SYLLABI-BOOK MAPPING TABLE

Advanced Psychopathology and Mental Hygiene

Syllabi	Mapping in Book
UNIT I **CLASSIFICATION OF SYSTEMS IN PSYCHOPATHOLOGY:** W.H.O. classification (ICD-10) and multiaxial systems (DSM-IV-R): Theoretical background/approaches to psychopathology (i) psychodynamic (ii) behavioural; (iii) cognitive (iv) phenomenological (v) biological, and (vi) sociocultural; Diagnosis–purposes of diagnosis, reducing undesirable variability: multiaxial model, evaluation of diagnostic system; models for the description of abnormal behaviour: medical psychodynamics and learning models; recent advances and research methods in psychopathology.	**Unit 1:** Classification of Systems in Psychopathology **(Pages 3-26)**
UNIT II **ANXIETY, DISSOCIATIVE AND SOMATOFORM DISORDERS:** (a) Panic, phobic, OCD, post-traumatic, GAB, (b) somatoform disorders (c) dissociative disorders, schizophrenia and other psychotic disorders, schizophreniform, schizoaffective, delusional brief psychotic disorders; mood disorders; depressive unipolar and bipolar disorders. ***Theories:*** Personality disposition, CHD, asthmatic, allergy, eczema, Itching, rheumatoid arthritis, peptic ulcer, diabetese and menstrual disorders.	**Unit 2:** Anxiety, Somatoform, Dissociative and Other Psychotic Disorders **(Pages 27-82)**
UNIT III **PERSONALITY AND ORGANIC MENTAL DISORDERS:** (a) Adjustment disorder, (b) impulse control disorders; (c) substance related disorders, (d) eating disorders and sleep disorder; sexual and gender identity disorders. Changing views of brain function and dysfunction. Neuropathological considerations; common syndromes.	**Unit 3:** Personality and Organic Mental D'sorders **(Pages 83-150)**
UNIT IV **MAJOR THERAPEUTIC APPROACHES:** Psychoanalytic, Behavioristic, Cognitive and Humanistic Therapies.	**Unit 4:** Major Therapeutic Approaches **(Pages 151-171)**
UNIT V **CONCEPT OF MENTAL HEALTH:** Stress and Coping, Nature of Stress & Health: Stress, sources and types, life events stress, occupational stress, consequences of stress, models of stress, self management, self-awareness, meditation, biofeedback, assertiveness, time management, effective communication, stress management techniques.	**Unit 5:** Concept of Mental Health **(Pages 173-195)**

CONTENTS

INTRODUCTION

NOTES

Psychopathology is the study of the origin, development and manifestations of mental or behavioural disorders. In this book, *Advanced Psychopathology and Mental Hygiene,* you will learn about various types of psychotic disorders, their causes, epidemiology (prevalence among populations), etiology (diagnosis, prognosis and course) and management (selection of appropriate therapy and treatment).

Unit 1 describes how to classify psychotic disorders into different categories on the basis of symptoms. This unit also explains how to evaluate a particular disorder from different perspectives before deciding on the therapy.

Unit 2 explains anxiety, somatoform, dissociative and other psychotic disorders, their causes and management.

Unit 3 educates the students about adjustment and impulse control; substance, eating and sleep related disorders; sexual and gender identity; and personality disorders.

Unit 4 focuses on different approaches employed to treat psychological disorders. Some of the well known therapies include psychoanalytical psychotherapy, behaviour therapy, cognitive therapy and humanistic psychotherapy.

Unit 5 talks about stress, which touches all of us in one way or another. The unit discusses the different types of disorders associated with stress, the ways to cope with them, and methods of managing stress-related disorders.

In each unit, we have presented the learning materials following the content exposition approach. In this approach, we begin with an 'Introduction' to the topic of the unit followed by the 'Unit Objectives', which gives the student an outline of the unit. Then we present the details of the contents in a simple and easy-to-learn manner. At the end of each unit, we have provided 'Summary' and 'Key Terms' for quick recollection. The 'Check Your Progress' section is set to ensure comprehension while studying. The 'Questions and Exercises' at the end of each unit helps the student to review whatever he has learnt.

UNIT 1 CLASSIFICATION OF SYSTEMS IN PSYCHOPATHOLOGY

NOTES

Structure

1.0 INTRODUCTION

The word 'abnormal' means away from the normal, but we do not apply this term for behaviours that are better than or superior to 'normal'. Abnormal behaviour is a maladaptive behaviour and is a manifestation of mental disorder, if it is both persistent and is of a serious degree.

The term mental disorder has been defined by APA's Diagnostic and Statistical Manual of Mental disorder (DSM IV) (1994) as:

> ... a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability or an important lose of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual.

NOTES

1.1 UNIT OBJECTIVES

After going through this unit, you will be able to:

- Know the historical background of the evolution of the study of psychology and psychological disorders
- Understand the different perspectives of human behaviour and psychology
- Learn how to diagnose and classify psychological disorders
- Know the recent advances and research methods

1.2 THE PSYCHODYNAMIC PERSPECTIVE

The psychodynamic perspective was founded by Freud, who laid a lot of emphasis on the role played by the unconscious processes in determining both normal and abnormal behaviour. He believed that the larger part of our mind is the unconscious, and the conscious part represents a very small area. The unconscious mind contains an individual's painful memories, forbidden desires and other experiences that have been repressed. But these painful memories, forbidden desires and anxiety evoking experiences that are repressed often surface as fantasies, dreams, slips of the tongue and also when the person is subjected to hypnosis. Freud believed that the person's should be made aware of his unconscious feelings must and then these feelings should be integrated with the conscious part of his mind. Failure of this integration could lead to irrational and maladaptive behaviour.

Freud further stated that a person's behaviour is the result of the interaction between the id, ego and superego. The **id** is the source of instinctual drives (Eros or the life instinct and Thanatos or the death instinct) that are inherited. The life instinct is a constructive drive which is sexual in nature and constitutes one's libido. The death instinct is a destructive drive and is aggressive in nature. The id operates by engaging in completely selfish and pleasure-oriented behaviour focused on immediate gratification of instinctual needs without reference to reality or moral considerations. It works on the principle of pleasure.

The **ego** acts as mediator between the id demands and the realities of the external world. It works on the reality principle. Ego tries to meet id demands in a way that ensures the individual's well being and survival. The superego is the outgrowth of internalizing the taboos and moral values of society. It works on the morality principle and becomes an inner control system that deals with the uninhibited desires of the id. The **superego** strives to compel the ego to inhibit desires that are considered wrong or immoral. Because the ego mediates between fulfilling the desires of the id, the demands of reality and the moral constraints of the superego, is known as the executive branch of the personality.

Freud believed that often the id, ego and superego are in conflict and these intrapsychic conflicts if remained unresolved may give rise to mental disorders.

NOTES

In addition to it, Freud believed that anxiety, which may be overly experienced or repressed, played a key causal role in most of the forms of psychopathology. According to Freud, there are three types of anxieties: (i) Reality anxiety that arises from real dangers or threats in the external world; (ii) Neurotic anxiety, caused as result of id's demands which try to bypass the ego's controls into behaviour that may be lead to some kind of punishment or danger; and (iii) Moral anxiety, that arises as a result of a completed or contemplated action that can conflict with an individual's superego and arouse feelings of guilt.

Freud postulated that ego is able to deal effectively with reality anxiety but makes use of irrational protective measures called defence mechanism to deal with neurotic or moral anxiety. Defense mechanisms reduce anxiety by pushing painful ideas out of consciousness. Though various defense mechanisms distort reality, yet some are more adaptive than others.

Freud also conceptualized five psychosexual stages of development that every individual passes through till puberty. Each stage is marked by the desire to achieve sexual pleasure. In the oral stage (the first two years of life), the infant's mouth remains the main desire satisfying zone. By sucking milk from breasts, the infant satisfies his sex desires. In the anal stage (age 2–3 years), the anus becomes the major organ of pleasure. During the time of toilet training the infant feels the urges of both to retain and eliminate. In the phallic stage (age 2–6 years), the infant derives pleasure by self-manipulating his genitals. In the latency stage (age 6–12 years), sex desires decrease as the child gets preoccupied with developing skills and other activities. In the genital stage (after puberty), sexual relations provide the the deepest feelings of pleasure. Freud believed that pathology or mental illness is the result of failure of an individual to achieve the appropriate sexual satisfaction at any of these stages. In general, Freud believed that while the personality is developing and the individual is growing, each stage places its demands which lead to conflicts that must be resolved. An important conflict that occurs during the phallic stage is the Oedipus complex, where each son longs for his mother sexually and views his father as a rival but also fears that his father will take revenge by cutting off his penis. The anxiety of being castrated forces the boy to suppress his sexual desire for his mother and his rivalry toward his father. Eventually if all goes well, the boy identifies himself with his father and desires only harmless affection of his mother.

The Electra complex is the female counterpart of the Oedipus complex, which is based on the view that each girl desires to possess her father and tries to replace her mother and experiences penis envy. According to Freud, the smooth resolution of these complexes is essential for a young adult to develop satisfactory hetero-sexual relationship.

The psychodynamic perspective has been criticized for lacking empirical support, inaccessible to direct testing, being subjective in nature, being based on unrepresentative sample, laying too much emphasis on sexuality, having demeaning views of women, neglecting the role of cultural differences in shaping behaviour

NOTES

and having a mechanistic view. However, it must be pointed out that psychodynamic theory has had a large influence on the modern treatment of abnormal behaviour and on modern thought in general. It has helped to demythologize mental disorders. Also, the popular projective techniques are based on psychoanalysis.

Check Your Progress

1. What do you mean by the term abnormal behaviour?
2. Define the term syndrome.
3. What is genotype environment interaction?
4. According to Freud, what are the three states the human psyche can be divided into?

1.3 THE PHENOMENOLOGICAL PERSPECTIVE

The humanistic or phenomenological or existential perspective views human nature as basically 'good'. It emphasizes individual's current conscious processes and lays strong emphasis on each person's inherent capacity for responsible self-direction. It focuses on relieving people of wrong and disabling assumptions and attitudes to enable them to live fuller lives. This perspective emphasizes on growth, personality development and self-actualization. It lays greater emphasis on concepts like hope, creativity, values, meaning, personal growth and self-fulfillment. Carl Rogers (1902–87), a humanistic psychologist, postulated that each individual lives in a private world of experiences; strives to maintain, enhance and actualize his self; reacts to situations the way he or she perceives them to be consistent with his or her self-concept and worldview. He also believed that an individual inherently focuses his attention on his health and wholeness, and under normal conditions, a person behaves in rational and constructive ways. He believes that individuals develop values based on their own experiences and evaluations and lays emphasis on the development of one's identity.

According to the phenomenological perspective, psychopathology results from the blocking or distortion of personal growth and the natural tendency toward physical and mental health. The blocking can result from the exaggerated use of ego-defense mechanisms that leave an individual increasingly out of touch with reality; from unfavorable social conditions and faulty learning and from excessive stress.

The existential perspective lays emphasis on the uniqueness of each individual; their quest for values and meanings; the existence of freedom for self-fulfillment; the irrational tendencies; the difficulties inherent in self-fulfillment and the inner experiences of an individual. It postulates that the existence is given but it is on the individual how he shapes it and leads a meaningful and constructive life. It

NOTES

further states that the individual is free to make choices and should take responsibility for his or her choices. And the choices we make determine our live. It believes that the will to meaning is a basic human characteristic and is primarily a matter of finding satisfying values and guiding one's life by them. According to it, the most important consideration is not what an individual gets out of life but what he or she contributes to it by having socially constructive values and making socially constructive choices. It states that existential anxiety stems from encountering nothingness. In its ultimate form, nothingness is death, which is the inescapable fate of all human beings. The awareness of our inevitable death and its implications for our living can lead to existential anxiety. It is only by living a meaningful constructive live, we can overcome existential anxiety. Much abnormal behaviour, therefore, is seen as the product of a failure to deal constructively with existential despair and frustration.

The phenomenological perspective has been criticized for being antiscientific and for being inaccessible for objective experimental testing. However, this perspective has led one to analyze the ways in which therapists, as individual with their own emotional histories and their own worldviews, influence the cause of therapy. It has also devised therapies that aim at helping people by offering them insights into their thoughts and emotions.

1.4 THE BEHAVIOURAL PERSPECTIVE

The behavioural perspective was developed in the early twentieth century as a scientific extension of earlier methods. Behavioural psychologists emphasized on the study of directly observable behaviours, the stimuli and the reinforcing conditions to understand the human behaviour, normal or abnormal. The perspective postulates that most human behaviour, adaptive or maladaptive, is learnt and attempts to explain the process of learning and the role of learning in explaining and treating maladaptive behaviour.

It says that a specific stimulus may come to elicit a specific response through the process of classical conditioning. The hallmark of classical conditioning is that a formerly neutral stimulus—the Conditioned Stimulus—acquires the capacity to elicit biologically adaptive response through repeated pairings with the Unconditioned Stimulus. Only CSs that provide reliable and non-redundant information about the occurrence of a UCS will acquire the capacity to elicit CRs (Hall, 1994; Rescorla, 1998).

Classically conditioned responses are well maintained over time. However, if a CS repeatedly presented without the UCS, the conditioned response will gradually extinguish (known as extinction). Moreover, a somewhat weaker CR may also still be elicited in different environmental context than that in which the extinction process took place (Bouton, 1994, 1997) Thus, any extinction of fear that has taken place in a therapist's office may not necessarily generalize completely and automatically to other context outside the therapist's office.

NOTES

The classical conditioning also explains how many physiological and emotional responses like fear, anxiety, sexual arousal, etc can be conditioned. Thus, for example, one can acquire a fear of snakes if bitten by a snake. Classical conditioning thus well explains how phobias are developed.

Instrumental Conditioning explains how an individual learns how to achieve a desired goal that is rewarding or to escape from something that is unpleasant. It states that new responses are learned and tend to recur if they are reinforced. Initially a high rate of reinforcement may be necessary to establish a response, but lesser rates are usually sufficient to maintain it. However, when reinforcement is consistently withheld over time, the conditioned response gradually extinguishes. This well explains the acquisition, maintenance and management of temper tantrums in children.

Behaviours that have been acquired through classical and instrumental conditioning tend to get generalized to similar situation or events that were involved in the acquisition of the behaviour.

A process complementary to generalization is discrimination that occurs when a person learns to distinguish between similar stimuli and to respond differently to them through differential reinforcement. Generalization and discrimination play important roles in the development of normal or maladaptive behaviour. The behavioural perspective also postulates that the individuals are capable of learning and unlearning both adaptive and maladaptive behaviours through observation alone. For example, children can acquire fears simply through observing a parent behaving fearfully with some object that the child was not initially afraid of. The behavioural perspective has been criticized for oversimplifying the complexities of human life; for being deterministic in nature and for viewing human being as passive. However, this perspective has given us several therapeutic techniques to help individuals acquire adaptive behaviours and modify maladaptive ones. Behaviour therapy also takes less time, is less expensive, and in many cases has been found more effective than other forms of treatment. In addition, it has made substantial contributions in the fields of education, business and sports physiology.

1.5 THE COGNITIVE BEHAVIOUR PERSPECTIVE

The cognitive behaviour perspective is based on the premise that human beings have both innate and acquired tendencies to engage in both rational and irrational thoughts. Thoughts affect both our feelings and behaviours and by bringing a change in our thoughts, and we can alter our behaviours and feelings. It also emphasizes that it is not the event in the outside world that causes pathology but it is the person's reaction caused by his irrational beliefs and cognitive distortions to such events that lead to pathology. Ellis has proposed an ABC system to explain how this process works; A is the activating experience; B refers to the belief or thoughts that irrationally follow; and C refers to the consequences for the person, both emotional and behavioural.

NOTES

Beck, a cognitive therapist, suggests that certain patterns of distorted thinking are associated with different psychological disorder. For example, in depression, the commonly seen cognitive distortions are catastrophizing, magnification, overgeneralization, and selective abstraction. These distortions tend to operate automatically without a person's being aware of them.

Beck also postulated that depression results from a negative schema about the self, the future and the world. Distorted schemas may generate unrealistic tasks and produce self-defeating strategies. Also individuals suffering from anxiety and depression are seen to harbour self-defeating beliefs. Walter Mischel (1973, 1979) has proposed that there are five basic categories of cognitive variables that help to determine an individual's response to a given stimulus, as follows:

- **Encoding:** Each of us has a special way of perceiving and categorizing experiences.
- **Competencies:** Each of us has a unique set of skills, acquired through past learning, for dealing with various situations.
- **Expectancies:** Through learning, each of us forms different expectations as to which circumstances are likely to lead to reward and punishment.
- **Values:** Each of us as a result of learning, places different values and different stimulus
- **Plans:** Through learning we also formulate plans and rules that guide our behaviour.

In addition to it, Bandura stated that whether or not an individual engages in a certain behaviour depends on both the Outcome expectations (i.e., expectations that a given behaviour will lead to a certain outcome) and efficacy expectations (i.e., expectations that one will be able to execute that behaviour successfully. Bandura claims, that efficacy expectations are the chief determinants of coping behaviour, and that they in turn are determined primarily by performance feedback from prior experience.

The information processing model believes that some forms of psychopathology may be due to a failure in selective attention such as ADHD. Similarly, schizophrenia is seen as a result of breakdown in selective attention and individuals with anxiety disorder are also known to focus selectively on anxiety evoking information.

Thus cognitive therapy involves disputing and confronting the irrational beliefs, cognitive distortions and negative schemas and replacing them with more rational adaptive beliefs and more positive schemas in order to bring a desired change in their behaviour and feelings.

The cognitive perspective has been criticized for being unscientific as cognitive processes cannot be seen objectively. Yet this perspectives major contribution has been the development of various effective therapies and techniques that have received lot of empirical evidence over these years.

NOTES

1.6 THE SOCIO-CULTURAL PERSPECTIVE

The socio-cultural perspective focuses on the role of socio-cultural factors in human development and behaviour. Works of socio-cultural theorists like Ruth Benedict, Ralph Linton, Abram Kardiner, Margaret Mead and Franz Boas have shown that an individual's personality development reflects the norms, values, ideas, etc. of the family and society in which he lived, Several studies have demonstrated a strong relationship between a particular stressor in a society and the types of mental disorders that typically occur in it. Studies have also shown that in a given society, the patterns of mental disorders could change with time as socio-cultural conditions change.

The socio-cultural viewpoint is concerned with the impact of the social and cultural environment on mental disorders, believes that the maladaptive behaviour is the result of complex interaction of various socio-cultural factors such as poverty, discrimination and illiteracy. It is difficult to ascertain whether factors like poverty, discrimination, etc are the causes or maintaining and contributing factors or the consequences of mental disorders.

It is strongly believed that cultural factors do influence abnormal behaviour by serving as causal factors and modifying influence in psychopathology. For example, socio-cultural factors often create stress for an individual. Such as children growing up in an oppressive society that offers few rewards and many hassles are likely to experience more stress and thus be more vulnerable to disorder than children growing up in a society that offers ample rewards and considerable social support. In addition, growing up during a period of war, famine, or a period of persecution, can make a child vulnerable to psychological problems.

The perspective further states that socio-cultural factors also appear to influence the development of disorders, the forms that they take, and their course and prognosis. They also influence the way we deal with stressors in our lives. For instance, Kleinman (1986, 1988) found that in Western societies, depression was a frequent reaction to individual stress, whereas in China, the effects of stress were more typically manifested in the form of physical problems, such as fatigue, weakness and other complaints.

This perspective has emphasized that professionals should adopt an appropriate cultural perspective when dealing with mental illness. Increasing research has shown that patients may do better when treated by therapists from their own ethnic group (or at least by someone familiar with the patient's culture) (Sue et al., 1991; Tharp, 1991; Yeh et al., 1994).

1.7 THE BIOLOGICAL PERSPECTIVE

The biological viewpoint focuses on mental disorders as diseases of the central nervous system, the autonomic nervous system, or the endocrine system, that are

either inherited or caused by some pathological process, whose primary symptoms are cognitive or behavioural rather than physiological or anatomical. Neither psychological factors nor a person's psychosocial environment is believed to play a causal role in mental disorder. This perspective emphasizes that neurotransmitter and hormonal imbalances in the brain, genetic vulnerabilities, constitutional liabilities, brain dysfunction and neural plasticity, and physical deprivation or disruption are factors that impact the development of maladaptive behaviour.

An imbalance in the availability and functioning of neurotransmitters in the brain can lead to abnormal behaviours such as is seen in depression, schizophrenia, anxiety and other mental disorders. These imbalances can be due to an over- or under- production and release of the neurotransmitter substances into the synapses; by deactivation of neurotransmitters by enzymes; by their excessive re-uptake back into the presynaptic axon button and by the presence of abnormally sensitive or insensitive receptors in the post-synaptic knob. Some forms of psychopathology like sexual disorders have also been linked to hormonal and neurotransmitter imbalances.

Evidence also suggests that heredity is an important causal factor behind many disorders such as depression, schizophrenia and alcoholism. Many temperamental features of newborns and children are genetically influenced and play an important role in the development of personality disorders in their later life. Abnormal behaviour is believed to result from an interaction between one's genetic makeup and environmental experiences.

Some inherited defects interfere directly with the normal development of the brain. Others more subtle defects can leave a person susceptible to sever mental disorders. These subtitle influences are usually transmitted in the genetic code itself, showing up as metabolic or biochemical variations such as mental retardation known as phenylketonuria (PKU).

Research in developmental genetics has shown that abnormalities in the structure or number of the chromosomes are associated with a wide range of malformations and disorders. For example, Down's syndrome is a type of mental retardation in which there is a trisomy (a set of three chromosomes instead of two) in chromosome 21. Anomalies may also occur in the sex chromosomes, producing a variety of complications that may predispose a person to develop abnormal behaviour.

Researchers have found three ways in which an individual's genotype may shape his or her environment (Plomin et al., 1997; Scarr, 1992)

- The genotype may have 'passive effect' on the environment resulting from the genetic similarity of parents and children. Such genetic similarity is likely to result in the parents automatically creating an environment compatible with the child's predisposition. For example, highly intelligent parents may provide a highly stimulating environment for their child, thus creating an environment that will interact in a positive way with the child's genetic endowment for high intelligence.

NOTES

- A child's genotype may evoke particular kinds of reactions from the social and physical environment, called as the evocative effect. For example, active happy babies evoke more positive responses from others than do passive, unresponsive infants (Lytton, 1980).
- The child's genotype may play a more active role in shaping the environment, called as the active effect. In this case the child seeks out or builds an environment that is congenial. Extraverted children may seek the company of others, for example, thereby enhancing their own tendencies to be sociable (Baumrind, 1991; Plomin et al., 1997).

It is also believed that people with different genotypes may be differentially sensitive or susceptible to their environments (known as a genotype environment interaction). For instance, people who are at genetic risk for depression are more likely to respond to stressful life events by becoming depressed than are people without the genetic risk factors (Kendler et al., 1995; Plomin et al., 1997).

The perspective also postulates that psychopathology may be the result of the action of many genes together in some sort of additive or interactive fashion. For instance, a genetically vulnerable person may have inherited a large number of these faulty genes which may in turn lead to structural abnormalities in the central nervous system or may lead to errors in the regulation of brain chemistry, or may result in excesses or deficiencies in the reactivity of the autonomic nervous system, which is involved in mediating many of our emotional responses. These various processes serve to predispose the person to later pathology.

The biological perspective examines the hereditary nature of the mental disorders using three methods: (i) the pedigree or family history method; (ii) method of comparing the twins and the adoption method. In the pedigree or family history method the investigator observes and compares a sample of relatives of each proband or index case (the subject or carrier of the trait or disorder in question) to see if there enough prevalence of the disorder among relatives to call it hereditary. In addition, the incidence of the trait in a normal population is compared (as a control) with its incidence among the relatives of the index cases.

The twin method compares the concordance rate of the disorder in both monozygotic and dizygotic twins. One would therefore expect concordance rates for a disorder to be much lower for dizygotic (DZ) than for monozygotic (MZ) twins if the disorder had a strong genetic component because DZs have much less genetic similarity.

In the adoption method, the biological parents of individuals who have a given disorder (and who were given away for adoption shortly after birth) are compared with the biological parents of individuals who do not have the disorder (who were also adopted shortly after birth) to determine their rates of disorder. If there is a genetic influence, one expects to find higher rates of the disorder in the biological relatives of those with the disorder than in those without the disorder. In another variation, one compares the rates of disorder in the adopted away offspring

of biological parents with a disorder with that seen in the adopted away offspring of normal biological parents. If there is a genetic influence, then there should be higher rates of disorder in the adopted away offspring of the biological parents with the disorder.

The biological perspective also aims at exploring the role of the constitutional factors like physical handicaps and temperament in the etiology of maladaptive behaviour. For instance, low birth weight has been seen to be positively co-related with the presence of learning disabilities, and emotional and behavioural disturbances in children later in life. Prenatal conditions that can lead to premature birth and to low birth weight include nutritional deficiencies, diseases, exposure to radiation, drugs, severe emotional stress, or the mother's excessive use of alcohol or tobacco.

The five dimensions of temperament namely fearfulness; irritability and frustration; positive affect; activity level and intentional persistence seem to be related to the three important dimensions of adult personality namely neuroticism or negative emotionality; extraversion or positive emotionality and constraint (conscientiousness and agreeableness) (Robert and Ahadi, 1994; Watson, Clark and Harkness, 1994). Research has shown that children with a fearful temperament are at the risk of developing anxiety disorders later in life (Kagan, 1997). Significant damage of brain tissue places a person at risk for psychopathology, but specific brain lesions are rarely a primary cause of psychiatric disorder (Eisenberg, 1990).

Research has shown that insufficient rest, inadequate diet or working too hard when ill, can all interfere with a person's ability to cope and may predispose him or her to a variety or problems like disorientation and depersonalization. Adolescents with decreasing total sleep time are likely to develop mood and behaviour problems. Mental retardation can also result from malnutrition. The physical development of the brain is adversely affected by lack of stimulating environment. At the same time, sensory overload can impair adult functioning.

The biological perspective has brought forward the important role played by biochemical factors and innate characteristics, in both normal and abnormal behaviour. This concept has led to the development of many drugs that can alter the severity and course of certain mental disorders like schizophrenia and depression. But we should remember that all mental disorders are not biological conditions.

1.8 DIAGNOSIS AND CLASSIFICATION OF PSYCHIATRIC DISORDERS

A psychiatric diagnosis involves classifying the patient's problem within the taxonomy of psychological disturbances developed by the psychiatric profession. Usually mental health professional classify mental disorders according to the patterns of behaviour, thought and emotion.

Any classification of psychiatric disorders like medical illness should ideally be based on etiology. For a large majority of psychiatric disorders, no distinct etiology is known at present and hence the only rational way to classify is to classify them based on syndromes. A syndrome is defined as a group of signs and symptoms that occur together and delineate a recognizable clinical condition. Some of classificatory systems that have been used to classy the diagnostic categories are as following:

1.8.1 Neurosis vs Psychosis

Neurosis refers to less severe form of mental disorder in which insight is present and symptoms are closer to normal experiences like anxiety. Whereas, the term psychosis refers to severe forms of mental disorder such as organic mental disorder, schizophrenia and some affective disorder and is used for condition in which insight is absent. However, both the terms neurosis and psychosis are unsatisfactory as they are less informative.

1.8.2 Categorical vs Dimensional vs Multi-axial Classifications

Traditionally, psychiatric disorders have been categorically classified by dividing them into discrete categories which have been defined in terms of symptoms, patterns and of the causes and outcome of the different disorders. Although, such categories have proved useful in both clinical work and research but they have been criticized as there is uncertainty about the validity of categories as representing distinct entities. Also, many systems of classification do not provide adequate definition and rules of application so categories cannot be used reliably. Further, many psychiatric disorders do not fall neatly within the boundaries of the categories but are intermediate between two categories (for example schizoaffective disorder).

Dimensional classification advocated by Kretschmer and strongly promoted by the psychologist Eysenck, rejects the use of separate categories. Based on multivariate analysis, Eysenck proposed a system of classification consisting of three dimensions of psychoticism, neuroticism and introversion–extroversion in which patient are given scores on each of these dimension. For instance, in the case of a person with a disorder that would be assigned to dissociative disorder in a categorical system, in Eysenck's system that person would have high score on the axis of neuroticism and extroversion and a low score on the axis of psychoticism. The dimensional classification system has been criticized on the premises that Eysenck's dimensions depend considerably on the initial assumption and the choice of method. Also, subsequent research has not confirmed specific predictions of this kind. In addition, the dimension of psychoticism bears little relation to the concept of psychosis as generally used for example artist and criminals score particularly highly on this dimension. Further the dimensions of neuroticism and introversion- extroversion have been useful in research with group of patients, but they are difficult to apply to the individual patient in clinical practice.

The multi-axial approach, proposed by Essen-Miller in 1947, takes into account two or more sets of information (such as symptoms and etiology) to classify disorders. Although this kind of classification system is likely to be more meaningful but its major drawback can be that it may end up being too comprehensive and complicated and hence difficult for everyday use. Both DSM-IV-R and ICD-10 are based on the multi-axial system.

The classification of the abnormal behaviour appears to have begun with Hippocrates (800 BC) it was in 1882, in Britain that the Statistical Committee of the Royal Medico-Psychological Association had produced a classification scheme that, even though revised times was never adopted by the members. In the US, in 1886, the Association of Medical Superintendents of American Institute for the Insane, a forerunner of the American Psychiatric Association, adopted a somewhat revised version of the British System. In 1889 in Paris, the Congress of Mental Science adopted a single classification system, but it was never widely used. Then, in 1913 this group accepted a new classification incorporating some of the Kraeplin's ideas. But again, consistency did not emerge. But the first truly comprehensive classification system of mental disorder was given by Kraepelin in late nineteenth century. All other systems were influenced by it.

It was in 1939 that the WHO added mental disorders to the International List of Causes of Death. In 1948, WHO expanded the previous list, and it became the International Statistical Classification of Diseases, Injuries and Causes of Death, a comprehensive listing of all diseases including a classification of abnormal behaviour. Although this nomenclature was unanimously adopted at a WHO conference, the mental disorders section failed to be widely accepted. In the US, as a result, the American Psychiatric Association (APA) published its own Diagnostic and Statistical Manual (DSM-I) in 1952. In 1962, its second version DSM-II was published and in Britain a glossary of definitions was produced to accompany it. Both DSM-II and the British glossary have provided the actual behaviour or symptoms that are the basis for the diagnosis but the symptoms given by the DSM-II and the British Glossary as the basis of diagnosis were not always the same. Later, in 1980, 1987, 1993 and 2000 the APA published an extensively revised diagnostic manual DSM-II, DSM-III-R, DSM-IV and DSM-IV-R respectively. DSM manual specifies what subtypes of mental disorder are currently officially recognized and provides for each a set of defining criteria. DSM has undergone several revisions in order to remove as far as possible subjective elements from the diagnostic process and to improve diagnostic reliability and validity.

1.8.3 Diagnostic and Statistical Manual

The number of recognized mental disorders had increased enormously from DSM-I to DSM-IV, due both to the addition of new diagnoses and the elaborate subdivision of older ones. It is now both more expanded and more finely differentiated into subsets of disorder.

The Diagnostic and Statistical Manual (DSM) provides the criteria for diagnosis in a detailed and specified manner by taking into account all the essential features of the disorder and information on differential diagnosis. In addition, the description offers details on the course of the disorder; age of onset; degree of impairment; complications; predisposing factors; prevalence; sex ratio and family pattern.

DSM-IV-R evaluates an individual according to five 'foci' or 'axes'. The first three axes assess an individual's present clinical status or condition.

Axis I consists of the particular clinical syndromes or other conditions that could be the focus of clinical attention. Such syndromes include schizophrenia, generalized anxiety disorder, major depression and substance dependence. Conditions listed in Axis I are somewhat similar to the various illnesses and diseases recognized in general medicine.

Axis II consists of personality disorders, such as histrionic, paranoid and antisocial personality disorders. Mental retardation is also diagnosed as an Axis II condition.

Axis III consists of general medical conditions, which are potentially relevant to understanding or management of the case. Axis III may be used in conjunction with an Axis I diagnosis.

On any of these first three axes where the pertinent criteria are met more than one diagnosis is permissible. That is, a person may be diagnosed as having multiple psychiatric syndromes, such as Panic Disorder and Major Depressive Disorder; disorders of personality, such as Dependent or Avoidant; or potentially relevant medical problems, such as Cirrhosis (liver disease often caused by excessive alcohol use) and Overdose, Cocaine. The last two DSM-IV axes are used to assess broader aspects of an individual's situation.

Axis IV refers to psychosocial and environmental problems. This group deals with the stressors such as divorce, retirement etc that may have contributed to the current disorder, particularly those that have been present during the prior year. The diagnostician should know whether the stressor is acute or enduring and should rate is severity on a scale of 1–6.

Axis V refers to global assessment of functioning. It involves rating on a scale of 1–100 of the patients current adjustment (work performance, social relationships, use of leisure time) and of his or her adjustment during the past year.

1.8.4 International Classification of Diseases

Apart from DSM, mental disorders were first included in the sixth edition of the International Classification of Diseases (ICD), produced by the WHO in 1948. But this first scheme for mental disorders was widely criticized. Then in 1968 came ICD-8, which made some progress towards solving the earlier problems but still had many flaws in it. It contained many categories and allowed alternative coding for some syndromes. ICD-9 was very similar to ICD-8 because the WHO

NOTES

believed that national government would not be willing to accept many changes. A little later a series of seminars were held which led to a revised and improved glossary which laid the foundation for the ICD-10. The ICD-10 was made with the aims of making it suitable for international communication about statistics of morbidity and mortality; it should be a reference for national and other psychiatric classifications; it should be acceptable and useful in research and clinical work and should contribute to education.

To achieve these aims, the classification has to acceptable to a wide range of users in different cultures. It also has to be practical in that it is easy to understand and can be translated into many languages. It also has to be versatile. For this reason, a policy of different versions for different purposes was used as follows:

Clinical descriptions and diagnostic guidelines (CDDG): Contain descriptions of each of the disorders in the classification

Diagnostic criteria for research (DCR): Contain lists of specific criteria that have to be met before diagnosis can be made. The format resembles that used in DSM-IV for clinical purposes as well as for research.

Primary care version: It is a simplified classification which contains only broad categories such as dementia, delirium, eating disorders, acute psychotic disorder, chronic psychotic disorder, depression and bipolar disorder. These categories are not sub-classified and the clinical description is similar to those in the main classification and are adapted for use in the primary care.

Multi-axial system: Mental disorders are classified in Chapter F of the ICD. The chapter is divided into ten groups containing mental disorders. A decimal system is used in which each group can be subdivided into 10 and each of these is subdivided into further 10. Categories are devoted by letter F, followed by a number for the main group, followed by a further number for the category within the group which can be further sub-divided if necessary. After wide consultation about a draft of the classification, the WHO carried out an international field trial at 112 clinical centres in thirty-nine countries to evaluate both the clinical descriptions, guidelines and the diagnostic criteria for research. It was found that the classification was generally easy to use and applicable to most common disorders. His field trials of ICD-10 carried out in Canada and the USA showed comparable reliability to the findings world-wide and to DSM (Regier et al., 1994).

The main purpose of diagnosis is:

- To group patient who share similar clinical features so that treatment can be planned and the likely outcome can be predicted.
- To enable clinician to communicate with one another about their patient's symptoms prognosis and treatment
- To ensure than research can be conducted on comparable group of parents.
- To enable epidemiology studies as a basis for research and planning services.

NOTES

- To facilitate comprehension of the underlying causes
- To aid prediction of the prognosis

At one hand, the diagnostic system has some advantages but at the other hand, it has been criticized as follows:

- Allocating patients to a diagnostic category tends to distract from the understanding of their unique personal difficulties which should be taken into account as they play an important role in prognosis and treatment.
- Diagnostic categories label a deviant behaviour as illness, which attracts social stigma. Such labeling serves only to increase the person's difficulties that cause suffering and require treatment.
- All individual do not fit neatly into the available categories.

1.9 EVALUATION OF DIAGNOSTIC SYSTEM

A diagnostic system should be high on both reliability and validity. Reliability refers to the extent to which different diagnosticians can agree that a person's behaviour 'fits' a given diagnostic category. In psychological assessment three types of reliability namely internal consistency, Test-Retest and inter-judge reliability are commonly used. For instance, test-retest reliability is most important in assessment of stable individual different in characteristics. Whereas, internal Consistency is the most important factor in tests that use many items to measures a single characteristic.

In psychiatric diagnosis, the most crucial criterion is the inter-judge reliability, which refers to the degree of agreement between different diagnosticians about the diagnosis of the patient. It is often seen that when diagnosticians are asked about major distinct diagnostic categories the inter-judge reliability is usually high but when asked to make finer distinctions the degree of agreement is seen to be low.

The diagnostic reliability can be increased by providing a clear definition of each category in a diagnostic scheme. Each definition should also specify discriminating symptoms rather than characteristic symptoms.

The DSM-IV-R is comparatively high on inter-judge reliability, when compared to the earlier versions of DSM but it incorporates stricter criteria, has lower coverage, with the result that more patient are swept into residual categories such as psychotic disorder not otherwise specified.

Validity refers to the degree to which the diagnostic category accurately conveys clinically important information about the person whose behaviour fits that diagnostic category. The kinds of validity that are most relevant to psychiatric diagnostic are descriptive validity and predictive validity (Blashfield and Diaguns, 1976). Descriptive validity refers to the degree to which it provides significant information about the current behaviour of the person being assessed. A frequent criticism of psychiatric diagnosis is that it has little descriptive validity, that is, it does not tell us much about the person diagnosed. Also, people assigned to the

same diagnostic group may in fact behave quite differently, while people assigned to different diagnostic group may show many of the same behavioural oddities.

The term 'etiological validity' means that the same factors must be found to have caused the disorder in the people who comprise the diagnostic group. A diagnosis is said to have concurrent validity, if other symptoms or disorder processes, not part of the diagnosis itself are discovered to be characteristic of those diagnosed. However, 'predictive validity' refers to information about the future course of the disorder. For instance, it may tell us whether a person suffering from a particular disorder is likely to recover or his condition is likely to worsen over time. It also provides information about how members suffering from a particular disorder are likely to respond to a particular treatment.

Although each classification system aims at achieving high reliability and validity yet a number of factors can alter the reliability and validity of any assessment tool, some having to do with the administration of measures, other with its interpretation. Also, patient on meeting the diagnostician are likely to present different sorts of information, which the diagnostician must filter all of it through their own minds, selecting the information that seems most important. It is in this selection process that the clinicians' biases can interfere. It is generally believed that often diagnosticians have a pathological bias, i.e., a tendency to see sickness instead of health in an individual.

1.10 RECENT ADVANCES AND RESEARCH METHODS

Several research methods have been used to understand the nature, causes and treatment of abnormal behaviour. These have been explained in the following subsections.

1.10.1 Physical or Biological Examination

For patients with certain psychological disorders, an initial medical evaluation is necessary to rule out physical abnormalities that could be causing or contributing to the mental abnormalities. The medical evaluation should include both general physical and sometimes special examinations assessing the structural (anatomical) and functional (physiological) integrity of the brain. For instance, the X-ray can sometimes detect tumors, and the Electroencephalograph (EEG) can detect abnormalities in the brain electrical activity. With Computerized Axial Tomography (CAT), without surgery, the accurate information about the localization and extent of anomalies in the brain's structural characteristics can be known. A Position Emission Tomography (PET) can give information about how an organ is functioning by measuring metabolic processes. Moreover the use of PET scan in research on brain pathology occurring in Abnormal conditions, such as schizophrenia, depression and alcoholism has the potential of leading to important discoveries about the organic processes underlying these disorders, thus providing clues to more effective treatment.

NOTES

Magnetic Resonance Imagery (MRI) has also been particularly useful in confirming degenerative brain processes and has considerable potential to illuminate the contribution of brain anomalies to 'non-organic' psychoses such as schizophrenia, and some progress in this area has in fact been made.

Laboratory tests can be used to identify psychogenic disorders. The polygraph can also measures a no. of other physiological responses, such as heart rate, blood volume and B.P. GSR (Galvanic skin response) measures changes in the electrical resistance of the skin whereas EMG (electromyography) pick up subtle changes in the electrical activity of muscles. All these measures can be used as indications if emotional response to specific stimuli and thus may aid in the process of assessment.

Physiological measures may be required to pinpoint the actual nature of the patient's problems. Polysomanography, which involves employment of variety of measures including EEG, EMG and respiration can be invaluable in determining whether the patient who complains of insomnia do in fact suffer from insomnia or sleep apnea or any other sleep disorder.

Also behavioural and psychological impairment due to organic brain abnormalities may manifest before any organic brain lesion is detectable by scanning or other means. In these instances reliable techniques are needed to measure any alteration in behavioural or psychological functioning that has occurred because of the organic brain pathology.

1.10.2 Neuropsychological Examination

Administration of neuropsychological battery is required to obtain information about cognitive and intellectual impairment following brain damage. Such testing can even provide clues as to the probable location of the brain damage.

1.10.3 Psychosocial Assessment

Psychosocial Assessment aims at obtaining information about the individual's personality makeup and the present level of functioning, as well as information about the stressors and resources in his or her life situations. The following are some of the psychosocial procedures that may be used.

The clinical interview consists of a face to face conversation between the clinician and the client. It may be structured where the client is asked a prearranged sequence of questions or it may be unstructured where the client is required to describe their problems in their own way and at their own pace. The degree of structure in the interview and the kind of questions asked depends on the purpose of the interview. For instance, for the purpose of clinical diagnosis, structured interviews like SCID or IPDE are usually used. However, clinical interviews have been criticized for being unreliable and are often subjective to error. Subjectivity and personal biases further lower their reliability.

Observation in natural setting is based on the assumption that the major determinants of behaviour are the situational variables. Hence, it focuses on gaining

NOTES

a complete understanding of the behaviour by carefully observing the physical and social setting in which the behaviour takes place. Although this method has many advantages like non-dependence on self-report and can accurately provide workable answers to behavioural problems; yet it is criticized for requiring lot of time, effort and money and for the occurrence of subjectivity bias in interpretation.

Psychological tests are standardized procedures in which individuals are presented with a series of stimuli to which they are asked to respond. Although it provides the subject with little freedom in responding, but provide more objective information. Hypothesis testing involves putting to test some plausible understandings underlying abnormal behaviour. Hypotheses are used to explain the causes and the reason behind engaging in abnormal behaviour. Often these hypotheses tend to cluster together in the form of distinct approaches or viewpoints such as the biological viewpoint, the psychodynamic viewpoint, etc. These viewpoints tend to form the basis for developing various therapeutic approaches to treat abnormal behaviour.

Sampling and generalization focuses on studying a small group of individuals diagnosed with the same disorder, who are representative of the much larger group of individuals having the same disorder. Ideally, a random sample is drawn in which every person in that population has an equal chance of being included in the study sample. The findings obtained from studying that sample are then generalized to the larger group from which the sample was drawn. Often a control group, consisting of a sample of people who do not exhibit the disorder being studied are comparable in all other respects to the criterion group, consisting of members of which do exhibit the disorder. Typically the control group is psychologically "normal" according to specified criteria. The differences so obtained are then tested for statistical significance.

The correlational method tends to give information about the relationship between the various variables indicating that these variables tend to co-vary together. It also tells about the nature of relationship between them, i.e., whether it is linear or curvilinear in nature and direct or inverse in nature. However, it does not give any information about the causal factors. Correlations nowhere mean that one variable causes the other; it only states that these variables vary together.

The experimental method, in contrast, tries to control all factors, except the one called independent variable, that could have an effect on the outcome of interest, which is known as dependent variable. This method tries to manipulate the independent variable. If the outcome of interest (the dependent variable) is observed to change as the manipulated factor (the independent variable) is changed, that factor can be regarded as a cause of the outcome.

Unfortunately, the experimental method cannot be applied to many problems of psychology because of practical and ethical reasons. For instance, it cannot be used to evaluate the hypothesis that stressful events can cause major depression. Also, many variables of potential importance in abnormal behaviour cannot be manipulated in the way the experimental method demands. Largely because of

NOTES

ethical reasons this method cannot be used to test the efficacy of various treatment approaches.

The experimental method is sometimes used in causal research with animals. These experiments attempt to establish the cause of maladaptive behaviour by inducing a model of the behaviour in subhuman species.

The case study method involves an in-depth examination of an individual or family suffering from a particular clinical disorder. The information is drawn using interviews and psychological testing or by intensively observing an individual's behaviour and by searching the background facts that might be influencing it. All this information aims to find out the causes behind the disorder and based on these causes it hopes to device a therapeutic management plan. Although this method can reveal quite relevant and important information but it is applicable only to that particular case and cannot be generalized.

Retrospective studies focus on studying the present abnormal behaviour by trying to reconstruct the developmental history with the hope of finding the various factors that might lead to the emergence of the abnormal behaviour. Although useful yet this method has been criticized for lacking objectivity as the background information is usually based on the patient's recollection of events which are highly subjective to error.

Whereas, Prospective studies focus on individuals who have a greater probability of developing abnormal patterns of behaviour before an abnormal behaviour emerges. It involves studying these individuals and evaluating the desired variables over a long period of time.

To sum up, we need different assessment methods since a host of factors could be involved in causing and maintaining maladaptive behaviours. Assessment may involve the coordinated use of physical, psychological and environmental procedures. The choice of assessment methods depends on type and the suspected causal factors behind the disorder.

Check Your Progress

5. What are the purposes and drawbacks of making a diagnosis?
6. List the various perspectives to understand the human behaviour and psychology.
7. What are retrospective and prospective studies?
8. Define and differentiate the terms neurosis and psychosis.
9. What is dimensional classification?
10. What is multi-axial approach?
11. What is primary care version?

1.11 SUMMARY

NOTES

- Abnormal behaviour is a maladaptive behaviour and is a manifestation of mental disorder, if it is both persistent and is in serious degree.
- The psychodynamic perspective was founded by Freud, who laid lot of emphasis on the role played by the unconscious processes in determining of both normal and abnormal behaviour. Freud postulated that a person's behaviour results from the interaction between the id, ego and superego. Freud distinguished three types of anxiety: (i) reality anxiety, (ii) neurotic anxiety, and (iii) moral anxiety.
- Behavioural psychologists believed that only the study of directly observable behaviour and the stimuli and reinforcing conditions that control it could serve as a basis for understanding human behaviour, normal or abnormal.
- The hallmark of classical conditioning is that a formerly neutral stimulus—the conditioned stimulus—acquires the capacity to elicit biologically adaptive response through repeated pairings with the Unconditioned Stimulus.
- The cognitive behaviour perspective is based on the premise that human beings have both innate and acquired tendencies to engage in both rational and irrational thoughts; thoughts affect both our feelings and behaviours and by bringing a change in our thoughts, we can alter our behaviours and feelings.
- The socio-cultural perspective focuses on the role of socio-cultural factors in human development and behaviour.
- The biological perspective has brought forward the important role played by biochemical factors and innate characteristics, in both normal and abnormal behaviour. This understanding led to the development of drugs that can alter the severity and course of certain mental disorders like schizophrenia.
- Some of classificatory systems that have been used to classy the diagnostic categories are as following:
  - o Neurosis vs Psychosis
  - o Categorical vs Dimensional vs Multi-Axial
  - o Diagnostic and Statistical manual (DSM)
- International Classification of Diseases (ICD), produced by WHO in 1948
- Recent advances and research methods are as follows:
  - o Electroencephalograph (EEG) can detect abnormalities in the brain electrical activity. With Computerized Axial Tomography (CAT), without surgery, the accurate information about the localization and extent of anomalies in the brain's structural characteristics can be known. A Position Emission Tomography (PET) can give information about how an organ is functioning by measuring metabolic processes. Magnetic

NOTES

Resonance Imagery (MRI) has also been particularly useful in confirming degenerative brain processes and has considerable potential to illuminate the contribution of brain anomalies to 'non-organic' psychoses such as schizophrenia, and some progress in this area has in fact been made.

1.12 KEY TERMS

- **Id:** It is the source of instinctual drives (Eros or the life instinct and Thanatos or the death instinct) that are inherited. The life instinct is a constructive drive which is sexual in nature and constitutes one's the libido, whereas the death instinct is a destructive drive and is aggressive in nature.
- **Ego:** It mediates between the demands of the id and the realities of the external world. It works on the reality principle and aims to meet id demands in a way as that ensures the individual's well being and survival.
- **Superego:** It is the outgrowth of internalizing the taboos and moral values of society. It works on the morality principle and becomes an inner control system that deals with the uninhibited desires of the id.
- **The humanistic perspective:** It views human nature as basically 'good'. It emphasizes an individual's current conscious processes and lays strong emphasis on each person's inherent capacity for responsible self-direction.
- **The existential perspective:** It lays emphasis on the uniqueness of each individual; their quest for values and meanings; the existence of freedom for self-fulfillment; the irrational tendencies; the difficulties inherent in self-fulfillment and the inner experiences of an individual.
- **The behavioural perspective:** Behavioural psychologists believed that only the study of directly observable behaviour and the stimuli and reinforcing conditions that control it could serve as a basis for understanding human behaviour, normal or abnormal.
- **The cognitive behaviour perspective:** It is based on the premise that human beings have both innate and acquired tendencies to engage in both rational and irrational thoughts; thoughts affect both our feelings and behaviours and by bringing a change in our thoughts, we can alter our behaviours and feelings.
- **The socio-cultural perspective:** This perspective strives towards understanding the role of socio-cultural factors in human development and behaviour.
- **The biological perspective:** This perspective focuses on mental disorders as diseases of the central nervous system, the autonomic nervous system, or the endocrine system, that are either inherited or caused by some pathological process, whose primary symptoms are cognitive or behavioural rather than physiological or anatomical.

- **Neurosis:** It refers to less severe forms of mental disorder; is used for conditions in which insight is present and symptoms are closer to normal experiences like anxiety.
- **Psychosis:** Severe forms of mental disorders such as organic mental disorder, schizophrenia and some affective disorder and is used for condition in which insight is absent.

1.13 ANSWERS TO 'CHECK YOUR PROGRESS'

1. The word abnormal basically means away from the normal. Abnormal behaviour is a maladaptive behaviour and is a manifestation of mental disorder, if it is both persistent and is in serious degree causing significant impairment in one's socio-occupational functioning.
2. A syndrome is defined as a group of signs and symptoms that occur together and delineate a recognizable clinical condition.
3. It is believed that people with different genotypes may be differentially sensitive or susceptible to their environments known as a genotype environment interaction.
4. Freud postulated that a person's behaviour results from the interaction between the id, ego and superego.
5. The main purpose of diagnosis is to group patients who share similar clinical features so that treatment can be planned and the likely outcome can be predicted; to enable clinician to communicate with one another about their patient's symptoms, prognosis and treatment. Its major drawbacks are that allocating patient to a diagnostic category tends to distract from the understanding of their unique personal difficulties which should be taken into account as they play an important role in prognosis and treatment.
6. (a) Psychodynamic perspective, (b) Humanistic perspective, (c) Existential perspective, (d) Behavioural perspective, (e) Cognitive behaviour perspective, (f) Socio-cultural perspective, and (g) Biological perspective.
7. Retrospective and prospective studies are two research methods that are used to gain a better understanding about mental disorders. Retrospective studies focus on studying the present abnormal behaviour by trying to reconstruct the developmental history with the hope of finding the various factors that might lead to the emergence of the abnormal behaviour, whereas prospective studies focus on individuals who have a greater probability of developing abnormal patterns of behaviour before an abnormal behaviour emerges. It involves studying these individuals and evaluating the desired variables over a long period of time.
8. Neurosis refers to less severe form of mental disorder in which insight is present and symptoms are closer to normal experiences like anxiety. The

NOTES

term psychosis refers to severe forms of mental disorder such as organic mental disorder, schizophrenia and some affective disorders and is used for condition in which insight is absent. However both the terms neurosis and psychosis are unsatisfactory as they are less informative.

9. Dimensional classification advocated by Kretschmer and strongly promoted by the psychologist Eysenck, rejects the use of separate categories. Based on multivariate analysis, Eysenck proposed a system of classification consisting of three dimensions of psychoticism, neuroticism and introversion–extroversion in which patients are given scores on each of these dimension.
10. The Multi-axial approach, proposed by Essen-Miller in 1947, takes into account two or more sets of information (such as symptoms and etiology) to classify disorders. Although this kind of classification system is likely to be more meaningful but its major drawback can be that it may end up being too comprehensive and complicated and hence difficult for everyday use.
11. Primary care version is a simplified classification which contains only broad categories such as dementia, delirium, eating disorders, acute psychotic disorder, chronic psychotic disorder, depression and bipolar disorder. These categories are not sub-classified and the clinical description is similar to those in the main classification and are adapted for use in the primary care.

1.14 QUESTIONS AND EXERCISES

Short-Answer Questions

1. Define id, ego and superego according to Freud.
2. List and define different perspectives developed to understand human behaviour and psychology.

Long-Answer Questions

1. Explain the psychodynamic perspective.
2. Explain phenomenological perspective.
3. Explain the behavioural perspective.
4. Explain the cognitive behaviour perspective.
5. Explain the socio-cultural perspective.
6. Explain the biological perspective.

1.15 FURTHER READING

Carson, R.C., J.N. Butcher and J.C. Coleman. 1988. *Abnormal Psychology and Modern Life*, Eighth edition. Glenview, IL: Scott Foresman.

Sadock, B.J., and V.A. Sadock. 2004. *Concise Textbook of Clinical Psychiatry*, Second edition. Philadelphia, USA: Lippincot Williams Wilkins.

UNIT 2 ANXIETY, SOMATOFORM, DISSOCIATIVE AND OTHER PSYCHOTIC DISORDERS

Structure

2.0 INTRODUCTION

There are different types of psychotic disorders which affect humans and cause various mental as well as physical illnesses. Psychotic disorders if not treated in time can also cause illnesses like heart disease, hypertension, peptic ulcer, asthma, arthritis, etc.

Earlier, all causes behind psychological disorders were considered to be supernatural and the treatments available were often irrational, harsh and ineffective. However, during last two centuries tremendous progress was made in the diagnosis and prognosis of mental illnesses. Today we have effective treatments for most of the mental illnesses.

In this unit, you will learn about different mental disorders, their subtypes, followed by epidemiology (the study of patterns of health and illness and associated factors at the population level), etiology (the study of the causes, the origin and the factors that produce the disorder) and management (the selection and administration of the therapy).

2.1 UNIT OBJECTIVES

After going through this unit, you will be able to:

- Understand anxiety disorder and its subcategories
- Learn about somatoform disorder, it epidemiology, etiology and management
- Describe dissociative disorders and their subtypes
- Explain what is schizophrenia, its different subtypes, their epidemiology, etiology and management
- Know about other types of psychotic disorders
- Explore the psychological aspects of medical illnesses

2.2 ANXIETY DISORDERS

In the present age of rapid changes and stiff competition, we hardly spend a day without experiencing some sort of anxiety. Anxiety consists of three main components as given below.

The 'subjective' response consists of tension, apprehension, sense of impending danger and dread and expectations of inability to cope. The 'behavioural' response consists of avoidance of the feared situation, impaired speech and motor activity and impaired performance at complex cognitive tasks. The 'physiological' response consists of muscle tension, increased heart attack, blood pressure, nausea, dizziness, dryness of mouth, rapid breathing, diarrhea, etc.

Anxiety can be seen as a distinct symptom in several psychiatric disorders and physical illnesses or can exist as a disorder by itself. Anxiety disorders refer to abnormal states associated with the mental and physical symptoms of extreme anxiety, where there is no presence of actual organic brain disease or psychiatric disorders that may cause similar symptoms. A patient of anxiety disorders has unrealistic fears or anxieties of extreme intensity. The various symptoms of anxiety are given below:

Symptoms of anxiety disorders:

Psychological arousal: Fearful anticipation, irritability, sensitivity to noise, restlessness, poor concentration, worrying thoughts

Autonomic arousal: Gastrointestinal, dry mouth, difficulty in swallowing, epigastric discomfort, and loose motions.

Respiratory: Constriction in the chest and difficulty inhaling

Cardiovascular: Palpitation, discomfort in chest, and awareness of missed beats.

Genitourinary: frequent or urgent micturition, failure of erection, menstrual discomfort, and amenorrhoea

Muscle Tension: Tremors, headache and aching muscles

Hyperventilation: Dizziness, tingling in the extremities and feeling of breathlessness.

Sleep disturbance: Insomnia and night terror.

Anxiety disorders can be broadly categorized into:

- Panic anxiety disorders
- Phobic anxiety disorders
- Obsessive compulsive disorder (OCD)
- Post traumatic stress disorder (PTSD)
- Generalized anxiety disorder

2.2.1 Panic Anxiety Disorders

Patients suffering from panic anxiety disorders have recurrent, sudden and intense attacks of anxiety where physical symptoms predominate and these usually reach their peak in less than a minute. Panic attacks are accompanied by intense fear of serious consequences such as an impending heart attack, death, losing control, etc. These attacks are erratic, sudden and unpredictable and not limited by situations or time—they can happen anytime and anywhere. Individual attacks mostly last only for a few minutes, but sometimes may prevail longer. The frequency of these attacks is highly variable.

The general symptoms of panic attacks include smothering sensations and shortness of breath; feelings of chocking; palpitations and accelerated heart rates; chest pain or discomfort; profuse sweating; dizziness or faintness; nausea or

NOTES

abdominal distress; numbness or tingling sensation; depersonalization or derealization; fear of dying; flushes or shaking and fear of going out of control. The major symptoms can vary from one person to the other.

2.2.1.1 Epidemiology of panic disorders

Using DSM-IIIR criteria, the one year prevalence of panic disorder in the general population is about thirteen per 1000 in men and about thirty-two per 1000 in women (Kessler et al., 1994). It is likely to be twice more common in women than men.

2.2.1.2 Onset and course of panic disorders

The onset of panic disorder is usually sudden and the frequency is variable. It has a prolonged course with fluctuating anxiety and depression (Roy-Byrne and Cowley, 1995). Some studies, for example, conducted by Wheeler et al. (1950), have found that most patients continued to have symptoms even 20 years after the first diagnosis, though most had a good social outcome.

2.2.1.3 Etiology of panic disorders

Several etiological factors that seem to underlie panic disorder are as follows:

Genetic factors: In studies conducted by Mendlwicz et al., 1993 and others, panic disorder is found to be familal in nature. Twin studies conducted by Kendler et al. (1993), found that rates of panic disorder in monozygotic twins were higher than in dizygotic twins, indicating that the family aggregation is due to genetic factors. However, the mode of inheritance is not fully known.

Biological factors: Abnormalities in the presynaptic a1-adrenoceptors that normally restrain the activity of presynaptic neurons in brain areas concerned with the control of anxiety and an abnormality of benzodiazepines or 5-HT receptor function may have a causal role in panic disorder. The effects of drugs like Clomipramine, Fluvoxamine and Imipramine, further suggest that 5-HT mechanisms are important in panic disorder.

Panic attack can also be provoked by the inhalation of carbon dioxide more readily in panic disorder patients than in controls. Therefore, it has been proposed that panic disorder patients are usually sensitive to feelings of suffocation and respond with panic anxiety (Klien, 1993). Although voluntary over-breathing can produce a panic attack (Hibbert, 1984), it has not been shown that panic disorder is caused by involuntary hyperventilation.

Psychological factors: The cognitive hypothesis is based on the observation that fears about serious physical or mental illness are more frequent among patients with panic attacks than among anxious patients without panic attacks (Hibbert, 1984). It has also been proposed by Clark (1986) that there is a spiral of anxiety in panic disorder as the physical symptoms of anxiety activate fears of illness and thereby generate more anxiety.

2.2.1.4 Management of panic disorders

Apart from supportive measures and attention to any causative personal or social problems, panic disorder is usually treated with drugs and cognitive behaviour therapy. Drugs like benzodiazepines (like Alprazolam, Diazepam, etc.), Imipramine, Clomipramine and SSRIs (like Fluvoxamine, Paroxetine and Sertraline) have shown to have a therapeutic effect. Cognitive behaviour therapy focuses on psycho-educating the patient and his family members about the problem, removing various myths and fears (such as palpitations will surely lead to a heart attack) associated with the physical effects of anxiety, and on teaching patients relaxation exercises and effective stress coping strategies. These individuals are also encouraged to engage in positive self-talk and to avoid focusing too much on their bodily signs of anxiety.

Research has shown that cognitive behaviour therapy and medications have comparable effects. The outcome is likely to be more positive when both the treatment modalities are used together as a way of complimenting each other. If panic disorder is accompanied by agoraphobic avoidance, then exposure treatments such as systematic desensitization can also be used.

2.2.2 Phobic Anxiety Disorders

The suffix 'phobia' is derived from a Greek God named *phobies*, who frightened his enemies. A phobia is characterized by a person's persistent, disproportionate and irrational fear of a particular event or situation or object which is in general of little or no danger. In case of a phobic anxiety disorder, only certain well-defined situations (for example, buses or crowded places) or objects (for example, lizards or spiders) or natural phenomena (for example, thunder or flowing water in canals or rivers), which are in general not regarded as dangerous by most people and they are external to the individual. The individual tends to avoid such feared situations and objects and experiences anticipatory anxiety whenever there is a possibility of encountering these circumstances and objects. The anxiety is not freed just due to the clear knowledge that most people regard such situations as not dangerous or threatening. Phobic anxiety often co-exists with depression. Phobic disorders, excepting the social phobias, are more common in women than in men and among adolescents and young adults than in older people. In short, phobic anxiety disorder has the following characteristics:

- Irrational fear of an object, situation or activity
- The fear is out of proportion to the actual danger
- Patient recognizes that the fear as irrational and unjustified but continues to have the fear
- Patient is unable to control the fear and is very distressed by it
- This leads to persistent avoidance of the particular object, place, situation or activity

NOTES

- Gradually, the phobia and the phobic object become a preoccupation with the patient, resulting in marked distress and restriction of freedom and mobility

For clinical purposes, the three principal phobic syndromes recognized are: Specific phobias, social phobias and agoraphobias.

2.2.2.1 Epidemiology of phobic anxiety disorders

Among adults, the life time prevalence of specific phobias has been estimated by Kessler et al. (1994) as 4 per cent in men and 13 per cent in women. Specific phobias are seen to be present more frequently in women than men. They often begin in early childhood (Marks and Gelder, 1966) and affect nearly 13 per cent of the population (Myers et al., 1984).

The one year prevalence of social phobia has been estimated as 7 per cent of men and 9 per cent of women (Davidson et al., 1993). Social phobia is seen to be equally present in both men and women. It affects nearly 2 per cent of the population.

In a study by Kessker et al. (1994), the one year prevalence of agoraphobia without panic disorders was estimated as 1.7 per cent in men and 3.8 per cent in women. The life time prevalence is found to be 6–10 per cent (Weissman and Merikangas, 1986). Agoraphobia is likely to be twice more common in women than in men.

2.2.2.2 Onset and course of phobic anxiety disorders

Phobias are more common among women than men. They usually start in late teens or early twenties. The onset is usually sudden and without any apparent cause. The course of phobias is usually chronic gradually increasing the restriction of daily activities. Sometimes, phobias are spontaneously disappear.

2.2.2.3 Etiology of phobic anxiety disorders

Several factors underlying phobic anxiety disorders are given below:

The psychoanalytical perspective: According to Freud, phobias are a defence against anxiety that is produced by repressed id impulses. This anxiety is replaced from id impulses of the fear of an object or situation that has some symbolic connection to it. Thus, phobia is ego's way of avoiding to deal with a repressed childhood conflict.

The behavioural perspective: Watson and Rayner's (1920) demonstration of fear/phobia of white furry things suggest that phobias are fears learnt through classical conditioning. According to Mowrer's two-factor theory, when a neutral object or event is paired with some painful or fearful experience, then the individual develops the phobia of that object or event through classical conditioning. According to classical conditioning, phobias once acquired, would generalize to other similar objects or situations. Direct classical conditioning may be especially common in the onset of dental phobia (Kent, 1997), Claustrophobia (Rachman, 1998) and accident phobia (Kuch, 1997).

In 1971, Seligman proposed that via natural selection human beings may be biologically prepared to fear certain stimuli that would have been threatening to our evolutionary ancestors. This explains the individual's fear of snakes more often than fear of table, chair, etc. (Ohman et al., 1993). Such fears are not inborn or innate but rather easily acquired or especially resistant to extinction. Ohman (1996), in a study found that fear was conditioned more effectively to fear relevant stimuli (such as snakes) than to fear irrelevant stimuli (such as flower or mushroom).

In one study, Bandura and Rosenthal (1966) showed that phobia may also develop through vicarious conditioning by observing others in an aversive conditioning situation. Vicarious learning may also be accomplished through verbal instructions. That is phobic reactions can be learned through another's description of what might happen as well as by observing other's fear.

In another study, Mineka and her colleagues (1984) demonstrated that adolescent rhesus monkey developed the phobia of snakes by simply observing their parents reacting fearfully with real or toy snakes but non-fearfully with neutral objects. Mineka (1998) further goes to say that events occurring before, during and after the conditioning experience are important determinants of the level of fear that is conditioned and whether the conditioned fear is maintained or strengthened.

Rescorla (1974) gave the inflation effect stating that a person who is exposed to a more intense traumatic experience after the first may be likely to become more fearful of the conditioned stimuli. For example, an individual who acquired a mild fear of automobiles following a minor crash might be expected to develop a full blown phobia, if he or she later were physically assaulted even though no automobile was present during the assault. Even verbal information that later alters one's interpretation of the dangerousness of a previous trauma can be sufficient to cause the level of fear to be inflated (Davey, 1997).

According to operant conditioning model, phobic reactions may also be learned by virtue of positive consequences that follow. Social phobias may also develop from lack of social skills or inappropriate behaviour that may cause social anxiety.

The cognitive perspective: This perspective believes that individuals having phobias tend to markedly overestimate the probability that feared objects have been or will be followed by aversive events (Mineka et al., 1989). They have a tendency to think negatively; have a bias towards remembering threatening cues and to focus automatically more on the threatening cues in the environment. It is likely that in their growing up years they must have encountered several unpredictable and uncontrollable events which may promote negative schemas, current anxiety and a vulnerability to anxiety in the presence of future stressors. Cognitive variables may also help in maintaining phobias once they have been acquired.

The biological perspective: According to Lacey (1967), the autonomic nervous system of these individuals becomes easily aroused. The family history

studies have shown that phobias may be transmitted genetically. 30 per cent of the first degree relatives of people with specific phobias; 16 per cent of the first degree relatives of people with social phobias; 5 per cent of the first degree relatives of people with general phobias; and 64 per cent of the first degree relatives of people with blood-injury phobias; also have phobias of the same category (Fyer et al., 1990; Kessler et al., 1988; Ost, 1992). This study found evidence that there may be two different types of genetic factors involved—the first being a modest inherited tendency to develop any specific phobias and second being a modest inherited tendency to develop a particular type of specific phobia.

Genetic and temperamental or personality variables are known to affect the speed and strength of conditioning to fear. Kagan and his colleagues found that children defined as behaviourally inhibited (i.e. excessively shy or timid, etc.) at twenty-one months of age were at a higher risk for the development of multiple specific phobias at 7–8 years of age than were inhibited children. The average number of reported fears in the inhibited group was 3–4 per cent per child (Biederman et al., 1990). Some studies have found that inadequate functioning of neurotransmitters GABA (gamma-aminobutyric acid) also contributes to anxiety leading to the development of phobias.

2.2.2.4 Management of phobic anxiety disorder

Before initiating any treatment, one should rule out other medically treatable conditions that may give rise to anxiety symptoms. For most patients, pharmacotherapy, empirically proven psychotherapy (e.g. cognitive behavioural therapy (CBT)), or some combination of both is believed to be an appropriate initial treatment option. The treatment approach is usually multi-modal. When it comes to 'pharmacotherapy', benzodiazepines, beta-blockers and antidepressants like SSRIs, MAOIs and tricyclics have been found to be quite effective in treating anxiety symptoms.

However, with regard to psychological treatments, 'cognitive behaviour therapy' is the most preferred. It aims at modifying the negative self-statements and cognitive distortions these individuals engage in. flooding, systematic desensitization, exposure and response prevention and relaxation techniques are largely used in helping these individuals to overcome their avoidance behaviour. 'Supportive psychotherapy' is also seen as a helpful adjunct to CBT.

2.2.3 Obsessive Compulsive Disorder

Diagnostically, Obsessive Compulsive Disorder (OCD) is defined by the occurrence of unwanted and intrusive obsessive thoughts or distressing images, usually followed by compulsive behaviour designed to neutralize these obsessive thoughts and images or to prevent some dreaded event or situation. Obsessions are intrusive and recurring thoughts and images that come unbidden to the mind and appear irrational and uncontrollable to the individual experiencing them (Foa, 1990). Obsessions may also take various forms like extreme doubting, procrastination and indecision which strongly interfere with one's normal functioning.

Compulsions involve repetitive behaviour (e.g. hand washing, checking, etc.) or mental acts (e.g. praying, counting, etc.) that the person feels driven to perform in response to an obsession to reduce distress or prevent a dreaded event or situation. A true compulsion is viewed by the person as somehow foreign to his or her personality. Stern and Cobb (1978), for example, found that 78 per cent of a sample of compulsives viewed their rituals as silly or absurd.

Several researches (Rachman and De Silva, 1978; Salkovskis and Harrison, 1984) indicate that normal and abnormal obsessions and compulsive behaviours exist on a continuum, with the primary difference being in the frequency and intensity of the obsessions and in the degree to which the obsession and compulsions are troubling and to which they are resisted. The diagnosis of OCD requires that these obsession and compulsions should cause the person marked distress, consume excessive time or interfere with occupational or social functioning.

The most commonly seen obsessions are obsessional thoughts and images, obsessional ruminations and doubts, obsessional impulses, obsessional phobias and obsessional slowness. Obsessional thoughts and images refer to words, ideas, images and beliefs recognized by the patients as his own, that intrude forcibly into his mind. These are usually unpleasant and attempts are made to exclude them. Obsessional thoughts may take the form of single words, phrases or rhymes; which are usually unpleasant or shocking to the patient and may be obscene or blasphemous.

- Obsessional images are vividly imagined scenes, often violent or disgusting in nature, involving abnormal sexual practices.
- Obsessive thoughts may centre on a variety of topics. In one study conducted by Jenike et al. (1988), the most frequent themes of obsessions were contamination (55 per cent), aggressive impulses (50 per cent), need for symmetry (37 per cent), somatic concerns (35 per cent) and sexual content (32 per cent). Similar range of themes was revealed in a similar study conducted in India, although the proportion of aggression and sex were somewhat smaller (Akhtar et al., 1975).
- Obsessional ruminations and doubts refer to internal debates in which arguments for and against even on the simplest everyday actions are reviewed endlessly. Some obsessional doubts may concern actions that may not have been completed adequately (such as locking the door) or that might have harmed the other people or may be related to religious convictions.
- Obsessional impulses refer to urges to perform acts usually of a violent or embarrassing kind, for example, jumping from a moving vehicle, shouting blasphemies in church, etc.
- Obsessional phobias refer to fear and avoidance of situations in which the possibility of performing the acts related to violent obsessional thoughts is high. For example, if an individual gets obsessional thoughts of harming another person, then he is likely to develop phobia for places like kitchen where knives are kept.

- Obsessional slowness refers to an extreme slowness seen in some patients which is out of proportion to other symptoms.

Common compulsive rituals centre on checking, counting or cleaning activities. These rituals can be mental activities or repeated actions. Mental activities may take the form of counting repeatedly in a special way or repeating a certain form of a word. The repeated actions may take the form of repeated senseless behaviours such as washing the hands twenty or more times in a day after touching any object. The compulsive rituals may (for example, washing hands following the thoughts of contamination) or may not be (for example, laying out the clothes in a complicated way before dressing) understandably related to obsessional thoughts. Some patients feel compelled to repeat such actions a certain number of times and if they are not able to do so, then they may start the whole sequence again. Patients are often aware that their rituals are illogical and usually try to hide them. Some individuals may show a high need for repeated reassurance.

An individual suffering from OCD may show symptoms of severe anxiety or depressive symptoms as a reaction to the obsessional symptoms or may complain of depersonalization. Although people with OCD may show several different symptoms but the following features are consistent across all patients of OCD.

Anxiety is the affective symptom. Nearly all people afflicted with OCD fear that something terrible will happen to themselves or others for which they will be responsible. Compulsions usually reduce anxiety, at least in the short term, and,

The tendency to judge risks unrealistically seems to be a very important feature of OCD.

2.2.3.1 Epidemiology of OCD

According to Epidemiologic Catchment Area Study, the average one year prevalence rate is 1.6 per cent and average life time prevalence rate is 2.5 per cent (Robins and Rogier, 1991). The disorder itself begins in late adolescence and early adulthood often following some stressful event such as pregnancy, child birth, family conflict and difficulties at work (Kringlen, 1970). It has been found that people who are separated, divorced or unemployed are at a greater risk (Karno et al., 1988)

OCD begins when a person is at a younger age with peak age of 6–15 years for males and 20–29 years for females (APA, 1994) and is equally common in both the sexes. As with all of the anxiety disorders, OCD frequently co-occurs with other mood and anxiety disorder. It is estimated that 80 per cent of those with OCD may experience major depression at sometime in their life (Barlow, 1988). The anxiety disorders with which OCD most often co-occurs include panic disorder, specific phobia and social phobia. The most common personality disorders in people with OCD are dependent and avoidant.

2.2.3.2 Etiology of OCD

Various etiological factors that seem to play a role in OCD are given below:

The psychoanalytical perspective: According to Freud, OCD patients have not been able to solve oedipal conflict and have either never advanced beyond this stage or have regressed to an earlier stage. They seem fixated at the anal stage. It is this anal stage where these children derive sensual pleasure from defecating— both as a physical release and as a creative act. This is also the time, when parents are trying to toilet train their children, which involves learning to control and delay these urges. If parents are too harsh and they make the child feel bad and dirty about soiling himself or herself and may instill rage in the child, as well as, guilt or shame about these drives.

According to this theory, the intense conflict that may develop between id and ego may result in the formation of defences which produce OCD symptoms. The four primary used defences are isolation, displacement, reaction formation and undoing. With isolation, the association between blasphemous thoughts and feelings that would ordinarily be associated with it are disconnected. Thus, the person might think about violence without experiencing anger, hence isolating himself from the affect which is associated with the distressing situation.

With displacement, the person substitutes one thought or activity for another that is more frightening or threatening. With reaction formation, the person thinks and acts in a fashion, that is, opposite to his or her true impulses. For example, someone who is obsessed with the thought of harming her child may become a supermom. With undoing, the person tries to obtain forgiveness for some transgression through some magical compulsive behaviour. For example, someone with blasphemous thoughts might engage in excessive praying and cleaning.

However, Adler believed that OCD develops when the children are kept from developing a sense of competence by their excessively dominant parents. Saddled with inferiority complex, people may unconsciously develop compulsive rituals in order to carve out a domain in which they exert control and can feel proficient.

The behavioural perspective: Behaviourists view obsessions and compulsions as learned behaviour reinforced by their consequences. According to Mowrer's two process theory of avoidance learning, neutral stimuli (shaking hands) become associated with aversive stimuli (scary idea of contamination) through a process of classical conditioning and come to elicit anxiety. When an action like washing hands reduces anxiety, then the washing response gets reinforced making it more likely to occur again in the future when the anxiety about contamination was evoked in other situation. Once learned, such avoidance responses are extremely resistant to extinction.

One group of researchers found that the preparedness concept as applied to phobias was also relevant to understanding the non random distribution of obsessive thoughts and compulsive rituals (De Silva, Rachman and Seligman, 1977). For example, the association between the obsession of dirt and contamination and the compulsion of washing hands is so common to make their occurrence seem non-random. This theory states that compulsive behaviours are those behaviours

NOTES

which defended pre-technological man against danger. Thus, the theory states that obsessions with dirt and contamination and other potentially dangerous situations did not arise out of vacuum but rather have deeper evolutionary roots (Mineka et al., 1996). Some theorists have argued that the displacement activities that many species of animals engage under conditions of conflict or high arousal bear a significant resemblance to the compulsive ritual seen in OCD. Thus, obsessions and compulsions seem to have deeper evolutionary roots.

The cognitive perspective: According to Carr (1974), OCD results from a negative cognitive set (of biases) that makes people to unrealistically over-estimate the risk involved in a situation. These people cannot shrug off negative thoughts which then reoccur persistently later leading to obsessions and compulsions (Clark and Purdon, 1993). According to Salkovskis et al. (1997) and Rachman and Hodgson (1985), these people cannot turn over their thoughts, are depressed, generally anxious and have more rigid and moralistic thinking because of which feelings of guilt easily seep in which may further lead to compulsions. Also Sher, Frost and Otis (1983, 1989) have shown that compulsive checkers have poor memory for their behavioural acts. It is this poor memory for behavioural act which contributes to repetitive nature of checking ritual. Recent research has found evidence that people with OCD do have impairments in their non-verbal memory but not in their verbal memory (Trivedi, 1996). Also, they show low confidence in their memory abilities.

The biological perspective: According to this view, monozygotic twins show a high concordance rate of about 65 per cent averaged across the studies reviewed by Radmussen and Tsuang (1986). Family studies have also shown that about 15–20 per cent of the first degree relatives have diagnosable OCD (Pauls et al., 1991). There is also quite convincing evidence of a genetic contribution to some forms of OCD, given that OCD is linked to Tourette's syndrome which is known to have a genetic basis. One study found that 23 per cent of the first degree relatives of patients with Tourette's syndrome had diagnosable OCD (Pauls et al., 1991).

PET scans have shown that patients with OCD have abnormally active metabolic levels in the orbital prefrontal cortex and caudate nucleus (Baxter et al., 1991). Rapoport's findings also implicate abnormalities in the functioning of the basal ganglia. Baxter et al. (1991) have speculated that the first dysfunction in OCD may be in the area of the brain called the straitum, which is involved in the preparation of appropriate behavioural response. Encephalitis, head injuries and brain tumours have all been associated with the development of OCD (Jenike, 1986).

Serotonin levels seem to play a role in OCD as drugs like clomipramine and some antidepressants (fluoxetine) which affect serotonin have been shown to be useful in the treatment of OCD. Also, both dopamine and acetylcholine coupled with serotonin seem to play a role in OCD (Rauch and Jenika, 1993).

2.2.3.3 Management of OCD

Observations show that OCD runs a fluctuating course with long periods of remission. Treatment should begin with an explanation of the symptoms to both the patient and his family members who may also be involved in the patient's rituals. The therapy which is most frequently used in the treatment of OCD is exposure and response prevention therapy (ERP). The therapy aims at exposing the individual to any environmental cues that increase the symptoms and then preventing the individual from engaging in the compulsive response. Exposure is likely to increase anxiety in the individual. To reduce anxiety, the individual is encouraged to engage in relaxation techniques.

To effectively deal with obsessions, the technique of thought-stopping has also been tried. However, cognitive therapy does not recommend the attempts aimed at suppressing and avoiding obsessional thoughts, because such attempts have been found to increase, instead of decreasing, the frequency of such thoughts. These techniques may be combined with exposure to tape-recorded repetition of the thoughts, and by disputing any other cognitive distortions present in the patient.

Drugs like clomipramine, specific serotonin re-uptake inhibitors (SSRIs), and anxiolytic drugs have also been found to be effective in the treatment of OCD. In some very severe cases of OCD, which have not responded to medication and intensive in-patient treatment, neurosurgery has also been used.

2.2.4 Post-Traumatic Stress Disorder

The post-traumatic stress disorder (PTSD) refers to an intense, prolonged and sometimes delayed reaction to an intensely stressful event like natural disaster, war, rape and/or serious assaults. Its essential features are hyper-arousal, re-experiencing of aspects of the stressful events and avoidance of reminders. The common symptoms seen in PTSD are persistent anxiety, irritability, insomnia, poor concentration, difficulty in recalling stressful events at will, intense intrusive imagery in the form of 'flash backs', recurrent distressing dreams, avoidance of reminders of the events, detachment, inability to feel emotions (numbness) and diminished interest in activities. Maladaptive coping responses, including persistent aggressive behaviour, excessive use of alcohol or drugs and deliberate self-harm, may occur. Depressive symptoms, feelings of guilt, dissociative symptoms and depersonalization may also be present in PTSD.

2.2.4.1 Onset and course of PTSD

PTSD may begin very soon after the stressful event or after an interval usually of days, but occasionally of months, though rarely more than six months (McFarlane, 1988). If the person experiences a new traumatic event, symptoms may return even if the second event is less severe than the original. Most cases resolve within about three months but some may persist for years (Blank, 1992). The course is fluctuating in nature. About half of the individuals with PTSD recover during the first year whilst the rest may continue for long periods (Ehlers, 2000).

2.2.4.2 Epidemiology of PTSD

Using DSM-IV criteria, the one month prevalence of PTSD has been found to be 1.2 per cent for men and 2.7 per cent for women (Stein et al., 1997). The lifetime prevalence has been reported as 5–6 per cent among men and 10–12 per cent among women (Breslace et al., 1997). PTSD tends to be more prevalent in women than men and in children and older people than young people.

2.2.4.3 Etiology of PTSD

Although an exceptionally stressful event leads to PTSD, some people due to their genetic or acquired vulnerability are more susceptible to develop PTSD even to less stressful event. Studies of twins suggest that differences in susceptibility are in part genetic (True et al., 1993). Genetic variation accounted for about one-third of the variance in susceptibility to self-reported PTSD. Factors like age, gender, psychiatric disorder, previous traumatic experiences, separation from parents, child abuse, pre-existing low self-esteem, temperament of neuroticism and differences in the ways threatening events are appraised and encoded in memory determine vulnerability to develop PTSD. Several neuro-endocrine abnormalities like increased cortisol levels have been reported in patients with PTSD (Charney et al., 1993).

PTSD can also develop through classical conditioning. For example, some patients with PTSD experience vivid memories of the traumatic events in response to smell and sounds related to the stressful situation. Individuals with PTSD tend to process emotionally charged information in an overwhelmed manner and these memories tend to persist in an unprocessed form and hence intrude into conscious awareness. Negative appraisals of early symptoms, avoidance of reminders of the traumatic situations and suppression of anxious thoughts are likely to maintain the symptoms of PTSD.

2.2.4.4 Management of PTSD

Treatment of PTSD involves imparting information about the normal response to severe stress and the importance of confronting situations and memories related to traumatic events. It aims at encouraging individuals to face the situations they have been avoiding and to engage in self-monitoring of the symptoms. Individuals are asked to recall images of traumatic events and to integrate these with the rest of their experience. Then the individual is helped to restructure his or her irrational or distorted thoughts by looking at the evidence for and against the appraisals and assumptions. These individuals are taught anger management skills to deal with their anger regarding the traumatic events and their causes. Psychodynamic psychotherapy aims to modify unconscious conflicts, which might have been reactivated by the traumatic event. Anxiolytics, antidepressants and hypnotic drugs can also be used as a part of management of PTSD.

2.2.5 Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is characterized by a chronic persistent worry about a number of events and activities. The worry is not restricted to, or markedly

increased in, any particular set of circumstances. The major areas of worry are health, work, money and family (Barlow, 1988). GAD is also known as free-floating anxiety because it is not hooked to any specific object or event or situation. All the symptoms of anxiety can occur in GAD but there is a characteristic pattern comprising the following features:

Worry and apprehension: should be prolonged, widespread, not focused on any specific issue and difficult to control when compared to the ordinary worries and concerns of healthy people

Psychological arousal: may be evident as irritability, poor concentration, and sensitivity to noise.

Autonomic over-activity: is often experienced as sweating, palpitations, dry mouth, epigastric discomfort and dizziness.

Muscle tension: may be experienced as restlessness, trembling, inability to relax, headache and pain in the back and the shoulders.

Hyperventilation: may lead to dizziness, tingling in the extremities and a feeling of shortness of breath.

Sleep disturbances: may be seen in the form of difficulty falling asleep and persistent worrying thoughts which may interfere with sleep. Sleep may be intermittent, un-refreshing and accompanied by unpleasant dreams.

Other features: include tiredness, depressive symptoms, obsessional symptoms and depersonalization which are never prominent throughout the illness.

These individuals also experience high levels of negative affect, chronic over arousal and a sense of uncontrollability. They may often fear that something terrible is going to happen to them or to others for whom they care, for example, loss of job, alienation from spouse. Usually individuals with GAD are able to function despite high levels of anxiety and less often visit clinics for treatment.

2.2.5.1 Epidemiology of GAD

Age of onset is difficult to determine as these individuals often report feeling anxious all their lives (Barlow, 1988). It strikes about 4 per cent of the population (Rapee, 1991). It is twice more common in women than in men (Kendler et al., 1995). People suffering from GAD are also likely to suffer from some other anxiety disorders like phobia, panic or mood disorder.

2.2.5.2 Etiology of GAD

Usually GAD is triggered by stressors on a person who is predisposed by several genetic factors, unpleasant experiences and environmental influences during childhood. Clinical observations indicate that GAD often begins in relation to stressful events and can sometimes become chronic when stressful problems persist. Stressful events involving threat are particularly related to anxiety disorder. Various etiological factors that seem to play a role in GAD are as follows:

The psychoanalytical perspective: This perspective believes that GAD is the result of unconscious conflict between ego and id impulses. Freud believed that it was the primarily sexual and aggressive impulses that have been blocked from expression or punished upon expression which lead to GAD. According to the psychoanalytical view, the difference between specific phobias and GAD is that, in phobia defence mechanism of repression and displacement are operative but in GAD, the defence mechanisms may have been broken down or are not operative. In GAD, the ego is readily overwhelmed because it has been weakened by development failure in childhood. Separation and loss are thought to be particularly important causes of this failure (Bowlby, 1969) because in early childhood anxiety is linked to separation from the mother.

The behavioural perspective: This perspective believes that GAD stems from classical conditioning of anxiety to many environmental cues in the same way as phobias are conditioned. The difference between the two lies only in the kind and number of environmental cues that have become sources of anxiety. Wolpe hypothesized that such conditioning is likely to occur when a person experiences extreme anxiety or if there is a lack of clearly defined environmental stimuli during the conditioning of anxiety.

The cognitive perspective: This perspective believes that experience with unpredictable and or uncontrollable events may promote both current anxiety as well as a vulnerability to anxiety in the presence of future stressors (Barlow, 1988). Barlow also found that these individuals have a history of experiencing events in their lives as unpredictable and uncontrolled. This was also supported by a study carried out by Mineka et al. (1986) on two groups of monkeys called—'masters' and 'yoked' monkeys.

People with GAD process threatening information in a biased way focusing on the threatening cues in the environment and are more inclined to interpret ambiguous stimuli as threatening and to rate negative events as more likely to occur to them (Butter and Mathews, 1983). These individuals seem to have developed negative schemas in the course of growing up. They also seem to have a memory bias, i.e. they are more likely to remember threatening cues they have encountered. Parental indifference and physical or sexual abuse may also play a role in GAD.

Beck and Emecy (1985) found evidence that clients with GAD tend to have images and automatic thoughts revolving around physical injury, illness or death; loss of control; failure and inability to cope; rejection and mental illness. It is believed that the automatic, persistent negative thoughts are generated by the underlying maladaptive assumptions or schemas about the people, world, personal circumstances, etc. that these people have developed during the course of growing up or early life.

According to Borkovec et al. (1994), the five most common benefits people with GAD think they derive from worrying are: actual avoidance of catastrophes; superstitious avoidance of catastrophes; a way to cope, prepare and motivate

themselves; and avoidance of deeper emotional topics. Whenever people with GAD worry, their physiological and emotional responses to aversive imagery are actually suppressed reinforcing the process of worrying. Since worry suppresses physiological responses, it also prevents the patient from completely processing or experiencing the topic that is the cause of worry. However, full processing is necessary to make that anxiety extinct. Thus, the threatening meaning of the topic being worried about is maintained and so is the long-term maintenance of emotional disturbance.

The biological perspective: Family studies done by Brown (1942) found that GAD was more frequent (19.5 per cent) among the first degree relatives of probands with GAD than among first degree relatives of controls. Early studies on twins, for example (Slater and Shields, 1969), showed a higher concordance for monozygotic twins, suggesting that the familial association has a genetic cause. However, evidence regarding genetic factors in GAD is mixed. It is not yet known that whether functional deficiency in GABA is a cause or a consequence of GAD.

2.2.5.3 Management of GAD

First a clear plan of management is agreed with the patient and when appropriate, a relative or partner. The individual is then psycho-educated about the problem. To help deal with his anxiety the individual is given training in relaxation. Cognitive-behaviour therapy focuses on disputing the individual's cognitive distortions, engaging in positive self-talk, teaching effective stress coping strategies and helping them to evaluate the situation realistically. In addition to psychological treatments, medications like benzodiazepines, buspirone, beta-adrenergic antagonists, monoamine oxidase inhibitors and antidepressants can also be used. However, medication should be used selectively to bring symptoms under control quickly, while the effects of psychological treatments are awaited.

Check Your Progress

1. Define anxiety disorders.
2. List the different categories of anxiety disorders.
3. Define panic disorder.
4. Define phobia.
5. What are the characteristic features of phobic anxiety disorder?
6. Define Obsessive Compulsive Disorder.
7. Define post-traumatic stress disorder.

2.3 SOMATOFORM DISORDERS

Somatoform disorders are characterized by the presence of physical symptoms suggesting a physical disorder without any organic basis and these symptoms are

linked to psychological factors or conflicts. These individuals seek regular medical checkups in spite of repeated negative findings and reassurance by doctors that the symptoms have no physical or organic basis. The patient often feels that the symptoms have their beginning after certain unpleasant life events or difficulties or conflicts, but the patient usually resists attempts to discuss the possibility of psychological causation.

The somatoform disorders can be broadly categorized into:

Somatization disorder: Somatization is where mental factors such as stress cause physical symptoms. Somatoform disorders are a severe form of somatization where physical symptoms can cause great distress, often long-term. However, people with somatoform disorders are usually convinced that their symptoms have a physical cause. Somatization disorder is characterized by recurrent, frequently changing, and multiple somatic or physical conditions (cardiovascular, gastrointestinal, neurogenital, skin and pain symptoms) of prolonged duration (for several years), beginning before the age of 30 years. Most patients have a long and complicated history of contacting primary as well as specialist medical services, where often the tests and observations show only negative results. Complaints related to sexual and menstrual problems are also common. The symptoms are chronic and fluctuating in nature and lead to the disruption and impairment of family, social and interpersonal behaviours. Abuse and dependence of medication, irrational anxiety and marked depression are frequent conditions. Women are twice as much prone to this disorder as men.

Undifferentiated somatoform disorder: in this disorder there is a presence of unexplained physical symptoms that last at least 6 months that are below the required level to be diagnosed for a somatization disorder. In case of this disorder associated impairment of family and social functioning may be totally absent. This disorder has a high prevalence in the general community.

Hypochondriacal disorder: This is characterized by persistent fear of having a serious and progressive illness or disease based on the individual's own interpretation of his physical sensations. In this case ,the patient interprets the normal or routine sensations often as abnormal and distressing and usually the attention is focused on only one or two organs or systems of the body. Even though the results of the physical examination are often negative and inspite of the repeated medical assurances, the patient continues to fear that the disease persists. To be called hypochondriacal disorder, these symptoms persist for least 6 months. The prevalence of this disorder similar in men and women.

Somatoform autonomic dysfunction: In this disorder the symptoms are presented by the patient as if they were due to a physical disorder of a system or organ that is largely or completely under autonomic innervations and control of the cardiovascular, gastrointestinal, respiratory or genitourinary system. Symptoms are usually of two types—objective signs of autonomic arousal such as palpitations, sweating, flushing or tremors and subjective, non-specific symptoms such as

sensations of fleeting pains, burning, heaviness and tightness. In most patients though not all, psychological stress, current difficulties and problems appear to be related to the disorder.

Persistent somatoform pain disorder: In this disorder, the major symptom is chronic pain of sufficient severity that causes distress or impairment of functioning. However, to account for this pain there would be no organic pathology or pathophysiological mechanism. The pain is usually seen to occur in association with emotional conflict or psychosocial problems.

2.3.1 Epidemiology of Somatoform Disorders

Studies report highly variable prevalence rates of somatoform disorder, in the range of 0.2–2.0 per cent for women and below 0.2 per cent among men. Nearly 5 per cent of primary care patients suffer from this disorder.

Children living with a family member, having this disorder along with substance abuse and antisocial symptoms, have higher chances of developing somatoform disorder. Among childred, the female to male ratio ranges from 5:1 to 20:1.

If a person has a biological or adoptive parent with any of the above three disorders, the risk that the person may develop antisocial personality, substance-related or somatoform disorder, is high.

2.3.2 Course and Prognosis of Somatoform Disorders

Somatoform disorder is often a chronic, relapsing disorder in which complete remittance is rare. Research shows that a person who is diagnosed with this disorder has an 80 per cent chance to be diagnosed again with this disorder 5 years later. Although patients with somatoform disorder believe that they are medically ill,, the evidence suggests that the chances that they may develop some medical illness in next 15 years are same as they are for those without this disorder.

2.3.3 Etiology of Somatoform Disorders

Various etiological factors that seem to play a role in somatoform disorder are given below:

The psychoanalytical perspective: According to this perspective, conversion disorder occurs when these individuals experience events that create intense emotional arousal and the associated affect is not expressed and the memory of that event is cut off from the conscious experience. Specific conversion symptoms are casually related to traumatic events that precede them. Freud believed that it is the anxiety created by the reawakening of repressed id impulses which gets transformed or converted to physical symptoms. The primary gain is the avoidance of unresolved electra complex and repressed id impulses. The secondary gain is reinforced by symptoms, because due to the presence of these symptoms, the individual is able to escape from some unpleasant situations, actions or responsibilities and may even receive attention from others.

Hypochondriasis is seen against the anxiety produced by unacceptable wishes largely sexual and aggressive. These individuals because of their harsh superego, instead of directing their sexual energy into external objects they redirect them towards self. This outflow of self-directed sexual energy is then transformed into physical symptoms.

Psychodynamic theorists see a strong element of regression in all somatoform disorders. Because of intense anxiety, the individual regresses to a state of a sick child, in which they hope to receive attention, babying and relief from responsibility.

The behavioural perspective: This perspective regards somatoform disorders as inappropriate adoption of the sick role. According to Ullmann and Krasner (1975), two conditions that increase the chances that an inappropriate sick role will be adopted are:

- The person must have some experience with the sick role either directly (being ill) or indirectly (i.e. having a sick role modelled). Also these individuals tend to have personal or family histories of physical illness or somatic symptoms.
- The adoption of the sick role must be reinforced. They have childhood histories of receiving attention and sympathy when ill.

These operant processes predispose the individual to adopt the sick role as a coping style in adult life. Respondent conditioning may also play a part. The autonomic nervous system which controls breathing, heart rate and other bodily functions is subject to conditioning. So if anxiety is paired to racing heart beat, then anxiety triggers these symptoms which in turn cause further anxiety, then further symptoms and so on. In other words, this marks the beginning of hypochondriasis (Kellner, 1985).

The cognitive perspective: This perspective describes somatoform disorders as disorders of perception and thinking. According to Klerman (1983), these individuals have a cognitive style predisposing them to exaggerate normal bodily sensations, to misinterpret and then catastrophize over minor symptoms and to think in concrete rather than subjective terms. Given these three tendencies, these individuals are likely to misinterpret minor physiological changes as major health problems. Thus, when under stress they see their heart racing, they jump to the conclusion that they are having a heart attack. Thus, these individuals end up over attending to their bodily symptoms.

In addition, they have difficulty expressing emotion or even having fantasies involving emotion. They also think concretely rather than abstractly. Thus, these feelings associated with trauma get redirected onto their bodies. However, in conversion disorder, there is withdrawal of attention from sensory experience.

The socio-cultural perspective: This perspective also regards somatoform disorders as inappropriate adoption of the sick role but they focus less on family and more on larger cultural forces. Thus, the likelihood of adoption of the sick role as a coping style depends on the patient's cultural modelling of and reaction to the

unexplained somatic symptoms. It is seen that the rates of somatoform disorder vary from culture to culture and they vary in ways consistent with cultural values. For example, somatoform disorders are more prevalent in non-Western cultures and in less industrialized cultures where the expression of emotional distress in psychological terms is less accepted but in physical terms is well accepted.

2.3.4 Management of Somatoform Disorders

The treatment is often difficult and mainly consists of:

Drug therapy: This therapy involves giving antidepressants and or benzodiazepines on a short-term basis for the associated depression and or anxiety. Benzodiazepines should be used with caution, as the risk of drug abuse is high in these patients.

Supportive psychotherapy: This therapy is usually the treatment of choice. The first step is to enlist the patient in the therapeutic alliance by establishing a rapport. It is useful to demonstrate the link between psychosocial conflicts and somatic symptoms, if it is apparent. In chronic cases, symptom reduction rather than complete cure might be a reasonable goal.

Behaviour modification: Under this, after rapport is established, attempts at modifying behaviour are made, for example, ignoring symptoms, and positively reinforcing good behaviour.

Relaxtion therapy: This therapy with graded physical exercises is frequently incorporated in the management of somatoform disorders.

CHECK YOUR PROGRESS

8. Define somatoform disorders.
9. Define hypochondriacal disorder.
10. Differentiate between somatization and somatoform disorders.

2.4 DISSOCIATIVE DISORDERS

Dissociative experiences are a part of normal experiences, both in relation to highly stressful or traumatic experience, and in a variety of trance, possession and other states which may be considered as normal, even admired, in many parts of the world. Dissociative disorder is characterized by a disruption of the usual integrated functions of memory, identity, unconsciousness and perception of the environment. The common symptom of dissociative or conversion disorder is a complete or partial loss of the normal integration between the past memories, identity, immediate sensations and body control movements; with no evidence of any physical disorder. The dissociative disorders can be broadly categorized into: dissociative amnesia, fugue, trance and possession disorders, and dissociative identity disorder.

Dissociative amnesia: It is characterized by the failure to recall personal information usually after some traumatic events like natural disasters, financial loss, divorce, death of a loved one, etc. In this case, it only the failure to recall, but the information is lost completely. This condition may last from a few months to several months. The extent and completeness of the amnesia often varies from day to day and between investigations. Complete and generalized amnesia is rare. There can be four kinds of amnesia:

Localized: Under this the individual has no memory for all events immediately following a traumatic event.

Specific: Under this the individual remembers some events and not others

Generalized: Under this the individual does not remember anything about the past history.

Continuous; Under this the individual does not remember anything beyond a certain point in his past history.

The affective states that accompany dissociative amnesia are varied. Perplexity, distress and varying degree of attention-seeking behaviour may be evident, but calm acceptance is also sometimes striking. Severe depression is rarely seen. Purposeless local wandering may occur; it is usually accompanied by self-neglect and rarely lasts more than a day or too.

Dissociative amnesia occurs suddenly and is also terminated suddenly. Recovery is usually complete. The episodic and autobiographical memory seems to be affected. In case of total amnesia the individual cannot recognize his family and relatives but retains talents and skills, and knowledge of the outside world and how to function in it. Life time prevalence rate is 7 per cent (Ross et al., 1991).

Fugue: Under this amnesia is extensive. The individual often leaves home and settles in a new city with a new name, job, even personality characteristics following a traumatic event. During the period of fugue individual appears normal to observers. The individual may travel to places that are previously known to him or have some emotional significance for him. It is relatively brief and sudden. On termination, there is no memory for events that took place during fugue. The shift to another city is often purposeful travel involving little social contact. The life time prevalence rate is 0.2 per cent (Ross et al., 1991).

Dissociative identity disorder: Under this, the patient manifests two or more complete systems of personality, each system having its own stable unique emotional and thought process. Usually there is one host personality and others are subordinate personalities, which differ markedly from the host. Behaviours and needs inhibited by the host are often displayed liberally by subordinate personality. The transition from one personality to the other may take place over a period ranging from a few minutes to years although shorter durations are more common. One alter (personality) may have no memory of the other alters. Alters may involve a non-human species but the most common alter are often of the child

and of the opposite sex. It should be chronic (long lasting) and severe (causing marked impairment) and not temporary under the influence of some drug.

The lifetime prevalence rate of dissociative identity disorder is 1.3 per cent. It usually occurs in childhood but diagnosed not until adolescence. According to Greaves (1980), it is nine times more prevalent in men than in women. It is commonly associated with depression, somatoform disorder and borderline personality disorder. DID is usually seen in individuals who have traumatic histories of abuse or of violent death of parents or siblings.

Trance and possession disorder: In case of this disorder the person temporarily loses the sense of his personal identity and full awareness his personal surroundings. This involuntary state of trance is not accepted by the person's culture or religious practices. This disorder causes considerable distress and functional impairment. Some cases resemble DID with the person acting as if taken over by another personality for a brief period of time. When the condition is induced by religious rituals, the person may feel taken over by a deity or spirit.

2.4.1 Onset and Course of Dissociative Disorders

Dissociative disorders are closely associated with past intolerable problems, traumatic events or disturbed relationships. The unpleasant affect, conflicts and distress get transformed into the symptoms. The onset and termination of dissociative states are usually sudden and tend to remit after a few weeks or months, particularly if their onset was associated with a traumatic life event. Usually the dissociative disorders that persisted for longer than 1–2 years before psychiatric attention are usually resistant to therapy.

2.4.2 Etiology of Dissociative Disorders

Different perspectives explain the etiological factors underlying dissociative disorders as follows:

The psychoanalytical perspective: According to it, all dissociative disorders are instances of massive repression. Whenever a severe trauma is repressed, then amnesia and fugue are possible outcomes. The person succeeds in this repression by splitting off an entire part of personality from awareness leading to the development of DID alters (alter personalities).

The behavioural perspective: According to this, dissociative disorders are developed because of their rewarding consequences of protecting the individual from stressful events. For instance, in dissociative amnesia, the individual has no memory of the stressful event, and in fugue the individual moves to an altogether different place thus taking himself away from the painful situation.

The cognitive perspective: According to this, dissociative disorders are fundamentally disorders of memory. An individual's episodic memory seems to have been impaired. There are three different cognitive theories that explain this impairment:

State-dependent memory: According to this, amnesia occurs as the patient desires to feel that there is a change in emotional state from a traumatic situation to a more normal situation now. This may explain the loss of memory in dissociative amnesia and fugue. It also explains dissociative identity disorder, as different personalities are characterized by different mood states. Therefore, state dependency may lead one personality to have amnesia from the experiences of others (Bower, 1981).

The second cognitive theory of dissociation: It has to do with control elements, that is, certain information about the self is categorized under certain headings and activation of one heading can inhibit the retrieval of the information stored under the other heading. The hypothesis concerns self-reference, that is, we retrieve autobiographical memories by linking them to our representation of the self. According to Kihlstrom (1987), the psychogenic amnesia and fugue may be the result of loss of episodic memory, for it depends on self-reference.

The socio-cultural perspective: According to it, the dissociative symptoms are the products of social reinforcement. It sees DID as a strategy that people use to escape responsibility for certain of their actions (Spanos, 1986). It is common in cultures where expression of emotional distress is considered unacceptable. According to Krippner (1994), people can create personalities as required to defend themselves against trauma, to conform to cultural pressures, or to meet the expectations of a psychotherapist. This malleability has both adaptive and maladaptive aspects. Also certain phenomena such as spirit possession occur more commonly in certain parts of the world. It occurs more commonly in those areas where such behaviours are culturally sanctioned.

The biological perspective: This perspective believes that dissociative disorders may in fact be neurological disorders. They may be a byproduct of undiagnosed epilepsy. Epileptic seizures have been associated with DID ever since the disorder was discovered (Charcot and Maris, 1892). Also many victims of epilepsy have dissociative symptoms.

The second hypothesis, suggests that we all have within us rebellious subparts that our normal brains know how to suppress. It is believed that corpus collastomy (i.e. cutting the connection between right and left hemisphere) may lead to dissociative symptoms.

2.4.3 Management of Dissociative Disorders

The psychoanalytical technique focuses on lifting repression and helping the client to deal with the stressful situations that led to dissociation. Here the mode of treatment is chosen not on the basis of conversion or dissociative symptoms but on the total personality structure of the patient.

The behaviour therapy postulates that one should ignore the attention seeking symptoms in hysterical patients and the sick role adopted by them should not be

encouraged. Aversion therapy (a form of psychological treatment in which the patient is exposed to a stimulus while simultaneously being subjected to some form of discomfort) may occasionally be employed in resistant cases. Supportive psychotherapy is an important adjunct to treatment especially when the conflict and current problems have been conscious and have to be faced in routine life.

Drug treatment has a very limited role in dissociative disorders. A few patients having disability anxiety may need short-term benzodiazepines.

CHECK YOUR PROGRESS

11. Define dissociative disorder and mention its subtypes.
12. What is 'trance and possession disorder'?
13. What is the course and prognosis of a dissociative disorder?
14. What is fugue?

2.5 SCHIZOPHRENIA

Though schizophrenia has probably been with us for thousands of years; it is recognized as a distinct disorder only in 1896 by Emil Kraepelin, who described the disorder as dementia praecox, which was later re-termed as schizophrenia by Bleuler in 1911. The word schizophrenia is derived from the Greek words schizein meaning 'to split' and phren meaning 'mind'.

Of all the major psychiatric syndromes, schizophrenia is the most difficult to define and describe as over the past 100 years, many widely divergent concepts of schizophrenia have been held in different countries and by different psychiatrists. Also, schizophrenic patients differ from one another more than the patients with other disorders. Thus, schizophrenia is considered to be a heterogeneous disorder.

The symptoms of schizophrenic patients involve disturbances in several major areas—thought, perception, and attention; motor behaviour, affect or emotion and life functioning. The symptoms are broadly classified into two categories: positive symptoms and negative symptoms.

2.5.1 Positive Symptoms of Schizophrenia

Positive symptoms comprise excesses, such as disorganized speech, hallucinations, delusions and bizarre behaviour.

Disorganized speech: Also known as formal thought disorder, it refers to problems in the organization of ideas and in speaking so that a listener can understand. Although the patient may make repeated references to a central idea or a theme, the images and fragments of thoughts are not connected, thus making it difficult for the listener to understand what the patient is saying (incoherence).

Speech may also be disordered by loose association or derailment in which case the patient has difficulty sticking to one topic. He or she seems to drift off on a train of associations evoked by an idea from the past. The result of loosened associations is that schizophrenic language may convey very little.

Another oddity found in the speech of schizophrenics is clanging, the juxtaposition of words that have no relation to one another beyond the fact that they rhyme or sound alike. Clanging may also be related to the associational problem.

Delusions: It refers to firmly held beliefs that have no basis in reality. Some of the commonly seen delusions in schizophrenia are delusions of persecution (the belief that one is being plotted against, spied upon, threatened, interfered with, or otherwise mistreated, interfered with or otherwise mistreated, particularly by a number of parties joined in a conspiracy), control (the belief that other people, forces, or perhaps extraterrestrial beings are controlling one's thoughts, feelings, and actions, often by means of electronic devices that send signals directly to one's brain), reference (the belief that events or stimuli unrelated to the individual are actually referring specifically to the patient), sin and guilt (the belief that one has committed an unpardonable sin or has inflicted great harm on others), grandeur (the belief that one is an extremely famous, powerful, and important person), nihilism (the belief that oneself or others or the whole world has ceased to exist) and hypochondriasis (the unfounded belief that one is suffering from a hideous physical disease).

Hallucinations: The most dramatic distortions of perception are hallucinations, which are defined as sensory experiences in the absence of any stimulation from the environment. Auditory hallucinations are the most frequent, followed by hallucinations of other senses.

Disorders of perception: Individuals suffering from schizophrenia often report significantly greater number of changes in their perceptual functioning including visual illusions, disturbingly acute auditory perception, olfactory changes, inability to focus attention, difficulty in identifying people and difficulty in understanding the speech of others. Individuals suffering from schizophrenia have been seen to do poorly on perceptual tasks such as size estimation, time estimation and proprioceptive discrimination.

2.5.2 Negative Symptoms of Schizophrenia

The negative symptoms of schizophrenia consist of behavioural deficits, such as avolition, alogia, anhedonia and flat affect.

Avolition or apathy: It refers to a lack of energy, absence of interest in routine activities, and lack of personal hygiene, with uncombed hair, dirty nails, un-brushed teeth and disheveled clothes. These individuals have difficulty persisting at work, school or household chores and spend much of their time sitting around doing nothing.

Alogia: It refers to poverty of speech and poverty of content of speech. In these individuals, the amount of speech is greatly reduced and it conveys little information and tends to be vague and repetitive.

Anhedonia: It refers to an inability to experience pleasure. It is manifested as a lack of interest in recreational activities, failure to develop close relationships with other people, and lack of interest in sex.

Flat or blunted affect: In patients with flat affect virtually no stimulus can elicit an emotional response. The patient may stare vacantly, the muscles of the face are flaccid and the eyes are lifeless. When spoken to, the patient answers in a flat and toneless voice.

Social withdrawal: It refers to a lack of interest in social activities, preoccupation with ones thoughts, and withdrawal from the involvement with the environment and absence of interpersonal interactions. Some schizophrenic patients have severe impairment in social relationships. They have few friends, poor social skills and little interest in being with other people.

2.5.3 Other Symptoms of Schizophrenia

These individuals in addition to positive and negative symptoms also show disorders of motor behaviour, inappropriate affect and a confused sense of self.

Disorders of motor behaviour: One of these is catatonia, which is defined by the presence of several motor abnormalities. Patients may gesture repeatedly, using peculiar and sometimes complex sequences of finger, hand and arm movements, which often seem to be odd. Some schizophrenic patients manifest an unusual increase in their overall level of activity including much excitement and great expenditure of energy similar to that seen in mania (catatonic excitability). On the other hand, some individuals adopt unusual postures and maintain them for very long periods of time, known as catatonic immobility.

These individuals may also show waxy flexibility, that is, another person may move the patient's limbs into strange positions that the patient will then maintain for long periods of time. These individuals may also show various forms of rigid posturing, mutism, ritualistic mannerisms and bizarre grimacing.

Inappropriate affect: It refers to a state in which an individual's emotional responses are out of context. For instance, the patient may laugh on hearing that his or her mother has just died or become angry on asking his or her name. These individuals are likely to rapidly shift from one emotional state to another for no discernable reasons.

Confused sense of self: These individuals may feel confused about their identity to the point of loss of subjective sense of self or of personal agency. The individual may be perplexed about aspects of his or her own body, including its gender and may be uncertain about the boundaries separating the self from the rest of the world.

2.5.4 Epidemiology of Schizophrenia

According to the World Mental Health report 2001, 24 million people worldwide suffer from schizophrenia. The point prevalence of schizophrenia is estimated to be about 0.5 per cent. The onset of schizophrenia occurs later in females and often runs a more benign course, as compared to males.

2.5.5 Course and Prognosis of Schizophrenia

Schizophrenia seems to follow a regular course or progression of stages through time. The three phases are the prodromal phase, the active phase and the residual phase. The onset of schizophrenia usually occurs during adolescence or early childhood. Its onset may be sudden or gradual. The slow, insidious deterioration of functioning that may go on for years before any clear psychotic symptoms appear constitutes 'the prodromal phase'. This phase is often characterized by the presence of social withdrawal and isolation; poor hygiene; deterioration in social and occupational functioning; shallow and inappropriate affect; noticeable changes in the personality and bizarre behaviour. In 'the active phase', the patient begins to show prominent psychotic symptoms such as delusions, hallucinations, disorganized speech, severe withdrawal and so forth. In most patients, the active phase is followed by a 'residual phase', in which the behaviour is similar to that seen during the prodromal phase. It is characterized by the presence of blunt or flat affect, rambled speech, unusual perceptual experiences, odd ideas and or magical thinking. The recovery is gradual. Many patients remain impaired to some degree and may go on to have further psychotic episodes, with increasingly impaired functioning between episodes. In a few cases, the residual phase ends with a return to completely normal functioning. It has been found that that relapses tend to be triggered by stressful life events.

The outcome of schizophrenia is worse than that of most psychiatric disorders. It is generally accepted that there are wide variations in outcomes. In a longitudinal study done by Luc Ciompi (1980), the complete remission, remission with minor residual deficit, intermediate outcome, severe disability and unstable or uncertain outcome were seen in 27, 22, 24, 18 and 9 per cent of schizophrenic patients respectively. So, almost 50 per cent patients showed complete or near complete recovery, and only 18 per cent showed severe disability with only 9 per cent needing institutionalization. The longer the duration of untreated psychosis, the worse is the outcome. There is an increased mortality in patients with schizophrenia by almost one and a half times (Barrablough, 1998). The life time risk of suicide is nearly 5–10 times higher in schizophrenia as compared to normal population.

Factors like presence of acute onset before 35 years of age, precipitating stressor, good pre-morbid adjustment, catatonic subtype, short duration (less than six months), depression, predominance of positive symptoms, first episode, predominance of mood disorder, female sex, good support system, absence of

substance abuse, good treatment compliance and normal cranial CT scan are found to be associated with good prognosis in schizophrenia.

However, factors like insidious onset before the age of 20 years, absence of a stressor, poor premorbid personality, chronic course, predominance of negative symptoms, family history of schizophrenia, poor social support, absence of proper treatment, poor response to treatment, poor compliance, presence of substance misuse and evidence of ventricular enlargement on cranial CT scan are associated with poor prognosis.

2.5.6 Etiology of Schizophrenia

The several etiological factors that play a role in schizophrenia are as follows:

The biological perspective: According to the neuro-developmental hypothesis, patients with schizophrenia are seen to show abnormalities in brain structure and morphology; altered patterns of cerebral blood flow; and disordered cellular architecture in some cortical and sub-cortical brain regions. It is largely believed that the pathological changes are neuro-developmental in origin, or that if any injury of some kind occurred to the brain, it happened before the end of the second trimester in utero.

Family studies have shown that about 10 per cent of the first degree relatives of schizophrenic patients have schizophrenia. Parnas et al. (1993) found that the first degree relatives of patients with schizophrenia are also likely to show an excess of schizotypal, paranoid and schizoid personality disorders. Twin studies show a concordance rate of nearly 50 per cent in monozygotic twins as compared to the concordance rate of 10 per cent in dizygotic twins (McGuffin, 1988). Hebephrenic and catatonic subtypes are likely to carry a greater genetic loading as compared to Paranoid schizophrenia.

Murray and Castle (2000) suggest that abnormalities like enlarged lateral ventricles, loss of cerebral asymmetry, abnormal eye tracking performance, abnormalities in EEG pattern, delayed P300 event potential, indicate familial transmission of genes for a variety of neurobiological character, each of which may increase the risk of schizophrenia in an additive way.

Molecular genetic studies suggest that schizophrenia is probably due to a functional increase of dopamine at the post-synaptic receptors, though other neurotransmitters like serotonin, GABA and acetylcholine may also be involved.

Post-mortem studies, however, have indicated that, in comparison with psychiatric and healthy controls, the brains of patients with schizophrenia are lighter and somewhat smaller. There is enlargement of the lateral ventricles, particularly in the anterior and temporal horns. This is associated with a reduction in the volume of medial temporal structures such as the hippocampus and para-hippocampal gyrus. The thalamus is reduced in size (Falkai and Bogerts, 1993).

Functional MRI investigations have shown that the presence of auditory hallucinations was linked to reduced activities of the temporal regions. In another

NOTES

study using PET, patients with passivity phenomena showed hyper-activation of parental and cingulated cone in a motor task.

Misuse of a number of psychoactive substances can give rise to psychotic symptoms. It is not clear whether prolonged and heavy substances misuse can lead to a schizophrenic illness in someone who would not otherwise have developed the disorder. Andreasson et al. (1987) found that the relative risk of developing schizophrenia was 2.5 times greater in subjects who used cannabis, and the relative risk for heavy users was 6 times greater. These data have largely led to two interpretations, that is, cannabis misuse is indeed a risk factor for the development of schizophrenia and that those predisposed to develop the illness are also predisposed to misuse cannabis. However, it is fairly clear that continuing substance misuse can worsen the outcome of an established schizophrenic illness.

Generalized cognitive deficits have been seen in schizophrenia in attention, perception, learning, semantic memory, language comprehension, motor skills and executive planning functions. Onset of illness leads to further cognitive decline. Cognitive decline is more in patients with predominant negative symptoms. Resolution of symptoms does not necessarily reverse the cognitive decline.

The psychodynamic perspective: According to Freud, schizophrenia is a form of regression. Schizophrenics are people whose egos are not strong enough to cope effectively with unacceptable id impulses. Overwhelmed by anxiety, they simply give up the fight and regress to the early oral stage. This regression accounts for the schizophrenic's break with reality, since it is the ego that mediates between the self and the reality.

According to Sullivan (1962), the cause of schizophrenic anxiety is not id impulses but a damaging anxious and hostile mother-child relationship. To Sullivan and many other post-Freudians, schizophrenia represents a gradual withdrawal from other people. Scared from intimacy with others, the child takes refuge in a private world of fantasy. This initiates a vicious cycle. The more the child withdraws, the less opportunity he or she has to develop the trust, confidence and the skills necessary for establishing close bonds with others and the fewer the bonds, the greater the anxiety. The spiral continues until in early adulthood, the individual withdraws to a significant level resulting in a schizophrenic break with reality.

The family theories perspective: Lidz (1973) claims that a great number of schizophrenic children come from families that fall into one of the two categories: the schismatic family (in which parental discord has divided the family into opposing fractions) and the skewed family (which remains reasonably calm but only because one spouse is totally dominated by the other). In both situations, the child is denied the emotional support necessary for a sense of security, self-worth and a feeling of self-identity.

Fromm-Reichmann (1948) came up with the concept of schizophrenogenic mothers, who according to him were calm, domineering, rejecting and at the same time over-protective. Such mothers tend to create a hostile and aggressive

NOTES

environment at home. Such environment and the schizophrenogenic mother's way of reacting can induce schizophrenia in their children.

In a number of studies (Goldstein et al., 1989; Jones et al., 1984) families of hospitalized schizophrenics were rated on expressed emotion (EE) towards the patient. It was found that the patients who lived with families who were high on expressed emotions were three to four times more likely to have been re-hospitalized within 6 months than patients who lived with low EE relatives. In another study it was found that schizophrenic patients showed higher autonomic nervous system arousal in the presence of high EE relatives than in the presence of low EE relatives (Tarrier et al., 1988).

Bateson and his co-workers (1956) feel that double-blind communication may be a strong causative agent in schizophrenia. In the double-blind situation, the mother gives the child mutually contradictory messages (for example, both rejection and affection), meanwhile implicitly forbidding the child to point out the contradiction. According to them, the type of mother most likely to engage in double-blind communication is one who finds closeness with her child intolerable and also finds it intolerable to admit this to herself. Thus, she pushes the child away, but when the child withdraws, she accuses the child of not loving her.

Singer and Wynne (1963) proposed that the parents that engage in communication deviance are likely to induce schizophrenia in their children. In this pattern of communication, parents present to the child ideas, feelings and demands that are mutually incompatible. In one study it was found that communication deviance (CD) in parents was a good predictor of whether their adolescent children would be diagnosed as schizophrenia fifteen years later (Goldstein et al., 1987).

The behavioural perspective: Ullmann and Krasner (1975) believe that due to disturbed family patterning it seems these individual have not learnt to respond to certain social stimuli the way we respond. Hence they are subject to social rejection, leading to feelings of alienation and to the belief that others are out to get them. This accounts for social withdrawal and bizarre behaviour. They may also have been exposed to models for such behaviour. There is little support for the idea that schizophrenia is caused by different type of reinforcement. However, behavioural approach is not used to explain but to treatment of schizophrenia.

The cognitive perspective: According to it, schizophrenia is a result of an abnormality in attention problem. They are unable to attend to one thing and screen out the other. This attention problem in turn creates a vulnerability to schizophrenia by making it hard for the person to cope with environmental stress (Nuechterlein and Dawson, 1984). According to it, the positive symptoms are the products of over-attention; and the negative symptoms are the products of under attention. The reason these patients are confused and disorganized is that their information processing functions are over-burdened by stimuli that they cannot screen out and their speech is full of irrelevant associations, unlike normal people, as they cannot filter out such associations (Maher, 1983). Thus, auditory hallucinations are seen as traces of real sounds that the patient heard but could not eliminate from

consciousness and delusions would arise at the patient's effort to account for these and other bizarre perceptions.

Humanistic-existential perspective: According to Laing (1964), schizophrenics are people who, because of severe psychological stress, find themselves unable to continue their false, socially acceptable self which crumbles, forcing them to retreat into their own minds in the effort to relocate the true self. It sees schizophrenia not as a form of insanity but rather a hyper-sanity, a voyage into another reality in the existential search for an authentic identity.

Socio-cultural perspective: According to it, some people believe that being in a low social class may cause schizophrenia—the 'sociogenic hypothesis'. The degrading treatment a person received from others, the low level of education, and the lack of both rewards and opportunity taken together may make membership in the lowest social class such a stressful experience that an individual develops schizophrenia. Alternatively, the stressors encountered by those in the lowest social class could be biological; for example, the children of mothers whose nutrition during pregnancy was poor are at increased risk for schizophrenia (Susser et al., 1996).

Another explanation of the correlation between schizophrenia and low social class is the 'social-selection theory'. It states that during the course of their developing psychosis, people with schizophrenia may drift into the poverty-ridden areas of the city. The cognitive and motivational problems seen in these individuals may so impair their earning capabilities that they cannot afford to live elsewhere. Or, they may choose to move to areas where little social pressure will be brought to bear on them and where they can escape intense social relationships.

In short, the role of biological, psychosocial and socio-cultural factors in schizophrenia undoubtedly varies according to the given case and clinical picture.

2.5.7 Management of Schizophrenia

The treatment of schizophrenia is concerned with both the acute illness and chronic disability. In general, the best results are obtained by combining drug and psychological treatments.

Pharmacological treatment: In schizophrenia, the commonly used drugs are risperidone, olanzapine, haloperidol, clozapine, etc. atypical antipsychotics like resperidone, olanzapine, etc are also useful when negative symptoms are prominent, in chronic schizophrenia. Clozapine has been found to be effective in about 30 per cent of patients who had no beneficial response to traditional antipsychotics. Antipsychotics probably act by blocking post synaptic dopamine D2 receptors probably in the meso-limbic system.

Hospitalization is indicated if there is neglect of food and water intake, danger to self or others, poor drug compliance, significant neglect of self care, suicidal intent and lack of social support. A majority of patients require maintenance treatment with antipsychotics to prevent relapse. Although there are no clear-cut

rules, generally treatment is continued for 6 months to 1 year for the first episode, for 1–2 years for the subsequent episode and for indefinite period for repeated episodes or persistent symptoms. However, the decision regarding the duration of treatment in a particular case has to be assessed individually by the treating psychiatrist.

In the treatment of schizophrenia, the traditional indicators for ECT are catatonic stupor, severe depressive symptoms and high suicidal intent accompanying schizophrenia. ECT is also used if the patient is pregnant or has stopped taking food and fluids.

The psychosocial approaches: They focus on attenuation of symptom severity and associated co-morbidity; enhancement of interpersonal and social functioning; promotion of independent living in the community and improvement in personal illness management. These interventions are of several kinds as given below:

Psycho-education: It involves providing psycho-education to the patient and especially the family regarding the nature of the illness, its course and treatment to establish a good therapeutic relationship with the patient and his family. It also helps in reducing expressed emotions and improving compliance, thus acting as an important ingredient of successful management of schizophrenia.

Dynamic psychotherapy: Earlier, individual dynamic psychotherapy was used quite commonly for schizophrenia, though much more in USA than in UK. Apart from the lack of convincing evidence that intensive individual psychotherapy is effective in Schizophrenia, there may be some danger that the treatment may cause over-stimulation and consequent relapse (Malmberg and Fenton, 2000).

Group therapy: It particularly aims at teaching problem-solving, communication and social skills to the patient. It is largely used in the rehabilitation of the patient when he is in the remission phase. Group therapy is of little benefit in the acute stage of the disorder.

Social skills training: It uses a variety of approaches such as behavioural rehearsal, feedback, in vivo training, etc to teach complex interpersonal skills. Skill training may be combined with self-management of the illness in which the patients learn to adjust their own medication and organize their lives to minimize troublesome symptomatology. The results of these interventions are generally positive but concerns remain about whether the gains are maintained when treatment ends and whether the benefit is restricted to patients who have a good prognosis (Muesen and Bond, 2000).

Family therapy: It is employed at various stages of the treatment with the objective of reducing expressed emotions in family members, psycho-educating them about the illness, imparting practical advice on management, preventing relapse, improving medication compliance and helping family members to reduce the burden the illness lays on them.

Cognitive behaviour therapy: Its use is based on the rationale that positive psychotic symptoms are amenable to structured reasoning and behavioural modification. For example, with delusional beliefs, individual ideas are traced back to their origin and alternative explanations are explored. However, direct confrontation is avoided. It is also used to impart insight into the illness to the patients.

Milieu therapy: It includes treatment in a living, learning or working environment ranging from inpatient psychiatric unit to day care hospitals and half-way homes. Rehabilitation programmes should be realistic and acceptable.

Psychosocial rehabilitation: It focuses on activity scheduling to develop the work habit in the patients. It aims at imparting training in new vocation; retraining in a previous skill; vocational guidance; independent job placement and occupational therapy. Early intervention in schizophrenia is essential as the longer the duration of untreated psychosis, the poorer is the prognosis. Also, the time taken to respond to the treatment increases during the subsequent psychotic episodes. Much of the deterioration in social functioning takes place in the first two years after diagnosis.

CHECK YOUR PROGRESS

15. What are the symptoms of schizophrenia?

2.6 OTHER PSYCHOTIC DISORDERS

Other psychotic disorders include the following:

- Delusional disorder
- Schizotypal disorder
- Acute and transient psychotic disorder
- Schizoaffective disorders

2.6.1 Delusional Disorders

They refer to disorders with persistent, well-systematized, non-bizarre delusion that is not due to any other mental disorder. It is characterized by the presence of persistent delusions of persecution, grandeur, jealousy, somatic delusions and erotomanic delusions in the absence of significant or persistent hallucinations, organic mental disorders, schizophrenia and mood disorders. There individuals usually carry on a near normal social and occupational life without arousing suspicion regarding the delusional disorder. It is only when the area of delusion is probed or confronted that the personality disorganization is evident. It is a disorder with usually a relatively stable and chronic course.

NOTES

2.6.1.1 Epidemiology of delusional disorders

It is regarded as being an uncommon illness. Copeland et al. (1998) found a prevalence of 0.04 per cent for delusional disorder.

2.6.1.2 Etiology of delusional disorders

Paranoid personality disorder, delusional disorder and schizophrenia have been seen to be genetically related. Recent family studies have found that the incidence of paranoid personality disorder is increased in first degree relatives of patients with schizophrenia and delusional disorder. There does seem to be a familial association between alcoholism and delusional disorder, which could explain the association between delusional jealousy and alcohol misuse.

Structural MRI studies have revealed that patients with delusional disorder have changes in cerebral ventricles similar to those of patients with schizophrenia (Howard et al., 1995). Patients with delusional disorder and schizophrenia show similar abnormalities in tasks of eye tracking. Delusional disorder may also be associated with polymorphisms in the gene for the dopamine D4 receptor.

2.6.1.3 Management of delusional disorders

Antipsychotics are used to control agitation and psychotic features. Antidepressants and/or ECT are used. Supportive psychotherapy is often found to helpful.

2.6.2 Schizotypal Disorder

It is characterized by odd and eccentric behaviour and anomalies of thinking and affect that resemble those seen in schizophrenia, but definite and characteristic schizophrenic anomalies have never occurred at any stage. There is no dominant or typical disturbance but any of the following may be present:

- Inappropriate or constricted affect (the individual may appear cold and aloof)
- Odd, eccentric or peculiar behaviour or appearance
- Poor rapport with others and a tendency of social withdrawal
- Odd beliefs or magical thinking, influencing behaviour and inconsistent with sub-cultural norms
- Suspicious or paranoid ideas
- Obsessive ruminations without inner resistance, often with dysmorphophobic, sexual or aggressive content
- Unusual perceptual experiences, including somatosensory (bodily) or other illusions, depersonalization or derealization
- Vague, circumstantial, metaphorical, over-elaborate or stereotyped thinking, manifested by odd speech or in other ways without gross incoherence
- Occasional transient quasi-psychotic episodes with intense illusions, auditory hallucinations or other hallucinations and delusions like ideas, usually occurring without external provocation

NOTES

The disorder is more common in individuals related to schizophrenia and is believed to be a part of the genetic 'spectrum' of schizophrenia.

2.6.3 Acute and Transient Psychotic Disorder

In the acute and transient psychotic disorder, there is an acute onset (within two weeks) and the presence of typical schizophrenic symptoms that are rapidly changing and variable in nature. The psychotic symptoms usually occur about 2 weeks of one or more stressful events (such as loss of job, death of a loved one, break of marriage, etc.). The patient usually recovers completely within 2–3 months. Only a small fraction of those suffering from these disorders may develop persistent disabling states.

2.6.4 Schizoaffective Disorder

In case of schizoaffective disorder there is a presence of both definite affective and definite schizophrenic symptoms simultaneously or within a few days of each other, within the same episode of illness. The episode of illness does not fall under depressive or manic episode or either schizophrenia. The term should not be applied to patients who exhibit schizophrenic symptoms and affective symptoms only in different episodes of illness. Some patients have recurrent schizoaffective episodes, which may be of the manic or depressive type or a mixture of the two.

The recovery rate of schizoaffective disorder patients is generally better that for schizophrenia (Tsuang et al., 2000). People, who suffer from manic rather than the depressive type recurrent schizoaffective episodes, usually make a full recovery.

2.6.5 Schizoaffective Disorder of Manic Type

In case of this disorder, both schizophrenic and manic symptoms become prominent in the same episode of illness. There is considerable change of mood combined with increased excitement or irritability and there must be at least one or two typical schizophrenic symptoms present. This category should be used both for a single schizoaffective episodes of the manic type and for a recurrent disorder in which the majority of episodes are schizoaffective, manic type. Patients with schizoaffective disorders fully recover within a few weeks.

2.6.6 Schizoaffective Disorder of Depressive Type

In this disorder, there is the presence of prominent depression accompanied by at least two characteristic depressive symptoms or associated behavioural abnormalities as listed for the depressive episode within the same episode, and at least one or two schizophrenic symptoms are also present. This category should be used both for a single schizoaffective episode, depressive type, and then recurrent disorder in which the majority of episodes are schizoaffective, depressive type. Schizoaffective episodes of the depressive type are usually less florid and alarming than schizoaffective episodes of the manic type, but they tend to last longer and the prognosis is less favourable. Although majority of the patients recover completely, some eventually develop a schizophrenic defect.

NOTES

2.6.7 Schizoaffective Disorder of Mixed Type

In this disorder, symptoms of schizophrenia coexist with those of mixed bipolar affective disorder.

CHECK YOUR PROGRESS

16. What are delusional disorders?
17. When can you make a diagnosis of schizoaffective disorder?
18. What is acute and transient psychotic disorder?

2.7 MOOD OR DEPRESSIVE DISORDERS

Emotions are largely described by terms like affect and mood. Affect refers to short-lived emotional responses to an idea or an event. Mood refers to sustained and pervasive emotional response. In mood or depressive disorders, the fundamental disturbance is a change in mood, usually to depression (with or without associated anxiety) or to elation (mania or hypomania).

2.7.1 Classification of Depressive Disorders

Many approaches have been tried to classify depressive disorders, some based on etiology (reactive vs. endogenous depression), some based on symptomatic picture (melancholic vs. neurotic depression) and others on the course of the illness (unipolar vs bipolar depression).

'Reactive depression', is one in which, the symptoms are a response to some external stressor and 'endogenous depression' is one in which the symptoms are caused by factors within the individual and are independent of the outside factors. 'Melancholic depression' is characterized by the presence of biological symptoms like loss of appetite, weight loss, constipation, reduced libido, amenorrhoea and early morning awakening, whereas 'neurotic depression' is characterized by the presence of symptoms like anxiety, irritability and phobias. Unipolar depression is one in which the patient has had only depressive episodes and the bipolar depression is one in which the patient experiences both depressive and manic episodes.

2.7.1.1 Bipolar affective disorder

This disorder is characterized by repeated episodes (at least two) of mania or hypomania and depression with inter-episodic remissions and complete recovery between these episodes. Patients with only manic episodes are also classified as having bipolar affective disorder. Among men and women, the prevalence rates are similar.

The depressive episodes can last longer (up to 6 months) with a gradual onset, while the manic episodes occur abruptly and last from 2 weeks to 4–5 months. Mental trauma or other stressful life events often precede both the manic

and depressive episodes, however, for diagnosis, the presence of such a stressor is not essential. The episode frequency and the pattern of remissions and relapses are highly variable, though remissions tend to get shorter with the passage of time and depressive episodes become more frequent and last longer after reaching middle age. The first episode may occur at any age between childhood and old age.

2.7.1.2 Recurrent depressive disorder

It is characterized by the presence of repeated episodes of depression (mild, moderate or severe) without any history of independent episodes of mood elevation and over activity that fulfil the criteria of mania. However, brief episodes of hypomania may be there often after the depressive episode, which can sometimes get apparently precipitated by treatment of a depression. Recovery is usually complete between the episodes, but a minority of patients may develop a persistent depression, mainly in old age. Individual episodes of any severity are often precipitated by stressful life events.

It is twice as common in women as men. The age of onset and the severity, duration and frequency of the episodes of depression are all highly variable. In general, the first episode occurs later than in bipolar disorder, with a mean age of onset in the fifth decade. Individual episodes also last 3–12 twelve months (lasting an average of 6 months) but recur less frequently. The risk of having a manic episode is never eliminated completely.

2.7.1.3 Persistent mood disorders

They are persistent and usually fluctuating disorders of mood in which individual episodes are rarely if ever sufficiently severe to warrant being described as hypomanic or even mild depressive episodes. They usually last for several years and cause significant subjective distress and disability. In some cases, recurrent or single episodes of manic disorder, or mild or severe depressive episodes, may become superimposed on a persistent affective disorder. They are seen to be genetically related to mood disorders and are amenable to the same treatments as mood disorders. Two commonly seen persistent mood disorders are cyclothymia and dysthymia.

2.7.1.4 Cyclothymia

Cyclothymia refers to a persistent instability of mood, involving numerous periods of mild depression and mild elation. Between the episodes, the mood may be normal and stable for months at a time. The mood swings may be unrelated to life events. The onset of the illness is usually early in life (in late teenage or the early twenties) and it runs a chronic course.

2.7.1.5 Dysthymia

Dysthymia refers to a chronic depression of mood which does not currently fulfil the criteria for recurrent depressive disorder. These individuals usually have periods

of days or weeks when they describe themselves as well, but most of the time they feel tired and depressed; everything is an effort and nothing is enjoyed. It usually begins early in adult life and lasts for several years. These individuals are usually able to cope with the basic demands of everyday life.

2.7.2 Epidemiology of Depressive Disorders

In community surveys of industrialized countries, the risk of suffering from depressive disorder during one's life time lies between 0.3–1.5 per cent. The prevalence in men and women is the same. The mean age of onset is about 21 years of age. Bipolar disorder is highly co-morbid with anxiety disorders and substance misuse.

When it comes to unipolar depression, the community surveys in industrialized countries indicate that the risk of suffering from depressive disorder during one's life time lies between 10 and 20 per cent. The mean age of onset is about 27 years. Rates of major depression are about twice as great in women as men, across different cultures. Major depression is highly co-morbid with anxiety disorders and substance misuse.

2.7.3 Course and Prognosis of Depressive Disorders

The age of onset of bipolar disorder is typically in twenties. Late onset of bipolar disorder is rare. It can be precipitated by organic brain disease. The average length of a manic episode is about 6 months. At least 90 per cent of patients with mania experience further episodes of mood disturbance. The interval between episodes becomes progressively shorter with both age and the number of episodes. Nearly all bipolar patients recover from acute episodes but the long-term prognosis is rather poor.

The average length of a depressive episode is about six months but about 25 per cent of the patients have episodes of more than a year and about 10–20 per cent develop a chronic unremitting course. About 80 per cent of the patients with major depression will experience further episodes. The intervals between episodes become progressively shorter. A high proportion of depressed patients do not achieve complete symptom remission between episodes. The long-term prognosis of depression is little better than that of bipolar.

The various factors that increase the risk of reoccurrence of further disorders are previous episodes, early age of onset, incomplete symptomatic remission, bipolar disorder, poor social support, poor physical health, high trait neuroticism and co-morbid substance abuse and personality disorder.

2.7.4 Etiology of Depressive Disorders

Genetic factors and childhood experiences may play a role in laying down a predisposition to mood disorders in adult life whereas stressors may precipitate mood disorder.

Genetic factors: Studies on twins and families suggest that the risk of mood disorders is increased in first-degree relatives of both bipolar and unipolar probands with the risk being about twice as great in relatives of bipolar patients. Relatives of bipolar probands have increased risks of unipolar depression and schizoaffective disorder as well as bipolar disorder. However, relatives of patients with unipolar depression do not have increased rates of bipolar disorder or schizoaffective disorder.

For bipolar disorder, the concordance rate in monozygotic twins is 60–70 per cent but for dizygotic twins the rate is only about 20 per cent (Sanders et al., 1999). For unipolar depression, the concordance rate is also greater in monozygotic twins (46 per cent) than dizygotic twins (20 per cent) (McGuffin et al., 1996). Overall, the genetic influence seems greater in bipolar disorder than in unipolar disorder.

Polygenic inheritance seems to play a role in mood disorder, suggesting that mood disorders result from the combined action of several genes of modest or small effect. Investigation of bipolar disorders has revealed many significant linkages involving chromosomes 4, 12 and 18 (Owen et al., 2000).

The psychological factors: Psychoanalysts have suggested that childhood deprivation of maternal affection through separation or loss predisposes an individual to depressive disorders in adult life. In depression, loss of a libidinal object, introjections of the lost object, fixation in the oral sadistic phase of development, and intense craving for narcissism or self-love have been postulated. It sees mania as a reaction formation to depression. Cognitive behaviour therapies propose that depressive negative cognition, learned helplessness and anger directed inwards is likely to play a significant role in the etiology of mood disorders. Personality factor like neuroticism has been seen as a predisposing factor for major depression. Increased stressful life events before the onset or relapse probably have a formative rather than a precipitating effect. Increased stressors in the early development are probably more important in depression.

2.7.5 Management of Depressive Disorders

Different management techniques that have been used in the treatment of mood disorders are as follows:

Pharmacotherapy: Antidepressant drugs like tricyclics (TCA), selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs) have been found to be effective in the acute treatment of depression. Mood stabilizers like lithium and anticonvulsants like valporate, carbamazepine, etc are seen to be useful in the management of bipolar disorder.

Electroconvulsive therapy (ECT): It is used as a therapeutic technique in case of stupor, severe depression, high suicidal risk, retardation, depressive psychosis and when the patient stops taking food and fluids.

Psychotherapy: It is used as an adjunct to pharmacotherapy and by itself in case of mild depression.

Cognitive behaviour therapy: It aims at helping patients to modify the cognitive distortions and disputing irrational beliefs. It makes use of various techniques such as social skills training, problem-solving techniques, assertiveness training, activity scheduling, stress management skills and decision making skills.

Interpersonal therapy: It attempts to recognize and explore interpersonal stressors, role disputes and transitions, social isolation, or social skills deficits, which act as precipitants for depression.

The short-term psychoanalytical psychotherapies: They aim at resolving underlying conflicts and changing the personality itself rather than just ameliorating the symptoms.

Marital therapy: It can be given to depressed patients for whom marital discord appears to have contributed to causing or maintaining the depressive disorder as an adjunct to drug treatment.

Supportive psychotherapy: It focuses on the identification and resolution of current life difficulties, and in using the patient's strengths and available coping resources.

CHECK YOUR PROGRESS

19. What are mood or depressive disorders?
20. What is cyclothymia?

2.8 PSYCHOLOGICAL ASPECTS OF MEDICAL ILLNESS

2.8.1 Theories of Personality Disposition

The term personality was defined by Gordon Allport as the 'dynamic organization within the individual of those psychophysical systems that determine his/her unique adjustment to his/her environment.' Human personality keeps continuously evolving, developing and changing. Hereditary dispositions and environmental influences both play important roles in the development of personality.

An individual's disposition, character, psyche, temperament, physique, etc. all contribute to shaping his personality. The term character refers to rational concepts about self and interpersonal relations; temperament generally refers to basic emotions; and the psyche refers to intelligence and intuitive self-awareness.

There are four 'temperamental traits' namely harm avoidance, novelty seeking, reward dependence, and persistence defined as heritable differences

NOTES

underlying one's automatic response to danger, novelty, and various types of reward, respectively. These four temperamental traits are closely associated with the four basic emotions of fear (harm avoidance), anger (novelty seeking), attachment (reward dependence), and ambition (persistence).

Individuals high on harm avoidance tend to fear uncertainty and are inclined to be socially inhibited, shy, have rapid fatigability, show passive avoidance of problems or danger and have pessimistic worry in anticipation of problems, where the same events do not worry people in general. People who are low in harm avoidance tend to be courageous, outgoing, carefree, energetic and optimistic even in situations that worry most people.

Novelty seeking is characterized by active approach to signals of reward, active avoidance of conditioned signals of punishment and escape from unconditioned punishment. Individuals high in novelty seeking are curious, impulsive, quick tempered, and extravagant, but they are easily bored, and get disorderly. On the contrary, persons low in novelty seeking are un-inquiring, stoical, slow tempered, reflective, reserved, tolerant of monotony, frugal and orderly.

Reward dependence reflects an inherent bias towards maintaining one's behaviour in response to cues of social reward. Reward dependence is characterized by social sensitivity, sentimentality, attachment and dependence on approval by others. Individuals high in reward dependence are sensitive, dedicated, tender-hearted, dependent and sociable. Individuals who are low in reward dependence are tough-minded, practical, cold, socially insensitive and indifferent if alone.

Persistence reflects a heritable bias in maintaining behaviour despite failures, frustration, fatigue and intermittent reinforcement. Persistence is observed as determination, industriousness, ambitiousness and perfectionism. People who are highly persistent are persevering, hard working and ambitious overachievers. They tend to intensify their efforts in response to anticipated rewards and perceive frustration and fatigue as personal challenges. On the other hand, individuals low in persistence are inactive, indolent, erratic and unstable; they tend to give up easily when faced with setbacks and frustration, rarely strive for higher accomplishments and manifest a low level of perseverance even in response to intermittent reward.

Temperament traits of harm avoidance, novelty seeking, reward dependence, and persistence, with their respective primary emotions of fear, anger, attachment, and ambition are observable early in development. Depending on whether a particular temperament trait is high or low, certain emotions tend to dominate one's motivation, perception, and behaviour. Individual differences in temperament and basic emotions modify the processing of sensory information and shape early learning characteristics and are moderately predictive of adolescent and adult behaviour.

'Character' (or the conceptual core of personality) involves higher cognitive functions, which include abstraction, symbolic interpretation and reasoning. These

NOTES

higher cognitive functions interact with temperament through cognitive processing of emotionally ridden sensory percepts regulated by temperament. This temperament–character interaction leads to the development of mature, realistic internalized concepts about the self and the external world.

Character matures in incremental shifts or steps from infancy through late adulthood. The timing and rate of transitions depend on antecedent temperament configurations, systematic cultural biases, and experiences unique to each individual. The developing character traits (i.e. newly internalized concepts about one's self and the external world) optimize adaptation of temperament (i.e. early emotionality) to the environment by reducing discrepancies between one's emotional needs and norm-favouring social pressures.

However, psychodynamic theories describe two forms of character disorders: neurotic character and character neurosis. 'Neurotic character' traits are postulated to derive from neurotic defences (e.g. suppression, reaction formation, projection, repression and undoing), which have dissociated from their original conflict and have become inflexible, pervasive, and ego-syntonic traits of everyday behaviour.

'Character neurosis' is observed when an inflexible neurotic character trait interferes with the healthy parts of personality. For example, character neurosis is present when excessive cleanliness (an ego-syntonic character trait observed with obsessive individuals) frequently interferes with the need to interact freely with others (generated by healthy parts of obsessive personality) and, instead of being perceived as natural, is perceived as frustrating.

'Psyche' refers to a person's consciousness, self-awareness or spirit. Levels of self-awareness vary from person to person and often the self-awareness has a strong influence on susceptibility to personality disorders. The development of self-awareness plays a crucial role in the growth of full, coherent personality, which manifests as well-being, wisdom and creativity. For instance, some patients with severe personality disorders complain of emptiness, which is a fearful feeling of separateness, isolation, annihilation or lack of being. Such patients lack a stable awareness of their being.

To sum up, personality is defined as a complex adaptive system that involves multidimensional interactions among character, temperament and psyche. Temperament regulates what a person notices, and, in turn, character modifies its meaning, so that the salience and significance of all the experience depend on a person's temperament and character. In turn, the development of character is derivative of individual differences in intuitive self-awareness.

2.8.2 Coronary Heart Disease

Mental stress is one of the major causes of cardiovascular diseases, which involve the heart and blood circulatory system. Scientists believe that many deaths caused by coronary heart disease could be prevented by dealing effectively with the psychological disorders and stress.

NOTES

Coronary heart disease is a potentially lethal blockage of the arteries supplying blood to the heart muscles or the myocardium. Its chief clinical manifestations are:

- Severe chest pain, a signal that the delivery of oxygenated blood to the affected area of the heart is insufficient for its current workload (known as 'angina pectoris'). Angina pectoris is characterized by the presence of severe chest pain, usually located behind the sternum, and frequently radiating into the back and left shoulder and arm. It is caused by insufficient supply of oxygenated blood to the heart (ischema) which in turn is due to coronary atherosclerosis (narrowing of coronary arteries by deposition of cholestrol) or constriction of blood vessel. Sometimes the episode of ischema is without pain termed as silent ischema. The angina and episode of silent ischema are precipitated by physical or emotional exertion and commonly relieved by rest or medication.
- Functionally complete blockage of a section of the coronary arterial system, resulting in death of the myocardial tissue supplied by that arterial branch (known as 'myocardinal infraction'). Myocardinal infraction usually results in permanent damage to the heart.
- Disturbance of the heart's electrical conduction consequent to arterial blockage, resulting in disruption or interruption of the heart's pumping action, often leading to death.

Many instances of sudden cardiac death, in which victims have no prior history of CHD symptoms, are attributed to silent CHD. This often occurs when a piece of the atherosclerotic material adhering to the arterial walls (plaque) breaks loose and lodges in a smaller vessel, blocking it.

Cardiovascular disease is the leading cause of death in the United States and most of the industrialized world. Approximately one-third of all the adults older than 35 years of age ultimately die of cardiovascular disease, most often of complications of CAD.

Established risk factors for coronary disease include family history, male sex, hypertension, hyperlipidemia, diabetes, sedentary life-style, stress and smoking.

Both biological and psychological factors are known to play a significant role in the etiology of CHD. For instance, excessive changes in heart rate and the force with which the blood is pumped can injure the arteries increasing the risk for myocardial infarction. In a study conducted by Kaplan, Manuck et al. (1993), it was found that monkeys with a high heart rate developed twice as much atherosclerosis as did monkeys with low heart rate. Changing living groups also increases the chances of myocardial infarction in dominant monkeys as they are continuously forced to re-establish a dominance hierarchy.

In humans, heart rate reactivity and ischemia elicited by laboratory stressors increase the risk for CHD. Heart rate variability which is an index of parasympathetic nervous system activity which reduces sympathetic nervous system activity (responsible for high BP and CHD) is seen to be predictive of lower death rate.

According to Friedman (1969) and Rosenman et al. (1975), Type A behaviour pattern (characterized as the presence of excessive competitive drive even when it is unnecessary; impatience or time urgency and hostility) is associated with CHD. It was supported by classic Western Collaborative Group Study (WCGS). They studied 3154 men aged 39 to 59 years for 8.5 years and found that individuals who were identified as Type A by interview by twice more likely to develop CHD. However, recent research has found no relationship between CHD and Type A (Williams, 1987). It is quite possible that all the aspects of Type A are not truly related to CHD

Further analyses of WCGS study found that anger and hostility are major predictors of CHD (Hecker et al., 1988). Studies conducted by Markowitz et al. (1996) and Weidner et al. (1987) found that high level of anger is associated with increased BP, increased cholesterol, increased smoking and drinking and increased activation of platelets which is known to play a role in formation of blockages in arteries.

Cynicism refers to an approach towards life that involves hostility. It has also been found to be related to CHD. In a study using MMPI, it was found that healthy individuals who indicated cynicism were more likely to die from CHD (Barefoot, Dahlstroon and Williams, 1983). Cynicism was also found to be higher among men and was associated with increased alcohol, obesity, marital conflict, and suppression of anger and avoidance of seeking social support. Julkumen et al. (1994) found that negative beliefs about others and inability to express anger were better predictors of CHD than impatience and irritability.

Anxiety has also been found to be related to increased risk for CHD. Anxiety is known to increase sympathetic nervous system activity, which is associated with increased B.P. and atherosclerosis.

Depression has also been seen to play a role in CHD. Studies by Musselman, Evans and Nemeroff (1998) have found that depression is related to greater tendency of platelets to aggravate, obesity, atherosclerosis, increase in steroidal hormone which is known to increase BP and damage cells of the arteries.

Denollet and Brutsaert (1997) have proposed that Type D people (who score high on anger, anxiety and depression) and people who tend to inhibit the expression of these emotions are likely to suffer from CHD.

2.8.3 Asthma

It is a disease of the respiratory system. The air passages of the lungs which are hypersensitive become narrowed and make breathing difficult. This narrowing may be triggered by viral infection, allergens, pollutants, smoke, cold and emotional states. In addition, an inflammation of lung tissue is mediated by the immune system, resulting in increase in mucus secretion and odema (accumulation of fluid in the tissues).

An asthmatic attack usually occurs intermittently, sometimes almost daily, sometimes with weekly or monthly periods between them and they vary in severity. For unknown reasons, attacks are more frequent in the early morning hours. The respiratory system may return to normal either spontaneously or after treatment. Most often, asthma attacks begin suddenly. Individual's experience a sense of tightness in the chest, wheezes, coughs and expectorates sputum. A severe attack is a frightening experience and may cause a panic attack which exacerbates the asthma. Since breathing becomes very difficult, the person may become exhausted by exertion and fall asleep as soon as breathing is more normal.

It is very common in young children. About 8 per cent of the children between the ages 6–11 years suffer from asthma (Sears, 1991). Asthma can be divided into the following classes:

- **Allergic asthma:** Caused by reaction to specific irritants such as pollens, molds, animal dander, etc.
- **Infective or non-allergic asthma:** It stems from a variety of organic disorders, for example, respiratory infections such as pneumonia, whooping cough.
- **Psychogenic asthma:** It includes asthmas for which there is no organic, allergic or otherwise cause that can be found and for which no medical therapy proves truly effective.

A diathesis-stress model explains the etiology of asthma. It proposes that a complex interaction between biological and psychological stressors is known to play a significant role in asthma. Individuals, whose asthma is primarily allergic, may have an inherited hypersensitivity of the respiratory mucosa. Several genetic studies have shown that asthma tends to run in families. There is also some indication that people with asthma have a less than normal responsive sympathetic nervous system. Activation of sympathetic nervous system is known to reduce the intensity of asthma attack.

Researchers like Rumbak et al. (1993) believe that tension produced by frustration, anger, depression and anticipated pleasure or excitement may, through induced emotionality, disturb the functioning of the respiratory system and thus bring on an asthma attack. Because of a link between autonomic nervous system and the constriction and dilation of airways and a connection between autonomic nervous system and emotions, most research has focused on emotionality. Several researches have also found higher levels of emotionality in people with asthma. For instance, in a study Lehrer et al. (1993) found that the facial expressions of the asthmatic patients were more intense and were rated as more hostile, mal-adjusted and helpless during the interviews. Their self reports on personality tests also reveal high levels of emotionality.

Whether heightened emotionality is a reaction to or a cause of asthma is still not clearly known (Hyland, 1990). Attempts to induce attacks in asthma sufferers by exposing them to emotion and stress inducing stimuli have resulted in slightly decreased airflow but no actual attack (Weiss et al., 1976).

In another study, high levels of stress and a negative mood were related to lower peak flow and more reports of asthma symptoms (Smyth et al., 1999). Fear of separation from the mother is also known to precipitate an asthmatic attack.

Even when asthma is induced by infection or allergy, psychological stress can precipitate attacks as infection weakens the lungs making it more vulnerable to stress. In a classic study of 388 asthmatic children, Rees (1964) found that various causes of asthma varied in importance depending on the age of the individual. It was seen that for children below 5 years of age infective symptoms tend to predominate; for the children of 6–16 years age psychological factors increase in importance and for them of 16–65 years age psychological factors decrease in importance.

A study done by Luparello et al. (1971) clearly showed the important role played by the psychological factors in asthma. They gave five substances to inhale (in reality they were non-allergic saline vapours) to forty asthmatic subjects and forty normal subjects. Asthmatics were told that they were inhaling irritants related to previous attacks. Normals were told that they were inhaling strong concentration of pollutants and might respond with breathing problems. Normals showed no pathological reactions whereas one-third asthmatic showed constriction of airways and twelve out of forty suffered full-scale attack. It could be that the asthmatics were showing a short-term conditioning effect on the basis of their previous attack.

High level of stress undergone by the mother during her pregnancy and presence of significant discord in the family is also associated with the increased risk of asthma in the offspring. It is yet not clear, whether familial variables are causal or maintaining factors in asthma.

2.8.4 Peptic Ulcer

Ulcer is an open sore varying in size from the pinhead to a quarter present in the wall of any part of the digestive system. Peptic ulcer encompasses both gastric and duodenal ulcers. Gastric ulcers develop in the stomach. They occur with equal frequency in both sexes. They are more likely to develop gastric carcinoma and are associated with normal or subnormal gastric secretion and weakness with mucosal lining. Emotional factors seem to play a less important role in gastric ulcers.

Duodenal ulcers develop in the duodenum and are more prevalent in men and in younger age groups. They are less likely to develop gastric carcinoma and are associated with increased gastric secretions. Emotional factors are likely to play an important role in duodenal ulcers.

Peptic ulcers are usually characterized by the presence of burning sensation in stomach. Once a lesion or actual tissue damage appears, then an individual experiences epigastric pain. Epigastric pain occurs between one and four hours after a meal, and lasts for 30–60 minutes and is relieved by food intake or alkalies. The pain is sharply localized in epigastrium and is more intense in afternoon and in

noon. If the lesion gets larger, there may be vomiting. If the blood vessels have broken, then blood in vomiting may occur.

The biologists believe that the increased level of pepsinogen in blood and urine may lead to peptic ulcers. Also studies of identical twins support the possibility that the concentration of pepsinogen in the serum may be genetically determined. But, psychologists believe that parental rejection, over permissive attitudes in early childhood, stress, social and economic pressures and increase an individual's vulnerability to develop peptic ulcer.

2.8.5 Eczema and Itching

Eczema is a chronic skin disorder characterized by pruritus and inflammation (eczema), which often begins as an erythematous, pruritic and maculopapular eruption. Scratching in response to the pruritus can lead to lichenification, excoriations and infections. Eczema usually arises during early infancy, childhood or adolescence and is frequently associated with a personal or family history of atopic dermatitis, allergic rhinitis or asthma.

A national census of dermatologic disease in the United States in 1977 found eczema to be a common disorder, affecting seven per 1,000 individuals and twentyfour per 1,000 children, with a female to male ratio of 1.2–1.0. Because of greater exposure to provocative factors, such as outdoor pollution, reagents in highly insulated buildings, house mites, food additives and increased parental and physician awareness of the disorder, the prevalence of eczema has increased to more than 10 per cent in the past few decades.

In mild cases, eczema can spontaneously resolve. But most patients experience persistent or relapsing symptoms. In general, presence of comorbid asthma or allergic rhinitis, early age of onset, severe dermatitis, female sex, and a family history of eczema are likely to make the illness chronic in an individual.

The cause of eczema is unknown, although recent studies suggest a genetic influence. Concordance rates were higher in monozygotic (0.75) twins than in dizygotic (0.25) twins, and the prevalence of eczema in children with two affected parents was 81 per cent versus 56 percent for those with a single affected parent. Heritable traits have been seem to affect the immune system, which exhibits an imbalance of immunoregulatory T cells that may explain the defective cell-mediated immunity and increased immunoglobulin E (IgE) production seen in eczema. Growing evidence on the role of neuropeptides such as substance P, a neuropeptide released by cutaneous nerves that can cause histamine secretion from mast cells, suggests a possible link between the central nervous system (CNS) and eczema.

In addition to genetic factors, psychological factors (such as food allergy or intolerance, contact irritants and allergens, aeroallergens like house dust mites, pollen, molds, human and animal dander, microbes, hormones, climate, sweating, and stress) are largely seen to frequently trigger or exacerbate the disease. Affected patients seem to have a lower response threshold and more prolonged reaction to pruritic stimuli than do controls. How stress affects this disorder is unclear, but it may involve interactions between the CNS and the immune system.

A vicious circle of itching, scratching, and lesion aggravation frequently develops and contributes to symptom chronicity.

2.8.6 Rheumatoid Arthritis

NOTES

Rheumatoid arthritis refers to a systemic, chronic, inflammatory and progressive disease. The illness begins with vague constitutional symptoms, fleeting musculoskeletal pain and variable morning stiffness that may last for weeks or months without yielding to diagnosis. Over time, these joints experience articular destruction, consequent instability, and subsequent deformity with collateral pain and functional impairment.

According to the American College of Rheumatology (ACR) a diagnosis of rheumatoid arthritis can be made when four of the following seven clinical features are present: morning stiffness, arthritis of three or more joint areas, arthritis of the hand joints, symmetric arthritis, rheumatoid nodules, serum rheumatoid factor and typical radiographic changes. The first four of these must be present for at least 6 weeks.

It is likely to afflict women two to three times more often than men, and usually begins by mid-forties. It usually has a gradual onset but a few patients may experience an abrupt onset.

A complex interaction between genetic, environmental, infectious and hormonal factors seems to play a role in the maintenance and progression of this disease. Stress and depression have been found to be significantly correlated with rheumatoid arthritis as both these factors are associated with the suppression of the immune system which may be associated with increased secretion of proinflammatory cytokines and may form the foundation for rheumatoid arthritis or aggravating preexistent disease.

2.8.7 Diabetes

Diabetes mellitus is a syndrome that includes a heterogeneous group of disorders, all of which are characterized by hyperglycemia and absolute or relative insulin deficiency. The two most common forms are Type I and Type II diabetes. Type I diabetes accounts for approximately 10 per cent of the cases, whereas type II diabetes accounts for more than 85 per cent. All other types of diabetes account for less than 5 per cent of the cases.

Type I (insulin-dependent) diabetes results from an autoimmune attack which damages the pancreatic beta cells leading to an absolute insulin deficiency. Subsequently, they cannot get glucose into the body's cells for use as energy, which causes blood glucose to rise.

Type II diabetes results from either insufficient amount of insulin or from a defect in the ability to drive glucose to its main target tissues. A variety of cellular and molecular defects like dysfunctional insulin receptors, aberrant receptor signaling pathways and abnormalities in glucose transport or glucose metabolism are believed

to be involved in Type II diabetes. However, the pathological mechanisms behind insulin resistance are still not fully understood.

Classic symptoms of Type I and Type II diabetes include polyphagia, polyuria, and polydipsia. Other symptoms might include blurred vision, fatigue, weight loss, poor wound healing, dry mouth, dry or itchy skin or recurrent infections (e.g., vaginal yeast infections, groin rash and external ear infections). Patients with Type I or Type II diabetes may also be present with acute metabolic compensation and dehydration, nausea, vomiting, abdominal pain, confusion or coma.

Individuals with Type I diabetes usually seeks medical help when the symptoms arise. They often experience weight loss associated with the onset of their diabetes. The onset of the first symptoms may be fairly abrupt or more gradual. Many patients with Type II diabetes remain asymptomatic for years with subtle signs and symptoms, such as neuropathy.

There is considerable evidence that genetic and environmental factors are major determinants of Type I diabetes. Presence of diabetes in parents increases the chances of developing diabetes in the child. Genes in the HLA region of chromosome 6 are known to be a causative role in Type I. Type I diabetes is likely to be affected by biological factors more than psychological factor like infant nutrition and the role of some viruses.

Unlike Type I, Type II diabetes is strongly affected by various psychological factors. For instance, factors like more than 40 years of age, overweight, old age, obesity, lack of exercise, smoking and a poor diet are known to increase the risk of developing Type II diabetes.

2.8.8 Menstrual Disorders

Menstrual disorders refer to a constellation of affective, cognitive, and behavioural symptoms, which may occur during the premenstrual phase of the menstrual cycle. Its diagnosis requires daily mood ratings over a two-month period to document the characteristic pattern of symptom exacerbation in the week before menses begins and remission shortly after the onset of menses.

A week before menses an exacerbation of symptoms like marked depression, feelings of hopeless, self-deprecating thoughts, anxiety, irritability, interpersonal conflict, affective lability, decreased interest in everyday activities, difficulty in concentration, lethargy, fatigability, decreased energy levels, decrease or increase in sleep and appetite and a subjective sense of being overwhelmed or out of control are present. Physical symptoms like breast tenderness or swelling, headaches, joint or muscle pain and a sensation of bloating may also be present. These symptoms are often associated with significant impairment in one's socio-occupational functioning.

Specific causes underlying menstrual disorders are still not fully known. But it is believed that changes in gonadal steroids and gonadotropins, decrease in beta-endorphin, deficiency in the serotonin neurotransmitter, changes in the timing

or the regulation of biological rhythm and genetic factors play a role in the etiology of menstrual disorders.

When it comes to the role of psychological factors in menstrual disorders, it is believed that conflicts over the feminine role, neurotic traits, stress, anger and negative mood underlie its etiology.

2.8.9 Psychological Management of Medical Illness

Management focuses on helping these individuals to develop better coping mechanisms, emotion regulation skills, stress management skills and pain management skills. It aims at encouraging these patients to actively engage in relaxation exercises and to adopt a healthy life style free from alcohol, smoking, obesity and unhealthy eating habits. Interventions also focus on reducing weight, engaging physical exercise and maintaining a healthy diet. Since most of the mentioned disorders run a chronic course, the medical compliance of these patients has found to be very poor. Thus, the management plan must always include psychoeducation of the patient and his or her family member about the illness and should lay emphasis on adhering to the medical compliance. To achieve these goals, several cognitive behavioural strategies are used by the therapist.

CHECK YOUR PROGRESS

21. Define persistence.
22. Define psyche.
23. What is coronary heart disease?
24. What are Type I and Type II diabetes?

2.9 SUMMARY

- The demands placed by various conditions today on our lives have increased anxiety by several-fold. Anxiety disorders are described as abnormal states in which the most striking features are mental and physical symptoms of anxiety, occurring in the absence of organic brain disease or other psychiatric disorders.
- The subtypes of anxiety disorders include disorders of panic, phobic anxiety, obsessive compulsive (OCD), post-traumatic stress (PTSD) and generalized anxiety (GAD).
- Somatoform disorders are characterized by the presence of physical symptoms suggesting a physical disorder without any organic basis and the symptoms are linked to psychological factors or conflicts.

- Dissociative disorder experiences are a part of normal experiences, both in relation to highly stressful or traumatic experience, and in a variety of trance, possession or other states which may be considered as normal, even admired, in many parts of the world. The essential feature of dissociative disorder is a disruption of the usually integrated functions of unconsciousness, memory, identity or perception of the environment.
- Schizophrenia is a mental disorder characterized by a disintegration of the process of thinking and of emotional responsiveness. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganized speech and thinking, and is accompanied by significant social or occupational dysfunction. The symptoms of schizophrenics include disturbances in several major areas like thought, perception, and attention; motor behaviour, affect or emotion and life functioning. The symptoms are broadly classified into two categories: positive symptoms and negative symptoms.
- Other psychotic disorders include delusional, schizotypal, acute and transient psychotic, schizoaffective (manic, depressive and mixed type) disorders.
- Mood or depressive disorders are the fundamental disturbance is a change in mood, usually to depression (with or without associated anxiety) or to elation (mania or hypomania).
- There is often strong relationship between psychotic disorders and the medical illnesses likes heart disease, hypertension, asthma, peptic ulcers, arthritis, etc. For the best results such ailments should be given both psychotic and medical treatments.
- Epidemiology is the study of patterns of health and illness and associated factors at the population level. It is the cornerstone method of public health research, and helps inform evidence-based medicine for identifying risk factors for disease and determining optimal treatment approaches to clinical practice and for preventative medicine.
- The term etiology deals with the causes the origin of disease, and the factors which produce or predispose toward a certain disease or disorder.
- Management of the disorder includes the suggesting the right therapy after evaluating the causes and the origin.

2.10 KEY TERMS

- **Acrophobia:** Fear of height
- **Algophobia:** Fear of pain
- **Astraphobia:** Fear of thunderstone or lightening
- **Claustrophobia:** Fear of enclosed spaces

- **Hydrophobia:** Fear of water
- **Monophobia:** Fear of being alone
- **Mysophobia:** Fear of contamination or germs
- **Nyctophobia:** Fear of darkness
- **Ochlophobia:** Fear of crowds
- **Pathophobia:** Fear of disease
- **Pyrophobia:** Fear of fire
- **Zoophobia:** Fear of animals or some particular animal
- **Schizophrenia:** It is a mental disorder characterized by a disintegration of the process of thinking and of emotional responsiveness
- **Psychotherapy:** The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relieving symptoms and changing behaviour
- **Marital therapy:** It can be given to depressed patients for whom marital discord appears to have contributed to causing or maintaining the depressive disorder as an adjunct to drug treatment
- **Epidemiology:** Tthe study of patterns of health and illness and associated factors at the population level
- **Etiology:** The study of the causes, the origin and the factors that produce the disorder

2.11 ANSWERS TO 'CHECK YOUR PROGRESS'

1. Anxiety disorders are described as abnormal states in which the most striking features are mental and physical symptoms of anxiety, occurring in the absence of organic brain disease or other psychiatric disorders.
2. Anxiety disorders can be broadly categorized into: (a) Panic anxiety disorder, (b) Phobic anxiety disorder, (c) Obsessive compulsive disorder (OCD), (d) Post traumatic stress disorder (PTSD), and (e) Generalized anxiety disorder.
3. Panic disorder is characterized as recurrent sudden intense attacks of anxiety in which physical symptoms predominate and usually reach their peak in less than a minute and are accompanied by fear of serious consequences such as heart attack, losing control or death, etc.
4. A phobia is a persistent and a disproportionate fear of a specific event or situation which otherwise poses little or no danger to the individual.
5. Phobic anxiety disorder has the following characteristic features: (i) Presence of fear of an object, situation or activity; (ii) The fear is out of proportion to

the dangerousness perceived; (iii) Patient recognizes the fear as irrational and unjustified; (iv) Patient is unable to control the fear and is very distressed at it; and (v) This leads to persistent avoidance of the particular object, situation or activity.

Gradually, the phobia and the phobic object becomes a preoccupation with the patient, resulting in marked distress and restriction of the freedom of mobility

6. Diagnostically Obsessive Compulsive Disorder (OCD) is defined by the occurrence of unwanted and intrusive obsessive thoughts or distressing images, usually followed by compulsive behaviour designed to neutralize these obsessive thoughts and images or to prevent some dreaded event or situation.
7. The post-traumatic stress disorder (PTSD) refers to an intense, prolonged and sometimes delayed reaction to an intensely stressful event like natural disaster, war, rape and/or serious assaults.
8. Somatoform disorders are characterized by the presence of physical symptoms suggesting a physical disorder without any organic basis and the symptoms are linked to psychological factors or conflicts.
9. Hypochondriacal disorder is characterized by preoccupation with a fear or belief of having a serious and progressive illness or disease based on the individual's interpretation of physical signs of sensations as evidence of physical illness.
10. Somatization is where mental factors such as stress cause physical symptoms. Somatoform disorders are a severe form of somatization where physical symptoms can cause great distress, often long-term.
11. The essential feature of dissociative disorder is a disruption of the usually integrated functions of unconsciousness, memory, identity or perception of the environment.
12. Trance and possession disorder is characterized by a temporary loss of the sense of personal identity and a full awareness of the person's surroundings. It is an involuntary state of trance not accepted by the person's culture as a normal part of a collective cultural or religious practice and that causes clinically significant distress of functional impairment.
13. Dissociative disorders tend to be associated closely in time with traumatic events, intolerable problems or disturbed relationships. It is the unpleasant affect, where distress and conflicts that get transformed into the symptoms. The onset and termination of dissociative states is usually sudden and they tend to remit after a few weeks or months, particularly if their onset was associated with a traumatic life event. It is usually seen that the dissociative states that have endured for more than one or two years before coming to psychiatric attention are often resistant to therapy.

14. Fugue is a state where amnesia is extensive. The individual often leaves home and settles in a new city with a new name, job, even personality characteristics following a traumatic event. The dissociative disorders can be broadly categorized into: dissociative amnesia, fugue, trance and possession disorders, and dissociative identity disorder.
15. The symptoms of schizophrenic patients involve disturbances in several major areas—thought, perception, and attention; motor behaviour, affect or emotion and life functioning. The symptoms are broadly classified into two categories: positive symptoms and negative symptoms.
16. Delusional disorders refer to disorders with persistent, well-systematized, non-bizarre delusion that is not due to any other mental disorder. It is characterized by the presence of persistent delusions of persecution, grandeur, jealousy, somatic delusions and erotomanic delusions in the absence of significant or persistent hallucinations, organic mental disorders, schizophrenia and mood disorders.
17. Schizoaffective disorder is characterized by the presence of both definite schizophrenic and definite affective symptoms which are prominent simultaneously or within a few days of each other, within the same episode of illness. This diagnosis is made only when the above episode of illness does not meet the criteria for either schizophrenia or a depressive or manic episode. The term should not be applied to patients who exhibit schizophrenic symptoms and affective symptoms only in different episodes of illness.
18. Acute and transient psychotic disorder is characterized by an acute onset (within two weeks) and the presence of typical schizophrenic symptoms that are rapidly changing and variable in nature and by the presence of the associated acute stress.
19. In mood or depressive disorders, the fundamental disturbance is a change in mood, usually to depression (with or without associated anxiety) or to elation (mania or hypomania).
20. Cyclothymia refers to a persistent instability of mood, involving numerous periods of mild depression and mild elation. Between the episodes, the mood may be normal and stable for months at a time.
21. Persistence reflects a heritable bias in the maintenance of behaviour despite frustration, fatigue, and intermittent reinforcement. It is observed as industriousness, determination, ambitiousness and perfectionism.
22. 'Psyche' refers to a person's consciousness, self-awareness or spirit. Human beings show variation in their levels of self-awareness in ways that have a strong influence on susceptibility to personality disorders.
23. Coronary heart disease (CHD) is a potentially lethal blockage of the arteries supplying blood to the heart muscles or the myocardium.

24. Type I (insulin-dependent) diabetes results from an autoimmune attack which damages the pancreatic beta cells leading to an absolute insulin deficiency. Type II diabetes results from either insufficient amount of insulin or from a defect in the ability to drive glucose to its main target tissues.

2.12 QUESTIONS AND EXERCISES

Short-Answer Questions

1. Define panic anxiety disorder.
2. Write a short note on phobic anxiety disorder.
3. What is Obsessive Compulsive Disorder?
4. What causes Post Traumatic Stress Disorder?
5. List the classification of depressive disorders.
6. Write a short note on delusional disorders.

Long-Answer Questions

1. Name the different types of anxiety disorders and explain each of them in detail.
2. Explain somatoform disorder, its epidemiology, etiology and management.
3. Explain dissociative disorder and its subtypes.
4. Classify and explain different types of mood or depressive disorders.
5. Explain the psychological aspects of medical illness in detail.

2.13 FURTHER READING

Carson, R.C., J.N. Butcher and J.C. Coleman. 1988. *Abnormal Psychology and Modern Life*, Eighth edition. Glenview, IL: Scott Foresman.

Davison, G.C., J.M. Neale and A.M. Kring. 2004. *Abnormal Psychology*, Ninth edition. MA, USA: John Wiley & Sons Inc.

Sadock, B.J., and V.A. Sadock. 2004. *Concise Textbook of Clinical Psychiatry*, Second edition. Philadelphia, USA: Lippincot Williams Wilkins.

World Health Organization. 2002. *International Classification of Diseases-10 Classification of Mental and Behavioural Disorders*. Geneva: WHO.

UNIT 3 PERSONALITY AND ORGANIC MENTAL DISORDERS

NOTES

Structure

NOTES

3.0 INTRODUCTION

This unit educates the students about adjustment and impulse control; substance, eating and sleep related; sexual and gender identity; and personality disorders.

You will learn the causes and effects of these disorders. Epidemiology focuses on the prevalence of the disorders. In etiology you will learn how to evaluate the disorder from different perspectives like psychoanalytic, cognitive, biological and humanistic, etc. Management of the disorders explains how to choose and apply the right therapy.

3.1 UNIT OBJECTIVES

After going through this unit, you will be able to:

- Learn adjustment disorders
- Describe impulse control disorders
- Understand substance, eating and sleep related disorders
- Explain sexual and gender identity disorders
- Understand organic mental disorders
- Learn personality disorders

3.2 CHANGING VIEWS ON BRAIN FUNCTION AND DYSFUNCTION

The study of the brain dates back to the early seventeenth century BC. Since that time till date, the function and the dysfunction of the brain have been studied and understood by various researchers in varied ways. For instance, the ancient Egyptians believed that the functioning of the brain is closely related to the functioning of the body. Long time back they noticed that the brain injuries affect the other parts of the body. The effects of the brain injury varied according to the site of the brain injury.

Despite the lack of anatomical knowledge, Hippocrates considered the brain as the seat of the soul and mental functions. Hippocrates' knowledge of the brain was based on a number of studies on his epileptic patients. He also saw that the damage to one hemisphere of the brain produced spasms on the other side of the body. Hippocrates also described how a blow on the head could produce paralysis on the opposite side of the body.

It was earlier thought that the mental processes of the faculty of the mind were located in the ventricular chamber of the brain. The cavities were regarded as cells. The lateral ventricle was considered as the first cell, the third ventricle was considered as the second cell and the fourth ventricle was regarded as the third

NOTES

cell. This doctrine was called as the cell doctrine of brain function. The 'ventricular doctrine' was first put forward by the church father Nemesius and Saint Augustine in the fourth century AD.

Later Aristotle divided mental activity into a number of faculties of thought and judgment for, e.g. imagination, fantasy, attention, memory, etc. These faculties were ascribed to the respective ventricular chamber in the cell doctrine. As early as 300 BC, Herophilus of Alexandria had localized the soul in the fourth ventricle.

Around the second century AD, Galen hinted at the association of the ventricle with intellectual functions. In the cell doctrine given by Gregor Reisch in 1504, the senses of smell, taste, sight and hearing were connected to the sensus communes (a mechanism dealing with the integration of different senses) at the front of the first chamber. This chamber was regarded as the seat of fantasy and imagination, the second of cogitation and estimation and the third of memory.

With the passage of time the knowledge about the structural neuro-anatomy increased but it was not paralleled by a corresponding increase in the knowledge of the brain function. This discrepancy between anatomy and physiology continued well into the twentieth century AD. During the second half of the seventeenth century and the early part of the eighteenth century, Descartes recognized the pineal gland as the seat of the soul.

This period was followed by the time in which other researchers divided mental processes into a number of separate specialized ability and begin to search for the neural substrate of such faculty. This system came to be known as 'phrenology'. The term phrenology was coined by Spurzheim according to which the brain is composed of a number of separate organs each of which controls a separate innate faculty. According to phrenology, there were as many cerebral organs to perform the mental processes, as there were the faculties.

Gall began to relate separate mental functions to discrete parts of the brain. It was Gall only who stressed the role of the cortex in which he located his faculty organs. This led to the careful recording and correlation of anatomo-clinical data, which formed the beginning of the idea of 'brain localization'.

It was Flourens (1794–1867) who came up with the 'holistic theory of brain function', according to which, the mental functions are not dependent upon the particular part of the brain but rather the brain function as a whole. Flourens' work also brought to light the 'notion of equipotentiality' (the ability of the other parts of the brain to take over the function of damaged neural tissues.

Broca, who conducted studies on lesions in the nineteenth century, believed that speech sense is localized in the left hemisphere. Broca also noted that exceptions to the location of language in the left hemisphere appeared in the left handed individuals. Such observations led to the notion that a cross-relationship existed between hand preference and hemispheric dominance.

In 1874, Wernicke proposed that a lesion in the left superior temporal gyrus causes difficulty in the comprehension of the speech. Wernicke was one of the first

NOTES

few researchers to see clearly the importance of connection between different parts of the brain in the building up of complex activities. He stated that complex activities were learnt by means of the connections between a small number of functional regions which dealt with the primary motor and sensory activities. This marked the beginning of the current understanding of the brain functions and dysfunctions.

3.3 ADJUSTMENT DISORDERS

Adjustment refers to the psychological reactions arising in relation to adapting to new circumstances such as divorce, separation, migration, birth of a handicapped child, new job, marriage, etc. When an individual fails to adjust or adapt himself to new circumstances and experiences anxiety, worry, poor concentration, depression, irritability, etc. together with physical symptoms caused by autonomic arousal, such as palpitations and tremors, to a significant degree that impairs his social functioning, then he is likely to suffer from 'adjustment disorders'.

Hence adjustment disorders are a diagnostic category characterized by an emotional response to a stressful event. Typically, the stressor involves financial issues, a medical illness or a relationship problem. The complex symptoms may include anxious or depressive affect or may involve a disturbance of conduct.

These individuals may also experience outbursts of dramatic or aggressive behaviour, single or repeated episodes of deliberate self-harm or the abuse of alcohol or drugs. Its onset is more gradual and prolonged. In children, regressive phenomena such as bed-wetting, babyish speech and thumb-sucking are frequently part of the symptom pattern.

The diagnosis of adjustment disorders is made soon after the change of circumstances and in the absence of depression, anxiety, schizophrenia and other psychiatric disorders that may precipitate from stressful life events. Different kinds of adjustment disorders and their subtypes are defined in the DSM-IV-TR including adjustment disorders with depressed mood, anxious mood, mixed anxiety and depressed mood, disturbance of conduct, mixed disturbance of emotions and conduct and unspecified type.

The diagnosis is done on the basis of a careful evaluation of the event, severity, form and content; personality, previous history, situation, stressful event and life crisis. If a temporal connection (less than 3 months) cannot be demonstrated or if the stressor is relatively minor, the disorder should be classified elsewhere.

3.3.1 Epidemiology

The prevalence of adjustment disorder in the community is not investigated. Prevalence in the US hospital attendees has been estimated as 5 per cent by Andereason and Wasek (1980).

NOTES

3.3.2 Course and Prognosis

Historically, adjustment disorder has been viewed as a transitional diagnostic category and, by definition, is not an enduring diagnosis. It usually starts within one month and the reaction appears to be understandably related to, and in proposition to, the stressful experience when account is taken of the patient's previous experiences and personality. Individual vulnerability and predisposition play an important role in shaping the manifestation of the adjustment disorders. The symptoms should begin within 3 months from the time affected by the stressor and should remit within 6 months after the stressor is removed. The symptoms do not usually persist beyond 6 months. If the symptoms persist more than 6 months, depending on the clinical picture, the diagnosis should be altered.

The role of personality type, age, comorbid conditions on the progress of adjustment disorders has to be evaluated.

Based on clinical experience, it has been observed that the adjustment disorders in most cases last for several months whereas they may persist for years in a few cases. Some patients with adjustment disorders can carry the risk of suicide. Andereason and Hoenck (1982) reported that while the prognosis is good for adults, some adolescents with adjustment disorder develop psychiatric disorders in adult life.

3.3.3 Etiology

Stressful circumstances are the necessary causes of an adjustment disorder, but individual vulnerability is equally important as not all the people exposed to the same stressful circumstances develop an adjustment disorder.

Psychoanalytic theory lays a great emphasis on the context occurrence of the event evaluating symptoms and their progress. Childhood experiences can have considerable impact on the vulnerability to the development of symptoms to stressors in the later life.

Familial and genetic factors also influence a person's response to stressors and the development of adjustment disorders. Thus, strongly suggesting that temperament or biological predisposition is likely to play a significant role in the development of adjustment disorders.

In short, the exact nature of this vulnerability is unknown and seems to vary from person to person and may depend in part on one's previous life experiences and the way the individual has handled them.

3.3.4 Management

The adjustment disorders may present with sub-threshold symptomatology across multiple symptom domains; thus, there is no single treatment intervention approach for the heterogeneous clinical manifestation of the disorder. The adjustment disorders require careful evaluation of the severity and nature of the symptoms.

NOTES

Before treating the patient, it is essential that he is clarified and convinced about the stressor that actually caused the symptoms.

First objective while treating the adjustment disorders should be relieving the symptoms to the level of adaptive functioning which should be comparable to or better than the levels of pre-morbid functioning. Treatment interventions focus on minimizing the impact of the stressors on day-to-day function and to mobilize adaptive stress-coping mechanisms.

Since stressful circumstances usually underlie adjustment disorder, the treatment focuses on helping the patient to deal effectively with stressful circumstances thereby aiding the natural process of adjustment. This is done by reducing denial and avoidance of the stressful events, encouraging problem-solving and discouraging maladaptive coping responses. Anxiety is reduced by encouraging the patient to talk about his problems, express his feelings and by encouraging him to engage in relaxation exercises. Occasionally, an anxiolytic or hypnotic drug may be needed for a few days. The individual is also encouraged to engage in effective stress coping strategies. If the problems cannot be resolved, the patient is encouraged to come to terms with them.

CHECK YOUR PROGRESS

1. Define adjustment disorders.

3.4 IMPULSE CONTROL DISORDERS

These disorders are characterized by repeated acts with no clear rational motivation that tend to harm the patient's own interests and those of other people. These behaviours are usually associated with impulses to act that cannot be controlled. Central to all the impulse control disorder is the repeated inability to resist an intense impulse, drive or temptation to perform a particular act that is obviously harmful to self or others or both. Before the event, the individual usually experiences mounting tension and arousal and after completing the action he or she is likely to experience immediate gratification and relief. But soon after a short while, the individual experiences feelings of remorse and guilt, which may arise from unconscious conflicts. They may also stem from their awareness of the impact of their actions on themselves and others (for example, the possibility of serious legal consequences).

So far, the causes underlying these conditions are not well understood. According to the genetic perspective, individuals with impulse-control disorders show family histories of depression, bipolarity, substance abuse, impulse-control disorders and personality disorders. Neurobiological research suggests that deficits in the frontal lobe may contribute to the disinhibition of some individuals with

impulse control disorders. Serotonin and other neurotransmitter dysregulation have also been seen to play a significant role in impulse control disorders.

The behavioural and cognitive perspectives believe that reinforcement and several cognitive distortions account for repeated acts of impulsive behaviours. In fact, some cognitive behavioural strategies have been found to be useful in the management of impulsive control disorders. The various impulse control disorders can be categorized as follows:

3.4.1 Pathological Gambling

Pathological gambling was first designated as a separate diagnostic entity in DSM-III. Parameters were revised in the revised DSM-III (DSM-III-R), redefined yet again for DSM-IV and essentially retained in DSM-IV-TR. These individuals have significant difficulty in controlling their gambling activity and are obsessed with gambling most of the time. The effects of gambling habit on their socio-occupational functioning are often devastating.

The pathological or compulsive gambling disorder is characterized by repeated, regular and increasing episodes of gambling in spite of the fact that they have adverse consequences like impairing family relationships, disrupting personal life, impoverishment, indebtedness, loss of job, etc. To obtain money and to evade debts, these individuals could even lie or break the law.

3.4.1.1 Epidemiology

Several studies have indicated that the percentage of problem gamblers in the general population is approximately 3–5 per cent and of these nearly 1 per cent meet the criteria to be categorized for pathological gambling. Several surveys have shown that pathological gambling may be seen across different ethnic, class, age and occupational groups.

Family histories of pathological gamblers show an increased rate of substance abuse (particularly alcoholism) and depressive disorders. A parent or influential relative of the patient often has been seen to have a problem of gambling or is seen to suffer from pathological gambling. The family members of these individuals have also been seen to be competitive and materialistically oriented.

3.4.1.2 Course and prognosis

The age of onset of the disorder is usually in the mid-thirties to forties. These individuals may be married or divorced, and are usually vocationally successful. Since early adolescence, these individuals may have a strong interest in gambling, which usually continues into adulthood. These individuals usually possess excellent gaming knowledge and skills and may be reasonably consistent winners. When they begin to loose, instead of stopping and cutting losses, they tend to spend even more time and money expanding their repertoire to include multiple gaming opportunities. Over several months to years of losses, they may engage in crime, take loan or do fraud to obtain more money.

NOTES

Some pathological gamblers get help and quit betting. Unfortunately, over a period of time these individuals seem to get bored and restless and again try to associate with other gamblers and soon return to pathological gambling and most of them end up ruining their lives.

Pathological gambling is seen to be co-morbid with mood disorders (especially major depression and bipolarity), substance abuse disorders (notably alcohol and cocaine abuse and caffeine and nicotine dependence), attention-deficit/hyperactivity disorder (ADHD) (particularly in childhood), various personality disorders (notably narcissistic, antisocial, and borderline personality disorders), and other impulse-control disorders. The presence of co-morbid conditions like substance abuse and affective illness tend to worsen the course as the easy accessibility of drugs and alcohol in gambling environments often dis-inhibits the pathological gambler from resisting an older play, and thus triggering off more gambling binges. Although many pathological gamblers have obsessive personality traits, full-blown obsessive-compulsive disorder is uncommon.

3.4.1.3 Etiology

Factors underlying pathological gambling seem to vary from one patient to the other. In addition, considerable differences in precipitating factors within the pathological gambler's life time have also been found.

The biological perspective: Studies on twins further suggest that the dysfunctional gambler may have inherited a genetic potential for the illness. Neurobiological studies have shown that patients with lesions in a neural system whose pathways involve the ventromedial (VM) prefrontal cortex, amygdala, and other structures show denial or unawareness of various problems calling for common-sense judgments. This type of injury is likely to predispose patients to pursue actions with short-term rewards but long-term negative consequences.

Studies suggest that complex, articulating neurotransmitter dysfunctions, similar to those in substance abusers, exist in pathological gamblers. Imbalances in serotoninergic, noradrenergic and dopaminergic mediation have been found to subvert the mechanisms underpinning behavioural arousal, disinhibition and reinforcement.

The psychoanalytical perspective: Edmund Bergler proposed that the pathological gambler is a pathological narcissist, who resents the loss of childhood megalomania and bears a profound grudge against parents and other authority figures for reining in inflated infantile omnipotence. The patient finds gambling as an expression of his rebellion against the authority figures such as parents, and sees the consequences of gambling as the expected punishments for defying. However, Greenson believed that pathological gambling gratified multiple pregenital and genital conflicts, rooted in oral-receptive, anal-sadistic and, especially, oedipal strivings. Greenson speculated that gambling might defend against depressive affect.

The cognitive behavioural perspective: Cognitive behavioural studies conceptualize pathological gambling as a learned, disastrous habit. Many pathological gamblers have seen to exhibit exquisite sensitivity to a gamut of reinforcers directly or indirectly related to wagering. Many pathological gamblers, according to cognitive studies, are susceptible to characteristic cognitive distortions and biases. These include the 'gambler's fallacy', a strong conviction that a series of losses will eventually lead to a definite big win in the long run. They have the tendency to selectively remember only wins ignoring losses.

Personality factors: Regardless of social background, ethnicity or comorbidity, many pathological gamblers exhibit strikingly similar personality traits. They tend to be intelligent (although not deeply intellectual), overconfident, perennial optimists, deniers, and rationalizers. They appear quite gregarious on the surface but deep inside harbour profound feelings of loneliness. They do not easily express their feelings and may experience difficulty in getting in touch with their inner life. Many of them are likely to be alexithymic.

3.4.1.4 Management

Management of pathological gambling is usually difficult as the patients rarely seek help on their own. Pathological gamblers are usually forced into therapy and many even tend to bitterly oppose treatment. In addition, their sense of enormous pride, formidable denial, lack of introspection, impatience and incurable optimism make it all the more difficult. They often tend to skip sessions, relapse or may quit therapy. These patients especially require firm but kind limit setting and a tolerant, noncritical attitude.

Medications like mood stabilizers (notably lithium) and antidepressants (notably SSRIs and clomipramine) are likely to show improvement in dual diagnosis patients with a significant co-morbid affective illness.

Cognitive behavioural approaches aim at undoing the habituating impact of specific gambling milieus and decreasing or redirecting the need for action. In it, patients are instructed in relaxation exercises to decrease tension, to identify specific gambling triggers, and to substitute gambling with competing rewards. The therapy also aims at disputing various irrational beliefs and cognitive distortions these individuals engage in.

3.4.2 Pathological Fire Setting (Pyromania)

Pyromania is defined as recurrent, deliberate fire setting. Whether it should be classified under the impulse-control disorders or should be classified as a separate entity is still controversial.

Pyromania is characterized by repeated acts of fire-setting without any clear rational motive such as monetary gain, revenge or political extremism. The individuals report an intense interest in watching fire burns. They often report feelings of increasing tension before engaging in such an act and intense excitement immediately after carrying out the act. These individuals tend to engage in multiple acts of

NOTES

setting fire, without any apparent motive. These individuals show a persistent preoccupation with subjects related to fire and burning. They may also show an abnormal interest in fire-engines and fire-fighting equipments and in calling out the fire services.

3.4.2.1 Epidemiology

It is a rare disorder and is 8 times more prevalent in men than in women. Fire setting is quite common in children and adolescents below 18 years of age. Usually, the families of pyromania patients show increased psychiatric problems, such as affective illnesses; substance abuse, particularly alcoholism; and various personality disorders.

3.4.2.2 Course and prognosis

A typical episode of pyromania begins with rising tension linked to thoughts of fire setting and may be accompanied by restlessness, headaches, palpitations and tinnitus. Before engaging in the act of fire setting, patients have reported dissociated feelings and alcohol intoxication. These patients are likely to seek pleasure by watching the flames (which may lead to an intense masturbation) and watching activities connected with the fire, including the destruction caused by fire and its impact on others. These individuals often strongly identify with the firefighter's strength and competence. After a fire-setting episode, the tension usually drops and the patient may fall into a deep, relaxed sleep.

Episodes of pyromania may occur sporadically, with prolonged impulse-free intervals. Despite repeated arrests, some patients continue with the habit of setting fires throughout their lives, and some of them may even permanently end up in prisons. Others persist in their fire setting habit indefinitely, but keep it secret doing it surreptitiously, just enough to avoid arrest. In case of some patients, daily urges to set fires continue for many years. Most of the pyromaniacs carry out their activities in the night as it increases the chances of going undetected. Pyromania can co-exist along with other violent tendencies like potent sexual and aggressive associations.

Mid- to late adolescence is the time when pyromania usually occurs. The typical patient of pyromania comes from an underprivileged social background and a violence-prone, dysfunctional family; is intellectually limited; and often has significant socialization and learning handicaps in childhood. Pyromaniac behaviour often coexists with other petty delinquent behaviours like truancy, running away and stealing. This coexistence of these disorders, often makes the primary diagnosis of pyromania uncertain (vide infra).

Some adult patients with pyromania are supposedly vocational underachievers, having difficulty in sustaining relationships, and may lead a marginal existence whereas other patients come from more stable families and exhibit better achievement levels vocationally and socially.

The prognosis of pyromania depends on the presence of co-morbid conditions like affective disorders (depressive or bipolar); substance abuse disorders; other impulse control disorders, such as kleptomania in female fire setters; and various personality disturbances like inadequate and borderline personality disorders. Learning disabilities and attention-deficit disorder (ADHD) may be associated with child pyromaniacs.

3.4.2.3 Etiology

Different perspectives have been used to examine pyromania from their respective points of view. For instance, Freud believed that there is an association between fire, ambition and urethral eroticism and theorized that pyromania represents a masturbatory equivalent. Some investigators view fire setting and its related preoccupations as activities expressing repressed childhood sexual or aggressive drives or both aimed at redressing a real or perceived early trauma, in the context of a dysfunctional, chaotic early family life.

Fire setting activities may also be seen as a striving for revenge against rejecting, abusive parents or other adult figures, to acquire power in the context of chronic feelings of helplessness and inadequacy or to master traumatic memories of the primal scene.

There has been little research on the biological and cognitive-behavioural features of pyromania. Preliminary studies hint at serotoninergic and other neurotransmitter dysfunction as well as disordered glucose regulation with the possibility of a hypoglycemic trigger as playing a significant role in pyromania.

3.4.2.4 Management

Treatment of pyromania is difficult as most of the patients are not willing to come for treatment. Despite anecdotal reports of success with psychoanalytic methods, most pyromania patients are hardly apt candidates for insight-oriented therapy owing to their profound denial, heavy drinking and an alexithymic inability to identify and to work through feelings.

Usually a multimodal approach that is often followed in the treatment for other impulse-control disorders is recommended when it comes to the management of pyromania. Family therapy combined with individual treatment is likely to be helpful.

3.4.3 Pathological Stealing (Kleptomania)

The diagnosis of kleptomania was first coined in 1838 by Esquirol and Charles-Chretien-Henri Marc. Esquirol subsumed kleptomania under the instinctive monomanias—conditions in which a single, irresistible impulse was acted out. However, kleptomania is characterized by repeated failure to resist the impulse to steal objects that are not required for personal use or monetary gain. These objects may instead be discarded, given away or hoarded. The patients often report intense anxiety before the act and extreme excitement or gratification immediately after

NOTES

the act. Although efforts at concealment are usually made but not all opportunities for this are taken. The theft is a solitary act. The individual may express anxiety or guilt between episodes of stealing yet they continue to engage in such acts.

3.4.3.1 Epidemiology

Kleptomania was earlier thought to be extremely rare but now it is believed that since these individuals may be ashamed of their acts and fear being punished by law, these cases may be substantially underreported.

It is likely to be 3 times more prevalent in females than males. Family histories reveal that first-degree relatives of kleptomania patients are likely to have affective illness and obsessive-compulsive traits. Their families may also be pervaded by preoccupation with financial success and material acquisition.

3.4.3.2 Course and prognosis

Most episodes of kleptomania seem to occur spontaneously and suddenly, usually precipitated by recent stress, such as an argument or fight accompanied by feelings of frustration, anger and an ambiguous sense of neediness.

Most patients report a mixture of dread of being caught and pleasure before stealing. But, some in whom a pattern of stealing has developed over repeated episodes may engage in such acts without a moment's hesitation. These patients usually feel good psychologically and morally when they are able to free themselves of stealing for a while; they feel devastated and despairing when they backslide. Many kleptomanic patients manifest obsessive-compulsive and narcissistic tendencies.

Kleptomania classically begins in late adolescence to the mid-twenties, often emerges in the context of compulsive shopping and can remain undetected for years. It is likely to be a chronic illness, characterized by repeated relapses over decades.

The course of kleptomania is decisively influenced by serious comorbid conditions like major affective illness (usually, but not exclusively, depressive), various anxiety disorders, other impulse-control disorders (notably pathological gambling and compulsive shopping), eating disorders and substance abuse disorders (alcoholism in particular).

3.4.3.3 Etiology

Several factors have been reported to play a role in its etiology as mentioned below:

Biological perspective: The significant co-morbidity of kleptomania with affective disorders and obsessive-compulsive disorder suggests that several neurobiological factors may play a role in kleptomania. Although it is yet to be confirmed, kleptomania has been theorized as an affective spectrum disturbance and an obsessive-compulsive spectrum disturbance.

Psychoanalytic perspective: According to this perspective, kleptomania is seen as an attempt to restore intra-psychic equilibrium and to redress childhood trauma and intra-psychic distortions. It treats the compulsive stealing disorder as a well-determined act, exquisitely balanced between gratification and punishment. The kleptomaniac syndrome has been interpreted as an attempt to rectify the perceived or actual narcissistic injuries and neglect in childhood via vengeful attacks to stave off painful feelings of low self-esteem through aggressive acquisition. Also the acts of stealing believed to gratify the forbidden infantile sexual wishes and masturbatory fantasies.

The object that is stolen appears to symbolize the perceived loss during the child development stages—oral, anal and genital. Depending on the developmental level of the patient's fixation, it may symbolize milk, feces, breast, penis or child.

Compulsive stealing, in some patients, is strongly influenced by the familial superego. A child, who has been dominated by his parents, may proceed to satisfy his ego by doing the act of stealing which his parents disavowed.

Cognitive behavioural perspective: It sees compulsive stealing to be self-reinforcing by virtue of its repetitive and highly ritualistic aspects.

3.4.3.4 Management

No controlled treatment studies of kleptomania have been undertaken. However, therapeutic approaches based on psychoanalysis, group and family work and several behavioural and cognitive strategies and medications (largely antidepressants and mood stabilizers) have been found to be helpful in the management of kleptomania.

3.4.4 Trichotillomania

The term trichotillomania was coined by a French dermatologist, Francois Hallopeau, in 1889. The condition, which was thought to be rare, is now regarded as more common. It is characterized by noticeable hair loss due to recurrent failure to resist impulse to pull out hairs. The hair pulling is usually preceded by mounting tension and is followed by a sense of relief or gratification. Thus, it is a chronic disorder characterized by repetitive hair pulling, driven by escalating tension and causing variable hair loss that is usually—but not always—visible to others. This diagnosis should not be made, if hair pulling is a reaction to a delusion or hallucination or any other condition.

Most patients pluck their hair at a particular site, typically the crown or side of the scalp, with variable spread into adjacent areas in time. Hair may also be pulled from the eyebrows, armpits and pubic region. Men tend to pull hair from beards and moustaches and from arms and legs. Usually patients describe an idiosyncratic pleasure in stripping the root away from a plucked hair. The hair is often nibbled and swallowed while pulling.

NOTES

After a while of pulling hair these individuals usually report feelings of shame, remorse, and disgust. These individuals usually conceal the hair loss from trichotillomania by careful combing, use of hair extensions or wearing hats on one pretext or another. But inevitably, the loss becomes obvious to others.

3.4.4.1 Epidemiology

Trichotillomania may be more prevalent than thought because of accompanying shame and secretiveness. The serious and chronic form of this disorder usually begins in the early to mid-adolescence, with a lifetime prevalence in the 0.6–3.4 per cent range in general populations and with a female to male ratio as high as 9:1. A chronic trichotillomania patient is most likely the only or oldest child in the family.

The prevalence of childhood type of trichotillomania is nearly equal in girls and boys. It is believed to be more common than the adolescent or young adult syndrome and is generally far less serious psychologically and dermatologically.

Family history of trichotillomania patients may show the presence of obsessive compulsive disorder, obsessive compulsive personality disorder, anxiety and affective disorders (notably depressive) and tics. Although a strong history of trichotillomania has not been discovered in family members, one study demonstrated a 25 per cent rate of unspecified alopecia in relatives of childhood hair pullers.

About 33–40 per cent of trichotillomania patients chew or swallow the hair that they pull out. Approximately 37.5 per cent of these people develop potentially hazardous bezoars.

Significant comorbidity is found between trichotillomania and OCD (as well as other anxiety disorders); Tourette's syndrome; affective illness, especially depressive conditions; eating disorders; and various personality disorders—particularly obsessive-compulsive, borderline and narcissistic personality disorders. Comorbid substance abuse disorder is not encountered as frequently as it is in pathological gambling, kleptomania, and other disorders.

3.4.4.2 Course and prognosis

Trichotillomania is a chronic illness. Sometimes this disorder is marked by little hair loss or even gradual improvement, but frequent remissions and serious exacerbations occur over years. Chronic trichotillomania can lead to permanent follicular damage and baldness.

The progression of childhood trichotillomania is usually benign compared to the adolescent and young adult variety. The prognosis often depends on the extent to which hair pulling is associated with co-morbid psychopathology.

3.4.4.3 Etiology

The precise causes of trichotillomania are still unknown. Psychoanalytically oriented theories see childhood loss or separation as a factor underlying trichotillomania. These individuals are likely to regress to an infantile state in order to avoid the

NOTES

pressures of adolescent sexuality. Psychoanalytical approach sees hair pulling as erotic and hair patting as sadomasochistic in nature that symbolize masturbation. The frequent hair twisting and hair patting by infants and young children (often combined with thumb sucking) are said to represent attempts to recuperate the absent mother's presence via the child's own body.

In families of most of these individuals one parent, usually the mother, is seen to be dominating, aggressive and intrusive. As children, these individuals are likely to have shown anxious clinging since infancy. The relationship between the mother and the child is likely to be an intense, hostile-dependent relationship that interferes with the child's healthy separation. With the onset of trichotillomania during puberty, the mother's attempts to make her daughter stop pulling her hair are countered by stubborn resistance. Thus, the symptom becomes a battleground for acting out conflicts over individuation.

According to the cognitive-behavioural perspective, chronic hair pulling is an intensely self-reinforcing activity which becomes a habit later in life.

3.4.4.4 Management

Most cases of childhood trichotillomania respond well to brief therapy, using support, psycho-education and simple behavioural strategies, focusing on stress management for family and patient, when necessary. However, it is the treatment of severe adolescent or adult trichotillomania which is likely to be prolonged and arduous requiring a combination of modalities.

While beginning treatment with them, the therapist should keep in his mind that these individuals are usually deeply ashamed of their hair pulling, get easily frightened, show intense denial and may have avoided help for years.

Psychoanalytically oriented psychotherapy: It yields mixed results. Improved understanding and esteem may lead to improved relationships and educational and vocational success, although hair pulling itself persists stubbornly.

Family therapy: It focuses on educating the family about the illness; advising them to avoid cajoling, bribing or criticizing the individual; to avoid putting lot of undue stress on the individual.

Cognitive behavioural therapy: It has shown encouraging results for trichotillomania. For instance, in habit reversal training (HRT), the therapist assembles a package of individualized strategies to address hair pulling, such as fostering awareness of specific affective and situational triggers, instruction in relaxation and stopping techniques, development of competing responses, and asking the family members to reinforce appropriate engagement in the techniques by the client. Individual HRT is combined with HRT group meetings for teaching as well as social support. As with other modalities, relapse after initial success is common, so patients should be counselled to see past a temporary defeat.

Medication: Medicines like serotoninergic agents, particularly SSRIs and clomipramine; clonazepam and monoamine oxidase inhibitors (MAOI) have shown

improvement in patients with trichotillomania. Tricyclics, lithium and buspirone (BuSpar) are used along with or for augmentation of SSRIs.

NOTES

Check Your Progress

2. What are different impulse control disorders?
3. What is kleptomania?
4. What is trichotillomania?

3.5 SUBSTANCE RELATED DISORDERS

From pre-historic times, mankind has been using various substances to reduce physical pain or to alter states of consciousness. By now several intoxicants have been discovered that are known to affect the CNS, relieving physical and mental anguish or producing euphoria. Despite the often devastating consequences of taking such substances into the body, their initial effects are usually pleasing. This is a major factor perhaps at the root of substance abuse.

These problem substances or drugs that can alter one's psychological state or mental functioning either occasionally or regularly are known as psychoactive drugs. A drug is defined by WHO as any substance that when taken into the living organism may modify one or more of its functions. The diagnostic classification of addictive or psychoactive substance-related disorders is includes two major categories:

1. **Psychoactive substance-induced organic mental disorders and syndromes:** These conditions involve organic impairment resulting from the ingestion of psychoactive substances such as in alcohol abuse dementia disorder involving amnesia, formerly known as Korsakoff's syndrome. These conditions stem from toxicity or physiological changes in the brain due to vitamin deficiency.
2. **Psychoactive substance-abuse and substance-dependence disorders:** They include the maladaptive behaviours resulting from regular and consistent use of a substance

Now let us understand the terms intoxication, abuse, dependence and addiction. I personally see these terms lying on a continuum, with both the abuse and dependence being two extremes.

Intoxication: It is seen as a transient syndrome due to recent substance ingestion that produces clinically significant psychological and physical impairment. These changes disappear when the substance is eliminated from the body. The nature of the psychological changes varies with the person as well as the drug.

Psychoactive substance abuse: It generally involves a pathological use of substance resulting in potentially hazardous behaviour (such as driving while intoxicated) or in continued use despite a persistent social, psychological, occupational or health problems. This is a maladaptive pattern of substance use that leads to clinically significant impairment or distress.

Psychoactive substance dependence: It involves more severe forms of substance-use disorders and usually involves a marked physiological need for increasing amounts of a substance to achieve the desired effects. Two terms that are closely associated with dependence are—tolerance and withdrawal.

Tolerance: It is defined by either of the following:

(i) There is a need for markedly increased amounts of the substance to achieve or desired effect.

(ii) There is a substantially diminished effect with continued use of the same amount of the substance.

Withdrawal: It is shown by either of the following problems:

(i) The individual shows the characteristic withdrawal syndrome for the substance.

(ii) The same or closely related substance is taken to relieve or avoid withdrawal symptoms.

Addiction: It is defined as a state in which the drug use has altered the body's chemistry to the point, where its 'normal state' was the drugged state so that the body required the drug to feel normal.

Two main psychoactive substance use disorders are:

(i) Alcoholism

(ii) Drug addiction

In your everyday clinical practice, you will usually find that in many cases drugs are not used individually. Some drug users like to combine effects, for example using a combination of marijuana and alcohol. Other drug users switch repeatedly from one drug to another. Identification of the psychoactive substance used may be made on the basis of:

- Self-report data
- Objective analysis of specimens of urine, blood, etc.
- Other evidence such as presence of drug samples, in the patient's possession, clinical signs and symptoms or reports from informed third parties

It is always advisable to seek corroboration from more than one source of evidence relating to substance abuse. Objective analyses provide the most compelling evidence of present or recent use, though these data have limitations with regard to past use and current levels of use.

NOTES

3.5.1 Alcoholism

A well-known Japanese proverb says:

> First the man takes a drink, then the drink takes a drink and then the drink takes the man.

This proverb contains the gist of the problem we are going to study. The World Health Organization (WHO) no longer recommends the term alcoholism, but prefers the term Alcohol Dependence Syndrome. It is defined as a psychic and physical state resulting from taking alcohol characterized by behavioural and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychological effects.

3.5.1.1 Approaches or models of alcohol use

Two common approaches or models of alcohol use are as follows:

The moral model: According to this model, if someone drinks too much, he does so of his own free will; and if his drinking causes harm to himself or his family, his actions are morally bad; hence public drunkenness should be punished. This particular model is followed less today.

The medical model: It views alcoholism as a disease and believes that the person who misuses alcohol is ill rather than wicked and hence should receive proper medical treatment. This concept of alcoholism embodies three basic ideas:

- Some people have a specific vulnerability to alcohol misuse.
- Excessive drinking progresses through well-defined stages, at one of which the person can no longer control his drinking.
- Excessive drinking may lead to physical and mental disease of several kinds.

3.5.1.2 Prevalence

Alcoholism cuts across all age, educational, occupational and socio-economic boundaries. One epidemiological study conducted in the US stated that lifetime prevalence rates for alcohol dependence defined by DSM criteria were greater than 20 per cent for men and just 8 per cent for women (Kessler et al., 1994). According to Helzer et al. (1990), marriage, having higher level of education and being older are associated with a lower incidence of alcoholism.

3.5.1.3 Co-morbidity

Alcoholism is co-morbid with antisocial personality disorder, mania, other drug use, schizophrenia and panic disorder (Robins et al., 1988).

3.5.1.4 Epidemiology

Some studies have shown that the highest consumption of alcohol is generally amongst young men who are unmarried, separated or divorced (Austoker, 1994). However, over the last 15 years drinking by women has increased. About 10-20 per cent of people who drink alcohol excessively develop cirrhosis of the liver.

Gender: Rates of alcohol misuse and dependence are consistently higher in men than in women but the ratio of affected men to women varies across cultures

Age: The heaviest drinkers are men in their late teens or early twenties. In most cultures, the prevalence of alcohol misuse and dependence is lower in those aged over 45 years (Helzer and Canino, 1992; Meltzer et al., 1994).

Ethnicity and culture: The followers of certain religions which proscribe alcohol, for example, Islam, Hinduism and the Baptist Church, are less likely than the general population to misuse alcohol.

Occupation: The risk of alcohol misuse is higher among some occupational groups that have an easy access to alcohol such as chefs, barmen, executives, salesmen, actors, entertainers, etc.

3.5.1.5 Effects of alcoholism

Alcohol misuse can result in different types of damage and complications—— physical, psychological and social

Physical damage: Physical complications of alcohol misuse can occur in several systems of body as follows:

- *Alimentary disorders:* Liver damage, gastritis, peptic ulcer, oesophageal varices and acute and chronic pancreatitis
- *Liver damage:* Fatty infiltration, hepatitis, cirrhosis and hepatoma
- *Nervous system:* Neurological conditions include peripheral neuropathy, epilepsy, dementia, limb paralysis, brain damage and cerebellar degeneration
- *Cardiovascular system:* Alcohol misuse is associated with hypertension and increased risk of stroke
- *Cancer:* Alcohol misuse is also linked to the development of certain cancers, notably of the mouth, pharynx, oesophagus and liver
- *Damage to faetus*: Alcohol misuse is associated with increased bleeding in early pregnancy, still-births, facial abnormality, small stature, low-birth weight, low intelligence and over activity in the infant. There is considerable evidence that faetal alcohol syndrome (FAS), occurs in some children born to mothers who drink excessively.
- *Mortality:* The major causes of death among individuals who misuse alcohol are diseases of circulatory system, cancer, injury, poisoning and in some cases suicide.

Psychological damage: Alcohol–related psychiatric disorders fall into four groups as follows:

1. *Intoxication phenomenon or acute intoxication:* Alcohol intake is often followed by a brief period of excitation which later leads to generalized CNS depression. With increasing intoxication, there is increased reaction time, slowed thinking, distractibility and poor motor control. Later,

NOTES

dysarthria, ataxia and in-coordination occur. There is a progressive loss of self control with frank disinhibited behaviour. At higher doses, alcohol intoxication can result in serious adverse effects such as falls, respiratory depression and hypothermia. The duration of intoxication depends on the amount and the rapidity of ingestion of alcohol. Occasionally a small dose of alcohol may produce acute intoxication in some persons. It is known as 'pathological intoxication'. Another feature, sometimes seen in acute intoxication is the development of amnesia or 'blackouts'.

Memory blackouts or short-term amnesia are frequently reported after heavy drinking. At first the events of the night before are forgotten, even though consciousness was maintained at that time. Such memory loses can occur after a single episode of heavy drinking in people who are not dependent on alcohol: if they occur regularly, they indicate habitual excessive consumption. With sustained excessive drinking, memory losses may become more severe and longer.

2. *Withdrawal phenomenon or syndrome:* The most common withdrawal syndrome is hangover on the next morning. Mild tremors, nausea, vomiting, weakness, irritability, insomnia and anxiety are common withdrawal symptoms. Sometimes, the withdrawal syndrome may be more severe characterized by one of the three following disturbances:

   Delirium tremens: It is the most severe alcohol withdrawal syndrome. It occurs usually within 2–4 days of complete or significant abstinence from heavy alcohol drinking in 5 per cent of the patients, as compared to acute tremulousness which occurs in 34 per cent of patients. The course is short, with recovery occurring within 3–7 days. It often ends with deep prolonged sleep from which the patient awakens with no symptoms and little or no memory of the period of delirium. This is an acute organic brain syndrome with the following characteristic features, which are often worse at night:

   - Clouding in consciousness with disorientation in time and place
   - Impairment of recent memory
   - Poor attention span and distractibility
   - Visual and auditory hallucinations and illusions, which are often vivid and frightening Tactile hallucinations of insects crawling over body
   - Marked autonomic disturbances with trachycardia, fever, sweating, hypertension, and papillary dilation
   - Psychomotor agitation and ataxia
   - Insomnia with reversal of sleep wake cycle
   - Dehydration with electrolyte imbalance

   Delirium tremens carries a significant risk of mortality and should be regarded as a medical emergency. Death, if occurs, is due to cardiovascular collapse, infection, hyperthermia or self-inflicted injury. Medical illnesses like

NOTES

pneumonia, fractures, liver disease and pulmonary tuberculosis may complicate the clinical picture.

Alcoholic seizures ('rum fits'): Generalized tonic-clonic seizures occur in about 10 per cent of alcohol dependence patients, usually 12–48 hours after a heavy bout of drinking. Usually these patients have been drinking alcohol in large amounts on a regular basis for many years. Multiple seizures (2–6) at one time are common than a single seizure.

Alcoholic hallucinosis: This is characterized by usually auditory hallucinations, largely containing voices uttering insults or threats, occurring in clear consciousness, during abstinence following regular alcohol intake. It occurs in about 2 per cent of patients. These hallucinations persist after the withdrawal syndrome is over and classically occur in clear consciousness.

3. *Toxic or nutritional conditions or iatrogenic complications of chronic alcohol use:* The complications that often result from chronic alcohol use are mentioned below:
   - Wernicke's encephalopathy: This is an acute reaction to severe thiamine deficiency, which results from chronic alcohol use. The onset occurs after a period of persistent vomiting. The important clinical signs are disorientation, confusion, recent memory disturbances, poor attention span, distractibility, apathy, ataxia, peripheral neuropathy, serious malnutrition, neuronal degeneration and hemorrhage.
   - Korsakoff's psychosis: As it often follows Wernicke's encephalopathy, these are together referred to as Wernicke-Korsakoff syndrome. Clinically, Korsakoff's psychosis presents as an amnestic syndrome, characterized by gross memory disturbances with confabulation. Insight is often impaired.
   - Alcoholic Dementia: Alcohol misuse can cause cognitive impairment particularly on the frontal lobe leading to dementia.
4. *Associated psychiatric disorder:* It includes the following:
   - Personality deterioration: As the patient becomes more and more concerned with the need to obtain alcohol, interpersonal skills and attendance to usual interests and responsibilities may deteriorate. These changes in social and interpersonal functioning should not be confused with personality disorder, which should be diagnosed only when the appropriate features have been clearly present prior to the development of alcohol dependence.
   - Mood disorder: The relationship between alcohol consumption and mood is complex. On the one hand, some depressed patients drink excessively in an attempt to improve their mood; on the other hand, excessive drinking may induce persistent depression or anxiety.
   - Suicidal behaviour: Suicide rates amongst alcoholics are higher than among non-alcoholics of same age. In a study of 50 alcohol misusers

NOTES

who had committed suicide, Murphy et al. (1992) identified a number of risk factors for suicidal behaviour, including continued drinking, co-morbid major depression, serious medical illness, unemployment and poor social support.

- Impaired psychosexual functions: Erectile dysfunction and delayed ejaculation are common. These difficulties may be worsened when drinking leads to marital estrangement, or if the wife develops revulsion for intercourse.
- Pathological jealousy: Excessive drinkers may develop an over-valued idea or delusion that their partner is being unfaithful.

Social damage: Various social problems associated with alcohol misuse are as follows:

- Family problems: Excessive drinking is liable to cause profound social disruption like marital discord and family tension. The divorce rate is high amongst heavy drinkers. The home environment is often detrimental to the children because of quarrelling and violence and a drunken parent provides a poor role model. Children of heavy drinkers are at a high risk of developing emotional or behavioural disorders and of performing badly at school.
- Work difficulties and road accidents: At work, the heavy drinker often progresses through declining efficiency, lower grade jobs, and repeated dismissals to lasting unemployment. There is also a strong association between road accidents and alcohol misuse (Zobeck et al., 1994).
- Crime: Excessive drinking is associated with petty offenses and crimes like fraud, sexual offences and crimes of violence including murder. It is not easy to know how far alcohol causes the criminal behaviour and how far it is just part of the lifestyle of the criminal. In addition, there is a link between certain forms of alcohol misuse and antisocial personality disorder.

3.5.1.6 Identification of alcoholism

Alcohol misuse often goes undetected because subjects conceal the extent of their drinking. It is useful to ask four following questions abbreviated as CAGE for easy recall:

- Have you ever felt you ought to cut down on your drinking?
- Have people annoyed you by criticizing your drinking?
- Have you ever felt guilty about your drinking?
- Have you ever had a drink first thing in the morning (an eye-opener) to steady your nerves or get rid of a hangover?

Two or more positive replies to these questions are said to identify alcohol misuse. In addition, it is always advisable to take a comprehensive drinking history. Several laboratory tests can also be used to detect alcohol misuse, though none gives an unequivocal answer. This is because the more sensitive tests can give 'false positives'

when there is disease of liver, heart, kidneys or blood, or if enzyme-inducing drugs, such as anticonvulsants, steroids or barbiturates, have been taken. However, abnormal values point to the possibility of alcohol misuse.

3.5.2 Drug Addiction

Some of the common drugs leading to addiction are amphetamine, caffeine, cannabis, cocaine, hallucinogens, opioid, phencyclidine, sedatives and hypnotics.

3.5.2.1 Amphetamine

Amphetamines and amphetamine derivatives such as 3,4-methylene-dioxymethamphetamine are stimulating drugs. Their psychomotor stimulant effects are believed to stem from their ability to release and block the re-uptake of dopamine and nor-adrenaline. These days, most amphetamines are illicitly synthesized and used as a 'street drug', popularly known as 'speed' or 'whizz'. They can be taken orally, intravenously, smoked, injected or can also be snorted.

These drugs are known to produce changes in mood and can lead to over-talkativeness, over-activity, insomnia, dryness of lips, mouth and nose, and anorexia. After the intake of these drugs, the pupil dilates, pulse rate increases and the blood pressure rises. Large doses can lead to cardiac arrhythmia, severe hypertension, cerebro-vascular accident, and occasionally circulatory collapse. At increasingly high doses, neurological symptoms such as seizures and coma may occur. Their psychological effects include dysphoria, anxiety, panic attack, irritability, insomnia and confusion. Obstetric complications include miscarriage, premature labour and placental abruption. Prolonged use of high doses of amphetamine is known to induce psychosis.

Dependence on amphetamines is likely to develop quickly. Its withdrawal syndrome is characterized by the presence of severe depression, anxiety, tremulousness, lethargy, fatigue and nightmares.

3.5.2.2 Caffeine

Caffeine is found in beverages (coffees, teas, soft drinks), foods (chocolate), and medications (both prescription and over-the-counter drugs), although most caffeine consumed is derived from coffee, tea and soft drinks.

Caffeine is the most widely consumed psychoactive substance in the world. Although numerous studies have documented the safety of caffeine when used in typical daily doses, there are psychiatric symptoms and disorders that can be associated with its use.

Repeated high doses of caffeine are known to cause restlessness, nervousness, excitement, insomnia, flushed face, dieresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, cardiac arrhythmia, periods of inexhaustibility and psychomotor agitation. Excessive caffeine intake is known to induce anxiety and sleep disorders.

NOTES

The withdrawal symptoms are characterized by the presence of marked fatigue, drowsiness, anxiety, depression, nausea or vomiting, impaired psychomotor and cognitive performance.

3.5.2.3 Cannabis

Cannabis is derived from the plant cannabis sativa. It is consumed either as the dried vegetative parts in the form of marijuana or grass or as the resin secreted by the flowering tops of the female plant.

The effects of cannabis vary with the dose, the person's expectations and mood and the social setting. It is known to exaggerate the pre-existing mood whether exhalation or depression; lead to increased enjoyment of aesthetic experiences; cause distortion of the perception of time and space; and may result in reddening of the eyes, dry mouth, tachycardia, irritation of the respiratory tract and coughing. Inhaled cannabis smoke irritates the respiratory tract and can cause cancer.

High doses of cannabis can induce anxiety, toxic confusion states and occasionally psychosis. Chronic use of cannabis can lead to a state of apathy and amotivational state. Its withdrawal syndromes are characterized by irritability, nausea, insomnia and anorexia.

3.5.2.4 Cocaine

It is a central nervous stimulant causing strong dependence in humans because it tends to block the re-uptake of dopamine into pre-synaptic dopamine terminals.

Cocaine can be consumed by smoking, sniffing and through injection. Intake of cocaine leads to excitement, increased energy, euphoria, grandiose thinking, impaired judgment, sexual inhibition, visual and auditory hallucinations, increased pulse rate, increased blood pressure, dilation of pupils, cardiac arrhythmia, myocardial infraction, cerebrovascular disease, transient ischaemic attacks, seizures and respiratory arrest. Obstetric complications include miscarriage, placental abruption and premature labour. Prolonged use of high doses of cocaine can result in a paranoid psychosis with violent behaviour. This state is usually short-lived but may be more enduring in those with a pre-existing vulnerability to psychotic disorder.

Its withdrawal syndrome is characterized by the presence of dysphoria, anhedonia, anxiety, irritability, fatigue and hyper-somnolence. Craving for cocaine can re-emerge after months of abstinence, particularly if the subjects are exposed to psychological or social cues previously associated with its use.

3.5.2.5 Hallucinogens

Hallucinogens are known to produce changes that bear some resemblance to those of the functional psychosis. The synthetic hallucinogens include lysergic acid diethylamide (LSD), dimethyl tryptamine and methyldimethoxyamphetamine.

Hallucinogens intake results in increase in heart rate and blood pressure and dilation of pupils. In predisposed subjects, the hypertensive effects of

hallucinations can cause adverse myocardial and cerebrovascular effects. The psychological effects develop during a period of 2 hours after LSD consumption and generally last from 8–14 hours. LSD intake is known to result in distortions or intensifications of sensory perception, confusion between sensory modalities (e.g. sounds may be experienced as visual in nature or movements may be experienced as if heard). Objects may appear to merge with one another or move rhythmically. The passage of time appears to be slowed and experiences seem to have a profound meaning.

Their intake may lead to distortions of the body images, exhilaration of mood, distress or acute anxiety. Use of LSD can cause long-term abnormalities in thinking and behaviour or even schizophrenia.

3.5.2.6 Inhalants

Inhalants or volatile substance abuse is common among adolescents. Volatile substances in the central nervous system may increase the fluidity of neural cell membranes and could also increase brain GABA function (Kaplan et al., 1994). There is some evidence that some volatile substance users have antisocial personalities and are likely to use and misuse multiple substances.

The volatile substances used are mainly solvents and adhesives, but may also include many other substances such as petrol, cleaning fluid, aerosols of all kinds, agents used in fire extinguishers, butane, toluene and acetone. The method of ingestion depends on the substance. It includes inhalation from tops of bottles, beer cans, cloths held over the mouth, plastic bags and sprays.

Volatile substance intake to known to first stimulate then depress central nervous system. It results in euphoria, blurring of vision, slurring of speech, loss of control, staggering gait, nausea, vomiting and coma. The volatile substance intoxication develops and wanes rapidly (within a few minutes to 2 hours). Some individuals may become disoriented or may develop frightening visual hallucinations.

Volatile substance abuse can also lead to sudden death largely caused by cardiac arrhythmias and respiratory depression. It may also lead to adverse neurological effects like impaired cerebellar function, encephalitis and dementia, and can cause damage to liver, kidney, heart and lungs.

Regular use can lead to dependence and its sustained use over 6–12 months can lead to tolerance. Their withdrawal symptoms usually consist of sleep disturbances, irritability, nausea, tachycardia and rarely hallucination and delusions.

3.5.2.7 Opioids

This group consists of drugs like morphine, heroin, codeine and synthetic analgesics such as pethidine, methadone and dipipanone. Opioid use can lead to rapid development of dependence. Opioids can be taken through the intravenous route or via subcutaneous administration (skin-popping) or can be sniffed. Heroin may also be heated on a metal foil and inhaled which also known as chasing the dragon.

NOTES

Opioids can lead to euphoria, analgesia, respiratory depression, constipation, reduced appetite and low libido. Their withdrawal symptoms include intensive craving for the drug, restlessness and insomnia, pain in the muscles and joints, running nose and eyes, sweating, abdominal cramps, vomiting, diarrhea, pilo-erection, dilated pupils, raised pulse rate and disturbance of temperature control. These symptoms usually appear about 6 hours after the last dose and reach a peak after 36–48 hours and wane thereafter.

3.5.2.8 Phencyclidine

Phencyclidine was developed as a dissociative anesthetic. It can be synthesized easily and can be taken by mouth, smoked or injected.

Its use is likely to result in agitation, depressed consciousness, aggressiveness, psychotic-like symptoms, nystagmus and raised blood pressure. Ataxia, muscle rigidity and convulsions can arise with its high dosage. A significant overdose of the drug can lead to death, hypertensive heart failure, malignant hyperthermia, status epilepticus, and respiratory failure. Tolerance to the effects of phencyclidine occurs, though withdrawal systems are rare. In chronic users, dependence can occur.

3.5.2.9 Sedatives and hypnotics

The most frequently misused drugs of this group are benzodiazepines. They are known to have euphoric and calming effects. Dependence on benzodiazepines often results from prolonged medical use. Their withdrawal syndromes consists of symptoms like anxiety, irritability, sweating, tremor, sleep disturbance, depersonalization, derealization, hypersensitivity to stimuli, abnormal bodily sensations, abnormal sensations of movement, depression, psychosis, seizures and delirium tremens.

3.5.2.10 Etiology

The various etiological factors can be classified into three broad categories as follows:

Biological factors: Various biological factors that are known to underlie substance use disorders are—genetic vulnerability, co-morbid psychiatric or a personality disorder, co-morbid medical disorder and bio-chemical factors such as neurotransmitters like dopamine and norepinephrine are known to play a role in cocaine, ethanol and opioid dependence. Craving, withdrawal and reinforcing effects of drugs further explain the continuation of drug use.

Psychological factors: Various psychological factors that are known to underlie substance use disorders are—curiosity, need for novelty seeking, general rebelliousness, social non-conformity, early initiation of alcohol and tobacco, poor impulse control, sensation seeking, low self-esteem, inferiority complex, poor stress management skills, concerns regarding personal autonomy, childhood trauma or loss, escape from reality, relief from pain, fatigue or boredom, psychological distress and lack of interest in conventional goals.

NOTES

Social factors: Various social factors that are known to underlie substance use disorders are—peer pressure, modelling, ease of availability of alcohol and drugs, strictness of drug law enforcement, intra-familial conflicts, religious reasons, poor social or familial support, perceived distance within the family, permissive social attitudes and rapid urbanization.

3.5.2.11 Management

Before starting any method of treatment, it is important to follow the following steps:

- Ruling out or diagnosing any physical disorder
- Ruling out or diagnosing any psychiatric disorder
- Assessment of the client's motivation for treatment
- Assessment of social support system
- Assessment of personality characteristics of the patients
- Current and past social, interpersonal and occupational functioning

Early detection of excessive consumption of alcohol and alcohol misuse is important, because treatment of established cases is difficult, particularly when dependence is present. The treatment can be broadly divided into two types, which are often interlinked:

1. Detoxification
2. Treatment of dependence

Detoxification: The aim of detoxification is the symptomatic management of the emergent withdrawal symptoms. Drugs are used in a standard protocol with dosage steadily decreasing every day before being stopped, usually on the tenth day.

In case of alcohol, the drugs of choice are benzodiazepines like chlordiazepoxide and diazepam. In addition, vitamins should be administered.

Treatment of dependence: After the step of detoxification is over, there are several methods to choose from, for further management. Research over the years has shown that when pharmacotherapy is used together with psychotherapy, the results are often better and stable. Some most widely used methods are:

Group Therapy: The aim of group therapy is to enable patients to observe their problems mirrored by others who also engage in substance use and to work out better ways of coping with their problems. Regular meetings are attended by about 10 patients and one or more members of the staff. In this process, they gain confidence and members of the group jointly strive to reorganize their lives without alcohol or drugs.

Cognitive-Behaviour Therapy: It focuses on psycho-education and the improvement of social and interpersonal skills, stress management skills, impulse regulation skills and conflict management skills as these relate to alcohol and drug misuse. It involves identifying various triggers that cause an individual to drink

NOTES

excessively, disputing the underlying irrational thoughts and cognitive distortions and eventually helping them to plan and rehearse new methods of coping with these situations or triggers. It lays lot of emphasis on relapse prevention. It also involves the use of various techniques ranging from covert sensitization, relaxation techniques, assertiveness training, self-control skills, positive reinforcement and aversive techniques.

Pharmacological treatment: They are often used to help in maintenance of abstinence. Some of the commonly used pharmacological agents are as follows:

Disulfiram: When alcohol is ingested by a person who is on disulfiram, alcohol-derived acetaldehyde cannot be oxidized to acetate and this leads to an accumulation of acetaldehyde in blood. This causes the disulfiram ethanol reaction (DER), characterized by flushing, tachycardia, hypotension, tachypnea, palpitations, headache, sweating, nausea, vomiting, giddiness, and a sense of impending doom associated with severe anxiety.

Acamprosate: It is described as an 'anti-craving' agent and produces modest but useful reductions in drinking behaviour in alcohol dependent subjects. It is believed to act by stimulating GABA inhibitory neurotransmission and decreasing the excitatory effects of glutamate.

Naltrexone: The opioid antagonist, naltrexone, is believed to block some of the reinforcing effects of alcohol and in this way decreases the likelihood of relapse after detoxification.

Antidepressant drugs: Antidepressant medication is useful in patients who experience persistent symptoms of major depression after detoxification. Some studies have suggested that SSRIs like citalopram and fluvoxamine can reduce drinking in non-depressed alcohol dependent patients.

Rehabilitation: It is an integral part of multimodal treatment of alcohol and drug dependence.

CHECK YOUR PROGRESS

5. What does the acronym CAGE stands for?
6. What do you know about opioids?

3.6 EATING DISORDERS

With the increasing consciousness of looks, physique and zero size popularized by media, more and more eating disorders are being seen in clinical practice. One study estimated that the general practitioner encounters nearly 45 per cent of anorexia nervosa and 12 per cent of bulimia nervosa.

NOTES

Eating disorders are disorders of eating behaviour deriving primarily from an overvaluation of the desirability of weight loss that results in functional medical, psychological and social impairment. Eating disorders are usually characterized into two main categories namely anorexia nervosa and bulimia nervosa.

3.6.1 Anorexia Nervosa

Anorexia nervosa is an eating disorder characterized by very low weight (defined as being 15 per cent below the standard weight or below body mass index (BMI) of 17.5); an extreme concern about weight and shape characterized by an intense fear of gaining weight and becoming fat; a strong desire to be thin and in women, amenorrhoea. It is a deliberate weight loss induced and or sustained by the patient. The disorder occurs most commonly in adolescent girls and young women, but adolescent boys and young men may be affected more rarely, as may children approaching puberty and older women up to the menopause.

The condition generally begins in adolescents with ordinary effort at dieting, which then gets out of control. These individuals are seen to have distorted image of the body and may have overvalued ideas about body shape and weight. If onset is prepubertal, the sequence of pubertal events is delayed or even arrested (for example, in girls the breasts do not develop and there is primary amenorrhoea; in boys the genitals remain juvenile). With recovery, puberty is often completed normally, but the menarche is late.

In order to keep themselves thin, these patients can engage in various activities, such as eating little; avoiding fattening foods; setting very low daily calorie limits for themselves (often between 600 and 1000 kcal); inducing vomiting; engaging themselves in excessive exercising and misusing laxatives, appetite suppressants or diuretics.

In these patients depression, anxiety, obsessive symptoms, instability of mood and social withdrawal is usually seen. The disorder is also associated with under-nutrition of varying severity, with resulting secondary endocrine and metabolic changes and disturbances of bodily functions. A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis manifests in women as amenorrhoea and in men as a loss of sexual interest and potency. There may be elevated levels of growth hormone, raised levels of cortisol, changes in the peripheral metabolism of the thyroid hormone, and abnormalities of insulin secretion. Certain physical changes such as sensitivity to cold, slow gastric emptying, constipation, low blood pressure, bradycardia, hypothermia, abnormalities of water regulation, electrolyte disturbances, epileptic seizures and cardiac arthythmia may be present.

3.6.1.1 Epidemiology

Reported incidence rates have increased recently, but these changes may reflect greater awareness of the condition as well as some real increase of incidence (Hoekin et al., 1998). It is difficult to determine the true prevalence of anorexia nervosa because many people with the condition deny their symptoms. Surveys

NOTES

have suggested prevalence rates of up to 0.5 per cent among school girls and female university students. Among anorexic patients seen in clinical practice only 5–10 per cent are males.

3.6.1.2 Course and prognosis

In its early stages anorexia nervosa often runs a fluctuating course with exacerbations and periods of partial remission. Full recovery can take place in cases with a short history. Studies on long-term outcomes show that, although the disorder may run a chronic course, recovery can occur even after many years. Outcome is often variable. About a fifth of patients make a full recovery, another fifth remain severely ill; the remainder show some degree of chronic or fluctuating disturbance. According to Plamer (2000), disorders with a short history and starting at a younger age are associated with a better prognosis. Although weight and menstrual functioning usually improve, eating habits often remain abnormal and some patients develop bulimia nervosa. It does not evolve into other forms of psychiatric disorder. Mortality rates are seen to be as high as 15 per cent.

3.6.1.3 Assessment

While assessing a case of eating disorder, one should take a thorough view of history of the development of disorder, the present pattern of eating and weight control, and the patient's ideas about body weight. It is essential to perform a physical examination, with particular attention to the degree of emaciation, cardiovascular status, signs of vitamin deficiency, endocrine disorders and electrolyte balance.

3.6.1.4 Etiology

Although the basic causes of anorexia nervosa remain elusive, there is growing evidence that interacting socio-cultural and biological factors contribute to its causation, as do less specific psychological mechanisms and a vulnerability of personality. There is evidence of a greater concordance in monozygotic than in dizygotic twins, suggesting genetic influences. Among the female siblings of patients with established anorexia nervosa, 6–10 per cent have this disorder, whereas in the general population of the same age, the prevalence is 1–2 per cent. Family genetic studies show an association between eating disorders and affective disorders.

Evidence suggests that those who develop anorexia nervosa (or bulimia nervosa) come from families and social backgrounds which are likely to promote concerns about eating, shape and weight (Fairburn et al., 1999). According to Bruch (1974), these patients are engaged in a struggle for control, for a sense of identity and effectiveness with the relentless pursuit of thinness as a final step in this effort. Clinical experience suggests that traits of low self-esteem, undue compliance and extreme perfectionism commonly precede the disorder (Vitousek and Manke, 1994). Crisp (1977) proposed that, whilst anorexia nervosa is at one level a 'weight phobia', the consequent changes in body shape and menstruation can be

NOTES

regarded as a regression to childhood and an escape from the emotional problems of adolescence. Certainly the timing of onset of the disorder suggests that developmental issues are important.

It has been suggested that the pre-morbid personality traits of these people equips them particularly poorly for the demands of adolescence (Fairburn et al., 1999). This idea has been demonstrated epidemiologically in case-control designs.

Minuchin et al. (1978) suggests that there is a relationship between families consisting of 'enmeshment', over protectiveness, rigidity and lack of conflict resolution and the occurrence of anorexia nervosa. A raised rate of parental problems preceding the onset of the disorder has also been seen by Fairburn et al. (1999).

3.6.1.5 Management

When it comes to eating disorders, the treatment focuses on educating the patient and his or her family that it is a disorder and its treatment is important. The treatment aims at helping the patient achieve an adequate weight, agree to a definite dietary plan, and to deal with accompanying psychological problems. Admission to hospital is indicated if the patient's weight is dangerously low, weight loss is rapid, there is severe depression or when out-patient care has failed.

In order to achieve an adequate weight, the target usually has to be a compromise between a healthy weight (a BMI above 20) and the patient's idea of what his or her weight should be.

Cognitive behaviour therapy focusing on disputing the underlying irrational beliefs or thoughts about shape, weight and eating and emphasizing a dietary regime is seen to bring positive outcomes. Family therapy aiming at modifying unhealthy family dynamics has also been seen to bring improvement in these individuals. Clinical experience suggests that supportive measures directed at improving the patient's sense of personal effectiveness and control are equally beneficial.

3.6.2 Bulimia Nervosa

It is an eating disorder characterized by an irresistible urge to over-eat, extreme measures undertaken by the patient to control body weight and overvalued ideas concerning one's body shape and weight. The episodes of uncontrolled excessive eating are known as binges.

Bulimia nervosa can take two forms—the purging type and the non-purging type. In the purging type, the individual tries to control his or her weight by the use of self-induced vomiting, laxatives and diuretics. However, in the non-purging type, the individual tries to control his or her weight by using methods like excessive exercise, fasting, etc. Individuals suffering from bulimia nervosa usually have normal weight, are often females and these females usually report of having normal menses.

The binging episodes are usually seen to be precipitated by stress or by the breaking of self-imposed dietary rules or may occasionally be planned. After

NOTES

engaging in an episode of binge eating, patients usually report relief from stress but the relief is soon followed by guilt and disgust. To deal with the feelings of guilt, the patients often induce vomiting or take laxatives. Depressive disorders are quite common in individuals suffering from bulimia nervosa.

Repeated vomiting is associated with several complications such as potassium depletion, urinary infections, tetany, epileptic fits, electrolyte imbalance, cardiac arrhythmias and renal damage.

3.6.2.1 Epidemiology

In a study conducted by Hoeken et al. (1998), the prevalence of bulimia nervosa was found to be around 1 per cent in women aged 16–40 years. The disorder is found to be more common in women than men and in more common Western countries compared to non-Western countries.

3.6.2.2 Course and prognosis

Bulimia nervosa usually has an onset in late adolescence, usually following a period of concern about shape and weight. Some of them may also show a history of a previous episode of anorexia nervosa. It is seen that these individuals usually begin with periods of dietary restriction which over nearly three years break down into increasing frequent episodes of over-eating. It is quite possible that abnormal eating habits persist for many years, which may vary in degree of severity. The overall outcome is variable in nature. There is no evidence that bulimia nervosa is associated with the onset of any other psychiatric disorder. The mortality rates are less in bulimia nervosa when compared too anorexia nervosa.

3.6.2.3 Etiology

Several factors that may predispose an individual to develop bulimia nervosa are a family history of psychiatric disorder (especially depression); adverse childhood experiences; low self-esteem; need for perfectionism; inherited abnormalities in the regulation of weight and eating habits. Once the disorder is established, then the continuing concerns about body shape and weight, together with the vicious cycle of overeating and weight control by purging and non-purging methods may maintain the disorder.

3.6.2.4 Management

Cognitive behaviour therapy, stress copying strategies, interpersonal therapy, self-help treatment, keeping behavioural records of food intake and episodes of vomiting with attempts to modify environmental stimuli, thoughts of emotional changes that regularly precede the urge to overeat and antidepressant medication have been considered as effective treatments for bulimia nervosa.

Usually the patient can be easily managed on out-patient bases. However, admission to the hospital is indicated only if there are severe depressive symptoms or physical complications and if out-patient treatment has failed (Palmer, 2000).

It always helps to review the initial treatment with the patient with the aim of agreeing a treatment approach that is more acceptable and in which compliance is likely to improve.

NOTES

CHECK YOUR PROGRESS

7. What are eating disorders?
8. List some etiological factors underlying bulimia nervosa.

3.7 SLEEP DISORDERS

Sleep is a process which the brain requires for proper functioning. Sleep performs several functions some being energy conservation, restoration of cellular energy stores, emotional regulation, consolidation of memory and preservation of context in which to organize memory of new stimuli.

Patients, whose main problem is either difficulty in sleeping or less often, excessive sleeping, may be asked to see a psychiatrist. Such sleep-related disorders should be carefully examined, because the symptoms can be easily mistaken for psychological disorders.

3.7.1 Epidemiology

Various epidemiological studies indicate that nearly 30 per cent of adults complain of insomnia, of which one-third report of having chronic problems. Excessive sleepiness occurs in 5 per cent of adults and possibly 15 per cent of adolescents. In the epidemiological catchment area study (Ford and Kameron, 1989), 10.2 per cent of the community sample reported insomnia and 3.2 per cent reported hypersomnia. 40 per cent of those who suffered insomnia and 46.5 per cent of those with hypersomnia had a psychiatric disorder compared with 16.4 per cent of those with no sleep complaints.

Groups at special risk of persistent sleep problems include young children, adolescents, the physically ill, those with learning disability and those with dementia.

3.7.2 Classification of Sleep Disorders

DSM-IV categorizes sleep disorder into the following categories:

- Primary sleep disorders which include dyssomnias and parasomnias
- Sleep disorders related to another medical disorder
- Sleep disorder due to general medical condition
- Substance induced sleep disorder

NOTES

3.7.2.1 Primary sleep disorders

The primary sleep disorders result from conditions inherent to the mechanisms by which sleep is regulated. They are dichotomized into dyssomnias and parasomnias.

Dyssomnias: They are characterized by disturbances in the amount, quality or timing of sleep. These are thought as disturbances involving sleep–wake generating or timing mechanism. They include primary insomnia, primary hypersomnia, narcolepsy, breathing-related sleep disorders and circadian rhythm sleep disorder.

Parasomnias: These are characterized by abnormal behaviours or physiological events associated with sleep. They are thought of as involving inappropriately timed activation (or failure to suppress) behavioural or physiological systems or both during sleep and sleep–wake transitions.

Sleep disorders related to another mental disorder: Sleep disturbances are often associated with various types of mental hearth.

Sleep disorders related to general medical conditions: Constant pain, obstructive lung disease, neurological diseases and stroke can disturb the integrity and architecture of sleep, rendering it restless and non-refreshing.

Substance-induced sleep disorder: Alcohol, anxiolytics, opioids and sedatives, hypnotics all promote sleep by sedation. However, the resulting sleep, while apparently of greater quantity is of poorer quality. Many benzodiazepine hypnotic medications reduce slow wave sleep, and some reduce REM sleep. Abnormally increased EEG beta and sleep spindle activity result from ingesting some hypnotic drugs.

Alcohol may relax a tense person and thereby decrease latency to sleep; however, sleep later in the night is fragmented by arousals. As tolerance develops to chronic drug and alcohol use, increased dosage is needed to sustain effects; lower dosage produces an abstinence syndrome, and sleep regresses to its initial abnormal pattern. Furthermore, during withdrawal or tolerance, the sleep disturbance can rebound to a more severe level than the initial problem.
Psycho-stimulant use poses a different problem. Cocaine, amphetamine and related stimulants, caffeine, and theobromine all produce CNS arousal that may persist into the sleep period and produce insomnia. Especially in case of stimulant abuse, an individual usually becomes severely sleep deprived. Over time a massive sleep debt accumulates, and upon substance discontinuation, profound hypersomnia results. This compensatory sleep or sleep rebound continues for an extended time.

3.7.3 Treatment

Some dyssomnias result directly from extrinsic factors. Often problems arise from environmental conditions or maladaptive habits. The management of sleep disorders involves the use of multiple strategies, as explained below.

Sleep hygiene refers to basic rules designed to provide circumstances and conditions conducive to sleep. They include a list of things to incorporate into a good sleep ritual and things to avoid. Sleep enhancing directives include maintaining

NOTES

a regular sleep–wake schedule; keeping a steady programme of daily exercise; insulating the bedroom against excessive noise, light, cold and heat; eating a light snack before retiring if hungry; and setting aside time to relax before getting into bed.

Stimulus control therapy aims to break the cycle of problems commonly associated with difficulty in initiating sleep. It states that one should go to bed only in when sleepy; should use the bed only for sleeping and not for reading or watching television; should not continue to lie in bed and get frustrated if unable to sleep; should rather get up and go to another room and do something non-arousing, like, reading, until sleepiness returns; should wakeup at the same time every morning, regardless of bedtime, total sleep time or day of the week; should completely avoid napping. This therapy certainly works; however, the results may not appear during the first few weeks or months. If the instructions are continuously practiced, the bouts of insomnia lessen in both frequency and intensity.

Sleep restriction therapy focuses on restricting time in bed and help consolidate sleep for patients who find themselves lying awake in bed unable to sleep. Sleep at other times during the day must be avoided, except elderly adults who may take a 30-minute nap. Sleep restriction therapy produces a gradual and steady decline in nocturnal wakefulness.

Cognitive-behavioural therapy (CBT) emphasizes the role of dysfunctional thoughts in the maintenance of primary insomnia. It suggests, for instance, that incorrect beliefs (e.g. that there is nothing one can do about poor sleep or that one night of poor sleep has disastrous consequences) may lead to anxiety that perpetuates the disorder and that insomniacs tend to have more emotion-oriented coping strategies to stressors.

In *paradoxical intention*, the patient is asked to try not to sleep. As he finds out how difficult it is to stay awake intentionally, he comes to recognize the potency of homeostatic sleep regulation. The therapist can then suggest to the patient that his body will not allow him to miss too much sleep.

Other techniques focus on breaking up the ruminative thought processes that typically occur while an insomniac lies awake in bed. The technique of *cognitive focusing*, helps the patient to prepare in advance a series of reassuring thoughts and images on which he or she is asked to concentrate, should he or she wake up during the night.

Relaxation therapy which aims at helping individuals attain a relaxed state of mind when clubbed with sleep hygiene and stimulus control therapy is likely to bring better results. Other techniques emphasize on somatic relaxation, including muscle relaxation procedures and electromyographic (EMG) biofeedback.

In case of obstructive sleep apnea, weight loss and surgical correction of airway obstruction and malformation is likely to be beneficial.

Although there is no cure for narcolepsy, symptom management is possible. Psycho-stimulants are commonly used to manage sleepiness. REM sleep suppressing drugs (for example, anti-depressants) are used to treat cataplexy.

NOTES

Although drug therapy is the treatment of choice, the overall therapeutic approach should include scheduled naps, lifestyle adjustment, psychological counselling, drug holidays to reduce tolerance, and careful monitoring of drug refills, general health and cardiac status. Also, judicious use of hypnotic medications or sleeping pills is strongly recommended.

CHECK YOUR PROGRESS

9. What are primary sleep disorders?
10. What do you understand by the term sleep hygiene?
11. Name the various interventions that can be used in the management of sleep disorder.

3.8 SEXUAL AND GENDER IDENTITY DISORDERS

Sexual behaviour is diverse and determined by a complex interaction of factors. It is affected by one's relationship with others, by life circumstances, and by the culture in which one lives. An individual's sexuality is enmeshed with other personality traits, with his or her biological makeup, and with a general sense of self. It includes the perception of being a man or a woman and reflects developmental experiences with sex throughout the life cycle. Sexuality encompasses all those thoughts, feelings, and behaviours connected with sexual gratification and reproduction, including the attraction of one person to another.

It is the least understood yet a quite prevalent aspect of our everyday living. It is essentially one's private and a personal affair where each individual has varied preferences and fantasies that may surprise or even shock us from time to time. As long as our fantasies and desires do not harm us or others in any unwanted ways, they are absolutely normal. But the moment they begin to affect or harm us or others in unwanted ways, they begin to qualify as abnormal in nature and are hence termed as sexual disorders. The sexual disorders have been categorized as—Gender identity disorder, paraphilias and sexual dysfunction. Below we shall understand about these in a bit more detail.

3.8.1 Gender Identity Disorder

The term gender identity refers to the gender an individual identifies with. It differs from sexual identity or sexual orientation, which refers to the preference an individual has for the sex of a partner. For instance, gays and lesbians fall into this category. It also differs from the term gender role as it refers to the masculinity and femininity of one's overt behaviour. Often gender identify is seen to closely relate to one's biological sex and tends to get deeply ingrained from earliest childhood experiences.

Most of the individuals are seen to be comfortable with their own biological sex. However, there are some individuals who experience persistent discomfort about one's biological sex and may regard the gender role of that sex as inappropriate. They may also have a strong and a persistent desire to be of the opposite sex and may even want to surgically alter his or her body to bring it in line with his gender identity. This disorder may occur in children or adults and in males or females. When seen in children, it is known as transsexualism and when seen in adults it is termed as gender identity disorder.

At the physical level, these individuals show normal development of primary and secondary sex characteristics of their respective biological sex, but deep within themselves, usually from early childhood, they feel like the opposite sex. They have aversion to same sex clothing and activities.

When gender identity disorder begins in childhood, it is associated with a number of cross-gender behaviours, such as dressing in opposite sex clothes, preferring opposite sex mates and engaging in play that would usually be considered more typical of the opposite sex. It seems to be more frequent in boys than girls. Most children with gender identity disorder do not grow up to be disordered in adulthood even without professional intervention (Zucker et al., 1984), although many demonstrate a homosexual orientation (Coates and Person, 1985; Green, 1985). Gender identity disorder in childhood is frequently associated with 'separation anxiety disorder' and in adults is frequently associated with anxiety and depression.

3.8.1.1 Epidemiology

In one study, predominant or exclusive homosexuality was estimated at approximately 2 per cent in men and 1.0–1.5 per cent in women. Estimates for homosexual men recalling childhood cross-gender behaviour were between 50 and 65 per cent, and estimates for homosexual women were approximately 50 per cent.

3.8.1.2 Course and prognosis

Most children with gender identity disorder are referred for clinical evaluation in early grade school years. However, parents typically report that the cross-gender behaviours were apparent before 3 years of age. In many children, the gender identity disorder tends to persist into adulthood.

3.8.1.3 Etiology

Evidence indicates that gender identity is influenced by hormones. In a study conducted by Imperato-McGinley et al. (1974), it was found that some individuals who are unable to produce a hormone that is responsible for shaping the penis and scrotum have a higher probability of developing gender identity disorder.

Another research conducted by Ehrhardt and Money (1967) found that offspring of mothers who had ingested prenatal sex hormones showed higher than

NOTES

usual levels of cross-gender interests and behaviour. Other researches also show that human and other primate offspring of mothers who have taken sex hormones during pregnancy frequently behave like members of the opposite sex and have anatomical abnormalities.

However, some investigations such as done by Gladue (1985) found few if any differences in hormone levels among men with GID, male heterosexuals and male homosexuals. Some research studies have found women with GID having elevated levels of male hormones, but others did not (Bosinski et al., 1997).

Researchers like Green (1974, 1987), Zuckerman and Green (1993) found that in homes where engagement of young children in cross-gender behaviours gets too much attention and reinforcement from parents and other relatives, the probability of these children developing GID is high. It is clearly evident that, biological and psychosocial factors may interact in multiple ways giving rise of GID.

3.8.1.4 Management

The treatment interventions are largely of two main types—one attempt to alter the body to suit the person's psychology and the other attempts to alter the psychology to match the person's body.

'Sex-reassignment surgery' aims at altering one's body to match the person's gender identity. In this, the individuals are given hormone treatments. Biological men are given estrogen to facilitate breast growth, skin softening and shrinking of muscles. Biological women are given testosterone to suppress menstruation, increase facial and body hair and to deepen the voice. After receiving hormonal therapy for several months, these individuals are required to live at least a year as a gender they wish to become. Only after completing the trial period successfully, they undergo surgery and continue to take hormones indefinitely.

In male–to-female transsexuals penis and testes are removed and an artificial vagina is created. They also undergo extensive electrolysis to remove their beards and body hair. They are also taught how to raise the pitch of their voice. Female-to-male transsexuals undergo mastectomies, hysterectomies and plastic surgery to alter various facial features such as the Adam's apple. An artificial penis is also created which is not capable of normal erection.

Research has shown that female-to-male reassignment, though rare, is generally more successful than male-to-female. The patients who are most likely to have successful outcomes are the ones who before surgery had a reasonable degree of emotional stability, lived with some comfort in the desired gender role for at least a year, had a good understanding of the limitations of the surgery and receive psychotherapy directed at their gender problems (Green and Fleming, 1990).

'Alteration of gender identity' aims at altering one's identity to match with his body. The treatment involves shaping various specific behaviours (such as the

style of walking, talking, mannerisms, interpersonal behaviour, etc.), cognitions and sexual fantasies. In some cases, the behavioural retraining is found to be successful in altering one's gender identity but not the sexual orientation.

3.8.2 Paraphilias

NOTES

The term paraphilias refers to a group of disorders involving sexual attraction to unusual objects or sexual activities that are unusual in nature. The term 'para' refers to deviation and the term 'philia' refers to what the person is attracted to. Hence, the term 'paraphilia' refers to deviation in what the person is attracted to. These fantasies, urges or behaviours must last at least six months causing significant distress or impairment. The incidence of paraphilia is seen to be higher in males as compared to females. The individuals can exhibit more than one paraphilia at a time. The various disorders included under paraphilia are:

- **Fetishism:** This is characterized by recurrent and intense sexual urges towards inanimate or non-living objects known as fetishes (for example, women's shoes, toilet articles, underpants, etc.) for sexual arousal. The presence of the fetish is strongly preferred or even necessary for sexual arousal to occur for these individuals.
- **Transvestic fetishism:** In this case, a man feels sexually aroused by dressing in women's clothing, although he still regards himself as a man. The extent of transvestism varies from wearing women's underwear under conventional clothing to full cross-dressing.
- **Pedophilia:** The term *pedos* in Greek language means 'child'. In it adults derive sexual gratification through physical and often sexual contact with children unrelated to them. The offender needs to be at least 16 years old and at least 5 years older than the child. The pedophile can be heterosexual or homosexual. They usually do not physically injure the child, but they may frighten them. They may manipulate the child's genitilia, encourage the child to manipulate his and less often, attempt intromission.
- **Incest:** It refers to sexual relations between close relatives for whom marriage is forbidden. It is most common between brothers and sisters and fathers and daughters.
- **Voyeurism:** In this the individuals get sexual gratification by watching others in a state of undress or having sexual relations.
- **Exhibitionism:** In this case, the individual gets sexual gratification by exposing one's genitals to an unwilling stranger, sometimes a child. According to Murphy (1997), exhibitionism begins in adolescence. As with voyeurism, there is seldom an attempt made by the individual to have actual sexual contact with the stranger.
- **Frotteurism:** In this case, the individuals feel sexually aroused by sexually oriented touching of an unsuspecting person. These individuals may rub their penis against a woman or fondle her breasts or genitals. These

NOTES

incidences typically occur in places such as a crowded bus or sidewalk that provides an easy means of escape. It usually begins in adolescence.

- **Sexual sadism:** In this case, the individual obtains sexual gratification by inflicting pain or psychological suffering such as humiliation on another person.
- **Sexual masochism:** In this case, the individual gains sexual gratification through subjecting oneself to pain or humiliation
- **Bestiality:** In this case, the individual obtains sexual gratification by having intercourse with a living animal.

3.8.2.1 Epidemiology

Paraphilias are likely to be present more in men than in women. Except for sadism and masochism, almost all of the reported cases are in men. Some paraphilias appear to be more common than others. In an individual psychiatric practice, masochism, sadism and fetishism appear to be the most commonly encountered paraphilias, whereas the excretory perversions are rarely seen. In contrast, in clinics that specialize in the treatment of sex offenders against whom criminal charges have been raised, the most commonly encountered paraphilias are pedophilia, voyeurism, and exhibitionism.

3.8.2.2 Course and prognosis

Since paraphilia yields pleasure, therefore many individuals so affected do not seek psychiatric intervention. Even those who feel anguished may avoid confiding in a doctor or psychiatrist out of profound shame. Restricted to studying a psychotherapy patient population or a population convicted of sexual crimes, relatively little is known about the incidence and distribution of the paraphilias or about the natural history of the course of any given paraphilia over time.

3.8.2.3 Etiology

Several factors that may interact in multiple ways and play a role in paraphilias are listed below:

Biological perspective: Since sexual arousal is controlled in part by CNS, it is possible that sexual aberrations may be related to neurological disorders. The fact paraphilias are usually seen in men, it is possible that androgen may also play a role. The human fetus begins as a female, with maleness emerging from later hormonal influences, perhaps it is possible that something may go wrong during fetal development which may lead to the emergence of paraphilias in adulthood. However, the findings of hormonal differences between normal people and people with paraphilias are inconclusive. A study done by Mason (1997) and Murphy (1997) suggested that a dysfunction in the temporal lobe may be relevant in a minority of cases of sadism and exhibitionism.

Psychodynamic perspective: The paraphilias are viewed by the psychodynamic theories as defensive in nature, guarding the ego from dealing with repressed fears and memories and representing fixations at pregenital stages of

psychosexual development. Unresolution of oedipal stage and castration anxiety is considered as the major source of trouble. The sexual deviations may also result from inability to control his or her basic id impulses.

NOTES

Behavioural perspective: According to this perspective, sexual deviations may also develop from classical conditioning, operant conditioning and modelling. Paraphilias may arise from classical conditioning that by chance has linked sexual arousal with classes of stimuli deemed by the culture to be inappropriate causes of sexual arousal (Kinsey, Pomeroy and Martin, 1948). For example, a young man may masturbate to pictures or images of women dressed in black leather boots. According to this perspective, repetition of these experiences may endow boots with properties of sexual arousal.

Sexual deviation may also result from a respondent conditioning process in which early sexual experiences, particularly masturbation, are paired with some unconventional stimuli, which then becomes the discriminative stimulus for arousal. For example, if a child learns to masturbate with the help of a furry toy or a pair of women's underpants, this may lead to fetishism.

Albert Bandura (1969) has argued that parents may knowingly or unknowingly model deviant sexual behaviour. The childhood histories of individuals with paraphilias often reveal that they were subjected to physical and sexual abuse and grew up in a family in which the parent-child relationship was disturbed (Mason, 1997; Murphy, 1997). These early experiences may contribute to the low level of social skill, low self-esteem, loneliness and lack of intimate social relationships often seen among those with paraphilias (Kaplan and Kreuger, 1997; Marshall et al., 1997). Distorted parent-child relationship may also create hostility or a general negative attitude and lack of empathy towards women, which may increase the chances of victimizing women. Alcohol and negative affect often are triggers of incidents of pedophilia, voyeurism and exhibitionism. Deviant sexual activity like alcohol use may be a means of escaping from negative affect (Baumeister and Butler, 1997).

Cognitive perspective: According to this perspective, sexually deviant behaviours may be a result of learning deviant attitudes. It believes that although we are born with a sex drive, but the way we express our drive depends largely on the attitudes we develop in childhood. Often few children in their growing years are seen to engage in sexual experimentation and display in ways that may cross normal, accepted boundaries. And when such behaviours get positively reinforced, then they are likely to be exhibited later in adult life too. For example, if a young boy's showing his genitals to a girl is met with a reaction of pleasure, interest and curiosity, then it is quite likely that he may engage in exhibitionism as an adult.

Rapists have also been seen to have several deviant attitudes and beliefs about sexuality. They often believe in sexual stereotypes and tend to objectify the women or see her as a commodity of gratification rather than as human beings with feelings of their own (Groth, 1983). When these deviant attitudes and beliefs get combined with other predisposing factors, such as uncorrected childhood norm

NOTES

violation, lack of parental modelling of normative sexual values, poor self-esteem, poor social skills and poor understanding of sexuality, then they are likely to engage in sexual deviations.

3.8.2.4 Management

Sexual offenders often lack motivation to bring about a change in their behaviour and are hence less likely to come for treatment. Dropout rate is also seen to be high in them. Miller and Rollnick (1991) have provided us with several methods that can be adopted to enhance their motivation such as—the therapist can empathize with the offender's reluctance to admit that he is an offender, thereby reducing the defensiveness and hostility. The therapist can point out to the offender the treatments that might help him control his behaviour better and emphasize the negative consequences of refusing treatment. Having elaborated on the possible benefits of treatment, the therapist can implement a paradoxical intervention by expressing doubt that the person is motivated to enter into or continue in treatment, thereby challenging him to prove wrong the therapist whom he has been resisting. The management of sexual deviations can also be looked from different perspectives as given below:

The psychodynamic perspective: The psychoanalytical therapy or psychoanalysis focuses on interpreting symbolic remarks, behaviours and dreams in an attempt to bring the unconscious sexual conflict to the conscious level so that it can be confronted and worked through.

The behavioural perspective: Focuses on changing the patient's sexual arousal patterns, beliefs and behaviour. It makes use of various techniques such as avoidance, stimulus satiation, covert sensitization, shame aversion, skill training, etc. The 'avoidance technique' requires the person to avoid situations which are likely to tempt him to engage in a sexually deviant behaviour. For example, a sex molester is required to stop any job or recreational activity that brings him in contact with children. 'Stimulus satiation' requires the person to masturbate his non-erect penis while focusing on deviant stimuli only when he is not aroused and is not feeling any physical pleasure. The moment he begins to have pleasurable sensations he is asked to shift his attention to a desirable stimuli and then engage in normal ejaculation. The individual is asked to repeat this procedure three times a week at least for a month, which results in making these individuals perceive the deviant stimuli as boring, uninteresting and even aversive.

In 'covet sensitization', the individual is taught to indulge in a deviant fantasy until he is aroused, then to imagine the worst possible consequences such as his wife finds him engaged in sex play with a child, he is arrested in front of his neighbours, etc. In 'shame aversion therapy', the patient is required to go through a deviant act in the therapist's office, while the therapist and his wife observe and comment at it. This technique is quite distressing and should be used only when other techniques seem to have failed.

NOTES

The 'skill training' focuses on teaching these individuals the basic social skills and sexual skills. It aims at training them in conversational skills, eye-contact, empathy skills, listening skills, asking for a date, making socially acceptable sexual advance, sensation exercises, communicating desires and exploring new sexual experiences.

In behaviour therapy the focus is largely on 'relapse prevention', which involves training them to avoid situations that place them at risk, interrupting thought chains that lead to the offense and exerting voluntary control over their impulses through behavioural strategies.

The cognitive perspective: The cognitive treatment focuses on identifying deviant beliefs, challenging them and then replacing them with more adaptive beliefs. It also focuses on victim awareness or victim empathy training that helps the sex offenders to begin to see the victim as an individual having feelings of her own than seeing her as an object. This training involves confronting the offender with the emotional damage that has been caused by him to the victim. The offender may be asked to imagine what one of their victims was thinking during the assault. They may also be assigned to read books, listen to audiotapes and view videotapes in which victims of rape or child molesting describe their experience of the episode and its psychological consequences.

The biological perspective: This perspective focuses on use of methods like castration, use of drugs like MPA (medroxy progesterone acetate, which is known to lower testosterone level) and cyproterone acetate (which lowers androgen level) to inhibit sexual arousal.

3.8.3 Sexual Dysfunctions

The term sexual dysfunction refers to impairment either in the desire for sexual gratification or in the ability to achieve it, which persists over time. They vary in degree and adversely affect the sexual enjoyment of both the partners. Occasional, random episodes of sexual failure are normal. They may be caused by dysfunctional psychosexual adjustments and training and are seen to occur in both heterosexual and homosexual individuals.

According to Masters and Johnson (1970, 1975, 1996), there are four relatively distinct phases of human sexual response as follows:

Desire phase: It consists of fantasies about sexual activity or a sense of desire to have sexual activity.

Excitement phase: Consists of both a subjective sense of sexual pleasure and physiological changes that accompany subjective pleasure, including penile erection in the male and vaginal lubrication and enlargement in the female.

Orgasm: In this phase, there is a release of sexual tension and a peaking of sexual pleasure.

Resolution: In this phase, the individual has a sense of relaxation and well being.

NOTES

Sexual dysfunctions can be lifelong or acquired and generalized or situational in nature. Lifelong dysfunctions refer to dysfunctions that have existed without relief, since the person's earliest sexual experiences. Acquired dysfunctions are those dysfunctions that develop after at least one episode of normal functioning. Generalized dysfunctions are those dysfunctions that are present in all sexual situations at the time of diagnosis. Situational dysfunctions are those dysfunctions that occur only in certain situations. According to Helen Singer Kaplan (1974), sexual dysfunctions are classified as per the phase in the sexual response cycle in which they occur, as given below:

Dysfunction of sexual desire: It covers hypoactive sexual desire disorder and sexual aversion disorder. 'Hypoactive sexual desire disorder' refers to little or no sexual drive or interest in sex. 'Sexual aversion disorder' refers to total lack of interest in sex and avoidance of sexual contact. These individuals often have a history of incest, childhood molestation or rape and show disgust, repulsion, anxiety and other negative emotions towards sex.

Dysfunctions of sexual arousal: These cover male erectile disorder and female sexual arousal disorder. 'Male erectile disorder' refers to inability to achieve or maintain an erection (formerly known as impotence). 'Female sexual arousal disorder' refers to non-responsiveness to erotic stimulation both physically and emotionally (formerly known as frigidity).

Dysfunctions of orgasm: These cover premature ejaculation, male orgasmic disorder and female orgasmic disorder. In the orgasm phase, the sexual pleasure triggers rhythmic contractions of the muscles in the genital region and in men leads to simultaneous ejaculation of the semen from the penis. If the ejaculation occurs too early in the orgasm phase then it interferes with the sexual enjoyment. This unsatisfactory brief period between the beginning of sexual stimulation and occurrence of ejaculation is known as 'premature ejaculation'. If, on the other hand, ejaculation is greatly delayed or does not occur at all, the condition is known as 'inhibited male orgasm'. The delay or absence of orgasm in women during sexual intercourse or manually is known as 'inhibited female orgasm'.

Sexual pain disorder: It consists of vaginismus and dyspareunia. During intercourse, when the penis is inserted into the vagina, the muscles surrounding the entrance to the vagina undergo involuntary spasmodic contractions. When these contractions make intercourse either impossible or painfully difficult, then this condition is known as vaginismus. Dyspareunia refers to pain during intercourse. It can occur in either sex, but it is usually a female complaint. The pain can be organic or psychological in nature.

3.8.3.1 Epidemiology

In an epidemiological study conducted by Laumann et al. (1994), it was found that for women the most common complaints were lack of sexual interest (33 per cent) and inability to experience orgasm (24 per cent). For men, climaxing too early (29 per cent), anxiety about sexual performance (17 per cent), and lack of

NOTES

sexual interest (16 per cent) were reported most frequently. Altogether 45 per cent of men and 55 per cent of women reported some dysfunction during the past year. In a study by Swan and Wilson (1979), sexual dysfunction is found in about 10 per cent of psychiatric out-patients.

A high percentage of people will experience sexual dysfunction sometime during their lives. Erectile dysfunction and premature ejaculation are likely to be common problems among the men. Factors such as increasing age, diabetes, heart disease, hypertension, cigarette smoking, depression and excessive alcohol intake are associated with reported impotence in males. Vaginal dryness and infrequent orgasm are the most common problems among the women.

3.8.3.2 Course and prognosis

Sexual aversion disorder may result from a traumatic sexual assault, such as rape or childhood abuse, from repeated painful experiences with coitus, or from early developmental conflicts that have left the patient with unconscious connections between the sexual impulse and overwhelming feelings of shame and guilt. The disorder may also be a reaction to a perceived psychological assault by the partner and to relationship difficulties.

It is estimated that the incidence of erectile dysfunction in young men is approximately 8 per cent. However, this sexual dysfunction may first appear later in life. Masters and Johnson reported a fear of impotence in all men over 40 years of age, which the researchers believed reflects the masculine fear of loss of virility with advancing age.

Complaints of persistent or intermittent lubrication difficulties are likely to increase in postmenopausal women. Female organism disorders are likely to increase with age.

3.8.3.3 Etiology

Sexual dysfunction arises from varying combinations of a poor general relationship with the partner, low sexual drive, and ignorance about sexual technique and anxiety about sexual performance. Other important factors are physical illness (like diabetes mellitus and myocardial infarction), depression, anxiety disorders, medication and excessive use of alcohol and street drugs.

They may also result from castration, anti-androgen drugs, history of sexual abuse or assault, incorrect and negative notions about sexual relationships received from the parents, failure to resolve the oedipal complex in boys and the corresponding attachment to the father in girls. Several drugs such as antipsychotics, anti-hypertensive's, etc. have sexual dysfunction as a side effect. Abnormalities of the vascular supply to the penile erectile tissue, including reduced arterial perfusion and increased venous leakage can also lead to sexual dysfunctions.

Numerous psychological factors are associated with female sexual inhibition are fears of impregnation; rejection by the sexual partner or damage to the vagina; hostility toward men; and feelings of guilt regarding sexual impulses. Some women

NOTES

equate orgasm with loss of control or with aggressive, destructive or violent behaviour. Fear of those impulses may be expressed through inhibition of excitement or orgasm.

Impaired lubrication of the vagina, scars or lesions or muscle spasms of the vagina, ovarian cysts, tumours or pelvic infection in women may underlie sexual pain disorders. Thus, several psychological and physical factors may interact in multiple complex ways in the etiology of sexual dysfunctions.

3.8.3.4 Management

Treatment of sexual dysfunctions involves giving psycho education about the physiology of the sexual response, rectifying several incorrect notions, myths and fears associated with sex and or providing marital therapy if the conflicts in the marriage seems to underlie the sexual dysfunction.

It also involves providing sex therapy directed to both partners wherever possible. Masters and Johnson's sex therapy (1970) has four characteristic features—the partners are treated together; they are helped to communicate better about their sexual relationship, desires and fantasies; they receive information about the anatomy and physiology of sexual intercourse; and they take part in a series of graded tasks.

In addition to various psychological methods, medication such as sildenafil, injections of prostaglandis, intracavernosal injections of the smooth muscle relaxant papaverine or the d-receptor blockers phenoxybenazmine, use of vacuum devices and surgical correction of vascular abnormalities and penile prostheses can also be used.

CHECK YOUR PROGRESS

12. What is meant by gender identity disorder?
13. What are the four relatively distinct phases of human sexual response according to Masters and Johnsons?
14. What is pedophilia?

3.9 ORGANIC MENTAL DISORDERS

For us to think, behave, feel and act adequately, it is essential that our brain functions normally. However, transient or permanent brain dysfunctions can lead to several behavioural or psychological disorders known as organic mental disorders. The organic mental disorders include only those mental and behavioural disorders that are due to demonstrable cerebral disease or disorder, either primary or secondary. The dysfunction may be primary (as in disease, injuries and insults that affect the brain directly or with predilection) or secondary (as in systemic diseases and

disorders that attack the brain only as one of the multiple organs or systems of the body involved).

Since organic brain illness can mimic any psychiatric disorder, especially in the initial stages, organic mental disorders should be the first consideration in evaluating a patient with any psychological or behavioural clinical syndrome. Several factors such as presence of first episode; sudden onset; older age of onset; history of drug or alcohol use disorder; concurrent medical or neurological illness; neurological symptoms or signs like seizures, impairment of consciousness, head injury, sensory or motor disturbance; prominent visual or other non-auditory hallucinations; soft neurological signs and presence of confusion, disorientation and memory impairment are more likely to indicate the presence of an organic mental disorder.

ICD-10 recommends the following four criteria for classifying a syndrome as organic:

- Evidence of cerebral disease, damage or dysfunction or of systemic physical disease known to be associated with one of the listed syndromes
- A temporal relationship (weeks or a few months) between the development of the underlying disease and the onset of the mental syndrome
- Recovery from the mental disorder following removal or improvement of the underlying presumed cause
- Absence of evidence to suggest an alternative cause of the mental syndrome (such as a strong family history or precipitating stress)

The three most commonly known organic mental disorders are:

- Delirium
- Dementia
- Organic amnesic syndrome

These are mainly characterized by the presence of impairment in cognition such as in memory, language and attention.

3.9.1 Delirium

Delirium is the most common organic disorder seen in clinical practice. It is characterized by global impairment in consciousness, resulting in reduced level of alertness, attention and perception of the environment. It is defined by the acute onset of fluctuating cognitive impairment and a disturbance of consciousness with reduced ability to attend. It is frequently associated with abnormalities in perception, thought, psychomotor activities and disturbances in the sleep–wake cycle. Speech, perceptual and thought disturbances like slurring of speech, incoherence, dysarthria, fleeting delusions (often persecutory), ideas of reference, slow and muddled thinking, experiences of depersonalization and derealization may also be present. These individuals appear most commonly disoriented in time, then in place and rarely in

NOTES

person. It is also associated with cognitive and functional decline. Anxiety, depression and emotional lability are common. Patient may be frightened or perplexed.

3.9.1.1 Epidemiology

Delirium is present in 1 per cent of adults in the community, in at least 10 per cent of emergency department patients, in 40 per cent of terminally ill patients and in as much as one-half of hospitalized patients. Prevalence increases with patient's age, complexity of medical co-morbidities and the number and frequency of medications prescribed.

3.9.1.2 Course and prognosis

Its onset is acute. The delirious state is transient and of fluctuating intensity. Its duration and intensity varies ranging from a mild to severe level. It may occur at any age but is most common after the age of 60 years. Most cases usually recover within four weeks or less. A delirious state may be superimposed on or may progress into dementia. It is known to complicate medical course and may increase the mortality risk.

3.9.1.3 Etiology

Delirium can be caused by any factor that disturbs the metabolism of brain sufficiently. It is most often caused by multiple etiologies, such as infection, metabolic abnormalities, endocrinopathies, substance intoxication and withdrawal. Neurochemical abnormalities, inflammatory changes, oxidative stress, blood–brain barrier dysfunction and interactions between these factors are known to explain the pathophysiology of delirium.

Some of the most important causes of delirium are metabolic causes (such as hypoxia, carbon dioxide narcosis, hypoglycemia, cardiac failure, cardiac arrest, water and electrolyte imbalance, fever and anemia); endocrine causes (such as hypo and hyper pituitarism, hypo and hyper thyroidism, hypo and hyper parathyroidism, hypo and hyper adrenalism); ingestion and withdrawal of drugs and poisons (such as quinidine, alcohol, sedatives, hypnotics, tricyclic antidepressants, anti psychotics and anticonvulsants); nutritional deficiencies (such as thiamine, niacin, folic acid and proteins); acute and chronic systemic infections (such as pneumonia); intracranial causes (such as epilepsy, head injury, intracranial infections, migraine and stroke) and other conditions (like post-operative states, sleep deprivation, heat, electricity and radiation).

3.9.1.4 Management

There are three major goals of delirium treatment: One is to find and to reverse the contributors to the delirium. The second is to ensure the patient's safety while educating patients, family, and staff. The third is the symptomatic treatment of behavioural disturbances associated with delirium.

NOTES

Management of delirium consists of identifying and immediately correcting the cause underlying delirium. Antipsychotics may be considered if psychosis, severely disorganized thought process or extreme physical or verbal agitation places the patient or others at risk of harm. Brief, judicious use of sedating agents, such as zolpidem (Ambien) or trazodone (Desyrel), to reset the sleep–wake cycle may be appropriate.

ECT can also be used as a last resort for delirious patients with severe agitation who are not responsive to pharmacotherapy, such as high doses of IV haloperidol. The ECT is usually given en bloc or daily for several days, sometimes with multiple treatments per day.

The psychological treatments focus on safety and orientation with provision of the appropriate level of stimulation and education toward the patient and family. The appropriate level of stimulation and orienting cues should be present in the patient's environment such as a large clock, calendar, well-lit room. Darkening the room at night is likely to help with the sleep–wake cycle disturbance seen in these clients.

During the delirious episode, families can be educated about the appropriate ways they can adopt to support the patient. They can also be told about what information is important to convey to the medical team. As the delirium symptoms resolve, the patient and family should be educated about the long-term prognosis.

3.9.2 Dementia

Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment. It is marked by the presence of severe intellectual deterioration. It is defined as a progressive impairment of cognitive functions occurring in clear consciousness (that is, in the absence of delirium).

Other mental functions such as mood, personality and social behaviour may also be affected. Impairment of cognitive functions are commonly accompanied and occasionally preceded by deterioration in emotional control, social behaviour or motivation. These individuals are likely to show two major behavioural syndromes—(i) apathy, inertia and loss of interest in work and hobbies; and (ii) restlessness, disinhibition, distractibility, loss of empathy and social skills. Behaviour becomes aimless and stereotypes and mannerism may appear. As dementia worsens, the patient is less able to care for himself or herself adequately and tends to neglect social conventions. The symptoms result in significant impairment in social or occupational functioning and they represent a significant decline from a previous level of functioning.

In short, dementia is an organic mental disorder characterized by impairment of intellectual functions; impairment of memory (predominantly of recent memory, especially in the early stages) and disorientation of personality with lack of personal

NOTES

care. Impairment of all functions occurs globally, causing interference with day-to-day activities and interpersonal relationships.

3.9.2.1 Epidemiology

The prevalence of dementia rises exponentially with age. The estimated prevalence of moderate to severe dementia in population aged 65–69 years is approximately 1.5–2.0 per cent; in population aged 75–79 years is approximately 5.5–6.5 per cent and in population aged 85–89 years is 20–22 per cent.

3.9.2.2 Course and prognosis

The course of dementia may be chronic, progressive, stationary or reversible depending on the types of dementia one is suffering from. The course and prognosis of dementia may also vary depending on etiology and severity at the time of presentation. Correcting potentially reversible causes is crucial, such as profound hypothyroidism, vitamin B_{12} deficiency, chronic subdural hematoma or severe major depression. However, treatment of these reversible causes of dementia may not completely restore cognitive function.

Most dementias are progressive and therefore inevitably have a poor prognosis. Modifying identifiable risk factors, such as poorly controlled hypertension in a vascular dementia, can alter progression of the illness. The progression of a dementia may be complicated by other inter-current medical illnesses, such as a stroke can complicate the course of Alzheimer's disease. In general, degenerative dementias have an insidious onset and are gradually progressive. The pattern may initially include periods of more gradual decline, followed by a more rapid progression. Vascular dementia tends to have an abrupt onset and a more stepwise pattern, associated with further vascular insults, but may have a gradual and progressive course. Radiation-induced dementia may present months after radiation exposure and may have a progressive course.

3.9.2.3 Etiology

Dementia may be caused by a large number of conditions such as parenchymatous brain disease (like Alzheimer's disease, Pick's disease, Parkinson's disease, Huntington's disease, etc); toxics (like bromide intoxication, drugs, alcohol, heavy metals, carbon monoxide, etc.); endocrine factors (thyroid, parathyroid, pituitary, adrenal dysfunctions, etc.); deficiencies (like pernicious anemia, pellagra, folic acid deficiency, thiamine deficiency, etc.); infections (like Crentzfeldt-Jacob disease, chronic meningitis, viral encephalitis, AIDS, etc.); neoplasms and other intracranial space occupying lesions; chronic subdural hematoma and head injury. Of these Alzheimer's disease, multi-infarct dementia and hypothyroidisms are the most common causes underlying dementia

3.9.2.4 Management

In general, there are three broad types of treatment for dementia: Treatments to modify risk that slows the course or to correct reversible causes of dementia,

NOTES

treatments of the cognitive symptoms of dementia, and treatment of associated symptoms and behaviours that may complicate the course of dementia (e.g. agitation).

Accurate diagnosis of dementia allows treatment of any modifiable factors (e.g. lipid levels, hypertension, glycemic control in diabetes, vitamin deficiencies and endocrine abnormalities) that may exacerbate the presentation or course of the dementia. Medications like antipsychotics, anti-depressants, mood stabilizers and cholinesterase inhibitors have been found to be of help in the management of dementia.

Behavioural interventions usually aiming at addressing the psychosocial or environmental reasons for the behaviour focus on reducing caregiver burden and may delay patient institutionalization. Wherever possible, activities such as exercise, socialization, predictable routines and recreation should be maintained. The patients should usually be kept in a familiar and a structured environment to reduce confusion and to help these patients become as self-reliant as possible.

Family and caregiver education, support groups and reassurance can be extremely effective in addressing caregiver stress and can help caregivers work more effectively with demented patients.

3.9.3 Organic Amnesic Syndrome

Organic amnesic syndrome is characterized by impairments of memory due to an underlying organic cause; absence of disturbance of consciousness and attention and absence of disturbance of global intellectual function, abstract thinking or personality. Its key feature is the inability of the individual to learn and later recall new information. Some of these patients may also show an inability to recall previously learned knowledge or past events. To make the diagnosis, the condition should cause significant impairment in one's personal, social or occupational functioning and the individual should not meet the criteria for delirium and or dementia.

These individuals may be able to recall events immediately after they occur but may forget them a few minutes later. New memory is grossly defective, but retrograde memory is variably preserved and shows a temporal gradient. Gaps in the memory may be filled by confabulations. In this order, other cognitive functions are relatively well preserved, although some emotional blunting and inertia is often observed.

3.9.3.1 Epidemiology

Although exact data is not available for estimating the point or lifetime prevalence, incidence or lifetime risk of persistent amnesic disorder, one recent study indicated that transient global amnesia may have an incidence of 5.2 cases per 100,000 population per year.

NOTES

3.9.3.2 Course and prognosis

The disorder is usually abrupt in its onset. Its course and prognosis largely depend on the etiological factors underlying amnesic disorder. For instance, alcohol-induced amnesic disorder may develop deficits insidiously over many years as a result of repeated toxic and nutritional deficiencies, whereas transient amnesia due to a cerebro-vascular etiology may be recurrent, with episodes lasting from several hours to several days. Amnesic disorder due to head injury may last for a variable period of time. Full recovery may occur, although severe injuries are typically characterized by residual deficits. The prognosis is poor in case of amnesic disorder due to encephalitis and other causes of irreversible bilateral hippocampal or di-encephalic damage.

3.9.3.3 Etiology

The most common cause of amnesic disorder is chronic alcoholism or alcohol dependence. It is also known as Wernicke-Korsakoff syndrome. Other etiological factors underlying amnesic disorder are lesions involving bilaterally the inner core of limbic system, head trauma, surgical procedure, hypoxia, posterior cerebral artery stroke and herpes simplex encephalitis, etc.

3.9.3.4 Management

The treatment of an amnesic disorder depends on its etiology. Presently there are no known definitive effective treatments for amnesic disorder that are specifically aiming at reversing apparent memory deficits. For example, Wernicke's encephalopathy is treated with replacement of thiamine, usually via the IV and IM routes and replenishment of other vitamins simultaneously.

Centres for cognitive rehabilitation have been established whose rehabilitation oriented therapeutic milieu is intended to promote recovery from brain injury, especially from traumatic causes. Most of the individuals require supportive care and supervised living situations to ensure appropriate feeding and care.

CHECK YOUR PROGRESS

15. Under what are organic mental disorders?
16. Write down the various clinical features of delirium?
17. What is organic amnesic syndrome?

3.10 PERSONALITY DISORDERS

The term personality refers to enduring qualities of an individual that are shown in his ways of behaving in a wide variety of circumstances. It is a deeply ingrained pattern of behaviour that includes modes of perception, relating to and thinking about oneself and the surrounding environment. This pattern of behaviour seems

NOTES

to be different in each individual as different individuals have their own way of perceiving, thinking and behaving in different situations and circumstances.

This variability in personality from the psychiatric view point is important for several reasons. Certain aspects of personality can predispose an individual to psychiatric disorders by increasing the individual's reaction to stressful events. For instance, adverse circumstances are more likely to induce an anxiety disorder in a person who has always worried about minor problems. Personality factors may also account for unusual features in a psychiatric disorder known as 'pathoplastic factors'. These factors refer to exaggerations in certain features of personality in response to stressful events associative with illness. For instance, under stressful situations, histrionic features in an individual's personality traits may get exaggerated suggesting a diagnosis of dissociative disorder. Some aspects of personality may even affect the way the patient approaches psychiatric treatment. For example, individuals with obsessional traits may become angry if the treatment does not follow their expectations exactly. Similarly, individuals with antisocial traits may be uncooperative with treatment.

Personality traits are defined as normal, prominent aspects of personality. However personality disorders result when these personality traits become abnormal, i.e. become inflexible and maladaptive and cause significant social or occupational impairment or significant distress.

Abnormal personality traits are usually 'ego-syntonic', that is, they do not necessarily cause significant distress to the patient. That is why individuals having personality disorders do not usually seek psychiatric help unless other psychiatric symptoms co-exist. Personal distress may occur in some personality disorders.

3.10.1 Types of Personality Disorders

Personality disorder is a common and chronic disorder. Its prevalence is estimated between 10 and 20 per cent in the general population. Many instances of violent and nonviolent crimes and a large percentage of the prison population are associated with underlying personality disorders. These individuals have chronic impairments in their ability to work and to love; tend to be less educated, drug dependent, single and unemployed; and tend to have marital difficulties. Different types of personality disorders are given below.

3.10.1.1 Paranoid personality disorder

Individuals having paranoid personality disorder are suspicious, mistrustful, resentful, jealous and sensitive and bear grudges, and have self-important ideas. These individuals tend to suspect actions of other people and are constantly on the look-out for attempts by others to deceive them or play tricks on them. As a result, other people find them difficult and unreasonable. They do not make friends easily and avoid involvement in groups. They appear secretive, devious and self-sufficient to a fault. They doubt the loyalty of other people and do not trust them.

NOTES

Sexual jealousy is common. They do not forgive real or perceived insults. They have a strong sense of their rights and may engage in litigation with which they persist long after the other has abandoned the case. They are sensitive to rebuff, prickly and argumentative. They read demeaning or threatening meaning into innocent remarks. They take offence easily and see rebuff, where none is intended. They have a strong sense of self-importance. They believe that they are unusually talented and are capable of great achievements. This unrealistic idea is maintained, despite modest accomplishments, by beliefs that others have prevented them from fulfilling their potential. They may become involved in litigation on small issues. Psycho-dynamically, the underlying defense mechanism is projection.

The prevalence rate of paranoid personality disorder is likely to be 0.5–2.5 per cent in the general population, 10–30 per cent for psychiatric inpatients, and 2–10 per cent for psychiatric outpatients according to DSM-IV-TR. It is likely to be more prevalent in men than women. It is more common in minority groups and immigrants.

The paranoid personality disorder is found premorbidly in some patients of paranoid schizophrenia. But whether it predisposes to the development of paranoid schizophrenia is not known. Differential diagnosis is from delusional (paranoid) disorders and paranoid schizophrenia.

The response to treatment is usually poor. The patients often do not seek treatment on their own and may resent treatment. Drug treatment has a very limited role.

3.10.1.2 Schizoid personality disorder

These individuals are seen to be emotionally cold, aloof, detached, introspective and prone to fantasy. They are unable to express either tender feelings or anger. They show little interest in sexual relationships. In extreme cases, these individuals appear cold and callous. They show little concern for the opinions of other people. They do not feel comfortable in intimate relationships and prefer solitary activities over group activities. They usually remain unmarried. They show greater interest in intellectual matters than in people. They have a complex inner world of fantasy often devoid of emotional content. They lack a sense of enjoyment, have little sense of humor, and take little pleasure in activities that most people enjoy. They appear insensitive to social norms and conventions.

The features of this disorder tend to overlap with paranoid and schizotypical personality disorder. Psychotic features are absent and it is more commonly seen in men. Psychodynamically, it is supposed to result from 'cold and aloof' parenting in a child with introverted temperament.

It has an onset in early childhood with stable course over the years. Earlier it was believed to predispose to development of schizophrenia, but later studies have failed to replicate the findings. The patients often do not seek treatment on their own. The response to treatment is usually not good. Drug treatment has a very limited role.

NOTES

3.10.1.3 Shizotypal personality disorder

These individuals are seen to be socially anxious, experience cognitive and perceptual distortions, show oddities of speech, make inappropriate affective responses and behave eccentrically. They tend to feel anxious in the company of others and have difficulty in making relationships. These individuals lack friends and feel different from other people and do not fit in. Cognitive and perceptual distortions include ideas of reference, suspicious ideas, odd beliefs, magical thinking and unusual perceptual experiences. These individuals at times show oddities of speech in the form of unusual constructions, words and phrases, vagueness and tendency to digress. They make inappropriate affective responses and appear odd, stiff and constricted in their emotions. Their behaviours seem eccentric. They seem to show odd mannerism, disregard conventions and their social behaviour seems awkward. These individuals may have unusual choice of clothing. These individuals show obsessive ruminations without inner resistance, often with dysmorpho-phobic, sexual or aggressive content. Occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations and delusion-like ideas, usually occurring without external provocation may be present.

This disorder lies between schizoid personality disorder and schizophrenia on a schizophrenia on a schizophrenic continuum. It is more common in individuals related to schizophrenics and is believed to be part of the genetic spectrum of schizophrenia. It seems to show high co-morbidity with schizophrenia, major depression and other personality disorders like schizoid, paranoid, avoidant and borderline.

The sex ratio is unknown. This disorder is frequently diagnosed in women with fragile X syndrome. According to DSM-IV-TR, it has a prevalence rate of 3 per cent in the general population.

Its onset, evolution and course are usually those of a personality disorder. It usually runs a chronic course. The response to treatment is usually poor. Anti-psychotic drugs have been found to be beneficial in the treatment of brief psychotic episodes.

3.10.1.4 Antisocial personality disorder

These individuals appear to be callous, irritable and impulsive people who seem to lack guilt or remorse and tend to avoid responsibilities. These individuals are irresponsible and depart from social norms. Their relationships are shallow and largely transient in nature. They tend to lack concern for the feelings of the other and their sexual activity is without tender feelings. These individuals may inflict cruel or degrading acts on other individuals. They do not obey rules and may get into problems with the law. They are often involved in violent offenses and their offenses typically begin in adolescence. These individuals lack goals, do not plan ahead and typically have an unstable work record marked by frequent dismissals. They tend to get easily provoked, irritable and angry and in anger they may end up assaulting the individual in a quite violent way. They lack guilt or remorse and often

NOTES

fail to learn from their adverse experiences and also fail to change their behaviour in response to punishment. They tend to blame others for their faults and try to rationalize their failures. They are also deceitful and irresponsible about finances. Their abnormal behaviour is made worse by the presence of drug abuse and alcohol.

These individuals are at increased risk for impulse control disorders, major depression, substance abuse or dependence, pathological gambling, anxiety disorders and somatization disorder. The most common co-occurring personality disorders are narcissistic, borderline and histrionic.

The disorder is likely to be 3 times more common in men than women. According to DSM-IV-TR, the prevalence rate of antisocial personality disorder is 3 per cent for men and 1 per cent for women in the general population and 3–30 per cent in clinical settings.

Antisocial personality disorder is more frequent among the first-degree biological relatives of probands with this disorder. Genetic studies have suggested familial transmission of antisocial personality disorder, substance use and somatization disorder, the former two being characteristic of men and the latter being characteristic of women in the same family. Adoption studies have shown that genetic and environmental factors contribute to the risk for this disorder.

Conduct disorder (before 10 years of age) and accompanying attention-deficit/hyperactivity disorder (ADHD) increase the likelihood of developing antisocial personality in adult life. Conduct disorder is more likely to develop into antisocial disorder with erratic parenting, neglect or inconsistent parental discipline.

3.10.1.5 Narcissistic personality disorder

This is characterized by a grandiose sense of self importance in these individuals. They tend to be boastful and pretentious. They tend to be occupied with fantasies of unlimited illness, power, beauty or intellectual brilliance. They believe themselves to be special and expect others to admire them and should offer special services and do them favours. They feel entitled to the best and seek to associate with people of high status. They tend to exploit others and do not empathize with or show concern for their feelings. They envy the possessions and achievements of the others and expect that others would envy them in the same way. They are arrogant and behave in patronizing or condescending ways.

These individuals tend to show social withdrawal, depressed mood, dysthymic or major depressive disorder in reaction to criticism or failure and are at an increased risk for major depression and substance abuse or dependence (especially cocaine use). The most common co-occurring personality disorders are borderline, antisocial, histrionic and paranoid. This disorder is likely to be more common in men than women.

Its course is chronic. However, narcissistic symptoms tend to diminish after 40 years of age, when pessimism usually develops. According to DSM-IV-TR,

the prevalence rate of narcissistic personality disorder is 2–16 per cent in the clinical population and less than 1 per cent in the general population.

NOTES

3.10.1.6 Histrionic personality disorder

These individuals are self dramatizing in nature. Their self-dramatization may extend to emotional blackmail, angry scenes and demonstrative suicidal attempts. These individuals are suggestible and are easily influenced by others, especially, by figures of authority. They follow the tastes and opinions of others and adopt the latest fads and fashions. They seek attention and excitement and crave new experiences, get easily bored and have short-lived enthusiasm. They have a shallow labile effect and display their emotions in a dramatic manner and may exhaust the others with tantrums of rage and unrestrained expectations of despair. There is little depth in their emotional outpourings and recover quickly and are surprised that other people have not forgotten the scenes as quickly as they have.

They are flirtatious and inappropriately seductive but their sexual feelings are shallow. They may fail to reach orgasm despite elaborate displays of passion. They are over concerned about physical attractiveness. In an attempt to impress others, they spend excessive amounts of time and money on clothes and personal grooming and are unreasonably upset by even minor criticisms of their appearance.

They are self-centred, lack consideration of others and put their interest and enjoyment first. They appear inconsiderate and demanding and may go to extreme lengths to force other people to fall in with their wishes. They have marked capacity for self-deception and believe their own lies, however elaborate and improbable, even when other people have come to know that they are lying.

There interpersonal relations are unstable, shallow, and generally ungratifying. There are frequent marital problems secondary to the tendency to neglect long-term relationships for the excitement of new relationships. These patients are at increased risk for major depression, somatization disorder and conversion disorder. The most common co-occurring disorders are narcissistic, borderline, antisocial and dependent.

There seems to be a general agreement that this disorder occurs far more frequently among women. According to DSM-IV-TR, the disorder might be equally frequent among men and women. As per the reports of DSM-IV-TR, its prevalence rate may be 2–3 per cent in the general population and 10–15 per cent in psychiatric inpatients and outpatients. This disorder tends to run in families. A genetic link between histrionic and antisocial personality disorder and alcoholism has been suggested.

3.10.1.7 Borderline personality disorder

The hallmarks of borderline personality disorder are pervasive and excessive instability of affects, self-image and interpersonal relationships, as well as marked impulsivity. These individuals are seen to engage in frantic efforts to avoid real or imagined abandonment; have unstable and intense interpersonal relationships

NOTES

alternating between idealization and devaluation; have markedly and persistently unstable self-image or sense of self-characterized by chronic feelings of emptiness. They may at times show a tendency to undermine self when they are close to realizing a goal. These individuals tend to show marked reactivity of mood and instability of affect. They tend to engage in recurrent suicidal behaviours, gestures, threats or self-mutilating behaviours. These individuals may show inappropriately intense anger and may experience difficulty in controlling anger. In them stress-related, transient paranoid ideation or dissociative symptoms are common. These individuals may feel more secure with nonhuman objects (pets and inanimate objects) than in interpersonal relationships. Impairment is frequent and severe and includes frequent job losses, interrupted education and broken marriages.

It is believed that early childhood traumatic experiences, vulnerable temperament and a series of triggering events may play a significant role in the etiology of this disorder.

Physical and sexual abuse, neglect, hostile conflict, and early parental loss or separation are more common in childhood histories of patients with this disorder. Borderline personality disorder is five times more common among relatives of probands with this disorder than in the general population. Familial aggregation of borderline personality disorder has been repeatedly demonstrated.

These patients are at increased risk for major depression, substance abuse or dependence, eating disorder (notably bulimia), posttraumatic stress disorder (PTSD), and ADHD. Borderline personality disorder co-occurs with most other personality disorders.

It is likely to be more prevalent in women than in men. Its course is variable and most commonly follows a pattern of chronic instability in early adulthood, with episodes of serious affective and impulsive dyscontrol. The impairment and the risk of suicide are the greatest during the young adult years and gradually wane with advancing age. In the fourth and fifth decades of life, these individuals tend to attain greater stability in their relationships and functioning.

Prevalence rates of 2 per cent in the general population, 10 per cent for psychiatric outpatients, 20 per cent for psychiatric inpatients, and 30–60 per cent among patients with personality disorders have been reported in DSM-IV-TR.

3.10.1.8 Avoidant personality disorder

Individuals with this disorder are persistently tensed, feel insecure and lack self-esteem. They feel socially inferior, unappealing and socially inept. They appear preoccupied with the possibility of rejection, disapproval or criticism and worry that they will be embarrassed or ridiculed. They are cautious about new experiences and avoid involvement with unfamiliar people. They are timid in the face of everyday hazards and avoid risk. They do not feel comfortable in company and tend to avoid social activities.

They have few friends, are inhibited in their personal situations and their intimate relationships are constrained by fears of being shamed or ridiculed. These individuals crave for social relationships but are unable to obtain them. These individuals are likely to experience occupational and social difficulties. The disorder frequently begins in childhood with shyness and fear of strangers and new situations.

These patients are at increased risk for mood and anxiety disorders (especially social phobia, generalized type). The most common co-occurring disorders are schizotypal, schizoid, paranoid, dependent and borderline. It is equally prevalent in men and women. According to DSM-IV-TR, its prevalence rate is 0.5–1.0 per cent in the general population and 10 per cent in psychiatric outpatients.

3.10.1.9 Dependent personality disorder

These individuals allow others to take responsibility for important decisions in their life. They appear weak-willed and unduly compliant with the wishes of others. They are unwilling to make direct demands on other people, but instead do it indirectly by appearing unable to help themselves. They lack vigour and feel that they will be unable to care for themselves and fear that may have to do so.

They lack self-reliance, avoid responsibility and need excessive help to make decisions and tend to ask repeatedly for advice and reassurance. These individuals need a more energetic and determined spouse who is willing to make decisions and arrange activities for them. If left to themselves, some of these individuals tend to drift down the social ladder and may be found among the long-term unemployed and homeless individuals. These individuals are likely to have poor family and marital functioning.

These patients are at increased risk for major depression, anxiety disorders and adjustment disorder. The most common co-occurring disorders are histrionic, avoidant, and borderline. It is the most frequently present personality disorder and is found to be equally present in both men and women. It is believed that chronic physical illness or separation anxiety disorder may predispose individuals for developing dependent personality disorder.

3.10.2 Epidemiology

Although personality disorders are usually recognized by early adolescence, they are not typically diagnosed before early adult life. The symptoms continue unchanged through the adult life and usually become less obvious in the later years of life. The prevalence of personality disorders in the general population is 5–10%. Often symptoms of more than one personality disorder are present in one person.

3.10.3 Etiology

The specific etiological factors underlying personality disorders are largely unknown. However, a complex interaction between genetic factors and early life experiences in known to predispose individuals to develop various personality disorders. For

NOTES

instance, genetic factors, XYY chromosomal abnormality, minor brain injury, abnormalities in brain 5-hydroxytryptamine (5-HT) neurotransmission, separation of a young child from his mother, presence of marital disharmony in family, behavioural problems in childhood, lack of consistent rules in the family, impediments in learning and poor ability to sustain attention have been known to play a significant role in antisocial personality disorder.

A disturbed relationship with the mother at the stage of individuation of the child is known to lead to the development of borderline personality disorder and failure to resolve either oedipal conflict or oral conflicts is known to underlie histrionic personality disorder.

Some personality disorders have also been linked etiologically with the psychiatric disorders which they resemble. For instance, paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder are etiologically linked with schizophrenia and obsessive compulsive personality disorder is linked with obsessive compulsive disorder.

3.10.4 Management

Most individuals with personality disorders perceive their lifestyles as normal and seldom seek or accept treatment. Typically, they seek help when their maladaptive behaviours culminate in severe marital, family and career problems or for co-morbid anxiety, depression, substance abuse or eating disorders.

Extreme temperament and immature character traits are optimally treated simultaneously with combined psychotherapy and pharmacotherapy.

3.10.4.1 Psychotherapy

Dynamic psychotherapy addresses the internal world of the patient's emotions and needs and treats symptoms as external manifestations of internal motivations. Behaviour therapy focuses on external manifestations (or symptoms) and enables patients to change behaviour or to achieve better control of their behaviours. Cognitive therapy helps patients correct their distorted cognitive appraisal of the significance of environmental cues and their underlying core beliefs that lead to maladaptive behaviours. Humanistic approaches, by increasing self-directedness and cooperativeness, assist patients in achieving personal and social maturity in a form of altruistic individualism.

This seems to be especially relevant to personality disorder, where both the reduction of internal discomfort and the improvement of social functioning are equally important. For example, a combination of dynamic therapy (which is insight-oriented) and cognitive-behavioural therapy (which is action-oriented) efficiently helps patients transform their insights into an actual behaviour change. Recently, dialectical behaviour therapy, based on a biosocial theory that borderline symptoms reflect primarily a dysfunction of the emotion regulation system, has shown effectiveness in reducing the core symptoms and improving the social adjustment of borderline patients. A growing number of therapists are beginning to ignore

NOTES

ideological barriers dividing different schools of psychotherapy and are attempting technical synthesis (eclecticism) and theoretical synthesis (integration) of various orientations (this is called integrative-eclectic psychotherapy).

Pure supportive psychotherapy is rarely used for personality disorder, because it encourages existing coping styles (which are, by definition, maladaptive in personality disorder), and this often reinforces the problems of these patients. Modified supportive therapy (supporting the motivation to change, not the coping mechanisms) can be used as the initial phase of treatment, during the contract and trust building phase. The psychobiological approach is eclectic and incorporates these strategies into a comprehensive treatment plan aimed at stimulating character development, primarily self-directedness and cooperativeness.

3.10.4.2 Pharmacotherapy

A growing body of evidence demonstrates that pharmacotherapy is at least equally important to psychotherapy in the overall treatment of personality disorder. Pharmacotherapy is (1) causal, aimed at correcting neurobiological dispositions to underlying deviant traits, or (2) symptomatic, aimed at correcting target symptoms of personality disorder. The central idea behind causal pharmacotherapy is that enduring personality changes may result from pharmacological manipulation of the underlying biological dispositions to deviant traits (also called trait vulnerability). In other words, pharmacotherapy is expected to modify neurophysiological systems that regulate affects and learning styles. This, in turn, is expected to reduce biases in affective and learning processes and, ultimately, change cognitive and behavioural symptoms of personality disorder.

Pharmacological intervention is usually focused on acute symptoms (e.g. suicidal tendency and agitation), but an increasing number of authors advocate treatment of chronic pathology (e.g. impulsiveness and affective dysregulation) in addition to the acute treatments. In that regard, most authors agree that there are three symptom domains that underlie chronic pathology of personality disorder. These include: (1) aggression and behavioural dyscontrol; (2) affective symptoms, anxiety, and mood dyscontrol; and (3) cognitive-perceptual distortions, including psychotic symptoms.

The interaction between biological and psychological factors in deviant behaviours is complex. One way to interrupt the feedback mechanisms by which unfavorable biology and psychology perpetuate each other is to combine drug treatment of the underlying biological vulnerability with psychotherapy of the associated psychological mechanisms. Hence, personality disorder is optimally treated with combined pharmacotherapy and psychotherapy.

Check Your Progress

18. What are personality disorders?
19. Name the various disorders that fall under Cluster A in DSM-IV-TR?

NOTES

3.11 SUMMARY

- When an individual fails to adjust or adapt himself to new circumstances and experiences anxiety, worry, poor concentration, depression, irritability, etc. together with physical symptoms caused by autonomic arousal, such as palpitations and tremors, to a significant degree that impairs his social functioning, then he is likely to suffer from 'adjustment disorder'.
- Clinical experience suggests that most adjustment disorders last for several months and a few persist for years. Individuals with adjustment disorder may carry a significant risk of suicide.
- Impulse control disorders are characterized by repeated acts with no clear rational motivation that tend to harm the patient's own interests and those of other people. These behaviours are usually associated with impulses to act that cannot be controlled. Different forms of impulse control disorders include: pathological gambling, pathological fire setting (pyromania), pathological stealing (kleptomania), and trichotillomania.
- Substance related disorders include: (i) Psychoactive substance-induced organic mental disorders and syndromes, and (ii) Psychoactive substance-abuse and substance-dependence disorders. Two terms that are closely associated with dependence are—tolerance and withdrawal.
- Addiction is defined as a state in which the drug use has altered the body's chemistry to the point, where its 'normal state' was the drugged state so that the body required the drug to feel normal. Two main psychoactive substance use disorders are: alcoholism and drug addiction.
- Eating disorders are usually characterized into two main categories namely anorexia nervosa and bulimia nervosa. Anorexia nervosa is an eating disorder characterized an extreme concern about weight and shape characterized by an intense fear of gaining weight and becoming fat; a strong desire to be thin and in women, amenorrhoea. It is a deliberate weight loss induced and or sustained by the patient.
- Bulimia Nervosa is an eating disorder characterized by an irresistible urge to over-eat, extreme measures undertaken by the patient to control body weight and overvalued ideas concerning one's body shape and weight. The episodes of uncontrolled excessive eating are known as binges.
- Sleep disorders are associated with either difficulty in sleeping or less often, excessive sleeping, may be asked to see a psychiatrist. DSM-IV categorizes sleep disorder into the following categories: (i) Primary sleep disorders which include dyssomnias and parasomnias; (ii) Sleep disorders related to another medical disorder; (iii) Sleep disorder due to general medical condition; and (iv) Substance induced sleep disorder.

NOTES

- Sexual behaviour is diverse and determined by a complex interaction of factors like one's relationship with others, by life circumstances, by the culture in which one lives, other personality traits, with his or her biological makeup, and with a general sense of self.
- The sexual disorders have been categorized as—gender identity disorder, paraphilias and sexual dysfunction. Below we shall understand about these in a bit more detail.
- The organic mental disorders include only those mental and behavioural disorders that are due to demonstrable cerebral disease or disorder, either primary or secondary. The dysfunction may be primary (as in disease, injuries and insults that affect the brain directly or with predilection) or secondary (as in systemic diseases and disorders that attack the brain only as one of the multiple organs or systems of the body involved).
- Personality disorders result when these personality traits become abnormal, i.e. become inflexible and maladaptive and cause significant social or occupational impairment or significant distress.
- Abnormal personality traits are usually 'ego-syntonic', that is, they do not necessarily cause significant distress to the patient. That is why individuals having personality disorders do not usually seek psychiatric help unless other psychiatric symptoms co-exist. Personal distress may occur in some personality disorders.
- Different types of personality disorders can be categorized as paranoid, scizoid, scizotypal, antisocial, narcissistic, histrionic, borderline, avoidant, dependent and obsessive compulsive disorders.
- While treating each disorder first epidemiology and etiology are examined. Then the prognosis and course are set. Then the disorder is managed prescribing the right therapy and time-frame of treatment.

3.12 KEY TERMS

- **Pyromania:** It is characterized by repeated acts of fire-setting without any clear rational motive such as monetary gain, revenge or political extremism.
- **Kleptomania:** It is characterized by repeated failure to resist the impulse to steal objects that are not required for personal use or monetary gain.
- **Trichotillomania:** It is characterized by noticeable hair loss due to recurrent failure to resist impulse to pull out hairs.
- **Delirium tremens:** It is the most severe alcohol withdrawal syndrome. It occurs usually within 2–4 days of complete or significant abstinence from heavy alcohol drinking in 5 per cent of the patients, as compared to acute tremulousness which occurs in 34 per cent of patients.

NOTES

- **Alcoholic hallucinosis:** This is characterized by usually auditory hallucinations, largely containing voices uttering insults or threats, occurring in clear consciousness, during abstinence following regular alcohol intake.
- **Hallucinogens:** They are known to produce changes that bear some resemblance to those of the functional psychosis. The synthetic hallucinogens include lysergic acid diethylamide (LSD), dimethyl tryptamine and methyldimethoxyamphetamine.
- **Opioids:** They consist of drugs like morphine, heroin, codeine and synthetic analgesics such as pethidine, methadone and dipipanone.
- **Dyssomnias:** They are characterized by disturbances in amount, quality or timing of sleep. They are thought as disturbances involving sleep–wake generating or timing mechanism.
- **Psycho-physiological insomnia (or conditioned insomnia):** It is characterized by excessive worry about not being able to sleep, trying too hard to sleep, rumination or inability to clear one's mind while trying to sleep.
- **Idiopathic insomnia:** It typically starts early in life, sometimes at birth and continues throughout life.
- **Anorexia nervosa:** An eating disorder characterized by an extreme concern about weight and shape characterized by an intense fear of gaining weight and becoming fat; a strong desire to be thin and in women, amenorrhoea.
- **Bulimia nervosa:** It is an eating disorder characterized by an irresistible urge to over-eat, extreme measures undertaken by the patient to control body weight and overvalued ideas concerning one's body shape and weight.
- **Narcolepsy:** It is a syndrome of unknown origin characterized by irresistible urges to sleep.
- **Cataplexy:** It can be seen as a transient weakness in the knees to a total loss of skeletal tone during full consciousness; often triggered by emotions and lasts for several seconds to several minutes.
- **Sleep paralysis:** In this case the person is awake and is unable to move for several seconds to minutes.

3.13 ANSWERS TO 'CHECK YOUR PROGRESS'

1. When an individual fails to adjust or adapt himself to new circumstances and experiences anxiety, worry, poor concentration, depression, irritability, etc. together with physical symptoms caused by autonomic arousal, such as palpitations and tremors, to a significant degree that impairs his social functioning, then he is likely to suffer from 'adjustment disorder'.

NOTES

2. The various types of impulse control disorders are: pathological gambling, athological fire-setting (pyromania), pathological stealing (kleptomania), and trichotillomania.
3. Kleptomania is characterized by repeated failure to resist the impulse to steal objects that are not required for personal use or monetary gain.
4. Trichotillomania is characterized by noticeable hair loss due to recurrent failure to resist impulse to pull out hairs.
5. The acronym CAGE refers to a set of four questions that are often used to identify the presence of alcohol misuse as it often goes undetected because subjects conceal the extent of their drinking. It consists of the following four questions:
   - Have you ever felt you ought to cut down on your drinking?
   - Have people annoyed you by criticizing your drinking?
   - Have you ever felt guilty about your drinking?
   - Have you ever had a drink first thing in the morning (an eye-opener) to steady your nerves or get rid of a hangover?

   Two or more positive replies to these questions are said to identify alcohol misuse.
6. Opioids consist of drugs like morphine, heroin, codeine and synthetic analgesics such as pethidine, methadone and dipipanone. Opioid use can lead to rapid development of dependence. Opioids can be taken through the intravenous route, or via subcutaneous administration (skin-popping) or can be sniffed. Heroin may also be heated on a metal foil and inhaled which also known as chasing the dragon. Opioids can lead to euphoria, analgesia, respiratory depression, constipation, reduced appetite and low libido.
7. Eating disorders are disorders of eating behaviour deriving primarily from an overvaluation of the desirability of weight loss that result in functional medical, psychological, and social impairment. Eating disorders are usually characterized into two main categories namely anorexia nervosa and bulimia nervosa.
8. Some of the etiological factors underlying bulimia nervosa are family history of psychiatric disorder (especially depression); adverse childhood experience; low self-esteem; need for perfectionism; inherited abnormalities in the regulation of weight and eating habits.
9. The primary sleep disorders result from conditions inherent to the mechanisms by which sleep is regulated. They are dichotomized into dyssomnias and parasomnias. Dyssomnias are characterized by disturbance in amount, quality or timing of sleep. They are thought as disturbances involving sleep–wake generating or timing mechanism. It includes—primary insomnia, primary hypersomnia, narcolepsy, breathing-related sleep disorders and circadian rhythm sleep disorder, whereas parasomnias are

NOTES

characterized by abnormal behaviours or physiological events associated with sleep. They are thought of as involving inappropriately timed activation (or failure to suppress) behavioural or physiological systems or both during sleep and sleep–wake transitions. It includes—nightmare disorder (also known as dream anxiety disorder), sleep terror disorder, sleep walking disorder, sleep talking, nocturnal leg cramps, sleep paralysis, sleep bruxism, sleep enuresis and sudden infant death syndrome.

10. Sleep hygiene refers to basic rules designed to provide circumstances and conditions conducive to sleep. They include a list of things to incorporate into a good sleep ritual and things to avoid. Sleep enhancing directives include maintaining a regular sleep wake schedule; keeping a steady program of daily exercise; insulating the bedroom against excessive noise, light, cold and heat; eating a light snack before retiring if hungry; and setting time aside to relax before getting into bed. Sleep hygiene 'don'ts' are designed to prevent behaviours or relieve conditions incompatible with restful sleep. They include avoiding strenuous exercise immediately before bedtime; abstaining from alcohol, tobacco and caffeinated beverages in the evenings (or early in the day if one is especially sensitive); not watching television in bed and not chronically taking sleeping pills. Finally try not to have fights and arguments when in bed. Often a few simple alterations in a patient's habit or sleep environment can be effective.
11. Some intervention strategies that can be used are sleep hygiene, stimulus control therapy, sleep restriction therapy, cognitive-behavioural therapy (CBT), paradoxical intention, relaxation therapy, surgical correction and judicial use of REM sleep suppressing drugs.
12. Gender identity disorder is a disorder in which an individual experiences persistent discomfort about one's biological sex and may regard the gender role of that sex as inappropriate. He or she may also have a strong and a persistent desire to be of the opposite sex and may even want to surgically alter his or her body to bring it in line with his gender identity.
13. According to Masters and Johnson (1996, 1970, 1975), four relatively distinct phases of human sexual response are: *The desire phase:* It consists of fantasies about sexual activity or a sense of desire to have sexual activity. *The excitement phase:* It consists of both a subjective sense of sexual pleasure and physiological changes that accompany subjective pleasure, including penile erection in the male and vaginal lubrication and enlargement in the female. *The orgasm:* In this phase, there is a release of sexual tension and a peaking of sexual pleasure. *The resolution:* In this phase, the individual has a sense of relaxation and well being.
14. The term 'pedos' in Greek language means 'child'. Pedophilia is a type of paraphilia in which adults derive sexual gratification through physical and often sexual contact with children unrelated to them. They usually do not physically injure the child, but they may frighten them. They may manipulate

the child's genitilia, encourage the child to manipulate his and less often, attempt intromission. The pedophile can be heterosexual or homosexual. The offender should be at least 16 years old and at least 5 years older than the child.

NOTES

15. The organic mental disorders include only those mental and behavioural disorders that are due to demonstrable cerebral disease or disorder, either primary or secondary. The dysfunction may be primary (as in disease, injuries and insults that affect the brain directly or with predilection) or secondary (as in systemic diseases and disorders that attack the brain only as one of the multiple organs or systems of the body involved).
16. Delirium is defined by the acute onset of fluctuating cognitive impairment and a disturbance of consciousness with reduced ability to attend. It is frequently associated with abnormalities in perception, thought, psychomotor activities and disturbances in the sleep–wake cycle. Speech, perceptual and thought disturbances like slurring of speech, incoherence, dysarthria, fleeting delusions (often persecutory), ideas of reference, slow and muddled thinking, experiences of depersonalization and derealization may also be present. These individuals appear most commonly disoriented in time, then in place and rarely in person. It is also associated with cognitive and functional decline. Anxiety, depression and emotional lability are common. Patient may be frightened or perplexed.
17. Organic amnesic syndrome is characterized by impairments of memory due to an underlying organic cause; absence of disturbance of consciousness and attention and absence of disturbance of global intellectual function, abstract thinking or personality. Its key feature is the inability of the individual to learn and later recall new information. Some of these patients may also show an inability to recall previously learned knowledge or past events. To make the diagnosis, the condition should cause significant impairment in one's personal, social or occupational functioning and the individual should not meet the criteria for delirium and or dementia.
18. Personality disorders result when these personality traits become abnormal, i.e. become inflexible and maladaptive and cause significant social or occupational impairment or significant distress. Abnormal personality traits are usually 'ego-syntonic', that is, they do not necessarily cause significant distress to the patient. That is why individuals having personality disorders do not usually seek psychiatric help unless other psychiatric symptoms co-exist. Personal distress may occur in some personality disorders. Different types of personality disorders can be categorized as paranoid, scizoid, scizotypal, antisocial, narcissistic, histrionic, borderline, avoidant, dependent and obsessive compulsive disorders.
19. Under Cluster A, those personality disorders are clubbed, that are thought to be on a 'schizophrenic-continuum'. It includes disorders like paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder.

NOTES

3.14 QUESTIONS AND EXERCISES

Short-Answer Questions

1. Write a short note on pathological gambling.
2. Write a short note on pathological fire setting (pyromania).
3. Write a short note on pathological stealing (kleptomania).
4. Write a short note on trichotillomania.
5. Write a short note on alcoholism.
6. Write a short note on drug addiction.
7. Write a short note on anorexia nervosa.
8. Write a short note on bulimia nervosa.
9. Write a short note on gender identity disorder.

Long-Answer Questions

1. Explain adjustment disorders along with epidemiology, course and prognosis, etiology and management.
2. Explain impulse control disorders in detail.
3. Explain substance related disorders.
4. Explain eating related disorders.
5. Explain sleep related disorders.
6. Explain in detail sexual and gender identity disorders.
7. Explain in detail organic mental disorders.
8. Explain in detail about personality disorders.
9. Describe how views about brain function and dysfunction underwent changes and development to reach the present state of knowledge.

3.15 FURTHER READING

Ahuja, N. 2002. *A Short Textbook of Psychiatry*, Fifth edition. New Delhi: Jaypee Brothers.

Davison, G.C., J.M. Neale and A.M. Kring. 2004. *Abnormal Psychology*, Ninth edition. MA, USA: John Wiley & Sons Inc.

Gelder, M., R. Mayou and P. Cowen. 2004. *Shorter Oxford Textbook of Psychiatry*, Fourth edition. Oxford: Oxford University Press.

Sadock, B.J. and V.A. Sadock. 2004. *Concise Textbook of Clinical Psychiatry*, Second edition. Philadelphia, USA: Lippincot Williams Wilkins.

World Health Organization. 2002. *International Classification of Diseases-10 Classification of Mental and Behavioural Disorders.* Geneva: WHO.

UNIT 4 MAJOR THERAPEUTIC APPROACHES

NOTES

Structure

4.0 INTRODUCTION

In this unit you will learn different approaches employed to treat psychological disorders. Psychoanalysis is a procedure to understand the functioning of mind and it is widely used as a therapeutic modality.

Once psychoanalysis is performed some tentative conclusions are drawn on the basis of which suitable therapy is applied for the respective disorders. Some of the well known therapies include psychoanalytical psychotherapy, behaviour therapy, cognitive therapy and humanistic psychotherapy.

4.1 UNIT OBJECTIVES

After going through this unit, you will be able to:

- Understand the concept of psychoanalysis
- Learn about psychoanalytic psychotherapy
- Analyse behaviour therapy
- Learn cognitive therapy
- Understand humanistic therapy

4.2 PSYCHOANALYSIS

Psychoanalysis refers the procedure adopted by Freud to understand the functioning of mind and it is also widely used as a therapeutic modality. Psychoanalysis literally

NOTES

means the breaking down the psyche into its constituent elements and their dynamic processes and then analysing each part, drawing conclusions for the purpose of studying and then providing the necessary treatment.

Psychoanalysis is an outgrowth of the treatment of neurotic patients using hypnosis. When in his medical practice, Freud did not receive much success in treating hysteria patients with hypnosis; he came up with the method of catharsis, which required the patients to talk about their problems in conscious awareness. Soon Breuer and Freud came to an understanding that symptoms represent repressed ideas that had not reached consciousness. These repressed ideas often manifest in an individual in the form of symptoms.

Freud gave up the hypnotic cathartic method on realizing that the events recalled during hypnosis could be recalled again by the patients in states of consciousness when these clients were prompted using leading questions by the therapist. Based on this premise, Freud developed a strategy which required the patients to lie on a couch with eyes closed and to concentrate on a particular symptom with the objective of recalling past memories, which later shaped the method of free association. The method of free association requires the patient to express freely whatever comes to his mind even if it appears irrelevant, unpleasant, or trivial to the patient.

With the new emphasis on recalling repressed memories into the conscious state, Freud observed that the same forces that led to repression interfered with the disclosure of the unconscious material during free association (resistance).

In addition, when Freud saw that the effects of hypnosis were transitory, he postulated that the therapeutic relationship was more essential than techniques in bringing about the desired change and this led to the development of the psychoanalytical concept of transference.

The method of psychoanalysis is based on the premises given below:

- It views human beings as struggling against their intra-psychic conflicts.
- These intra-psychic conflicts usually consist of inner, unknown desires and urges, largely libidinal and aggressive in nature, which an individual continually defends himself by repressing them thus making them inaccessible to the conscious self.
- Mental phenomena result from a continual interaction of opposing forces.
- Human behaviours and motivations are changing at all times and this leads to conflict and resistance, which tend to precipitate psychopathology.
- Mental phenomena reveal themselves at different levels ranging from the unconscious mind to the preconscious mind and, finally, to the conscious mind.
- The expression and integration of repressed wishes, desires and conflicts at the conscious level is likely to bring relief from the symptoms.

NOTES

- Human beings have a tendency to pervasively avoid painful feelings or experiences by keeping unpleasant thoughts, wishes, and desires away from conscious awareness.
- Unresolved conflicts at various stages of development can also lead to pathology.

Based on the above assumptions, the psychoanalytical method focuses on analyzing, interpreting and managing an individual's transference and resistance. Transference refers to a phenomenon in which patients consistently project their intense, personal, unresolved childhood feelings to the analyst during psychoanalysis, whereas, resistance refers to any attempt that prevents the repressed or forbidden materials to become conscious. At any point in therapy, the transference can be transformed into resistance. Transference can be positive or negative in nature.

Positive transference refers to the expression of good feelings such as love, trust, admiration, respect, sympathy, and so on towards the analyst, that can act as motivating forces for the client to bring about the necessary change. At the other end, negative transference refers to equally intense bad feelings such as anger, hostility, mistrust, rebelliousness, and so on towards the analyst. In negative transference, the patient tends to undervalue the analyst in ways that are quite similar to the way the client feels towards his parents or other authority figures in the past. Both types of transference should be interpreted as they can impede the therapy process. Intense positive transference may take the form of resistance in which the patient avoids too much probing into his unresolved conflicts.

During the therapeutic process, the patient may psychologically regress to the earliest stages of development which are marked by the presence of unresolved conflicts thus providing a platform where these conflicts could now be resolved in the therapeutic process (known as transference neurosis).

Psychoanalysis also aims to confront, understand and resolve the various defence mechanisms used by the patient with the purpose of preventing anxiety evoking information out of consciousness.

A client may show resistance to the transference, thereby preventing the development of a transference neurosis or may show transference resistance, in which the transference itself may take the form of resistance.

Freud further stated that resistance can be conscious or unconscious and can be produced by the ego, the id, or the superego. Conscious resistance occurs when the client deliberately withholds information from the analyst. Such resistance is transient and is usually rectified by pointing it out to the patient. Unconscious resistance, however, is more resilient and arises as a defence against uncovering repressed material.

Resistance can take multiple forms like an absolute silence of the client, or the unproductive over-talkativeness on the part of the client or avoidance of painful or emotion-laden topics or coming late for the session or missing sessions and or delaying or forgetting to pay one's bill.

NOTES

In psychoanalysis, the first task of the analyst is to manage resistances, which involves dealing with the various defence mechanisms adopted by the client before the repressed material can be dealt with. In psychoanalysis, the therapist makes a note of how the patient resists, what is being resisted, and the reasons for the same.

Another obstacle to analytical progress may be the analyst's own strong reactions to the patient, or counter-transference, which can inappropriately affect the treatment if the analyst is not sufficiently aware of his personal feelings. Counter-transference refers to the analyst's unconscious emotional needs, wishes, and conflicts that can influence the patient and can impact negatively on the analyst's objective judgment and reason. That is why psychoanalysis stresses that the therapist must undergo his or her analysis as a training requisite.

Some of the common warning signs of counter-transference in analysis include experiencing uneasy feelings during or after sessions with certain patients; persistently feeling drowsy or actually falling asleep during sessions; coming late for his session, etc. In psychoanalysis, a collaborative, rational and a trusting 'therapeutic alliance' is essential, which focuses on forming an alliance with the patient using which the therapist helps the patient to distinguish between realistic, healthy, and appropriate behaviour and distorted, neurotic, and inappropriate behaviour. He also helps them to differentiate between fantasy and reality and is able to monitor the patient's regression and irrationality. He also enables the patient to receive and comprehend the therapist's communications rationally, to review and assess interpretations reasonably, to participate cooperatively and responsibly, and, to integrate the insights that are gathered in treatment.

Once a therapeutic relationship has been established, the therapist makes use of the techniques of confrontation, clarification, interpretation and working through to help the client to resolve the underlying forbidden and repressed conflicts.

'Confrontation' involves asking the client to face a particular event that he has been inappropriately avoiding. 'Clarification' helps the client to differentiate important aspects from the unimportant ones and tries to elaborate on them. 'Interpretation' involves making the client aware of the repressed conflicts based on the information the client brought to his consciousness during the therapy. Through interpretation, the therapist tries to attribute an underlying meaning or cause to the events in question. 'Working through' involves providing repetitive, progressive, and elaborated exploration of interpretations by the therapist to the client till he or she has been able to adequately integrate the repressed material in his consciousness.

The interpretive process makes use of the material revealed by the method of free association, dreams, slips of the tongue, mislaying of objects, etc. In psychoanalysis, the therapist should take into consideration when and how an interpretation should be delivered to the client. Interpretations are hypotheses that the client eventually accepts or rejects and hence may be modified in the light of new information.

NOTES

Psychoanalysis also involves the interpretation of dreams. Freud regarded dreams as a royal road to the unconscious. Dreams seem to act as a wish-fulfilment of underlying instinctual repressed conflicts.

Psychoanalysis is best suited for clients having good ego functioning; who are highly motivated; who are capable of forming and maintaining a trusted therapeutic relationship; who are psychologically minded and show capacity for developing insight. It is best suited for the management of anxiety and depressive disorders.

Psychoanalysis is usually not the treatment of choice when dealing with psychotic disorders, personality disorders (e.g. narcisstic, paranoid, antisocial, etc.), sexual disorders and substance abuse disorders. Infantile demands, poor impulse control, an inability to tolerate frustration, impaired social judgment, and the physical concomitants of substance abuse severely limit benefits of psychoanalysis.

Psychoanalysis has been criticized for being a time consuming, expensive, long-term therapy; lacking scientific support; for being subjective, deterministic and mechanistic in nature; and for laying over-emphasis on the development of the insight. The validity and reliability of various psychoanalytical concepts like oedipal complex, id, ego and superego, etc. has been questioned. It has also been criticized for being unduly restricted to a diagnostically, socioeconomically, or intellectually advantaged patient population.

4.3 PSYCHOANALYTICAL PSYCHOTHERAPY

To some extent as a response to the criticism psychoanalysis, psychoanalytical psychotherapy came into emergence. It is based on the fundamental dynamic formulations and techniques of psychoanalysis but it is broader in scope. Psychoanalytical psychotherapy makes use of a variety of techniques ranging from expressive insight-oriented, interpretive techniques to more supportive relationship-oriented techniques.

In this therapy, the therapist decides to what extent he will use or manage transference and the extent to which he would interpret, foster or suppress it. Unlike psychoanalysis, it focuses on the present rather than on the past. It makes use of both here-and-now interpretations and interpretations that trace patient's behaviour and feelings back to their origins in early infancy and childhood. The therapy is of relatively less duration and does not make use of the couch. Instead in it the patient and the therapist sit face to face to prevent regression.

The psychoanalytical psychotherapy deals with selected problems or highly focused conflict. In it, though the numbers of sessions are often decided in the beginning but the course of therapy can be altered as the patient's needs and goals change. It rarely makes use of the free-association method, except when the therapist wishes to gain access to fantasy material or dreams to know more about an underlying issue.

NOTES

The primary goals of psychoanalytical psychotherapy are to increase the patient's self-awareness, resolve some of the specific conflicts, undo resistances and to deal with preconscious or conscious derivatives of conflicts as they became manifest in present interactions. It largely aims at symptom relief and focuses on clarifying recent dynamic maladaptive patterns.

The therapeutic process involves establishment of a therapeutic alliance and early recognition and interpretation of negative transference. In it only limited or controlled regression is encouraged, and positive transference is used largely unexplored, unless they interfere with the therapeutic progress. Here the therapist relatively plays a more active role. The techniques of clarification and interpretation are still used, but are altered both qualitatively and quantitatively.

The therapist makes use of clarification much more than the technique of interpretation to achieve the goals of the therapy. Unlike psychoanalysis, it makes use of adjunctive treatment, like psychotropic drugs, to relieve acute symptoms of anxiety or depression so that analytical exploration can then be adequately undertaken. Other measures such as hospitalization, rehabilitative therapies or family therapy may also be used if necessary.

Psychoanalytical psychotherapy has become a desirable and widely applicable form of treatment over psychoanalysis because of the following reasons:

- The psychiatric patients are usually seen to lack sufficient ego strength; are often deficient in the cognitive resources necessary for the achievement of deep insight; are usually not very motivated and sometimes their problems can be too pressing, thus making lengthy treatments unsuitable.
- Often patients are unable to continue long-term treatments because of financial reasons.

Psychoanalytical psychotherapy is regarded as the treatment of choice for neurotic disorders, narcissistic personality disorder, borderline personality disorder and non-psychotic character disorders. It is best suited for individuals having fairly well integrated egos and for individuals who are psychologically minded, have the capacity for introspection and are self-motivated, and are able to tolerate frustration without disintegrating.

Check Your Progress

1. Define psychoanalysis.
2. Define psychoanalysis method.
3. Name the Freud's three ego states.
4. Define the term confrontation (with reference to psychoanalysis).
5. Define the term working through (with reference to psychoanalysis).

4.4 BEHAVIOUR THERAPY

NOTES

The term behaviour includes both overt (observable) and covert (non-observable) responses. The roots of behaviourism go back to the nineteenth and early twentieth centuries, beginning with the works of Watson. Watson advocated the study of only observable behaviour using objective methods. Pavlov further showed a relationship between learning and psychopathology in humans. In addition to Pavlov's works, the Thorndike's and Skinner's concepts of operant conditioning demonstrated that behaviour is a function of its consequences involving the manipulation of reinforcement and punishment. Social learning theory later introduced the concept of cognitive control and reciprocal determinism to behaviour therapy by emphasizing the prominent role played by vicarious, symbolic and self-regulatory processes. It stated that the relationship between external stimuli and overt behaviour is mediated by cognitive processes.

All these contributions eventually shaped the behaviour therapy. Behaviour therapy involves changing the maladaptive and self-defeating actions and responses of the patients to reduce dysfunction and to increase well-being and quality of life. It makes use of behaviour analysis as a way of both assessing and identify the target behaviours that need to be changed and as a way of modifying antecedents or consequences to bring about the desired behaviour changes. It makes use of principles of learning for the replacing maladaptive behaviours of an individual with more adaptive ones. It largely focuses on overt behaviours and their environmental influences. Behaviour therapy is based on the premises that:

- It is the situational, rather than mental, events that ultimately control an individual's behaviour.
- An individual's behaviour can be observed, monitored and altered.
- Human beings are largely passive and inactive.
- Human beings are both the producers and the products of the environment.
- Both adaptive and maladaptive behaviours are learnt.
- Learning principles can be used to modify maladaptive behaviours.

Behaviour therapy rejects the classical trait theory. Clear, specific, well-defined goals in measurable terms are important to the therapeutic process. The general, goal in behaviour therapy is to create new conditions for learning. The goals are set in the beginning of the therapy in agreement with the client. The therapy involves continued assessment to ascertain the extent to which the goals have been met. In behaviour therapy, assessment and treatment occurs together. The method of treatment is usually adapted to the client's problems. It focuses on the current problems faced by the client and avoids dwelling deeply into the presumed causes underlying the maladaptive behaviour. It tends to concentrate on the challenges currently faced by the client and is less concerned with his or her

NOTES

childhood histories. Behaviour therapists lay lot of emphasis on obtaining empirical support for their various techniques.

The different techniques that are usually employed by the behavioural therapists in the management of the client's problems are as follows:

Reinforcement: It aims to increase the occurrence of a particular behaviour in future when that behaviour (known as the operant behaviour) is consistently followed by consequences (also known as reinforcer). It can be of two types—positive reinforcement and negative reinforcement. In positive reinforcement, it is the addition of a stimulus or an increase in the intensity of a stimulus that strengthens a behaviour, whereas, in negative reinforcement, it is the removal of a stimulus or a decr se in the intensity of a stimulus that strengthens a behaviour.

For reinforcement to be more effective, the target behaviour should be reinforced immediately and consistently; the reinforcer should be of sufficient intensity and should appear reinforcing to the individual.

Extinction: It involves the removal of a reinforcer so that the reinforced behaviour stops occurring. The removal of a reinforcer may be followed by a sudden increase in the frequency, duration, or intensity of the behaviour before it decreases and ultimately stops. This phenomenon is known as extinction burst. During extinction burst novel behaviours, emotional responses and aggressive behaviours may occur.

Extinction is resistant to intermittent reinforcement, i.e. when a behaviour is continuously reinforced, it decreases rapidly once the reinforcement is terminated, but when a behaviour is intermittently reinforced, it often decreases more gradually once the reinforcement is terminated.

Punishment: It aims to decrease the occurrence of a particular behaviour in future when that behaviour is consistently followed by consequences (also known as punisher). It can be of two types—positive punishment and negative punishment. In positive reinforcement, it is the presentation of an aversive stimulus that weakens a behaviour, whereas in negative reinforcement, it is the removal of a reinforcing stimulus that weakens a behaviour. For punishment to be effective, it should be presented immediately and consistently; it should of sufficient intensity, it should appear punishing and should be seen as justified by the individual.

Shaping: It is a procedure which is used in the acquisition of a new behaviour. It involves reinforcing every successive approximations of a target behaviour and non-reinforcement of all other behaviours until the person exhibits the target behaviour.

Chaining: It is used to help the individuals acquire a complex behaviour consisting of many component behaviours that occur together in a sequence (called as a 'behavioural chain'). To accomplish this goal, the complex behaviour is broken down into its components (a process known as task analysis). Then using the process of chaining, which involves the use of prompting and fading strategies, the individuals are taught the complex task. Various chaining procedures that can be

NOTES

used are 'backward chaining' (which involves teaching the last step in the behaviour chain, first followed by teaching each previous behaviour in the chain), 'forward chaining' (which involves teaching the first step in the behaviour chain followed by the subsequent behaviour in the chain), 'total task presentation' (which involves performing all the steps of the behaviour chain together in one go using prompts), 'written task analysis' (which involves using written descriptions of each step of the behavioural chain as prompts), 'picture prompts' (which involves using pictures of each step of the behavioural chain as prompts), 'self-instructions' (which involves giving oneself verbal prompts for each step of the behavioural chain).

Behavioural skills training procedures: They focus on helping individuals to learn various skills like communicating, problem-solving, socializing, etc through the use of the procedures of modelling, instructions, rehearsal, and feedback. 'Modelling' involves the demonstration of the behaviour to be learnt by the therapist which is then imitated by the client. In live modelling, the therapist demonstrates the appropriate behaviour in the appropriate situation, whereas, in symbolic modelling, the correct behaviour is demonstrated using audio-visual aids.

For modelling to be effective, the correct behaviour modelled by the therapist should be met with a successful outcome; the learner should be able to identify with the model; the complexity of the modelled behaviour should match the developmental level of the learner; the learner should pay attention to the modelled behaviour; the learner should imitate the behaviour soon after observing the model and the modelled behaviour should be repeated as often as possible till the learner is able to imitate the modelled behaviour correctly at least on a few occasions.

Instruction: It involves adequate description of the appropriate behaviour that the learner desires to learn. For instructions to be effective, they should be clear and specific describing exactly the behaviour that the learner is expected to learn. The instructions should also match the cognitive level of the learner; should be delivered by a credible source; should be immediately rehearsed by the learner and should be repeated till the therapist is certain that the learner has heard the instructions correctly.

Rehearsal: It refers to the opportunity the learner gets to practice the modelled and instructed behaviour. For rehearsal to be effective, it should be carried out in the proper context; should result in a successful outcome; should always be followed by corrective feedback and it should be rehearsed until it is demonstrated correctly at least a few times by the learner.

Feedback: It involves providing information about how well the individual formed the target skill or behaviour that was modelled and instructed to and rehearsed by him. For feedback to be effective, it should be given immediately after the behaviour; should always involve praise for some aspect of the behaviour; the praise should be descriptive; should be worded in positive terms and should provide corrective feedback on one aspect of the performance at a time.

NOTES

Time out: It involves the loss of access to a positively reinforcing environment as a consequence of engaging in an inappropriate behaviour. It can be 'exclusionary' (here the individual is taken away from the setting in which the problem-behaviour occurred to another setting) or 'non-exclusionary' (here the individual remains in the same setting but is denied access to positive reinforcers) in nature.

Response cost: It refers to the removal of a specified amount of a reinforcer as a consequence of engaging in the problem-behaviour. It aims to decrease the probability of occurrence of a problem-behaviour in future.

Habit reversal training: It is often used to treat nervous habits like nail-biting, hair-pulling; motor tics and stuttering. It involves 'awareness training' (in which the individual is made aware of the various behaviours involved in the habit; about when the habit occurs or is about to occur); 'competing response training' (involves teaching a behaviour incompatible with the habit-behaviour); 'social support' (where the client's family members are instructed to prompt the client to use the competing response when the habit occurs; to appreciate the client for not engaging in the habit and for using the competing response successfully); and 'motivation procedures' (in which the therapist reviews with the client how embarrassing or inconvenient he might have felt when these habit-behaviours occur in a variety of situations; with the objective of increasing the client's motivation to stop engaging in habit-behaviours).

Token economy: It involves increasing the occurrence of a target-behaviour by providing tokens as conditioned reinforcers, which can later be exchanged for the desired objects or activities as per a predetermined rate of exchange and the reinforcement schedule.

The behavioural contract: It refers to a written agreement between two parties in which one (one-party contract) or both parties (two-party contract) agree to bring about a change in their behaviour by engaging in the corresponding appropriate behaviour; non-engagement of which shall be followed by predetermined consequences.

Choice from these techniques depends on the problem at hand and the various factors precipitating and maintaining the problem behaviour. Behaviour therapy has been found to be quite effective in the management of various problems like depression, obesity, drug abuse, temper tantrums, phobias, anxiety, etc.

However, behaviour therapy has been criticized for its focus on treating symptoms rather than causes; it may change behaviour but fails to change the underlying feelings; it lays less emphasis on the importance of therapeutic relationship; it involves control and manipulation by the therapist and does not provide insight. It does not fully answer the question that why an individual behaves the way he does? It has also been criticized for not taking into account the major role played by cognitive factors in determining one's behaviour.

Over the last few years the field of behaviour therapy has undergone significant development. One such development has been the acceptance of the role played

by cognitive variables in influencing an individual's behaviour. In fact, their acceptance has bridged the gap between behaviour change and attitude change, thus giving way to the emergence of cognitive behaviour therapy.

NOTES

Check Your Progress

6. Define the term punishment (with reference to behaviour therapy).
7. Define the term reinforcement (with reference to behaviour therapy).
8. Define the term extinction (with reference to behaviour therapy).
9. Define the term chaining (with reference to behaviour therapy).

4.5 COGNITIVE THERAPY

Cognitive therapy, pioneered by Aaron Beck, refers to the application of any techniques that aims to modify faulty patterns of thinking and to replace them with more adaptive and healthy patterns of thinking. The emergence of cognitive therapy can be seen both as a reaction to the dissatisfaction with the mechanistic, psychoanalytical approach with its excessive emphasis on the childhood histories, sexuality, unconscious processes, development of insight; and the need for long-term therapy and as a development within behaviour therapy. The acceptance of the role of cognitive variables in behaviour theory and therapy has been quite slow as the cognitive variables are not amenable to direct observation, measurement and manipulation. It was the works of Bandura on vicarious learning, the concept of self-efficacy and Mischel's work on delay of gratification which emphasized the role of cognitive variables and led to their inclusion in behavioural theory and therapy.

Cognitive therapy is an active, directive, time-limited, problem-focused, collaborative therapy which is based on the following assumptions:

- Cognition, feelings and behaviour affect each other.
- Cognition, feeling and behaviour share a reciprocal cause-and-effect relationship.
- Individuals have both innate and acquired tendencies to think, feel and behave both rationally and irrationally.
- Individuals are self-training, self-evaluating and self-sustaining who develop behavioural and emotional difficulties when they mistake simple preferences for dire needs.
- Individuals have strong tendencies to escalate their desires and preferences into diagnostic 'shoulds', 'musts' and 'oughts' which create dysfunctional and disruptive behaviours and feelings.

NOTES

- Desired changes in one's feelings and behaviour can be achieved by bringing changes in the cognition.

Cognitive therapy is based on the Beck's theory which states that negative beliefs and logical errors in thinking acquired during the developmental period become the substances of schemata that predispose individuals to experience emotional problems. Hence, the way an individual structures his reality determines the way he or she is likely to feel. Beck came up with the depressive schema according to which depressed individuals view themselves, their world and their future in a negative manner.

Beck further proposed that individuals are likely to exhibit systematic distortions in their patterns of thinking known as 'cognitive distortions'. Various cognitive distortions are as follows:

- **All-or-none thinking:** Here the individual engages in dichotomous thinking, placing experiences in one of the two opposite categories.
- **Overgeneralization:** Refers to the tendency of drawing sweeping inferences from a single incident.
- **Discounting positives:** Refers to the tendency of regarding good and positive things as unimportant.
- **Jumping to conclusions:** Refers to the tendency of over-focusing on one aspect of situation in trying to understand the whole of it.
- **Mind reading:** Refers to the tendency of believing that one knows what the other person is thinking in the absence of any significant evidence.
- **Fortune telling:** Refers to the belief that the one knows what the future holds while ignoring all other possibilities.
- **Magnifying or minimizing:** Refers to the tendency of over-emphasizing the importance of negative events and under-emphasizing the importance of positive things.
- **Emotional reasoning:** Refers to the tendency of believing that a particular thing is true as it feels like true.
- **Making should statements:** It refers to telling oneself that one should have done or should have not done something, when it is more accurate to say that one would like to do the preferred thing.
- **Labeling:** Refers to the tendency of assigning a label to an event or a person and then seeing that event or the person in the light of the meaning the label carries.
- **Inappropriate blaming:** Refers to the tendency of ignoring the role played by others in bringing about a negative consequence and blaming oneself for it.
- **Selective abstraction:** Refers to the tendency of selectively picking one event from a series of events that support one's negative thinking.

NOTES

- **Catastrophizing:** Refers to the tendency of exaggerating the negative consequences of an event.
- **Personalization:** Refers to the tendency of attributing an event to oneself when in reality that event has nothing to do with the individual.

Cognitive therapy lays lot of importance on the active collaborative relationship between the client and the therapist, which regards the client as an expert of his or her experiences and to actively participate in therapy taking over lot of responsibility in bringing about the positive change within himself or herself.

The cognitive therapy process requires teaching the client the basic principles underlying therapy. It requires the client to learn to monitor his automatic thoughts; recognize the relationship between cognition, affect and behaviour; learn to test the validity of automatic thoughts; to substitute more realistic cognitions for unrealistic thoughts; and learn to identify and alter the underlying assumptions or beliefs that predispose individuals to engage in faulty thinking patterns.

To achieve its goal of helping the client to attain realistic adaptive cognition, cognitive therapy makes use of various techniques as follows:

Socratic dialogue: It challenges the client's faulty cognitions by using open-ended questions which are adapted according to the client's respective problem. These questions focus on identifying the evidence for and against the belief; exploring alternative interpretations of the event or situation; and looking at real implications if the belief is correct.

Downward arrow technique: It refers to using a series of 'if-then' questions in which each answer calls for another question. The questions aim at probing the meaning an individual attaches to a belief with the objective to arriving at the underlying cognitive distortion.

Specifying automatic thoughts: Here the clients are asked to specify automatic thoughts using a Dysfunctional Thought Record (DTR). DTR requires an individual to record situations, beliefs, emotional consequences and the alternative more rational responses to the belief. It is used both for the purpose of assessment and management of thoughts, as it helps the therapist and the client to identify various irrational, maladaptive thoughts and then to generate more rational corresponding thoughts.

Disputing: The technique of disputing requires the individual to detect one's beliefs and thoughts; discriminate between rational and irrational thoughts and then debate irrational thoughts by looking for evidences in favour and against the irrational thought and eventually replace them with more rational thoughts.

An integral component of cognitive therapy is the 'assignment of homework' to the clients at the end of the each session. Homework is designed in a way that it provides opportunities to the client to face and test his irrational thoughts and helps to eventually adopt more effective functional thoughts and thus bring about the desired behavioural change. Often homework is based on the material developed

NOTES

in the previous session. The therapist and the client review homework and collaborate to see how the benefits of the therapy can be enhanced for the client.

In the beginning of every new session, the therapist takes a feedback from the client about the previous session looking into the difficulties the client faced, the goals he accomplished, the reasons behind the problems faced by him and the concerns the client may have about the issues discussed in the last meeting.

The therapy eventually focuses on imparting the necessary skills to the client that aims to make the client his own therapist. As the client becomes more and more equipped, the frequency of sessions tapers off to once in every two weeks or once a month and finally the therapy is terminated.

Cognitive therapy has been empirically found to be effective in the management of various clinical conditions like major depression, bipolar disorder, generalized anxiety disorder, panic disorder, social phobia, and somatoform disorders; substance abuse; anger; chronic pain; relationship discord; anorexia, bulimia, and body dysmorphic disorder; a variety of childhood disorders, as well as schizophrenia. Cognitive therapy has been used with all age groups, ranging from children to elderly populations.

Check Your Progress

10. Define cognitive therapy.
11. What is discounting positives with reference to cognitive therapy?
12. What is fortune telling with reference cognitive therapy?

4.6 HUMANISTIC PSYCHOTHERAPY

Humanistic therapy, created in 1940 by Carl Rogers, is a passive, non-directive therapy which largely deals with listening, understanding, and reflecting what the therapist perceived the patient felt. The therapy is based on the following assumptions:

- Human beings have the potential to understand and solve their own problems and are reservoirs of limitless inner powers.
- Human beings have an inherent tendency to grow and to take steps towards self-actualization.
- In order to resolve their problems, human beings should become aware of the things that are going on inside them.
- And an empathetic, non-judgmental, warm and accepting relationship between the client and the therapist is essential for the self-actualization of the clients to occur.

NOTES

Rogers believed that each individual perceives reality differently by attaching his own meaning to the events. Hence, what is important is not the event but the way the client perceived it. He further stated that an individual's self-concept consists of his perception of his own characteristics, his relationship with others and the value he attaches to these perceptions. Each individual has a true self and an ideal self. The discrepancy between the two selves is likely to create anxiety and forms the basis for development of pathology. To do away with anxiety, human beings often tend to deny the presence of unacceptable aspects of their self.

The therapy focuses on building a warm and accepting therapeutic relationship between the client and the therapist, in which the client feels relaxed and is able to admit his unacceptable parts of the self. The presence of genuineness, empathy and unconditional positive regard on the part of the therapist is essential for the building up of such a relationship. Genuineness refers to the ability of the therapist to be present as a person having genuine interest in the client. Unconditional positive regard refers to the therapist conveying to the client that he accepts him the way he is without judging or evaluating him. Empathy refers to the skill of the therapist to understand the client's problems as if they were his own and then being able to communicate his understandings to the client. When these three conditions are met, the client tends to feel relaxed and understood and continues to become aware of his unacceptable parts of self which he had been denying from long. He is then able to accept and integrate these aspects with the rest of his self-concept. The therapy aims at integrating these unacceptable parts with the objective of enhancing the individual's functioning. Integration of these parts is likely to make the individual come out of his denial and conflicts, and to become more accepting and tolerant of self and others.

In humanistic psychotherapy, the therapeutic relationship is seen to play a key role in which the therapist tries to actively and empathetically clarify what the patient feels. The therapist tends to restate and reflect, according to him what the clint may be feeling. The acceptance and the empathy provided by the therapist is in itself therapeutic in nature.

The therapist in humanistic therapy is not concerned about the interpreting the client's unconscious motivations or conflicts but only attempts to reflect what the client feels. Instead of interpreting the client's resistance towards acknowledging his disowned parts of the self, the therapist focuses on overcoming the resistance by consistently accepting and valuing the client and by empathetically reflecting the feelings of the client. The therapy does not follow the medical model of illness and does not believe in placing individuals into distinct diagnostic categories.

The humanistic therapy is chosen when the clients feel that their organized self-structures are unable to meet their demands of the reality; or when they see discrepancy within themselves and see that they are unable to control their behaviours.

Humanistic therapy has been reported to be useful with children as well as adults, and in dealing with neurotic problems, situational problems, speech

NOTES

difficulties, psychosomatic problems (e.g. allergies), and, to some extent, psychosis. It has been practiced with individuals and groups, and its principles have been applied in industry, education and child rearing.

CHECK YOUR PROGRESS

13. Define humanistic psychotherapy.

4.7 SUMMARY

- Psychoanalysis literally means the breaking down of the psyche into its constituent elements and their dynamic processes and then analysing each part, drawing conclusions for the purpose of studying and then providing the necessary solutions.
- 'Positive transference' refers to the expression of good feelings such as love, trust, admiration, respect, sympathy, and so on towards the analyst, that can act as motivating forces for the client to bring about the necessary change. At the other end, 'negative transference' refers to equally intense bad feelings such as anger, hostility, mistrust, rebelliousness, and so on towards the analyst.
- During the therapeutic process, the patient may psychologically regress to the earliest stages of development which are marked by the presence of unresolved conflicts thus providing a platform where these conflicts could now be resolved in the therapeutic process (known as 'transference neurosis'). 'Resistance' (with reference to psychoanalysis) refers to all the forces that prevent unconscious repressed memories to become conscious in the process of therapy. A client may show 'resistance to the transference', thereby preventing the development of a transference neurosis or may show 'transference resistance', in which the transference itself may take the form of resistance.
- In psychoanalysis, a collaborative, rational and a trusting 'therapeutic alliance' is essential, which focuses on forming an alliance with the patient using which the therapist helps the patient to distinguish between realistic, healthy, and appropriate behaviour and distorted, neurotic, and inappropriate behaviour.
- Psychoanalytical psychotherapy is based on the fundamental dynamic formulations and techniques of psychoanalysis but it is broader in scope. It makes use of a variety of techniques ranging from expressive insight-oriented, interpretive techniques to more supportive relationship-oriented techniques.
- The primary goals of psychoanalytical psychotherapy are to increase the patient's self-awareness, resolve some of the specific conflicts, undo

NOTES

resistances and to deal with preconscious or conscious derivatives of conflicts as they became manifest in present interactions. It largely aims at symptom relief and focuses on clarifying recent dynamic maladaptive patterns. Psychoanalytical psychotherapy is regarded as the treatment of choice for neurotic disorders, narcissistic personality disorder, borderline personality disorder and non-psychotic character disorders.

- Behaviour therapy involves changing the maladaptive and self-defeating actions and responses of the patients to reduce dysfunction and to increase well-being and quality of life. It makes use of 'behaviour analysis' as a way of both assessing and identify the target behaviours that need to be changed and as a way of modifying antecedents or consequences to bring about the desired behaviour change.
- Cognitive therapy is based on the Beck's theory which states that negative beliefs and logical errors in thinking acquired during the developmental period become the substance of schemata that predispose individuals to experience emotional problems. Hence, the way an individual structures his reality determines the way he or she is likely to feel. Beck came up with the depressive schema according to which depressed individuals view themselves, their world and their future in a negative manner.
- Beck further proposed that individuals are likely to exhibit systematic distortions in their patterns of thinking known as 'cognitive distortions'. Various cognitive distortions are as follows: All-or-none thinking, Overgeneralization, Discounting positives, Jumping to conclusions, Mind reading, Fortune telling, Magnifying or minimizing, Emotional reasoning, Making should statements, Labeling, Inappropriate blaming, Selective abstraction, Catastrophizing and Personalization.

4.8 KEY TERMS

- **Method of free association:** This method requires the patient to express freely whatever comes to his mind even if it appears irrelevant, unpleasant, or trivial to the patient.
- **Transference** (with reference to psychoanalysis)**:** It refers to a phenomenon in which patients consistently project their intense, personal, unresolved childhood feelings to the analyst during psychoanalysis. Transference can be positive or negative in nature.
- **Resistance:** It refers to any attempt that prevents the repressed or forbidden materials to become conscious. At any point in therapy, the transference can be transformed into resistance.
- **Psychoanalytical method:** This method focuses on analyzing, interpreting and managing an individual's transference and resistance.

NOTES

- **Positive transference** (with reference to psychoanalysis)**:** It refers to the expression of good feelings such as love, trust, admiration, respect, sympathy, and so on towards the analyst, which can act as motivating forces for the client to bring about the necessary change.
- **Negative transference:** It refers to equally intense bad feelings such as anger, hostility, mistrust, rebelliousness, etc., towards the analyst.
- **Transference neurosis:** During the therapeutic process, the patient may psychologically regress to the earliest stages of development which are marked by the presence of unresolved conflicts thus providing a platform where these conflicts could now be resolved in the therapeutic process.
- **Resistance** (with reference to psychoanalysis)**:** It refers to all the forces that prevent unconscious repressed memories to become conscious in the process of therapy.
- **Resistance to transference** (with reference to psychoanalysis)**:** A client may show resistance to the transference, thereby preventing the development of a transference neurosis.
- **Transference resistance:** Here the transference itself may take the form of resistance.
- **Conscious resistance** (with reference to psychoanalysis)**:** It occurs when the client deliberately withholds information from the analyst. Such resistance is transient and is usually rectified by pointing it out to the patient.
- **Unconscious resistance:** It is more resilient and arises as a defence against uncovering repressed material.
- **Counter-transference:** It refers to the analyst's unconscious emotional needs, wishes, and conflicts that are evoked by the patient and have the potential of negatively influencing the analyst's objective judgment and reason.
- **Confrontation** (with reference to psychoanalysis)**:** It involves asking the client to face a particular event that he has been inappropriately avoiding.
- **Clarification** (with reference to psychoanalysis)**:** It helps the client to differentiate important aspects from the unimportant ones and tries to elaborate on them.
- **Interpretation** (with reference to psychoanalysis)**:** It involves making the client aware of the repressed conflicts based on the information the client brought to his consciousness during the therapy.
- **Working through** (with reference to psychoanalysis)**:** It involves providing repetitive, progressive, and elaborated exploration of interpretations by the therapist to the client till he or she has been able to adequately integrate the repressed material in his consciousness.
- **Psychoanalytical psychotherapy:** This therapy is based on the fundamental dynamic formulations and techniques of psychoanalysis but it is broader in scope.

NOTES

- **Behaviour therapy:** This therapy involves changing the maladaptive and self-defeating actions and responses of the patients to reduce dysfunction and to increase well-being and quality of life.
- **Behaviour analysis:** Is a way of both assessing and identify the target behaviours that need to be changed and as a way of modifying antecedents or consequences to bring about the desired behaviour change.
- **Reinforcement:** Aims to increase the occurrence of a particular behaviour in future when that behaviour (known as the operant behaviour) is consistently followed by consequences (also known as reinforcer). It can be of two types—-positive reinforcement and negative reinforcement.
- **Extinction:** It involves the removal of a reinforcer so that the reinforced behaviour stops occurring.
- **Punishment:** It aims to decrease the occurrence of a particular behaviour in future when that behaviour is consistently followed by consequences (also known as punisher).
- **Shaping:** A procedure which is used in the acquisition of a new behaviour. It involves reinforcing every successive approximations of a target behaviour and non-reinforcement of all other behaviours until the person exhibits the target behaviour.
- **Chaining:** It is used to help the individuals acquire a complex behaviour consisting of many component behaviours that occur together in a sequence (called as a 'behavioural chain').
- **Backward chaining:** Involves teaching the last step in the behaviour chain first followed by teaching each previous behaviour in the chain.
- **Forward chaining:** Involves teaching the first step in the behaviour chain first followed by teaching each subsequent behaviour in the chain.
- **Cognitive therapy:** Based on the Beck's theory, it states that negative beliefs and logical errors in thinking acquired during the developmental period become the substance of schemata that predispose individuals to experience emotional problems.
- **All-or-none thinking:** The individual engages in dichotomous thinking, placing experiences in one of the two opposite categories.
- **Inappropriate blaming:** Ignoring the role played by others in bringing about a negative consequence and blaming oneself for it.
- **Selective abstraction:** Selectively picking one event from a series of events that support one's negative thinking.
- **Catastrophizing:** Exaggerating the negative consequences of an event.
- **Personalization:** Attributing an event to oneself when in reality that event has nothing to do with the individual.

NOTES

4.9 ANSWERS TO 'CHECK YOUR PROGRESS'

1. Psychoanalysis literally means the breaking down of the psyche into its constituent elements and their dynamic processes and then analyzing each part, drawing conclusions for the purpose of studying and then providing the necessary solutions.
2. The psychoanalytical method focuses on analyzing, interpreting and managing an individual's transference and resistance. Transference refers to a phenomenon in which patients consistently project their intense, personal, unresolved childhood feelings to the analyst during psychoanalysis, whereas, resistance refers to any attempt that prevents the repressed or forbidden materials to become conscious. At any point in therapy, the transference can be transformed into resistance. Transference can be positive or negative in nature.
3. Freud's three ego states are: id, ego and superego.
4. Confrontation (with reference to psychoanalysis) involves asking the client to face a particular event that he has been inappropriately avoiding.
5. Working through (with reference to psychoanalysis) involves providing repetitive, progressive, and elaborated exploration of interpretations by the therapist to the client till he or she has been able to adequately integrate the repressed material in his consciousness.
6. Punishment aims to decrease the occurrence of a particular behaviour in future when that behaviour is consistently followed by consequences (also known as punisher). It can be of two types—positive punishment and negative punishment.
7. Reinforcement (with reference to behaviour therapy) aims to increase the occurrence of a particular behaviour in future when that behaviour (known as the operant behaviour) is consistently followed by consequences (also known as reinforcer). It can be of two types—positive reinforcement and negative reinforcement. In positive reinforcement it is the addition of a stimulus or an increase in the intensity of a stimulus that strengthens a behaviour. In negative reinforcement it is the removal of a stimulus or a decrease in the intensity of a stimulus that strengthens a behaviour.
8. Extinction (with reference to behaviour therapy) involves the removal of a reinforcer so that the reinforced behaviour stops occurring.
9. Chaining is used to help the individuals acquire a complex behaviour consisting of many component behaviours that occur together in a sequence (called as a 'behavioural chain'). To accomplish this goal, the complex behaviour is broken down into its components (a process known as task analysis). Then using the process of chaining, which involves the use of prompting and fading strategies, the individuals are taught the complex task.

NOTES

10. Cognitive therapy, pioneered by Aaron Beck, refers to the application of any techniques that aims to modify faulty patterns of thinking and to replace them with more adaptive and healthy patterns of thinking.
11. Discounting positives refers to the tendency of regarding good and positive things as unimportant.
12. Fortune telling refers to the belief that the one knows what the future holds while ignoring all other possibilities.
13. The humanistic psychotherapy focuses on building a warm and accepting therapeutic relationship between the client and the therapist, in which the client feels relaxed and is able to admit his unacceptable parts of the self.

4.10 QUESTIONS AND EXERCISES

Short-Answer Questions

1. Name the different therapies for treating psychological disorders.
2. What are the criticisms against psychoanalysis?
3. What are the premises on which the psychoanalysis method is based?
4. State the assumptions on which cognitive therapy is based.
5. Name the types of cognitive distortions and briefly explain what they mean.

Long-Answer Questions

1. Explain the method of psychoanalysis.
2. Discuss psychoanalytical psychotherapy.
3. Explain behaviour therapy.
4. Explain cognitive therapy.
5. Explain humanistic psychotherapy.

4.11 FURTHER READING

Gelder, M., R. Mayou and P. Cowen. 2004. *Shorter Oxford Textbook of Psychiatry*, Fourth edition. Oxford: Oxford University Press.

Sadock, B.J. and V.A. Sadock. 2004. *Concise Textbook of Clinical Psychiatry*, Second edition. Philadelphia, USA: Lippincot Williams Wilkins.

UNIT 5 CONCEPT OF MENTAL HEALTH

NOTES

Structure

NOTES

5.0 INTRODUCTION

Stress in multiple ways and fashions touches each of us everyday. It is an integral part of our lives. Researchers define stress as a physical, mental, or emotional response to events that causes bodily or mental tension. Simply put, stress is any outside force or event that has an effect on our body or mind.

Stress can be seen both as a stimulus (as a property of the situation we face, for example, natural disasters, noise, crowding, etc.) and as a response (to a stimulus event known as a stressor that threatens to disrupt our physical and social functioning).

Stressors can be external conditions like earthquakes; pollution, etc. or they can be internal conditions like one's thinking patterns. Stressors perceived to threaten one's well-being, demand some kind of adaptive response.

Stress is usually experienced in terms of three components: emotion (such as anxiety or fear), thought (such as pessimistic self-talk) and behaviour (such as smoking). All situations, positive and negative, that require adjustment can be stressful. Thus, according to Hans Selye (1956), there are two kinds of stress—eustress (refers to stress caused by positive situations such as marriage, promotion, etc.) and distress (refers to stress caused by negative situations such as death, divorce, loss of a job, etc.). Though both eustress and distress tax an individual's coping skill and resources, distress has more potential to cause damage.

5.1 UNIT OBJECTIVES

After going through this unit, you will be able to:

- Understand the meaning and nature of stress
- Identify the sources and consequences of stress
- Assess the different models of stress
- Learn how to cope with stress
- Learn the techniques of stress management

5.2 NATURE OF STRESS

Stress is considered to be subjective in nature as what may be stressful for one may not be for the other. The severity of stress is assessed by the degree to which it disrupts functioning. Various factors that predispose a person to stress have been categorized below based on the nature of stressor, person's perception and tolerance of stress and external resources and available social support.

NOTES

5.2.1 Nature of the Stressor

The impact of a stressor depends on many factors such as:

Its importance to the person: Stressors that involve important aspects of a person's life—such as the death of a loved one, a divorce, loss of job, getting a promotion or a serious illness—tend to be highly stressful for most people.

Duration of the stress: The longer a stressor operates, the more severe are its effects. For example, chronic stressors like living with a frustrating job or an unhappy marriage are likely to have more adverse effect than an acute stressor like having a fight with a friend.

Cumulative effects of stressors: The more the number of stressors one faces in succession, the more the stress, since, these stressors tend to have a cumulative effect.

Number of stressors: The more the number of stressors one experiences at the same time the more the stress. For example, if a man has a heart attack, loses his job, and receives news that his son has died in a road accident—all at the same time—the resulting stress will be more severe than if these events occurred separately.

The nature of the circumstances: In difficult situations, especially those involving conflicts, the severity of stress usually increases as the time to deal with the demand approaches. For example, the anxiety of performing in an exam is likely to be higher in the hour just prior to the exam.

Degree of involvement: The more closely an individual is involved in a traumatic situation, the more is the stress experienced by him or her.

Controllability: The more control an individual thinks he or she can exert over the stressor, the less is the stress experienced by him or her. That is why uncontrollable events like death of a closed one are likely to be more stressful.

Predictability: Being able to predict the occurrence of a stressful event, even if the individual cannot control it, usually reduces the severity of the stress as it allows an individual to initiate some sort of preparatory process that acts to lessen the effects of a stressor. Also, with a predictable stressor, there is a safe period in which the individual can relax to some extent.

Challenging limits: Situations despite being controllable and predictable can be experienced as stressful if they push one's limits and capabilities and challenge an individual's view of himself or herself. Similarly, any change in life that requires numerous readjustments can be perceived as stressful.

Personality characteristics: Research done by Friedman and Rosenman in 1974, found that men with personality characteristics of intense drive, aggressiveness, ambition, competitiveness and the pressure for getting things done were two to three times more likely to have heart attack in middle age than men who were equally competent but more easygoing. People low on self-esteem may find moderate criticism of their work highly threatening, while people with high self esteem might find the same criticism helpful in improving their skills.

NOTES

5.2.2 A Person's Perception and Tolerance of Stress

One person's stressor is another person's piece of cake. This difference in reaction to the same stressor by different people can be due to both a person's perception of threat and his or her stress tolerance.

Perception of threat: If a situation is perceived as threatening and more likely to occur, whether or not the threat is real, it is likely to evoke significant stress. Also an individual who feels overwhelmed or feels that he or she will not be able to deal with the threat is more likely to experience negative consequences from the situation than a person who believes that he or she will be able to manage it. Understanding the nature of a stressful event, preparing for it, and knowing how long it will last, can lessen the severity of the stress.

Stress tolerance: The term stress tolerance refers to a person's ability to withstand stress without becoming seriously impaired. Not only individuals differ in their biological and psychological vulnerability to stress but they also differ in their vulnerability to different stressors. Early traumatic experiences, lack of self-confidence and self-esteem, insecurity can leave a person especially vulnerable to certain stressors.

Optimism–Pessimism: Simply put optimists are people who see the glass as the half full and pessimist are those who see it as half empty. Research has shown that optimists (i.e., people who have general expectancies for good outcomes) are likely to be more stress resistant than pessimists (i.e., people who have general expectation for poor outcomes). One reason behind this could be the difference in the stress coping strategies adopted by them.

Hardiness: According to Kobasa (1979), hardy people (i.e. relatively stress-resistant) seem to differ from other with respect to their high level of Commitment; tendency to see change as challenge (i.e. an opportunity for growth and development) and a stronger sense of control over events and outcomes in their life. Research findings indicate that persons high in hardiness tend to report better health than those low in hardness, even when they encounter major stressful life changes.

5.2.3 External Resources and Social Support

Presence of *positive social and family relationships* has been seen to reduce the negative effects of stress on a person and lack of social support has been seen to increase the potency of a stressor and to reduce one's capacity to cope with it. Also presence of a chronic or life threatening illness or a psychiatric disability in an individual is likely to increase the level of tension for all family members. Certain cultural rituals are also seen to aid an individual's coping with certain type of stressor. For instance, rituals enhancing one's faith in God, confessions and atonement can greatly help people to deal with stress related to feelings of guilt and sin.

To sum up, the degree of stress experienced by a person depends on the complex interaction between the nature of a stressor and a person's resources of dealing with it.

5.3 SOURCES AND TYPES OF STRESS

NOTES

For the purpose of convenience, the various sources of stress can be categorized into the following headings:

5.3.1 Major Life Events

Some of the major life events that evoke stress are break up of relationship, death of a family member; presence of a chronic disabling illness in oneself or in his or her family; shifting of home, job; change in one's social status; significant financial loss, etc. Holves and Rahe have devised a social readjustment rating scale (SRRS) by asking an individual to assign a value to various events in terms of LCU (life changing units), indicating the amount of change an individual is requested to make in response to these events. If stress inducing life events continue, then it can either lead to habituation or to chronic strain.

5.3.2 Problems in Daily Life

These include issues like forgetting things, getting stuck in traffic jam, falling ill quite often etc which also carry a potential to evoke significant stress in an individual. In contrast to these hassles are daily life events like receiving a compliment, listening to one's favorite song, meeting friends etc. that can uplift one's mood and help in reducing stress. To measure an individual's experience of daily life hassles and daily uplifts, Lazarus has devised the Hassles and Uplift Scale. Research has suggested that daily life hassles are a better indicator of one's illness. Also they tend to interact with the chronic background stressors like living in a crowded place.

5.3.3 Environmental Stress

Environmental stress is caused by stressors like noise, crowding and natural disasters. Noise tends to impair one's ability to attend to cognitive tasks and affects one's short-term memory. In a study conducted by Even et al. (1995), it was seen that children who lived near airport had increased blood pressure, increased cortisol levels and increased stress hormones. Crowding is seen as a psychological state which refers to an individual's subjective sense of space he or she needs to work and live comfortably. Crowding has also been found to correlate positively with aggression, crime rate and withdrawal from interpersonal relationships. Freedman's work (1975) on the effects of crowding on inmate prisoners showed that crowding is associated with increase in death rate, increase in blood pressure, and increase in levels of stress hormones. Natural disasters result in loss of property, money and lives; victims of broken relationships need to re-start life from a scratch in its victims. Survivors of natural disasters sometimes suffer from Post Traumatic Stress Disorder (PTSD).

NOTES

5.3.4 Occupational Stress

Today occupational stress is one of major causes of stress-related illnesses. However, it can be managed effectively by redesigning one's job and taking appropriate intervention measures. The occupational stress can result from various sources as mentioned below:

Work overload: It refers to working too hard, too long, on a number of tasks. In fact in Japan a tern called as *karoshi* has been coined to indicate death resulting from work overload. Work load is often determined by the quality of work and individual is supposed to undertake. For instance, it is seen that if the work is felt meaningful by people, then they are likely to experience less stress. Also, when work load involves responsibility to people, then the degree of stress is higher than in conditions where workload involves responsibility for products. Similarly, the job of an Air Traffic Police is regarded as being quite stressful.

Globalizing, down-sizing and technology advancement: The changing conditions and work scenarios have led to globalization, down-sizing and significant advancement in technology and its use in one's work places. 'Globalization' is associated with culture shock which in turn calls for heavy adaptation demands. 'Down-sizing' may lead to loss of job, inability to find another suitable job and to the fear of losing one's job which is quite stressful in its nature and can make the individual feel depressed and suicidal. It may also lead to significant long-term adjustment difficulties, poor self-concept, feelings of worthlessness, helplessness and hopelessness. 'Advancements in technology' at one hand has made work faster and efficient, but on the other hand too much computerization has made the job monotonous and boring in nature, thus reducing its meaningfulness and causing stress. It has also forced individuals to adapt and continuously upgrade themselves with the new demands of technology.

Role related stress: The term role refers to expectations associated with one's position, rank or status. The more the number of roles an individual is required to perform (role space); the lesser the clarity about the expectations and demands associated with job (role ambiguity); the more an individual is required to sacrifice his own interests in order to meet expectations of others (role bondness); the more the stagnation and the lesser the opportunity for growth (glass ceiling effect); the more inadequate the resources available to the more inadequate an individual felt to perform the job (role inadequacy); the more the conflicting expectations and demands associated with the job (role conflict); the more the expectations demanded out of a role (role overload); and the more an individual has demanding roles to fulfill both at the workplace and at home; the more the individual is likely to feel stress. It is usually seen that women who are required to manage both their family and work pressures are likely to experience more stress than men who have to manage their work pressures only. Often work at job requires an individual to work in a team. The lack of cohesiveness and social support in one's team is likely to further increase the stress level.

NOTES

Burnout: It refers to a state of complete physical and psychological exhaustion which is job-related. Burnout is characterized by the presence of feelings of being emotionally drained, loss of energy and fatigue (emotional exhaustion); loss of idealism in work and presence of negative attitude towards job and other people at the work place (Depersonalization) and loss of sense of work-related competence and achievement (reduced personal accomplishment).

Lack of control over work: Jobs that are dull, repetitive and requiring less personal control are likely to be more stressful.

Shift work: Jobs that require an individual to make day and night shifts are likely to be more stressful as the shifts tend to disrupt one's biological rhythm. Also these individuals tend to frequently report complaints of headache, loss of appetite, sleep disturbances, gastro-intestinal problems and other health complaints.

Gender harassment: Harassment of women at work in the form of verbal and physical abuse, eve-teasing and criticisms or nasty comments based on one's gender are likely to add to job-related stress as such behaviours may lead to the development of low self-esteem, insecurity, anxiety and threat of being unsafe.

5.3.5 Personal Relationships

Presence of stable, healthy, meaningful relationships is regarded as a major stress buster. But at the same time, interpersonal conflicts, conflicts with family members at home, unhappy conflict-ridden marriage, can cause significant stress, especially when the individual desires to be understood by his friends, family and or spouse but often feels misunderstood. In addition, sudden death of a family member or a loved one; divorce or separation from the partner can also evoke a lot of stress. Several factors that can make divorce or separation all the more stressful are holding oneself responsible for the failure of marriage; the need to justify the separation or divorce to family and friends; associated cultural and societal stigma; loss of valuable friendships; involvement of children; custody issues of children; court trials; readjustment to a single life and the need to form new friendships.

5.3.6 Frustration, Threat and Conflict

Presence of frustration (i.e, any obstruction in one's way to achieve his goal); threat (i.e. fear of something negative happening or the fear of harm in future) and conflict (i.e. difficulty in deciding between available options) can be a major source of stress. High expectations, lack of ability and lack of resources (like time, money, support, etc) needed to achieve one's goal can cause immense frustration. Individuals having a negative cognitive bias, being high on anxiety and apprehension are more likely to experience threat when faced with uncertainty and hence may feel more stressful. Conflict can be of three types—approach-approach conflict (is a conflict between to desirable options); approach-avoidance conflict (it arises when an individual has both positive and negative feelings towards a particular

object or a choice in life) and avoidance-avoidance conflict (is a conflict experienced by the individual towards two undesirable options).

NOTES

CHECK YOUR PROGRESS

1. Define stress.
2. What is eustress?
3. What is distress?
4. Name some of the sources of stress.

5.4 CONSEQUENCES OF STRESS

Stress at its optimum level can have adaptive and positive effects, for instance, it can increase one's tolerance for future stressors but continued exposure to severe stress can have more negative and damaging effect on one's physiological and psychological functioning, for instance, it can lower one's efficiency, cause depletion of adaptive resources, resulting in severe personality and physical deterioration, even death.

The term stress was coined by Cannon (1932) and he believed it to underlie all medical problems. He termed the body's physiological response to stress as a fight or flight syndrome. In fight-flight syndrome, the epinephrine, cortisol and other hormones prepare the body to defend against stress by attacking or by running away from the stressful situation. He regarded this response as highly functional and adaptive in nature. Different physiological mechanisms that seem to play a role in stress are—brain; the nervous system and the endocrine system.

5.4.1 Role of Brain and Central Nervous System

Body's overall reaction to stress is regulated by central nervous system (CNS). A potential stressor is perceived by the sense organs. The sense organs and the sympathetic nervous system then transmit impulses to the middle of the brain stem. The brain stem alert's the brain about the impending threat of challenge by activating the reticular formation. The reticular formation either carries neural instructions from the brain to the target organs, muscles and glands by sympathetic nervous system thus mobilizes the body for defensive action or it may carry neural instructions from the brain to the thalamus. At the thalamus, the higher regions of cerebral cortex, limbic system and thalamus sort this sensory information by interpreting the meaning of the potential stressor. In hypothalamus lies the Periventricular hypothalamic nucleus (PVH), which contains endocrine neurons. The endocrine neurons release hormones which coordinate the activity of the endocrine system which is known to play a key role in response to stress.

NOTES

5.4.2 Role of Sympathetic Nervous System

When faced with stress, the sympathetic nervous system, coverts anabolic metabolism into catabolic metabolism; which involves the breakdown of tissues to produce energy. Sympathetic nervous system sends signals to the adrenal gland to release hormones to cause a fight-flight response in which increase in heart rate, dilation of pupils, and secretion of stress hormones, slow down of digestion process and increase in the blood flow to the muscles takes place. The stored energy is readily converted into a form in which it can be directly used by the muscles.

5.4.3 Role of Endocrine System

Under stress, the pituitary gland sends messages to the hypothalamus, which stimulates the adrenal medulla to secrete epinephrine and nor-epinephrine into blood. Epinephrine and nor-epinephrine trigger a fight or flight response. Since epinephrine and nor-epinephrine and sympathetic nervous system interact together in producing a fight or flight response, it is called as the Sympathaadreno-medullary system (SAM). SAM is the body's initial response to stress.

However, hypothalamic-pituitary-adrenocortical system (HPAC) is a delayed response to stress that restores the body to its baseline level called as homeostasis. HPAC involves the interaction between hypothalamus, pituitary gland and the adrenal cortex. It operates with the Central Nervous System stimulating the Hypothalamus to release Corticotrophin Releasing Hormone (CRH), which stimulates the production of Adrenocorticotrophic hormone (ACTH). ACTH activates the adrenal cortex to secrete corticosteroids. Corticosteroids are steroid hormones which are responsible for combating inflammation, promoting health and for mobilizing the body's energy resources.

Endocrine system works by a feedback mechanism which involves cortisol (a hormone secreted by the adrenal gland). Cortisol results in an increase in the level of glucose in blood, stimulates the breakdown of protein into amino acids and inhibits the uptake of glucose by body tissues but not by the brain. However, too much of cortisol leads to hypertension, weakening of the immune system to fight infection, and results in psychological problems like depression. Cortisol acts using a feedback system by acting back on the hypothalamus and pituitary to suppress the release of CRH and ACTH. As ACTH levels decrease in blood, adrenal cortex shuts down its production of cortisol.

5.4.4 Stress and the Immune System

Through the hypothalamic-pituitary-adrenal glands, stress can increase the corticosteroid levels and can lead to serious endocrine imbalance thus impairing the functioning of an individual's immune system. The hypothalamus releases hormones that stimulate the pituitary to release other hormones that regulate body functions like bone growth and reproduction. The suppression of the immune system under chronic stress can have long-term negative effects on one's health making

NOTES

an individual susceptible to external diseases. Increase in corticosteroids can reduce an individual's immunity to disease by decreasing lymphocyte metabolism.

Changes in the immune system are known to be caused by several stressors like unemployment, divorce, occupational stress, etc. as it causes reduction of lymphocytes, natural killer cells, T-cells and white blood cells (WBCs). Two hypotheses, namely, the direct effect hypothesis and the indirect effect hypothesis, have been proposed to explain how stress causes suppression of the immune system. Direct effect hypothesis sees immune-suppression as a result of stress-caused damage to hypothalamus; increase in cortisol and epinephrine; and decrease in the production of T-cells, lymphocytes, natural killer cells, WBCs, etc. Indirect effect hypothesis states that stress influences immune system by encouraging maladaptive behaviourus like smoking, alcohol drinking, fragmented sleep, poor nutrition etc that disrupt immune functioning. It sees immune-suppression as an after effect of stress response.

5.5 MODELS OF STRESS

5.5.1 Selye's Theory of Stress

Hans Selye first introduced the concept of stress in 1936, and systematically investigated the effects of continued severe stress on the body. His theory of stress is based on the following assumptions:

- He believed that the nature of the stressor has no effect on the physiological response to stress.
- There is a universal pattern of defense reactions that aim to protect the person or an animal or any species, which experiences stress, and helps to maintain them their equilibrium.
- With continued or repeated exposure to the stressor, the defense reactions always move in succession through the three stages of alarm, resistance and exhaustion. These three stages together represent his concept of General Adaptation Syndrome (GAS).
- In case of severe and prolonged stress, these defence responses result in disease states which in extreme cases can even lead to death.

He used the term General Adaptation Syndrome (GAS) to explain the concept of stress. He called it general because it is produced only by agents which have a general effect upon large parts of the body. He called it adaptive because it prepares an individual to acquire and maintain strategies that can help in coping with it. He called it a syndrome because stress is characterized by the presence of a set of symptoms occurring together. Selye's theory of stress states that different kinds of stressors can trigger the same reaction or general bodily response. Usually, organisms have a need to maintain their equilibrium and balance

NOTES

(homeostasis). A stress tends to disrupt this equilibrium and thereby calls for the body to adapt and take actions to restore the equilibrium.

Thus, when faced with stress the individual's resources for coping with a stressor are altered and mobilized and his body prepares for immediate physical action by activating its sympathetic nervous system and by releasing stress hormones in greater amounts. In order to prepare to face the threat, an increase in the body's adrenal activity, cardiovascular and respiratory functions; enlargement of lymphatic system and a greater release of epinephrine is seen. In this stage known as the 'Alarm Stage', the individual is likely to experience, emotional arousal, increased tension, heightened sensitivity and susceptibility to stressors and illness, greater alertness (vigilance) and determined efforts at self control. In addition the individual makes use of task oriented or defense oriented or a combination of the coping measures in order to meet the emergency. During this stage, the individual may experience continuous anxiety and tension, gastro-intestinal upset or other bodily disease, and lowered efficiency, suggesting that the resources available to deal effectively with the stress are inadequate.

At this point, the individual enters the second stage of resistance, which is marked by the individual's efforts to endure and resist further debilitating effects of the stressor by maintaining a moderate level of physiological arousal thereby decreasing its response to other stimuli. At this stage, the individual actively makes use of task oriented coping mechanisms and ego-defense mechanisms. Here, indications of strain may exist in the form of psycho-physiological symptoms and mild reality distortion. A shrinkage in the adrenal cortex; return of lymph nodes back to its normal size; sustaining of hormone levels; high physiological arousal; and heightened sensitivity to stress may also be seen. This intermediate stage of restoration is able to successfully restore the body's balance only when the stressor is short-lined or acute.

However, if the stressor continues or there is an addition of more stressors, the body may enter the stage of exhaustion, where it may exhaust all his resources and is no longer in a position to resist the stressor. At this point, the individual tends to become rigid and to inappropriately hold on to previously developed defenses instead of devising more adaptive coping strategies. This can eventually lead to the onset of physical symptoms and in many cases, a major illness may occur. As the stage continues the body experiences more disintegration and is not able to maintain homeostasis. An enlargement or dysfunction of lymphatic structures; increase in hormone levels; depletion of adaptive hormones and affective experiences like depression may occur. This stage may further be characterized by psychological disorganization and a break with reality, involving delusions and hallucination and may eventually lead to a stage of complete psychological disintegration, perhaps involving continuous uncontrolled violence, apathy, stupor and eventually death.

Although Selye's model has been able to effectively describe the effects of continued or chronic stress on our body, his model has been criticized on various grounds.

NOTES

- For instance, Pestonjee (1987) stated that Selye's theory is based largely on the researches conducted on other animals, which are more likely to face physical or environmental stressors whereas human beings are less often confronted by such stressors. Hence, the generalization of his theory to human beings should be done with caution.
- Selye's model states that all stressors irrespective of their nature result in a non- specific physiological response. But it has been noted by researchers that there are certain stress-evoking stimuli, for example, exercise, fasting and heat (Mason 1971) which does not produce such a non-specific physiological response and hence the GAS does not hold true.
- Human beings are likely to face more intra-psychic or social (interpersonal/ interactional) stressors, which have not been given their due place in this model.
- The reactions of infra-human subjects are more directed and perceptible in nature and thus can be easily measured. However, human responses are always mediated through several layers of cultural and social factors.
- There is also some evidence that when faced with stressors, all the symptoms of the syndrome may not appear together as stated in the model.
- Further, research suggests that different kinds of stressors can evoke different physiological responses. For instance, situations producing anxiety are associated with adrenaline release while situations which produce aggression are associated with nor-adrenaline release.

5.5.2 Lazarus Model of Stress

This model proposes that cognitive mechanisms are strong and the demands of the situation can be easily met, then the individual does not experience stress. Stress is, however, experienced when the cognitive mechanisms are weak or the stressor exceeds ones coping mechanisms. Lazarus believed that the experience of stress depends upon both the stressor and the cognitive appraisal of the stressor.

In response to a stressor, the transactions between the individual and his environment are driven largely by cognitive appraisals that take place at three levels as follows:

Primary appraisal: It determines whether an event is irrelevant, benign, positive or threatening in nature.

Secondary appraisal: It determines whether he has enough resources or coping (cognitive or behavioural) abilities to deal effectively with the threatening event. If the individual has enough resources to deal with the event effectively then he or she doesn't experience any stress. However, when the individual does not have enough resources, then he experiences stress.

NOTES

Tertiary appraisal: It involves constant evaluation of the potential stressful event in the light of new available information. It is an ongoing process.

It is also quite possible that an event that was earlier seen as non-threatening or irrelevant may suddenly become threatening with change in the individual's perception of events which may make the individual realize that his coping resources are not adequate. Thus, the same non-stressful irrelevant event may be perceived by the individual as stressful.

Individuals largely engage in different types of cognitive appraisal, namely, challenge, harm, loss and threat. When an individual engages in the 'cognitive appraisal of challenge', then he is likely to perceive a new change as an opportunity for growth and development. For example, such an individual may see loss of a job as an opportunity for a better job or a new career option. Individuals that engage in the 'cognitive appraisal of harm and loss', tend to assess the damage, loss or harm caused by the events, disease or illness. For instance, they are likely to see loss of job as an economic loss leading low self-esteem. However, the individuals that engage in the 'cognitive appraisal of threat' believe that the situation or event may cause loss or harm in future. For instance, they are likely to see rash car driving as a potential tendency for causing an accident or serious injury or death in future.

In a study conducted by Lazarus et al. on students who were shown a film on an accident that took place in a shop, showed that stress is not the property of the event alone, but it also depends on one's appraisal of the event. In this study, the students were divided into three groups and were then shown a movie on an accident that took place in a shop. After the film was shown, the groups were given different information about the accident. Group I was told that no harm or injury followed the accident. Group II was told that the accident was actually designed to improve the worker's safety. However, the group III was not given any explanation. The stress was found to be low in both Group I and Group II as the explanations given to them enabled them to make less threatening appraisals of the event. But the stress was seen to be high in Group III as no explanation was given to them which could have altered their appraisal of the event.

The above stated Lazarus model has three important implications. It implies that an event is not inherently stressful. It may be appraised by someone as threatening whereas others may see it non-threatening based on their cognitive appraisal of the event. Secondly, the cognitive appraisals are extremely susceptible to changes in mood, health and motivation. Hence, under different conditions different appraisals may be made. Thirdly, the body's stress response is nearly the same, whether the event is really experienced or imagined. Thus, an imagined or a recalled appraisal of a situation can also evoke a stress response.

5.5.3 Diathesis Stress Model

The diathesis stress model proposes that an individual's susceptibility to illness and stress depends upon interaction between the biological factors (predisposition)

NOTES

and the environmental factors (precipitating factors). An individual's predisposition to illness and stress depends on his or her biological vulnerability to illness, the genetic make-up and his personality and behavioural characteristics. When an individual who has a higher predisposition to illness and stress when encounters external stressors such as loss of job, death of a spouse, divorce, etc. then they are more likely to manifest the illness or disease. Individuals having high vulnerability are also seen to over react to minor stress.

5.6 COPING WITH STRESS

Generally speaking, increased levels of stress threaten a person's well-being and automatically results in the individual taking some actions to do away with stress and its harmful effects. What action an individual takes often depends on a complex interplay between internal factors like a person's frame of references, motives, competencies, or stress tolerance and external factors like one's social demands and expectations.

Ironically, some people are seen to create stress for themselves by engaging in maladaptive behaviours and cognitions rather than coping with it. Some individuals get caught in the vicious cycle of generating life events that in turn produce adjustment problems.

Individuals tend to cope with stress at three levels—at the biological or the physiological level (through the use of immunological defences and damage-repair mechanisms), the psychological or the interpersonal level (through the use of learned coping patterns, self-defences, and support from family and friends) and at the socio-cultural level (through group resources, such as labour unions, religious organizations, and law enforcement agencies). The failure of coping efforts at any of these levels may seriously increase a person's vulnerability on other levels and also to other stressors.

In order to effectively cope with stress, individuals are seen to engage in various coping strategies. Coping strategies refer to various cognitive, behavioural and emotional ways people engage in to manage stress. They are dynamic processes which neither eliminate a stressor nor prevent its re-occurrence but increase one's tolerance of the situations. All the coping strategies an individual engages in are not equally effective.

Lazarus has given two kinds of coping strategies—emotion-coping strategies and problem-focused coping strategies.

5.6.1 Emotion-Focused Coping

It involves the use of cognitive and behaviour strategies to manage one's emotional reaction to stress. Cognitive strategies include changing one's appraisal of stressor and denying unpleasant information, whereas, behavioural strategies include taking

social support and alcohol or psychoactive drug. Emotion-focused coping primarily aims at distracting attention from unpleasant situations, stress evoking events and problems. An individual tends to make use of them when nothing significantly can be done to alter the stressor or stress evoking situation and events and when he or she lacks the skills or resource to meet demands posed by the stressors. Three types of emotion-focused coping strategies that are frequently used are:

Escape avoidance: In it the individual physically and psychologically separates himself or herself from the stressors. For instance, to avoid the fear of failing in the exam one may either not give the exam or may engage in excessive sleeping.

Distancing: It refers to psychological detachment of oneself from the stressor. For instance, over-weight people may stop thinking about their weight.

Position reappraisal: It refers to reinterpreting the situation to turn the negative aspects of the situation or the stressor into its positive aspects. For example, one may look at the loss of job as an opportunity to get something better.

5.6.2 Problem-Focused Coping

It involves directly dealing with the stressful situation by either reducing its demands, or by increasing one's capacity to deal with it. Three types of problem-focused coping strategies that are frequently used are:

Proactive coping (preventive coping): It refers to anticipate potential stressors and act in advance to either prevent their occurrence or to reduce their impact. To achieve this goal it may make use of several mechanisms like improving problem-solving skills, develop stronger social support network, etc. For example, the fear of failing can be prevented by studying in advance for one's exams. This coping strategy often requires long-term effects and may bring about a change in one's attitudes, cognitive styles and behaviours.

Combating coping: It refers to escape from stressors that cannot be avoided. Combating coping involves the active use of relaxation techniques, meditation and eating nutritious diet.

Research has shown that women in general and individuals from a low socio-economic status are more likely to use emotion-focused strategies than men in general and people from a high socioeconomic status, who are seen to make use of more problem-focused strategies. One reason behind this could be that women are seen to react emotionally more to stress than men and past experiences may create feelings of helplessness and hopelessness in individuals from a low socio-economic status. In fact, in dealing with various stressors, both the coping strategies are often used together.

In addition to the various coping strategies, certain factors that can affect one's ability to cope with stress are as follows:

NOTES

Hardiness: It is seen that individuals high on hardiness are more likely to make use of problem-focused coping strategies.

Resilience: Some individual's are seen to be more resilient than others. For instance, it is seen that some children have the ability to develop into competent well-adjusted people despite being raised in extremely disadvantaged environment. Resilience may be a result of child's personality traits and the available social support. Resilient children tend to have well-developed social, academic and creative skills; an easy temperament; high self-esteem, high-self description; better personal control; healthy social relationship with others; and at least one consistently supportive person in their life.

Explanatory style: It can be of two types namely, positive explanatory style and a negative explanatory style. Individuals who adopt a positive explanatory style tend to attribute outcomes always to a positive event such as one's personality, hard work, etc. whereas individuals who adopt a negative explanatory style tend to attribute outcomes always to a negative event. These individuals tend to feel that they are always surrounded by failures. Pessimists have a negative explanatory style and are vulnerable to experience negative emotions like depression, anger, anxiety and hostility. They are also likely to have suppressed immune systems. However, in contrast to them optimists have a positive explanatory style and are more likely to experience positive emotions and are likely to increase one's social, physical and cognitive resources. They are also likely to have healthy attitudes and healthy habits. The functioning of their immune system is also seen to be better.

Self-regulation: It refers to the ability to modulate their thoughts, behaviours, emotions in any and every situation. However, too much of self-control is not healthy as it leads to suppression of anger and may make an individual vulnerable to develop ulcers later in life.

Repression: It is a defence mechanism adopted by some individuals who tend to repress or block the awareness of negative stress evoking events out of consciousness. It is unhealthy and may result in pathology.

Learned helplessness: It is a phenomenon, in which after experiencing a series of negative uncontrolled events, the individual comes to an understanding that he is helpless in the face of adverse circumstances and hence does not make effort to overcome his difficulties.

Social support: Presence of adequate social support is likely to reduce stress. There are two hypotheses, namely, buffering hypothesis and the direct effect hypothesis, which have been proposed to explain how social support reduces the negative effects of stress. According to the 'buffering hypotheses', social support reduces stress by providing resources on the spot to cope with the stress effectively. People with good social support tend to ruminate less and this further minimizes the negative impact of the stressor on the individual. According to the 'direct effect

hypotheses', social support enhances the physical response to challenging situations. For example, pressure of others may reduce Sympathetic Nervous System arousal and may decrease the release of CRH.

Individuals with better social skills tend to create stronger social network and are likely to receive more social support.

NOTES

5.7 STRESS MANAGEMENT

Stress management refers to the use of various methods that have been designed to reduce the impact of potential stressful experiences. The various stress management techniques can be broadly divided into eastern and western techniques. The eastern techniques include—meditation, yoga, *pranayam* and self awareness (anasakti). The western techniques include—relaxation techniques (Jacobson's Progressive Muscle Relaxation Technique, Autogenic Training), biofeedback, assertiveness, time management, effective communication.

5.7.1 Meditation

Meditation means directing one's attention to an object. It may provide direct accesses to inner conscious energies. For meditation, one requires a quite room, free from distraction; a comfortable place to sit; and a desire to focus attention. It is effective as it slows metabolism, lowers blood pressure and reduces arousal.

5.7.2 Yoga

Yoga literally means to unite. It is the unity of physical and mental energies. It may mean different things to different people. For some it is a way to keep the body free from ailments by reducing stress but for some it is a way of life. It helps to control one's intellect, emotion, and behaviour.

Yoga prescribes some *asanas* (bodily postures) to restore balance. *Asana* is a Sanskrit word meaning at ease and relaxed. *Shavasana* is the simplest *asana* and a quite effective relaxation technique. It requires a quite room with subdued lighting free from distraction. In it the individual is asked to lie down straight on his back by keeping his head in a comfortable position. He asked to focus on his breathing, on the air that passes in and out of the nostril. It focuses on passive observation of one thoughts, which is quite difficult but essential for total relaxation to take place. Individual is instructed to release tension from the body from time to time.

Shavasana is called so because of its resemblance to a death body. Another *asana* that is good for relaxation is *makarasana* (crocodile position). Depending upon needs and capabilities of each individual different techniques can be prescribed. Research has shown that it is effective in regulating blood pressure, anxiety, stress, insomnia etc.

NOTES

5.7.3 *Pranayam*

Pranayam refers to breathing exercise. It is based on the principle that if one could harmonize breathing then on can alter lives thought, behaviour and emotion. During pranayama, lungs take in air which is rich in oxygen and hence energies both body and mind.

5.7.4 Self-Awareness or *Anasakti*

Anasakti is an Indian concept based on self-realization/self-actualization. It is emotional detachment from something/someone. *Anasakti* means detachment of spirit (basis of consciousness) from the body, ego and the body movement which create tension and interfere with the functions of internal organs and can lead to psychosomatic illness.

While practicing *anasakti* a person tends to perceive his work as duty and show lack of concern for the consequences of action. He appraises his own success and failure in objective rather than egoistic terms and is less governed by the external standards like social approval and concerns. He does not insist on seeking pleasure or avoiding pain. He shows absence of egoism and maintains an emotional equipoise both in the face of positive and negative experiences. He maintains mental stability with few mood swings. He shows total absorption in the work / task at hand and shows heightened concentration, trying to make efforts towards achieving task excellence.

5.7.5 Relaxation Technique

Relaxation is often misunderstood as simply rest or lying down in a crazy manner. It is rest after effort, more accurately conscious rest after conscious effort. Stebbins (1960) has very well defined relaxation as – the complete resignation of body to law of gravity and of the mind to the law of nature. It involves the total energy transformation into deep dynamic breathing. It is both a means and an end to self realization.

The main goal of relaxation is not to eliminate stressors or to prevent its recurrence by to increase one's tolerance. Through suitable for all people but when and how it is to introduced varies from person to person. It possesses both curative and preventive characteristics.

For the relaxation techniques to be effective, they should be administered live by the therapist; the client should be told about its nature and how to works; clients should be motivated and encouraged to use it on regular basis; their benefits should be transferred to real life situations and the client should be made to see its several beneficial applications. Some of the relaxation techniques commonly used are Jacobson's muscle relaxation technique and Autogenic Training.

NOTES

5.7.6 Biofeedback

The biofeedback method involves converting physiological response into electrical activity and provides a visual / auditory feedback about them. It is based on the principle that when we make a response then feedback about the consequence of the response enables us to make appropriate adjustment. It requires making an individual to be aware of a metabolic response; drawing his attention to signals that desire changes in internal responses. While trying to By analyzing biofeedback signals, the persone controls his physiological responses..Two commonly used biofeedback techniques are EMG (electromyography), which measures muscle tension and thermal biofeedback, which measures skin temperature. It is based on the principle that under stress, blood vessels constrict and body temperature drops.

The method of biofeedback has been criticized for being expensive; and the difficulty in transferring controls from laboratory to real life settings. It is difficult to know whether the change is due to biofeedback only or something else. Biofeedback has been found to be effective in treating chronic tension headaches, blood pressure, muscle tension and lower back pain.

5.7.7 Assertiveness Training

Individuals who are unable to say 'NO' that is who are non-assertive are likely to experience stress as they are unable to express their feelings and tend to suppress their emotions like anger, hostility, disgust which are associated with chronic stress. Hence, assertiveness training is likely to benefit the individual. Assertiveness training involves teaching individuals the assertiveness skills using modelling, instruction, rehearsal and feedback. Assertiveness training involves three components namely, refusal (the ability to say no for things that you do not wish to do), commendatory (i.e., the ability to express positive emotions), and request (i.e., asking someone to do things that help you to accomplish your goal).

5.7.8 Time Management

It helps individuals to learn to prioritize their tasks and do them efficiently. It involves first making a list of the task that one needs to; rate them in terms of their importance; assign the amount of time you wish to spend at it and review how much you were able to achieve. Stress usually occurs when various tasks pile up and one is not able to finish them on time.

5.7.9 Effective Communication or Calming Self-Talk

It involves engaging in silence, relaxing, reasoning self-talk statement aimed at telling oneself that stress is temporary and it shall soon go away. It also helps in reducing autonomous arousal such as telling oneself to count one to ten or instructing oneself to take a deep breath. It also helps individuals to preserve a sense of personal control, for instance, by as telling himself that he can handles the stress.

In short, individuals can learn to handle their stress effectively by with the help of the stress management strategies we discussed so far.

NOTES

CHECK YOUR PROGRESS

5. Define hardiness.
6. List the various sources of stress.
7. List the three models of stress.
8. List the three ancient Indian methods of managing stress.

5.8 SUMMARY

- Stress in multiple ways and fashions touches each of us in different ways. Stress can be seen both as a stimulus (as a property of the event or situation we face, for example, natural disasters, noise, crowding, etc.) and as a response (to a stimulus event known as a stressor that threatens to disrupt or disrupts one's physical and social functioning).
- Stressors can be external conditions like earthquakes, pollution, etc. or they can be internal conditions like one's thinking patterns. Stressors perceived to threaten one's well-being, demand some kind of adaptive response.
- Stress is usually experienced in terms of three components: emotion (such as anxiety or fear), thought (such as pessimistic self-talk) and behaviour (such as smoking). All situations, positive and negative, that require adjustment can be stressful. Thus, according to Hans Selye (1956), there are two kinds of stress—eustress (refers to stress caused by positive situations such as marriage, promotion, etc.) and distress (refers to stress caused by negative situations such as death, divorce, loss of a job, etc.). Though both eustress and distress tax an individual's coping skill and resources, distress has more potential to cause damage.
- A person's tolerance of stress depends on his perception of the threat, his innate ability to tolerate, his hardiness, and tendency to be optimistic or pessimistic. Research has shown that optimists (i.e. people who have general expectancies for good outcomes) are likely to be more stress resistant than pessimists (i.e., people who have general expectation for poor outcomes). One reason behind this could be the difference in the stress coping strategies adopted by them. 'Stress hardiness' is the ability or mindset exhibited by an individual that makes him or her resistant to the negative impacts of stressful circumstances and events. Three attitudes are associated with this concept: control, challenge and commitment. See also control, challenge, and commitment.

NOTES

- Presence of *positive social and family relationships* has been seen to reduce the negative effects of stress on a person and lack of social support has been seen to increase the potency of a stressor and to reduce one's capacity to cope with it.
- Various sources of stress can be categorized into the following: 1. Major life events (like break up of relationship, death of a family member; chronic illness, loss job, significant financial loss, etc), 2. Daily life hassles (like forgetting things, getting stuck in traffic jam, falling ill quite often, etc), 3. Environmental stress (like noise, crowding and natural disasters, etc.), 4. Occupational stress (like work overload, conflicts with the colleagues, downsizing, changes in technology, demanding roles, shift changes, etc.), 5. Personal relations, 6. Personal relationships (like separation or divorce, losing friendships, problems related to children, etc.), and 7. Presence of frustration.
- Stress at its optimum level can have adaptive and positive effects, for instance, it can increase one's tolerance for future stressors but continued exposure to severe stress can have more negative and damaging effect on one's physiological and psychological functioning, for instance, it can lower one's efficiency, cause depletion of adaptive resources, resulting in severe personality and physical deterioration, even death.
- Body's overall reaction to stress is regulated by central nervous system (CNS).
- Stress management involves the use of several methods that have been designed to reduce the impact of potential stressful experiences. The different stress management techniques can be broadly divided into eastern and western techniques. The eastern techniques include—meditation, yoga, pranayam and self-awareness (anasakti). The western techniques include—relaxation techniques (Jacobson's Progressive Muscle Relaxation Technique, Autogenic Training), biofeedback, assertiveness, time management, effective communication.

5.9 KEY TERMS

- **Eustress:** It refers to stress caused by positive situations such as marriage, promotion, etc.
- **Distress:** It refers to stress caused by negative situations such as death, divorce, loss of a job, etc.
- **Stress:** It is both a stimulus (as a property of the event or situation we face, for example, natural disasters, noise, crowding, etc.) and a response (to a stimulus event known as a stressor that threatens to disrupt or disrupts one's physical and social functioning).

NOTES

- **Stress hardiness:** It is the ability or mindset exhibited by an individual that makes him or her resistant to the negative impacts of stressful circumstances and events.
- **Cognitive appraisal of challenge:** The individual is likely to perceive a new change as an opportunity for growth and development. For example, such an individual may see loss of a job as an opportunity for a better job or a new career option.
- **Cognitive appraisal of harm and loss:** The individuals who engage in this tend to assess the damage, loss or harm caused by the events, disease or illness. For instance, they are likely to see loss of job as an economic loss leading low self-esteem.
- **Cognitive appraisal of threat:** The individuals who engage in this tend to believe that the situation or event may cause loss or harm in future. For instance, they are likely to see rash car driving as a potential tendency for causing an accident or serious injury or death in future.
- **Diathesis stress model:** It proposes that an individual's susceptibility to illness and stress depends upon interaction between the biological factors (predisposition) and the environmental factors (precipitating factors).

5.10 ANSWERS TO 'CHECK YOUR PROGRESS'

1. Researchers define stress as a physical, mental, or emotional response to events that causes bodily or mental tension. Simply put, stress is any outside force or event that has an effect on our body or mind.
2. Eustress refers to stress caused by positive situations such as marriage, promotion, etc.
3. Distress refers to stress caused by negative situations such as death, divorce, loss of a job, etc.
4. Stress can result from various sources like major life events (such as break up of relationship, death of a family member; presence of a chronic disabling illness in oneself or in his or her family; shifting of home, losing a job; change in one's social status; significant financial loss, and son on.
5. Hardiness is the tendency to see change as challenge (i.e., an opportunity for growth and development) and a stronger sense of control over events and outcomes in their life. Research findings indicate that persons high in hardiness tend to report better health than those low in hardness, even when they encounter major stressful life changes.
6. Varies sources of stress include major life events, daily life hassles, Environmental factors, Occupational factors, personal relationships, frustration, threat, conflict, etc.

7. (a) Selye's theory of stress, (b) Lazarus model of stress, and (c) Diathesis stress model.
8. Some of the ancient methods of managing stress include meditation, *yoga, pranayam* and *anasakti*

NOTES

5.11 QUESTIONS AND EXERCISES

Short-Answer Questions

1. Write a short note on environmental stress.
2. Write short note on occupational stress.
3. Write a short note on Selye's Theory of Stress.
4. Write a short note one emotion-focused coping of stress.
5. Write a short note one problem-focused coping of stress.

Long-Answer Questions

1. Explain the nature of stress.
2. Explain in detail the sources of stress.
3. Explain the consequences of threat.
4. Elaborate on the different models of stress.
5. Discuss the methods used to cope with stress.
6. Explain the different stress management techniques.
7. What do you understand by frustration, threat and conflict?
8. Discuss the Lazarus Model of Stress.
9. Discuss the diathesis stress model.

5.12 FURTHER READING

Gelder, M., R. Mayou and P. Cowen. 2004. *Shorter Oxford Textbook of Psychiatry*, Fourth edition. Oxford, UK: Oxford University Press.

Carson, R.C., J.N. Butcher and J.C. Coleman. 1988. *Abnormal Psychology and Modern Life*, Eighth edition. Glenview, IL, USA: Scott Foresman.