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SCHOOL OF SCIENCE AND HUMANITIES

DEPARTMENT OF PSYCHOLOGY

UNIT – I - PSYCHOPATHOLOGY - I – SPSY1402

HISTORY OF ABNORMAL PSYCHOLOGY

INTRODUCTION

You must have come across people who are unhappy, troubled and dissatisfied. Their minds and hearts are filled with sorrow, unrest and tension and they feel that they are unable to move ahead in their lives; they feel life is a painful, uphill struggle, sometimes not worth living. Famous analytical psychologist Carl Jung has quite remarkably said, “How can I be substantial without casting a shadow? I must have a dark side, too, if I am to be whole and by becoming conscious of my shadow, I remember once more that I am a human being like any other”. At times, some of you may have felt nervous before an important examination, tense and concerned about your future career or anxious when someone close to you was unwell. All of us face major problems at some point of our lives. However, some people have an extreme reaction to the problems and stresses of life. In this chapter, we will try to understand what goes wrong when people develop psychological problems, what are the causes and factors which lead to abnormal behaviour, and what are the various signs and symptoms associated with different types of psychological disorders?

The study of psychological disorders has intrigued and mystified all cultures for more than 2,500 years. Psychological disorders or mental disorders (as they are commonly referred to), like anything unusual may make us uncomfortable and even a little frightened. Unhappiness, discomfort, anxiety, and unrealised potential are seen all over the world. These failures in living are due mainly to failures in adaptation to life challenges. As you must have studied in the previous chapters, adaptation refers to the person's ability to modify her/his behaviour in response to changing environmental requirements. When the behaviour cannot be modified according to the needs of the situation, it is said to be maladaptive. Abnormal Psychology is the area within psychology that is focused on maladaptive behaviour – its causes, consequences, and treatment.

PREHISTORIC AND ANCIENT BELIEFS

Prehistoric cultures often held a supernatural view of abnormal behavior and saw it as the work of evil spirits, demons, gods, or witches who took control of the person. This form of demonic possession was believed to occur when the person engaged in behavior contrary to the religious teachings of the time. Treatment by cave dwellers included a technique called **trephination**, in which a stone instrument known as a trephine was used to remove part of the skull, creating an opening. They believed that evil spirits could escape through the hole in the skull, thereby ending the person's mental affliction and returning them to normal behavior. Early Greek, Hebrew, Egyptian, and Chinese cultures used a treatment method called **exorcism** in which evil spirits were cast out through prayer, magic, flogging, starvation, noise-making, or having the person ingest horrible tasting drinks.

GRECO-ROMAN THOUGHT

Rejecting the idea of demonic possession, Greek physician, Hippocrates (460-377 B.C.), said that mental disorders were akin to physical disorders and had natural causes. Specifically, he suggested that they arose from brain pathology, or head trauma/brain dysfunction or disease, and were also affected by heredity. Hippocrates classified mental disorders into three main categories – melancholia, mania, and phrenitis (brain fever) and gave detailed clinical descriptions of each. He also described four main fluids or **humors** that directed normal functioning and personality – blood which arose in the heart, black bile arising in the spleen, yellow bile or choler from the liver, and phlegm from the brain. Mental disorders occurred when the humors were in a state of imbalance such as an excess of yellow bile causing frenzy/mania and too much black bile causing melancholia/depression. Hippocrates believed mental illnesses could be treated as any other disorder and focused on the underlying pathology.

Also important was Greek philosopher, Plato (429-347 B.C.), who said that the mentally ill were not responsible for their own actions and so should not be punished. He emphasized the role of social environment and early learning in the development of

mental disorders and believed it was the responsibility of the community and their families to care for them in a humane manner using rational discussions. Greek physician, Galen (A.D. 129-199) said mental disorders had either physical or mental causes that included fear, shock, alcoholism, head injuries, adolescence, and changes in menstruation.

In Rome, physician Asclepiades (124-40 BC) and philosopher Cicero (106-43 BC) rejected Hippocrates' idea of the four humors and instead stated that melancholy arises from grief, fear, and rage; not excess black bile. Roman physicians treated mental disorders with massage and warm baths, with the hope that their patients be as comfortable as possible. They practiced the concept of "contrariis contrarius", meaning opposite by opposite, and introduced contrasting stimuli to bring about balance in the physical and mental domains. An example would be consuming a cold drink while in a warm bath.

THE MIDDLE AGES – 500 AD TO 1500 AD

The progress made during the time of the Greeks and Romans was quickly reversed during the Middle Ages with the increase in power of the Church and the fall of the Roman Empire. Mental illness was yet again explained as possession by the Devil and methods such as exorcism, flogging, prayer, the touching of relics, chanting, visiting holy sites, and holy water were used to rid the person of the Devil's influence. In extreme cases, the afflicted were confined, beat, and even executed. Scientific and medical explanations, such as those proposed by Hippocrates, were discarded at this time.

Group hysteria, or **mass madness**, was also seen in which large numbers of people displayed similar symptoms and false beliefs. This included the belief that one was possessed by wolves or other animals and imitated their behavior, called **lycanthropy**, and a mania in which large numbers of people had an uncontrollable desire to dance and jump, called **tarantism**. The latter was believed to have been caused by the bite of the wolf spider, now called the tarantula, and spread quickly from Italy to Germany and other parts of Europe where it was called **Saint Vitus's dance**.

Perhaps the return to supernatural explanations during the Middle Ages makes sense given events of the time. The Black Death or Bubonic Plague had killed up to a

third, and according to other estimates almost half, of the population. Famine, war, social oppression, and pestilence were also factors. Death was ever present which led to an epidemic of depression and fear. Nevertheless, near the end of the Middle Ages, mystical explanations for mental illness began to lose favor and government officials regained some of their lost power over nonreligious activities. Science and medicine were once again called upon to explain mental disorders.

THE RENAISSANCE – 14TH TO 16TH CENTURIES

The most noteworthy development in the realm of philosophy during the Renaissance was the rise of **humanism**, or the worldview that emphasizes human welfare and the uniqueness of the individual. This helped continue the decline of supernatural views of mental illness. In the mid to late 1500s, Johann Weyer (1515-1588), a German physician, published his book, *On the Deceits of the Demons*, that rebutted the Church's witch-hunting handbook, the *Malleus Maleficarum*, and argued that many accused of being witches and subsequently imprisoned, tortured, hung, and/or burned at the stake, were mentally disturbed and not possessed by demons or the Devil himself. He believed that like the body, the mind was susceptible to illness. Not surprisingly, the book was met with vehement protest and even banned from the church. It should be noted that these types of acts occurred not only in Europe but also in the United States. The most famous example was the Salem Witch Trials of 1692 in which more than 200 people were accused of practicing witchcraft and 20 were killed.

The number of **asylums**, or places of refuge for the mentally ill where they could receive care, began to rise during the 16th century as the government realized there were far too many people afflicted with mental illness to be left in private homes. Hospitals and monasteries were converted into asylums. Though the intent was benign in the beginning, as they began to overflow patients came to be treated more like animals than people. In 1547, the Bethlem Hospital opened in London with the sole purpose of confining those with mental disorders. Patients were chained up, placed on public display, and often heard crying out in pain. The asylum became a tourist attraction, with sightseers paying a penny to view the more violent patients, and soon was called "Bedlam" by local people; a term that today means "a state of uproar and confusion" (<https://www.merriam-webster.com/dictionary/bedlam>).

REFORM MOVEMENT – 18TH TO 19TH CENTURIES

The rise of the **moral treatment movement** occurred in Europe in the late 18th century and then in the United States in the early 19th century. Its earliest proponent was Phillipe Pinel (1745-1826) who was assigned as the superintendent of la Bicetre, a hospital for mentally ill men in Paris. He emphasized the importance of affording the mentally ill respect, moral guidance, and humane treatment, all while considering their individual, social, and occupational needs. Arguing that the mentally ill were sick people, Pinel ordered that chains be removed, outside exercise be allowed, sunny and well-ventilated rooms replace dungeons, and patients be extended kindness and support. This approach led to considerable improvement for many of the patients, so much so, that several were released.

Following Pinel's lead in England, William Tuke (1732-1822), a Quaker tea merchant, established a pleasant rural estate called the York Retreat. The Quakers believed that all people should be accepted for who they were and treated kindly. At the retreat, patients could work, rest, talk out their problems, and pray (Raad & Makari, 2010). The work of Tuke and others led to the passage of the County Asylums Act of 1845 which required that every county in England and Wales provide asylum to the mentally ill. This was even extended to English colonies such as Canada, India, Australia, and the West Indies as word of the maltreatment of patients at a facility in Kingston, Jamaica spread, leading to an audit of colonial facilities and their policies.

Reform in the United States started with the figure largely considered to be the father of American psychiatry, Benjamin Rush (1745-1813). Rush advocated for the humane treatment of the mentally ill, showing them respect, and even giving them small gifts from time to time. Despite this, his practice included treatments such as bloodletting and purgatives, the invention of the "tranquilizing chair," and a reliance on astrology, showing that even he could not escape from the beliefs of the time.

Due to the rise of the moral treatment movement in both Europe and the United States, asylums became habitable places where those afflicted with mental illness could recover. However, it is often said that the moral treatment movement was a victim of its own success. The number of mental hospitals greatly increased leading to staffing shortages and a lack of funds to support them. Though treating patients humanely was a

noble endeavor, it did not work for some and other treatments were needed, though they had not been developed yet. It was also recognized that the approach worked best when the facility had 200 or fewer patients. However, waves of immigrants arriving in the U.S. after the Civil War were overwhelming the facilities, with patient counts soaring to 1,000 or more. Prejudice against the new arrivals led to discriminatory practices in which immigrants were not afforded moral treatments provided to native citizens, even when the resources were available to treat them.

Another leader in the moral treatment movement was Dorothea Dix (1802-1887), a New Englander who observed the deplorable conditions suffered by the mentally ill while teaching Sunday school to female prisoners. She instigated the **mental hygiene movement**, which focused on the physical well-being of patients. Over the span of 40 years, from 1841 to 1881, she motivated people and state legislators to do something about this injustice and raised millions of dollars to build over 30 more appropriate mental hospitals and improve others. Her efforts even extended beyond the U.S. to Canada and Scotland.

Finally, in 1908 Clifford Beers (1876-1943) published his book, *A Mind that Found Itself*, in which he described his personal struggle with bipolar disorder and the “cruel and inhumane treatment people with mental illnesses received. He witnessed and experienced horrific abuse at the hands of his caretakers. At one point during his institutionalization, he was placed in a straightjacket for 21 consecutive nights.” . His story aroused sympathy in the public and led him to found the National Committee for Mental Hygiene, known today as Mental Health America, which provides education about mental illness and the need to treat these people with dignity. Today, MHA has over 200 affiliates in 41 states and employs 6,500 affiliate staff and over 10,000 volunteers.

For more information on MHA, please visit: <http://www.mentalhealthamerica.net/>

20TH – 21ST CENTURIES

The decline of the moral treatment approach in the late 19th century led to the rise of two competing perspectives – the biological or somatogenic perspective and the psychological or psychogenic perspective.

BIOLOGICAL OR SOMATOGENIC PERSPECTIVE

Recall that Greek physicians Hippocrates and Galen said that mental disorders were akin to physical disorders and had natural causes. Though the idea fell into oblivion for several centuries it re-emerged in the late 19th century for two reasons. First, German psychiatrist, Emil Kraepelin (1856-1926), discovered that symptoms occurred regularly in clusters which he called **syndromes**. These syndromes represented a unique mental disorder with its own cause, course, and prognosis. In 1883 he published his textbook, *Compendium der Psychiatrie* (Textbook of Psychiatry), and described a system for classifying mental disorders that became the basis of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) that is currently in its 5th edition (published in 2013).

Secondly, in 1825, the behavioral and cognitive symptoms of advanced syphilis were identified to include delusions (e.g., false beliefs that everyone is plotting against you or that you are God), and were termed general paresis by French physician A.L.J. Bayle. In 1897, Viennese psychiatrist Richard von Krafft-Ebbing injected patients with general paresis with matter from syphilis spores and noted that none of the patients developed symptoms of syphilis, indicating they must have been previously exposed and were now immune. This led to the conclusion that syphilis (a bacterial infection) was the cause of the general paresis. In 1906, August von Wassermann developed a blood test for syphilis and in 1917 a cure was stumbled upon. Julius von Wagner-Jauregg noticed that patients with general paresis who contracted malaria recovered from their symptoms. To test this hypothesis, he injected nine patients with blood from a soldier afflicted with malaria. Three of patients fully recovered while three others showed great improvement in their parietic symptoms. The high fever caused by malaria burned out the syphilis bacteria. Hospitals in the United States began incorporating this new cure for paresis into their treatment approach by 1925.

Also noteworthy was the work of American psychiatrist John P. Grey. Appointed as superintendent of the Utica State Hospital in New York, Grey asserted that insanity always had a physical cause. As such, the mentally ill should be seen as physically ill and treated with rest, proper room temperature and ventilation, and a proper diet.

The 1930s also saw the use of electric shock as a treatment method, which was stumbled upon accidentally by Benjamin Franklin while experimenting with electricity in the early 18th century. He noticed that after experiencing a severe shock his memories had changed and in published work, suggested physicians study electric shock as a treatment for melancholia.

Beginning in the 1950s, psychiatric or psychotropic drugs were used for the treatment of mental illness and made an immediate impact. Though drugs alone cannot cure mental illness, they can improve symptoms. Classes of psychiatric drugs include antidepressants used to treat depression and anxiety, mood-stabilizing medications to treat bipolar disorder, antipsychotic drugs to treat schizophrenia and other psychotic disorders, and anti-anxiety drugs used to treat generalized anxiety disorder or panic disorder

Frank (2006) found that by 1996, psychotropic drugs were used in 77% of mental health cases and spending on these drugs to treat mental disorders grew from \$2.8 billion in 1987 to about \$18 billion in 2001 (Coffey et al., 2000; Mark et al., 2005), representing a greater than sixfold increase. The largest classes of psychotropic drugs are antipsychotic and anti-depressant medications followed closely by anti-anxiety medications. Frank, Conti, and Goldman (2005) point out, “The expansion of insurance coverage for prescription drugs, the introduction and diffusion of managed behavioral health care techniques, and the conduct of the pharmaceutical industry in promoting their products all have influenced how psychotropic drugs are used and how much is spent on them.” Is it possible then that we are overprescribing these medications? Davey (2014) provides ten reasons why this may be so to include individuals believing that recovery is out of their hands but instead in the hands of their doctors, increased risk of relapse, drug companies causing the “medicalization of perfectly normal emotional processes, such as bereavement” to ensure their own survival, side effects, and a failure to change the way the person thinks or the socioeconomic environments that may be the cause of the disorder. For more on this article, . Smith (2012) echoed similar sentiments in an article on inappropriate prescribing and cites the approval of Prozac by the Food and Drug Administration (FDA) in 1987 as when the issue began and the overmedication/overdiagnosis of children with ADHD as a more recent example.

A result of the use of psychiatric drugs was **deinstitutionalization** or the release of patients from mental health facilities. This shifted resources from inpatient to outpatient care and placed the spotlight back on the biological or somatogenic perspective. Today, when people with severe mental illness do need inpatient care, it is typically in the form of short-term hospitalization.

PSYCHOLOGICAL OR PSYCHOGENIC PERSPECTIVE

The **psychological or psychogenic perspective** states that emotional or psychological factors are the cause of mental disorders and represented a challenge to the biological perspective.

THE HISTORY OF HYPNOSIS

This perspective had a long history but did not gain favor until the work of Viennese physician Franz Anton Mesmer (1734-1815). Influenced heavily by Newton's theory of gravity, he believed that the planets also affected the human body through the force of animal magnetism and that all people had a universal magnetic fluid that determined how healthy they were. He demonstrated the usefulness of his approach when he cured Franzl Oesterline, a 27-year old woman experiencing what he described as a convulsive malady. Mesmer used a magnet to disrupt the gravitational tides that were affecting his patient and produced a sensation of the magnetic fluid draining from her body. This removed the illness from her body and produced a near instantaneous recovery. In reality, the patient was placed in a trancelike state which made her highly suggestible. With other patients, Mesmer would have them sit in a darkened room filled with soothing music, into which he would enter dressed in a colorful robe and passed from person to person touching the afflicted area of their body with his hand or a special rod/wand. He successfully cured deafness, paralysis, loss of bodily feeling, convulsions, menstrual difficulties, and blindness.

His approach gained him celebrity status as he demonstrated it at the courts of English nobility. The medical community was hardly impressed. A royal commission was formed to investigate his technique but could not find any proof for his theory of animal magnetism. Though he was able to cure patients when they touched his "magnetized" tree, the result was the same when "non-magnetized" trees were touched.

As such, Mesmer was deemed a charlatan and forced to leave Paris. His technique was called **mesmerism**, and today we know it as an early form of hypnosis.

The psychological perspective gained popularity after two physicians practicing in the city of Nancy in France discovered that they could induce the symptoms of hysteria in perfectly healthy patients through hypnosis and then remove the symptoms in the same way. The work of Hippolyte-Marie Bernheim (1840-1919) and Ambroise-Auguste Liebault (1823-1904) came to be part of what was called the Nancy School and showed that hysteria was nothing more than a form of self-hypnosis. In Paris, this view was challenged by Jean Charcot (1825-1893) who stated that hysteria was caused by degenerative brain changes, reflecting the biological perspective. He was proven wrong and eventually turned to their way of thinking.

The use of hypnosis to treat hysteria was also carried out by fellow Frenchman Pierre Janet (1859-1947), and student of Charcot, who believed that hysteria had psychological, not biological causes. Namely, these included unconscious forces, fixed ideas, and memory impairments. In Vienna, Josef Breuer (1842-1925) induced hypnosis and had patients speak freely about past events that upset them. Upon waking, he discovered that patients sometimes were free of their symptoms of hysteria. Success was even greater when patients not only recalled forgotten memories but also relieved them emotionally. He called this the **cathartic method** and our use of the word catharsis today indicates a purging or release, in this case, of pent-up emotion. Sigmund Freud's development of psychoanalysis followed on the heels of the work of Breuer, and others who came before him.

CONCEPT OF ABNORMAL AND PSYCHOLOGICAL DISORDER

Although many definitions of abnormality have been used over the years, none has won universal acceptance. Still, most definitions have certain common features, often called the 'four Ds': **deviance**, **distress**, **dysfunction** and **danger**. That is, psychological disorders are **deviant** (different, extreme, unusual, even bizarre), **distressing** (unpleasant and upsetting to the person and to others), **dysfunctional** (interfering with the person's ability to carry out daily activities in a constructive way), and possibly **dangerous** (to the person or to others).

This definition is a useful starting point from which we can explore psychological abnormality. Since the word ‘abnormal’ literally means “away from the normal”, it implies deviation from some clearly defined norms or standards. In psychology, we have no ‘ideal model’ or even ‘normal model’ of human behaviour to use as a base for comparison. Various approaches have been used in distinguishing between normal and abnormal behaviours. From these approaches, there emerge two basic and conflicting views:

The first approach views abnormal behaviour as a **deviation from social norms**. Many psychologists have stated that ‘abnormal’ is simply a label that is given to a behaviour which is deviant from social expectations. Abnormal behaviour, thoughts and emotions are those that differ markedly from a society’s ideas of proper functioning. Each society has **norms**, which are stated or unstated rules for proper conduct. Behaviours, thoughts and emotions that break societal norms are called abnormal. A society’s norms grow from its particular **culture** — its history, values, institutions, habits, skills, technology, and arts. Thus, a society whose culture values competition and assertiveness may accept aggressive behaviour, whereas one that emphasises cooperation and family values (such as in India) may consider aggressive behaviour as unacceptable or even abnormal. A society’s values may change over time, causing its views of what is psychologically abnormal to change as well. Serious questions have been raised about this definition. It is based on the assumption that socially accepted behaviour is not abnormal, and that normality is nothing more than conformity to social norms.

THE SECOND APPROACH VIEWS ABNORMAL

Behaviour as **maladaptive**. Many psychologists believe that the best criterion for determining the normality of behaviour is not whether society accepts it but whether it fosters the well-being of the individual and eventually of the group to which s/he belongs. **Well-being** is not simply maintenance and survival but also includes growth and fulfilment, i.e. the actualisation of potential, which you must have studied in Maslow’s need hierarchy theory. According to this criterion, conforming

behaviour can be seen as abnormal if it is maladaptive, i.e. if it interferes with optimal functioning and growth. For example, a student in the class

prefers to remain silent even when s/he has questions in her/his mind. Describing behaviour as maladaptive implies that a problem exists; it also suggests that vulnerability in the individual, inability to cope, or exceptional stress in the environment have led to problems in life.

If you talk to people around, you will see that they have vague ideas about psychological disorders that are characterised by superstition, ignorance and fear. Again it is commonly believed that psychological disorder is something to be ashamed of. The **stigma** attached to mental illness means that people are hesitant to consult a doctor or psychologist because they are ashamed of their problems. Actually, psychological disorder which indicates a failure in adaptation should be viewed as any other illness.

HISTORICAL BACKGROUND

To understand psychological disorders, we would require a brief historical account of how these disorders have been viewed over the ages. When we study the history of abnormal psychology, we find that certain theories have occurred over and over again. One ancient theory that is still encountered today holds that abnormal behaviour can be explained by the operation of **supernatural** and **magical forces** such as evil spirits (bhoot-pret), or the devil (shaitan). **Exorcism**, i.e. removing the evil that resides in the individual through counter magic and prayer, is still commonly used. In many societies, the shaman, or medicine man (ojha) is a person who is believed to have contact with supernatural forces and is the medium through which spirits communicate with human beings. Through the shaman, an afflicted person can learn which spirits are responsible for her/his problems and what needs to be done to appease them.

A recurring theme in the history of abnormal psychology is the belief that individuals behave strangely because their bodies and their brains are not working properly. This is the **biological** or **organic approach**. In the modern era, there is evidence that body and brain processes have been linked to many types of maladaptive behaviour. For certain types of disorders, correcting these defective

biological processes results in improved functioning. Another approach is the **psychological approach**. According to this point of view, psychological problems are caused by inadequacies in the way an individual thinks, feels, or perceives the world.

All three of these perspectives — supernatural, biological or organic, and psychological — have recurred throughout the history of Western civilisation. In the ancient Western world, it was philosopher-physicians of ancient Greece such as Hippocrates, Socrates, and in particular Plato who developed the **organismic approach** and viewed disturbed behaviour as arising out of conflicts between emotion and reason. Galen elaborated on the role of the **four humours** in personal character and temperament. According to him, the material world was made up of four elements, viz. earth, air, fire, and water which combined to form four essential body fluids, viz. blood, black bile, yellow bile, and phlegm. Each of these fluids was seen to be responsible for a different temperament. Imbalances among the humours were believed to cause various disorders. This is similar to the Indian notion of the three doshas of vata, pitta and kapha which were mentioned in the Atharva Veda and Ayurvedic texts. You have already read about it in Chapter 2. In the **Middle Ages**, demonology and superstition gained renewed importance in the explanation of abnormal behaviour. Demonology related to a belief that people with mental problems were evil and there are numerous instances of ‘witch-hunts’ during this period. During the early Middle Ages, the Christian spirit of charity prevailed and St. Augustine wrote extensively about feelings, mental anguish and conflict. This laid the groundwork for modern psychodynamic theories of abnormal behaviour.

The **Renaissance Period** was marked by increased humanism and curiosity about behaviour. Johann Weyer emphasised psychological conflict and disturbed interpersonal relationships as causes of psychological disorders. He also insisted that ‘witches’ were mentally disturbed and required medical, not theological, treatment.

The seventeenth and eighteenth centuries were known as the **Age of Reason and Enlightenment**, as the scientific method replaced faith and dogma as ways of understanding abnormal behaviour. The growth of a scientific attitude towards psychological disorders in the eighteenth century contributed to the **Reform Movement** and to increased compassion for people who suffered from these

disorders. Reforms of asylums were initiated in both Europe and America. One aspect of the reform movement was the new inclination for **deinstitutionalisation** which placed emphasis on providing community care for recovered mentally ill individuals.

In recent years, there has been a convergence of these approaches, which has resulted in an **interactional**, or **bio- psycho-social approach**. From this perspective, all three factors, i.e. biological, psychological and social play important roles in influencing the expression and outcome of psychological disorders.

each disorder, a description of the main clinical features or symptoms, and of other associated features including diagnostic guidelines is provided in this scheme.

CLASSIFICATION OF PSYCHOLOGICAL DISORDERS

In order to understand psychological disorders, we need to begin by classifying them. A classification of such disorders consists of a list of categories of specific psychological disorders grouped into various classes on the basis of some shared characteristics. Classifications are useful because they enable users like psychologists, psychiatrists and social workers to communicate with each other about the disorder and help in understanding the causes of psychological disorders and the processes involved in their development and maintenance.

The American Psychiatric Association (APA) has published an official manual describing and classifying various kinds of psychological disorders. The current version of it, the **Diagnostic and Statistical Manual of Mental Disorders, IV Edition (DSM-IV)**, evaluates the patient on five axes or dimensions rather than just one broad aspect of 'mental disorder'. These dimensions relate to biological, psychological, social and other aspects.

The classification scheme officially used in India and elsewhere is the tenth revision of the **International Classification of Diseases (ICD-10)**, which is known as the **ICD-10 Classification of Behavioural and Mental Disorders**. It was prepared by the World Health Organisation (WHO).

FACTORS UNDERLYING ABNORMAL BEHAVIOUR

In order to understand something as complex as abnormal behaviour, psychologists use different approaches. Each approach in use today emphasises a different aspect of human behaviour, and explains and treats abnormality in line with that aspect. These approaches also emphasise the role of different factors such as biological, psychological and interpersonal, and socio-cultural factors. We will examine some of the approaches which are currently being used to explain abnormal behaviour.

Biological factors influence all aspects of our behaviour. A wide range of biological factors such as faulty genes, endocrine imbalances, malnutrition, injuries and other conditions may interfere with normal development and functioning of the human body. These factors may be potential causes of abnormal behaviour. We have already come across the biological model. According to this model, abnormal behaviour has a biochemical or physiological basis. Biological researchers have found that psychological disorders are often related to problems in the transmission of messages from one neuron to another. You have studied in Class XI, that a tiny space called synapse separates one neuron from the next, and the message must move across that space. When an electrical impulse reaches a neuron's ending, the nerve ending is stimulated to release a chemical, called a **neuro-transmitter**. Studies indicate that abnormal activity by certain neuro-transmitters can lead to specific psychological disorders. Anxiety disorders have been linked to low activity of the neurotransmitter gamma aminobutyric acid (GABA), schizophrenia to excess activity of dopamine, and depression to low activity of serotonin.

Genetic factors have been linked to mood disorders, schizophrenia, mental retardation and other psychological disorders. Researchers have not, however, been able to identify the specific genes that are the culprits. It appears that in most cases, no single gene is responsible for a particular behaviour or a psychological disorder. Infact, many genes combine to help bring about our various behaviours and emotional reactions, both functional and dysfunctional. Although there is sound evidence to believe that genetic/ biochemical factors are involved in mental disorders as diverse as schizophrenia, depression, anxiety, etc. and biology alone cannot account for most mental disorders. There are several **psychological models** which provide a psychological explanation of mental disorders. These models maintain that psychological and interpersonal factors have a significant role to

play in abnormal behaviour. These factors include maternal deprivation (separation from the mother, or lack of warmth and stimulation during early years of life), faulty parent-child relationships (rejection, overprotection, over-permissiveness, faulty discipline, etc.), maladaptive family structures (inadequate or disturbed family), and severe stress.

The psychological models include the psychodynamic, behavioural, cognitive, and humanistic-existential models. The **psychodynamic model** is the oldest and most famous of the modern psychological models. You have already read about this model in Chapter 2 on Self and Personality. Psychodynamic theorists believe that behaviour, whether normal or abnormal, is determined by psychological forces within the person of which s/he is not consciously aware. These internal forces are considered dynamic, i.e. they interact with one another and their interaction gives shape to behaviour, thoughts and emotions. Abnormal symptoms are viewed as the result of conflicts between these forces. This model was first formulated by Freud who believed that three central forces shape personality — instinctual needs, drives and impulses (id), rational thinking (ego), and moral standards (superego). Freud stated that abnormal behaviour is a symbolic expression of unconscious mental conflicts that can be generally traced to early childhood or infancy.

another model that emphasises the role of psychological factors is the **behavioural model**. This model states that both normal and abnormal behaviours are learned and psychological disorders are the result of learning maladaptive ways of behaving. The model concentrates on behaviours that are learned through conditioning and proposes that what has been learned can be unlearned. Learning can take place by classical conditioning (temporal association in which two events repeatedly occur close together in time), operant conditioning (behaviour is followed by a reward), and social learning (learning by imitating others' behaviour). These three types of conditioning account for behaviour, whether adaptive or maladaptive.

Psychological factors are also emphasised by the **cognitive model**. This model states that abnormal functioning can result from cognitive problems. People may hold assumptions and attitudes about themselves that are irrational and inaccurate. People may also repeatedly think in illogical ways and make overgeneralisations,

that is, they may draw broad, negative conclusions on the basis of a single insignificant event.

Another psychological model is the **humanistic-existential model** which focuses on broader aspects of human existence. Humanists believe that human beings are born with a natural tendency to be friendly, cooperative and constructive, and are driven to self-actualise, i.e. to fulfil this potential for goodness and growth. Existentialists believe that from birth we have total freedom to give meaning to our existence or to avoid that responsibility. Those who shirk from this responsibility would live empty, inauthentic, and dysfunctional lives.

In addition to the biological and psychosocial factors, socio-cultural factors such as war and violence, group prejudice and discrimination, economic and employment problems, and rapid social change, put stress on most of us and can also lead to psychological problems in some individuals. According to the **socio-cultural model**, abnormal behaviour is best understood in light of the social and cultural forces that influence an individual. As behaviour is shaped by societal forces, factors such as family structure and communication, social networks, societal conditions, and societal labels and roles become more important. It has been found that certain family systems are likely to produce abnormal functioning in individual members. Some families have an enmeshed structure in which the members are overinvolved in each other's activities, thoughts, and feelings. Children from this kind of family may have difficulty in becoming independent in life. The broader social networks in which people operate include their social and professional relationships. Studies have shown that people who are isolated and lack social support, i.e. strong and fulfilling interpersonal relationships in their lives are likely to become more depressed and remain depressed longer than those who have good friendships. Socio-cultural theorists also believe that abnormal functioning is influenced by the societal labels and roles assigned to troubled people. When people break the norms of their society, they are called deviant and 'mentally ill'. Such labels tend to stick so that the person may be viewed as 'crazy' and encouraged to act sick. The person gradually learns to accept and play the sick role, and functions in a disturbed manner.

In addition to these models, one of the most widely accepted explanations of abnormal behaviour has been provided by the **diathesis-stress model**. This model states

that psychological disorders develop when a diathesis (biological predisposition to the disorder) is set off by a stressful situation. This model has three components. The first is the diathesis or the presence of some biological aberration which may be inherited. The second component is that the diathesis may carry a vulnerability to develop a psychological disorder. This means that the person is 'at risk' or 'predisposed' to develop the disorder. The third component is the presence of pathogenic stressors, i.e. factors/stressors that may lead to psychopathology. If such "at risk" persons are exposed to these stressors, their predisposition may actually evolve into a disorder. This model has been applied to several disorders including anxiety, depression, and schizophrenia.

MAJOR PSYCHOLOGICAL DISORDER

ANXIETY DISORDERS

One day while driving home, Deb felt his heart beating rapidly, he started sweating profusely, and even felt short of breath. He was so scared that he stopped the car and stepped out. In the next few months, these attacks increased and now he was hesitant to drive for fear of being caught in traffic during an attack. Deb started feeling that he had gone crazy and would die. Soon he remained indoors and refused to move out of the house.

We experience anxiety when we are waiting to take an examination, or to visit a dentist, or even to give a solo performance. This is normal and expected and even motivates us to do our task well. On the other hand, high levels of anxiety that are distressing and interfere with effective functioning indicate the presence of an anxiety disorder — the most common category of psychological disorders.

Everyone has worries and fears. The term **anxiety** is usually defined as a diffuse, vague, very unpleasant feeling of fear and apprehension. The anxious individual also shows combinations of the following symptoms: rapid heart rate, shortness of breath, diarrhoea, loss of appetite, fainting, dizziness, sweating, sleeplessness, frequent urination and tremors. There are many types of anxiety disorders (see Table 4.2). They include **generalised anxiety disorder**, which consists of prolonged, vague, unexplained and intense fears that are not attached to any particular object. The symptoms include worry and apprehensive feelings about the future; hypervigilance, which involves constantly

scanning the environment for dangers. It is marked by motor tension, as a result of which the person is unable to relax, is restless, and visibly shaky and tense.

Another type of anxiety disorder is **panic disorder**, which consists of recurrent anxiety attacks in which the person experiences intense terror. A panic attack denotes an abrupt surge of intense anxiety rising to a peak when thoughts of a particular stimuli are present. Such thoughts occur in an unpredictable manner. The clinical features include shortness of breath, dizziness, trembling, palpitations, choking, nausea, chest pain or discomfort, fear of going crazy, losing control or dying.

You might have met or heard of someone who was afraid to travel in a lift or climb to the tenth floor of a building, or refused to enter a room if s/he saw a lizard. You may have also felt it yourself or seen a friend unable to speak a word of a well-memorised and rehearsed speech before an audience. These kinds of fears are termed as **phobias**. People who have phobias have irrational fears related to specific objects, people, or situations. Phobias often develop gradually or begin with a generalised anxiety disorder. Phobias can be grouped into three main types, i.e. specific phobias, social phobias, and agoraphobia.

Specific phobias are the most commonly occurring type of phobia. This group includes irrational fears such as intense fear of a certain type of animal, or of being in an enclosed space. Intense and incapacitating fear and embarrassment when dealing with others characterises **social phobias**. **Agoraphobia** is the term used when people develop a fear of entering unfamiliar situations. Many agoraphobics are afraid of leaving their home. So their ability to carry out normal life activities is severely limited.

Have you ever noticed someone washing their hands everytime they touch something, or washing even things like coins, or stepping only within the patterns on the floor or road while walking? People affected by **obsessive-compulsive disorder** are unable to control their preoccupation with specific ideas or are unable to prevent themselves from repeatedly carrying out a particular act or series of acts that affect their ability to carry out normal activities. **Obsessive behaviour** is the inability to stop thinking about a particular idea or topic. The person involved, often finds these thoughts to be unpleasant and shameful. **Compulsive behaviour** is the need to perform certain behaviours over and over again. Many compulsions deal with counting, ordering, checking, touching and washing.

Very often people who have been caught in a natural disaster (such as tsunami) or have been victims of bomb blasts by terrorists, or been in a serious accident or in a war-related situation, experience **post-traumatic stress disorder** (PTSD). PTSD symptoms vary widely but may include recurrent dreams, flashbacks, impaired concentration, and emotional numbing.

SOMATOFORM DISORDERS

These are conditions in which there are physical symptoms in the absence of a physical disease. In somatoform disorders, the individual has psychological difficulties and complains of physical symptoms, for which there is no biological cause. Somatoform disorders include pain disorders, somatisation disorders, conversion disorders, and hypochondriasis.

Pain disorders involve reports of extreme and incapacitating pain, either without any identifiable biological symptoms or greatly in excess of what might be expected to accompany biological symptoms. How people interpret pain influences their overall adjustment. Some pain sufferers can learn to use active coping, i.e. remaining active and ignoring the pain. Others engage in passive coping, which leads to reduced activity and social withdrawal.

Patients with **somatisation disorders** have multiple and recurrent or chronic bodily complaints. These complaints are likely to be presented in a dramatic and exaggerated way. Common complaints are headaches, fatigue, heart palpitations, fainting spells, vomiting, and allergies. Patients with this disorder believe that they are sick, provide long and detailed histories of their illness, and take large quantities of medicine.

The symptoms of **conversion disorders** are the reported loss of part or all of some basic body functions. Paralysis, blindness, deafness and difficulty in walking are generally among the symptoms reported.

These symptoms often occur after a stressful experience and may be quite sudden.

Hypochondriasis is diagnosed if a person has a persistent belief that s/he has a serious illness, despite medical reassurance, lack of physical findings, and failure to

develop the disease. Hypochondriacs have an obsessive preoccupation and concern with the condition of their bodily organs, and they continually worry about their health.

DISSOCIATIVE DISORDERS

Dissociation can be viewed as severance of the connections between ideas and emotions. Dissociation involves feelings of unreality, estrangement, depersonalisation, and sometimes a loss or shift of identity. Sudden temporary alterations of consciousness that blot out painful experiences are a defining characteristic of **dissociative disorders**. Four conditions are included in this group: dissociative amnesia, dissociative fugue, dissociative identity disorder, and depersonalisation. Salient features of somatoform and dissociative disorders are given in Box 4.1.

SALIENT FEATURES OF SOMATOFORM AND DISSOCIATIVE DISORDERS

SOMATOFORM DISORDERS

Hypochondriasis : A person interprets insignificant symptoms as signs of a serious illness despite repeated medical evaluation that point to no pathology/disease.

Somatisation : A person exhibits vague and recurring physical/bodily symptoms such as pain, acidity, etc., without any organic cause.

Conversion : The person suffers from a loss or impairment of motor or sensory function (e.g., paralysis, blindness, etc.) that has no physical cause but may be a response to stress and psychological problems.

Dissociative Disorders

Dissociative amnesia : The person is unable to recall important, personal information often related to a stressful and traumatic report. The extent of forgetting is beyond normal.

Dissociative fugue : The person suffers from a rare disorder that combines amnesia with travelling away from a stressful environment.

Dissociative identity (multiple personality) : The person exhibits two or more separate and contrasting personalities associated with a history of physical abuse.

Dissociative amnesia is characterised by extensive but selective memory loss that has no known organic cause (e.g., head injury). Some people cannot remember anything about their past. Others can no longer recall specific events, people, places, or objects, while their memory for other events remains intact. This disorder is often associated with an overwhelming stress.

Dissociative fugue has, as its essential feature, an unexpected travel away from home and workplace, the assumption of a new identity, and the inability to recall the previous identity. The fugue usually ends when the person suddenly ‘wakes up’ with no memory of the events that occurred during the fugue.

Dissociative identity disorder, often referred to as multiple personality, is the most dramatic of the dissociative disorders. It is often associated with traumatic experiences in childhood. In this disorder, the person assumes alternate personalities that may or may not be aware of each other.

Depersonalisation involves a dreamlike state in which the person has a sense of being separated both from self and from reality. In depersonalisation, there is a change of self-perception, and the person’s sense of reality is temporarily lost or changed.

MOOD DISORDERS

Mood disorders are characterised by disturbances in mood or prolonged emotional state. The most common mood disorder is **depression**, which covers a variety of negative moods and behavioural changes. Depression can refer to a symptom or a disorder. In day-to-day life, we often use the term depression to refer to normal feelings after a significant loss, such as the break-up of a relationship, or the failure to attain a significant goal. The main types of mood disorders include depressive, manic and bipolar disorders

. **Major depressive disorder** is defined as a period of depressed mood and/or loss of interest or pleasure in most activities, together with other symptoms which may include change in body weight, constant sleep problems, tiredness, inability to think

clearly, agitation, greatly slowed behaviour, and thoughts of death and suicide. Other symptoms include excessive guilt or feelings of worthlessness.

Factors Predisposing towards Depression : Genetic make-up, or heredity is an important risk factor for major depression and bipolar disorders. Age is also a risk factor. For instance, women are particularly at risk during young adulthood, while for men the risk is highest in early middle age. Similarly gender also plays a great role in this differential risk addition. For example, women in comparison to men are more likely to report a depressive disorder. Other risk factors are experiencing negative life events and lack of social support.

Another less common mood disorder is **mania** . People suffering from mania become euphoric ('high'), extremely active, excessively talkative, and easily distractible. Manic episodes rarely appear by themselves; they usually alternate with depression. Such a mood disorder, in which both mania and depression are alternately present, is sometimes interrupted by periods of normal mood. This is known as **bipolar mood disorder**.

Bipolar mood disorders were earlier referred to as manic-depressive disorders. Among the mood disorders, the lifetime risk of a suicide attempt is highest in case of bipolar mood disorders. Several risk factors in addition to mental health status of a person predict the likelihood of suicide. These include age, gender, ethnicity, or race and recent occurrence of serious life events. Teenagers and young adults are as much at high risk for suicide, as those who are over 70 years. Gender is also an influencing factor, i.e. men have a higher rate of contemplated suicide than women. Other factors that affect suicide rates are cultural attitudes toward suicide. In Japan, for instance, suicide is the culturally appropriate way to deal with feeling of shame and disgrace. Negative expectations, hopelessness, setting unrealistically high standards, and being over-critical in self-evaluation are important themes for those who have suicidal preoccupations.

Suicide can be prevented by being alert to some of the symptoms which include :

- changes in eating and sleeping habits
- withdrawal from friends, family and regular activities
- violent actions, rebellious behaviour, running away

- drug and alcohol abuse
- marked personality change
- persistent boredom
- difficulty in concentration
- complaints about physical symptoms, and
- loss of interest in pleasurable activities.
- However, seeking timely help from a professional counsellor/psychologist can help to prevent the likelihood of suicide.

SCHIZOPHRENIC DISORDERS

Schizophrenia is the descriptive term for a group of psychotic disorders in which personal, social and occupational functioning deteriorate as a result of disturbed thought processes, strange perceptions, unusual emotional states, and motor abnormalities. It is a debilitating disorder. The social and psychological costs of schizophrenia are tremendous, both to patients as well as to their families and society.

SYMPTOMS OF SCHIZOPHRENIA

The symptoms of schizophrenia can be grouped into three categories, viz. **positive symptoms** (i.e. excesses of thought, emotion, and behaviour), **negative symptoms** (i.e. deficits of thought, emotion, and behaviour), and **psychomotor symptoms**.

Positive symptoms are ‘pathological excesses’ or ‘bizarre additions’ to a person’s behaviour. Delusions, disorganised thinking and speech, heightened perception and hallucinations, and inappropriate affect are the ones most often found in schizophrenia.

Many people with schizophrenia develop **delusions**. A delusion is a false belief that is firmly held on inadequate grounds. It is not affected by rational argument, and has no basis in reality. **Delusions of persecution** are the most common in schizophrenia. People with this delusion believe that they are being plotted against, spied on, slandered, threatened, attacked or deliberately victimised. People with schizophrenia may also experience **delusions of reference** in which they attach special and personal

meaning to the actions of others or to objects and events. In **delusions of grandeur**, people believe themselves to be specially empowered persons and in **delusions of control**, they believe that their feelings, thoughts and actions are controlled by others.

People with schizophrenia may not be able to think logically and may speak in peculiar ways. These **formal thought disorders** can make communication extremely difficult. These include rapidly shifting from one topic to another so that the normal structure of thinking is muddled and becomes illogical (loosening of associations, derailment), inventing new words or phrases (neologisms), and persistent and inappropriate repetition of the same thoughts (perseveration).

Schizophrenics may have **hallucinations**, i.e. perceptions that occur in the absence of external stimuli. **Auditory hallucinations** are most common in schizophrenia. Patients hear sounds or voices that speak words, phrases and sentences directly to the patient (second-person hallucination) or talk to one another referring to the patient as s/he (third-person hallucination). Hallucinations can also involve the other senses. These include **tactile hallucinations** (i.e. forms of tingling, burning), **somatic hallucinations** (i.e. something happening inside the body such as a snake crawling inside one's stomach), **visual hallucinations** (i.e. vague perceptions of colour or distinct visions of people or objects), **gustatory hallucinations** (i.e. food or drink taste strange), and **olfactory hallucinations** (i.e. smell of poison or smoke).

People with schizophrenia also show **inappropriate affect**, i.e. emotions that are unsuited to the situation.

Negative symptoms are 'pathological deficits' and include poverty of speech, blunted and flat affect, loss of volition, and social withdrawal. People with schizophrenia show **alogia** or poverty of speech, i.e. a reduction in speech and speech content. Many people with schizophrenia show less anger, sadness, joy, and other feelings than most people do. Thus they have **blunted affect**. Some show no emotions at all, a condition known as **flat affect**. Also patients with schizophrenia experience **avolition**, or apathy and an inability to start or complete a course of action. People with this disorder may withdraw socially and become totally focused on their own ideas and fantasies.

People with schizophrenia also show **psychomotor symptoms**. They move less spontaneously or make odd grimaces and gestures. These symptoms may take extreme forms known as **catatonia**. People in a **catatonic stupor** remain motionless and silent for long stretches of time. Some show **catatonic rigidity**, i.e. maintaining a rigid,

upright posture for hours. Others exhibit **catatonic posturing**, i.e. assuming awkward, bizarre positions for long periods of time. Sub-types of schizophrenia and their characteristics.

BEHAVIOURAL AND DEVELOPMENTAL DISORDERS

Apart from those mentioned above, there are certain disorders that are specific to children and if neglected can lead to serious consequences later in life. Children have less self-understanding and they have not yet developed a stable sense of identity nor do they have an adequate frame of reference regarding reality, possibility, and value. As a result, they are unable to cope with stressful events which might be reflected in behavioural and emotional problems. On the other hand, although their inexperience and lack of self-sufficiency make them easily upset by problems that seem minor to an adult, children typically bounce back more quickly.

We will now discuss several disorders of childhood like **Attention-deficit Hyperactivity Disorder (ADHD)**, **Conduct Disorder**, and **Separation Anxiety Disorder**. These disorders, if not attended, can lead to more serious and chronic disorders as the child moves into adulthood.

Classification of children's disorders has followed a different path than that of adult disorders. Achenbach has identified two factors, i.e. externalisation and internalisation, which include the majority of childhood behaviour problems. The **externalising disorders**, or undercontrolled problems, include behaviours that are disruptive and often aggressive and aversive to others in the child's environment. The **internalising disorders**, or overcontrolled problems, are those conditions where the child experiences depression, anxiety, and discomfort that may not be evident to others.

There are several disorders in which children display disruptive or externalising behaviours. We will now focus on three prominent disorders, viz. Attention-deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder.

The two main features of ADHD are **inattention** and **hyperactivity-impulsivity**. Children who are **inattentive** find it difficult to sustain mental effort during work or play. They have a hard time keeping their minds on any one thing or in following instructions. Common complaints are that the child does not listen, cannot concentrate, does not follow instructions, is disorganised, easily distracted, forgetful, does not finish assignments, and is quick to lose interest in boring activities. Children who are **impulsive** seem unable to control their immediate reactions or to think before they act. They find it difficult to wait or take turns, have difficulty resisting immediate temptations or delaying gratification. Minor mishaps such as knocking things over are common whereas more serious accidents and injuries can also occur. **Hyperactivity** also takes many forms. Children with ADHD are in constant motion. Sitting still through a lesson is impossible for them. The child may fidget, squirm, climb and run around the room aimlessly. Parents and teachers describe them as 'driven by a motor', always on the go, and talk incessantly. Boys are four times more likely to be given this diagnosis than girls.

Children with **Oppositional Defiant Disorder** (ODD) display age-inappropriate amounts of stubbornness, are irritable, defiant, disobedient, and behave in a hostile manner. Unlike ADHD, the rates of ODD in boys and girls are not very different. The terms **Conduct Disorder** and **Antisocial Behaviour** refer to age-inappropriate actions and attitudes that violate family expectations, societal norms, and the personal or property rights of others. The behaviours typical of conduct disorder include aggressive actions that cause or threaten harm to people or animals, non-aggressive conduct that causes property damage, major deceitfulness or theft, and serious rule violations. Children show many different types of aggressive behaviour, such as **verbal aggression** (i.e. name-calling, swearing), **physical aggression** (i.e. hitting, fighting), **hostile aggression** (i.e. directed at inflicting injury to others), and **proactive aggression** (i.e. dominating and bullying others without provocation).

Internalising disorders

Separation Anxiety Disorder (SAD) and **Depression**. Separation anxiety disorder is an internalising disorder unique to children. Its most prominent symptom is excessive anxiety or even panic experienced by children at being separated from

their parents. Children with SAD may have difficulty being in a room by themselves, going to school alone, are fearful of entering new situations, and cling to and shadow their parents' every move. To avoid separation, children with SAD may fuss, scream, throw severe tantrums, or make suicidal gestures.

The ways in which children express and experience depression are related to their level of physical, emotional, and cognitive development. An infant may show sadness by being passive and unresponsive; a pre-schooler may appear withdrawn and inhibited; a school-age child may be argumentative and combative; and a teenager may express feelings of guilt and hopelessness.

Children may also have more serious disorders called **Pervasive Developmental Disorders**. These disorders are characterised by severe and widespread impairments in social interaction and communication skills, and stereotyped patterns of behaviours, interests and activities. **Autistic disorder** or **autism** is one of the most common of these disorders. Children with autistic disorder have marked difficulties in social interaction and communication, a restricted range of interests, and strong desire for routine. About 70 per cent of children with autism are also mentally retarded.

Children with autism experience profound difficulties in relating to other people. They are unable to initiate social behaviour and seem unresponsive to other people's feelings. They are unable to share experiences or emotions with others. They also show serious abnormalities in communication and language that persist over time. Many autistic children never develop speech and those who do, have repetitive and deviant speech patterns. Children with autism often show narrow patterns of interests and repetitive behaviours such as lining up objects or stereotyped body movements such as rocking. These motor movements may be self-stimulatory such as hand flapping or self-injurious such as banging their head against the wall.

Another group of disorders which are of special interest to young people are **eating disorders**. These include anorexia nervosa, bulimia nervosa, and binge eating. In **anorexia nervosa**, the individual has a distorted body image that leads her/him to see herself/himself as overweight. Often refusing to eat, exercising compulsively and

developing unusual habits such as refusing to eat in front of others, the anorexic may lose large amounts of weight and even starve herself/himself to death. In **bulimia nervosa**, the individual may eat excessive amounts of food, then purge her/ his body of food by using medicines such as laxatives or diuretics or by vomiting. The person often feels disgusted and ashamed when s/he binges and is relieved of tension and negative emotions after purging. In **binge eating**, there are frequent episodes of out-of-control eating.

QUESTION

1. what are the various signs and symptoms associated with different types of psychological disorders?
2. Discribe the Biological or Somatogenic Perspective Psychological disorder.
3. What are the criteria that must be considered in order to determine if one's abnormal behavior can be diagnosed as a psychological disorder?
4. What are the four main criteria that psychologists use to determine the presence of a psychological disorder?
5. Why do we study abnormal psychology? - Expalin in detail.

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SCHOOL OF SCIENCE AND HUMANITIES

DEPARTMENT OF PSYCHOLOGY

UNIT – II - PSYCHOPATHOLOGY - I – SPSY1402

ANXIETY DISORDERS

INTRODUCTION

Anxiety is a normal reaction to stress and can be beneficial in some situations. It can alert us to dangers and help us prepare and pay attention. Anxiety disorders differ from normal feelings of nervousness or anxiousness, and involve excessive fear or anxiety. Anxiety disorders are the most common of mental disorders and affect nearly 30% of adults at some point in their lives. But anxiety disorders are treatable and a number of effective treatments are available. Treatment helps most people lead normal productive lives. Anxiety refers to anticipation of a future concern and is more associated with muscle tension and avoidance behavior.

Fear is an emotional response to an immediate threat and is more associated with a fight or flight reaction – either staying to fight or leaving to escape danger.

Anxiety disorders can cause people to try to avoid situations that trigger or worsen their symptoms. Job performance, school work and personal relationships can be affected.

In general, for a person to be diagnosed with an anxiety disorder, the fear or anxiety must:

- Be out of proportion to the situation or age inappropriate
- Hinder ability to function normally

There are several types of anxiety disorders, including generalized anxiety disorder, panic disorder, specific phobias, agoraphobia, social anxiety disorder and separation anxiety disorder.

Anxiety is a normal part of living. It's the body's way of telling us something isn't right. It keeps us from harm's way and prepares us to act quickly in the face of danger. However, for some people, anxiety is persistent, irrational, and overwhelming. It may get in the way of day-to-day activities or even make them impossible. This may be a sign of an anxiety disorder. The term "anxiety disorders" describes a group of conditions

including generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD), social anxiety disorder, and specific phobias. For more information about anxiety disorders

TYPES OF ANXIETY DISORDERS

We all have things that frighten us or make us uneasy. New places, insects, driving over high bridges, or creaky elevators. And although we sometimes try to avoid things that make us uncomfortable, we generally manage to control our fears and carry on with daily activities. Some people, however, have very strong irrational, involuntary fear reactions that lead them to avoid common everyday places, situations, or objects even though they know logically there isn't any danger. The fear doesn't make any sense, but it seems nothing can stop it. When confronted with the feared situation, they may even have a panic attack, the spontaneous onset of intense fear that makes people feel as if they might stop breathing and pass out, are having a heart attack, or will lose control and die. People who experience these seemingly out-of-control fears have a phobia.

There are three types of phobias – agoraphobia, social phobia (also known as social anxiety disorder) and specific phobias. This brochure focuses on specific phobias. For information about agoraphobia and social phobia go to [What is a specific phobia?](#) People with a specific phobias have an excessive and unreasonable fear in the presence of or anticipation of a specific object, place, or situation. Common specific phobias include animals, insects, heights, thunder, driving, public transportation, flying, dental or medical procedures, and elevators. Although the person with a phobia realizes that the fear is irrational, even thinking about it can cause extreme anxiety..

Normal Anxiety	Normal Anxiety
Feeling queasy while climbing a tall ladder	Refusing to attend your best friend's wedding because it's on the 25th floor of a hotel
Worrying about taking off in an airplane during a lightening storm	Turning down a big promotion because it involves air travel
Feeling anxious around your neighbor's pit bull	Avoiding visiting your neighbors for fear of seeing a dog

A phobia is a type of anxiety disorder that causes an individual to experience extreme, irrational fear about a situation, living creature, place, or object. When a person has a phobia, they will often shape their lives to avoid what they consider to be dangerous. The imagined threat is greater than any actual threat posed by the cause of terror.

PHOBIAS ARE DIAGNOSABLE MENTAL DISORDERS.

The person will experience intense distress when faced with the source of their phobia. This can prevent them from functioning normally and sometimes leads to panic attacks. In the United States, approximately 19 million people have phobias.

A phobia is an exaggerated and irrational fear.

The term 'phobia' is often used to refer to a fear of one particular trigger. However, there are three types of phobia recognized by the American Psychiatric Association (APA). These include:

Specific phobia: This is an intense, irrational fear of a specific trigger.

Social phobia, or social anxiety: This is a profound fear of public humiliation and being singled out or judged by others in a social situation. The idea of large social gatherings is terrifying for someone with social anxiety. It is not the same as shyness.

Agoraphobia: This is a fear of situations from which it would be difficult to escape if a person were to experience extreme panic, such as being in a lift or being outside of the home. It is commonly misunderstood as a fear of open spaces but could also apply to being confined in a small space, such as an elevator, or being on public transport. People with agoraphobia have an increased risk of panic disorder.

Specific phobias are known as simple phobias as they can be linked to an identifiable cause that may not frequently occur in the everyday life of an individual, such as snakes. These are therefore not likely to affect day-to-day living in a significant way.

Social anxiety and agoraphobia are known as complex phobias, as their triggers are less easily recognized. People with complex phobias can also find it harder to avoid triggers, such as leaving the house or being in a large crowd.

A phobia becomes diagnosable when a person begins organizing their lives around avoiding the cause of their fear. It is more severe than a normal fear reaction. People with a phobia have an overpowering need to avoid anything that triggers their anxiety.

SYMPTOMS

A person with a phobia will experience the following symptoms. They are common across the majority of phobias:

- a sensation of uncontrollable anxiety when exposed to the source of fear
- a feeling that the source of that fear must be avoided at all costs

- not being able to function properly when exposed to the trigger
- acknowledgment that the fear is irrational, unreasonable, and exaggerated, combined with an inability to control the feelings

A person is likely to experience feelings of panic and intense anxiety when exposed to the object of their phobia. The physical effects of these sensations can include:

- sweating
- abnormal breathing
- accelerated heartbeat
- trembling
- hot flushes or chills
- a choking sensation
- chest pains or tightness
- butterflies in the stomach
- pins and needles
- dry mouth
- confusion and disorientation
- nausea
- dizziness
- headache

A feeling of anxiety can be produced simply by thinking about the object of the phobia. In younger children, parents may observe that they cry, become very clingy, or attempt to hide behind the legs of a parent or an object. They may also throw tantrums to show their distress.

COMPLEX PHOBIAS

A complex phobia is much more likely to affect a person's wellbeing than a specific phobia. For example, those who experience agoraphobia may also have a number of other phobias that are connected. These can include monophobia, or a fear of being left alone, and claustrophobia, a fear of feeling trapped in closed spaces.

In severe cases, a person with agoraphobia will rarely leave their home.

The most common specific phobias in the U.S. include:

- **Claustrophobia:** Fear of being in constricted, confined spaces
- **Aerophobia:** Fear of flying
- **Arachnophobia:** Fear of spiders
- **Driving phobia:** Fear of driving a car
- **Emetophobia:** Fear of vomiting
- **Erythrophobia:** Fear of blushing
- **Hypochondria:** Fear of becoming ill
- **Zoophobia:** Fear of animals
- **Aquaphobia:** Fear of water
- **Acrophobia:** Fear of heights
- **Blood, injury, and injection (BII) phobia:** Fear of injuries involving blood
- **Escalaphobia:** Fear of escalators
- **Tunnel phobia:** Fear of tunnels

These are far from the only specific phobias. People can develop a phobia of almost anything. Also, as society changes, the list of potential phobias changes. For instance, nomophobia is the fear of being without a cell phone or computer. As described in one paper, it is “the pathologic fear of remaining out of touch with technology.”

CAUSES

It is unusual for a phobia to start after the age of 30 years, and most begin during early childhood, the teenage years, or early adulthood.

They can be caused by a stressful experience, a frightening event, or a parent or household member with a phobia that a child can 'learn.'

SPECIFIC PHOBIAS

These usually develop before the age of 4 to 8 years. In some cases, it may be the result of a traumatic early experience. One example would be claustrophobia developing over time after a younger child has an unpleasant experience in a confined space.

Phobias that start during childhood can also be caused by witnessing the phobia of a family member. A child whose mother has arachnophobia, for example, is much more likely to develop the same phobia.

COMPLEX PHOBIAS

More research is needed to confirm exactly why a person develops agoraphobia or social anxiety. Researchers currently believe complex phobias are caused by a combination of life experiences, brain chemistry, and genetics.

They may also be an echo of the habits of early humans, leftover from a time in which open spaces and unknown people generally posed a far greater threat to personal safety than in today's world.

HOW THE BRAIN WORKS DURING A PHOBIA

Some areas of the brain store and recall dangerous or potentially deadly events.

If a person faces a similar event later on in life, those areas of the brain retrieve the stressful memory, sometimes more than once. This causes the body to experience the same reaction.

In a phobia, the areas of the brain that deal with fear and stress keep retrieving the frightening event inappropriately.

Researchers have found that phobias are often linked to the amygdala, which lies behind the pituitary gland in the brain. The amygdala can trigger the release of “fight-or-flight” hormones. These put the body and mind in a highly alert and stressed state.

TREATMENT

Phobias are highly treatable, and people who have them are nearly always aware of their disorder. This helps diagnosis a great deal.

Speaking to a psychologist or psychiatrist is a useful first step in treating a phobia that has already been identified.

If the phobia does not cause severe problems, most people find that simply avoiding the source of their fear helps them stay in control. Many people with specific phobias will not seek treatment as these fears are often manageable.

It is not possible to avoid the triggers of some phobias, as is often the case with complex phobias. In these cases, speaking to a mental health professional can be the first step to recovery.

Most phobias can be cured with appropriate treatment. There is no single treatment that works for every person with a phobia. Treatment needs to be tailored to the individual for it to work.

The doctor, psychiatrist, or psychologist may recommend behavioral therapy, medications, or a combination of both. Therapy is aimed at reducing fear and anxiety symptoms and helping people manage their reactions to the object of their phobia.

MEDICATIONS

The following medications are effective for the treatment of phobias.

Beta blockers

These can help reduce the physical signs of anxiety that can accompany a phobia.

Side effects may include an upset stomach, fatigue, insomnia, and cold fingers.

ANTIDEPRESSANTS

Serotonin reuptake inhibitors (SSRIs) are commonly prescribed for people with phobias. They affect serotonin levels in the brain, and this can result in better moods.

SSRIs may initially cause nausea, sleeping problems, and headaches.

If the SSRI does not work, the doctor may prescribe a monoamine oxidase inhibitor (MAOI) for social phobia. Individuals on an MAOI may have to avoid certain types of food. Side effects may initially include dizziness, an upset stomach, restlessness, headaches, and insomnia.

Taking a tricyclic antidepressant (TCA), such as clomipramine, or Anafranil, has also been found to help phobia symptoms. Initial side effects can include sleepiness, blurred vision, constipation, urination difficulties, irregular heartbeat, dry mouth, and tremors.

TRANQUILIZERS

Benzodiazepines are an example of a tranquilizer that might be prescribed for a phobia. These may help reduce anxiety symptoms. People with a history of alcohol dependence should not be given sedatives.

In 2020, the Food and Drug Administration (FDA) strengthened their warning about benzodiazepines. Using these drugs can lead to physical dependence, and withdrawal can be life threatening. Combining them with alcohol, opioids, and other substances can result in death. It is essential to follow the doctor's instructions when using these drugs.

BEHAVIORAL THERAPY

There are a number of therapeutic options for treating a phobia.

DESENSITIZATION, OR EXPOSURE THERAPY

This can help people with a phobia alter their response to the source of fear. They are gradually exposed to the cause of their phobia over a series of escalating steps. For example, a person with aerophobia, or a fear of flying on a plane, may take the following steps under guidance:

1. They will first think about flying.
2. The therapist will have them look at pictures of planes.
3. The person will go to an airport.
4. They will escalate further by sitting in a practice simulated airplane cabin.
5. Finally, they will board a plane.

COGNITIVE BEHAVIORAL THERAPY (CBT)

The doctor, therapist, or counselor helps the person with a phobia learn different ways of understanding and reacting to the source of their phobia. This can make coping easier. Most importantly, CBT can teach a person experiencing phobia to control their own feelings and thoughts.

THE DIFFERENCE BETWEEN NORMAL ANXIETY AND A PHOBIA.

How can specific phobias affect your life? The impact of a phobia on one's life depends on how easy it is to avoid the feared object, place, or situation. Since individuals do whatever they can to avoid the uncomfortable and often terrifying feelings of phobic anxiety, phobias can disrupt daily routines, limit work efficiency, reduce self-esteem, and place a strain on relationships. What causes specific phobias? Specific phobias are the most common type of anxiety disorder, affecting 19 million American adults. Most phobias seem to come out of the blue, usually arising in childhood or early adulthood. Scientists believe that phobias can be traced to a combination of genetic tendencies, brain chemistry and other biological, psychological, and environmental factors.

What treatments are available? Most individuals who seek treatment for phobias and other anxiety disorders see significant improvement and enjoy a better quality of life. A variety of treatment options exists, including cognitive-behavioral therapy (CBT), exposure therapy, anxiety management, relaxation techniques, and medications. One or a combination of these may be recommended. Details about these treatments are available on the ADAA website at www.adaa.org. It is important to remember that there is no single “right” treatment. What works for one person may not be the best choice for someone else. A course of treatment should be tailored to individual needs. Ask your doctor to explain why a particular type of treatment is being recommended, what other options are available, and what you need to do to fully participate in your recovery. How can ADAA help you? Suffering from a specific phobia or any anxiety disorder can interfere with many aspects of your life. You may feel alone, embarrassed, or frightened. ADAA can provide the resources that will help you and your loved ones better understand your condition, connect you with a community of people who know what you are experiencing, and assist you in finding local mental health professionals. Visit the ADAA website at www.adaa.org to locate mental health professionals who treat phobias and other anxiety disorders in your area, as well as local support groups. Learn about the causes, symptoms, and best treatments for anxiety disorders, review questions to ask a therapist or doctor, and find helpful materials for family and loved ones. ADAA is here to help you make good decisions so that you can get on with your life.

GENERALIZED ANXIETY DISORDER (GAD) AND PANIC DISORDER (PD) are among the most common mental disorders in the United States, and they can negatively impact a patient’s quality of life and disrupt important activities of daily living. Evidence suggests that the rates of missed diagnoses and misdiagnosis of GAD and PD are high, with symptoms often ascribed to physical causes. Diagnosing GAD and PD requires a broad differential and caution to identify confounding variables and comorbid conditions. Screening and monitoring tools can be used to help make the diagnosis and monitor response to therapy. The GAD-7 and the Severity Measure for Panic Disorder are free diagnostic tools. Successful outcomes may require a combination of treatment modalities tailored to the individual patient. Treatment often includes medications such as selective serotonin reuptake inhibitors and/or psychotherapy, both of which are highly effective. Among psychotherapeutic treatments, cognitive behavior therapy has been studied widely and has an extensive

evidence base. Benzodiazepines are effective in reducing anxiety symptoms, but their use is limited by risk of abuse and adverse effect profiles. Physical activity can reduce symptoms of GAD and PD. A number of complementary and alternative treatments are often used; however, evidence is limited for most. Several common botanicals and supplements can potentiate serotonin syndrome when used in combination with antidepressants. Medication should be continued for 12 months before tapering to prevent relapse.

Generalized anxiety disorder (GAD) and panic disorder (PD) are among the most common mental disorders in the United States and are often encountered by primary care physicians. The hallmark of GAD is excessive, out-of-control worry, and PD is characterized by recurrent and unexpected panic attacks. Both conditions can negatively impact a patient's quality of life and disrupt important activities of daily living. The rates of missed diagnoses and misdiagnosis of GAD and PD are high, with symptoms often ascribed to physical causes. This article reviews the diagnosis and management of GAD and PD in adults. Diagnosis and care of children and adolescents with these conditions require special considerations that are beyond the scope of this review.

The etiology of PD is also not well understood. The neuroanatomical hypothesis suggests that a genetic-environment interaction is likely responsible. Patients with PD may exhibit irregularities in specific brain structures, altered neuronal processes, and dysfunctional corticolimbic interaction during emotional processing

GENERALIZED ANXIETY DISORDER Patients with GAD typically present with excessive anxiety about ordinary, day-to-day situations. The anxiety is intrusive, causes distress or functional impairment, and often encompasses multiple domains (e.g., finances, work, health). The anxiety is often associated with physical symptoms, such as sleep disturbance, restlessness, muscle tension, gastrointestinal symptoms, and chronic headaches.⁵ Diagnostic and Statistical Manual of Mental Disorders, 5th ed, (DSM-5) diagnostic criteria for GAD are listed in Table 1. ⁵ Some factors associated with GAD include female sex, unmarried status, lower education level, poor health, and presence of life stressors.⁶ The age of onset is variable, with a median age of 30 years.¹ A number of scales are available to establish diagnosis and assess severity. The GAD-7 (Table 27) has been validated as a diagnostic tool and a severity assessment scale, with a score of 10 or more having good diagnostic sensitivity

and specificity.⁸ Greater GAD-7 scores correlate with more functional impairment.⁸ The scale was developed and validated based on DSM-IV criteria, but it remains clinically useful after publication of the DSM-5 because the differences in GAD diagnostic criteria are minimal. The PROMIS Emotional Distress–Anxiety–Short Form for adults and the Severity Measure for Generalized Anxiety Disorder–Adult, available from the assessment-measures, are intended to aid clinical evaluation of GAD and monitor treatment effectiveness.

Table 1. Diagnostic Criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months): Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder)

PANIC DISORDER PD is characterized by episodic, unexpected panic attacks that occur without a clear trigger.⁵ Panic attacks are defined by the rapid onset of intense fear (typically peaking within about 10 minutes) with at least four of the physical and psychological symptoms in the DSM-5 diagnostic criteria (Table 3). ⁵ Another

requirement for the diagnosis of PD is that the patient worries about further attacks or modifies his or her behavior in maladaptive ways to avoid them. The most common physical symptom accompanying panic attacks is palpitations.⁹ Although unexpected panic attacks are required for the diagnosis, many patients with PD also have expected panic attacks, occurring in response to a known trigger. is an assessment scale that can complement the clinical assessment of patients with PD.

Differential Diagnosis and Comorbidity

When evaluating a patient for a suspected anxiety disorder, it is important to exclude medical conditions with similar presentations (e.g., endocrine conditions such as hyperthyroidism, pheochromocytoma, or hyperparathyroidism; cardiopulmonary conditions such as arrhythmia or obstructive pulmonary diseases; neurologic diseases such as temporal lobe epilepsy or transient ischemic attacks). Other psychiatric disorders (e.g., other anxiety disorders, major depressive disorder, bipolar disorder); use of substances such as caffeine, albuterol, levothyroxine, or decongestants; or substance withdrawal may also present with similar symptoms and should be ruled out.⁵ Complicating the diagnosis of GAD and PD is that many conditions in the differential diagnosis are also common comorbidities. Additionally, many patients with GAD or PD meet criteria for other psychiatric disorders, including major depressive disorder and social phobia. Evidence suggests that GAD and PD usually occur with at least one other psychiatric disorder, such as mood, anxiety, or substance use disorders.¹⁰ When anxiety disorders occur with other conditions, historic, physical, and laboratory findings may be helpful in distinguishing each diagnosis and developing appropriate treatment plans.

Treatment Some studies evaluating anxiety treatments assess nonspecific anxiety-related symptoms rather than the set of symptoms that characterize GAD or PD. When possible, the treatments described in this section will differentiate between GAD and PD; otherwise, treatments refer to anxiety-related symptoms in general. Medication or psychotherapy is a reasonable initial treatment option for GAD and PD.¹¹ Some studies suggest that combining medication and psychotherapy may be more effective for patients with moderate to severe symptoms.¹² The National Institute for Health and Care Excellence (NICE) guidelines on GAD and PD in adults are a useful review of available evidence; however, information about self-help and group therapies may have less utility in the United States because of their relative lack of availability.

DIAGNOSTIC CRITERIA FOR PANIC DISORDER

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur: Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. . Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or “going crazy.”
13. Fear of dying. Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).

2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessivecompulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder)

TREATMENT

MEDICATION

First-Line Therapies. A number of medications are available for treating anxiety (Table 4). Selective serotonin reuptake inhibitors (SSRIs) are generally considered first-line therapy for GAD and PD.¹⁹⁻²² Tricyclic antidepressants (TCAs) are better studied for PD, but are thought to be effective for both GAD and PD.^{19,20} In the treatment of PD, TCAs are as effective as SSRIs, but adverse effects may limit the use of TCAs in some patients.²³ Venlafaxine, extended release, is effective and well tolerated for GAD and PD, whereas duloxetine (Cymbalta) has been adequately evaluated only for GAD.²⁴ Azapirones, such as buspirone (Buspar), are better than placebo for GAD²⁵ but do not appear to be effective for PD.²⁶ Mixed evidence suggests bupropion (Wellbutrin) may have anxiogenic effects for some patients, thus warranting close monitoring if used for treatment of comorbid depression, seasonal affective disorder, or smoking cessation.²⁷ Bupropion is not approved for the treatment of GAD or PD.

Medications should be titrated slowly to decrease the initial activation. Because of the typical delay in onset of action, medications should not be considered ineffective until they are titrated to the high end of the dose range and continued for at least four weeks. Once symptoms have improved, medications should be used for 12 months

before tapering to limit relapse.¹¹ Some patients will require longer treatment. Benzodiazepines are effective in reducing anxiety, but there is a dose-response relationship associated with tolerance, sedation, confusion, and increased mortality.²⁸ When used in combination with antidepressants, benzodiazepines may speed recovery from anxiety-related symptoms but do not improve longer-term outcomes.

The higher risk of dependence and adverse outcomes complicates the use of benzodiazepines.²⁹ NICE guidelines recommend only short-term use during crises.¹¹ Benzodiazepines with an intermediate to long onset of action (such as clonazepam [Klonopin]) may have less potential for abuse and less risk of rebound.³⁰ Second-Line Therapies. Second-line therapies for GAD include pregabalin (Lyrica) and quetiapine (Seroquel), although neither has been evaluated for PD. Pregabalin is more effective than placebo but not as effective as lorazepam (Ativan) for GAD. Weight gain is a common adverse effect of pregabalin.

There is limited evidence for the use of antipsychotics to treat anxiety disorders. Although quetiapine seems to be effective for GAD, the adverse effect profile is significant, including weight gain, diabetes mellitus, and hyperlipidemia.³¹ Hydroxyzine is considered a second-line treatment for GAD,³² but there are minimal data for its use in PD. Its rapid onset can be appealing for patients needing immediate relief, and it may be a more appropriate alternative if benzodiazepines are contraindicated (e.g., in patients with a history of substance abuse). Based on clinical experience, gabapentin (Neurontin) is sometimes prescribed by psychiatrists to treat anxiety on an as-needed basis when benzodiazepines are contraindicated. Of note, the placebo response for medications used to treat GAD and PD is high. PSYCHOTHERAPY AND RELAXATION THERAPIES Psychotherapy includes many different approaches, such as cognitive behavior therapy (CBT) and applied relaxation (Table 5).^{33,34} CBT may use applied relaxation, exposure therapy, breathing, cognitive restructuring, or education.

Psychotherapy is as effective as medication for GAD and PD.¹¹ Although existing evidence is insufficient to draw conclusions about many psychotherapeutic interventions, structured CBT interventions have consistently proven effective for the treatment of anxiety in the primary care setting.³⁴⁻³⁶ Psychotherapy may be used alone or combined with medication as first-line treatment for PD³⁷ and GAD,¹¹ based on patient preference. Psychotherapy should be performed weekly for at least eight weeks to

assess its effect. Mindfulness has similar effectiveness to traditional CBT or other behavior therapies,³⁸ particularly mindfulness-based stress reduction.³⁹ A meta-analysis of 36 randomized controlled trials on meditation showed that meditative therapies reduce anxiety symptoms, but most studies looked at anxiety symptoms rather than anxiety disorders.⁴⁰ Transcendental meditation has similar effectiveness to other relaxation therapies.⁴¹ After a treatment course, rebound symptoms may occur less often with psychotherapy than with medications. Successful treatment requires tailoring options to individuals and may often include a combination of modalities.^{11,37,42} Combined treatment with medications and psychotherapy reduces relapse even at two years.⁴³

COMPLEMENTARY AND ALTERNATIVE MEDICINE THERAPIES Although a number of complementary and alternative products have evidence for treating depression, most lack sufficient evidence for the treatment of anxiety.

Botanicals and supplements sometimes used to treat GAD and PD are listed in Table 6. Kava extract is an effective treatment for anxiety ⁴⁴; however, case reports of hepatotoxicity have decreased its use.⁴⁵ St. John's wort, tryptophan, 5-Hydroxytryptophan, and S-adenosyl-L-methionine should be used with caution in combination with SSRIs because of the increased risk of serotonin syndrome.⁴⁶ Evidence indicates that music therapy, aromatherapy, acupuncture, and massage are helpful for anxiety associated with specific disease states, but none have been evaluated specifically for GAD or PD.

OCD

OCD is a mental health condition that involves an obsession or compulsion, distressing actions, and repetitive thoughts. It can be challenging for a person with OCD to carry out routine tasks.

A person with OCD typically:

- has thoughts, images, or urges that they feel unable to control
- does not want to have these intrusive thoughts and feelings
- experiences a significant amount of discomfort, possibly involving fear, disgust, doubt, or a conviction that things must be done in a certain way

- spends a lot of time focusing on these obsessions and engaging in compulsions, which interferes with personal, social, and professional activities

Types

OCD can affect different people in different ways. It may involve:

Concern with checking

A person with OCD may feel the need to check repeatedly for problems. This might include:

- checking taps, alarms, door locks, house lights, and appliances to prevent leaks, damage, or fire, for example
- checking their body for signs of illness
- confirming the authenticity of memories
- repeatedly checking communication, such as e-mails, for fear of having made a mistake or offending the recipient

FEARS OF CONTAMINATION

Some people with OCD feel a continual, overwhelming need to wash. They may fear that objects that they touch are contaminated.

This can lead to:

- excessive toothbrushing or handwashing
- repeatedly cleaning the bathroom, kitchen, and other rooms
- avoiding crowds for fear of contracting germs

Some people experience a sense of contamination if they feel that someone has mistreated or criticized them. They may try to remove this feeling by washing.

Hoarding

This involves a person feeling unable to throw away used or useless possessions.

Intrusive thoughts

This involves feeling unable to prevent repetitious unwanted thoughts. These may involve violence, including suicide or harming others.

The thoughts can cause intense distress, but the person is unlikely to act in a way that reflects this violence.

A person with this type of OCD may fear that they are a pedophile, even with no evidence to support this.

Symmetry and orderliness

A person with this type of OCD may feel that they need to arrange objects in a certain order to avoid discomfort or harm.

Symptoms

OCD involves obsessions, compulsions, or both. These can cause distress and interfere with the person's ability to perform routine activities.

Below, learn more about obsessions and compulsions.

OBSESSIONS

While everyone worries, in people with OCD, worries and anxiety can take over, making it hard to carry out everyday tasks.

Common topics of this anxiety include:

- **Contamination**, by bodily fluids, germs, dirt, and other substances
- **Losing control**, such as the fear of acting on an urge to self-harm or hurt others
- **Perfectionism**, which may involve the fear of losing things or an intense focus on exactness or remembering things
- **Harm**, including a fear of being responsible for a catastrophic event
- **Unwanted sexual thoughts**, including thoughts about inappropriate activities
- **Religious or superstitious beliefs**, such as a concern about offending God or stepping on cracks in the sidewalk

COMPULSIONS

Not every repetitious behavior is a compulsion. Most people use repetitive behaviors, such as bedtime routines, to help them manage everyday life.

For a person with OCD, however, the need to perform repetitious behavior is intense, it occurs frequently, and it is time-consuming. The behavior may take on a ritualistic aspect.

Some examples include:

- washing and cleaning, including handwashing
- monitoring the body for symptoms
- repeating routine activities, such as getting up from a chair
- mental compulsions, such as repeatedly reviewing an event

OCD in children

The first signs of OCD often appear in adolescence, but they sometimes emerge in childhood.

Complications among young people, including children, with OCD include:

- low self-esteem
- disrupted routines
- difficulty completing schoolwork
- physical illness, due to stress, for example
- trouble forming or maintaining friendships and other relationships

When OCD begins in childhood, it may be more common in males than females. By adulthood, however, it affects males and females at equal rates.

Causes

Experts do not know what causes OCD, but there are various theories. Genetic, neurological, behavioral, cognitive, and environmental factors may all contribute.

Genetic causes

OCD appears to run in families, suggesting a possible genetic link, which experts are investigating.

Imaging studies have suggested that the brains of people with OCD function with characteristic differences. Genes that affect how the brain responds to the neurotransmitters dopamine and serotonin, for example, may play a role in causing the disorder.

Autoimmune-related causes

Sometimes, symptoms of OCD appear in children after an infection, such as:

- group A streptococcal infections, including strep throat
- Lyme disease
- the H1N1 flu virus

Clinicians sometimes call this occurrence of OCD symptoms pediatric acute-onset neuropsychiatric syndrome (PANS).

In a child with PANS, the symptoms start suddenly and reach full intensity within 24–72 hours. They may then disappear but return at a later date.

BEHAVIORAL CAUSES

One theory suggests that a person with OCD learns to avoid fear associated with certain situations or objects by performing rituals to reduce the perceived risk.

The initial fear may begin around a period of intense stress, such as a traumatic event or significant loss.

Once the person associates an object or circumstance with this feeling of fear, they begin to avoid that object or situation in a way that comes to characterize OCD.

This may be more common among people with a genetic predisposition for the disorder.

COGNITIVE CAUSES

Another theory is that OCD starts when people misinterpret their own thoughts.

Most people have unwelcome or intrusive thoughts at times, but for people with OCD, the importance of these thoughts becomes more intense or extreme.

Take the example of a person caring for an infant while under intense pressure and having intrusive thoughts of accidentally harming the baby.

A person might usually disregard these thoughts, but if the thoughts persist, they may take on unwarranted significance.

A person with OCD may become convinced that the action in the thought is likely to happen. In response, they take excessive, continual action to prevent the threat or danger.

ENVIRONMENTAL CAUSES

Stressful life events may trigger OCD in people with a predisposition, genetic or otherwise.

Many people have reported that the symptoms appeared within 6 months of events such as:

- childbirth
- complications during pregnancy or delivery
- a severe conflict
- a serious illness
- a traumatic brain injury

Also, OCD may occur alongside post-traumatic stress disorder, or PTSD.

DIAGNOSIS

Doctors look for specific criteria when diagnosing OCD, including:

- the presence of obsessions, compulsions, or both
- obsessions and compulsions that are time-consuming or cause significant distress or impairment in social, occupational, or other important settings
- OCD symptoms that do not result from the use of a substance or medication
- OCD symptoms that cannot be better explained by another health issue

Many other disorders, such as depression and anxiety, have similar features to OCD, and they can also occur alongside OCD.

TREATMENT

There are effective treatments for OCD. The right approach depends on the person's set of symptoms and the extent that they affect the person's life and well-being. Some effective options include:

COGNITIVE BEHAVIORAL THERAPY

This type of psychotherapy, sometimes called CBT, can help a person change the way that they think, feel, and behave.

It may involve two different treatments: exposure and response prevention (ERP) and cognitive therapy.

ERP involves:

- **Exposure:** This exposes the person to situations and objects that trigger fear and anxiety. Over time, through a process called habituation, repeated exposure leads to a decrease or disappearance of the anxiety.
- **Response:** This teaches the person to resist performing compulsive behaviors.

Cognitive therapy starts by encouraging the person to identify and reevaluate their beliefs about the consequences of engaging or refraining from engaging in compulsive behavior.

Next, the therapist encourages the person to:

- examine the evidence that supports and does not support the obsession
- identify cognitive distortions relating to the obsession
- develop a less threatening alternative response to the intrusive thought, image, or idea

MEDICATIONS

A number of drugs can help treat OCD, including selective serotonin reuptake inhibitors (SSRIs), which are a type of antidepressant.

Some examples include:

- escitalopram (Lexapro)
- fluvoxamine (Luvox)
- paroxetine (Paxil)
- fluoxetine (Prozac)
- sertraline (Zoloft)

A doctor may prescribe a higher dosage to treat OCD, compared with depression. Still, a person may not notice results for up to 3 months.

About half of all people with OCD do not respond to SSRI treatment alone, and doctors may also prescribe antipsychotic medications.

Also, in 2010, some researchers noted that the tuberculosis drug D-cycloserine (Seromycin) alongside CBT may help treat OCD. It may also help people with social anxiety.

Here, find more strategies for managing OCD.

Bob worried about being responsible for bad things that could happen. He worried about leaving the stove on, which could cause a fire, or hitting someone with his car. He spent all day repeatedly checking every action to make sure he hadn't done something wrong or dangerous. For example, Bob would circle back in his car to check if he had hit someone and rechecked his locks over and over again at home to make sure the doors were locked. Bob also avoided using his oven for fear he might leave it on. The key features of Obsessive-Compulsive Disorder are obsessions and compulsions. Most people have both, but for some it may seem as though they have only one or the other.

Obsessions are thoughts, images, or urges. They can feel intrusive, repetitive, and distressing. Everyone has bothersome thoughts or worries sometimes (e.g. worry about money or whether or not we remembered to lock the front door, or regret over past mistakes). When a person is preoccupied with these thoughts, and is unable to control the thoughts, get rid of them, or ignore them, they may be obsessions. Obsessions are usually unrealistic and don't make sense. Obsessions often don't fit one's personality; they can feel unacceptable or disgusting to the person who has them. Obsessions cause distress, usually in the form of anxiety. People with obsessive thoughts will often try to reduce this distress by acting out certain behaviours, known as rituals or compulsions. Compulsions are behaviours a person does to relieve the distress they feel because of the obsessions. They can be overt (observable) or covert (hidden). While most people have preferred ways of doing certain things (e.g. a morning routine or a certain way to arrange items on a desk), people with OCD feel they "must" perform their compulsions and find it almost impossible to stop. Usually, people with OCD know the compulsion is senseless. However, he or she feels helpless to stop doing it and may need to repeat the compulsion over and over again. Sometimes this is described as a ritual. Common compulsions include excessive washing and checking, and mental rituals such as counting, repeating certain words, or praying. While compulsions often help relieve distress in the short-term, they don't help in the long-term. As a person with OCD gets used to doing them, the rituals become less helpful at reducing his or her anxiety. To make them more effective again, the person may perform them more frequently and for longer periods of time. This is why people with OCD can appear to be "stuck" doing the same thing over and over again.

For someone with severe OCD, these compulsions can take up a considerable amount of time. Even simple tasks can become very time-consuming, having a significant impact on a person's ability to manage their daily lives. These difficulties can result in significant shame, sadness, and frustration.

Obsessive-Compulsive disorder is common: about 2.5% of the population or 1 adult in 40 are afflicted, which makes it about twice as common as schizophrenia and bipolar disorder. It is also the fourth most common psychiatric disorder. It can be severe and debilitating: OCD can invade all aspects of a person's life; family, work, and leisure can all be negatively impacted by the disorder. In fact, the World Health Organization (WHO) considers OCD to be one of the top 10 leading causes of disability out of all

medical conditions worldwide. Other facts about OCD: • it affects people from all cultures • rates of OCD are equal in men and women • it can start at any age but typical age of onset is adolescence or early adulthood (childhood onset is not rare however) • tends to be lifelong if left untreated.

QUESTION

1. What are the criteria for determining mental illness?
2. What are phobias? If someone had an intense fear of snakes, could this simple phobia be a result of faulty learning? Analyse how this phobia could have developed.
3. Anxiety has been called the “butterflies in the stomach feeling”. At what stage does anxiety become a disorder? Discuss its types.
4. Discuss the diagnostic Criteria for Panic Disorder and its treatment.

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DEPARTMENT OF PSYCHOLOGY

UNIT – III - PSYCHOPATHOLOGY - I – SPSY1402

SOMATOFORM & DISSOCIATIVE DISORDERS

INTRODUCTION

The Concept of Somatization Coined first, not, as conventionally thought, by the German psychoanalyst Wilhelm Stekel, but by his translator in 1925 (Marin and Carron, 2002), who was searching for an approximation to the German *organsprache* (organ-speech), the word somatization at first was close to Freud's concept of conversion. When Stekel (1943) later used the word in an English-language book on dreams, he defined it as the bodily representation of a deep-seated neurosis, the expression of mental conflict through organ language (Kellner, 1991). Freud (1905) had called it "somatic compliance" in his early studies of hysteria, referring to the symbolic representation in particular organs of an otherwise insoluble emotional conflict. Somatization has since achieved some popularity as a way to comprehend the variety of ways in which mind and body seem to interact.

The word helps to establish a bridge between such diverse conditions as hypochondriasis or conversion and irritable bowel syndrome or chronic fatigue syndrome. The term and concept are not universally approved, and indeed there is some early action on redefining somatoform disorders in the next DSM edition. Theories about somatization are scarce, but at least one group of authors has attributed it to abnormalities of attachment in early life (Waller et al., 2002).

A more psychoanalytic explanation is provided by the Viennese psychoanalyst Max Schur (1955), who was also Freud's primary care doctor. Schur's theory provides a developmental model in which the infant's undifferentiated somatic responsiveness to all stimuli gives way, with the development of language and increased ego mastery, to a more de-somatized state with normal emotional adaptation. In the face of trauma or developmental failure, otherwise normal adaptation reverts to a previous somatic state in which physical representation becomes the major response mode. Given our common developmental heritage, we are all—in one sense or another and one time or another—

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somatizers. But it is only those individuals concerned about or distressed enough by their physical reactions to seek medical Hypochondriasis and Somatization Disorder 153 attention or take medications who earn the name “somatizers.” Such individuals tend to attribute their somatic symptoms to signs of physical illness, even in the absence of pathologic medical findings.

Consulting a primary care physician often marks the beginning of what, for many, becomes a lifelong quest for relief.

Classification Classification is an earmark of science and especially medicine, wherein the recognition of similarities and differences permits manageable groupings for research, communication, and treatment with the greatest parsimony. Major contributions to medicine by the earliest physicians like Hippocrates and Galen addressed this problem in efforts to understand and treat the many symptoms they encountered in their patients. In time, progress is achieved through constantly evolving and, it is hoped, better classifications. In mental illness, classification and “official” recognition of a uniform nomenclature of mental disease is a rather recent enterprise.

Beginning with the collection of hospital statistics in 1917, classification gradually paid more attention to diagnosis and treatment, with the first DSM classification established after World War II.

From DSM-I to DSM-III From the very earliest days of efforts to classify mental disorders, how to characterize somatization clearly presented a very sticky problem. In choosing the subclassification of psychophysiologic autonomic and visceral disorders, the authors of the first edition of the DSM (DSM-I) wrote, “This term is used in preference to ‘psychosomatic disorders,’ since the latter term refers to a point of view on the discipline of medicine as a whole rather than to certain specified conditions. It is preferred to the term ‘somatization reactions,’ which term implies that these disorders are simply another form of psychoneurotic reaction” (American Psychiatric Association, 1952, p. 29). Thus, the place of somatization in the lexicon and theory of psychiatric disorder has had a long and controversial journey.

A large number of practicing psychiatrists and others, in attempts to lend some structure and common language to the vast field of “unexplainable” medical syndromes, finally located the unifying concept of somatization in a separate formal classification.

Beginning in 1980, the third edition of the standardized nomenclature (American Psychiatric Association, 1980) introduced the category of somatoform disorders and somatization, replacing the previous catalog of so-called psychophysiological disorders. Although verbally described as distinct entities, the spectrum of somatoform disorders is large, diffuse, and often defying of definitive diagnosis. While sometimes distinguishable one from another, they all share the symptomatic representation of somatization. Sometimes mistaken for a diagnosis itself, somatization is more appropriately acknowledged as merely a descriptive term for a process, much as fever might be for a host of diseases.

Physicians, frustrated by the challenge of accurately diagnosing patients with medically uncertain syndromes, may pejoratively simply characterize such patients as “somatizers” in cases that in previous decades have called forth such epithets as “crock,” “gomer,” “turkey,” or worse (Lipsitt, 1970). Because most patients with unremitting physical symptoms of uncertain origin are more likely to consult a general physician than a psychiatrist, patients with 154 D.R. Lipsitt Ch14.qxd 28/6/07 1:36 PM Page 154 somatoform disorders are seen infrequently in general psychiatric practice and more frequently by psychiatrists who work closely with nonpsychiatrist colleagues in medical settings. It often falls to the consultation-liaison psychiatrist to treat or manage these patients in the medical setting or to adopt a pedagogical relationship with primary care physicians to help them treat these patients. A case history helps to elucidate the commonalities of somatizing patients, as well as the diagnostic and therapeutic challenges of sometimes confusing clinical presentations. Case History (Part 1) Melissa, an attractive, intelligent black college student, was referred to a psychiatrist at the age of 27 by her primary care physician (PCP) requesting help with “this complex and problematic young woman.” He had been seeing her for about a year for complaints of left-sided abdominal as well as pelvic pain and urinary frequency. Having failed to obtain relief with over-the-counter medications, she urgently sought medical help and recommendations.

Her physician, a highly skilled and competent young doctor, assiduously pursued an explanation for her symptoms, including referrals to a gastroenterologist, two urologists, and three gynecologists; they added equivocal diagnoses to her history of gastroenteritis, esophageal reflux, irritable bowel syndrome, cervical inflammation, and diverticulosis. Because of a fear of cancer, she also underwent several cystoscopies with

vaginal and urethral biopsies, with negative results. Her repeated thorough physical examinations and all laboratory and procedural studies were within normal limits. On verbal referral to the psychiatrist, Melissa's doctor revealed that he was "concerned about the frequency of her visits to a hospital emergency room and to various physicians," and also "about the increasing aggressiveness of the workups she was receiving despite essentially negative data." The consulting psychiatrist found Melissa to be a willing, if dubious, patient, eager for "anything that will help the pain" and "get my life back on track." He learned that she had experienced a "painful belly" since around age 5, and that both her mother and father, who both had "drinking problems," took her to doctors at a young age.

Her father was an advertising executive who had lost his job; her mother worked as a secretary and battled a skin disorder for many years. Melissa revealed little capacity, in spite of her obvious intelligence, for any psychological assessment of her distress or her relationships to family and others. She had been close to a grandfather who died of colon cancer, and she remembers thinking "catastrophic thoughts" when she first began to have crampy periods around the age of 12. Her grandmother had died of diabetes only a few years ago. In spite of a long-standing struggle with vague pains, Melissa had managed to do her college work reasonably well until she began a sexual relationship with a boyfriend. At that time, all of her pains escalated, with additional throbbing sensations in her urethra, painful intercourse, and painful urinary frequency.

As repeated referrals turned up no satisfactory explanation for her symptoms, she became more and more anxious and demanding in seeking medical care. She was reading the medical literature and raising questions about illnesses she thought she might have. Attempts at reassurance by her doctors had fallen on deaf ears. To her doctor, she was also beginning to seem depressed. She had begun to complain of additional symptoms including back and hip pain and constipation. Chapter 14 Hypochondriasis and Somatization Disorder 155 Ch14.qxd 28/6/07 1:36 PM Page 155 The psychiatrist recommended to Melissa's physician that he see her on a regular basis, but severely curtail further surgical and medical workups. Although she did not seem a strong candidate for psychotherapy, listening to her story and tolerating her complaints without an urge to "do something" might be of some help. Prescribing an antidepressant (beginning with small doses) could possibly ameliorate both pain and depression, but should not be administered with any optimistic promise of fast (or any) results. He

suggested that a stable, continuous patient–physician relationship could potentially offer the greatest therapeutic benefit and that definite appointments should be made unrelated to occurrence or intensity of symptoms.

The somatoform disorders are a group of psychiatric disorders in which patients present with a myriad of clinically significant but unexplained physical symptoms. They include somatization disorder, undifferentiated somatoform disorder, hypochondriasis, conversion disorder, pain disorder, body dysmorphic disorder, and somatoform disorder not otherwise specified.¹ These disorders often cause significant emotional distress for patients and are a challenge to family physicians.

Up to 50 percent of primary care patients present with physical symptoms that cannot be explained by a general medical condition. Some of these patients meet criteria for somatoform disorders.^{2,3} Although most do not meet the strict psychiatric diagnostic criteria for one of the somatoform disorders, they can be referred to as having “somatic preoccupation,”⁴ a subthreshold presentation of somatoform disorders that can also cause patients distress and require intervention.

The unexplained symptoms of somatoform disorders often lead to general health anxiety; frequent or recurrent and excessive preoccupation with unexplained physical symptoms; inaccurate or exaggerated beliefs about somatic symptoms; difficult encounters with the health care system; disproportionate disability; displays of strong, often negative emotions toward the physician or office staff; unrealistic expectations; and, occasionally, resistance to or noncompliance with diagnostic or treatment efforts. These behaviors may result in more frequent office visits, unnecessary laboratory or imaging tests, or costly and potentially dangerous invasive procedures.

Little is known about the causes of the somatoform disorders. Limited epidemiologic data suggest familial aggregation for some of the disorders.¹ These data also indicate comorbidities with other mental health disorders, such as mood disorders, anxiety disorders, personality disorders, eating disorders, and psychotic disorders.^{1,3}

DIAGNOSIS

The challenge in working with somatoform disorders in the primary care setting is to simultaneously exclude medical causes for physical symptoms while considering a

mental health diagnosis. The diagnosis of a somatoform disorder should be considered early in the process of evaluating a patient with unexplained physical symptoms. Appropriate nonpsychiatric medical conditions should be considered, but over-evaluation and unnecessary testing should be avoided. There are no specific physical examination findings or laboratory data that are helpful in confirming these disorders; it often is the lack of any physical or laboratory findings to explain the patient's excessive preoccupation with somatic symptoms that initially prompts the physician to consider the diagnosis.

Two related disorders, factitious disorder and malingering, must be excluded before diagnosing a somatoform disorder. In factitious disorder, patients adopt physical symptoms for unconscious internal gain (i.e., the patient desires to take on the role of being sick), whereas malingering involves the purposeful feigning of physical symptoms for external gain (e.g., financial or legal benefit, avoidance of undesirable situations). In somatoform disorders, there are no obvious gains or incentives for the patient, and the physical symptoms are not willfully adopted or feigned; rather, anxiety and fear facilitate the initiation, exacerbation, and maintenance of these disorders.

Clinical diagnostic tools have been used to assist in the diagnosis of somatoform disorders. One screening tool for psychiatric disorders that is used in primary care settings is the Patient Health Questionnaire (PHQ). The somatoform screening questions on the PHQ include 13 physical symptoms. If a patient reports being bothered "a lot" by at least three of the symptoms without an adequate medical explanation, the possibility of a somatoform disorder should be considered.

Somatic symptom disorder (SSD formerly known as "somatization disorder" or "somatoform disorder") is a form of mental illness that causes one or more bodily symptoms, including pain. The symptoms may or may not be traceable to a physical cause including general medical conditions, other mental illnesses, or substance abuse. But regardless, they cause excessive and disproportionate levels of distress. The symptoms can involve one or more different organs and body systems, such as:

- Pain
- Neurologic problems
- Gastrointestinal complaints

- Sexual symptoms

Many people who have SSD will also have an anxiety disorder.

People with SSD are not faking their symptoms. The distress they experience from pain and other problems they experience are real, regardless of whether or not a physical explanation can be found. And the distress from symptoms significantly affects daily functioning.

Doctors need to perform many tests to rule out other possible causes before diagnosing SSD.

The diagnosis of SSD can create a lot of stress and frustration for patients. They may feel unsatisfied if there's no better physical explanation for their symptoms or if they are told their level of distress about a physical illness is excessive. Stress often leads patients to become more worried about their health, and this creates a vicious cycle that can persist for years.

DISORDERS RELATED TO SOMATIC SYMPTOM DISORDER

Several conditions related to SSD are now described in psychiatry. These include:

- **Illness Anxiety Disorder (formerly called Hypochondriasis).** People with this type are preoccupied with a concern they have a serious disease. They may believe that minor complaints are signs of very serious medical problems. For example, they may believe that a common headache is a sign of a brain tumor.
- **Conversion disorder (also called Functional Neurological Symptom Disorder).** This condition is diagnosed when people have neurological symptoms that can't be traced back to a medical cause. For example, patients may have symptoms such as:
 - Weakness or paralysis
 - Abnormal movements (such as tremor, unsteady gait, or seizures)
 - Blindness
 - Hearing loss
 - Loss of sensation or numbness

- Seizures (called nonepileptic seizures and pseudoseizures)

Stress usually makes symptoms of conversion disorder worse.

- **Other Specific Somatic Symptom and Related Disorders.** This category describes situations in which somatic symptoms occur for less than six months or may involve a specific condition called pseudocyesis, which is a false belief women have that they are pregnant along with other outward signs of pregnancy, including an expanding abdomen; feeling labor pains, nausea, fetal movement; breast changes; and cessation of the menstrual period.

TREATMENT OF SOMATIC SYMPTOM DISORDERS

Patients who experience SSD may cling to the belief that their symptoms have an underlying physical cause despite a lack of evidence for a physical explanation. Or if there is a medical condition causing their symptoms, they may not recognize that the amount of distress they are experiencing or displaying is excessive. Patients may also dismiss any suggestion that psychiatric factors are playing a role in their symptoms.

A strong doctor-patient relationship is key to getting help with SSD. Seeing a single health care provider with experience managing SSD can help cut down on unnecessary tests and treatments.

The focus of treatment is on improving daily functioning, not on managing symptoms. Stress reduction is often an important part of getting better. Counseling for family and friends may also be useful.

Cognitive behavioral therapy may help relieve symptoms associated with SSD. The therapy focuses on correcting:

- Distorted thoughts
- Unrealistic beliefs
- Behaviors that feed the anxiety.

PSYCHOTHERAPY

Because physical symptoms can be related to psychological distress and a high level of health anxiety, psychotherapy — specifically, cognitive behavioral therapy (CBT) — can help improve physical symptoms.

CBT can help you:

- Examine and adapt your beliefs and expectations about health and physical symptoms
- Learn how to reduce stress
- Learn how to cope with physical symptoms
- Reduce preoccupation with symptoms
- Reduce avoidance of situations and activities due to uncomfortable physical sensations
- Improve daily functioning at home, at work, in relationships and in social situations
- Address depression and other mental health disorders

Family therapy may also be helpful by examining family relationships and improving family support and functioning.

MEDICATIONS

Antidepressant medication can help reduce symptoms associated with depression and pain that often occur with somatic symptom disorder.

If one medication doesn't work well for you, your doctor may recommend switching to another or combining certain medications to boost effectiveness. Keep in mind that it can take several weeks after first starting a medication to notice an improvement in symptoms.

Illness anxiety disorder, sometimes called hypochondriasis or health anxiety, is worrying excessively that you are or may become seriously ill. You may have no physical symptoms. Or you may believe that normal body sensations or minor symptoms are signs of severe illness, even though a thorough medical exam doesn't reveal a serious medical condition.

You may experience extreme anxiety that body sensations, such as muscle twitching or fatigue, are associated with a specific, serious illness. This excessive anxiety

— rather than the physical symptom itself — results in severe distress that can disrupt your life.

Illness anxiety disorder is a long-term condition that can fluctuate in severity. It may increase with age or during times of stress. But psychological counseling (psychotherapy) and sometimes medication can help ease your worries.

Hypochondria

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association, no longer includes hypochondriasis — also called hypochondria — as a diagnosis. Instead, people previously diagnosed with hypochondriasis may be diagnosed as having illness anxiety disorder, in which the focus of the fear and worry is on uncomfortable or unusual physical sensations being an indication of a serious medical condition.

On the other hand, somatic symptom disorder — a related disorder — involves focusing on the disabling nature of physical symptoms, such as pain or dizziness, without the worry that these symptoms represent a specific illness.

SYMPTOMS

Symptoms of illness anxiety disorder involve preoccupation with the idea that you're seriously ill, based on normal body sensations (such as a noisy stomach) or minor signs (such as a minor rash). Signs and symptoms may include:

- Being preoccupied with having or getting a serious disease or health condition
- Worrying that minor symptoms or body sensations mean you have a serious illness
- Being easily alarmed about your health status
- Finding little or no reassurance from doctor visits or negative test results
- Worrying excessively about a specific medical condition or your risk of developing a medical condition because it runs in your family
- Having so much distress about possible illnesses that it's hard for you to function
- Repeatedly checking your body for signs of illness or disease

- Frequently making medical appointments for reassurance — or avoiding medical care for fear of being diagnosed with a serious illness
- Avoiding people, places or activities for fear of health risks
- Constantly talking about your health and possible illnesses
- Frequently searching the internet for causes of symptoms or possible illnesses

Causes

The exact cause of illness anxiety disorder isn't clear, but these factors may play a role:

- **Beliefs.** You may have a difficult time tolerating uncertainty over uncomfortable or unusual body sensations. This could lead you to misinterpret that all body sensations are serious, so you search for evidence to confirm that you have a serious disease.
- **Family.** You may be more likely to have health anxiety if you had parents who worried too much about their own health or your health.
- **Past experience.** You may have had experience with serious illness in childhood, so physical sensations may be frightening to you.

Risk factors

Illness anxiety disorder usually begins in early or middle adulthood and may get worse with age. Often for older individuals, health-related anxiety may focus on the fear of losing their memory.

Risk factors for illness anxiety disorder may include:

- A time of major life stress
- Threat of a serious illness that turns out not to be serious
- History of abuse as a child
- A serious childhood illness or a parent with a serious illness
- Personality traits, such as having a tendency toward being a worrier
- Excessive health-related internet use

Complications

Illness anxiety disorder may be associated with:

- Relationship or family problems because excessive worrying can frustrate others

- Work-related performance problems or excessive absences
- Problems functioning in daily life, possibly even resulting in disability
- Financial problems due to excessive health care visits and medical bills
- Having another mental health disorder, such as somatic symptom disorder, other anxiety disorders, depression or a personality disorder

PREVENTION

Little is known about how to prevent illness anxiety disorder, but these suggestions may help.

- **If you have problems with anxiety, seek professional advice** as soon as possible to help stop symptoms from getting worse and impairing your quality of life.
- **Learn to recognize when you're stressed and how this affects your body** — and regularly practice stress management and relaxation techniques.
- **Stick with your treatment plan** to help prevent relapses or worsening of symptoms.

While the diagnosis of hypochondria has been split into somatic symptom disorder and illness anxiety disorder in the *DSM-5*, it still often means obsessive worry about sickness and sometimes, medically unexplained symptoms.

As researchers continue to learn what factors are most likely to trigger hypochondria, more individuals may be able to access effective treatment that helps them reduce the stress and, ironically, poor health that may often accompany hypochondria.

TREATMENT FOR HYPOCHONDRIA

Symptoms of somatic symptom disorder and illness anxiety can dramatically reduce a person's quality of life and may also significantly impact friends and family members. Working with a mental health professional can help people identify and build coping mechanisms that reduce symptoms and address any underlying issues that contribute the anxiety and somatic symptoms.

Therapists and counselors treating hypochondria will generally first rule out the possibility of a serious medical condition. Some people with health anxiety avoid medical treatment, and many of the behaviors associated with this avoidance can superficially manifest as hypochondria. If there are co-occurring physical or

mental health issues, such as OCD, depression, diabetes, or cancer, a treatment plan should accommodate these conditions.

TYPES OF THERAPY FOR HYPOCHONDRIA

Psychotherapy and, in some cases, psychotropic medication can be highly effective at treating hypochondria. Some common types of therapy that have been proven to successfully address the roots of health anxiety include:

- Cognitive behavioral therapy (CBT): Hypochondria is often characterized by seemingly irrational beliefs or concerns about a health symptom or condition. CBT helps people identify those beliefs and replace them with more rational and realistic thoughts.
- Bibliotherapy: Because it can help deepen one's understanding of a condition, bibliotherapy may be a helpful treatment approach for many who experience hypochondria. Literature about overcoming hypochondria or books that help describe and normalize the condition could be used in bibliotherapy for hypochondria.
- Behavioral stress management: This type of therapy may help individuals with hypochondria lower their stress levels and feelings of anxiety about a health condition or symptom. While it may be used to help people who are truly at risk for a medical condition, it could also be promising for those with health anxiety.
- Group therapy: One study points to the effectiveness of group CBT in reducing somatic symptoms that may accompany hypochondria. In addition to being cost-effective, group-style treatment could make it easier for some people to identify irrational health-related thoughts since it allows them to work with others who have similar health concerns.

If you think you could be experiencing hypochondria or a related diagnosis, it may help to first visit your health care provider or a therapist. In addition to the types of therapy listed above, individual or talk therapy can be a helpful first step that allows people with hypochondria to address their health anxiety in a safe, validating space and be referred to medical treatment if physical health is the root concern. Find a therapist in your area.

HOW TO DEAL WITH HYPOCHONDRIA

Although seeing a therapist and/or doctor can be key when addressing hypochondria, individuals with a somatic symptom disorder diagnosis and those with troubling thoughts about disease may find these research-based tips helpful.

- **Don't research symptoms.** If you know you're prone to worrying about health or physical symptoms, it may help to stay offline and avoid searching for potential medical explanations. For example, someone may have a sore throat due to allergies but find out online that their discomfort could also be caused by the unlikely diagnosis of throat cancer.
- **Find support.** Joining a support group in your area for people with health anxiety could help you connect with others who have similar worries or symptoms. Talking about your concerns with others may help you put health anxiety into perspective.
- **Communicate with your doctor.** Let your doctor know if you have difficulty letting go of concerns related to your physical health or medical condition. Open communication can help you and your doctor stay on the same page and may also allow your doctor to better understand you and give you any reassurance you need.

While dealing with hypochondria isn't always a simple matter of banishing distracting or unhelpful thoughts, it is possible to overcome. Whether you are healthy or have a medical condition, professional care can help soothe fears brought on by health anxiety.

HYPOCHONDRIA IN THERAPY: CASE EXAMPLE

Cognitive behavioral therapy for health anxiety: Harriet has always been very careful about her health and does not have a family history of serious medical issues. However, she is preoccupied by the worry that at 36 she is developing arthritis in her hands, due to pain in two of her knuckles. Doctors have assured her she does not have arthritis, but she continues to be consumed by the thought and sees other medical professionals. Her visits are not very helpful, and she begins to wonder whether her symptoms indicate another condition. After a psychiatrist assigns a diagnosis of illness anxiety, Harriet works with a psychotherapist to identify the sources and factors contributing to her anxiety. Though she still feels something is "off" about her health and experiences strange aching in her finger joints, the therapist encourages her to resist the urge to visit more doctors and asks Harriet to instead examine what else is happening in her life during the times when the pain and temptation to visit doctors is strongest. She gradually begins to notice patterns of significant stress—a daunting project at work, a visit from her sister, or

her best friend's wedding—precipitating her pain and many medical visits. As Harriet pays more attention to her general stress and anxiety levels and develops better coping skills and habits with the help of her therapist, her constant worry is eased. She still notices pain from time to time, but it's far less severe and she does not rush to see a doctor when it happens.

People with **hysterical somatoform disorders** suffer actual changes in their physical functioning. These somatoform disorders are often hard to distinguish from genuine medical problems (Phillips et al., 2008). In fact, it is always possible that a diagnosis of hysterical disorder is a mistake and that the patient's problem has an undetected organic cause (Merskey, 2004). DSM-IV-TR lists three hysterical somatoform disorders: conversion disorder, somatization disorder, and pain disorder associated with psychological factors.

Hypochondriasis People who suffer from **hypochondriasis** unrealistically interpret bodily symptoms as signs of a serious illness (see Table 7-2 on the next page). 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 Hypochondriasis can present a picture very similar to that of somatization disorder (Noyes, 2008, 2003, 1999; Fink et al., 2004). 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. Between 1 and 5 percent of all people experience the disorder (Asmundson & Taylor, 2008; Bouman, 2008; APA, 2000). As with pain disorder associated with psychological factors, physicians report seeing many cases (Mitchell, 2004). As many as 7 percent of all patients seen by primary care physicians may display hypochondriasis (Asmundson & Taylor, 2008). For most patients, the symptoms rise and fall over the years (Bouman, 2008).

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 (see again Table 7-2). 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 (McKay, Gosselin, & Gupta, 2008; Shapiro & Gavin, 2006; Veale, 2004). Some worry about the appearance of their feet, hands, breasts, penis, or other body parts (see *Eye on Culture* on page 212). Still others are concerned about bad odors coming from sweat, breath, genitals, or the rectum (Phillips & Castle, 2002). Here

we see such a case: A woman of 35 had for 16 years been worried that her sweat smelled terrible. The fear began just before her marriage when she was sharing a bed with a close friend who said that someone at work smelled badly, and the patient felt that the remark was directed at her. For fear that she smelled, for 5 years she had not gone out anywhere except when accompanied by her husband or mother. She had not spoken to her neighbors for 3 years because she thought she had overheard them speak about her to some friends. She avoided cinemas, dances, shops, cafes, and private homes. . . . Her husband was not allowed to invite any friends home; she constantly sought reassurance from him about her smell. . . .

Her husband bought all her new clothes as she was afraid to try on clothes in front of shop assistants. She used vast quantities of deodorant and always bathed and changed her clothes before going out, up to 4 times daily

It is common in our society to worry about appearance (see Figure 7-2). 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 (Phillips, 2005). As many as half of people with this disorder seek plastic surgery or dermatology treatment, and often they feel worse rather than better afterward (McKay et al., 2008; Miller, 2005).

One study found that 30 percent of participants with body dysmorphic disorder were housebound and 17 percent had attempted suicide (Phillips et al., 1993). Similarly, people with this disorder are more likely than others to be unemployed and to have limited academic success (Frare et al., 2004). Most cases of body dysmorphic disorder begin during adolescence. Often, however, people don’t reveal their concerns for many

years (McKay et al., 2008; Phillips et al., 2005). Up to 5 percent of people in the United States—including many college students—suffer from the disorder (Ovsiew, 2006; Miller, 2005). Clinical reports suggest that it may be equally common among women and men (APA, 2000). Although both women and men with this disorder complain about their skin, hair, and nose, women are more likely to be concerned about their hips, buttocks, and breasts, while men are particularly likely to be preoccupied with their body build, genitals, and height (McKay et al., 2008)

DISASSOCIATIVE DISORDER

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. Others recognize us and expect certain things of us. But more important, 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. Without a memory, we would always be starting over; with it, life moves forward.

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.

Several memorable books and movies have portrayed dissociative disorders. Two of the best known are *The Three Faces of Eve* and *Sybil*, each about a woman with multiple personalities. The topic is so fascinating that most television drama series seem to include at least one case of dissociation every season, creating the impression that the disorders are very common (Pope et al., 2007). 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 changes: their mental processes or bodies feel unreal or foreign to them. You will read more about this disorder at the close of the chapter. Outside of that discussion, however, “dissociative disorders” will refer to those problems that involve clear changes in memory and identity: dissociative amnesia, dissociative fugue, and dissociative identity disorder.

As you read through the remainder of this chapter, keep in mind that dissociative symptoms are often found in cases of acute or posttraumatic stress disorder. Recall from Chapter 6 that sufferers of those disorders may feel dazed, have trouble remembering things, or experience a sense of unreality. When such symptoms occur as part of a stress disorder, they do not necessarily indicate a dissociative disorder, in which the dissociative symptoms dominate. On the other hand, research suggests that a number of people with one of these disorders also develop the other as well (Bremner, 2002).

DISSOCIATIVE AMNESIA

At the beginning of this chapter you met the unfortunate man named Brian. As you will recall, Brian developed a conversion disorder after a traumatic boating accident in which his wife was killed. To help examine dissociative amnesia, let us now revisit that case, changing the reactions and symptoms that Brian develops in the aftermath of the traumatic event.

In this revised scenario, Brian is reacting to his traumatic experience with symptoms of **dissociative amnesia**. People with this disorder 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 (see Table 7-5). Often an episode of amnesia is directly triggered by a specific upsetting event (McLeod, Byrne, & Aitken, 2004).

Dissociative amnesia may be *localized*, *selective*, *generalized*, or *continuous*. Any of these kinds of amnesia can be triggered by a traumatic experience such as Brian's, but each represents a particular pattern of forgetting. Brian was suffering from *localized*, or *circumscribed*, *amnesia*, 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. Recall that Brian awakened on the day after the funeral and could not recall any of the events of the past difficult days, beginning after the boating tragedy. He remembered everything that happened up to and including the accident. He could also recall everything from the morning after the funeral onward, but the days in between remained a total blank. The forgotten period is called the *amnesic episode*. During an amnesic episode, people may appear confused; in some cases they wander about aimlessly. They are already experiencing memory difficulties but seem unaware of them. In the revised case, for example, Brian felt as though he were in a trance on the day of Helen's funeral.

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. If Brian had selective amnesia, he might remember certain conversations with friends but perhaps not the funeral itself.

In some cases the loss of memory extends back to times long before the upsetting period. Brian might awaken after the funeral and find that, in addition to forgetting events of the past few days, he could not remember events that occurred earlier in his life. In this case, he would be experiencing *generalized amnesia*. In extreme cases, Brian might not even remember who he was and might fail to recognize relatives and friends. 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. Brian might forget new and ongoing experiences as well as what happened before and during

the tragedy. Continuous forgetting of this kind is actually quite rare in cases of dissociative amnesia but not, as you will see in Chapter 18, in cases of organic amnesia.

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 president of the United States and how to write, read, or drive a car. Clinicians do not know how common dissociative amnesia is (Pope et al., 2007), but they do know that many cases seem to begin during serious threats to health and safety, as in wartime and natural disasters (Cardena & Gleaves, 2008; Witztum et al., 2002). Combat veterans often report memory gaps of hours or days, and some forget personal information, such as their names and addresses (Bremner, 2002). It appears that childhood abuse, particularly child sexual abuse, can also sometimes trigger dissociative amnesia; indeed, the 1990s witnessed many reports in which adults claimed to recall long forgotten experiences of childhood abuse (see *A Closer Look* on page 223). In addition, dissociative amnesia may occur under more ordinary circumstances, such as the sudden loss of a loved one through rejection or death or guilt over certain actions (for example, an extramarital affair) (Koh et al., 2000). The personal impact of dissociative amnesia depends on how much is forgotten. Obviously, an amnesic episode of two years is more of a problem than one of two hours. Similarly, an amnesic episode during which a person’s life changes in major ways causes more difficulties than one that is quiet.

DISSOCIATIVE FUGUE

People with a **dissociative fugue** not only forget their personal identities and details of their past lives but also flee to an entirely different location (see again Table 7-5). Some individuals travel but a short distance and make few social contacts in the new setting (APA, 2000). Their fugue may be brief—a matter of hours or days—and end suddenly. In other cases, however, the person may travel far from home, take a new name, and establish a new identity, new relationships, and even a new line of work. Such

people may also display new personality characteristics; often they are more outgoing (APA, 2000).

This pattern is seen in the case of the Reverend Ansel Bourne, Approximately 0.2 percent of the population experience dissociative fugue. Like dissociative amnesia, a fugue usually follows a severely stressful event (Cardena & Gleaves, 2008; APA, 2000). Some adolescent runaways may be in a state of fugue (Loewenstein, 1991). Like cases of dissociative amnesia, fugues usually affect personal (episodic) memories rather than encyclopedic or abstract (semantic) knowledge (Maldonado & Spiegel, 2007; Glisky et al., 2004; Kihlstrom, 2001).

Fugues tend to end abruptly. In some cases, as with Reverend Bourne, the person “awakens” in a strange place, surrounded by unfamiliar faces, and wonders how he or she got there. In other cases, the lack of personal history may arouse suspicion. Perhaps a traffic accident or legal problem leads police to discover the false identity; at other times friends search for and find the missing person. When people are found before their state of fugue has ended, therapists may find it necessary to ask them many questions about the details of their lives, repeatedly remind them who they are, and even initiate psychotherapy before they recover their memories. As these people recover their past, some forget the events of the fugue period (APA, 2000).

The majority of people who experience dissociative fugue regain most or all of their memories and never have a recurrence. Since fugues are usually brief and totally reversible, individuals tend to experience few aftereffects. People who have been away for months or years, however, often do have trouble adjusting to the changes that have occurred during their flights. In addition, some people commit illegal or violent acts in their fugue state and later must face the consequences.

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 (see again Table 7-5). 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). Eric, for example, twisted his face, growled, and yelled obscenities while changing personalities. Switching is usually triggered by a stressful event, although clinicians can also bring about the change with hypnotic suggestion (APA, 2000). Cases of dissociative identity disorder were first reported almost three centuries ago (Rieber, 2002). Many clinicians consider the disorder to be rare, but some reports suggest that it may be more common than was once thought (Sar et al., 2007; Lilienfeld & Lynn, 2003; APA, 2000). Most cases are first diagnosed in late adolescence or early adulthood, but, more often than not, the symptoms actually dissociative identity disorder. A dissociative disorder in which a person develops two or more distinct personalities. Also known as *multiple personality disorder*. Subpersonalities. The two or more distinct personalities found in individuals suffering with dissociative identity disorder. Also known as *alternate personalities*. m Eve”

In 1975 Chris Sizemore revealed that she had been the subject of the book and the film *The Three Faces of Eve*. A fully integrated personality for more than 30 years, Ms. Sizemore is now an accomplished author, artist, and mental health spokesperson.

began in early childhood after episodes of abuse (often sexual abuse), perhaps even before the age of 5 (Maldonado & Spiegel, 2007; Roe-Sepowitz et al., 2007; Ross et al., 1991). Women receive this diagnosis at least three times as often as men (APA, 2000).

How Do Subpersonalities Interact? How subpersonalities relate to or recall one another varies from case to case. Generally, however, there are three kinds of relationships. In *mutually amnesic relationships*, the subpersonalities have no awareness of one another (Ellenberger, 1970). 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 (Huntjens et al., 2005). 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).

Investigators used to believe that most cases of dissociative identity disorder involved two or three subpersonalities. Studies now suggest, however, 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. In the case of “Eve White,” made famous in the book and movie *The Three Faces of Eve*, a woman had three subpersonalities—Eve White, Eve Black, and Jane (Thigpen & Cleckley, 1957). Eve White, the primary personality, was quiet and serious; Eve Black was carefree and mischievous; and Jane was mature and intelligent. According to the book, these three subpersonalities eventually merged into Evelyn, a stable personality who was really an integration of the other three.

The book was mistaken, however; this was not to be the end of Eve’s dissociation. In an autobiography 20 years later, she revealed that altogether 22 subpersonalities had come forth during her life, including 9 subpersonalities after Evelyn. Usually they appeared in groups of three, and so the authors of *The Three Faces of Eve* apparently never knew about her previous or subsequent subpersonalities. She has now overcome her disorder, achieving a single, stable identity, and has been known as Chris Sizemore for over 30 years (Sizemore, 1991).

Conversion Disorder In **conversion disorder**, a psychosocial conflict or need is converted into dramatic physical symptoms that affect voluntary motor or sensory functioning (see Table 7-1). Brian, the man with the unexplained paralysis, would probably receive this particular diagnosis. The symptoms often seem neurological, such as paralysis, blindness, or loss of feeling (*anesthesia*), and so may be called “pseudoneurological” (APA, 2000). One woman developed dizziness in apparent response to her unhappy marriage:

PAIN

Pain Disorder Associated with Psychological Factors

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** (see again Table 7-1). 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 (de Waal et al., 2004). 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. Laura, a 36-year-old woman, reported pains that went far beyond the usual symptoms of her tubercular disease, called sarcoidosis.

QUESTION

1. Identify the symptoms associated with depression and mania.
2. What do you understand by the term ‘dissociation’? Discuss its various forms.
3. Explain the Body Dysmorphic disorder .
4. How many personalities are in dissociative identity disorder?

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DEPARTMENT OF PSYCHOLOGY

UNIT – IV - PSYCHOPATHALOGY - I – SPSY1402

PERSONALITY DISORDETS

INTRODUCTION

A personality disorder is a type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving. A person with a personality disorder has trouble perceiving and relating to situations and people. This causes significant problems and limitations in relationships, social activities, work and school.

In some cases, you may not realize that you have a personality disorder because your way of thinking and behaving seems natural to you. And you may blame others for the challenges you face.

Personality is vital to defining who we are as individuals. It involves a unique blend of traits—including attitudes, thoughts, behaviors, and moods—as well as how we express these traits in our contacts with other people and the world around us. Some characteristics of an individual's personality are inherited, and some are shaped by life events and experiences. A personality disorder can develop if certain personality traits become too rigid and inflexible.

People with personality disorders have long-standing patterns of thinking and acting that differ from what society considers usual or normal. The inflexibility of their personality can cause great distress, and can interfere with many areas of life, including social and work functioning. People with personality disorders generally also have poor coping skills and difficulty forming healthy relationships.

Unlike people with anxiety disorders, who know they have a problem but are unable to control it, people with personality disorders generally are not aware that they

have a problem and do not believe they have anything to control. Because they do not believe they have a disorder, people with personality disorders often do not seek treatment on their own.

COMMON ARE PERSONALITY DISORDERS

Personality disorders are among the most common of the severe mental disorders and often occur along with other mental illnesses, such as substance abuse disorders, mood disorders (depression or bipolar disorder), and anxiety disorders. It is estimated that 10 percent to 13 percent of the world's population suffer from some form of personality disorder. Most personality disorders begin in the teen years, when the personality further develops and matures. As a result, almost all people diagnosed with personality disorders are above the age of 18.

Some personality disorders—such as borderline personality disorder and histrionic personality disorder—are more common in women, and others—such as antisocial personality disorder and obsessive-compulsive personality disorder—are more common in men. Many people in prison also have a diagnosable personality disorder.

THE TYPES OF PERSONALITY DISORDERS

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which is the standard reference book for recognized mental illnesses, organizes personality disorders into three main categories, with several types of personality disorders in each category.

ECCENTRIC PERSONALITY DISORDERS

People with these disorders often appear odd or peculiar. The eccentric personality disorders include:

- **Paranoid personality disorder.** Paranoia is the hallmark of this disorder. People with paranoid personality disorder have a constant mistrust and suspicion of others. They believe that others are trying to demean, harm, or threaten them.

- **Schizoid personality disorder.** People with this disorder are distant, detached, and indifferent to social relationships. They generally are loners who prefer solitary activities and rarely express strong emotion.
- **Schizotypal personality disorder.** People with this disorder display unusual thinking and behavior, as well as appearance. People with schizotypal personality disorder might have odd beliefs and often are very superstitious.

DRAMATIC PERSONALITY DISORDERS

People with these disorders have intense, unstable emotions and a distorted self-image. They also often tend to behave impulsively. These disorders include:

- **Antisocial personality disorder.** People with this disorder are sometimes called “sociopaths” or “psychopaths.” This disorder is characterized by rash, irresponsible, and aggressive behavior, which often is expressed by a disregard for others and an inability to abide by society’s rules. People with this disorder often commit serious crimes and have a lack of remorse for their actions.
- **Borderline personality disorder.** This disorder is marked by unstable moods, poor self-image, chaotic relationships, and impulsive behavior (such as sexual promiscuity, substance abuse, over-spending, and reckless driving).
- **Histrionic personality disorder.** People with this disorder are shallow and constantly seek attention. They often are very dramatic, possibly even childish, and overly emotional.
- **Narcissistic personality disorder.** This disorder is characterized by an exaggerated sense of superiority, and a preoccupation with success and power. However, this preoccupation is fueled by a fragile self-esteem. People with this disorder are very self-centered, tend to lack empathy, and require constant attention and admiration.

ANXIOUS PERSONALITY DISORDERS

People with these disorders often are nervous or fearful. These disorders include:

- **Avoidant personality disorder.** People with this disorder tend to avoid social contacts. This behavior is not the result of a desire to be alone but due to excessive concern over being embarrassed or harshly judged. They often miss out on many valuable social experiences because of their fear of being rejected.
- **Dependent personality disorder.** This disorder is marked by dependency and submissiveness, a need for constant reassurance, feelings of helplessness, and an inability to make decisions. People with dependent personality disorder often become very close to another individual and spend great effort trying to please that person. They tend to display passive and clinging behavior, and have a fear of separation.
- **Obsessive-compulsive personality disorder.** This disorder is characterized by a pattern of perfectionism and inflexibility, control and orderliness, with a strong fear of making mistakes. This fear often results in an inability to make decisions, difficulty finishing tasks, and a preoccupation with details.

People might have mixed symptoms of more than one personality disorder. Personality disorders usually begin in the teenage years or early adulthood. There are many types of personality disorders. Some types may become less obvious throughout middle age.

DIAGNOSIS

If your doctor suspects you have a personality disorder, a diagnosis may be determined by:

- **Physical exam.** The doctor may do a physical exam and ask in-depth questions about your health. In some cases, your symptoms may be linked to an underlying physical health problem. Your evaluation may include lab tests and a screening test for alcohol and drugs.
- **Psychiatric evaluation.** This includes a discussion about your thoughts, feelings and behavior and may include a questionnaire to help pinpoint a diagnosis. With your permission, information from family members or others may be helpful.

- **Diagnostic criteria in the DSM-5.** Your doctor may compare your symptoms to the criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association.

DIAGNOSTIC CRITERIA

Each personality disorder has its own set of diagnostic criteria. However, according to the DSM-5, generally the diagnosis of a personality disorder includes long-term marked deviation from cultural expectations that leads to significant distress or impairment in at least two of these areas:

- The way you perceive and interpret yourself, other people and events
- The appropriateness of your emotional responses
- How well you function when dealing with other people and in relationships
- Whether you can control your impulses

Sometimes it can be difficult to determine the type of personality disorder, as some personality disorders share similar symptoms and more than one type may be present. Other disorders such as depression, anxiety or substance abuse may further complicate diagnosis. But it's worth the time and effort to get an accurate diagnosis so that you get appropriate treatment.

It is important to understand the difference between personality styles and personality disorders. A person who is shy or likes to spend time alone does not necessarily have an avoidant or schizoid personality disorder. The difference between personality style and a personality disorder often can be determined by assessing the person's personality function in certain areas, including:

- Work
- Relationships
- Feelings/emotions
- Self-identity
- Awareness of reality
- Behavior and impulse control

If symptoms are present, the doctor will begin an evaluation by performing a complete medical history and physical examination. Although there are no laboratory tests to specifically diagnose personality disorders, the doctor might use various diagnostic tests—such as X-rays and blood tests—to rule out physical illness as the cause of the symptoms.

If the doctor finds no physical reason for the symptoms, he or she might refer the person to a psychiatrist or psychologist, health care professionals who are specially trained to diagnose and treat mental illnesses. Psychiatrists and psychologists use specially designed interview and assessment tools to evaluate a person for a personality disorder. The doctor or therapist bases his or her diagnosis on the person's description of the symptoms and on his or her observation of the person's attitude and behavior. The therapist then determines if the person's symptoms point to a personality disorder as outlined in the DSM-5.

SYMPTOMS

Types of personality disorders are grouped into three clusters, based on similar characteristics and symptoms. Many people with one personality disorder also have signs and symptoms of at least one additional personality disorder. It's not necessary to exhibit all the signs and symptoms listed for a disorder to be diagnosed.

CLUSTER A PERSONALITY DISORDERS

Cluster A personality disorders are characterized by odd, eccentric thinking or behavior. They include paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder.

PARANOID PERSONALITY DISORDER

- Pervasive distrust and suspicion of others and their motives
- Unjustified belief that others are trying to harm or deceive you
- Unjustified suspicion of the loyalty or trustworthiness of others

- Hesitancy to confide in others due to unreasonable fear that others will use the information against you
- Perception of innocent remarks or nonthreatening situations as personal insults or attacks
- Angry or hostile reaction to perceived slights or insults
- Tendency to hold grudges
- Unjustified, recurrent suspicion that spouse or sexual partner is unfaithful

SCHIZOID PERSONALITY DISORDER

- Lack of interest in social or personal relationships, preferring to be alone
- Limited range of emotional expression
- Inability to take pleasure in most activities
- Inability to pick up normal social cues
- Appearance of being cold or indifferent to others
- Little or no interest in having sex with another person

SCHIZOTYPAL PERSONALITY DISORDER

- Peculiar dress, thinking, beliefs, speech or behavior
- Odd perceptual experiences, such as hearing a voice whisper your name
- Flat emotions or inappropriate emotional responses
- Social anxiety and a lack of or discomfort with close relationships
- Indifferent, inappropriate or suspicious response to others
- "Magical thinking" — believing you can influence people and events with your thoughts
- Belief that certain casual incidents or events have hidden messages meant only for you

CLUSTER B PERSONALITY DISORDERS

Cluster B personality disorders are characterized by dramatic, overly emotional or unpredictable thinking or behavior. They include antisocial personality disorder, borderline personality disorder, histrionic personality disorder and narcissistic personality disorder.

ANTISOCIAL PERSONALITY DISORDER

- Disregard for others' needs or feelings
- Persistent lying, stealing, using aliases, conning others
- Recurring problems with the law
- Repeated violation of the rights of others
- Aggressive, often violent behavior
- Disregard for the safety of self or others
- Impulsive behavior
- Consistently irresponsible
- Lack of remorse for behavior

BORDERLINE PERSONALITY DISORDER

- Impulsive and risky behavior, such as having unsafe sex, gambling or binge eating
- Unstable or fragile self-image
- Unstable and intense relationships
- Up and down moods, often as a reaction to interpersonal stress
- Suicidal behavior or threats of self-injury
- Intense fear of being alone or abandoned

- Ongoing feelings of emptiness
- Frequent, intense displays of anger
- Stress-related paranoia that comes and goes

HISTRIONIC PERSONALITY DISORDER

- Constantly seeking attention
- Excessively emotional, dramatic or sexually provocative to gain attention
- Speaks dramatically with strong opinions, but few facts or details to back them up
- Easily influenced by others
- Shallow, rapidly changing emotions
- Excessive concern with physical appearance
- Thinks relationships with others are closer than they really are

NARCISSISTIC PERSONALITY DISORDER

- Belief that you're special and more important than others
- Fantasies about power, success and attractiveness
- Failure to recognize others' needs and feelings
- Exaggeration of achievements or talents
- Expectation of constant praise and admiration
- Arrogance
- Unreasonable expectations of favors and advantages, often taking advantage of others
- Envy of others or belief that others envy you

CLUSTER C PERSONALITY DISORDERS

Cluster C personality disorders are characterized by anxious, fearful thinking or behavior. They include avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder.

AVOIDANT PERSONALITY DISORDER

- Too sensitive to criticism or rejection
- Feeling inadequate, inferior or unattractive
- Avoidance of work activities that require interpersonal contact
- Socially inhibited, timid and isolated, avoiding new activities or meeting strangers
- Extreme shyness in social situations and personal relationships
- Fear of disapproval, embarrassment or ridicule

DEPENDENT PERSONALITY DISORDER

- Excessive dependence on others and feeling the need to be taken care of
- Submissive or clingy behavior toward others
- Fear of having to provide self-care or fend for yourself if left alone
- Lack of self-confidence, requiring excessive advice and reassurance from others to make even small decisions
- Difficulty starting or doing projects on your own due to lack of self-confidence
- Difficulty disagreeing with others, fearing disapproval
- Tolerance of poor or abusive treatment, even when other options are available
- Urgent need to start a new relationship when a close one has ended

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

- Preoccupation with details, orderliness and rules
- Extreme perfectionism, resulting in dysfunction and distress when perfection is not achieved, such as feeling unable to finish a project because you don't meet your own strict standards
- Desire to be in control of people, tasks and situations, and inability to delegate tasks
- Neglect of friends and enjoyable activities because of excessive commitment to work or a project
- Inability to discard broken or worthless objects
- Rigid and stubborn
- Inflexible about morality, ethics or values
- Tight, miserly control over budgeting and spending money

Obsessive-compulsive personality disorder is not the same as obsessive-compulsive disorder, a type of anxiety disorder.

CAUSES

Personality is the combination of thoughts, emotions and behaviors that makes you unique. It's the way you view, understand and relate to the outside world, as well as how you see yourself. Personality forms during childhood, shaped through an interaction of:

- **Your genes.** Certain personality traits may be passed on to you by your parents through inherited genes. These traits are sometimes called your temperament.
- **Your environment.** This involves the surroundings you grew up in, events that occurred, and relationships with family members and others.

Personality disorders are thought to be caused by a combination of these genetic and environmental influences. Your genes may make you vulnerable to developing a personality disorder, and a life situation may trigger the actual development. Personality disorders are among the least understood and recognized of the mental disorders. It is believed that both genetics and environment play a role in the development of personality disorders. Certain personality disorders seem to be linked to a family history of mental illness. For example, people with antisocial personality disorder are more likely to have family members who also have personality disorders; and a family history of depression might be a risk factor for borderline personality disorder or obsessive-compulsive personality disorder.

Although research on personality disorders has been limited, no study has been able to show that a person is born with a personality disorder. As is the case with many other mental disorders, the tendency to develop a personality disorder might be inherited, not the disorder itself. The disorder arises when something interferes with the development of a healthy personality.

Personality disorders might develop as a way of coping with a troubling situation or unreasonable stress. For example, a person who was abused or neglected as a child might develop a personality disorder as a way of coping with the pain, fear, and anxiety that exists in his or her surroundings. One thing is known: personality disorders develop over time. A person does not suddenly “come down with” a personality disorder.

RISK FACTORS

Although the precise cause of personality disorders is not known, certain factors seem to increase the risk of developing or triggering personality disorders, including:

- Family history of personality disorders or other mental illness
- Abusive, unstable or chaotic family life during childhood
- Being diagnosed with childhood conduct disorder
- Variations in brain chemistry and structure

COMPLICATIONS

Personality disorders can significantly disrupt the lives of both the affected person and those who care about that person. Personality disorders may cause problems with relationships, work or school, and can lead to social isolation or alcohol or drug abuse.

TREATMENT

The treatment that's best for you depends on your particular personality disorder, its severity and your life situation. Often, a team approach is needed to make sure all of your psychiatric, medical and social needs are met. Because personality disorders are long-standing, treatment may require months or years.

Your treatment team may include your primary doctor or other primary care provider as well as a:

- Psychiatrist
- Psychologist or other therapist
- Psychiatric nurse
- Pharmacist
- Social worker

If you have mild symptoms that are well-controlled, you may need treatment from only your primary doctor, a psychiatrist or other therapist. If possible, find a mental health professional with experience in treating personality disorders.

Psychotherapy, also called talk therapy, is the main way to treat personality disorders.

The first step in the treatment of psychological disorders is recognizing that a problem exists. Often, people who have psychological disorders deny their problem and do not seek medical care for their symptoms. Regular medical care can be helpful because it allows a health care professional to provide early screening tests. Regular medical care also provides an opportunity for your health care professional to promptly evaluate symptoms and your risks for developing psychological disorders.

Treatment frequently involves psychotherapy to work on behaviors, skill development, and thought process. Initial hospitalization may be necessary for coexisting medical problems, serious complications, severe disorders, or substance abuse. Medications can be quite helpful for some personality disorders. Significant improvement can occur with proper treatment.

Common treatments for psychological disorders

Common treatments of psychological disorders include:

- Antianxiety medications
- Antidepressant medications to improve moods
- Antipsychotic medications to treat disordered thought patterns and altered perceptions
- Cognitive behavioral therapy to work on thought patterns and behavior
- Family therapy to help develop support and understanding
- Group therapy
- Hospitalization for coexisting medical problems, serious complications, severe disorders, or substance abuse
- Identification and treatment of coexisting conditions
- Individual therapy
- Mood-stabilizing medications
- Psychodynamic therapy to work on discovering and understanding past issues and their relationship to current thoughts and behaviors
- Support groups
- Talk therapy

PSYCHOTHERAPY

During psychotherapy with a mental health professional, you can learn about your condition and talk about your moods, feelings, thoughts and behaviors. You can learn to cope with stress and manage your disorder.

Psychotherapy may be provided in individual sessions, group therapy, or sessions that include family or even friends. There are several types of psychotherapy — your mental health professional can determine which one is best for you.

You may also receive social skills training. During this training you can use the insight and knowledge you gain to learn healthy ways to manage your symptoms and reduce behaviors that interfere with your functioning and relationships. Family therapy provides support and education to families dealing with a family member who has a personality disorder.

MEDICATIONS

There are no medications specifically approved by the Food and Drug Administration (FDA) to treat personality disorders. However, several types of psychiatric medications may help with various personality disorder symptoms.

- **Antidepressants.** Antidepressants may be useful if you have a depressed mood, anger, impulsivity, irritability or hopelessness, which may be associated with personality disorders.
- **Mood stabilizers.** As their name suggests, mood stabilizers can help even out mood swings or reduce irritability, impulsivity and aggression.
- **Antipsychotic medications.** Also called neuroleptics, these may be helpful if your symptoms include losing touch with reality (psychosis) or in some cases if you have anxiety or anger problems.
- **Anti-anxiety medications.** These may help if you have anxiety, agitation or insomnia. But in some cases, they can increase impulsive behavior, so they're avoided in certain types of personality disorders.

HOSPITAL AND RESIDENTIAL TREATMENT PROGRAMS

In some cases, a personality disorder may be so severe that you need to be admitted to a hospital for psychiatric care. This is generally recommended only when you can't care for yourself properly or when you're in immediate danger of harming yourself or someone else. After you become stable in the hospital, your doctor may recommend a day hospital program, residential program or outpatient treatment.

QUESTION

1. Discuss the Borderline Personality and treatment
2. Do you know people who suffer from antisocial personality disorder? What behaviours do they engage in, and why are these behaviours so harmful to them and others?
3. What characteristics of men and women do you think make them more likely to have APD and BDP, respectively?

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SCHOOL OF SCIENCE AND HUMANITIES

DEPARTMENT OF PSYCHOLOGY

UNIT – V - PSYCHOPATHOLOGY - I – SPSY1402

MENTAL RETARDATION & ORGANIC MENTAL DISORDERS

INTRODUCTION

Mental retardation (MR) refers to substantial limitations in present functioning. It starts before age 18 and is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas:

- communication
- self-care
- home living
- social skills
- community use
- self-direction
- health and safety
- functional academics
- leisure
- work

TRADITIONALLY, MR HAS BEEN CLASSIFIED INTO 5 CATEGORIES

- mild MR – IQ from (50-55) to 70
- moderate MR – IQ from (35-40) to (50-55)
- severe MR – IQ from (20-25) to (35-40)
- profound MR – IQ below (20-25)
- MR, severity unspecified – this is diagnosed when there is a strong suspicion of MR, but the individual cannot be tested with standardized intelligence tests.

Mental retardation: The condition of having an IQ measured as below 70 to 75 and significant delays or lacks in at least two areas of adaptive skills. Mental retardation is present from childhood. Between 2 and 3 percent of the general population meet the criteria for mental retardation. Causes of mental retardation include **fetal alcohol syndrome** and fetal **alcohol** effect; **brain damage** caused by the use of prescription or illegal **drugs** during **pregnancy**; **brain injury** and disease; and genetic disorders, such as **Down syndrome** and **fragile X syndrome**. Treatment of mental retardation depends on the underlying cause. In some cases, such as **phenylketonuria** and congenital **hypothyroidism**, **special diets** or medical treatments can help. In all cases, special education starting as early in infancy as possible can help people with mental retardation maximize their abilities.

FETAL ALCOHOL SYNDROME (FAS) FACTS

- Combined 2015 to 2016 data from the National Survey on **Drug Use** and Health (NSDUH) show that 10% of **pregnant** women 15 to 44 years of age drank **alcohol** in the past month. About 3% admitted to binge drinking during **pregnancy**. ("Binge drinking" in women is defined as four or more "hard alcohol" **drinks** consumed at one time. Male binge drinking is consuming five or more "hard alcohol" drinks consumed at one time.) Among women aged 18 to 45 years of age who were not pregnant, 55.5% drank alcohol in the past month, and 38.4% binge drank.

- Most alcohol use by pregnant women occurred during the **first trimester**. Alcohol use was lower during the second and third **trimesters** than during the first (4.2% and 3.7% vs. 17.9%, respectively). These findings suggest that many pregnant women are getting the message and not drinking alcohol. It is speculated that the larger frequency of first trimester drinking may have occurred prior to the woman becoming aware of her pregnancy.
- Infants of mothers who drank during pregnancy may experience a spectrum of consequences that range from "fetal alcohol effects" (FAE), alcohol-related **birth defects** (ARBD), partial **fetal alcohol syndrome** (PFAS), and fetal alcohol syndrome (**FAS**). Fetal alcohol syndrome is the most severe.
- Some children sustain no obvious side effects of maternal alcohol consumption during pregnancy. Exactly why this occurs is a paradox.

ALCOHOLIC DRINKS

Alcohol metabolism is the process by which the body breaks down and eliminates alcohol. Take a sip of alcohol and you may start to feel its effects right away. But it could take several hours or even longer for your body to fully break down that booze. Even after the breakdown is complete, alcohol can still affect how you think and feel. Some of the byproducts your body creates when it processes alcohol can hang around in your system for hours or even days. What follows will help you better understand what happens to alcohol once you consume it and what it can do to your body.

What Is Alcohol Metabolism?

Alcohol metabolism is the process through which your body breaks down and rids itself of alcohol.

When you swallow alcohol, it soaks into the tissues of your stomach and upper intestine. From there, the alcohol floods your bloodstream.

In healthy people, blood circulates throughout the body in just 90 seconds. It goes to your brain, **lungs**, and other tissues. That's why you feel the effect of alcohol almost immediately after drinking -- because it courses through your whole body in minutes. The effects continue to build for 15 to 45 minutes. Longer if you keep drinking.

Most of the alcohol your body absorbs ends up in your **liver**. There, enzymes break the alcohol down into byproducts. One of the byproducts, acetaldehyde, is highly toxic. It causes or contributes to these effects of drinking:

- Poor coordination
- **Memory loss** and blacking out
- Sleepiness
- **Hangover**

Normally, your body quickly turns acetaldehyde into acetate, which is harmless. Acetate and other alcohol byproducts quickly move to your kidneys and then to your urine.

But if you drink faster than your **liver** can break the stuff down, your blood alcohol level (BAC) will keep going up. Also, your liver will struggle to turn toxic acetaldehyde into harmless acetate. This makes you feel drunker.

How Long Do Alcohol's Effects Last?

That depends on how quickly and efficiently your body breaks down and clears out alcohol.

Those processes depend on a lot of different factors, including:

- How much you weigh
- Your sex
- Your age
- How much you've had to drink
- The type of alcohol you're drinking
- Your liver's health

It also matters how much you've had to eat. Food soaks up alcohol and slows its absorption. This can reduce the effects. It can also change the amount of time alcohol stays in your blood, which can range from 6 to 14 hours, depending on how much you've had to drink.

BRAIN DAMAGE INTRODUCTION

Brain damage is an injury that causes the destruction or deterioration of brain cells. In the U.S., every year, about 1.4 million people have some type of **brain injury**. And approximately 5.3 million people suffer from the effects of brain damage. About 50,000 die as a result of brain injury. Medical costs and lost productivity are estimated at between \$48 billion and \$60 billion per year.

What are the types of brain damage and how severe are they?

All traumatic brain injuries are head injuries. But **head injury** is not necessarily brain injury. There are two types of brain injury: traumatic brain injury and acquired brain injury. Both disrupt the brain's normal functioning.

- **Traumatic Brain Injury (TBI)** is caused by an external force -- such as a blow to the head -- that causes the brain to move inside the skull or damages the skull. This in turn damages the brain.
- **An Acquired Brain Injury (ABI)** occurs at the cellular level. It is most often associated with pressure on the brain. This could come from a **tumor**. Or it could result from neurological illness, as in the case of a **stroke**.

Both traumatic brain injury and acquired brain injury occur after birth. And neither is degenerative. Sometimes, the two terms are used interchangeably. There is a kind of brain damage that results from genetics or birth **trauma**. It's called congenital brain damage. It is not included, though, within the standard definition of brain damage or traumatic brain injury.

Most brain injuries cause focal -- or localized -- brain damage, such as the damage caused when a bullet enters the brain. In other words, the damage is confined to a small area. Closed head injuries frequently cause diffuse brain damage, which means damage to several areas of the brain. For example, both major speech and language areas might be involved.

The severity of brain damage can vary with the type of brain injury. A mild brain injury is temporary. It causes such symptoms as **headaches**, **confusion**, memory problems, and **nausea**. In a moderate brain injury, symptoms can last longer and be more pronounced. In both cases, most patients make a good recovery. With a serious brain

injury, the person may suffer life-changing and debilitating problems. People who are in a **coma** or a minimally responsive state are examples of those who are likely to have permanent brain damage.

CAUSES BRAIN DAMAGE

When the brain is starved of oxygen for a prolonged period of time, brain damage may occur. Brain damage can occur as a result of a wide range of injuries, illnesses, or conditions. Because of high-risk behaviors, males between the ages of 15 and 24 are most vulnerable. Young children and the elderly also have a higher risk.

Causes of traumatic brain injury include:

- car accidents
- blows to the head
- sports injuries
- falls or accidents
- physical violence

Causes of acquired brain injury include:

- poisoning or exposure to toxic substances
- infection
- strangulation, choking, or **drowning**
- **stroke**
- heart attacks
- tumors
- aneurysms
- neurological illnesses
- abuse of illegal **drugs**

SYMPTOMS OF BRAIN DAMAGE

There are numerous symptoms of brain damage, whether traumatic or acquired. They fall into four major categories:

- cognitive
- perceptual
- physical
- behavioral/emotional

Cognitive symptoms of brain damage include:

- difficulty processing information
- difficulty in expressing thoughts
- difficulty understanding others
- shortened attention span
- inability to understand abstract concepts
- impaired decision-making ability
- **memory loss**

Perceptual symptoms of brain damage include:

- change in vision, **hearing**, or sense of touch
- spatial disorientation
- inability to sense time
- disorders of smell and taste
- balance issues
- heightened sensitivity to **pain**

Physical symptoms of brain damage include:

- persistent **headaches**
- extreme mental **fatigue**
- extreme physical **fatigue**
- **paralysis**
- **tremors**
- **seizures**
- sensitivity to light
- **sleep disorders**
- slurred speech

- **loss of consciousness**

Behavioral/emotional symptoms of brain damage include:

- irritability and impatience
- reduced tolerance for **stress**
- sluggishness
- flattened or heightened emotions or reactions
- denial of disability
- increased aggressiveness

Intellectual Disability (ID), once called mental retardation, is characterized by below-average intelligence or mental ability and a lack of skills necessary for day-to-day living. People with intellectual disabilities can and do learn new skills, but they learn them more slowly. There are varying degrees of intellectual disability, from mild to profound. The term "mental retardation" is no longer used, as it's offensive and has a negative tone.

INTELLECTUAL DISABILITY

Someone with intellectual disability has limitations in two areas. These areas are:

- **Intellectual functioning.** Also known as IQ, this refers to a person's ability to learn, reason, make decisions, and solve problems.
- **Adaptive behaviors.** These are skills necessary for day-to-day life, such as being able to communicate effectively, interact with others, and take care of oneself.

IQ (intelligence quotient) is measured by an IQ test. The average IQ is 100, with the majority of people scoring between 85 and 115. A person is considered intellectually disabled if they have an IQ of less than 70 to 75.

To measure a child's adaptive behaviors, a specialist will observe the child's skills and compare them to other children of the same age. Things that may be observed include how well the child can feed or dress themselves; how well the child is able to

communicate with and understand others; and how the child interacts with family, friends, and other children of the same age.

Intellectual disability is thought to affect about 1% of the population. Of those affected, 85% have mild intellectual disability. This means they are just a little slower than average to learn new information or skills. With the right support, most will be able to live independently as adults.

SIGNS OF INTELLECTUAL DISABILITY IN CHILDREN

There are many different signs of intellectual disability in children. Signs may appear during infancy, or they may not be noticeable until a child reaches school age. It often depends on the severity of the disability. Some of the most common signs of intellectual disability are:

- Rolling over, sitting up, crawling, or walking late
- Talking late or having trouble with talking
- Slow to master things like **potty training**, dressing, and feeding themselves
- Difficulty remembering things
- Inability to connect actions with consequences
- Behavior problems such as explosive tantrums
- Difficulty with problem-solving or logical thinking

In children with severe or profound intellectual disability, there may be other health problems as well. These problems may include **seizures**, **mood disorders** (**anxiety**, **autism**, etc.), motor skills impairment, **vision** problems, or hearing problems.

CAUSES INTELLECTUAL DISABILITY

Anytime something interferes with normal **brain** development, intellectual disability can result. However, a specific cause for intellectual disability can only be pinpointed about a third of the time.

The most common causes of intellectual disability are:

- **Genetic conditions.** These include things like Down syndrome and fragile X syndrome.
- **Problems during pregnancy.** Things that can interfere with fetal **brain** development include alcohol or drug use, malnutrition, certain infections, or **preeclampsia**.
- **Problems during childbirth.** Intellectual disability may result if a baby is deprived of oxygen during childbirth or born extremely premature.
- **Illness or injury.** Infections like **meningitis**, **whooping cough**, or the **measles** can lead to intellectual disability. Severe **head injury**, near-drowning, extreme malnutrition, infections in the brain, exposure to toxic substances such as lead, and severe neglect or abuse can also cause it.
- **None of the above.** In two-thirds of all children who have intellectual disability, the cause is unknown.

INTELLECTUAL DISABILITY BE PREVENTED

Certain causes of intellectual disability are preventable. The most common of these is **fetal alcohol syndrome**. Pregnant women shouldn't drink alcohol. Getting proper prenatal care, taking a prenatal vitamin, and getting vaccinated against certain infectious diseases can also lower the risk that your child will be born with intellectual disabilities.

In families with a history of genetic disorders, genetic testing may be recommended before **conception**.

Certain tests, such as **ultrasound** and **amniocentesis**, can also be performed during pregnancy to look for problems associated with intellectual disability. Although these tests may identify problems before birth, they cannot correct them.

INTELLECTUAL DISABILITY DIAGNOSED

Intellectual disability may be suspected for many different reasons. If a baby has physical abnormalities that suggest a genetic or **metabolic disorder**, a variety of tests may be done to confirm the diagnosis. These include **blood** tests, urine tests, imaging tests to look for structural problems in the **brain**, or electroencephalogram (EEG) to look for evidence of seizures.

In children with developmental delays, the doctor will perform tests to rule out other problems, including hearing problems and certain neurological disorders. If no other cause can be found for the delays, the child will be referred for formal testing.

Three things factor into the diagnosis of intellectual disability: interviews with the parents, observation of the child, and testing of intelligence and adaptive behaviors. A child is considered intellectually disabled if they have deficits in both IQ *and* adaptive behaviors. If only one or the other is present, the child is not considered intellectually disabled.

After a diagnosis of intellectual disability is made, a team of professionals will assess the child's particular strengths and weaknesses. This helps them determine how much and what kind of support the child will need to succeed at home, in school, and in the community.

Services are available for people with intellectual disability

For babies and **toddlers**, early intervention programs are available. A team of professionals works with parents to write an Individualized Family Service Plan, or IFSP. This document outlines the child's specific needs and what services will help the child thrive. Early intervention may include speech therapy, occupational therapy, physical therapy, family counseling, training with special assistive devices, or **nutrition** services.

School-age children with intellectual disabilities (including **preschoolers**) are eligible for special education for free through the public school system. This is mandated by the Individuals With Disabilities Education Act (IDEA). Parents and educators work together to create an **Individualized Education Program**, or IEP, which outlines the child's needs and the services the child will receive at school. The point of special education is to make adaptations, accommodations, and modifications that allow a child with an intellectual disability to succeed in the classroom.

Steps to help your intellectually disabled child include:

- Learn everything you can about intellectual disabilities. The more you know, the better advocate you can be for your child.

- Encourage your child's independence. Let your child try new things and encourage your child to do things by themselves. Provide guidance when it's needed and give positive feedback when your child does something well or masters something new.
- Get your child involved in group activities. Taking an art class or participating in Scouts will help your child build social skills.
- Stay involved. By keeping in touch with your child's teachers, you'll be able to follow their progress and reinforce what your child is learning at school through practice at home.
- Get to know other parents of intellectually disabled children. They can be a great source of advice and emotional support.

It is defined as an intellectual functioning level (as measured by standard tests for intelligence quotient) well below average and significant limitations in daily living skills (adaptive functioning).

Description of MR

- According to the 'Centre for Disease Control and Prevention', in the 1990s, mental retardation occurred in 2.5 to 3 percent of the general population. Mental retardation begins in childhood or adolescence before the age of 18.
- It persists throughout adulthood. Intellectual functioning level is defined by standardized tests (Wechsler-Intelligence Scales) that measure the ability to reason in terms of mental age (intelligence quotient or IQ). Diagnosis of mental retardation is made if an individual has an intellectual functioning level well below average and significant limitations in two or more adaptive skill areas.
- Mental retardation is defined as IQ score below 70 to 75.
- Adaptive skills are the skills needed for daily life. Such skills include the ability to produce and understand language (communication); home-living skills; use of community resources; health, safety, leisure, self-care, and social skills; self-direction; functional academic skills (reading, writing, and arithmetic); and work skills.
- In general, mentally retarded children reach developmental milestones such as walking and talking much later than the general population.

- Symptoms of mental retardation may appear at birth or later in childhood. Time of onset depends on the suspected cause of the disability.
- Some cases of mild mental retardation are not diagnosed before the child enters pre-school.
- These children typically have difficulties with social, communication, and functional academic skills.
- Children who have a neurological disorder or illness such as encephalitis or meningitis may suddenly show signs of cognitive impairment and adaptive difficulties.

CAEGORIES OF MENTAL RETARDATION

MILD MENTAL RETARDATION

Approximately 85 percent of the mentally retarded population is in the mildly retarded category. Their IQ score ranges from 50 to 75 and they can often acquire academic skills up to the sixth grade level. They can become fairly self-sufficient and in some cases live independently, with community and social support.

MODERATE MENTAL RETARDATION

About 10 percent of the mentally retarded population is considered moderately retarded. Moderately retarded individuals have IQ scores ranging from 35 to 55. They can carry out work and self-care tasks with moderate supervision. They typically acquire communication skills in childhood and are able to live and function successfully within the community in a supervised environment such as a group home.

Severe Mental Retardation

About 3 to 4 percent of the mentally retarded population is severely retarded. Severely retarded individuals have IQ scores of 20 to 40. They may master very basic self-care skills and some communication skills. Many severely retarded individuals are able to live in a group home.

PROFOUND MENTAL RETARDATION

Only 1 to 2 percent of the mentally retarded population is classified as profoundly retarded. Profoundly retarded individuals have IQ scores under 20 to 25. They may be able to develop basic self-care and communication skills with appropriate support and training. Their retardation is often caused by an accompanying neurological disorder. The profoundly retarded need a high level of structure and supervision

CAUSES OF MENTAL RETARDATION

PRENATAL CAUSES (CAUSES BEFORE BIRTH)

- **Chromosomal Disorders:** Down's syndrome, fragile X syndrome, prader willi syndrome, klinefelter's syndrome
- **Single Gene Disorders:** Inborn errors of metabolism like galactosemia, phenyl ketonuria, hypothyroidism, mucopolysaccharidoses, tay sachs disease
- **Neuro Cutaneous Syndromes:** Tuberous sclerosis, neurofibromatosis
- **Dysmorphic Syndromes:** Laurence Moon Biedl syndrome
- **Brain Malformations:** Microcephaly, hydrocephalus, myelomeningocele

ABNORMAL MATERNAL ENVIRONMENTAL INFLUENCES

- **Deficiencies:** Iodine deficiency and folic acid deficiency, severe malnutrition
- **Substance use:** Alcohol, nicotine, cocaine
- **Exposure to harmful chemicals:** Pollutants, heavy metals, harmful drugs like thalidomide, phenytoin, warfarin sodium etc.
- **Maternal infections:** Rubella, toxoplasmosis, cytomegalovirus infection, syphilis, HIV
- **Exposure to:** Radiation and Rh incompatibility
- **Complications of Pregnancy:** Pregnancy induced hypertension, ante partum hemorrhage, placental dysfunction
- **Maternal Disease:** Diabetes, heart and kidney disease

DURING DELIVERY

Difficult and /or complicated delivery, severe prematurity, very low birth weight, birth asphyxia, birth trauma

- **Neonatal period:** Septicemia, jaundice, hypoglycemia, neonatal convulsions
- **Infancy and childhood:** Brain infections like tuberculosis, Japanese encephalitis, bacterial meningitis, Head trauma, chronic lead exposure, severe and prolonged malnutrition, gross under stimulation

SYMPTOMS OF MENTAL RETARDATION

- Failure to meet intellectual developmental markers
- Failure to meet developmental milestones such as sitting, crawling, walking, or talking, in a timely manner
- Persistence of childlike behaviour, possibly demonstrated in speaking style, or by a failure to understand social rules or consequences of behaviour
- Lack of curiosity and difficulty solving problems
- Decreased learning ability and ability to think logically
- Trouble remembering things
- An inability to meet educational demands required by school

TREATMENT

- Treatment for Mental Retardation is not designed to "cure" the disorder. Rather, therapy goals include reducing safety risks (e.g., helping an individual maintain safety at home or school) and teaching appropriate and relevant life skills. Interventions should be based on the specific needs of individuals and their families, with the primary goal of developing the person's potential to the fullest.
- Medications are required to treat co morbidities like aggression, mood disorders, self injurious behaviour, other behavioral problems and convulsions which occur in 40%to 70% of cases

your child has an intellectual disability (ID), their brain hasn't developed properly or has been injured in some way. Their brain may also not function within the normal range of both intellectual and adaptive functioning. In the past, medical professionals called this condition "mental retardation."

There are four levels of ID:

- mild
- moderate
- severe
- profound

Sometimes, ID may be classified as:

- “other”
- “unspecified”

ID involves both a low IQ and problems adjusting to everyday life. There may also be learning, speech, social, and physical disabilities.

Severe cases of ID may be diagnosed soon after birth. However, you might not realize your child has a milder form of ID until they fail to meet common developmental goals. Almost all cases of ID are diagnosed by the time a child reaches 18 years of age.

SYMPTOMS OF INTELLECTUAL DISABILITY

Symptoms of ID will vary based on your child’s level of disability and may include:

- failure to meet intellectual milestones
- sitting, crawling, or walking later than other children
- problems learning to talk or trouble speaking clearly
- memory problems
- inability to understand the consequences of actions
- inability to think logically
- childish behavior inconsistent with the child’s age
- lack of curiosity
- learning difficulties

- IQ below 70
- inability to lead a fully independent life due to challenges communicating, taking care of themselves, or interacting with others

If your child has ID, they may experience some of the following behavioral issues:

- aggression
- dependency
- withdrawal from social activities
- attention-seeking behavior
- depression during adolescent and teen years
- lack of impulse control
- passivity
- tendency toward self-injury
- stubbornness
- low self-esteem
- low tolerance for frustration
- psychotic disorders
- difficulty paying attention

Some people with ID may also have specific physical characteristics. These can include having a short stature or facial abnormalities.

Levels of intellectual disability

ID is divided into four levels, based on your child's IQ and degree of social adjustment.

Mild intellectual disability

Some of the symptoms of mild intellectual disability include:

- taking longer to learn to talk, but communicating well once they know how
- being fully independent in self-care when they get older
- having problems with reading and writing
- social immaturity
- increased difficulty with the responsibilities of marriage or parenting
- benefiting from specialized education plans
- having an IQ range of 50 to 69

Moderate intellectual disability

If your child has moderate ID, they may exhibit some of the following symptoms:

- are slow in understanding and using language
- may have some difficulties with communication
- can learn basic reading, writing, and counting skills
- are generally unable to live alone
- can often get around on their own to familiar places
- can take part in various types of social activities
- generally having an IQ range of 35 to 49

Severe intellectual disability

Symptoms of severe ID include:

- noticeable motor impairment
- severe damage to, or abnormal development of, their central nervous system
- generally having an IQ range of 20 to 34

Profound intellectual disability

Symptoms of profound ID include:

- inability to understand or comply with requests or instructions
- possible immobility
- incontinence
- very basic nonverbal communication
- inability to care for their own needs independently
- the need of constant help and supervision
- having an IQ of less than 20

Other intellectual disability

People in this category are often physically impaired, have hearing loss, are nonverbal, or have a physical disability. These factors may prevent your child's doctor from conducting screening tests.

Unspecified intellectual disability

If your child has an unspecified ID, they will show symptoms of ID, but their doctor doesn't have enough information to determine their level of disability.

What causes intellectual disability?

Doctors can't always identify a specific cause of ID, but causes of ID can include:

- trauma before birth, such as an infection or exposure to alcohol, drugs, or other toxins
- trauma during birth, such as oxygen deprivation or premature delivery
- inherited disorders, such as phenylketonuria (PKU) or Tay-Sachs disease

- chromosome abnormalities, such as Down syndrome
- lead or mercury poisoning
- severe malnutrition or other dietary issues
- severe cases of early childhood illness, such as whooping cough, measles, or meningitis
- brain injury

How is intellectual disability diagnosed?

To be diagnosed with ID, your child must have below-average intellectual and adaptive skills. Your child's doctor will perform a three-part evaluation that includes:

- interviews with you
- observations of your child
- standard tests

Your child will be given standard intelligence tests, such as the Stanford-Binet Intelligence Test. This will help the doctor determine your child's IQ.

The doctor may also administer other tests such as the Vineland Adaptive Behavior Scales. This test provides an assessment of your child's daily living skills and social abilities, compared to other children in the same age group.

It's important to remember that children from different cultures and socioeconomic statuses may perform differently on these tests. To form a diagnosis, your child's doctor will consider the test results, interviews with you, and observations of your child.

Your child's evaluation process might include visits to specialists, who may include a:

- psychologist
- speech pathologist

- social worker
- pediatric neurologist
- developmental pediatrician
- physical therapist

Laboratory and imaging tests may also be performed. These can help your child's doctor detect metabolic and genetic disorders, as well as structural problems with your child's brain.

Other conditions, such as hearing loss, learning disorders, neurological disorders, and emotional problems can also cause delayed development. Your child's doctor should rule these conditions out before diagnosing your child with ID.

You, your child's school, and your doctor will use the results of these tests and evaluations to develop a treatment and education plan for your child.

Treatment options for intellectual disability

Your child will probably need ongoing counseling to help them cope with their disability.

You will get a family service plan that describes your child's needs. The plan will also detail the services that your child will need to help them with normal development. Your family needs will also be addressed in the plan.

When your child is ready to attend school, an Individualized Education Program (IEP) will be put in place to help them with their educational needs. All children with ID benefit from special education.

The federal Individuals with Disabilities Act (IDEA) requires that public schools provide free and appropriate education to children with ID and other developmental disabilities.

The main goal of treatment is to help your child reach their full potential in terms of:

- education
- social skills
- life skills

Treatment may include:

- behavior therapy
- occupational therapy
- counseling
- medication, in some cases

When ID occurs with other serious physical problems, your child may have a below-average life expectancy. However, if your child has mild to moderate ID, they will probably have a fairly normal life expectancy.

When your child grows up, they may be able to work a job that complements their level of ID, live independently, and support themselves.

Support services are available to help adults with ID live independent and fulfilling lives.

ORGANIC MENTAL DISORDER

An organic mental disorder is a previously used term to describe a dysfunction of the brain that was meant to exclude psychiatric disorders. It is currently known under the category of neurocognitive disorders. It describes reduced brain function due to illnesses that are not psychiatric in nature.

Sometimes the term organic mental disorder is used interchangeably with the terms organic brain syndrome (OBS), chronic organic brain syndrome, or neurocognitive disorder—this latter term is the one used more commonly now.¹

Organic psychiatric disorders are those with demonstrable pathology or aetiology, or which arise directly from a medical disorder. They are thereby distinguished from all

other psychiatric disorders, which are traditionally called functional. This distinction is an oversimplification and conceptually flawed as all disorders have biological, psychological and social contributions (Chapter 1).

The term causes both practical and semantic problems, but remains in widespread use and so is used here:

The major organic disorders, dementia and delirium, are defined, like other psychiatric syndromes, by their characteristic clinical features. However, unlike other syndromes they are known to arise from different diseases with various aetiologies and pathologies. A complete diagnosis requires the disease as well as the dementia syndrome to be identified.

Other organic disorders are simply psychiatric disorders of any type that appear, in a particular case, to be caused by an identifiable medical condition. Sometimes it is the psychiatric symptoms that first bring the person to medical attention.

Substance misuse disorders are organic, in that there is a specific pharmacological cause. By convention they are classified separately (Chapter 14)

Psychiatric disorders which are considered psychological reactions to illness —such as becoming depressed after being told you have cancer —are excluded from the organic category

DEMENTIA CLINICAL FEATURES OF DEMENTIA

Dementia is also known as chronic brain syndrome. Its cardinal feature is memory impairment (shortterm worse than long-term) without impaired consciousness (cf. delirium). The overall clinical profile differs depending on the specific type of dementia, as outlined below, but other common features of dementia are:

Symptoms present for 6 months, of sufficient severity to impair functioning.

Personality and behavioural change —e.g. wandering, aggression, disinhibition.

Dysphasias, dyspraxias and focal neurological signs may be present.

Psychotic symptoms in half of cases at some stage.

Unawareness of deficits (except early on).

Nearly always progressive (though this is not a diagnostic criterion).

The incidence of dementia rises rapidly with age, affecting <5% of 65 year olds and 20% of 80 year olds. (Exact figures depend on severity threshold.) The risk of dementia is doubled in those with an affected first-degree relative. Other risk factors depend on the type of dementia concerned

The rapid rise with age is typified by Alzheimer's disease (Figure 13.1).

Dementia in the under 65s is termed presenile dementia. Differential diagnosis of dementia Established dementia is usually unmistakable, but mild dementia can be confused with (or coexist with) other conditions:

Depression. Poor concentration and impaired memory are common in depression in the elderly, hence pseudodementia. Two factors which help distinguish depression from dementia are: Did low mood or poor memory come first? Is the failure to answer questions due to lack of ability or lack of motivation?

Delirium. See next section.

Deafness. Check the person can hear.

Dysphasia. Check they can understand and speak.

Amnesic syndrome. A purer short-term memory defect (see below).

Late-onset schizophrenia (paraphrenia). Check for prominent symptoms of psychosis. The causes of dementia The common dementias are listed in Alzheimer's disease accounts for over half of all cases, with the majority of the rest explained by vascular dementia and Lewy body dementia.

The syndromes are not mutually exclusive, and the common ones often coexist.

In presenile dementia, a higher percentage of cases are due to rare genetic disorders or severe head injury. Clinical features differentiating the dementias Careful clinical evaluation identifies the specific dementia in more than 80% of cases .

A distinction is sometimes made clinically between cortical dementia (e.g. Alzheimer's disease) and subcortical dementia (e.g. Huntington's

Delirium Also known as acute confusional state or acute brain syndrome. It is common on medical and surgical wards—a third of elderly patients in hospital have an episode of delirium—so all doctors should be able to recognize and manage it.

Review the unresponsive patient and cognition modules . Clinical features of delirium Clouding of consciousness is the most important diagnostic sign. It refers to drowsiness, decreased awareness of surroundings, disorientation in time and place, and distractibility. At its most severe the patient may be unresponsive, but more commonly the impaired consciousness is quite subtle.

Minor degrees of impaired consciousness can be detected by problems estimating the passage of time (e.g. how long the interview has been going on), and with concentration tasks (e.g. counting from 20 down to 1). Because clouding of consciousness may not be apparent, the first clue to the presence of delirium is often one of its other features:

Fluctuating course, worse at night.

Visual hallucinations.

Transient persecutory delusions.

Irritability and agitation, or somnolence and decreased activity.

Impaired concentration and memory. The differential diagnosis includes dementia (Table 13.6), acute psychosis, and depression. Usually the clinical picture (especially the acute onset and rapid fluctuations), and its context, is sufficiently characteristic to make delirium a relatively simple diagnosis. However, differentiating delirium from Lewy body dementia can be difficult without a good history.

Management of delirium Delirium is managed where it occurs —usually in general hospitals. Psychiatrists may be asked to assess the patient, make the diagnosis and give advice. Treatment is directed both at the symptoms and at the cause, and includes both medical and environmental interventions .

In practice (and in an exam), emphasize both the need to search for a cause and for environmental steps whilst this is ongoing. The latter may avoid the need for medication, which can complicate the problem, and should only be used when necessary.

Antipsychotics are the first-line pharmacological treatment. Haloperidol is often used, by intramuscular injection if it cannot be taken orally. It can be given intravenously but this is rarely required.

The exception is for alcohol- or seizure-related delirium, when a benzodiazepine (e.g. lorazepam) is indicated (because of the epileptogenic potential of antipsychotics)

A delirious person may occasionally be a risk to self, other patients, or staff. Call for help, ensure safety, and use physical restraint if essential (e.g. to allow drug to be administered).

Patients with delirium are often incapable of giving informed consent. Treatment is therefore given under the common law. If continuing interventions without consent are anticipated, the Mental Health Act may be required.

CAUSES

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.²

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.

SYMPTOMS

A person with an organic mental disorder may have difficulty concentrating for a long period of time. Others may get confused while performing tasks that seem routine to others. Managing relationships and collaborating and communicating with colleagues, friends, or family may also prove difficult.

Overall the severity of the symptoms and the type of symptoms a person has varies, depending on the cause of their disorder.

Primary Symptoms

- Confusion
- Agitation
- Irritability
- A change in behavior, impaired brain function, cognitive ability, or memory

If you or your loved one is experiencing any of these symptoms, it's important to seek medical care as soon as possible. A serious medical problem may have caused these symptoms to surface, and early intervention may be key.

DIAGNOSIS AND TREATMENT

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.⁶

Treatments for organic mental disorders vary on what the underlying cause of the disorder 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.

COMPLICATIONS

While some organic mental disorders may only be temporary, others often get worse with time. Disorders that don't respond to treatment may lead the patient to lose the ability to function independently or to interact with others.

In short, the chance of recovery or the outlook of a person's disorder depends on a number of factors, mostly what the cause is behind the impaired brain function. While the diagnosis of an organic mental disorder (or neurocognitive disorder, as it is now referred to) can be frightening, you are not alone, and there are ample resources available to help you or your loved one.

QUESTIONS

1. What are the types of mental retardation?
2. What is the most common cause of mental retardation?
3. What are some examples of organic mental disorders?

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