Altruistic suicide*** applies to those whose proneness to suicide stems from their excess integration into a group seen in the suicide human bombs of the Liberation Tigers of the Tamil Elam or the terrorist attackers of the 9/11 incidents in United States. ***Anomic suicide*** applies to those persons

whose integration into the society is disturbed. This explains why cotton farmers in Guntur district whose economic situation has changed drastically are more vulnerable and have committed suicide with change in fortune.

Several studies suggested the presence of ***genetic*** factors in suicides. It is possible that one family member who has committed suicide may serve as a role model to a young impressionable person who may consider suicide as a possible solution to his psychological distress. Also the psychological disorders associated with suicide are genetically transmitted aggravating the cause for suicide. The association between *deficiency in* ***serotonin*** *level* and *poor impulse control* found in depressed patients was also seen as a possible explanation for suicide.

Treatment for people who are suicidal falls into two major categories: treatment after suicide has been attempted and suicide prevention. Treatment may also be given to relatives and friends, who experience feelings of bereavement, guilt and anger after suicide fatality or attempt. Treatment that follow a suicide attempt involve in helping the client in achieving a non-suicidal state of mind and developing more constructive ways of handling stress and solving problems. There seems to be a shift in emphasis from suicide treatment to suicide prevention in the recent years. Suicide prevention programmes include 24 hours a day "**suicide hotlines**" and "**walk in centers**" staffed largely by paraprofessionals who follow the crisis intervention model. Most suicidal people also need long-term therapy.

9.7 Summary

People with mood disorders tend to have moods that disrupt their normal functioning. The most common pattern of mood disorder is the unipolar or major depressive disorder, which is characterized by a low, sad state in which life seems to be bleak. Mania is the extreme opposite of depression-characterized by euphoria and intense energy.

Women experience unipolar depression more than men. Depressive disorders are Major depressive disorders, Dysthymic disorder that are distinguished from bipolar disorders as there is no history of having had manic episodes.

In bipolar disorders, episodes of mania alternate or intermix with episodes of depression. Mania is a state of dramatic, inappropriate or disproportionate elevation of mood.

The symptoms of depression span four areas of functioning: emotional, behavioural, cognitive and physical. Depressed people are also at greater risk for suicidal behaviour

According to the psychodynamic perspective depression results from anger turned inwards. The behaviourists believe that depression results from changes in the rewards and punishments, which people receive in their lives**.** The cognitive theorists focus on the loss of control and leading to a sense of learned hopelessness and helplessness. The

biological perspective views deficiencies in two chemical neurotransmitters, norepinephrine and serotonin as the causes for depression.

Suicide is a self-inflicted death in which one makes an intentional, direct and conscious effort to end one's life. Many suicidal acts are tied to stressful events and situations, mood changes, alcohol, drug use and mental disorders.

The psychodynamic theorists believe that suicide is a result of self-directed anger. The socio cultural theory of Durkheim explains suicide in terms of either egoist, altruistic or anomic because of their relationship with society. The biological view of suicide had focused on the lower activity of the neurotransmitter serotonin.

There has been a shift of focus from suicide treatment to suicide prevention with several suicide hotlines and walk-in centers emerging that follow crisis intervention model.

9.8 Technical terms

Anomic suicide	Persons whose integration into the society is disturbed and commit suicide
Altruistic suicide	Persons whose proneness to suicide stems from their excess integration into a group such as the suicide human bombs of LTTE
Bipolar disorder	A mood disorder where the individual experiences both the lows of depression and the highs of mania
Egoist suicide	Individuals whose proneness to suicide stems from being not strongly included into any social group and lack family integration
Hopelessness theory	This theory is based on the premise that depression is caused by the feelings of hopelessness and learned helplessness
Suicide	A self-inflicted death in which one makes an intentional, direct and conscious effort to end one's life
Unipolar depression	***A mood disorder characterized by a low, sad state in which life seems bleak. There is no history of mania and suffer exclusively from depression***

9.9 Model Questions

What are the symptoms of depression and mania?

What is the difference between unipolar depression and bipolar disorder?
Describe the theories that explain the causes for depression
What is suicide? Discuss the causes of suicide?

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LESSON 10

SCHIZOPHRENIA

10.0 Objectives

1. To understand the nature and course of schizophrenia.
2. To be able to differentiate between the different types of schizophrenia.

Structure

10.1 Introduction

Schizophrenia is considered the most devastating of the mental illnesses because of its early onset and its effects on the person, his/her family and friends. The disorder includes some of the most extreme human behaviors – **psychosis** – referring to a pervasive contact with reality. There is usually a more or less defined break with the world. Schizophrenia represents the ultimate in psychological breakdown.

Emil Kraepelin used the term *dementia praecox* to refer to a group of conditions that seemed to have the feature of mental deterioration beginning early in life. However, it was Eugene Bleuler who coined the term *schizophrenia* (split mind) as he thought the condition was characterized primarily by disorganization of though processes, a lack of coherence between thought and emotion, and an inward orientation away from reality. In schizophrenia, the split is within the intellect, between the intellect and emotion, and between the intellect and external reality.

10.2 Characteristics of schizophrenia

10.2.1 Premorbid symptoms

Although the onset of illness is often defined at either the time of the diagnosis or first hospitalization, symptoms often develop slowly over months or years. Family and friends may notice that the person has changed and is no longer functioning well in occupational, social, and personal activities.

The typical history is that of the schizotypal personality – quiet, passive, few friends in childhood, daydreaming, and introverted. As an adolescent, the patient would have preferred activities that excluded social interactions.

10.2.2 Characteristics of schizophrenia

- **Disturbance of language and communication.** Often referred to as *formal thought disorder*, communication disturbance is usually considered a prime indicator of a schizophrenic disorder. The person fails to make sense though he or she may be grammatically correct. This process is referred to as "cognitive slippage", "derailment" or "loosening" of associations.

- **Disturbance of thought content.** Disturbances in the content of thought typically involve standard types of *delusion* (false belief). Most common among these are beliefs that one's thoughts, feelings, or actions are being controlled by external agents; that one's private thoughts are being broadcast to others, that thoughts are being inserted into one's brain by alien forces, etc. Delusions of bizarre bodily changes are also observed.

- **Disruption of Perception.** Hallucinations may occur in any of the five senses. Auditory hallucinations are most common among schizophrenics; they complain of hearing voices which are threatening, obscene, accusatory or insulting. Visual hallucinations occur less frequently, but are not rare.

- **Inappropriate emotion.** The most common affective presentations of schizophrenia are inappropriate emotions or affect; sometimes even anhedonia (inability to experience joy or pleasure); and emotional shallowness or "blunting" (lack of intensity or clear definition). The person may appear nearly emotionless, with a mere intellectual recognition of what is happening.

- **Confused sense of self.** Patients may be confused about their identity that they lose a subjective sense of self. The person may be confused about aspects of his/her own body including gender, or may be uncertain about boundaries separating the self from the rest of the universe. These feelings seem to be related to ideas of external control.

- **Disrupted volition.** Goal-directed activity is almost universally disrupted in schizophrenic individuals. The impairment occurs in areas of routine daily functioning such as work, social relations, and self-care. Thus, deterioration from a previously mastered standard of performance is apparent. Personal hygiene, personal safety and health may be completely disregarded.

- **Retreat to an inner world.** Contacts with the external world are loosened in schizophrenia. There seems to be a deliberate withdrawal from reality and an active disengagement from the environment. This rejection is accompanied by an elaborate development of an inner world full of illogical and fantastical ideas.

- **Disturbed motor behavior.** Motor disturbances range from an excited hyperactivity to a marked decrease in all movement or an apparent clumsiness. Peculiarities of movement are seen mostly in catatonic schizophrenia.

10.2.3 Attention and cognition

It is the cognition of the person that is most severely affected in schizophrenia. Disorders of thought are divided into disorders of content, form and process.

Disorders of content reflect ideas, beliefs, and interpretations of stimuli. Delusions are the most obvious example of a disorder of content. Delusions can be persecutory, grandiose, religious or somatic. Patients may have an intense preoccupation with esoteric, abstract, symbolic, psychological or philosophical ideas. Patients lack a clear sense of where the patient's own body, mind and influence end, and where those of other inanimate and animate objects begin.

Disorders of the form of thought are objectively observable in the spoken and written language and in the drawings of the patient. These disorders include looseness of associations, derailment, incoherence, neologisms, echolalia, word salad, and mutism.

Disorders in process of thought concern how ideas and language are formulated. These include flight of ideas, thought blocking, impaired attention, poverty of thought and content of speech, poor memory, poor abstraction abilities, perseveration, idiosyncratic associations (clang associations), illogical ideas, and vagueness.

10.3 Subtypes of schizophrenia

The DSM-IV has listed five subtypes of schizophrenia based on differing clinical pictures.

10.3.1 Undifferentiated Type

A person diagnosed with schizophrenia, undifferentiated type, meets the usual diagnostic criteria for schizophrenia – including delusion, hallucinations, disordered thoughts and bizarre behaviors – but does not fit into one of the other types because of a mixed symptom picture. Commonly observed are indications of perplexity, confusion, emotional turmoil, delusions of reference, excitement, dreamlike autism, depression, and fear. This picture is seen most often in patients who are in the process of breaking down and becoming schizophrenic.

10.3.2 Catatonic Type

The central feature of schizophrenia, catatonic type, is pronounced motor symptoms, either of an excited or stuporous type. The clinical picture is often an early manifestation of a disorder that will become chronic and intractable. In the stuporous state, there is a sudden loss of all animation and a tendency to remain motionless for hours or even days in a single position. Some of these patients are highly suggestible and will automatically obey commands or imitate the actions of others (**echopraxia**) or mimic their phrases (**echolalia**). Ordinarily, patients in a catatonic stupor stubbornly resist any effort to change their position and may become mute, resist all attempts at feeding, and refuse to comply with even the slightest request.

10.3.3 Paranoid Type

Paranoid-type schizophrenic patients show histories of increasing suspiciousness and of sever difficulties in interpersonal relationships. This type of schizophrenia is characterized mainly by the presence of delusions of **persecution** or **grandeur**. Typically, paranoid schizophrenics are tense, suspicious, guarded, and reserved. They are often hostile and aggressive, and conduct themselves well socially. There tends to be a higher level of adaptive coping and intact cognitive functioning among paranoid-schizophrenic patients than the other types. However, their delusions and hallucinations results in a loss of critical judgement and erratic, unpredictable behavior – paranoid schizophrenics can be dangerous and attack people who, they are convinced, are persecuting them.

10.3.4 Disorganized type

Schizophrenia of the disorganized type (earlier known as hebephrenic schizophrenia) usually occurs at an earlier age and represents a more severe disintegration of the personality. An affected person has a history of oddness, overscrupulousness about trivial things, and preoccupation with obscure religious and philosophical issues. As the disorder progresses, the person becomes emotionally indifferent and infantile. Speech becomes incoherent – a **word salad**. Auditory hallucinations are common while delusions are usually of a sexual, religious, or persecutory nature. Obscene behavior and the absence of any modesty or sense of shame are characteristic. They are indifferent to real-life situations; prognosis is generally poor if a person develops disorganized schizophrenia.

10.3.5 Residual type

This category is used for people who have experienced an episode of schizophrenia from which they have recovered sufficiently. Emotional blunting, social withdrawal, eccentric behavior, illogical thinking, and mild loosening of associations are common. Even if delusions and hallucinations are present, they are not prominent and are not accompanied by strong affect.

10.4 Causes of schizophrenia

The cause of schizophrenia is not known and remains unclear. However, biological factors, psychosocial factors, and sociocultural factors are considered to have some role in the causation of schizophrenia. However, these three factors are not mutually exclusive.

The major model which integrates the causative factors is the **stress-diathesis** model. It suggests that a person may have a specific vulnerability that, when acted upon by some environmental influence, allows the symptoms of schizophrenia to develop.

The most widely accepted biological explanation about the cause of schizophrenia is the **dopamine hypothesis,** which states that a hyperactivity of dopamine causes schizophrenia. The causes of schizophrenia will be discussed in detail later on in this lesson.

10.5 What causes schizophrenia?

As mentioned earlier, three sets of factors have been identified as being likely to cause schizophrenia – biological factors, psychosocial factors and sociocultural factors.

10.5.1 Biological factors

The study of biological factors in the causation of schizophrenia has focused largely on heredity, and on the various biochemical, neurophysiological and neuroanatomical processes.

Heredity. Genetic factors are believed to play an important causal role in the disorder based on the incidence of schizophrenia in the family backgrounds of patients. Nevertheless, it is not easy to identify only the genetic factors amidst a host of causative environmental factors. No specific gene or chromosome has been identified, increasing the likelihood of *polygenic* (multiple genes) involvement. Twin studies have been inconclusive, though monozygotic twins have shown a higher concordance rate than dizygotic twins.

Biochemical factors. Chemical imbalances in the brain have been implicated as the cause of mental disorders. In research on schizophrenia, the dopamine hypothesis has received acceptance as a possible cause of schizophrenia. Dopamine is a neurotransmitter and it has been found that an excess of dopamine activity at certain synaptic sites leads to schizophrenia. Though other biochemical theories have been forwarded to explain the occurrence of schizophrenia, the dopamine theory has been the most promising so far, though the brain chemistry of schizophrenia has not been perfectly understood yet.

Neurophysiological factors. Neurophysiological disturbances such as an imbalance in the various neurophysiological processes and inappropriate autonomic arousal have been the focus of recent research in schizophrenia. These changes in the physiology disrupt normal attentional and information-processing capabilities that underlie the cognitive and perceptual distortions characteristic of schizophrenia. Abnormal neurophysiological

processes in schizophrenia could also be genetic in origin, but could also be attributed to biological deviations caused by other factors.

Neuroanatomical factors. With the development of CAT and MRI technologies, evidence now indicates that in chronic negative-symptom schizophrenia, there is an abnormal enlargement of the brain ventricles, and sometimes, enlarged sulci (fissures of the cerebral cortex). PET scans have revealed that there is abnormally low frontal lobe activation among schizophrenic persons.

Though biological findings have sought to explain schizophrenia, it must be understood that these findings have to be supplemented by both psychosocial and sociocultural research in order to provide a comprehensive understanding of schizophrenia.

10.5.2 Psychosocial factors

The diathesis-stress model has emphasized the role of psychosocial factors in contributing to schizophrenia. Discussed briefly are the psychosocial factors which have been found to play a role in the causation of schizophrenia:

Pathogenic parent-child and family relationships. Studies on family interactions focused on factors such as schizophrenogenic parents, destructive marital interactions, and faulty communication. A schizophrenogenic mother was observed to be rejecting, domineering, cold, overprotective and impervious to the feelings and needs of others. Such a mother was said to reject her child and at the same time, depend on the child for her emotional satisfaction. This explanation was however rejected in the 1970s.

Destructive family interactions. The subculture of a family is not constant – every child raised within the family experiences a family pattern in many ways unique to him or her. It was found that 9 out of 10 schizophrenic siblings encountered periods of maximum family crisis during the critical period of early childhood. These crises included financial disasters, major parental strife, and depressive episodes in one or the other parent.

Faulty communication. Bateson (1960) was the first to emphasize the conflicting and confusing nature of communication among members of schizophrenic families. In the **double-bind communication**, the parent presents ideas, feelings, and demands that are mutually incompatible, to the child. For example, a parent may be verbally loving and accepting, but emotionally anxious and rejecting. However, no confirmation has been reported on the pathogenic contribution of double-bind communication.

10.5.3 Sociocultural factors

Schizophrenia has been described in all cultures and societies, and across all socioeconomic status groups. It has been observed that the lower SES group has a greater

number of cases of schizophrenia – explained by the **downward drift hypothesis** which states that affected persons either move into a lower SES group or fail to rise out of the low SES group because of the illness. Alternative explanations have been offered by the **social causation hypothesis** which alleges that stresses experienced by the low SES group contribute to the development or even the cause of schizophrenia.

10.6 Treatment and outcomes

One of the first steps in treating schizophrenia is to hospitalize the patient. **Hospitalization** decreases the stress on a patient and helps him or her structure daily activities. The length of hospitalization depends on the severity of the patient's illness. A primary goal of hospitalization should be to establish an effective link between the patient and community support systems.

The most common form of treatment for schizophrenia is the prescription of **antipsychotic drugs** like dopamine receptor antagonists, clozapine, lithium, etc. Antipsychotic drugs are safe and the doctor can administer these drugs without prior clinical testing. However care should be taken to consider contraindications. **Electroconvulsive treatment** (ECT) is also administered to schizophrenic patients in order to stabilize neurotransmitter activity.

Research has demonstrated that **psychosocial interventions** coupled with antipsychotic medication have proved effective in the treatment of schizophrenia. Psychosocial interventions include behavior therapy, family therapy, group therapy, social skills training and individual psychotherapy.

The outcome of treatment depends to a certain extent upon the nature of schizophrenia in the individual. A good prognosis is indicated by late onset, clearly identifiable precipitating factors, acute onset, good support systems, etc.

Overall, about 25 percent of schizophrenic patients in time recover permanently and without debilitating residual problems. Only 10 percent show deterioration and profound disability. The rest of the people who experience a first time episode (65 percent), show varying degrees of personality impoverishment, oddities of thought and behavior, and episodic psychotic behavior. The outcome of treatment for schizophrenic patients is not as bleak as it was some 60 years ago, and has made significant advances by integrating the biopsychosocial model into the treatment regimen.

10.7 Therapeutic approaches

Along with drug treatment, psychosocial modalities should be carefully integrated into the treatment regimen.

- **Behavior therapy.** Treatment usually addresses both the abilities and the deficits of the patient. Behavioral techniques use token economies, and social skills training to increase social abilities, self-sufficiency, practical skills and interpersonal

communication. Adaptive behaviors are reinforced by praise or tokens that can be exchanged for desired items. Consequently, the frequency of maladaptive or deviant behavior is reduced.

- **Family therapy.** Families tend to blame themselves for any illness or accident that happens to a member. It has been demonstrated that specific approaches to family therapy can reduce the relapse rates of schizophrenic patients. Families with high expressed emotion can have hostile, critical, emotionally overinvolved or intrusive interactions with the schizophrenic patient. When these behaviors are directly modified, the relapse rate for the patients may be dramatically reduced. The psychiatrist/psychologist should educate the family, support them in their difficult situation and introduce them to family support groups.

- **Group therapy.** Group therapy generally focuses on real-life plans, problems, and relationships. Groups may be behaviorally oriented, psychodynamically or insight-oriented, or supportive. Group therapy is particularly effective in reducing social isolation, increasing the sense of cohesiveness, and improving reality testing for patients. Groups led in a supportive manner, are most helpful for schizophrenic patients.

- **Social skills training.** This process is a highly structured form of group therapy. Social skills are defined as those interpersonal behaviors required to attain instrumental goals necessary for community survival and independence to establish, maintain, and deepen supportive and socially rewarding relationships. The therapist uses a variety of techniques such as focused instructions, role modeling, feedback, and social reinforcement.

- **Individual psychotherapy.** This form of psychotherapy provides a positive treatment relationship. Supportive psychotherapy is employed most often. It is important to maintain distance and privacy, simple directness, patience, sincerity and sensitivity to social conventions in the therapeutic relationship. The right attitude towards schizophrenic patients is that of acceptance, conveying that the therapist can be trusted.

10.8 Summary

Even though schizophrenia is the most disruptive of all mental illnesses, no single cause has been identified for its occurrence.

The stress-diathesis model tries to explain the illness by integrating all the causative factors.

Characteristic of schizophrenia are disturbances in thought, mood and perception.

Biological, psychosocial and sociocultural explanations have tried to explain the causation of schizophrenia.

Treatment includes antipsychotic drugs and psychosocial interventions such as behavior therapy, group therapy, family therapy, social skills training and individual psychotherapy.

10.9 Technical Terms

schizophrenia	Greek word meaning split in the mind
word salad	a mixture of meaningless words
neologisms	coining of new, meaningless terms
double-bind communication	communicating contradicting messages

10.10 Model Questions

1. Explain the biological causes of schizophrenia.
2. What are the characteristic features of schizophrenia?
3. Briefly explain the psychosocial interventions that are used in the treatment of schizophrenia.

10.11 Reference Books

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LESSON 11

COGNITIVE IMPAIRMENT DISORDERS

11.0 Objectives

1. To have an overview of the various cognitive impairments and disorders
2. To understand the course, prognosis and treatment of cognitive impairment disorder

Structure of the lesson

11.1 The Brain- An interactional Perspective

11.2 Delirium

11.3 Dementia

11.4 Amnestic disorders

11.5 An Integrative Approach to Brain Disorders

11.1 The Brain- An interactional Perspective

The brain acts as the control system of the body, which maintains normal functioning of the body. Thus the brain may be considered as the command center that receives and sends impulses from the various parts of the body and thereby provides an interaction of the mind and body that is vital for the functioning of the human being.

The cognitive disorders are defined in the DSM-IV as being caused by abnormalities of brain structure, neurochemistry or neurophysiology. The underlying disease may originate in the brain or could be caused by some systemic disease. Cognitive impairment is considered the hallmark of cognitive disorders. In the past these conditions were classified as organic syndromes and disorders. Cognitive impairments include deficit in orientation, memory, language comprehension, calculation, and judgment. These symptoms are also accompanied by anxiety, depression, paranoia and aggressive impulses. The various symptoms include

- Impairment of orientation- unawareness of person, place and time
- Impairment of intellectual functions-includes inability to comprehend, speech is impaired and general knowledge is low
- Impairment in memory- there is difficulty in remembering the past and the present events. The ability to learn and retain information is affected.
- Impairment in judgment- the individual is highly decisive
- Emotional lability- there is a quick shift of emotions in the individual

- Lack of mental resilience- resilience is the mental elasticity in times of stress. In stressful situations the individual's problem solving ability and decision making ability is badly affected

The cognitive disorders dealt in this lesson are delirium, dementia and amnestic disorders.

11.2 Delirium

Delirium can be diagnosed as either an organic mental syndrome when the specific organic cause is suspected or known or can also be a symptom of several substance abuse disorders. Delirium is a syndrome and not a disease. It is characterized by the acute onset of impaired cognitive functioning. The course is usually fluctuating and brief. It is usually a reversible condition.

Although the onset of delirium is sudden there may be some symptoms such as daytime restlessness, anxiety, fearfulness, and hypersensitivity to light or sounds that usually occur before the onset of delirium. The patient is usually confused and disoriented and had impaired reality testing. The patient is unable to distinguish between dreams, illusions, and true hallucination or between sleep and wakefulness, thus contributing to a disturbance of sleep wake cycle. The patient is usually distracted by irrelevant stimuli. The ability to think coherently is reduced and the thought process tends to become slow, disorganized and more concrete. Reasoning and problem solving become difficult. Recall of what transpires during a delirium episode is spotty and the patient may refer to it as a bad dream and may remember it vaguely.

Orientation to time and place is impaired but orientation to person is intact and the patient is aware of his or her own identity. Perceptual disturbances are common including illusions and hallucinations that are mostly visual.

Some patients may be delirious only at night and regain lucidity during the day. Delirium is predictably more severe and incapacitating during the night and early morning hours, an observation that has led to delirious patients being called as sundowners. Psychomotor behaviour is usually abnormal. The patient is either hypoactive or lethargic or hyperactive leading to agitation and exhaustion. The most commonly observed emotions are fear and anxiety which the result of frightening illusions and hallucinations that they may be harmed by others. The fear is so intense that they may attempt to escape possible injury to self or to others.

The major causes of delirium are central nervous system disease such as epilepsy, systemic disease (such as cardiac failure) and other intoxication or withdrawal from pharmacological or toxic agents. The syndrome of delirium is caused by one or more systemic or cerebral derangements that may affect the brain.

The treatment of delirium primarily is to identify the cause and apply appropriate medical or surgical therapeutic techniques. Sensory, social and nursing environment should be provided so that the patient will be benefited to maintain orientation. An agitated, restless or fearful patient needs to be sedated to prevent complications and accidents.

11.3 Dementia

There are progressive pathological changes in the brain and this is called degeneration. This is characterized by emotional, intellectual and motor impairments. Degeneration is of two types. (1) Degeneration of the cortical and region and the there are memory disturbances, impaired comprehension and problems with gait. (2) Degeneration of the sub-cortical region where there is forgetfulness, fluctuations in the mood, motor disturbances and disturbances in problem solving. These are mostly called as dementia. DSM-IV indicated that dementia could either be an organic mental syndrome or an organic mental disorder. It describes two types of dementia disorders- primary degenerative of Alzheimer type and multi-infarct dementia. Dementia of Alzheimer type is further specified as having senile onset (after the age of 65) or a presenile dementia. Dementia of either type can be uncomplicated or complicated when associated with delirium, delusions, or depression.

Dementia is characterized by loss of cognitive and intellectual abilities severe enough to impair social and occupational performance. Also present are impairment of memory, abstract thinking and judgment and some degree of personality change. The disorder may be progressive or static, permanent or reversible. An underlying cause is always assumed and the reversibility of dementia is related to underlying pathology.

Dementia occurs most often in old age. There is a slowing down of the functioning of the Central Nervous System, and all the motor activities. They have less capacity for complex tasks and novel tasks. There is decrease in efficiency in terms of memory. There is decreased efficiency to learn. These changes are normal with aging and thus it is difficult to distinguish dementia. This is usually seen after 65 years of age.

The most common cause of dementia is primary degenerative dementia of Alzheimer type. The next common is multi-infarct dementia. There also an alarming increase in number of dementias related to human immuno-deficiency virus (HIV). Other causes of dementia are Pick's disease, Creutzfudt Jackob disease, Huntington's disease and Parkinson's disease.

11.3.1 Alzheimer disease

This disorder is characterized by severe loss of intellectual functioning. It is basically a physical disorder based on neuro-pathological examination. The cause of Alzheimer's disease is unknown. Genetic factors are presumed to play a role. Other causative theories have also been proposed. Aluminum toxicity or metabolism have been

hypothesized to be a causative factor since high levels of aluminum have been found in the brains of some patients who died from the disease. Biochemical studies have tried to explain the disease in terms of the deficit of the neurotransmitter acetylcholine. Other studies have reported specific degeneration of the cholinergic neurons in the brain. Neurofibrillary tangles and senile plaques are associated with Alzheimer's disease and are found outside the neurons and around cerebral blood vessels.

The classical symptoms of dementia are disturbances of orientation, memory, calculation, and judgment. Mild symptoms of depression and anxiety are present. Suspiciousness, paranoia, delusions and visual hallucinations may be present in most of the patients. Previous personality traits become exaggerated and patients become paranoid, obsessed in thoughts and compulsive rituals are observed. Defects in judgment may lead to inappropriate behaviour such as exhibitionism.

There is no specific treatment for these disorders and patients may require institutionalization or 24 hour custodial care because of the severe psychological and physical deterioration that accompanies this disorder. Maintenance of physical health, supportive environment and symptomatic treatment are indicated. Particular attention must be provided to caretakers and family members who must deal with frustration, grief and psychological burnout as they care for the patient over a long period of time.

11.3.2 Multi-infarct dementia or Vascular dementia

Multi-infarct dementia is characterized by the deterioration in cognitive functioning because of significant cerebrovascular disease. Vascular disease is assumed to be responsible the dementia. This disorder affects small and medium size cerebral vessels, which undergo infarction and produce multiple lesions over wide areas of the brain. When the blood flow is not adequate the individual may suffer a stroke. There may be black outs, heart and kidney failure, hypertension and necrosis. Memory deficits and emotional liability and declining of interests in personal hygiene is commonly observed.

Alzheimer type of dementia and multi-infarct dementia are examples of the deterioration of the cerebral cortex. The victims are generally old people however presenile dementia is also seen when people in their 40s can also get affected.

11.4 Amnestic disorders

An impairment of memory is the single cognitive defect in Amnestic syndrome and Amnestic disorder. Psychologists consider the existence of two kinds of memory-*short-term memory* (also known as primary memory, or immediate memory) and *long-term memory* (also known as secondary, recent, recent past, or remote memory). Short-term memory usually includes first few seconds or minutes of memory; long-term memory covers all memories after that time period. There are three basic types amnesia. *Retrograde amnesia* refers to memory loss of events that occurred before the amnesia producing events. *Post-traumatic amnesia* refers to memory loss of events for a restricted period of time after the amnesia-producing event. *Anterograde amnesia* refers to

impairment in acquiring new memories. Amnestic syndrome is most often seen in persons with chronic alcoholism. Causes for Amnestic syndrome could be because of frontal dysfunction when confabulation is a major feature of the syndrome. Damage to temporal structures also result in Amnestic syndrome. Other causes include brain trauma, thiamin deficiency tumors and degenerative diseases.

This disorder is characterized by impairment of memory of short-term and recent memory. Patients with deficits in short term memory cannot remember what they had for breakfast or lunch or cannot name their hospital. The deficit in recent memory accounts for the anterograde amnesia. Memory for over learned information or events from the remote past, such as childhood experiences, is good; but memory for events from the less remote past is impaired which accounts for retrograde amnesia. Immediate memory remains intact.

Korsakoff's syndrome is the persistent amnestic syndrome associated with alcoholism. Recent memory tends to be affected more than remote memory. **Alcoholic blackouts** occur in alcoholics with particularly heavy drinking patterns. **ECT** (electro convulsive therapy) is associated with retrograde and anterograde amnesi, which usually resolves almost completely by six months after treatment. **Head injury** is often associated with a brief period of retrograde amnesia and longer period of posttraumatic amnesia. Patients with **Transient global amnesia** abruptly lose their ability to recall recent events or to record new memories. However events of the distant past are readily recalled. This disorder is thought to result from a temporary physiological alteration of the brain. Treatment of amnestic syndromes must be first directed to the underlying cause, such as a brain tumor. In alcoholic patients it is important to prevent the development of Wernicke's encephalopathy (confusion, ataxia) by giving high doses of thiamin and other vitamins. Once the amnestic syndrome is fixed supportive measures such as structured environment and medicines for anxiety and agitation are helpful.

11.5 An Integrative approach to Brain Disorders

An understanding of the biology of the brain is central to a complete appreciation of human behaviour. However a comprehension of the interface between biological processes of the brain and psychosocial factors assists in bringing about an integrative approach to the study of brain disorders.

The major model for integrating the causative factors is the **stress-diathesis model**. It postulates that some people are predisposed to react abnormally to environmental stressors. The predisposition (diathesis) is either inherited through biochemical or organ system weakness or through acquired propensities as components of vulnerability. The environmental influences can also arise from biological (as an infection) or psychological (stressful family situation, death of partner). The biological basis of diathesis can be further shaped by drug abuse, psychological stress and trauma. Whether inherited or acquired the vulnerability is relatively permanent. What varies over the time is the presence of environmental stressors, which may account for the waxing and waning of cognitive impairments.

George Engel an exponent of another model of disease known as the **bio-psychosocial model** of disease emphasized on integrated systems approach to human behaviour and disease. The bio-psychosocial model is derived from general systems theory. According to this model the ***biological system*** emphasizes the anatomical, structural and molecular substrate of disease and its impact on the patient's biological functioning. The ***psychological system*** emphasizes the impact of psychodynamic factors, motivation and personality on the experience of illness. The ***social system*** emphasizes cultural environmental and familial influence on the expression and experience of illness. The biopsychosocial model recognizes the importance of macro level processes (such as the existence of social support and psychological factors) and micro level processes (such as cellular disorders or chemical imbalances) interact to produce a state of health or illness. To take a specific example, consider a high-powered business executive in his late 40s who has memory lapses and disorientation. A traditional medical approach to this problem would emphasize control of the problem through the regular administration of drugs. The biopsychosocial approach to this man's problem would identify his health practices that may have contributed to the early memory lapses. Treatment efforts would focus on stress management, and a recommendation to a program to help him stop alcohol consumption. In addition, such an assessment might look at his social environment, recognize that he spends less time with his wife and children and recommend that he make positive social interaction with his family an additional goal for his rehabilitation. At the core of this model is the belief that by working together the three systems help people maintains a high level of behavioural factors that give to diseases and ameliorate many of the adverse consequences of diseases and its treatment.

11.6 Summary

Brain is considered to be the command center that receives and sends impulses from the various parts of the body and provides an interaction of the mind and body that is vital for the functioning of the human being. Cognitive disorders are caused by abnormalities of brain structure, neurochemistry or neurophysiology

Cognitive impairments include deficit in orientation, memory, language comprehension, calculation, and judgment; along with these symptoms anxiety, depression, paranoia and aggressive impulses are also accompanied. Most commonly seen cognitive disorders are delirium, dementia and amnestic disorders.

Delirium is a syndrome characterized by the acute onset of impaired cognitive functioning. The course is usually fluctuating and brief and is usually a reversible condition.

Dementia disorders are of two kinds - primary degenerative of Alzheimer type and multi-infarct dementia. Dementia of Alzheimer type is specified as having senile onset and symptoms include disturbances of orientation, memory, calculation, and

judgment. Multi-infarct dementia is characterized by the deterioration in cognitive functioning because of significant cerebrovascular disease

Impairment of memory is the single cognitive defect in Amnestic syndrome and Amnestic disorder. Retrograde amnesia refers to memory loss of events that occurred before the amnesia producing events. Post-traumatic amnesia refers to memory loss of events for a restricted period of time after the amnesia-producing event. Anterograde amnesia refers to impairment in acquiring new memories. Amnestic syndrome is most often seen in persons with chronic alcoholism.

Comprehension of the interface between biological processes of the brain and psychosocial factors assists in bringing about an integrative approach to the study of brain disorders. The two major models for integrative approach to brain disorders are the stress-diathesis model and bio-psychosocial model proposed by Engel.

11.7 Technical Terms

Anterograde amnesia	***Anterograde amnesia refers to impairment in acquiring new memories***
Bio-psychosocial model	An integrated systems approach to human behaviour and disease proposed by George Engel
Delirium	Delirium is a syndrome characterized by the acute onset of impaired cognitive functioning. It is usually a reversible condition. The patient is usually confused and disoriented and had impaired reality testing.
Dementia of Alzheimer's type	The most common cause of dementia is primary degenerative dementia of Alzheimer type characterized by severe loss of intellectual functioning
Korsakoff syndrome	Korsakoff's syndrome is the persistent amnestic syndrome associated with alcoholism where recent memory tends to be affected more than remote memory.

Multi-infarct dementia	Multi-infarct dementia is characterized by the deterioration in cognitive functioning because of significant cerebrovascular disease
Retrograde amnesia	Retrograde amnesia refers to memory loss of events that occurred before the amnesia producing events.
Transient global amnesia	Patients with Transient global amnesia abruptly lose their ability to recall recent events or to record new memories
Posttraumatic amnesia	Post-traumatic amnesia refers to memory loss of events for a restricted period of time after the amnesia-producing event
Stress-diathesis model	Stress diathesis model postulates that some people are predisposed to react abnormally to environmental stressors

11.8 Model Questions

1. Describe the various cognitive impairment disorders
2. Elaborate on the etiology, course and prognosis of dementia

11.9 Reference Books

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LESSON 12

SUBSTANCE RELATED DISORDERS

12.0 Objectives

1. To be able to identify the substance related disorders
2. To learn about alcohol and related disorders

Structure

12.1 Introduction

12.2 Substance use disorders

12.3 Substance induced disorders

12.4 Alcohol

12.5 Related disorders

12.1 Introduction

Addictive behavior, behavior based on the pathological need for a substance or activity, may involve the abuse of substances such as alcohol or cocaine, or the excessive ingestion of high-caloric food, resulting in obesity. Addictive behavior is one of the most pervasive and intransigent mental health problems facing our society today.

The most commonly used substances are the **psychoactive drugs** – those that affect mental functioning – alcohol, barbiturates, minor tranquilizers, amphetamines, heroin, and marijuana. A psychoactive substance is one that, when taken into the body, *can alter consciousness or state of mind*. The diagnostic classification of psychoactive substance-related disorders is divided into:

1. psychoactive substance induced organic mental disorders and syndromes (which involve organic impairment) and
2. psychoactive substance use disorders (maladaptive behaviors resulting from regular and consistent use of a substance).

12.2 Substance use disorders

The psychoactive substance use disorders define the patterns of maladaptive behavior related to the procurement and ingestion of substances of abuse, as well as the behavioral and social consequences of these patterns of behavior.

These disorders are divided into psychoactive substance dependence and psychoactive substance abuse. Psychoactive substance abuse generally involves a pathological use of a substance resulting in potentially hazardous behavior such as

driving while intoxicated or continuing to use a substance despite a persistent social, psychological, occupational or health problem. Psychoactive substance dependence includes more severe forms of substance use disorders and usually involves a marked physiological need for increasing amounts of a substance to achieve the desired effects. In other words, dependence means that an individual shows **tolerance** for a drug, or **withdrawal symptoms** when the drug is unavailable.

The psychoactive drugs most commonly associated with abuse and dependence are:

a) *narcotics* – opium and its derivatives
b) *sedatives* – barbiturates
c) *stimulants* – cocaine and amphetamines
d) *anti-anxiety drugs* – benzodiazepines
e) *hallucinogens* – LSD and PCP

Caffeine and nicotine are also drugs of dependence, and disorders associated with tobacco withdrawal and caffeine intoxication are included in the DSM-IV.

Drug abuse and dependence may occur at any age, but are most common during adolescence and young adulthood. Among those who abuse drugs, behavior patterns vary markedly, depending on the type, amount and duration of drug use; the physiological and psychological makeup of the individual; and sometimes, the social setting in which the drug experience occurs.

12.2.1 Narcotics (Opium and its derivatives)

The use of opium and its derivatives – **morphine, codeine** and **heroin** – leads to an alleviation of physical pain, inducing relaxation and a pleasant reverie, and an alleviation of anxiety and tension. Morphine and heroin are commonly introduced into the body by smoking, snorting (inhaling the powder), eating, "skin-popping", or "main lining" (hypodermic injections).

It has been estimated that continual use over a period of 30 days is sufficient to cause addiction. Users build up a tolerance to these drugs and gradually require larger amounts to achieve the same results. Withdrawal symptoms are experienced within 8 hours of taking a dose of the drug. Addiction to opiates usually leads to a gradual deterioration of well-being.

The three most frequently cited reasons for addiction were pleasure, curiosity and peer pressure. Other reasons such as life stress, personal maladjustment, and sociocultural conditions also play a role.

Treatment for heroin addiction involves building up an addict both physically and psychologically and providing help through the withdrawal period. After the withdrawal, treatment focuses on helping a former addict make an adequate adjustment to his/her community and abstain from further use of narcotics.

12.2.2 Sedatives (Barbiturates)

Barbiturates were once widely used by physicians to calm patients and induce sleep. They act as depressants to slow down the action of the central nervous system. After taking a barbiturate, an individual experiences a feeling of relaxation in which tensions seem to disappear, followed by a physical and intellectual lassitude and a tendency toward drowsiness and sleep.

Excessive use of barbiturates leads to increased tolerance as well as to physiological and psychological dependence. A variety of side effects such as sluggishness, slow speech, impaired comprehension and memory, extreme and sudden mood shifts, motor incoordination and depression are also evidenced.

Though young people experiment with barbiturates (downers), it is usually the middle-aged and older people who often rely on them as "sleeping pills". Barbiturates are commonly used with alcohol. One possible effect of combining the two is death as each drug potentiates (increases the action) the other.

Withdrawal symptoms of barbiturates are more dangerous, severe and long-lasting than opiate withdrawal. During withdrawal, a patient becomes anxious and apprehensive and experiences tremors of the hands and face. The withdrawal symptoms can be minimized by administering increasingly smaller doses of the barbiturate itself or another drug producing similar effects.

12.2.3 Stimulants (Cocaine and amphetamines)

Cocaine and amphetamines stimulate or speed up the action of the central nervous system. Cocaine may be ingested by sniffing, swallowing or injecting, and stimulates the cortex of the brain, inducing sleeplessness and excitement as well as stimulating and accentuating sexual feelings. Chronic abusers of cocaine, who abstain from the taking the drug develop temporary depression-like symptoms. Neurological symptoms such as concentration and memory deficits have also been found in cocaine users.

The psychological and life problems experienced by cocaine users include employment, family, psychological and legal matters. Treatment for psychological dependence on cocaine includes the use of medication to reduce craving for the drug and the use of psychological therapy to ensure treatment compliance.

The stimulating effects of **amphetamines** were discovered by chance – "wonder pills" that helped people stay alert and awake and helped people function beyond their normal level for a temporary period. Amphetamines Benzedrine, Dexedrine and Methedrine (*speed*) tend to suppress appetite and became popular with people trying to lose weight. Amphetamines are also sometimes prescribed for alleviating mild feelings of depression, fatigue and maintaining alertness for sustained periods of time.

Amphetamines tend to push users toward greater expenditures of their own resources – often to a point of hazardous fatigue. They are physiologically and psychologically addictive and consumption results in heightened blood pressure, enlarged pupils, unclear or rapid speech, profuse sweating, tremors, excitability, loss of appetite, confusion and sleeplessness. Chronic abuse can result in brain damage.

Withdrawal is usually physically painless as there is minimal or no physiological addition. Abrupt withdrawal can result in cramping, nausea, diarrhea and even convulsions, along with feelings of weariness and depression which may last for weeks or even months. If there is brain damage, residual effects include impaired ability to concentrate, learn and remember, with resulting social, economic and personality deterioration.

12.2.4 Hallucinogens (LSD and PCP)

Hallucinogens are drugs whose properties are thought to induce hallucinations. These drugs do not "create" sensory images, but distort them so that an individual sees or hears things in different and unusual ways. LSD and PCP are often referred to as *psychedelics*.

Odorless, colourless, and tasteless, **LSD** is the most potent of the hallucinogens and can produce intoxication with an amount smaller than a grain of salt. After taking LSD, a person typically goes through about 8 hours of changes in sensory perception, mood swings and feelings of depersonalization and detachment. An unusual phenomenon that may occur following the use of LSD is a **flashback**, an involuntary recurrence of perceptual distortions or hallucinations weeks or even months after taking the drug.

Although users of LSD do not develop physiological dependence, some frequent users do develop psychological dependence – they focus their life around LSD experiences. Acute psychosis induced by LSD intoxication requires hospitalization and medication. Brief psychotherapy is effective in psychological dependence on LSD and in preventing the recurrence of flashbacks. Therapy is aimed at helping the individual work through the painful experience induced by the drug and integrate it into his/her self structure.

Phencyclindine (**PCP**) also known as *angel dust, peace weed, super grass*, may be taken orally, intravenously or by sniffing, but is usually sprinkled onto a marijuana cigarette and smoked. Users report that the effects of 2-3 mg of smoked PCP are felt within 5 minutes and plateau within half an hour. They experience speedy feelings, euphoria, bodily warmth, tingling, and occasionally feelings of depersonalization, isolation and estrangement. Auditory and visual hallucinations are sometimes experienced.

12.2.5 Anti-anxiety drugs (Benzodiazepines)

Benzodiazepines are used mainly to treat anxiety but are also used as sedatives, muscle relaxants, anticonvulsants, and anesthetics and in the treatment of alcohol withdrawal.

Some benzodiazepines have a disinhibiting effect, which may cause frustrated people to become aggressive or hostile. These drugs produce less euphoria than other tranquilizing drugs, so the risk of dependence and abuse is relatively low. But both tolerance and withdrawal symptoms can develop. Withdrawal occurs within two or three days after stopping use.

12.3 Psychoactive substance induced organic mental disorders

The substance induced organic mental disorders include delirium, dementia, amnestic disorder, delusional disorder, hallucinosis, mood disorder, anxiety disorder and personality disorder.

12.4 Alcohol

Alcoholic and alcoholism are obsolete, replaced by the term *alcohol dependence syndrome.* The term **alcoholic** is often used to refer to a person with a serious drinking problem, whose drinking impairs his or her life adjustment in terms of health, personal relationships, and occupational functioning. **Alcoholism** refers to a dependence on alcohol that seriously interferes with life adjustment.

Alcoholism cuts across all the boundaries of age, educational, occupational and socioeconomic status. Most problem drinkers are men, and problem drinking may develop during any life period from early childhood through old age. The life span of the average alcoholic is about 12 years shorter than an ordinary person and organic brain impairment occurs in a high proportion of alcoholics.

12.4.1 Clinical Picture of Alcohol

Alcohol is a depressant that affects the higher brain centres, impairing judgement and other rational processes and lowering self-control. Some degree of motor incoordination becomes apparent and the drinker's discrimination and perception of cold, pain, and other discomforts are dulled. The drinker experiences a sense of warmth, expansiveness, and well-being. Consequently, the person's feelings of self-esteem and adequacy increase.

An alcohol content of 0.1 percent in the bloodstream indicates that the person is intoxicated, and muscular coordination, speech, and vision are impaired, while thought processes are confused. Judgement is impaired even before this level is reached. When

blood-alcohol level reaches 0.5 percent, the entire neural balance is upset, and the individual passes out.

The effects of alcohol vary for different drinkers, depending on physical condition, gender, amount of food in the stomach and duration of the drinking. Several physiological effects of alcohol are common:

- a tendency toward increased sexual stimulation, but lowered sexual performance
- an increased number of **blackouts** – memory lapses
- experiencing a **hangover** – one form of a mild withdrawal.

12.4.2 Development of alcohol dependence

Drinking patterns vary by age and sex. For both men and women, the prevalence of drinking is highest and abstaining is lowest in the 21-34 year age range. Men and women tend to have differing courses of alcoholism. Alcoholism in men usually has an onset in the late teens or 20s. It often has an insidious course and is not recognized as alcohol dependence until a person is in his/her 30s. The onset of alcoholism is generally later in women than in men. Box 12-A presents some of the common early warning signs of excessive drinking.

Box 12-A

Early Warning Signs of Drinking Problems

1. *Frequent desire* – increase in desire, often evidenced by eager anticipation of drinking after work and careful attention to maintaining supply.
2. *Increased consumption* – increase that seems gradual but is marked from month to month. Individual begins to worry and lie about the amount consumed.
3. *Extreme behavior* – commission of various acts that leave an individual feeling guilty and embarrassed the next day.
4. *"Pulling blanks"* – inability to remember what happened during an alcoholic bout.
5. *Morning drinking* – either as a means of reducing a hangover or as a "bracer" to help start the day.

12.4.3 Symptoms of abuse

The first symptom of abuse which can be evidenced in a person is the interference with major obligations – **impaired performance** at work, home and/or school. Impairments may arise due to intoxication, recovery from intoxication, and/or time devoted to search for liquor. The second symptom is **intoxication in unsafe settings** such as driving a car or operating hazardous machinery. The third symptom included in the diagnosis of alcohol abuse concerns **legal problems**. Any legal troubles related to public intoxication, driving while intoxicated, drunk and disorderly behavior, alcohol related

aggression, etc. are included. The fourth symptom of alcohol abuse concerns **consistent use** despite occupational, social, interpersonal, psychological, and/or health problems.

12.5 Factors contributing to Alcoholism

There are numerous theories about the development of alcohol problems. There is, however, agreement that people drink alcohol because it makes them feel good. Principles of operant conditioning suggest that either positive reinforcement, negative reinforcement or a combination of the two play a role in drinking behavior. Almost 50 years ago, Conger (1956) advanced the classic **tension reduction hypothesis** which speaks broadly about alcohol's negatively reinforcing properties. Regardless of the type, reinforcement appears to play a central role in the initiation and maintenance of drinking behavior. The question now is: what factors contribute to the reinforcement value of alcohol?

12.5.1 Specific Genetic Factors

Genetic studies have demonstrated quite clearly that alcoholism has a substantial heredity component. Studies have estimated that upto 60 per cent of individual differences in alcoholism can be attributed to genetic factors. Other epidemiological studies have established that individuals who have an alcoholic parent are 3-4 times more likely to develop alcoholism themselves. Thus, there seems to be a preeminent role of genetics in increasing the vulnerability to problem drinking.

12.5.2 Cognitive factors

A large body of research has demonstrated that individuals with a genetic predisposition to alcoholism display substantial cognitive and neuropsychological deficits. Children of alcoholics performed poorly on tasks that assess frontal lobe functioning, and have poorer attentional capacities than other children. It can be explained that drinkers with cognitive deficits lack the cognitive resources to regulate their intake or say "no" when offered a drink. Alternatively, research has suggested that cognitive deficits may also stem from growing up with an alcoholic parent. The precise mechanism through which cognitive and neuropsychological deficits lead to alcoholism remains unclear, and whether these deficits are genetic or environmental in origin is also unclear.

12.5.3 Characterologic Factors

It is well established that specific personality factors are strongly predictive of drinking behavior. Symptoms of antisocial and borderline personality disorders are common among problem drinkers, alcoholics, and children of alcoholics. Problem drinking appears to be related to other personality constructs such as sensation- or novelty-seeking. Children who scored high on novelty-seeking were more likely to become alcoholics as adults. The physiological convergence of these biogenetic,

cognitive, and personality factors points to the preeminent role of a "hungry" brain in dramatically increasing the incentive salience and reward value of alcohol consumption.

12.5.4 Exogenous Factors

Stress is the most consistently reported antecedent to drinking behavior. Naturalistic studies of stress have found strong relations between a number of stressors and drinking behaviors. While **social**, **cognitive** and **physical** stressors can induce alcohol craving, the **magnitudes** of stress reactions also predict drinking behavior.

If stress predicts drinking behavior, coping skills should moderate the degree to which stress has an impact. Studies have demonstrated that coping skills can buffer the effects of stress on drinking behavior. Darwin, Freud, and Bandura have underscored the importance of coping in adapting to stressful situations.

Another major predictor of drinking behavior is one's expectations of the consequences of drinking. The *more* one expects alcohol consumption to lead to *positive outcomes* (e.g., better social and sexual performance, more tension reduction, euphoria), the more one will drink. Similarly, the *less* one expects alcohol consumption to lead to *negative consequences* (e.g., hangover, excessive sedation, sluggishness, trouble with family, friends, work and the law), the more one will drink.

Modeling is another critical component in the development of drinking behavior, according to Bandura's social learning theory. Children and teens often rely on role models when developing behavioral patterns related to health. Observing parents, siblings, and other peers may play a powerful role in shaping future behavior.

Excessive drinking often begins during crisis periods in marital or other intimate personal relationships – especially crises that lead to hurt and self-devaluation. The marital relationship may actually serve to maintain the pattern of drinking. Family relationship problems such as father's alcoholism, marital conflict, lax maternal supervision, shifting towns frequently, no attachment to father, and no family cohesiveness were found to be significant etiological sources of alcoholism.

Social support is yet another factor found to be involved in the development of problem drinking. Individuals who report low levels of social support are more likely to report problem drinking than others. Research has shown that individuals with poor social skills, especially those who are uncomfortable with saying "no", and those who have lower levels of self-efficacy, are more likely to consume alcohol.

12.6 Alcohol-related disorders

Several acute psychotic reactions may develop in people who have been drinking excessively over long periods of time or who have a reduced tolerance for alcohol. Such acute reactions usually last only a short time, and generally consist of confusion, excitement, and delirium. They are called alcoholic psychoses because they are marked by a temporary loss of contact with reality.

12.6.1 Alcohol withdrawal delirium (*Delirium tremens)*

This reaction usually happens following a prolonged drinking spree when the person is in a state of withdrawal. Full-blown symptoms include:

- Disorientation for time and place
- Vivid hallucinations
- Acute fear
- Extreme suggestibility
- Marked tremors of the hands, tongue and lips
- Other symptoms, including perspiration, fever, a rapid and weak heart beat, coated tongue, and foul breath.

The delirium lasts from 3-6 days and is generally followed by a deep sleep. Very few symptoms remain once the person awakens.

12.6.2 Alcohol Amnestic Disorder *(Korsakoff's Psychosis)*

The outstanding symptom is a memory defect (particularly with regard to recent events), which is sometimes accompanied by falsification of events (confabulation). Persons with this disorder may not recognize faces, pictures, rooms, and other objects they have just seen, although they feel that they are 'familiar". Such people increasingly tend to fill in their memory gaps with reminiscences and fanciful tales. The confusion and disordered actions of these people are closely related to their attempts to fill in memory gaps. The memory disturbance seems to be related to an inability to form new associations that are readily retrievable. These patients have also been observed to show other cognitive impairments such as planning deficits and intellectual decline.

12.6.3 Fetal Alcohol Syndrome

Heavy drinking by expectant mothers can affect the health of unborn babies. Newborn infants whose mothers drank heavily during pregnancy have been found to have physical and behavioral abnormalities. Such infants have a growth deficiency, show facial and limb irregularities, and a central nervous system dysfunction. However, safe amounts of alcohol consumption for pregnant women are yet to be determined.

12.7 Summary

Addictive disorders are among the most widespread and intransigent mental health problems in the world today.

Many problems of alcohol or drug abuse involve difficulties that stem solely from the intoxicating effects of the substances.

Dependence occurs when an individual develops a tolerance for the substance or exhibits withdrawal symptoms when the substance is not available.

Although data are inconclusive, it appears that genetic factors may play some role in causing vulnerability.

Psychological factors such as vulnerability, stress, and the desire for tension reduction are also important in the causation of alcoholism.

Possible causal factors in drug abuse include influence of peer groups, and the availability of drugs as tension reducers and pain relievers.

12.8 Technical Terms

addictive behavior	pathological need for a substance or activity
tolerance	need for increased amounts of a substance to achieve desired effects
withdrawal symptoms	physical symptoms such as sweating, tremors, and tension, that accompany abstinence from the drug
psychoactive drugs	drugs that affect mental functioning

12.9 Model Questions

1. What are substance use disorders?
2. Briefly explain the factors contributing to alcohol dependence.
3. Explain the effects of any two psychoactive substances.

12.10 Reference Books

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LESSON 13

DISORDERS OF CHILDHOOD & ADOLESCENCE

13.0 Objectives

1. To identify the disorders of childhood and adolescence
2. To learn about the therapies used to treat children and adolescence

Structure

13.1 The scope of the problem

13.2 Disruptive behavior disorders

13.3 Internalizing disorders

13.4 Eating disorders

13.5 Therapy for children and adolescents

13.1 Scope of the problem

The early conceptualizations of children reflected the view of children as "miniature adults" and failed to take into account problems associated with developmental changes that take place in the child or adolescent. Progress made in assessing, treating and understanding the maladaptive behavior pattern of children and adolescents has been very recent, and lags behind efforts to deal with adult problems.

Though great progress has been made in providing treatment for disturbed children, our facilities are woefully inadequate in relation to the magnitude of the task and most children do not receive the psychological attention they require. Studies have revealed that maladjustment is more commonly found among boys than girls, and boys were diagnosed more frequently than girls. Boys also have higher rates of emotional

problems during childhood and adolescence. The most prevalent disorders were attention-deficit hyperactivity disorder and separation anxiety disorders.

Young children have less self-understanding and have not yet developed a stable sense of identity and an adequate frame of reference regarding reality, possibility and value. Children have more difficulty in coping with stressful events than adults, and their dependence on other people serves as a buffer as well as making them highly vulnerable.

Many of the problematic behaviors that characterize maladjustment or emotional disturbance emerge over the course of *normal* development. However, we cannot understand or consider as "abnormal" a child's behavior without considering whether the behavior is appropriate for the child's age.

Despite the distinctive characteristics of childhood disturbances at different ages, there is no sharp line of demarcation between the maladaptive behavior patterns of childhood and adolescence, and those of adolescence and adulthood.

During the earlier years, a major problem of diagnosing disorders in children and adolescents was the fact that the same classification system that had been developed for adults was being used for childhood problems; thereby not accounting for autism, learning disorders, etc. Secondly, these early systems ignored the role of environmental factors in childhood disorders, and thirdly, symptoms were not considered with respect to a child's developmental level. Over the years, a *categorical strategy* and a *dimensional strategy* have become prominent in the classification of childhood disorders.

13.2 Disruptive Behavior Disorders

13.2.1 Conduct Disorder

The essential feature of conduct disorder is a repetitive and persistent pattern of conduct in which either the basic rights of others or major age-appropriate societal norms or rules are violated. The conduct is more serious than the ordinary mischief and pranks of children and adolescents.

Conduct disorder is fairly common during childhood and adolescence. It is estimated that approximately nine per cent of boys and two per cent of girls under the age of 18 years have the disorder. The disorder is more common among boys than girls and is more common in children of parents with antisocial personality and alcohol dependence.

In general, children who are seen as conduct-disordered manifest characteristics such as overt or covert hostility, disobedience, physical and verbal aggressiveness, quarrelsomeness, vengefulness and destructiveness. Lying, solitary stealing and temper tantrums are common. Such children tend to be sexually uninhibited and inclined toward sexual aggressiveness. They may also engage in setting fire, vandalism, and even homicidal acts.

Etiology

A variety of psychosocial factors contribute to the development of conduct disorder in children.

- **Parental factors**. Chaotic home conditions and the strife between parents contribute to conduct disorder. Parental psychopathology, child abuse, negligence, sociopathy, alcoholism, and substance abuse are also considered to contribute to conduct disorder. Psychodynamic explanations suggest that children with conduct disorder unconsciously act out their parents' antisocial wishes.

- **Sociocultural factors**. Current theories suggest that socioeconomically deprived children, unable to achieve status and obtain material goods through legitimate routes are forced to resort to socially unacceptable means to reach those goals. Such behavior is normal and acceptable under such circumstances of socioeconomic deprivation.
- **Psychological factors**. Children brought up in chaotic, negligent conditions generally become angry, disruptive, demanding and unable to develop the necessary tolerance for frustration. As their role models are poor and frequently changing, the basis for developing both an ego-ideal and a conscience is lacking.

13.2.2 Attention-Deficit Hyperactivity Disorder

Attention-deficit hyperactivity disorder (ADHD) is composed of symptoms in three areas: short attention span, impulsivity, and hyperactivity. Often referred to as hyperactivity, ADHD is characterized by difficulties that interfere with effective task-oriented behavior in children in the above mentioned three areas. 3-5 per cent of elementary school children are estimated to manifest symptoms of ADHD; 6-7 per cent of preadolescent boys are said to be exhibiting ADHD. The disorder, which is 6-9 times more prevalent among boys than girls, occurs with the greatest frequency before age eight and tends to become less frequent.

ADHD children show excessive muscular activity, have difficulty in sustaining attention, are highly distractible and often fail to follow instructions or respond to demands placed on them. Impulsive behavior and a low frustration tolerance are also

characteristic. These children tend to talk incessantly and are socially uninhibited and immature.

Etiology

- **Biological factors.** Investigations into neurobiological factors, genetic factors and brain damage as possible causes of ADHD have yielded inconclusive results. No single neurotransmitter has been identified so far as producing ADHD.
- **Psychosocial factors.** Children in institutions are frequently overactive and have poor attention spans due to prolonged emotional deprivation. Stressful psychic events, disruption of family equilibrium and other anxiety inducing factors contribute to the initiation and/or perpetuation of ADHD. Predisposing factors may include the child's temperament, genetic-familial factors and the demands of society to adhere to a routine way of behaving and performing.

13.2.3 Delinquent Behavior

Delinquent behavior includes such acts as destruction of property, violence against other people and various behaviors contrary to the needs and rights of others and in violation of society's laws.

Various conditions, either singly or in combination with other factors may be involved in the development of delinquent behavior. Some of the identified factors that lead to delinquency are:

Personal pathology includes genetic determinants, brain damage and learning disability, psychological disorders, antisocial traits and drug abuse. **Pathogenic family**

patterns such as parental absence or family conflict, parental rejection and faulty discipline, antisocial parental models and limited parental relationship outside the family contribute to delinquent behavior.

Delinquency tends to be a shared experience and **undesirable peer relationships** often play a major role, leading to delinquent behavior. It has been found that delinquents are victims of social progress and find themselves unable to fit into society – they become "social rejects".

Juvenile institutions and training schools are of great help to young people who need to be removed from aversive environments. These institutions provide an opportunity for the youngsters to learn about themselves and their world, and to further their education and develop needed skills. Psychological counseling and group therapy are also extremely useful. Behavior therapy techniques are especially successful in rehabilitating delinquents.

13.2.4 Oppositional Defiant Disorder

The essential feature of oppositional defiant disorder is a pattern of negativistic, hostile, and defiant behavior, often directed toward parents or teachers. These actions are not as serious as those that characterize conduct disorder.

Oppositional, negativistic behavior is usually a normal developmental characteristic in early childhood. This disorder usually begins at age 8, and not later than adolescence, though there are instances when oppositional defiant disorder occurs as early as 3 years of age. The disorder is more prevalent in boys than in girls before puberty. There are no distinct family patterns, but almost all parents of children with

oppositional defiant disorder are over concerned with issues of power, control, and autonomy.

Children with this disorder often argue with adults, lose their temper, swear, and are angry, resentful and easily annoyed by others. They tend to blame others for their own mistakes and difficulties. Chronic oppositional defiant disorder almost always interferes with interpersonal relationships and school performance. These children have no friends and perceive human relationships as unsatisfactory. Secondary to these difficulties are low self-esteem, poor frustration tolerance, depressed mood and temper outbursts. This disturbance often evolves into a conduct disorder or mood disorder.

Etiology

Asserting one's own will and opposing that of others is crucial to normal development, and is related to establishing one's autonomy, forming an identity and setting inner standards and controls. Normal oppositional behavior peaks between 18 and 24 months, when this negativistic behavior is an expression of growing autonomy of the toddler. Pathology begins when this developmental phase persists abnormally, or authority figures overreact. Another normative oppositional stage occurs in adolescence as an expression of the need to separate from the parents and establish an autonomous identity.

13.3 Internalizing Disorders

Internalizing disorders or disorders of emotions are characterized by subjective distress in the child. Disorders of emotion are characterized by feelings of inferiority,

self-consciousness, social withdrawal, shyness, anxiety, crying, hypersensitivity, depression and sadness. The diagnosis of disorder of emotion is based on whether the child has a psychiatric disorder as judged by

1. persistent disturbed behavior
2. emotions and relationships which are accompanied by an impairment in personal or social functioning, and/or
3. a distortion of the developmental process

Internalizing disorders in childhood are:

(a) anxiety-related conditions

(b) depression

13.3.1 Anxiety Disorders of Childhood or Adolescence

Anxiety disorders of childhood or adolescence include three disorders in which anxiety is the predominant clinical feature. In separation anxiety disorder, and avoidant disorder of childhood or adolescence, the anxiety is focused on specific situations. In overanxious disorder, the anxiety is generalized to a variety of situations. Children and adolescents may also present with several of the phobias listed as adult disorders.

- **Separation Anxiety Disorder.** In a child with this disorder, anxiety can reach enormous proportions during separation or while anticipating separation from a major caretaker. The extent of anxiety experienced is beyond that of the child's developmental level. The disorder is common in early childhood and onset maybe as early as preschool years. Separation anxiety disorder occurs when there is a disproportionate fear of mother-loss. Fears of personal harm and of danger to one's

parents are persistent preoccupations, and the child can feel safe and secure only in the parent's presence. External life stresses often coincide with the development of the disorder.

- **Avoidant Disorder of Childhood or Adolescence.** In avoidant disorder of childhood or adolescence, the patient shows a persistent and excessive shrinking from contact with unfamiliar people. Children with this disorder hold back excessively from establishing interpersonal contacts or satisfactory relationships with strangers to such an extent that it interferes with their peer functioning. These children are slow to warm up and may be clinging, whining, and overly demanding with caretakers. Devastating losses early in childhood, sexual traumas, and other kinds of physical abuse or neglect may contribute to avoidant disorder of childhood or adolescence.
- **Overanxious Disorder.** The principal characteristics of this disorder are that the children are always worried, especially about future events that require meeting expectations. They may be greatly concerned about their competence and about being judged negatively. Physical signs and symptoms such as insomnia, nail-biting, palpitations, etc. are common. The disorder rarely results in an inability to meet at least the minimal demands of school, home and social life, but youngsters with overanxious disorder may have a great deal of inner stress that persists into adult life as an anxiety disorder such as generalized anxiety disorder or social phobia.
- **School Phobia.** A typical phobia in children is school phobia wherein the child refuses to go to school. School phobias are divided into 2 types: **Type I** which occurs in the younger group and has an acute and traumatic onset; **Type II** where the onset is in adolescence and is gradual. Type I phobia is attributed to separation anxiety and

generally occurs in a child who is functioning well in all other areas. In Type II, the disturbance is more pervasive and the condition more resistant to treatment. It is essential that the child is returned to school at the earliest, as the longer the absence, the poorer the prognosis.

13.3.2 Childhood Depression

Childhood depression includes behaviors such as withdrawal, crying, avoidance of eye contact, physical complaints, poor appetite, aggressive behavior and sometimes, suicide.

Research on the causal factors of childhood depression has identified a possible genetic component in childhood and adolescent depression. There appears to be an association between parental depression and behavioral and mood problems in children. Maladaptive learning appears to be important in childhood depressive disorders. Children who are exposed to negative parental behavior or negative emotional states may develop depressed affect themselves. The cognitive-behavioral perspective explains childhood depression as the tendency to develop distorted "mental representations" – for e.g., a child may learn to attribute peer rejection or teasing to a mistaken belief that he or she has some internal flaw.

13.4 Eating Disorders

13.4.1 Pica

Pica is the repeated ingestion of non-nutritive substances such as dirt, clay, plaster and paper. Eating inedible substances after 18 months of age is usually considered

abnormal. The onset of pica is usually between 12 and 24 months. Except in the case of mentally retarded persons, pica usually remits by adolescence. The incidence of pica diminishes with age and the disorder is seen with equal frequency in both sexes. There are three commonly suggested causes of pica:

1. An inadequate mother-child relationship that results in unsatisfied oral needs expressed in the persistent search for inedible substances
2. A specific nutritional deficiency
3. Cultural factors suspected to be important among pregnant women who have the disorder.

13.4.2 Rumination

Rumination is an extremely rare illness. It is a regurgitation disorder which can be fatal and occurs predominantly in infants between 3 months and 1 year of age and among mentally retarded children and adults. “Rumination” is derived from the Latin word *ruminare,* meaning to chew cud. Food or milk is regurgitated without nausea, retching, or disgust and is subjected to innumerable pleasurable sucking and chewing movements. The food is then re-swallowed or ejected from the mouth. The disorder is equally common in boys and girls. Secondary complications such as progressive malnutrition, dehydration, and lowered resistance to disease may develop. Failure to thrive, with growth failure and developmental delays in all areas may also occur.

13.4.3 Anorexia Nervosa

In anorexia nervosa, food and dieting are all-consuming preoccupations. There is a significant disturbance in body image – anorexic patients feel fat even when emaciated. Weight loss or failure to maintain expected weight is marked. Onset is usually between the ages of 10 and 30 years, and frequency increases rapidly after the age of 13 years. Anorexia nervosa is 10 to 20 times more frequent in women than in men; incidence is greatest in the high socioeconomic groups, in high-achieving women, and in professions like modeling and ballet.

Most of the behavior directed towards losing weight occurs in secret. Patients usually refuse to eat with their families or in public places and there is a drastic reduction in their total food intake. Some patients cannot continuously control their voluntary restriction of food intake and so they have eating binges. These binges occur secretly, and self-induced vomiting follows the binge with the help of laxatives and diuretics. An intense fear of gaining weight and becoming obese is present in all patients with this disorder and contributes to their lack of interest and resistance to therapy.

Biological, psychological and environmental factors are implicated in the causation of anorexia nervosa, though biological explanations have not been confirmed. Environmentally, patients find support for their practices in society's emphasis on thinness and exercise. Psychologically, anorexia nervosa appears to be a reaction to demands on adolescents for more independence and increased social and sexual functioning.

13.4.4 Bulimia Nervosa

Bulimia nervosa is characterized by episodic, uncontrolled, compulsive, and rapid ingestion of large quantities of food over a short period of time (binge eating). Binge eating is usually accompanied by feelings of lack of control over eating behavior, self-induced vomiting, the use of laxatives or diuretics, strict dieting, fasting or vigorous exercise to prevent weight gain and persistent over concern with body shape and weight. Most bulimia nervosa patients are within their normal weight range. These patients are concerned about their body image and their appearance, and worry about how others see them, and are concerned about their sexual attractiveness.

Bulimia nervosa, like anorexia nervosa, is more common in women than in men, and is more prevalent than anorexia nervosa. Biological, psychological and social factors are associated with bulimia nervosa. Serotonin and norepinephrine have been implicated with the cycles of binging and purging. Patients tend to be high achievers and respond to societal pressures to stay thin. Many of them are depressed and families of bulimia nervosa patients are less close and have more conflicts than those of anorexia bulimia. Psychologically, patients with bulimia nervosa are outgoing, angry and impulsive. Alocholism, shoplifting, and emotional liability are associated with bulimia nervosa.

13.5 Therapy for children and adolescents

The kind of therapy to be used is usually determined by the age and competencies of the child. In general, the younger the child, the more the work that needs to be done with the caretakers (parents). Therapy with the child involves psychotherapy using verbal communication or play, with psychodynamic, behavioral or other supportive approaches. Establishing a warm therapeutic relationship with the child is a prerequisite for any kind

of individual psychotherapy. The therapist should be interested in the child and the relationship should be trusting and interesting for the child.

13.5.1 Play Therapy

Play is one of the firmly established principles of psychology that is very essential for the process of development of the child. Through play, children develop their intellectual, emotional, perceptual, motor and social skills. There are many creative aspects of play:

- Releases tensions and pent-up emotions
- Allows for compensation for loss, hurt or failures in fantasy
- Facilitates self-discovery of adaptive behavior
- Promotes awareness of conflicts revealed symbolically or through displacement
- Offers opportunity to re-educate children
- Alters behavior through role-play and story-telling
- Is a medium of expression, learning, relationship and catharsis

Play is the natural mode of a child's self-expression. As a technique of therapy, play helps in establishing rapport and provides for a natural relationship. For therapeutic play, selection of material is essential. Some toys elicit self-expression, while others elicit cooperative social play and still others tend to elicit isolated play. Toys should be simple, durable and capable of being adapted for different purposes. They should also be familiar and within the child's cognitive and manipulative skills. The toys which should be readily available with the therapist are:

- Toys that represent the child's family and physical environment (doll house, doll's family, animals, cars trees, etc.)
- Art materials (paints, crayons, etc.)
- Manipulable toys (blocks, plasticine, clay, water, sand, etc.)
- Special purpose toys (feeding bottles, doctor sets, etc.)

13.5.2 Behavior Modification

Behavior modification with children dates back to Watson's experiments with Little Albert and the white furry object. Research on both normal and disturbed children reveals that their behavior is governed largely by the environmental settings in which they were observed. Behavior modification techniques need to be carried out by those around the child in her/his natural setting – parents and siblings at home, teachers and peers at school. Training significant others in the child's environment is essential, particularly as it is important to identify and understand what initiates and maintains a problem behavior.

Positive reinforcement is central to solving children's behavior problems. The parent or teacher should provide **social** (a smile or praise) and **material** (chocolates or TV viewing time) reinforcers so that only the child's desirable behaviors are reinforced. **Time-out** and **response-cost** are used for suppressing problems behaviors and are used as temporary loss of reinforcers. Punishment should be seen as a temporary measure; positive reinforcement always represents a stable, and successful treatment programme with long-term benefits.

Behavior modification techniques have contributed a great deal to the effective management of behavior problems, especially the externalizing disorders where behavior is disruptive in nature.

13.5.3 Family Therapy

In India, because of the presence of strong family ties, the family is the main unit the therapist has to work with. The closely linked family system offers ideal opportunities for family therapy. Family therapy is a preferred mode of therapy along with individual therapy with the child. Not only does it offer a briefer, more effective and more economic method, this holistic approach also offers opportunity for environmental manipulation at home, in school and in the neighbourhood.

Family therapy consists of the following:

- Understanding the meaning of the presenting symptoms of the child in the family homeostasis
- Assessing the family schedule (daily schedules of all family members)
- Assessing the flexibility of the family structure and acceptability of alternative patterns
- Uncovering the family's developmental stage (young couple with toddlers or middle-aged parents with teen-aged children)
- Analyzing internal conflicts in the family and the degree of cohesion or dissociation in the family
- Recognizing sources of external stress and support.

Thus, family therapy is a process of understanding why the child has a symptom in a particular family context, what triggers off and maintains the symptom in that system, and how to change it by engaging the whole family.

13.5.4 Group Therapy

Group therapy represents a broad range of psychological therapies where group processes are an essential component. Groups can comprise different diagnostic categories, and can be either homogenous or heterogenous. They may be open or closed, educational or therapeutic.

The group provides a practice ground for generalization of new modes of behavior acquired in individual therapy. A major advantage is that it is economical as it requires less time and manpower resource. It is also helpful to have a few sessions with parents in open group settings where they discuss the problems faced by them and their ways of coping with them.

13.6 Summary

Childhood disorders were, till recently, diagnosed according to adult criteria, and posed the problem of inaccurate and inappropriate classifications.

Separate classification systems have since been evolved to diagnose and treat childhood disorders within the developmental framework.

Childhood disorders can be classified as disruptive behavior disorders consisting of conduct disorder, ADHD, oppositional defiant disorder and delinquent behavior.

Internalizing disorders are disorders of emotion and comprise the anxiety related conditions including school phobia, and childhood depression.

Eating disorders of childhood and adolescence include pica, rumination, anorexia nervosa and bulimia nervosa.

Therapy for children is different from that used for adults and along with play therapy; behavior modification seems to be very successful with young children.

13.7 Technical Terms

conduct disorder	a repetitive and persistent pattern of behavior in which either the basic rights of others or major age-appropriate societal norms or rules are violated.
Oppositional defiant disorder	a pattern of negativistic, hostile, and defiant behavior often directed toward parents or teachers.
school phobia	refusal to go to school.
Anorexia nervosa	eating disturbance wherein the patient is preoccupied with dieting and maintaining a thin appearance
bulimia nervosa	episodic, uncontrolled, compulsive, and rapid ingestion of large quantities of food over a short period of time. Also known as binge eating.

13.8 Model Questions

1. Briefly describe the problems faced earlier in classifying and diagnosing childhood mental disorders.
2. What are the eating disorders of childhood and adolescence?
3. Bring out the differences between disruptive behavior disorders and internalizing disorders.

13.9 Reference Books

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LESSON-14

DEVELOPMENTAL DISORDERS

14.0 Objectives

3. To understand the various developmental disorders
4. To know about the course, prognosis and treatment of autistic disorder
5. To describe mental retardation and its causes

Structure of the lesson

14.1 Introduction

14.2 Autistic disorder

14.3 Mental retardation

14.1 Introduction

Developmental psychologists categorize psychological disorders seen in children into three types. They are **externalizing problems** that involve outwardly directed inappropriate behaviour, such as aggression. **Internalizing problems** involve deviations from the typical developmental pathway that are directed internally against the self. **Attention problems** that relate particularly to attention deficit hyperactivity disorder which impair the ability to concentrate Besides these developmental disorders there are various forms of atypical intellectual development that occur as psychopathologies among children. Autism characterized by emotional disturbance and mental retardation also referred to as intellectual disability are discussed in the following sections.

14.2 Autistic disorder

In 1943 Leo Kanner, in his paper "Autistic Disturbances of Affective Contact" coined the term ***infantile autism*** and provided a clear and comprehensive account of early childhood syndrome. He described children who exhibited extreme autistic aloneness, failure to assume anticipatory posture, delayed or deviant language development and echolalia and pronominal reversal (using "you" for "I"), monotonous repetitions of noises or verbal utterances, excellent rote memory, limited range in the variety of spontaneous activities, stereotypes and mannerisms and abnormal relationships with people. Kanner suspected the syndrome to be more frequent than it seemed and suggested that some children had misclassified as mentally retarded or schizophrenic.

Autistic disorder is a developmental behavioural disorder. There is a marked ***failure to show relatedness*** *(autism)*. All autistic children fail to show the usual relatedness to their parents and other people. As infants many lack a social smile and anticipatory posture of being picked up as an adult approaches. The cornerstone of

autistic behaviour is the lack of attachment behaviour and failure of bonding. These children do not seem to recognize or differentiate the significant family members like mother, father and siblings. And they do not show any separation anxiety on being left in an unfamiliar environment with strangers. As they grow they fail to play with peers and make friends. They become upset at minor changes in objects or in their routine. Kanner labeled this characteristic a ***preservation of sameness.*** The motor movements of children with autism are unusual and self-stimulatory behaviours like flapping arms, twisting hands and fingers, facial grimacing are also observed. Because of their social awkwardness and inappropriateness and failure to develop empathy they do not show any interest in people. Autistic adolescents and adults have sexual feelings but their lack of social competence and skills prevents them from developing a sexual relationship. It is extremely difficult for autistic persons to get married. Another important characteristic of autistic children is ***disturbances of communication and language***. Most autistic children fail to speak or develop language skills. Those who do talk may show peculiarities in their speech. One of the most common speech problems is ***echolalia***, the exact echoing or parroting of the phrases spoken by others. The children repeat words with the same accent or inflection, but without comprehension. Some even repeat a sentence hours or days after they have heard it. Many autistic children seem to enjoy music. Unusual or precocious cognitive or visumotor abilities are present in some autistic children. The most striking examples are the ***idiot savants*** who have prodigious rote memories or calculating abilities.

14.2.1 Explanations of Autism

A variety of explanations have been offered for autism that include perceptual-cognitive, biological, and family and environmental views. Although each had received some support, none is without limitations. **Perceptual- Cognitive** theory views autism as disturbances in perception and cognition that makes normal communication and relationships and interactions impossible. Theoretically they can hear sounds but cannot make sense of them, as they do not respond appropriately to sounds. As autism unfolds early in life many theorists believe that it must be the result of **genetic and biological** factors. Chromosomal abnormalities have been discovered in autistic people. Studies also emphasis on the link between autism and prenatal difficulties or birth complications. Research also indicates the involvement of neurological dysfunction. The biological basis for understanding autism suggest that any of these causes may lead to problems in the brain or neurotransmitter abnormalities, that produces autistic patterns of behaviours. When first identifies autism, Kanner argues that particular personality characteristics of the parents of the autistic children contribute to the disorder. Research has failed to support this view about the role of **environmental stress** that occurs in the form of trauma early in life that may stifle their development and lead them into lives of near-total withdrawal.

14.2.2 Anatomy of an Autistic brain

The autistic brain differs in several ways from a typical brain. The differences in the brain structure may be the cause or the result of autism. The differences include

- The frontal lobes, center to higher reasoning are greatly enlarged, due to excess white matter, the brains connector cables. The brains of kids who develop autism are grow at an unusual rate and have puzzling signs of inflammation
- The corpus callosum is undersize. This band of tissues links the left and right hemispheres of the brain. Activity across diverse regions of the brain is poorly coordinated in autistic people.
- The amygdala is also enlarged. This area plays an important role in sizing up threats in the environment and in emotion and social behaviour. Its size may be related to the high level of anxiety in autistic children.
- The hippocampus is also larger than the normal. This area is vital to memory. Since autistic children rely largely on memory to interpret situation it becomes enlarged.
- The cerbellum is overloaded with white matter. This region plays a key role in physical coordination, motor planning and anticipating events- all can be weak areas for people with autism.
- It is problem with how the brain is wired.

14.2.3 Treatment for Autism

There is no known treatment that reverses the autistic pattern. The goals of treatment are to decrease behavioural symptoms and to aid in the development of communication skills and self-care skills. In addition the parents also need support and counseling. Educational and behavioural models are considered effective treatments of choice. For nearly two decades the dominant way to work with autistic children has been based on Applied Behaviour Analysis (ABA). However in the recent years new ways of working with autistic children have been devised. Stanley Greenspan, a child psychiatrist developed a method called DIR (developmental, individual-difference, relationship based) which has as its premise the idea that an exchange of emotional signals , initially between mother and infant, forms the basis of learning in childhood. Careful training and individual tutoring of parents in the concepts and skills of behaviour modification and the resolution of parents' problems and concerns within a problem solving format have yielded considerable gains n the child's language, cognitive and social areas of behaviour. This training program requires a great deal of parent's time.

There is no specific drug for autistic disorder but administration of **haloperidol** reduces behavioural symptoms and accelerates learning. The drug decreases hyperactivity, stereotypes, withdrawal, fidgetiness, abnormal object relations and irritability.

14.3 Mental Retardation

Mental retardation is not a unitary disorder. Mental retardation varies in etiology, course and treatment. The essential features of mental retardation as described in the DSM-IV is as follows

- Significantly subaverage general intellectual functioning, accompanied by
- Significant deficits or impairments in adaptive functioning with
- Onset before the age of 18

General intellectual functioning is determined by the results of a standardized test of intelligence, and the term significantly subaverage is defined as an intelligence quotient (I.Q) of approximately 70 or below. The DSM-IV recognized four degrees of severity of mental retardation relying on the standardized intelligence test (IQ) score.

Diagnosed level of Mental Retardation	Corresponding IQ Range
Mild retardation	50-55 to approx 70
Moderate retardation	35-40 to 50-55
Severe retardation	20-25 to 35-40
Profound retardation	below 20-25

14.3.1 Causes of Mental retardation

Mental retardation can be caused be several factors either singly or in combination: genetic factors, environmental biological factors (e.g., malnutrition) and childrearing experiences.

About 25 percent of all cases of mental retardation are caused by **biological abnormalities**. Mental retardation associated with biological abnormalities includes those that are associated with prenatal factors, chromosomal and metabolic abnormalities. These disorders is diagnosed at birth or relatively early in childhood, and the severity is generally moderate to profound Maternal health during pregnancy is important for the development of the foetus. ***Prenatal factors*** that cause foetal damage and mental retardation are *maternal chronic illnesses* (diabetes, anemia, hypertension, and long-term use of alcohol) *maternal infections* (viral infections, rubella or German measles and syphilis). Physical injury at birth, prematurity can also result in mental retardation. Hypoxia-lack of sufficient oxygen to the brain stemming from delayed breathing may also lead to brain damage resulting n mental retardation. ***Chromosomal Abnormalities i***n mental retardation are always associated with autosomal chromosomes. Increased age of the mother and exposure to X-ray radiation are some of the predisposing factors in chromosomal disorders. Chromosomal - such as Down's syndrome, fragile X syndrome the most common disorders manifesting mental retardation. Patients with trisomy 21 (three chromosomes of 21) represent mental retardation called as **Down's syndrome.** Children with this syndrome were called mongoloid because of heir physical characteristics of slanted eyes, epicanthal folds and flat nose. Patients with Down's

syndrome are placid, cheerful, and cooperative and are well adjusted at home. The life expectancy is low and many of them do not live beyond the age of 40.

An inheritable condition known as **Fragile X**, where there is a constriction or breaking off of the end portion of the long arm of the X chromosome seems to be determined by a specific gene defect. Dietary deficiencies in protein and other essential nutrients during early development can also result in irreversible physical and mental damage. **Phenylketonuria** (**PKU**), is a metabolic disorder, resulting in mental retardation, there is lack of a liver enzyme that needs to breakdown phenylalanine, an amino acid found in many foods. The early detection of PKU and dietary treatment that involves elimination of phenyalanine containing foods the deterioration process can be arrested so that the intellectual functioning may range from borderline to normal.

No specific biological causes can be identified in the remaining 75 percent of the cases. When there is no known biological cause and the level of intellectual impairment of a person is IQ between 50 and 70 a familial pattern is often seen in parents and siblings.

The low socioeconomic groups are overrepresented in the cases of mild retardation. **Psychosocial depravation** such as deprivation in social, linguistic, and intellectual stimulation has been suspected of contributing to mental retardation. The prospective mother is malnourished and a proper antenatal care is often lacking. The diet of low socioeconomic group is often lacking in necessary ingredients required during pregnancy. Untreated infections are also quite common and the baby is also exposed to various pollutants. In the Indian sociocultural context due to poverty and large size of the family the mother is unable to provide proper infant care. They may lack in appropriate sensory stimulation of the young infant that facilitate intellectual development.

14.3.2 Assessment of Mental retardation

As mental retardation is defined in terms of both intellectual and social competence it is essential to assess both these characteristics before labeling a person as mentally retarded. Assessment for mental retardation also establishes the eligibility for special educational or psychological services needed by the child and the family. Assessment process includes an evaluation of the child's cognitive and adaptive functioning, including behavioural concerns and evaluation of the family, home and classroom to establish goals and resources. A variety of assessment tools and instruments are criticized for insensitivity to cultural differences and accused of resulting in misdiagnosis. However assessment have many valid uses. They allow for the measurement of change and evaluation of the effectiveness of a program. In assessing children's cognitive functioning **Wechsler's Intelligence Scale for Children** and **Bayley scale of Infant Development** are chiefly used. In assessing adaptive behaviour **Vineland Adaptive Beahviour Scales** a revision of Vineland Social Maturity Scale (1953) is used.

Many parents who are told that their child is mentally retarded hope for a cure-for some means of making their child “normal”. Though retardation can be identified there is no way to undo it. However special training can sometimes produce modest changes in IQ and adaptive behaviour. Training can enhance the retarded person’s social skills thereby ensuring that people outside the family would also meet the child’s legitimate needs for help and affection and that peers will accept the child. Thus intervention that involves social and self-help skills can aid the retarded person’s ability to live in community settings. **Intervention** can be psycho educational, social/ interpersonal or psychopharmacological, based on the needs of the children or a combination of all. The needs of the child are determined by a team of professionals based on the priorities and concerns of the family. Such interventions are not likely to cure mental retardation but they can make a big difference in the personal, social and occupational adjustment of the retarded person.

14.4 Summary

Psychological disorders in children are categorized by developmental psychologists into externalizing problems that include behaviours such as aggression, internalizing problems involving behaviours directed internally against the self and attention problems.

Kanner first described children who exhibited extreme autistic aloneness. The characteristics of infantile autism are failure to assume anticipatory posture, delayed or deviant language development and echolalia and pronominal reversal, excellent rote memory, limited range in the variety of spontaneous activities, stereotypes and mannerisms and abnormal relationships with people.

A variety of explanations have been offered for autism that include perceptual-cognitive, biological, and family and environmental views. However there is no known treatment that reverses the autistic pattern. The goals of treatment are to decrease behavioural symptoms and to aid in the development of communication skills and self-care skills.

Mental retardation as described in the DSM-IV is characterized by significantly subaverage general intellectual functioning, accompanied by significant deficits or impairments in adaptive functioning with

Mental retardation may be caused be several factors such as genetic factors, environmental biological factors (e.g., malnutrition) and childrearing experiences. Mental retardation can be classified into four categories relying on the standardized intelligence test (IQ) score as mild (50-70), moderate (40-50), severe (25-40) and profound (below 20-25).

In assessing children’s cognitive functioning Wechsler’s Intelligence Scale for Children and Bayley scale of Infant Development are chiefly used. In

assessing adaptive behaviour Vineland Adaptive Beahviour Scales a revision of Vineland Social Maturity Scale (1953) is used.

Intervention can be psycho educational, social/ interpersonal or psychopharmacological, that are not likely to cure mental retardation but assist in personal, social and occupational adjustment of the retarded person.

14.5 Technical Terms

Autism	Autistic disorder is a developmental behavioural disorder marked by a failure to show relatedness.
Down's syndrome	Trisomy 21 (three chromosomes of 21) represent mental retardation called as Down's syndrome**.** Children with this syndrome have mongoloid features such as slanted eyes, epicanthal folds and flat nose.

Fragile X **An inheritable condition, where there is a breaking off of the end portion of the long arm of the X chromosome resulting in mental retardation.**

Idiot savants	Autistic children with unusual cognitive or visumotor abilities and have prodigious rote memories or calculating abilities.
Mental retardation	Mental retardation is a condition of significantly subaverage general intellectual functioning, accompanied by significant deficits or impairments in adaptive functioning.
Phenylketonuria	***A metabolic disorder, resulting in mental retardation, because of lack of a liver enzyme that needs to breakdown phenylalanine, an amino acid found in many foods.***

14.6 Model Questions

3. Describe the various developmental disorders
4. Explain mental retardation, its classification, etiology, course and prognosis

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LESSON 15

THERAPIES AND THEIR OUTCOMES

15.1. Objectives

- To know about the various methods of psychotherapy.
- To have an idea of cognitive behavioural therapies.
- To know about group therapy.
- To have a glimpse of research on psychological therapies.
- To understand the integration of psychologically based therapeutic approaches.
- To know of the various biological therapies.
- To understand the issue of hospitalization.

15.2. Structure

15.2.1. Psychotherapy

15.2.2. Cognitive behavioural therapies

15.2.3. Group Therapy

15.2.4. Research on the psychological therapies

15.2.5. Integration of psychologically based therapeutic approaches

15.2.6. Biological therapies

15.2.7. Hospitalizations

15.3. Psychotherapy

In psychotherapy – the psychological treatment of emotional problems – the therapist's aim is to establish a relationship with the patient to (1) remove or modify symptoms, (2) mediate disturbed patterns of behaviour, and (3) promote positive personality growth. Insight therapy tries to help clients understand their behaviour so that they can change or control it; action therapy focuses not on motives but on the problem behaviour itself, in an attempt to correct it. Some therapists see psychotherapy as an applied science, whereas others regard it as both a science and an art that depends largely on empathy and intuition.

All psychodynamic therapy is based to some extent on Freudian psychoanalytic theory. In psychoanalysis, the client or patient talks, and the analyst interprets possible connections with unconscious material. The process relies on free association, dream interpretation, analysis of resistance, and analysis of transference. Most psychodynamic therapists today practice a modified form of psychoanalysis that include neo Freudian approaches. Two examples are ego psychology, which stresses the importance of interpersonal relationships and of the ego as a source of energy, and Sullivanian therapy. Critics of psychodynamic therapies say that it cannot be validated

scientifically, works better for neurotics than for psychotics, is more effective with the articulate, well-educated client, and is prohibitively expensive. Other critics have countered that psychodynamic methods do lead to insight and self-discovery and do identify interpersonal conflicts. Briefer treatment schedules are provided today in response to the financial objection.

Humanistic and existential therapies share the goal of helping clients to become more truly themselves. Rogers' client-centered therapy aims to remove unrealistic conditions of worth – clients' view that they must be something other than themselves in order to be loved. The therapist relies on warmth, unconditional positive regard, and empathy to promote self-actualization. Existential therapy stresses the acceptance and exercise of freedom through the phenomenological approach. Gestalt therapy helps patients to act out unresolved conflicts, confront their feelings and become more honest, open, spontaneous, and decisive in dealing with others. Humanistic-existential therapies, like psychodynamic therapies, are criticized as being difficult to validate by scientific measures.

15.4. Cognitive-Behavioural Therapies

All psychiatric disorders have cognitive and behavioral components and these features have to change if the patient is to recover. With most treatments, the change comes about indirectly but cognitive-behaviour therapy is designed to change cognitions and behaviour directly. Cognitive-behaviour therapy differs from dynamic psychotherapy, in that it is not concerned with the way in which the disorder developed. Instead the focus is on the factors, which are maintaining the disorder at the time of treatment.

Most behavioural techniques are concerned with factors that provoke or maintain psychiatric disorders. Provoking factors are most obvious in the phobic disorders, but are important, though less obvious, in other disorders. For example, in bulimia nervosa, episodes of excessive eating may be provoked by situations, which cause the patient to feel inadequate. Avoidance is a common maintaining factor, which is important in phobic and other anxiety disorders, which prevents the extinction of anxiety response to provoking situations. Many behaviours are maintained by their consequences. For example, escape from an anxiety-provoking situation is followed by a fall in anxiety, and this fall reinforces the phobic avoidance. Increased attention is another powerful reinforcer of behaviour. For example, a child's noisy and unruly behaviour will be reinforced if the parents pay more attention when the child behaves in this way than when he is quiet and well behaved.

Most cognitive therapy focuses on two kinds of disturbed thinking: intrusive thoughts and dysfunctional beliefs and attitudes. Automatic thoughts provoke an immediate emotional reaction, usually of anxiety or depression. Dysfunctional beliefs and attitudes determine the way in which situations are perceived and interpreted.

Three factors maintain dysfunctional beliefs and attitudes. First, patients attend selectively to evidence that confirms these beliefs and attitudes, and ignore or discount evidence that contradicts them. For example, patients with social phobias attend more to the critical behaviour of others, than to signs of approval. Second, people think illogically. The third factor that maintains dysfunctional beliefs and attitudes is safety behaviour. People develop this kind of behaviour as a way of reducing their immediate concerns but the long-term effect is to perpetuate the concerns. For example, a patient who believes that she will faint during a panic attack may tense her muscles every time she feels anxious. She continues to believe that she will faint, even

though she has not done so in hundreds of attacks, because she is convinced she would have fainted had she not tensed her muscles on each occasion.

Certain features characterize cognitive behavioural treatments:

- The patient as an active partner. The patient takes an active part in treatment, with the therapist acting as an expert advisor who asks questions, and offers information and guidance.
- Attention to provoking and maintaining factors. Patients keep daily records to identify factors, which precede or follow the disorder and may be provoking or maintaining it. This kind of assessment is sometimes called the ABC approach, the initials referring to antecedents, behaviour and consequences.
- Treatment as experiment. Therapeutic procedures are usually presented as experiments, which, even if they fail to produce improvement, will help the patient find out more about his condition.
- Homework assignments. Patients practice new behaviours between sessions with the therapist, or carry out experiments to test explanations suggested by the sessions.
- Highly structured sessions. At each session, progress since the last session is reviewed, including any homework. New topics are considered, the following week's homework is planned, and the main points of the session are summarized.
- Monitoring of progress. Assessment of progress does not rely solely on the patient's verbal account but typically includes the checking of daily record kept by the patient, and sometimes formal rating scales.
- Treatment manuals are often available describing the procedures and the way in which they are to be applied. Manuals ensure that different therapists use procedures that are closely similar to those shown to be effective in clinical trials.

15.5.Group Therapy

The popularity of group therapy is due largely to the belief that many psychological difficulties are basically interpersonal and must be worked out in an interpersonal context. Ten factors have been identified that help to promote therapeutic change in this type of treatment:

- Information. From the group leader the clients can acquire information about psychological disturbance, psychodynamics, reinforcement contingencies, and so on. Clients may also receive advice and direct guidance as to their specific problems from both the group leader and the other members of the group.
- Hope. Like most other kinds of therapy, group therapy instills in clients the hope that they can change, and this hope has great therapeutic value.
- Universality. Clients often enter therapy believing that they are unique in their wretchedness – that no one else could possibly have thoughts or feelings as frightening and unacceptable as theirs. In the group they make the comforting discovery that such problems are relatively common.
- Altruism – Group members help one another with advice, encouragement, and sympathy. In the process, the givers learn that they have something to offer their fellow human beings, while the receivers learn that they are not alone. This exchange of social support is perhaps the chief virtue of group therapy.

- Corrective recapitulation of the family group. The group is like a family, with leaders representing parents and other members representing siblings. Thus the group, as a sort of the new family, may help to heal wounds and ease inhibitions produced by the client's original family.
- Development of social skills. Corrective feedback from other group members may help to correct flaws in the client's interpersonal behaviour.
- Imitative behaviour. The group leader and other members of the group may serve as useful models for new kinds of behaviour.
- Interpersonal learning. By interacting with the group, the clients may gain insight into themselves and revise their ideas of the kinds of relationships they want to have. Furthermore, the group may serve as a social laboratory in which to try out new selves and new kinds of relationships.
- Group cohesiveness. The sense of belongingness and intimacy that develops within the group as a whole may give clients both comfort and courage.
- Catharsis. Within the protective atmosphere of the group, members may feel free to express emotions that they have been bottling up, to the detriment of their behaviour, for years.

Different kinds of groups stress different factors as the key to change. Psychodrama is a psychodynamic approach to group treatment in which participants act out their emotional conflicts using such techniques as role reversal, the double technique and mirroring. Most behavioural group therapy is directed toward a goal. Social-skills training and assertiveness training are forms of behavioural therapy that are most compatible with the group interaction process. Assertiveness training uses the therapeutic tools of modeling, rehearsal, and reinforcement; it is an extinction therapy, and to some extent a cognitive therapy, insofar as clients lose their fear of expressing feelings and examine their attitudes through interaction with the group.

The humanistic perspective has contributed most to the group therapy movement. The two original humanistic groups were the encounter group and the sensitivity-training or T-group. A third form is Gestalt therapy, in which the participant acts out unresolved emotional conflicts, taking responsibility for the feelings involved. The central goals of humanistically oriented group therapy are personal growth and increased honesty and openness in personal relations, accomplished through free interchange among group members. Of the factors that promote change, humanistic approaches emphasize altruism, interpersonal learning and catharsis.

15.6. Research on psychological therapies

Since Eysenck's review of therapy effectiveness in 1952, the value of different therapies and of psychotherapy itself has been debated, and assessment measures have been criticized for their reliance on self-reports. Recent studies show, however that people who receive psychotherapy do better than 80 per cent of those who receive no treatment. In comparing therapies, Eysenck concluded that only behavioural techniques brought clear results, but other studies have suggested that psychodynamic, behavioural, humanistic-existential therapies are roughly equally effective. Very recent studies indicate that cognitive therapy is as effective as or more effective than drug therapy for acute episodes of depression. Psychotherapies are now in a period of integration: as ideas are traded across perspectives, therapists are becoming more eclectic. Psychodynamic therapists may emphasize behaviour change along with the goal of insight, and behaviourists may attend not only to cognitive events representing covert responses but also to cognitive variables lying outside awareness.

Evaluations of the effectiveness of specific forms of group therapy have yielded mixed results; social-skills training, assertiveness training, marital and family therapy, and behaviour therapy all appear to be generally successful. Outcome studies of humanistic-existential groups indicate that their effectiveness is more modest than that of other kinds of therapy. People who are in serious psychological distress should avoid encounter groups, and those who experience negative effects should be referred for follow-up therapy by group leaders who have been trained to identify participants who need referral.

15.7. Integration of psychologically based therapeutic approaches

In the history of all disciplines, periods of differentiation and competition between theoretical schools are followed by periods of integration, in which different theories mingle, make truces, and learn from one another. Psychology is now in a period of integration.

With the provisional finding that all the psychotherapies work, and may work equally well, defensiveness among adherents of different approaches has diminished. Today, writings on treatment tend to emphasize not the differences among the psychotherapies but their similarities and the therapeutic importance of these shared qualities: the provision of support, the giving of information, and the raising of hopes.

With the recognition of common ground has come a tendency to enlarge that common ground by trading ideas across perspectives. Already some years ago it was found that most therapists regarded themselves not as adherents of a specific perspective but as eclectic practitioners choosing the techniques that served them best from whatever source.

Behaviourism has been profoundly affected by cognitive theory, and in the process has become increasingly interested in mental events. Mahoney, a prominent cognitive behaviourist, has even proposed that behaviour therapists should start to pay attention to cognitive variables lying outside awareness, and look for ways to bring them into awareness – a concern that would sound familiar to Freud. Conversely, psychodynamic therapists have become more interested in promoting direct behaviour change. As with the behaviourists, this shift came originally from within the school – from ego psychology, with its emphasis on the active, adaptive functions of the ego. But today there is a conscious willingness in many quarters to incorporate into psychodynamic therapy the strengths of behaviourism. Wachtel, for example, has suggested that the ideal therapy might involve, first, a psychodynamic working through of the patient's problem, with the goal of insight, and then a behavioural treatment aimed at changing the maladaptive behaviours involved in that problem.

15.8. Biological Therapies

In addition to the psychotherapies, other treatments available to people with psychological disorders include biological therapy. The biological approach has received increased professional approval and support in the last decade, following evidence of the biochemical bases of such major disorders as schizophrenia and depression.

15.8.1. Drugs

Most advances have been in psychopharmacological, or drug, treatment. The three main categories of drugs are antianxiety drugs, antipsychotic drugs and antidepressant drugs. Antianxiety drugs, including Librium, Tranxene, Valium and Xanax, provide effective temporary

relief from panic attacks or anxiety, but they can be harmful if they are taken regularly or to avoid problem solving. Antipsychotic drugs, including the phenothiazines, help to reduce symptoms of schizophrenia but may produce side effects of apathy, fatigue, and motor disturbances. Antidepressant drugs include MAO inhibitors and tricyclics; lithium carbonate works effectively to relieve symptoms of mania, particularly in patients with bipolar disorder.

15.8.2. Electroconvulsive Therapy

Electroconvulsive Therapy or ECT involves administering to the patient a shock of approximately 70 to 130 volts, thus inducing a convulsion similar to a tonic-clonic epileptic seizure. Typically, therapy involves about nine or ten such treatments, spaced over a period of several weeks, though the total may be much lower or higher.

This technique was first discovered in the thirties. Since that time it has become clear that, like antidepressants the shock affects the levels of norepinephrine and serotonin in the brain, but theories as to its exact mode of operation are as various and incomplete as those regarding anti depressants.

Like other biological treatments, ECT has its complications. The most common side effect is memory dysfunction, both anterograde and retrograde. Research indicates that in the great majority of cases, anterograde memory gradually improves after treatment. As for retrograde memory, there is generally a marked loss one week after treatment, with nearly complete recovery within seven months after treatment. In many cases, however, some subtle memory losses, particularly for events occurring within the year preceding hospitalization, will persist beyond seven months. And in very rare cases, such persisting losses are not subtle, but comprehensive and debilitating. The probability of memory dysfunction is less if ECT is confined to only one hemisphere of the brain, the one having less to do with language functions, this is usually the right hemisphere – and this approach has proved as effective as bilateral shock.

ECT has become an extremely controversial issue in recent years. Defenders of ECT point out that many studies have found it highly effective – more effective, in fact, than antidepressants. Furthermore, like antidepressants, it works relatively quickly – an important advantage with suicidally depressed patients. On the other hand, ECT has vociferous critics, who consider it yet another form of psychiatric assault on mental patients.

Though the controversy over ECT is not settled, it has already had its impact on practice. State legislatures have established legal safeguards against the abuse of ECT, and in general the technique is being used less frequently than it was a decade ago.

15.8.3. Psychosurgery

Psychosurgery is also called prefrontal lobotomy. In this surgical procedure an instrument is inserted into the frontal lobe and rotated, thus destroying a substantial portion of brain tissue. The theory behind this technique was that in extremely disturbed patients, activity in the frontal lobe was intensifying emotional impulses originating in lower parts of the brain, especially the thalamus and hypothalamus. Presumably, if some of the connections between the frontal lobe and these lower regions could be severed, behaviour would improve.

In recent years, researchers have developed more refined psychosurgical techniques – techniques that destroy less brain tissue and therefore produce fewer and milder side effects. In one procedure called stereotactic subcaudate tractotomy, a small localized area of the brain is

destroyed by radioactive particles inserted through small ceramic rods. The site varies with the nature of the disturbance. For depressed patients, it is the frontal lobe; for aggressive patients, it is the amygdala, a structure in the lower part of the brain.

These techniques are used only for severely disturbed patients who have not responded to other treatments. Psychosurgery has been found to be effective with severe depression, anxiety, and obsessions. Nevertheless, it is still extremely controversial. Its defenders claim that the benefits are substantial and the side effects relatively mild. Other observers doubt both claims and feel that the public should be very wary of such radical and irreversible treatments.

15.9. Hospitalizations

It is sometimes necessary to remove persons from their family and community settings and place them in mental hospitals or inpatient clinics for treatment. Any of the traditional forms of therapy may be used in the hospital setting. In more and more mental hospitals, however, these techniques are being supplemented by an effort to make the hospital environment itself a therapeutic community. That is, all the ongoing activities of the hospital are brought into the total treatment program, and the environment, or milieu, is a crucial aspect of therapy. The aim is to get patients back into their family and community settings as soon as possible.

In the therapeutic community, as few restraints as possible are placed on the freedom of the patient, and the orientation is toward encouraging patients to take responsibility for their behaviour as well as to participate actively in their treatment programs. Open wards permit patients the use of grounds and premises. Self-government programs confer citizenship on them, giving them responsibility for managing their own affairs and those of the ward. All hospital personnel are oriented toward treating the patients as human beings who merit consideration and courtesy. A number of studies have shown the beneficial effects of such staff attitudes on everyone concerned, staff and patients alike.

The interaction among patients – whether in encounter groups, social events, or other activities is planned in such a way as to be of therapeutic benefit. In fact, it is becoming apparent that often the most beneficial aspects of the therapeutic community are the interactions among the patients themselves. Differences in social roles and backgrounds may make empathy between staff and patients difficult, but fellow patients have been there, they have had similar problems and breakdowns and have experienced the anxiety and humiliation of being labeled mentally ill and hospitalized. Thus constructive and helping relationships frequently develop among patients in a warm, encouraging milieu.

It may be emphasized that the ultimate goal of hospitalization is to enable the patient to resume his place in society. There is always the danger that the mental hospital may become a permanent refuge from the world, either because it offers total escape from the demands of everyday living or because it encourages patients to settle into a chronic sick role. To avoid this, hospital staffs try to establish close ties with the family and community and to maintain a recovery-expectant attitude. Between 70 and 85 per cent of patients labeled as psychotic and admitted to mental hospitals can now be discharged within a few weeks, or at most months, and with adequate aftercare the readmission rate ca be markedly reduced.

15.10. Summary

In psychotherapy – the psychological treatment of emotional problems – the therapist's aim is to establish a relationship with the patient to remove or modify symptoms, mediate disturbed patterns of behaviour, and promote positive personality growth. Cognitive-behaviour therapy differs from dynamic psychotherapy, in that it is not concerned with the way in which the disorder developed. Instead the focus is on the factors, which are maintaining the disorder at the time of treatment. The popularity of group therapy is due largely to the belief that many psychological difficulties are basically interpersonal and must be worked out in an interpersonal context. Studies show that people who receive psychotherapy do better than 80 per cent of those who receive no treatment. Today, writings on treatment tend to emphasize not the differences among the psychotherapies but their similarities and the therapeutic importance of these shared qualities: the provision of support, the giving of information, and the raising of hopes. In addition to the psychotherapies, other treatments available to people with psychological disorders include biological therapy in the form of drugs, ECT and psychosurgery. Even with all these forms of therapy it is sometimes necessary to remove persons from their family and community settings and place them in mental hospitals or inpatient clinics for treatment. However, between 70 and 85 per cent of patients labeled as psychotic and admitted to mental hospitals can now be discharged within a few weeks, or at most months.

15.11. Technical Terms

Action therapy - focuses not on motives but on the problem behaviour itself, in an attempt to correct it.

Electro convulsive therapy - involves administering to the patient a shock of approximately 70 to 130 volts, thus inducing a convulsion similar to a tonic-clonic epileptic seizure

Group cohesiveness – It is the sense of belongingness and intimacy that develops within a group as a whole.

Insight therapy - tries to help clients understand their behaviour so that they can change or control it.

Psychotherapy – is the psychological treatment of emotional problems with an aim to establish a relationship with the patient to remove or modify symptoms, mediate disturbed patterns of behaviour, and promote positive personality growth.

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15.13. Model Questions

15.12.1. What are the various forms of psychotherapy? How effective are these forms comparatively?

15.12.2. What is Cognitive-Behaviour Therapy? How is it different from the dynamic therapies?

15.12.3. What are the therapeutic features of Group Therapy?

15.12.4. What are the various forms of Biological Therapies in use for the treatment of psychological distress?

15.12.5. Describe the trends towards integration and eclectism in psychotherapy.

LESSON 16
SOCIETY'S RESPONSE TO MALADAPTIVE BEHAVIOUR

16.1. Objectives

- To know about the types and sites of prevention.
- To be aware of the challenges to prevention
- To understand the various aspects of treatment in the community.
- To become familiar with the legal aspects of treatment and prevention.

16.2. Structure

16.2.1. Types and sites of prevention

16.2.3. The challenge of prevention

16.2.4. Treatment in the community

16.2.5. Legal aspects of treatment and prevention

16.3. Types and sites of Prevention

As modern psychology, psychiatry, and allied fields have become established and sophisticated sciences, they have directed their efforts toward preventing abnormal behaviour. Just as medical science developed vaccines and antitoxins for treating smallpox, diphtheria, and polio, so the contemporary social sciences are attempting to formulate and apply principles that can help us prevent maladaptive behaviour and foster a better world for all people. Such efforts are taking place on international as well as national, state, and local levels, and by governmental, professional, and voluntary citizen groups.

We know that metabolic deficiencies as well as sociocultural deprivation underlie certain types of mental retardation, and it has become possible to detect and correct many of these conditions before the individual's development is seriously blocked. Likewise, genetic counseling may aid prospective individuals who would probably bear children with genetic defects. Unfortunately, we still lack sufficient knowledge about the causes of the functional psychoses and other forms of maladaptive behaviour to be equally positive and specific in preventing them. However, as our understanding of maladaptive behaviour is continually enhanced by the new scientific findings, we are becoming increasingly capable of preventing the distress and waste of human potentials that mental disorders are inevitably associated.

In the prevention of mental disorders we are concerned with two key tasks: seeking out and eradicating the causes of mental disorders, and establishing conditions that foster positive mental health. Preventive measures thus run the gamut from programs directed toward known and specific causal agents to programs aimed at more general social advances.

16.3.1. Primary Prevention

Primary prevention includes all measures designed to foster healthy development and effective coping behaviour – on biological, psychosocial and sociocultural levels.

Preventive physical health measures begin with help in family planning and include both prenatal and postnatal care. A good deal of current emphasis is being placed on guidance in family planning – how many children to have, when to have them in relation to marital and other family conditions, and even whether to have children at all. Such guidance may include genetic counseling, in which a variety of new tests for diagnosing genetic defects may be administered to potential parents to assess their risk of having defective children.

Breakthroughs in genetic research have also made it possible to detect and often alleviate genetic defects before the baby is born. When in utero treatment is not feasible, such information provides the parents with the choice of having an abortion rather than a seriously defective baby. Continued progress in genetic research may make it possible to correct faulty genes, thus providing human kind with fantastic new power to prevent hereditary pathology. But while this would help ensure a healthy beginning in life, it would not minimize the crucial importance of adequate prenatal and postnatal care – including medical supervision to ensure adequate nutrition for the expectant mother, obstetric care at the time of delivery, and follow-up postnatal care.

Our definition of normality as optimal development and functioning implies opportunities for learning needed competencies – physical, intellectual, emotional, and social. Failure to develop the skills required for effective problem solving, for handling emotions constructively, and for establishing satisfying interpersonal relationships places the individual at a serious disadvantage in coping with life problems.

Another crucial psychosocial health measure involves acquiring an accurate frame of reference – in terms of reality, possibility, and value assumptions. When an individual's assumptions about himself or herself or the world around are inaccurate, his or her behaviour is likely to be maladaptive. Likewise, inability to find satisfying values that foster a meaningful and fulfilling life becomes a major source of maladjustment and mental disorders.

Psychosocial health measures also ordinarily require preparation of the individual for the types of problems he is likely to encounter during given life stages. For example, pregnancy and childbirth usually have a great deal of emotional significance to both parents and may disturb family equilibrium or exacerbate an already disturbed marital situation. Thus family planning may involve psychosocial as well as physical health considerations. Similarly, the individual needs to be prepared adequately for other developmental tasks characteristic of given life periods, including old age.

The third type of preventive measures involves sociocultural strategies. With our growing realization of the importance of pathological social conditions in producing maladaptive behaviour, increased attention is being focused on broad sociocultural measures that will foster the healthy development and effective functioning of all members of the group. This trend is reflected in a wide spectrum of social measures ranging from public education and social security

to economic planning and social legislation directed toward ensuring adequate health care for all citizens.

Such sociocultural measures must, of course, take into consideration the future stresses and health problems we are likely to encounter in our rapidly changing society. In the final analysis, the mental health of each citizen is affected by the maturity and health of our society – from the smallest unit to the largest.

16.3.2. Secondary Prevention

Secondary prevention emphasizes the early detection and prompt treatment of maladaptive behaviour in the individual's family and community setting. Thus it is concerned with the incidence and scope of maladaptive behaviour in specific populations, with the early detection of such behaviour, with the variety and availability of mental health facilities, and with crisis intervention.

Science has found that most diseases can be brought under control once their distribution and modes of communication are discovered via epidemiological studies. Epidemiological studies are also helping investigators obtain information concerning the incidence and distribution of various maladaptive behaviours in our society. Epidemiological studies tell us what to look for and where to look; the next step is to deal with these troubled spots.

We have witnessed a marked increase in the variety and availability of mental health facilities. The new comprehensive community mental health centers are of particular significance, since they mark a distinct trend way from the traditional state mental hospital approach. Such centers are designed to provide both inpatient and outpatient treatment, partial hospitalization on either a day or a night basis and emergency services 24 hours a day – in essence to provide individuals and families with the type of care they need when they need it and close to home. Further, the community mental health center makes it possible to elicit the active participation of members of the community in planning the treatment programs that will best meet the needs of its particular population and in serving as nonprofessional volunteers. As of now, such community mental health centers exist in western countries only. In India Community Mental Health programmes have been initiated in Karnataka, Vellore, Ranchi, Chandigarh and a few other places. The focus of these community mental health programmes has been training of trainers, holding diagnostic camps, developing local level educational materials on mental health, distribution of drugs and other related activities. They are not widespread in the country because of (a) lack of sufficient awareness about mental health problems and (b) lack of integration of mental health care in primary health care.

Broadly, three types of activities/approaches are visible in community participation in our country: (1) Family members of patients meet and find solutions for their special needs. This can be seen more often with substance abusers, mentally disabled, autistic and physically disabled groups. However, not many such groups exist for the severely mentally ill and their families. (2) Professionals and non-professionals collaborate to initiate services not available in the organized sector. The Schizophrenia Research Foundation (SCARF) Chennai, Sangath Centre for Child and Family Guidance, Goa, Richmond Fellowship (Bangalore) are examples of such services. (3) Trained volunteers provide care in crisis situations, for example, Sanjivini (Delhi), The Samaritans (Bombay), Sneha (Chennai).

One important technique of secondary prevention is crisis intervention. Crises may confront individuals of all ages, as well as family groups, communities, and even entire societies. Emergency services for a wide range of emotional problems are increasingly available not only in the community mental health centers and the psychiatric wards of general hospitals but also via the hot lines. These telephone services bring help to many troubled people who would never present themselves at a mental health facility. Callers seek help with a wide range of problems including personal relationships, drugs, sex, family conflicts, legal questions, loneliness and abortion.

In addition, intervention in times of large-scale natural disasters such as earthquakes, the recent tsunami, floods, and so on is possible. In addition, such efforts have been initiated in Bhopal (after the gas disaster), Latur, Maharashtra, and Kutch, Gujarat (earthquakes) and in Tamil Nadu (tsunami). Intervention measures included (1) assessment of mental health needs of victims (2) base line studies (3) training of personnel (4) development of mental health educational materials (5) manuals of mental health for various professionals.

It is not possible, of course, to prevent crises altogether, nor would we wish to avoid all stress and challenge. Successful mastery of challenges and crises is needed for individual and group growth. On the other hand, failure to deal adequately with crises can lead to the breakdown of individual or group functioning. Thus crises intervention must be considered a crucial aspect of secondary prevention.

16.3.3. Tertiary Prevention

Despite crisis intervention and other secondary preventive measures, some persons do require hospitalization for emotional disorders. Tertiary prevention involves prompt and intensive inpatient treatment for such disorders. Its aim is to prevent the disorder from becoming chronic and to enable the individual to return home as soon as possible.

In many cases, intensive inpatient treatment can be given in the local community mental health center or in a nearby general hospital. But even where the individual requires treatment in a state mental hospital – which could be located in a city and at a considerable distance from the person's home – the emphasis is on brief hospitalization and long-range follow-up care. Such follow-up care becomes the primary responsibility of community mental health facilities and personnel as well as of the person's family and of the community as a whole. It seeks to ensure that the individual will be helped to make an adequate readjustment and return to full participation in his or her home and community setting with a minimum of delay and difficulty.

The comprehensive preventive approach involving primary, secondary, and tertiary prevention places a heavy strain on our resources. However, the alternative would be even more costly in both financial and human terms. There needs to be a strong trend towards the comprehensive public health concept – the goal advanced by the World Health Organization of a "sound mind, in a sound body, in a sound society."

16.4. The Challenge of Prevention

In our country, minimal health standards are far from being met, and often the standards themselves are open to question. In fact, the organization and delivery of mental health services in India is today considerably poor.

There is a serious inadequacy in the number of professional and paraprofessional personnel to deal with the mental health problems. There are severe shortages of personnel in social work, psychiatric nursing, childcare, and other mental health fields. India with an enormous population still has only a handful of professionally trained mental health personnel. According to the Directorate General of Health Services, there are currently 42 mental hospitals, and a human resource base of 2500 psychiatrists and around 700-800 clinical psychologists.

Many of the buildings still used to house mental patients are badly deteriorated and obsolete. Furthermore, the construction of the new community mental health centers required as a result of the shift toward local treatment has lagged badly; this, of course, affects the delivery of services to both young people and adults. Thus the recognized need for early detection and correction of behaviour disorders before they become more severe and disabling is not being adequately met in most Indian states.

In relation to the magnitude and social importance of mental disorders in our society, research in the area of mental health is very inadequately financed. In fact, we spend over 100 times as much money on alcohol as on research in mental health. Even then, very little research is being carried on. Yet it is apparent that a key factor in the effectiveness of the mental health movement is the research upon which its concepts and procedures are based.

In general, our treatment and prevention programs suffer from serious limitations in personnel, facilities, research and finances. Of course, as the government's programs for better general health care for all citizens gather momentum, it seems likely that these limitations will gradually be corrected. Ultimately, however, mental illness treatment and prevention is inextricably tied to the values and priorities that we choose in building the world of the future.

16.4. Treatment in the Community

As the trend toward treatment in the family and community setting – rather than in large state mental hospitals – has gathered impetus, we have seen the development of community mental health facilities are available to provide immediate assistance to the individual or the family, many crises can be rapidly alleviated. Thus, the family is not disrupted, nor does the individual have to be sent to a distant institution and, later, face the problem of return to family and community.

However, returning "madness" to the community is not without its problems. The family must be willing to participate in therapy, and the home must provide a supportive environment and not one that reinforces and maintains the maladaptive behaviour. Qualified therapists must be available in the community, and the resistance of family members as well as neighbours to having a mentally ill person in their midst must be overcome. However, this approach tends to shift the criterion for hospitalization from the severity of the individual's symptoms to the degree of family support and the availability of therapeutic supervision outside the hospital setting.

Community Mental Health Centres offer at least five types of services to local residents and institutions: (a) inpatient care for persons requiring short-term hospitalization; (b) partial hospitalization, with day hospitalization for patients able to return home evenings, or night hospitalization for patients able to work but in need of further care; (c) outpatient therapy permitting patients to live at home and go about their daily activities; (d) emergency care with psychiatric services around the clock; and (e) consultation and education for members of the

community. These services are provided without discrimination for all who need them – young or old, well-to-do or indigent.

These community mental health centers are highly flexible and have a number of advantages. For example, the emotionally disturbed individual need no longer face the choice between being admitted to a distant hospital or receiving no treatment at all. If his disturbance is severe he can enter the center's inpatient facility for short-term hospitalization; if he can remain on the job or in his family with supportive care, he can enter partial hospitalization; and if outpatient therapy is sufficient for his needs, he can obtain it at the center. In addition, such community centers usually utilize an interdisciplinary approach to therapy, involving psychiatrists, psychologists, social workers, nurses, and other mental health personnel. Finally, such centers have many resources at their disposal, thus enabling the individual to obtain most or all of the needed services at one agency instead of traveling around the city from one place to another.

16.5. Legal Aspects of Treatment and Prevention

For a long time, the Indian Lunacy Act of 1912 regulated the functioning of mental hospitals in the country. Following continuous demands that this obsolete act be replaced, the Mental Health Act was passed in 1987. This law is in line with the mental health policy formulated in India in 1982 and known as the National Mental Health Programme (NMHP).

The Indian Mental Health Act, 1987 is an act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental thereto. The Act is divided into 10 chapters consisting of 98 sections. Chapter IV deals with treatment and prevention in that it talks about admission and detention in psychiatric hospital or psychiatric nursing home. It consists of 3 parts; with part III divided into 4 further subdivisions. A mentally ill person, under this Act, can be admitted in a psychiatric hospital or psychiatric nursing home in one of the following ways:

- Admission as a voluntary patient
- Admission under special circumstances
- Reception order on application
- Reception order on production of mentally ill persons before Magistrate
- Admission as an inpatient after inquisition
- Admission as a mentally ill prisoner.

In addition, the Magistrate can order detention of an alleged mentally ill person for short periods pending report by medical officer (for a period not exceeding 10 days in aggregate) or pending his removal to psychiatric hospital or psychiatric nursing home (for a period not exceeding 30 days).

Voluntary admission can be effected by the medial officer in-charge of a psychiatric hospital/nursing home, if:

- A major mentally ill person (not a minor) requests for admission as a voluntary patient.
- The guardian of a minor mentally ill person requests for admission of the minor as a voluntary patient.

Chapter VIII deals with the protection of human rights of mentally ill persons. It specifies that:

- Mentally ill persons shall not be subjected during treatment to any physical or mental indignity, or cruelty.
- Mentally ill persons under treatment shall not be used for research purposes unless such research is of direct benefit to him for diagnosis or treatment; or written consent has obtained from the patient (if a major, voluntary patient) or guardian (if minor or incompetent) for such research.
- Unless otherwise specified, no letters or other communications sent by or to a mentally ill person under treatment shall be intercepted, detained or destroyed.

16.6. Summary

Primary prevention includes all measures designed to foster healthy development and effective coping behaviour, occurring at the societal level. Secondary prevention emphasizes the early detection and prompt treatment of maladaptive behaviour in the individual's family and community setting. Tertiary prevention involves prompt and intensive inpatient treatment for serious mental disorders at the level of the state mental health institutions level. Our treatment and prevention programs suffer from serious limitations in personnel, facilities, research and finances. Community Mental Health Centres offer at least five types of services to local residents and institutions: (a) inpatient care for persons requiring short-term hospitalization; (b) partial hospitalization, with day hospitalization for patients able to return home evenings, or night hospitalization for patients able to work but in need of further care; (c) outpatient therapy permitting patients to live at home and go about their daily activities; (d) emergency care with psychiatric services around the clock; and (e) consultation and education for members of the community. The Indian Mental Health Act, 1987 is an act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental thereto.

16.7. Technical Terms

Primary prevention - includes all measures designed to foster healthy development and effective coping behaviour on biological, psychosocial and sociocultural levels.

Secondary prevention - emphasizes the early detection and prompt treatment of maladaptive behaviour in the individual's family and community setting.

Tertiary prevention - involves prompt and intensive inpatient treatment for serious mental disorders.

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16.9. Model Questions

16.9.1. What are the various types and sites of prevention of mental illness?

16.9.2. List out the challenges facing treatment and prevention of mental illness.

16.9.3. Describe the concept of treatment for mental illness in the community.

16.9.4. What are the legal aspects of mental illness treatment and prevention?