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DIRECTORATE OF DISTANCE EDUCATION

M.Sc. PSYCHOLOGY

III SEMESTER

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PSYCHOPATHOLOGY

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SYLLABI – BOOK MAPPING TABLE
PSYCHOPATHOLOGY

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BLOCK I: BEHAVIOURS AND DISORDERS
UNIT 1: ABNORMAL BEHAVIOUR

Structure

1.1 Introduction

Abnormal psychology also called psychopathology deals with understanding the nature, causes, and treatment of mental disorders. This field of psychology surrounds us every day, one hears of it through newspapers, on the web or in a movie. Some commonly known disorders are depression, schizophrenia, phobias and panic attacks. The issues of abnormal psychology capture our interest, demand our attention, and trigger our concern.

1.2 Objectives

On Completion of this unit, you will:

- Understand the meaning of abnormal behaviour
- Know how abnormal behaviour was conceived in the past
- Understand different viewpoints of abnormal behaviour

1.3 Meaning

1.3.1 Definition

According to the DSM 5, a mental disorder is defined as a syndrome that is present in an individual and that involves clinically significant disturbance in behaviour, emotional regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological or developmental processes that are necessary for mental functioning. Thus, abnormality is associated with significant decrease in social, occupational and other activities that are important for human functioning.

1.3.2 Indicators of abnormality

The more that someone has a difficulty in the following areas, the more likely that they have a mental disorder.

1.3.2.1 Subjective distress

If people suffer from psychological pain we can consider this as an indication of abnormality. For example, people with depression clearly report being distressed. However there can be instances where worry is common and normal, such as when you have to study for a test. Therefore, although subjective distress may be an element of abnormality, in many cases it is neither a sufficient condition nor a necessary condition for abnormality.

1.3.2.2 Maladaptiveness

Maladaptive behaviour is often an indicator for abnormality. It interferes with our ability to enjoy our occupations and relationships. A depressed person may withdraw from family and friends.

1.3.2.3 Statistical Deviance

If something is statistically rare and undesirable we are more likely to consider it abnormal than something that is statistically common but undesirable. But this has to be understood right, for example, severe intellectual disability is considered abnormal while being a genius or being rude is not an abnormality.

1.3.2.4 Violations of the standards of society

Breaking cultural rules, laws, norms and moral standards may indicate signs of abnormality. Much depends on the degree of violation of the rule. Parking in the wrong spot may be against the law but it is not abnormal while a mother killing her children is a sign of abnormal behaviour.

1.3.2.5 Social discomfort

When someone violates an unwritten social rule that causes discomfort to someone else, it may be considered abnormal. If a stranger decides to sit next to you in an empty bus, you will be uncomfortable. But again, much depends on circumstances.

1.3.2.6 Irrationality and unpredictability

Irrational and unpredictable behaviour makes no sense and can indicate possible abnormality.The most important factor is our evaluation of whether the person can control their behaviour.

1.3.2.7 Dangerousness

It is quite reasonable to think that a person who can pose as a danger to themselves or other people has an abnormality .Psychologists are required to hospitalize such people and alert the police.

One must note that no single indicator is sufficient in and of itself to determine abnormality.

Check your Progress – 1
Note: a. Write your answer in the space given below
　　　b. Compare your answer with those given at the end of the unit.

1. Name the indicators of abnormality.

2. Define mental disorders according to the DSM 5.

1.4 Historical Conceptions of Abnormal Behaviour

Throughout history the dominant social, economic and religious views have had a great influence on how people perceived abnormal behaviour. In the ancient world superstitious explanations for mental disorders were popular. In the fifteenth and sixteenth centuries it was widely believed that mental disorders were attributed by demonic possessions.

However, Hippocrates denied that Gods and demons caused illnesses and insisted that mental disorders had natural causes and required proper treatment. He also believed that dreams are important to understand the patients' personality. He also recognised the importance of environment for mental health and thus removed some patients from their families.

The Greek and Roman were among the few to treat people with mental disorders with appropriate care. They provided pleasant surroundings with constant activities like parties, dances and massages. They also followed the principle of contrariiscontrarius (opposite by opposite). For example, having their patient drink chilled wine while taking a warm bath. Chinese physician, Chung Ching conducted treatments that were similar to Hippocrates. Other references to mental health disorders were also made in the Indian texts of CharakaSamhitha and Sushruta Samhita.

In Europe during the Middle age and Renaissance period, there was a general movement away from superstitions and toward reasoned scientific studies. Mental asylums were created in the 16th century, however, it lead to the isolation and maltreatment of the patients. Some patients were displayed to the public in return for money. Slowly by the eighteenth century efforts were made for the better care of patients by providing them with better living conditions and humane treatment.

In the 19th and 20th century rapid growth of abnormal psychology was observed. This can be because of the growth of technology and scientific advancements. Thus the treatment of individuals with mental illnesses was advanced. Because of the works of several renowned psychologists like Pavlov and Freud, the gradual acceptance of patients with mental illnesses as people who need care and attention, was possible. Successful application of biomedical methods to disorders and the growth of scientific research into the biological, psychological and sociocultural roots of abnormal behaviour were observed.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. What were Hippocrates' contributions to psychopathology?

4. Describe the methods used by the Greeks and Romans to treat people with mental disorders.

1.5 Biological Viewpoint

The biological viewpoint focuses on mental disorders as diseases whose primary symptoms are cognitive, behavioural and emotional in nature. Disorders are thus viewed as abnormalities in the nervous system, endocrine system.

The four categories of the biological viewpoint include:

1.5.1 Genetic Vulnerabilities

Genes are very long molecules of DNA that we inherit from our parents. Genes are present in fibrous structures called the chromosomes. There is substantial evidence that most mental disorders show at least some genetic influence. Abnormalities in the structure of chromosomes can be associated with major disorders. Anomalies in the sex chromosome may cause abnormal sexual behaviours. Generally disorders are influenced by several genes, thus no single gene anomaly can cause a mental disorder because of their small effects. Genes tend to indirectly influence behaviour, they can get 'turned on' or 'turned off' in response to the environment.

1.5.2 Brain Dysfunction and Neural Plasticity

Subtle deficiencies of brain can cause brain disorders. This has been discovered due to the advancement in technology and brain scans to study the function and structure of the brain. The brain has an ability to change its organization and function in response to pre and post natal experiences, stress, diet, disease and other environmental conditions. This ability is called plasticity. The brain is immensely affected by the experiences of young infants and children. The plastic nature of the brain can be beneficial or detrimental based on an individuals' experiences.

1.5.3 Imbalances of Neurotransmitters and Hormones

Neurotransmitters are chemical substances that are released by neurons in order to pass messages to other neurons. There are different kinds of neurotransmitters; some can cause a neural impulse while others can inhibit an impulse.

- Norepinephrine plays an important role in emergency responses to dangerous and stressful situations.
- Dopamine influences pleasure and cognitive processing and has been implicated in schizophrenia.
- Serotonin is responsible for the way we think and process information thus it plays an important role in emotional disorders like anxiety and depression
- GABA is an inhibitory neurotransmitter, thus it is used to reduce anxiety and other emotional states.

Hormones are chemicals that are secreted directly into the bloodstream by endocrine glands. They cause the flight or fight response, physical growth

and other physical expressions of mental states. Malfunctioning in hormone release can cause various forms of psychopathology such as depression and post-traumatic stress disorder.

1.5.4 Temperament
Temperament refers to a child's reactivity and characteristic ways of self-regulation. Temperament is believed to be biologically programmed. Temperament causes differences in emotional and arousal responses to various situations. Early temperament is thought to be the basis of our personality. Not surprisingly temperament may also cause the development for various psychopathologies later in life. Children who are fearful and very anxious may become behaviourally inhibited as they grow older.

1.6 Psychosocial Viewpoint

In general there are many more psychological interpretations of abnormal behaviour than biological perspectives. It reflects a wide range of opinions on how to understand human motives, desires, thoughts and perceptions.
The psychosocial perspective can be further subdivided into three different perspectives:

1.6.1 The psychodynamic perspective
This perspective emphasizes the role of unconscious motives and thoughts that govern behaviour of human beings. According to this perspective abnormal behaviour is because of the hurtful memories, forbidden desires and repressed experiences in the unconscious mind. The unconscious continues to express itself in dreams, fantasies and slips of tongue. When such unconscious material is brought to the consciousness it can lead to irrational and maladaptive behaviour. Sigmund Freud is considered the founder of the psychoanalytic school of thought.

1.6.2 The behavioural perspective
The behavioural perspective emerged as a reaction against the unscientific methods of the psychodynamic approach. Behavioural scientists believed that the study of subjective experiences cannot be tested by other investigators. They resorted to laboratory research rather than clinical practice. Behaviorists focus on the effects of environmental conditions when subjected to various stimuli. The central theme of this perspective is learning- the modification of behaviour based on its consequences.

1.6.3 The Cognitive-Behavioural Perspective
This approach focused on cognitive processes and their impact on behaviour. It involved the study of information processing mechanisms like attention, memory, thinking, planning and decision making. Thus, the cognitive behavioural perspective on abnormal behaviour generally focuses on how thoughts and information processing can become distorted and leads to maladaptive emotions and behaviour.

Check your Progress – 3
Note: a. Write your answer in the space given below
    b. Compare your answer with those given at the end of the unit.
  5. What is a gene?

  6. What are the categories of explanation of abnormal behaviour from the biological viewpoint?

1.7 Sociocultural Viewpoint

According to this viewpoint our life experiences and interaction with the society help us face challenges resourcefully and may lead to resilience during stress in the future. Unfortunately some of our experiences as a child may be unhelpful and may influence us later in life. Social factors are influences in the environment that consists of unpredictable and uncontrollable negative events.

Different social factors that can have a detrimental effect on a child's socioemotional development are listed below.

1.7.1 Early Deprivation and trauma

Children who do not receive adequate food, shelter, love and attention may be left with deep and irreversible psychological scars. This kind of treatment is usually observed in foster homes and other institutions for children. Sometimes deprivation can occur in families where the parents suffer from mental disorders themselves thus are unwilling to provide care to the child.

1.7.2 Problems in parenting style

Deviations in parenting can also have profound impacts on a child's ability to cope with life's difficulties. This may cause the child to be vulnerable to various forms of psychopathology. For example, children who are anxious, irritable and impulsive may cause the parents to become anxious and irritable thus further worsening the condition of the child. Parenting styles like authoritarian and neglectful parents may result in aggressive behaviour of children and cause them to resort to drug and alcohol abuse.

1.7.3 Marital Discord and Divorce

A disturbed family structure serves as a high risk factor to psychopathology. Marital discord can affect the offspring's marriage and may lead to negative interaction styles. Divorce of parents and have traumatic effects on the child. It can lead to a feeling of insecurity, disloyalty and delinquency.

1.7.4 Low socioeconomic status and unemployment

The lower economic class have a higher incidence of mental and physical disorders. For example antisocial disorder occurs in the lower socioeconomic backgrounds thrice as often as it occurs in better economic conditions. People with mental disorders are usually prejudiced and slide down the economic ladder because of the lack of opportunities. Unemployment, financial hardships, self-devaluation and emotional distress is associated with enhanced chance of psychopathology.

Other social factors that can cause abnormal behaviors include prejudice, discrimination and strained relationship among peers.

Cultural variables such as over and undercontrolledbehaviour can also contribute to mental disorders. Although many serious mental disorders are fairly universal, the form some mental disorders take varies widely among different cultures.

1.8 Let's Sum It Up

Understanding of abnormal behaviour has not evolved smoothly or uniformly over the centuries; the steps have been uneven, with gaps in between. Central to the field of abnormal psychology is knowing the

causes which might help in prevention and reversal of conditions that led to them or maintain them. Different viewpoints explain the potential causes of abnormal behaviour. In recent years, we have come to recognize the need for an integrative biopsychosocial model that acknowledges the biological, psychological and sociocultural factors all interact and play a role in psychopathology and treatment.

1.9 Unit End Exercises

1. Define abnormality.
2. Briefly explain the various indicators of an abnormality.
3. Give an account of the historical conceptions of abnormal behaviour.
4. Explain in detail the psychosocial and sociocultural viewpoint of psychopathology.
5. What is the meaning of temperament?

1.10 ANSWERS TO CHECK YOUR PROGRESS

1. Subjective distress, maladaptiveness, statistical deviance, violations of the standards of society, social discomfort, irrationality and unpredictability and dangerousness.

2. Abnormal psychology also called psychopathology deals with understanding the nature, causes, and treatment of mental disorders.

3. Hippocrates denied that Gods and demons caused illnesses and insisted that mental disorders had natural causes and required proper treatment. He also believed that dreams are important to understand the patients' personality. He also recognized the importance of environment for mental health and thus removed some patients from their families.

4. The Greek and Roman were among the few to treat people with mental disorders with appropriate care. They provided pleasant surroundings with constant activities like parties, dances and massages. They also followed the principle of contrariiscontrarius (opposite by opposite).For example having their patient drink chilled wine while taking a warm bath

5. Genes are very long molecules of DNA that we inherit from our parents. Genes are present in fibrous structures called chromosomes.

6. Genetic Vulnerabilities, brain dysfunction and neuroplasticity imbalances of neurotransmitters and hormones and temperament are the components of the biological viewpoint.

7. It reflects a wide range of opinions on how to understand human motives, desires, thoughts and perceptions.

1.11 Suggested Readings

1. Butcher, J.N. (2014). Abnormal Psychology. New Delhi: Pearson Education.
2. Butcher, J.N., Hooley, J. M., Mineka, S &Dwivedi, C.B. (2017). Abnormal Psychology 16th ed. Noida: Pearson.
3. Sarason, G.I. &Sarason, R.V. (2007). Abnormal Psychology: The Problem of Maladaptive Behaviour (II Edition). Pearson Education, Inc. and Dorling Kindersley Publication Inc.

UNIT II: ANXIETY DISORDERS

Structure

2.1 Introduction

Anxiety is a general feeling of apprehension of possible danger. Anxiety disorders create many personal, economic, and health problems for those

who are affected. It is one of the earliest disorders that a person may be affected with. It is more oriented to the future and is much more than fear. Fear occurs when the person is in immediate danger. Anxiety involves a negative mood, worry about future possible threats and self-preoccupation. At a behavioural level anxiety might create a strong tendency to avoid situations where danger is perceived.

A phobia is a persistent and disproportionate fear of some specific object or situation that presents little or no actual danger and yet leads to a great deal of avoidance of these fearful situations.

2.2 Objectives

On completion of this unit you will be able to:

- Understand the different types of anxiety disorders and their nature
- Know the causes of various anxiety disorders
- Be aware of the different treatments available for different types of anxiety disorders

2.3 Panic Disorders & Agoraphobia

Panic disorder is characterized by the occurrence of panic attacks that often seem out of the blue (from nowhere). According to the DSM 5 the person must have experienced recurrent, unexpected attacks and must have been persistently concerned about having another attack for at least a month (anticipatory attack).Panic attacks are fairly brief but intense, the symptoms develop abruptly and the attacks subside within 20-30 minutes. They sometimes occur in the least expected situations like while relaxing or during sleep (nocturnal panic)

Agoraphobia is a type of anxiety disorder in which the person fears and avoids places or situations that might cause panic and feel trapped, helpless or embarrassed. In agoraphobia the most commonly feared and avoided situations include streets and crowded places. Standing in line becomes especially difficult. People with agoraphobia are also frightened by their own sensations and thus avoid activities that might arouse them such as exercise or watching a scary movie. Agoraphobia is a frequent complication of panic disorder.

Panic disorders generally begin in the 20's to 40's but sometimes may begin in the late teenage. It is twice as prevalent in women as in men. Men who are prone to panic disorders are more likely to self-medicate with nicotine or alcohol in order to cope with the disorder. This is because of the societal expectations laid on men.

The vast majority of people with panic disorders have at least one comorbid disorder such as generalized anxiety disorder, social phobia, specific phobia or depression. Panic disorder is also a strong predictor for suicidal behaviour. The first attack usually follows a feeling of distress or high stress.

2.3.1 Biological Causal Factors

The biological causal factors of panic disorders include genetic factors, panic in the brain caused by the amygdala and certain biochemical abnormalities.

Check your Progress – 1

Note: a. Write your answer in the space given below

    b. Compare your answer with those given at the end of the unit.

   1. Define agoraphobia.

   2. What are the biological causal factors of panic disorders?

2.3.2 Psychological causal factors
2.3.2.1 Cognitive theory of Panic
This theory proposes that people with panic disorders are hypersensitive to their body sensations and are highly likely to interpret their sensations extremely seriously.
2.3.2.2 Comprehensive learning theory of panic disorder
This theory suggests that the initial panic attacks become associated with initially neural internal and external cues through conditioning.
2.3.2.3 Anxiety sensitivity and perceived control
A belief that certain bodily symptoms are dangerous and can cause anxiety can increase the likelihood of panic attacks. Greater effects of panic symptoms are seen in people with low perceived control.
2.3.2.4 Cognitive biases and maintenance of panic can increase a person's probability of having a panic disorder.
2.3.3 Treatments
Treatments include behavioural and cognitive behavioural therapy and different categories of medication.

2.4 Specific Phobias

A specific phobia is a strong and persistent fear triggered by a specific object or situation and leads to significant distress and/or impairment in the person's ability to function. They often show an immediate fear response that resembles a panic attack. Blood-injection-injury phobia can induce unique physiological responses to the sight of blood or injury. People show an initial acceleration followed by a dramatic drop in both heart rate and blood pressure. This is accompanied with fainting, dizziness and nausea. Nomophobia is when an individual experiences discomfort, anxiety and nervousness when they are unable to use their phones. This phobia is highly prevalent in the youth.

Phobias are more common in women than in men. Animal phobias generally affect women and begin in early childhood.

Check your Progress – 2
Note: a. Write your answer in the space given below
    b. Compare your answer with those given at the end of the unit.
    3. Name some specific phobias.
    4. What is a specific phobia?

2.4.1 Psychological Causal Factors
2.4.1.1 The Psychoanalytic Viewpoint
According to this viewpoint phobias represent a defense against anxiety that occurs due to repressed impulses from the id.Because these impulses are too dangerous to know they are exerted into an external object that is symbolic to the real impulse
2.4.1.2 Phobias as learned behaviour
When a neutral stimulus is paired with a traumatic or painful event, phobias can be learned through classical conditioning. Vicarious conditioning occurs when a person develops a phobia simply by watching other phobic people behave fearfully with the phobic object.
2.4.2 Biological Causal Factors
Genetics and a person's temperament can affect the possibility of acquiring a phobia. Behaviourally inhibited toddlers at 21 months of age are at a higher risk of developing multiple specific phobias by age 7-8 yrs.

2.4.3 Treatments

The most effective treatment is exposure therapy which is a form of behaviour therapy that involves controlled exposure to the stimulus that elicits the phobic fear. One variant of this procedure is called participant modelling in which the therapist calmly models ways of interacting with the phobic stimulus or situation. This enables the client to learn that the stimulus is not threatening. For small animal phobias, flying phobia, claustrophobia and blood injury phobia, exposure is often highly effective when administered in a single long session.

2.5 Social Phobia

Social anxiety disorder or social phobia is the disabling fear of one or more specific social situations. Examples include urinating in a public restroom, public speaking, writing or eating in public. A person fear that they may be exposed to negative comments or may act in a humiliating or embarrassing manner. People with social phobia either avoid these situations or endure them with great distress. Performance situations (public speaking) or non-performance situations (eating in public) are the two subtypes of social phobia.

Approximately 12 percent of the population meets the category for social phobia at some poi8nt in their lives. Social phobia is more common in women than men. It typically begins around adolescence or early adulthood. In one study it was observed approximately 12.8 percent of social phobia occurred in high school students with depression and less academic performance.

2.5.1 Psychological Causal Factors

2.5.1.1 Social Phobia as learned behaviour

Social phobias generally originate from simple instances of direct or vicarious classical conditioning such as such as experiencing a perceived social defeat, or witnessing the target of anger or criticism. A history of severe teasing during childhood can cause social phobia.

2.5.1.2 Social fears and phobia in an evolutionary context

Social phobia is the fear of the members of one's own species. Social phobia may be the byproduct of dominance hierarchies that are common social arrangements in primates. Aggression between members can lead the defeated individual to display submissive behaviour and fear.

2.5.1.3 Being exposed to uncontrollable and unpredictable stressful events (such as parental separation, divorce, family conflict or sexual abuse) may play an important role in social phobia.

2.5.2 Biological Causal Factors

Behavioural inhibition, increased neuroticism and introversion can cause social phobia. Infants that are easily distressed, shy and avoidant are more likely to become avoidant and fearful in their childhood.

2.5.3 Treatments

Cognitive and behavioural therapies as well as medications like antidepressants can help treat social phobia.

2.6 Generalized Anxiety Disorder

Chronic, excessive and unreasonable anxiety causes generalized anxiety disorder (GAD).This must occur on more days than not for a period of 6 months. It must be difficult to control and the worry must be about a number of different things. People suffering from GAD live in a relatively future oriented mood state, chronic tension, worry that they cannot control. The most common areas of worry include family, work, finances and

personal illness. This can lead to a difficulty in making effective decisions. Approximately 3 percent of the population suffers from GAD in any 1 year period. GAD is twice as common in women. Age of onset of GAD is difficult to determine because people believe that they have had it all their lives. GAD often occurs with other disorders like anxiety and mood disorders, panic disorder and major depressive disorder.

Check your Progress – 3

Note: a. Write your answer in the space given below

    b. Compare your answer with those given at the end of the unit.

    5. Write about the age and onset of GAD.

    6. What are the biological factors that affect social phobia?

2.6.1 Psychological Causal Factors
2.6.1.1 The psychoanalytic viewpoint
According to this viewpoint generalized anxiety results from an unconscious conflict between ego and id impulses that is not adequately dealt with because the person's defense mechanisms have either broken down or have never developed. Freud believed that it was primarily sexual or aggressive impulsive that were blocked by the defenses thus leading to GAD.

2.6.1.2 Perceptions of uncontrollability and unpredictability
Uncontrollable and unpredictable aversive events are much more stressful than controllable and predictable aversive events, so it's not surprising that the former create more fear and anxiety.

2.6.1.3 A sense of mastery: A possibility of immunizing against anxiety
A person's history of control over important aspects of their environment strongly influences the reactions to anxiety provoking situations.

2.6.1.4 The reinforcing properties of worry
The worry process is now considered the central feature of GAD. Benefits that people with GAD might derive from worrying includes: Superstitious avoidance of catastrophe, avoidance of deeper emotional topics, coping and preparation.

2.6.1.5 The negative consequences of worry
Some of worry's effects are clearly negative. Worry is certainly not an enjoyable activity and can actually lead to a greater sense of danger and anxiety because of all the possible outcomes the worried person imagines. People who worry about something are more likely to have more negative intrusive thoughts.

2.6.1.6 Cognitive biases for threatening information.
People with GAD process threatening information with biases. Anxious people tend to allocate their attention towards threatening cues when both threatening and non-threatening cues are present in the environment. They are more likely to think that bad things are going to happen.

2.6.2 Biological Causal Factors
Genetic factors, neurotransmitter and neurohormone abnormalities, neurobiological differences between anxiety and panic are the biological causal factors of GAD.

2.6.3 Treatments
Medications such as Xanax or Klonopin are generally used or misused to relieve tension and to relax. Yoga and meditation can help decrease

anxiety. Cognitive behavioural therapy has become increasingly effective. Training in deep muscle relaxation and cognitive restructuring can also help.

2.7 Obsessive Compulsive Disorders

Obsessive Compulsive disorder is defined by the occurrence of both obsessive thoughts and compulsive behaviours performed in an attempt to neutralize such thoughts. Obsessions are persistent and recurrent intrusive thoughts, images or impulses that are experienced as disturbing, inappropriate and uncontrollable. Compulsions involve repetitive behaviours that are performed as lengthy rituals (hand washing, checking, putting things in order over and over again) Compulsions may involve more covert mental rituals such as praying, counting or saying certain words over and over again. The rituals can be mild or intense. Approximately 2-3 percent of people meet the criteria for OCD at some point in their lifetime and approximately 1 percent meet the criteria in a given year. Divorced, separated and unemployed people are more likely to have OCD.OCD typically begins in adolescence and or early adulthood but may also occur ion children. In most cases OCD has a gradual onset and once it becomes severe it tends to be long lasting. OCD often co occurs with anxiety disorders like social phobia, panic disorder, GAD and PTSD.

2.7.1 Psychological causal factors

2.7.1.1 OCD as learned Behaviour

Neutral stimuli become associated with frightening thoughts or experiences through classical conditioning and thus elicit anxiety. Once having made this connection people might believe that performing rituals might decrease their anxiety. This model predicts that exposure to fearful situations or objects can decrease OCD.

2.7.1.2 OCD and Preparedness

The preparedness concept considers the evolutionary adaptive nature of fear and anxiety. OCD have obsessions and compulsions focused on dirt, contamination and other potentially dangerous situations that may have deep evolutionary roots.

2.7.1.3 Cognitive causal factors

When most people attempt to suppress unwanted thoughts they sometimes experience an increase in the same thoughts. Thought suppression lead to the general increase in OCD symptoms.

2.7.2 Biological Causal Factors

Genetic factors, brain abnormalities and neurotransmitter abnormalities can cause OCD.

2.7.3 Treatments

Behavioural and cognitive behavioral therapy as well as medications like clomipramine can help in the treatment of OCD.

2.8 Let Us Sum Up

Anxiety disorders are believed to be acquired through conditioning or other learning mechanisms. However, some people are more vulnerable than others to acquiring such responses (due to temperamental or experiential factors). We also seem to have an evolutionarily based preparedness to acquire readily fears of objects or situations that posed a threat to our ancestors.

Many people with anxiety disorders are unaware of the treatment options available to them. Because of the prevalence of this condition, people

should be made aware of the different treatment options, pros and cons and make an informed decision to find relief from anxiety symptoms.

2.9 Unit-End Exercises

1. Define anxiety.
2. What is agoraphobia?
3. Define OCD and state its causal factors.
4. Write a note on social phobia.
5. What is the most effective treatment for specific phobias?

2.10 Answers To Check Your Progress

1. Agoraphobia is a type of anxiety disorder in which the person fears and avoids places or situations that might cause panic and feel trapped, helpless or embarrassed. In agoraphobia the most commonly feared and avoided situations include streets and crowded places.

2. The biological causal factors of panic disorders include genetic factors, panic in the brain caused by the amygdala and certain biochemical abnormalities.

3. Claustrophobia, nomophobia and arachnophobia are examples of different specific phobias.

4. A specific phobia is a strong and persistent fear triggered by a specific object or situation and leads to significant distress and/or impairment in the person's ability to function.

5. Approximately 3 percent of the population suffers from GAD in any 1 year period. GAD is twice as common in women. Age of onset of GAD is difficult to determine because people believe that they have had it all their lives.

6. Behavioural inhibition, increased neuroticism and introversion can cause social phobia. Infants that are easily distressed, shy and avoidant are more likely to become avoidant and fearful in their childhood.

2.11 Suggested Readings

1. Butcher, J.N. (2014). Abnormal Psychology. New Delhi: Pearson Education.

2. Butcher, J.N., Hooley, J. M., Mineka, S &Dwivedi, C.B. (2017). Abnormal Psychology 16th ed. Noida: Pearson.

3. Sarason, G.I. &Sarason, R.V. (2007). Abnormal Psychology: The Problem of Maladaptive Behaviour (II Edition). Pearson Education, Inc. and Dorling Kindersley Publication Inc.

UNIT - III SOMATOFORM AND DISSOCIATIVE DISORDERS

Structure

3.1 Introduction

Sometimes we feel like walking in a daze, especially during times of stress. At other times we may have felt that we weren't really present in the situation. These are examples of dissociating with the situation. Somatic symptoms refers to physical sensations, experiences or movements (eg., pain, fatigue, nausea, dizziness etc.) Around 80% of the population says that they have experienced such symptoms in the past week (Hiller et al, 2006). But when the concern about these symptoms are severe, and lead to significant distress and impairment in their daily work and functioning, a somatic symptom disorder may be diagnosed.

SOMATIC SYMPTOM DISORDER AND RELATED DISORDERS:

Soma means "body". So people with Somatic Symptom Disorder experience bodily symptoms that causes them significant psychological distress and impairment. This includes bodily symptoms combined with abnormal thought processes, feelings or behaviour as a response to these symptoms. These symptoms are usually common and mostly go away by itself. But in 25% of the cases these symptoms persist and prompt people to visit a doctor. In almost half of the cases, there is no medical explanation for the symptoms. Many people are satisfied when the tests come back negative. But a few of them persist in visiting the doctor for their physical symptoms sure that there's something wrong with them.

3.2 Objectives

By the end of this unit you'll be able to:

- List the four disorders included under Somatic symptom and related disorder in *DSM-5*.
- Explain Causes and Treatment of Somatic Symptom Disorder.
- Summarize Conversion Disorder.
- Describe Dissociative Disorders.
- Describe the treatments for Dissociative Disorder.

3.3 Somatic Symptom Disorder:

Somatic Symptom Disorder is regarded as the most major diagnosis in its category. This has the diagnosis of previous disorders that were considered

separate in *DSM-IV*. The old disorders of Hypochondriasis, Somatization Disorder and Pain Disorder have all disappeared in the *DSM-V*. Most of the people who would have been diagnosed within any of the above disorders will now be diagnosed with Somatic Symptom Disorder. (For Example: 75% of the people who were previously diagnosed with Hypochondriasis will now be diagnosed with Somatic Symptom Disorder).

Diagnosis: (*DSM-V)*

1. Individuals must have chronic somatic symptoms that are distressing to them.
2. They must also have excessive thoughts, feelings or behaviours related to somatic symptoms or associated health concerns. Like, continuous thoughts about the seriousness of their symptoms, high level of anxiety about their health, and lots of time spent on worrying and concern of these symptoms.
3. Although one somatic symptom will not be continuously present, the state of being symptomatic (having at least one symptom) remains persistently (typically more than 6 months).

DSM-5 criteria for this diagnosis may result in a wide variety of people being assigned the same diagnosis. Estimates suggest that this diagnosis could be applied to 5-7 % of the general population. This is because it has very loose definition and is flawed according to the previous chair of task force of *DSM-IV*. This is because in this *DSM-5,* only one symptom is required. So, if any person is distressed from *any* physical problem (that involves a single symptom *and* is medically explained) the diagnosis of somatic symptom disorder is possible.

Causes:

Earlier it was thought that the symptoms developed due to unresolved or unacceptable unconscious conflicts as part of a defense mechanism. As somatic symptom disorder is a new diagnosis under *DSM-5*it has not been investigated much. Nonetheless, cognitive-behavioural perspectives on hypochondriasis and somatoform disorders (which are part of this new diagnosis) are most likely valid for this disorder too as the core features are quite similar. First, the focus of attention is on the body and its changes (hypervigilance and increased awareness of bodily changes). Second, the person sees bodily *sensations* as somatic *symptoms* that are physical symptoms attributed to illness. Third, the person worries excessively about these symptoms (catastrophizing cognition can be seen). Fourth, the person becomes distressed and seeks medical treatment for their perceived physical problems.

Figure 3.1: Simplified Model of Somatic Symptom Disorder

People with this disorder tend to be hypersensitive to bodily changes. They also experience   these sensations an intense, disturbing and highly aversive. They also consider these symptoms as catastrophically fatal and often overestimate the medical severity of their condition.

According to the information given above, it can be seen that somatic symptom disorder is of both perception (of benign sensations) and
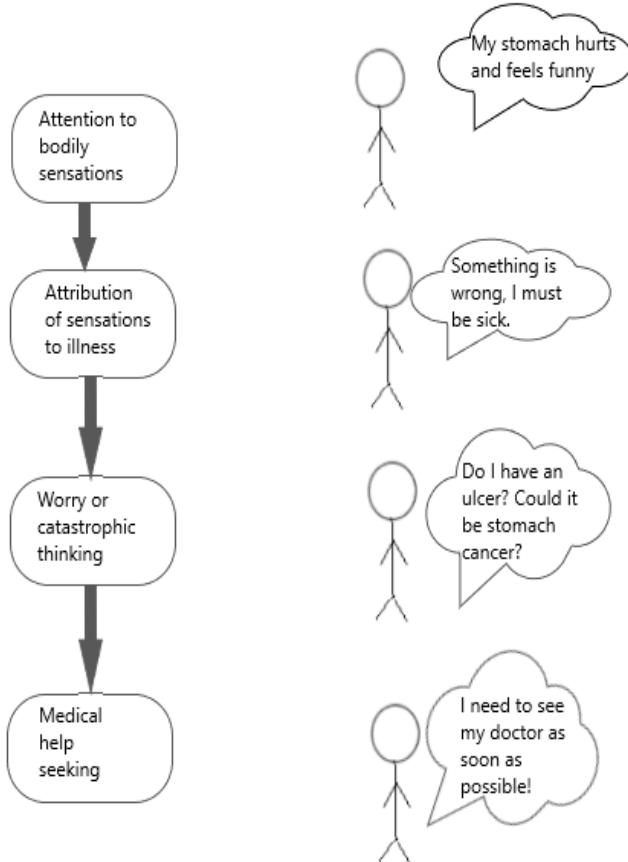
cognition. The individuals with this disorder mostly have an attentional bias for illness-related information and they seem to label their physical sensations as symptoms and perceive these symptoms as dangerous. Once the misinterpretation sets in, they start looking for confirming evidence as they seem to think that being healthy means being completely symptom-free. They also have low expectations for their ability to cope up with an illness. It is also believed that an individual's past experiences with illnesses (either personally or through media) can also set in dysfunctional assumptions regarding illness and symptoms. An example of a dysfunctional assumption: "Bodily changes are usually a sign of serious disease, because every symptom should have an identifiable cause" (a sign of top-down process).

Negative affect could be a risk-factor for this disorder. However, this alone is not sufficient. Other characteristics like **Absorption** (a tendency to be absorbed in one's own experiences) and **Alexithymia** (a condition that is characterized by having difficulties in identifying one's feelings).People who don't have any medical condition tend to score high on these three traits.

They repeatedly seek medical advice for their symptoms and thus, their medical costs are higher. High levels of functional impairments can be common and many are severely disabled by their physical symptoms. Patients with somatic symptom disorder seem to be most likely in female and have high levels of comorbid depression and anxiety.

In *DSM-IV,* many who were diagnosed with hypochondriasis also reported higher childhood sickness and missed a lot of school. Also, their families tended to have an excessive amount of diseases while they were growing up (which may have led to strong memories of pain and illness). It is important to keep in mind that people with somatic symptom disorder are not *malingering-* constantly faking symptoms to attain a certain goal. These are people who actually experience physical problems that cause them great concern. These may be caused by brain processes that occur below their conscious awareness.

Check your Progress – 1
Note: a. Write your answer in the space given below
     b. Compare your answer with those given at the end of the unit.
1. What is Somatic Symptom Disorder?

Treatment:
Cognitive Behavioural Model provides a good explanation for the causes of this disorder. **CBT** (Cognitive Behavioural Therapy) might be a good treatment approach for people with somatic symptom disorder. The cognitive aspects of this method might help the person focus on assessing their beliefs about illness and modifying misinterpretations of the bodily sensations that they feel. The behavioural aspects may include making the person focus on other parts of their body so that they can understand that their selective attention might also play a role in their symptoms. This approach also helps in reducing anxiety and depression levels. In a recent study, patients reported considering alternative reasons for the presence of symptoms (a headache doesn't necessarily mean that they have a brain tumor).

The duration of CBT is usually brief (6-16 sessions). These sessions can also be in group format. Treatment programs can include relaxation training, support and validation that the pain is real, scheduling daily activities, cognitive restructuring and reinforcement of "no-pain" behaviours (for patients with pain). In addition to all of this, pain-killers and antidepressants reduce the amount of pain felt.

3.4 Illness Anxiety Disorder:

Illness anxiety disorder is also new to *DSM-5*. In this disorder people, have high anxiety and distress about having or developing a serious illness but there are very few or mild somatic symptoms. Estimates state that around 25% of people diagnosed with hypochondriasis will be diagnosed with illness anxiety disorder. The remaining 75% of people will be diagnosed with somatic symptom disorder.

The key difference between somatic symptom disorder and illness anxiety disorder is that when hypochondriasis is accompanied by significant

somatic symptoms then it is classified under somatic symptom disorder and when hypochondriasis is without any physical symptoms (or very mild symptoms), then diagnosis will be illness anxiety disorder.

3.5 Conversion Disorder (Functional Neurological Symptom Disorder):

Another disorder that can come under somatic symptoms and related disorders is *conversion disorder*. Although this term *conversion disorder* is new, earlier it was one of several disorders that came under **hysteria**.

This disorder is characterized by the presence of neurological symptoms in the absence of a neurological diagnosis. To put it simply, the patient has symptoms that strongly suggest medical or neurological deficits, *but*the pattern of symptoms is not consistent with known neurological disorder or medical problem. Some examples include partial paralysis, blindness, deafness, and episodes of limb shaking with the loss of consciousness that resemble seizures. Keep in mind that this diagnosis can only be made after medical and neurological tests. It is also important to emphasize that the person is not faking the symptoms intentionally. On the other hand, a host of psychological factors play a role because most of the episodes are succeeded by emotional or interpersonal conflicts or stressors.

Early observations by Freud brought to light that most of the people diagnosed with this showed a marked lack of concern or anxiety over their health (they weren't worried if they will lose their sight or if their arms will be paralyzed) and *la belle indifférence*-French for "the beautiful indifference" was the term to refer to it. But later research proved that only 20% of the patients feel this way. Hence, this term is no longer popularly used (like it used to be) to refer to this disorder or explain this disorder.

Symptoms:

It is useful to think of all the symptoms under 4 categories:

1. Sensory
2. Motor
3. Seizures
4. Mixed of the three

1. Sensory symptoms or deficits:

Conversion disorder can involve any sensory modality (pathway). It can be diagnosed as a conversion disorder because of how the symptoms in the affected area are inconsistent with how the sensory pathways anatomically work. Some common deficits are in the visual system (like tunnel vision and blindness), auditory system (like deafness) or in the sensitivity to touch (especially anesthesia). One of the most common is *glove anaesthesia,* in which the person cannot feel the fingers in the hand that has the glove worn, although the loss of sensation makes no sense anatomically.

With conversion blindness, the person reports not being able to see, but can navigate correctly in a room full of objects. Similarly, a person reporting conversion deafness says that they cannot hear but can orient themselves when someone calls their name out. From both these we understand that the sensory information is registered but is somehow screened from conscious recognition (explicit perception).

2. Motor symptoms or deficits:

Motor conversion covers a large area of symptoms. Conversion paralysis is mostly confined to one limb (arm or leg) and it's usually a selective loss of function in that area. For example, a person who cannot write with one arm

may be able to scratch with those same muscles or a person who abruptly wakes up from sleep may be able to use their "paralyzed" limb (for example: the person cannot walk but can walk when there is an emergency).

The most common speech-related conversion disorder is *aphonia*in which then person can only talk in whispers but can cough normally. Another common motor symptom is *globus*, which involves the sensation of a lump in the throat.

3. Seizures:

This is a relatively common form of conversion symptoms in which the person goes through epileptic-like seizures although they are not the true seizures, as the patients usually do not have any EEG abnormality, loss of memory or confusion after the episode. Patients with conversion seizures show excessive thrashing about and writhing that is not seen in true epileptic seizures.

Diagnosis:

The symptoms of conversion disorder look very similar to that of other medical conditions so one should go through careful medical and neurological testing to avoid misdiagnosis. Other criteria that should also be considered when diagnosing are:

1. The frequency rate for the dysfunction to conform clearly to the symptoms of the disease that is stimulated. There is no wasting away of the limb that is "paralyzed" in conversion cases except in long standing ones.
2. The nature of the dysfunction is highly selective. As mentioned above, the "blind" people do not bump into obstacles or people and the "paralyzed" limb has selective functions.
3. Under hypnosis or narcosis (a sleep-like state by using drugs), the symptoms can be removed, shifted, or re-induced at the suggestion of the therapist.

Causes:

Conversion disorder is said to develop in people under stressful conditions or internal conflicts. Freud called it *conversion hysteria* in the belief that this occurred due to the body's repressed sexual needs. Thus, in his view, the repressed desire threatens to become conscious, so the body unconsciously *converted* it into physical symptoms, thereby allowing the person to avoid the internal conflict. Freud noted two gains from having this disorder: **Primary gain** would be the avoidance of intrapsychic conflict and the **Secondary gain** would be the attention from loved ones. Though Freud's reasons are no longer valid, his clinical study on the gains is still incorporated. There is some negative reinforcement that the person receives from having physical disabilities, for example, to avoid stressful situations and to gain attention from loved ones.

Given the weightage of importance to stressful life situations as the onset of conversion disorder, it is unfortunate that the exact cause and timing for these psychological stress factors is still unknown. But studies have shown that the greater negative impact of previous life events, increase the severity of the conversion disorder symptoms.

Treatment:

The best way to treat conversion disorder is very limited and only based on a few well-controlled studies. Some hospitals use the behavioural approach to treat patients with motor conversion in which specific

exercises for those limbs were involved and reinforcements were given for their efforts. Any sort of negative reinforcement was removed to eliminate sources for secondary gain. Cognitive-Behaviour approach was used, some used hypnosis, and there are some that consider hypnosis with other therapeutic techniques can be useful.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. What are the clinical features of conversion disorder?

3.6 Factitious Disorder:

The disorders discussed above assume that all the patients experience some sort of physical symptom. But in this disorder, the person is faking symptoms of a real disorder. In factitious disorder the person intentionally produces psychological or physical symptoms, the goal being to obtain and maintain a "sick role" for the attention and care of the family. The key point to note is the deceptive behaviour is present even in the absence of external rewards.

The difference between factitious disorder and malingering is that, in factitious disorder the person receives no tangible external rewards. On the other hand, a person who's malingering is intentionally or grossly exaggerating the symptoms of a disorder and is motivated by external rewards, attention, avoiding work, military life etc,.

A dangerous variant of factitious disorder is *factitious disorder imposed on another* (sometimes referred to as *Munchausen's syndrome by proxy*). Here, the person seeking medical help has intentionally produced a medical or psychiatric illness (or the appearance of one) in another person. The most common example is that of a mother producing an illness in her child, by withholding food, adding blood to urine and so on. When the child is hospitalized, the person might also tamper with the intravenous (IV) line making the child sicker. This disorder may be suspected when there are atypical lab reports, or frequent and urgent visits to the hospital. Most of these people have extensive knowledge about medical problems and are highly resistant to admitting that they are wrong.

Check your Progress – 3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. What are the possible reasons for a person to deliberately pretend to have medical problems?

DISSOCIATIVE DISORDERS:

Dissociative disorders are a group of conditions involving disruptions in a person's normally integrated functions of consciousness, memory, identity or perception. The concept of dissociation was first promoted by French neurologist Pierre Janet. We all dissociate at some point, mild dissociative symptoms occur when we daydream and lose track of time, and also track of what was going on, when we miss a part of a conversation that we are engaged in. Dissociation only becomes pathological when then dissociative

symptoms are perceived as 'disruptive, invoking a loss of needed information, as producing discontinuity of experience' or as 'recurrent, jarring involuntary intrusions into executive functioning and sense of self'.

Much of our mental life involves automatic non-conscious processes that occur below the radar of self-awareness. Most of this extends to implicit memory and implicit perception, by remembering things that they cannot consciously recall (**implicit memory**) and respond to senses (**implicit perception**) as if they have experienced this before. This type of responding is common in people having conversion disorders (like the person who is blind but can respond to certain visual stimuli).

In people with dissociative disorder this type of processing is interrupted and not well-coordinated or integrated. When this happens, the person may be unable to understand and access information in the forefront of their conscious (such as their identity, or certain memories), that other people can. The usual ongoing mental capacity seems to be interrupted, sometimes for the sole purpose of preventing a severe psychological threat, which brings with it the pathological symptoms that seem to be the key feature of dissociative disorder.

Like somatic symptom disorder, dissociative disorders appears to also be a way to avoid stress and anxiety of managing life problems that overwhelmed then person's coping mechanisms. In the case of *DSM* which explains dissociative disorders, the person avoids stress by pathological dissociation- in essence, by escaping from their autobiographical memory or personal identity.

3.7 Depersonalisation/Derealisation Disorder:

In **Derealisation** one's sense of the reality of the outside world is temporarily lost and in **Depersonalisation** one's sense of one's own self and one's own reality is temporarily lost.

These are very common occurrences during/after panic attacks. As many as 50-74% of the general population have had mild experiences usually after periods of severe stress, sleep deprivation, or sensory deprivation. But when these episodes become persistent and recurrent and interfere with normal functions then depersonalisation and derealisation disorder may be diagnosed. The people diagnosed may feel a sense of them not belonging in their own body, but floating somewhere. The one thing that distinguishes this from psychotic disorders, is when the person is going through an episode of depolarisation, reality testing (the knowledge of what is real and unreal) remains intact.

Emotional experiences are known to be more attenuated or reduced in people diagnosed with this disorder. When shown an emotional clip, the participants with depersonalization, showed higher subjective and objective memory fragmentation than the controls. Memory fragmentation is marked by difficulties in coherent and accurate sequence of events, which shows that time distortion, is key feature of depersonalization.

Occasional depersonalisation and derealisation symptoms are also sometimes reported by people with schizophrenia, borderline personality disorder, panic disorder and so on. But keep in mind that only recurrent or persistent symptoms result in this disorder. Comorbid symptoms include mood and anxiety disorders. Avoidant, borderline obsessive compulsive disorders are elevated in people with depersonalisation and derealisation.

This disorder can begin in childhood, with a mean age of onset being 16 years. Only a minority of people develop this disorder after 25.

Treatment:
This disorder might be fairly resistant to treatment. Although, treatment might work for the associated disorders of anxiety and depression. Many types of antidepressant drugs have been tried with modest effects. However, some don't show a difference between a drug and a placebo. A recent treatment that shows promise is rTMS (repetitive transcranial magnetic stimulation) to the tempo-parietal region of the brain. After 3 weeks of treatment, half of the subjects showed significant reductions in their episodes of depersonalization/derealisation.

3.8 Dissociative Amnesia:

Dissociative amnesia is mostly limited to the failure to recall certain memories that are not part of normal forgetting. These gaps in memories are usually due to traumatic and stressful events, like wartime combat, catastrophic events or traumatic events. Amnesiac episodes can last for a few days to years. In a typical dissociative amnesia, people cannot remember certain aspects of their personal life history and facts about their identity. Thus, these gaps are mostly, lack of recall of episodic (events) memory or autobiographical (personal experience to events) memory. Semantic and procedural memories seem intact.

In rare cases then person may still further retreat from real-life problems by going into an amnesiac stage called **Dissociative Fugue** (*fugue* means flight). It is a defense by flight- where the person might not only be amnesiac but also retreat or run away from home surroundings. This is accompanied by confusion of their personal identity or the assumption of a new identity (but here the alternate identity do not alternate with the actual identity, like they do in dissociative identity disorder). In the fugue state, the individuals are unaware of memory loss prior to this, but the memories made in this state remain intact. Also, their behaviour is normal during this state and unlikely to be figured out. But their lifestyle in this state is drastically different from their previous one. Days, months or years later, when the person emerges from this state, they may be in an unfamiliar environment doing unfamiliar things. Most of the cases with recovery only recovered after constant questioning and reminders of who they are.

The patterns of dissociative amnesia are very similar to those in conversion disorder. But unlike the latter in which the person copes up with being physically weak and sick, in dissociative amnesia the person unconsciously forgets the situation that is stressful or leaves the scene. The stress becomes so intolerable that large chunks of their personality and their memories of the stressful situation is suppressed.

Though its known that semantic memory is intact and only autobiographical memory is compromised, some cases have shown that implicit memory (cannot be expressed verbally) is intact. For example: A German man in the United States has been wandering around in unfamiliar streets after being shot and robbed. He eventually reached a motel and asked to call the police as he could not remember his identity. He spoke English with a German accent but denied that he spoke German. When instructed in English he could do tasks well but could not follow instructions when it was in German. In Spite of his extensive

autobiographical and German language loss, he could perform well in memory tasks that were implicit. His ability to learn German-English word pairs were higher than the controls, suggesting that his implicit knowledge of the German language was intact.

Treatment:

It is important that the person remains in a safe environment. Sometimes, removing them from what they perceive as a threatening situation might help in the spontaneous recovery of their memory. Hypnosis, as well as drugs like benzodiazepines, barbiturates, is often used to facilitate recall, or repressed memories.

3.9 Dissociative Identity Disorder:

Dissociative Identity Disorder (DID) formerly known as Multiple Personality Disorder, is a dramatic dissociative disorder. There have been subtle changes in the criteria for diagnosing DID in *DSM-5*, with the requirements being the person should have two or more distinct personality changes with recurrent bouts of amnesia, the personality changes can be self-reported or witnessed by another person.

Another inclusion in the *DSM-5* is the inclusion of *trance* which is said to occur when a person experiences a marked alteration in their state of consciousness or identity. Associated with a narrowing awareness of the surroundings or stereotyped behaviours that are out of one's own control. A *possessive trance* is similar except the alteration of consciousness is that of a new identity and the person is said to have been possessed by a spirit. It is common to see amnesia in both the types of trances. When trances are entered voluntarily, for religious or spiritual reasons, these are not pathological. But when it occurs involuntarily, and causes distress in everyday functioning, it is a critical problem.

In a typical case of DID, each identity might have a different name and different personal history, or self-image. Some identities maybe completely distinct from each other and others partially distinct. In most cases, the one identity that appears most frequently is known as the **host identity** and the other identities (that are not the host) are known as **alter identities**. Alter identities may differ in their age, name, sex, handedness, handwriting and so on. Needs and behaviours inhibited by the host can be noted and seen in one or more alter identities. Alter identities also take control at different point of times and switches typically occur very quickly (in a few seconds), although gradual and slow switches can also occur. When switches occur, amnesia of events that happened to them when another identity took place can be seen, but this amnesia is not symmetrical. Some identities may know more about the alters than other identities. DID usually starts in childhood and is more commonly seen in females than males. Females also have more alters than males.

Interidentity memory is a key feature of DID. Here, implicit memory can be shared by the identities, even when complete amnesia was reported by the identity before a memory task that tests this (implicit memory).

Additional symptoms: Depression, self-harm behaviours, erratic behaviour, headaches, hallucinations, posttraumatic symptoms, and other amnesia and fugue symptoms.A study conducted showed that PTSD is mostly seen along with DID.

Causal Factors:

Mostly DID follow a series of childhood abuse and trauma. Studies among the prevalence of childhood abuse as a causal factor for DID have shown that abuse and trauma in childhood might have played a role.

There are two theories that many professionals believe in for the onset of DID:

1. **Posttraumatic theory:** The vast majority of patients report memories of severe and horrific tales of abuse in childhood. According to this theory, DID is coping mechanism of the child against that traumatic memory. Lacking other sources of escape, the child dissociates and escapes into fantasy. If the child is fantasy-prone the child may remain in the same state and thus accept different identities.

2. **Socio-cognitive Theory:** According to this theory, it develops when a highly suggestible person learns to adopt and enact different people and overtime learn to integrate them into their own lives. Important to note is that this theory does not suggest that the person does this intentionally or consciously.

Treatment:

There has been no conclusive research on the best way to treat a patient with DID. Most therapists goal is to integrate the other alter identities to that of the host. But there is resistance of the patients with DID, who consider dissociation as a protective measure. If integration occurs successfully, then there is a unified personality, although partial integration is common. Treatment generally improves the functional and symptom improvement of the person.

The treatment of DID is psychodynamic and insight-oriented, mostly focusing on overcoming the trauma or conflicts that led to the disorder. Most of the patients are hypnotizable and can easily recover past traumatic memories of childhood, they can be made aware that the dangers that they faced are no longer present (but keep in mind that patients who are hypnotized can be easily influenced so the recalled memories may not have actually happened). Most therapists can make contact with the alter identities in this hypnotized state. Successful negotiation between all the alter identities and host identity, is a critical feature that the therapist has to develop along with treatment process. In general, it has been found that for the treatment to be successful, it should last longer (spanning years) especially if it is a severe case.

Check your Progress – 4

Note: a. Write your answer in the space given below

    b. Compare your answer with those given at the end of the unit.

  4. What is Depersonalisation/ Derealisation disorder?

  5. How is Dissociative Amnesia different from normal retrograde or anterograde amnesia?

  6. What is DID?

3.10 Let's Sum Up

Somatic symptom and related disorders included disorders that focused on the extreme distress caused by the patient by physical and somatic symptoms that they catastrophically assess. These included: Somatic symptom disorder, Illness anxiety disorder, Factitious disorder and Conversion disorder. Dissociative disorders focused on the unconsciousness that disrupts and does not let the conscious mind access

information (memory).These included: Depersonalization/ Derealisation, Dissociative amnesia, Dissociative identity disorder.

3.11 Unit End Exercises:

1. Write a note on somatic symptom disorder.
2. Describe dissociative disorders.
3. What are the symptoms of conversion disorder?
4. Write a note on factitious disorder.

3.12 Answers To Check Your Progress:

1.Somatic symptom disorder is an integration of hypochondriasis, somatization diorder and pain disorder. It involves the catastrophic reasons behind somatic symptoms (physical ain/symptoms) and lack of normal functioning due to the distress over their health.

2. Conversion disorder involves patterns of symptoms or deficits, that affect sensory or voluntary motor functions. Although it sounds like a medical condition, it is not observed in neurological and medical tests. Patients with this disorder show very little anxiety to their disorder and it's commonly referred to as *la belle indifference*.

3. A person might fake symptoms of an illness for monetary gain, sympathy, affection and care from a loved one.

4.**Depersonalisation**- One's sense of one's own self and one's own reality is temporarily lost.

   Derealisation- One's sense of the reality of the outside world is temporarily lost.

5. **Retrograde amnesia** refers to the inability to recall memories of the past.

Anterograde amnesia refers to the inability of the brain to no longer form new memories.

Dissociative amnesia is limited to the failure to recall previously stored personal information (retrograde amnesia) when that failure cannot be explained by normal forgetting. It is usually limited to mostly episodic and autobiographical memory traces.

6. **DID** stands for Dissociative Identity Disorder. This disorder results in people dissociating themselves into many identities (also known as alters, with different personalities) after possibly a traumatic or stressful event in their life.

3.13 Suggested Readings

4. Butcher, J.N. (2014). Abnormal Psychology. New Delhi: Pearson Education.
5. Butcher, J.N., Hooley, J. M., Mineka, S &Dwivedi, C.B. (2017). Abnormal Psychology 16th ed. Noida: Pearson.
6. Sarason, G.I. &Sarason, R.V. (2007). Abnormal Psychology: The Problem of Maladaptive Behaviour (II Edition). Pearson Education, Inc. and Dorling Kindersley Publication Inc.

UNIT IV: PERSONALITY DISORDERS

Structure

4.1 Introduction:

Each of us has a personality—a set of uniquely expressed characteristics that influence our behaviors, emotions, thoughts, and interactions. Our particular characteristics, often called personality traits, lead us to react in fairly predictable ways as we move through life. Yet our personalities are also flexible. We learn from experience. As we interact with our surroundings, we try out various responses to see which feel better and which are more effective. This is a flexibility that people who suffer from a personality disorder usually do not have. People with a personality disorder display an enduring, rigid pattern of inner experience and outward behavior that impairs their sense of self, emotional experiences, goals, capacity for empathy, and/or capacity for intimacy. Put another way, they have personality traits that are much more extreme and dysfunctional than those of most other people in their culture, leading to significant problems and psychological pain for themselves or others.

▸ PERSONALITY DISORDER DEFINITION:

An enduring, rigid pattern of inner experience and outward behavior that repeatedly impairs a person's sense of self, emotional experiences, goals, capacity for empathy, and/ or capacity for intimacy.

The symptoms of personality disorders last for years and typically become recognizable in adolescence or early adulthood, although some start during childhood. These disorders are among the most difficult psychological disorders to treat. Many people with the disorders are not even aware of their personality problems and fail to trace their difficulties to their maladaptive style of thinking and behaving.

It is common for a person with a personality disorder to also suffer from another disorder, a relationship called comorbidity. For example, many people with avoidant personality disorder, who fearfully shy away from all relationships, may also display social anxiety disorder. Perhaps avoidant personality disorder predisposes people to develop social anxiety disorder. Or perhaps social anxiety disorder sets the stage for the personality

disorder. Then again, some biological factor may create a predisposition to both the personality disorder and the anxiety disorder. Whatever the reason for the relationship, research indicates that the presence of a personality disorder complicates a person's chances for a successful recovery from other psychological problems.

4.2 Objectives:

At the end of the unit you will:
- Know the difference between Personality disorders and other disorders.
- Gain knowledge about different Personality disorders
- Understand about Antisocial disorder.

4.3 Clinical Features:

According to DSM 5 criteria for diagnosing a personality disorder, the person's enduring pattern of behavior must be pervasive and inflexible, as well as stable and long duration. It must also cause either clinically significant distress or impairment in functioning and must be manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control. Other people tend to find the behavior of the individuals with personality disorders confusing, exasperating, unpredictable, and to varying degrees as unacceptable. Personality disorders typically do not stem from debilitating reactions to stress just like PTSD or many cases major depression. These disorders stem from largely from the gradual development of inflexible and distorted personality and behavioural patterns that result in maladaptive way of thinking, perceiving things about the world.

4.4 Types:

The types are grouped into three categories or clusters:

The **first cluster** contains personality disorders that cause "odd" and "suspiciousness" behavior.

> **DISORDERS:**Paranoid Personality Disorder, Schizoid Personality Disorder, Schizotypal Personality Disorder and Antisocial Personality Disorder.

The **second cluster** causes "dramatic, emotional and impulsive" behavior.

> **DISORDERS:**Borderline Personality Disorder, Histrionic Personality Disorder and Narcissistic Personality Disorder.

The **third** is a cluster that causes behavior driven by high anxiety.

> **DISORDERS:** Avoidant Personality Disorder, Dependent Personality Disorder and
>
> Obsessive compulsive Personality Disorder Personality Disorder.

4.4.1 CLUSTER "A" PERSONALITY DISORDERS

The cluster of **"odd"** personality disorders consists of the paranoid, schizoid, and schizotypal personality disorders.

People with these disorders typically have odd or eccentric behaviors that are similar to but not as extensive as those seen in schizophrenia, including extreme suspiciousness, social withdrawal, and peculiar ways of thinking and perceiving things. Such behaviors often leave the person isolated. Some clinicians believe that these personality disorders are related to schizophrenia. In fact, schizotypal personality disorder is listed twice in

DSM-5—as one of the schizophrenia spectrum disorders and as one of the personality disorders (APA, 2013). Directly related or not, people with an odd cluster personality disorder often qualify for an additional diagnosis of schizophrenia or have close relatives with schizophrenia.

Clinicians have learned much about the symptoms of the odd cluster personality disorders but have not been so successful in determining their causes or how to treat them. People with these disorders rarely seek treatment.

PARANOID PERSONALITY DISORDER:

People with paranoid personality disorder deeply distrust other people and are suspicious of their motives. Because they believe that everyone intends them harm, they avoid close relationships. They find "hidden" meanings, which are usually belittling or threatening, in everything.

Quick to challenge the loyalty or trustworthiness of acquaintances, people with paranoid personality disorder remain cold and distant. A woman might avoid confiding in anyone, for example, for fear of being hurt, or a husband might, without any justification, persist in questioning his wife's faithfulness. Although inaccurate and inappropriate, their suspicions are not usually delusional; the ideas are not so bizarre or so firmly held as to clearly remove the individuals from reality. They may experience transient psychotic symptoms. People with this disorder are critical of weakness and fault in others, particularly at work. They are unable to recognize their own mistakes, though, and are extremely sensitive to criticism. They often blame others for the things that go wrong in their lives, and they repeatedly bear grudge. They do appear to be at elevated liability for schizophrenia.

CAUSAL FACTOR:

Some have argued for partial genetic transmission that may link the disorder to the schizophrenia, but results examining this issue are inconsistent. There is modest genetic liability that may occur through the heritability of high levels of antagonism (low agreeableness) and neuroticism (angry-hostility) which are the primary traits in paranoid personality disorder. Psychosocial causal factors that are suspected to play a role includes parental neglect or abuse and exposure to violent adults, although any links between early adverse experiences and adult paranoid personality disorders are clearly not specific to this one disorder.

TREATMENT FOR PARANOID PERSONALITY DISORDER

People with paranoid personality disorder do not typically see themselves as needing help, and few come to treatment willingly. Furthermore, many who are in treatment view the role of patient as inferior and distrust and rebel against their therapists. Thus it is not surprising that therapy for this disorder, as for most other personality disorders, has limited effect and moves very slowly.

Object relations therapists—the psychodynamic therapists who give center stage to relationships—try to see past the patient's anger and work on what they view as his or her deep wish for a satisfying relationship.

Cognitive and behavioral techniques have also been used to treat people with paranoid personality disorder and are often combined into an integrated cognitive-behavioral approach. On the behavioral side, therapists help clients to master anxiety-reduction techniques and to improve their skills at solving interpersonal problems. On the cognitive side, therapists guide the clients to develop more realistic interpretations of other people's

words and actions and to become more aware of other people's points of view. Antipsychotic drug therapy seems to be of limited help.

Check your Progress – 1

Note: a. Write your answer in the space given below

     b. Compare your answer with those given at the end of the unit.

1. What is the difference between paranoid personality with paranoid schizophrenia?
2. What are the primary causes of paranoid personality disorder?

SCHIZOID PERSONALITY DISORDER:

People with schizoid personality disorder persistently avoid and are removed from social relationships and demonstrate little in the way of emotion. Like people with paranoid personality disorder, they do not have close ties with other people. The reason they avoid social contact, however, has nothing to do with paranoid feelings of distrust or suspicion; it is because they genuinely prefer to be alone. They are usually unable to form social relationships and usually lack much interest in doing so.

They seek out jobs that require little or no contact with others. They have solitary interests. When necessary, they can form work relations to a degree, but they prefer to keep to themselves. Many live by themselves as well. Not surprisingly, their social skills tend to be weak. If they marry, their lack of interest in intimacy may create marital or family problems. People with schizoid personality disorder focus mainly on themselves and are generally unaffected by praise or criticism. They rarely show any feelings, expressing neither joy nor anger. They seem to have no need for attention or acceptance; are typically viewed as cold, humorless, or dull. They generally show apathetic mood. In terms of five factor model, they show extremely high levels of introversion (especially low on warmth, gregariousness, and positive emotions) and they are low on openness to feeling (one facet of openness to experience). Men are slightly more likely to experience it than are women, and men may also be more impaired by it.

CAUSAL FACTORS:

Like Paranoid personality disorder, Schizoid personality disorder has not been the focus of such research attention. This is hardly surprising since people with schizoid personality disorder are not exactly the people we might expect to volunteer for a research study. It is considered to be a likely precursor to the development of schizophrenia, but this viewpoint has been challenged and any genetic link that may exist is very modest. Schizoid personality traits have also been shown to have only modest heritability. Some theorists have suggested that the severe disruption in sociability seen in schizoid personality disorder may be due to severe impairment in an underlying affiliative system. Cognitive theorists propose that individuals with schizoid personality disorder exhibit cool and aloof behaviour because of maladaptive underlying schemas that lead them to view themselves as self-sufficient loners to view others as intrusive.

TREATMENT FOR SCHIZOID PERSONALITY DISORDER:

Their social withdrawal prevents most people with schizoid personality disorder from entering therapy unless some other disorder, such as alcoholism, makes treatment necessary. These clients are likely to remain emotionally distant from the therapist, seem not to care about their treatment, and make limited progress at best.

Cognitive-behavioral therapists have sometimes been able to help people with this disorder experience more positive emotions and more satisfying social interactions. On the cognitive end, their techniques include presenting clients with lists of emotions to think about or having them write down and remember pleasurable experiences. On the behavioral end, therapists have sometimes had success teaching social skills to such clients, using role-playing, exposure techniques, and homework assignments as tools. Group therapy is apparently useful when it offers a safe setting for social contact, although people with schizoid personality disorder may resist pressure to take part. As with paranoid personality disorder, drug therapy seems to offer limited help.

SCHIZOTYPAL PERSONALITY DISORDER:

People with schizotypal personality disorder display a range of interpersonal problems marked by extreme discomfort in close relationships, very odd patterns of thinking and perceiving, and behavioral eccentricities. They have cognitive and perceptual distortions, as well as oddities and eccentricities in their communication and behavior. They are excessively introverted. Anxious around others, they seek isolation and have few close friends. Some feel intensely lonely.

The disorder is more severe than the paranoid and schizoid personality disorders. Under extreme stress, they may experience transient psychotic symptoms. The symptoms may include ideas of reference—beliefs that unrelated events pertain to them in some important way—and bodily illusions, such as sensing an external "force" or presence. A number of people with this disorder see themselves as having special extrasensory abilities, and some believe that they have magical control over others. Examples of schizotypal eccentricities include repeatedly arranging cans to align their labels, organizing closets extensively, or wearing an odd assortment of clothing. The emotions of these individuals may be inappropriate, flat, or humorless. People with schizotypal personality disorder often have great difficulty keeping their attention focused. Oddities in thinking, speech, and other behaviors are the most stable characteristics of schizotypal personality disorder. Many researchers conceptualize schizotypal personality disorder as attenuated form of schizophrenia. According to five factor model (introversion and neuroticism), the other aspects related to cognitive and perceptual distortions are not adequately explained by this model. This final pathological trait is psychoticism, which consists of three facets: unusual beliefs and experiences, eccentricity, and cognitive and perceptual dysregulation.

Correspondingly, their conversation is typically vague, even sprinkled with loose associations. They are likely to choose undemanding jobs in which they can work below their capacity and are not required to interact with other people. Surveys suggest that 3.9 percent of adults—slightly more males than females display schizotypal personality disorder.

CAUSAL FACTORS:

In the original proposal of DSM-5, Schizotypal personality was the only categorical disorder retained from Cluster A. The heritability of this disorder is moderate. The biological associations of Schizotypal personality disorder with schizophrenia are remarkable. A number of studies on patients, as well as on college students, with schizotypal personality disorder have shown the same deficit in the ability to track a moving target

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visually that is found in schizophrenia. They also show numerous mild impairments in cognitive functioning including deficits in their ability to sustain attention and deficits in working memory. In addition, individuals with Schizotypal personality disorder, like patients with Schizophrenia, show deficits in their ability to inhibit attention to a second stimulus that rapidly follows presentation of first stimulus. For example, normal individuals presented with weak auditory stimulus about 0.1 second before loud sound that elicits a startle response show a smaller startle response show a smaller startle response than those not presented with weak auditory stimulus first. This normal inhibitory effect is reduced in people with schizotypal personality disorder and with schizophrenia, a phenomenon that may be related to high levels of distractibility and difficulty staying focused. They also show language abnormalities. A genetic relationship to schizophrenia has long been suspected. This disorder appears to be a part of spectrum of liability for schizophrenia that often occurs in some of the first degree relatives of people with schizophrenia. Teenagers who have schizotypal personality disorder have been shown to be at increased risk for developing schizophrenia and schizophrenias spectrum disorder in adulthood. It has also been proposed that there is second subtype of schizotypal personality disorder that is not genetically linked to schizophrenia. This subtype is characterized by cognitive and perceptual deficits and is instead linked to a history of childhood abuse and early trauma. In adolescence it has been associated with elevated exposure to stressful life events.

TREATMENT FOR SCHIZOTYPAL PERSONALITY DISORDER

Therapy is as difficult in cases of schizotypal personality disorder as it is in cases of paranoid and schizoid personality disorders. Most therapists agree on the need to help these clients "reconnect" with the world and recognize the limits of their thinking and their powers. The therapists may thus try to set clear limits—for example, by requiring punctuality—and work on helping the clients recognize where their views end and those of the therapist begin. Other therapy goals are to increase positive social contacts, ease loneliness, reduce overstimulation, and help the individuals become more aware of their personal feelings.

Cognitive-behavioral therapists further combine cognitive and behavioral techniques to help people with schizotypal personality disorder function more effectively. Using cognitive interventions, they try to teach clients to evaluate their unusual thoughts or perceptions objectively and to ignore the inappropriate ones. Therapists may keep track of clients' odd or magical predictions, for example, and later point out their inaccuracy. When clients are speaking and begin to digress, the therapists might ask them to sum up what they are trying to say. In addition, specific behavioral methods, such as speech lessons, social skills training, and tips on appropriate dress and manners, have sometimes helped clients learn to blend in better with and be more comfortable around others. Antipsychotic drugs have been given to people with schizotypal personality disorder, again because of the disorder's similarity to schizophrenia. In low doses the drugs appear to have helped some people, usually by reducing certain of their thought problems.

> **Check your Progress – 2**
> Note: a. Write your answer in the space given below
>   b. Compare your answer with those given at the end of the unit.
>
> 3. Which personality disorder is known as the attenuated form of schizophrenia?

4.4.2 CLUSTER "B" PERSONALITY DISORDERS

The cluster of **"dramatic"** personality disorders includes the antisocial, borderline, histrionic, and narcissistic personality disorders. The behaviors of people with these problems are so dramatic, emotional, or erratic that it is almost impossible for them to have relationships that are truly giving and satisfying. These personality disorders are more commonly diagnosed than the others. However, only the antisocial and borderline personality disorders have received much study, partly because they create so many problems for other people. The causes of the disorders, like those of the odd personality disorders, are not well understood. Treatments range from ineffective to moderately effective.

HISTRIONIC PERSONALITY DISORDER:

People with histrionic personality disorder, once called hysterical personality disorder, are extremely emotional—they are typically described as "emotionally charged"—and continually seek to be the center of attention. Their exaggerated moods and neediness can complicate life.

Approval and praise are their lifeblood; they must have others present to witness their exaggerated emotional states. Vain, self-centered, demanding, and unable to delay gratification for long, they overreact to any minor event that gets in the way of their quest for attention. Some make suicide attempts, often to manipulate others. People with histrionic personality disorder may draw attention to themselves by exaggerating their physical illnesses or fatigues. They may also behave very provocatively and try to achieve their goals through sexual seduction. These qualities do not lead to stable and satisfying relationships because others tire of providing this level of attention. Most obsess over how they look and how others will perceive them, often wearing bright, eye catching clothes. They exaggerate the depth of their relationships, considering themselves to be the intimate friends of people who see them as no more than casual acquaintances. Often they become involved with romantic partners who may be exciting but who do not treat them well. This disorder was once believed to be more common in women than in men. Research, however, has revealed gender bias in past diagnoses. When evaluating case studies of people with a mixture of histrionic and antisocial traits, clinicians in several studies gave a diagnosis of histrionic personality disorder to women more than men, this is because it -involves maladaptive variants of female related traits such as over dramatization, vanity, seductiveness, and over-concern about physical appearance Surveys suggest that 1.8 percent of adults have this personality disorder, with males and females equally affected.

CAUSAL FACTORS:

Very little systematic research has been conducted on histrionic personality disorder, perhaps as a result of the difficulty researchers have had in differentiating it from other personality disorders and/or because many do not believe it is a valid diagnosis. Reflecting this, histrionic personality disorder was one of the four diagnoses that was recommended for removal

in DSM-5. Histrionic personality disorder is highly comorbid with borderline, antisocial, narcissistic and dependent personality disorder diagnoses.

There is some genetic link with antisocial personality disorder, the idea being that there may be some common underlying predisposition that is more likely to be manifested in women a histrionic personality disorder and in men as antisocial personality disorder. Histrionic personality disorder may be characterized as involving extreme versions of two common, normal personality traits, extraversion and to a lesser extent, neuroticism-two normal personality traits known to have a partial genetic basis. In terms of the five-factor model, the very high levels of extraversion of patients with histrionic personality disorder include high levels of gregariousness, excitement seeking, and positive emotions. Their high levels of neuroticism, particularly involve the depression and self-consciousness facets; they are also high on openness to fantasies. Cognitive theorists emphasize the importance of maladaptive schemas revolving around the need for attention to validate self-worth.

TREATMENT FOR HISTRIONIC PERSONALITY DISORDER

People with histrionic personality disorder are more likely than those with most other personality disorders to seek out treatment on their own. Working with them can be very difficult, however, because of the demands, tantrums, and seductiveness they are likely to deploy. Another problem is that these clients may pretend to have important insights or to change during treatment merely to please the therapist. To head off such problems, therapists must remain objective and maintain strict professional boundaries. Cognitive therapists have tried to help people with this disorder to change their belief that they are helpless and also to develop better, more deliberate ways of thinking and solving problems. Psychodynamic therapy and various group therapy formats have also been used. In all these approaches, therapists ultimately aim to help the clients recognize their excessive dependency, find inner satisfaction, and become more self-reliant. Clinical case reports suggest that each of the approaches can be useful. Drug therapy appears less successful except as a means of relieving the depressive symptoms that some patients have.

ANTISOCIAL PERSONALITY BEHAVIOR:

Individuals with ASPD continually violate and show disregard for the rights of others through deceitful, aggressive or antisocial behaviour, typically without remorse or loyalty to anyone. They tend to be impulsive, irritable and aggressive and to show a pattern of generally irresponsible behaviour. This pattern of behaviour must have been occurring since the age of 15, and before age 15 the person must had symptoms of conduct disorder, a similar disorder occurring in children and young adolescents who show persistent patterns of aggression toward people, animals, destruction of property, deceitfulness, or theft.

Check your Progress – 3

Note: a. Write your answer in the space given below
    b. Compare your answer with those given at the end of the unit.

4. Name the common, extreme versions of personality traits in Histrionic Personality disorder.

BORDERLINE PERSONALITY DISORDER:

People with borderline personality disorder display great instability, including major shifts in mood, an unstable self-image, and impulsivity. Originally, it was most often used to refer to a condition that was thought to occupy the "border" between neurotic and psychotic disorders. Later, it was identified with schizotypal personality disorder. These characteristics combine to make their relationships very unstable as well. People with borderline personality disorder swing in and out of very depressive, anxious, and irritable states that last anywhere from a few hours to a few days or more. Their emotions seem to be always in conflict with the world around them. They are prone to bouts of anger, which sometimes result in physical aggression and violence. Just as often, however, they direct their impulsive anger inward and inflict bodily harm on themselves. Many seem troubled by deep feelings of emptiness.

Another important feature of BPD is impulsivity characterized by rapid responding to environmental triggers without thinking about long term consequences. Borderline personality disorder is a complex disorder, and it is fast becoming one of the more common conditions seen in clinical practice. Self-mutilation is another characteristic feature of this disorder. Many of the patients who come to mental health emergency rooms are people with this disorder who have intentionally hurt themselves. Their impulsive, self-destructive activities may range from alcohol and substance abuse to delinquency, unsafe sex, and reckless driving. Many engage in self-injurious or self-mutilation behaviors, such as cutting or burning themselves or banging their heads, such behaviors typically cause immense physical suffering, but those with borderline personality disorder often feel as if the physical discomfort offers relief from their emotional suffering. It may serve as a distraction from their emotional or interpersonal upsets, "snapping" them out of an "emotional overload". Many try to hurt themselves as a way of dealing with their chronic feelings of emptiness, boredom, and identity confusion. Scars and bruises also may provide them with a kind of concrete evidence of their emotional distress. Suicidal threats and actions are also common. Studies suggest that around 75 percent of people with borderline personality disorder attempt suicide at least once in their lives; as many as 10 percent actually commit suicide. It is common for people with this disorder to enter clinical treatment by way of the emergency room after a suicide attempt.

People with borderline personality disorder frequently form intense, conflict-ridden relationships in which their feelings are not necessarily shared by the other person. They may come to idealize another person's qualities and abilities after just a brief first encounter. They also may violate the boundaries of relationships. They quickly feel rejected and may become furious when their expectations are not met, yet they remain very attached to the relationships. In fact, they have recurrent fears of impending abandonment and frequently engage in frantic efforts to avoid real or imagined separations from important people in their lives. Sometimes they cut themselves or carry out other self -destructive acts to prevent partners from leaving.

People with borderline personality disorder typically have dramatic identity shifts. Because of this unstable sense of self, their goals, aspirations, friends, and even sexual orientation may shift rapidly. They may at times have no sense of themselves at all, leading to the feelings of emptiness

described earlier. According to surveys, 5.9 percent of the adult population display borderline personality disorder. Close to 75 percent of the patients who receive the diagnosis are women and have cognitive symptoms. These include relatively short or transient episodes in which they appear to be out of contact with reality and experience delusions or other psychotic like symptoms such as hallucinations. The course of the disorder varies from person to person. In the most common pattern, the person's instability and risk of suicide peak during young adulthood and then gradually wane with advancing age. Given the chaotic and unstable relationships characteristic of borderline personality disorder, it is not surprising that the disorder tends to interfere with job performance even more than most other personality disorders do.

CAUSAL FACTORS:

Research suggests that genetic factor play a significant role in the development of BPD. This heritability may be partly a function of the fact that personality traits of affective instability and impulsivity, which are both very prominent in BPD, are themselves partially heritable. There is some preliminary evidence that certain parts of the 5-HTT gene implicated in depression also be associated with BPD. Recent research also suggests a link with other gene involved in regulating dopamine transmission. People with BPD often appear to be characterized by owed functioning of the neurotransmitter serotonin, which is involved in inhibiting behavioural responses. This may be why they show impulsive-aggressive behaviour, as in acts of self-mutilation. Patients also show disturbances in the regulation of noradrenergic neurotransmitters that are similar to those seen in chronic stress conditions such as PTSD. In particular, their hyper responsive noradrenergic system may be related to their hypersensitivity to environmental changes.

Moreover, certain brain areas that ordinarily serve to inhibit aggressive behavior when activated by serotonin seem to show decreased activation in BPD. In addition, research suggests certain structural brain abnormalities in BPD, including reductions in both hippocampal and amygdala volume, features associated with aggression and impulsivity. Much theoretical and research attention has also been directed to the role of psychosocial causal factors in BPD. Although the vast majority of this research is retrospective in nature relying on people's memories of their past to discover the antecedents of the disorder, two prospective community based studies have shown that childhood adversity and maltreatment is linked to adult BPD. People with this disorder, usually report a large number of negative-even traumatic-events in childhood. These experiences include abuse and neglect, and separation and loss.

Patients with BPD reported significantly higher rates of abuse than did patients with other personality disorders. Overall, about 90 per cent of patients with BPD reported some type of childhood abuse or neglect. Majority of children who experience early abuse and neglect do not end up with any serious personality disorders or other psychopathology. Most studies, unfortunately cannot tell us that such early childhood trauma plays a causal role. First, majority of evidence comes from retrospective self-reports of individuals who are known for their exaggerated and distorted views of other people. Second, childhood abuse is certainly not a specific risk factor for borderline pathology because it is also reported at relatively

high rates with some other personality disorders as well as with other disorders such as dissociative identity disorder. Paris offered an interesting multidimensional diathesis stress theory of BPD. He proposes that people who have high levels of two normal personality traits-impulsivity and affective instability- may have a diathesis to develop BPD, but only in the presence of certain psychological risk factors such as trauma, loss and parental failure. When such non-specific pathological risk factors occur in someone who is affectively unstable, he or she may become dysphoric and labile and, if he or she is also impulsive, may engage in impulsive acting out to cope with this negative mood. Thus, the dysphoria and impulsive acts for each other. Paris also proposed that children who are impulsive and unstable tend to be" difficult" or troublesome children. Moreover, if the parents themselves have personality pathology, they may be especially insensitive to their difficult child, leading to vicious cycle in which the child's problems are exacerbated by inadequate parenting, which in turn leads to increased dysphoria, and so on. He further suggests that BPD may be more prevalent in our society than in many other cultures, and more prevalent today in the past, because of the weakening of family structure in our society.

TREATMENT FOR BORDERLINE PERSONALITY DISORDER:

It appears that psychotherapy can eventually lead to some degree of improvement for people with borderline personality disorder. It is, however, extraordinarily difficult for a therapist to strike a balance between empathizing with the borderline client's dependency and anger and challenging his or her way of thinking. The wildly fluctuating interpersonal attitudes of clients with the disorder can also make it difficult for therapists to establish collaborative working relationships with them. Moreover, clients with borderline personality disorder may violate the boundaries of the client–therapist relationship (for example, calling the therapist's emergency contact number to discuss matters of a less urgent nature). Over the past two decades, an integrative treatment for borderline personality disorder, called dialectical behavior therapy (DBT) has been receiving considerable research support and is now considered the treatment of choice in many clinical circles. DBT, grows largely from the cognitive-behavioral treatment model. It includes a number of the same cognitive and behavioral techniques that are applied to other disorders: homework assignments, psychoeducation, the teaching of social and other skills, modelling by the therapist, clear goal setting, reinforcements for appropriate behaviors, and collaborative examinations by the client and therapist of the client's ways of thinking.

DBT also borrows heavily from the humanistic and contemporary psychodynamic approaches, placing the client–therapist relationship itself at the center of treatment interactions, making sure that appropriate treatment boundaries are adhered to and providing an environment of acceptance and validation of the client. Indeed, DBT therapists regularly empathize with their borderline clients and with the emotional turmoil they are experiencing, locate kernels of truth in the clients' complaints or demands, and examine alternative ways for them to address valid needs.

Antidepressant, antibipolar, antianxiety, and antipsychotic drugs have helped calm the emotional and aggressive storms of some people with borderline personality disorder. However, given the numerous suicide

attempts by people with this disorder, the use of drugs on an outpatient basis is controversial.

Check your Progress – 4

Note: a. Write your answer in the space given below

     b. Compare your answer with those given at the end of the unit.

5. What are the characteristics of Borderline personality disorder?

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 feeling of others. Numerous studies support the notion of two subtypes of narcissism: grandiose and vulnerable narcissism. People with narcissistic personality disorder are generally grandiose, need much admiration, and feel no empathy with others. According to DSM-V criteria, manifested by traits related to grandiosity, aggression, and dominance. Convinced of their own great success, power, or beauty, they expect constant attention and admiration from those around them. They behave in stereotypical ways to gain the acclaim and recognition they crave.

People with narcissistic personality disorder have a grandiose sense of self-importance. They exaggerate their achievements and talents, expecting others to recognize them as superior, and often appear arrogant. They are very choosy about their friends and associates, believing that their problems are unique and can be appreciated only by other "special," high-status people. Because of their charm, they often make favourable first impressions, yet they can rarely maintain long-term relationships. People with narcissistic personality disorder are seldom interested in the feelings of others. They may not even be able to empathize with such feelings. Many take advantage of other people to achieve their own ends, perhaps partly out of envy; at the same time, they believe others envy them. Though grandiose, some react to criticism or frustration with bouts of rage, humiliation, or embitterment. Others may react with cold indifference. And still others become extremely pessimistic and filled with depression. They may have periods of zest that alternate with periods of disappointment.

Vulnerable narcissists have a very fragile and unstable sense of self-esteem, and for these individuals, arrogance and condescension is merely a façade for intense shame and hypersensitivity to rejection and criticism. They have become completely absorbed and preoccupied with fantasies of outstanding achievements but at the same time experience profound shame about their ambitions. They may avoid interpersonal relationships due to fear of rejection or criticism. In terms of the five-factor model, both subtypes are associated with high levels of interpersonal antagonism/low agreeableness, low altruism and tough mindedness. However, grandiose narcissist is exceptionally low in certain facets of neuroticism and high in extraversion. Vulnerable narcissist has very high levels of negatively affectivity/neuroticism. Thus, spouse describes patients with either grandiosity or vulnerability as being bossy, intolerant, cruel, demanding, etc. Only those high on grandiosity were additionally described as being aggressive, assertive, outspoken, with those high on vulnerability were described as worrying, emotional, defensive, anxious, etc. Some may fluctuate between both types. They also share another central trait- they are

unwilling or unable to take perspective of others. If they do not receive the validation they desire, they are inclined to be hypercritical or retaliatory. As many as 6.2 percent of adults display narcissistic personality disorder, up to 75 percent of them men. It is thought to be rare. Narcissistic-type behaviors and thoughts are common and normal among teenagers and do not usually lead to adult narcissism.

CAUSAL FACTOR:

Little empirical data on the environmental and genetic factors involved in the etiology of narcissistic personality disorder. A key finding has been that the grandiose and vulnerable forms of narcissism have not generally been associated with childhood abuse, neglect, or poor parenting. Indeed, there is some evidence that grandiose narcissism is associated with parental overvaluation. By contrast, vulnerable narcissism has been associated with emotional, physical and sexual abuse, as well as parenting styles characterized as intrusive, controlling and cold.

TREATMENT FOR NARCISSISTIC PERSONALITY DISORDER

Narcissistic personality disorder is one of the most difficult personality patterns to treat because the clients are unable to acknowledge weaknesses, to appreciate the effect of their behavior on others, or to incorporate feedback from others. The clients who consult therapists usually do so because of a related disorder such as depression. Once in treatment, the clients may try to manipulate the therapist into supporting their sense of superiority. Some also seem to project their grandiose attitudes onto their therapists and develop a love-hate stance toward them. Psychodynamic therapists seek to help people with this disorder recognize and work through their basic insecurities and defenses. Cognitive therapists, focusing on the self-centered thinking of such individuals, try to redirect the clients' focus onto the opinions of others, teach them to interpret criticism more rationally, increase their ability to empathize, and change their all-or-nothing notions

4.4.3 CLUSTER "C" PERSONALITY DISORDERS:

The cluster of **"anxious"** personality disorders includes the avoidant, dependent and obsessive-compulsive personality disorders. People with these patterns typically display anxious and fearful behavior. Although many of the symptoms of these personality disorders are similar to those of the anxiety and depressive disorders, researchers have not usually found direct links between this cluster and those disorders. As with most of the other personality disorders, research support for the various explanations is very limited. At the same time, treatments for these disorders appear to be modestly to moderately helpful— considerably better than for other personality disorders.

AVOIDANT PERSONALITY DISORDER:

People with avoidant personality disorder are very uncomfortable and inhibited in social situations, overwhelmed by feelings of inadequacy, and extremely sensitive to negative evaluation. They are so fearful of being rejected that they give no one an opportunity to reject them—or to accept them either. Unlike schizoid personalities, people with avoidant personality disorder do not enjoy their aloneness. Feeling inept and socially inadequate are the two most prevalent and stable features of avoidant personality disorder.

At the center of this withdrawal lies not so much poor social skills as a dread of criticism, disapproval, or rejection. They are timid and hesitant in

social situations, afraid of saying something foolish or of embarrassing themselves by blushing or acting nervous. Even in intimate relationships they express themselves very carefully, afraid of being shamed or ridiculed.

People with this disorder believe themselves to be unappealing or inferior to others. They exaggerate the potential difficulties of new situations, so they seldom take risks or try out new activities. They usually have few or no close friends, though they actually yearn for intimate relationships, and frequently feel depressed and lonely. As a substitute, some develop an inner world of fantasy and imagination. The key difference between the loner with schizoid personality disorder and the loner who is an avoidant is that the latter is shy, insecure and hypersensitive to criticism, whereas someone with a schizoid personality disorder is more aloof, cold and relatively indifferent to criticism. The person with avoidant personality also desires interpersonal contact but avoids it for fear of rejection, whereas in schizoid personality disorder there is a lack of desire or ability to form social relationships.

Avoidant personality disorder is similar to social anxiety disorder, and many people with one of these disorders also experience the other. The similarities include a fear of humiliation and low confidence. Some theorists believe that there is a key difference between the two disorders— namely, that people with social anxiety disorder primarily fear social circumstances, while people with the personality disorder tend to fear close social relationships. Other theorists, however, believe that the two disorders reflect the same psychopathology and should be combined.

A less clear distinction is that between avoidant personality disorder and generalized social phobia. Numerous studies have found substantial overlap between these disorders, which led to the conclusion that avoidant personality disorder simply maybe somewhat more severe manifestation of generalized social phobia. This is consistent with the findings that there are cases of generalized social phobia without avoidant personality disorder but very few cases of avoidant personality disorder without generalized social phobia. Around 2.4 percent of adults have avoidant personality disorder, men as frequently as women. Many children and teenagers are also painfully shy and avoid other people, but this is usually just a normal part of their development.

CAUSAL FACTOR:

Some research suggests that avoidant personality may have its origins in innate "inhibited" temperament that leaves the infant and child shy and inhibited in novel and ambiguous situations. A large twin study in Norway has shown that traits prominent in avoidant personality disorder show a modest genetic influence and that the genetic vulnerability for avoidant personality disorder is at least partially shared with that for social phobia. Moreover, there is also evidence that fear of being negatively evaluated, which is prominent in avoidant personality disorder, is moderately heritable; introversion and neuroticism are both elevated and they too are moderately heritable. This genetically and biologically based inhibited temperament may often serve as the diathesis that leads to avoidant personality disorder in some children who experience emotional abuse, rejection, or humiliation from parents who are not particularly affectionate.

Such abuse and rejection would be especially likely lead to anxious and fearful attachment patterns in temperamentally inhibited children.

TREATMENT FOR AVOIDANT PERSONALITY DISORDER

People with avoidant personality disorder come to therapy in the hope of finding acceptance and affection. Keeping them in treatment can be a challenge, however, for many of them soon begin to avoid the sessions. Often they distrust the therapist's sincerity and start to fear his or her rejection. Thus, as with several of the other personality disorders, a key task of the therapist is to gain the person's trust. Beyond building trust, therapists tend to treat people with avoidant personality disorder much as they treat people with social anxiety disorder and other anxiety disorders. Such approaches have had at least modest success. Psychodynamic therapists try to help clients recognize and resolve the unconscious conflicts that may be operating. Cognitive therapists help them change their distressing beliefs and thoughts and improve their self-image. Behavioral therapists provide social skills training as well as exposure treatments that require people to gradually increase their social contacts. Group therapy formats, especially groups that follow cognitive and behavioral principles, have the added advantage of providing clients with practice in social interactions. Antianxiety and antidepressant drugs are sometimes useful in reducing the social anxiety of people with the disorder, although the symptoms may return when medication is stopped.

Check your Progress – 5
Note: a. Write your answer in the space given below
     b. Compare your answer with those given at the end of the unit.
6. Which causal factor often acts as a diathesis that lead to avoidant personality disorder?

DEPENDENT PERSONALITY DISORDER

People with dependent personality disorder have a pervasive, excessive need to be taken care of. As a result, they are clinging and obedient, fearing separation from their parent, spouse, or other person with whom they are in a close relationship and show submissive behavior. They rely on others so much that they cannot make the smallest decision for themselves.It is normal and healthy to depend on others, but those with dependent personality disorder constantly need assistance with even the simplest matters and have extreme feelings of inadequacy and helplessness. Afraid that they cannot care for themselves, they cling desperately to friends or relatives. People with avoidant personality disorder have difficulty initiating relationships. In contrast, people with dependent personality disorder have difficulty with separation. They feel completely helpless and devastated when a close relationship ends, and they quickly seek out another relationship to fill the void. Many cling persistently to relationships with partners who physically or psychologically abuse them. Lacking confidence in their own ability and judgment, people with this disorder seldom disagree with others and allow even important decisions to be made for them. They may depend on a parent or spouse to decide where to live, what job to have, and which neighbours to befriend. Because they so fear rejection, they are overly sensitive to disapproval and keep trying to meet other people's wishes and expectations, even if it means volunteering for unpleasant or demeaning tasks.

Many people with dependent personality disorder feel distressed, lonely, and sad; often they dislike themselves. Thus they are at risk for depressive, anxiety, and eating disorders. Their fear of separation and their feelings of helplessness may leave them particularly prone to suicidal thoughts, especially when they believe that a current relationship is about to end. For years, clinicians have believed that more women than men display this pattern, but some research suggests that the disorder is just as common in men. This gender difference is not due to a sex bias in making diagnosis but rather to higher prevalence in women of certain personality traits such as neuroticism and agreeableness.

It is common for people with dependent personality disorder to have a comorbid diagnosis of mood and anxiety disorder. Some features of dependent disorder overlap with those of borderline, histrionic and avoidant personality disorder but there are differences as well. For example, both borderline and dependent personalities fear abandonment. However, borderline personality, who usually has intense and stormy relationships reacts with feelings of emptiness, rag if abandonment occurs, whereas dependent personality reacts initially with submissiveness and then finally with an urgent seeking of new relationship. Histrionic and dependent personalities have strong needs for reassurance and approval, but histrionic personality is much more gregarious, flamboyant, and actively demanding of attention whereas dependent personality is more docile and self-effacing. It is also hard to distinguish between dependent and avoidant personality disorder. Dependent personality have great difficulty in separating in relationships because they feel incompetent on their own and have a need to be taken care, whereas, avoidant personalities have trouble initiating relationship because they fear criticism or rejection. We should also remember that avoidant personality occurs with dependent personality disorder rather frequently. In terms of five-factor model, dependent personality disorder is associated with high levels of neuroticism and agreeableness.

CAUSAL FACTORS:

Some evidence suggests that there is a modest genetic influence on dependent personality traits. Moreover, several other personality traits such as neuroticism and agreeableness that are also prominent in dependent personality disorder also have a genetic component. It is possible that people with these partially genetically based predispositions to dependence and anxiousness may be especially prone to the adverse effects of parents who are authoritarian and overprotective. This might lead children to believe that they are reliant on others for their own well-being and are incompetent on their own. Cognitive theorists describe the underlying maladaptive schemas for these individuals as involving core beliefs about weakness and competence and needing others to survive.

TREATMENT FOR DEPENDENT PERSONALITY DISORDER

In therapy, people with dependent personality disorder usually place all responsibility for their treatment and well-being on the clinician. Thus a key task of therapy is to help patients accept responsibility for themselves. Because the domineering behaviors of a spouse or parent may help foster a patient's symptoms, some clinicians suggest couple or family therapy as well, or even separate therapy for the partner or parent. Treatment for dependent personality disorder can be at least modestly helpful.

Psychodynamic therapy for this pattern focuses on many of the same issues as therapy for depressed people, including the transference of dependency needs onto the therapist. Cognitive-behavioral therapists combine the behavioral and cognitive interventions to help the clients take control of their lives. On the behavioral end, the therapists often provide assertiveness training to help the individuals' better express their own wishes in relationships. On the cognitive end, the therapists also try to help the clients challenge and change their assumptions of incompetence and helplessness. Antidepressant drug therapy has been helpful for people whose personality disorder is accompanied by depression. As with avoidant personality disorder, a group therapy format can be helpful because it provides opportunities for the client to receive support from a number of peers rather than from a single dominant person. In addition, group members may serve as models for one another as they practice better ways to express feelings and solve problems.

Check your Progress – 6

Note: a. Write your answer in the space given below

     b. Compare your answer with those given at the end of the unit.

7. What are the features which overlap between Histrionic and Dependent personality disorder?

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

People with obsessive-compulsive personality disorder are so preoccupied with order, perfection, and control that they lose all flexibility, openness, and efficiency. Their concern for doing everything "right" impairs their productivity.When faced with a task, people who have obsessive-compulsive personality disorder may become so focused on organization and details that they fail to grasp the point of the activity. As a result, their work is often behind schedule (some seem unable to finish any job), and they may neglect leisure activities and friendships. People with this personality disorder set unreasonably high standards for themselves and others. Their behavior extends well beyond the realm of conscientiousness. They can never be satisfied with their performance, but they typically refuse to seek help or to work with a team, convinced that others are too careless or incompetent to do the job right. Because they are so afraid of making mistakes, they may be reluctant to make decisions. They also tend to be rigid and stubborn, particularly in their morals, ethics, and values. They live by a strict personal code and use it as a yardstick for measuring others. They may have trouble expressing much affection, and their relationships are sometimes stiff and superficial. In addition, they are often stingy with their time or money. Some cannot even throw away objects that are worn out or useless. Research, indicates that rigidity, stubbornness and perfectionism, as well as reluctance to delegate, are the most prevalent and stable features of OCPD. According to surveys, as many as 7.9 per cent of the adult population display obsessive-compulsive personality disorder, with white, educated, married, and employed people receiving the diagnosis most often. Men are twice as likely as women to display the disorder. Many clinicians believe that obsessive-compulsive personality disorder and obsessive-compulsive disorder are closely related. Certainly, the two disorders share a number of features, and many people who suffer from one of the disorders meet the diagnostic criteria for the other disorder.

However, it is worth noting that people with the personality disorder are more likely to suffer from either major depressive disorder, generalized anxiety disorder, or a substance use disorder than from obsessive compulsive disorder. In fact, researchers have not consistently found a specific link between obsessive-compulsive personality disorder and obsessive-compulsive disorder.

It is important to note that people with OCPD do not have true obsessions or compulsive rituals that are the source of extreme anxiety or distress in people with OCD. People with OCPD have lifestyles characterized by over conscientiousness, high neuroticism, inflexibility and perfectionism but without the presence of true obsessions or compulsive rituals. Indeed, only about 20% of patients with OCD have comorbid diagnosis of OCPD. People with OCD are more likely to be diagnosed with avoidant or dependent personality disorder than with OCPD and there are only three symptoms of OCPD that seem to occur at elevated rates in people with OCD relative to controls: Perfectionism, Preoccupation with details, Hoarding.

CAUSAL FACTORS:

Theorists who take a five factor dimension approach to understanding OCPD note that these individuals have excessively high levels of conscientiousness. This leads to extreme devotion to work, perfectionism, and excessive controlling behaviour. They are also high on assertiveness and low on compliance. Another influential biological dimensional approach- that of Cloninger- posits three primary dimensions of personality: novelty seeking, reward dependence and harm avoidance. Individuals with obsessive compulsive personalities have low levels of novelty seeking and reward dependence but high levels of harm avoidance. Recent research has also demonstrated that the traits of OCPD traits show a modest genetic influence.

TREATMENTS FOR OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

People with obsessive-compulsive personality disorder do not usually believe there is anything wrong with them. They therefore are not likely to seek treatment unless they are also suffering from another disorder, most frequently an anxiety disorder or depression, or unless someone close to them insists that they get treatment. People with obsessive-compulsive personality disorder often respond well to psychodynamic or cognitive therapy. Psychodynamic therapists typically try to help these clients recognize, experience, and accept their underlying feelings and insecurities and perhaps take risks and accept their personal limitations. Cognitive therapists focus on helping the clients to change their dichotomous thinking, perfectionism, indecisiveness, procrastination, and chronic worrying. A number of clinicians, report that people with obsessive-compulsive personality disorder, like those with obsessive compulsive disorder, respond well to serotonin-enhancing antidepressant drugs; however, researchers have yet to study this issue fully.

Check your Progress – 7
Note: a. Write your answer in the space given below
　　　b. Compare your answer with those given at the end of the unit.

8. What is the difference between OCD and OCPD?

4.5 Causal Factors In Personality Disorder:

There's no clear reason why some people develop a personality disorder and others don't. Most researchers think that a complex mix of factors is involved, such as:

THE ENVIRONMENT WE GROW UP IN:

The environment we grow up in and the quality of care we receive can affect the way our personality develops. We may be more likely to develop personality disorder if we've experienced: an unstable or chaotic family life, such as living with a parent who is an alcoholic or who struggles to manage a mental health problem, little or no support from caregiver, if we experienced a traumatic event or situation, a lack of support or bad experiences during our school life, in our peer group or wider community.

If we had a difficult childhood or experiences like these, we might have developed certain beliefs about how people think and how relationships work. We might have developed certain strategies for coping which aren't helpful in our adult life.

Not everyone who experiences a traumatic situation will develop these problems. The way we and others reacted to it, alongside the support and care we received to help we cope, will have made a lot of difference. Similarly, not everyone who develops a personality disorder will have had a traumatic experience.

Many people who are diagnosed with borderline or schizotypal personality disorder experienced sexual trauma or bullying during childhood.

Verbal abuse: Children who've suffered from insensitive parenting and verbal abuse during childhood are three times more likely to suffer from narcissistic personality disorder.

GENETIC FACTORS:

Some elements of our personality are inherited. We are born with different temperaments – for example, babies vary in how active they are, their attention span and how they adapt to change. Some experts believe inheritance may play a part in the development of personality disorder. Some malfunctioning genes might cause certain personality disorders.

Sensitivity to light, texture, noise and other stimuli might also cause a child to develop anxious personalities during their teenage years and into adulthood.

4.6 Treatment:

Personality disorders are generally difficult to treat, in part, because they are, by definition relatively enduring, pervasive, and inflexible patterns of behavior and inner experience. They are different goals of treatment like reducing subjective distress, changing specific dysfunctional behaviours, and changing whole patterns of behavior or the entire structure of the personality.

In many cases, people with personality disorders enter treatment only at someone else's insistence and they often do not believe that need to change. Moreover, those from the odd/eccentric Cluster A and the erratic

/dramatic Cluster B have general difficulties in forming and maintaining good relationships, including the therapist. For those from the erratic/dramatic Cluster B, the pattern of acting out typical in their other relationships is carried into the therapy session, and instead of dealing with their problems at verbal level they may become angry at their therapist and loudly disrupt the sessions. Non completion of treatment is a particular problem in the treatment of personality disorders, as they usually drop out of therapy. People with personality disorder have rigid, ingrained personality trait that often lead to poor therapeutic relationships and additionally make them resist doing the things that would help improve their other conditions.

4.7 Anti-Social (Psychopathic) Personality:

Sometimes described as "psychopaths" or "sociopaths," people with antisocial personality disorder persistently disregard and violate others' rights. Aside from substance use disorders, this is the disorder most closely linked to adult criminal behavior. DSM-5 stipulates that a person must be at least 18 years of age to receive this diagnosis; however, most people with antisocial personality disorder displayed some patterns of misbehavior before they were 15, including truancy, running away, cruelty to animals or people, and destroying property. People with antisocial personality disorder lie repeatedly. Many cannot work consistently at a job; they are absent frequently and are likely to quit their jobs altogether. Usually they are also careless with money and frequently fail to pay their debts. They are often impulsive, taking action without thinking of the consequences. Correspondingly, they may be irritable, aggressive, and quick to start fights. Many travel from place to place.

Recklessness is another common trait: people with antisocial personality disorder have little regard for their own safety or for that of others, even their children. They are self-centered as well, and are likely to have trouble maintaining close relationships. Usually they develop a knack for gaining personal profit at the expense of other people. Because the pain or damage they cause seldom concerns them, clinicians commonly say that they lack a moral conscience. They think of their victims as weak and deserving of being conned, robbed, or even physically harmed.

Studies and clinical observations also indicate that people with antisocial personality disorder have higher rates of alcoholism and other substance use disorders than do the rest of the population. Perhaps intoxication and substance misuse help trigger the development of antisocial personality disorder by loosening a person's inhibitions. Perhaps this personality disorder somehow makes a person more prone to abuse substances. Or perhaps antisocial personality disorder and substance use disorders both have the same cause, such as a deep-seated need to take risks. Interestingly, drug users with the personality disorder often cite the recreational aspects of drug use as their reason for starting and continuing.

Many behavioral theorists have suggested that antisocial symptoms may be learned through modelling, or imitation. As evidence, they point to the higher rate of antisocial personality disorder found among the parents of people with this disorder. Other behaviorists have suggested that some parents unintentionally teach antisocial behavior by regularly rewarding a child's aggressive behavior. When the child misbehaves or becomes

violent in reaction to the parents' requests or orders, for example, the parents may give in to restore peace. Without meaning to, they may be teaching the child to be stubborn and perhaps even violent.

The cognitive view says that people with antisocial personality disorder hold attitudes that trivialize the importance of other people's need. Such a philosophy of life, some theorists suggest, may be far more common in our society than people recognize. Cognitive theorists further propose that people with this disorder have genuine difficulty recognizing points of view or feelings other than their own. Finally, studies suggest that biological factors may play an important role in antisocial personality disorder.

Researchers have found that antisocial people, particularly those who are highly impulsive and aggressive, have lower serotonin activity than other people. As you'll recall, both impulsivity and aggression also have been linked to low serotonin activity in other kinds of studies, so the presence of this biological factor in people with antisocial personality disorder is not surprising.

Other studies indicate that individuals with this disorder display deficient functioning in their frontal lobes, particularly in the prefrontal cortex. Among other duties, this brain region helps people to plan and execute realistic strategies and to have personal characteristics such as sympathy, judgment, and empathy. These are, of course, all qualities found wanting in people with antisocial personality disorder.

In yet another line of research, investigators have found that people with antisocial personality disorder often feel less anxiety than other people, and so lack a key ingredient for learning. This would help explain why they have so much trouble learning from negative life experiences or tuning in to the emotional cues of others. Why should people with antisocial personality disorder experience less anxiety than other people? The answer may lie once again in the biological realm. Research participants with the disorder often respond to warnings or expectations of stress with low brain and bodily arousal. Perhaps because of the low arousal, they easily tune out threatening or emotional situations, and so are unaffected by them.

It could also be argued that because of their physical under arousal, people with antisocial personality disorder would be more likely than other people to take risks and seek thrills. That is, they may be drawn to antisocial activity precisely because it meets an underlying biological need for more excitement and arousal. In support of this idea, as you read earlier, antisocial personality disorder often goes hand in hand with sensation-seeking behavior.

PSYCHOPATHY AND ANTISOCIAL PERSONALITY DISORDER:

The use of the term "antisocial personality disorder" dates back only to 1980 when personality disorders first entered DSM III. However, many of the central features of this disorder have long been labelled "psychopathy" or "sociopathy". Although several investigations identified the syndrome in the 19th century using such terms as "moral insanity" the most comprehensive early descriptions of psychopathy was made by Cleckley in 1940. In addition to the defining features noted in the DSM criteria, psychopathy also includes such affective and interpersonal traits as lack of empathy, inflated and arrogant self-appraisal, and glib and superficial charm. However, much less attention has been paid to the validity of the

ASPD diagnosis- that is, whether it measures a meaningful construct and whether that construct is the same as psychopathy.

TWO DIMENSIONS OF PSYCHOPATHY:

Research suggests that ASPD and Psychopathy are related but differ in significant ways. Robert Hare developed a 20 item Psychopathy Checklist Revised (PCL-R) as a way for clinicians and researchers to diagnose psychopathy on the basis of Cleckley criteria following an extensive interview and careful checking of past school, police and prison records. Extensive research with this checklist has shown that there are two related but separable dimensions of psychopathy.

The first dimension involves the affective and interpersonal core of the disorder and reflects traits such as lack of guilt or remorse, callousness, grandiose sense of self-worth, pathological lying.

The second dimension reflects behaviour- the aspects of psychopathy that involve antisocial or impulsive acts, social deviance a well as need for stimulation, poor behavior controls, irresponsibility, and a parasitic lifestyle.

The second dimension is much more deeply related than the first to the DSM diagnosis of ASPD. When comparisons have been made in prison settings to determine what percentage of prison inmates qualify for a diagnosis of psychopathy versus ASPD, it is typically found that about 70% to 80% qualify for a diagnosis of ASPD but only about 25% to 30% meet the criteria for psychopathy. Only about half of imprisoned individuals diagnosed with ASPD also meet the criteria for psychopathy, but most imprisoned individuals with a diagnosis of psychopathy also meet the criteria for ASPD. That is, a significant number of inmates show the antisocial and aggressive behaviors necessary for a diagnosis of ASPD but do not show enough selfish, callous, and exploitative behaviors to qualify for a diagnosis of psychopathy.

The issues surrounding these diagnoses remain highly controversial. There was considerable discussion by the DSM-IV criteria for ASPD to include more of the traditional affective and interpersonal features of psychopathy. However, in the end no official changes were made.

An additional concern about the current conceptualization of ASPD is that it fails to include people who show many of the features of the first, affective and interpersonal dimension of psychopathy but not as many features of the second, antisocial dimension, or at least few enough that these individuals do not generally get into trouble with the law. Cleckley did not believe that aggressive behaviors were central to the concept of psychopathy. This group might include, for example, unprincipled and predatory business or financial professionals, manipulative lawyers, crooked politicians. Unfortunately, because they are difficult to find to study, little researches has been conducted on psychopathic people who manage to stay out of correctional institutions.

4.8 Clinical Picture:

Often charming, spontaneous, and likable on first acquaintance, psychopaths are deceitful and manipulative, callously using others to achieve their own ends. Many of them seem to live in a series of present moments without consideration for the past or future. But also included in

this general category are hostile people are prone to act out impulses in remorseless and often senselessly violent ways.

INADEQUATE CONSCIENCE DEVELOPMENT:

Psychopaths appear unable to understand and accept ethical values except on a verbal level. They may glibly claim to adhere to high moral standards that have no apparent connections with their behavior. In short, their conscience development in severely retarded or nonexistent, and they behave as though social regulations and laws do not apply to them. These characteristics are most strongly related to interpersonal and affective core of psychopathy. In spite of their stunted conscience development, their intellectual development is typically normal. Nevertheless, intelligence is one trait that has different relationships with two dimension of psychopathy. The first, affective and interpersonal dimension is positively related to verbal intelligence; the second, antisocial dimension is negatively related to intelligence.

IRRESPONSIBLE AND IMPULSIVE BEHAVIOUR:

They learn to take rather than earn what they want. Prone to thrill seeking and deviant and unconventional behavior, they often break the law impulsively and without regard for the consequences. They seldom forgo immediate pleasure for future gains and long range goals. These aspects of psychopathy are most closely related to the second, antisocial dimension of psychopathy.

Many studies have shown that antisocial personalities and some psychopaths have high rates of alcohol abuse and dependence and other substance abuse/ dependence disorders. Alcohol abuse is related only to antisocial or deviant dimension of the PCL-R. Antisocial personalities also have elevated rates of suicide, which are also associated with the second dimension.

ABILITY TO IMPRESS AND EXPLOIT OTHERS:

Some psychopaths are superficially charming and likable, with a disarming manner that easily wins new friends. They seem to have good insight into other people's needs and weakness and are adept at exploiting them. These frequent liars usually seem sincerely sorry if caught in a lie and promise to make amends they- but they do not do so. Psychopaths are seldom able to keep close friends. They cannot understand love in others or give it in return. Manipulative, exploitative, and sometimes coercive in sexual relationships, psychopaths are irresponsible and unfaithful mates.

4.9 Causal Factors:

Contemporary research has variously stressed the causal roles of genetic factors, temperamental characteristics, deficiencies in fear and anxiety, more general emotional deficits, the early learning of antisocial behaviour as a coping style, and the influence of particular family and environmental patterns. Since the traits tend to appear early in life, many investigators have focussed on here of early biological and environmental factors as causative agents in antisocial and psychopathic behaviors.

GENETIC INFLUENCES:

Behavioral genetic research relies on the different levels of genetic relatedness between family members in order to estimate the contribution of heritable and environmental factors to individual differences in a phenotype of interest, in our case antisocial behavior. The early adoption studies typically demonstrated that the combination of a genetic

predisposition (i.e., psychopathology in biological parents) with a high risk environment (i.e., adverse adoptive home environment) lead to greater pathology than what would be expected from either factor acting alone or both in an additive combination. In the past two decades, adoption samples have become less accessible, instead studies utilizing large twin, sibling and/or parent–child (multi generation) samples have emerged. One of the key methodological designs in behavioral genetic research is the classical twin design. In the classical twin design monozygotic (identical) twin pairs are assumed to share their common environment and 100% of their genes. Dizygotic (fraternal) twin pairs also share their common environment and they are assumed to share on average 50% of their genes. By comparing the resemblance for antisocial behavior between monozygotic and dizygotic twins the variance of antisocial behavior can be divided into additive genetic factors, shared environmental factors, and non-shared environmental factors. Shared environmental factors refer to non-genetic influences that contribute to similarity within pairs of twins. Non-shared environmental factors refer to experiences that make siblings dissimilar.

There is compelling evidence from behavioral genetic research that heritable influences are of importance in the development of antisocial behavior; approximately 50% of the total variance in antisocial behavior is explained by genetic influences. Yet, there is also evidence of a large environmental effect, both shared and non-shared environmental influences have been found to explain the remaining half of the variance

One excellent study by Cadoret and collegues found that adopted away children of biological parents with ASPD were more likely to develop antisocial personalities if their adoptive parents exposed them to adverse environments than if their adoptive parents exposed them to a more normal environment. Adverse environments were characterized by some of the following: marital conflicts or divorce, legal problem and parental psychopathology. Similar findings of a gene-environment interaction were also found in twins who were at high or low risk for conduct disorder; in this study, the environment risk factor was physical maltreatment.

Several candidate genes have been identified to be associated with antisocial behavior or their known risk factors. Many of these candidate genes findings have also been replicated in both human and animal studies. A majority of these candidate genes were identified through examination of (1) the dopamine system, which is involved in mood, motivation and reward, arousal, and other behaviors; (2) the serotonin system, which is involved in impulse control, affect regulation, sleep, and appetite; or (3) the epinephrine/norepinephrine system, which facilitate fight-or-flight reactions and autonomic nervous system activity. All three of these systems are affected by monoamine oxidase A (*MAO-A*) function. The low-activity alleles of *MAO-A* interacts with maladaptive childhood environment and has been associated with aggression, violent delinquency, externalizing behavior, and lower inhibitory control

The relationship between antisocial behaviour and substance abuse is sufficiently strong that some have questioned whether there may be a common factor leading to both alcoholism and antisocial personality.

THE LOW FEAR HYPOTHESIS AND CONDITIONING:

One of the classic theoretical approaches to explaining psychopathy is the low fear hypothesis. Research evidence indicates that psychopaths who are

high on the egocentric, callus, and exploitative dimension have low trait anxiety and show poor conditioning of fear. Mainly based on research with criminal populations, the low fear hypothesis considers deficient emotional responding to aversive stimulation as the core underlying substrate for the disorder. Consistent with this hypothesis, empirical studies have demonstrated deficient acquisition of fear-conditioned responses in psychopathy, providing evidence that this deficiency reflects impairments on an affective-evaluative level (i.e., psychopathic participants do not form emotional associations between the cue and the noxious event) as opposed to a cognitive-information processing level (i.e., psychopaths display adequate evaluation of and reactivity to noxious stimuli themselves).

In addition, research focusing on the neural systems known to be involved in emotional learning (i.e., the limbic-prefrontal circuit) has provided evidence of underactivity in structures including the left amygdala, the right ventromedial orbitofrontal cortex, the insula, the anterior cingulate cortex, and the right secondary somatosensory cortex in psychopathic individuals during the acquisition phase of a fear conditioning task.

The second important neural system is the behavioural activation system. This system activates behaviour in response to cues for reward a well as cues for active avoidance of threatened punishment. According to Fowle's theory, the behavioural activation system is thought to be normal or possibly over reactive in psychopaths. This hypothesis of Fowles that psychopaths have a deficient behavioural activation system seems to account for three important features of psychopathy: i) Deficient conditioning of anxiety to signals of punishment ii) Their difficult learning to inhibit responses that may result in punishment and iii) Their normal or hyper normal active avoidance of punishment when actively threatened with punishment.

MORE GENERAL EMOTIONAL DEFICITS:

Psychopaths showed less significant physiological reactivity to distress cues than non- psychopaths. This is consistent with the idea that psychopaths are low on empathy, in addition to being low on fear. However, they were not under responsive to unconditioned threat cues such as slides of sharks, pointed guns, or angry faces. Patrick and colleagues have demonstrated that this effect of smaller startle response when viewing unpleasant slides is especially pronounced with slides depicting scenes of victim who have been mutilated or assaulted but not with slides representing threats to self. This specific failure to show larger startle response with victim scenes must be related to lack of empathy in psychopathy.

Hare has hypothesized that the kinds of emotional deficits discussed are only a subset of more general difficulties that psychopaths have with processing and understanding the meaning of affective stimuli, including positive and negative words and sounds. It has also been suggested that such deficits in turn are closely linked to deficits in moral reasoning and behaviour seen in psychopathy.

EARLY PARENTAL LOSS, PARENTAL REJECTION, AND INCONSISTENCY:

In addition to genetic factors and emotional deficits they show conscience development and high levels of both reactive and instrumental aggression are influenced by the damaging effects of parental rejection, abuse, and neglect accompanied by inconsistent discipline. However, studies of gene-

environment interactions reviewed earlier clearly indicates that these kinds of disturbances are not sufficient explanations for the origins of psychopathy or antisocial personality because some people are clearly more susceptible to these effects than others.

The exact cause of antisocial personality disorder isn't known, but: Genes may make us vulnerable to developing antisocial personality disorder — and life situations may trigger its development. Changes in the way the brain functions that may have resulted during brain development may also be a cause.

4.10 Treatment:

It's rare that someone with APD would even seek help on their own. So the majority of people with APD remain undiagnosed and untreated.

Treatments for people with antisocial personality disorder are typically ineffective. Major obstacles to treatment include the individuals' lack of conscience, desire to change, or respect for therapy. Most of those in therapy have been forced to participate by an employer, their school, or the law, or they come to the attention of therapists when they also develop another psychological disorder. Biological treatment approaches for antisocial and psychopathic personalities including ECT and drugs have not been systematically studied, partly because the few results that have been reported suggest modest changes at best. Drugs such as Lithium and anticonvulsants used to treat bipolar disorder have had some success in treating the aggressive/impulse behaviour of violent aggressive criminals, but evidence in this is scant. There are promising results using antidepressants from the SSRI category, which can sometimes reduce aggressive/impulsive behaviour and increase interpersonal skills. However, none of these biological treatments has any substantial impact on the disorder as a whole.

COGNITIVE-BEHAVIOR THERAPY:

Some cognitive therapists try to guide clients with antisocial personality disorder to think about moral issues and about the needs of other people. In a similar vein, a number of hospitals and prisons have tried to create a therapeutic community for people with this disorder, a structured environment that teaches responsibility toward others. Some patients seem to profit from such approaches, but it appears that most do not. In recent years, clinicians have also used psychotropic medications, particularly atypical antipsychotic drugs, to treat people with antisocial personality disorder. Some report that these drugs help reduce certain features of the disorder, but systematic studies of this claim are still needed.

Common targets of cognitive behavioural interventions include:
- ❖ Increasing self-control, self-critical thinking and social perspective taking
- ❖ Increasing victim awareness
- ❖ Teaching anger management
- ❖ Changing antisocial attitudes
- ❖ Cutting drug addiction.

Such an intervention requires a controlled situation in which the therapist can administer or withhold reinforcement and the individual cannot leave treatment, because when treating antisocial behaviour we are dealing with a total lifestyle rather than few specific, maladaptive behaviour. They may be

useful in reducing inmates' antisocial behaviour while in a prison or other forensic setting the results do not usually generalize to real world if the person is released. Fortunately, the crime activities of many psychopathic and antisocial personalities seem to decline after the age of 40 even without treatment possibly because of weaker biological drives, better insight into self-defeating behaviors. One important study that followed a group of male psychopaths over many years found a clear and dramatic reduction in levels of criminal behaviour after age40. However, over 50% of these people continued to be arrested after age 40. Moreover, it is only the antisocial behavioural dimension of psychopathy that seems to diminish with age.

For those who do seek help, one of the most common treatments for APD is CBT, or cognitive behavioral therapy. CBT helps affected people learn how to slow down reaction times, reduce impulsive behavior, and incorporate consequential thinking into decision-making. Any psychotherapy, though, would focus on improving conduct to reduce negative consequences in the person's life, how to modify expectations to be more in line with reality, or use relaxation techniques to calm down the flare of an angry reaction when a sense of entitlement conflicts with what they're getting out of a situation.

Psychotherapy for APD only works if the affected person is actually motivated to change. Like most mental health disorders, the desire for change must come from the person. They must have their own personal reasons for changing their behaviour, and that's why it's especially hard to treat someone with APD.

4.11 Let Us Sum Up:

The defining features of a personality disorder are: a) distorted thinking, b) problems with emotional regulation, and c) problems with impulse regulation) that all work together to contribute to the fourth and most important core feature of personality disorders, d) interpersonal difficulties. When people have distorted ways of thinking about themselves and others, have difficulty regulating their emotions, and have trouble regulating their impulses, it only makes sense that these problems will go on to affect the way they enter into, and behave in relationships. Likewise, these problematic patterns of thoughts, feelings, and behaviors affect the way they handle conflict with others; and the way other people will react to them.

CLUSTER A:

Paranoid Personality Disorder:

Distrust; suspiciousness; expectations of being exploited; questioning the loyalty of friends; reading hidden demeaning and threatening meanings into benign remarks or events; bearing grudges; being easily slighted; questioning the fidelity of spouse.

Schizoid Personality Disorder:

Indifference to social relationships; restricted range of emotional experience and expression; avoiding close relationships; always choosing solitary activities; phlegmatic temperament; rarely experiencing strong emotions; avoiding sexual experiences; indifference to praise and criticism; having no close friends or confidants; constricted affect: aloofness, coldness, and little reciprocation of gestures or facial expressions.

Schizotypal Personality Disorder:

Deficits in interpersonal relatedness; peculiarities of ideation, appearance, and behavior; ideas of reference; excessive social anxiety; odd beliefs or magical thinking; unusual perceptual experiences; odd, eccentric behavior or appearance; having no close friends or confidants; odd speech; inappropriate or constricted affect; suspiciousness or paranoid ideation.

CLUSTER B:

Histrionic Personality Disorder:

Excessive emotionality and attention-seeking; dependence upon reassurance, approval, and praise; sexual seductiveness; over concern with physical attractiveness; emotional exaggeration and shallow expression of emotions; self-centeredness; strong drive for immediate gratification of desires; impressionistic speech.

Narcissistic Personality Disorder:

High self-esteem; grandiosity; lack of empathy; an arrogant, haughty attitude; interpersonal exploitation; grandiose sense of self-importance; exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements; conviction of uniqueness, specialness; belief that they can only be understood by, or should associate with, other special or high-status people (or institutions); fantasies of unlimited success, power, brilliance, beauty, or ideal love; sense of entitlement; requiring constant attention and admiration; feelings of envy, believes that others are envious.

Antisocial Personality Disorder:

Irresponsible, antisocial behavior; failure to honor financial obligations; failure to be a responsible parent; failure to plan ahead; inability to sustain consistent work behavior; failure to conform to social norms; antisocial acts that are grounds for arrest, e.g., destroying property, harassing others, stealing, or having an illegal occupation; irritability and aggression; reckless behavior without regard to personal safety; promiscuity; callousness and lack of remorse; inability to tolerate boredom; depression; beliefs that others are hostile to them; incapacity for close, lasting relationships.

Borderline Personality Disorder:

Instability of mood, interpersonal relationships, and self-image; alternation between extremes of over idealization and devaluation in relationships; impulsiveness in spending, sex, substance use, shoplifting, reckless driving, or binge eating; affective instability; inappropriate, intense anger or lack of control of anger; suicidal threats, gestures, or behavior; self-mutilation; identity disturbance; feelings of emptiness or boredom; frantic efforts to avoid abandonment.

CLUSTER C:

Obsessive Compulsive Personality Disorder:

Perfectionism; inflexibility; correctness; self-righteousness; authoritarianism; workaholism; indecisiveness; overconscientiousness; scrupulousness; restricted expression of affection; parsimony; obstinacy; orderliness; hoarding.

Avoidant Personality Disorder:

Social discomfort; fear of negative evaluation; timidity; sensitivity to criticism and disapproval; introversion; social anxiety; fear of

embarrassment; fear of rejection; social isolation; yearning for affection and acceptance.

Dependent Personality Disorder:

Dependent and submissive behavior; excessive dependence upon advice and reassurance; allowing others to make important personal decisions; agreeing with others to avoid being rejected; lack of initiative; doing unpleasant and demeaning tasks for the sake of acceptance; feelings of helplessness when alone; feelings of devastation and helplessness when relationships end; being easily hurt by criticism and disapproval.

4.12 Unit-End Exercises:

1. What are the general DSM criteria for diagnosing personality disorders?
2. Why is Schizotypal personality disorder known as attenuated form of schizophrenia?
3. Explain the two types of Narcissistic personality disorder.
4. How is Avoidant personality disorder different from Schizoid and Social phobias?
5. Explain the antisocial personality disorder and psychopathy.
6. Explain the treatments for Personality disorders.

4.13 Answers to Check Our Progress:

1. PARANOID DISORDER: Although inaccurate and inappropriate, their suspicions are not usually delusional; the ideas are not so bizarre or so firmly held as to clearly remove the individuals from reality. They may experience transient psychotic symptoms.

PARANOID SCHIZOPHRENIA: They experience psychotic symptoms.

2. There is modest genetic liability that may occur through the heritability of high levels of antagonism (low agreeableness) and neuroticism(angry-hostility) which are the primary traits in paranoid personality disorder.

3. Schizotypal personality disorder

4. Histrionic personality disorder may be characterized as involving extreme versions of two common, normal personality traits, extraversion and to a lesser extent, neuroticism- two normal personality traits known to have a partial genetic basis.

5. People with borderline personality disorder display great instability, including major shifts in mood, an unstable self-image, and impulsivity.

6. Genetically and biologically based inhibited temperament may often serve as the diathesis that leads to avoidant personality disorder in some children who experience emotional abuse, rejection, or humiliation from parents who are not particularly affectionate. Such abuse and rejection would be especially likely lead to anxious and fearful attachment patterns in temperamentally inhibited children.

7. Histrionic and dependent personalities have strong needs for reassurance and approval, but histrionic personality is much more gregarious, flamboyant, and actively demanding of attention whereas dependent personality is more docile and self-effacing.

8. It is important to note that people with OCPD do not have true obsessions or compulsive rituals that are the source of extreme anxiety or distress in people with OCD. People with OCPD have lifestyles characterized by over conscientiousness, high neuroticism, inflexibility and perfectionism but without the presence of true obsessions or compulsive rituals.

4.14 Suggested Readings

7. Butcher, J.N. (2014). Abnormal Psychology. New Delhi: Pearson Education.

8. Butcher, J.N., Hooley, J. M., Mineka, S &Dwivedi, C.B. (2017). Abnormal Psychology 16th ed. Noida: Pearson.

   - Sarason, G.I. &Sarason, R.V. (2007). Abnormal Psychology: The Problem of Maladaptive Behaviour (II Edition). Pearson Education, Inc. and Dorling Kindersley Publication Inc.

BLOCK II: PERSONALITY DISORDERS

UNIT V: SEXUAL DYSFUNCTION

Structure

5.1 Introduction
5.2 Objectives
5.3 Sexual Desire Disorders
       5.3.1 Male Hypoactive Sexual Desire Disorder
       5.3.2 Female Sexual Interest/Arousal Disorders
5.4 Sexual Arousal Disorders
       5.4.1 Erectile Disorder
5.5 Orgasmic Disorders
       5.5.1 Premature (Early) Ejaculation
       5.5.2 Delayed Ejaculation Disorder
       5.5.3 Female Orgasmic Disorder
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5.7 Let Us Sum Up
5.8 Unit-End Exercises
5.9 Answer To Check Your Progress
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5.1 Introduction

Sexual behavior and feelings is a crucial part of our development and daily functioning, sexual activity is tied to the satisfaction of our basic needs, and sexual performance is linked to our self-esteem. Most people are fascinated by the abnormal sexual behavior of others and worry about the normality of their own sexuality.

The term **sexual dysfunction** refers to impairment either in the desire for sexual gratification or in the ability to achieve it. **Sexual dysfunctions,** disorders in which people cannot respond normally in key areas of sexual functioning, make it difficult or impossible to enjoy sexual inter- course. The impairment varies markedly in degree, but regardless of which partner is alleged to be dysfunctional, the enjoyment of sex by both parties in a relationship is typically adversely affected. In some cases, sexual dysfunctions are caused primarily by psychological factors. In others, physical factors are most important, including many cases of sexual dysfunctions that are secondary consequences of medications people may be taking for other, unrelated medical conditions. In recent years, both explanations and treatments of sexual dysfunction have become more biological although some psychological treatments have been empirically validated, and psychosocial factors clearly play a causal role as well.

Today researchers and clinicians typically identify four different phases of human sexual response as originally proposed by Masters and Johnson and Kaplan. According to DSM-5, disorders can occur in any of the first three phases:

- The first phase is the **desire phase**, which consists of fantasies about sexual activity or a sense of desire to have sexual activity.
- The second phase is the **excitement or arousal phase**, characterized both by a subjective sense of sexual pleasure and by

physiological changes that accompany this subjective pleasure, including penile erection in the male and vaginal lubrication and clitoral enlargement in the female.

- The third phase is **orgasm**, during which there is a release of sexual tension and a peaking of sexual pleasure.
- The final phase is **resolution** during which the person has a sense of relaxation and well- being.

Check your Progress -1
Note: a.Write your answer in the space given below
b.Compare your answer with those given at the end of the unit
1. What is sexual dysfunction?
2. List the four phases of human sexual response.

5.2 Objectives

On completion of this unit, you will be able to understand:
- Different sexual disorders
- Differentiate between types of sexual disorders
- The various treatment available for sexual disorders

5.3 Sexual Desire Disorders

The desire phase of the sexual response cycle consists of an urge to have sex, sexual fantasies, and sexual attraction to others. Two dysfunctions—hypoactive sexual desire disorder and sexual aversion disorder—affect the desire phase. Sexual desire disorder is a psychiatric condition marked by a lack of desire for sexual activity over a prolonged period. In the DSM-5, Sexual Desire Disorder has been broken down into two separate conditions: Female Sexual Interest/Arousal Disorder and Male Hypoactive Sexual Desire Disorder. Both of these refer to a low level of sexual interest resulting in a failure to initiate or respond to sexual intimacy. This can include an absence of sexual thoughts or fantasies, reduced or absent pleasure during sexual activity, and absent or reduced interest in internal or external erotic cues. Neither of these conditions can be diagnosed if the main problem is a "desire discrepancy" in which one partner desires more sexual activity than the other; rather, the conditions are diagnosed when symptoms have been present for a minimum of six months and cause clinically significant distress for the individual. In the DSM-5, male hypoactive sexual desire disorder is characterized by "persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity", as judged by a clinician with consideration for the patient's age and cultural context. Female sexual interest/arousal disorder is defined as a "lack of, or significantly reduced, sexual interest/arousal", manifesting as at least three of the following symptoms: no or little interest in sexual activity, no or few sexual thoughts, no or few attempts to initiate sexual activity or respond to partner's initiation, no or little sexual pleasure/excitement in most of sexual experiences, no or little sexual interest in internal or external erotic stimuli, and no or few genital/non-genital sensations in most of sexual experiences.

For both diagnoses, symptoms must persist for at least six months, cause clinically significant distress, and not be better explained by another

condition. Simply having lower desire than one's partner is not sufficient for a diagnosis. Self-identification of a lifelong lack of sexual desire as asexuality excludes diagnosis.

5.3.1 Male Hypoactive Sexual Desire Disorder

People with hypoactive sexual desire disorder lack interest in sex and, in turn, display little sexual activity. Nevertheless, when these individuals do have sex, their physical responses may be normal and they may enjoy the experience. While our culture portrays men as wanting all the sex they can get, hypo- active sexual desire may be found in as many as 16 percent of men, and the number seeking therapy has increased during the past decade. Hypoactive sexual desire disorder is diagnosed in men who have for at least 6 months been distressed or impaired due to levels of sexual thoughts, desires, or fantasies. Men given this diagnosis are also assessed for the course and possible causal factors, including problems emanating from partners, relationship, cultural belief, personal vulnerabilities etc. In an American survey it was found that older men were three times more likely to suffer from low desire compared with younger men. Predictors of low desire included daily alcohol use, stress, unmarried status and poorer health. Most experts believe that male hypoactive sexual desire disorder is acquired or situational rather than lifelong. Typical situational risk factors include depression and relationship stress.

Male hypoactive sexual desire disorder is sometimes associated with erectile and/or ejaculatory problems. Men with this disorder may also have difficulty obtaining an erection, which can lead to a reduced interest in sex. Men with hypoactive sexual desire disorder often report that they no longer initiate sexual activity and that they are minimally receptive to a partner's attempt to initiate. Sexual activities, like masturbation, may occur even in the presence of low sexual desire. Although men are more likely to initiate sexual activity, and thus low desire may be characterized by a pattern of non-initiation, many men may prefer to have their partner initiate sexual activity. In such situations, the man's lack of response to a partner's invitation should be considered when evaluating this disorder.

There are five factors that should be taken into consideration during the assessment and diagnosis of male hypoactive sexual desire disorder 1)Partner's sexual history and health status,2)Relationship quality such as ability to effectively communication, differences in sexual activity preference),3)Individual factors such as body image, history of physical or sexual abuse, psychiatric comorbidity, life stressors, 4) Cultural and religious background such as rules and attitudes towards sexual activity and sexuality, 5)Medical background and treatment.

Many men with male hypoactive sexual desire disorder may have low self-esteem or self-confidence, a decreased sense of masculinity, and may experience depressed affect. Their partners commonly report reduced sexual satisfaction and reduced sexual desire. A man's feelings about himself, his perception of his partner's desire, and a couple's connectivity can all negatively impact sexual desire. Thus, this disorder can interfere with fertility and produce both individual and interpersonal distress.

Age is a significant risk factor for low desire in men. Mood and anxiety disorders, such as major depressive disorder, are a common comorbidity with this population. Endocrine disorders such as can reduce sexual desire in men. Low testosterone levels may also play a role in sexual desire. Male hypoactive sexual desire disorder can also result from unresolved sexual

identity issues stemming from gender identity, sexual orientation, lack of adequate sex education and trauma from early life experiences.

TREATMENT

Hypoactive sexual desire and sexual aversion are among the most difficult dysfunctions to treat because of the many issues that may feed into them. Thus therapists typically apply a combination of techniques. In a technique called *affectual awareness,* patients visualize sexual scenes in order to discover any feelings of anxiety, vulnerability, and other negative emotions they may have concerning sex. In another technique, patients receive cognitive *self-instruction training* to help them change their negative reactions to sex. That is, they learn to replace negative statements during sex with "coping statements," such as "I can allow myself to enjoy sex; it doesn't mean I'll lose control."

Therapists may also use behavioral approaches to help heighten a patient's sex drive. They may instruct clients to keep a "desire diary" in which they record sexual thoughts and feelings, to read books and view films with erotic content, and to fantasize about sex. Pleasurable shared activities such as dancing and walking together are also encouraged. The treatment literature on low sexual desire in men is less. In men whose testosterone levels are markedly low(includinghypogonadal men whose testes make insufficient testosterone and men with HIV that diminishes their testosterone production) testosterone injections have helped. Pharmacotherapy and Androgen replacement also helps. Cognitive-behavioral therapy focuses on dysfunctional thoughts, unrealistic expectations, partner behavior that decreases desire for intercourse, and insufficient physical stimulation. These sessions can include both partners. Homework assignments and specific exercises are often used. Psychodynamic sex therapy, addresses underlying developmental and identity issues that impact sexual desire.

5.3.2 Female Sexual Interest/Arousal Disorders

Sexual interest refers to the motivation to engage in sexual activity. Interest is commonly referred to as "desire," "sex drive," and "sexual appetite," and describes the sexual feelings motivating a person to seek some type of sexual activity, whether partnered or alone. Sexual arousal is conceptualized as the second phase of the sexual response cycle and defined by both physical and mental readiness for sexual activity. Physiological changes occur in the body to prepare for a sexual interaction

Female Sexual Interest/Arousal Disorder (FSIAD) is defined in the DSM-5 as lack of, or significantly reduced, sexual interest/arousal. A woman must have three of the following six symptoms in order to receive the diagnosis: absent or reduced interest in sexual activity; absent or reduced sexual thoughts or fantasies; no or reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate; absent or reduced sexual excitement or pleasure in almost all or all sexual encounters; absent or reduced sexual interest/arousal in response to any internal or external sexual cues; and absent or reduced genital or non-genital sensations during sexual activity in all or almost all sexual encounters. These symptoms must cause clinically significant distress and have persisted for a minimum of six months. The disorder is specified by severity level and sub typed into lifelong versus acquired, generalized versus situational.

In past editions of the DSM, sexual interest and sexual arousal have been considered to be separate, though related, constructs. Most recently, the DSM-IV-TR had separate diagnoses of hypoactive sexual desire disorder (HSDD) and female sexual arousal disorder (FSAD). HSDD was characterized by the absence of sexual fantasies, lack of desire for sexual activity, and FSAD was characterized by continuous or recurrent inability to retain, or maintain, sufficient lubrication or swelling. The DSM-5 Sexual Dysfunction sub-work group cited evidence that desire and arousal could not be reliably distinguished in women. Other experts in the field disagree with this conceptualization, and the categorization of desire and arousal disorders into one diagnostic category has led to substantial controversy in the field.

As FSIAD is new to the DSM, prevalence studies have not yet been published. However, previous work has examined the prevalence of low sexual interest (HSDD) and low sexual arousal (FSAD) in women. One of the most frequently cited prevalence studies found low sexual interest in 22% of women in the general U.S. population In a survey of women from 29 countries, the rates of self-reported low sexual interest ranged from 26 to 43%. For a clinical diagnosis takes levels of distress, depending on a woman's age, cultural background, and reproductive status.

Prevalence studies of sexual arousal problems in women have focused primarily on self-reported lack of vaginal lubrication. Lubrication problems have been found to increase with age and menopausal status.

An interesting change from DSM IV TR to DSM-5 is the elimination of sexual aversion disorder. People with sexual aversion disorder find sex distinctly unpleasant or repulsive. Sexual advances may sicken, disgust, or frighten them. Some people are repelled by a particular aspect of sex, such as penetration of the vagina; others experience a general aversion to all sexual stimuli, including kissing or touching. 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 biological, psychological, and sociocultural factors, and any of them may reduce sexual desire. Most cases of low sexual desire or sexual aversion are caused primarily by sociocultural and psychological factors, but biological conditions can also lower sex drive significantly.

Biological causes-Endocrine levels are the most commonly discussed biological factor that may be related to low sexual interest in women. Lack of sexual desire has been associated with menopause, during which decreased ovarian function results in lower estrogen production. Researchers have concluded that sex hormones, specifically androgens, estrogens, and progestin, affect female sexual interest and function, but there is still some uncertainty as to which hormones are most important. Evidence for the relationship between testosterone and women's sexual desire indicates that the hormone is correlated with solitary desire. Oral contraceptives involve a combination of estrogens and progesterone, and produce substantial increases in sex hormone-binding globulin, which can lower testosterone levels. It is possible that this decrease in testosterone could contribute to the low sexual desire reported by some women taking oral contraceptives. It is well known that many psychoactive medications affect sexual desire. There are both intra-class and inter-class variations among antidepressants with respect to sexual dysfunction and particularly

sexual desire. These variations are largely dependent on neurotransmitter receptor profiles and genetics . Selective serotonin reuptake inhibitors (SSRIs), used most commonly for treating depression and anxiety, increase serotonin levels and produce a variety of sexual side effects in both men and women including decreased desire.

Psychological Factors-Low sexual interest and/or arousal has also been linked with a number of psychosocial factors in both men and women. Research found that relationship duration significantly predicted variance in sexual desire. Specifically, women's sexual desire decreased as relationship duration increased. Similarly, in married women, feelings of overfamiliarity and institutionalization of the relationship led to decreased desire. Daily hassles such as worrying about children and paying the bills, and high-stress jobs are offenders for suppressing sexual desire, as are a multitude of relationship or partner-related issues. In regard to the latter, couples reporting sexual difficulties have been characterized by sex therapists as having less overall satisfaction within their relationships, an increased number of disagreements, more communication and conflict resolution problems, and more sexual communication problems including discomfort discussing sexual activities compared to couples without sexual problems. Warmth, caring, and affection within the relationship are undoubtedly linked to feelings of sexual desire. Beliefs and attitudes about sexuality acquired over the course of sexual development can influence sexual desire and sexual response across the lifespan. Women who internalize passive gender roles or negative attitudes toward sexuality may be at greater risk of experiencing sexual problems.

Societal factors may also contribute to low sexual interest and arousal. Sexual norms differ greatly by region and by culture. Women who are socialized to believe that being interested in sex is shameful often experience guilt and shame during sex, which in turn have been associated with both low levels of sexual desire and low levels of arousal.

Psychological conditions most commonly associated with a lack of sexual interest include social phobia, obsessive-compulsive disorder, panic disorder, and mood disorders—depression in particular. It is feasible that sexuality becomes of secondary importance when an individual is experiencing substantial distress in other areas of his or her life. With regard to depression, it is feasible that rumination about negative events, a common cognitive aspect of depression, may contribute to the decrease in desire noted in depressed persons by causing an exclusive focus on aspects of sexuality that are unpleasant. It is well known that people with depression are prone to interpret negative events as caused by stable, global causes, and this cognitive style could certainly negatively affect one's perception of sexuality.

A history of unwanted sexual experiences can also negatively affect sexual desire. Many, but not all, women with a history of childhood sexual abuse fear sexual intimacy, are likely to avoid sexual interactions with a partner, and are less receptive to sexual approaches from their partners. Sexual self-schemas, cognitive generalizations about sexual aspects of the self that guide sexual behavior and influence the processing of sexually relevant information, have been shown to differ between women with and without a history of childhood sexual abuse). A high proportion of women with a history of childhood sexual abuse engage in risky sexual behaviors such as engaging in sex with strangers while intoxicated It is unknown whether this

behavior is a reflection of high levels of sexual desire, an inability to maintain or enforce physical boundaries, a compulsive act, emotional avoidance, or some combination of these reasons. Other studies have found that prior sexual abuse is associated with low sexual interest.

TREATMENT

Treatment for FSIAD focuses on identifying any underlying causes and treating them. Many women find that a combination of treatments seems to work best. Depending on the underlying cause, treatments often include medication, therapy, or a combination of both.

Some medication-related treatments include:

- Hormone therapy. If the underlying cause is hormonal, hormone therapy may help treat low estrogen or testosterone, vaginal dryness, or pain during intercourse.
- Changing medication dosage. If a medication, such as an antidepressant, is causing the symptoms, adjusting the dosage may help.

Psychological treatments for low desire include education about factors that affect sexual desire, couples exercises (e.g., scheduling times for physical and emotional intimacy), communication training (e.g., opening up about sexual issues and needs), cognitive restructuring of dysfunctional beliefs (e.g., a good sexual experience does not always end with an orgasm), sexual fantasy training (e.g., training people to develop and explore mental imagery), and sensate focus. Sensate focus, introduced by Masters and Johnson in the 1970s, is a behavioral technique in which couples learn to focus on the pleasurable sensations that are brought about by touching, while decreasing attention on goal-directed sex (e.g., orgasm). Recent research has also indicated that mindfulness-based approaches, which cultivate active awareness of the body and its sensations in a nonjudgmental and compassionate way, may be helpful for women with FSIAD By focusing on the physical sensations of sexual activity instead of being preoccupied with sexual performance, or current level of desire or arousal, couples can learn to be present and respond to their partner during the sexual situation. In the beginning stages of sensate focus couples are encouraged to touch each other's bodies and feel for sexual sensations but refrain from touching breasts or genitals, or engaging in intercourse. The exercises aim to build an organic desire for full intercourse. Over time the couples are encouraged to touch more and more areas and then finally to have intercourse. For women in satisfying relationships, treatment may include identifying potential distracting, negative thoughts and helping them let go of these thoughts during sexual activity.

5.4 Sexual Arousal Disorders

The excitement phase of the sexual response cycle is marked by changes in the pelvic region, general physical arousal, and increases in heart rate, muscle tension, blood pressure, and rate of breathing. In men, blood pools in the pelvis and leads to erection of the penis; in women, this phase produces swelling of the clitoris and labia, as well as lubrication of the vagina. Dysfunctions affecting the excitement phase according to DSM-IV-TR are female sexual arousal disorder (once referred to as "frigidity") and male erectile disorder (once called "impotence"). The DSM-5, published in May of 2013, seeks to incorporate some of the aforementioned findings. Changes were made in the sexual dysfunctions chapter in an attempt to

correct, expand and clarify the different diagnoses and their respective criteria. Although many of the changes are subtle, some are noteworthy: gender-specific sexual dysfunctions were added, and female disorders of desire and arousal were amalgamated into a single diagnosis called "female sexual interest/arousal disorder". Female hypoactive desire dysfunction and female arousal dysfunction were merged into a single syndrome called sexual interest/arousal disorder.

5.4.1 Erectile Disorder

Erectile dysfunction is defined as persistent difficulty achieving and maintaining an erection sufficient to have sex It was initially known as impotence, occurs when a man can't get or keep an erection firm enough for sexual intercourse. **Erectile disorder (ED)** is defined in the DSM-5 as the recurrent inability to achieve an erection, the inability to maintain an adequate erection, and/or a noticeable decrease in erectile rigidity during partnered sexual activity. In order to meet the diagnostic criteria, these symptoms must have persisted for at least six months and must have occurred on at least 75% of occasions. The disorder can be specified by severity and subtyped as either generalized or situational.

Men of all ages occasionally have difficulty obtaining or maintaining an erection, but true erectile disorder is more common after age 50. There are a number of factors beyond age that are associated with the prevalence of ED. Married men are less likely to report erectile problems compared to never married or divorced men. Men with cardiovascular disease, diabetes, and metabolic syndrome are more likely to have ED than men without these diseases. Health factors such as smoking, obesity, and lack of exercise have been linked to higher prevalence of ED. It can be devastating to the self-esteem of a man and of his partner

Erectile dysfunction in older men. Because erections primarily involve the blood vessels, it is not surprising that the most common causes in older men are conditions that block blood flow to the penis, such as atherosclerosis or diabetes. Another vascular cause may be a faulty vein, which lets blood drain too quickly from the penis. Other physical disorders, as well as hormonal imbalances and certain operations, may also result in erectile dysfunction. The vesicular processes that produce an erection are controlled by the nervous system and certain prescription medications may have the side effect of interfering with necessary nerve signals. Among the possible culprits are a variety of stimulants, sedatives, diuretics, antihistamines, and drugs to treat high blood pressure, cancer, or depression. But never stop a medication unless your doctor tells you to. In addition, alcohol, tobacco, and illegal drugs, such as marijuana, may contribute to the dysfunction

Erectile dysfunction in younger men. With younger men, psychological problems are the likeliest reason for erectile dysfunction. Tension and anxiety may arise from poor communication with the sexual partner or a difference in sexual preferences. The sexual difficulties may also be linked to these factors: Depression, Fatigue, Stress, Feelings of inadequacy, Personal sexual fears, Rejection by parents or peers, Sexual abuse in childhood etc.

Factors Associated With Erection and Erectile Dysfunction

There has been a great deal of research on erectile dysfunction, identifying a number of key biological and psychological causes. Biological factors are

related to changes in blood flow to the penis, and psychological factors involve anxiety and negative expectations for performance.

Biological Factors

Erection is caused by increased blood pressure in the corpora cavernosa via increased blood inflow and decreased blood outflow. A large body of evidence indicates that the likelihood of ED increases with different types of vascular disease, such as hyperlipidemia, coronary heart disease, and diabetes. The link between vascular problems and ED is so strong that ED is considered an early warning sign of vascular disease, especially in men under the age of 40 .Some researchers are in favor of viewing ED as a vascular disorder.

Surgery, diabetes, alcoholism, infectious diseases such as HIV and other viral infections, and pelvic pathologies such as systemic lupus are all potential causes of ED. Drugs that decrease dopamine or reduce testosterone production are also implicated in ED. These include antihypertensive medications, antipsychotic drugs, anxiolytics, antiandrogens, anti-cholesterol agents, and drugs used to regulate heart rate. Antiparkinsonian medications increase dopamine and facilitate erection.

Psychological Factors

With respect to the different psychological factors that play a role in male sexual function, Perelman proposed the sexual tipping point model, defined as any one individual's characteristic threshold for the expression of a sexual response. Perelman suggested that one's sexual tipping point is determined by a variety of multidimensional factors that fall into two general categories, physiological or organic issues and psychosocial, cultural, and behavioral issues. For men, psychosocial issues may include performance anxiety, strong religious backgrounds that lead to guilt or strong avoidance behaviors, and a history of sexual trauma The major psychological contributors to ED as identified by feedback model of sexual dysfunction are anxiety, negative expectations, and spectating. Men who are anxious about not being able to have an erection tend to focus on themselves and how they are performing more than on what gives them pleasure. This spectating increases anxiety, which, physiologically, inhibits the relaxation of the smooth muscles necessary for erection and, psychologically, leads to a negative mood state and a focus on negative expectancies. Since the result is impaired erectile responding, the man's fears of not being able to perform are confirmed, and they are likely to repeat the process in subsequent sexual situations. Performance anxiety is inherent in most cases of ED. As a man's penis is visible to both the man and his partner, the occurrence—or absence—of an erection is a known event, which increases focus on performance. Men experiencing performance anxiety will not only worry about erections during sexual activity, but they also engage in visual or tactile checking of the penis.

By contrast, men with normal erectile response approach sexual situations with positive expectancies and a focus on erotic cues. Consequently, they become aroused and are able to obtain and sustain an erection, which creates a positive feedback loop for future sexual encounters. Although spectating can be detrimental for men of any age, it appears to be particularly problematic in young men when they are first becoming sexually active. In the absence of sexual experience and a variety of sexual

events in which to view evidence of their ability to attain an erection, these young men are particularly vulnerable to the influence of negative expectations about erectile performance.

Other psychosocial factors can contribute to the development and maintenance of ED. en are likely to meet for ED if they (1) endorse myths about male sexuality (e.g. "men always want to have sex"), (2) view themselves as incompetent, and (3) view their sexual problem as internal and stable over time. Mental health conditions, such as depression, generalized anxiety disorder, obsessive-compulsive disorder, and paraphilic disorders, have been linked to ED. In a survey of college-aged men, Researchers found a high incidence of off-label Viagra use that was correlated with erectile dysfunction. They suggested that recreational Viagra use could lead to subsequent cause erectile problems by making users psychologically dependent on the drug for performance.

TREATMENT

Biomedical treatments for ED include vacuum devices and constriction rings, intracavernosal injections, intraurethral pharmacotherapy, topical pharmacotherapy, oral pharmacotherapy, and penile implants. Vacuum constriction devices, vasoactive gels, and intracavernosal injections are also recommended by clinicians. Vacuum devices typically consist of a tube that is placed over the penis, and a vacuum pump that draws blood into the penile arteries. A constriction ring is placed at the base of the penis to prevent blood outflow so that the erection is maintained until completion of the sexual act. Vasoactive gels can be produced in different dosage levels and with different mixtures of vasodilators. Penile implants are generally considered a last resort treatment technique when tissue damage or deterioration is severe or when all other treatments have failed. This may be the case in men with severe diabetes mellitus or who have had radical prostatectomy. Researchers are investigating the application of gene therapy principles to the treatment of ED

It has been proposed that more comprehensive instruction at the beginning of pharmacological treatment as well as re-education throughout the course of treatment might improve the rates of medication compliance.

Psychosocial treatments for ED include sensate focus, increasing the level of erotic stimulation during sexual activity, sex education, and interpersonal therapy. Sensate focus is considered to be the cornerstone of sex therapy. Developed by Masters and Johnson, sensate focus centers on heightening awareness of the sensations associated with sexual activity rather than on the performance of the sexual act. In certain cases of ED, the patient may not experiencing sufficient erotic stimulation to achieve an erection. This may be due to the environment or to a lack of variety or skill on the part of the male and/or his partner. Couples in long-standing relationships may have a routine, predictable approach to sexual activity and thus may be more vulnerable to erectile problems as well as decreased sexual interest. Sex education involves therapist guidance on the different aspects of sexual intercourse, and interpersonal therapy focuses on the relationship problems that may be driving psychogenic erectile dysfunction.

Lifestyle modifications can significantly improve erectile function. Studies have shown that targeting factors associated with erectile problems, such as smoking, obesity, alcohol consumption, and physical activity reduces the rate of sexual dysfunction.

5.5 Orgasmic Disorders

During the orgasm phase of the sexual response cycle, an individual's sexual pleasure peaks and sexual tension is released as the muscles in the pelvic region contract, or draw together, rhythmically. The man's semen is ejaculated, and the outer third of the woman's vaginal wall contracts. Dysfunctions of this phase of the sexual response cycle are rapid, or premature, ejaculation; male orgasmic disorder; and female orgasmic disorder (according to DSM-IV).In DSM 5 Male orgasmic disorder was changed to delayed ejaculation, however premature ejaculation and female orgasmic disorder remains unchanged. Orgasmic dysfunction is the medical term for difficulty reaching an orgasm despite sexual arousal and stimulation.

Orgasms are the intensely pleasurable feelings of release and involuntary pelvic floor contractions that occur at the height of sexual arousal. Orgasmic dysfunction is also known as anorgasmia.

There are several different types of orgasmic dysfunction, including:

- Primary orgasmic dysfunction, when a person has never had an orgasm.
- Secondary orgasmic dysfunction, when a person has had an orgasm but then has difficulty experiencing one.
- General orgasmic dysfunction, when a person cannot reach orgasm in any situation despite adequate arousal and stimulation.
- Situational orgasmic dysfunction, when a person cannot orgasm in certain situations or with certain kinds of stimulation. This type of orgasmic dysfunction is the most common.

Orgasmic dysfunction can affect both males and females but is more common in females.

5.5.1 Premature (Early) Ejaculation

Premature ejaculation is when ejaculation happens sooner than a man or his partner would like during sex. Occasional premature ejaculation is also known as rapid ejaculation, premature climax or early ejaculation. It can be frustrating if it makes sex less enjoyable and impacts relationships. Premature (early) ejaculation is defined in DSM-5 as a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within about one minute following vaginal penetration and before the individual wishes it. Although the diagnosis may be applied to individuals who engage in non-vaginal sexual intercourse, specific duration criteria for such activities have not been established. In order to meet the diagnostic criteria, the problem must have persisted for at least six months, must be experienced on almost all or approximately all occasions of sexual activity, and must cause significant distress. The disorder may be specified by severity and can be categorized as lifelong, acquired, generalized, and situational.

In recent years, there has been considerable disagreement about the definition, nature, and even the name of the disorder. The DSM-5 sexual dysfunction sub-workgroup changed the name of the disorder from

"premature ejaculation" to "premature (early) ejaculation," due to criticism of the existing name, which some saw as pejorative. The diagnostic criteria of the disorder have also been critiqued, as researchers have argued that the time to ejaculation after penetration criterion oversimplifies and may limit scientific understanding of the condition. Varying prevalence rates of the disorder have been reported, likely due to the lack of a universally accepted set of diagnostic criteria. It is important to note that there are currently no published epidemiological studies that assess the prevalence of premature (early) ejaculation as defined in DSM-5. However, many studies have assessed the prevalence of premature ejaculation concerns. Masters and Johnson (1970) identified premature (early) ejaculation as one of the most common male sexual dysfunctions.Unlike ED, this condition has been estimated to affect younger men more than older men.High rates of comorbidity are reported for premature (early) ejaculation and ED, with about one third of men who suffer from premature (early) ejaculation also experiencing ED.

Factors Associated With Premature (Early) Ejaculation
A number of factors have been shown to play an important role in both normal and premature ejaculation. Historically, premature ejaculation has been considered to be a psychological problem. But recent research has implicated different biological systems in the development and maintenance of the disorder, indicating that it may be important to focus on the physiological underpinnings of the ejaculatory process.

Biological Factors
During the first stage of ejaculation (sperm emission), sperm moves from the epididymis into the vas deferens. This process is controlled by the contraction of smooth muscles, which is generated by the sympathetic branch of the autonomic nervous system. After sperm emission, the individual has the subjective experience that ejaculation is "inevitable," known as the "point of inevitable ejaculation" or, more commonly, "the point of no return!" The striated muscles surrounding the spongiosum tissue, the cavernous tissue, and in the pelvic floor contract rhythmically, causing ejaculation to occur. Usually, the subjective experiences of orgasm is associated with the contractions of the striate muscles and, in most men, emission, ejaculation, and orgasm are interconnected. For a small portion of men, however, these phenomena are independent. For example, some men train themselves to have the subjective experience of orgasm without ejaculation and some men with premature (early) ejaculation experience emission without ejaculation.

The precise cause of premature (early) ejaculation is not known, but the most promising biological etiologies include malfunction of the serotonin receptors, genetic predisposition, and disruptions of the endocrine system. It is possible that men who report symptoms of the disorder may have disturbances in central serotonergic neurotransmission, which could result in a lower threshold for sexual stimulation. Genetic predispositions may also play a role in the development of PE. In first-degree male relatives of Dutch men with lifelong PE, researchers found a high prevalence of PE suggested a genetic study. Recent research has confirmed the role of the endocrine system in the control of the ejaculatory reflex. Research also found that 50% of men with hyperthyroidism also had PE. Indeed, the

hormone thyrotropin, in addition to testosterone and prolactin, has been shown to play an independent role in the control of ejaculatory function

Psychological Factors

Anxiety has been hypothesized to be one of the primary causes and maintaining factors for PE. Althof explained that there are three different mental phenomena related to PE that are characterized by the term "anxiety." First, anxiety may reference a phobic response, such fear of the vaginal canal. Anxiety may also refer to an affectiveresponse, such as anger towards one's partner. Finally, anxiety may indicate performance concerns, such that a preoccupation with poor sexual performance leads to decreased sexual function and increased avoidance of sexual situations. Anxiety may have a reciprocal relationship with premature (early) ejaculation; specifically, performance anxiety may lead to problems with early ejaculation, and then those problems could increase performance anxiety. However, laboratory studies have generally not shown significant differences in levels of anxiety reported by men with and without PE.

One psychological variable that has been shown to distinguish men with PE from men without PE is perceived control over ejaculation. In an observational study of men with and without PE Researchers determined that subject-reported control over ejaculation and personal distress most strongly predicted a PE diagnosis. A greater understanding of the meaning men attribute to ejaculatory control may provide important insight into the psychological factors involved in this disorder.

Early learned experiences and lack of sensory awareness may also be important psychological factors that lead to PE. Masters and Johnson examined case histories of men with PE and found that many of these men had early sexual experiences during which they felt nervous and rushed. According to Masters and Johnson, these men learned to associate sex and sexual performance with speed and discomfort. Kaplan considered lack of sensory awareness to be the immediate cause of premature ejaculation. She believed that men with PE fail to develop sufficient awareness of their own level of arousal.

TREATMENT

The most commonly used psychotherapy for increasing ejaculatory latency is an integration of psychodynamic, behavioral, and cognitive approaches in a short-term model the focus of psychotherapy for men with PE is to learn to control ejaculation while understanding the meaning of the symptom and the context in which the symptom occurs. Psychodynamically-oriented therapists consider PE to be a metaphor for conflict in the relationship, while behavior-oriented therapists view the disorder as a conditioned response to certain interpersonal or environmental contexts .Common behavioral techniques for increasing ejaculatory latency are the squeeze technique developed by Masters and Johnson (1970) and the pause technique (Kaplan, 1989). The squeeze technique consists of engaging in sexual stimulation alone or with a partner for as long as possible before ejaculation. Before reaching the "point of inevitable ejaculation" the man is instructed to stop the activity and apply tactile pressure to the penile glans to decrease the urge to ejaculate but not to the point that he completely loses his erection. When the urge has subsided, the man resumes masturbation or intercourse stopping as many times as needed to delay ejaculation. The pause technique is similar to the squeeze technique with the exception that no pressure is applied to the

penis. At times, clinicians may suggest using a PDE5 inhibitor (e.g., Viagra) along with these techniques so that the man can practice delaying ejaculation without worrying about maintaining an erection. Recent treatments combine these techniques and experimentation with new sexual positions that may reduce the propensity towards premature ejaculation. In one of the few well-controlled premature (early) ejaculation treatment studies, there was significant increase in ejaculation latency time among men treated with the squeeze technique compared to men in a wait-list control condition

Medical treatments include the use of topical anesthetics, such as prilocaine/lidocaine, to diminish sensitivity used in combination with condoms (to prevent to the partner's genitals from being anesthetized). In men with lifelong PE, treatment with pharmacological antidepressants have been shown to increase the ejaculation latency and increase sexual pleasure and satisfaction. Selective serotonin reuptake inhibitors, such as sertraline, fluoxetine, and paroxetine, have most often been used to treat PE because of their known side effects of delaying or inhibiting orgasm. These medications can be taken either daily or on demand 4 to 6 hours before sexual activity. Clinicians who treat men with PE have come to view the disorder as a "couple's problem" and recommend including the partner in treatment as much as possible to enhance both treatment compliance and treatment efficacy .In clinical trials, dapoxetine taken before sexual activity was shown to significantly increase ejaculation latency compared to a pill placebo

5.5.2 Delayed Ejaculation Disorder

Delayed ejaculation (DE) is defined in DSM-5 as a persistent difficulty or inability to achieve orgasm despite the presence of adequate desire, arousal, and stimulation. In order to be diagnosed with the disorder, patients must present with one of two symptoms: either a delay or an infrequency of ejaculation on 75-100% of occasions for at least six months. The disorder can be specified as lifelong or acquired as well as generalized or situational. Most commonly, the term refers to a condition in which a man is unable to orgasm with his partner, even though he is able to achieve and maintain an erection. Typically, men who present with DE are able to ejaculate during masturbation or sleep.Researchers and clinicians alike agree that DE is not only the least common of the male sexual dysfunctions but also the least understood. A key concern that is often associated with DE but missed by clinicians is that partnered sexual activity may not be as exciting as masturbation. Techniques used during masturbation, such as rubbing the penis against different objects or rolling the penis between one's hands, may create an intense sense of friction, which is otherwise elusive during sexual activity with a partner. In addition, masturbation may have a strong fantasy component, which again may be challenging to maintain when engaging in sexual intercourse with a partner.

It is important to note that men who are experiencing retrograde ejaculation do not meet the diagnostic criteria for DE. Retrograde ejaculation occurs when the ejaculatory fluid travels backward into the bladder rather than forward through the urethra. This may result from complications after prostate surgery or as a side effect of certain medications, particularly anticholinergic drugs.

A "delay" in ejaculation suggests that there are normative amounts of time in which ejaculation typically occurs. Only one study has addressed this

question. Prevalence rates of DE in the literature are low. Researchers have suggested that the rate of DE will rise due to age-related ejaculatory decline as well as widespread use of SSRIs, which have been implicated in increased ejaculation latency.

Factors Associated With Delayed Ejaculation

A number of biological and psychological factors have been shown to play an important role in delayed ejaculation. Biological factors include damage to the nerve pathways that facilitate ejaculation, chronic medical conditions, and potentially age. The various psychological etiologies of the disorder span from insufficient stimulation to assorted manifestations of "psychic conflict."

Biological Factors

During ejaculation, the efferent nerves that cause the release of semen and the closure of the bladder neck are sympathetic fibers which travel through the sympathetic ganglia and the peripheral pelvic nerves. Damage to any of these pathways may compromise ejaculation. Spinal cord injury is most likely to cause nerve damage that result in DE.

Chronic medical conditions, such as multiple sclerosis and diabetes, are correlated with DE Short-term, reversible medical conditions, including prostate infection, urinary tract infection, and substance abuse may also lead to symptoms of DE. Many psychopharmacological agents, including antipsychotics and antidepressants, may also lead to ejaculatory delay.

According to researchers, there is conflicting evidence regarding the effect of age on ejaculatory function. As DE is more common in older males the disorder may be related to low penile sensitivity, which is associated with aging. However, low penile sensitivity usually is not the primary cause of DE .Rather, individual variability in the sensitivity of the ejaculatory reflex, which is exacerbated with age, may be driving the relationship between age and DE.

Psychological Factors

Recently, researchers reviewed the four leading psychological theories of DE. The first theory focuses on insufficient mental or physical stimulation. Men with DE may have a diminished ability to experience penile sensations, as they have been shown to experience less sexual arousal than men without the disorder. A lack of proper ambiance for sexual activity may also contribute to insufficient mental stimulation.

The second theory that Althof mentions posits that DE is caused by a high frequency of masturbation or by a unique, idiosyncratic masturbatory style that differs greatly from the physical stimulation that occurs during vaginal penetration. Men with DE may experience a large disparity between the sensations that they experience when masturbating to a specific fantasy and the sensations that they experience during partnered sexual activity.

The third theory reviewed centers on "psychic conflict" as the root cause of DE. This theory was more common in the early stages of psychological treatment for DE, but some psychodynamically-oriented therapists still conceptualize the disorder in terms of psychic conflict. Examples of psychic conflict include fear of loss of self due to loss of semen; fear that ejaculation may hurt the partner, fear of impregnating the partner, and guilt from strict religious upbringing.

The final theory suggests that delayed ejaculation may be masking the presence of a desire disorder. In this case, the male may be overly

concerned with pleasing his partner, and, even when he is not aroused, may seek to ejaculate

TREATMENT

There has been limited success in the development and testing of pharmacological agents aimed at treating DE. Drugs that have been shown to be somewhat effective may only indirectly affect ejaculatory latency by altering other components of the sexual response cycle or by countering the effects of the drugs that led to the ejaculatory problem in the first place.

If the disorder is determined to be primarily psychological in origin, there are a number of psychosocial interventions that have been shown to effectively reduce ejaculation latency. Most sex therapists who treat DE rely on masturbatory retraining as a way to induce higher levels of arousal and help men rehearse for partnered sexual activity. This intervention may be particularly helpful for men who have grown accustomed to masturbating in idiosyncratic ways, such as with specific objects or under certain conditions. Masturbatory retraining typically entails introducing the patient to an alternative style of masturbation that mimics the sensations of partnered sexual activity. Masturbation exercises that progress from neutral to pleasurable sensations remove the "demand aspects" of performance. If the disorder is derived from insufficient stimulation, therapists typically recommend vibrator stimulation, enhanced mental stimulation, and vigorous pelvic thrusting. For those who are experiencing DE due to heightened concern for the sexual pleasure of their partners, therapists encourage less focus on pleasing the partner and more attention to the self and the sensations experienced during sexual activity.

5.5.3 Female Orgasmic Disorder

The DSM-5 defines female orgasmic disorder (FOD) as reduced intensity, delay, infrequency, and/or absence of orgasm. These symptoms must persist for at least six months, and they may not be related to other physical or relational problems. The presence of distress related to these symptoms is necessary for a diagnosis of FOD. The DSM-5 classification of FOD distinguishes between lifelong and acquired subtypes as well as between generalized and situational subtypes. Although not stated in the DSM-5, the clinical consensus is that a woman who can obtain orgasm during intercourse with manual stimulation but not intercourse alone would not meet criteria for clinical diagnosis unless she is distressed by the low frequency of her sexual response.

Operationalizing FOD is complicated by the fact that the field still lacks a clear consensus on the definition of the female orgasm. The following definition of female orgasm was derived by the committee on female orgasm, presented at the International Consultation on Urological Diseases in Official Relationship with the World Health Organization (WHO), Paris, 2003:

An orgasm in the human female is a variable, transient peak sensation of intense pleasure, creating an altered state of consciousness, usually accompanied by involuntary, rhythmic contractions of the pelvic, striated circumvaginal musculature often with concomitant uterine and anal contractions and myotonia that resolves the sexually-induced vasocongestion (sometimes only partially), usually with an induction of well-being and contentment

Orgasms are caused by erotic stimulation of both genital and nongenital zones of women's bodies. These areas include the clitoris, vagina, other

areas of the vulva, and the breasts and nipples. Orgasm may also be caused by fantasy, mental imagery, and hypnosis. Orgasms can occur during sleep, precluding the necessity of consciousness for an orgasm to occur. Orgasms are not generally reported to occur spontaneously without at least some amount of physical or psychological sexual stimulation; however, some psychotropic drugs have been reported to induce spontaneous orgasms in women.

Women who are having difficulties with orgasm do not typically present with the same degree of distress that has been reported in men with ED. This may be because women, unlike men, are able to "fake" orgasm, thus rendering the performance anxiety seen in men unlikely.Young women (18 to 24 years) show lower rates of orgasm than older women for both orgasm with a partner and orgasm during masturbation This is likely due to age differences in sexual experience. It is important to note that differences in research methodology and diagnostic criteria make it difficult to accurately determine prevalence rates for FOD.

Factors Associated with Women's Orgasm and FOD

The female orgasm results from a complex interaction of biological, psychological, and cultural processes. Disruptions in any of these systems can affect a woman's ability to orgasm. The most common causes of the disorder include disturbances in the sympathetic nervous system, different types of chronic illness, particularly spinal cord injury, sexual guilt, anxiety, and relationship concerns.

Biological Factors

Impairments in nervous system, endocrine, or brain mechanisms involved in female orgasm may cause orgasmic dysfunction in some women. Disease, injury, and disruptions of the sympathetic or parasympathetic nervous systems in women have been identified as potential causes of orgasmic difficulties in women. Medical conditions that affect women's orgasmic ability include damage to the sacral/pelvic nerves, multiple sclerosis, Parkinson's disease, epilepsy, hysterectomy complications, vulvodynia, hypothalamus-pituitary disorders, kidney disease, fibromyalgia, and sickle-cell anemia. Women with spinal cord injuries in the sacral region (interfering with the sacral reflex arc of the spinal cord) have shown difficulty attaining orgasm . This is believed to be caused by interference with the vagus nerve, which has been shown to connect the cervix to the brain

Both vascular and nervous system problems have also been association with orgasm difficulties. Vascular diseases, such as diabetes mellitus and atherosclerosis, have been linked to orgasmic dysfunction. With respect to the nervous system, studies examining blood plasma levels of neuromodulators before, during, and after orgasm suggest that epinephrine and norepinephrine levels peak during orgasm in normally functioning women. With respect to the endocrine system, oxytocin levels are positively correlated with subjective intensity of orgasm among orgasmic women, and prolactin levels are elevated for up to 60 minutes following orgasm. Studies in humans suggest that the paraventricular nucleus of the hypothalamus, an area of the brain that produces oxytocin, is involved in the orgasmic response Impairments in any of these systems could feasibly lead to FOD.

A number of psychotherapeutic drugs have been noted to affect the ability of women to attain orgasm. Drugs that increase serotonergic activity (e.g.,

antidepressants, such as paroxetine, fluoxetine, and sertraline) or decrease dopaminergic activity (e.g., antipsychotics) have been shown to affect orgasmic capacity. Indeed about one third of women who take SSRIs report problems with orgasm . These drugs can lead to delayed orgasm or a complete inability to reach orgasm. There is variability, however, in that some antidepressants have been associated with impaired orgasm more often than others. This seems to be related to which specific serotonin receptor subtype is being activated. As noted earlier, drugs that inhibit serotonin activity at the serotonin2 receptor cause fewer sexual side effects in women.

Recently, clinicians have reported that an increasing number of women believe that the structure of their genitalia may be contributing to difficulties achieving or maintaining orgasm. This belief has contributed to an increase in genital plastic surgery, specifically labiaplasty (reduction of the size of the inner labia and the outer labia), vaginoplasty (rebuilding the vaginal canal and its mucous membrane), hymenoplasty (reconstruction of the hymen), perineoplasty (tightening or loosening of the perineal muscles and the vagina and/or correcting clinical defects or damages of the vagina and the anus), and G-spot augmentation.

Psychological Factors

The psychological factors associated with FOD include sexual guilt, anxiety related to sex, childhood loss or separation from the father, and relationship issues. Sexual guilt can affect orgasmic abilities by increasing anxiety and discomfort during sex and also by distracting a woman from what gives her pleasure. Women who strictly abide by to the values of Western religions sometimes view sexual pleasure as a sin. Sins are later connected with a sense of shame and guilt, which could produce negative affect and cause distracting thoughts during sexual activities. Women who initiate and are more active participants during sexual activities report more frequent orgasms, most likely because being active allows women to assume positions that can provide a greater sense of sexual pleasure. More frequent masturbation and sexual activities are associated with more frequent orgasms. It is likely that women who engage in more sexual activities have a greater understanding of what gives them sexual pleasure and this can help them more easily reach orgasm. A romantic relationship in which the woman feels comfortable communicating her sexual needs may facilitate orgasmic capacity. Therefore, women experiencing relationship discord might be more at risk of orgasm problems than women who are satisfied with their relationships. It is important to note that only a small percentage of women are distressed by their anorgasmia (Graham, 2010).

Certain demographic factors such as age, education, and religion also provide clues as to psychological factors involved in FOD. Younger women, aged 18 to 24 years, compared to older women are more likely to report orgasm problems, during both masturbation and partnered sexual activity. It is possible that as women age they gain more sexual experience as well as become more aware of what their bodies need to attain orgasm. Women with lower levels of education reported more orgasm difficulties during masturbation than women with higher levels of education. More educated women might hold more liberal views on sexuality and might be more likely to see their own pleasure as a goal of sexual activity.

A negative relation between high religiosity and orgasmic ability in women is frequently reported in the clinical literature. Possibly, the more religious a person, the more likely they are to experience guilt during sexual activity. Feasibly, guilt could impair orgasm via a number of cognitive mechanisms, in particular distraction processes. A relationship between improved orgasmic ability and decreased sexual guilt has also been reported

In addition to specific demographics, it is also possible that overarching cultural notions of women's sexuality in general, and the value of women's sexual pleasure, in particular, may also play a role in women's orgasmic capacity. Women who live in societies that value female orgasm tend to have more orgasms than women living in societies that discourage the concept of sexual pleasure for women At the opposite end of the spectrum are societies that assume women will have no pleasure from coitus and that the female orgasm does not exist. It may also be that in societies where sexual pleasure is discouraged it may be shameful to admit to having an orgasm.

TREATMENT

In general, sex therapy for FOD focuses on promoting healthy changes in attitudes and sexually relevant thoughts, decreasing anxiety, and increasing orgasmic ability and satisfaction. Sensate focus and systematic desensitization are used to treat FOD when anxiety seems to play a role. Sex education and communication skills training are often included as adjuncts to treatment. Kegel exercises, which involve tightening and relaxing the pubococcygeus muscle, are also sometimes included as part of a treatment regime. Feasibly, they could help facilitate orgasm by increasing blood flow to the genitals, or by helping the women become more aware and comfortable with her genitals.

To date, the most efficacious treatment for FOD is directed masturbation (DM). This treatment utilizes cognitive behavioral therapy techniques to educate a woman about her body and the sensations of manual self-stimulation. DM includes several stages that gradually build on one another. Directed masturbation has been shown to effectively treat primary FOD when provided in a variety of formats, including individual, group, couples therapy, and bibliotherapy has been proposed that DM is so effective because, in the early stages, it eliminates several factors that can impair orgasmic capacity, such as anxiety that may be associated with the presence of a partner. Since the exploration is focused on the woman's manual sexual stimulation, she is not dependent on her partner's sexual ability, or her ability to communicate her sexual needs to her partner until later in the treatment. Recent research has indicated that DM is particularly effective for women with primary FOD. If the etiology of the FOD appears to be related to anxiety about sex, then anxiety reduction techniques such as systematic desensitization and sensate focus may be useful. These strategies are often combined with sexual techniques training, DM, sex education, communication training, bibliotherapy, and Kegel exercises. For women who have orgasm difficulties resulting from hysterectomy and oophorectomy, combined estrogen and testosterone therapy has been shown to enhance orgasmic ability. A number of psychotherapeutic drugs have been used to try to eliminate orgasm problems that are secondary to antidepressant drug treatments. Results from placebo-controlled studies, to date, have failed to identify any drugs that enhance orgasmic ability better than placebo. However, one study indicated that exercise increases genital

arousal in women taking both SSRIs and SNRIs. As SSRIs are known to have greater SNS suppression compared to SNRIs, women talking SSRIs experienced significantly greater genital response post-exercise than women taking SNRIs.

Check your Progress -3
Note: a.Write your answer in the space given below
   b.Compare your answer with those given at the end of the unit
4.Explain orgasm phase

5.6 Sexual Pain Disorders

Painful intercourse can occur for reasons that range from structural problems to psychological concerns. Many women have painful intercourse at some point in their lives. Persistent, recurrent difficulty with sexual response, desire, orgasm or pain is the symptom. DSM-5 merged the previously two distinct types of sexual pain vaginismus and dyspareunia, as recognised by DSM IV, which was marked by enormous physical discomfort when sexual activity is attempted into Genito-Pelvic Pain or Penetration Disorder.

5.6.1 Genito-Pelvic Pain or Penetration Disorder

The disorder represents an important change in DSM-5 .GPPD is a new diagnosis that subsumes a number of diagnoses, including vulvodynia, vaginismus, and non-coital sexual pain disorder due to lack of scientific research to support this distinction . During any attempt to penetrate, a reflex action triggers tension in the muscles, resulting in pain. It is an involuntary reflex, wherein the female has no control over the contraction of the muscles, and experiences pain that may vary from mild to intense.

The tightening of the muscles can cause difficulties with the use of tampons, instruments used for gynecological examinations, and the penis or other sexual objects. The disorder is commonly associated with a reduced sexual desire and interest. Even when individuals with the disorder report interest or motivation in sex, they may avoid sexual activity for fear of pain. Individuals with this disorder may also avoid gynecological examinations despite medical recommendations. Extreme discomfort or pain while experiencing or attempting intercourse can reduce sexual desire, disrupt relationships, and leave a woman feeling less feminine. In DSM 5 there is only one Genito-Pelvic Pain or Penetration Disorder, which combines genital pain of dyspareunia with muscle tension and fear and anxiety related to genital plan or penetrative sexual activity Genito-pelvic pain/penetration disorder may involve a number of causes and symptoms, both physical and psychological, and a clinician can help an individual or couple take steps toward restoring a healthy sex life.

The disorder involves difficulty having intercourse and feeling significant pain upon penetration. The severity can range from a total inability to experience vaginal penetration to the ability to experience penetration in one situation but not another. For example, a woman might not feel discomfort when inserting a tampon but might experience intense pain when attempting to have vaginal intercourse.

Genito-pelvic pain/penetration disorder was previously referred to as a sexual pain disorder consisting of dyspareunia (pain in the pelvic area during or after sexual intercourse) or vaginismus (an involuntary spasm of

the musculature surrounding the vagina causing it to close, resulting in penetration being difficult, painful, or impossible).

The disorder is associated with other challenges, including reduced sexual desire and avoidance of any genital contact that might cause pain. As a result, many women living with the disorder may have problems in their romantic relationships and many report that their symptoms make them feel less feminine.

Based on past studies of women with "sexual pain disorders" it appears that genito-pelvic pain/penetration disorder is more likely to have organic causes than psychological causes.Some examples of physical causes include acute or chronic infections or inflammation of the vagina or internal reproductive organs, vaginal atrophy that occurs with aging,scars from vaginal tearing,or insufficiency of sexual arousal.Recently,some prominent researchers have argued classifying sexual pain disorders as "sexual disorders" rather than "pain disorders"

TREATMENT

In past treatment studies of vaginismus and dyspareunia, cognitive-behavioural interventions have been effective in some cases. Cognitive-behavioural treatment techniques tend to include education about sexuality, identifying and correcting maladaptive cognitions, graduated vaginal dilation exercises to facilitate vaginal penetration, and progressive muscle relaxation. Medical treatments, such as surgical removal of the vulvar vestibule, a small area of vulva between the labia minor, can be very successful. It is likely that genio-pelvic pain/penetration disorder comprises several distinct syndromes with different etiologies and potentially different treatments.

5.7 Let Us Sum Up

Sexual dysfunctions are characterized by a significant impairment in a person's ability to respond sexually or to experience sexual pleasure. This can refer to an inability to perform or reach an orgasm, painful sexual intercourse, a strong repulsion of sexual activity, or an exaggerated sexual response cycle or sexual interest. An individual may have several sexual dysfunctions at the same time. The etiology of sexual dysfunction is frequently unclear, and clinical judgment is needed. Often, multiple possible explanations need to be explored, using both medical and psychiatric examination procedures. Sexual dysfunctions are a group of psychiatric conditions that include: Delayed Ejaculation, Erectile Disorder, Male Hypoactive Sexual Desire Disorder, Premature Ejaculation, Female Orgasmic Disorder, Female Sexual Interest/Arousal Disorder, Genito-Pelvic Pain/Penetration Disorder.

Several factors can disrupt sexual functioning. Medical conditions such as multiple sclerosis, spinal cord injury or other nerve damage, diabetes, endocrine (hormonal) disorders, and menopausal status can all lead to problems of sexual interest or sexual capacity. Certain medications, such as selective serotonin reuptake inhibitors (SSRIs), may have sexual side effects. Some age-related vascular, nerve-related, and hormonal changes can also adversely affect sexual functioning. It is important to note that when sexual dysfunctions can be primarily attributed to one or more of these biological factors, it should not be diagnosed as a psychiatric disorder, and treatment should target the underlying medical problem.

However, in many cases, medical concerns can contribute to a sexual problem, though not necessarily be the primary cause of the problem. In such cases, a psychiatric diagnosis may be appropriate.

Other psychiatric disorders can adversely affect sexual function. For example, Major Depressive Disorder may be characterized by decreased interest in all or almost all of one's usual activities. Sexual interest, therefore, may be diminished. In such cases, a separate diagnosis of sexual dysfunction is not warranted. However, as was the case with medical conditions, other psychiatric disorders can contribute to a sexual problem, though not necessarily be the primary cause of the problem. In such cases, a diagnosis of sexual dysfunction may be appropriate.

Several psychological issues, even in the absence of a diagnosable psychiatric disorder, can contribute to sexual dysfunction. Negative body image may lead to feelings of anxiety around sexuality, inhibiting desire or capacity. Performance anxiety may similarly lead to problems of sexual function. Stressors, such as work or family concerns, may preoccupy the individual, affecting sexual interest or performance. A history of sexual trauma or other negative historical events may create negative associations with sexuality, thus undermining function. In such cases, a diagnosis of a sexual dysfunction is usually warranted.

Relationship factors can also contribute to problems of sexual functioning. At a purely physical level, often an individual's sexual concerns stem not from a problem within the individual, but from a lack of appropriate sexual stimulation from his or her partner. At an interpersonal level, some couples suffer from poor sexual communication, have poor understanding of sexuality, have different desires or preferences for sexual activity, or feel negatively about each other. All of these factors have the potential to adversely affect sexual arousal or performance. Such cases should not be diagnosed as a psychiatric disorder. Again, however, relationship problems can contribute to a sexual problem, though not necessarily be the primary cause of the problem. In such cases, a diagnosis of sexual dysfunction may be appropriate.

5.8 Unit-End Exercises

1. Compare and contrast the symptoms of the dysfunction of sexual desire, arousal, and orgasm in men and women.

2. What are the most effective treatments for male erectile disorder and premature ejaculation and for female orgasmic disorder?

3. Highlight the changes in Diagnostic Criteria of Sexual Dysfunctions in DSM-5

5.9 Answer To Check Your Progress

1. The term **sexual dysfunction** refers to impairment either in the desire for sexual gratification or in the ability to achieve it. **Sexual dysfunctions** are disorders in which people cannot respond normally in key areas of sexual functioning, make it difficult or impossible to enjoy sexual inter- course.

2. The four different phases of human sexual response as originally proposed by Masters and Johnson and Kaplan are Desire phase, excitement or arousal phase, orgasm and resolution.

3. Hypoactive disorder is a disorder marked by a lack of interest in sex and hence a low level of sexual activity.

4. The orgasm phase is the phase of the sexual response cycle during which an individual's sexual pleasure peaks and sexual tension is released as muscles in the pelvic region contract rhythmically.

5.10 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

UNIT VI : SCHIZOPHRENIA AND PERSONALITY DISORDERS

Structure

6.1 Introduction

Schizophrenia is characterized by an array of diverse symptoms, including extreme oddities in perception, thinking, action, sense of self, and manner of relating to others. However, the hallmark of schizophrenia is a significant loss of contact with reality, referred to as psychosis.

6.2 Objectives

The objectives of this unit are to:
- Bring out an understanding of psychotic condition, schizophrenia
- Explain different types of schizophrenia
- Describe the causal factors of schizophrenia
- Discuss the treatment and outcome of schizophrenia

6.3 Schizophrenia: Clinical Picture

The hallmark symptoms of this major form of psychotic disorder are
Delusions
A delusion is essentially an erroneous belief that is fixed and firmly held despite clear contradictory evidence. People with delusions believe things that others who share their social, religious, and cultural backgrounds do not believe. A delusion therefore involves a disturbance in the content of thought. Not all people who have delusions suffer from schizophrenia. However, delusions are common in schizophrenia, occurring in more than 90 percent of patients at some time during their illness. Prominent among these are beliefs that one's thoughts, feelings, or actions are being controlled by external agents (made feelings or impulses), that one's private thoughts are being broadcast indiscriminately to others (thought broadcasting), that thoughts are being inserted into one's brain by some external agency (thought insertion), or that some external agency has robbed one of one's thoughts (thought withdrawal). Also common are delusions of reference, where some neutral environmental event (such as a television program or a song on the radio) is believed to have special and personal meaning intended only for the person. Other strange propositions,

including delusions of bodily changes (e.g, bowels do not work) or removal of organs, are also not uncommon. Sometimes delusions are not just isolated beliefs. Instead they become elaborated into a complex delusional system.

Hallucinations

A hallucination is a sensory experience that seems real to the person having it, but occurs in the absence of any external perceptual stimulus. This is quite different from an illusion, which is a misperception of a stimulus that actually exist. Hallucinations can occur in any sensory modality (auditory, visual, olfactory, tactile, or gustatory). However, auditory hallucinations (e.g, hearing voices) are by far the most common.

Hallucinations often have relevance for the patient at some affective, conceptual, or behavioral level. Patients can become emotionally involved in their hallucinations, often incorporating them into their delusions. In some cases, patients may even act on their hallucinations and do what the voices tell them to do.

Disorganized Speech and Behavior

Delusions reflect a disorder of thought content. Disorganized speech, on the other hand, is the external manifestation of a disorder in thought form. Basically, an affected person fails to make sense, despite seeming to conform to the semantic and syntactic rules governing verbal communication. The failure is not attributable to low intelligence, poor education, or cultural deprivation.

In disorganized speech, the words and word combinations sound communicative, but the listener is left with little or no understanding of the point the speaker is trying to make. In some cases, completely new, made-up words known as neologisms (literally, "new words") appear in the patient's speech.

Disorganized behavior can show itself in a variety of ways. Goal-directed activity is almost universally disrupted in schizophrenia. The impairment occurs in areas of routine dally functioning, such as work, social relations, and self-care, to the extent that observers note that the person is not himself or herself anymore. For example, the person may no longer maintain minimal standards of personal hygiene or may exhibit a profound disregard of personal safety and health. In other cases, grossly disorganized behavior appears as silliness or unusual dress.

Catatonia is an even more stirking behavioral disturbance. The patient with catatonia may show a virtual absence of all movement and speech and be in what is called a catatonic stupor. At other times, the patient may hold an unusual posture for an extended period of time without any seeming discomfort.

Positive and Negative Symptoms

Positive symptoms are those that reflect an excess or distortion in a normal repertoire of behavior and experience, such as delusions and hallucinations. Negative symptoms, by contrast, reflect an absence or deficit of behaviors that are normally present. Important negative symptoms in schizophrenia include flat affect, or blunted emotional expressiveness, and alogia, which means very little speech. Another negative symptom is avolition, or the inability to initiate or persist in goal-directed activities. For example, the patient may sit for long periods of time staring into space or watching TV with little interest in any outside work or social activities.

Although most patients exhibit both positive and negative symptoms during the course of their disorders, a preponderance of negative symptoms in the clinical picture is not a good sign for the patient's future outcome.

Check your Progress – 1
Note: a. Write your answer in the space given below
    b. Compare your answer with those given at the end of the unit.
1. What are the symptoms of schizophrenia?
2. What is delusion? How is it different from illusion?

6.4 Subtypes Of Schizophrenia

There is a great deal of heterogeneity in the presentation of schizophrenia, and patients with this disorder often look quite different clinically. In consideration of this, the DSM-IV-TR recognized several subtypes of schizophrenia. The most clinically meaningful of these were paranoid schizophrenia (where the clinical picture is dominated by absurd and illogical beliefs that are often highly elaborated and organized into a coherent, though delusional, framework), disorganized schizophrenia (which is characterized by disorganized speech, disorganized behavior, and flat or inappropriate affect) and catatonic schizophrenia (which involves pronounced motor signs that reflect great excitement or stupor. **Research using the subtyping approach did not yield major insights into the etiology or treatment of the disorder. Reflecting this, subtypes of schizophrenia are no longer included in DSM-5.**

6.4.1 PARANOID

People with *paranoid type of schizophrenia* have an organized system of delusions and auditory hallucinations that may guide their lives. Patients may also believe that people are out to get him/her (delusions of persecution) and that people on television were stealing their ideas (delusions of reference). In addition, they may hear noises and feel "funny sensations" that confirmed their beliefs.

6.4.2 DISORGANIZED

The central symptoms of *disorganized type of schizophrenia* are confusion, incoherence, and flat or inappropriate affect. Attention and perception problems, extreme social withdrawal, and odd mannerisms or grimaces are common. So is flat or inappropriate affect. Silliness, in particular, is common; some patients giggle constantly without apparent reason. This is why the pattern was first called "hebephrenic," after Hebe, the goddess who, according to Greek mythology, often acted like a clown to make the other gods laugh. Not surprisingly, people with disorganized schizophrenia are typically unable to take good care of themselves, maintain social relationships, or hold a job.

6.4.3 CATATONIC

The psychomotor symptoms of schizophrenia may take certain extreme forms, collectively called **catatonia**. People in a *catatonic stupor* stop responding to their environment, remaining motionless and silent for long stretches of time. They can lie motionless and mute in bed for days. People who display *catatonic rigidity* maintain a rigid, upright posture for hours and resist efforts to be moved. Others exhibit *catatonic posturing,* assuming awkward, bizarre positions for long periods of time. They may spend hours holding their arms out at a 90-degree angle or balancing in a squatting position. They may also display "waxy flexibility," indefinitely

maintaining postures into which they have been placed by someone else. If a nurse raises a patient's arm or tilts the patient's head, for example, the individual will remain in that position until moved again. Finally, people who display *catatonic excitement,* a different form of catatonia, move excitedly, sometimes with wild waving of arms and legs.

6.4.4 UNDIFFERENTIATED

When people with this disorder do not fall neatly into one of the other categories, they are diagnosed with *undifferentiated type of schizophrenia.* Because this category is somewhat vague, it has been assigned to a wide assortment of unusual patterns over the years. Many clinicians believe that it is in fact overused.

6.4.5 RESIDUAL TYPE AND OTHER PSYCHOTIC DISORDERS

When the symptoms of schizophrenia lessen in strength and number yet remain in a residual form, the patient's diagnosis is usually changed to *residual type of schizophrenia. P*eople with this pattern may continue to display blunted or inappropriate emotions, as well as social withdrawal, eccentric behavior, and some illogical thinking.

Other Psychotic Disorders

SCHIZOAFFECTIVE DISORDER The DSM-5 recognizes a diagnostic category called schizoaffective disorder. This diagnosis is conceptually something of a hybrid, in that it is used to describe people who have features of schizophrenia and severe mood disorder. In other words, the person not only has psychotic symptoms that meet criteria for schizophrenia but also has marked changes in mood for a substantial amount ot time. Because mood disorders can be unipolar or bipolar in type, these are recognized as subtypes of schizoaffective disorder.

SCHIZOPHRENIFORM DISORDER

Schizophreniform disorder is a category reserved for schizophrenia-like psychoses that last at least a month but do not last for 6 months and so do not warrant a diagnosis of schizophrenia. It may include any of the symptoms described in the preceding sections. Because of the possibility of an early and lasting remission after a first psychotic breakdown, the prognosis for schizophreniform disorder is better than that for established forms of schizophrenia.

DELUSIONAL DISORDER

Patients with delusional disorder, like many people with schizophrenia, hold beliefs that are considered false and absurd by those around them. Unlike individuals with schizophrenia, however, people given the diagnosis of delusional disorder may otherwise behave quite normally. Their behavior does not show the gross disorganization and performance deficiencies characteristic of schizophrenia, and general behavioral deterioration is rarely observed in this disorder, even when it proves chronic. One interesting subtype of delusional disorder is erotomania. Here, the theme of the delusion involves great love for a person, usually of higher status.

BRIEF PSYCHOTIC DISORDER

Brief psychotic disorder is exactly what its name suggests. It involves the sudden onset of psychotic symptoms or disorganized speech or catatonic behavior. Even though there is often great emotional turmoil, the episode usually lasts only a matter of days (too short to warrant a diagnosis of schizophreniform disorder). After this, the person returns to his or her former level of functioning and may never have another episode again.

6.5 Causal Factors

Genetic factors are clearly implicated in schizophrenia. Having a relative with the disorder significantly raises a person's risk of developing schizophrenia. Other factors that have been implicated in the development of schizophrenia include prenatal exposure to the influenza virus, early nutritional deficiencies, rhesus incompatibly, maternal stress, and perinatal birth complications. Urban living, immigration, and cannabis use during adolescence have also been shown to increase the risk of developing schizophrenia. Current thinking about schizophrenia emphasizes the interplay between genetic and environmental factors.

Patients with schizophrenia have problems in many aspects of their cognitive functioning. They show a variety of attentional deficits (e.g poor P50 suppression and deficits on the Continuous Performance Test). They also show eye-tracking dysfunctions. Many brain areas are abnormal in schizophrenia, although abnormalities are not found in all patients. The brain abnormalities that have been found include enlarged ventricles (which reflects decreased brain volume), frontal lobe dysfunction, reduced volume of the thalamus, and abnormalities in temporal lobe areas such as the hippocampus and amygdala. Major changes in the brain occur during adolescence. These include synaptic pruning, decreases in the number of excitatory neurons, and increases in the number of inhibitory neurons. There is also an increase in white matter which enhances the connectivity of the brain. Some of these changes may be abnormal in people who will later develop schizophrenia. Some of the brain abnormalities that are characteristic of schizophrenia get worse over time. This suggests that, in addition to being a neurodevelopmental disorder, schizophrenia is also a neuroprogressive disorder.

The most important neurotransmitters implicated in schizophrenia are dopamine and glutamate. Research shows that the dopamine (D2) receptors of patients with schizophrenia are supersensitive to dopamine.

Family environment

Patients with schizophrenia are more likely to relapse if their relatives are high in expressed emotion (EE). High-EE environments may be stressful to patients and may trigger biological changes that cause dysregulations in the dopamine system. This could lead to a return of symptoms.

6.6 Treatment And Outcome

For many patients, schizophrenia is a chronic disorder requiring long-term treatment or institutionalization. However, when treated with therapy and medications, around 38 percent of patents can show a reasonable recovery. Only about 14 percent of patients recover to the extent that they have minimal symptoms and function well socially.

Patients with schizophrenia are usually treated with first or second-generation antipsychotic (neuroleptic) medications. Second-generation antipsychotics are about as effective as first generation antipsychotic but cause fewer extrapyramidal (motor abnormality) side effects. Antipsychotic drugs work by blocking dopamine receptors.

Psychosocial treatments for patients with schizophrenia include cognitive-behavioral therapy, social-skills training, cognitive remediation training, and other forms of individual treatment, as well as case management. Family therapy provides families with communication skills and other skills that are helpful in managing the illness. Family therapy also reduces high levels of expressed emotion

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Check your Progress – 3
Note: a. Write your answer in the space given below
     b. Compare your answer with those given at the end of the unit.
5. What are the important neurotransmitters implicated in schizophrenia?
6. What psychosocial treatments will be helpful for schizophrenics?

6.7 Let Us Sum Up

Schizophrenia is a disorder in which personal, social, and occupational functioning deteriorate as a result of disturbed thought processes, distorted perceptions, unusual emotions, and motor abnormalities. The symptoms of schizophrenia fall into three groupings. *Positive symptoms* include *delusions,* certain *formal thought disorders, hallucinations* and other *disturbances in perception and attention,* and *inappropriate affect. Negative symptoms* include *poverty of speech, blunted and flat affect, loss of volition,* and *social withdrawal.* The disorder may also include *psychomotor symptoms,* collectively called *catatonia* in their extreme form. Schizophrenia usually emerges during late adolescence or early adulthood and tends to progress through three phases: *prodromal, active,* and *residual.* Most clinical theorists now agree that schizophrenia can probably be traced to a combination of biological, psychological, and sociocultural factors. However, the biological factors have been more precisely identified.

For years all efforts to treat schizophrenia brought only frustration. The disorder is still difficult to treat, but today's therapies are more successful than those of the past. For more than half of the twentieth century, the main treatment for schizophrenia and other severe mental disorders was *institutionalization* and *custodial care.*In the 1950s two in-hospital approaches were developed, *milieu therapy* and *token economy programs* which brought improvement and particularly helped patients to care for themselves and feel better about themselves.

The discovery of *antipsychotic drugs* in the 1950s revolutionized the treatment of schizophrenia and other disorders marked by psychosis. Today they are almost always a part of treatment. Theorists believe that the first generation of antipsychotic drugs operates by reducing excessive dopamine activity in the brain. These "conventional" antipsychotic drugs reduce the positive symptoms of schizophrenia more completely, or more quickly, than the negative symptoms. The conventional antipsychotic drugs can also produce dramatic unwanted effects, particularly movement abnormalities called extrapyramidal effects, which include Parkinsonian and related symptoms, neuroleptic malignant syndrome, and tardive dyskinesia. Tardive dyskinesia apparently occurs in more than 10 percent of the people who take conventional antipsychotic drugs for an extended time and can be difficult or impossible to eliminate, even when the drugs are stopped. Recently atypical antipsychotic drugs (such as clozapine, risperidone, and

olanzapine) have been developed, which seem to be more effective than the conventional drugs and to cause fewer or no extrapyramidal effects.

Today *psychotherapy* is often employed successfully in combination with antipsychotic drugs. Helpful forms include *cognitive-behavioral therapy, family therapy,* and *social therapy. Family support groups* and *family psychoeducational programs* are also growing in number.

Among the key elements of effective community care programs are coordination of patient services by a *community mental health center, short-term hospitalization* (followed by *aftercare*), *day centers, halfway houses,* and *occupational training.* Unfortunately, such care is not widespread in India until today.The potential of proper community care to help people recovering from schizophrenia and other severe disorders, however, continues to capture the interest of clinicians and policy makers.

6.8 Unit-End Exercises

1. Describe the clinical features of schizophrenia.
2. Discuss the causal factors of schizophrenia
3. Evaluate the treatment and outcome of schizophrenia.

6.9 Answer to Check Your Progress

1. Characteristic symptoms of schizophrenia includes hallucinations, delusions, disorganized speech, disorganized and catatonic behaviour, and negative symptoms such as flat affect or social withdrawal.
2. A delusion is essentially an erroneous belief that is fixed and firmly held despite clear contradictory evidence. Illusion is misperception.
3. Research using the subtyping approach did not yield major insights into the etiology or treatment of the disorder hence, subtypes of schizophrenia are no longer included in DSM-5.
4. The psychomotor symptoms of schizophrenia are collectively called catatonia
5. Dopamine and Glutamate
6. Cognitive-behavioural therapy, social-skills training, cognitive remediation training, other forms of individual treatment, case management and family therapy.

6.10   Suggested Readings

1. Butcher, J. N., Hooley, J. M., Mineka, S., &Dwivedi, C.B. (2017). *Abnormal Psychology*. Noida: Thomson Press India Ltd.
2. Carson, R. C., & Butcher, J. N. (2007). *Abnormal Psychology*. New Delhi: Pearson Education Inc.
3. Sarason&Sarason (2010). *Abnormal Psychology: The Problem of Maladaptive Behaviour* (11[th]Edn). New Delhi: Prentice Hall of India Pvt Ltd.

UNIT VII: PERSONALITY DISORDERS

Structure

7.1 Introduction

Each of us has a *personality*—a unique and enduring pattern of inner experience and outward behavior. We tend to react in our own predictable and consistent ways. These consistencies, often called *personality traits,* may be the result of inherited characteristics, learned responses, or a combination of the two. Yet our personalities are also flexible. We learn from experience. As we interact with our surroundings, we try out various responses to see which are more effective. This is a flexibility that people who suffer from a personality disorder usually do not have.

A **personality disorder** is an inflexible pattern of inner experience and outward behavior. The pattern is seen in most of the person's interactions, continues for years, and differs markedly from the experiences and behaviors usually expected of people. The rigid traits of people with personality disorders often lead to psychological pain for the individual and social or occupational difficulties. The disorders may also bring pain to others. Personality disorders typically become recognizable in adolescence or early adulthood, although some start during childhood. These are among the most difficult psychological disorders to treat. Many sufferers are not even aware of their personality problems and fail to trace their difficulties to their inflexible style of thinking and behaving.

DSM-IV-TR identifies 10 personality disorders and separates them into three groups, called *clusters* (APA, 2000). One cluster, marked by odd or eccentric behavior, consists of the *paranoid, schizoid,* and *schizotypal* personality disorders. A second group features dramatic behavior and consists of the *antisocial, borderline, histrionic,* and *narcissistic* personality disorders. The final cluster features a high degree of anxiety

and includes the *avoidant, dependent,* and *obsessive-compulsive* personality disorders. The personality disorders listed in DSM IV-TR overlap so much that it can be difficult to distinguish one from the other.

7.4 Objectives

At the end of this unit, you will be able to

- Understand the reasons for individual's behavioural problems arising from their personality makeup.
- Identify the key features of different personality disorders
- Analyze the cause factors of various personality disorders
- Understand the difficulty in treating personality problems and devise strategies for healthy personality development

7.5 Clinical Features

There are certain people who, although they do not necessarily display obvious symptoms of most of the disorders. Nevertheless have certain traits that are so inflexible and maladaptive that they are unable to perform adequately at least some of the varied roles expected of them by their society, in which case we may say that they have a personality disorder.

Two of the general features that characterize most personality disorder are the chronic interpersonal difficulties and problem with one's identify or sense of self.

According to general DSM-5 criteria for diagnosing a personality disorder, the person's enduring pattern of behaviour must be pervasive and inflexible, as well as stable and of long duration. It must also cause either clinically significant distress or impairment in functioning and be manifested in at least two of the following areas; cognition, affectivity, interpersonal functioning, or impulses control. From a clinical standpoint, people with personality disorder often cause at least as much difficulty in the lives of others as they do in their own lives.

7.4 Categories of Personality Disorders

Stem largely from the gradual development of inflexible and distorted personality and behavioural patterns that result in persistently maladaptive ways of perceiving, thinking about, and relating to the world. In many cases, major stressful life events early in life help set the stage for the development of these inflexible and distorted personality patterns.

The category of personality disorders is broad, encompassing behavioural problems that differ greatly in form and severity. In the milder cases there are people who generally function adequately but who would be described by their relatives, friends, or associates as troublesome, eccentric, or hard to get know. One severe form of personality disorder (antisocial personality disorder) results in extreme and often unethical "acting out" against society.

The DSM-5 personality disorders are grouped into three clusters.

Cluster A: Includes paranoid, schizoid and schizotypal personality disorders. People with these disorders often seem odd or eccentric, with unusual behaviour ranging from distrust and suspiciousness to social detachment.

Cluster B: Includes histrionic, narcissistic, antisocial and borderline personality disorders. Individuals with these disorders share a tendency to be dramatic, emotional and erratic.

Cluster C: Includes avoidant, dependent and obsessive compulsive personality disorders often show anxiety and fearfulness.

Check your Progress – 1

Note: a. Write your answer in the space given below

     b. Compare your answer with those given at the end of the unit.

1. What are the characteristic features of Cluster A personality disorders?

2. What are the characteristic features of Cluster B personality disorders?

3. What are the characteristic features of Cluster C personality disorders?

CLUSTER A PERSONALITY DISORDERS

People with Cluster A personality disorders display unusual behaviours such as distrust, suspiciousness, and social detachment and often come across as odd or eccentric.

7.10.1 PARANOID PERSONALITY DISORDER

Individuals with paranoid personality disorder have a pervasive suspiciousness and distrust of other, leading to numerous interpersonal difficulties. They tend to see themselves as blameless, instead blaming others for their own mistakes and failures. Such people are chronically tense and "on guard" constantly expecting trickery and looking for clues to validate their expectations which disregarding all evidence to the contrary. They are often preoccupied with doubts about the loyalty of friends and hence are reluctant to confide in others. They commonly bear grudges, refuse to forgive perceived insults and slights, and are quick to react with anger and sometimes violent behavior. People with paranoid personalities are not usually psychotic; that is, most of the time they are in clear contact with reality, although they may experience transient psychotic symptoms during periods of stress. People with paranoid schizophrenia share some symptoms found in paranoid personality, but they have many additional problems including more persistent loss of contact with reality, delusions, and hallucinations. Nevertheless, individuals with paranoid personality disorder do appear to be at increased risk for schizophrenia.

7.10.2 SCHIZOID PERSONALITY DISORDER

Individuals with schizoid personality disorder are usually unable to form social relationships and usually lack must interest in doing so. Consequently, they tend not to have good friends, with the possible exception of a close relative. Such people are unable to express their feelings and are seen by others as cold and distant. They often lack social skills and can be classified as loners or introverts, with solitary interests and occupations, although not all loners or introverts have schizoid personality disorder. People with this disorder tend not to take pleasure in many activities, including sexual activity, and rarely marry. More generally, they are not very emotionally reactive, rarely experiencing strong positive or negative emotions, but rather show a generally apathetic mood. They show extremely high levels of introversion (especially low on

warmth, gregariousness, and positive emotions). They are also low on openness to feeling (one facet of openness to experience)

7.10.3 SCHIZOTYPAL PERSONALITY DISORDER

Individuals with schizotypal personality disorder are also excessively introverted and have pervasive social and interpersonal deficits. In addition they have cognitive and perceptual distortions, as well as oddities and eccentricities in their communication and behaviour. Although contact with reality is usually maintained, high personalized and superstitious thinking is characteristic of people with schizotypal personality, and under extreme stress they may experience transient psychotic symptoms. Indeed, they often believe that they have magical powers and may engage in magical rituals. Other cognitive-perceptual problems include ideas of reference (the belief that conversations or gestures of others have special meaning or personal significance), odd speech and paranoid beliefs.

Oddities in thinking, speech, and other behaviors are the most stable characteristics of schizotypal personality disorder and are similar to those often seen in patients with schizophrenia.

CLUSTER B PERSONALITY DISORDERS

People with Cluster B personality disorders share a tendency to be dramatic, emotional, and erratic.

7.10.4 HISTRIONIC PERSONALITY DISORDER

Excessive attention-seeking behavior and emotionality are the key characteristics of individuals with histrionic personality disorder. These individuals tend to feel unappreciated if they are not the center to attention; their lively, dramatic and excessively extraverted styles often ensure that they can charm others into attending to them. But these qualities do not lead to stable and satisfying relationship because others tire of providing this level of attention. In craving stimulation and attention, their appearance and behavior are often quite theatrical and emotional as well as sexually provocative and seductive. They may attempt to control their partners though seductive behavior and emotional manipulation, but they also show a good deal of dependence. Their speech is often vague and impressionistic and they are usually considered self-centered, vain and excessively concerned about the approval of others, who see them as overly reactive, shallow and insincere

7.10.5 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. Numerous studies support the notion of two subtypes of narcissism: grandiose and vulnerable narcissism. The grandiose presentation of narcissistic patients is manifested by traits related to grandiosity, aggression, and dominance. These are reflected in a strong tendency to overestimate their abilities and accomplishments while underestimating the abilities and accomplishment of others. Their sense of entitlement is frequently a source of astonishment to others, although they themselves seem to regard their lavish expectations as merely what they deserve. They behave in stereotypical way (e.g., with constant self-reference and bragging) to grain the acclaim and recognition they crave. Because they believe they are so special, they often think they can be understood only by other high-status people or that they should associate only with such people. Finally, their sense of entitlement is also associated

with their unwillingness to forgive others for perceived slights, and they easily take offense.

Narcissistic personalities also share another central trait they unwilling or unable to take the perspective of other, to see things other than "through their own eyes." Moreover if they do not receive the validation or assistance they desire, they are inclined to be hypercritical and retaliatory.

7.10.6 ANTISOCIAL PERSONALITY DISORDER

Individuals with antisocial personality disorder (ASPD) continually violate and show disregard for the rights of other through deceitful, aggressive, or antisocial behavior, typically without remorse or loyalty to anyone. They tend to be impulsive, irritable, aggressive and to show a pattern of generally irresponsible behavior. This pattern of behaviour must have been occurring since the age of 15, and before age 15 the person must have had symptoms of conduct disorder, a similar disorder occurring in children and young adolescents who show persistent patterns of aggression towards people or animals, destruction of property, deceitfulness or theft, and serious violation of rules at home or in schools.

7.10.7 BORDERLINE PERSONALITY DISORDER

People with borderline personality disorder (BPD) show a pattern of behaviour characterized by impulsivity and instability in interpersonal relationship, self-image, and moods. The central characteristic of BPD is affective instability, manifested by unusually intense emotional responses to environmental triggers, with delayed recovery to a baseline emotional state. Affective instability is also characterized by drastic and rapid shifts from one emotion to another. People with BPD have a highly unstable self-image or sense of self, which is sometimes described as "impoverished and/or fragmented". These people have highly unstable interpersonal relationship. These relationships tend to be intense but stormy, typically involving overidealizations, disappointment, and anger. Nevertheless, they may make desperate efforts to avoid real or imagined abandonment, perhaps because their fears of abandonment are so intense. Another very important feature of BPD is impulsivity characterized by rapid responding to environmental triggers without thinking (or caring) about long term consequence. These individuals' high level of impulsivity combined with their extreme affective instability often lead to erratic, self-destructive behavior such as gambling sprees or reckless driving, suicide attempts, sometimes flagrantly manipulative, can be part of clinical picture. Self-mutilation (such as repetitive cutting behavior) is another characteristic feature of borderline personality. However many people who engage in self-injury do not have BPD. In some cases the self-injurious behavior is associated with relief from anxiety or dysphoria, and it also serves to communicate the person's level of distress to others. Research has also documented that borderline personality is associated with analgesia in as many as 70 to 80 percent of women with BPD (analgesia is the absence of the experience of pain in the presence of theoretically painful stimulus)

In addition to affective and impulsive behavioral symptoms, as many as 75 percent of people with BPD has cognitive symptoms. These include relatively short or transient episodes in which they appear to be out of contact with reality and experience delusions or other psychotic-like symptoms such as hallucination, paranoid ideas, or severe dissociative symptoms.

CLUSTER C PERSONALITY DISORDERS

People with Cluster C personality disorders often show anxiety and fearfulness. These are characteristics that we do not see in the other two clusters.

7.10.8 AVOIDANT PERSONALITY DISORDER

Individuals with avoidant personality disorder show extreme social inhibition and introversion, leading to lifelong patterns of limited social relationships and reluctance to enter into social interactions. Because of their hypersensitivity to, and fear of, criticism and rebuff, they do not seek out other people, yet they desire affection and are often lonely and bored. Unlike schizoid personalities, people with avoidant personality disorder do not enjoy their aloneness; their inability to relate comfortably to other people causes acute anxiety and is accompanied by low self-esteem and excessive self-consciousness, which in turn are often associated with depression. Feeling inept and socially inadequate are the two most prevalent and stable features of avoidant personality. The person with avoidant personality also desires interpersonal contact but avoids it for fear of rejection, whereas in schizoid personality disorder there is a lack of desire or ability to form social relationships.

7.10.9 DEPENDENT PERSONALITY DISORDER

Individuals with dependent personality disorder show an extreme need to be taken care of, which leads to clinging and submissive behavior. They also show acute fear at the possibility of separation or sometimes of simply having to be alone because they see themselves as incompetent. These individuals usually build their lives around other people and subordinate their own needs and views to keep these people involved with them. Accordingly, they may be indiscriminate in their selection of mates. They often fail to get appropriately angry with others because of a fear of losing their support, which means that people with dependent personalities may remain in psychologically or physically abusive relationships. They have great difficulty making even simple, everyday decisions without a great deal of advice and reassurance because they lack self-confidence and feel helpless even when they have actually developed good work skills or other competencies. They may function well as long as they are not required to be on their own.

It is quite common for people with dependent personality disorder to have comorbid diagnosis of mood and anxiety disorder. Some features of dependent personality disorder overlap with those of borderline, histrionic, and avoidant personality disorders, but there are differences as well. For example, both borderline personalities and dependent personalities fear abandonment. However, the borderline personality, who usually has intense and stormy relationships, reacts with feelings of emptiness or rage if abandonment occurs, whereas the dependent personality reacts initially with submissiveness and appeasement and then finally with an urgent seeking of a new relationship. Histrionic and dependent personalities both have strong needs for reassurance and approval, but the histrionic personality is much more gregarious, flamboyant, and actively demanding of attention, whereas the dependent personality is more docile and self-effacing. It can also be hard to distinguish between dependent and avoidant personalities. As noted, dependent personalities have great difficulty separating in relationships because they feel incompetent on their own and have a need to be taken care of, whereas avoidant personalities have

trouble initiating relationships because they fear criticism or rejection, which will be humiliating.

7.10.10 OBSESSIVE COMPULSIVE PERSONALITY DISORDER

Perfectionism and an excessive concern with maintaining order and control characterize individuals with obsessive-compulsive personality disorder (OCPD). Their preoccupation with maintaining mental and interpersonal control occurs in part through careful attention to rules, order, and schedules. They are very careful in what they do so as not to make mistakes, but because the details they are preoccupied with are often trivial they use their time poorly and have a difficult time seeing the larger picture. This perfectionism is also often quite dysfunctional in that it can result in their never finishing projects. They also tend to be devoted to work to the exclusion of leisure activities and may have difficulty relaxing or doing anything just for fun. At an interpersonal level, they have difficulty delegating tasks to others and are quite rigid, stubborn, and cold, which is how others tend to view them. Research indicates that rigidity, stubbornness, and perfectionism, as well as reluctance to delegate, are the most prevalent and stable features of OCPD.

It is important to note that people with OCPD do not have true obsessions or compulsive rituals that are the source of extreme anxiety or distress in people with obsessive-compulsive disorder. Instead, people with OCPD have lifestyles characterized by over-conscientiousness, high neuroticism, inflexibility, and perfectionism but without the presence of true obsessions or compulsive rituals. Some features of OCPD overlap with some features of narcissistic, antisocial, and schizoid personality disorders, although there are also distinguishing features. For example, individuals with narcissistic and ASPDs may share the lack of generosity toward others that characterizes OCPD, but the former tend to indulge themselves, whereas those with OCPD are equally unwilling to be generous with themselves. In addition, both the schizoid and the obsessive-compulsive personalities may have a certain amount of formality and social detachment, but only the schizoid personality lacks the capacity for close relationships. The person with OCPD has difficulty in interpersonal relationships because of excessive devotion to work and great difficulty expressing emotions.

Check your Progress – 2

Note: a. Write your answer in the space given below

    b. Compare your answer with those given at the end of the unit.

4. What is the difference between OCD and OCPD?

5. What disorder precedes antisocial personality disorder before age 15?

7.11 Causal Factors Of Personality Disorders

Casual factors of Paranoid Personality Disorder

Little is known about important causal factors for paranoid personality disorders. Some have argued for partial genetic transmission that may link the disorder to schizophrenia, but results examining this issue are inconsistent, and if there is a significant relationship it is not a strong one. Psychosocial causal factors that are suspected to play a role include parental neglect or abuse and exposure to violent adults, although any links

between early adverse experiences and adult paranoid personality disorder are clearly not specific to this one personality disorder and may play a role in other disorders as well.

Causal factors of Schizoid Personality Disorder

Early theorists considered a schizoid personality to be a likely precursor to the development of schizophrenia, but this viewpoint has been challenged, and any genetic link that may exist is very modest. Schizoid personality traits have also been shown to have only a modest heritability. Some theorists have suggested that the severe disruption is sociability seen in schizoid personality disorder may be due to severe impairment in an underlying affiliative system. Cognitive theorists purpose that individuals with schizoid personality disorder exhibit cool and aloof behaviour because of maladaptive underlying schemas that lead them to view themselves as self-sufficient loners and to view others as intrusive. Their core dysfunctional belief might be "I am basically alone" or "Relationship are messy [and] undesirable". Unfortunately, we do not know why or how some people might develop such dysfunctional beliefs.

Causal factors of Schizotypal personality Disorder

The heritability of schizotypal personality disorder is moderate. The biological associations of schizotypal personality disorder with schizophrenia are remarkable. A number of studies on patients, as well as college students, with schizotypal personality disorder have shown the same deficit in the ability to track a moving target visually that is found in schizophrenia. They also show numerous other mild impairments in cognitive functioning including deficits in their ability to sustain attention and deficits in working memory. Both of which are common in schizophrenia. In addition, individuals with schizotypal personality disorder, like patients with schizophrenia, show deficits in their ability to inhibit attention to a second stimulus that rapidly follows presentation of a first stimulus. They are also show language abnormalities that may be related to abnormalities in their authority processing.

A genetic relationship to schizophrenia has also long been suspected. In fact, this disorder appears to be part of a spectrum of liability of schizophrenia that often occurs in some of first-degree relatives of people with schizophrenia. Moreover, teenagers who have schizotypal personality disorder have been shown to be at increased risk for developing schizophrenia and schizophrenia-spectrum disorders in adulthood. Nevertheless, it has also been proposed that there is a second subtype of schizotypal personality disorders that is not genetically linked to schizophrenia. This subtype is characterized by cognitive and perceptual deficits and is instead linked to a history of childhood abuse and early trauma. Schizotypal personality disorders in adolescence have been associated with elevated exposure to stressful life events and low family socioeconomic status.

Causal factors of Histrionic personality Disorder

Histrionic personality disorder is highly comorbid with borderline, antisocial, narcissistic, and dependent personality disorder diagnoses. There is some evidence for a genetic link with antisocial personality disorder, the idea being that there may be some common underlying predisposition that is more likely to be manifested in women as histrionic personality disorder and in men as antisocial personality disorder. The suggestion of some genetic propensity to develop this disorder is also

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supported by findings that histrionic personality disorder may be characterized as involving extreme versions of two commons, normal personality traits, extraversion and, to a lesser extent, neuroticism two normal personality traits known to have a partial genetic basis.

Cognitive theorists emphasize the important of maladaptive schemas revolving around the need for attention to valid self-worth. Core dysfunctional beliefs might include, "Unless I captivate people, I am nothing" and "If I can't entertain people, they will abandon me". No systematic research has yet explored how these dysfunctional beliefs might develop.

Casual factors of Narcissistic personality disorder

The grandiose and vulnerable forms of narcissism are associated with different causal factors. Grandiose narcissism has not generally been associated with childhood abuse, neglect or poor parenting. Indeed there is some evidence that grandiose narcissism is associated with parental overvaluation. By contrast, vulnerable narcissism has been associated with emotional, physical, and sexual abuse, as well parenting styles characterized as intrusive, controlling, and cold.

Casual factors of Anti-social personality disorder

Genetic and temperamental, learning, and adverse environmental factors seem to be important in causing psychopathy and ASPD. Pscyhopaths also show deficiency in fear and anxiety as well as more general emotional deficits.

Casual Factors of Borderline Personality Disorder

Research suggested that genetic factors play a significant role in the development of BPD. There is also some preliminary evidence that certain parts of the 5-HTT gene implicated in depressive many also be associated with BPD. Recent research also suggests a link with other genes involved in regulating dopamine transmission.

There has also been an intense search for the biological substrate of BPD. For example, people with BPD often appear to be characterized by lowered functioning of the neurotransmitter serotonin, which is involved in inhibiting behavioral responses. This is may be why they show impulsive - aggressive behavior, as in acts of self-mutilation; that is, their serotonergic activity is too low to "put the brakes on" impulsive behavior.

Much theoretical and research attention has also been directed to the role of psychosocial causal factors in BPD. Although the vast majority of this research is retrospective in nature, relying on people's memories of their past to discover the antecedents of the disorder, two prospective community based studies have shown that childhood adversity and maltreatment is linked to adult BPD. People with this disorder usually report a large number of negative-even traumatic-events in childhood. These experiences include abuse and neglects, and separation and loss.

Causal Factors of Avoidant Personality Disorder

Some research suggests that avoidant personality may have its origins in an innate "inhibited' temperament that leaves the infant and child shy and inhibited in novel and ambiguous situations. Genetically and biologically based inhibited temperament may often serve as the diathesis that leads to avoidant personality disorder in some children who experience emotional abuse, rejection, or humiliation from parents who are not particularly affectionate.

Causal Factors of Dependent Personality Disorder

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Some evidence indicates that there is a modest genetic influence on dependent personality traits. Several other personality traits such as neuroticism and agreeableness that are also prominent in dependent personality disorder also have a genetic component. It is possible that people with these partially genetically based predispositions to dependence and anxiousness may be especially prone to the adverse effects of parents who are authoritarian and overprotective (not promoting autonomy and individuation in their child but instead reinforcing dependent behavior) This might lead children to believe that they are reliant on others for their own well-being and are incompetent on their own. Cognitive theorists describe the underlying maladaptive schemas for these individuals as involving core beliefs about weakness and competence and needing others to survive. Such as, "I am completely helpless" and "I can function only if I have access to somebody competent"

Causal Factors of Obsessive-Compulsive Personality Disorder

Theorists who take a five-factor dimensional approach to understanding OCPD note that these individuals have excessively high levels of conscientiousness. This leads to extreme devotion to work, perfectionism, and excessive controlling behavior. They are also high on assertiveness and low on compliance. Individuals with obsessive-compulsive personalities have low levels of novelty seeking (i.e., they avoid change) and reward dependence (i.e., they work excessively at the expense of pleasurable pursuits) but high levels of harm avoidance (i.e., they respond strongly to aversive stimuli and try to avoid them). Recent research has also demonstrated that the OCPD traits show a modest genetic influence. The sociocultural factors that contribute to personality disorders are not well understood.

7.12 Treatment and Outcome

Personality disorders are generally very difficult to treat, in part because they are, by definition, relatively enduring, pervasive, and inflexible patterns of behavior and inner experience. Moreover, many different goals of treatment can be formulated, and some are more difficult to achieve than others. Goals might include reducing subjective distress, changing specific dysfunctional behaviors, and changing whole patterns of behavior or the entire structure of the personality.

In many cases, people with personality disorders enter treatment only at someone else's insistence, and they often do not believe that they need to change. Moreover, those from the odd/ eccentric Cluster A and the erratic/dramatic Cluster B have general difficulties in forming and maintaining good relationships, including with a therapist. For those from the erratic/dramatic Cluster B, the pattern of acting out typical in their other relationships is carried into the therapy situation, and instead of dealing with their problems at the verbal level they may become angry at their therapist and loudly disrupt the sessions. Non-completion of treatment is a particular problem in the treatment of personality disorders.

In addition, people who have a personality disorder in addition to another disorder (such as depression or an eating disorder) do not, on average, do as well in treatment for their other disorder as do patients without comorbid personality disorders. This is partly because people with personality disorders have rigid, ingrained personality traits that often lead to poor

therapeutic relationships and additionally make them resist doing the things that would help improve their other conditions.

7.13 Let Us Sum Up

Personality disorders appear to be rather inflexible and distorted behavioural patterns and traits that result in maladaptive ways of perceiving, thinking about , and relating to other people and the environment. Cluster A include paranoid, schizoid and schizotypal personality disorders; individuals with these disorders seem odd or eccentric. Cluster B includes histrionic, narcissistic, antisocial, and borderline personality disorders; individuals with these disorders share a tendency to be dramatic, emotional and erratic. s Cluster C includes avoidant, dependent, and obsessive-compulsive personality disorders; individuals with these disorders show fearfulness or tension, as in anxiety-based disorders. A person with psychopathy shows elevated levels of two different dimension of traits: (1) an affective-interpersonal set of traits reflecting lack of remorse or guilt, callousness/lack of empathy, glibness/superficial charm, grandiose sense of self-worth, and pathological lying, and (2) antisocial, impulsive, and socially deviant behaviour; irresponsibility and parasitic lifestyle. A person diagnosed with antisocial personality disorder (ASPD) is primarily characterized by traits from the second dimension of psychopathy.

7.14 Unit-End Exercises

1. Describe the different personality disorders.
2. Give an account of different causal factors of personality disorders.
3. Why is treating personality disorder difficult? What is the solution for it?

7.15 Answer To Check Your Progress

1. People with Cluster A disorders often seem odd or eccentric, with unusual behaviour ranging from distrust and suspiciousness to social detachment.
2. Individuals with Cluster B disorders share a tendency to be dramatic, emotional and erratic.
3. People with Cluster C personality disorders often show anxiety and fearfulness.
4. People with OCPD have lifestyles characterized by over-conscientiousness, high neuroticism, inflexibility, and perfectionism; they do not have true obsessions or compulsive rituals as in OCD.
5. Conduct disorder

7.16 Suggested Readings

1. Butcher, J. N., Hooley, J. M., Mineka, S., &Dwivedi, C.B. (2017). *Abnormal Psychology*. Noida: Thomson Press India Ltd.
2. Carson, R. C., & Butcher, J. N. (2007). *Abnormal Psychology*. New Delhi: Pearson Education Inc.
3. Sarason&Sarason (2010). *Abnormal Psychology: The Problem of Maladaptive Behaviour* (11thEdn). New Delhi: Prentice Hall of India Pvt Ltd.

BLOCK III: THERAPY AND ASSESSMENT
UNIT VIII: THERAPY

Structure

8.1 INTRODUCTION

The belief that people with psychological problems can change-can learn more adaptive ways of perceiving, evaluating and behaving - is the conviction underlying all psychotherapy. **Psychotherapy** (psychological therapy or talking therapy) is the use of psychological methods, particularly when based on regular personal interaction, to help a person change behavior and overcome problems in desired ways. Psychotherapy aims to improve an individual's well-being and mental health, to resolve or mitigate troublesome behaviors, beliefs, compulsions, thoughts, or emotions, and to improve relationships and social skills. Certain psychotherapies are considered evidence-based for treating some diagnosed mental disorders. Others have been criticized as pseudoscience.

There are over a thousand different psychotherapy techniques, some being minor variations, while others are based on very different conceptions of psychology, ethics (how to live), or techniques. Most involve one-to-one sessions, between client and therapist, but some are conducted with groups, including families. Therapists offer many different types of psychotherapy, and may possess specific training in different treatments. In determining the most appropriate therapy or therapies for an individual, a psychotherapist will consider the problem to be treated and the individual's personality, cultural and family background, and personal experiences. Each type has certain characteristic techniques, which may be especially useful in treating people with particular conditions, but most are broadly effective, and all share many commonalities.

8.2 OBJECTIVES

At the end of this unit, you will:
- Understand the different approaches to therapy
- Know the rationale and assumptions behind different therapies
- Identify the usefulness of various approaches in treatment of different problems

8.3 PSYCHOLOGICAL APPROACHES

An approach is a perspective or view that involves certain assumptions or beliefs about human behavior: the way they function, which aspects of them are worthy of study and what research methods are appropriate for undertaking this study. Psychological Approaches target the "software," learned faulty behaviors and habits, along with damaging words, thoughts, interpretations, and feedback that direct strategies for daily living. Psychological approaches assume that many disorders result from mental, behavioral, and social factors, such as personal experiences, traumas, conflicts, and environmental conditions. Psychological treatments attempt to change behaviors, thoughts, and thought processes that impair daily living, thereby improving functioning. Practiced by clinical psychologists, psychiatrists, social workers and counselors, psychological treatments include four types of psychotherapy. There may be several different theories within an approach, but they all share these common assumptions. Although psychologists may blend concepts from more than one approach, each approach represents a distinct view of the central issues in psychology.

Check your Progress -1

Note: a. Write your answer in the space given below

     b. Compare your answer with those given at the end of the unit

        1. Explain the assumptions behind psychological approaches in treatment of abnormal behaviour.

8.4 BEHAVIOUR THERAPY

Behavior therapy or behavioral psychotherapy is a broad term referring to clinical psychotherapy that uses techniques derived from behaviorism. Those who practice behavior therapy tend to look at specific, learned behaviors and how the environment influences those behaviors. Those who practice behavior therapy are called behaviourists, or behavior analysts. They tend to look for treatment outcomes that are objectively measurable. Behavior therapy does not involve one specific method but it has a wide

range of techniques that can be used to treat a person's psychological problems. Traditional behavior therapy draws from respondent conditioning and operant conditioning to solve patients' problems. Applied behavior analysis (ABA) is the application of behavior analysis that focuses on assessing how environmental variables influence learning principles, particularly respondent and operant conditioning, to identify potential behavior-change procedures, which are frequently used throughout clinical therapy.Behaviour therapy is a direct and active treatment that recognizes the importance of behaviour, acknowledges the role of learning, and includes a thorough assessment and evaluation.Instead of exploring past traumatic events or inner conflicts, behaviour therapists' focus on the presenting problem-the problem or symptom that is causing the patient great distress. A major assumption of behaviour therapy is that abnormal behaviour is acquired in the same way as normal behaviour - that is by learning. A variety of behavioural techniques have therefore been developed to help patients "unlearn" maladaptive behaviors by one means or another.

8.4.1 EXPOSURE THERAPY

Exposure therapy is a technique in psychological treatment of anxiety disorders that involves exposing the patient to the feared object or context without any danger in order to overcome the anxiety.If anxiety is learned, then, from the behaviour therapy perspective it can be unlearned. This accomplished through guided exposure to anxiety-provoking stimuli. During exposure therapy, the patient or client is confronted with the fear producing stimulus in a therapeutic manner. This can be accomplished in a very controlled, slow, and gradual way, as in **systematic desensitization** or in a more extreme manner as in **flooding**, in which the patient directly confronts the feared stimulus at full strength. The form of the exposure can be real which is known as **in vivo exposure** or imaginary which is known as **imaginal exposure.** An important development in behaviour therapy is the use of virtual reality to help overcome their fears and phobias.

The rationale behind systematic desensitization is quite simple: Find a behaviour that is incompatible with being anxious (such as being relaxed or experiencing something pleasant) and repeatedly pair this with the stimulus that provokes anxiety in the patient. Because it is difficult to feel both anxious and relaxed at the same time, systematic desensitization is aimed at teaching a person, while in the presence of (real or imagined) anxiety provoking stimulus, to behave in a relaxed way that is inconsistent with anxiety. In a way it is a type of counterconditioning procedure.

The use of exposure as a mode of therapy began in the 1950s, at a time when psychodynamic views dominated Western clinical practice and behavioral therapy was first emerging. South African psychologists and psychiatrists first used exposure as a way to reduce pathological fears, such as phobias and anxiety-related problems, and they brought their methods to England in the Maudsley Hospital training program.

Joseph Wolpe was one of the first psychiatrists to spark interest in treating psychiatric problems as behavioral issues. He sought consultation with other behavioral psychologists, among them James G. Taylor , who worked in the psychology department of the University of Cape Town in South Africa. Although most of his work went unpublished, Taylor was the first psychologist known to use exposure therapy treatment for anxiety, including methods of situational exposure with response prevention—a

common exposure therapy technique still being used. Since the 1950s several sorts of exposure therapy have been developed, including systematic desensitization, flooding, implosive therapy, prolonged exposure therapy, in vivo exposure therapy, and imaginal exposure therapy.

8.4.2 AVERSION THERAPY

Aversion therapy involves modifying undesirable behavior by the old fashioned method of punishment. Aversion therapy is a form of behavior therapy in which an aversive (causing a strong feeling of dislike or disgust) stimulus is paired with an undesirable behavior in order to reduce or eliminate that behavior. Aversion therapies can take many forms, for example: placing unpleasant-tasting substances on the fingernails to discourage nail-chewing; pairing the use of an emetic with the experience of alcohol; or pairing behavior with electric shocks of mild to higher intensities. For example, a person undergoing aversion therapy to stop smoking might receive an electrical shock every time they view an image of a cigarette. The goal of the conditioning process is to make the individual associate the stimulus with unpleasant or uncomfortable sensations.

During aversion therapy, the client may be asked to think of or engage in the behavior they enjoy while at the same time being exposed to something unpleasant, such as a bad taste, a foul smell, or even mild electric shocks. Once the unpleasant feelings become associated with the behavior, the hope is that the unwanted behaviors or actions will begin to decrease in frequency or stop entirely. Generally, aversion therapy tends to be successful while it is still under the direction of a therapist, but relapse rates are high. Once the individual is out in the real-world and exposed to the stimulus without the presence of the aversive sensation, it is highly likely that they will return to the previous behavior patterns.

8.4.3 MODELING

Modeling is a method used in certain techniques of psychotherapy whereby the client learns by imitation alone, without any specific verbal direction by the therapist. As the name implies, in modeling the client learns new skills by imitating another person, such as a parent or therapist, who performs the behavior to be acquired. A younger client may be exposed to behaviors or roles in peers who act as assistants to therapist & then be encouraged to imitate & practice the desired new responses. For example, modeling may be used to promote the learning of simple skills such as self-feeding for a profoundly intellectually disabled child, or more complex skills such as being more effective in social situations for a shy withdrawn adolescent. Bandura identified three kinds of models: live, verbal, and symbolic.

8.4.5 SYSTEMATIC USE OF REINFORCEMENT

It is a behavior modification technique in which appropriate behavior is strengthened through systematic reinforcement. Systematic programs that use reinforcement to suppress (extinguish) unwanted behavior or to elicit and maintain desired behavior have achieved notable success. Often called contingency management programs, these approaches are often used in institutional settings, although that is not always the case. Examples of such approaches are **response shaping** and **token economies**. In response shaping, positive reinforcement is used to establish, by gradual approximation, a response that is actively resisted or is not initially in an individual's behavioural repertoire. Token economy is based on operant

conditioning and resembles the outside world, where an individual is paid for their work in tokens that can later be exchanged for desired objects or activities.

8.4.6 TREATMENT OUTCOMES

Systematic desensitization has been shown to successfully treat phobias about heights, driving, insects as well as any anxiety that a person may have. Anxiety can include social anxiety, anxiety about public speaking as well as test anxiety. It has been shown that the use of systematic desensitization is an effective technique that can be applied to a number of problems that a person may have.

When using modeling procedures this technique is often compared to another behavioural therapy technique. When compared to desensitization, the modeling technique does appear to be less effective. However it is clear that the greater the interaction between the patient and the subject he is modeling the greater the effectiveness of the treatment.

While undergoing exposure therapy a person usually needs five sessions to see if the treatment is working. After five sessions exposure treatment is seen to benefit the patient and help with their problems. However even after five sessions it is recommended that the patient or client should still continue treatment.

Virtual Reality treatment has shown to be effective for a fear of heights. It has also been shown to help with the treatment of a variety of anxiety disorders. Virtual reality therapy can be very costly so therapists are still awaiting results of controlled trials for VR treatment to see which applications show the best results.

For those with suicidal ideation treatment depends on how severe the person's depression and feeling of hopelessness is. If these things are severe the person's response to completing small steps will not be of importance to them because they don't consider it to be a big deal. Generally those who aren't severely depressed or fearful, this technique has been successful because the completion of simpler activities build up their confidence and allows them to continue on to more complex situations.

Contingency contracts have been seen to be effective in changing any undesired behaviours of individuals. It has been seen to be effective in treating behaviour problems in delinquents regardless of the specific characteristics of the contract.

Token economies have been shown to be effective when treating patients in psychiatric wards who had chronic schizophrenia. The results showed that the contingent tokens were controlling the behaviour of the patients.

8.4.7 EVALUATING BEHAVIOUR THERAPY

Compared to some other forms of therapy, behaviour therapy has some distinct advantages. Behavior therapy usually achieves results in a short period of time because it's generally directed to specific symptoms, leading to faster relief of a clients' distress and to lower costs. The methods used are delineated and the results can be readily evaluated. Overall, the outcomes achieved by behavioural therapy compare very favourably with those of other approaches.

Generally the more pervasive and vaguely defined the clients problem, the less likely behavior therapy is to be useful. For example, it appears to be only rarely employed to treat complex personality disorders, although *dialectical behavior therapy* for patients with borderline personality disorders is an exception. Behavioural techniques remain central to the

treatment of anxiety disorders. Because behavioural treatments are quite straightforward, behavior therapy can be used with psychotic patients.

Check your Progress -2

Note: a.Write your answer in the space given below

   b.Compare your answer with those given at the end of the unit

    2. List the varied behavioral therapy techniques.

8.5 COGNITIVE AND COGNITIVE-BEHAVIOUR THERAPY

The early behavior therapists focused on observable behavior and regarded the inner thoughts of their clients as unimportant. However, starting in the 1970s, a number of behavior therapists began to reappraise the importance of "private events"- thoughts, perceptions, evaluations and self statements- and started to see them as processes that mediated the effects of objective stimulus conditions to determine behavior and emotions.

Cognitive and cognitive-behavioural therapy stem from both cognitive psychology (with its emphasis on the effects of thoughts on behaviour) and behaviorism (with rigorous methodology and performance oriented focus). No single set of techniques defines cognitively oriented treatment approaches. However two main themes are important: (1) the conviction that cognitive processes influence emotion, motivation, and behavior; and (2) the use of cognitive and behavior-change techniques in a hypothesis testing manner. Cognitive behavioral therapy (CBT) is a type of psychotherapeutic treatment that helps patients understand the thoughts and feelings that influence behaviors. CBT is commonly used to treat a wide range of disorders, including phobias, addictions, depression, and anxiety. Cognitive behavior therapy is generally short-term and focused on helping clients deal with a very specific problem. During the course of treatment, people learn how to identify and change destructive or disturbing thought patterns that have a negative influence on behavior and emotions.

8.5.1 RATIONAL EMOTIVE BEHAVIOR THERAPY

The first form of behaviorally oriented cognitive therapy was developed by Albert Ellis and called Rational emotive behavior therapy (REBT). REBT attempts to change a client's maladaptive thought process, on which maladaptive emotional responses and thus behavior, are presumed to depend. Rational Emotive Behavior Therapy (REBT) focuses on resolving emotional and behavioral problems. The goal of the therapy is to change irrational beliefs to more rational ones.

REBT encourages a person to identify their general and irrational beliefs (e.g. I must be perfect") and subsequently persuades the person challenge these false beliefs through reality testing. Cognitive therapy and rational emotive behavior therapy acknowledge the least amount of unconscious processing; i.e., are perhaps the most conscious-centric contemporary psychological interventions. They assume that cognitive biases cause all psychological distress and aim to help people think differently about themselves and other people.

It is heavily cognitive and philosophic, and specifically uncovers clients' irrational or dysfunctional beliefs and actively-directively disputes them. But it also sees people's self-defeating cognitions, emotions, and behaviors as intrinsically and holistically connected, not disparate. People disturb themselves with disordered thoughts, feelings, and actions, all of which importantly interact with each other and with the difficulties they encounter in their environment. Therefore, with emotionally and behaviorally

disturbed people, REBT employs a number of thinking, feeling, and action techniques that are designed to help them change their self-defeating and socially sabotaging conduct to self-help and socially effective ways. Ellis believes that people often forcefully hold on to this illogical way of thinking, and therefore employs highly emotive techniques to help them vigorously and forcefully change this irrational thinking. Ellis's rational emotional behaviour therapy attends less to faulty inferences and more to the fundamental evaluations we make about the world. The task of REBT is to restructure an individual's belief and self-evaluation, especially with respect to the irrational "shoulds", "oughts" and "musts" that are preventing the individual from having a more positive sense of self-worth and an emotionally satisfying, fulfilling life.

Rational emotive behavior therapists have cited many studies in support of this approach. Most early studies were conducted on people with experimentally induced anxieties or non-clinical problems such as mild fear of snakes. However, a number of recent studies have been done on actual clinical subjects and have also found that rational emotive behavior therapy (REBT) is often helpful.

8.5.2 BECK'S COGNITIVE THERAPY

Beck's (1967) system of therapy is similar to Ellis's, but has been most widely used in cases of depression. Cognitive therapists help clients to recognize the negative thoughts and errors in logic that cause them to be depressed.

The therapist also guides clients to question and challenge their dysfunctional thoughts, try out new interpretations, and ultimately apply alternative ways of thinking in their daily lives. Beck's cognitive therapy focuses on errors in information processing. Aaron Beck believes that a person's reaction to specific upsetting thoughts may contribute to abnormality. As we confront the many situations that arise in life, both comforting and upsetting thoughts come into our heads. Beck calls these unbidden cognition's automatic thoughts.

When a person's stream of automatic thoughts is very negative you would expect a person to become depressed. Now however this form of treatment is used for a broad range of conditions, including eating disorders and obesity personality disorders, substance abuse, and even schizophrenia. The cognitive model is basically an information processing model of psychopathology. A fundamental assumption of the cognitive model is that problems result from biased processing of external events or internal stimuli. These biases distort the way that a person makes sense of their experiences i=of the world, leading to cognitive errors. It was found that the therapy was more successful than drug therapy and had a lower relapse rate, supporting the proposition that depression has a cognitive basis.

This suggests that knowledge of the cognitive explanation can improve the quality of people's lives.

8.5.3 Differences between REBT & Cognitive Therapy

• Albert Ellis views the therapist as a teacher and does not think that a warm personal relationship with a client is essential. In contrast, Beck stresses the quality of the therapeutic relationship.

• REBT is often highly directive, persuasive and confrontive. Beck places more emphasis on the client discovering misconceptions for themselves.

• REBT uses different methods depending on the personality of the client, in Beck's cognitive therapy, the method is based upon the particular disorder.

8.5.4 Strengths of CBT

1. Model has great appeal because it focuses on human thought. Human cognitive abilities has been responsible for our many accomplishments so may also be responsible for our problems.

2. Cognitive theories lend themselves to testing. When experimental subjects are manipulated into adopting unpleasant assumptions or thought they became more anxious and depressed.

3. Many people with psychological disorders, particularly depressive , anxiety , and sexual disorders have been found to display maladaptive assumptions and thoughts (Beck et al., 1983).

4. Cognitive therapy has been very effective for treating depression (Hollon& Beck, 1994), and moderately effective for anxiety problems (Beck, 1993).

8.5.5 Limitations of CBT

1. The precise role of cognitive processes is yet to be determined. It is not clear whether faulty cognitions are a cause of the psychopathology or a consequence of it.

Lewinsohn (1981) studied a group of participants before any of them became depressed, and found that those who later became depressed were no more likely to have negative thoughts than those who did not develop depression. This suggests that hopeless and negative thinking may be the result of depression, rather than a cause of it.

2. The cognitive model is narrow in scope - thinking is just one part of human functioning, broader issues need to be addressed.

3. Ethical issues: RET is a directive therapy aimed at changing cognitions sometimes quite forcefully. For some, this may be considered an unethical approach

8.6 HUMANISTIC-EXPERIENTIAL THERAPY

Humanistic and existential psychotherapies use a wide range of approaches to case conceptualization, therapeutic goals, intervention strategies, and research methodologies. They are united by an emphasis on understanding human experience and a focus on the client rather than the symptom. Psychological problems (including substance abuse disorders) are viewed as the result of inhibited ability to make authentic, meaningful, and self-directed choices about how to live. Consequently, interventions are aimed at increasing client self-awareness and self-understanding.

Whereas the key words for humanistic therapy are acceptance and growth, the major themes of existential therapy are client responsibility and freedom. Many aspects of humanistic and existential approaches (including empathy, encouragement of affect, reflective listening, and acceptance of the client's subjective experience) are useful in any type of brief therapy session, whether it involves psychodynamic, strategic, or cognitive-behavioral therapy. They help establish rapport and provide grounds for meaningful engagement with all aspects of the treatment process. Also known as humanism, humanistic therapy is a positive approach to psychotherapy that focuses on a person's individual nature, rather than categorizing groups of people with similar characteristics as having the same problems. Humanistic therapy looks at the whole person, not only

from the therapist's view but from the viewpoint of individuals observing their own behavior. The emphasis is on a person's positive traits and behaviors, and the ability to use their personal instincts to find wisdom, growth, healing, and fulfillment within themselves. Humanistic therapy is used to treat depression, anxiety, panic disorders, personality disorders, schizophrenia, addiction, and relationship issues, including family relationships. People with low self-esteem, who are having trouble finding their purpose or reaching their true potential, who lack feelings of "wholeness," who are searching for personal meaning, or who are not comfortable with themselves as they are, may also benefit from humanistic therapy.

8.6.1 CLIENT CENTERED THERAPY

The client centered therapy or person centered therapy of Carl Rogers focuses on the natural power of the organism to heal itself. Rogers saw therapy as a process of removing the constraints and restrictions that grow out of unrealistic demands that people tend to place on themselves when they believe as a condition of self-worth, that they should not have certain kinds of feelings such as hostility. By denying these feelings they lose touch with their own genuine experience which results in lowered integration, impaired personal relationships and various forms of maladjustment. Carl Rogers' client-centered therapy assumes that the client holds the keys to recovery but notes that the therapist must offer a relationship in which the client can openly discover and test his own reality, with genuine understanding and acceptance from the therapist. Therapists must create three conditions that help clients change:

1. Unconditional positive regard
2. A warm, positive, and accepting attitude that includes no evaluation or moral judgment
3. Accurate empathy, whereby the therapist conveys an accurate understanding of the client's world through skilled, active listening

According to Carson, the client-centered therapist believes that

- Each individual exists in a private world of experience in which the individual is the center.
- The most basic striving of an individual is toward the maintenance, enhancement, and actualization of the self.
- An individual reacts to situations in terms of the way he perceives them, in ways consistent with his self-concept and view of the world.
- An individual's inner tendencies are toward health and wholeness; under normal conditions, a person behaves in rational and constructive ways and chooses pathways toward personal growth and self-actualization .

A client-centered therapist focuses on the client's self-actualizing core and the positive forces of the client (i.e., the skills the client has used in the past to deal with certain problems). The client should also understand the unconditional nature of the therapist's acceptance. This type of therapy aims not to interpret the client's unconscious motivation or conflicts but to reflect what the client feels, to overcome resistance through consistent acceptance, and to help replace negative attitudes with positive ones.

Rogers' techniques are particularly useful for the therapist who is trying to address a substance-abusing client's denial and motivate her for further

treatment. For example, the techniques of motivational interviewing draw heavily on Rogerian principles

8.6.2 MOTIVATIONAL INTERVIEWING

People tend to be ambivalent about making changes in lives. They want to change, but they also don't want to change. Motivational interviewing is a brief form of therapy that can be delivered in one or two sessions. It was developed as a way to help people resolve their ambivalence about change and make a commitment to treatment. At its center is a supportive and empathetic style of relating to the client has its origin in the work of Carl Rogers. However, MI differs from client centered counselling because it also employs a more direct approach that explores the clients own reason for wanting change .Motivational interviewing is most often used in the areas of substance abuse and addiction. When added to the beginning of a treatment program, it appears to benefit patients perhaps because it facilitates patients staying in treatment and following treatment plan. The collaborative and non-confrontational style of MI may also make it more acceptable to adolescents. Even a small number of sessions of MI can promote behavior change in people who use drugs and alcohol.

8.6.3 GESTALT THERAPY

Humanistic therapy is talk therapy that to a great deal encompasses a Gestalt approach, exploring how a person feels in the here and now, rather than trying to identify past events that led to these feelings. Additionally, the humanistic therapist provides an atmosphere of support, empathy, and trust that allows the individual to share their feelings without fear of judgment. The therapist does not act as an authority figure; rather, the relationship between client and therapist is one of equals. In German, the term Gestalt means "whole" and Gestalt therapy emphasizes the unity of mind and body- placing strong emphasis on the need to integrate thought, feeling and action. The word "Gestalt" means whole. Gestalt therapy was developed by psychotherapist Fritz Perls on the principle that humans are best viewed as a whole entity consisting of body, mind, and soul, and best understood when viewed through their own eyes, not by looking back into the past but by bringing the past into the present. Gestalt therapy emphasizes that to alleviate unresolved anger, pain, anxiety, resentment, and other negative feelings, these emotions cannot just be discussed, but must be actively expressed in the present time. If that doesn't happen, both psychological and physical symptoms can arise. Perls believed that we are not in this world to live up to others' expectations, nor should we expect others to live up to ours. By building self-awareness, gestalt therapy helps clients better understand themselves and how the choices they make affect their health and their relationships. With this self-knowledge, clients begin to understand how their emotional and physical selves are connected and develop more self-confidence to start living a fuller life and more effectively deal with problems. Gestalt therapy can help clients with issues such as anxiety, depression, self-esteem, relationship difficulties, and even physical ones like migraine headaches, ulcerative colitis, and back spasms. It helps clients focus on the present and understand what is really happening in their lives right now, rather than what they may perceive to be happening based on past experience. Instead of simply talking about past situations, clients are encouraged to experience them, perhaps through re-enactment. Through the Gestalt process, clients learn to become more aware of how their own negative thought patterns and behaviors are

blocking true self-awareness and making them unhappy. Gestalt techniques are often used in combination with body work, dance, art, drama, and other therapies.

8.6.4 EVALUATING HUMANISTIC-EXPERIENTIAL THERAPIES

One of the main strengths of the humanistic-existential model of psychology is that it is optimistic. Instead of focusing on what's lacking in people, it looks at the potential of people to become great. The health part of mental health is stressed; that is, the focus is on what the healthiest and happiest people do and what everyone else can do to get there.

Another strength of the humanistic-existential model of psychology is that it emphasizes individuality and autonomy. Patients are encouraged to focus on their decisions, and great stress is given to free will. Therapists reinforce their patients' ability to choose and act according to their own internal compass.

There's also a strong emphasis on the individual's own experiences and viewpoints. No two people are alike, and so no two patients are expected to have the same ideas, feelings, and experiences. As a result, humanistic-experiential therapy is tailor made for each patient. However there are some limitations of this therapy for one being that it is based on philosophical concepts that are abstract and somewhat vague. As a result it is not empirical in nature, that is , it is non-scientific and hard to validate. It has also been criticized for their lack of agreed-upon therapeutic procedures.

8.7 PSYCHODYNAMIC THERAPY

Psychodynamics emphasizes systematic study of the psychological forces that underlie human behavior, feelings, and emotions and how they might relate to early experience. It is especially interested in the dynamic relations between conscious motivation and unconscious motivation. Psychodynamic therapy is similar to psychoanalytic therapy, which is based on the idea that a person's development is often determined by forgotten events in early childhood. Psychodynamic therapy tends to be briefer and less intensive than traditional psychoanalysis. Psychodynamic therapy works to uncover repressed childhood experiences that are thought to explain an individual's current difficulties. There are several forms of psychodynamic therapy, such as interpersonal therapy (IPT) and person-centered therapy. Sigmund Freud first used the term "psychodynamics" to describe the processes of the mind as flows of psychological energy in an organically complex brain. Psychodynamic therapy uses free association and focuses on unconscious conflicts, defense mechanisms, transference, and current symptoms. While the effectiveness of psychodynamic therapy is difficult to measure, several studies have indicated its usefulness in treatment. However, this form of therapy is often criticized for its lack of quantitative and experimental research" Psychotherapy" is a general term that encompasses a wide variety of approaches to treatment. One such approach is psychodynamic therapy, which studies the psychological forces underlying human behavior, feelings, and emotions, as well as how they may relate to early childhood experience. This theory is especially interested in the dynamic relations between conscious and unconscious motivation; it asserts that behavior is the product of underlying conflicts of which people often have little awareness. The primary focus of psychodynamic therapy is to uncover the unconscious content of a client's

psyche in order to alleviate psychic tension. Psychodynamic therapy is similar to psychoanalytic therapy, or psychoanalysis, in that it works to uncover repressed childhood experiences that are thought to explain an individual's current difficulties. Psychoanalytic therapy is based on the ideas that a person's development is often determined by forgotten events in early childhood, and that human behavior and dysfunction are largely influenced by irrational drives that are rooted in the unconscious.

In terms of approach, psychodynamic therapy tends to be briefer and less intensive than traditional psychoanalysis; it adapts some of the basic principles of psychoanalysis to a less intensive style of working, usually at a frequency of once or twice per week. Compared to other forms of therapy, psychodynamic therapy emphasizes the relationship between client and therapist as an agent of change.

Psychodynamic theory emphasizes the systematic study of the psychological forces that underlie human behavior. It is especially interested in the dynamic relations between conscious motivation and unconscious motivation. In the treatment of psychological distress, psychodynamic therapies target the client's inner conflict, from where repressed behaviors and emotions surface into the patient's consciousness. All psychodynamic therapies have a core set of characteristics:

- An emphasis on unconscious conflicts and their relation to development, dysregulation, and dysfunction.
- The belief that defense mechanisms are responses that develop in order to avoid unpleasant consequences of conflict.
- The belief that psychopathology develops from early childhood experiences.
- The idea that representations of experiences are founded upon interpersonal relations.
- A conviction that life issues and dynamics will re-emerge in the context of the client-therapist relationship as transference and countertransference.
- The use of free association as a core method to explore internal conflicts. During free association, patients are invited to relate whatever comes to mind during the therapeutic session, without censoring their thoughts.
- The focus on interpretations of defense mechanisms (often unconscious coping techniques that reduce anxiety arising from unacceptable or potentially harmful impulses), transference (a phenomenon in which a patient unconsciously redirects their feelings onto the therapist or another person), and current symptoms.

Psychodynamic therapy is primarily used to treat depression and other serious psychological disorders, especially in those who have lost meaning in their lives and have difficulty forming or maintaining personal relationships. Studies have found that other effective applications of psychodynamic therapy include addiction, social anxiety disorder, and eating disorders. The theories and techniques that distinguish psychodynamic therapy from other types of therapy include a focus on recognizing, acknowledging, understanding, expressing, and overcoming negative and contradictory feelings and repressed emotions in order to improve the patient's interpersonal experiences and relationships. This includes helping the patient understand how repressed earlier emotions

affect current decision-making, behavior, and relationships. Psychodynamic therapy also aims to help those who are aware of and understand the origins of their social difficulties, but are not able to overcome their problems on their own. Patients learn to analyze and resolve their current issues and change their behavior in current relationships through this deep exploration and analysis of earlier experiences and emotions.

8.7.1 FREUDIAN PSYCHOANALYSIS

Psychoanalysis was founded by Sigmund Freud (1856-1939). Freud believed that people could be cured by making conscious their unconscious thoughts and motivations, thus gaining insight.

The aim of psychoanalysis therapy is to release repressed emotions and experiences, i.e., make the unconscious conscious. It is only having a cathartic (i.e., healing) experience can the person be helped and "cured." In psychoanalysis (therapy) Freud would have a patient lie on a couch to relax, and he would sit behind them taking notes while they told him about their dreams and childhood memories. Psychoanalysis would be a lengthy process, involving many sessions with the psychoanalyst. Due to the nature of defense mechanisms and the inaccessibility of the deterministic forces operating in the unconscious, psychoanalysis in its classic form is a lengthy process often involving 2 to 5 sessions per week for several years. This approach assumes that the reduction of symptoms alone is relatively inconsequential as if the underlying conflict is not resolved, more neurotic symptoms will simply be substituted. The analyst typically is a 'blank screen,' disclosing very little about themselves in order that the client can use the space in the relationship to work on their unconscious without interference from outside.

The psychoanalyst uses various techniques as encouragement for the client to develop insights into their behavior and the meanings of symptoms, including ink blots, parapraxes, free association, interpretation (including dream analysis), resistance analysis and transference analysis.

Free Association

A simple technique of psychodynamic therapy, is free association, in which a patient talks of whatever comes into their mind.

This technique involves a therapist reading a list of words (e.g.. mother, childhood, etc.) and the patient immediately responds with the first word that comes to mind. It is hoped that fragments of repressed memories will emerge in the course of free association.

Free association may not prove useful if the client shows resistance, and is reluctant to say what he or she is thinking. On the other hand, the presence of resistance (e.g., an excessively long pause) often provides a strong clue that the client is getting close to some important repressed idea in his or her thinking, and that further probing by the therapist is called for.

Freud reported that his free associating patients occasionally experienced such an emotionally intense and vivid memory that they almost relived the experience. This is like a "flashback" from a war or a rape experience.

Such a stressful memory, so real it feels like it is happening again, is called an abreaction. If such a disturbing memory occurred in therapy or with a supportive friend and one felt better--relieved or cleansed--later, it would be called a catharsis.

Frequently, these intense emotional experiences provided Freud a valuable insight into the patient's problems.

Dream Analysis

According to Freud the analysis of dreams is "the royal road to the unconscious." He argued that the conscious mind is like a censor, but it is less vigilant when we are asleep. As a result, repressed ideas come to the surface - though what we remember may well have been altered during the dream process. As a result, we need to distinguish between the manifest content and latent content of a dream. The former is what we actually remember. The latter is what it really means. Freud believed that very often the real meaning of a dream had a sexual significance and in his theory of sexual symbolism he speculates on the underlying meaning of common dream themes.

Analysis of resistance

Resistance, in psychoanalysis, refers to oppositional behavior when an individual's unconscious defenses of the ego are threatened by an external source. Sigmund Freud, the founder of psychoanalytic theory, developed his concept of resistance as he worked with patients who suddenly developed uncooperative behaviors during sessions of talk therapy. He reasoned that an individual that is suffering from a psychological affliction, which Sigmund Freud believed to be derived from the presence of suppressed illicit or unwanted thoughts, may inadvertently attempt to impede any attempt to confront a subconsciously perceived threat. This would be for the purpose of inhibiting the revelation of any repressed information from within the unconscious mind.

Analysis of transference

Transference refers to redirection of a patient's feelings for a significant person to the therapist. Transference is often manifested as an erotic attraction towards a therapist, but can be seen in many other forms such as rage, hatred, mistrust, substituting as a parent, extreme dependence, or even placing the therapist in a god-like or guru status. When Freud initially encountered transference in his therapy with patients, he thought he was encountering patient resistance, as he recognized the phenomenon when a patient refused to participate in a session of free association. But what he learned was that the analysis of the transference was actually the work that needed to be done: "the transference, which, whether affectionate or hostile, seemed in every case to constitute the greatest threat to the treatment, becomes its best tool". The focus in psychodynamic psychotherapy is, in large part, the therapist and patient recognizing the transference relationship and exploring the relationship's meaning. Since the transference between patient and therapist happens on an unconscious level, psychodynamic therapists who are largely concerned with a patient's unconscious material use the transference to reveal unresolved conflicts patients have with childhood figures.

Countertransference is defined as redirection of a therapist's feelings toward a patient, or more generally, as a therapist's emotional entanglement with a patient. A therapist's attunement to their own countertransference is nearly as critical as understanding the transference. Not only does this help therapists regulate their emotions in the therapeutic relationship, but it also gives therapists valuable insight into what patients are attempting to elicit in them. For example, a therapist who is sexually attracted to a patient must understand the countertransference aspect (if any) of the attraction, and look at how the patient might be eliciting this attraction. Once any countertransference aspect has been identified, the therapist can ask the

patient what his or her feelings are toward the therapist, and can explore how those feelings relate to unconscious motivations, desires, or fears.

Another contrasting perspective on transference and countertransference is offered in classical Adlerian psychotherapy. Rather than using the patient's transference strategically in therapy, the positive or negative transference is diplomatically pointed out and explained as an obstacle to cooperation and improvement. For the therapist, any signs of countertransference would suggest that his or her own personal training analysis needs to be continued to overcome these tendencies

8.7.2 EVALUATING PSYCHODYNAMIC THERAPIES

Therapy is very time-consuming and is unlikely to provide answers quickly. People must be prepared to invest a lot of time and money into the therapy; they must be motivated. They might discover some painful and unpleasant memories that had been repressed, which causes them more distress. This type of therapy does not work for all people and all types of disorders. The nature of Psychoanalysis creates a power imbalance between therapist and client that could raise ethical issues.

Fisher and Greenberg (1977), in a review of the literature, conclude that psychoanalytic theory cannot be accepted or rejected as a package, 'it is a complete structure consisting of many parts, some of which should be accepted, others rejected and the others at least partially reshaped.'

Freud's theory questions the very basis of a rationalist, scientific approach and could well be seen as a critique of science, rather than science rejecting psychoanalysis because it is not susceptible to disproof. The case study method is criticized as it is doubtful that generalizations can be valid since the method is open to many kinds of bias. However, psychoanalysis is concerned with offering interpretations to the current client, rather than devising abstract dehumanized principles.

Check your Progress -3

Note: a.Write your answer in the space given below

b.Compare your answer with those given at the end of the unit

3. What is transference and countertransference?

8.8 Marital And Family Therapy

Many problems that therapists deal with concern distressed relationships. A common example is couple or marital distress. Here, the maladaptive behavior exists between the partners in the relationship. Extending the focus even further, a family systems approach reflects the assumption that within the family behavior of any particular family member is subject to the influence of the behaviors and communication patterns of other family members. It is in other words, the product of a "system" that may be amenable to both understanding and change. Addressing problems deriving from the in-place system thus requires therapeutic techniques that focus on relationships as much as, or more than, on individuals. Marriage and Family Therapy (MFT) is a form of psychotherapy that addresses the behaviors of all family members and the way these behaviors affect not only individual family members, but also relationships between family members and the family unit as a whole. As such, treatment is usually divided between time spent on individual therapy and time spent on couple therapy, family therapy, or both, if necessary. MFT may also be referred to as couple and family therapy, couples counseling, marriage counseling, or

family counseling. The range of physical and psychological problems treated by MFT include marital and couple conflict, parent and child conflict, alcohol and drug abuse, sexual dysfunction, grief, distress, eating disorders and weight issues, children's behavior problems, and issues with eldercare, such as coping with a parent's or grandparent's dementia. MFT practitioners also work with mental-health issues such as a family member's depression, anxiety, or schizophrenia, and the impact these issues have on the rest of the family.

8.8.1 COUPLE THERAPY

Couples therapy has been found to be an efficacious treatment for persons with substance use problems. Therapy programmes which have included spouses have been found to be effective in motivating patients to enter and continue treatment. They have also been associated with better outcomes in treatment such as lower substance use, longer periods of abstinence and better marital functioning. The theoretical framework underlying couples therapy is an understanding of substance use and marital discord as being cyclic. Problems in the marital relationship, poor communication and poor problem solving may precede harmful use of substances, and dysfunctional relationships can maintain and facilitate the substance use. Marital and family conflicts also have the propensity to facilitate relapse. In a critique of 41 different treatments for alcohol problems, Behavioural Couples Therapy (BCT) was found to be the only type of family intervention and one of 16 therapies to have adequate empirical support for effectiveness. Hence, the National Institute of Clinical Excellence Guidelines recommends BCT for individuals with harmful drinking and alcohol dependence.

In BCT, the patient and spouse are typically seen together in 12-20 weekly outpatient sessions over a 3-6 month period. BCT can be an adjunct to other psychotherapeutic interventions or the mainstay in therapy. Indications for BCT are: availability of both partners for sessions; couples that are married or cohabiting at least for the last one year; one member with substance use problems. Contraindications for BCT are: couple ordered by court to have no contact with each other; gross cognitive impairment or psychosis; severe physical aggression; when both spouses have substance use problems. Relationship focused interventions are introduced once the patient has maintained abstinence and the couple is regular to sessions. The major goals of this part of the treatment are to enhance positive feelings, communication skills and problem solving. Communication skills include listening skills, expressing emotions directly and negotiation skill

Traditional behavioral couple therapy (TBCT; Jacobson &Margolin, 1979) has had the distinction of being the most widely studied and empirically supported intervention available for the treatment of relationship distress for more than two decades. TBCT was developed to target the dysfunctional patterns, communication difficulties, and poor problem-solving behaviors often associated with relationship discord. Based on social learning theory and findings from research with distressed couples, TBCT consists largely of strategies to promote skill acquisition and behavioral change among partners. Empirical support for the efficacy of TBCT is considerable; however, several studies have highlighted key limitations of this approach. In an effort to address the shortcomings of TBCT, Jacobson and Christensen (1996) developed Integrative Behavioral

Couple Therapy (IBCT). IBCT is grounded in contextually based behavioral theory and interweaves the well-established components of TBCT that promote accommodation and change between partners with newer acceptance-based strategies. Consequently, many of the treatment recommendations in IBCT share similarities with those proposed in several of the burgeoning treatment approaches based in contextual-behavioral theory that emphasize acceptance-based strategies, such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2000), Functional Analytic Psychotherapy (FAP; Kohlenberg& Tsai, 1991), and Dialectical Behavior Therapy (DBT; Linehan, 1993).

8.8.2 FAMILY THERAPY

The focus of family therapy treatment is to intervene in complex relational patterns and to alter them in ways that bring about productive change for the entire family. Family therapy rests on a systems perspective, which proposes that changes in one part of the system can and do produce changes in other parts of the system, and these changes can contribute to solutions. Family therapy in substance abuse treatment has two main purposes. First, it seeks to use the family's strengths and resources to help find or develop ways to live without substances of abuse. Second, it reduces the impact of chemical dependency on both the patient and the family. In family therapy, the focus of treatment is the family, and/or the individual within the context of the family system. The person abusing substances is regarded as a subsystem within the family unit—the person whose symptoms have severe repercussions throughout the family system. The familial relationships within this subsystem are the points of therapeutic interest and intervention.

Family is a key resource in the care of patients in India as its culture of inter-dependence gives the family a pre-eminent status. Psychoactive substance abuse and dependence has a significant deleterious impact on the family of the substance user. This impact can then lead to a chain of events which can not only spiral out of control but also spiral downward. In a study carried out in India, family burden was found to be moderate to severe in families with a substance dependent person. The burden was characterized by disruption of family interactions, disruption of family routine, disruption of family leisure and financial burden. According to Kumfer, since substance abuse is a 'family disease' of lifestyle, including both genetic and family environmental causes, effective family strengthening prevention programmes should be included in all comprehensive substance abuse prevention activities.The term 'Family Based Interventions' is used to describe a collection of intervention models that focus on family communication, cohesion, conflict and parenting practices. The most common evidenced based family interventions are Brief Strategic Family Therapy, Multidimensional Family Therapy, Family Behaviour Therapy, Functional Family Therapy and Community Reinforcement Programme. The goals of these interventions are to bring about systemic changes, skills building, enhancing positive family and social activities, improving communication, problem solving and making non-substance use rewarding. These interventions have shown better outcomes in terms of reduction in substance use, improved family relations, better work outcomes, adherence to treatment, treatment retention and long- term maintenance of gains.

Gender and culture are also significant in planning or developing a therapy that aims to modify the immediate social and cultural environment of the adolescent. For instance, abuse, abandonment and depression are key issues that must be addressed for girls with substance use disorders in treatment. Trauma models of substance abuse among girls and women indicate the need to make their family environments safer and healthier. Such gender sensitivity and targeting of delicate issues are very therapeutic and are key factors in reducing self-harm behaviours among girls and young women. Family interventions also effectively reduce intimate partner violence and thereby reduce child exposure to domestic violence (CEDV). The greater stigma attached to substance abuse among girls and women can also be addressed in family therapy in order to reduce feelings of shame and guilt. In addition, the professional treating a patient and family cannot overlook the cultural background that the patient's family comes from. Being culturally sensitive necessarily does not mean that the therapist must belong to the culture, but rather that they have developed sensitivity to the culture by gaining knowledge, observing and paying attention to various behaviours and dynamics and is ready to learn from the patients and their families. The therapist should understand how cultural differences influence substance abuse, health beliefs, help-seeking behaviour and perceptions of behavioural health services.

Structural family therapy (SFT) is a treatment that addresses patterns of interaction that create problems within families. Mental health issues are viewed as signs of a dysfunctional family; therefore, the focus of treatment is on changing the family structure rather than changing individual family members. The goal of SFT is to improve communications and interactions among family members and to highlight appropriate boundaries to create a healthier family structure. Families and children at risk, including single parents, blended families, and extended families, can benefit from SFT. Settings for SFT include private practice, mental health clinics, substance abuse programs, child welfare agencies, and schools.

8.9 Eclecticism And Integration

The various "school" of psychotherapy that we have just described once stood in opposition to one another than they do now. Today, clinical practice is characterized by a relaxation of boundaries and a willingness on the part of therapists to explore different ways of approaching clinical problems, a process sometimes called multimodal therapy. When asked what their orientation is most psychotherapists today reply "eclectic" which usually means that they try to borrow and combine concepts and techniques from various schools, depending on what seems best for the individual case. This inclusiveness extends to efforts to combine biological and psychosocial approaches as well as individual and family therapies. "Integrative" usually means that the therapy combines different approaches and fuses them together. Therapists are considered "eclectic" when they selectively apply techniques from a variety of approaches to best fit the needs.

One example of an eclectic therapy is interpersonal psychotherapy. IPT was originally developed to treat major depressive disorder. It's also used effectively to treat eating disorders, perinatal depression, drug and alcoholaddiction, dysthymia, and other mood disorders—including bipolar disorder. Interpersonal psychotherapy (IPT) is a brief, attachment-focused

psychotherapy that centers on resolving interpersonal problems and symptomatic recovery. It is an empirically supported treatment (EST) that follows a highly structured and time-limited approach and is intended to be completed within 12–16 weeks. IPT is based on the principle that relationships and life events impact mood and that the reverse is also true. It was developed by Gerald Klerman and Myrna Weissman for major depression in the 1970s and has since been adapted for other mental disorders. Interpersonal psychotherapy (IPT) is a time-limited, focused, evidence-based approach to treat mood disorders. The main goal of IPT is to improve the quality of a client's interpersonal relationships and social functioning to help reduce their distress. IPT provides strategies to resolve problems within four key areas.

Check your Progress -4

Note: a.Write your answer in the space given below

b.Compare your answer with those given at the end of the unit

4. What is eclectic therapy?

5. What is the difference between eclectic therapy and integrative therapy?

8.10   Let Us Sum Up

Psychotherapy (psychological therapy or talking therapy) is the use of psychological methods, particularly when based on regular personal interaction, to help a person change behavior and overcome problems in desired ways. Psychotherapy aims to improve an individual's well-being and mental health, to resolve or mitigate troublesome behaviors, beliefs, compulsions, thoughts, or emotions, and to improve relationships and social skills. Behavioural therapy is focused on human behaviour and looks to eradicate unwanted or maladaptive behaviour. Typically, this type of therapy is used for those with behavioural problems or mental health conditions that involve unwanted behaviour. Cognitive behavioral therapy (CBT) is a psycho-social intervention that aims to improve mental health. CBT focuses on challenging and changing unhelpful cognitive distortions (e.g. thoughts, beliefs, and attitudes) and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. Humanistic and existential psychotherapies use a wide range of approaches to case conceptualization, therapeutic goals, intervention strategies, and research methodologies. They are united by an emphasis on understanding human experience and a focus on the client rather than the symptom. Psychological problems (including substance abuse disorders) are viewed as the result of inhibited ability to make authentic, meaningful, and self-directed choices about how to live. Consequently, interventions are aimed at increasing client self-awareness and self-understanding. Psychodynamic psychotherapy or psychoanalytic psychotherapy is a form of depth psychology, the primary focus of which is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension.

Psychodynamic psychotherapy relies on the interpersonal relationship between client and therapist more than other forms of depth psychology. In terms of approach, this form of therapy uses psychoanalysis adapted to a less intensive style of working, usually at a frequency of once or twice per

week. Principal theorists drawn upon are Freud, Klein, and theorists of the object relations movement, e.g., Winnicott, Guntrip, and Bion.

Family therapy, also referred to as couple and family therapy, marriage and family therapy, family systems therapy, and family counseling, is a branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development. It tends to view change in terms of the systems of interaction between family members. It emphasizes family relationships as an important factor in psychological health. Eclectic therapy is a therapeutic approach that incorporates a variety of therapeutic principles and philosophies in order to create the ideal treatment program to meet the specific needs of the patient or client.

Psychodynamic therapy
• View: Problems are symptoms of unresolved traumas and conflicts
• Focus: Inner, often unconscious motivations as well as attempts to resolve conflicts between personal needs and social requirements
• Approach: By understanding and making more conscious the relationships between overt problems and the unresolved, internal conflicts that caused them, people can work through problems to reach an effective solution

Behavioral Therapy
• View: Problems are the result of learned, self-defeating behaviors
• Focus: Observable behavior and conditions that sustain unhealthy behavior
• Approach: By applying the principles of conditioning and reinforcement, people can learn healthy behaviors

Cognitive Therapy
• View: Problems are the result of what we think (cognitive content) and how we think (cognitive process), including distorted view of situations and self, faulty reasoning, and poor problem solving
• Focus: Thoughts and thought processes that cause problematic emotions and behaviors
• Approach: By reconfiguring damaging thinking patterns, people can learn healthy, realistic ways of thinking about life experiences

Existential/Humanistic Therapy
• View: Problems are the result of issues related to difficulties in daily life, especially a lack of both meaningful relationships and significant goals
• Focus: Ways to unite mind and body, that is, the whole person, and thus release the potential for greater levels of performance and greater richness of experience
• Approach: By examining experiences in current life situations, people can develop their individuality and learn how to realize their full potential

8.11   Unit-End Exercises

1. Describe the different techniques that can be used to provide anxious patients with exposure to the stimuli they fear.
2. In what ways are REBT and Cognitive therapy similar and in what ways are they different?
3. Discuss Psychodynamic therapies.
4. Explain humanistic-experiential therapy.

8.12   Answer to Check Your Progress

1. Psychological Approaches target the "software," learned faulty behaviors and habits, along with damaging words, thoughts, interpretations, and feedback that direct strategies for daily living. Psychological approaches assume that many disorders result from mental, behavioral, and social factors, such as personal experiences, traumas, conflicts, and environmental conditions.

2. Exposure therapy, aversion therapy, modeling and systematic use of reinforcement.

3. Transference is the process by which emotions and desires originally associated with one person, such as a parent, are unconsciously shifted to another. Countertransference is the transference of a therapist's own unconscious feelings to his or her patient; unconscious or instinctive emotion felt towards the patient.

4. Eclectic therapy is a therapeutic approach that incorporates a variety of therapeutic principles and philosophies in order to create the ideal treatment program to meet the specific needs of the patient or client.

5. "Integrative" usually means that the therapy combines different approaches and fuses them together. Therapists are considered "eclectic" when they selectively apply techniques from a variety of approaches to best fit your needs.

8.13   Suggested Readings

1. Butcher, J. N., Hooley, J. M., Mineka, S., &Dwivedi, C.B. (2017). Abnormal Psychology. Noida: Thomson Press India Ltd.
2. Carson, R. C., & Butcher, J. N. (2007). Abnormal Psychology. New Delhi: Pearson Education Inc.
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UNIT IX: PREVENTION

Structure

9.1 Introduction

Many mental health professionals are trying not only to cure mental health problems but also to prevent them, or at least to reduce their effects. Prevention efforts are classified into three subcategories:

1. **Universal interventions**: Efforts that are aimed at influencing the general population.

2. **Selective interventions**: Efforts that are aimed at specific subgroups of the population considered at risk for developing mental health problems-for example, adolescents or ethnic minorities.

3. **Indicated interventions**: Efforts that are directed toward high-risk individuals who are identified as having minimal but detectable symptoms of mental disorder but who do not meet criteria for clinical diagnosis.

9.2 Objectives

On completion of this unit you will be able to

- Understand the goals and objectives of prevention
- Enlist the basic requirements to sustain and enhance mental health
- Discern the major role of society and culture in promoting mental health

9.3 Universal Interventions

Universal strategies of prevention are aimed at the general population. The term 'universal' is to be preferred to the traditional concept of primary prevention because it specifies that the population to which the intervention is applied is not preselected. Most universal prevention strategies do identify high-risk populations, but unlike selected intervention programmes they do not target a specific group that has characteristics that define its

members as being at high risk within the population for developing the disorder. Thus, the program is delivered universally. It is the population, and not the individual within the population, that may carry the risk, which is generally relatively low in these interventions. Universal interventions perform two key tasks: 1) altering conditions that can cause or contribute to mental disorders (risk factors) and 2) establishing conditions that foster positive mental health (protective factors). Epidemiological studies help investigators obtain information about the incidence and distribution of various maladaptive behaviors. These findings can then be used to suggest what preventive efforts might be most appropriate. For example, various epidemiological studies and reviews have shown that certain groups are at high risk for mental disorders: recently divorced people, physically abused, the physically disabled people etc. Although findings such as these may be the basis for immediate selective or indicated prevention, they may also aid in universal prevention by telling us what to look for and where to look- in essence, by focusing our efforts in the right direction. Universal prevention is very broad and includes biological, psychosocial and sociocultural efforts. Virtually any effort that is aimed at improving the human condition would be considered as a part of universal prevention of mental disorders.

9.3.1. Biological strategies

Biologically based universal strategies for prevention begin with promoting adaptive lifestyles. Many of the goals for health psychology can be viewed as Universal prevention strategies. Efforts towards improving diet, establishing a routine of physical exercise, and developing overall good health habits can do much to improve physical well-being. Physical Illness always produces some sort of psychological stress that can result in such problems at depression, so with respect to good mental health help maintaining good physical health is prevention.

9.3.2. Psychosocial strategies

In viewing normality as optimal development and viewing high functioning (rather than mere absence of pathology) as the goal, we imply that people need opportunities to earn physical, intellectual, emotional and social competencies.

1. The first requirement for psychosocial health is that the person develops the skills needed for effective problem solving, for expressing emotions constructively, and for engaging in satisfying relationship with others. Failure to develop these protective skills places the individual at a serious disadvantage in coping with the stresses and the unavoidable risk factors for mental disorders.

2. The second requirement for psychosocial health is that a person acquires an accurate frame of reference on which to build his or her identity. We have seen repeatedly that when people assumptions about themselves or their world are inaccurate, their behaviour is likely to be maladaptive. Consider, for example, the young women who believe that being thin can bring happiness and so becomes anorexic.

3. The third requirement for psychosocial health is that a person be prepared for the types of problems likely to be encountered during given life stages. For example, young people who want to marry and have children must be prepared for the tasks of building a mutually satisfying relationships and helping children develop their abilities.

In recent years, psychosocial measures aimed at prevention have received a great deal of attention. The field of behavioural medicine has been

influential, with efforts being made to change the psychological factors underlying unhealthy habits such as smoking, excessive drinking, and poor eating habits.

9.3.4 Socio-Cultural strategies

Responsible psychologically healthy individuals are essential in order for the community to thrive and be supportive. The psychosocial impaired victims of disorganized communities lack the wherewithal to create better communities to protect and sustain the psychological health of those who come after them, and a persistently unprotective environment results. Socio-cultural efforts toward universal prevention are focused on making the community as safe and attractive as possible for the individual within it. With our growing recognition of the role that pathological social conditions play in producing maladaptive behaviour (in socially impoverished communities), increased attention must be devoted to creating social conditions that will foster healthy development and functioning in individuals. Efforts to create these conditions include a broad spectrum of measures ranging from public education and social security to economic planning and social legislation directed at ensuring adequate healthcare for all.

Check your Progress -1

Note: a.Write your answer in the space given below

b.Compare your answer with those given at the end of the unit

1. What is a universal intervention and what are the three types of strategies that are used in universal interventions?

9.4 Selective Interventions

Preventing mental health problems through social change in the community is difficult. Although the whole psychological climate can ultimately be changed by a social movement such as the ones initiated by Gandhiji, Raja Ram Mohan Roy, and PeriyarE.V.Ramaswamy, the payoff of such efforts is generally far in the future and may be difficult or impossible to predict or measure. Attempts to effect psychologically desirable social change are also likely to involve ideological and political issues that may inspire powerful opposition, including opposition from the government system. Efforts to bring about change through targeting a smaller segment of the population can have more effective results. For example, a recent review of the research in reducing depression in children concludes that selective intervention programs are more effective than universal intervention programs in reducing the extent of depressive disorders. Selective prevention interventions are generally considered to be secondary prevention, although it might be more appropriate to put many of these under the heading of primary prevention. Selective prevention interventions are aimed at individuals who are at high risk of developing the disorder or are showing very early signs or symptoms. Interventions tend to focus on reducing risk and strengthening resilience. Risk is obviously higher in these selected groups and is often the result of a combination of risk factors rather than the intensity of any single factor. Factors such as poverty, unemployment, inadequate transportation, substandard housing, parental mental health problems, and marital conflict,

which may affect a particular child, could be addressed by selected prevention programmes.

Anillustration of selective prevention strategies

Though difficult to formulate, mobilize, and carry out, selective intervention can bring about major improvements. In this section, we will look at the mobilization of prevention resources aimed at curtailing or reducing the problem of teenage alcohol and drug abuse. Prominent social forces such as advertising and marketing campaigns that are attractive to youth, the influence of peer groups, and the ready availability of alcohol, tobacco and even many illicit drugs are instrumental in promoting the early use of alcohol in young people.

Alcohol use among youth is related to many social, emotional, and behavioural problems. Early alcohol use is a strong predictor of lifetime alcohol abuse or dependence. Because the factors that entice adolescents to begin using alcohol and drugs are influenced by social factors, it is tempting to think that if these forces could be counterbalanced with equally powerful alternative influences, the rate of substance abuse might radically decline. But this is easier said than done.

1. Intercepting and/or Reducing the Supply of Drugs Available.

The reduction of supply by policing our borders has had minimal impact on the availability of drugs. These programs do little to affect the supply of the two drive most abused by adolescents - alcohol and tobacco - which are, of course, available in corner stores and even in adolescents home. Reducing the supply of these drugs to adolescents is especially challenging given mass media messages and other societal signals and these legal products can bring about social acceptance, are essential for celebrations, and can mark a young person's passage into adulthood, with limited cautions about their potential to damage health.

2. Providing Treatment services for those who Develop Drug Problems.

Although much money is spent every year on treatment, treating substance abuse is perhaps the least effective way to reduce the problem. Addictive disorders are very difficult to overcome, and treatment failure or relapse are the rule rather than the exception. Therapeutic programs for those addicted to drugs or alcohol, though necessary, are not the answer to eliminating or even significantly reducing the problems in our society.

3. Encouraging prevention.

By far the most desirable- and potentially the most effective-means of reducing the drug problem in our country is through prevention methods aimed at altering citizens to the problems that surround drugs and teaching young people ways to avoid using them. Although past efforts have had some limited success in discouraging adolescent drug use, many initially promising prevention efforts have failed to bring about the desired reduction in substance use.

In recent years prevention specialists have taken a more proactive position and have attempted to establish programs that prevents the development of abuse disorders before young people become so involved with drugs or alcohol that future adjustment becomes difficult, if not impossible. These recent prevention strategies have taken some diverse and promising directions.

9.4.1. School-Based Interventions

The most promising alcohol and drug prevention curricula are based on behavioural theory; they target the risk (e.g, peer pressure, mass-media

messages) and protective (e.g, alcohol free activities, messages supporting "no use" norms) factors associated with adolescents include developmentally appropriate information about alcohol and other drugs; are skill-based and interactive; and emphasize normative education that increase the awareness that most students do not use alcohol, tobacco, or other drugs. Individuals from the field can be invited to spread awareness based on their practical knowledge about the implications of the behaviour.

9.4.2 Intervention programs for High-Risk Teens

Intervention programs identify high-risk teenagers and take special measures to circumvent their further use of alcohol or other potentially dangerous drugs. Programs such as these are often school-based efforts and are not strictly prevention programs because they intervene with young people who have already developed problems. Programs for early intervention can be effective in identifying adolescents before their alcohol or drug problems become entrenched. This research strategy involves identifying High-Risk individuals and providing special approaches to circumvent their problems.

9.4.3 Parent Education and Family-based Intervention

Through their own drinking or positive verbalizations about alcohol, parents may encourage or sanction alcohol use among teens. Some research has shown that parental involvement and monitoring reduces substance use among adolescents. Thus, many prevention programs focus upon family interventions with good success.

9.4.4 Extracurricular Strategies

Various extracurricular activities and youth programs have the potential to reduce problem behaviours like alcohol and drug use, school dropouts, violence, and juvenile delinquency. These programs may be especially beneficial for high-risk teens who are unsupervised outside of school or who, because of poverty, may not have access to opportunities like sports, music, or other programs available to middle-class youth.

9.4.5 Internet-based Intervention Programs

One recent study examined adolescent girls (seventh through ninth grade) who were given an online test battery and 12 sessions of gender-specific drug prevention strategies. At follow-up, girls receiving the Internet intervention program lower rates of use for alcohol and drugs compared with the control sample.

9.4.6 Comprehensive Prevention Strategies

A consensus seems to be developing in the field that the most effective way to prevent complex problems like adolescent alcohol and other drug use is through the use of multicomponent programs that combine aspects of the various strategies described previously. Typically, classroom curricula are used as the core component to which other strategies (e.g., parent programs, mass media, extracurricular activities, and community strategies to reduce access to alcohol via enforcement of age of drinking laws) are added.

Partly because of this lack of positive results for alcohol use, a team of University of Minnesota researchers developed Project Northland - an exemplary research-based set of interventions that aims to delay the onset of drinking in young adolescents, reduce alcohol use among those already drinking, and limit the number of alcohol-related problems during adolescence. Project Northland included multiple years of behaviouralcurricula, parental involvement and education, peer leadership

opportunities, community task forces, and community-wide media campaigns. Interventions started with students in the sixth grade and continued until high school graduation. The program included peer-led and activity-driven learning strategies that involved students, parents, teachers, and community members in support of "no use" messages, while at the same time promoting alcohol-free norms for youth, providing fun alternatives to alcohol use, and reducing youth access alcohol. Innovative activities and games were used to ensure high participation rates in the program, and comprehensive teacher and peer-leader trainings were core features.

The success of prevention programs has come to the attention of educators, and a number of efforts are under way to "export" these laboratory programs for broader use in America's schools. Perhaps the most noteworthy is the National Registry of Effective Prevention Programs (NREPP), a program of the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. However, the jury is still out on the relative success of the various substance-abuse prevention programs at reducing alcohol and drug problems in adolescents. For example, an effort to implement the Northland project in a large Midwestern inner city where problems with gangs, violence, drug dealing and housing were perceived as more pressing than underage drinking did not have a positive outcomes that were obtained in the more rural environment of northern Minnesota. It will take time and further research efforts to determine which of the strategies are superior to others in reducing alcohol and drug problems in adolescents, and in which settings.

Check your Progress -2

Note: a.Write your answer in the space given below

b.Compare your answer with those given at the end of the unit

       2. What is selective intervention?

       3. Whom does the selective intervention target?

9.5 Indicated Interventions

Indicated intervention emphasizes the early detection and prompt treatment of maladaptive behaviour in a person's family and community setting. In some cases - for example, in a crisis or after a disaster indicated prevention involves immediate and relatively brief intervention to prevent any long-term behavioural consequences of the traumatic events.

Indicated prevention interventions in part mirror the category of tertiary prevention. These interventions are aimed at specific groups in which prodromal symptoms of a disorder are already evident but the full disorder has not yet developed. It is often difficult to distinguish between selective and indicated prevention interventions in terms of the therapeutic activity that might be involved. Parent training, for example, can be part of both selective and indicated interventions for prevention of conduct problems. Some intervention programmes are complex packages made up of universal, selective and indicated prevention interventions.

9.5.1 Inpatient Mental Health Treatment in Contemporary Society

While most people experiencing mental health problems seek or obtain help in an outpatient program, some individuals require admission to an

inpatient treatment program because of perceived danger they experience in their daily lives. Inpatient admission to a psychiatric hospital can be a significant step that is taken as a means of protecting the individual or those close to her or him from harm by providing a secure environment to allow the patient to recover from her or his extreme symptoms.

9.5.2 The Mental Hospital as a Therapeutic Community

In cases where individuals might be considered dangerous to themselves or others or where their symptoms are so severe that they are unable to care for themselves in the community, psychiatric hospitalization may be necessary in order to prevent the development of further problems and the individual's further psychological deterioration. Most of the traditional forms of therapy can be used in residential or inpatient hospital setting. In addition, in many mental hospitals these techniques are supplemented by efforts to make the hospital environment itself a "therapeutic community". That is, the social environment is manipulated to provide the patient with the greatest benefit. All the ongoing activities of the hospital are brought into the total treatment program, and the environment, or **milieu,** is a crucial aspect of the therapy. This approach is thus often referred to as milieu therapy. Three general therapeutic principles guide this approach to treatment:

1. Staff expectations are clearly communicated to patients. Both positive and negative feedback are used to appropriate verbalization and actions by patients.
2. Patients are encouraged to become involved in all decisions made, and in all actions taken, concerning them. A self-care, do-it-yourself attitude prevails.
3. All patients belong to social groups on the ward. The group cohesiveness that results gives the patients support and encouragement, and the related process of group pressure helps shape their behaviour in positive ways.

In a therapeutic community, few restraints as possible are placed on patients' freedom, and patients are encouraged to take responsibility for their behaviour and participate actively in their treatment programs. Open wards permit patients to use the grounds and premises. Self-government programs give patients responsibility for managing their own affairs and those of the ward. All hospital personnel are expected to treat the patients as human beings who merit consideration and courtesy. The interaction among the patients - whether in group therapy sessions, 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 aspect of a therapeutic community is the interaction 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 being hospitalized. Constructive relationships frequently develop among patients in a supportive, encouraging milieu. However, although residential treatment has improved over time, such treatment for children and adolescents continues to face challenges.

Another successful method for helping patients take increased responsibility for their own behaviour is the use of social-learning programs. Such programs normally make use of learning principles and

techniques such as token economies to shape more socially acceptable behaviour.

Although a strong case can be made for the use of psychiatric hospitalization in stabilizing adjustment of people living with psychiatric disorders, a persistent concern about hospitalization is that the mental hospital may become a permanent refuge from the world. Over the past four decades, considerable effort has been devoted to reducing the population of inpatients by closing hospitals and treating patients who have mental disorders as outpatients. This effort, which is often referred to as deinstitutionalization, was initiated to prevent the negative effects, for many psychiatric patients, of being confined to a mental hospital for long periods of time as well as to lower health care costs. To keep the focus on returning patients to the community and on preventing their return to the institution, contemporary hospital staff try to establish close ties with patients' families and communities and to provide them with positive expectations about the patients' recovery.

9.5.3 Aftercare Programs

Even where hospitalization has successfully modified maladaptive behaviour and a patient has learned needed occupational and interpersonal skills, readjustment in the community following release may still be difficult. Many studies have shown that in the past, up to 45 percent of individuals with schizophrenia have been readmitted within their first year of discharge. Community-based treatment programs, now referred to as "aftercare programs "are live-in facilities that serve as a home base for former patients as they make the transition back to adequate functioning in the community. Typically, community-based facilities are run not by professional mental health personnel but by residents themselves. Aftercare programs can help smooth the transition from institutional to community life and reduce the number of relapses. However, some individuals do not function well in aftercare programs. Sometimes aftercare includes a "halfway" period in which a released patient makes a gradual return to the outside world in what were formerly known as "halfway houses". Some people who have been kept in hospital under the Mental Health Act can get free help and support after they leave the hospital.

Check your Progress -3

Note: a.Write your answer in the space given below

b.Compare your answer with those given at the end of the unit

    4. Explain milieu therapy.

    5. What are aftercare programs?

9.5 Deinstitutionalization

Deinstitutionalization (or deinstitutionalization) is the process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with a mental disorder or developmental disability. In the late 20th century, it led to the closure of many psychiatric hospitals, as patients were increasingly cared for at home, in halfway houses and clinics, and in regular hospitals in the US. It is a government policy that moved mental health patients out of state-run "insane asylums" into federally funded community mental health centers. It began in the 1960s as a way to improve treatment of the mentally ill while also cutting government budgets.

In 1955, the number peaked at 558,000 patients or 0.03 percent of the population. If the same percentage of the population were institutionalized today, that would be 750,000 mentally ill people.

Deinstitutionalization works in two ways. The first focuses on reducing the population size of mental institutions by releasing patients, shortening stays, and reducing both admissions and readmission rates. The second focuses on reforming psychiatric care to reduce (or avoid encouraging) feelings of dependency, hopelessness and other behaviors that make it hard for patients to adjust to a life outside of care. Three societal and scientific changes occurred that caused deinstitutionalization. First, the development of psychiatric drugs treated many of the symptoms of mental illness. These included chlorpromazine and clozapine.

Second, society accepted that the mentally ill need to be treated instead of locked away. This change of heart began in the 1960s.

Third, federal funding such as Medicaid and Medicare went toward community mental health centers instead of mental hospitals.

The modern deinstitutionalization movement was made possible by the discovery of psychiatric drugs in the mid-20th century, which could manage psychotic episodes and reduced the need for patients to be confined and restrained. Another major impetus was a series of socio-political movements that campaigned for patient freedom. Lastly, there were financial imperatives, with many governments also viewing it as a way to save costs.

The movement to reduce institutionalization was met with wide acceptance in Western countries, though its effects have been the subject of many debates. Critics of the policy include defenders of the previous policies as well as those who believe the reforms did not go far enough to provide freedom to patients. It has been a source of considerable controversy. Some authorities consider the emptying of mental hospitals a positive expression of society's desire to free previously confined persons, maintaining that deinstitutionalized patients show significant improvement compared with those who remain hospitalized. Others, however, speak of the 'abandonment' of chronic patients to a cruel and harsh which for many include homelessness, violent victimizations harassed, intimidated and frightened by obviously disturbed persons wandering the streets of the neighbourhood. Many of those released from institutions were severely mentally ill. They were not good candidates for community centers due to the nature of their illnesses. Long-term, in-patient care provides better treatment for many with severe mental illnesses.

There wasn't enough federal funding for mental health centers. That meant there weren't enough centers to serve those with mental health needs. It also made it difficult to create any comprehensive programs. Mental health professionals underestimated how difficult it was to coordinate community resources scattered throughout a city for those with disorders.

The courts made it almost impossible to commit anyone against their will. That's true regardless of whether it was for the person's own safety and welfare or for that of others.

However Deinstitutionalization successfully gave more rights to the mentally challenged. Many of those in mental hospitals lived in the backwater for decades. They received varying levels of care. It also changed the culture of treatment from "send them away" to integrate them into society where possible. It especially benefited those with Down's

syndrome and other high-functioning mental disorders. In Europe, particularly in Italy and the United Kingdom, the forms taken by deinstitutionalization have been numerous and diverse, such as alternating periods in the institution and in the community, host programs in the institutions, and the creation of work cooperatives. Thus, the struggle against institutionalization has not necessarily been one of radical opposition—everything institutional or community-based. These efforts, in their various forms, may have permitted the extension of the deinstitutionalization movement into areas well beyond psychiatry.

Check your Progress -4

Note: a.Write your answer in the space given below

b.Compare your answer with those given at the end of the unit

6. What is deinstitutionalization?

9.6 Let Us Sum Up

Many mental health professionals are trying not only to cure mental health problems but also to prevent them, or at least to reduce their efforts.

Prevention can be viewed as focusing on three levels:

1. universal interventions, which attempt to reduce the long-term consequences of having had a disorder;
2. selective interventions, which are aimed at reducing the possibility of disorder and fostering positive mental health efforts in subpopulations that are considered at special risk;
3. Indicated interventions, which attempt to reduce the impact or duration of a problem that has already occurred.

With the advent of many new psychotropic medications and changing treatment philosophies, there has been a major effort to discharge psychiatric patients into the community.

There has been a great deal of controversy over deinstitutionalization and the failure to provide prompt and adequate follow-up of these patients in the community as soon as possible.

9.7 Unit-End Exercises

1. What are some strategies for biological, psychological, and socio-cultural universal interventions?
2. Define the term selective intervention. What selective intervention programs have shown promise in helping prevent teenage alcohol and drug abuse?
3. What is indicated intervention?

9.8 Answer to Check Your Progress

1. Universal interventions target the general population and are not directed at a specific risk group. Universal prevention measures address an entire population (national, local, community, school, or neighborhood) with messages and programs aimed at preventing or delaying the use of alcohol, tobacco, and other drugs. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals with the information and skills necessary to prevent the problem. The entire population is considered at risk and able to benefit from prevention programs. The three strategies used are biological,psychosocial and socio-cultural strategies.

2. Selective prevention interventions are aimed at individuals who are at high risk of developing the disorder or are showing very early signs or symptoms. Interventions tend to focus on reducing risk and strengthening resilience.

3. Selective prevention measures target subsets of the total population that are considered at risk for substance abuse by virtue of their membership in a particular segment of the population. Selective prevention targets the entire subgroup, regardless of the degree of risk of any individual within the group

4. Milieu therapy is the treatment of mental disorder or maladjustment by making substantial changes in a patient's immediate life circumstances and environment in a way that will enhance the effectiveness of other forms of therapy. The goal of milieu therapy is to manipulate the environment so that all aspects of the client's hospital experience are considered therapeutic.
Within this therapeutic community setting the client is expected to learn adaptive coping, interaction and relationship skills that can be generalized to other aspects of his or her life.

5. Aftercare programs are live-in facilities that serve as a home base for former patients as they make the transition back to adequate functioning in the community.
6. Deinstitutionalization is the process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with a mental disorder or developmental disability.

9.9 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

UNIT X: ASSESSMENT AND DIAGNOSIS

Structure

10.1 Introduction

Clinical assessment is one of the most important and complex responsibilities of mental health professionals. The extent to which a person's problems are understood and appropriately treated depends largely on the adequacy of the psychological assessment. The goals of psychological assessment include identifying and describing the individual's symptoms; determining the chronicity and severity of problems; evaluating the potential causal factors in the person's background; and exploring the individual's personal resources that might be an asset in his or her treatment program.

10.2 Objectives

After going through this unit you will:

- Understand the need and importance of assessing psychological disorders
- Understand in detail the two major classification systems and issues
- Be able to appreciate the usefulness of assessment in treatment and prevention of psychological disorders

10.3 Assessing Psychological Disorders

Assessment is simply the collecting of relevant information in an effort to reach a conclusion. It goes on in every realm of life. *Clinical assessment* is used to determine how and why a person is behaving abnormally and how that person may be helped. It also enables clinicians to evaluate people's progress after they have been in treatment for a while and decide whether the treatment should be changed.

The specific tools that are used to do an assessment depend on the clinician's theoretical orientation. Psychodynamic clinicians, for example, use methods that assess a client's personality and probe for any unconscious conflicts he or she may be experiencing. This kind of assessment, called a *personality assessment,* enables them to piece together

a clinical picture in accordance with the principles of their model. Behavioral and cognitive clinicians are more likely to use assessment methods that reveal specific dysfunctional behaviors and cognitions. The goal of this kind of assessment, called a *behavioral assessment,* is to produce a *functional analysis* of the person's behaviors—an analysis of how the behaviors are learned and reinforced. The hundreds of clinical assessment techniques and tools that have been developed fall into three categories: *clinical interviews, tests,* and *observations.* To be useful, these tools must be *standardized* and must have clear *reliability* and *validity.*

10.3.1 Clinical Interview

A *clinical interview* is a face-to-face encounter. If during a clinical interview a man looks as happy as can be while describing his sadness over the recent death of his mother, the clinician may suspect that the man actually has conflicting emotions about this loss. Almost all practitioners use interviews as part of the assessment process.

Conducting the Interview The interview is often the first contact between client and clinician. Clinicians use it to collect detailed information about the person's problems and feelings, lifestyle and relationships, and other personal history. They may also ask about the person's expectations of therapy and motives for seeking it.

Beyond gathering basic background data, clinical interviewers give special attention to whatever topics they consider most important. Psychodynamic interviewers try to learn about the person's needs and memories of past events and relationships. Behavioral interviewers try to pinpoint the precise nature of the abnormal responses, including information about the stimuli that trigger

such responses and their consequences. Cognitive interviewers try to discover assumptions

and interpretations that influence the person. Humanistic clinicians ask about the person's self-evaluation, self-concept, and values. Biological clinicians gather a family history from the individual to help uncover inherited tendencies and also look more directly for signs of biochemical or brain dysfunction. And sociocultural interviewers ask about the family, social, and cultural environments.

Interviews can be either unstructured or structured. In an *unstructured interview,* the clinician asks open-ended questions, perhaps as simple as "Would you tell me about yourself?" The lack of structure allows the interviewer to follow interesting leads and explore relevant topics that could not be anticipated before the interview. In a *structured interview,* clinicians ask prepared questions. Sometimes they use a published *interview schedule*—a standard set of questions designed for all interviews. Many structured interviews include a **mental status exam,** a set of questions and observations that systematically evaluate the client's awareness, orientation with regard to time and place,

attention span, memory, judgment and insight, thought content and processes, mood, and appearance. A structured format ensures that clinicians will cover the same kinds of important issues in all of their interviews and enables them to compare the responses of different individuals. Unstructured interviews typically appeal to psychodynamic and humanistic clinicians, while structured formats are widely used by behavioral and cognitive clinicians, who need to pinpoint behaviors, attitudes, or thinking processes that may underlie abnormal behavior.

Limitations of Clinical Interviews

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

Interviewers too may make mistakes in judgments which may distort the information they gather. They usually rely too heavily on first impressions, for example, and give too much weight to unfavorable information about a client. Interviewer biases, including gender, race, and age biases, may also influence the interviewers' interpretations of what a client says. Interviews, particularly unstructured ones, may also lack reliability. People respond differently to different interviewers, providing, for example, less information to a cold interviewer than to a warm and supportive one. Similarly, a clinician's race, sex, age, and appearance may influence a client's responses.

10.3.2 PHYSICAL EXAMINATION

Psychophysiological Tests Clinicians may also use **psychophysiological tests,** which measure physiological responses as possible indicators of psychological problems. This practice began three decades ago after several studies suggested that states of anxiety are regularly accompanied by physiological changes, particularly increases in heart rate, body temperature, blood pressure, skin reactions (*galvanic skin response*), and muscle contraction.

One psychophysiological test is the *polygraph,* popularly known as a *lie detector*. Electrodes attached to various parts of a person's body detect changes in breathing, perspiration, and heart rate while the individual answers questions. The clinician observes these functions while the person answers "yes" to *control questions*—questions whose answers are known to be yes, such as "Are your parents both alive?" Then the clinician observes the same physiological functions while the person answers *test questions,* such as "Did you commit this robbery?" If breathing, perspiration, and heart rate suddenly increase, the person is suspected of lying.

Like other kinds of clinical tests, psychophysiological tests have their drawbacks. Many require expensive equipment that must be carefully tuned and maintained. In addition, psychophysiological measurements can be inaccurate and unreliable. The laboratory equipment itself—elaborate and sometimes frightening— may arouse a participant's nervous system and thus change his or her physical responses. Physiological responses may also change when they are measured repeatedly in a single session. Galvanic skin responses, for example, often decrease during repeated testing.

Neurological and Neuropsychological Tests Some problems in personality or behavior are caused primarily by damage to the brain or changes in brain activity. Head injury, brain tumors, brain malfunctions, alcoholism, infections, and other disorders can all cause such impairment. If a psychological dysfunction is to be treated effectively, it is important to know whether its primary cause is a physical abnormality in the brain.

A number of techniques may help pinpoint brain abnormalities. Some procedures, such as brain surgery, biopsy, and X ray, have been used for many years. More recently, scientists have developed a number of **neurological tests,** designed to measure brain structure and activity directly. One neurological test is the *electroencephalogram* (*EEG*), which records *brain waves,* the electrical activity taking place within the brain as a result of neurons firing. In this procedure, electrodes placed on the scalp transmit brain-wave impulses to *a* machine that records them. When the electroencephalogram reveals an abnormal brain-wave pattern,clinicians suspect the existence of brain injuries, tumors, seizures, or other brain abnormalities, and they turn to more precise and sophisticated techniques to determine the nature and scope of the problem.

In particular, there are a group of other neurological tests that actually take "pictures" of brain structure or brain activity. These tests, called **neuroimaging techniques,** include *computerized axial tomography* (*CAT scan* or *CT scan*), *positron emission tomography* (*PET scan*), *magnetic resonance imaging* (*MRI*), and *functional magnetic resonance imaging* (*fMRI*). A **CT scan** is a procedure in which X rays of the brain's *structure* are taken at different angles and then the images are combined by a computer. This kind of scan is considered superior to a conventional X ray because it yields a three-dimensional image of the brain's structure. Rather than showing the structure of the brain, a **PET scan** reveals the *functioning* of different areas in the brain. A person who undergoes this procedure is administered a harmless radioactive compound, which travels to the brain. Then, as the individual experiences particular emotions or performs specific cognitive tasks (say, reading or speaking), his or her brain is scanned for radiation. Higher radioactivity in various brain areas reflects higher blood flow and neuron activity in those areas. The radioactivity readings are converted by a computer into a motion picture, revealing which brain areas are active during the individual's emotional experiences or cognitive behaviors.

An **MRI** is a procedure in which a computer gathers information about the magnetic properties of hydrogen atoms in the brain and then produces a very detailed picture of the brain's *structure*. An **fMRI** goes still further, producing a detailed picture of the *functioning* brain. In this procedure, an MRI scanner detects rapid changes in the flow or volume of blood in areas across the brain while an individual is experiencing emotions or performing specific cognitive tasks. By interpreting these blood changes as indications of neuron activity at sites throughout the brain, a computer then generates images of which brain areas are active during the individual's emotional experiences or cognitive behaviors, thus offering a picture of the functioning brain. Partly because fMRI-produced images of brain functioning are so much clearer than PET scan images, the fMRI has generated enormous enthusiasm among brain researchers since it was first developed in 1990.

Though widely used, these techniques are sometimes unable to detect subtle brain abnormalities. Clinicians have therefore developed **neuropsychological tests** that measure cognitive, perceptual, and motor performances on certain tasks and interpret abnormal performances as an indicator of underlying brain problems. Brain damage is especially likely to affect visual perception, memory, and visual-motor coordination, so neuropsychological tests focus particularly on these areas. The *Bender Visual-Motor Gestalt Test* (Bender, 1938), one of the first

neuropsychological tests, consists of nine cards, each displaying a simple design. Patients look at the designs one at a time and copy each one on a piece of paper. Later they try to redraw

the designs from memory. By the age of 12, most people can remember and redraw the designs accurately. Notable errors in accuracy are thought to reflect organic brain impairment. To achieve greater precision and accuracy in their assessments of brain abnormalities, clinicians often use a *battery,* or series, of neuropsychological tests, each targeting a specific skill area.

10.3.3 Behavioural Assessment

Clinical Observations

In addition to interviewing and testing people, clinicians may systematically observe their behavior. In one technique, called *naturalistic observation,* clinicians observe clients in their everyday environments. In another, *analog observation,* they observe them in an artificial setting, such as a clinical office or laboratory. Finally, in *self-monitoring,* clients are instructed to observe themselves.

Naturalistic and Analog Observations

Naturalistic clinical observations usually take place in homes, schools, institutions such as hospitals and prisons, or community settings. Most of them focus on parent-child, sibling-child, or teacher-child interactions and on fearful, aggressive, or disruptive behavior. Often such observations are made by *participant observers,* key persons in the client's environment, and

reported to the clinician.

When naturalistic observations are not practical, clinicians may resort to analog observations,often aided by special equipment such as a videotape recorder or one-way mirror. Analog observations have often focused on children interacting with their parents, married couples attempting to settle a disagreement, speech-anxious people giving a speech, and fearful people approaching an object they find frightening.

There are limitations in clinical observations. They are not always reliable. It is possible for various clinicians who observe the same person to focus on different aspects of behavior, assess the person differently, and arrive at different conclusions. Careful training of observers and the use of observer checklists can help reduce this problem. Similarly, observers may make errors that affect the validity, or accuracy, of their observations. The observer may not be able to see or record all of the important behaviors and events. Or the observer may experience, a steady decline in accuracy as a result of fatigue. Another possible problem is *observer bias*—the observer's judgments may be influenced by information and expectations he or she already has

about the person. The client's behavior may be affected by the very presence of the observer. If schoolchildren are aware that someone special is watching them, for example, they may change their usual classroom behavior, perhaps in the hope of creating a good impression. Finally, clinical observations may lack *external, validity.* A child who behaves aggressively in school is not necessarily aggressive at home or with friends after school. Because behavior is often specific to particular situations, observations in one setting cannot always be applied to other settings.

Self-Monitoring

In *self-monitoring,* people observe themselves and carefully record the frequency of certain behaviors, feelings, or cognitions as they occur over time. How frequently, for instance, does a headache sufferer have a headache? What kinds of circumstances bring those feelings about?

Self-monitoring is especially useful in assessing behavior that occurs so infrequently that it is unlikely to be seen during other kinds of observations. It is also useful for behaviors that occur so frequently that any other method of observing them in detail would be impossible—for example, smoking, drinking, or other drug use. Third, self-monitoring may be the only way to observe and measure private thoughts or perceptions.

Like all other clinical assessment procedures, self-monitoring has drawbacks. In this method too validity is often a problem. People do not always receive proper instruction in this form of observation, nor do they always try to record their observations accurately. Furthermore, when people monitor themselves, they may change their behaviors unintentionally. Smokers, for example, often smoke fewer cigarettes than usual when they are monitoring themselves, drug users take drugs less frequently, and teachers give more positive and fewer negative comments to their students.

10.3.4 Psychological Testing

Tests are devices for gathering information about a few aspects of a person's psychological

functioning, from which broader information about the person can be inferred. Clinicians use six kinds most often: projective tests, personality inventories, response inventories, psychophysiological tests, neurological and neuropsychological tests, and intelligence tests.

PROJECTIVE TESTS

Projective testsrequire that clients interpret vague stimuli, such as inkblots or ambiguous pictures, or follow open-ended instructions such as "Draw a person." Theoretically, when clues and instructions are so vague, people will "project" aspects of their personality into the task. Projective tests are used primarily by psychodynamic clinicians to help assess the unconscious drives and conflicts they believe to be at the root of abnormal functioning. The most widely used projective tests are the *Rorschach test,* the *Thematic Apperception Test, sentence-completion tests,* and *drawings.*

Rorschach test

In 1911, Hermann Rorschach, a Swiss psychiatrist, experimented with the use of inkblots in his clinical work. He made thousands of blots by dropping ink on paper and then folding the paper in half to create a symmetrical but wholly accidental design. Rorschach found that everyone saw images in these blots. In addition, the images a viewer saw seemed to correspond in important ways with his or her psychological condition. People diagnosed with schizophrenia, for example, tended to see images that differed from those described by people suffering from depression.

Rorschach selected 10 inkblots and published them in 1921 with instructions for their use in assessment. This set was called the *Rorschach Psychodynamic Inkblot Test.* Rorschach died just eight months later, at the age of 37, but his work was continued by others, and his inkblots took their place among the most widely used projective tests of the twentieth century. Clinicians administer the "Rorschach," as it is commonly called, by presenting one inkblot card at a time and asking respondents what they see, what the inkblot seems to be, or what it reminds them of. In the early years,

Rorschach testers paid special attention to the themes and images that the inkblots evoked, called the *thematic content*. Testers now also pay attention to the style of the responses: Do the clients view the design as a whole or see specific details? Do they focus on the blots or on the white spaces between them? Do they use or ignore the shadings and colors in several of the cards? Do they see human movement or animal movement in the designs?

Thematic Apperception Test

The Thematic Apperception Test (TAT) is a pictorial projective test. People who take the TAT are commonly shown 30 black-and-white pictures of individuals in vague situations and are asked to make up a dramatic story about each card. They must tell what is happening in the picture, what led up to it, what the characters are feeling and thinking, and what the outcome of the situation will be.

Clinicians who use the TAT believe that people always identify with one of the characters on each card, called the *hero.* The stories are thought to reflect the individuals' own circumstances, needs, emotions, and sense of reality and fantasy.

Sentence-completion test

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

Drawings

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

Advantages of Projective Tests

Until the 1950s, projective tests were the most common technique for assessing personality. In

recent years, however, clinicians and researchers have relied on them largely to gain "supplementary" insights. The tests have not consistently demonstrated much reliability or validity. In reliability studies, different clinicians have tended to score the same person's projective test quite differently. To address this problem and improve scoring consistency, several standardized procedures for administering and scoring the tests have been developed. For example, the *Rorschach Comprehensive System* is a highly regarded scoring system that has often yielded impressive reliability scores among clinicians who are trained in its use and application. However, only a minority of projective test administrators actually use such standardized procedures.

Research has also challenged the validity of projective tests. When clinicians try to describe a client's personality and feelings on the basis of responses to projective tests, their conclusions often fail to match the self-report of the client, the view of the psychotherapist, or the picture gathered from an extensive case history. Another validity problem is that projective

tests are sometimes biased against minority ethnic groups. For example, people are supposed to identify with the characters in the Thematic Apperception Test (TAT) when they make up stories about them, yet no members of minority groups/ or people from other race are represented in the TAT pictures. In response to this problem, some clinicians have developed other TAT-like testswith African American or Hispanic figures.

Personality Inventories

An alternative way to collect information about individuals is to ask them to assess themselves. The **personality inventory** asks respondents a wide range of questions about their behavior, beliefs, and feelings. In the typical personality inventory, individuals indicate whether each of a long list of statements applies to them. Clinicians then use the responses to draw conclusions about the person's personality and psychological functioning.

Personality inventories appear to have greater validity, or accuracy, than projective tests. However, they can hardly be considered *highly* valid. When clinicians have used these tests alone, they have not typically been able to judge a respondent's personality accurately. One problem is that the personality traits that the tests seek to measure cannot be examined directly. A person's character, emotions, and needs cannot be fully known from self-reports alone. Another problem is that despite the more diverse sampling of standardization groups conducted by personality tests, there are cultural limitations in certain tests. Responses indicative of apsychological disorder in one culture may be normal responses in another. Despite their limited validity, personality inventories continue to be popular. Research indicates that they can help clinicians learn about people's personal styles and disorders as long as they are used in combination with interviews or other assessment tools.

Response Inventories

Like personality inventories, **response inventories** ask people to provide detailed information about themselves, but these tests focus on one specific area of functioning. For example, one such test may measure affect (emotion), another social skills, and still another cognitive processes. Clinicians can use them to determine the role such factors play in a person's disorder. *Affective inventories* measure the severity of such emotions as anxiety, depression, and anger. In one of the most widely used affective inventories, the Beck Depression Inventory, people rate their level of sadness and its effect on their functioning. *Social skills inventories,* used particularly by behavioral and family-social clinicians, ask respondents to indicate how they would react in a variety of social situations. *Cognitive inventories* reveal a person's typical thoughts and assumptions and can uncover counterproductive patterns of thinking that may be at the root of abnormal functioning.

Because response inventories collect information directly from the clients themselves, they have strong face validity. Thus both the number of these tests and the number of clinicians who use them have increased steadily in the past 25 years. At the same time, however, these inventories have major limitations. Unlike the personality inventories, they rarely include questions to indicate whether people are being careless or inaccurate in their accounts. Moreover, with the notable exceptions of the Beck Depression Inventory and a few others, response inventories generally have not been subjected to careful standardization, reliability, and validity procedures.

Intelligence Tests An early definition of intelligence described it as "the capacity to judge well, to reason well and to comprehend well" (Binet& Simon, 1916). Because intelligence is an *inferred* quality rather than a specific physical process, it can be measured only indirectly. In 1905 the French psychologist Alfred Binet and his associate Theodore Simon produced an **intelligence test** consisting of a series of tasks requiring people to use various verbal and nonverbal skills. The general score derived from this and subsequent intelligence tests is termed an **intelligence quotient,** or **IQ,** so called because initially it represented the ratio of a person's "mental" age (score obtained from the test) to his or her "chronological" age (actual age), multiplied by 100. There are now more than 100 intelligence tests available, including the widely used *Wechsler Adult Intelligence Scale, Wechsler Intelligence Scale for Children,* and *Stanford-Binet Intelligence Scale.*

Though intelligence tests have shown high validity and reliability, they have some shortcomings. Factors that have nothing to do with intelligence, such as low motivation and high anxiety, can greatly influence test performance. In addition, IQ tests may contain cultural biases in their language or tasks that place people of one background at an advantage over those of another. Similarly, members of some minority groups may have little experience with this kind of test, or they may be uncomfortable with test examiners of a majority ethnic background. Either way, their performances may suffer.

Check your Progress – 1

Note: a. Write your answer in the space given below

    b. Compare your answer with those given at the end of the unit.

    1. What is the purpose of clinical assessment?

    2. What are the commonly used psychological tests?

10.4 Diagnosis

Clinicians use the information from interviews, tests, and observations to construct an integrated picture of the factors that are causing and maintaining a client's disturbance, which is referred to a *clinical picture*. Such pictures are also influenced by the clinicians' theoretical orientation.

With the assessment data and clinical picture in hand, clinicians are ready to make a **diagnosis** (from the Greek word for "a discrimination")—that is, a determination that a person's psychological problems constitute a particular disorder. When clinicians decide, through diagnosis, that a client's pattern of dysfunction reflects a particular disorder, they are saying that the pattern is basically the same as one that has been displayed by many other people, has been observed and investigated in a variety of studies, and perhaps has responded to particular forms of treatment. They can then apply what is generally known about the disorder to the particular individual they are trying to help. They can, for example, better predict the future course of the person's problem and the treatments that are likely to be helpful.

When certain symptoms regularly occur together—a cluster of symptoms is called a **syndrome**—and follow a particular course, clinicians agree that those symptoms make up a particular mental disorder. When people display this particular pattern of symptoms, diagnosticians assign them to that diagnostic category. A list of such categories, or disorders, with

descriptions of the symptoms and guidelines for assigning individuals to the categories,

is known as a **classification system.**

In 1883 Emil Kraepelin developed the first modern classification system for abnormal behavior. His categories have formed the foundation for the psychological part of the *International Classification of Diseases* (*ICD*), the classification system now used by the World Health Organization. They have also influenced the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), a classification system developed by the American Psychiatric Association.

The DSM, like the ICD, has been changed over time. First published in 1952, the DSM underwent major revisions in 1968 (DSM-II), 1980 (DSM-III), 1987 (DSM-IIIR), and 1994 (DSM-IV). DSM-IV lists approximately 400 mental disorders. Each entry describes the criteria for diagnosing the disorder and its key clinical features. The system also describes related features, which are often but not always present. The classification system is further accompanied by *text information* (that is, background information) such as research indications; age, culture, or gender trends; and each disorder's prevalence, risk, course, complications, predisposing factors, and family patterns.

In 2000, the American Psychiatric Association published an update of the text information that accompanies DSM-IV. This update, called the *DSM-IV Text Revision* (*DSM-IV-TR*), also changed the *diagnostic criteria* for a few disorders (certain sexual disorders).

10.4.1 CLASSIFICATION ISSUES

Even with trustworthy assessment data and reliable and valid classification categories, clinicians will sometimes arrive at a wrong conclusion. Like all human beings, they are flawed information processors. They are influenced disproportionately by information gathered early in the assessment process. They sometimes pay too much attention to certain sources of information, such as a parent's report about a child, and too little to others, such as the child's point of view. Finally, their judgments can be distorted by any number of personal biases, such as, gender, age, race, and socioeconomic status, to name just a few.

Given the limitations of assessment tools, assessors, and classification systems, studies sometimes uncover shocking errors in diagnosis, especially in hospitals. Beyond the potential for misdiagnosis, the very act of classifying people can lead to unintended results. Diagnostic labels can become self-fulfilling prophecies. When people are diagnosed as mentally disturbed, they may be viewed and reacted to correspondingly. If others expect them to take on a sick role, they may begin to consider themselves sick as well and act that way. Furthermore, our society attaches a stigma to abnormality. People labeled mentally ill may find it difficult to get a job, especially a position of responsibility, or to be welcomed into social relationships. Once a label has been applied, it may stick for a long time. Because of these problems, some clinicians would like to do away with diagnoses. Others disagree. They believe we must simply work to increase what is known about psychological disorders and improve diagnostic techniques. They hold that classification and diagnosis are critical to understanding and treating people in distress.

10.4.2 DSM IV – TR

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), is a classification system developed by the American Psychiatric Association.

It has changed over time. First published in 1952, the DSM underwent major revisions in 1968 (DSM-II), 1980 (DSM-III), 1987 (DSM-IIIR), and 1994 (DSM-IV). DSM-IV lists approximately 400 mental disorders.Each entry describes the criteria for diagnosing the disorder and its key clinical features. The system also describes related features, which are often but not always present. The classification system is further accompanied by *text information* (that is, background information) such as research indications; age, culture, or gender trends; and each disorder's prevalence, risk, course, complications, predisposing factors, and family patterns.

In 2000, the American Psychiatric Association published an update of the text information that accompanies DSM-IV. This update, called the *DSM-IV Text Revision* (*DSM-IV-TR*), also changed the *diagnostic criteria* for a few disorders (certain sexual disorders.

DSM requires clinicians to evaluate a client's condition on five separate *axes,* or branches of information, when making a diagnosis. First, they must decide whether the person is displaying one or more of the disorders found on *Axis I,* an extensive list of clinical syndromes that typically cause significant impairment. Some of the most frequently diagnosed disorders listed on this axis are the anxiety disorders and mood disorders:

Anxiety disorders People with anxiety disorders may experience general feelings of anxiety and worry (*generalized anxiety disorder*), anxiety centered on a specific situation or object (*phobias*), periods of panic (*panic disorder*), persistent thoughts or repetitive behaviors or both (*obsessive-compulsive disorder*), or lingering anxiety reactions to unusually traumatic events (*acute stress disorder* and *posttraumatic stress disorder*).

Mood disorders People with mood disorders feel extremely sad or elated for long periods of time. These disorders include *major depressive disorder* and *bipolar disorders* (in which episodes of mania alternate with episodes of depression).

Next, diagnosticians must decide whether the person is displaying one of the disorders listed on *Axis II,* which includes long-standing problems that are frequently overlooked in the presence of the disorders on Axis I. There are only two groups of Axis II disorders, *mental retardation* and *personality disorders.*

Although people usually receive a diagnosis from *either* Axis I or Axis II, they may receive diagnoses from both axes.

The remaining axes of DSM-IV-TR guide diagnosticians in reporting other factors. *Axis III* asks for information concerning relevant general medical conditions from which the person is currently suffering. *Axis IV* asks about special psychosocial or environmental problems the person is facing, such as school or housing problems.

And *Axis V* requires the diagnostician to make a *global assessment of functioning* (*GAF*), that is, to rate on a 100-point scale the person's psychological, social, and occupational functioning overall.

Diabetes, for example, might be included under Axis III information and recent breakup in relationship would be noted on Axis IV and GAF of 50/55 on Axis V would indicate a moderate level of dysfunction.

Because DSM-IV-TR uses several kinds of diagnostic information, each defined by a different "axis," it is known as a *multiaxial system.* The diagnoses arrived at under this classification system are thought to be more informative and more carefully considered than those derived from the early DSMs.

DSM -5, published in 2013, incorporated more theoretical shifts in diagnostic thinking for many years and has been the most controversial alteration to diagnostic thinking to date. Most diagnostic categories in DSM-5 contain a listing of subtypes and specifiers that allow the diagnostician to further refine the diagnosis in order to provide more specific subgroupings.

10.4.3 ICD 10

The official classification system of the World Health Organization (WHO) for all physical and mental diseases is known as the *International Classification of Diseases* (*ICD*). It was developed with the purpose of having a standard format for the collection and comparison of mortality statistics. First ICD was adopted in 1900 in a conference in Paris with delegates from 26 countries. Another parallel list of classification of diseases was adopted in 1909. Since then, ICD has been revised every 10 years or so. ICD-10, the latest revision was concluded in 1992. The eleventh revision ICD-11 is underway.

Chapter V (F) of ICD-10 is concerned with mental and behavioural disorders. It is available in three different formats – clinical descriptions and diagnostic guidelines, diagnostic criteria for research, and a shorter and simpler version for primary healthcare workers. ICD-10 follows alphanumeric codes and mental disorders have been classified under 10 categories. The first letter, F, in the ICD list represents mental and behavioural disorders. The numeral after F denotes the main category of the mental disorder. For example, F20 to F29 classify the various kinds of schizophrenia and schizotypal and delusional disorders. F20 is a code specifically assigned to schizophrenia. A subtype of a particular disorder is denoted with the use of a decimal point after the numeral. F.20.0 stands for paranoid schizophrenia, while a digit following this shows the progressive course of the disease (F20.01 denotes paranoid schizophrenia with progressive deficit).

ICD-10 also has a provision for a multiaxial system of classification on three different axes. Clinical diagnoses are represented on the first axis. The second axis is for disablements with four dimensions – disablements due to personal care, occupational functioning, functioning with family, and broad social behaviour, respectively. The third axes takes into account the contextual factors.

Check your Progress – 2
Note: a. Write your answer in the space given below
     b. Compare your answer with those given at the end of the unit.
  3. What is a syndrome?
  4. Expand DSM and ICD.

10.5 Let Us Sum Up

Psychological assessment refers to a procedure by which clinicians, using psychological tests, observation and interviews develop a summary of the client's symptoms and problems. Clinical diagnosis is the process through which a clinician arrives at a general 'summary classification' of the patient's symptoms by following a clearly defined system such as DSM-5 or ICD-10.

Assessment is an ongoing process and may be important at various points during treatment. In the initial clinical assessment, an attempt is usually made to identify the main dimensions of a client's problem and to predict

the probable course of events under various conditions. Assessment before treatment is also important for establishing baseline for various psychological functions so that the effects of treatment can be measured.

10.6 Unit-End Exercises

1. What does clinical assessment of psychological disorders mean? Discuss its usefulness.
2. Describe the evolution of DSM-5.
3. Write a note on ICD.
4. What are psychological tests?
5. Discuss the issues in classification.

10.8 Answer To Check Your Progress

1. Clinical assessmentis used to determine how and why a person is behaving abnormally and how that person may be helped. It also enables clinicians to evaluate people's progress after they have been in treatment for a while and decide whether the treatment should be changed.
2. Projective tests, personality inventories, response inventories, psychophysiological tests, neurological and neuropsychological tests, and intelligence tests.
3. When certain symptoms regularly occur together—a cluster of symptoms is called a syndrome
4. DSM - Diagnostic and Statistical Manual of Mental Disorders
   ICD - International Classification of Diseases

10.8 Suggested Readings

1. Butcher, J. N., Hooley, J. M., Mineka, S., &Dwivedi, C.B. (2017). *Abnormal Psychology*. Noida: Thomson Press India Ltd.
2. Carson, R. C., & Butcher, J. N. (2007). *Abnormal Psychology*. New Delhi: Pearson Education Inc.
3. Sarason&Sarason (2010). *Abnormal Psychology: The Problem of Maladaptive Behaviour* (11[th]Edn). New Delhi: Prentice Hall of India Pvt Ltd.

BLOCK IV: DISORDERS
UNIT XI: Anxiety Disorders

Structure

11.1   Introduction

The vague sense of being in danger is usually called anxiety, and it has the same features—the same increase in breathing, muscular tension, perspiration, and so forth—as fear. Although everyday experiences of fear and anxiety are not pleasant, they often have an adaptive function: they prepare us for action—for "fight or flight"—when danger threatens. However, when anxiety becomes excessive and unnecessary it results in an anxiety disorder.

11.2 Objectives

After completing this unit, you will understand:
- Different types of anxiety disorders, including generalized anxiety disorder, phobias, panic disorder, and obsessive-compulsive disorder along with post-traumatic stress disorder
- The causes of the above listed disorders
- Different treatment options available for anxiety disorders

11.3 Generalized Anxiety Disorder

People with generalized anxiety disorder experience excessive anxiety under most circumstances and worry about practically anything. In fact,

their problem is sometimes described as 'free-floating anxiety'. They typically feel restless, keyed up, or on edge; tire easily; have difficulty concentrating; suffer from muscle tension; and have sleep problems. The symptoms last at least six months. Nevertheless, most people with the disorder are able, although with some difficulty, to carry on social relationships and job activities. Generalized anxiety disorder is common in Western society. Altogether, close to 6 percent of all people develop generalized anxiety disorder sometime during their lives. It may emerge at any age, but usually it first appears in childhood or adolescence. Women diagnosed with the disorder outnumber men 2 to 1. Around one-quarter of individuals with generalized anxiety disorder are currently in treatment.

11.11.1   Clinical Description

DSM-5 criteria specify that the worry must occur on more days than not for at least 6 months and it must be experienced as difficult to control. The worry must be about a number of different events or activities, and its content cannot be exclusively related to the worry associated with the concurrent disorder, such as the possibility of having a panic attack. There was much discussion among the task force working on revisions for DSM-5 as to whether this is the optimal set of criteria for GAD (eg-6-month duration requirement and excessive worry requirement) and whether this is the optimal name for the disorder (versus generalized worry disorder or pathological worry disorder). However, in the end a conservative approach was taken and no changes were made from DSM-4 to DSM-5.

The general picture of people suffering from generalized anxiety disorder is that they live in relatively constant future-oriented mood state of anxious apprehension, chronic tension, worry, and diffuse uneasiness that they cannot control. They also show marked vigilance for possible signs of threat in the environment in the environment and constantly engage in subtle avoidance activities like procrastination, checking, calling a loved one frequently to check if he/she is safe. This apprehension is the essence of GAD, leading Barlow and others to refer to GAD as the "basic" anxiety disorder.

The nearly constant worries of people with GAD leave them continually upset and discouraged. One study showed the common spheres of worry to be family, work, finances and personal illness. Not only they have difficulty in making decisions, they worry endlessly even after making it over possible errors and unforeseen circumstances that may prove their decision wrong. Ultimately, they fail to escape the illusory world created in their thoughts and images and rarely experience the present moment that possesses the potential to bring them joy. A recent study found that those with GAD experienced a similar amount of role impairment and lessened quality of life to those with major depression.

11.11.2   Causes

Sociocultural perspective:

According to sociocultural theorists, generalized anxiety disorder is most likely to develop in people who are faced with societal conditions that are truly dangerous. Studies have found that people in highly threatening environments are indeed more likely to develop the general feelings of tension, anxiety, and fatigue; the exaggerated startle reactions; and the sleep disturbances found in this disorder. One of the most powerful forms of societal stress is poverty. People without financial means are likely to have less equality, less power, and greater vulnerability; to live in run-

down communities with high crime rates; to have fewer educational and job opportunities; and to run a greater risk for health problems. As sociocultural theorists would predict, such people also have a higher rate of generalized anxiety disorder.

Although poverty and various societal and cultural pressures may help create a climate in which generalized anxiety disorder is more likely to develop, sociocultural variables are not the only factors at work. After all, most people in poor, war-torn, politically oppressed, or dangerous environments do not develop this anxiety disorder. Even if sociocultural factors play a broad role, theorists still must explain why some people develop the disorder and others do not. The psychodynamic, humanistic-existential, cognitive, and biological schools of thought have all tried to explain why and have offered corresponding treatments.

Psychodynamic perspective:

Sigmund Freud (1933, 1917) believed that all children experience some degree of anxiety as part of growing up, and all use ego defense mechanisms to help control such anxiety. Children experience realistic anxiety when they face actual danger; neurotic anxiety when they are repeatedly prevented, by parents or by circumstances, from expressing their id impulses; and moral anxiety when they are punished or threatened for expressing their id impulses. According to Freud, some children experience particularly high levels of such anxiety, or their defense mechanisms are particularly inadequate, and these individuals may, in turn, develop generalized anxiety disorder.

According to Freud, some children are overrun by neurotic or moral anxiety, thus setting the stage for generalized anxiety disorder. Say that a boy is spanked every time he cries for milk as an infant, messes his pants as a 2-year-old, and explores his genitals as a toddler. He may eventually come to believe that his various id impulses are very dangerous, and he may experience overwhelming anxiety whenever he has such impulses. Alternatively, a child's ego defense mechanisms may be too weak to cope with even normal levels of anxiety. Overprotected children, shielded by their parents from all frustrations and threats, have little opportunity to develop effective defense mechanisms. When they face the pressures of adult life, their defense mechanisms may be too weak to cope with the resulting anxieties.

Today's psychodynamic theorists often disagree with specific aspects of Freud's explanation for generalized anxiety disorder. People who live in dangerous environments experience greater anxiety and have a higher rate of generalized anxiety disorder than those residing in other settings.Most continue to believe, however, that the disorder can be traced to inadequacies in the early relationships between children and their parents. However, a major disadvantage is that studies on this issue have been contradictory and not fully supporting either point of view.

Humanistic perspective:

Humanistic theorists propose that generalized anxiety disorder, like other psychological disorders, arises when people stop looking at themselves honestly and acceptingly. Repeated denials of their true thoughts, emotions, and behavior make these people extremely anxious and unable to fulfill their potential as human beings.

Rogers believed that children who fail to receive unconditional positive regard from others may become overly critical of themselves and develop

harsh self-standards, what Rogers called conditions of worth. They try to meet these standards by repeatedly distorting and denying their true thoughts and experiences. Despite such efforts, however, threatening self-judgments keep breaking through and causing them intense anxiety. This onslaught of anxiety sets the stage for generalized anxiety disorder or some other form of psychological dysfunction. In spite of such optimistic case reports, controlled studies have failed to offer strong support for this approach.

Cognitive perspective:

Initially, cognitive theorists suggested that generalized anxiety disorder is primarily caused by maladaptive assumptions, a notion that continues to be influential. Albert Ellis, for example, proposed that many people are guided by irrational beliefs that lead them to act and react in inappropriate ways. Ellis called these basic irrational assumptions. Similarly, cognitive theorist Aaron Beck argued that people with generalized anxiety disorder constantly hold silent assumptions (for example, "A situation or a person is unsafe until proven to be safe" or "It is always best to assume the worst") that imply they are in imminent danger.

However, new wave cognitive theories like the 'metacognitive theory', developed by the researcher Adrian Wells (2005), suggests that people with generalized anxiety disorder implicitly hold both positive and negative beliefs about worrying. On the positive side, they believe that worrying is a useful way of appraising and coping with threats in life. And so they look for and examine all possible signs of danger—that is, they worry constantly.

At the same time, Wells argues, individuals with generalized anxiety disorder also hold negative beliefs about worrying, and these negative attitudes are the ones that open the door to the disorder. Because society teaches them that worrying is a bad thing, the individuals come to believe that their repeated worrying is in fact harmful (mentally and physically) and uncontrollable. Now they further worry about the fact that they always seem to be worrying (so-called metaworries). The net effect of all this worrying: generalized anxiety disorder. This explanation has received considerable research support.

Another explanation is the 'intolerance of uncertainty' theory, certain individuals believe that any possibility of a negative event occurring, no matter how slim, means that the event is likely to occur. Given this intolerance of uncertainty, such persons are inclined to worry and are, in turn, more prone to develop generalized anxiety disorder. Like the metacognitive theory of worry, considerable research supports this theory.

Finally, a third new explanation for generalized anxiety disorder, the avoidance theory, developed by researcher Thomas Borkovec, suggests that people with this disorder have greater bodily arousal (higher heart rate, perspiration, respiration) than other people and that worrying actually serves to reduce this arousal, perhaps by distracting the individuals from their unpleasant somatic feelings. In short, the avoidance theory holds that people with generalized anxiety disorder worry repeatedly in order to reduce or avoid uncomfortable states of bodily arousal. Borkovec's explanation has also been supported in numerous studies.

Biological perspective:

This perspective is primarily supported by family pedigree studies, in which researchers determine how many and which relatives of a person

with a disorder have the same disorder. If biological tendencies toward generalized anxiety disorder are inherited, people who are biologically related should have similar probabilities of developing this disorder. Studies have in fact found that biological relatives of persons with generalized anxiety disorder are more likely than nonrelatives to have the disorder also. Approximately 15 percent of the relatives of people with the disorder display it themselves—much more than the 6 percent lifetime prevalence rate found in the general population. And the closer the relative (an identical twin, for example, as opposed to a fraternal twin or other sibling), the greater the likelihood that he or she will also have the disorder. Of course, investigators cannot have full confidence in biological interpretations of such findings. Because relatives are likely to share aspects of the same environment, their shared disorders may reflect similarities in environment and upbringing rather than similarities in biological makeup. And, indeed, the closer the relatives, the more similar their environmental experiences are likely to be.

GABA INACTIVITY: Investigators discovered that benzodiazepine receptors ordinarily receive gamma-aminobutyric acid (GABA), a common and important neurotransmitter in the brain. GABA carries inhibitory messages: when GABA is received at a receptor, it causes the neuron to stop firing. On the basis of such findings, biological researchers eventually pieced together several scenarios of how fear reactions may occur. One of the leading scenarios began with the notion that in normal fear reactions, key neurons throughout the brain fire more rapidly, triggering the firing of still more neurons and creating a general state of excitability throughout the brain and body. Perspiration, breathing, and muscle tension increase. This state is experienced as fear or anxiety. Continuous firing of neurons eventually triggers a feedback system—that is, brain and body activities that reduce the level of excitability. Some neurons throughout the brain release the neurotransmitter GABA, which then binds to GABA receptors on certain neurons and instructs those neurons to stop firing. The state of excitability ceases, and the experience of fear or anxiety subsides. Some researchers concluded that a malfunction in this feedback system can cause fear or anxiety to go unchecked. In fact, when investigators reduced GABA's ability to bind to GABA receptors, they found that animal subjects reacted with a rise in anxiety. This finding suggested that people with generalized anxiety disorder may have ongoing problems in their anxiety feedback system. Perhaps they have too few GABA receptors, or perhaps their GABA receptors do not readily capture the neurotransmitter. However, there are some issues with this finding. The first problem is that recent biological discoveries have complicated the picture. It has been found, for example, that other neurotransmitters, such as serotonin and norepinephrine, may also play important roles in anxiety and generalized anxiety disorder, acting alone or in conjunction with GABA. The second problem is that some of this research on the biology of anxiety has been done on laboratory animals. Finally, biological theorists are faced with the problem of establishing a causal relationship. The biological responses of anxious persons may be the result, rather than the cause, of their anxiety disorders.

11.11.3   TREATMENT

Psychodynamic therapies:
Psychodynamic therapists use the same general techniques to treat all psychological problems: free association and the therapist's interpretations of transference, resistance, and dreams. Freudian psychodynamic therapists use these methods to help clients with generalized anxiety disorder become less afraid of their id impulses and more successful in controlling them. Other psychodynamic therapists particularly object relations therapists, use them to help anxious patients identify and settle the childhood relationship problems that continue to produce anxiety in adulthood. Controlled studies have typically found psychodynamic treatments to be of only modest help to persons with generalized anxiety disorder. An exception to this trend is short-term psychodynamic therapy, which has in some cases significantly reduced the levels of anxiety, worry, and social difficulty of patients with this disorder.

Humanistic approach:
Practitioners of Rogers's treatment approach, client-centered therapy, try to show unconditional positive regard for their clients and to empathize with them. The therapists hope that an atmosphere of genuine acceptance and caring will help clients feel secure enough to recognize their true needs, thoughts, and emotions. When clients eventually are honest and comfortable with themselves, their anxiety or other symptoms will subside.

Cognitive therapies:
CHANGING MALADAPTIVE ASSUMPTIONS: In Ellis's technique of rational-emotive therapy, therapists point out the irrational assumptions held by clients, suggest more appropriate assumptions, and assign homework that gives the individuals practice at challenging old assumptions and applying new ones. Studies do suggest that this approach and similar cognitive approaches bring at least modest relief to persons suffering from generalized anxiety. Beck's similar but more systematic approach, called, simply, cognitive therapy, is an adaptation of his influential and very effective treatment for depression. Researchers have found that, like Ellis's rational emotion therapy, it often helps reduce generalized anxiety to more tolerable levels.

FOCUSING ON WORRYING: Alternatively, some of today's new-wave cognitive therapists specifically guide clients with generalized anxiety disorder to recognize and change their dysfunctional use of worrying. They begin by educating the clients about the role of worrying in their disorder and have them observe their bodily arousal and cognitive responses across various life situations. In turn, the clients come to appreciate the triggers of their worrying, their misconceptions about worrying, and their misguided efforts to control and predict their emotions and their lives by worrying. As their insights grow, clients are expected to see the world as less threatening (and so less arousing), try out and adopt more constructive ways of dealing with arousal, and worry less about the fact that they worry so much.

The approach, mindfulness-based cognitive therapy (very similar to the previous approach) was developed by the psychologist Steven Hayes and his colleagues. Therapists help clients to become aware of their streams of thoughts, including their worries, as they are occurring and to accept such thinking as mere events of the mind. By accepting their thoughts rather than trying to eliminate them, the clients are expected to be less upset and affected by them. Mindfulness-based cognitive therapy has also been

applied to a range of other psychological problems such as depression, posttraumatic stress disorder, personality disorders, and substance abuse, often with promising results.

Biological treatments:

ANTI-ANXIETY DRUG THERAPY: Studies indicate that benzodiazepines often provide temporary relief for people with generalized anxiety disorder. However, clinicians have come to realize the potential dangers of these drugs. First, when the medications are stopped, many persons' anxieties return as strong as ever. Second, we now know that people who take benzodiazepines in large doses for an extended time can become physically dependent on them. Third, the drugs can produce undesirable effects such as drowsiness, lack of coordination, memory loss, depression, and aggressive behavior. Finally, the drugs mix badly with certain other drugs or substances.

In recent decades, still other kinds of drugs have become available for people with generalized anxiety disorder. In particular, it has been discovered that a number of antidepressant medications, drugs that are usually used to lift the moods of depressed persons, are also helpful to many people with generalized anxiety disorder. Only certain kinds of antidepressant drugs seem to reduce the symptoms of generalized anxiety disorder—namely, those that operate by increasing the activity of the neurotransmitter serotonin. Like GABA, serotonin is a neurotransmitter that carries messages between neurons. However, serotonin acts at different neurons and brain areas than GABA.

RELAXATION TRAINING: A nonchemical biological technique commonly used to treat generalized anxiety disorder is relaxation training. The notion behind this approach is that physical relaxation will lead to a state of psychological relaxation. In one version, therapists teach clients to identify individual muscle groups, tense them, release the tension, and ultimately relax the whole body. With continued practice, they can bring on a state of deep muscle relaxation at will, reducing their state of anxiety. Research indicates that relaxation training is more effective than no treatment or placebo treatment in cases of generalized anxiety disorder. The improvement it produces, however, tends to be modest (Leahy, 2004; Butler et al., 1991), and other techniques that are known to relax people, such as meditation, often seem to be equally effective.

BIOFEEDBACK: In biofeedback, therapists use electrical signals from the body to train people to control physiological processes such as heart rate or muscle tension. Clients are connected to a monitor that gives them continuous information about their bodily activities. By attending to the therapist's instructions and the signals from the monitor, they may gradually learn to control even seemingly involuntary physiological processes. The most widely applied method of biofeedback for the treatment of anxiety uses a device called an electromyograph (EMG), which provides feedback about the level of muscular tension in the body. Electrodes are attached to the client's muscles—usually the forehead muscles—where they detect the minute electrical activity that accompanies muscle tension. The device then converts electric potentials coming from the muscles into an image, such as lines on a screen, or into a tone whose pitch changes along with changes in muscle tension. Thus clients "see" or "hear" when their muscles are becoming more or less tense. Through repeated trial and error, the individuals become skilled at voluntarily

reducing muscle tension and, theoretically, at reducing tension and anxiety in everyday stressful situations. Research finds that, in most cases, EMG biofeedback, like relaxation training, has only a modest effect on a person's anxiety level.

Check your progress-1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

1. What are some of the biological treatment methods used on those with GAD?

11.12 Panic Disorder With And Without Agoraphobia

Sometimes an anxiety reaction takes the form of a smothering, nightmarish panic in which people lose control of their behavior and, in fact, are practically unaware of what they are doing. Anyone can react with panic when a real threat looms up. Some people, however, experience panic attacks—periodic, short bouts of panic that occur suddenly, reach a peak within 10 minutes, and gradually pass. Lots of people are capable of experiencing a panic attack when faced with something they dread. Indeed, more than one-quarter of all individuals have one or more panic attacks at some point in their lives. Some people, however, have panic attacks repeatedly and unexpectedly without apparent reason. They may be suffering from 'panic disorder'.

11.12.1   CLINICAL DESCRIPTION

According to the DSM-5 criteria for panic disorder, the person must have experienced recurrent, unexpected attacks and must have been persistently worried about having another attack for at least a month (anticipatory anxiety). For such an event to qualify as a full blown panic attack, there must be abrupt onset of at least 4 of 13 symptoms, most of which are physical, although three are cognitive: (1) depersonalization (a feeling of being detached from one's body) or derealization (a feeling that the external world is unreal); (2) fear of dying; (3) fear of "going crazy" or "losing control". Panic attacks are fairly brief but intense, with symptoms developing abruptly and usually reaching peak intensity within 10 minutes' the attacks subside in 20-30 minutes and rarely last more than an hour. These attacks are often "uncued" in the sense that they do not appear to be provoked by identifiable aspects of the immediate situation. They may also occur during sleep (known as 'nocturnal panic'). However, they may also be situationally predisposed.

Since most symptoms of a panic attack are physical, it is not surprising that as many as 85% of people having a panic attack may show up repeatedly in emergency rooms for what they are convinced as some cardiac, respiratory or neurological issue.

Panic disorder is often accompanied by agoraphobia (from the Greek word for "fear of the marketplace") and some cases it may not be present. These people are afraid to leave the house and travel to public places or other locations where escape might be difficult or help unavailable should panic symptoms develop. The intensity of agoraphobia may fluctuate. In severe cases, people become virtual prisoners in their own homes. Their social life dwindles, and they cannot hold a job.

11.12.2   CAUSES
Biological perspective:
Several studies produced evidence that norepinephrine activity is irregular in people who suffer from panic attacks. For example, the 'locus coeruleus', an area in the midbrain, is rich in neurons that use norepinephrine. When this area is electrically stimulated in monkeys, the monkeys have a panic-like reaction, suggesting that panic reactions may be related to increases in norepinephrine activity in the locus coeruleus. A possible reason for this malfunction could be one's genetic predisposition.

However, research conducted in recent years indicates that the root of panic attacks is probably more complicated than a single neurotransmitter or single brain area. Researchers have determined that emotional reactions of various kinds are tied to brain circuits—networks of brain structures that work together, triggering each other into action and producing a particular kind of emotional reaction. It turns out that the circuit that produces panic reactions includes brain areas such as the amygdala, ventromedial nucleus of the hypothalamus, central gray matter, and locus coeruleus.

While most of today's researchers agree that this brain circuit probably functions improperly in people who experience panic disorder, they disagree as to where in the circuit the problem lies. Many researchers continue to believe that the locus coeruleus and the neurotransmitter norepinephrine are the key culprits. However, other investigators argue that dysfunctioning by other brain structures or neurotransmitters in the circuit are primarily responsible for panic disorder.

Cognitive perspective:

Cognitive theorists believe that panic-prone people may be very sensitive to certain bodily sensations; when they unexpectedly experience such sensations, they misinterpret them as signs of a medical catastrophe. The panic-prone grow increasingly upset about losing control, fear the worst, lose all perspective, and rapidly plunge into panic. For example, many people with panic disorder seem to "over breathe," or hyperventilate, in stressful situations. The abnormal breathing makes them think that they are in danger of suffocation, so they panic. Such individuals further develop the belief that these and other "dangerous" sensations may return at any time and so set themselves up for future panic attacks.

In 'biological challenge tests', researchers produce hyperventilation or other biological sensations by administering drugs or by instructing clinical research participants to breathe, exercise, or simply think in certain ways. Those with panic disorder seem to be more prone to misinterpretation. One possibility is that panic-prone individuals generally experience, through no fault of their own, more frequent or more intense bodily sensations than other people do. Still other clinical theorists suggest that people are more prone to misinterpret bodily sensations (and, in turn, to experience panic attacks) if they have poor coping skills or lack social support. Perhaps their childhoods were filled with unpredictable events, lack of control, chronic illnesses in the family, or parental overreactions to their children's bodily symptoms.

11.12.3   TREATMENT

Drug therapies:

It appears that any antidepressant drugs that restore proper activity of norepinephrine in the locus coeruleus and other parts of the panic brain circuit are able to help prevent or alleviate the symptoms of panic disorder. Such drugs bring at least some improvement to 80 percent of patients who have panic disorder. Approximately half recover markedly or fully, and the improvements can last indefinitely, as long as the drugs are continued. In recent years, alprazolam (Xanax) and other powerful benzodiazepine drugs have also proved very effective. Apparently, the benzodiazepines help people with panic disorder by indirectly reducing the activity of norepinephrine throughout the brain. Clinicians have also found these antidepressant drugs or powerful benzodiazepines to be helpful in most cases of panic disorder with agoraphobia. Some people with this disorder, however, need a combination of medication and behavioral exposure treatment to overcome their agoraphobic fears fully.

Cognitive therapy:

Cognitive therapists try to correct people's misinterpretations of their body sensations. The first step is to educate clients about the general nature of panic attacks, the actual causes of bodily sensations, and the tendency of clients to misinterpret their sensations. The next step is to teach clients to apply more accurate interpretations during stressful situations, thus short-circuiting the panic sequence at an early point. Therapists may also teach clients to cope better with anxiety—for example, by applying relaxation and breathing techniques—and to distract themselves from their sensations.

Cognitive therapists may also use biological challenge procedures (called interoceptive exposure when applied in therapy) to induce panic sensations, so that clients can apply their new skills under watchful supervision. Cognitive therapy has proved to be at least as helpful as antidepressant drugs or alprazolam in the treatment of panic disorder, sometimes even more so. In view of the effectiveness of both cognitive and drug treatments, many clinicians have tried combining them. It is not yet clear, however, whether this strategy is more effective than cognitive therapy alone.

Check your progress-2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

2. Name a few drugs used to treat panic disorder.

11.13 Specific Phobia

A specific phobia is a persistent fear of a specific object or situation. When sufferers are exposed to the object or situation, they typically experience immediate fear. Common specific phobias are intense fears of specific animals or insects, heights, enclosed spaces, thunderstorms, and blood. More than 12 percent of individuals develop such phobias at some point during their lives, and many people have more than one at a time. Women with the disorder outnumber men by at least 2 to 1. The impact of a specific phobia on a person's life depends on what arouses the fear. People whose phobias center on dogs, insects, or water will keep encountering the objects they dread. Their efforts to avoid them must be elaborate and may

greatly restrict their activities. The vast majority of people with a specific phobia do not seek treatment. They try instead to avoid the objects they fear.

11.13.1 Clinical Description

According to DSM-5 a person is diagnosed as having a specific phobia if she/he shows strong and persistent fear that is triggered by the presence of a specific object or situation. When individuals with specific phobias encounter a phobic stimulus, they often show an immediate fear response that often resembles a panic attack except for the presence of a clear external trigger. They also experience anxiety when they anticipate an encounter with the phobic object. They often even avoid seemingly innocent representations of it such as photographs or television images. Generally, people with specific phobias recognize that their fear is somewhat excessive or unreasonable although occasionally they may not have this insight.

Avoidance is a cardinal characteristic of phobias; it occurs both because the phobic response itself is so unpleasant and because of the phobic person's irrational appraisal of the likelihood that something terrible will happen. If people who suffer from phobias attempt to approach their phobic situation, they are overcome with fear or anxiety, which may vary from mild feelings of apprehension and distress to full-fledged activation of the fight-flight response.

One category of specific phobias that has a number of interesting and unique characteristics is 'blood-injection-injury phobia'. People with this phobia show a unique physiological response when confronted with the sight of blood or injury. This includes initial acceleration, followed by dramatic drop in both heart rate and blood pressure which is frequently accompanied by nausea, dizziness or fainting. This pattern is not found in other phobic reactions.

11.13.2 Causes
Psychological factors:

According to the psychodynamic viewpoint, phobias represent a defense against anxiety that stems from repressed impulses from the id. Because it is dangerous to "know" the repressed id impulse, the anxiety is displaced onto some external object or situation that has a symbolic relationship to the real object.

Later, Wolpe and Rachman developed the learning theory explanation in which they said that the principles of classical conditioning appeared to account for the acquisition of irrational fears and phobias. However, direct traumatic conditions were not the only way that people acquired irrational, phobic fears. Simply watching a phobic person behave fearfully with his/her phobic object can facilitate learning. In one experiment, rhesus monkeys that were laboratory-reared showed fear of snakes simply through observing a wild-reared monkey behave fearfully with snakes. This fear was acquired only after 4-8 minutes of exposure and there were no signs that the fear diminished 3 months later. This suggests that mass media may also pay a role in vicarious conditioning of fears and phobias.

Individual factors:
Differences in life experiences of individuals strongly affect whether or not conditioned fears or phobias actually develop. For example, children who have more positive experiences with a dog are less likely to develop dental anxiety after a bad and painful experience with the dentist. This shows the importance of the individual's prior familiarity with an object or situation in determining whether a phobia develops. Events that occur during a conditioning experience, as well as before it is also important in determining the level of fear that is conditioned. For example, if the event is seen as uncontrollable or inescapable, such as being attacked by a dog that one cannot escape from after being bitten, is more powerful than something that is seen as escapable or to some extent controllable. For example, the 'inflation effect' suggests that a person who acquired a mild fear of driving following a minor crash might be expected to develop a full-blown phobia if he/she were later physically assaulted, even though no automobile was present during the assault.

It has also been shown that our cognitions or thoughts can maintain our phobias once they have been acquired. People with phobias are constantly on the alert for their phobic objects or situations and for other stimuli relevant to their phobia. This cognitive bias may maintain and strengthen their fears with the passage of time.

Evolutionary explanation:
Primates and humans seem to be evolutionarily prepared to associate certain objects like snakes, spiders and enclosed spaces with frightening or unpleasant events. This is called 'prepared learning'- one explanation for the existence of phobias. According to this theory, these fears are not innate or inborn but are rather resistant to extinction. Researchers also say that this "preparedness" gave a certain selective advantage to our ancestors.

Biological factors:
Genetic and temperamental variables affect the speed and strength of conditioning of fear. For example, Lonsdorf and colleague found that individuals who are carriers of one or two variants on the serotonin transporter gene (the s allele, which has been linked to heightened neuroticism) show superior conditioning relative to individuals who do not carry the s allele. However, those with one of two variants of the COMT met/met genotype did not show superior conditioning but did show enhanced resistance to extinction. In terms of temperament, those with the behaviorally inhibited temperament, especially at 21 months of age were at higher risk for developing multiple specific phobias by 7 or 8.

11.13.3   Treatment
A form of behavior therapy called 'exposure therapy' which involves controlled exposure to the stimuli or situations that elicit phobic fear is the best treatment for specific phobias. In this therapy, clients are symbolically or increasingly placed under "real-life" conditions in the situations that they find most frightening. One variant of this procedure is also called 'participant modelling' in which the therapist calmly models ways of interacting with phobic stimulus or situations. For certain phobias such as

small-animal phobias, flying phobia, claustrophobia, and blood-injury phobia, exposure therapy is often highly effective when administered in a single long session. Recently, therapists have also started using virtual reality as means of phobia extinction.

In terms of cognitive techniques, studies have found that using these techniques alone have not produced results as good as those using exposure-based techniques. Similarly, medication treatments are ineffective by themselves, anti-anxiety medications may interfere with the effects of exposure therapy. Recently however, studies have shown that a drug called 'd-cycloserine', which is known to facilitate extinction of conditioned fear in animals may enhance the effects of exposure therapy. This drug, however, by itself, has no effect.

Check your progress-3

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

3. What is 'blood-injection-injury' phobia?

11.14 Post-Traumatic Stress Disorder

The diagnosis for PTSD entered the DSM in 1980. At this time, psychiatrists began to realize that many veterans were scarred emotionally and were unable to return to normal civilian life after their military service in Vietnam. Initially, PTSD was viewed as a normal response to an abnormal stressor. But overtime the definitions have changed.

11.14.1   Clinical Description

In PTSD a traumatic event is thought to cause a 'pathological memory' that is the central characteristic. These memories are often fragments of experience and often concerned with events that happened just before the major emotional impact. The symptoms of PTSD fall into 4 categories-

1. Intrusion- Recurrent re-experiencing of the traumatic event through nightmares, intrusive images, and physiological reactivity to reminders of the trauma.
2. Avoidance- Avoidance of thoughts, feelings or reminders of the trauma.
3. Negative cognitions and mood- This includes feelings of detachment and negative emotional states such as shame and anger, or distorted blame of oneself or others.
4. Arousal and reactivity- Hypervigilance, excessive response when startled, aggression, and reckless behavior.
   The difference in prevalence of PTSD in men and women is interesting as men are much more likely to be exposed to traumatic events. This sex difference reflects the fact that women are more likely to be exposed to certain kinds of traumatic events, such as rape, that may be more inherently traumatic. However, rates of PTSD vary based on the severity of the trauma.

11.14.2   Causes

Biological factors:

Investigators have learned that traumatic events trigger physical changes in the brain and body that may lead to severe stress reactions and, in some cases, to stress disorders. They have, for example, found abnormal activity

of the hormone cortisol and the neurotransmitter/hormone norepinephrine in the urine, blood, and saliva of combat soldiers, rape victims, concentration camp survivors, and survivors of other severe stresses.

Two areas in the brain in particular seem to be affected—the hippocampus and the amygdala. Clearly, a dysfunctional hippocampus may help produce the intrusive memories and ongoing arousal that characterize posttraumatic stress disorder. The excessive arousal generated by extraordinary traumatic events may lead to stress disorders in some people, and the stress disorders may produce yet further brain abnormalities, locking in the disorders all the more firmly. It may also be that posttraumatic stress disorder leads to the transmission of biochemical abnormalities to the children of persons with the disorder. Many theorists believe that people whose biochemical reactions to stress are unusually strong are more likely than others to develop acute and posttraumatic stress disorders. More direct genetic studies are currently under way to determine whether a particular gene or combination of genes predisposes individuals to PTSD.

Individual risk factors:
When it comes to PTSD, there are two important things- risk for experiencing trauma and risk for PTSD. Not everyone has equal risk when it comes to the likelihood that he/she will experience a traumatic event. Risk factors that increase the likelihood of being exposed to trauma include being male, having less than a college education, having conduct problems in childhood, having a family history of a psychiatric disorder, and scoring high on measures of extraversion and neuroticism. As for females, the chance of developing PTSD is higher. Other individual risk factors identified by researchers include lower levels of social support, neuroticism, having preexisting problem with depression and anxiety, as well as having a family history of depression, anxiety and substance abuse. Apart from that, if people believe that their symptoms are a sign of weakness or if they believe that others will be ashamed of them for because they are experiencing symptoms, they are at an increased risk for developing PTSD.

Sociocultural factors:
Vulnerability to this disorder is related to factors such as a person's coping style, general attitudes, sense of control, childhood experiences, and social support system, and these factors frequently vary from culture to culture. However, the overall rate of PTSD has been surprisingly stable from group to group. But now the wind is shifting. A more careful look at the research literature suggests that there may indeed be important cultural differences in the occurrence of posttraumatic stress disorder.
One case in point: Studies of combat veterans from the wars in Vietnam and Iraq have found higher rates of posttraumatic stress disorder among Hispanic American veterans than among white American and African American veterans. Several explanations have been suggested for this. One centers on the initial reactions of Hispanic Americans to traumatic events. It appears that an early dissociative reaction (altered state of consciousness) is one of the strongest predictors that an individual will go on to develop PTSD. Another explanation holds that as part of their cultural belief system, many Hispanic Americans tend to view traumatic events as

inevitable and unalterable, a coping response that may heighten their risk for posttraumatic stress disorder. And still another explanation suggests that their culture's emphasis on social relationships and social support may place Hispanic American victims at special risk when traumatic events deprive them—temporarily or permanently—of important relationships and support systems.

11.14.3 Treatment

Therapists have used a variety of techniques to reduce veterans' posttraumatic symptoms. Among the most common are drug therapy, behavioral exposure techniques, insight therapy, family therapy, and group therapy. Typically, the approaches are combined, as no one of them successfully reduces all the symptoms. Antianxiety drugs help control the tension that many veterans experience. In addition, antidepressant medications may reduce the occurrence of nightmares, panic attacks, flashbacks, and feelings of depression. Behavioral exposure techniques, too, have helped reduce specific symptoms, and they have often led to improvements in overall adjustment.

A widely applied form of exposure therapy is 'eye movement desensitization and reprocessing' (EMDR), in which clients move their eyes in a saccadic, or rhythmic, manner from side to side while flooding their minds with images of the objects and situations they ordinarily try to avoid. Case studies and controlled studies suggest that this treatment can often be helpful to persons with posttraumatic stress disorder. Veterans may also benefit from group therapy, often provided in a form called rap groups, in which individuals meet with others like themselves to share experiences and feelings, develop insights, and give mutual support.

Psychological debriefing is also used as an immediate treatment method. It is actually a form of crisis intervention that has victims of trauma talk extensively—a session typically lasts three to four hours—about their feelings and reactions within days of the critical incident. Because such sessions are expected to prevent or reduce stress reactions, they are commonly applied to victims who have not yet manifested any symptoms at all, as well as those who have. During the sessions, often conducted in a group format, counselors guide the individuals to describe the details of the recent trauma and the thoughts that had accompanied the unfolding event vividly, to vent and relive the emotions provoked at the time of the event, and to express their lingering reactions. The clinicians then clarify to the victims that their reactions are perfectly normal responses to a terrible event, offer stress management tips, and, when necessary, refer the victims to professionals who can provide long-term counseling.

Check your progress-4

Note: a. Write your answer in the space given below

     b. Compare your answer with those given at the end of the unit

4. What are the 4 categories of symptoms in PTSD?

11.15 Obsessive-Compulsive Disorder

Obsessions are persistent thoughts, ideas, impulses, or images that seem to invade a person's consciousness. Compulsions are repetitive and rigid behaviors or mental acts that people feel they must perform in order to

prevent or reduce anxiety. People with OCD have occurrence of unwanted and intrusive obsessive thoughts or distressing images. These are usually accompanied by compulsive behaviors performed to undo or neutralize the obsessive thoughts or images as a way of preventing some dreaded situation or event.

11.15.1   Clinical Description

According to DSM-V, a diagnosis of obsessive-compulsive disorder is called for when obsessions or compulsions feel excessive or unreasonable, cause great distress, take up much time, or interfere with daily functions. The disorder is classified as an anxiety disorder because the obsessions cause intense anxiety, while the compulsions are aimed at preventing or reducing anxiety. In addition, anxiety rises if individuals try to resist their obsessions or compulsions. These obsessive thoughts involve contamination fears, fears of harming oneself or others, and pathological doubt.Touching, verbal, and counting compulsions are also common.Obsessions are thoughts that feel both intrusive ("ego dystonic") and foreign ("ego alien") 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. OCD is often one of the most disabling mental disorder that leads to lower quality of life and a great deal of functional impairment. Between 1 and 2 percent of the people in the United States and other countries throughout the world suffer from obsessive-compulsive disorder in any given year. Between 2 and 3 percent develop the disorder at some point during their lives. It is equally common in men and women and among people of different races and ethnic groups. The disorder usually begins by young adulthood and typically persists for many years, although its symptoms and their severity may fluctuate over time. It is estimated that more than 40 percent of people with obsessive-compulsive disorder seek treatment.

11.15.2   Auses

Psychodynamic perspective:

According to psychodynamic theorists, three ego defense mechanisms are particularly common in obsessive-compulsive disorder: isolation, undoing, and reaction formation. People who resort to isolation simply disown their unwanted thoughts and experience them as foreign intrusions. People who engage in undoing perform acts that are meant to cancel out their undesirable impulses. Those who wash their hands repeatedly, for example, may be symbolically undoing their unacceptable id impulses. People who develop a reaction formation take on a lifestyle that directly opposes their unacceptable impulses. A person may live a life of compulsive kindness and devotion to others in order to counter unacceptably aggressive impulses. Sigmund Freud traced obsessive-compulsive disorder to the anal stage of development (occurring at about 2 years of age). He proposed that during this stage some children experience intense rage and shame as a result of negative toilet-training experiences. Other psychodynamic theorists have argued instead that such early rage reactions are rooted in feelings of insecurity. Either way, these children repeatedly feel the need to express their strong aggressive id impulses while at the same time knowing they should try to restrain and control the impulses. If this conflict between the id and ego continues, it may eventually blossom into obsessive-

compulsive disorder. Overall, research has not clearly supported the psychodynamic explanation.

Behavioral perspective:
Behaviorists have concentrated on explaining and treating compulsions rather than obsessions. They propose that people happen upon their compulsions quite randomly. In a fearful situation, they happen just coincidentally to wash their hands, say, or dress a certain way. When the threat lifts, they link the improvement to that particular action. After repeated accidental associations, they believe that the action is bringing them good luck or actually changing the situation, and so they perform the same actions again and again in similar situations. The act becomes a key method of avoiding or reducing anxiety.

Cognitive perspective:
Cognitive theorists begin their explanation of obsessive-compulsive disorder by pointing out that everyone has repetitive, unwanted, and intrusive thoughts. Anyone might have thoughts of harming others or being contaminated by germs, for example, but most people dismiss or ignore them with ease. Those who develop this disorder, however, typically blame themselves for such thoughts and expect that somehow terrible things will happen. To avoid such negative outcomes, they try to neutralize the thoughts—thinking or behaving in ways meant to put matters right or to make amends. Neutralizing acts might include requesting special reassurance from others, deliberately thinking "good" thoughts, washing one's hands, or checking for possible sources of danger.

Researchers have also found that those who are likely to develop OCD tend to be (1) to be more depressed than other people, (2) to have exceptionally high standards of conduct and morality, (3) to believe that their intrusive negative thoughts are equivalent to actions and capable of causing harm to themselves or others, and (4) generally to believe that they should have perfect control over all of their thoughts and behaviors.

Biological approach:
In recent years two lines of research have uncovered evidence that biological factors play a key role in obsessive-compulsive disorder, and promising biological treatments for the disorder have been developed as well. The research points to (1) abnormally low activity of the neurotransmitter serotonin and (2) abnormal functioning in key regions of the brain.

ABNORMAL SEROTONIN ACTIVITY: Serotonin, like GABA and norepinephrine, is a brain chemical that carries messages from neuron to neuron. Some researchers concluded that the disorder is caused by low serotonin activity. Although serotonin is the neurotransmitter most often cited in explanations of obsessive-compulsive disorder, recent studies have suggested that other neurotransmitters, particularly glutamate, GABA, and dopamine, may also play important roles in the development of this disorder (Lambert & Kinsley, 2005). Some researchers even argue that, with regard to obsessive-compulsive disorder, serotonin may act largely as

a neuromodulator, a chemical whose primary function is to increase or decrease the activity of other key neurotransmitters.

ABNORMAL BRAIN STRUCTURE AND FUNCTIONING: Another line of research has linked obsessive-compulsive disorder to abnormal functioning by specific regions of the brain, particularly the orbitofrontal cortex (just above each eye) and the caudate nuclei (structures located within the brain region known as the basal ganglia). These regions are part of a brain circuit that converts sensory information into thoughts and actions. The circuit begins in the orbitofrontal cortex, where sexual, violent, and other primitive impulses normally arise. These impulses next move on to the caudate nuclei, which act as filters that send only the most powerful impulses on to the thalamus, the next stop on the circuit. If impulses reach the thalamus, the person is driven to think further about them and perhaps to act. Many theorists now believe that either the orbitofrontal cortex or the caudate nuclei of some people are too active, leading to a constant eruption of troublesome thoughts and actions. Additional parts of this brain circuit have also been identified in recent years, including the cingulate cortex and, once again, the amygdala. Of course, it may turn out that these regions also play key roles in obsessive-compulsive disorder.

11.15.3 Treatment

Psychodynamic approach:

When treating patients with obsessive-compulsive disorder, psychodynamic therapists try to help the individuals uncover and overcome their underlying conflicts and defenses, using the customary techniques of free association and therapist interpretation. Research has offered little evidence, however, that a traditional psychodynamic approach is of much help.

Behavioral approach:

In a behavioral treatment called exposure and response prevention (or exposure and ritual prevention), first developed by psychiatrist Victor Meyer (1966), clients are repeatedly exposed to objects or situations that produce anxiety, obsessive fears, and compulsive behaviors, but they are told to resist performing the behaviors they feel so bound to perform. Because people find it very difficult to resist such behaviors, therapists may set an example first. Many behavioral therapists now use exposure and response prevention in both individual and group therapy formats. Some of them also have people carry out self-help procedures at home. Between 55 and 85 percent of clients with obsessive-compulsive disorder have been found to improve considerably with exposure and response prevention, improvements that often continue indefinitely.

Cognitive approach:

Cognitive therapists focus treatment on the cognitive processes that help produce and maintain obsessive thoughts and compulsive acts. Initially, they provide psychoeducation, teaching clients about their misinterpretations of unwanted thoughts, excessive sense of responsibility, and neutralizing acts. They then move on to help the clients identify, challenge, and change their distorted cognitions. Many cognitive therapists also include habituation training in their sessions, directing clients to call forth their obsessive thoughts again and again. The clinicians expect that with such repetitions, the obsessive thoughts will lose their power to

frighten or threaten the clients, and thus will produce less anxiety and trigger fewer new obsessive thoughts and compulsive acts.

In cognitive-behavioral treatments, clients are taught to view their obsessive thoughts as inaccurate occurrences rather than as valid and dangerous cognitions for which they are responsible and upon which they must act. As they become better able to identify and understand such thoughts—to recognize them for what they are—they also become less inclined to act on them, more willing and able to subject themselves to the rigors of exposure and response prevention, and more likely to make gains in behavioral techniques (in the previous approach).

Biological therapies:

Two antidepressant drugs, clomipramine (Anafranil) and fluoxetine (Prozac) are generally used in treatment. These drugs not only increase brain serotonin activity but also help produce more normal activity in the orbitofrontal cortex and caudate nuclei. Studies have found that fluvoxamine (Luvox), and other similar antidepressant drugs also bring improvement to between 50 and 80 percent of those with obsessive-compulsive disorder.

Nowadays, more and more individuals with obsessive-compulsive disorder are now being treated by a combination of behavioral, cognitive, and drug therapies. According to research, such combinations often yield higher levels of symptom reduction and bring relief to more clients than do each of the approaches alone.

Check your progress-5

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit

5. Define obsessions and compulsions.

11.16 Let Us Sum Up

In this unit, you have been introduced to the clinical picture, causes and treatment of Generalized Anxiety Disorder, Panic disorder with or without agoraphobia, Specific phobia, Post-Traumatic Stress Disorder and Obsessive-Compulsive Disorder.

11.17 Unit-End Exercises

1. Describe generalized anxiety disorder in detail.
2. Describe panic disorder with and without agoraphobia in detail.
3. Write about specific phobias in detail.
4. Write about PTSD in detail.
5. Describe obsessive-compulsive disorder in detail.

11.18 Answer to Check Your Progress

1. Anti-anxiety drug therapy, relaxation training and biofeedback
2. Antidepressants, alprazolam (Xanax) and other powerful benzodiazepines
3. People with this phobia show a unique physiological response when confronted with the sight of blood or injury. This includes initial acceleration, followed by dramatic drop in both heart rate and blood pressure which is frequently accompanied by nausea, dizziness or fainting. This pattern is not found in other phobic reactions.

4. Intrusion, avoidance, negative cognitions and mood, arousal and reactivity

5. Obsessions are persistent thoughts, ideas, impulses, or images that seem to invade a person's consciousness. Compulsions are repetitive and rigid behaviors or mental acts that people feel they must perform in order to prevent or reduce anxiety.

11.19 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

UNIT XII: MOOD DISORDERS

12.7   Introduction

Most of us feel depressed from time to time. However, mood disorders involve much more severe alterations in mood for much longer periods of time. In such cases, the disturbances of mood are intense and persistent enough to be clearly maladaptive and often lead to serious problems in relationships and work performance.

12.8   Objectives

After going through this unit, you will be able to
- Understand the meaning of mood disorders
- Enlist the various types and symptoms of mood disorders
- Understand treatment methods for mood disorders
- Know about suicide- it's risk factors, prevention and treatment

12.9   Mood Disorders

People with mood disorders have mood problems that tend to last for months or years, dominate their interactions with the world, and disrupt their normal functioning. Depression and mania are the key moods in these disorders. Most people with a mood disorder suffer only from depression, a pattern called unipolar depression. They have no history of mania and return to a normal or nearly normal mood when their depression lifts. Others experience periods of mania that alternate with periods of depression, a pattern called bipolar disorder.

Unipolar depression:

Around 17 percent of all adults experience an episode of severe unipolar depression at some point in their lives. People of any age may suffer from unipolar depression. In most countries, however, people in their forties are more likely than those in any other age group to have the disorder. Women are at least twice as likely as men to experience episodes of severe unipolar depression.

The symptoms, which often exacerbate one another, span five areas of functioning: emotional, motivational, behavioral, cognitive, and physical.

Emotional symptoms- Most people who are depressed feel sad and dejected. They describe themselves as feeling "miserable," "empty," and "humiliated." They tend to lose their sense of humor, report getting little pleasure from anything, and in some cases display anhedonia, an inability

to experience any pleasure at all. A number also experience anxiety, anger, or agitation. This sea of misery may lead to crying spells.

Motivational symptoms- Depressed people typically lose the desire to pursue their usual activities. Almost all report a lack of drive, initiative, and spontaneity. They may have to force themselves to go to work, talk with friends, eat meals, or have sex. This state has been described as a "paralysis of will".

Behavioral symptoms- Depressed people are usually less active and less productive. They spend more time alone and may stay in bed for long periods.

Cognitive symptoms- Depressed people hold extremely negative views of themselves. They consider themselves inadequate, undesirable, inferior, perhaps evil. They also blame themselves for nearly every unfortunate event, even things that have nothing to do with them, and they rarely credit themselves for positive achievements.

Physical symptoms- People who are depressed frequently have such physical ailments as headaches, indigestion, constipation, dizzy spells, and general pain (Fishbain, 2000). In fact, many depressions are misdiagnosed as medical problems at first. Disturbances in appetite and sleep are particularly common.

There are two categories of mood disorders- depressive disorders and bipolar disorders.

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. Name some of the cognitive symptoms in people with unipolar depression.

12.10 Depressive Disorders

People who experience a major depressive episode without having any history of mania receive a diagnosis of *'major depressive disorder'*. The disorder may be additionally categorized as *recurrent* if it has been preceded by previous episodes; *seasonal* if it changes with the seasons (for example, if the depression recurs each winter); *catatonic* if it is marked by either immobility or excessive activity; *postpartum* if it occurs within four weeks of giving birth; or melancholic if the person is almost totally unaffected by pleasurable events (APA, 2000). It sometimes turns out that an apparent case of major depressive disorder is, in fact, a depressive episode occurring within a larger pattern of bipolar disorder—a pattern in which the individual's manic episode has not yet appeared. When the person experiences a manic episode at a later time, the diagnosis is changed to bipolar disorder.

People who display a longer-lasting (at least two years) but less disabling pattern of unipolar depression may receive a diagnosis of *dysthymic disorder*. When dysthymic disorder leads to major depressive disorder, the sequence is called 'double depression'.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. What does the term 'double depression' indicate?

12.11 BIPOLAR DISORDER

People with a bipolar disorder experience both the lows of depression and the highs of mania. Many describe their life as an emotional roller coaster, as they shift back and forth between extreme moods. A number of sufferers eventually become suicidal.

People with bipolar disorders generally go through manic episodes. Unlike people sunk in the gloom of depression, those in a state of mania typically experience dramatic and inappropriate rises in mood. The symptoms of mania span the same areas of functioning—emotional, motivational, behavioral, cognitive, and physical—as those of depression, but mania affects those areas in an opposite way. A person in the throes of mania has active, powerful emotions in search of an outlet. The mood of euphoric joy and well-being is out of all proportion to the actual happenings in the person's life. In the motivational realm, people with mania seem to want constant excitement, involvement, and companionship. They enthusiastically seek out new friends and old, new interests and old, and have little awareness that their social style is overwhelming, domineering, and excessive. The behavior of people with mania is usually very active. They move quickly, as though there were not enough time to do everything they want to do. In the cognitive realm, people with mania usually show poor judgment and planning, as if they feel too good or move too fast to consider possible pitfalls. Filled with optimism, they rarely listen when others try to slow them down, interrupt their buying sprees, or prevent them from investing money unwisely. They may also hold an inflated opinion of themselves, and sometimes their self-esteem approaches grandiosity. During severe episodes of mania, some have trouble remaining coherent or in touch with reality. Finally, in the physical realm, people with mania feel remarkably energetic. They typically get little sleep yet feel and act wide awake. Even if they miss a night or two of sleep, their energy level may remain high.

DSM-V distinguishes two kinds of bipolar disorders—*bipolar I* and *bipolar II*. People with bipolar I disorder have full manic and major depressive episodes. Most of them experience an alternation of the episodes; for example, weeks of mania followed by a period of wellness, followed, in turn, by an episode of depression. Some people, however, have mixed episodes, in which they swing from manic to depressive symptoms and back again on the same day. In bipolar II disorder, hypomanic—that is, mildly manic— episodes alternate with major depressive episodes over the course of time. Some people with this pattern accomplish huge amounts of work during their mild manic periods.

Surveys from around the world indicate that between 1 and 2.6 percent of all adults suffer from a bipolar disorder at any given time (Merikangas et al., 2007; Kessler et al., 2005). As many as 4 percent experience one of the bipolar disorders over the course of their lives. Bipolar I disorder seems to be a bit more common than bipolar II disorder (Rihmer& Angst, 2005; Kessler et al., 1994). The disorders appear to be equally common in women and men and among all socioeconomic classes and ethnic groups (Shastry, 2005; APA, 2000). However, women may experience more depressive episodes and more rapid cycling than men.

When a person experiences numerous periods of hypomanic symptoms and mild depressive symptoms, DSM-V assigns a diagnosis of *'cyclothymic disorder'*. The symptoms of this milder form of bipolar disorder continue

for two or more years, interrupted occasionally by normal moods that may last for only days or weeks. This disorder, like bipolar I and bipolar II disorders, usually begins in adolescence or early adulthood and is equally common among women and men.

12.11 Causes

Psychodynamic theorists suggested that mania, like depression, emerges from the loss of a love object. Whereas some people introject the lost object and become depressed, others deny the loss and become manic. To avoid the terrifying conflicts generated by the loss, they escape into a dizzying round of activity (Lewin, 1950). Although case reports sometimes fit this explanation (Krishnan et al., 1984; Cohen et al., 1954), only a few controlled studies have found a relationship between loss early or later in life and the onset of manic episodes.

The biological insights have come from research into neurotransmitter activity, ion activity, brain structure, and genetic factors.

Neurotransmitter activity:

Studies have found a relationship between low norepinephrine activity and unipolar depression. In another study patients with a bipolar disorder were given 'reserpine', the blood pressure drug known to reduce norepinephrine activity in the brain, and the manic symptoms of some subsided. Low activity of serotonin, acting again as a neuromodulator, opens the door to a mood disorder and permits the activity of norepinephrine (or perhaps other neurotransmitters) to define the particular form the disorder will take. That is, low serotonin activity accompanied by low norepinephrine activity may lead to depression; low serotonin activity accompanied by high norepinephrine activity may lead to mania.

Ion activity:

Positively charged sodium ions (Na+) sit on both sides of a neuron's cell membrane. When the neuron is at rest, more sodium ions sit outside the membrane. When the neuron receives an incoming message at its receptor sites, pores in the cell membrane open, allowing the sodium ions to flow to the inside of the membrane, thus increasing the positive charge inside the neuron. This starts a wave of electrical activity that travels down the length of the neuron and results in its "firing." After the neuron "fires," potassium ions (K+) flow from the inside of the neuron across the cell membrane to the outside, helping to return the neuron to its original resting state. If messages are to be relayed effectively down the axon, the ions must be able to travel easily between the outside and the inside of the neural membrane. Some theorists believe that irregularities in the transport of these ions may cause neurons to fire too easily (resulting in mania) or to stubbornly resist firing (resulting in depression).

Brain structure:

The basal ganglia and cerebellum of these individuals tend to be smaller than those of other people. In addition, their dorsal raphe nucleus, striatum, amygdala, and prefrontal cortex have some structural abnormalities. It is not clear what role such structural abnormalities play in bipolar disorders. the structural problems may simply be the result of the neurotransmitter or ion abnormalities or of the medications that many patients with bipolar disorders now take.

Genetic factors:

Many theorists believe that people inherit a biological predisposition to develop bipolar disorders. Family pedigree studies support this idea. Researchers have also conducted genetic linkage studies to identify possible patterns in the inheritance of bipolar disorders. After studying the records of Israeli, Belgian, and Italian families that had shown high rates of bipolar disorders across several generations, one team of researchers seemed to have linked bipolar disorders to genes on the X chromosome. Other research teams, however, later used techniques from molecular biology to examine genetic patterns in large families, and they linked bipolar disorders to genes on chromosomes 1, 4, 6, 10, 11, 12, 13, 15, 18, 21, and 22 (Maier et al., 2005; Baron, 2002).

Check your Progress – 4

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

4. What is the difference between mania and depression with respect to neurotransmitters?

12.12 Treatment

Treatments for unipolar depression:

Believing that unipolar depression results from unconscious grief over real or imagined losses, compounded by excessive dependence on other people, psychodynamic therapists seek to help clients bring these underlying issues to consciousness and work them through. In a typical behavioral approach, therapists (1) reintroduce depressed clients to pleasurable events and activities, (2) appropriately reinforce their depressive and nondepressive behaviors, and (3) help them improve their social skills. While reintroducing pleasurable events into a client's life, the therapist makes sure that the person's various behaviors are rewarded correctly. Behaviorists argue that when people become depressed, their negative behaviors—crying, ruminating, complaining, or self-depreciation—keep others at a distance, reducing chances for rewarding experiences and interactions. To change this pattern, therapists guide clients to monitor their negative behaviors and to try new, more positive ones (Farmer & Chapman, 2008; Addis & Martell, 2004). In addition, the therapist may use a contingency management approach, systematically ignoring a client's depressive behaviors while praising or otherwise rewarding constructive statements and behavior, such as going to work. Sometimes family members and friends are recruited to help with this feature of treatment.

The cognitive approach follows four phases and usually requires fewer than 20 sessions. These steps are-

1) Increasing activities and elevating mood
2) Challenging automatic thoughts- The individuals are instructed to recognize and record automatic thoughts as they occur and to bring their lists to each session. Therapist and client then test the reality behind the thoughts, often concluding that they are groundless.
3) Identifying negative thinking and biases
4) Changing primary attitudes

Therapists who use family and social approaches to treat depression help clients change how they deal with the close relationships in their lives. The most effective family-social approaches are interpersonal psychotherapy

and couple therapy. Interpersonal psychotherapy (IPT) is a treatment for unipolar depression that is based on the belief that clarifying and changing one's interpersonal problems will help lead to recovery. Couple therapy is a therapy format in which the therapist works with two people who share a long-term relationship.

Biological approaches include electroconvulsive therapy, or ECT. Clinicians and patients alike vary greatly in their opinions of ECT. Some consider it a safe biological procedure with minimal risks; others believe it to be an extreme measure that can cause troublesome memory loss and even neurological damage. Despite the heat of this controversy, ECT is used frequently, largely because it is an effective and fast-acting intervention for unipolar depression.

Antidepressants mainly of the MAO inhibitors (mono amine oxidase inhibitors), SSRI (selective serotonin reuptake inhibitors) and tricyclic category are also used. MAO category includes drugs like *iproniazid* (a drug being tested on patients with tuberculosis, had an interesting effect: it seemed to make the patients happier). There is, however, a potential danger with regard to these drugs. People who take them experience a dangerous rise in blood pressure if they eat foods containing the chemical *tyramine*, including such common foods as cheeses, bananas, and certain wines. Thus people on MAO inhibitors must stick to a rigid diet. In recent years, a new MAO inhibitor has become available in the form of a skin patch that allows for slow, continuous absorption of the drug into the client's body. As for SSRI's, *fluoxetine* (trade name Prozac), *sertraline* (Zoloft), and *escitalopram* (Lexapro). Newly developed selective norepinephrine reuptake inhibitors, such as *atomoxetine* (Strattera), which increase norepinephrine activity only, and serotonin-norepinephrine reuptake inhibitors, such as *venlafaxine* (Effexor), which increase both serotonin and norepinephrine activity, are also now available.

Other invasive techniques include-
1) Vagus nerve stimulation- A treatment procedure for depression in which an implanted pulse generator sends regular electrical signals to a person's vagus nerve; the nerve, in turn, stimulates the brain.
2) Transcranial magnetic stimulation- A treatment procedure for depression in which an electromagnetic coil, which is placed on or above a person's head, sends a current into the individual's brain.
3) Deep brain stimulation- A treatment procedure for depression in which a pacemaker powers electrodes that have been implanted in Brodmann Area 25, thus stimulating that brain area.

Treatments for bipolar disorders:

Lithium and other mood stabilizers:

In 1949 an Australian psychiatrist, John Cade, hypothesized that manic behavior is caused by a toxic level of uric acid in the body. He set out to test this theory by injecting guinea pigs with uric acid, but first he combined it with lithium to increase its solubility. To Cade's surprise, the guinea pigs became not manic but quite lethargic after their injections. Cade suspected that the lithium had produced this effect. When he later administered lithium to 10 human beings who had mania, he discovered that it calmed and normalized their mood. Many countries began using lithium for bipolar disorders soon after, but, it was not until 1970 that the FDA approved it. Determining the correct lithium dosage for a given patient is a delicate process requiring regular analyses of blood and urine

samples and other laboratory tests. Too low a dose will have little or no effect on the bipolar mood swings, but too high a dose can result in lithium intoxication, which can cause nausea, vomiting, sluggishness, tremors, dizziness, slurred speech, seizures, kidney dysfunction, and even death.

Some patients respond better to the other mood stabilizing drugs, such as the anti-seizure drugs carbamazepine or valproate, or to a combination of such drugs. The mood stabilizers also help those with bipolar disorder overcome their depressive episodes, though to a lesser degree than they help with their manic episodes. However, researchers do not fully understand how mood stabilizing drugs operate. They suspect that the drugs change synaptic activity in neurons, but in a way different from that of antidepressant drugs. Antidepressant drugs affect a neuron's initial reception of neurotransmitters whereas, mood stabilizers appear to affect a neuron's second messengers. In one of the most important systems, chemicals called 'phosphoinositides' are produced once neurotransmitters are received. Research suggests that lithium, and perhaps the other mood stabilizers as well, affect this particular messenger system. Alternatively, it may also be that the mood stabilizers correct bipolar functioning by directly changing sodium and potassium ion activity in neurons.

Adjunctive psychotherapy:

Psychotherapy alone is rarely helpful for persons with bipolar disorders. At the same time, clinicians have learned that mood stabilizing drugs alone are not always sufficient either. A number of patients stop taking mood stabilizers on their own because they are bothered by the drugs' unwanted effects, feel too well to recognize the need for the drugs, miss the euphoria felt during manic episodes, or worry about becoming less productive when they take the drugs.

In view of these problems, many clinicians now use individual, group, or family therapy as an adjunct to mood stabilizing drugs. Few controlled studies have tested the effectiveness of such adjunctive therapy, but those that have been done, along with numerous clinical reports, suggest that it helps reduce hospitalization, improves social functioning, and increases patients' ability to obtain and hold a job.

Check your Progress – 5

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

5. What are some of the invasive techniques used to treat unipolar depression?

12.13 Suicide

Today suicide is one of the leading causes of death in the world. Millions of other people throughout the world make unsuccessful attempts to kill themselves; such attempts are called *"parasuicides"*. Actually, it is difficult to obtain accurate figures on suicide, and many investigators believe that estimates are often low. For one thing, suicide can be difficult to distinguish from unintentional drug overdoses, automobile crashes, drownings, and other accidents. Many apparent "accidents" were probably intentional. For another, since suicide is frowned on in our society, relatives and friends often refuse to acknowledge that loved ones have taken their own lives.

Suicide is not classified as a mental disorder by DSM-V, but clinicians are aware of the high frequency with which psychological dysfunction—a breakdown of coping skills, emotional turmoil, a distorted view of life—plays a role in this act. People from all walks of life commit suicide, and they do so for a wide range of reasons. The public is often misinformed about the symptoms and causes of suicide.

Edwin Shneidman (2005, 1993, 1981, 1963), one of the most influential writers on this topic, defines suicide as an intentioned death—a self-inflicted death in which one makes an intentional, direct, and conscious effort to end one's life. Accordingly, Shneidman has distinguished four kinds of people who intentionally end their lives: the death seeker, death initiator, death ignorer, and death darer.

1) *Death seekers* clearly intend to end their lives at the time they attempt suicide. This singleness of purpose may last only a short time. It can change to confusion the very next hour or day, and then return again in short order.

2) *Death initiators* also clearly intend to end their lives, but they act out of a belief that the process of death is already under way and that they are simply hastening the process. Some expect that they will die in a matter of days or weeks. Many suicides among the elderly and very sick fall into this category.

3) *Death ignorers* do not believe that their self-inflicted death will mean the end of their existence. They believe they are trading their present lives for a better or happier existence. Many child suicides fall into this category, as do those of adult believers in a hereafter who commit suicide to reach another form of life.

4) *Death darers* experience mixed feelings, or ambivalence, in their intent to die even at the moment of their attempt, and they show this ambivalence in the act itself. Many death darers are as interested in gaining attention, making someone feel guilty, or expressing anger as in dying per se.

When individuals play indirect, covert, partial, or unconscious roles in their own deaths, Shneidman (2001, 1993, 1981) classifies them in a suicide-like category called 'subintentional death'. Seriously ill people who consistently mismanage their medicines may belong in this category.

Check your Progress – 6

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

6. According to Shneidman, what are the 4 categories of people that try to intentionally end their lives?

12.14 Risk Factors

Stressful events and situations:

The stressors that help lead to suicide do not always need to be as horrific as those tied to combat. Common forms of immediate stress seen in cases of suicide are the loss of a loved one through death, divorce, or rejection (Ajdacic-Gross et al., 2008); loss of a job (Yamasaki et al., 2005); and the stress associated with hurricanes or other natural disasters, even among very young children.

People whose illnesses cause them great pain or severe disability may try to commit suicide, believing that death is unavoidable and imminent (Schneider &Shenassa, 2008; Hendin, 2002, 1999). Victims of an abusive or repressive environment from which they have little or no hope of escape sometimes commit suicide. For example, prisoners of war, inmates of concentration camps, abused spouses, abused children, and prison inmates have tried to end their lives. They may also believe that the suffering and problems are more than they can endure. Some jobs create feelings of tension or dissatisfaction that may precipitate suicide attempts. Research has found particularly high suicide rates among psychiatrists and psychologists, physicians, nurses, dentists, lawyers, police officers, farmers, and unskilled laborers.

Mood and thought changes:

Shneidman (2005, 2001) suggests that the key to suicide is *"psychache,"* a feeling of psychological pain that seems intolerable to the person. The most common change is an increase in sadness. Also common are increases in feelings of anxiety, tension, frustration, anger, or shame.

Suicide attempts may also be preceded by shifts in patterns of thinking. Individuals may become preoccupied with their problems, lose perspective, and see suicide as the only effective solution to their difficulties (Shneidman, 2005, 2001, 1987). They often develop a sense of hopelessness. Hopelessness is a pessimistic belief that one's present circumstances, problems, or mood will not change. Thus, some clinicians believe that a feeling of hopelessness is the single most likely indicator of suicidal intent, and they take special care to look for signs of hopelessness when they assess the risk of suicide. Many people who attempt suicide fall victim to dichotomous thinking, viewing problems and solutions in rigid either/or terms.

Alcohol and other drug use:

Studies indicate that as many as 70 percent of the people who attempt suicide drink alcohol just before the act. It may be that the use of alcohol lowers the individuals' fears of committing suicide, releases underlying aggressive feelings, or impairs their judgment and problem-solving ability.

Mental disorders:

Research suggests that as many as half of all suicide victims had been experiencing severe depression, 20 percent chronic alcoholism, and 10 percent schizophrenia. Correspondingly, as many as 15 percent of people with each of these disorders try to kill themselves. People who are both depressed and dependent on alcohol seem particularly prone to suicidal impulses. It is also the case that many people with borderline personality disorder try to harm themselves or make suicidal gestures as part of their disorder. Suicide is the leading cause of premature death among people with schizophrenia. The popular notion is that when such persons kill themselves, they must be responding to an imagined voice commanding them to do so or to a delusion that suicide is a grand and noble gesture. Research indicates, however, that suicides by people with schizophrenia more often reflect feelings of demoralization or fears of further mental deterioration.

Modelling behavior:

It is not unusual for people, particularly teenagers, to try to commit suicide after observing or reading about someone else who has done so. Research suggests that suicides by entertainers, political figures, and other well-

known persons are regularly followed by unusual increases in the number of suicides across the nation. The word-of-mouth publicity that attends suicides in a school, workplace, or small community may also trigger suicide attempts. For example, during the year after a widely publicized, politically motivated suicide by self-burning in England, for example, 82 other people set themselves on fire, with equally fatal results.

Check your Progress – 7

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

7. What are the two major mood or thought changes implicated in suicide intention and what do they mean?

12.15 Treatment

Treatment of suicidal people falls into two major categories: treatment after suicide has been attempted and suicide prevention.

Treatment after a suicide:

After a suicide attempt, most victims need medical care. Some are left with severe injuries, brain damage, or other medical problems. Once the physical damage is treated, psychotherapy or drug therapy may begin, on either an inpatient or outpatient basis. The goals of therapy are to keep people alive, help them achieve a nonsuicidal state of mind, and guide them to develop better ways of handling stress (Reinecke et al., 2008; Shneidman, 2001). Various therapies have been employed, including drug, psychodynamic, cognitive, cognitive-behavioral, group, and family therapies. Research indicates that cognitive and cognitive-behavioral therapies may be particularly helpful for suicidal individuals (Ghahramanlou-Holloway et al., 2008; Tarrier et al., 2008). These approaches focus to a large degree on the painful thoughts, sense of hopelessness, dichotomous thinking, poor coping skills, and other cognitive and behavioral features that characterize the functioning of suicidal persons. Using elements of Beck's cognitive therapy (see pages 280–283), therapists may help their suicidal clients to assess, challenge, and change many of their negative attitudes and illogical thinking processes (Brown et al., 2005).

Suicide prevention:

Suicide prevention programs and hotlines respond to suicidal people as individuals in crisis—that is, under great stress, unable to cope, feeling threatened or hurt, and interpreting their situations as unchangeable. Thus the programs offer crisis intervention: they try to help suicidal people see their situations more accurately, make better decisions, act more constructively, and overcome their crises (Van Orden et al., 2008; Frankish, 1994). Because crises can occur at any time, the centers advertise their hot lines and also welcome people who walk in without appointments. Today suicide prevention takes place not only in special settings but also in therapists' offices. Suicide experts encourage all therapists to look for and address signs of suicidal thinking and behavior in their clients, regardless of the broad reasons that the clients are seeking treatment. Although specific techniques vary from therapist to therapist or from prevention center to prevention center, the general approach used by Suicide

Prevention Centers reflects the goals and techniques of many clinicians and organizations. During the initial contact at the center, the counselor has several tasks:

1) Establishing a positive relationship- As callers must trust counselors in order to confide in them and follow their suggestions, counselors try to set a positive and comfortable tone for the discussion. They convey that they are listening, understanding, interested, nonjudgmental, and available.

2) Understanding and clarifying the problem- Counselors first try to understand the full scope of the caller's crisis and then help the person see the crisis in clear and constructive terms

3) Assessing suicide potential- Crisis workers fill out a questionnaire, often called a lethality scale, to estimate the caller's potential for suicide. It helps them determine the degree of stress the caller is under, relevant personality characteristics, how detailed the suicide plan is, the severity of symptoms, and the coping resources available to the caller.

4) Assessing and mobilizing the caller's resources- Although they may view themselves as ineffectual, helpless, and alone, people who are suicidal usually have many strengths and resources, including relatives and friends.

5) Formulating a plan- Together the crisis worker and caller develop a plan of action. In essence, they are agreeing on a way out of the crisis, an alternative to suicidal action. Most plans include a series of follow-up counseling sessions over the next few days or weeks, either in person at the center or by phone.

Check your Progress – 8

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

8. What are the 5 steps a counsellor must follow when dealing with a suicidal client?

12.16 Let Us Sum Up

In this unit, we have given an introduction to mood disorders, it's symptoms and treatment. We have discussed depressive disorders and bipolar disorders in further detail and have talked about the symptoms and treatment. We have also gone through suicide; risk factors and ways to treat or prevent suicide.

12.17 Unit-End Exercises

1) Write a note on the possible causes of bipolar disorder
2) What are some of the risk factors of suicide?
3) Write a note on treatment with respect to suicide.
4) Write a note on treatment of mood disorders.

12.18 Answer to Check Your Progress

1. Depressed people hold extremely negative views of themselves. They consider themselves inadequate, undesirable, inferior, perhaps evil. They also blame themselves for nearly every

unfortunate event, even things that have nothing to do with them, and they rarely credit themselves for positive achievements.

2. People who display a longer-lasting (at least two years) but less disabling pattern of unipolar depression may receive a diagnosis of *dysthymic disorder*. When dysthymic disorder leads to major depressive disorder, the sequence is called 'double depression'

3. DSM-V distinguishes two kinds of bipolar disorders—*bipolar I* and *bipolar II*. People with bipolar I disorder have full manic and major depressive episodes. Most of them experience an alternation of the episodes; for example, weeks of mania followed by a period of wellness, followed, in turn, by an episode of depression. Some people, however, have mixed episodes, in which they swing from manic to depressive symptoms and back again on the same day. In bipolar II disorder, hypomanic—that is, mildly manic— episodes alternate with major depressive episodes over the course of time. Some people with this pattern accomplish huge amounts of work during their mild manic periods.

4. Low serotonin activity accompanied by low norepinephrine activity may lead to depression; low serotonin activity accompanied by high norepinephrine activity may lead to mania.

5. Vagus nerve stimulation, transcranial magnetic stimulation (TMS), and deep brain stimulation.

6. Death seekers, death initiators, death ignorers and death darers.

7. (i) Hopelessness is a pessimistic belief that one's present circumstances, problems, or mood will not change. (ii) Many people who attempt suicide fall victim to dichotomous thinking, viewing problems and solutions in rigid either/or terms.

8. (i) Establishing a positive relationship (ii) Understanding and clarifying the problem (iii) Assessing suicide potential (iv) Assessing and mobilizing the caller's resources (v) formulating a plan.

12.19 Suggested Readings

4. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.

5. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.

6. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

UNIT XIII: EATING DISORDERS

Structure

13.1   Introduction

It has not always done so, but most society today equates thinness with health and beauty. For many, thinness has become an obsession. Most of us are as preoccupied with how much we eat as with the taste and nutritional value of our food. Thus it is not surprising that during the past few years we have also witnessed an increase in eating disorders that have at their core a morbid fear of gaining weight. Sufferers of *anorexia nervosa,* are convinced that they need to be extremely thin, and they lose so much weight that they may starve themselves to death. People with *bulimia nervosa* go on frequent eating binges, during which they uncontrollably consume large quantities of food, and then force themselves to vomit or take other extreme steps to keep from gaining weight. Clinicians now understand that the similarities between anorexia nervosa and bulimia nervosa can be as important as the differences between them. For example, many people with anorexia nervosa binge as they persist in losing dangerous amounts of weight; some later develop bulimia nervosa. Conversely, people with bulimia nervosa sometimes develop anorexia nervosa as time goes on. Eating disorders are more common in women than men. They can develop at any age, although typically emerge in adolescence or early adulthood. Anorexia nervosa usually begins at an early age then bulimia nervosa. Many more people suffer from less severe forms of disturbed eating patterns.

13.2   Objectives

On completion of this unit, you will be able to understand:
- The nature and causes of eating disorders
- The symptoms and treatment of different eating disorders

13.3   Bulimia Nervosa

Bulimia nervosa is characterized by uncontrollable binge eating and efforts to prevent resulting weight gain by using inappropriate behaviors such as self-induced vomiting and excessive exercise. Bulimia nervosa was recognized as a psychiatric syndrome relatively recently. The British psychiatrist G. F. M. Russell (1997) proposed the term in 1979, and it was adopted into the DSM in 1987. The word bulimia comes from the Greek

bous (which means "ox"), and limos (hunger). It is meant to denote a hunger of such proportions that the person could eat an ox. The clinical picture of the binge-eating/purging type of anorexia nervosa has much in common with bulimia nervosa. By definitions, the person with anorexia nervosa is severely underweight. This is not true of the person with bulimia nervosa.

Consequently, if the person who binges or purges also meets criteria for anorexia nervosa, the diagnosis is anorexia nervosa (binge-eating/purging type) and not bulimia nervosa. People with anorexia nervosa and bulimia nervosa share a common fear or being or becoming fat. However, unlike patients with anorexia nervosa, those with bulimia nervosa are typically of normal weight or sometimes even slightly overweight. The fear of becoming fat helps explain the development of bulimia nervosa. Bulimia typically begins with restricted eating motivated by the desire to be slender. During these early stages, the person diets and eats low-calorie foods. Over time, however, the early resolve to restrict gradually erodes, and the person starts to eat "forbidden foods' such as potato chips, pizza, cake, ice cream, and chocolate. Of course, some patients binge on whatever food is available, including such things as raw cookie dough. After the binge, in an effort to manage the breakdown of self-control, the person begins to vomit, fast, exercise excessively, or abuse laxatives. This pattern then persists because, even though those with bulimia nervosa are disgusted by their behaviour, the purging alleviates the fear of gaining weight that comes for eating.

Whereas people with anorexia nervosa often deny the seriousness of their disorder and are surprised by the shock and concern with which others view their emaciated conditions, those with bulimia nervosa are often preoccupied with shame, guilt, and self-deprecation. They make efforts to conceal their behavior as they struggle (often unsuccessfully) to master their urges to binge.

Criteria for Bulimia Nervosa DSM-5

Recurrent episodes of binge eating - An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g, within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
2. Sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).

Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

Self-evaluation is unduly influenced by body shape and weight.

The disturbance does not occur exclusively during episodes of anorexia nervosa.

Check your Progress – 1

Note: a. Write your answer in the space given below

     b. Compare your answer with those given at the end of the unit.

  1. What is Bulimia nervosa?

  2. Trace the etymology of Bulimia.

13.4   Anorexia Nervosa

The term anorexia nervosa literally means "lack of appetite induced by nervousness." At the heart of anorexia nervosa is an intense fear of gaining weight or becoming fat, combined with behaviors that result in a significantly low body weight. The DSM-5 criteria for anorexia nervosa are shown in the DSM criteria box. An important change from DSM-IV to DSM-5 is that in DSM amenorrhea (cessation of menstruation) is no longer required tor a person to be given the diagnosis. Amenorrhea is also not a criterion that can be used for males, nor can it be assessed in prepubescent girls or in women who use hormonal contraceptives.

     The disorder did not receive its current name until 1873, when Charles Lasegue in Paris and Sir William Gull in London independently described the clinical syndrome. In his last publication on the condition, Gull (1888) described a 14-year-old girl who began "without apparent cause, to evince a repugnance to food; and soon afterwards declined to take any whatever, except half a cup of tea or coffee." After being prescribed to eat light food every few hours, the patient made a good recovery.

Criteria for anorexia nervosa DSM-5

  A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

  B. Intense fear of gaining weight or of becoming fat or persistent behavior that interferes with weight gain, even though at a significantly low weight.

  C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Even though they may look painfully thin or even emaciated, many patients with anorexia nervosa deny having any problem. Indeed, they may come to feel fulfilled by their weight loss. Despite this quiet satisfaction, however, they may feel ambivalent about their weight. Efforts may be made to conceal their thinness by wearing baggy clothes or carrying hidden bulky objects so that they will weigh more when measured by others. Patients with anorexia nervosa may even resort to drinking large amounts of water to increase their weight temporarily

There are two types of anorexia nervosa: the restricting type and the binge-eating/ purging type. The central difference between these two subtypes concerns the way in which patients maintain their very low weight. In the restricting type, every effort is made to limit the quantity of food consumed. Caloric intake is tightly controlled. Patients often try to avoid eating in the presence of other people.

Patients with the binge-eating/purging type of anorexia nervosa differ from patients with restricting anorexia nervosa because they either binge, purge, or binge and purge. A binge involves an out-of-control consumption of an amount of food that is far greater than what most people would eat in the same amount of time and under the same circumstances. These binges may be followed by efforts to purge, or remove from their bodies, the food they have eaten. Methods of purging commonly include self-induced vomiting or misusing laxatives, diuretics, and enemas. Other compensatory behaviors that do not involve purging are excessive exercise or fasting.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

3. What does the term 'anorexia nervosa' mean?

4. What is the difference between the two types of anorexia nervosa?

13.5 Binge Eating Disorder

A new addition to DSM-5 is the diagnosis of binge eating disorder (BED). BED is a distinct clinical syndrome. Although BED has some clinical features in common with bulimia nervosa, there is an important difference. After a binge (which may be at a level comparable to that of a patient with bulimia nervosa), the person with BED does not engage in any form of inappropriate "compensatory" behavior. This might include purging, using laxatives, or even exercising to limit weight gain. There is also much less dietary restraint in BED than is typical of either bulimia nervosa or anorexia nervosa. Not surprisingly, binge-eating disorder is associated with being over-weight or even obese although weight is not a factor involved in making the diagnosis. Interestingly, individuals with binge-eating disorder are more likely to have overvalued ideas about the importance of weight and shape than overweight or obese patients who do not have binge-eating disorder. In this respect, they also resemble people with bulimia nervosa

Criteria for Binge-Eating Disorder DSM-5

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.

2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:

1. Eating much more rapidly than normal.

2. Eating until feeling uncomfortably full.

3. Eating large amounts of food when not feeling physically hungry.

4. Eating alone because of feeling embarrassed by how much one is eating.

5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.
D. The binge eating occurs, on average, at least once a week for 3 months.
E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

13.6 Causes of Eating Disorders

There is no single cause of eating disorders. In all probability, they reflect the complex interaction between genetic and environmental factors. Biological, sociocultural, family, and individual variables likely all play a role.

Genetic factors play an important role in eating disorders. Genes may make some people more susceptible to binge eating or to sociocultural influences, or may underlie personality styles (eg, perfectionism) that increase risk for eating disorders.

The neurotransmitter serotonin has been implicated in eating disorders. This neurotransmitter is also involved in mood disorders, which are highly comorbid with eating disorders.

Sociocultural influences are integral in the development of eating disorders. Our society places great value on being thin. Western values concerning thinness may be spreading. This may help explain why eating disorders are now found throughout the world.

Individual risk factors such as internalizing the thin ideal, body dissatisfaction, dieting, negative affect, and perfectionism have been implicated in the development of eating disorders.

13.7 Treatment of Eating Disorders

13.7.1 Medical Complications of Eating Disorder

Many patients with anorexia nervosa disorder look extremely unwell. Their hair on the scalp thins and becomes brittle, as do their nails. Their skin becomes very dry, and downy hair (called lanugo) starts to grow on the face, neck, arms, back, and legs. Many patients also develop a yellowish tinge to their skin, especially on the palms of their hands and bottoms of their feet.

Because they are so undernourished, people with this disorder have a difficult time coping with cold temperatures. Their hands and feet are often cold to the touch and have a purplish-blue tinge due to problems with temperature regulation and lack of oxygen to the extremities. As a consequence of chronically low blood pressure, patients often feel tired, weak, dizzy, and faint. Thiamin (vitamin B1) deficiency may also be present; this could account for some of the depression and cognitive changes documented in low-weight anorexia patients. Although many of these problems resolve when patients gain weight, anorexia nervosa may result in increased risk for osteoporosis in later life. The failure to eat healthily during this time may result in more brittle and fragile bones forever.

People with anorexia nervosa can die from heart arrhythmias (irregular heartbeats). Sometimes this is caused by major imbalances in key electrolytes such as potassium. Chronically low levels of potassium

(hypokalemia) can also result in kidney damage and renal failure severe enough to require dialysis.

Abuse of laxatives, which occurs in 10 to 60 percent of patients with eating disorders, makes all of these problems much worse. Laxatives are used to induce diarrhea so that the person feels thinner or to remove unwanted calories from the body. Laxative abuse can lead to dehydration, electrolyte imbalances, and kidney disease as well as damage to the bowels and gastrointestinal tract.

Bulimia nervosa is much less lethal than anorexia nervosa. Bulimia nervosa also creates a number of medical concerns. Purging can cause electrolyte imbalances and low potassium puts the patient at risk for heart abnormalities. Another complication is damage to the heart muscle, which may be due to using ipecac syrup (a poison that causes vomiting). More typically, however, patients develop calluses on their hands from sticking their fingers down their throats to make themselves sick. In extreme cases, where objects such as a toothbrush are used to induce vomiting, tears to the throat can occur.

Because the contents of the stomach are acidic, patients damage their teeth when they throw up repeatedly. Brushing teeth immediately after vomiting damages them even more. Mouth ulcers and dental cavities are a common consequence of repeated purging, as are small red dots around the eyes that are caused by the pressure of throwing up. Finally, patients with bulimia very often have swollen parotid (salivary) glands caused by repeatedly vomiting. These are known as "puffy cheeks" or "chipmunk cheeks'" by many bulimia sufferers.

13.7.2 Treatment of Anorexia Nervosa

Individuals with anorexia nervosa view the disorder as a chronic condition and are generally pessimistic about their potential for recovery. They have a high dropout rate from therapy. The most immediate concern with patients who have anorexia nervosa is to restore their weight to a level that is no longer life threatening. In severe cases, this requires hospitalization and extreme measures such as intravenous feeding. This is followed by rigorous control of the patient's caloric intake so as to progress toward a targeted range of weight gain (Andersen et al.. 1997). Normally, this short-term effort is successful. However, without treatment designed to address the psychological issues that fuel the anorexic behavior, any weight gain will be temporary and the patient will soon need medical attention again.

Medications

Antidepressants are sometimes used in the treatment of anorexia nervosa, although there is no evidence that they are especially effective. In contrast, research suggests that treatment with an antipsychotic medication called olanzapine may be beneficial. Antipsychotic medications (which help with disturbed thinking) are routinely used in the treatment of schizophrenia). These medications also provide benefits in the treatment of anorexia nervosa, which is characterized by distorted beliefs about body shape and size. More importantly, one side effect of olanzapine is weight gain. Although this is a problem for patients with schizophrenia, in the treatment of anorexia nervosa weight gain is obviously much more desirable.

Family Therapy

For adolescents with anorexia nervosa, family therapy is considered to be the treatment of choice. Family meals are observed by the therapist, and efforts are made to guide the parents as a functioning support team in the termination phase of treatment, focus is on the development of more healthy relationships between the patient and parents.

COGNITIVE-BEHAVIORAL THERAPY

Cognitive-Behavioral Therapy (CBT), which involves changing behavior and maladaptive styles of thinking, has proved to be very effective in treating bulimia nervosa. Because anorexia nervosa shares many features with bulimia nervosa, CBT is often used with anorexia nervosa patients as well A major focus of the treatment involves modifying distorted beliefs concerning weight and food, as well as distorted beliefs about the self that may have contributed to the disorder (e.g, "People will reject me unless I am thin").

13.7.3 Treatment of Bulimia Nervosa

Medication

It is quite common for patients with Bulimia Nervosa to be treated with antidepressants medications. Antidepressants seem to decrease the frequency of binges as well as improve patient's mood and preoccupation with shape and weight.

Cognitive behavioral therapy

The leading treatment for Bulimia Nervosa is CBT. The behavioral component of CBT for bulimia nervosa focuses on normalizing eating patterns. This includes meal planning, nutritional education, and ending binging and purging cycles by teaching the person to eat small amounts of food more regularly. The cognitive element of the treatment is aimed at changing the cognitions and behaviors that initiate or perpetuate a binge cycle. This is accomplished by challenging the dysfunctional thought patterns typically present in bulimia nervosa, such as the all-or-nothing or dichotomous thinking described earlier. For instance, CBT challenges the tendency to divide all foods into "good' and "bad' categories. This is done by providing factual information, as well as by arranging tor the patients to demonstrate to themselves that ingesting bad food does not inevitably lead to a total loss of control over eating. Treatment with CBT clearly helps to reduce the severity of symptoms in patients with bulimia nervosa.

13.7.4 Treatment of Binge Eating Disorder

BED has attracted a lot of attention from researchers, and a number of different treatment approaches have been suggested. Due to the high level of comorbidity between binge-eating disorder and depression, antidepressant medications are sometimes used to treat this disorder. Other categories of medications, such as appetite suppressants and anticonvulsant medications have also been a focus of interest. Interpersonal therapy (IPT), which is sometimes used in the treatment of depression, seems to be helpful for binge eating disorder.

Check your Progress – 3

Note: a. Write your answer in the space given below

    b. Compare your answer with those given at the end of the unit.

   5. What kind of distorted beliefs characterize the thinking of people with eating disorders?

13.8　Let Us Sum Up

Three different kinds of eating disorders are included in DSM-5: anorexia nervosa, bulimia nervosa and binge eating disorder. Both anorexia nervosa and bulimia nervosa are characterized by an intense fear of becoming fat and by a drive for thinness. Patients with anorexia nervosa are severely underweight.

Anorexia nervosa is very difficult to treat. Treatment is long term, and many patients resist getting well. For younger patients, family therapy appears to be very beneficial. Olanzapine is also helpful. The treatment of choice for bulimia nervosa is CBT. CBT is also helpful for binge-eating disorder. Interpersonal therapy (IPT) seems to be helpful for binge eating disorder.

13.9　Unit-End Exercises

1. Write a brief account of various eating disorders.
2. How is anorexia nervosa different from Bulimia nervosa?
3. What are the potential disastrous medical complications of eating disorder?
4. Describe the different treatment options available for managing eating disorders.

13.10　Answer to Check Your Progress

1. Bulimia nervosa is an eating disorder characterized by uncontrollable binge eating and efforts to prevent resulting weight gain by using inappropriate behaviors such as self-induced vomiting and excessive exercise.
2. The word bulimia comes from the Greek bous (which means "ox"), and limos (hunger). It is meant to denote a hunger of such proportions that the person could eat an ox.
3. The term anorexia nervosa literally means "lack of appetite induced by nervousness."
4. There are two types of anorexia nervosa: the restricting type and the binge-eating/ purging type. In the restricting type, every effort is made to limit the quantity of food consumed. Caloric intake is tightly controlled. Patients with the binge-eating/purging type of anorexia nervosa either binge, purge, or binge and purge.
5. People will reject me unless I am thin.

13.11　Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

UNIT XIV : SLEEPDISORDERS

Structure

14.1   Objectives

After going through this unit you will be able to:

- Understand the meaning of dys-somnias
- Know the characteristics of primary insomnia, primary hypersomnia, narcolepsy, breathing related disorders and circadian rhythm disorders.
- Know ways to treat these sleep disorders.

14.2 Dys-Somnias

The dyssomnias (insomnia, hypersomnia, breathing-related sleep disorder, narcolepsy, and circadian rhythm sleep disorder) involve disturbances in the amount, quality, or timing of sleep. Generally, there are 2 types of dyssomnias.

Extrinsic dyssomnias are sleep disorders that originate from external causes and may include: Insomnia, Sleep apnea, Narcolepsy, Restless legs syndrome, Periodic Limb movement disorder, Hypersomnia, Toxin-induced sleep disorder and Kleine-Levin syndrome. Intrinsic dyssomnias are sleep disorders that originate from internal causes and may include: Altitude insomnia, Substance use insomnia, Sleep-onset association disorder, Nocturnal paroxysmal dystonia and Limit-setting sleep disorder.

14.3 Primary Insomnia

Insomnia complaints typically include difficulty initiating and/or maintaining sleep, and they usually include extended periods of nocturnal wakefulness and/or insufficient amounts of nocturnal sleep. Both a symptom and a diagnostic category, the insomnia diagnoses are best referred to by their subcategory terms. The insomnia disorders can be either primary or secondary. Primary insomnia is sleeplessness or the perception of poor quality sleep that is not caused by medical or psychiatric diseases, conditions, genetics, or illnesses; or environmental causes (such as drug abuse, medication, shift-work). Primary insomnias can have both intrinsic and extrinsic factors involved in their etiology, but they are not regarded as being secondary to another disorder. Secondary forms occur when the insomnia is a symptom of a medical or psychiatric illness,

another sleep disorder, or substance abuse. At present, the DSM-V has changed the name of this disorder to '*insomnia disorder*' from *'primary insomnia'*.

Check your Progress – 1

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

1. What are the types of dys-somnias? Give some examples.

No matter what the cause, those who struggle with an insomnia disorder may ultimately develop a dependence upon any medication prescribed to them that aids in falling asleep or staying asleep. Though most of these medications are only designed to be used for a couple of weeks, many patients take them longer, developing a tolerance that requires them to take more and more of the pills in order to experience their effects.

Dependence upon medications like these – especially zolpidem, or Ambien, one of the most commonly prescribed sleep aid drugs – can cause a host of unwanted side effects as well. Some patients report periods of partial arousal during the night that they don't remember characterized by performing activities that can include driving, making and eating food, moving furniture, and having sex.

Check your Progress – 2

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

2. What is insomnia disorder?

14.4 Primary Hypersomnia

Primary hypersomnia is thought to be caused by problems in the brain systems that control sleep and waking functions. Secondary hypersomnia is the result of conditions that cause fatigue or insufficient sleep.

For the primary hypersomnia disorders, classification is based mostly on symptoms and sleep testing results. Also known as *'idiopathic hypersomnia'*, primary hypersomnia disorder is defined by hypoarousal, or a state of being less awake and alert and experiencing lesser cognitive and motor function as well as emotional capacity. In simpler terms, those who are living with primary hypersomnia disorder are often very sleepy and experience longer episodes of non-REM (rapid eye movement) sleep as compared to the general public.

The Diagnostic and Statistical Manual of Mental Disorders specifies that primary hypersomnia is characterized by excessive sleepiness but is not narcolepsy or another sleep disorder. Those who struggle with disorder often wake so often during the night despite spending long periods of time in nocturnal sleep that they experience "sleep drunkenness" when they get up the next day.

Many patients find it so difficult to wake up and feel alert in the morning that they take stimulant drugs in the hopes of giving themselves a boost. Drugs like crystal meth, cocaine and prescription stimulants that provide this effect may be utilized by patients to help them overcome the grogginess that stops them from functioning. Unfortunately, this does nothing to address the primary hypersomnia disorder and can ultimately cause a drug addiction that can be fatal.

14.5 Narcolepsy

Narcolepsy is a sleep disorder characterized by excessive sleepiness, sleep paralysis, hallucinations, and in some cases episodes of cataplexy (partial or total loss of muscle control, often triggered by a strong emotion such as laughter).

People with narcolepsy feel very sleepy during the day and may involuntarily fall asleep during normal activities. In narcolepsy, the normal boundary between awake and asleep is blurred, so characteristics of sleeping can occur while a person is awake. For example, cataplexy is the muscle paralysis of REM sleep occurring during waking hours. It causes sudden loss of muscle tone that leads to a slack jaw, or weakness of the arms, legs, or trunk. People with narcolepsy can also experience dream-like hallucinations and paralysis as they are falling asleep or waking up, as well as disrupted night time sleep and vivid nightmares.

Narcolepsy with cataplexy (It is a sudden and involuntary loss of muscle tone that occurs while the patient is awake. This muscle weakness can impact the entire body, specific limbs or certain areas of the body. It can last for a few seconds, or it can last for a few minutes) is caused by the loss of a chemical in the brain called 'hypocretin'. Hypocretin acts on the alerting systems in the brain, keeping us awake and regulating sleep wake cycles. In narcolepsy, the cluster of cells that produce hypocretin—located in a region called the hypothalamus—is damaged or completely destroyed. Without hypocretin, the person has trouble staying awake, and also experiences disruptions in the normal sleep-wake cycles.

Many patients find the difficulties associated with narcolepsy so overwhelming that they abuse drugs and alcohol to deal with the frustrations they experience in everyday life. Some adopt the use of stimulant drugs in the hopes that it will help them overcome the sleep episodes that occur randomly throughout the day. Still others are prescribed medications to treat the disorder that are addictive. In all of these cases, a co-occurring addiction issue is a possibility, and the risks associated with drug and alcohol abuse often serve to exacerbate the problems caused by narcolepsy.

14.6   Breathing Related Sleep Disorders

Disordered ventilation during sleep is the characteristic feature of these disorders. *Central apnea syndromes* include those in which respiratory effort is diminished or absent in an intermittent or cyclical fashion as a result of central nervous system dysfunction. Other central sleep apnea forms are associated with underlying pathologic or environmental causes, such high-altitude periodic breathing.

Primary central sleep apnea is a disorder of unknown cause characterized by recurrent episodes of cessation of breathing during sleep without associated ventilatory effort. A complaint of excessive daytime sleepiness, insomnia, or difficulty breathing during sleep is reported. This diagnosis requires that 5 or more apneic episodes per hour of sleep be seen by polysomnography. Central sleep apnea due to high-altitude periodic breathing is characterized by sleep disturbance that is caused by cycling periods of apnea and hyperpnea without ventilatory effort. The cycle length is typically between 12 and 34 seconds. Five or more central apneas per hour of sleep are required to make the diagnosis. Most people will have this ventilatory pattern at elevations greater than 7600 meters, and some at lower altitudes. A secondary form of central sleep apnea due to drug or substance (substance abuse) is most commonly associated with users of long-term opioid use

Primary sleep apnea of infancy is a disorder of respiratory control most often seen in preterm infants (apnea of prematurity), but it can occur in predisposed infants (apnea of infancy). This may be a developmental pattern, or it may be secondary to other medical disorders. Respiratory pauses of 20 seconds or longer are required for the diagnosis.

The *obstructive sleep apnea syndromes* include those in which there is an obstruction in the airway resulting in increased breathing effort and inadequate ventilation. Upper airway resistance syndrome has been recognized as a manifestation of obstructive sleep apnea syndrome and therefore is not included as a separate diagnosis. Obstructive sleep apnea in adults is characterized by repetitive episodes of cessation of breathing (apneas) or partial upper airway obstruction (hypopneas). These events are often associated with reduced blood oxygen saturation. Snoring and sleep disruption are typical and common. Excessive daytime sleepiness or insomnia can result. Five or more respiratory events (apneas, hypopneas, or respiratory effort-related arousals) per hour of sleep are required for diagnosis. Increased respiratory effort occurs during the respiratory event. At least 1 obstructive event, of at least 2 respiratory cycles of duration per hour of sleep, is required for diagnosis.

Sleep-related hypoventilation/hypoxemic syndromes comprise 5 disorders associated with hypoventilation or hypoxemia during sleep. *Sleep-related non obstructive alveolar hypoventilation*, refers to decreased alveolar hypoventilation resulting in sleep-related arterial oxygen desaturation in patients with normal mechanical properties of the lungs. *Congenital central alveolar hypoventilation syndrome* is a failure of automatic central control of breathing in infants who do not breathe spontaneously or whose breathing is shallow and erratic. It is a failure of the central automatic control of breathing. The hypoventilation begins in infancy and it is worse in sleep than in wakefulness. *Sleep-related hypoventilation/hypoxemia due to a medical condition* is a subgroup of 3 disorders of impaired lung function or chest wall mechanics. Sleep-related hypoventilation/hypoxemia related to pulmonary parenchymal or vascular pathology is due to disorders of interstitial lung disease, such as interstitial pneumonitis, or disorders such as sickle-cell anemia or other hemoglobinopathies. *Sleep-related hypoventilation/hypoxemia due to lower airway obstruction* is seen in patients with lower airway disease, such as chronic obstructive lung disease and emphysema, bronchiectasis, alpha1-antitrypsin deficiency.

Check your Progress – 5

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

5. What is primary central sleep apnea?

14.7 Circadian Rhythm Sleep Disorders

The circadian rhythm sleep disorders have a specific diagnostic category because they share a common underlying chronophysiologic basis. The major feature of these disorders is a persistent or recurrent misalignment between the patient's sleep pattern and the pattern that is desired or regarded as the societal norm. Maladaptive behaviors influence the presentation and severity of the circadian rhythm sleep disorders. The underlying problem in the majority of the circadian rhythm sleep disorders is that the patient cannot sleep when sleep is desired, needed, or expected. The wake episodes can occur at undesired times as a result of sleep episodes that occur at inappropriate times, and therefore, the patient may complain of insomnia or excessive sleepiness. For several of the circadian rhythm sleep disorders, once sleep is initiated, the major sleep episode is normal in duration with normal REM and nREM cycling.

The *delayed sleep phase type*, which is more commonly seen in adolescents, is characterized by a delay in the phase of the major sleep period in relation to the desired sleep time and wake time. The *advanced sleep phase type*, which is more commonly seen in older adults, is characterized by an advance in the phase of the major sleep period in relation to the desired sleep time and wake time. An alteration in the homeostatic regulation of sleep may be responsible. However, the delayed and advanced sleep phase types can have a predominant influence caused by the individual's choice to remain awake late into the night or by going to bed earlier, which is associated with behavioral, social, or professional demands. The irregular sleep–wake type, a disorder that involves a lack of a clearly defined circadian rhythm of sleep and wakefulness, is most often seen in institutionalized older adults and is associated with a lack of synchronizing agents, such as light, activity, and social activities. The *free running type, or non-trained type* (formerly known as the non-24-h sleep–wake syndrome), occurs because there is a lack of entrainment to the 24-h period, and the sleep pattern often follows that of the underlying free-running pacemaker with a sequential shift in the daily sleep pattern.

The jet lag type, or *jet lag disorder*, is related to a temporal mismatch between the timing of the sleep–wake cycle generated by the endogenous circadian clock produced by a rapid change in time zones. The severity of the disorder is influenced by the number of time zones crossed and the direction of travel, with eastward travel usually being more disruptive. *Shift work type* is characterized by complaints of insomnia or excessive sleepiness that occurs in relation to work hours being scheduled during the usual sleep period. *Circadian rhythm sleep disorders due to a medical condition* is related to an underlying primary medical or neurological disorder. A disrupted sleep–wake pattern leads to complaints of insomnia or excessive daytime sleepiness.

Another circadian rhythm sleep disorder not due to a known physiological condition is an irregular or unconventional sleep–wake pattern that can be

the result of social, behavioral, or environmental factors. Noise, lighting, or other factors can predispose an individual to developing this disorder.

The appropriate timing of sleep within the 24-h day can be disturbed in many other sleep disorders, particularly those associated with the complaint of insomnia. Patients with narcolepsy may have a pattern of sleepiness that is identical to that described as being caused by an irregular sleep–wake type. However, because the primary sleep diagnosis is narcolepsy, the patient should not receive a second diagnosis of a circadian rhythm sleep disorder unless the disorder is unrelated to the narcolepsy. For example, a diagnosis of jet lag type could be stated along with a diagnosis of narcolepsy, if appropriate. Similarly, patients with mood disorders or psychoses can, at times, have a sleep pattern similar to that of delayed sleep phase type. A diagnosis of delayed sleep phase type would be coded only if the disorder is not directly associated with the psychiatric disorder.

Some disturbance of sleep timing is a common feature in patients who have a diagnosis of inadequate sleep hygiene. Only if the timing of sleep is the predominant cause of the sleep disturbance and is outside the societal norm, then the patient would be given a diagnosis of a circadian rhythm sleep disorder. *Limit-setting sleep disorder* is also associated with an altered time of sleep within the 24-h day. If the setting of limits is a function of the caretaker, then the sleep disorder is more appropriately diagnosed as a limit-setting sleep disorder.

Check your Progress – 6

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

6. What is jet-lag disorder?

14.8   Treatment

14.8.1 PSYCHOLOGICAL TREATMENT

Generally, a combination of psychological and behavioral treatments is used for treating sleep disorders. CBT (cognitive-behavioral therapy) uses both psychological behavioral techniques to help all kinds of sleep disorders- mainly insomnia. Some of the techniques used by therapists are as follows:

Sleep restriction therapy (SRT) reduces the time you spend lying in bed awake by eliminating naps and forcing you to stay up beyond your normal bedtime. This method of sleep deprivation can be especially effective for insomnia.

Stimulus control therapy helps to identify and change sleep habits that prevent you from sleeping well. This means training you to use your bedroom for just sleep and sex, rather than working or watching TV, and maintaining consistent sleep-wake times, even on weekends.

Improving your sleep environment and sleep hygiene. Sleep hygiene involves improving your daytime habits to include exercising regularly, avoiding nicotine and caffeine late in the day, and learning to unwind at night.

Remaining passively awake, also known as "paradoxical intention". Since worrying about not being able to sleep generates anxiety that keeps

you awake, letting go of this worry and making no effort to sleep may, paradoxically, help you to unwind and fall asleep.

Relaxation training. When practiced regularly, relaxation techniques such as mindfulness meditation, progressive muscle relaxation, and breathing exercises can help you relax at night, relieving tension and anxiety and preparing you for sleep.

Biofeedback uses sensors that measure specific physiological functions—such as heart rate, breathing, and muscle tension. Biofeedback teaches you to recognize and control your body's anxiety response that impacts sleep patterns.

Hypnosis can also sometimes be used in CBT for sleep disorders. While you're in a state of deep relaxation, the hypnotherapist uses different therapeutic techniques to help you change negative thought patterns or unhelpful habits and promote restful sleep.

14.8.2 BEHAVIOURAL TREATMENT

Cognitive behavioral therapy is the most widely-used therapy for sleep disorders. It may be conducted individually, in a group of people with similar sleeping problems, or even online. Since the causes and symptoms of sleep disorders vary considerably, CBT should always be tailored to your specific problems. Cognitive behavioral therapy for insomnia (CBT-I), for example, is a specific type of therapy designed for people who are unable to get the amount of sleep they need to wake up feeling rested and refreshed.

The length of therapy also depends on the type and severity of the sleep disorder. While CBT is rarely an immediate or easy cure, it is relatively short-term. The cognitive aspects of CBT include thought challenging—otherwise known as cognitive restructuring—in which the person challenges the negative thinking patterns that contribute to your sleep problems, replacing them with more positive, realistic thoughts.

Cognitive behavioral therapy for insomnia can benefit nearly anyone with sleep problems. CBT-I can help people who have primary insomnia as well as people with physical problems, such as chronic pain, or mental health disorders, such as depression and anxiety. What's more, the effects seem to last. And there is no evidence that CBT-I has negative side effects. CBT-I requires steady practice, and some approaches may cause the client to lose sleep at first. But stick with it, and they are likely to see lasting results.

Check your Progress – 7

Note: a. Write your answer in the space given below

b. Compare your answer with those given at the end of the unit.

7. Name some cognitive-behavioral techniques used to treat sleep disorders

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14.9 Let Us Sum Up

In this unit, we have seen what dyssomnias mean and what its characteristics are. We have explored features of various disorders such as primary insomnia, primary hypersomnia, narcolepsy, breathing related disorders and circadian rhythm disorders and we have looked at ways to diagnose and treat such disorders.

14.10 Unit-End Exercises

1. Write a note on breathing related sleep disorders.
2. Write a note on circadian rhythm sleep disorders.

3. Narcolepsy- a disorder with serious consequences. Explain.
4. Write briefly about psychological and behavioral methods that can be used to treat sleep disorders.

14.11   Answer to Check Your Progress

1. Extrinsic dyssomnias are sleep disorders that originate from external causes and may include: Insomnia, Sleep apnea, Narcolepsy, Restless legs syndrome, Periodic Limb movement disorder, Hypersomnia, Toxin-induced sleep disorder and Kleine-Levin syndrome. Intrinsic dyssomnias are sleep disorders that originate from internal causes and may include: Altitude insomnia, Substance use insomnia, Sleep-onset association disorder, Nocturnal paroxysmal dystonia and Limit-setting sleep disorder.

2. Primary insomnia is sleeplessness or the perception of poor quality sleep that is not caused by medical or psychiatric diseases, conditions, genetics, or illnesses; or environmental causes (such as drug abuse, medication, shift-work).

3. The Diagnostic and Statistical Manual of Mental Disorders specifies that primary hypersomnia is characterized by excessive sleepiness but is not narcolepsy or another sleep disorder. It is characterized by hypoarousal, or a state of being less awake and alert and experiencing lesser cognitive and motor function as well as emotional capacity.

4. It is a sudden and involuntary loss of muscle tone that occurs while the patient is awake. This muscle weakness can impact the entire body, specific limbs or certain areas of the body. It can last for a few seconds, or it can last for a few minutes.

5. Primary central sleep apnea is a disorder of unknown cause characterized by recurrent episodes of cessation of breathing during sleep without associated ventilatory effort. A complaint of excessive daytime sleepiness, insomnia, or difficulty breathing during sleep is reported. This diagnosis requires that 5 or more apneic episodes per hour of sleep be seen by polysomnography.

6. Jet lag disorder is related to a temporal mismatch between the timing of the sleep–wake cycle generated by the endogenous circadian clock produced by a rapid change in time zones. The severity of the disorder is influenced by the number of time zones crossed and the direction of travel, with eastward travel usually being more disruptive.

7. Sleep restriction therapy (SRT), stimulus control therapy, biofeedback, hypnosis, relaxation training, using paradoxical intention technique and helping to improve sleep environment and hygiene.

14.12 Suggested Readings

1. Robert C. Carson &James N. Butcher. (2007). Abnormal Psychology. Pearson Education Inc. New Delhi.
2. Barlow and Durand. (2006). Abnormal Psychology. New York. Pearson India Ltd.
3. Sarason and Sarason. (2010). Abnormal Psychology: The Problem of Maladaptive Behaviour (11th Edition). New Delhi. Prentice Hall of India Pvt. Ltd.

Distance Education – CBCS – (2018-19 Academic Year Onwards)
MODEL QUESTION PAPER
B.Sc(Psychology).,
11934 - PSYCHOPATHOLOGY

Time : 3 Hours   **Marks :75**

PART – A (10X 2 = 20 Marks)

I. Answer all questions.

1. What is the meaning of abnormal behaviour?
2. What is transference?
3. What is eclecticism?
4. What are different types of obsessions and compulsions that are experienced by people with OCD?
5. How is fear different from phobia?
6. What is learned helplessness?
7. Expand DSM and ICD.
8. What is anorexia nervosa?
9. What does 'deinstitutionalization' mean?
10. What is circadian rhythm?

PART – B (5X 5 = 25 Marks)

II .Answer all questions choosing either (a) or (b).

11. a. What are the sociocultural factors that cause abnormal behaviour?

(or)

b. What are the psychosocial reasons for abnormal behaviour?

12. a. Write a note on phobia.

(or)

b. What is a panic disorder?

13. a. How do symptoms of depression manifest in five areas of functioning?

(or)

b. Write a note on body dysmorphic disorder.

14. a. Describe the clinical features of Borderline personality disorder.

(or)

b. Describe dissociative amnesia.

15. a. Write a short note on various eating disorders.

(or)

b. What are the symptoms of post-traumatic stress disorder?

PART – B (3X10 = 30 Marks)

III. Answer any 3 out of 5 questions.

16. What did the humanitarian approach emphasize about treatment of abnormal behaviour?

17. Describe in detail the assumptions and techniques underlying cognitive behaviour therapy.

18. Discuss the clinical picture and treatment of schizophrenia.

19. Discuss various sleep disorders.

20. Discuss the various ways in which psychological disorders may be assessed.