



# ALAGAPPA UNIVERSITY

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**KARAIKUDI – 630 003**



## DIRECTORATE OF DISTANCE EDUCATION

### B.Sc. PSYCHOLOGY

#### III-SEMESTER

#### 11934- PSYCHOPATHOLOGY

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# **BLOCK I: BEHAVIOURS AND DISORDERS**

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*Abnormal Behaviour*

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## **UNIT 1: ABNORMAL BEHAVIOUR**

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### **1.1 INTRODUCTION**

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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.

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### **1.2 OBJECTIVES**

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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

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### **1.3 MEANING**

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#### **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

*Self – Instructional Material*

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.

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#### **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.

Name the indicators of abnormality.

Define mental disorders according to the DSM 5.

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## **1.4 HISTORICAL CONCEPTIONS OF ABNORMAL BEHAVIOUR**

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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 *contrariis contrarius* (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 Charaka Samhitha and Sushruta Samhitha.

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 led 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.

*Self – Instructional Material*

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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.

What were Hippocrates' contributions to psychopathology?

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

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**1.5 BIOLOGICAL VIEWPOINT**

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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.

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## 1.6 PSYCHOSOCIAL VIEWPOINT

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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

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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.

What is a gene?

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

What factors constitute the psychosocial viewpoint?

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## **1.7 SOCIOCULTURAL VIEWPOINT**

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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 undercontrolled behaviour 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.

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## 1.8 LET'S SUM IT UP

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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.

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## 1.9 UNIT END EXERCISES

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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?

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### 1.10 ANSWERS TO CHECK YOUR PROGRESS

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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 contrariis contrarius (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.

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### 1.11 SUGGESTED READINGS

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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 16<sup>th</sup> 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.

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# UNIT II: ANXIETY DISORDERS

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## Structure

- 2.1 Introduction
- 2.2 Objectives
- 2.3 Panic disorders & agoraphobia
  - 2.3.1 Biological causal factors
  - 2.3.2 Psychological causal factors
  - 2.3.3 Treatment
- 2.4 Specific Phobias
  - 2.4.1 Psychological causal factors
  - 2.4.2 Biological causal factors
  - 2.4.3 Treatments
- 2.5 Social Phobia
  - 2.5.1 Psychological causal factors
  - 2.5.2 Biological causal factors
  - 2.5.3 Treatments
- 2.6 Generalized anxiety disorder
  - 2.6.1 Psychological causal factors
  - 2.6.2 Biological causal factors
  - 2.6.3 Treatments
- 2.7 Obsessive Compulsive disorders
  - 2.7.1 Psychological causal factors
  - 2.7.2 Biological causal factors
  - 2.7.3 Treatments
- 2.8 Let us sum up
- 2.9 Unit-End Exercises
- 2.10 Answers to Check your Progress
- 2.11 Suggested Readings

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## 2.1 INTRODUCTION

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**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.

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## 2.2 OBJECTIVES

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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

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## 2.3 PANIC DISORDERS & AGORAPHOBIA

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**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.

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### 2.3.1 Biological Causal Factors

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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?

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### 2.3.2 Psychological causal factors

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#### 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.

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**2.4 SPECIFIC PHOBIAS**

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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?

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**2.4.1 Psychological Causal Factors**

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**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.

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### **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.

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## **2.5 SOCIAL PHOBIA**

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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 point 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.

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## 2.6 GENERALIZED ANXIETY DISORDER

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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 impulses 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.

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## **2.7 OBSESSIVE COMPULSIVE DISORDERS**

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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 in 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.

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## 2.8 LET US SUM UP

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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.

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## 2.9 UNIT-END EXERCISES

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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?

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## 2.10 ANSWERS TO CHECK YOUR PROGRESS

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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.

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## **2.11 SUGGESTED READINGS**

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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* 16<sup>th</sup> 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.

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# UNIT – III - SOMATOFORM AND DISSOCIATIVE DISORDERS

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*Somatoform and  
Dissociative Disorders*

NOTES

## Structure

- 3.1 Introduction
- 3.2 Objectives
- 3.3 Somatic Symptom Disorder
- 3.4 Illness Anxiety Disorder
- 3.5 Conversion Disorder (Functional Neurological Symptom Disorder)
- 3.6 Factitious Disorder
- 3.7 Depersonalization/Serialization Disorder
- 3.8 Dissociative Amnesia
- 3.9 Dissociative Identity Disorder
- 3.10 Let Us Sum Up
- 3.11 Unit-End Exercises
- 3.12 Answers to Check Your Progress
- 3.13 Suggested Readings

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## 3.1 INTRODUCTION

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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.

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## 3.2 OBJECTIVES

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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.

*Self – Instructional Material*

NOTES

- Describe the treatments for Dissociative Disorder.

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### 3.3 SOMATIC SYMPTOM DISORDER:

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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.

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. 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.

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## **3.4 ILLNESS ANXIETY DISORDER:**

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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.

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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.

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### 3.5 CONVERSION DISORDER (Functional Neurological Symptom Disorder):

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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.

NOTES

**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?

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**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.

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### **3.7 DEPERSONALISATION/DEREALISATION DISORDER:**

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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

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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. 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.

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### 3.8 DISSOCIATIVE AMNESIA:

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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.

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### **3.9 DISSOCIATIVE IDENTITY DISORDER:**

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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.

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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.

What is Depersonalisation/ Derealisation disorder?

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

What is DID?

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### 3.10 LET'S SUM UP

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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.

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### 3.11 UNIT END EXERCISES:

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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.

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### 3.12 ANSWERS TO CHECK YOUR PROGRESS:

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1. Somatic symptom disorder is an integration of hypochondriasis, somatization disorder and pain disorder. It involves the catastrophic reasons behind somatic symptoms (physical pain/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.

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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.

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### **3.13 SUGGESTED READINGS**

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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* 16<sup>th</sup> 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.

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# UNIT IV: PERSONALITY DISORDERS

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## Structure

- 4.1 Introduction
- 4.2 Objectives
- 4.3 Clinical features
- 4.4 Types
  - 4.4.1 Cluster “A” Personality Disorders.
    - 4.4.1.1 Paranoid Personality Disorder
      - Causal factors
      - Treatment
    - 4.4.1.2 Schizoid Personality Disorder
      - Causal factors
      - Treatment
    - 4.4.1.3 Schizotypal Personality Disorder
      - Causal factor
      - Treatment
  - 4.4.2 Cluster “B” Personality Disorders.
    - 4.4.2.1 Histrionic Personality Disorder
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      - Treatment
    - 4.4.2.2 Antisocial Personality Disorder
      - Causal factors
      - Treatment
    - 4.4.2.3 Borderline Personality Disorder
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      - Treatment
    - 4.4.2.4 Narcissistic Personality Disorder
      - Causal factors
      - Treatment
  - 4.4.3 Cluster “C” Personality Disorders
    - 4.4.3.1 Avoidant Personality Disorder
      - Causal factors
      - Treatment
    - 4.4.3.2 Dependent Personality Disorder
      - Causal factors
      - Treatment
    - 4.4.3.3 Obsessive-Compulsive Personality Disorder.
      - Causal factors
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- 4.5 Causal factors in Personality disorder
- 4.6 Treatment
- 4.7 Anti-Social (Psychopathic) personality
  - 4.7.1 Psychopathy and Antisocial Personality Disorder
  - 4.7.2 Two Dimensions of Psychopathy
- 4.8 Clinical picture
  - 4.8.1 Inadequate Conscience Development
  - 4.8.2 Irresponsible and Impulsive Behavior
  - 4.8.3 Ability to Impress and Exploit Others
- 4.9 Causal factors

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- 4.9.1 Genetic Influences
- 4.9.2 The Low-Fear Hypothesis and Conditioning
- 4.9.3 More General Emotional Deficits
- 4.9.4 Early Parental Loss, Parental Rejection and Inconsistency.

- 4.10 Treatment
- 4.11 Let us sum up
- 4.12 Unit-End Exercises
- 4.13 Answers to Check our Progress
- 4.14 Suggested Readings

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#### **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.

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## 4.2 OBJECTIVES:

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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.
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## 4.3 CLINICAL FEATURES:

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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.

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## 4.4 TYPES:

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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

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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.

What is the difference between paranoid personality with paranoid schizophrenia?

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.

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**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 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 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 schizoprenias 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

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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.

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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 as 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

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behaviour. 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 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 factors 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 altered 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

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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

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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

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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, rage 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 personalities have great difficulty in 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 relationship because they fear criticism or rejection.

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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,

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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.

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#### **4.6 TREATMENT:**

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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.

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#### **4.7 ANTI-SOCIAL (PSYCHOPATHIC) PERSONALITY:**

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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

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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 19<sup>th</sup> 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 as well as need for stimulation, poor behavior controls, irresponsibility, and a parasitic lifestyle.

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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.

**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.

9. What are the two dimensions of antisocial personality disorder proposed by Cleckley?

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**4.8 CLINICAL PICTURE:**

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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 is 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

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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 colleagues 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 as 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

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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 age 40. 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.

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#### **4.11 LET US SUM UP:**

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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.

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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.

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## 4.12 UNIT-END EXERCISES:

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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.

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## 4.13 ANSWERS TO CHECK OUR PROGRESS:

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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,

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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.

9. 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 as well as need for stimulation, poor behavior controls, irresponsibility, and a parasitic lifestyle.

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#### 4.14 SUGGESTED READINGS

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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* 16<sup>th</sup> 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.

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# UNIT V- INTELLECTUAL DISABILITIES

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*Intellectual Disabilities*

## **Structure**

- 5.1 Introduction
- 5.2 Objectives
- 5.3 Definition
- 5.4 Signs of intellectual disability
- 5.5 Levels of intellectual disability
- 5.6 Causal factors
  - 5.6.1 Biological
  - 5.6.2 Psychosocial deprivations
- 5.7 Few Intellectual Disabilities
  - 5.7.1 Down's Syndrome (Trisomy 21)
  - 5.7.2 Autism Spectrum Disorder (ASD)
  - 5.7.3 Fragile-X syndrome
  - 5.7.4 Congenital Hypothyroidism (Cretinism)
- 5.8 Management
  - 5.8.1 Assessment tools
  - 5.8.2 Therapy
- 5.9 Let's sum up
- 5.10 Unit-End Exercises
- 5.11 Answers to Check Your Progress
- 5.12 Suggested Readings

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## **5.1 INTRODUCTION**

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Intellectual Disability (ID) previously called Mental Retardation is characterized by below average intelligence and lack of skills necessary for day-to-day living. It should not be misunderstood as people with intellectual disability cannot learn, they do learn new skills but at a slower pace.

DSM-5 defines intellectual disability as a neurodevelopmental disorder that begins in childhood and is characterized by intellectual difficulties as well as difficulties in social, practical and conceptual areas of living.

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## **5.2 OBJECTIVES**

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This Unit shall strive to make the readers understand:

- What Intellectual Disability is and the DSM criteria for it
- Causes for Intellectual Disability
- Different types of intellectual disability that is prevalent
- Care and Treatment of those with intellectual disability

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## **5.3 DEFINITION**

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Intellectual disability (intellectual developmental disorder) is characterized by deficits in general mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgement, academic learning, and learning from experience. For the diagnosis to apply, these problems must begin

*Self – Instructional Material*

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before the age of 18. Intellectual disability is thus defined in terms of level of performance as well as intelligence. The definition says nothing about causal factors, which may be primarily biological, psychosocial, sociocultural, or a combination of these. By definition, any functional equivalent of intellectual disability that has its onset after age 17 must be considered a dementia rather than intellectual disability

**Diagnosis**

Diagnosis of intellectual disability should satisfy the following categories

- Deficits in intellectual functioning - like reasoning, problem solving, abstract thinking, making judgments, and learning from experience- through standardized IQ evaluations.
- Deficits in adaptive behaviour, hampering the individual's development for independence.
- Onset of these deficits in childhood.

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**5.4 SIGNS OF INTELLECTUAL DISABILITY:**

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There are many signs of intellectual disability that can appear in children from infancy or during toddlerhood. It is very difficult to assess intellectual capabilities in infants, so developmental delays can be a sign of intellectual disability. The inability of some children to reach certain developmental milestones (in infancy) can be a factor indicating developmental delays (like Global developmental delay) or intellectual disability. But the both should not be confused with. Some of the most common signs are:

- Rolling over, crawling, sitting up, walking late
- Trouble with talking or talking late
- Difficulty in remembering
- Inability to do certain independent actions (like using the bathroom, dressing oneself, etc)
- Inability to solve problems
- Inability to connect causes and consequences
- Throwing explosive tantrums

**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.

What is Intellectual Disability according to DSM-5?

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**5.5 LEVELS OF INTELLECTUAL DISABILITY**

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There are 4 levels of intellectual disability. These are based on IQ scores.

1. Mild intellectual disability - IQ 50-55 to approximately 70
2. Moderate intellectual disability - IQ 35-40 to 50-55
3. Severe intellectual disability - IQ 20-25 to 35-40
4. Profound intellectual disability - IQ below 20-25

**Mild Intellectual Disability**

Individuals with mild intellectual disability constitute by far the largest number of those diagnosed with intellectual disability. Within the educational context, people in this group are considered educable, and their intellectual levels as adults are comparable to those of average 8 to 11 year old children (though not too literally). An adult with mild disability with a

mental age of for example, 10, may not in fact be comparable to the average 10-year old in information processing ability or speed.

The social adjustment of people with mild intellectual disability often approximates that of adolescents, although they tend to lack normal adolescents' imagination, inventiveness, and judgement. Ordinarily, they do not show signs of brain pathology or other physical anomalies, but often they require some measure of supervision because of their limited abilities to foresee the consequences of their actions. With early diagnosis, parental assistance, and special educational programs, the great majority of borderline and individuals with mild intellectual disability can adjust socially, master simple academic and occupational skills and become self-supporting citizens.

### **Moderate Intellectual Disability**

The rate of learning of individuals with moderate intellectual disability is slow and their level of conceptualizing is extremely limited. They usually appear clumsy and awkward and they suffer from bodily deformities and poor motor coordination. Some individuals with moderate intellectual disability are hostile and aggressive, more typically, they are affable and nonthreatening. In general, with early diagnosis, parental help and adequate opportunities for training, most individuals with moderate intellectual disability can achieve partial independence in daily self-care, acceptable behaviour and economic sustenance in a family or sheltered environment.

### **Severe Intellectual Disability**

In individuals with severe intellectual disability, motor and speech development are severely retarded and sensory defects and motor handicaps are common. They can develop limited levels of personal hygiene and self-help skills, which somewhat lessen their dependency, but they are always dependent on others for care. However, many can benefit to some extent from training and can perform simple occupational tasks under supervision.

### **Profound Intellectual Disability**

Most individuals with profound intellectual disability are severely deficient in adaptive behaviour and unable to master even simplest tasks. Useful speech, if it develops, is rudimentary. Severe physical deformities, central nervous system pathology, and retarded growth are typical; convulsive seizures, mutism, deafness, and other physical anomalies are also common. These individuals must remain in custodial care. They tend, however, to have poor health and low resistance to disease and thus have a short life expectancy. Severe and profound cases of intellectual disability can usually be readily diagnosed in infancy because of the presence of obvious physical malformations, grossly delayed development and other obvious symptoms of abnormality. These individuals show a marked impairment of overall intellectual functioning.

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## **5.6 CAUSES**

There are many causes for intellectual disability including prenatal (before birth), perinatal (during birth) and postnatal (after birth) causes. Some causes are preventable but a few others like genetics and inheritance are not. It is seen that genetic factors are responsible for 45% of the cases of intellectual disability. Of which Down's syndrome accounts for the largest

number of cases through genetic means, Fragile-X as the largest inherited cause, and Fetal Alcohol Spectrum Disorder as the largest environmental cause.

### 5.6.1 BIOLOGICAL

#### 1. Prenatal toxins

Prenatal toxins are avoidable but they exist. Intake of such toxins by the pregnant mother can potentially harm the developing foetus.

- Smoking- Causes early placental rupture and also preterm labour. Disrupts the growth of the baby
- Alcohol- **Fetal Alcohol Spectrum Disorder (FASD)** occurs in 1.9% of 1000 live births. It is a factor that plays in developmental delay and intellectual disability and also causes microcephaly.
- Other toxins- Exposure of the mother to abuse recreational drugs also poses a serious risk.

#### 2. Birth Asphyxia (oxygen deprivation before or after birth)

Studies have shown that survivors of birth asphyxia are at risk for motor and cognitive impairments. Birth asphyxia also remains an important cause for intellectual disability, cerebral palsy, and other neurodevelopmental problems. One study stated that 18% of the survivors have suffered severe or permanent neurological disorder.

#### Infection

- **Congenital** (before birth): The acronym TORCH would help in remembering all the infections that cause potential brain damage in then growing foetus and thus intellectual disability after birth. Pregnant women should be careful and take vaccines to keep them and their baby safe.

**T-** Toxoplasma or toxoplasmosis

**O-** Other infections like syphilis, Hepatitis B, Viral Herpes Zoster

**R-** Rubella

**C-** Cytomegalovirus

**H-** Herpes Simplex II

- **Post-natal** (after birth): Any bacterial, viral infections that affect the brain. Bacterial infections that affect other body parts may also hinder the development of the brain.

#### 3. Brain malformation

Due to certain causes, the developing foetus might also not go through proper development in the womb and the brain (in some babies) might not be formed correctly (as in partial development or no development in brain structures, like the corpus callosum).

The size of the head circumference of the baby also matters. Microcephaly (smaller than the usual size of head) and macrocephaly (larger than the usual head size) also contribute to learning difficulties and intellectual disability.

#### 4. Chromosomal defects

Chromosomal defects include deletion of an entire chromosome (monosomy) or partial deletion, replication of a chromosome (Trisomy 21 or Down's Syndrome) or other abnormalities in the chromosomes of the gametes (sperm or egg) that when fertilized cause problems to the developing foetus.

## 5. Genetic defects

These include problems in the genes and abnormalities in the expression of them. For example, Fragile-X Syndrome.

## 6. Seizures

Seizures are sudden, uncontrollable electrical impulses in the brain that can change the processes happening in the brain. It has been noted that seizures occur in one-eighth of the individuals with severe intellectual disability and one-tenth with mild intellectual disability. Seizure prevalence is higher than X-Linked Intellectual disability (XLID) symptoms.

## 7. Malnutrition

Malnutrition also seems to play a role in intellectual disability. It is important to eat a balanced diet to prevent this. Iodine deficiency in pregnancy may lead the child to have congenital hypothyroidism (cretinism; lack of a fully functioning thyroid).

## 8. Traumatic Brain Injury

This can be a blow to the head. TBI can cause a lot of complications in a person's life. It can happen any time after the child is born till death. TBI can also give rise to seizures and cause severe brain injury thus affecting intellect.

### 5.6.2 PSYCHOSOCIAL DEPRIVATIONS

#### 1. Isolation and Social Deprivation

Isolation and Social deprivation is both a cause and consequence of intellectual disability. Generally people with Intellectual Disability are socially isolated with limited family support and mostly taken care of in out-of-home facilities. The only social interaction is supportive group therapy with other people having intellectual disability. This creates a narrow range for meaningful relations and opportunities to improve their social circle. It is important to note the difference between social isolation (done by oneself) and social exclusion (done by a community). Many people with intellectual disability might be socially excluded in the community. They might be socially visible but ignored. This might be due to the prejudice and misconceptions against people with intellectual disability might be a factor for their lack of inclusion in the social networks. First impressions of people with intellectual disability by people with no disability matter a lot in setting the latter's (people with no intellectual disability) opinions of people with such a disability and these experiences with encourage in including or excluding such people in social group.

People with intellectual disability face numerous personal and social barriers that lead to community isolation:

- Being ignored and not accepted
- Limited community facilities and social exchanges
- Transport and financial issues

Community centre staff who prioritize other activities than meaningful community membership

#### 6. Poverty

Poverty has also seemed to play a role as a cause for intellectual disability. Poverty might have affected the mother and thus indirectly the growing foetus. Consistent research has shown that poverty and intellectual disability is linked. Lack of resources, poorer health and increased social

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exclusion might worsen the conditions of people living with disability in poverty.

**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 various causes for intellectual disability?

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## **5.7 FEW INTELLECTUAL DISABILITIES**

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A few very common intellectual disabilities are described below:

### **5.7.1 Down’s Syndrome (Trisomy 21)**

Down’s syndrome consists of distinct facial features, developmental delays including intellectual disability. Individuals, who have this, are at risk for thyroid and heart disease. Due to abnormal cell division, instead of the usual 46 chromosomes in the cell that are paired, there is one extra chromosome 21 making it a total of 47 chromosomes in the cell. It is the largest identifiable cause for intellectual disability with a population of 15-20% of those with intellectual disability having Down’s Syndrome.

### **5.7.2 Autism Spectrum Disorder (ASD)**

It is a neurological and developmental disorder, affecting the interaction of the person with others, communication and learning. It usually begins in early childhood and lasts throughout life. There is nothing in particular that sets people with ASD apart from others physically. The only thing that sets them apart is communication and certain behavioural characteristics.

Scientists are trying to see if there is a common genetic link between intellectual disability and ASD. Certain genetic syndromes (Fragile X, Down’s, Phenylketonuria) are associated with severe intellectual disability and also have a high incidence rate for autistic traits. However, other research has shown that intellectual disability is associated with a high number of deletions while in ASD is associated with high number of duplications in the individual’s genetic code.

Around 10% of individuals with intellectual disability have ASD or autistic traits. However recent studies show that around 38% of autistic children have intellectual disability. It’s also seen that females who have autism have higher prevalence of intellectual disability than males. 46% for females with ASD compared to 37% of males with ASD.

Recent studies have shown that the previous hypothesis of ASD co-occurring with intellectual disability is not true. Results from the studies show that there is a rise in ASD with no intellectual disability.

### **5.7.3 Fragile-X Syndrome**

Fragile-X syndrome is a genetic condition that involves changes in a part of the X chromosome. It is the most common form of intellectual disability most often seen in boys. Fragile-X is caused by a change in a gene FMR1 a small part in the fragile site on the X chromosome. The more repetitions, the more severe the problem. Boys and girls can be affected but it’s more commonly seen in boys because they have only one X chromosome. Children can have Fragile-X even if their parents weren’t affected by this.

A blood test can diagnose Fragile-X syndrome. Genetic testing is usually done when symptoms are seen. Genetic testing for fragile-X is

recommended for any unexplained cognitive delay. Fragile-X affects twice as many males compared to females. But it is noted that four times as many females are carriers of a Fragile-X chromosome. Every 1 in 4000 males and 1 in every 8000 females have Fragile-X syndrome.

#### **5.7.4 Congenital Hypothyroidism (Cretinism)**

CH involves a lack of adequate Thyroid hormone production in the newborn infant. This might be due to a problem in the infant's thyroid gland or iodine deficiency in the mother's body during pregnancy. This is a preventable disorder.

Children born with CH can develop intellectual disability if the condition isn't treated quickly. For every month that the child receives no treatment, the child's IQ can drop several points. Growth is hindered. Other complications from this may include mutism (inability to speak), autism, vision and hearing problems, abnormal gait, problems with memory and attention. Even after treatment, children with congenital hypothyroidism will learn slower than others.

There is a higher incidence of CH in Hispanic and Asian communities. Especially in places like India, China and Kazakhstan. In the world, every 1 in 2000 or 1 in 4000 babies have CH. Research studies have shown an increase in the prevalence of CH in India. Indian Council of Medical Research (ICMR) National Task Force Team on New Born Screening (NBS) at AIIMS New Delhi (2007-2012) show preliminary results of 1 in 1172 newborn infants having CH. Particularly the South (1 in 727).

There are a lot of other disorders that are associated with intellectual disability, like Cerebral palsy, ADHD (attention deficit hyperactivity disorder), epilepsy and other anxiety and depression related disorders.

There is difference between intellectual disability and learning disability. An intellectual disability refers to a below-average IQ and a lack of skills needed for daily living. A learning disability refers to weakness in academic related skills, like reading, arithmetic and writing. Lots of causes should be ruled out before diagnosing a learning disability.

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### **5.8 MANAGEMENT**

There is no treatment or permanent cure for intellectual disability except for congenital hypothyroidism which can be prevented if treated as early as possible. Treatment mostly includes screening, diagnosing through various standardized tests and then caring for the individuals.

It is important to note that Global Developmental Delay (GDD) defines a significant functional delay in two or more developmental domains and is typically applied to children less than 5 years of age. Whereas, Intellectual Disability is applied to children over 5 years of age and show significant cognitive limitations after psychometric testing documents are applied. Most of the children who fall under GDD might also show intellectual disability but can be diagnosed properly only after 5 years of age.

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### 5.8.1 ASSESSMENT TOOLS

There are various types of standardized psychological tests used to assess intellectual disability. These tests may assess intelligence (IQ), learning abilities and behavioral skills.

Some of the most commonly used IQ tests are given:

#### 1. Wechsler Intelligence Scale for Children (WISC):

IQ test for children ages 6-16 years. There are two subsets for different areas of intelligence, verbal skills and spatial performance.

#### 2. Wechsler Preschool and Primary Scale of Intelligence:

IQ test for children ages 3-7 years. The test is divided into two subsets like WISC. This test is not appropriate for people with severe intellectual disability.

#### 3. Stanford-Binet Intelligence Scale:

IQ test for ages 2-23 years. There are six subsets for all age groups but fifteen for the older group. The six that they look for are vocabulary, comprehension, pattern analysis, quantitative, bead memory, memory for sentences.

#### 4. McCarthy Scales of Children's Abilities:

IQ test for ages 2.5-8.5 years. There are six sections. These do not give an IQ score instead they add up to a General Cognitive Index (GCI). Individual scores can be obtained helping diagnosticians evaluate learning problems in the younger children.

#### 5. Bayley Scales of Infant Development:

IQ test for infants 1-42 months. This test is used for older children who are unable to take age-appropriate tests. There are three sections to test: mental abilities, motor abilities, and behavioural abilities.

Some of the tests used to test adaptive behaviour.

#### 1. Woodcock-Johnson Scales of Independent Behaviour:

This test measures independent behaviour in children.

#### 2. Vineland Adaptive Behaviour Scale (VABS):

Used for people from 0-19 years of age. Measures social skills. This test is applied to children with behavioural disorders and physical handicaps. This test is not administered directly to the child but the parents. Questions are directed to the people close to the child. It is divided into 4 sections: communication, daily living skills, socialization, and motor skills.

#### 3. The Diagnostic Adaptive Behaviour Scale (AAIDD, 2013)

This test measures adaptive behavioural skills. There are three categories: conceptual, social, and practical life skills. This test is very helpful in determining the intensity and types of support needed to maximize independent functioning.

### 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. Name a few IQ tests for children that can be used to detect intellectual disability.

### 5.8.2 THERAPY

There are different types of therapy that the child can obtain depending on the assessment scores, age and severity of intellectual disability. Treatment

options used for behavioral and communication problems are addressed below.

### **1. Applied behavioural analysis (ABA):**

A treatment approach using principles of learning theory to bring about results. Techniques can be used to nurture a variety of skills (communication, social skills and so on) that can be used in varied situations. Usually used for individuals with intellectual disability, particularly those with ASD.

### **2. Environmental arrangement**

A technique that involves in making the surrounding environment interesting for the children to explore and encourage communication. For example, keeping an interesting object in sight but out of reach.

### **3. Functional communication training (FCT)**

A behavioral intervention program that combines the communicative functions of the problem behaviour and techniques used in ABA to teach alternative response. Problem behaviour can be eliminated through extinction and replaced with an alternate, more appropriate forms of behaviour. This approach has been used with students with intellectual disability to replace challenging behaviours with appropriate communicative alternatives.

### **4. Incidental teaching**

Uses behavioral procedures and techniques to teach elaborate language training skills. Individual is encouraged to communicate effectively through reinforcement.

### **5. Milieu training**

A range of methods (time delay, incidental teaching etc.) that are integrated into the child's natural environment. Training lasts throughout the day and not just during therapy time. Offers a systematic approach to language teaching and encourages children to expand their skills.

### **6. Time delay**

A behavioural method that fades the use of prompts during teaching. For example, the time interval between the initial instruction and the prompts during the reproduction phase will be higher until the instructor does not prompt anymore.

## **5.9 LET'S SUM UP**

Intellectual disability is a neurodevelopmental disorder usually diagnosed in childhood. It is characterized by intellectual impairment and inability to understand necessary skills for day-to-day living. Severity of intellectual disability is usually based on IQ scores after performing the standardized IQ tests. Diagnosis of intellectual disability can be done only if it meets certain criteria: impairment intellectually, inability to perform day-to-day tasks, seen in childhood. To diagnose early infants, inability of the children to reach the developmental milestone for that age might be useful. The causal factors for intellectual disability are numerous and a few environmental causes can be prevented. Permanent cure for intellectual disability doesn't exist but therapy helps in making the individual more adept at living independently. There are many different types of therapies that are custom-tailored to every individual's needs.

## **5.10 UNITS-END EXERCISES**

1. Define Mental retardation.

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2. Explain the different levels of mental retardation.
3. What are the different causes of mental retardation?

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### 5.11 ANSWERS TO CHECK YOUR PROGRESS

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1. DSM-5 defines intellectual disability as a neurodevelopmental disorder that begins in childhood and are characterized by intellectual difficulties as well as difficulties in social, practical and conceptual areas of living. Diagnosis of intellectual disability should satisfy the following categories  
Deficits in intellectual functioning - like reasoning, problem solving, abstract thinking, making judgments, and learning from experience- through standardised IQ evaluations.

- Deficits in adaptive behaviour, hampering the individual's development for independence.
- Onset of these deficits in childhood.

2. **Prenatal:**

Chromosomal defects

- Genetic defects
- Iodine deficiency
- Infections from the mother (TORCH - congenital infections)
- Brain malformations (like microcephaly)
- Environmental toxins from mother (alcohol, smoking)

**Perinatal:**

- Birth asphyxia
- Problems during labour and delivery

**Postnatal:**

Infections (bacterial or viral)

- Brain Injury (due to a fall)
- Seizures
- Environmental toxins (exposure to chemicals like lead, mercury)
- Poverty [Psychosocial cause]
- Isolation or social deprivation [Psychosocial cause]
- Depression [Psychosocial cause]

3.

- Wechsler Intelligence Scale for Children (WISC)
- Wechsler Preschool and Primary Scale of Intelligence
- Stanford-Binet Test
- McCarthy Scales of Children's Abilities
- Bayley Scales of Infant Development

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### 5.12 SUGGESTED READINGS

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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* 16<sup>th</sup> 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.

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# UNIT VI: MENTAL ILLNESS

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## **Structure**

- 6.1 Introduction
- 6.2 Objectives
- 6.3 Signs, symptoms and syndromes of mental illness
- 6.4 Causes of abnormal behaviour
  - 6.4.1 Biological Factors
  - 6.4.2 Psychological Factors
  - 6.4.3 Social Factors
  - 6.4.4 Cultural Factors
- 6.5 Treatment
- 6.6 Let us sum up
- 6.7 Unit-End Exercises
- 6.8 Answers to Check your Progress
- 6.9 Suggested Readings

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## **6.1 INTRODUCTION:**

Mental illnesses are diseases or conditions that affect how you think, feel, act, or relate to other people or to your surroundings. Symptoms of mental illness can range from mild to severe. They can also vary from person to person. In many cases, it makes daily life hard to handle.

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## **6.2 OBJECTIVES:**

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

- Gain knowledge about mental illnesses
- Understand the factors and treatments of mental illnesses

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## **6.3 SIGNS, SYMPTOMS AND SYNDROMES OF MENTAL ILLNESS:**

Mental disorders are typically defined by a set of characteristic features; one symptom by itself is seldom sufficient to make a diagnosis. A group of symptoms that appear together and are assumed to represent a specific type of disorder is referred to as a syndrome. Each symptom is taken to be an imperfect indicator of the presence of the disorder. The significance of any specific feature depends on whether the person also exhibits additional behavior that is characteristic of particular disorder. The duration of a person's symptoms is also important. Mental disorders are defined in terms of persistent maladaptive behaviors. Many unusual behaviors and inexplicable experiences are short lived; if we ignore them, they go away. Unfortunately, some forms of problematic behavior are not transient, and they eventually interfere with the person's social and occupational functioning.

Impairment in the ability to perform social and occupational roles is another consideration in identifying the presence of mental disorder. Delusional beliefs and disorganized speech typically lead to profound disruption of relationships with other people.

Psychologists and other mental health professionals do not at present, have laboratory tests that can be used to confirm definitively the presence of

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psychopathology because the processes that are responsible for mental disorders have not yet been discovered. Unlike specialists in other areas of medicine where many specific disease mechanisms have been discovered by advances in the biological sciences, psychologists and psychiatrists cannot test for the presence of a viral infection or a brain lesion or genetic defect to confirm a diagnosis of mental disorder. Clinical psychologists, still depend on their observations of the person's behavior and descriptions of personal experience. "Insanity", which years ago, referred to mental dysfunction but today is a legal term that refers to the judgement about whether a person should be held responsible for criminal behavior if he or she is also mentally disturbed. Another old fashioned term that you may have heard is "nervous breakdown". This expression does not convey any specific information about the nature of the person's problems. This is an informal, disapproving term that does not convey specific information and carries with it many unfortunate, unfounded, and negative implications. Mental health professionals refer to psychopathological conditions as mental disorders or abnormal behaviors.

There are many different mental illnesses, and their symptoms vary. Some common symptoms include:

- Problems with thinking (like being confused, suspicious, or unusually angry or sad)
- Keeping to themselves
- Mood swings
- Relationship problems
- Hallucinations (seeing or hearing things that aren't there)
- Abusing alcohol or drugs
- Feeling low on hope and not enjoying things that they used to like
- Thoughts of suicide or harming themselves or others
- Sleep problems (too much or too little)
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#### **6.4 CAUSES OF ABNORMAL BEHAVIOUR:**

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The exact cause of most mental illnesses is not known. A combination of things, including genes, biology, and your life experiences, seems to be involved. Many mental illnesses run in families. But that doesn't mean you will have one if your mother or father did. Some conditions involve circuits in brain that are used in thinking, mood, and behavior. For instance, you may have too much, or not enough, activity of certain brain chemicals called "neurotransmitters" within those circuits. Brain injuries are also linked to some mental conditions. Some mental illnesses may be triggered or worsened by psychological trauma that happens at childhood or adolescence, such as:

- Severe emotional, physical, or sexual abuse
- A major loss, such as the death of a parent, early in life
- Neglect
- Major sources of stress, such as a death or divorce, problems in family relationships, job loss, school, and substance abuse, can trigger or aggravate some mental disorders in some people. But not everyone who goes through those things develops a mental illness.

- It's normal to have some grief, anger, and other emotions when you have a major setback in life. A mental illness is different from that.

#### **6.4.1 BIOLOGICAL FACTORS:**

The biological perspective concerns the role bodily disturbances play in disordered behavior. The bodily disturbance may be due to genetic defect, an injury or infection before or after birth, or a more or less temporary physiological malfunction caused by some condition present at a particular time.

##### **GENETIC FACTORS:**

Genes, the elements of human heredity, are transmitted from parent to child in the form of deoxyribonucleic acid(DNA). It is found in the chromosomes, present in pairs in all body cells. Behavior genetics emphasizes the interaction of heredity and environment. Research in behavior genetics is carried out either through the study of family history or through studies of twins.

##### **THE NERVOUS SYSTEM AND THE BRAIN:**

The two major divisions of the nervous system are the central nervous system (CNS), the nerve cells in the brain and spinal cord, and the Peripheral Nervous System (PNS), the neurons connecting the CNS with the glands, muscles, and sensory receptors. Research has shown that brain development is flexible and at time dependent on environmental stimulation.

##### **THE ENDOCRINES:**

The endocrine system is made up of several glands including the pituitary, thyroid, adrenal, and gonadal (sex) glands. The glands are ductless, which means they discharge hormones directly into bloodstream. They play an important role in stress.

##### **PSYCHONEUROIMMUNOLOGY:**

It is an interdisciplinary field aimed at understanding the relationship between thinking, feeling, and behavior and the structure and function of the brain. The use of new techniques to study molecular level events at the synapse and the use of imaging techniques that made possible the study of living brain are contributing to the understanding of relationships between the brain and behavior. Psychoneuroimmunology is an area of research focused on the effects of psychological and neural events on immunological process.

##### **INTEGRATION OF BIOLOGICAL AND PSYCHOLOGICAL SYSTEM:**

One major contribution of this perspective is drug therapy. A variety of drugs are used in treating maladaptive behavior. However, it is important to recognize the multiple determinants of abnormal behavior, which includes interactions among the physical environment, psychological factors and biological functioning.

##### **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 major contribution of biological perspective to mental illness?

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**SOURCES OF BIOLOGICAL ABNORMALITIES:**

Three factors - *genetics*, *evolution*, and *viral infections* explain why some people have brain structures or biochemical activities that differ from the norm

**GENETICS AND ABNORMAL BEHAVIOR :**

Abnormalities in brain anatomy or chemistry are sometimes the result of genetic inheritance. Each cell in the human brain and body contains 23 pairs of *chromosomes*, with each chromosome in a pair inherited from one of the person's parents. Every chromosome contains numerous genes—segments that control the characteristics and traits a person inherits. Scientists have known for years that genes help determine such physical characteristics as hair color, height, and eyesight. Genes can make people more prone to heart disease, cancer, or diabetes, and perhaps to possessing artistic or musical skill. Studies suggest that inheritance also plays a part in mood disorders, schizophrenia, Alzheimer's disease, and other mental disorders. In the *Human Genome Project* in 2000, scientists used the tools of molecular biology to *map*, or *sequence*, all of the genes in the human body in great detail. With this information in hand, researchers hope eventually to be able to prevent or change genes that help cause medical or psychological disorders.

**EVOLUTION AND ABNORMAL BEHAVIOR:**

An abnormal condition may occur by genetic mutation. *Mutation*, is an abnormal form of the appropriate gene that emerges by accident. In general, evolutionary theorists argue that human reactions and the genes responsible for them have survived over the course of time because they have helped individuals to thrive and adapt. The evolutionary position with regard to abnormal functioning follows a similar logic. According to evolutionary theorists, the capacity to experience fear was, and in many instances still is, adaptive. Fear alerted individuals to dangers, threats, and losses, so that persons could avoid or escape potential problems. People who were particularly sensitive to danger—those with greater fear responses—were more likely to survive catastrophes, battles, and the like and to reproduce, and so to pass on their fear genes.

**VIRAL INFECTIONS AND ABNORMAL BEHAVIOR:**

Another possible source of abnormal brain structure or biochemical dysfunctioning is *viral infections*. For example, research suggests that *schizophrenia*, a disorder marked by delusions, hallucinations, or other departures from reality, may be related to exposure to certain viruses during childhood or *in utero*, before birth. Studies have found that the mothers of many individuals with this disorder contracted influenza or related viruses during their pregnancy. This and related pieces of circumstantial evidence suggest that a damaging virus may enter the fetus's brain and remain dormant there until the individual reaches puberty or young adulthood. At that time, activated by hormone changes or by another infection, the virus may produce the symptoms of schizophrenia.

**6.4.2 PSYCHOLOGICAL FACTORS:**

The psychodynamic perspective is based on the idea that thoughts and emotions are important causes of behavior.

**FREUD AND PSYCHOANALYSIS:**

Freud developed psychoanalysis, a method in which the patient recaptures forgotten memories without the use of hypnosis. The two most basic assumptions of Freud's theories of personality are psychic

determinism and the conscious –unconscious dimension. The latter includes three levels of consciousness: the conscious, preconscious, unconscious. Freud's theory placed great emphasis on the first 5 years of life. During this period, he thought the libido, or basic human drives, was focused on a series of specific erogenous zones or sources of pleasure. His theory divided the mental world into three structures- the Id, Ego, Superego. Freud also placed great emphasis on the concept of anxiety and the use of ego defense mechanisms.

#### **MORE RECENT APPROACHES TO PSYCHOANALYSIS:**

This theory has been modified by many later theorists. Erikson developed a psychosocial theory. He described a series of psychosocial stages of development over the entire life cycle. Object relations theory was developed by psychoanalysts such as Klein. Kohut developed a theory of self-psychology.

#### **EVALUATING PSYCHOANALYTIC THEORY:**

Psychoanalysis is both a theoretical framework and a therapeutic method. Its full evaluation will be possible only when its therapeutic effectiveness can be objectively assessed and its concepts explored using scientific methods, such as the experiment.

#### **6.4.3 SOCIAL FACTORS:**

Social variables such as poverty, unemployment, inferior education, and prejudice are potential causes for at least some mental disorders.

#### **EMPLOYMENT AND MENTAL HEALTH:**

Mental health issues have had more of an impact on an individual's ability to work than any other group of conditions. Workers who suffer from mental ill health don't often work at full capacity, as these problems impair their ability to do so. It causes approximately 40% of all days lost due to sickness, accounts for 40% of all days lost through claiming Incapacity Benefit and 23% of new claimants of the Disability Living Allowance. Mental health problems typically cause poor memory, impaired concentration, attention and fatigue. If an individual is on medication to treat the mental health issues, it can make these problems worse. Depression, one of the most common mental health issues, was found to have a greater impact on productivity and time management than any other health problem. It rivals rheumatoid arthritis on having an impact on physical tasks. Mental ill health can cause problems that act as barriers to jobs that involve a high amount of contact with the public and also high status occupations.

Presenteeism - where an employee attends work but is less productive - can be caused by poor mental health. This problem can cause up to 60% of mental health related costs to businesses. This could be because people who suffer from mental health issues don't show any symptoms and don't want to 'prove' that they have a problem because of the stigma surrounding it.

#### **FINANCIAL COSTS:**

Many face extra financial costs when caring for a loved one that can put a strain on family relationships and mental health - this is one of the major social influences affecting mental health for carers.

#### **PHYSICAL AND MENTAL HEALTH OF CAREGIVERS:**

The pressures that carers face can have an impact on their mental and physical health, including depression and stress. This impact is

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worsened due to carers not being able to find the time for check-ups or treatment or not being able to find adequate and affordable replacement care. Two in five care givers have been forced to delay treatment due to their responsibilities.

Care givers also found it difficult to maintain social relationships because many don't understand what impact caring has on the individual. Due to the sheer amount of responsibilities a carer takes on, they often report feelings of isolation.

**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 sources of biological abnormalities for the mental illnesses?

3. What are the social factors which causes mental illness?

**6.4.4 CULTURAL FACTORS:**

The community cultural perspective directs attention to the roles played by community wide factors (for example-poverty) and cultural diversity in maladaptive behavior. Community psychologists focus on the failure of social support system as the cause of maladaptive behaviour. They emphasize preventive intervention- such as special programs in schools- and programs for specific groups that are at high risk because they need help in solving problems of living.

**SOCIAL ROLES AND LABELLING:**

Social roles are defined by the person's group and the functions of the person in that group. Each role has a script that determines how the person is expected to act in different situations. Labelling is the result of categorizing people on some basis, such as social groups to which they belong, without attention to their individual characteristics.

**CONTRIBUTIONS OF THE COMMUNITY-CULTURAL PERSPECTIVE:**

Social, economic, and cultural factor play roles in emotional expression and maladaptive behavior. Community psychology has been influential in reaching people whose needs have been ignored by the other perspective that focus more on treating the individual instead of changing the environment.

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**6.5 TREATMENT:**

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**BIOLOGICAL TREATMENTS:**

The three leading kinds of biological treatments used today are *drug therapy*, *electroconvulsive therapy*, and *neurosurgery*. Drug therapy is by far the most common of these approaches. In the 1950s, researchers discovered several effective psychotropic medications, drugs that mainly affect emotions and thought processes. These drugs have greatly changed the outlook for a number of mental disorders and today are used widely, but also have produced some major problems. Many people believe, for example, that the drugs are overused. Moreover, while drugs are effective in many cases, they do not help everyone. Four major psychotropic drug groups are used in therapy: antianxiety, antidepressant, antibipolar and

antipsychotic drugs. Antianxiety drugs, also called minor tranquilizers or anxiolytics, help reduce tension and anxiety. Antidepressant drugs help improve the mood of people who are depressed. Antibipolar drugs, also called mood stabilizers, help stabilize the moods of those with a bipolar disorder, a condition marked by mood swings from mania to depression. Antipsychotic drugs help reduce the confusion, hallucinations, and delusions of *psychotic disorders*, disorders marked by a loss of contact with reality.

The second form of biological treatment, used primarily on depressed patients, is electroconvulsive therapy (ECT). A third form of biological treatment is neurosurgery, or psychosurgery, brain surgery for mental disorders. They are used only after certain severe disorders have continued for years without responding to any other form of treatment.

**THE OTHER COMMON TREATMENTS INCLUDE:**

**PSYCHOTHERAPY:**

This may be one-on-one with a counselor. Or it may happen with a group. It may include learning different ways to respond to challenging situations.

**LIFESTYLE CHANGE:**

In some cases, changing the habits makes a difference. For instance, exercise is one of the treatments for mild depression.

**CREATIVE THERAPIES** (such as art therapy, music therapy, or play therapy), mindfulness and meditation, and brain stimulation therapies, such as:

**VAGUS NERVE STIMULATION**, in which doctors implant a device that stimulates the vagus nerve, which relays messages to areas in the brain that are thought to affect mood and thinking. It's approved to treat severe cases of depression that don't respond to two or more antidepressant treatments.

**TRANSCRANIAL MAGNETIC STIMULATION**, which uses magnets (outside the body) to stimulate the brain. It's approved to treat major depression if other treatments haven't worked. The research on how well it works is mixed.

Some people may need day treatment or hospitalization, at least for a time, for more severe conditions.

**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 the four psychotropic groups used in drug therapy.

**6.6 LET US SUM UP:**

Mental illness, also called mental health disorders, refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behaviour. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviours. Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function. At different times in the past, psychological disorders were attributed to supernatural causes or natural causes. The modern psychological view suggests that mental

disorders involve biological, psychological, and socio-cultural factors as well as the joint effects of individual vulnerabilities and stressors.

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### **6.7 UNIT-END EXERCISES:**

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1. Explain the Psychological perspective of mental illness.
2. What are the possible social risk factors for the mental illness?
3. What are the treatments suggested for patients with mental illness?

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### **6.8 ANSWERS TO CHECK YOUR PROGRESS:**

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- 1 One major contribution of this perspective is drug therapy. A variety of drugs are used in treating maladaptive behavior.
2. Genetics and Abnormal Behavior; Viral infection; Evolution
3. Employment and Mental Health; Caring for loved ones; Financial Costs; Physical and Mental Health; Social Exclusion and Relationship; Homelessness and Mental Health.
4. Four major psychotropic drug groups are used in therapy: antianxiety, antidepressant, antibipolar and antipsychotic drugs. Antianxiety drugs, also called minor tranquilizers or anxiolytics, help reduce tension and anxiety. Antidepressant drugs help improve the mood of people who are depressed. Antibipolar drugs, also called mood stabilizers, help stabilize the moods of those with a bipolar disorder, a condition marked by mood swings from mania to depression. Antipsychotic drugs help reduce the confusion, hallucinations, and delusions of *psychotic disorders*, disorders marked by a loss of contact with reality.

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### **6.9 SUGGESTED READINGS**

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- Butcher, J.N. (2014). *Abnormal Psychology*. New Delhi: Pearson Education.
- Butcher, J.N., Hooley, J. M., Mineka, S & Dwivedi, C.B. (2017). *Abnormal Psychology* 16<sup>th</sup> 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.

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# UNIT VII: ORGANIC MENTAL DISORDERS

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*Organic Mental Disorders*

## **Structure**

- 7.1 Introduction
- 7.2 Objectives
- 7.3 Delirium
  - 7.3.1 Causal factors
  - 7.3.2 Diagnosis and Treatment
- 7.4 Dementias associated with age
  - 7.4.1 Alzheimer's disorder
- 7.5 Causal Factors
- 7.6 Treatment
- 7.7 Let us sum up
- 7.8 Unit-End Exercises
- 7.9 Answers to Check individual's Progress
- 7.10 Suggested Readings

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## **7.1 INTRODUCTION**

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There is a traditional distinction made in psychopathology between the organic and functional disorders. The latter type of disorder is generally viewed as a reaction to some environmental or psychosocial stress or as a condition in which the presence of a specific organic etiological factor is strongly suspected, but not proven. The anxiety disorders are examples of the first alternative, and schizophrenia is an example of the second. Organic mental disorders are those conditions that can be more or less definitively associated with temporary or permanent dysfunction of the brain. Thus, individuals who have these illnesses are frequently described as "brain-damaged" patients or patients who have "organic brain syndromes."

Organic mental disorders are basically brain disorders or diseases produced by pathological agents that may impair any organ or system of the body. The brain may be damaged by trauma, or it may become infected. The brain can become cancerous or can lose adequate oxygen through occlusion of the blood vessels that supply it. The brain can be affected through acute or chronic exposure to toxins, such as carbon monoxide or other poisonous substances. Nutritional deficiencies can alter brain function just as they alter the function of other organs and organ systems. Aside from these general systemic and exogenous factors, there are diseases that more or less specifically have the central nervous system as their target. According to the DSM-IV-TR, the organic mental disorder has been categorized into three categories: delirium, dementia, and amnesic.

Delirium, a mental confusion and emotional disruption, is caused by the sudden change in the brain. Thinking, remembering, sleeping, and paying attention can become difficult during alcohol withdrawal, after surgery, or with dementia.

Dementia, a decline in mental ability, can be severe or not, and can interfere with daily life and cause memory loss in most instances.

*Self – Instructional Material*

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Amnesic pertains to amnesia and is the impairment in ability to learn or recall new information, or recall previously learned information. Although similar, it is not coupled with dementia or delirium.

Organic brain syndrome can be divided into 2 major subgroups: acute (delirium or acute confusional state) and chronic (dementia). A third entity, encephalopathy (subacute organic brain syndrome), denotes a gray zone between delirium and dementia; its early course may fluctuate, but it is often persistent and progressive. Damage to brain functioning can not only depends on organic (physical) injury (a severe blow to the head, stroke, chemical and toxic exposures, organic brain disease, substance abuse, etc.) but also to non-organic means such as severe deprivation, abuse, neglect, and severe psychological trauma.

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## 7.2 OBJECTIVES:

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**At the end of the unit you will:**

- Gain knowledge about the different organic mental disorders
  - Understand the diagnosis and treatment of organic mental disorders
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## 7.3 DELIRIUM:

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It is a major disturbance in attention and orientation to the environment. As the person's focus becomes less clear, he or she has great difficulty concentrating and thinking in an organized way, leading to misinterpretations, illusions, and, on occasion, hallucinations. Sufferers may believe that it is morning in the middle of the night or that they are home when actually they are in a hospital room. Delirium is an abrupt change in the brain that causes mental confusion and emotional disruption. Individuals might experience delirium during alcohol withdrawal, after surgery, or with dementia. Delirium is usually temporary and can often be treated effectively.

**Definition:**

A rapidly developing, acute disturbance in attention and orientation that makes it very difficult to concentrate and think in a clear and organized manner.

Fever, certain diseases and infections, poor nutrition, head injuries, strokes, and stress (including the trauma of surgery) may all cause delirium. So may intoxication by certain substances, such as prescription drugs. Partly because older people face so many of these problems, they are more likely than younger ones to experience delirium. If a clinician accurately identifies delirium, it can often be easy to correct—by treating the underlying infection, for example, or changing the patient's drug prescription. However, the syndrome typically fails to be recognized for what it is.

**TYPES OF DELIRIUM:**

Delirium is categorized by its cause, severity, and characteristics:

- **Delirium tremens** is a severe form of the condition experienced by people who are trying to stop drinking. Usually, they've been drinking large amounts of alcohol for many years.
- **Hyperactive delirium** is characterized by being highly alert and uncooperative.
- **Hypoactive delirium** is more common. With this type, individuals tend to sleep more and become inattentive and disorganized with daily tasks. Individuals might miss meals or appointments.

- Some people have a combination of both hyperactive and hypoactive delirium (called mixed delirium), alternating between the two states.

### 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 do you understand by the term "Mixed Delirium"?

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### CAUSES:

Diseases that cause inflammation and infection, such as pneumonia, can interfere with brain function. Additionally, taking certain medications (such as blood pressure medicine) or misusing drugs can disrupt chemicals in the brain. Alcohol withdrawal and eating or drinking poisonous substances can also cause delirium. When individuals have trouble breathing due to asthma or another condition, their brain doesn't get the oxygen it needs. Any condition or factor that significantly changes individual's brain function can cause severe mental confusion.

The following factors may also contribute to delirium:

- Sleep deprivations.
- certain medications (such as sedatives, blood pressure medications, sleeping pills, and pain relievers)
- dehydration
- poor nutrition
- infections such as a urinary tract infection

### TREATMENT:

Depending on the cause of the delirium, treatment may include taking or stopping certain medications. In older adults, an accurate diagnosis is important for treatment, as delirium symptoms are similar to dementia, but the treatments are very different.

#### Medications

Doctor will prescribe medications to treat the underlying cause of individual's delirium. For example, if individual's delirium is caused by a severe asthma attack, individuals might need an inhaler or breathing machine to restore individual's breathing:

- antidepressants to relieve depression
- sedatives to ease alcohol withdrawal
- dopamine blockers to help with drug poisoning
- thiamine to help prevent confusion
- People who are extremely agitated or who have hallucinations must be prevented from injuring themselves or their caregivers.
- The environment should be as quiet and calm as possible, preferably with low lighting but not total darkness.
- Benzodiazepine drugs help relieve agitation.
- Antipsychotic drugs (haloperidol, chlorpromazine) given to people who are aggressively paranoid or severely fearful
- All psychoactive drugs should be eliminated as soon as possible.

Self – Instructional Material

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- Additional drugs should be avoided
- A patient suspected of alcohol abuse should be given thiamine 100 mg IM daily for at least 5 days, to ensure absorption.

**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 the drugs that are prescribed to individuals who are aggressively paranoid?

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## **7.4 DEMENTIAS ASSOCIATED WITH AGE**

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Dementia describes a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with individual's daily life. It isn't a specific disease, but several different diseases may cause dementia. Though dementia generally involves memory loss, memory loss has different causes. Having memory loss alone doesn't mean individuals have dementia.

Alzheimer's disease is the most common cause of a progressive dementia in older adults, but there are a number of causes of dementia. Depending on the cause, some dementia symptoms may be reversible.

### **DEMENTIA'S STAGES:**

The early stage - loss of recent memory, inability to learn and retain new information, language problems (especially word finding), mood swings, and personality changes, progressive difficulty performing activities of daily living

The intermediate stage - unable to learn and recall new information, require assistance with bathing, eating, dressing, or toileting. Wandering, agitation, hostility, uncooperativeness, or physical aggressiveness. disorientation in place and time, often hallucinations, delusions, mood disturbances.

The severe stage - unable to walk or to perform any activity of daily living and usually are totally incontinent. Recent and remote memory is completely lost. Patients may be unable to swallow and eat and are at risk of malnutrition, pneumonia (especially from aspiration), and pressure sores. Often aphasia, bulimia, apathy, sexual disinhibition, cry.

### **SYMPTOMS:**

Dementia symptoms vary depending on the cause, but common signs and symptoms include:

#### **Cognitive changes**

- Memory loss, which is usually noticed by a spouse or someone else
- Difficulty communicating or finding words
- Difficulty with visual and spatial abilities, such as getting lost while driving
- Difficulty reasoning or problem-solving
- Difficulty handling complex tasks
- Difficulty with planning and organizing

- Difficulty with coordination and motor functions
- Confusion and disorientation

### Psychological changes

- Personality changes
- Depression
- Anxiety
- Inappropriate behavior
- Paranoia
- Agitation
- Hallucinations

### CAUSES:

Dementia is caused by damage to or loss of nerve cells and their connections in the brain. Depending on the area of the brain that's affected by the damage, dementia can affect people differently and cause different symptoms. Dementias are often grouped by what they have in common, such as the protein or proteins deposited in the brain or the part of the brain that's affected. Some diseases look like dementias, such as those caused by a reaction to medications or vitamin deficiencies, and they might improve with treatment. Dementia-like symptoms can result from fever or other side effects of individual's body's attempt to fight off an infection. Multiple sclerosis and other conditions caused by the body's immune system attacking nerve cells also can cause dementia.

- **Metabolic problems and endocrine abnormalities.**
- **Nutritional deficiencies.**
- **Medication side effects.**
- **Subdural hematomas.** Bleeding between the surface of the brain and the covering over the brain, which is common in the elderly after a fall, can cause symptoms similar to those of dementia.
- **Poisoning.**
- **Brain tumors.** Rarely, dementia can result from damage caused by a brain tumor.
- **Anoxia.** This condition, also called hypoxia, occurs when organ tissues aren't getting enough oxygen. Anoxia can occur due to severe sleep apneas, asthma, heart attack, carbon monoxide poisoning or other causes.
- **Normal-pressure hydrocephalus.**

### 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 Subdural hematoma?

### PROGRESSIVE DEMENTIAS

Types of dementias that progress and aren't reversible include:

- **Alzheimer's disease.** Alzheimer's disease is the most common cause of dementia.

Although not all causes of Alzheimer's disease are known, experts do know that a small percentage are related to mutations of three genes, which can be passed down from parent to child. While

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several different genes are probably involved in Alzheimer's disease, one important gene that increases risk is apolipoprotein E4 (APOE).

Alzheimer's disease patients have plaques and tangles in their brains. Plaques are clumps of a protein called beta-amyloid, and tangles are fibrous tangles made up of tau protein. It's thought that these clumps damage healthy neurons and the fibers connecting them.

Other genetic factors might make it more likely that people will develop Alzheimer's.

- **Vascular dementia.** This second most common type of dementia is caused by damage to the vessels that supply blood to individual's brain. Blood vessel problems can cause strokes or damage the brain in other ways, such as by damaging the fibers in the white matter of the brain. The most common symptoms of vascular dementia include difficulties with problem-solving, slowed thinking, focus and organization. These tend to be more noticeable than memory loss.
- **Lewy body dementia.** Lewy bodies are abnormal balloon like clumps of protein that have been found in the brains of people with Lewy body dementia, Alzheimer's disease and Parkinson's disease. This is one of the more common types of progressive dementia. Common signs and symptoms include acting out one's dreams in sleep, seeing things that aren't there (visual hallucinations), and problems with focus and attention. Other signs include uncoordinated or slow movement, tremors, and rigidity (parkinsonism).
- **Frontotemporal dementia.** This is a group of diseases characterized by the breakdown (degeneration) of nerve cells and their connections in the frontal and temporal lobes of the brain, the areas generally associated with personality, behavior and language. Common symptoms affect behavior, personality, thinking, judgment, and language and movement.
- **Mixed dementia.** Autopsy studies of the brains of people 80 and older who had dementia indicate that many had a combination of several causes, such as Alzheimer's disease, vascular dementia and Lewy body dementia. Studies are ongoing to determine how having mixed dementia affects symptoms and treatments.

**Other disorders linked to dementia**

- **Huntington's disease.** Caused by a genetic mutation, this disease causes certain nerve cells in individual's brain and spinal cord to waste away. Signs and symptoms, including a severe decline in thinking (cognitive) skills, usually appear around age 30 or 40.
- **Traumatic brain injury (TBI).** This condition is most often caused by repetitive head trauma. People such as boxers, football players or soldiers might experience TBI.

Depending on the part of the brain that's injured, this condition can cause dementia signs and symptoms such as depression, explosiveness, memory

loss and impaired speech. TBI may also cause parkinsonism. Symptoms might not appear until years after the trauma.

- **Creutzfeldt-Jakob disease.** This rare brain disorder usually occurs in people without known risk factors. This condition might be due to deposits of infectious proteins called prions. Creutzfeldt-Jakob disease usually has no known cause but can be inherited. It may also be caused by exposure to diseased brain or nervous system tissue, such as from a cornea transplant. Signs and symptoms of this fatal condition usually appear after age 60.
- **Parkinson's disease.** Many people with Parkinson's disease eventually develop dementia symptoms (Parkinson's disease dementia).
- **Infections and immune disorders.** Dementia-like symptoms can result from fever or other side effects of individual's body's attempt to fight off an infection. Multiple sclerosis and other conditions caused by the body's immune system attacking nerve cells also can cause dementia.

#### Check your Progress – 4

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

- Compare your answer with those given at the end of the unit.
- Name the gene which increases the risk of Alzheimer's disorder.
  - Name the most common progressive form of dementia.

#### RISK FACTORS:

Many factors can eventually contribute to dementia. Some factors, such as age, can't be changed. Others can be addressed to reduce individual's risk.

#### Risk factors that can't be changed

- **Age.** The risk rises as individual's age, especially after age 65. However, dementia isn't a normal part of aging..
  - **Family history.** Having a family history of dementia puts individuals at greater risk of developing the condition. However, many people with a family history never develop symptoms, and many people without a family history do. There are tests to determine whether individuals have certain genetic mutations.
  - **Down syndrome.** By middle age, many people with Down syndrome develop early-onset Alzheimer's disease.

#### Risk factors individuals can change

Individuals might be able to control the following risk factors for dementia.

- **Diet and exercise.** Research shows that lack of exercise increases the risk of dementia. And while no specific diet is known to reduce dementia risk, research indicates a greater incidence of dementia in people who eat an unhealthy diet compared with those who follow a Mediterranean-style diet rich in produce, whole grains, nuts and seeds.
- **Heavy alcohol use.** If individuals drink large amounts of alcohol, individuals might have a higher risk of dementia. While some studies have shown that moderate amounts of alcohol might have a

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protective effect, results are inconsistent. The relationship between moderate amounts of alcohol and dementia risk isn't well-understood.

- **Cardiovascular risk factors.** These include high blood pressure (hypertension), high cholesterol, buildup of fats in individual's artery walls (atherosclerosis) and obesity.
- **Depression.** Although not yet well-understood, late-life depression might indicate the development of dementia.
- **Diabetes.** Having diabetes may increase individual's risk of dementia, especially if it's poorly controlled.
- **Smoking.** Smoking might increase individual's risk of developing dementia and blood vessel (vascular) diseases.
- **Sleep apnea.** People who snore and have episodes where they frequently stop breathing while asleep may have reversible memory loss.
- **Vitamin and nutritional deficiencies.** Low levels of vitamin D, vitamin B-6, vitamin B-12 and folate may increase individual's risk of dementia.

**PREVENTION:**

There's no sure way to prevent dementia, but there are steps individuals can take that might help. More research is needed, but it might be beneficial to do the following:

- **Keep individual's mind active.** Mentally stimulating activities, such as reading, solving puzzles and playing word games, and memory training might delay the onset of dementia and decrease its effects.
- **Be physically and socially active.**
- **Quit smoking.** Some studies have shown that smoking in middle age and beyond may increase individual's risk of dementia and blood vessel (vascular) conditions. Quitting smoking might reduce individual's risk and will improve individual's health.
- **Get enough vitamins.** Some research suggests that people with low levels of vitamin D in their blood are more likely to develop Alzheimer's disease and other forms of dementia. Individuals can get vitamin D through certain foods, supplements and sun exposure.
- More study is needed before an increase in vitamin D intake is recommended for preventing dementia, but it's a good idea to make sure individuals get adequate vitamin D. Taking a daily B-complex vitamin and vitamin C may also be helpful.
- **Manage cardiovascular risk factors.** More research is needed to determine whether treating high blood pressure may reduce the risk of dementia.
- **Treat health conditions.** See individual's doctor for treatment if individuals experience hearing loss, depression or anxiety.
- **Maintain a healthy diet.**
- **Get quality sleep.**
- Family education and support groups
- **Drug therapy for cognitive deficits:** cholinesterase inhibitors/vitamin. E

- **Drug therapy for psychosis and agitation:** haloperidol, promazine, lorazepam
- **Drugs to treat depression:** SSRI, venlafaxine, ECT
- 

#### 7.4.1 ALZHEIMER'S DISORDER

Alzheimer's disease is the most common type of neurocognitive disorder, accounting for around two-thirds of all neurocognitive cases. Alzheimer's disease sometimes appears in middle age (early onset), but in the vast majority of cases it occurs after the age of 65 (late onset), and its prevalence increases markedly among people in their late 70s and early 80's. At least 17 percent of those with Alzheimer's also experience major depressive disorder.

Alzheimer's disease is a gradually progressive disease in which memory impairment is the most prominent cognitive dysfunction (APA, 2013). Technically, sufferers receive a DSM-5 diagnosis of mild neurocognitive disorder due to Alzheimer's disease during the early and mild stages of the syndrome and major neurocognitive disorder due to Alzheimer's disease during the later, more severe stages. Alzheimer's disease is named after Alois Alzheimer, the German physician who formally identified it in 1907. Alzheimer first became aware of the syndrome in 1901 when a new patient, Auguste D., was placed under his care. Some people with Alzheimer's disease may survive for as many as 20 years, the time between the onset and death is typically 8 to 10 years. It usually begins with mild memory problems, lapses of attention, and difficulties in language and communication. As symptoms worsen, the person has trouble completing complicated tasks or remembering important appointments. Eventually sufferers also have difficulty with simple tasks, forget distant memories, and have changes in personality that often become very noticeable. For example, a gentle man may become uncharacteristically aggressive. People with Alzheimer's disease may at first deny that they have a problem, but they soon become anxious or depressed about their state of mind; many also become agitated.

As the neurocognitive symptoms intensify, people with Alzheimer's disease show less and less awareness of their limitations. They may withdraw from others during the late stages of the disorder, become more confused about time and place, wander, and show very poor judgment. Eventually they become fully dependent on other people. They may lose almost all knowledge of the past and fail to recognize the faces of even close relatives. They also become increasingly uncomfortable at night and take frequent naps during the day. During the late phases of the disorder, they require constant care. People with Alzheimer's usually remain in fairly good health until the later stages of the disease. As their mental functioning declines, however, they become less active and spend much of their time just sitting or lying in bed. This makes them prone to develop illnesses such as pneumonia, which can result in death.

In most cases, Alzheimer's disease can be diagnosed with certainty only after death, when structural changes in the person's brain, such as excessive senile plaques and neurofibrillary tangles, can be fully examined.

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Senile plaques are sphere-shaped deposits of a small molecule known as the beta-amyloid protein that form in the spaces between cells in the hippocampus, cerebral cortex, and certain other brain regions, as well as in some nearby blood vessels. The formation of plaques is a normal part of aging, but it is exceptionally high in people with Alzheimer's disease. Neurofibrillary tangles, twisted protein fibers found within the cells of the hippocampus and certain other brain areas, also occur in all people as they age, but again people with Alzheimer's disease form an extraordinary number of them. Scientists do not fully understand what role excessive numbers of plaques and tangles play in Alzheimer's disease, but they suspect they are very important. Today's leading explanations for this disease center on these plaques and tangles and on the various factors that may contribute to their formation.

**SYMPTOMS:**

Memory loss is the key symptom of Alzheimer's disease. An early sign of the disease is usually difficulty remembering recent events or conversations. As the disease progresses, memory impairments worsen and other symptoms develop. At first, a person with Alzheimer's disease may be aware of having difficulty with remembering things and organizing thoughts. Brain changes associated with Alzheimer's disease lead to growing trouble with:

**Memory**

Everyone has occasional memory lapses. It's normal to lose track of where individuals put individual's keys or forget the name of an acquaintance. But the memory loss associated with Alzheimer's disease persists and worsens, affecting the ability to function at work or at home.

People with Alzheimer's may:

- Repeat statements and questions over and over
- Forget conversations, appointments or events, and not remember them later
- Routinely misplace possessions, often putting them in illogical locations
- Get lost in familiar places
- Eventually forget the names of family members and everyday objects
- Have trouble finding the right words to identify objects, express thoughts or take part in conversations

**Thinking and reasoning**

Alzheimer's disease causes difficulty concentrating and thinking, especially about abstract concepts such as numbers. Multitasking is especially difficult, and it may be challenging to manage finances, balance checkbooks and pay bills on time. These difficulties may progress to an inability to recognize and deal with numbers.

**Making judgments and decisions**

The ability to make reasonable decisions and judgments in everyday situations will decline. For example, a person may make poor or

uncharacteristic choices in social interactions or wear clothes that are inappropriate for the weather. It may be more difficult to respond effectively to everyday problems, such as food burning on the stove or unexpected driving situations.

### **Planning and performing familiar tasks**

Once-routine activities that require sequential steps, such as planning and cooking a meal or playing a favorite game, become a struggle as the disease progresses. Eventually, people with advanced Alzheimer's may forget how to perform basic tasks such as dressing and bathing.

### **Changes in personality and behavior**

Brain changes that occur in Alzheimer's disease can affect moods and behaviors. Problems may include the following:

- Depression
- Apathy
- Social withdrawal
- Mood swings
- Distrust in others
- Irritability and aggressiveness
- Changes in sleeping habits
- Wandering
- Loss of inhibitions
- Delusions, such as believing something has been stolen

### **Preserved skills**

Many important skills are preserved for longer periods even while symptoms worsen. Preserved skills may include reading or listening to books, telling stories and reminiscing, singing, listening to music, dancing, drawing, or doing crafts.

These skills may be preserved longer because they are controlled by parts of the brain affected later in the course of the disease.

#### **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. What are the possible symptoms for Alzheimer disease?

### **CAUSAL FACTORS:**

Scientists believe that for most people, Alzheimer's disease is caused by a combination of genetic, lifestyle and environmental factors that affect the brain over time. Less than 1 percent of the time, Alzheimer's is caused by specific genetic changes that virtually guarantee a person will develop the disease. These rare occurrences usually result in disease onset in middle age. The exact causes of Alzheimer's disease aren't fully understood, but at its core are problems with brain proteins that fail to function normally, disrupt the work of brain cells (neurons) and unleash a series of toxic events. Neurons are damaged, lose connections to each other and eventually die. The damage most often starts in the region of the brain that controls memory, but the process begins years before the first symptoms.

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The loss of neurons spreads in a somewhat predictable pattern to other regions of the brains. By the late stage of the disease, the brain has shrunk significantly.

Researchers are focused on the role of two proteins:

- **Plaques.** Beta-amyloid is a leftover fragment of a larger protein. When these fragments cluster together, they appear to have a toxic effect on neurons and to disrupt cell-to-cell communication. These clusters form larger deposits called amyloid plaques, which also include other cellular debris.
- **Tangles.** Tau proteins play a part in a neuron's internal support and transport system to carry nutrients and other essential materials. In Alzheimer's disease, tau proteins change shape and organize themselves into structures called neurofibrillary tangles. The tangles disrupt the transport system and are toxic to cells.

**RISK FACTORS:**

**Age**

Increasing age is the greatest known risk factor for Alzheimer's disease. Alzheimer's is not a part of normal aging, but as individuals grow older the likelihood of developing Alzheimer's disease increases. One study, for example, found that annually there were two new diagnoses per 1,000 people ages 65 to 74, 11 new diagnoses per 1,000 people ages 75 to 84, and 37 new diagnoses per 1,000 people age 85 and older.

**Family history and genetics**

Individual's risk of developing Alzheimer's is somewhat higher if a first-degree relative — individual's parent or sibling — has the disease. Most genetic mechanisms of Alzheimer's among families remain largely unexplained, and the genetic factors are likely complex. One better understood genetic factor is a form of the apolipoprotein E gene (APOE). A variation of the gene, APOE e4, increases the risk of Alzheimer's disease, but not everyone with this variation of the gene develops the disease. Scientists have identified rare changes (mutations) in three genes that virtually guarantee a person who inherits one of them will develop Alzheimer's. But these mutations account for less than 1 percent of people with Alzheimer's disease.

**Down syndrome**

Many people with Down syndrome develop Alzheimer's disease. This is likely related to having three copies of chromosome 21 — and subsequently three copies of the gene for the protein that leads to the creation of beta-amyloid. Signs and symptoms of Alzheimer's tend to appear 10 to 20 years earlier in people with Down syndrome than they do for the general population.

**Sex**

There appears to be little difference in risk between men and women, but, overall, there are more women with the disease because they generally live longer than men.

### **Mild cognitive impairment**

Mild cognitive impairment (MCI) is a decline in memory or other thinking skills that is greater than what would be expected for a person's age, but the decline doesn't prevent a person from functioning in social or work environments. People who have MCI have a significant risk of developing dementia. When the primary MCI deficit is memory, the condition is more likely to progress to dementia due to Alzheimer's disease. A diagnosis of MCI enables the person to focus on healthy lifestyle changes, develop strategies to compensate for memory loss and schedule regular doctor appointments to monitor symptoms.

### **Post head trauma**

People who've had a severe head trauma have a greater risk of Alzheimer's disease.

### **Poor sleep patterns**

Research has shown that poor sleep patterns, such as difficulty falling asleep or staying asleep, are associated with an increased risk of Alzheimer's disease.

### **Lifestyle and heart health**

- Research has shown that the same risk factors associated with heart disease may also increase the risk of Alzheimer's disease. These include:
  - Lack of exercise
  - Obesity
  - Smoking or exposure to secondhand smoke
  - High blood pressure
  - High cholesterol
  - Poorly controlled type 2 diabetes

These factors can all be modified. Therefore, changing lifestyle habits can to some degree alter individual's risk. For example, regular exercise and a healthy low-fat diet rich in fruits and vegetables are associated with a decreased risk of developing Alzheimer's disease.

### **Lifelong learning and social engagement**

Studies have found an association between lifelong involvement in mentally and socially stimulating activities and a reduced risk of Alzheimer's disease. Low education levels — less than a high school education — appear to be a risk factor for Alzheimer's disease.

### **PREVENTION:**

Alzheimer's disease is not a preventable condition. However, a number of lifestyle risk factors for Alzheimer's can be modified. Evidence suggests that changes in diet, exercise and habits — steps to reduce the risk of cardiovascular disease — may also lower individual's risk of developing Alzheimer's disease and other disorders that cause dementia. Heart-healthy lifestyle choices that may reduce the risk of Alzheimer's include the following:

- Exercise regularly

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- Eat a diet of fresh produce, healthy oils and foods low in saturated fat
- Follow treatment guidelines to manage high blood pressure, diabetes and high cholesterol
- If individuals smoke, ask individual's doctor for help to quit smoking

Studies have shown that preserved thinking skills later in life and a reduced risk of Alzheimer's disease are associated with participating in social events, reading, dancing, playing board games, creating art, playing an instrument, and other activities that require mental and social engagement.

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## 7.5 CAUSAL FACTORS:

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There are several factors that could lead to organic mental disorder.

### **Physical or medical conditions that cause organic mental disorder:**

#### **Brain injury due to trauma**

- Bleeding within the brain (intracerebral hemorrhage)
- Bleeding into the space around the brain (subarachnoid hemorrhage)
- Blood clot inside the skull causing pressure on brain (subdural hematoma)
- Concussion

#### **Breathing conditions**

- Low oxygen in the body
- High carbon dioxide levels in the body

#### **Cardiovascular conditions**

- Stroke
- Dementia due to many strokes
- Heart infections
- Transient ischemic attack (TIA)

#### **Degenerative disorders**

- Alzheimer's disease
- Dementia
- Huntington disease
- Multiple sclerosis
- Parkinson's disease

#### **Other conditions**

- Organic amnesic syndrome: A syndrome that causes prominent impairment of recent and remote memory while immediate recall is preserved. The ability to learn new things slows down with time.
- Delirium: An acute but temporary organic cerebral syndrome that affects consciousness, attention, perception, thinking, memory, behavior, and sleep-wake schedule.
- Personality and behavioral disorders due to brain disease, damage or dysfunction.

Organic mental disorders are disturbances that may be caused by injury or disease affecting brain tissues as well as by chemical or hormonal abnormalities. Exposure to toxic materials, neurological impairment, or abnormal changes associated with aging can also cause these disorders. Alcohol or metabolic disorders, such as liver, kidney or thyroid disease or vitamin deficiencies, may be factors, too. Concussions, blood clots, or

bleeding in or around the brain from trauma may lead to organic brain syndrome. Low oxygen in the blood, high amounts of carbon dioxide in the body, strokes, brain infections, and heart infections can lead to an organic mental disorder as well. Degenerative disorders like Parkinson's disease, Alzheimer's disease, Huntington disease, and multiple sclerosis may also be contributing factors.

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## 7.6 TREATMENT:

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Blood tests, spinal taps, or an electroencephalogram may be administered to diagnose organic brain syndrome or an organic mental disorder. Imaging of the brain, like a CT scan or MRI, is also useful, depending on a doctor's suspicion. Treatments for organic mental disorders vary on what the underlying cause is. Medication may be prescribed or rehabilitation therapy may help patients recover function in the parts of the brain affected by the organic mental disorder.

It also depends on the severity of injury or type of disease that causes this condition. Temporary organic mental health disorders such as concussion may only require rest and medication. Many of the conditions are treated mainly with rehabilitation and supportive care. Treatments for improving independence include physical therapy (to aid in walking) and occupational therapy (to help relearn daily tasks). The treatment depends on which particular disorder is involved in Organic Mental Disorder, a few that are possible. Treatments can include, but are not limited to, rehabilitation therapy such as physical or occupational, pharmacological modification of the neurotransmitter function, or medication. The affected parts of the brain can recover some function with the help of different types of therapy. Online therapy can be just as intense and helpful as rehabilitation therapy, in person, and can help those affected regain function in daily life.

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## 7.7 LET US SUM UP

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An **organic mental disorder (OMD)**, also known as **organic brain syndrome** or **chronic organic brain syndrome**, is any disorder involving decreased mental function due to a medical or physical disease of the brain, rather than to psychiatric illness. An organic cause to brain dysfunction is suspected when there is no indication of a clearly defined psychiatric or "inorganic" cause, such as a mood disorder.

Delirium is a potentially reversible condition that usually comes on suddenly; the person has diminished ability to pay attention and is confused, disoriented, and unable to think clearly. Delirium is an abnormal mental state, not a disease, with a variety of symptoms. Children and older adults are most susceptible

Dementia is a chronic deterioration of intellectual function and other cognitive skills severe enough to interfere with the ability to perform activities of daily living and it is mostly a disease of the elderly. Dementia associated features are Emotional changes, disinhibition, liableness, anger,

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anxiety, depressive symptoms, Personality disturbances, Psychotic symptoms.

Alzheimer's disease is a gradually progressive disease in which memory impairment is the most prominent cognitive dysfunction.

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**7.8 UNIT-END EXERCISES:**

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1. Explain about delirium.
2. Differentiate between delirium and dementia.
3. Explain about the most common form of neurocognitive disorders.
4. What are the possible causes and treatment for the organic mental disorder?
5. What are the different types of progressive dementias and other disorders that are linked to dementia?

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**7.9 ANSWERS TO CHECK YOUR PROGRESS:**

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1. Some people have a combination of both hyperactive and hypoactive delirium (called mixed delirium), alternating between the two states.
2. Antipsychotic drugs (haloperidol, chlorpromazine) given to people who are aggressively paranoid or severely fearful.
3. Bleeding between the surface of the brain and the covering over the brain, which is common in the elderly after a fall, can cause symptoms similar to those of dementia.
4. One important gene that increases risk is apolipoprotein E4 (APOE).
5. Lewy bodies dementia.
6. Memory, thinking and reasoning, making judgements and decision making, planning and performing familiar tasks, changes in personality and behavior, preserved skills.

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**7.10 SUGGESTED READINGS**

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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* 16<sup>th</sup> 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.

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# UNIT VIII: CONVERSION AND DISSOCIATIVE DISORDER

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*Conversion and Dissociative Disorder*

## Structure

- 8.1 Introduction
- 8.2 Objectives
- 8.3 Somatoform Disorders
  - 8.3.1 Hypochondriasis
  - 8.3.2 Somatization Disorder
  - 8.3.3 Pain Disorder
  - 8.3.8 Conversion Disorder
  - 8.3.5 Body Dysmorphic Disorder
- 8.8 Dissociative Disorders
  - 8.8.1 Depersonalization Disorder
  - 8.8.2 Dissociative Amnesia
  - 8.8.3 Dissociative Identity Disorder
- 8.5 Causal Factors
  - 8.5.1 Causes of Somatoform Disorders
  - 8.5.2 Causes of Dissociative Disorders
- 8.6 Treatment and outcome of Somatoform Disorders
- 8.7 Treatment and Outcome of Dissociative Disorders
- 8.8 Let Us Sum Up
- 8.9 Unit-End Exercises
- 8.10 Answer to Check Your Progress
- 8.11 Suggested Readings

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## 8.1 INTRODUCTION

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*Somatoform disorders* are problems that appear to be medical but are actually caused by psychosocial factors. Unlike psychophysiological disorders, in which psychosocial factors interact with physical ailments, the somatoform disorders are psychological disorders hidden as physical problems.

*Dissociative disorders* are patterns of memory loss and identity change that are caused almost entirely by psychosocial factors rather than physical ones. The somatoform and dissociative disorders have much in common. Both, for example, may occur in response to severe stress, and both have traditionally been viewed as forms of escape from that stress.

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## 8.2 OBJECTIVES

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The objectives of this unit are to enable you:

- Learn the different ways in which psychological problems can be shown up as physical problems
- To understand how individuals resort to extreme forms of coping by withdrawing themselves from reality as in dissociative disorders
- To understand the causes and treatment of somatoform and dissociative disorders

*Self – Instructional Material*

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### 8.3 SOMATOFORM DISORDERS:

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When a physical ailment has no apparent medical cause, doctors may suspect a **somatoform disorder**, a pattern of physical complaints with largely psychosocial causes. People with such disorders do not consciously want or purposely produce their symptoms; they almost always believe that their problems are genuinely medical. In some somatoform disorders, known as *hysterical somatoform disorders*, there is an actual change in physical functioning. In others, the *preoccupation somatoform disorders*, people who are healthy mistakenly worry that there is something physically wrong with them.

#### SOMATIC SYMPTOM DISORDERS

The old disorders of (i) hypochondriasis (2) somatization disorder and (3) pain disorder which were diagnosed separately in DSM IV have now disappeared from DSM V. Now it is people with any one of these disorders would be diagnosed with a somatic symptom disorder. In the past, the diagnosis required that the symptoms were medically unexplained. Now, the focus is at least one of the three features: (1) disproportionate and persistent thoughts about the seriousness of one's symptoms (2) persistently high level of anxiety about health or symptoms and (3) excessive time and energy devoted to these symptoms or health concerns. Symptoms have to have persisted for at least six months.

Though technically dropped from DSM-5, individually these disorders are still important to understand.

#### 8.3.1 Hypochondriasis

People who suffer from hypochondriasis unrealistically interpret bodily symptoms as signs of a serious illness. Often their symptoms are merely normal bodily changes, such as occasional coughing, sores, or sweating. Although some patients recognize that their concerns are excessive, many do not. Hypochondriasis can present a picture very similar to that of somatization disorder. Each typically involves numerous physical symptoms and frequent visits to doctors, and each causes considerable upset. If anxiety is great and bodily symptoms are relatively minor, a diagnosis of hypochondriasis is probably in order; if the symptoms overshadow the patient's anxiety, they may indicate somatization disorder. Although hypochondriasis can begin at any age, it starts most often in early adulthood, among men and women in equal numbers.

#### 8.3.2 Somatization disorder

People with somatization disorder have many long-lasting physical ailments that have little or no organic basis. This hysterical pattern, first described by Pierre Briquet in 1859, is also known as Briquet's syndrome. To receive this diagnosis, a person must have a range of ailments, including several pain symptoms (such as headaches and chest pain), gastrointestinal symptoms (such as nausea and diarrhea), a sexual symptom (such as erectile or menstrual difficulties), and a neurological symptom (such as double vision or paralysis) (APA, 2000). People with somatization disorder usually go from doctor to doctor in search of relief. They often

describe their many symptoms in dramatic and exaggerated terms. Most also feel anxious and depressed.

A somatization disorder lasts much longer than a conversion disorder, typically for many years. The symptoms may fluctuate over time but rarely disappear completely without therapy.

### 8.3.3 Pain Disorder

When psychosocial factors play a central role in the onset, severity, or continuation of pain, patients may receive a diagnosis of pain disorder associated with psychological factors. Patients with a conversion or somatization disorder may also experience pain, but it is the key symptom in this disorder. Although the precise prevalence has not been determined, pain disorder associated with psychological factors appears to be fairly common. The disorder may begin at any age, and women seem more likely than men to experience it (APA, 2000). Often it develops after an accident or during an illness that has caused genuine pain, which then takes on a life of its own.

### 8.3.8 Conversion Disorder

In conversion disorder, a psychosocial conflict or need is converted into dramatic physical symptoms that affect voluntary motor or sensory functioning. The symptoms often seem neurological, such as paralysis, blindness, or loss of feeling (*anesthesia*), and so may be called “pseudoneurological”. Most conversion disorders begin between late childhood and young adulthood; they are diagnosed at least twice as often in women as in men. They usually appear suddenly, at times of extreme stress, and last a matter of weeks. Some research suggests that people who develop this disorder tend to be generally suggestible; many are highly susceptible to hypnotic procedures. Conversion disorders are thought to be quite rare, occurring in at most 5 of every 1,000 persons.

### 8.3.5 Body Dysmorphic Disorder

People who experience **body dysmorphic disorder**, also known as **dysmorphophobia**, become deeply concerned about some imagined or minor defect in their appearance. Most often they focus on wrinkles; spots on the skin; excessive facial hair; swelling of the face; or a misshapen nose, mouth, jaw, or eyebrow. Some worry about the appearance of their feet, hands, breasts, penis, or other body parts. Still others are concerned about bad odors coming from sweat, breath, genitals, or the rectum.

It is common to worry about appearance. Many teenagers and young adults worry about acne, for instance. The concerns of people with body dysmorphic disorder, however, are extreme. Sufferers may severely limit contact with other people, be unable to look others in the eye, or go to great lengths to conceal their “defects”—say, always wearing sunglasses to cover their supposedly misshapen eyes. As many as half of people with this disorder seek plastic surgery or dermatology treatment, and often they feel worse rather than better afterward. Many with body dysmorphic disorder are housebound and few attempt suicide. Similarly, people with this disorder are more likely than others to be unemployed and to have limited academic success.

Most cases of body dysmorphic disorder begin during adolescence. Often, however, people don't reveal their concerns for many years.

**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.

What is somatic symptom disorder?

What is Conversion Disorder?

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**8.8 DISSOCIATIVE DISORDERS:**

Most of us experience a sense of wholeness and continuity as we interact with the world. We perceive ourselves as being more than a random collection of isolated sensory experiences, feelings, and behaviors. In other words, we have an *identity*, a sense of who we are and where we fit in our environment. We recognize ourselves and have our own expectations, values, and goals. **Memory** is a key to this sense of identity, the link between our past, present, and future. Our recall of past experiences, although not always precisely accurate, helps us react to present events and guides us in making decisions about the future. We recognize our friends and relatives, teachers and employers, and respond to them in appropriate ways. People sometimes experience a major disruption of their memory, identity, or consciousness. They may, for example, lose their ability to remember new information they just learned or old information they once knew well. When such changes in memory lack a clear physical cause, they are called **dissociative disorders**. In such disorders, one part of the person's memory typically seems to be *dissociated*, or separated, from the rest.

There are several kinds of dissociative disorders. The primary symptom of *dissociative amnesia* is an inability to recall important personal events and information. A person with *dissociative fugue* not only forgets the past but also travels to a new location and may assume a new identity. Individuals with *dissociative identity disorder* (also known as *multiple personality disorder*) have two or more separate identities that may not always be aware of each other's thoughts, feelings, and behavior. Many clinicians, however, believe that they are rare.

DSM-IV-TR also lists *depersonalization disorder* as a dissociative disorder. People with this problem feel as though they have become detached from their own mental processes or body and are observing themselves from the outside. This listing is controversial because the memories and identities of people with depersonalization disorder seem to remain intact. It is their sense of self that change: their mental processes or bodies feel unreal or foreign to them.

**8.8.1 Depersonalization Disorder**

Depersonalization disorder is a dissociative disorder, its central symptom is persistent and recurrent episodes of *depersonalization*, a change in one's experience of the self in which one's

mental functioning or body feels unreal or foreign. People with depersonalization disorder feel as though they have become separated from their body and are observing themselves from outside.

Occasionally their mind seems to be floating a few feet above them—a sensation known as *doubling*. Their body parts seem foreign to them, the hands and feet smaller or bigger than usual. Many sufferers describe their emotional state as “mechanical,” “dreamlike,” or “dizzy.” Throughout the whole depersonalization experience, however, they are aware that their perceptions are distorted, and in that sense they remain in contact with reality. In some cases this sense of unreality also extends to other sensory experiences and behavior. People may, for example, experience distortions in their sense of touch or smell or their judgments of time or space, or they may feel that they have lost control over their speech or actions.

Depersonalization is often accompanied by an experience of *derealization*—the feeling that the external world, too, is unreal and strange. Objects may seem to change shape or size; other persons may seem removed, mechanical, or even dead. Depersonalization experiences by themselves do not indicate a depersonalization disorder. Transient depersonalization reactions are fairly common, while a depersonalization disorder is not. One-third of individuals who confront a life-threatening danger experience feelings of depersonalization or derealization. People sometimes have feelings of depersonalization after practicing meditation, and individuals who travel to new places often report a temporary sense of depersonalization. Young children may also experience depersonalization from time to time as they are developing their capacity for self-awareness. In most such cases, the individuals are able to compensate for the distortion and continue to function with reasonable effectiveness until the temporary episode eventually ends.

The symptoms of a depersonalization disorder, in contrast, are persistent or recurrent, cause considerable distress, and interfere with social relationships and job performance. The disorder occurs most frequently in adolescents and young adults, hardly ever in people over 80 (APA, 2000). It usually comes on suddenly, triggered by experiences such as extreme fatigue, physical pain, intense stress, anxiety, depression, or recovery from substance abuse. Survivors of traumatic experiences or people caught in life-threatening situations, such as hostages or kidnap victims, seem to be particularly vulnerable (APA, 2000). The disorder tends to be long-lasting; the symptoms may improve and even disappear for a time, only to return or intensify during times of severe stress.

Like other dissociative symptoms, feelings of depersonalization and derealization may appear in other disorders. Sufferers of panic disorder, for example, commonly experience some feelings of unreality. Similarly, people with acute and posttraumatic stress disorders often have a sense of derealization. Few theories have been offered to explain depersonalization disorder, and little research has been conducted on the problem. In recent times some investigators have used brain scan techniques, such as PET and fMRI scans, to determine whether the disorder is accompanied by particular changes in brain activity. However, clear biological factors have

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yet to emerge. Similarly, treatments for this disorder have not received much study, although a range of approaches, including psychodynamic, cognitive, hypnotic, and drug therapies, have been tried.

### 8.8.2 DISSOCIATIVE AMNESIA

People with dissociative amnesia are unable to recall important information, usually of an upsetting nature, about their lives (APA, 2000). The loss of memory is much more extensive than normal forgetting and is not caused by organic factors. Often an episode of amnesia is directly triggered by a specific upsetting event. Dissociative amnesia may be *localized*, *selective*, *generalized*, or *continuous*. Any of these kinds of amnesia can be triggered by a traumatic experience, but each represents a particular pattern of forgetting.

*Localized*, or *circumscribed*, *amnesia*, is the most common type of dissociative amnesia, in which a person loses all memory of events that took place within a limited period of time, almost always beginning with some very disturbing occurrence. The forgotten period is called the *amnestic episode*. During an amnestic episode, people may appear confused; in some cases they wander about aimlessly. They are already experiencing memory difficulties but seem unaware of them.

People with *selective amnesia*, the second most common form of dissociative amnesia, remember some, but not all, events that occurred during a period of time. In some cases the loss of memory extends back to times long before the upsetting period and cannot remember events that occurred earlier in life, which would be *generalized amnesia*.

In the forms of dissociative amnesia discussed so far, the period affected by the amnesia has an end. In *continuous amnesia*, however, forgetting continues into the present. Continuous forgetting of this kind is actually quite rare.

All of these forms of dissociative amnesia are similar in that the amnesia interferes mostly with *episodic memory*—a person's memory of personal material. *Semantic memory*—memory for abstract or encyclopedic information—usually remains. People with dissociative amnesia are as likely as anyone else to know the name of the prime minister of India and how to write, read, or drive a car.

### 8.8.3 Dissociative Identity Disorder (Multiple Personality Disorder)

Dissociative identity disorder is both dramatic and disabling. A person with **dissociative identity disorder**, or **multiple personality disorder**, develops two or more distinct personalities, often called **subpersonalities** or **alternate personalities**, each with a unique set of memories, behaviors, thoughts, and emotions. At any given time, one of the subpersonalities takes center stage and dominates the person's functioning. Usually one subpersonality, called the *primary*, or *host*, personality, appears more often than the others. The transition from one subpersonality to another, called *switching*, is usually sudden and may be dramatic (APA, 2000). Switching is usually triggered by a stressful event, although clinicians can also bring about the change with hypnotic suggestion (APA, 2000).

Many clinicians consider the disorder to be rare, but some reports suggest that it may be more common than was once thought. Most cases are first diagnosed in late adolescence or early adulthood, but, more often than not, the symptoms actually began in early childhood after episodes of abuse (often sexual abuse), perhaps even before the age of 5. Women receive this diagnosis at least three times as often as men (APA, 2000).

**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.

What is characteristic symptom of depersonalization disorder?

What are different types of dissociative amnesia?

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## **8.5 CAUSAL FACTORS**

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### **8.5.1 Causes of Somatoform Disorders**

Theorists typically explain the preoccupation somatoform disorders much as they explain anxiety disorders. Behaviorists, for example, believe that the fears found in hypochondriasis and body dysmorphic disorder are acquired through classical conditioning or modeling. Cognitive theorists suggest that people with the disorders are so sensitive to and threatened by bodily cues that they come to misinterpret them.

In contrast, the hysterical somatoform disorders—conversion, somatization, and pain disorders—are widely considered unique and in need of special explanations. The ancient Greeks believed that only women had hysterical disorders. The uterus of a sexually ungratified woman was supposed to wander throughout her body in search of fulfillment, producing a physical symptom wherever it lodged. Thus Hippocrates suggested marriage as the most effective treatment for such disorders. Work by Ambroise-Auguste Liébault and Hippolyte Bernheim in the late nineteenth century set the stage for today's prevailing opinion that psychosocial factors cause hysterical disorders. These researchers founded the Nancy School in Paris for the study and treatment of mental disorders. There they were able to produce hysterical symptoms in normal people—deafness, paralysis, blindness, and numbness—by hypnotic suggestion, and they could remove the symptoms by the same means. If hypnotic suggestion could both produce and reverse physical dysfunctioning, they concluded, hysterical disorders might themselves be caused by psychological processes.

Today's leading explanations for hysterical somatoform disorders come from the psychodynamic, behavioral, cognitive, and multicultural models. None has received much research support, however, and the disorders are still poorly understood.

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## The Psychodynamic View

Freud's theory of psychoanalysis began with his efforts to explain hysterical symptoms. Indeed, he was one of the few clinicians of his day to treat patients with these symptoms seriously, as people with genuine problems. After studying hypnosis in Paris and becoming acquainted with the work of Liébault and Bernheim, Freud became interested in the work of an older physician,

Josef Breuer (1882–1925). Breuer had successfully used hypnosis to treat a woman he called Anna O., who suffered from hysterical deafness, disorganized speech, and paralysis. Critics have since questioned whether Anna's ailments were entirely hysterical and whether Breuer's treatment helped her as much as he claimed.

But on the basis of this and similar cases, Freud (1898) came to believe that hysterical disorders represented a *conversion* of underlying emotional conflicts into physical symptoms. Observing that most of his patients with hysterical disorders were women, Freud centered his explanation of hysterical disorders on the needs of girls during their *phallic stage* (ages 3 through 5). At that time in life, he believed, all girls develop a pattern of desires called the *Electra complex*: each girl experiences sexual feelings for her father and at the same time recognize that she must compete with her mother for his affection. However, aware of her mother's more powerful position and of cultural taboos, the child typically represses her sexual feelings and rejects these early desires for her father. Freud believed that if a child's parents overreact to her sexual feelings—with strong punishments, for example—the Electra conflict will be unresolved and the child may reexperience sexual anxiety throughout her life. Whenever events trigger sexual feelings, she may experience an unconscious need to hide them from both herself and others. Freud concluded that some women hide their sexual feelings by unconsciously converting them into physical symptoms.

Most of today's psychodynamic theorists take issue with Freud's explanation of hysterical disorders, particularly his notion that the disorders can always be traced to an unresolved Electra conflict. They continue to believe, however, that sufferers of these disorders have unconscious conflicts carried forth from childhood, that the conflicts arouse anxiety, and that the individuals convert this anxiety into "more tolerable" physical symptoms (Brown et al., 2005). Consistent with these beliefs, studies have found that people with the disorders often have childhood histories of trauma, abuse, or neglect.

Psychodynamic theorists propose that two mechanisms are at work in hysterical somatoform disorders—primary gain and secondary gain. People achieve **primary gain** when their hysterical symptoms keep their internal conflicts out of awareness. During an argument, for example, a man who has underlying fears about expressing anger may develop a conversion paralysis of the arm, thus preventing his feelings of rage from reaching consciousness. People achieve **secondary gain** when their hysterical symptoms further enable them to avoid unpleasant activities or to receive sympathy from others. When, for example, a conversion paralysis allows a

soldier to avoid combat duty or conversion blindness prevents the breakup of a relationship, secondary gain may be at work.

### **The Behavioral View**

Behavioral theorists propose that the physical symptoms of hysterical disorders bring *rewards* to sufferers. Perhaps the symptoms remove the individuals from an unpleasant relationship or bring attention from other people. In response to such rewards, the sufferers learn to display the symptoms more and more prominently. Behaviorists also hold that people who are familiar with an illness will more readily adopt its physical symptoms. In fact, studies find that many sufferers develop their hysterical symptoms after they or their close relatives or friends have had similar medical problems.

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The behavioral focus on rewards is similar to the psychodynamic idea of secondary gains. The key difference is that psychodynamic theorists view the gains as indeed secondary—that is, as rewards that come only after underlying conflicts produce the disorder. Behaviorists view them as the primary cause of the development of the disorder. Like the psychodynamic explanation, the behavioral view of hysterical disorders has received little research support. Even clinical case reports only occasionally support this position. In many cases the pain and upset that surround the disorders seem to outweigh any rewards the symptoms may bring.

### **The Cognitive View**

Some cognitive theorists propose that hysterical disorders are forms of *communication*, providing a means for people to express emotions that would otherwise be difficult to convey. Like their psychodynamic colleagues, these theorists hold that the emotions of patients with hysterical disorders are being converted into physical symptoms. They suggest, however, that the purpose of the conversion is not to defend against anxiety but to communicate extreme feelings—anger, fear, depression, guilt, jealousy—in a “physical language” that is familiar and comfortable for the patient.

According to this view, people who find it particularly hard to recognize or express their emotions are candidates for a hysterical disorder. So are those who “know” the language of physical symptoms through firsthand experience with a genuine physical malady. Because children are less able to express their emotions verbally, they are particularly likely to develop physical symptoms as a form of communication. Like the other explanations, this cognitive view has not been widely tested or supported by research.

### **The Multicultural View**

The key feature of hysterical somatoform disorders is *somatization*, the development of somatic symptoms in response to personal distress. Whether somatization reaches the level of a full-blown disorder or is but an

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isolated symptom that an individual displays, it is considered inappropriate in most Western countries. Some theorists believe that this attitude reflects a bias held by Western clinicians—a bias that sees somatic symptoms as an *inferior* way of dealing with emotions. In fact, the transformation of personal distress into somatic complaints is the norm in many non-Western cultures. In such cultures, somatization is viewed as a socially and medically correct—and less stigmatizing—reaction to life’s stressors. Studies have found very high rates of somatization in non-Western medical settings throughout the world, including those in China, Japan, and Arab countries. Individuals in Latin countries seem to display the greatest number of somatic symptoms. Hence, it can be concluded that reactions to life’s stressors are often influenced by one’s culture. Overlooking this point can lead to misdiagnoses.

### A Possible Role for Biology

Although hysterical somatoform disorders are, by definition, thought to result largely from psychological and sociocultural factors, the impact of biological processes should not be overlooked. For centuries physicians have observed that patients suffering from many kinds of illnesses, from seasickness to angina, often find relief from **placebos**, substances that have no known medicinal value. Some studies have raised questions about the actual number of patients helped by placebos, but it is generally agreed that such “pretend” treatments do bring help to many people.

Theorists used to believe that placebos operated in purely psychological ways—that the power of suggestion worked almost magically upon the body. More recently, however, researchers have found that a belief or expectation can trigger certain chemicals throughout the body into action, and these chemicals then may produce a medicinal effect. The body chemicals most often implicated are *hormones* and *lymphocytes*.

Our bodies are capable of producing many substances that can heal a wide variety of illnesses, and make us feel generally healthier and more energized. When the body simply secretes these substances on its own, we have what is often termed “spontaneous healing.” Some of the time, our bodies seem slow to react, and a message from outside can serve as a wake-up call to our inner pharmacy. The placebo response can thus be seen as the reaction of our inner pharmacies to that wake-up call. If placebos can “wake up” our inner pharmacies in this way, perhaps traumatic events and related concerns or needs are doing the same thing (although in a negative way) in cases of conversion disorder, somatization disorder, or pain disorder associated with psychological factors. That is, such events and reactions may, in fact, be triggering our inner pharmacies and setting in motion the bodily symptoms of hysterical somatoform disorders.

### 8.5.2 CAUSES OF DISSOCIATIVE DISORDERS

A variety of theories have been proposed to explain dissociative disorders. Older explanations, such as those offered by psychodynamic and behavioral theorists have not received much investigation. However, newer viewpoints, which combine cognitive, behavioral, and biological principles

and highlight such factors as *state-dependent learning* and *self-hypnosis*, have captured the interest of clinical scientists.

### **The Psychodynamic View**

Psychodynamic theorists believe that dissociative disorders are caused by *repression*, the most basic ego defense mechanism: people fight off anxiety by unconsciously preventing painful memories, thoughts, or impulses from reaching awareness. Everyone uses repression to a degree, but people with dissociative disorders are thought to repress their memories excessively. In the psychodynamic view, dissociative amnesia and fugue are *single episodes* of massive repression. In each of these disorders, a person unconsciously blocks the memory of an extremely upsetting event to avoid the pain of facing it. Repressing may be their only protection from overwhelming anxiety. In contrast, dissociative identity disorder is thought to result from a *lifetime* of excessive repression. Psychodynamic theorists believe that continuous use of repression is motivated by traumatic childhood events, particularly abusive parenting.

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According to psychodynamic theorists, children who experience such traumas may come to fear the dangerous world they live in and take flight from it by pretending to be another person who is looking on safely from afar. Abused children may also come to fear the impulses that they believe are the reasons for their excessive punishments. Whenever they experience “bad” thoughts or impulses, they unconsciously try to disown and deny them by assigning them to other personalities. Most of the support for the psychodynamic position is drawn from case histories, which report such brutal childhood experiences as beatings, cuttings, burnings with cigarettes, imprisonment in closets, rape, and extensive verbal abuse. Yet some individuals with dissociative identity disorder do not seem to have experiences of abuse in their background. Moreover, child abuse appears to be far more common than dissociative identity disorder.

### **The Behavioral View**

Behaviorists believe that dissociation grows from normal memory processes such as drifting of the mind or forgetting. Specifically, they hold that dissociation is a response learned through *operant conditioning*. People who experience a horrifying event may later find temporary relief when their minds drift to other subjects. For some, this momentary forgetting, leading to a drop in anxiety, increases the likelihood of future forgetting. In short, they are reinforced for the act of forgetting and learn—without being aware that they are learning—that such acts help them escape anxiety. Thus, like psychodynamic theorists, behaviorists see dissociation as escape behavior. But behaviorists believe that a reinforcement process rather than a hardworking unconscious is keeping the individuals unaware that they are using dissociation as a means of escape. Like psychodynamic theorists, behaviorists have relied largely on case histories to support their view of dissociative disorders. Such descriptions do often support this view, but they are equally consistent with other kinds of explanations as well: a case that seems to show

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reinforcement of forgetting can usually also be interpreted as an instance of unconscious repression. In addition, the behavioral explanation fails to explain precisely how temporary and normal escapes from painful memories grow into a complex disorder or why more people do not develop dissociative disorders.

**State-Dependent Learning** If people learn something when they are in a particular situation or state of mind, they are likely to remember it best when they are again in that same condition. If they are given a learning task while under the influence of alcohol, for example, their later recall of the information may be strongest under the influence of alcohol. Similarly, if they smoke cigarettes while learning, they may later have better recall when they are again smoking. This link between state and recall is called **state-dependent learning**. One possibility for state-dependent learning is that *arousal* levels are an important part of learning and memory. That is, a particular level of arousal will have a set of remembered events, thoughts, and skills attached to it. When a situation produces that particular level of arousal, the person is more likely to recall the memories linked to it. Although people may remember certain events better in some arousal states than in others, most can recall events under a variety of states. However, perhaps people who are prone to develop dissociative disorders have state-to-memory links that are unusually rigid and narrow. Maybe each of their thoughts, memories, and skills is tied *exclusively* to a particular state of arousal, so that they recall a given event only when they experience an arousal state almost identical to the state in which the memory was first acquired. When such people are calm, for example, they may forget what occurred during stressful times, thus laying the groundwork for dissociative amnesia or fugue. Similarly, in dissociative identity disorder, different arousal levels may produce entirely different groups of memories, thoughts, and abilities—that is, different subpersonalities. This could explain why personality transitions in dissociative identity disorder tend to be sudden and stress-related.

**Self-Hypnosis** People who are *hypnotized* enter a sleeplike state in which they become very suggestible. While in this state, they can behave, perceive, and think in ways that would ordinarily seem impossible. They may, for example, become temporarily blind, deaf, or insensitive to pain. Hypnosis can also help people remember events that occurred and were forgotten years ago, a capability used by many psychotherapists. Conversely, it can make people forget facts, events, and even their personal identities—an effect called *hypnotic amnesia*. Most studies of hypnotic amnesia follow similar formats. Participants are asked to study a word list or other material until they are able to repeat it correctly. Under hypnosis, they are then directed to forget the material until they receive a *cancellation signal* (such as the snap of a finger), at which time they will suddenly recall the learned material. Repeatedly these experiments have found the participants' memories to be poor during the period of hypnotic amnesia and then restored after the cancellation signal is given.

The parallels between hypnotic amnesia and dissociative disorders are striking. Both are conditions in which people forget certain material for a period of time yet later remember it. And in both, the people forget without

any insight into why they are forgetting or any awareness that something is being forgotten. These parallels have led some theorists to conclude that dissociative disorders may be a form of **self-hypnosis** in which people hypnotize themselves to forget unpleasant events. Dissociative amnesia may occur, for example, in people who, consciously or unconsciously, hypnotize themselves into forgetting horrifying experiences that have recently occurred in their lives. If the self-induced amnesia covers all memories of a person's past and identity, that person may undergo a dissociative fugue. Self-hypnosis might also be used to explain dissociative identity disorder. On the basis of several investigations, some theorists believe that this disorder often begins between the ages of 8 and 6, a time when children are generally very suggestible and excellent hypnotic subjects. These theorists argue that some children who experience abuse or other horrifying events manage to escape their threatening world by self-hypnosis, mentally separating themselves from their bodies and fulfilling their wish to become some other person or persons.

There are different schools of thought about the nature of hypnosis. Some theorists see hypnosis as a *special process*, an out-of-the-ordinary kind of functioning. Accordingly, these theorists contend that people with dissociative disorders place themselves in internal trances during which their conscious functioning is significantly altered. Other theorists believe that hypnotic behaviors, and hypnotic amnesia in particular, are produced by *common social and cognitive processes*, such as high motivation, focused attention, role enactment, and self-fulfilling expectations. According to this point of view, hypnotized people are simply highly motivated individuals performing tasks that are asked of them, while believing all along that the hypnotic state is doing the work for them. Common-process theorists holds that people with dissociative disorders provide themselves (or are provided by others) with powerful suggestions to forget and that social and cognitive mechanisms then put the suggestions into practice. Hypnosis research effectively demonstrates the power of our normal thought processes, and so renders the notion of dissociative disorders somewhat less remarkable.

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## 8.6 TREATMENT AND OUTCOME OF SOMATOFORM DISORDERS

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People with somatoform disorders usually seek psychotherapy only as a last resort. They fully believe that their problems are medical and at first reject all suggestions to the contrary. When a physician tells them that their problems have no physical basis, they often go to another physician. Eventually, however, many patients with these disorders do consent to psychotherapy, psychotropic drug therapy, or both.

Individuals with preoccupation somatoform disorders—hypochondriasis and body dysmorphic disorder—typically receive the kinds of treatment that are applied to anxiety disorders, particularly obsessive-compulsive disorder. Studies reveal, for example, that patients with either of the preoccupation disorders often improve considerably when treated with the same *antidepressant drugs* that are helpful in cases of obsessive-compulsive disorder. *Exposure and response prevention* a behavioral

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approach used to treat obsessive-compulsive disorder is being successfully combined with a cognitive approach that also helps clients with body dysmorphic disorder identify, test, and change their distorted thoughts about their appearance and social impact. Cognitive-behavioral therapies of this kind are also being applied to cases of hypochondriasis. Here, therapists repeatedly highlight bodily variations to clients while, at the same time, preventing them from seeking their usual medical attention. In addition, the therapists guide the clients to identify and change the illness-related cognitions that are helping to maintain their disorder.

Treatments for hysterical somatoform disorders—conversion, somatization, and pain disorders—often focus on the *cause* of the disorder (the trauma or anxiety behind the physical symptoms) and apply the same kinds of techniques used in cases of posttraumatic stress disorder, particularly insight, exposure, and drug therapies. Psychodynamic therapists, for example, try to help individuals with hysterical disorders become conscious of and resolve their underlying fears, thus eliminating the need to convert anxiety into physical symptoms. Alternatively, behavioral therapists use exposure treatments: they expose clients to features of the horrific events that first triggered their physical symptoms, expecting that the individuals will become less anxious over the course of repeated exposures and, in turn, more able to face those upsetting events directly rather than through physical channels. And biological therapists use antianxiety drugs or certain antidepressant drugs to help reduce the anxiety of clients with hysterical disorders.

Other therapists try to address the *physical symptoms* of the hysterical disorders rather than the causes, applying techniques such as *suggestion*, *reinforcement*, or *confrontation* (Yutzy, 2007). Those who employ *suggestion* offer emotional support to patients and tell them persuasively that their physical symptoms will soon disappear, or they suggest the same thing to them under hypnosis. Therapists who take a *reinforcement* approach arrange the removal of rewards for a client's "sick" behaviors and an increase of rewards for healthy behaviors. And therapists who take a *confrontational* approach try to force patients out of the sick role by straightforwardly telling them that their symptoms are without medical basis.

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## 8.7 TREATMENT AND OUTCOME OF DISSOCIATIVE DISORDERS

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People with dissociative amnesia and fugue often recover on their own. Only sometimes do their memory problems linger and require treatment. In contrast, people with dissociative identity disorder usually require treatment to regain their lost memories and develop an integrated personality. Treatments for dissociative amnesia and fugue tend to be more successful than those for dissociative identity disorder, probably because the former disorders are less complex.

### **Dissociative Amnesia and Fugue**

The leading treatments for dissociative amnesia and fugue are *psychodynamic therapy*, *hypnotic therapy*, and *drug therapy*.

Psychodynamic therapists guide patients with these disorders to search their unconscious in the hope of bringing forgotten experiences back to consciousness. The focus of psychodynamic therapy seems particularly well suited to the needs of people with these disorders. After all, the patients need to recover lost memories, and the general approach of psychodynamic therapists is to try to uncover memories—as well as other psychological processes—that have been repressed. Thus many theorists, including some who do not ordinarily favor psychodynamic approaches, believe that psychodynamic therapy may be the most appropriate treatment for these disorders.

Another common treatment for dissociative amnesia and fugue is **hypnotic therapy**, or **hypnotherapy**. Therapists hypnotize patients and then guide them to recall forgotten events. Experiments have repeatedly indicated that hypnotic suggestion can help elicit forgotten memories, and experience has shown that people with dissociative disorders are usually highly susceptible to hypnosis. Given the possibility that dissociative amnesia and fugue may each be a form of self-hypnosis, hypnotherapy may be a particularly useful intervention. It has been applied both alone and in combination with other approaches.

Sometimes intravenous injections of barbiturates such as *sodium amobarbital* (Amytal) or *sodium pentobarbital* (Pentothal) are used to help patients with dissociative amnesia and fugue regain lost memories. These drugs are often called “truth serums,” but the key to their success is their ability to sedate people and free their inhibitions, thus helping them to recall anxiety-producing events (Fraser, 1993; Kluft, 1988). These drugs do not always work, however, and if used at all, they are likely to be combined with other treatment approaches.

### **Dissociative Identity Disorder**

Unlike victims of amnesia and fugue, people with dissociative identity disorder do not typically recover without treatment. Treatment for this pattern is complex and difficult, much like the disorder itself. Therapists usually try to help the clients (1) recognize fully the nature of their disorder, (2) recover the gaps in their memory, and (3) integrate their subpersonalities into one functional personality.

Once a diagnosis of dissociative identity disorder is made, therapists typically try to bond with the primary personality and with each of the subpersonalities. As bonds are formed, therapists try to educate patients and help them to recognize fully the nature of their disorder. Some therapists actually introduce the subpersonalities to one another under hypnosis, and some have patients look at videotapes of their other personalities. Many therapists have also found that group therapy helps to educate patients. Being with a group of people who all have multiple personalities helps relieve a person’s feelings of isolation. Family therapy may also be used to help educate spouses and children about the disorder and to gather helpful information about the patient.

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To help patients recover the missing pieces of their past, therapists use many of the approaches applied in other dissociative disorders, including psychodynamic therapy, hypnotherapy, and drug treatment. These techniques work slowly for patients with dissociative identity disorder, as some subpersonalities may keep denying experiences that the others recall. One of the subpersonalities may even assume a “protector” role to prevent the primary personality from suffering the pain of recollecting traumatic experiences. Some patients become self-destructive and violent during this phase of treatment.

The final goal of therapy is to merge the different subpersonalities into a single, integrated identity. Integration is a continuous process that occurs throughout treatment until patients “own” all of their behaviors, emotions, sensations, and knowledge. **Fusion** is the final merging of two or more subpersonalities. Many patients distrust this final treatment goal, and their subpersonalities are likely to see integration as a form of death. Therapists have used a range of approaches to help merge subpersonalities, including psychodynamic, supportive, cognitive, and drug therapies.

Once the subpersonalities are integrated, further therapy is typically needed to maintain the complete personality and to teach social and coping skills that may help prevent later dissociations. In case reports, some therapists note high success rates, but others find that patients continue to resist full and final integration. A few therapists have in fact questioned the need for full integration. The limited number of reported cases generally prevents researchers from gathering samples that are large enough to conduct enlightening research on the treatment of this disorder.

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## 8.8 LET US SUM UP

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Somatic symptom disorders lie at the interface of abnormal psychology and medicine. These are disorders in which psychological problems are manifested in physical symptoms. In response to the symptoms the person also experiences abnormal thoughts, feelings and behaviours. Dissociative disorders occur when the processes that normally regulates awareness and the multichannel capacities of the mind apparently become disorganized, leading to various anomalies of consciousness and personal identity.

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## 8.9 UNIT-END EXERCISES

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1. Write a note on somatoform disorders.
2. Explain the different types of dissociative amnesia.
3. Discuss the causes and treatment of somatoform disorders.
8. Discuss the causes and treatment of dissociative disorders.

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## 8.10 ANSWER TO CHECK YOUR PROGRESS

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1. Somatic symptom disorders are disorders in which psychological problems are manifested in physical symptoms. In response to the symptoms the person also experiences abnormal thoughts, feelings and behaviours.
2. In conversion disorder, a psychosocial conflict or need is converted into dramatic physical symptoms that affect voluntary motor or sensory

functioning. The symptoms often seem neurological, such as paralysis, blindness, or loss of feeling (*anesthesia*), and so may be called “pseudoneurological”.

3. Characteristic symptom of depersonalization disorder is persistent and recurrent episodes of *depersonalization*, a change in one’s experience of the self in which one’s mental functioning or body feels unreal or foreign. People with depersonalization disorder feel as though they have become separated from their body and are observing themselves from outside.

8. Localized, selective, generalized, or continuous are different types of dissociative amnesia.

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### **8.11 SUGGESTED READINGS**

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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<sup>th</sup> Edn). New Delhi: Prentice Hall of India Pvt Ltd.

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## BLOCK III: SYSTEMS IN PSYCHOPATHOLOGY

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### UNIT IX: PSYCHOLOGICAL MODELS OF PSYCHOPATHOLOGY

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#### Structure

- 9.1 Introduction
- 9.2 Objectives
- 9.3 Biological
- 9.4 Psychodynamic
- 9.5 Behavioral
- 9.6 Cognitive Behavioral
- 9.7 Let us sum up
- 9.8 Unit-End Exercises
- 9.9 Answers to Check your Progress
- 9.10 Suggested Readings

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#### 9.1 INTRODUCTION

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The various systems in psychopathology strives to explain the different causal factors for abnormal behaviour and tries to find ways of treating them based on the root of the disorder. This unit discusses the biological, psychodynamic, behavioural and cognitive-behavioural perspectives in detail.

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#### 9.2 OBJECTIVES

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On successful completion of this unit, you will be able to:

- Identify the causes of abnormal behaviour arising from biological factors
- Understand the psychodynamic perspective
- Explain the behavioural viewpoint of abnormal behavior

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#### 9.3 BIOLOGICAL MODEL

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Adopting a medical perspective, biological theorists view abnormal behavior as an illness brought about by malfunctioning parts of the organism. Typically, they point to a malfunctioning brain as the cause of abnormal behavior, focusing particularly on problems in brain anatomy or brain chemistry (Lambert & Kinsley, 2005).

**Brain Anatomy and Abnormal Behavior** The brain is made up of approximately 100 billion nerve cells, called **neurons**, and thousands of billions of support cells, called *glia* (from the Greek meaning “glue”). Within the brain large groups of neurons form distinct areas, or *brain regions*. At the bottom of the brain is the *hindbrain*, which is in turn made up of regions called the *medulla*, *pons*, and *cerebellum*. In the middle of the brain is the *midbrain*. And at the top is the *forebrain*, which consists of

regions called the *cerebrum* (the two cerebral hemispheres), the *thalamus*, and the *hypothalamus*, each in turn made up of further small regions. The cerebrum, for instance, includes structures such as the *cortex*, *corpus callosum*, *basal ganglia*, *hippocampus*, and *amygdala*. The neurons in each of these brain regions control important functions. The cortex is the outer layer of the brain; the corpus callosum connects the two cerebral hemispheres; the basal ganglia plays a crucial role in planning and producing movement; the hippocampus helps control emotions and memory; and the amygdala plays a key role in emotional memory.

Clinical researchers have discovered connections between certain psychological disorders and problems in specific areas of the brain. One such disorder is *Huntington's disease*, a disorder marked by violent emotional outbursts, memory loss, suicidal thinking, involuntary body movements, and absurd beliefs. This disease has been traced to a loss of cells in the basal ganglia.

**Brain Chemistry and Abnormal Behavior** Biological researchers have also learned that psychological disorders can be related to problems in the transmission of messages between neurons. Information is communicated throughout the brain in the form of electrical impulses that travel from one neuron to one or more others. An impulse is first received by a neuron's *dendrites*, antenna-like extensions located at one end of the neuron. From there it travels through the neuron's body and down the neuron's *axon*, a long fiber extending from the neuron's body. Finally, it is transmitted through the nerve ending at the end of the axon to the dendrites of other neurons.

The neurons do not actually touch each other. There is a tiny space, called the **synapse**, that separates one neuron from the next, and the message must somehow traverse that space. When an electrical impulse reaches the end of a neuron's axon, the ending is stimulated to release a chemical, called a **neurotransmitter**, that travels across the synaptic space to **receptors** on the dendrites of the neighboring neurons. After binding to the receiving neuron's receptors, some neurotransmitters tell the receiving neurons to "fire," that is, to trigger their own electrical impulse. Other neurotransmitters carry an inhibitory message; they tell receiving neurons to stop all firing. Clearly, neurotransmitters play a key role in moving information through the brain.

Dozens of neurotransmitters have been identified in the brain, and they have learned that each neuron uses only certain kinds. Studies indicate that abnormal activity by certain neurotransmitters can lead to specific mental disorders. Certain anxiety disorders, for example, have been linked to low activity of the neurotransmitter *gamma-aminobutyric acid (GABA)*, schizophrenia has been linked to excessive activity of the neurotransmitter *dopamine*, and depression has been linked to low activity of the neurotransmitters *serotonin* and *norepinephrine*.

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In addition to neurons and neurotransmitters, mental disorders are sometimes related to abnormal chemical activity in the body's *endocrine system*. Endocrine glands, located throughout the body, work along with neurons to control such vital activities as growth, reproduction, sexual activity, heart rate, body temperature, energy, and responses to stress. The endocrine glands release chemicals called **hormones** into the bloodstream, and these chemicals then boost body organs into action. During times of stress, for example, the *adrenal glands*, located on top of the kidneys, secrete the hormone *cortisol*. Abnormal secretions of this chemical have been tied to anxiety and mood disorders.

### Sources of Biological Abnormalities

Three factors - *genetics*, *evolution*, and *viral infections* explain why some people have brain structures or biochemical activities that differ from the norm

### Genetics and abnormal behavior

Abnormalities in brain anatomy or chemistry are sometimes the result of genetic inheritance. Each cell in the human brain and body contains 23 pairs of *chromosomes*, with each chromosome in a pair inherited from one of the person's parents. Every chromosome contains numerous **genes**—segments that control the characteristics and traits a person inherits. Scientists have known for years that genes help determine such physical characteristics as hair color, height, and eyesight. Genes can make people more prone to heart disease, cancer, or diabetes, and perhaps to possessing artistic or musical skill. Studies suggest that inheritance also plays a part in mood disorders, schizophrenia, Alzheimer's disease, and other mental disorders.

Yet, with few exceptions, researchers have not been able to identify the specific genes, nor the extent to which genetic factors contribute to various mental disorders. It appears that in most cases several genes combine to help produce our actions and reactions, both functional and dysfunctional. In the *Human Genome Project* in 2000, scientists used the tools of molecular biology to *map*, or *sequence*, all of the genes in the human body in great detail. With this information in hand, researchers hope eventually to be able to prevent or change genes that help cause medical or psychological disorders.

### Evolution and abnormal behavior

An abnormal condition may occur by genetic mutation. *Mutation*, is an abnormal form of the appropriate gene that emerges by accident. In general, evolutionary theorists argue that human reactions and the genes responsible for them have survived over the course of time because they have helped individuals to thrive and adapt. Ancestors who had the ability to run fast, for example, or to hide were most able to escape their enemies and to reproduce. Thus, the genes responsible for effective walking, running, or problem solving were particularly likely to be passed on from generation to generation to the present day.

The evolutionary position with regard to abnormal functioning follows a similar logic. According to evolutionary theorists, the capacity to experience fear was, and in many instances still is, adaptive. Fear alerted

individuals to dangers, threats, and losses, so that persons could avoid or escape potential problems. People who were particularly sensitive to danger—those with greater fear responses—were more likely to survive catastrophes, battles, and the like and to reproduce, and so to pass on their fear genes.

In today's world, pressures are more numerous, subtle, and complex than they were in the past, condemning many individuals with such genes to a near-endless stream of fear and arousal. That is, the very genes that helped their ancestors to survive and reproduce might now leave these individuals particularly prone to fear reactions and anxiety disorders. Today's evolutionary theorists are interested in a combination of variables—adaptive behaviors of the past, genes, and the interaction between genes and current environmental events.

### **Viral infections and abnormal behavior**

Another possible source of abnormal brain structure or biochemical dysfunctioning is *viral infections*. For example, research suggests that *schizophrenia*, a disorder marked by delusions, hallucinations, or other departures from reality, may be related to exposure to certain viruses during childhood or *in utero*, before birth. Studies have found that the mothers of many individuals with this disorder contracted influenza or related viruses during their pregnancy. This and related pieces of circumstantial evidence suggest that a damaging virus may enter the fetus's brain and remain dormant there until the individual reaches puberty or young adulthood. At that time, activated by hormone changes or by another infection, the virus may produce the symptoms of schizophrenia.

### **Biological Treatments**

The three leading kinds of biological treatments used today are *drug therapy*, *electroconvulsive therapy*, and *neurosurgery*. Drug therapy is by far the most common of these approaches. In the 1950s, researchers discovered several effective **psychotropic medications**, drugs that mainly affect emotions and thought processes. These drugs have greatly changed the outlook for a number of mental disorders and today are used widely, but also have produced some major problems. Many people believe, for example, that the drugs are overused. Moreover, while drugs are effective in many cases, they do not help everyone.

Four major psychotropic drug groups are used in therapy: antianxiety, antidepressant, antibipolar, and antipsychotic drugs. **Antianxiety drugs**, also called **minor tranquilizers** or **anxiolytics**, help reduce tension and anxiety. **Antidepressant drugs** help improve the mood of people who are depressed. **Antibipolar drugs**, also called **mood stabilizers**, help stabilize the moods of those with a bipolar disorder, a condition marked by mood swings from mania to depression. **Antipsychotic drugs** help reduce the confusion, hallucinations, and delusions of *psychotic disorders*, disorders marked by a loss of contact with reality.

The second form of biological treatment, used primarily on depressed patients, is **electroconvulsive therapy (ECT)**. A third form of biological treatment is **neurosurgery**, or **psychosurgery**, brain surgery for mental disorders. They are used only after certain severe disorders have continued for years without responding to any other form of treatment.

### **Assessing the Biological Model**

Today the biological model enjoys considerable respect. Biological research constantly produces valuable new information. And biological treatments often bring great relief when other approaches have failed. At the same time, this model has its shortcomings. Some of its proponents seem to expect that all human behavior can be explained in biological terms and treated with biological methods. This view can limit rather than enhance our understanding of abnormal functioning. Our mental life is an interplay of biological and nonbiological factors, and it is important to understand that interplay rather than to focus on biological variables alone.

A second shortcoming is that much of the evidence for biological explanations is incomplete or inconclusive. Many brain studies, for example, are conducted on animals in whom symptoms of depression, anxiety, or some other abnormality have been produced by drugs, surgery, or experimental manipulation. Researchers can never be certain that the animals are experiencing the human disorder under investigation. Finally, several of today's biological treatments are capable of producing significant undesirable effects. Certain antipsychotic drugs, for example, may produce movement problems such as severe shaking, bizarre-looking contractions of the face and body, and extreme restlessness. Clearly such costs must be addressed and weighed against the drug's benefits.

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## **9.4 PSYCHODYNAMIC MODEL**

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In examining the psychologically based vulnerabilities for abnormal behaviour, there are three primary perspectives that have developed since the end of the nineteenth century: psychodynamic, behavioural, and cognitive behavioural.

The psychological perspective emphasizes the role of basic psychological processes in the occurrence of mental disorders. The oldest psychological viewpoint on abnormal behaviour is Freudian psychoanalytic theory. For many years this view was preoccupied with questions about libidinal energies and their suppression. More recently, second-generation psychodynamic theories departed in significant ways from Freud's original ideas. Anna Freud's Ego psychology focused on the important role of the ego in normal and abnormal behaviour, with special attention focused on ego-defense reactions. Object-relations theorists focused on the role of the quality of very early (pre-Oedipal) mother-infant relationships for normal development. The originators of the interpersonal perspective took exception to the Freudian emphasis on the internal determinants of motivation and behaviour and instead emphasized the social and cultural forces that shape behaviour. Psychoanalysis and closely related therapeutic approaches are termed psychodynamic in recognition of their attention to inner, often unconscious forces.

The sociocultural viewpoint is concerned with the contribution of sociocultural variables to mental disorder. Social variables such as poverty, unemployment, inferior education, and prejudice are potential causes for at least some mental disorders. In other words, the sociocultural perspective emphasizes the fact that external factors such as negative environments, a disadvantaged position in society, and cultural traditions can play a role in mental disorders.

A modern perspective on mental disorders is the diathesis-stress model. This view suggests that mental disorders result from the joint effects of two influences: (1) a predisposition for a given disorder, termed a diathesis, and (2) stressors in an individual's environment that tend to activate or stimulate the predisposition or vulnerability. This model suggests that for various reasons – genetic factors, early traumatic experiences, specific personality traits – individuals show varying degrees of vulnerability to specific mental disorders. Whether and to what extent an individual actually experiences such a disorder, however, depends on the environment in which the person lives. If the environment is favorable, the vulnerability (diathesis) may never be activated, and the person may never experience a mental disorder. If environmental factors are unfavourable, the diathesis may be activated, and one or more mental disorders may result.

Another new perspective, developmental psychopathology perspective emphasize the fact that problems that first appear during childhood or adolescence often are linked to and serve as precursors for disorders that occur later in life.

### **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 biological causal factors of abnormal behaviour?
2. What are the psychological causal factors behind abnormal behaviour?

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## **9.5 BEHAVIOURAL MODEL**

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The behavioural perspective focuses on the role of learning in human behaviour and attributes maladaptive behaviour either to a failure to learn appropriate behaviours or to the learning of maladaptive behaviours. The primary forms of learning studied are classical conditioning and instrumental (operant) learning. The effects of each are modified by principles of generalization and discrimination. Observational learning is also important. Those who adopt behavioural approach attempt to alter maladaptive behaviour by extinguishing it or providing training in new, more adaptive behaviours.

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## **9.6 COGNITIVE BEHAVIOURAL**

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The cognitive –behavioural viewpoint attempts to incorporate the complexities of human cognition, and how it can become distorted, into an understanding of the causes of psychopathology. People's schemas and

self-schemas play a central role in the way they process information, in how they attribute outcomes to causes, and in their values. The efficiency, accuracy, and coherence of a person's schemas and attributions appear to provide an important protection against breakdown. Treatments developed from the cognitive-behavioural perspective attempt to alter maladaptive thinking and improve a person's abilities to solve problems and to achieve goals.

### 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 are the behavioural factors that cause abnormal behaviour?

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## 9.7 LET US SUM UP

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Though various models stress on various factors, the understanding of different models enables us to view psychopathology from a holistic perspective. This also enables treatment of abnormal behaviour also to be more comprehensive

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## 9.8 UNIT-END EXERCISES

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1. Describe the biological model of abnormal behaviour.
2. What psychological factors cause abnormal behaviour?
3. Write a note on behavioural and cognitive behavioural model.

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## 9.9 ANSWERS TO CHECK YOUR PROGRESS

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1. Genetic vulnerabilities, temperament, neurotransmitter and hormonal abnormalities, brain dysfunction and neural plasticity.
2. Early social deprivation, severe emotional trauma, inadequate parenting styles, marital discord, divorce, and maladaptive peer relationships
3. Failure to learn appropriate behaviours or to the learning of maladaptive behaviours.

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## 9.10 SUGGESTED READINGS

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1. Butcher, J.N. (2014). *Abnormal Psychology*. New Delhi: Pearson Education.
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# UNIT 10: PSYCHOTIC DISORDER

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## Structure

- 10.1 Introduction
- 10.2 Objectives
- 10.3 Symptoms
- 10.4 Types
- 10.5 Etiology
- 10.6 Treatment
- 10.7 Schizophrenia and delusional disorder
- 10.8 Let us sum up
- 10.9 Unit-End Exercises
- 10.10 Answers to Check your Progress
- 10.11 Suggested Readings

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## 10.1 INTRODUCTION

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Psychotic disorders are mental disorders that can cause abnormal thinking and one's ability to perceive normally. Many who experience psychoses lose touch with reality and are unable to cope with the outside world.

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## 10.2 OBJECTIVES

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The objectives of this unit are to:

- Bring out an understanding of psychotic disorders
- Explain schizophrenia and delusional disorder
- Describe the causes and treatment of psychotic disorders

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## 10.3 SYMPTOMS

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Some of the major symptoms associated with psychotic disorders include: delusions, hallucinations, incoherent or disorganized speech, tangentially, loose associations or derailment, preservation, alogia, avolition, bizarre behavior, and/or disorganized behavior. There are two types of symptoms that coincide with schizophrenia; positive and negative symptoms. Positive symptoms include delusions, hallucinations, disorganized speech, and disorganized or catatonic behavior. Negative symptoms are those who experience the flat affect, alogia, and avolition.

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## 10.4 TYPES

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There are several types of psychotic disorders but one which is reported frequently is schizophrenia. Schizophrenia affects people from all walks of life; and is about as prevalent as epilepsy. This psychotic disorder usually begins in late adolescence or early adulthood. Schizoaffective disorder is a disorder, that when diagnosed, an individual demonstrates symptoms of both Schizophrenia and a severe mood disorder: bipolar or unipolar. Another example of schizophrenia is Schizophreniform disorder. This disorder can last up to six months. The individual may experience social and occupational impairment during the episodes and a brief psychotic disorder. If the symptoms of brief psychotic disorder last for a month or longer, they will turn into one of the other disorders previously listed.

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## 10.5 ETIOLOGY

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The exact cause of psychotic disorders is not known. Psychotic disorders associated with mental illnesses such as schizophrenia, depression and bipolar disorder are thought to arise by a combination of genetic, biochemical and environmental factors. Alcohol and other drug abuse can also cause psychotic disorders.

**Hereditary Cause of Psychotic Disorders:** There is a great deal of argument and discussion going on regarding the causes of psychotic disorders. There are many factors that might lead to psychotic disorders. Some doctors believe that psychotic disorders are genetically endowed, which means that these are passed on from one generation to the other in a family. According to this theory, psychotic disorders are heritable factors that run in the blood of the patient.

**Psychotic Disorders Caused Due To Lesions In The Brain Centers:** Psychotic disorders are mainly caused because of some abrasion or lesions in the brain centers controlling thinking, learning and perception. Any injury or harm to these areas of the brain is particularly dangerous, as these functions are very important to carry on with our day to day activities. In case of schizophrenia, it has been found through research that this psychotic disorder lies particularly in the nerve cell receptors. Nerve cell receptors that particularly work in association with a brain chemical called glutamate stops to work and this causes a problem in the functions of learning and memory causing this psychotic disorder known as schizophrenia.

**Other Causes of Psychotic Disorders:** Others are of the opinion that psychotic disorders are caused by other things that have an effect during the developmental phase of a human being. Other such leading causes are excessive drug abuse, stress, strain and major life changes.

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## 10.6 TREATMENT

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Psychotic disorders are generally treated with the help of a combination of medications as well a type of counseling which is known as psychotherapy.

**Medications for Treating Psychotic Disorders:** The types of drugs that are most generally prescribed by psychiatrist for treating psychotic disorders are called “antipsychotics.” These drugs cannot absolutely “cure” the psychotic disorder, but they most definitely can help to manage the most troubling symptoms of the psychotic disorders like delusions, hallucinations, lack of judgment and thinking problems.

Some of the older antipsychotic drugs include: Chlorpromazine, fluphenazine, haloperidol, loxapine, perphenazine and thioridazine.

The newer “atypical antipsychotics” include: Aripiprazole, Brexpiprazole, Clozapine, Iloperidone, Lurasidone, Paliperidone, Asenapine, Cariprazine, Quetiapine, Ziprasidone, Olanzapine and Risperidone.

Usually doctors prescribe the newer varieties of antipsychotics first, as they have more bearable side effects. The older varieties of antipsychotics cause side effects that were too much to tolerate. Some of these antipsychotic medications are administered via injections and they need to be taken only once or twice a month. Antipsychotic injections are

definitely a better option, as patients of psychotic disorders often make it very difficult to administer antipsychotic pills.

**Psychotherapy for Treating Psychotic Disorders:** Psychotherapy or counseling can be approached in many different ways, individual, family or group counseling. All of these counseling sessions are done to make the patient feel more connected to the reality. Most people who are dealing with psychotic disorders are not institutionalized. However, if the patients start having outrageous symptoms, they may need to be hospitalized.

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## **10.7 SCHIZOPHRENIA AND DELUSIONAL DISORDER**

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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.

### **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

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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 daily 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 striking 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.

What are the symptoms of schizophrenia?  
What is delusion? How is it different from illusion?

## 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.**

### 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.

### 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.

### 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.

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**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.

**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*. People 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 of 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.

**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.

Why are subtypes of schizophrenia not included in DSM V?

What is catatonia?

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Delusional disorder, previously called paranoid disorder, is a type of serious mental illness called a psychotic disorder. People who have it can't tell what's real from what is imagined. Delusions are the main symptom of delusional disorder. They're unshakable beliefs in something that isn't true or based on reality. But that doesn't mean they're completely unrealistic. Delusional disorder involves delusions that aren't bizarre, having to do with situations that could happen in real life, like being followed, poisoned, deceived, conspired against, or loved from a distance. These delusions usually involve mistaken perceptions or experiences. But in reality, the situations are either not true at all or highly exaggerated.

A bizarre delusion, by contrast, is something that could never happen in real life, such as being cloned by aliens or having your thoughts broadcast on TV. A person who has such thoughts might be considered delusional with bizarre-type delusions.

People with delusional disorder often can continue to socialize and function normally, apart from the subject of their delusion, and generally do not behave in an obviously odd or bizarre manner. This is unlike people with other psychotic disorders, who also might have delusions as a symptom of their disorder. But in some cases, people with delusional disorder might become so preoccupied with their delusions that their lives are disrupted.

**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.

What is the characteristic of delusional disorder?

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## 10.8 LET US SUM UP

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Psychotic disorders are a group of severe mental disorders that cause a person to have abnormal thinking and perception. Psychotic disorders make it impossible for the person to lead a normal life as they make it difficult to stay in touch with reality. Patients suffering from psychotic disorders have a broken perception of what is real and unreal. It is extremely difficult for people with psychotic disorders to think clearly, respond to stimuli with correct set of emotions, to communicate effectively, and behave appropriately in social as well as an individual environment. Life of a patient with a psychotic disorder is difficult, to the say the least.

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## 10.9 UNIT-END EXERCISES

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1. Give an overview of psychotic disorders.
2. What causes Psychotic disorders?
3. What is delusional disorder?

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## 10.10 ANSWERS TO CHECK YOUR PROGRESS

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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.Delusions are the main symptom of delusional disorder. They're unshakable beliefs in something that isn't true or based on reality. These delusions usually involve mistaken perceptions or experiences.

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## 10.11 SUGGESTED READINGS

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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* 16<sup>th</sup> ed. Noida: Pearson.
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# UNIT XI: CLASSIFICATION SYSTEMS IN PSYCHOPATHOLOGY

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*Classification Systems in  
Psychopathology*

## **Structure**

- 11.1 Introduction
- 11.2 Objectives
- 11.3 ICD-10
- 11.4 DSM-5
- 11.5 Approaches to psychopathology
  - 11.5.1 Biological
  - 11.5.2 Psychodynamic
  - 11.5.3 Behavioural
  - 11.5.4 Cognitive
  - 11.5.5 Social Constructionist
- 11.6 Let us sum up
- 11.7 Unit-End Exercises
- 11.8 Answers to Check your Progress
- 11.9 Suggested Readings

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## **11.1 INTRODUCTION**

A first step in the study of psychological disorders is carefully and systematically discerning significant signs and symptoms. Appropriately identifying and labeling a set of defined symptoms—is absolutely crucial for mental health professionals ascertain whether or not a person’s inner states and behaviors truly represent a psychological disorder This process enables professionals to use a common language with others in the field and aids in communication about the disorder with the patient, colleagues and the public. A proper diagnosis is an essential element to guide proper and successful treatment. For these reasons, classification systems that organize psychological disorders systematically are necessary.

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## **11.2 OBJECTIVES**

On completion of this unit you will be able to

- Understand the major classification systems
- Understand and differentiate between major perspectives of psychopathology
- Have a holistic view of abnormal behavior

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## **11.3 ICD-10**

The *International Classification of Diseases* (ICD) is also widely recognized as a classification system. Published by the World Health Organization (WHO), the ICD was developed in Europe shortly after World War II and, like the DSM, has been revised several times. The categories of psychological disorders in both the DSM and ICD are similar, as are the criteria for specific disorders; however, some differences exist. Although the ICD is used for clinical purposes, this tool is also used to examine the general health of populations and to monitor the prevalence of diseases and other health problems internationally (WHO, 2013). The ICD is in its 10th edition (ICD-10); however, efforts are now underway to

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develop a new edition (ICD-11) that, in conjunction with the changes in DSM-5, will help harmonize the two classification systems as much as possible (APA, 2013).

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### 11.4 DSM-5

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Although a number of classification systems have been developed over time, the one that is used by most mental health professionals in the United States is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), published by the American Psychiatric Association (2013). (Note that the American Psychiatric Association differs from the American Psychological Association; both are abbreviated APA.) The first edition of the DSM, published in 1952, classified psychological disorders according to a format developed by the U.S. Army during World War II (Clegg, 2012). In the years since, the DSM has undergone numerous revisions and editions. The most recent edition, published in 2013, is the DSM-5 (APA, 2013). The DSM-5 includes many categories of disorders (e.g., anxiety disorders, depressive disorders, and dissociative disorders). Each disorder is described in detail, including an overview of the disorder (diagnostic features), specific symptoms required for diagnosis (diagnostic criteria), prevalence information (what percent of the population is thought to be afflicted with the disorder), and risk factors associated with the disorder.

The DSM-5 also provides information about comorbidity; the co-occurrence of two disorders. For example, the DSM-5 mentions that 41% of people with obsessive-compulsive disorder (OCD) also meet the diagnostic criteria for major depressive disorder. Drug use is highly comorbid with other mental illnesses; 6 out of 10 people who have a substance use disorder also suffer from another form of mental illness.

The DSM has changed considerably in the half-century since it was originally published. The first two editions of the DSM, for example, listed homosexuality as a disorder; however, in 1973, the APA voted to remove it from the manual (Silverstein, 2009). Additionally, beginning with the DSM-III in 1980, mental disorders have been described in much greater detail, and the number of diagnosable conditions has grown steadily, as has the size of the manual itself. DSM-I included 106 diagnoses and was 130 total pages, whereas DSM-III included more than 2 times as many diagnoses (265) and was nearly seven times its size (886 total pages) (Mayes & Horowitz, 2005). Although DSM-5 is longer than DSM-IV, the volume includes only 237 disorders, a decrease from the 297 disorders that were listed in DSM-IV. The latest edition, DSM-5, includes revisions in the organization and naming of categories and in the diagnostic criteria for various disorders, while emphasizing careful consideration of the importance of gender and cultural difference in the expression of various symptoms.

Some believe that establishing new diagnoses might overpathologize the human condition by turning common human problems into mental illnesses. The DSM-5 is also criticized on the grounds that its diagnostic criteria have been loosened. For example, DSM-IV specified that the symptoms of major depressive disorder must not be attributable to normal bereavement (loss of a loved one). The DSM-5, however, has removed this bereavement exclusion, essentially meaning that grief and sadness after a loved one's death can constitute major depressive disorder.

### 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.

Expand ICD.

Expand DSM.

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## 11.5 APPROACHES TO PSYCHOPATHOLOGY

### 11.5.1 BIOLOGICAL

Basically, the biological approach to psychopathy is assuming that the mental disorder the person is suffering from is caused by faulty biological mechanisms. The mental disorders are treated like your usual illness in that they are cured by removing the root cause of the illness to restore the body back to its normal state. The biological approach says that mental disorders illnesses are caused by four things:

- **genetic inheritance**

Abnormal neuroanatomy/chemistry can be characteristics that were passed down from a person's parents. For a long time, psychologists have studied identical twins to try to investigate this theory that psychopathy or abnormalities are genetic. Psychologists will compare identical twins to see if when one twin shows symptoms of a mental disorder, whether the other one will too. For some mental disorders, such as schizophrenia, if one twin has it then the other one will often have it too—this shows that it could very well be genetic.

- **biochemistry and neuroanatomy**

Once again genes play a huge role in this theory of how mental disorders come about. Genes determine a lot of functions in our body, they determine hormone and various neurotransmitter levels. To understand how this cause a mental disorder, take the neurotransmitter serotonin for example. The levels of serotonin will be determined, for the most part, by our genes. High levels of serotonin have been associated with anxiety and low levels have been associated with depression. This shows that a person's mental state can rely on their hormone or neurotransmitter levels and thus their biochemistry or neuroanatomy.

- **viral infection**

Some research shows that the occurrence of certain mental disorders can be related to the exposure the individual had to certain viruses whilst in the womb. Torrey found that the mothers of individuals with schizophrenia had contracted a specific strain of flu during pregnancy. This virus may then stay in the child's brain until certain hormones activate it (i.e. during puberty) and the child will develop schizophrenia or associated symptoms.

### 11.5.2 PSYCHODYNAMIC

The psychodynamic approach is essentially based on the view that the abnormal behaviour that an individual is showing is due to underlying

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psychological conflicts that they may not even be aware of. Freud is the most well-known psychologist that believed in this approach. Freud believed that it was psychological rather than physical things that cause mental disorders such as unresolved conflicts of childhood. There are a few different factors that were believed to make up an individual's personality and these were:

- **Id:** the irrational and primitive part of an individual's personality that wants immediate satisfaction
- **Ego:** the rational part of one's personality
- **Superego:** the sense of right and wrong
- **Ego defenses:** methods such as repression and displacement that help a person deal with their feelings.

It was believed that conflicts between these different parts of an individual's personality would result in things such as anxiety. The ego defense would then try and deal with these emotions. For instance by repressing something, and if overused would result in disturbed or abnormal behaviour. Freud also believed that children didn't have the emotional maturity to be able to deal with traumas and thus would repress them if they occurred. If a similar trauma then occurred later in the individual's life then the repressed feelings that they felt originally would be re-experienced and mental disorders such as depression may develop.

### 11.5.3 BEHAVIOURAL

Basically, the behavioural approach to psychopathy suggests that the response that a person makes to their environment, albeit internal or external, are what determines their mental state rather than their underlying pathology or other such things. This approach is based on the idea that abnormal behaviors are no different from normal ones in terms of how we learn them and are all learned through social learning or classical conditioning.

Also, it is thought that the environment the individual is in will be partly to blame for their mental disorder. For instance, if an individual were to show depressive symptoms or behaviours, someone else might be more inclined to help that person. Also, things we see in the media can influence our mental state, for example, if you saw someone on TV crash their car you might then develop a phobia of crashing your own car.

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### 11.5.4 COGNITIVE

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The cognitive approach is based on the idea that the way that we perceive reason and judge the environment and the world that we're in is what determines our behaviour. If this cognitive thinking is distorted, lacking or dysfunctional then abnormal behavior (or mental disorders) will occur. There are four different concepts regarding human cognition and these are:

- **Cognitive structures:** how an individual organizes information; for example do they see a spider as just another daily object that they need to live with or do they see that spider as an object of fear?
- **Cognitive content:** whether a person thinks negatively or positively about certain situations

- **Cognitive processes:** how the individual then processes this information and operate on it and whether they do so in a rational or irrational way
- **Cognitive products:** this refers to the conclusion that the individual will draw from the processed information  
Psychologists will use these concepts to judge an individual's mental state—for example when overhearing someone say 'I don't like what he's wearing today', your immediate thought is 'it must be me they are speaking about!' then this might show that your cognitive process is somewhat distorted!

### 11.5.5 SOCIAL CONSTRUCTIONIST

Social constructivist perspective of psychopathology mainly focuses on observing how people view and understand the world, how they make sense and explain what happens in it each day, as well as the social and political processes which influence these views. They assign mental disorders based on the individuals' actions. They believe universal or "true" definitions do not exist, because essentially people in power to make certain decisions are the ones who are creating the definitions of what a mental disorder is, and how it should be categorized. Social constructivists believe psychopathology and mental disorders can include the biased views of these individuals to what is the most beneficial to them, and are in a sense made up justifications to label a condition they truly do not understand. This explains why there are so many debates over terms such as domestic violence and child sexual abuse.

#### 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.

What are the different approaches that explain abnormal behaviour?

What is the basic assumption of behavioural approach in understanding abnormal behaviour?

### 11.6 LET US SUM UP

The diagnosis and classification of psychological disorders is essential in studying and treating psychopathology. The classification system used by most U.S. professionals is the DSM-5. The first edition of the DSM was published in 1952, and has undergone numerous revisions. The 5th and most recent edition, the DSM-5, was published in 2013. The diagnostic manual includes a total of 237 specific diagnosable disorders, each described in detail, including its symptoms, prevalence, risk factors, and comorbidity. Over time, the number of diagnosable conditions listed in the DSM has grown steadily, prompting criticism from some. Nevertheless, the diagnostic criteria in the DSM are more explicit than that of any other system, which makes the DSM system highly desirable for both clinical diagnosis and research.

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## **11.7 UNIT-END EXERCISES**

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1. Write a note on the need for classification systems.
2. Critically evaluate classification systems.
3. Describe the different approaches to understanding psychopathology.

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## **11.8 ANSWERS TO CHECK YOUR PROGRESS**

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1. International Classification of Diseases
2. Diagnostic and Statistical Manual of Mental Disorders
3. Biological, Psychodynamic, Behavioural, Cognitive, and Social Constructionist approaches
4. Abnormal behaviors are learned through social learning or classical conditioning.

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## **11.9 SUGGESTED READINGS**

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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* 16<sup>th</sup> ed. Noida: Pearson.
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# UNIT 12: TRAUMA AND STRESS RELATED DISORDERS

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*Trauma and Stress Related Disorders*

## Structure

- 12.1 Introduction
- 12.2 Objectives
- 12.3 Post Traumatic Stress Disorder (PTSD)
- 12.4 Dissociative Disorders
  - 12.4.1 Dissociative Identity Disorders
  - 12.4.2 Derealization disorders
- 12.5 Let us sum up
- 12.6 Unit-End Exercises
- 12.7 Answers to Check your Progress
- 12.8 Suggested Readings

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## 12.1 INTRODUCTION

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Extremely stressful or traumatic events, such as combat, natural disasters, and terrorist attacks, place the people who experience them at an increased risk for developing psychological disorders such as posttraumatic stress disorder (PTSD). The term *posttraumatic stress disorder* was developed given that these symptoms could happen to anyone who experienced psychological trauma, such as sexual trauma and trauma caused by other factors. Trauma and stress can also lead to other conditions such as dissociative disorders which are described in this chapter.

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## 12.2 OBJECTIVES

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The objectives of this unit are to make you understand:

- How people when they fail to cope adequately with stress may develop various pathological conditions
- The various manifestations of abnormal behaviour as a result of overwhelming stress

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## 12.3 POST TRAUMATIC STRESS DISORDER (PTSD)

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PTSD was listed among the anxiety disorders in previous DSM editions. In DSM-5, it is now listed among a group called Trauma-and-Stressor-Related Disorders. For a person to be diagnosed with PTSD, he/she be must exposed to, witness, or experience the details of a traumatic experience (e.g., a first responder), one that involves “actual or threatened death, serious injury, or sexual violence” (APA, 2013). These experiences can include such events as combat, threatened or actual physical attack, sexual assault, natural disasters, terrorist attacks, and automobile accidents. This criterion makes PTSD the only disorder listed in the DSM in which a cause (extreme trauma) is explicitly specified.

Symptoms of PTSD include intrusive and distressing memories of the event, flashbacks (states that can last from a few seconds to several days, during which the individual relives the event and behaves as if the event were occurring at that moment [APA, 2013]), avoidance of stimuli connected to the event, persistently negative emotional states (e.g., fear, anger, guilt, and shame), feelings of detachment from others, irritability,

*Self – Instructional Material*

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prone to outbursts, and an exaggerated startle response (jumpiness). For PTSD to be diagnosed, these symptoms must occur for at least one month.

Of course, not everyone who experiences a traumatic event will go on to develop PTSD; several factors strongly predict the development of PTSD: trauma experience, greater trauma severity, lack of immediate social support, and more subsequent life stress. Traumatic events that involve harm by others (e.g., combat, rape, and sexual molestation) carry greater risk than do other traumas (e.g., natural disasters). Factors that increase the risk of PTSD include female gender, low socioeconomic status, low intelligence, personal history of mental disorders, history of childhood adversity (abuse or other trauma during childhood), and family history of mental disorders. Personality characteristics such as neuroticism and somatization (the tendency to experience physical symptoms when one encounters stress) have been shown to elevate the risk of PTSD. People who experience childhood adversity and/or traumatic experiences during adulthood are at significantly higher risk of developing PTSD if they possess one or two short versions of a gene that regulates the neurotransmitter serotonin. This suggests a possible diathesis-stress interpretation of PTSD: its development is influenced by the interaction of psychosocial and biological factors.

**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. Expand PTSD.
2. What are the symptoms of PTSD?

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## 12.4 DISSOCIATIVE DISORDERS

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Most of us experience a sense of wholeness and continuity as we interact with the world. We perceive ourselves as being more than a random collection of isolated sensory experiences, feelings, and behaviors. In other words, we have an *identity*, a sense of who we are and where we fit in our environment. We recognize ourselves and have our own expectations, values, and goals. **Memory** is a key to this sense of identity, the link between our past, present, and future. Our recall of past experiences, although not always precisely accurate, helps us react to present events and guides us in making decisions about the future. We recognize our friends and relatives, teachers and employers, and respond to them in appropriate ways. People sometimes experience a major disruption of their memory, identity, or consciousness. They may, for example, lose their ability to remember new information they just learned or old information they once knew well. When such changes in memory lack a clear physical cause, they are called **dissociative disorders**. In such disorders, one part of the person's memory typically seems to be *dissociated*, or separated, from the rest.

There are several kinds of dissociative disorders. The primary symptom of *dissociative amnesia* is an inability to recall important personal events and information. A person with *dissociative fugue* not only forgets the past but also travels to a new location and may assume a new identity. Individuals with *dissociative identity disorder* (also known as *multiple personality disorder*) have two or more separate identities that may not always be aware of each other's thoughts, feelings, and behavior. Many clinicians, however, believe that they are rare.

DSM-IV-TR also lists *depersonalization disorder* as a dissociative disorder. People with this problem feel as though they have become detached from their own mental processes or body and are observing themselves from the outside. This listing is controversial because the memories and identities of people with depersonalization disorder seem to remain intact. It is their sense of self that change: their mental processes or bodies feel unreal or foreign to them.

### DISSOCIATIVE AMNESIA

People with dissociative amnesia are unable to recall important information, usually of an upsetting nature, about their lives (APA, 2000). The loss of memory is much more extensive than normal forgetting and is not caused by organic factors. Often an episode of amnesia is directly triggered by a specific upsetting event. Dissociative amnesia may be *localized*, *selective*, *generalized*, or *continuous*. Any of these kinds of amnesia can be triggered by a traumatic experience, but each represents a particular pattern of forgetting.

*Localized*, or *circumscribed*, *amnesia*, is the most common type of dissociative amnesia, in which a person loses all memory of events that took place within a limited period of time, almost always beginning with some very disturbing occurrence. The forgotten period is called the *amnestic episode*. During an amnestic episode, people may appear confused; in some cases they wander about aimlessly. They are already experiencing memory difficulties but seem unaware of them.

People with *selective amnesia*, the second most common form of dissociative amnesia, remember some, but not all, events that occurred during a period of time. In some cases the loss of memory extends back to times long before the upsetting period and cannot remember events that occurred earlier in life, which would be *generalized amnesia*.

In the forms of dissociative amnesia discussed so far, the period affected by the amnesia has an end. In *continuous amnesia*, however, forgetting continues into the present. Continuous forgetting of this kind is actually quite rare.

All of these forms of dissociative amnesia are similar in that the amnesia interferes mostly with *episodic memory*—a person's memory of personal material. *Semantic memory*—memory for abstract or encyclopedic information— usually remains. People with dissociative amnesia are as likely as anyone else to know the name of the prime minister of India and how to write, read, or drive a car.

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### 12.4.1 DISSOCIATIVE IDENTITY DISORDERS

Dissociative identity disorder is both dramatic and disabling. A person with **dissociative identity disorder**, or **multiple personality disorder**, develops two or more distinct personalities, often called **subpersonalities** or **alternate personalities**, each with a unique set of memories, behaviors, thoughts, and emotions. At any given time, one of the subpersonalities takes center stage and dominates the person's functioning. Usually one subpersonality, called the *primary*, or *host*, personality, appears more often than the others. The transition from one subpersonality to another, called *switching*, is usually sudden and may be dramatic (APA, 2000). Switching is usually triggered by a stressful event, although clinicians can also bring about the change with hypnotic suggestion (APA, 2000).

Many clinicians consider the disorder to be rare, but some reports suggest that it may be more

common than was once thought. Most cases are first diagnosed in late adolescence or early adulthood, but, more often than not, the symptoms actually began in early childhood after episodes of abuse (often sexual abuse), perhaps even before the age of 5. Women receive this diagnosis at least three times as often as men (APA, 2000).

Generally, there are three kinds of relationships in the way subpersonalities interact. In *mutually amnesic relationships*, the subpersonalities have no awareness of one another. Conversely, in *mutually cognizant patterns*, each subpersonality is well aware of the rest. They may hear one another's voices and even talk among themselves. Some are on good terms, while others do not get along at all. In *one-way amnesic relationships*, the most common relationship pattern, some subpersonalities are aware of others, but the awareness is not mutual. Those who are aware, called *co-conscious subpersonalities*, are "quiet observers" who watch the actions and thoughts of the other subpersonalities but do not interact with them. Sometimes while another subpersonality is present, the co-conscious personality makes itself known through indirect means, such as auditory hallucinations (perhaps a voice giving commands) or "automatic writing" (the current personality may find itself writing down words over which it has no control).

Studies suggest that the average number of subpersonalities per patient is much higher—15 for women and 8 for men (APA, 2000). In fact, there have been cases in which 100 or more subpersonalities were observed (APA, 2000). Often the subpersonalities emerge in groups of two or three at a time.

Subpersonalities often exhibit dramatically different characteristics. They may also have their own names and different *vital statistics*, *abilities and preferences*, and even *physiological responses*. The subpersonalities may differ in features as basic as age, sex, race, and family history. Although memories of abstract or encyclopedic information are not usually affected in dissociative amnesia or fugue, they are often disturbed in dissociative identity disorder. It is not uncommon for the different subpersonalities to have different abilities: one may be able to drive, speak a foreign language,

or play a musical instrument, while the others cannot. Their handwriting can also differ. In addition, the subpersonalities usually have different tastes in food, friends, music, and literature. Researchers have discovered that subpersonalities may have physiological differences, such as differences in autonomic nervous system activity, blood pressure levels, and allergies.

Dissociative identity disorder has traditionally been thought of as rare. Some researchers even argue that many or all cases are *iatrogenic*—that is, unintentionally produced by practitioners. They believe that therapists create this disorder by subtly suggesting the existence of other personalities during therapy or by explicitly asking a patient to produce different personalities while under hypnosis. In addition, they believe, a therapist who is looking for multiple personalities may reinforce these patterns by displaying greater interest when a patient displays symptoms of dissociation.

These arguments seem to be supported by the fact that many cases of dissociative identity disorder first come to attention while the person is already in treatment for a less serious problem. But such is not true of all cases; many people seek treatment because they have noticed time lapses throughout their lives or because relatives and friends have observed their subpersonalities. The number of people diagnosed with dissociative identity disorder has been increasing. Although the disorder is still uncommon, thousands of cases have now been diagnosed in the United States and Canada alone. Two factors may account for this increase. First, a growing number of today's clinicians believe that the disorder does exist and are willing to diagnose it. Second, diagnostic procedures tend to be more accurate today than in past years. For much of the twentieth century, schizophrenia was one of the clinical field's most commonly applied diagnoses. It was applied, often incorrectly, to a wide range of unusual behavioral patterns, perhaps including dissociative identity disorder. Under the stricter criteria of recent editions of the DSM, clinicians are now more accurate in diagnosing schizophrenia, allowing more cases of dissociative identity disorder to be recognized. In addition, several diagnostic tests have been developed to help detect dissociative identity disorder. Despite such changes, however, many clinicians continue to question the legitimacy of this category.

#### **12.4.2 DEPERSONALIZATION/DEREALIZATION DISORDER**

Depersonalization disorder is a dissociative disorder, its central symptom is persistent and recurrent episodes of *depersonalization*, a change in one's experience of the self in which one's mental functioning or body feels unreal or foreign. People with depersonalization disorder feel as though they have become separated from their body and are observing themselves from outside.

Occasionally their mind seems to be floating a few feet above them—a sensation known as *doubling*. Their body parts seem foreign to them, the hands and feet smaller or bigger than usual. Many sufferers describe their emotional state as “mechanical,” “dreamlike,” or “dizzy.” Throughout the whole depersonalization experience, however, they are aware that their

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perceptions are distorted, and in that sense they remain in contact with reality. In some cases this sense of unreality also extends to other sensory experiences and behavior. People may, for example, experience distortions in their sense of touch or smell or their judgments of time or space, or they may feel that they have lost control over their speech or actions.

Depersonalization is often accompanied by an experience of *derealization*—the feeling that the external world, too, is unreal and strange. Objects may seem to change shape or size; other persons may seem removed, mechanical, or even dead. Depersonalization experiences by themselves do not indicate a depersonalization disorder. Transient depersonalization reactions are fairly common, while a depersonalization disorder is not. One-third of individuals who confront a life-threatening danger experience feelings of depersonalization or derealization. People sometimes have feelings of depersonalization after practicing meditation, and individuals who travel to new places often report a temporary sense of depersonalization. Young children may also experience depersonalization from time to time as they are developing their capacity for self-awareness. In most such cases, the individuals are able to compensate for the distortion and continue to function with reasonable effectiveness until the temporary episode eventually ends.

The symptoms of a depersonalization disorder, in contrast, are persistent or recurrent, cause considerable distress, and interfere with social relationships and job performance. The disorder occurs most frequently in adolescents and young adults, hardly ever in people over 40 (APA, 2000). It usually comes on suddenly, triggered by experiences such as extreme fatigue, physical pain, intense stress, anxiety, depression, or recovery from substance abuse. Survivors of traumatic experiences or people caught in life-threatening situations, such as hostages or kidnap victims, seem to be particularly vulnerable (APA, 2000). The disorder tends to be long-lasting; the symptoms may improve and even disappear for a time, only to return or intensify during times of severe stress.

Like other dissociative symptoms, feelings of depersonalization and derealization may appear in other disorders. Sufferers of panic disorder, for example, commonly experience some feelings of unreality. Similarly, people with acute and posttraumatic stress disorders often have a sense of derealization. Few theories have been offered to explain depersonalization disorder, and little research has been conducted on the problem. In recent times some investigators have used brain scan techniques, such as PET and fMRI scans, to determine whether the disorder is accompanied by particular changes in brain activity. However, clear biological factors have yet to emerge. Similarly, treatments for this disorder have not received much study, although a range of approaches, including psychodynamic, cognitive, hypnotic, and drug therapies, have been tried.

### **CAUSES OF DISSOCIATIVE DISORDERS**

A variety of theories have been proposed to explain dissociative disorders. Older explanations, such as those offered by psychodynamic and behavioral theorists have not received much investigation. However, newer

viewpoints, which combine cognitive, behavioral, and biological principles and highlight such factors as *state-dependent learning* and *self-hypnosis*, have captured the interest of clinical scientists.

### **The Psychodynamic View**

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Psychodynamic theorists believe that dissociative disorders are caused by *repression*, the most basic ego defense mechanism: people fight off anxiety by unconsciously preventing painful memories, thoughts, or impulses from reaching awareness. Everyone uses repression to a degree, but people with dissociative disorders are thought to repress their memories excessively. In the psychodynamic view, dissociative amnesia and fugue are *single episodes* of massive repression. In each of these disorders, a person unconsciously blocks the memory of an extremely upsetting event to avoid the pain of facing it. Repressing may be their only protection from overwhelming anxiety. In contrast, dissociative identity disorder is thought to result from a *lifetime* of excessive repression. Psychodynamic theorists believe that continuous use of repression is motivated by traumatic childhood events, particularly abusive parenting.

According to psychodynamic theorists, children who experience such traumas may come to fear the dangerous world they live in and take flight from it by pretending to be another person who is looking on safely from afar. Abused children may also come to fear the impulses that they believe are the reasons for their excessive punishments. Whenever they experience “bad” thoughts or impulses, they unconsciously try to disown and deny them by assigning them to other personalities. Most of the support for the psychodynamic position is drawn from case histories, which report such brutal childhood experiences as beatings, cuttings, burnings with cigarettes, imprisonment in closets, rape, and extensive verbal abuse. Yet some individuals with dissociative identity disorder do not seem to have experiences of abuse in their background. Moreover, child abuse appears to be far more common than dissociative identity disorder.

### **The Behavioral View**

Behaviorists believe that dissociation grows from normal memory processes such as drifting of the mind or forgetting. Specifically, they hold that dissociation is a response learned through *operant conditioning*. People who experience a horrifying event may later find temporary relief when their minds drift to other subjects. For some, this momentary forgetting, leading to a drop in anxiety, increases the likelihood of future forgetting. In short, they are reinforced for the act of forgetting and learn—without being aware that they are learning—that such acts help them escape anxiety. Thus, like psychodynamic theorists, behaviorists see dissociation as escape behavior. But behaviorists believe that a reinforcement process rather than a hardworking unconscious is keeping the individuals unaware that they are using dissociation as a means of escape. Like psychodynamic theorists, behaviorists have relied largely on case histories to support their view of dissociative disorders. Such descriptions do often support this view, but they are equally consistent with

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other kinds of explanations as well: a case that seems to show reinforcement of forgetting can usually also be interpreted as an instance of unconscious repression. In addition, the behavioral explanation fails to explain precisely how temporary and normal escapes from painful memories grow into a complex disorder or why more people do not develop dissociative disorders.

**State-Dependent Learning** If people learn something when they are in a particular situation or state of mind, they are likely to remember it best when they are again in that same condition. If they are given a learning task while under the influence of alcohol, for example, their later recall of the information may be strongest under the influence of alcohol. Similarly, if they smoke cigarettes while learning, they may later have better recall when they are again smoking. This link between state and recall is called **state-dependent learning**. One possibility for state-dependent learning is that *arousal* levels are an important part of learning and memory. That is, a particular level of arousal will have a set of remembered events, thoughts, and skills attached to it. When a situation produces that particular level of arousal, the person is more likely to recall the memories linked to it. Although people may remember certain events better in some arousal states than in others, most can recall events under a variety of states. However, perhaps people who are prone to develop dissociative disorders have state-to-memory links that are unusually rigid and narrow. Maybe each of their thoughts, memories, and skills is tied *exclusively* to a particular state of arousal, so that they recall a given event only when they experience an arousal state almost identical to the state in which the memory was first acquired. When such people are calm, for example, they may forget what occurred during stressful times, thus laying the groundwork for dissociative amnesia or fugue. Similarly, in dissociative identity disorder, different arousal levels may produce entirely different groups of memories, thoughts, and abilities—that is, different subpersonalities. This could explain why personality transitions in dissociative identity disorder tend to be sudden and stress-related.

**Self-Hypnosis** People who are *hypnotized* enter a sleeplike state in which they become very suggestible. While in this state, they can behave, perceive, and think in ways that would ordinarily seem impossible. They may, for example, become temporarily blind, deaf, or insensitive to pain. Hypnosis can also help people remember events that occurred and were forgotten years ago, a capability used by many psychotherapists. Conversely, it can make people forget facts, events, and even their personal identities—an effect called *hypnotic amnesia*. Most studies of hypnotic amnesia follow similar formats. Participants are asked to study a word list or other material until they are able to repeat it correctly. Under hypnosis, they are then directed to forget the material until they receive a *cancellation signal* (such as the snap of a finger), at which time they will suddenly recall the learned material. Repeatedly these experiments have found the participants' memories to be poor during the period of hypnotic amnesia and then restored after the cancellation signal is given.

The parallels between hypnotic amnesia and dissociative disorders are striking. Both are conditions in which people forget certain material for a

period of time yet later remember it. And in both, the people forget without any insight into why they are forgetting or any awareness that something is being forgotten. These parallels have led some theorists to conclude that dissociative disorders may be a form of **self-hypnosis** in which people hypnotize themselves to forget unpleasant events. Dissociative amnesia may occur, for example, in people who, consciously or unconsciously, hypnotize themselves into forgetting horrifying experiences that have recently occurred in their lives. If the self-induced amnesia covers all memories of a person's past and identity, that person may undergo a dissociative fugue. Self-hypnosis might also be used to explain dissociative identity disorder. On the basis of several investigations, some theorists believe that this disorder often begins between the ages of 4 and 6, a time when children are generally very suggestible and excellent hypnotic subjects. These theorists argue that some children who experience abuse or other horrifying events manage to escape their threatening world by self-hypnosis, mentally separating themselves from their bodies and fulfilling their wish to become some other person or persons.

There are different schools of thought about the nature of hypnosis. Some theorists see hypnosis as a *special process*, an out-of-the-ordinary kind of functioning. Accordingly, these theorists contend that people with dissociative disorders place themselves in internal trances during which their conscious functioning is significantly altered. Other theorists believe that hypnotic behaviors, and hypnotic amnesia in particular, are produced by *common social and cognitive processes*, such as high motivation, focused attention, role enactment, and self-fulfilling expectations. According to this point of view, hypnotized people are simply highly motivated individuals performing tasks that are asked of them, while believing all along that the hypnotic state is doing the work for them. Common-process theorists holds that people with dissociative disorders provide themselves (or are provided by others) with powerful suggestions to forget and that social and cognitive mechanisms then put the suggestions into practice. Hypnosis research effectively demonstrates the power of our normal thought processes, and so renders the notion of dissociative disorders somewhat less remarkable.

People with dissociative amnesia and fugue often recover on their own. Only sometimes do their memory problems linger and require treatment. In contrast, people with dissociative identity disorder usually require treatment to regain their lost memories and develop an integrated personality. Treatments for dissociative amnesia and fugue tend to be more successful than those for dissociative identity disorder, probably because the former disorders are less complex.

### **Dissociative Amnesia and Fugue**

The leading treatments for dissociative amnesia and fugue are *psychodynamic therapy*, *hypnotic therapy*, and *drug therapy*. Psychodynamic therapists guide patients with these disorders to search their unconscious in the hope of bringing forgotten experiences back to consciousness. The focus of psychodynamic therapy seems particularly well suited to the needs of people with these disorders. After all, the

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patients need to recover lost memories, and the general approach of psychodynamic therapists is to try to uncover memories—as well as other psychological processes—that have been repressed. Thus many theorists, including some who do not ordinarily favor psychodynamic approaches, believe that psychodynamic therapy may be the most appropriate treatment for these disorders.

Another common treatment for dissociative amnesia and fugue is **hypnotic therapy**, or **hypnotherapy**. Therapists hypnotize patients and then guide them to recall forgotten events. Experiments have repeatedly indicated that hypnotic suggestion can help elicit forgotten memories, and experience has shown that people with dissociative disorders are usually highly susceptible to hypnosis. Given the possibility that dissociative amnesia and fugue may each be a form of self-hypnosis, hypnotherapy may be a particularly useful intervention. It has been applied both alone and in combination with other approaches.

Sometimes intravenous injections of barbiturates such as *sodium amobarbital* (Amytal) or *sodium pentobarbital* (Pentothal) are used to help patients with dissociative amnesia and fugue regain lost memories. These drugs are often called “truth serums,” but the key to their success is their ability to sedate people and free their inhibitions, thus helping them to recall anxiety-producing events (Fraser, 1993; Kluft, 1988). These drugs do not always work, however, and if used at all, they are likely to be combined with other treatment approaches.

**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.

What is characteristic symptom of depersonalization disorder?

What are different types of dissociative amnesia?

**Dissociative Identity Disorder**

Unlike victims of amnesia and fugue, people with dissociative identity disorder do not typically recover without treatment. Treatment for this pattern is complex and difficult, much like the disorder itself. Therapists usually try to help the clients (1) recognize fully the nature of their disorder, (2) recover the gaps in their memory, and (3) integrate their subpersonalities into one functional personality.

Once a diagnosis of dissociative identity disorder is made, therapists typically try to bond with the primary personality and with each of the subpersonalities. As bonds are formed, therapists try to educate patients and help them to recognize fully the nature of their disorder. Some therapists actually introduce the subpersonalities to one another under hypnosis, and some have patients look at videotapes of their other personalities. Many therapists have also found that group therapy helps to

educate patients. Being with a group of people who all have multiple personalities helps relieve a person's feelings of isolation. Family therapy may also be used to help educate spouses and children about the disorder and to gather helpful information about the patient.

To help patients recover the missing pieces of their past, therapists use many of the approaches applied in other dissociative disorders, including psychodynamic therapy, hypnotherapy, and drug treatment. These techniques work slowly for patients with dissociative identity disorder, as some subpersonalities may keep denying experiences that the others recall. One of the subpersonalities may even assume a "protector" role to prevent the primary personality from suffering the pain of recollecting traumatic experiences. Some patients become self-destructive and violent during this phase of treatment.

The final goal of therapy is to merge the different subpersonalities into a single, integrated identity. Integration is a continuous process that occurs throughout treatment until patients "own" all of their behaviors, emotions, sensations, and knowledge. **Fusion** is the final merging of two or more subpersonalities. Many patients distrust this final treatment goal, and their subpersonalities are likely to see integration as a form of death. Therapists have used a range of approaches to help merge subpersonalities, including psychodynamic, supportive, cognitive, and drug therapies.

Once the subpersonalities are integrated, further therapy is typically needed to maintain the complete personality and to teach social and coping skills that may help prevent later dissociations. In case reports, some therapists note high success rates, but others find that patients continue to resist full and final integration. A few therapists have in fact questioned the need for full integration. The limited number of reported cases generally prevents researchers from gathering samples that are large enough to conduct enlightening research on the treatment of this disorder.

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## **12.5 LET US SUM UP**

**Stress** has been defined as *the physiological and psychological experience of significant life events, trauma, and chronic strain*. There is no doubt that the level of stress an individual experiences can negatively impact his or her physical and mental health. This chapter illustrated the extreme negative effects of stress in the form of different psychopathological conditions.

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## **12.6 UNIT-END EXERCISES**

1. Describe PTSD.
2. Describe how stress and trauma can be manifested as dissociative disorders.
3. What is dissociative amnesia?

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## 12.7 ANSWERS TO CHECK YOUR PROGRESS

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1. Post-traumatic stress disorder.
2. Symptoms of PTSD include intrusive and distressing memories of the event, flashbacks (states that can last from a few seconds to several days, during which the individual relives the event and behaves as if the event were occurring at that moment, avoidance of stimuli connected to the event, persistently negative emotional states (e.g., fear, anger, guilt, and shame), feelings of detachment from others, irritability, proneness toward outbursts, and an exaggerated startle response (jumpiness).
- 3 Characteristic symptom of depersonalization disorder is persistent and recurrent episodes of *depersonalization*, a change in one's experience of the self in which one's mental functioning or body feels unreal or foreign. People with depersonalization disorder feel as though they have become separated from their body and are observing themselves from outside.
4. Localized, selective, generalized, or continuous are different types of dissociative amnesia.

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## 12.8 . SUGGESTED READINGS

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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* 16<sup>th</sup> 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.

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# UNIT 13: EATING AND SLEEP DISORDERS

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## **Structure**

- 13.1 Introduction
- 13.2 Objectives
- 13.3 Anorexia Nervosa
- 13.4 Bulimia Nervosa
- 13.5 Insomnia
- 13.6 Narcolepsy
- 13.7 Let us sum up
- 13.8 Unit-End Exercises
- 13.9 Answers to Check your Progress
- 13.10 Suggested Readings

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## **13.1 INTRODUCTION**

Psychological health and physiological functioning are complementary and the relationship between both is bidirectional. Psychological health influences eating and sleep behaviour and disturbed sleep and eating pattern contributed to psychological dysfunction. This chapter elaborates on the chief eating and sleep disorders and their implications.

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## **13.2 OBJECTIVES**

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

- Understand the significance of healthy eating and sleep behaviour
- Understand about major eating disorders
- Understand the major sleep disorders

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## **13.3 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 for 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**

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- 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 – 1**

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

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

What does the term ‘anorexia nervosa’ mean?

What is the difference between the two types of anorexia nervosa?

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### 13.4 BULIMIA NERVOSA

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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 definition, 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 of 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.

NOTES

**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.

What is Bulimia nervosa?

From where does the term ‘Bulimia’ originate?

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**13.5 INSOMNIA**

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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*’.

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 – 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 insomnia disorder?

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**13.6 NARCOLEPSY**

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*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.

**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 narcolepsy?

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**13.7 LET US SUM UP**

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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.

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'.

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### 13.8 UNIT-END EXERCISES

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1. Describe eating disorders.
2. Discuss sleep disorders.

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### 13.9 ANSWERS TO CHECK YOUR PROGRESS

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1. The term anorexia nervosa literally means "lack of appetite induced by nervousness."
2. 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.
3. 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.
4. The word bulimia comes from the Greek bouos (which means "ox"), and limos (hunger). It is meant to denote a hunger of such proportions that the person could eat an ox.
5. 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).
6. *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).
7. *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).

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### 13.10 SUGGESTED READINGS

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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* 16<sup>th</sup> 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.

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# UNIT 14: SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

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*Schizophrenia Spectrum and  
Other Psychotic Disorders*

NOTES

## Structure

- 14.1 Introduction
- 14.2 Objectives
- 14.3 Schizophrenia
- 14.4 Delusional disorder
- 14.5 Brief Psychotic Disorder
- 14.6 Bipolar and related disorder
  - 14.6.1 Bipolar I disorder
  - 14.6.2 Bipolar II disorder
  - 14.6.3 Cyclothymic disorder
  - 14.6.4 Depressive Disorder
  - 14.6.5 Disruptive mood dysregulatorities
  - 14.6.6 Major depressive disorder
- 14.7 Let us sum up
- 14.8 Unit-End Exercises
- 14.9 Answers to Check your Progress
- 14.10 Suggested Readings

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## 14.1 INTRODUCTION

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Psychotic disorders are mental disorders that can cause abnormal thinking and one's ability to perceive normally. Many who experience psychoses lose touch with reality and are unable to cope with the outside world. Some of the major symptoms associated with psychotic disorders include: delusions, hallucinations, incoherent or disorganized speech, tangentially, loose associations or derailment, preservation, alogia, avolition, bizarre behavior, and/or disorganized behavior.

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## 14.2 OBJECTIVES

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This objective of this unit is to

- Bring out an understanding of schizophrenia and other psychotic conditions
- Describe mood disorders
- Discuss the causes, treatment and outcome of schizophrenia and other related disorders

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## 14.3 SCHIZOPHRENIA

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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.

The characteristic 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

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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 striking 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.

NOTES

#### 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.

What are the symptoms of schizophrenia?

What is delusion?

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## 14.4 SUBTYPES OF SCHIZOPHRENIA

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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.**

### 14.4.1 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.

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#### 14.4.2 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.

#### 14.4.3 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.

#### 14.4.4 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.

#### 14.4.5 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*. People 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 of 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.

*Schizophrenia Spectrum and  
Other Psychotic Disorders*

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### 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.

Why are subtypes of schizophrenia not included in DSM V?

What is catatonia?

---

## 14.5 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.

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## 14.6 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.

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## 14.7 BIPOLAR AND RELATED 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

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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.

#### 14.7.1 BIPOLAR I DISORDER

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.

#### 14.7.2 BIPOLAR II DISORDER

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.

#### 14.7.3 CYCLOTHYMIC DISORDER

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.

#### 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 differences between bipolar I and bipolar II?

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## **14.8. CAUSES**

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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<sup>+</sup>) 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<sup>+</sup>) 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

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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).

**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.

#### 14.8.1 DEPRESSIVE DISORDER

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'.

#### 14.8.2 DISRUPTIVE MOOD DYSREGULARITIES

Disruptive mood dysregulation disorder (DMDD) is a childhood condition of extreme irritability, anger, and frequent, intense temper outbursts. DMDD symptoms go beyond a being a "moody" child—children with DMDD experience severe impairment that requires clinical attention. DMDD is a fairly new diagnosis, appearing for the first time in the DSM-5 published in 2013. DMDD symptoms typically begin before the age of 10, but the diagnosis is not given to children under 6 or adolescents over 18. A child with DMDD experiences:

- Irritable or angry mood most of the day, nearly every day
- Severe temper outbursts (verbal or behavioral) at an average of three or more times per week that are out of keeping with the situation and the child's developmental level
- Trouble functioning due to irritability in more than one place (e.g., home, school, with peers)

To be diagnosed with DMDD, a child must have these symptoms steadily for 12 or more months.

DMDD is a new diagnosis. Therefore, treatment is often based on what has been helpful for other disorders that share the symptoms of irritability and temper tantrums. These disorders include attention deficit hyperactivity disorder (ADHD), anxiety disorders, oppositional defiant disorder, and major depressive disorder.

#### 14.8.3 MAJOR DEPRESSIVE DISORDER

A person who suffers from a major depressive disorder must either have a depressed mood or a loss of interest or pleasure in daily activities consistently for at least a 2 week period. This depressed mood must represent a significant change from the person's normal mood.

Social, occupational, educational, or other important functioning must also be negatively impacted by the change in mood. For instance, when a

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person who's depressed starts missing work or school, or has stopped going to classes or their usual social engagements (such as hanging out with friends).

Clinical depression is characterized by the presence of 5 or more of these depressive symptoms:

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feeling sad, blue, “down in the dumps,” or empty) or observations made by others (e.g., appears tearful or about to cry). (In children and adolescents, this may present as an irritable or cranky, rather than sad, mood.)
- Markedly diminished interest or pleasure in all, or almost all, activities every day, such as no interest in hobbies, sports, or other things the person used to enjoy doing
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day
- Insomnia (inability to get to sleep or difficulty staying asleep) or hypersomnia (sleeping too much) nearly every day
- More days than not, problems with sitting still, including constant restlessness, pacing, or picking at one's cloths (called *psychomotor agitation* by professionals); or the opposite, a slowing of one's movements, talking very quietly with slowed speech (called *psychomotor retardation* by professionals)
- Fatigue, tiredness, or loss of energy nearly every day — even the smallest tasks, like dressing or washing, seem difficult to do and take longer than usual
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day (e.g., ruminating over minor past failings)
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (e.g., appears easily distracted, complains of memory difficulties)
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideas without a specific plan, or a suicide attempt or a specific plan for committing suicide

A depressed mood caused by substances (such as drugs, alcohol, medications) is not considered a major depressive disorder, nor is one which is caused by a general medical condition. Major depressive disorder generally cannot be diagnosed if a person has a history of manic, hypomanic, or mixed episodes (e.g., a bipolar disorder) or if the depressed mood is better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, a delusion or psychotic disorder.

Depression is also experienced as a loss of interest and energy in things the person normally enjoys doing, things like working, going out, or being with family and friends. Most people with this condition also experience problems with eating and sleeping — either too much or too little. A depressed person's memory and ability to concentrate will often be impaired, too; they may also be more irritable or feel restless all the time.

In keeping with updates to the major depressive disorder criteria in DSM-5 (the latest diagnostic manual of mental disorders), a person can suffer from a major depressive episode during a period of bereavement or grief, such as after the loss of a loved one. This is a significant change from the previous DSM-IV criteria, which did not give the diagnosis of major

depression if the person was grieving over a significant loss in their lives. This change was made with the rationale that since bereavement may induce great suffering in a person, it may induce an episode of major depressive disorder.

In other words, it's not normal for the symptoms of bereavement to induce significant functional impairment, morbid preoccupation with worthlessness, suicidal thoughts, psychotic symptoms, or psychomotor retardation (a slowing of a person's physical movements) for two months or more. Thus, when they do occur together, the depressive symptoms and functional impairment tend to be more severe and the prognosis is worse compared with bereavement that is not accompanied by major depressive disorder. Bereavement-related depression tends to occur in persons with other vulnerabilities to depressive disorders, and recovery may be facilitated by antidepressant treatment.

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#### **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 DMDD?

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### **14.9 LET US SUM UP**

There are several types of psychotic disorders but one which is reported frequently is schizophrenia. Schizophrenia affects people from all walks of life; and is about as prevalent as epilepsy. This psychotic disorder usually begins in late adolescence or early adulthood. Schizoaffective disorder is a disorder, that when diagnosed, an individual demonstrates symptoms of both Schizophrenia and a severe mood disorder: bipolar or unipolar. Another example of schizophrenia is Schizophreniform disorder. This disorder can last up to six months. The individual may experience social and occupational impairment during the episodes and a brief psychotic disorder. If the symptoms of brief psychotic disorder last for a month or longer, they will turn into one of the other disorders previously listed.

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### **14.10 UNIT-END EXERCISES**

1. Discuss the different psychotic disorders.
2. Explain the potential causes of psychotic disorders.
3. What is disruptive mood dysregulation?
4. Distinguish between Bipolar I and Bipolar II disorders.
5. What are the symptoms of major depressive disorder?

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### **14.11 ANSWERS 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.
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.

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4. The psychomotor symptoms of schizophrenia are collectively called catatonia
5. In Bipolar I disorder there is presence of mania and people experience episodes of mania and periods of depression (even if it does not reach the threshold of major depressive episode) whereas in Bipolar II disorder people experience hypomania (symptoms are below the threshold for full-blown mania) and also experience periods of depressed mood that meet the criteria for major depression.
6. Disruptive mood dysregulation disorder (DMDD) is a childhood condition of extreme irritability, anger, and frequent, intense temper outbursts.

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### **14.12 SUGGESTED READINGS**

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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* 16<sup>th</sup> 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.

**DISTANCE EDUCATION – CBCS –  
(Question Paper Pattern (ESE) – Theory  
B.Sc Psychology  
11934 – PSYCHOPATHOLOGY**

**Time: 3 hours**

**Max Marks: 75**

**PART A – (10 x 2 = 20 Marks)**

Answer all questions.

1. What is abnormal behaviour?
2. What is social phobia?
3. Define Intellectual disability.
4. What is Alzheimer's disorder?
5. What is dissociative fugue?
6. What are the chief symptoms of psychotic disorders?
7. Expand DSM and ICD.
8. What is anorexia nervosa?
9. What is cyclothymic disorder?
10. What are obsessions?

**PART B – (5 x 5 = 25 marks)**

Answer all questions choosing either (a) or (b)

11. a. What are the sociocultural factors that cause abnormal behaviour?  
(or)  
b. Write a note on how abnormal behaviour was conceived in the past.
12. a. Write a note on specific phobia.  
(or)  
b. What is generalized anxiety disorder?
13. a. What are the major symptoms of clinical depression?  
(or)  
b. Write a note on dissociative amnesia.
14. a. Describe antisocial personality disorder.  
(or)  
b. What is conversion disorder?
15. a. Write a short note on various eating disorders.  
(or)  
b. Write a note on sleep disorders.

*Model question Paper*

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*Self – Instructional Material*

**PART C – (3 x 10 = 30 marks)**

(Answer any 3 out of 5 questions)

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16. Describe the major viewpoints that explain abnormal behaviour.
17. Describe in detail about anxiety disorders, causes and treatment.
18. Discuss the clinical picture and treatment of schizophrenia.
19. Discuss the clinical picture and treatment of personality disorders.
20. Discuss the classification systems in psychopathology.

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