Psychopathology of Children and Family

FEM 4104

Units 1 – 15

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MODUL PEMBELAJARAN : FEM 4104 PSYCHOPATHOLOGY OF CHILDREN AND FAMILY disediakan dalam bentuk bahan pengajaran dan pembelajaran kendirian bawah program Pendidikan Jarak Jauh, Universiti Putra Malaysia. Sebarang pertanyaan dan cadangan untuk memperbaiki gaya penyampaian dan isi kandungan modul ini bolehlah dikemukakan kepada penulis dengan menggunakan alamat Pusat Pendidikan Luar.

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A. Information on the course

Department: Human Development & Family Studies

Course Name: Psychopathology of Children & Family
(Psikopatologi Kanak-kanak & Keluarga)

Course Code: FEM 4104

Credit Hours : 3(3+0)
This course comprises three hours of lectures a week, which adds up to 42 hours of lectures per semester. In order to complete the course requirement, each student is expected to complete an equivalent of six to nine hours of reading a week and complete related assignments.

Course Description

This course discusses on child and family psychopathology with emphasis on abnormal behaviour, its causes, consequences and treatment. Focus is also given on the role of the individual, family and society in assisting individuals in handling psychopathological problems.
Course Objectives:

1. Provide an overview of the symptoms, demographic features, and typical progression of major forms of psychopathology.

2. Describe the major theoretical approaches to the causes and treatment of psychopathology.

3. Explain the process and the importance of the context in which psychopathological behavior occurs in children and families.

4. Explain the factors that contribute to the existence of psychopathological children and families and its effects.

5. Describe the treatment required of clients who are experiencing psychopathology.

6. Explain the role of the individual, family and society in facing and helping individuals who suffer from psychopathology.

Working with children and families who experience psychopathology, we must understand what is "normal" and what is not. To be able to make that distinction we must be able to:

- Observe behavior carefully, objectively and see patterns in behaviors;
- Understand the behavior in context for that individual, setting and culture;
- Identify developmental and cultural norms and compare people’s behavior to these;
- Compare behavior with some overarching definition of mental health.

In other words, sometimes it is "normal" to be depressed. Sometimes it is "abnormal" to react with laughter. We will approach the goals described above using the diagnostic system, DSM-IV, learning both the strategies they use to categorize patterns of abnormal behavior as well as what those characteristic patterns are. Although this is not a "therapy course," we will also glance at accepted treatment strategies for particular diagnostic categories.

As we explore these issues we will examine the major controversies in the field, such as:

- What are the advantages and disadvantages of using labels?
- Can people with psychopathology be held "responsible" for their behavior?
- Why are people of certain gender, age, race, or ethnicity more likely to diagnosed with some disorders than others?
Student Learning Outcomes

1. Demonstrate an understanding of the diagnostic features and DSM-IV-TR classification of the major forms of psychopathology as evidenced by examinations and papers.

2. Develop an understanding of the major theoretical explanations of the etiology of various forms of psychopathology as demonstrated by class examinations and papers.

3. Develop an understanding of the major theoretical approaches to the treatment of various forms of psychopathology as demonstrated by class examinations and papers.

4. Demonstrate an ability to frame the diagnosis of individual psychopathology within the appropriate situational and sociocultural contexts, as evidenced by examinations and papers.

5. Develop an understanding of broad constructs (e.g., the historical and cultural relativism of diagnosis, the connection between mind and body, etc.) that influence the definition, classification, explanation, and/or treatment of mental disorders, as evidenced by examinations and papers.

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  - The Biological Perspective  
    o Genetic Factors  
    o The Nervous System and the Brain  
  - The Psychodynamic Perspective  
  - The Behavioral Perspective  
  - The Cognitive Perspective  
  - The Humanistic-Existential Perspective  
  - The Community-Cultural Perspective  
  An Interational Approach |
| 3    | Classification and Evaluation of Maladaptive Behavior  
  - Advantages and Disadvantages of Classification  
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  - The Major Diagnostic Categories  
  Assessment: The Basis of Classification |
| 4    | Stress and Stress-related Disorders  
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| 5    | The Experience of Anxiety  
  - Generalized Anxiety Disorder  
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| 6    | Mood Disorders  
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  - Dysthymic Disorder  
  - Major Depressive Disorder  
  Bipolar Disorders  
  - Bipolar I  
  - Bipolar II  
  - Cyclothymic  
  Suicide |
| 7    | Somatoform and Dissociative Disorders  
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  - Conversion Disorders  
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| 10   | Substance-Related Disorders  
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| 12   | Schizophrenia  
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- Schizophreniform Disorder  
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| 13   | Cognitive Disorders  
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- Brain Trauma: Injuries, Tumors, and Infections  
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| 14   | Disorders of Childhood and Adolescence  
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### Suggested Student Centered Learning Schedule

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<td>Butcher, Mineka &amp; Hooley, Chapter 1: What do we mean by abnormal behavior?</td>
<td>Assignment 1: What is normal and What is not? (3%)</td>
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<tr>
<td></td>
<td>• Psychopathological perspective on children and family</td>
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<td></td>
<td>• Historical background of psychopathology</td>
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<td>Theories of Maladaptive behavior</td>
<td>Chapter 2: Causal Factors and Viewpoints</td>
<td>Assignment 2: Explain what causes psychopathology. (7%)</td>
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<td></td>
<td>• Biological perspective</td>
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<td>• Psychodynamic perspective</td>
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<td>• Learning perspective</td>
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<td>• Cognitive perspective</td>
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<td>• Socio-cultural perspective</td>
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<td>Classification and Evaluation of Maladaptive Behavior</td>
<td>Chapter 3: Clinical assessment, diagnosis and treatment approaches</td>
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<td>• Diagnosis system</td>
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<td>• Psychological evaluation</td>
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<td>• Behavioral evaluation</td>
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<td>• Biological evaluation</td>
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**Assignments 1 & 2 due**

| 4    | Stress, Psychological Factors & Health                                | Chapter 4: Stress, and related disorders                                 |                           |
|      | • Adaptation disorderian                                              |                                                                          |                           |
|      | • Health and disease                                                  |                                                                          |                           |
|      | • Psychological factors and physical disturbances                    |                                                                          |                           |
|      | • Acute and post-traumatic stress disorder                            |                                                                          |                           |
| 5    | Fear and anxiety: Observed and Inferred                              | Chapter 5: Panic, anxiety and their disorders                           | Assignment 3: The Best Therapy. (5%)                                   |
|      | • General anxiety disorder                                           |                                                                          |                           |
|      | 1. General anxiety disorder                                           |                                                                          |                           |
|      | 2. Panic, agoraphobia                                                 |                                                                          |                           |
|      | 3. Obsessions Phobias                                                 |                                                                          |                           |
|      | • Depression: The "common cold" of mental health                     |                                                                          |                           |
|      | • Bipolar disorder                                                    |                                                                          |                           |
|      | • Suicide                                                              |                                                                          |                           |

**Assignments 3 due.**

| 6    | Mood Disorders                                                        | Chapter 7: Mood disorders and suicide                                   |                           |
|      | • Depression: The "common cold" of mental health                     | - Best things to say to someone who is depressed                       |                           |
|      | • Bipolar disorder                                                    |                                                                          |                           |
|      | • Suicide                                                              |                                                                          |                           |

Midsemester Examination (Chs. 1-6)
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<td>Chapter 7: Somato dan dissociative disorders</td>
<td>Assignment 4: Name that headache. (5%)</td>
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<td>• Hypochondriasis, somatization, pain and conversion disorder</td>
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<td>Assignment 5: The Charming Psychopath (5%)</td>
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<td>• Strange of eccentric behavior</td>
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<td>• Dramatic, emotional or erratic behavior</td>
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<td>• Addictions – alcohol, sedatives, narcotics, stimulants, hallucinogens</td>
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Evaluation Criteria and Procedures

Your final grade will be calculated based on a semester total of 100 percent. The points are determined as follows:

Mid-Term Exam
Total: 25%
Topics 1 – 6
Consists of
- 26 multiple choice questions (13%) and 4 short answer questions (choose 4 from 6 questions) (12%)

Final Exam
Total: 30%
Topics 7 – 15
Consists of
- 30 multiple choice questions (15%) and 5 short answer questions (choose 5 from 8 questions) (15%)

Assignments:
Total: 45%
- Consists of 9 papers. Please refer to descriptions in the assignment section for the details on the assignments and marks allocated.

Student activities include several types of activities:

Module activities and self-tests: Designed as a supplement to enhance the student’s understanding of the content and to assist them in their preparation for their examinations.

Assignments: Designed to reinforce the material in the module. Individual works are suggested throughout the manual. You have a total of eight assignments, which adds up to 45% of the course marks. Each assignment should be about 4-8 pages in length (depending on the marks given), single-spaced, typed in Arial 11-point font, with 1 inch margin. In order to receive useful feedback from me, which will help you improve your assignments and maximize your marks for each assignment, please e-mail your assignments directly to me. Refer to the tentative schedule of events and complete the assignments according to the suggested weeks, in order to pace your work and optimize your learning.
Assignment One: What is normal and What is not? (3%)

One of the many controversies about diagnosing psychopathology has to do with where psychopathology is “located” – Is it in individuals, in relationships, in families, or in broader social structures?

Those who suffer from mental disorders frequently face direct, implied, or imagined stigma (a narrow set of beliefs that applies to a broad group of people and damages their ability to live freely) against their illness. Whether considering a stranger, a friend, or yourself, write an essay from the perspective of the stigmatized person. What would you say to those who are ignorant or insensitive to help them understand? Discuss how stigmatization relate with the location of the diagnosis, i.e. individually, in relationships, in families or society.

Assignment Two: Explain what causes psychopathology (7%)

Paper one: Fixations, defense mechanisms and psychopathology. (3%)

According to Sigmund Freud, defense mechanisms protect individuals from psychic conflicts, which may occur between the id and the superego. Discuss how conflicts during the first six years of life can lead to fixations within each of those psychosexual stages (oral, anal and phallic) and how the ego use defense mechanisms to protect the individual from developing psychopathology?

Paper Two: Behavior Theory and Day-to-Day Living (4%)

Discuss the following points:

1. What are the side effects if severe punishment is used to control behavior? Are there any examples of these side effects that we see in everyday life? According to behavior theory, what is the best way to control undesirable behavior? How does our society deal with undesirable behaviors? What are the results? What improvements could be made?

2. Discuss the implications of modeling and today's violence in children. Does violence on television affect children, boys and girls, younger or older children equally? Should television viewing be limited? Are there other examples of cultural violence that would confound a finding that television is highly related to violence.
Assignment Three: The Best Therapy (5%)

1. Examine the following perspectives: the psychodynamic perspective, the behavioral perspective, the cognitive perspective, and the biological perspective in explain the phobia.

2. Based on these perspectives, diagnose, interpret, and recommend treatments for the following illnesses:
   b. A constant state of anxiety, worry, pacing behavior, sweating, “nervousness”
   c. Because of extreme fear, the inability to leave one’s house or neighborhood, the inability to drive, go out of town, to shop in malls
   d. The re-experiencing of a traumatic event, recurrent of distressful thought or dreams of the event, avoidance of similar situations, hypervigilance, inability to feel tender feelings.

Assignment Four: Name That Headache (5%)

Ask four to six of your friends or relatives who have headaches to volunteer for a short research on distinguishing among different kinds of headaches. Summarize the following information about their headaches:

- Gender of the Sufferer
- Age of Onset
- Time of Year of Most Headaches
- Time of Onset
- Length of Headache (minutes, hours, days)
- Location of Headache
- Severity of Pain
- Other Symptoms
- Symptoms Associated with Onset
- Other Symptoms Occurring During Headache
- Precipitating or Aggravating Symptoms
- Personality of Sufferer
Assignment Five: The Charming Psychopath (5%)

Hare states that many psychopaths are criminals. Many simply charm, manipulate, and destroy lives without being arrested and convicted for their activities. At times their behaviors leave total devastation but still are not classified as criminal. Hare (1993) describes these individuals as charmers. The person is capable of mortgaging his/her grandmother’s house for money and then feeling no guilt when he does not pay the mortgage payments and the grandmother is left homeless. He/she might say, “I deserved the money because I’m special and she should have planned better.” He accepts no blame.

This person may easily latch onto a middle-aged person whose husband or wife has died, charm the person, sleep with her/him, and then robs her/him. He/she then will say, “That old rag shouldn’t be so stupid.” He/she feels no remorse. The persons feels no obligation to pay debts. He/she will commit crime just for the thrill. Even if arrested, he/she will continue in this irresponsible behavior.

Signs of “psychopath” began in preschool years. Most of these children will lie, steal from the family members or neighbors, try to burn the neighbor’s house or own house, treat animals with cruelty, and have difficulties at home and later at school. During the school years, they may be truant, steal the class money, and graduate to auto theft and assault.

Is a personality disorder learned, physiological, or both? Defend your argument with two current resources. What are the characteristics of a typical psychopath? Could you apply the same criteria that you have developed to multiple personality disorder? Compare the characteristics of the antisocial personality disorder with the psychopath. What are the major differences? Are all individuals with antisocial personality disorder psychopaths? Are all psychopaths individuals who exhibit antisocial personality disorder?

Assignment Six: Guess which schizos am I? (10%)

The major subtypes of schizophrenia including paranoid, catatonic, disorganized, undifferentiated, and residual. Discuss and classify the following cases. Give your reason for your classifications:

a. Janie hears voices telling her what to do and believes that she is an earthly representative of the Virgin Mary. Janie can’t concentrate because of continuous noise from "noisemakers" in her head. At times Janie becomes very depressed, and at other times she becomes very energetic, sings, dances, and needs very little sleep. These mood changes occur both when Janie is hearing voices and when she is not.

b. Jim was hospitalized for mental illness. He heard voices and believed that he was a CIA agent for the government. He often could be seen taking notes on suspicious activity. Jim is now back at home and gets along fairly well. Jim takes his medication, but seems to be rather emotionless and flat, and at times people find him staring blankly.

c. Jill has been brought into the hospital. She does not speak and remains standing in an awkward stance for hours. When the doctor moved her arm above her head, she remained in that position for over an hour. Her family reported to the physician that she had been hospitalized before for this condition and on one occasion Jill became very agitated, jumped, talked, and shouted continuously. In this state, she was very violent.

d. Amy has become very suspicious during the past year. She often hears voices and noises and is convinced that they ultimately will destroy her. She also suspects that her dentist has implanted tiny electrodes in her teeth and her enemies are able to read her thoughts and control her behavior through those electrodes. Amy always checks her food for poison, is convinced that her telephone is tapped, and that agents are sitting in the apartment across the way spying on her.

e. Shirley is a woman who has been hospitalized for some time. Her speech is often incoherent, her behavior is disorganized, and her emotional reactions are inappropriate. She hears voices interrupting her thoughts and often talks as if someone is present. At times she appears to be irritable and at other times she appears to be frightened. She has been arrested for urinating on a public street and for disrupting the peace.
Assignment Seven: The Viagra Explosion (5%)

1. Viagra, is a drug used to increased blood circulation to the blood system of the male genitalia enabling erection and recovered sexual activity. What sexual dysfunction is this drug often successful in helping? Discuss what has been written about some of the events associated with the use of Viagra in newspaper articles, TV programs and internet.

2. Suggest other problems that may arise from the use of Viagra. Discuss what you think of such events related to Viagra use, like the seventy-year-old woman who is leaving her seventy-year-old husband because, after taking Viagra, he chased his wife around, and when she became “tired out,” he left her in search of a younger woman. The wife is suing the drug company that makes Viagra for her marital breakdown.

3. Why was Viagra developed for men and not women? Why do most drug studies relate to problems with men? Is this trend changing? Will the use of Viagra in men lead to the development of a drug for women who have some similar sexual dysfunction? Men will demand it. In your discussion, take into account that:
   a. Older women’s sex drive may not resemble that of their male partners.
   b. Older men may suffer from other problems (heart attack, respiration) during the recovered sexual activity.
   c. The changing nature of the relationship may interfere with the long-standing stability and expectations of the couple.

4. Do you think the introduction of Viagra in our society (particularly to older men) is going against ‘nature’? Is it normal for a seventy-year-old man to have sex several times a day? Several times a week? What do you think is normal? After the “What is normal?” question, lead a class discussion about what is meant by normal. Look at such norm groups as age groups, ethnic groups, social class groups, different cultures, etc.

Assignment Eight: What happened to Sufiah Yusof? (5%)

The following case is a story of a Malaysian math child prodigy from the time she was accepted to Oxford University at the age of 13, got married at the age of 19, divorced a year later, and finally ended up as a high class prostitute in 2008. Read the following brief of Sufiah Yusof’s life. Then, based on your knowledge about psychopathology, discuss what might have happened to Sufiah Yusof.
(U.K) Daily Mail, Friday, October 16, 1998

Sufiah Yusof was Britain's youngest undergraduate. At 12, Sufiah Yusof was among the top eight junior tennis players in Britain, but she decided to drop tennis to the pursuit of knowledge at Oxford University.

The Yusofs educated their children at home. 'As long as children can sit down, listen and receive, they can be taught,' says Farooq Yusof, 'It is not about sending them off to nurseries to learn. It is all done by the parents. It is about quiet, patient application and a whole currency of ideas and values which are provided within the home. From their earliest years, we do everything to enable the children to learn. We are sensitive to them. We don't let them develop phobias about work.'

Farooq, who says his children are not gifted. He believes he could teach almost any child to be as able as his own, even if they were handicapped. The house is kept cold and quiet, without any distractions. They rise at 7.30am and begin the day with prayers. He says these help to 'spark in the children the process of inquiry'. After breakfast there are stretching and breathing exercises. An open window ensures there is plenty of fresh air, because Farooq believes it makes the brain sharper.

When they were educated at home, the elder children studied independent projects such as astronomy or Egyptology until lunch. In the afternoon, there was a walk and rigorous tennis training followed by more study. An important part of their education is also the 'exchange of ideas'. The children's facility is essentially right-brained, to do with maths and science, not the arts, but because they were literate and numerate by the age of two, they were able to interact in debate very early on. 'They are not passive,' says Farooq. 'They are taught to think. We invite them to put their point of view and always encourage them to be serious, not casual. Most people in Britain are sleep-walking,' he says. 'They haven't been taught to think. They don't exercise their critical faculties in any way.' His methods have been proved right, in that the children excel at academic work. The Yusofs are probably brightest family in Great Britain.

July 7, 2000

Sufiah disappeared just after finishing her exams for a masters on June 22. She failed to board a train from Oxford to the family home in Coventry, where she was expected to return for the holidays. Her email came in response to a disquieting interview her father had given to the Times on Tuesday... 'I've finally had enough of 15 years of physical and emotional abuse,' wrote Sufiah. She vowed never to return to the "living hell" of home. She accused her father of ruining his five children's lives by hotheating them, of exploiting her older brother's tennis skills for money, of labelling her "Crybaby Soo-Fi" as part of his motivation technique. Worst of all, she said that when she was 11, two years before she started her maths degree at Oxford University and when everything was
apparently fine, she had twice tried to kill herself. "Maybe the public will have a
different view of you as devoted parents . . . ."

**July 10, 2004**

Sufiah returned to Oxford, but her early promise was beginning to dissipate. It was
then that she met Jonathan Marshall, a law student. The two fell in love and
married in 2004. Jonathan had already converted to Islam. He was 24 and she was
19. The marriage lasted less than two years.

Speaking from Saudi Arabia, where he works for a leading firm of City solicitors,
Mr Marshall explained: "The reason we split was that I became more observant
and Sufiah became less so. She was confused, really. She didn't know quite what
she wanted. She wasn't particularly extrovert. She wasn't a difficult person to live
with. We simply had different goals, different ideas of where we wanted to be."
Mr Marshall said there was little contact between Sufiah and her family in her final
year at Oxford.

When Mr Marshall secured a job with a law firm, the couple moved to London and
then, briefly to Singapore. It was there that they decided to split. On returning to
London, Sufiah was admitted to London University's School of Oriental and
African Studies (SOAS) to read economics. Despite their split in August 2005, Mr
Marshall supported her for eight months before taking up a job with his firm in
Saudi Arabia. He has remarried and has two children. "We agreed that I would
assist her for a specific time. I felt a moral obligation to help her out while she was
still at university. She wanted to concentrate on university and I agreed she
should."

**April 1 2008**

The gifted girl with the winning smile had the world at her feet ten years ago and
should be a rich woman by now. Sunday's News of the World went on to relate
how Miss Yusof, admitted to Oxford University at the age of 13, had taken to
hiring herself out over the internet as an "Asian escort" - at the rate of £130 per
hour.

"Would you like to start your half hour now?" said Sufiah, 23, as she danced on the
bed, displaying her body for examination. Calling herself Shilpa Lee, the former
child prodigy still juggles with figures on a hookers' website, describing herself as
a "very pretty size 8, 32D bust and 5'5" tall - available for booking every day from
11am to 8pm." She says she is a "sexy, smart student" who prefers "older
gentlemen" - but a former pal who has witnessed her downfall told us: "It is all
desperately heartbreaking. With her amazing brain she should be able to make
money any way she wants. But instead her life has spiralled completely out of
control." Sufiah, however, disagreed. In an interview, she confessed, "I love what
I do. I am now in complete control of what I do."

A British court jailed her father, Farooq Khan for 18 months after he admitted to
groping two girls, both aged 15, while tutoring them in math at his home. He had
been jailed for three years in 1992 for his part in a $3 million (£1.5 million) mortgage swindle involving several family members. Her mother, Halimaton, left the family home in Coventry to arrange her divorce from her husband. "We want nothing to do with my dad," said Sufiah’s brother, Isaac Abraham, 26. "He was so abusive to us. That’s why Sufiah had to get away." The temperature in the family home was always low to ensure their attention. Television, pop music and anything else that might lead to "shallow thinking" was banned. Fresh air was essential for a fresh mind. Punching helped as well. "It depended on whatever mood he was in," said Abraham. "He used to wake us up in the middle of the night by punching our faces. It was awful what he put us through."

How to do well in this class

Attend face-to-face meetings and participate. Attendance, per se, is not part of your grade, but attending class is essential for you to do well. In addition to talking about ideas not in your module, you’ll hear discussions about people and the disorders. These will make the material “come alive.”

Read the text before coming to class. Our class time will be lecture/discussion based. It’s harder to discuss this material well if you haven’t read it first. When you read the chapter first you’ll have a better understanding of class material, and the questions that you ask will be more useful for you and your classmates.

Get involved! As you read the text or listen to class discussions, make it interesting and become involved! Relate the ideas to yourself, your friends, and your families. Think about those places where the material applies -- and those where it doesn’t. Wonder about what puts people at risk, as well as what makes others resilient in the worst possible situations. Actively read the material by thinking about, applying and using it, rather than only passively reading it.

Visit your text’s website. Pearson at http://www.ablongman.com offers a variety of services, such as companion websites, to make your learning the material easier. Take the online quizzes to assess how you’re doing; check out the video segments; use the flashcard and notes, etc. These will help you process the material more deeply and check your understanding of it.

Read over your notes every day. Doing so will eliminate the “need to cram,” which is almost impossible with this much information. It’s hard to forget something that you use every day.

Put time and energy into this course. For a 4000 level course, you should spend a minimum of 2-3 hours outside of class for every credit hour required for the class, in order to do well. For a class like this one that meets 3 hours/week, you need to spend an additional 6-9 hours on the course each week.
Get together with other students to study together. Helping someone else understand something is an excellent way to learn. And, if you get lost somewhere along the way, it's helpful to have some friends who can help you out. Besides, it's fun and can increase your motivation for the understanding the course content!

Check out these websites for helpful study skills information. There are numerous sites containing information on test-taking, time management, note-taking (both in class and from the text), etc.

- Study Strategies (University of Minnesota - Duluth): http://www.d.umn.edu/student/loom/acad/strat/
- Academic Success Center (George Washington University): http://gwired.gwu.edu/counsel/asc/
- How-to-Study.com

### Grading Criteria for Student Centered Learning

<table>
<thead>
<tr>
<th></th>
<th>Excellent (Full marks allocated)</th>
<th>Ok (50% of the marks allocated)</th>
<th>Below college level work (10% of the marks allocated)</th>
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<tbody>
<tr>
<td><strong>Case History</strong></td>
<td>Detailed history – both strengths &amp; weaknesses. Observations are strength-based rather than judgmental.</td>
<td>Paper takes the form of a book report, with it being unclear why descriptions are made.</td>
<td>Description is off-track or not clearly relevant to the case history in the book.</td>
</tr>
<tr>
<td><strong>Nature of functioning</strong></td>
<td>Complete description of symptoms is given. Mental status (cognitive, affective, behavioral functioning) is well-described.</td>
<td>Major symptoms are missed. All aspects of functioning are not described.</td>
<td>Major symptoms are misunderstood. Normal behavior is seen as pathological.</td>
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<tr>
<td><strong>Diagnosis</strong></td>
<td>Appropriate diagnoses are given and defended. Alternative diagnoses are considered.</td>
<td>A single diagnosis is proposed and described well. Alternative diagnoses are not considered.</td>
<td>The diagnosis proposed is superficially a good fit for the problem, but does not.</td>
</tr>
<tr>
<td><strong>Technical Style</strong></td>
<td>Paper is logical, clear, and nicely written, spell and grammar-checked. Uses good, recent references. Citations and references are complete and accurate.</td>
<td>Paper is well organized and logical, but need to be spell and grammar-checked. Three good references are used.</td>
<td>Paper is illogical, poorly proofed, and poorly researched; not performed at a college level. No references beyond textbook are used.</td>
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Texts and Reference Books:

Main Text:


Additional References:


Unit 1

What Do We Mean By Psychopathology?

LEARNING OUTCOME
At the end of the chapter, you will learn about:
1. Defining Psychopathological Behavior
2. Recognizing The Presence Of A Disorder
3. Elements Of Psychopathology
4. The Dim-in-Tr Definition Of Mental Disorder
5. Culture-Specific Disorders
6. Historical Views Of Psychopathological Behaviors
7. Research On Psychological Psychology
8. The Mental Health Professionals

Case 1
“My father was abusive towards both me and my mother... My mother, on the other hand, was kind and loving but struggled badly with her own anorexia, a series of hospitalizations and absences from the home being the result, leaving me even more at the mercy of my father. I started at high school, aged twelve, with the weight of a five-year-old. Tiny and clearly sick, I was avoided by my peers and became very withdrawn. I threw myself with determination into my schoolwork, as I felt that it was all I had left, caught up with my contemporaries despite continuing absences due to illness, and began to excel in my work. I discovered a perfectionist streak and worked obsessively, starving myself all the while.”
INTRODUCTION

Psychopathology refers to the symptoms and signs of mental disorders. Literally translated, this term means “disease of the mind.”

Abnormal psychology is the application of psychological science to the study of mental disorders.

1.1 DEFINING PSYCHOPATHOLOGICAL BEHAVIOR

Psychosis is a general term that refers to several types of severe mental disorder in which the person is considered to be out of contact with reality. Mental disorders are typically defined by a set of characteristic features; one symptom by itself is seldom sufficient to make a diagnosis. A group of symptoms that appear together and are assumed to represent a specific type of disorder is referred to as a syndrome. Psychologists and other mental health professionals do not at present have laboratory tests that can be used to confirm definitively the presence of psychopathology because the processes that are responsible for mental disorders have not yet been discovered. Clinical psychologists must still depend on their observations of the person’s behavior and descriptions of personal experience.
1.2 RECOGNIZING THE PRESENCE OF A DISORDER

Insanity is a legal term that refers to judgments about whether a person should be held responsible for criminal behavior if he or she is also mentally disturbed. Mental health professionals refer to psychopathological conditions as mental disorders or abnormal behaviors. One approach to the definition of abnormal behavior places principal emphasis on the individual’s experience of personal distress. We might say that abnormal behavior is defined in terms of subjective discomfort that leads the person to seek help from a mental health professional. People with mental disorders may not have insight regarding their disorders.

Another approach is to define abnormal behavior in terms of statistical norms – how common or rare it is in the general population. By this definition, people with unusually high levels of anxiety or depression would be considered abnormal because their experience deviates from the expected norm.

ACTIVITY 1.2

What does it mean to have a disorder? There are several criteria used to define behavior as “abnormal.” However, many psychologists argue that these criteria are unclear and leave considerable room for interpretation. Classification of a condition as disordered ranges from those of “labeling” a child or adult as disordered to determining whether it is appropriate to treat the condition with drugs. What does it mean for a child to have a psychological disorder given the fact that what is abnormal remains challenging to define?

Suggested Reading:
1.3 ELEMENTS OF PSYCHOPATHOLOGY

(a) Suffering: People who suffer psychologically, depression. Not sufficient/necessary to be considered abnormal.

(b) Maladaptiveness: Interferes with our well-being and ability to enjoy our work/relationships. Anorexia, depression.

(c) Deviancy: If something is statistically rare and undesirable it is abnormal (mental retardation).

(d) Violation of Standards of Society: A failure to follow the rules, norms and moral standards to an extent that is statistically uncommon. A mother drowning her baby.

(e) Social Discomfort: When someone violates a social rule, those around him or her may experience a sense of discomfort or unease. Someone telling you just met telling you about her suicide attempt.

(f) Irrationality and Unpredictability: People who behave in ways unexpected and are unable to control their behavior. Schizophrenia, mania.

What myths do people have about maladaptive psychology? Survey five of your friends about perceptions of maladaptive behavior. Survey questions can include:

Mental illness is due to emotional weakness.  
Bad parenting is a major cause of mental illness.  
Sinful behavior is responsible for much mental illness.  
The mentally ill could recover if they really wanted to.  
The mentally ill are more violent than "normal" people.  
mMental illnesses are generally curable.  
Mental illness has a biological cause.
1.4 THE DSM-IV-TR DEFINITION OF MENTAL DISORDER

The gold standard for defining mental disorders is the American Psychiatric Association’s Diagnostic and Statistical Manual Of Mental Disorders (DSM). DSM-IV-TR refers to its fourth edition, text revision. The dysfunctions in mental disorders are assumed to be the product of disruptions of thought, feeling communication, perception and motivation. Not every dysfunction leads to a disorder, only those that result in significant harm.

1.1.1 Harmful Dysfunction

Jerome Wakefield propose the idea of mental disorder as “harmful dysfunction”, meets two criteria:

(a) The condition causes harm according to social values of a persons culture (suffering, unable to work)

(b) The condition results from and underlying mechanism that fails to perform according to its natural function.

(c) Characteristics:
   a. Present distress (painful symptoms)
   b. Disability (impairment in important areas of functioning)
   c. Significantly increased risk of suffering pain, death, disability or loss of freedom

(d) Conditions Excluded from Consideration:
   a. This syndrome/pattern should not be merely
   b. An expectable and culturally sanctioned response to a particular event (death of loved one).
   c. Deviant behavior (actions of political, religious, sexual minorities).
   d. Conflicts between individual and society (voluntary efforts to express individuality).

ACTIVITY 1.3

Is the DSM biased? A common criticism of the DSM-IV-TR diagnostic system is that it is biased. Specifically, critics argue that particular subgroups of individuals are more likely to be diagnosed with some disorders than others because the diagnostic criteria for those disorders reflect characteristics that are more normative for those subgroups. Select a disorder in the DSM-IV-TR that they believe may be overdiagnosed in a particular subgroup of the population, and to search the web for epidemiological statistics about the prevalence of the disorder among that subgroup.
1.5 HOW DOES A CULTURE AFFECT WHAT IS DETERMINED AS ABNORMAL?

There is considerable variation in the way different cultures describe psychological distress:

(a) Epidemiological studies comparing the frequency of mental disorders in different cultures suggest that some disorders, like schizophrenia, show important consistencies in cross-cultural comparisons. Other disorders, like bulimia, are more specifically associated with certain cultural and socioeconomic conditions.

(b) Several general conclusions can be drawn from cross-cultural studies of psychopathology, including the following points:
   a. All mental disorders are shaped, to some extent, by cultural factors.
   b. No mental disorders are entirely due to cultural or social factors.

Psychotic disorders are less influenced by culture than are non-psychotic disorders. The symptoms of certain disorders are more likely to vary across cultures than are the disorders themselves.

1.6 CULTURE-SPECIFIC DISORDERS

Certain forms of psychopathology are more common in certain areas of the world and highly linked to culturally bound concerns.

(a) Taijin kyofusho: an anxiety disorder prevalent in Japan, fear that one’s body, body parts or functions might offend, embarrass or make others feel uncomfortable.

(b) Ataque de nervios: Found in Latinos, triggered by stressful events, and includes trembling, uncontrollable screaming and a general feeling of being out of control.

Abnormal behavior deviates from the norms of society. Hearing voices might be a norm in one culture (Native Americans) but abnormal in others.
1.7 HOW COMMON ARE PSYCHOPATHOLOGICAL DISORDERS?

1.7.1 Prevalence And Incidence

(a) Epidemiology is the scientific study of the frequency and distribution of disorders within a population.

(b) Prevalence refers to the total number of active cases, both old and new, that are present in a population during a specific period of time.
   a. Point prevalence refers to the estimated proportion of actual, active cases of the disorder in a given time.
   b. 1-year prevalence, how often a disorder occurs during the whole year.
   c. The lifetime prevalence of a disorder is the total proportion of people in a given population who have been affected by the disorder at some point during their lives.

(c) Incidence refers to the number of new cases of a disorder that appear in a population during a specific period of time.

1.7.2 Prevalence Estimates For Psychological Disorders

The lifetime prevalence of having any DSM-IV-TR is 46.4%. The most prevalent psychological disorders are anxiety disorders (28.8%) and most common individual disorders are major depressive disorders (16.6%), alcohol abuse (13.2%), specific phobia (12.5%), social phobia (12.1%) and conduct disorders (9.5%).

One large-scale study, known as the Epidemiological Catchment Area (ECA) Study, was conducted in the 1980s. The ECA study found that 32 percent of the people they interviewed received at least one lifetime diagnosis. All of us can expect to encounter the challenges of a mental disorder—for ourselves or for someone we love—at some point during our lives. Anxiety disorders and depression are more common among women; alcoholism and antisocial personality are more common among men. Other conditions, like schizophrenia and bipolar disorder, appear with equal frequency in both women and men.

Comorbidity is the term used to describe the presence of two or more disorders in the same person. Comorbidity seems to be especially high in people who have severe forms of mental disorders. Data from the National Comorbidity Survey (NCS)—indicate that most severe disorders are concentrated in a much smaller segment of the population. Often these are people who simultaneously qualify for the diagnosis of more than one diagnosis. Fourteen percent of the people in the NCS sample had three or more lifetime disorders, and 9 out of 10 people with a severe disorder fell into that highly comorbidity group.
1.8 HISTORICAL VIEWS OF PSYCHOPATHOLOGICAL BEHAVIORS

Throughout history, many other societies have held quite different views of the problems that we consider to be mental disorders. The search for explanations of the causes of abnormal behavior dates to ancient times, as do conflicting opinions about the etiology of emotional disorders.

1.8.1 Demonology, Gods And Magic

Ancient records (Chinese, Hebrews, Egyptians, and Greeks) attribute abnormal behavior to the disfavor of the gods or the mischief of demons. If the person’s speech was or behavior was religious or mystical, they were possessed by a god or good spirit, but most were considered the work of an angry god or evil spirit. This was often treated by exorcism.

1.8.2 Hippocrates’ Early Medical Concepts

Hippocrates denied that deities and demons intervened in the development of mental disorders instead it had natural causes and treatments. He believed the brain was the central organ of intellectual activity and mental disorders were due to brain pathology. He classified them into three categories: mania, melancholia and phrenitis.

His explanation for personality was the four humors; these four essential fluids were blood (sanguis), phlegm, bile (choler) and black bile (melancholer). From this came the four types of human behavior: sanguine, phlegmatic, choleric and melancholic. Hippocrates argued that various types of disorder, including psychopathology, resulted from either excess or a deficiency of one of these four fluids.

The Hippocratic perspective dominated medical thought in Western countries until the middle of the nineteenth century. People trained in the Hippocratic tradition viewed “disease” as a unitary concept. In other words, physicians did not distinguish between mental disorders and other types of illness. His emphasis on natural causes of disease, clinical observation and brain pathology were revolutionary.

1.8.3 Later Greek And Roman Thought

One of the most influential Greek physicians was Galen. He made a number of original contributions to the anatomy of the nervous system. He also divided the psychological disorders into categories: injuries to the head, excessive use of alcohol, shock, fear, adolescence, menstrual change, economic reversals, and disappointment in love.

The Roman physicians wanted to make their patients comfortable and used pleasant physical therapies like warm baths and massage.
1.9 PSYCHOPATHOLOGY DURING THE MIDDLE AGES

(a) The first mental hospital was established in Baghdad in A.D. 792, followed by others in Damascus and Aleppo. Mentally disturbed individuals were treated humanely. Avicenna wrote the Canon of Medicine frequently referring to hysteria, epilepsy, manic reactions and melancholia.

(b) In Europe psychologically disturbed individuals were characterized often by ritual of superstition than attempts to understand. Mass madness, occurrence of group behavior disorders (hysteria) emerged. One episode occurred in Italy referred to as tarantism, included an uncontrollable impulse to dance was attributed to the bite of a tarantula.

(c) Management of the mentally ill was left mostly to the clergy, monasteries served as refuge and places of confinement. Treatment consisted of prayer holy water, sanctified ointments and in some cases exorcism. It had long been thought that mentally disturbed people were accused of being witches thus were being punished and often killed.

1.10 THE RESURGENCE OF SCIENTIFIC QUESTIONING IN EUROPE

(a) Paracelsus, a Swiss physician, was an early critic of superstition beliefs about possession. He postulated a conflict between the instinctual and spiritual natures of human beings, formulated the idea of psychic treatment of bodily magnetism (hypnotism). He believed in astral influences (lunatic was derived from the word Luna or moon).

(b) Johann Weyer, a German physician was one of the first to specialize in mental disorders and is considered the father of modern psychopathology. However, his works were banned by the church and remained so till the end of the 20th century. The clergy however, were starting to question practices of the time. St. Vincent declared that mental disorder is no different from any other bodily disease and Christianity demands of the humane and powerful to protect and the skillful to relieve the well as the other.
1.11

THE ESTABLISHMENT OF EARLY ASYLUMS AND SHRINES

In Europe during the Middle Ages, “lunatics” and “idiots,” as the mentally ill and mentally retarded were commonly called, aroused little interest and were given marginal care. Disturbed behavior was considered to be the responsibility of the family rather than the community or the state.

In the 1600s and 1700s, “insane asylums” were established. Early asylums were little more than human warehouses, but as the nineteenth century began, the moral treatment movement led to improved conditions in at least some mental hospitals. Founded on a basic respect for human dignity and the belief that humanistic care would help to relieve mental illness, moral treatment reform efforts were instituted by leading mental health professionals of the day.

Rather than simply confining mental patients, moral treatment offered support, care, and a degree of freedom. Belief in the importance of reason and the potential benefits of science played an important role in the moral treatment movement. Many of the large mental institutions in the United States were built in the nineteenth century as a result of the philosophy of moral treatment.

By the middle of the 1800s, superintendents of asylums for the insane were almost always physicians who had experience in the care of people with severe mental disorders. The Association of Medical Superintendents of American Institutions for the Insane (AMSII), which later became the American Psychiatric Association (APA), was founded in 1844.

1.12

WORCESTER LUNATIC HOSPITAL: A MODEL INSTITUTION

In 1833, the state of Massachusetts opened a publicly supported asylum for lunatics, a term used at the time to describe people with mental disorders, in Worcester. Samuel Woodward, the asylum’s first superintendent, also became the first president of the AMSII. Woodward claimed that mental disorders could be cured just like other types of diseases. Treatment at the Worcester Lunatic Hospital included a blend of physical and moral procedures.
1.13 HUMANITARIAN REFORM

(a) In 1792, Philippe Pinel was placed in charge of La Bicêtre in Paris. He received permission from the Revolutionary Commune to remove the chains of the inmates to test the views that patients should be treated with kindness and consideration. The effect was miraculous.

(b) About the same time William Tuke, established the York Retreat a pleasant country house where the mental patients lived, worked and rested in a kindly religious atmosphere.

(c) Benjamin Rush, founder of American psychiatry, was associated with the Pennsylvania Hospital in 1793. He encouraged more humane treatment and was the first American to organize a course in psychiatry.

(d) The moral management method, stemmed largely from the work of Pinel and Tuke focused on the patient’s individual and occupational need. Usually patients were treated through manual labor and spiritual discussion along with humane treatment. It achieved a high degree of effectiveness but was nearly abandoned by the later part of the 19th century due to ethnic prejudices, the failure to train replacements and the over extension of hospital facilities.

(e) Mental hygiene movement advocated a method of treatment that focused on the well being of patients but offered no help for their mental problems and thus condemned them to helplessness and dependency. Dorothea Dix was a champion for the poor and forgotten people in the mental institutions during the 19th century. She carried out a zealous campaign that aroused people and legislatures to do something about the inhumane treatment of the mentally ill. She was instrumental in improving conditions in American hospitals, directed two institutions in Canada and reformed the asylum system in Scotland.
1.14 MENTAL CARE IN THE TWENTIETH CENTURY

During this period, hospital stays were quite lengthy and the mentally ill were hospitalized for many years, treatment was often harsh, punitive and inhumane. In 1946, the National Institutes of Mental Health was organized and provided active research and training through psychiatric residencies and clinical psychology programs. The Hill Burton Act was passed during this period. Along with the Community Health Services Act helped created a set of programs to develop outpatient psychiatric clinics and community consultation and rehabilitation programs.

Vigorous efforts were made to close down mental health hospitals and return patients to the community. This movement referred to as deinstitutionalization created great difficulties for disturbed persons. Many patients have not fared well and speak of the abandonment of chronic patients to a cruel harsh existence.

1.15 CONTEMPORARY VIEWS OF PSYCHOPATHOLOGICAL BEHAVIOR

1.15.1 Biological Discoveries: Establishing A Link Between The Brain And Psychological Disorder

(a) A major biomedical breakthrough came from the discovery of the organic factors underlying paresis - syphilis of the brain. The discovery for a cure began in 1825, when A. L. J. Bayle, a French physician differentiated general paresis as a specific type of mental disorder. In 1897, Richard von Krafft-Ebing conducted experiments involving the inoculation of paretic patients with matter from syphilitic sores. In 1906, August von Wassermann devised a test for syphilis. Finally, in 1917, Julius von Wagner-Jauregg, introduced the malarial fever treatment for syphilis to kill the bacteria.

(b) German psychiatrist Wilhelm Griesinger, in his text book The Pathology and Therapy of Psychic Disorder (1845) insisted that all mental disorders could be explained in terms of brain pathology. Eventually, in the 20th century, the organic pathologies underlying toxic disorders, certain types of mental retardation and other mental illnesses were discovered.
1.15.2 The Development Of A Classification System For Psychological Disorders

Emil Kraepelin devised a textbook, Lehrbuch der Psychiatrie, emphasized on the importance of brain pathology in mental disorders. The most important contribution was his system of classification of mental disorders, which is today’s forerunner for DSM-IV-TR. Kraepelin noted certain symptom patterns occurred together regularly enough to be considered as specific types of mental disease. He worked out a scheme of classification that is the basis of our current system.

1.15.2.1 Causation Views: Establishing the Psychological Basis of Psychological Disorder

(a) The first major steps were taken by Sigmund Freud, who developed a comprehensive theory emphasizing on the inner dynamics of the unconscious mind (psychodynamics) that are at the heart of psychoanalytic perspective. The methods came to be known as psychoanalysis.

(b) Anton Mesmer believed that the planets affected the magnetic fluid in the body, the distribution of which determined health or disease. Mesmer concluded that all people possessed magnetic forces that could be used to influence the magnetic fluid in others. His methods (mesmerism) and results however, were at the center of scientific controversy.

(c) Ambrose August Liebeault, a French physician and Hippolyte Bernheim worked together to develop a theory that hypnosis and hysteria were related and both were due to suggestion. It seemed that hysteria was a form of self-hypnotism. This came to be known as the Nancy School.

(d) Jean Charcot insisted that degenerative brain changes lead to hysteria, he was later proven wrong. The debate over whether mental disorders are caused by biological factors or psychological factors continue to this day.

(e) Freud and Joseph Breuer incorporated hypnosis, allowing patients to talk freely about their problems under hypnosis. The patients displayed considerable emotion on awakening from hypnosis, an emotional release (catharsis). This led to the discovery of the unconscious.

(f) By encouraging his patients to say whatever came to their mind without regard to logic, Freud found that patients would eventually overcome inner obstacles and discuss their problems freely. Two methods enabled him to understand patients conscious and unconscious: free association and dream analysis. These techniques helped analyst gain insight and achieve better understanding of their patients.
1.15.3 The Revolution of Psychological Research Tradition: Experimental Psychology

(a) Wilhelm Wundt established the first experimental psychology laboratory at the University of Leipzig while studying the psychological factors involved in memory and sensation. The rapid and objective communication of scientific findings was perhaps as important as the collection and interpretation of research findings.

(b) The behavioral perspective is organized around the role of learning in human behavior. Classical conditioning was a form of learning in which neutral stimulus is paired repeatedly with and unconditioned stimulus that naturally elicits and unconditioned behavior. This work began with the discovery of the conditioned reflex by Russian physiologist Ivan Pavlov.

(c) Behaviorism, originated by John B. Watson, changed the focus of psychology to the overt study of behavior rather than theoretical mentalistic constructs. Operant conditioning, based on B. F. Skinner's experiments, explained that consequence determined behavior.

How would you recognize maladaptive behavior? What criteria would you use to distinguish maladaptive behavior from normal behavior? How do judgments about maladaptive behavior reflect the cultural context in which they are made? What behaviors have you observed in members of other cultural groups that might be considered maladaptive in your own? What behaviors in your own cultural group might members of other groups consider maladaptive? Give at least one specific example.
1.16 RESEARCH ON PSYCHOLOGICAL PSYCHOLOGY

Through research we study the nature of disorders – what the symptoms are, how acute or chronic they are, what kinds of deficits their associate with and so forth. The application of science to questions regarding abnormal behavior carries with it the implicit assumption that these problems can be studied systematically and objectively.

Clinical scientists adopt an attitude of open minded skepticism, tempered by an appreciation for the research methods that are used to collect empirical data. They formulate specific hypotheses, test them, and then refine them based on the results of these tests.

1.16.1 Sources Of Information

(a) The case study is an in-depth look at the symptoms and circumstances surrounding one person’s mental disturbance. Case study material often forms the basis for hypotheses about the causes of a person’s problems.

a. The most obvious limitation of case studies is that they can be viewed from many different perspectives. Any case can be interpreted in several ways, and competing explanations may be equally plausible.

b. The other main limitation of case studies is that it is risky to draw general conclusions about a disorder from a single example. Hypotheses generated on the basis of the single case must be tested in research with larger, more representative samples of patients.

(b) Direct observation is also used where the behavior of the subject studied is directly observed. Self-report data allows you to collect data through questionnaires of interviews.

1.16.2 Forming A Hypotheses about Behavior

Hypotheses are efforts to explain, predict or explore something (behavior). They frequently determine the therapeutic approaches used to treat a particular clinical problem. In other words, our working about the causes of disorders shape what kind of approaches we take to treating them.
1.16.3 Sampling and Generalization.

We need to study a larger group of people with the same problem in order to discover which of our observations or hypotheses have scientific credibility. We would find people who fit our criteria and try to get a representative sample of people who are drawn to this underlying population. Sampling means that we try to select a group of who are representatives of a much larger group who have mental disorders. To test their hypotheses researchers use a comparison group (control group) to compare them to the criterion group (people with the disorder).

1.16.4 Studying the World as It Is: Observational Research Designs

Observational research does not involve any variables, the researcher selects a group of interest, and compares the groups on a variety of characteristics. While correlational studies may not be able to pin down causal relationships, thus can be a rich source of inference.

1.16.5 Retrospective Vs. Prospective Strategies

(a) Retrospective strategy is attempting to reconstruct the past of a people already experiencing a disorder to determine what causes it.

(b) Prospective strategy is to identify individuals who have a higher than average likelihood of becoming psychologically disordered and to focus on them before the disorder develops.

1.16.6 Single-Case Experimental Designs

The same subject is observed over time, behavior or performance at one point can be compared to behavior or performance much later, after a specific intervention or treatment has been introduced. The ABAB design, collects data on a subject and at the B phase, treatment is introduced.
THE MENTAL HEALTH PROFESSIONALS

People receive treatment for psychological problems in many different settings and from various kinds of service providers. Specialized mental health professionals treat fewer than half (40 percent) of those people who seek help for mental disorders. Roughly one-third (34 percent) are treated by primary care physicians, who are most likely to prescribe some form of medication.

(a) Psychiatry is the branch of medicine that is concerned with the study and treatment of mental disorders. Psychiatrists complete the normal sequence of coursework and internship training in medical school before going on to receive specialized residency training that is focused on abnormal behavior. Psychiatrists are licensed to practice medicine and therefore are able to prescribe medication.

(b) Clinical psychology is concerned with the application of psychological science to the assessment and treatment of mental disorders. A clinical psychologist typically completes five years of graduate study in a department of psychology, as well as a 1-year internship, before receiving a doctoral degree. One can also obtain a Ph.D. degree in counseling psychology, a more applied field that focuses on training, assessment, and therapy.

(c) Social work is a third profession that is concerned with helping people to achieve an effective level of psychosocial functioning. Most practicing social workers have a master’s degree in social work. In contrast to psychology and psychiatry, social work is based less on a body of scientific knowledge than on a commitment to action.

(d) Social work is practiced in a wide range of settings, from courts and prisons to schools and hospitals, as well as other social service agencies. The emphasis tends to be on social and cultural factors, such as the effects of poverty on the availability of educational and health services, rather than individual differences in personality or pathology. Psychiatric social workers receive specialized training in treatment of mental health problems.

(e) Professional counselors work in many different settings, ranging from schools and government agencies to mental health centers and private practice. Most are trained at the master’s degree level, and the emphasis of their activity is also on providing direct service.

(f) Marriage and family therapy (MFT) is a multidisciplinary field in which professionals are trained to provide psychotherapy. Most MFTs are trained at the master’s level, and many hold a degree in social work, counseling, or psychology as well. Training for psychiatric nursing typically involves a bachelor’s degree in nursing plus graduate level training in the treatment of mental health problems.

(g) Psychosocial rehabilitation (PSR) professionals work in crisis, residential, and case management programs for people with severe forms of disorder, such as schizophrenia.
Mental health care reform is currently being driven by the pervasive influence of mediated care, which refers to the way that services are financed. Insurance companies typically place restrictions on the types of services that will be reimbursed, as well as the specific professionals who can provide them. Managed care places a high priority on cost containment and the evaluation of treatment effectiveness.

**Self Test**

1. Which edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders was pivotal in disseminating for the first time descriptive information about child and adolescent psychological disorders based upon empirical research and clinical observations?
   a. DSM
   b. DSM-II
   c. DSM-III
   d. DSM-III-R
   e. DSM-IV

2. Comorbidity* refers to:
   a. Having two different psychological disorders simultaneously.
   b. The likelihood that an individual will continue to have the same disorder over time.
   c. The long-term prognosis for an individual who has a particular disorder.
   d. The likelihood that individuals with the disorder will commit suicide.
   e. The likelihood of being diagnosed with a particular disorder.

3. According to Freudian theory, which of the following processes is most likely to play a role in the etiology of psychological disorders in young people?
   a. Arrested development at any stage of psychosexual development
   b. Deficiencies in the operation of the pleasure principle
   c. A lack of defense mechanisms
   d. Insecure maternal attachment
   e. Deficiencies in the operation of the reality principle
Required Reading:


Other Suggested Books And Readings


Weblinks

American Psychological Association - www.apa.org

American Psychological Society - www.psycscience.org

American Psychiatric Association - www.psych.org

National Association of the Mentally Ill (NAMI) - www.nami.org
The site of the National Association of the Mentally Ill, a resource for people suffering from mental illness and their families. Has resources about treatment and support groups for every type of mental disorder.

National Institutes of Mental Health - www/nimh.nih.gov

National Mental Health Association (NMHA) - www.nmha.org
The site of the national office, with more than 300 affiliates nationwide
Unit 2
What causes Psychopathology?

LEARNING OUTCOME
At the end of the topic, you will learn about:
1. Necessary Sufficient And Contributory Cause
2. Diathesis-Stress Models
3. Viewpoints for Understanding the Causes of Psychopathology Behavior
   a. The Biological Viewpoint And Biological Causal Factors
   b. The Psychosocial Viewpoints
   c. Behavioral Perspective
   d. The Cognitive Behavioral Perspective
   e. Systems Theory
   f. The sociocultural Causal Factors

The myth of the ideal parent:
Although there are basic strategies essential to effective parenting, there is no magic formula to produce a healthy, well-adapted child. Each family has contextual factors (e.g., individual, familial, environmental, societal) that affect how the members interact with each other and the social climate of the home. Discuss with the class some of the factors that parents need to take into account when parenting and disciplining their children? How might parents have to adjust their parenting styles to meet the needs of each child? How do certain types of parenting and disciplining styles lead to psychopathological behaviors?

Suggested site: http://www.aboutourkids.org/articles/parentingstyles.html
CAUSES AND FACTORS OF ABNORMAL BEHAVIOR

Unit 2 presents various perspectives of abnormal behavior: biological, psychodynamic, behavioral, cognitive, humanistic-existential, and community-cultural. Human behaviors have multiple determinants. Theories guide clinicians and the researchers in their investigations of maladaptation. Etiologies and treatment are considered within the discussion of each perspective. Many psychologists share the interactional approach because it is an approach that incorporates the many factors that affect an individual's behavior. The factors discussed in the six perspectives are viewed as contributing to the vulnerability and resiliency of the individual.

2.1 NECESSARY SUFFICIENT AND CONTRIBUTORY CAUSE

Several terms can be used to specify a role a factor plays in etiology or causal pattern of abnormal behavior. Necessary cause is a condition that must exist for a disorder to occur. A sufficient cause of a disorder is a condition that guarantees the occurrence of a disorder. A contributory cause is one that increases the probability of a disorder developing but is neither necessary nor sufficient for the disorder to occur.

Some causal factors occurring relatively early may not show their effects for many years, these are considered distal causal factors. Causal factors that operate shortly before an occurrence of the symptoms of a disorder is considered a proximal causal factor.

(a) Equifinality, the view that there are many routes to the same destination (or disorder).

(b) Multifinality, says that the same event can lead to different outcomes.

(c) Reciprocal causality is the idea that causality works in both directions.
2.2 DIATHESIS-STRESS MODELS

The diathesis-stress model suggests that mental disorders develop only when a stress is added on top of a predisposition; neither the diathesis nor the stress alone is sufficient to cause the disorder.

A diathesis is a predisposition toward developing a disorder, for example, an inherited tendency toward depression. A stress is a difficult experience, for example, the loss of a loved one through an unexpected death. Risk factors are events or circumstances that are correlated with an increased likelihood or risk of a disorder and potentially contribute to causing the disorder.

Protective factors are influences that modify a person’s response to environmental stressors, making it less likely for that person to experience adverse consequences of the stressors. This leads to resilience, used to describe three distinct phenomena:

(a) Good outcome despite high risk status
(b) Sustained competence under threat
(c) Recovery from trauma

Developmental psychopathology is a new approach to abnormal psychology that emphasizes the importance of developmental norms—age-graded averages—to determine what constitutes abnormal behavior. Many psychological disorders follow unique developmental patterns.

Sometimes there is a characteristic premorbid history, a pattern of behavior that precedes the onset of the disorder. A disorder may also have a predictable course, or prognosis, for the future. By discussing the premorbid adjustment and the course of different psychological disorders, we hope to present abnormal behavior as a moving picture of development and not just as a diagnostic snapshot.
2.3 VIEWPOINTS FOR UNDERSTANDING THE CAUSES OF PSYCHOPATHOLOGICAL BEHAVIOR

Advances in the scientific understanding of abnormal behavior were not made until the nineteenth and early twentieth centuries, when three major events occurred.

- One was the discovery of the cause of general paresis, a severe mental disorder that has a deteriorating course and eventually ends in death.
- The second was the writing of Sigmund Freud, a thinker who has a profound influence not only on the field of abnormal psychology, but also on Western society as a whole. The third was the creation of a new academic discipline called psychology.

**Activity 2.1**

**Children's adjustment after parental divorce:** In a behavioral genetics study, O'Connor, Plomin, DeFries, and Caspi found that, in both biological and adoptive families where parents separated before the children turned 12, children displayed more aggressive behavior, delinquency, depression, anxiety and withdrawal than children whose parents did not divorce. Furthermore, these same children reported earlier drug use than their peers who had not experienced divorce. For children from biological families where parents separated before the children turned 12, the teachers of these children reported that they displayed lower levels of academic achievement and poorer social adjustment, compared with children whose parents' marriages remained intact. However, there were no significant differences between teacher reports of academic achievement and social adjustment for adopted children who had experienced parental separation before age 12 and their adoptive peers who had not experienced parental separation. The researchers concluded that the findings for emotional and behavioral problems are consistent with the explanation that the association between parent divorce and child adjustment is mediated by the environment. In contrast, they concluded that the findings for academic achievement and social adjustment are consistent with the explanation that the association between these factors and parental divorce may be partially genetically based.

**Suggested Reading:**
2.3 THE BIOLOGICAL VIEWPOINT AND BIOLOGICAL CAUSAL FACTORS

2.3.1 Neurotransmitter and Hormonal Imbalances
The field of anatomy is concerned with the study of biological structures, and the field of physiology investigates biological functions. Neuroanatomy and neurophysiology are subspecialties within these broader fields that focus specifically on brain structures and brain functions. The study of neuroanatomy and neurophysiology is the domain of an exciting, multidisciplinary field of research called neuroscience.

2.3.2 The Neuron and Neurotransmitters

Billions of tiny nerve cells—neurons—form the basic building blocks of the brain. Each neuron has four major anatomic components: the soma, or cell body, the dendrites, the axon, and the axon terminal. The soma—the cell body and largest part of the neuron—is where most of the neuron’s metabolism and maintenance are controlled and performed. The dendrites branch out from the soma; they serve the primary function of receiving messages from other cells. The axon is the trunk of the neuron. Messages are transmitted down the axon toward other cells with which a given neuron communicates.
The axon terminal is the end of the axon, where messages are sent out to other neurons. Within each neuron, information is transmitted as a change in electrical potential that moves from the dendrites and cell body, along the axon, toward the axon terminal. The axon terminal is separated from other cells by a synapse, a small gap filled with fluid.

Unlike the electrical communication within a neuron, information is transmitted chemically across a synapse to other neurons. The axon terminal contains vesicles containing chemical substances called neurotransmitters, which are released into the synapse and are received at the receptors on the dendrites or soma of another neuron.

The process of reuptake, or reabsorption, captures some neurotransmitters in the synapse and returns the chemical substances to the axon terminal. Neuromodulators are chemicals that may be released from neurons or from endocrine glands. Neuromodulators can influence communication among many neurons by affecting the functioning of neurotransmitters. Scientists have found that disruptions in the functioning of various neurotransmitters are present among some people with mental disorders.

An oversupply of certain neurotransmitters is found in some mental disorders, an undersupply in other cases, and disturbances in reuptake in other psychological problems. Abnormalities in the dopamine system in the brain may be involved in schizophrenia.

There may be dysfunctions in the normal processes by which neurotransmitters, once released into the synapse are deactivated. Finally there may be problems with the receptors in the postsynaptic neuron, which may be either abnormally sensitive or insensitive.

Although over a hundred neurotransmitters have been discovered to date, four different kinds have been studied in relationship to psychopathology: norepinephrine, dopamine, serotonin and gamma aminobutyric acid (GABA).

Other evidence links the availability of various neurotransmitters with depression, hyperactivity, posttraumatic stress disorder, and many other psychological problems. The identification of biochemical differences definitely does not mean that these problems are caused by “a chemical imbalance in the brain,” even though many people mistakenly leap to this conclusion.

2.3.2 Hormonal Imbalance

(a) Hormones are chemical messengers secreted by a set of endocrine glands. Our central nervous system is linked to the endocrine system by the effects on the pituitary gland.

(b) One particularly important set of interaction occurs in the hypothalamic-pituitary-adrenal-cortical-axis.

(c) Messages in form of corticotrophin-releasing hormone (CRH) travel from the hypothalamus to the pituitary.

(d) In response, the pituitary releases adrenocorticotropic hormone (ACTH), which stimulates the cortical part of the adrenal gland to produce epinephrine and the stress hormone cortisol.
(e) Cortisol in turn provides negative feedback to the hypothalamus and pituitary to decrease their release of CRH and ACTH. This negative feedback operates as much as a thermostat does to regulate temperature.

(f) Psychophysiology is the study of changes in the functioning of the body that result from psychological experiences. Psychophysiological arousal results from the activity of two different communication systems within the body, the endocrine system and the nervous system.

(g) The endocrine system is a collection of glands found at various locations throughout the body. Endocrine glands produce psychophysiological responses by releasing hormones into the bloodstream—chemical substances that affect the functioning of distant body systems and sometimes act as neuromodulators.

(h) Certain abnormalities in the functioning of the endocrine system are known to cause psychological symptoms. The more familiar and basic system of communication within the body is the nervous system. The human nervous system is divided into the central nervous system, which includes the brain and the spinal cord, and the peripheral nervous system.

(i) The peripheral nervous system includes all connections that stem from the central nervous system and innervate the body’s muscles, sensory systems, and organs. The peripheral nervous system itself has two subdivisions. The voluntary, somatic nervous system governs muscular control, and the involuntary, autonomic nervous system regulates the functions of various body organs, such as the heart and stomach. The somatic nervous system controls intentional or voluntary actions.

(j) The autonomic nervous system is responsible for psychophysiological reactions—responses that occur with little or no conscious control. The autonomic nervous system can be subdivided into two branches, the sympathetic and parasympathetic nervous systems.

(k) Psychophysiological overarousal and underarousal both may contribute to abnormal behavior. For example, overactivity of the autonomic nervous system (a pounding heart and sweaty hands) has been linked with excessive anxiety.

(l) In contrast, chronic autonomic underarousal may explain some of the indifference to social rules and the failure to learn from punishment found in antisocial personality disorder.

2.3.3 Major Brain Structures

(a) Neuroanatomists divide the brain into three subdivisions: the hindbrain, the midbrain, and the forebrain. Basic bodily functions are regulated by the structures of the hindbrain, which include the medulla, pons, and cerebellum. The medulla controls various bodily functions involved in sustaining life, including heart rate, blood pressure, and respiration. The pons serves various functions in regulating stages of sleep.
2.3.4 Cerebral Hemispheres

(a) Most of the forebrain is composed of the two cerebral hemispheres. Many brain functions are lateralized, so that one hemisphere serves a specialized role as the site of specific cognitive and emotional activities.

(b) In general, the left cerebral hemisphere is involved in language and related functions, and the right cerebral hemisphere is involved in spatial organization and analysis. The two cerebral hemispheres are connected by the corpus callosum, which is involved in coordinating the different functions that are performed by the left and the right hemispheres of the brain.

(c) When we view a cross section of the forebrain, four connected chambers, or ventricles, become apparent. The ventricles are filled with cerebrospinal fluid, and they become enlarged in some psychological and neurological disorders. The cerebral cortex is the uneven surface area of the brain that lies just underneath the skull. It is the site of the control and integration of sophisticated memory, sensory, and motor functions.

(d) The cerebral cortex is divided into four lobes. The frontal lobe is involved in controlling a number of complex functions, including reasoning, planning, emotion, speech, and movement. The parietal lobe receives and integrates sensory information and also plays a role in spatial reasoning. The temporal lobe processes sound and smell, regulates emotions, and is involved in some aspects of learning, memory, and language. The occipital lobe receives and interprets visual information.

(e) The brain is incredibly complex, and scientists are only beginning to understand the relations among various anatomic structures and functions. Because of the rudimentary knowledge we have about the brain, only obvious brain injuries and infections and the most severe mental disorders have clearly been linked with abnormalities in neuroanatomy. In most of these cases, brain damage is extensive.
(f) Scientists have made breakthroughs in observing the anatomic structure of the living brain and in recording some of its global physiological processes. These various imaging procedures are now being used to study psychological disorders ranging from schizophrenia to learning disabilities.

(g) At present, the new brain imaging measures are more exciting technically than practically in terms of furthering our understanding of the etiology of psychopathology. Scientific advances frequently follow the development of new measures, however, and there is every reason to hope that advances in brain imaging will lead to improvements in understanding abnormalities in brain structure and function.

2.3.5 Genetic Vulnerabilities

(a) Genes are ultramicroscopic units of DNA that carry information about heredity. Genes are located on chromosomes, chainlike structures found in the nucleus of cells. The field of genetics identifies specific genes and their hereditary functions, often by literally focusing at the level of molecules.

(b) Behavior genetics is a much broader approach that studies genetic influences on the evolution and development of normal and abnormal behavior. A genotype is an individual's actual genetic structure. It is impossible to observe much of an individual's genotype directly. Instead, what we observe is the phenotype, the expression of a given genotype. It is usually impossible to infer a precise genotype from a given phenotype, because the environment influences phenotypes, but not genotypes.

(c) Genes have alternative forms known as alleles. Dominant/recessive inheritance occurs when a trait is caused by a single or autosomal gene that has only two alleles (for example, A and a) and only one locus, a specific location on a chromosome.

(d) Dominant/recessive inheritance causes some rare forms of mental retardation, but a single gene does not cause most mental disorders—if they have genetic causes at all. Instead, they are polymeric, that is, they are caused by more than one gene. Behavior geneticists have developed important methods for studying broad, genetic contributions to behavior, including family incidence studies, twin studies, and adoption studies.

(e) Family incidence studies ask whether diseases “run in families.” Investigators identify normal and ill probands, or index cases, and tabulate the frequency with which other members of their families suffer from the same disorder.

(f) If a higher prevalence of illness is found in families where there is an ill proband, this is consistent with genetic causation. The finding also is consistent with environmental causation, however, because families share environments as well as genes. For this reason, no firm conclusions about the relative role of genes or the environment can be reached from family incidence studies alone.
(g) Studies of twins, in contrast, can provide strong evidence about genetic and environmental contributions to a disorder. **Monozygotic (MZ) twins are identical.** One egg is fertilized by one sperm, and thus MZ twins have identical genotypes. **Dizygotic (DZ) twins are fraternal.** These twins are produced from two eggs and two sperm. Thus, like all siblings, DZ twins share an average of 50 percent of their genes, whereas MZ twins share 100 percent of their genes. The key comparison involves determining the **concordance rate** of the two sets of twins; specifically whether MZ twins are more alike than DZ twins are alike.

(h) A twin pair is concordant when both twins either have the same disorder or are free from the disorder, for example, both suffer from schizophrenia. The twin pair is discordant when one twin has the disorder but the other does not, for example, one twin has schizophrenia but the co-twin does not. If we assume that the environmental effects on a disorder are the same for DZ twin pairs as they are for MZ twin pairs, then any differences between the concordance rates for MZ and DZ twins must be caused by genetics.

(i) In contrast, similar concordance rates for MZ and DZ twins rule out genetic contributions and instead implicate environmental causes of a disorder. High concordance rates for both MZ and DZ twins point to the etiological role of the **shared environment**, the experiences the two twins share in common, for example, growing up in poverty. When both MZ and DZ pairs have similarly high concordance rates, we know that genes do not explain the similarities. Instead, the common cause must be found in the environment shared by the twins. Similar but low concordance rates for both MZ and DZ pairs point to the influence of the **nonshared environment**, the experiences that are unique to one twin, for example, being the favored child. In this case, genetic causes are again ruled out, and the importance of unique experiences is indicated by the fact that only one twin has a psychological disorder.

(k) Evidence from twin studies often indicates that genes have a substantial influence on mental disorders. Somewhat surprising, behavior genetic research also indicates that many environmental influences appear to be nonshared. However, the logic of twin studies depends on the assumption that the environment affects DZ twins in the same way that it influences MZ twins.

(l) Behavior genetic researchers also conduct adoption studies to examine genetic versus environmental contributions to the development of a disorder. In this research design, people who were adopted as infants are compared with their biological versus their adoptive relatives (usually their parents) in terms of concordance for a disorder. Adoption studies have some potential problems, for example, the fact that adoption placement is selective.

(m) Behavior genetic research is powerful, but unfortunately; people often misinterpret it. One serious misinterpretation is that a psychological disorder is inevitable, even predestined, if it has a genetic component. This conclusion is wrong, in part because of polygenic inheritance. Behavior genetic findings also do not tell us what genetically influenced mechanism is at work.

(n) It is also wrong to think that genetic characteristics cannot be modified. Nature and nurture are not separate influences on behavior. Nature and nurture always work together.
(o) Genes have very broad effects on abnormal—and normal—behavior. Genetic influences are important to recognize, but we are skeptical that specific genetic causes will be discovered for many mental disorders.

Remember that

(a) Most emotional problems, like most normal behaviors, appear to be polygenic;
(b) Behavior genetic findings fail to specify the mechanism of genetic influence; and
(c) Shared or nonshared environmental contributions to a disorder typically are found to be as large as genetic ones.

In short, you should recognize pervasive genetic influences on behavior, but also think critically and beyond familiar models of dominant and recessive inheritance.

2.3.5 Linkage Analysis: an Association Studies

Linkage analysis studies the mental disorders capitalize on several currently known locations on chromosomes of genes for other inherited physical characteristics or biological processes.

Association studies start with a large group of individuals both with and without a given disorder. Researchers then compare the frequencies of the people both with and without the disorder of certain genetic markers that are known to be located on particular chromosomes.

2.3.6 Human Nature and Temperament

(a) Evolutionary psychology is the application of the principles of evolution to our understanding of the animal and human mind. Evolutionary psychologists assume that animal and human psychology, like animal and human anatomy, have evolved based on two broad evolutionary principles, natural selection and sexual selection.

(b) Natural selection is the process through which successful inherited adaptations to environmental problems become more common over successive generations of offspring. Sexual selection improves inclusive fitness through increased access to mates and mating.

(c) Evolutionary psychology seeks to understand how evolution shaped human behavior. Among other things, the approach actually seeks to answer the age-old question, "What is human nature?"

(d) The theoretical writings of British psychiatrist John Bowlby greatly influenced psychologists' views about the human need to form close relationships. The heart of Bowlby's theory was the observation that infants form attachments early in life—special and selective bonds with their caregivers. Bowlby based his
approach, known as attachment theory, on findings from ethology, the study of animal behavior.

(e) Bowlby’s writings were theoretical and clinical, but psychological scientists have found empirical support for many aspects of attachment theory. Research on the effects of insecure or anxious attachments—uncertain or ambivalent parent—child relationships that are a product of inconsistent and unresponsive parenting during the first year of life—is of particular relevance to the development of abnormal behavior.

(f) The development of attachments, or more generally of affiliation with other members of the same species, is one of the two broad categories of social behaviors studied by ethologists.

(g) The second is dominance, the hierarchical ordering of a social group into more and less privileged members. Additional social motivations, as well as cognitive ones, belong on the list of basic human qualities. Still, we are confident that attachment and dominance will rank high on any final list.

(h) One of the most important areas of research on individual differences in personality is the study of temperament, characteristic styles of relating to the world. Psychologists long debated what elements make up the basic temperamental styles, but researchers apparently have reached consensus.

(i) Based on extensive analyses of people’s responses to structured questionnaires, researchers now agree on five dimensions. The “big five” dimensions of temperament and the opposite extremes that define them are:

a. Openness to experience—imaginative and curious versus shallow and imperceptive;

b. Conscientiousness—organized and reliable versus careless and negligent;

c. Extraversion—active and talkative versus passive and reserved;

d. Agreeableness—trustworthy and kind versus hostile and selfish; and

e. Neuroticism—nervous and moody versus calm and pleasant.

(j) Individual differences in temperament may play a role in a number of psychological disorders, especially personality disorders and child behavior problems. Still, you should view temperamental contributions to personality from a systems perspective. The critical issue is the goodness of fit between a child’s biologically based temperament and the psychological and social environments.

(k) Emotions, internal feeling states, are essential to human experience and to our understanding of mental disorders. Researchers have used statistical analysis to reduce our lexicon of feelings to six basic emotions:

a. The basic positive emotions include love, joy, and surprise.

b. The basic negative emotions include anger, sadness, and fear.
(l) Emotions come to us without intention, effort, or desire, and are controlled primarily by subcortical brain structures. Cognition can shape or modify emotion, but we cannot wholly control our feelings intellectually. This fact often becomes an issue in treating abnormal behavior, as people often want to, but cannot easily change, their emotions.

2.3.7 Brain Dysfunction And Neural Plasticity

(a) Specific brain lesions with observable defects in brain tissue are rarely the primary cause of mental disorders. There is considerable neural plasticity, flexibility of the brain in making changes in organization and/or function in response to pre- and postnatal stress, diet, disease, drugs, maturational, etc.

(b) Existing neural circuits can be modified or new ones can be generated. The effects can either be beneficial or detrimental to the person depending on circumstances.

(c) The developmental systems approach acknowledges that genetic activity influences neural activity which in turn influences behavior which in turn influences environment, but also that these influences are bi-directional.

2.3.8 The Impact of the Biological Viewpoint

We now recognize the important role of biochemical factors and innate characteristics, many which are genetically determined, in both normal and abnormal behavior.

Psychological events are mediated through the activities of the central nervous system. Thus if we find some dysfunction of the nervous system, this could have arisen from psychosocial as from biological causes. Psychosocial treatments are often as effective as drugs in producing changes in brain structure and function.
2.4 THE PSYCHOSOCIAL VIEWPOINTS

2.4.1 The Psychodynamic Perspectives

The psychodynamic paradigm, an outgrowth of the work and writings of Sigmund Freud, asserts that abnormal behavior is caused by unconscious mental conflicts that have roots in early childhood experience. Freud believed that psychological conflicts could be "converted" into physical symptoms.

Freud also believed that many memories, motivations, and protective psychological processes are unconscious, and this basic assumption was the impetus for his elaborate psychoanalytic theory. The term psychoanalytic theory refers specifically to Freud's theorizing; the broader term psychodynamic theory includes not only Freudian theory but also the revisions of his followers.

Psychoanalytic theory divides the mind into three parts: the id, the ego, and the superego. The id is present at birth and houses biological drives, such as hunger, as well as two key psychological drives: sex and aggression. The id operates according to the pleasure principle—the impulses of the id seek immediate gratification and create discomfort or unrest until they are satisfied.

The ego is the part of the personality that must deal with the realities of the world as it attempts to fulfill id impulses as well as perform other functions. Thus the ego operates on the reality principle. Unlike id impulses, which are primarily unconscious, much of the ego resides in conscious awareness.

The third part of the personality is the superego, which is roughly equivalent to the conscience. The superego contains societal standards of behavior, particularly rules that children learn from trying to be like their parents in their later preschool years. In Freud's view, societal rules are attempts to govern id impulses.

As a result, he suggested that the three parts of the personality are often in conflict with one another. The ego must constantly mediate between the demands of the id and the prescriptions of the superego. According to Freud, conflict between the superego and the ego produces moral anxiety, whereas conflict between the id and the ego produces neurotic anxiety.

Freud suggested that the ego protects itself from anxiety by utilizing various defense mechanisms, unconscious self-deceptions that reduce conscious anxiety by distorting anxiety-producing memories, emotions, and impulses.

(a) Displacement: discharging pent-up feelings, often of hostility on objects less dangerous than those arousing the feelings.
(b) Fixation: Attaching oneself in an unreasonable or exaggerated way to some person or arresting emotional development on a childhood or adolescent level.

(c) Projection: Attributing one’s unacceptable motives or characteristics to others.

(d) Rationalization: Using contrived explanations to conceal or disguise unworthy motives for one’s behavior.

(e) Reaction formation: Preventing the awareness or expression of unacceptable desires by exaggerated adoption of seemingly opposite behavior.

(f) Regression: Retreating to an earlier developmental level involving less mature behavior and responsibility.

(g) Repression: Preventing painful or dangerous thoughts from entering the consciousness.

(h) Sublimination: Channeling frustrated sexual energy into substitutive activities.

Freud viewed early childhood experiences, especially related to forbidden topics, as shaping personality and emotional health. In his theory of *psychossexual development*, in fact, Freud argued that each stage of development is defined by a sexual conflict.

(a) Oral stage: During first 2 years of life, the mouth is the principle erogenous zone.

(b) Anal stage: From

(c) Phallic stage: From ages 3 to 5 or 6, self-manipulation of the genitals provides the major source of pleasurable sensation.

(d) Latency period: From ages 6 to 12, sexual motivations recede in importance as the child become preoccupied with developing skills and other activities.

(e) Genital stage: After puberty, the deepest feelings of pleasure come from sexual relations.

The most important is the *Oedipal conflict*, which centers on boys’ forbidden sexual desires for their mothers. In Freud’s view, girls face a similar dilemma, which he termed the Electra complex. Psychoanalytic theory has been criticized for being overly sexualized, blatantly sexist, vague, and untestable.

However, Freud proposed many challenging concepts, and research supports some general aspects of his theorizing, for example, that much mental processing occurs outside of conscious awareness.

### 2.4.2 Newer Psychodynamic Perspectives:

Later theorists developed some of Freud’s basic ideas in three somewhat different directions. His daughter, Anna Freud, who was much more concerned with how the ego performed it’s
central function as the executive of personality. According to this view, psychopathy develops when the ego does not function adequately to control or delay impulse gratification or does not make adequate use of defense mechanisms when face with internal conflict. This became known as ego psychology.

2.4.3 Objects-Relations Theory

The focus is on individuals' interactions with real and imagined other people and on the relationships that people experience between external and internal objects. Object in this context refers to the symbolic representation of another person in the infant or child's environment. Through a process of introjections, a child symbolically incorporates into his or her personality important people in his or her life.

The general notion is that internalized objects could have various conflicting properties—such as exciting or attractive versus hostile, frustrating, or rejecting also that these objects could split off from the central ego and maintain independent existences, thus giving rise to inner conflicts.

2.4.4 The Interpersonal Perspective

Much of what we are is a product of our relationship with others. It is logical to expect that, it is logical to expect much of psychopathy reflects this fact—unfortunate tendencies we have developed while dealing with our interpersonal environments.

This is the focus of the Interpersonal Perspective, which began with the defection in 1911 of Alfred Adler from Freud, instead he emphasizes on social and cultural forces rather than inner instincts as determinants of behavior. In Adler's view people are inherently social beings motivated primarily by a desire to participate in a group.

Erik Erikson extended the interpersonal aspects of psychoanalytical theory; he elaborated Freud's psychosexual concepts into more socially oriented concepts describing crises or conflict that occurred in eight stages that could be resolved in a healthy or unhealthy way.

2.4.4.1 The Sense of Self

One important and influential conceptualization is Erik Erikson's concept of identity. Erikson viewed identity as the product of the adolescent's struggle to answer the question "Who am I?"

Other theorists have countered that we do not have one identity but many "selves." Kelly argued that people develop many different role identities, various senses of oneself that correspond with actual life roles.

The idea that children and adults must develop self-control—internal rules for guiding appropriate behavior—is an important concept in research on abnormal behavior. Self-esteem, valuing one's abilities, is another important and much discussed aspect of our sense of self.
Evidence indicates that high self-esteem is more of a product of success than a cause of it, while raising self-esteem in isolation produces little if any benefit. Similarly, low self-esteem may result from psychological problems rather than causing them.

2.4.5 Attachment Theory

John Bowlby’s attachment theory emphasizes the importance of early experience, especially with attachment relationships, as laying foundation for later functioning throughout childhood, adolescence and adulthood. He stressed the importance of the quality of parental care to the development of secure attachments.

2.4.6 Impact Of The Psychodynamic Perspectives

Two of Freud’s contributions standout as particularly noteworthy:

(a) He developed therapeutic techniques such as free association and dream analysis for becoming acquainted with both the conscious and the unconscious aspects of mental life.

(b) He demonstrated that certain abnormal mental phenomena occur in the attempt to cope with difficult problems and are simply exaggerations of normal ego-defense mechanisms.

2.5 BEHAVIORAL PERSPECTIVE

(a) The cognitive behavioral paradigm views abnormal behavior—and normal behavior—as a product of learning. Like the biological and psychodynamic paradigms, the foundations of the cognitive behavioral paradigm can be traced to the nineteenth century. In 1879, Wilhelm Wundt began the science of psychology at the University of Leipzig. Wundt made a profound and lasting contribution by introducing the scientific study of psychological phenomena, especially learning.

The two most prominent early contributors to learning theory and research were the Russian physiologist Ivan Pavlov and the U.S. psychologist B. F. Skinner. These psychological scientists articulated, respectively, the principles of classical conditioning and operant conditioning—concepts that continue to be central to contemporary learning theory.
(b) **Classical conditioning** is learning through association, and it involves four key components. There is an *unconditioned stimulus*, a stimulus that automatically produces the *unconditioned response*. A *conditioned stimulus* is a neutral stimulus that, when repeatedly paired with an unconditioned stimulus, comes to produce a *conditioned response*.

Finally, **extinction** occurs once a conditioned stimulus no longer is paired with an unconditioned stimulus.

(c) Eventually, the conditioned stimulus no longer elicits the conditioned response. **Skinner's principle of operant conditioning** asserts that learned behavior is a function of its consequences. Specifically, behavior increases if it is rewarded, and it decreases if it is punished.

**Positive reinforcement** is when the onset of a stimulus increases the frequency of behavior. **Negative reinforcement** is when the cessation of a stimulus increases the frequency of behavior. **Punishment** is when the introduction of a stimulus decreases the frequency of behavior. **Extinction** results from ending the association between a behavior and its consequences, similar to the concept of extinction in classical conditioning.

**Generalization** is when a response is conditioned to one stimulus or a set of stimuli; it can be evoked by another similar stimuli. **Discrimination** is when a person learns to distinguish between similar stimuli and to respond to them differently based on ones followed by reinforcement.

(a) **Observational Learning** is learning through observation without directly experiencing an unconditioned stimulus or a reinforcement. The possibilities for observational learning of both classical and instrumental responses greatly expand out opportunities for learning both adaptive and maladaptive behavior.

The U.S. psychologist John B. Watson was an influential proponent of applying learning theory to human behavior. Watson argued for **behaviorism**, suggesting that observable behavior was the only appropriate subject matter for the science of psychology, because thoughts and emotions cannot be measured objectively.

### 2.5.1 Impact Of The Behavioral Perspective

Maladaptive behavior is viewed as essentially the result of a failure to learn necessary adaptive behaviors or competencies and/or learning of ineffective or maladaptive responses.
2.6 THE COGNITIVE BEHAVIORAL PERSPECTIVE

The cognitive or cognitive-behavioral perspective focuses on how thoughts and information processes can become distorted and lead to maladaptive emotions and behavior. On central construct of this perspective is a schema, and underlying representation of knowledge that guides the current processing of information that often leads to distortions in attention, memory, and comprehension. People develop schema based on their temperament, abilities and experiences.

Our self-schema includes our views on who we are, what we might become, and what is important to us. Other aspects concern our notions of the various roles we occupy in our social environment. Schemas about the world are vital to our ability to engage in effective and organized behavior because they enable us to focus in what are the most relevant and important bits of information among the amazingly complex array of information that is available to our senses.

Maladaptive schemas that have developed as function of adverse early learning experiences lead to the distortions in thinking that are characteristic of certain disorders such as anxiety, depression and personality disorders.

Another important feature is that a great deal of information is processed nonconsciously or outside our awareness. Implicit memory is demonstrated when a person reveals that she or he cannot consciously remember it.

Attribution is simply the process of assigning causes to things that happen. We may attribute behavior to external rewards or punishment or assume that the causes are internal and derive from traits within others or us. Causal attributions help us explain our own or other people’s behavior and make it possible to predict what others or we are likely to do in the future. Attributional style is a characteristic way in which an individual tends to assign causes to bad events or good events. Self-serving bias is where they are more likely to make internal, stable and global attributions for positive rather than negative events.

2.7 THE HUMANISTIC PARADIGM

The humanistic paradigm argued that the essence of humanity is free will, the view that human behavior is not caused by either internal or external events, but by the choices we make voluntarily.

In many respects, the humanistic paradigm was a reaction against determinism, the scientific view that human behavior is caused by potentially knowable factors (an assumption made by the other three paradigms).
Because free will, by definition, is not predictably determined, it is impossible to conduct research on the causes of abnormal behavior within the humanistic paradigm. For this reason, the approach perhaps is best considered an alternative philosophy of human behavior, not as an alternative psychological theory.

The humanistic paradigm is also distinguished by its explicitly positive view of human behavior. Humanistic psychologists assume that human nature is inherently good, and blame dysfunctional, abnormal, or aggressive behavior on society, not on the individual.

2.7.1 The Problem with Paradigms

Paradigms can tell us where and how to find answers to questions, but sometimes the apparent guidance can be a hindrance. The four paradigms make assumptions about the causes of abnormal psychology that can be too narrow.

The biological paradigm can overemphasize the medical model, the analogy between physical and psychological illnesses. The psychodynamic paradigm can be unyielding in focusing on the past and the unconscious, even in the face of current life difficulties.

The cognitive behavioral paradigm can be too literal, and overlook the rich social context of human behavior. The humanistic approach can be antiscientific, for reasons we have already discussed. Each paradigm has strengths and weaknesses.

2.7 SYSTEMS THEORY

Systems theory is an approach to integrating evidence on different contributions to abnormal behavior. You can think of systems theory as a synonym for the biopsychosocial model, but systems theory also embraces several key concepts that deserve some elaboration. A central principle of systems theory is holism, the idea that the whole is more than the sum of its parts. A human being is more than the sum of a nervous system, an organ system, a circulatory system, and so on. Similarly, abnormal psychology is more than the sum of inborn temperament, early childhood experiences, and learning history, or of nature and nurture.

We can better appreciate the principle of holism if we contrast it with its scientific counterpoint, reductionism. Reductionism attempts to understand problems by focusing on smaller and smaller units, viewing the smallest possible unit as the true or ultimate cause. For example, when depression is linked with the depletion of certain chemicals in the brain, reductionists assume that brain chemistry is the cause of depression.

Systems theory reminds us, however, that experiences such as having a negative view of the world or living in a prejudiced society may cause the changes in brain chemistry that
accompany depression. That is, the "chemical imbalance in the brain" may be a product of adverse life experiences.

Different psychologists focus on different—but not necessarily inconsistent—levels of analysis in trying to understand the causes of abnormal behavior. Each level of analysis in the biopsychosocial model views abnormal behavior through a different "lens": one is a microscope, another a magnifying glass, and the third a telescope.

2.7 PSYCHOSOCIAL CAUSAL FACTORS

Exposure to multiple uncontrollable and unpredictable events is likely to leave a person vulnerable to anxiety and negative affect.

2.7.1 Early Deprivation or Trauma

Children who do not have resources that are normally supplied by parents may be left with deep and sometimes irreversible scars. The most severe manifestations of deprivation are seen among abandoned or orphaned children. Such deprivation might result in fixation of the oral stage of psychosexual development (Freud), it might interfere with the development of basic trust (Erikson), it might retard the attainment of needed skills because of lack of reinforcements (Skinner); or it might result in the child’s acquiring dysfunctional schemas and self-schemas in which relationships are represented as unstable, untrustworthy and without affection (Beck).

2.7.2 Institutionalization

In some cases children raised in an institution where there is less warmth and physical contact; less intellectual, emotional and social stimulation and a lack of encouragement and help in positive learning. Many children institutionalized show severe emotional, behavioral and learning problems and are at risk for disturbed attachment relationships and psychopathology.

2.7.3 Neglect and Abuse in the Home

Parents can neglect a child in various ways, by physical neglect, denial of love and affection, lack of interest in a child’s achievements or failure to spend time with the child or to supervise his or her activities. Parental abuse involves cruel treatment in the form of emotional, physical and/or sexual abuse. Abused and maltreated infants and have a
tendency to be overly aggressive, have significant problems in behavioral, emotional and social functioning.

2.7.4 Inadequate Parenting Styles

(a) Parenting Styles: Warmth and Control

(b) Authoritative Parenting: The parents are both very warm and very careful to set clear standards and limits to certain behaviors while allowing considerable freedom within these limits.

(c) Authoritarian Parenting: High on control but low on warmth, often appear cold and demanding favoring punitive methods if their children disobey.

(d) Permissive/Indulgent Parenting: High on warmth but low on discipline, children are often spoiled, selfish, impatient and demanding.

(e) Neglectful/Uninvolved Parenting: Low both on warmth and control. Disengaged and not supportive of their children.

(f) Restrictiveness can protect children growing up in high-risk environments as defined by a combination of family occupation and education level, minority status and absence of father.

(g) Marital Discord and Divorce

More severe cases of marital discord may expose children to one or more stressors. Some of the intergenerational transmission of marital discord may be the result of the offspring having learned negative interaction styles by observing their own parents’ marital interactions. Divorce is a major source of psychopathology including physical illness, death, suicide and homicide. It can have traumatic effects on children, feelings of insecurity and rejection and delinquency.

2.7.5 Maladaptive Peer Relationships

A significant number of children with psychosocial deficits or who are temperamental withdraw from their peers and become loners. Others adopt intimidation and aggressive lifestyles becoming bullies. However, children who have social competence can use their resources to protect themselves against frustration, demoralization, despair and mental disorder.
2.7 THE SOCIOCULTURAL CAUSAL FACTORS

2.7.1 Harmful Societal Influences

2.7.1.1 Low Socioeconomic Status and Underemployment

The lower the socioeconomic class, the higher the incidence of mental disorder. There are several explanations, those who live in poverty encounter more severe stressors and have fewer resources to deal with them.

An increased risk for psychological disorders is associated with prejudice and poverty, although the separate consequences of race and poverty need to be disentangled. The conditions of poverty affect a disproportionate number of African Americans, but the experiences of American blacks and whites differ in many more ways than income.

2.7.1.2 Prejudice and Discrimination in Race, Gender and Ethnicity

Vast numbers of people have been subjected to demoralizing stereotypes as well as discrimination in areas such as employment, education and housing.

Gender and gender roles, expectations regarding the appropriate behavior of males or females, can dramatically affect social relationships and social interaction. Gender roles may influence the development, expression, or consequences of psychopathology.

2.7.1.3 Social Change and Uncertainty

Constantly trying to keep up with social change can be a source of considerable stress. So can trying to cope with new problems (environmental change and terrorist attacks).
2.7.1.4 Urban Stressors: Violence and Homelessness

People in big cities are becoming victims of urban and domestic violence and homelessness. This results in increased rates of anxiety, post-traumatic stress, depression and suicide. There are almost endless number of potential social influences on behavior, including many aspects of interpersonal relationships, social institutions, and cultural values.

Social perspectives all emphasize that the development of psychopathology is a product of people’s social roles, styles of behaving according to the expectations of the social situation. According to labeling theory, abnormal behavior is created by social expectations; it is only what a given group or society deems to be abnormal. Labeling theory also suggests that people’s actions conform to the expectations created by the label, a process termed the self-fulfilling prophecy. The roles people play in life— including roles shaped by gender, race, social class, and culture—help to shape who they become, but psychopathology is much more than the expectations a label creates.

Cultural differences:

A child’s cultural group and values can be very influential throughout development. It is important to remember that children from different cultural backgrounds experience and manifest symptoms in different ways, which has implications for clinical diagnosis and treatment. More research is needed to define ways in which culture affects development and psychopathology in different populations. Invite students to find research studies and clinics targeting this issue using internet resources.

Suggested sites:
http://www.uchsc.edu/at/nciamhr/abtnoin.htm
http://www.georgetown.edu/research/guide/cultural.html
http://www.nap.edu/readingsroom/books/earlyed/
1) Which edition of the Diagnostic and Statistical Manual (DSM) of Mental Health is used today? According to _____ theory, the quality of the relationship or affectionate bond that young children develop with their mother or mother substitute plays a major role in determining their behavioral and emotional development.
   a. Psychoanalytic
   b. Attachment
   c. Coercion
   d. Proactive parenting
   e. Behavioral

2) Which of the following illustrates the diathesis-stress model of the etiology of psychological disorders?
   a. Maria’s mother drank alcohol when she was pregnant with Maria and Maria now displays the symptoms of fetal alcohol syndrome.
   b. Even in infancy, Josiah was easily startled. Since his father and mother separated when he turned six, Josiah has refused to leave his mother’s side, even to go to school or to go to the bathroom.
   c. Jake was bitten by a dog when he was young and is now terrified whenever he sees a dog.
   d. Mariah has temper tantrums whenever she wants something. Because her tantrums are very aversive and stressful for her mother, her mother typically gives in and lets her have what she wants.
   e. All of the above are illustrations of the diathesis-stress model.
Required Reading


Weblinks

Classical Conditioning - http://www.bremsb.net/classical/classical.html
Learn more about classical conditioning.

Demonstration/Simulation of operant conditioning using Macromedia Shockwave.

Human Genome Project - http://www.ornl.gov/hgmp
You can learn about how genes are “discovered” and keep up with the latest research findings.

Recent Developments in Human Behavioral Genetics –
This article, written by a number of leading behavior geneticists, describes traditional and innovative methods in the field of behavior genetics.
Schedules of Reinforcement - http://www.bremsb.net/operant/schedule.html
Learn more about operant conditioning reinforcement schedules.

Self-Efficacy - http://www.emory.edu/EDUCATION/mfp/publications.html
This site is devoted to the topic of self-efficacy with links to many self-efficacy research programs, how self-efficacy can be assessed, and the role of self-efficacy in motivation.

Sigmund Freud - http://plaza.interport.net/nyrsan/feudarc.html
This site is devoted to Sigmund Freud and has links to other Freud sites.
Unit 3

Assessment, Diagnosis & Treatment

LEARNING OUTCOME

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

1. Discuss historical origins of modern diagnostic systems and the development of the DSM system.
2. Describe the features of the mental status examination and different types of interviewing techniques.
3. Describe the use of psychological tests in the assessment of neuropsychological functioning.
4. Discuss the advantages and limitations of behavioral assessment.
5. Discuss cognitive methods of assessment.
6. Discuss the use of physiological measurement in assessment, including the use of brain-imaging techniques.
7. Discuss the role of sociocultural and ethnic factors in the classification of maladaptive behavior.

Unit 3 covers the advantages and disadvantages of classification systems for abnormal behaviors. It investigates the diagnostic process as it applies to behavioral, cognitive, and emotional problems. The problems are discussed in terms of an individual’s stress, vulnerability, resiliency and coping skills. Assessment techniques such as the interview, intelligence tests, personality tests and scales, behavioral assessments, cognitive assessments, and other related tools used in the field of abnormal psychology are also discussed.
INTRODUCTION

Brief Historical Perspective

We can trace the roots of the treatment of psychological disorders to two broad traditions of healing: the spiritual/religious tradition and the naturalistic/scientific tradition.

One of the earliest examples of this tradition is the practice of trephining—chipping a hole through the unfortunate sufferer’s skull with a crude stone tool—presumably, to allow evil spirits to escape. The influence of spiritual beliefs and rituals should not be ignored since believing is a powerful part of healing.

Naturalistic/scientific approaches to helping the mentally disturbed also have ancient roots. Hippocrates recommended treatments such as rest, exercise, and a healthy diet.

In the 1600s, “insane asylums” were developed as a new treatment for the mentally ill. One rationale for these institutions was to remove disturbed individuals from society; another was the hope that rest and isolation would alleviate their bizarre behavior.

3.1 THE BASIC ELEMENTS IN ASSESSMENT

3.1.1 The Relationship Between Diagnosis And Analysis

Knowledge of a disorder can help in planning and managing the appropriate treatment.

3.1.2 Taking a Social Or Behavioral History

3.1.2.1 Personality Factors

Assessment should include a description of any relevant long-term personality characteristics that predispose the individual to maladaptive ways.

3.1.2.2 The Social context

What kind of environmental demands are placed on the person and what supports or special stressors exist in his or her life situation.
3.1.3 Assessment Of The Physical Organism

3.1.3.1 The General Physical Exam

Typically, a medical history is obtained, and the major systems in the body are checked. This procedure is for disorders that entail physical disorders.

3.1.3.2 The Neurological Exam

This may involve the client getting an electroencephalogram (EEG) to assess brain wave patterns in awake and sleeping states. When and EEG reveals dysrhythmia (irregular pattern) in the brain's electrical activity, other specialized techniques may be used to arrive at a more precise diagnosis.

3.1.3.3 Anatomical Brain Scans

Computerized Axial Tomography (CAT) scans reveal the images of parts of the brain that might be diseased. Magnetic Resonance Imaging (MRI) provides sharper images allowing the superior ability to differentiate subtle variations in soft tissue.

3.1.3.4 PET Scans: A Metabolic Portrait

Positron Emission Tomography (PET) scans allow for an appraisal of how an organ is functioning, provides metabolic portraits by tracking natural compounds.

3.1.3.5 The Functional MRI

The MRI could reveal brain measure changes in local oxygenation (blood flow) of specific areas of brain tissue; ongoing psychological activity (sensations, images and thoughts) can be mapped.

3.1.3.6 The Neuropsychological Exam

Neuropsychological assessment involves the use of various testing devices to measure a person's cognitive, perceptual and motor performances as clues to the extent of brain damage. The person's performance on standardized tests can give clues about any cognitive and intellectual impairment following brain damage.
3.1.4 Psychosocial Assessment

3.1.4.1 Assessment Interviews

Usually involves a face-to-face interaction in which a clinician obtains information about a patient's situation, behavior and personality.

3.1.4.2 Structured And Unstructured Interviews

Research data shows that the more controlled and structured type of assessment interviews yields more reliable results. Clinical interviews can be subject to error because they rely on human judgment to choose the questions and process information.

3.1.4.3 The Clinical Observation of Behavior

The main purpose of direct observation is to learn more about the person's psychological functioning through the objective appearance and behavior in various contexts. Clinicians can provide their patients instructions in self-monitoring: self-observation and objective reports of behavior, thoughts and feelings as they occur in natural settings.

3.1.4.4 Rating Scales

The use of rating scales helps organize information and to encourage reliability and objective. The most useful rating scales are those that enable a rater to indicate not only presence or absence of a trait or behavior but also its prominence or degree. The Brief Psychiatric Rating Scale (BPRS) provides a structured and quantifiable format for rating clinical symptoms such as anxiety and hostility.

3.1.5. Psychological Tests

3.1.5.1 Intelligence Tests

**Vocabulary (verbal):** This test consists of a list of words to define that are presented orally to the individual.

**Digit Span (performance):** A sequence of numbers is administered orally and the individual is asked to repeat the digits in the order administered. Intelligence test may be the most crucial diagnostic procedure in cases where intellectual or organic brain damage may be central to a patient's problem.

3.1.5.2 Projective Personality Tests

Projective tests are unstructured since they rely on ambiguous stimuli such as inkblots rather than explicit verbal questions. Interpretations of the materials reveal their personal preoccupations, conflicts, motives, coping technique.
• **The Rorschach test**: The test uses ten inkblot pictures to which a subject responds what they see. The responses are up to the administrator to interpret.

• **The Thematic Apperception Test (TAT)**: Uses a series of simple pictures about which a subject is instructed to make up stories about. The content of the pictures are ambiguous, so subjects tend to project their own conflicts and worries on to it.

• **Sentence Completion Test**: Such test consists of beginnings of sentences that a person is asked to complete. They help examiners pinpoint important cues to an individual’s problems, attitudes and symptoms.

• **Objective Personality Tests**
  - Structured, typically use questionnaires; self report inventories or rating scales where responses are specified as choices.

• **The Minnesota Multiphasic Personality Index (MMPI)**: The original MMPI consisted of 550 items covering topics ranging from physical condition and psychological state to moral and social attitudes. True or False.

Self-report inventories are cost-effective, highly reliable and objective. However, some clinicians consider it too mechanistic to portray the complexity of humans and their problems accurately.

### 3.1.6 The Integration Of Assessment Data

#### 3.1.6.1 Ethical Issues in Assessment

1. Potential cultural bias of the instrument or the clinician
2. Theoretical orientation of the clinician
3. Underemphasis of the external situation
4. Insufficient validation
5. Inaccurate data or premature evaluation

![Activity 3.1](image)

(a) What is the difference between diagnosis and clinical assessment?
(b) What are some ethical issues that clinicians should be aware of when evaluating a patient’s test results?
3.2 CLASSIFYING ABNORMAL BEHAVIOR

3.2.1 Reliability and Validity

Reliability is the degree to which a measuring device produces the same result each time it is used to measure the same thing or an index of the extent to which different observers can agree that a person’s behavior fits a given diagnostic class.

Validity is the extent to which a measuring instrument actually measures what it is supposed to measure or the degree to which a diagnosis accurately conveys something clinically important about the person. Normally validity presupposes reliability.

3.2.2 Formal Diagnostic Classification of Mental Disorders

There are two major psychiatric classification systems in use: the International Classification of Disease System (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The criteria that define the recognized categories consist mainly of symptoms and signs. Symptom refers to the patient’s subjective description. Signs are objective observations that the diagnostician may make directly or indirectly.

3.2.3 The Five Axes of DSM-IV-TR

Axis I: The particular clinical syndromes or other conditions that may be a focus of clinical attention.
Axis II: Personality disorders.
Axis III: General medical conditions.
Axis IV: Psychosocial and environmental problems.
Axis V: Global assessment of functioning.

ACTIVITY 3.2
(a) Why is a classification system needed in abnormal psychology?
(b) What are some of the limitations of the DSM-IV-TR classification system?
3.2.4 Main Categories of Axis I and Axis II disorder

1. Disorders secondary to gross dysfunctions or malfunctioning tissue.

2. Substance use disorders.

3. Disorders of psychological or sociocultural origin having no known brain pathology as primary causal factor.

4. Disorders usually arising during childhood or adolescence.

Acute is used to describe disorders of relatively short duration (under 6 months).

Chronic refers to long-standing and often permanent disorders.

Mild, moderate and severe are terms that reflect different points on a dimension of severity or seriousness. Episodic and recurrent are unstable disorders that tend to come and go.

3.2.5 The Limitations of DSM Classification

The DSM classification has limits on the extent to which a conceptually strict categorical system can adequately represent the abnormalities of behavior. The real problems of real patients often do not fit in the precise lists of signs and symptoms.

3.2.6 The Problem of Labeling

One important criticism is that a psychiatric diagnosis is little more than a label applied to a defined category of socially disapproved or otherwise problematic behavior.

The diagnostic label describes neither a person nor any underlying pathological condition the person necessarily harbors, but, rather, some behavioral pattern associated with that person’s current level of functioning.

Once an individual is labeled, he or she may accept a redefined identity and play out the expectations of that role. They can also have a devastating effect on a person’s morale, self-esteem, and relationships with other.
3.3 AN OVERVIEW OF TREATMENT

Psychotherapy is the use of psychological techniques and the therapist–client relationship to produce emotional, cognitive, and behavior change.

Today, the largest group of mental health professionals describe themselves as eclectic, meaning they use different treatments for different disorders.

*Psychotherapy outcome research* examines whether and when treatments are effective, while *psychotherapy process research* searches for the "active ingredients" in psychotherapy, that is, the therapeutic activities that promote positive change. Research shows that therapy is more effective when therapists appropriately reveal a bit about their own, similar struggles.

Unfortunately, some therapists do not offer or even educate their clients about more and less effective treatments, and there is an even bigger problem: Most people who need it do not get *any* psychological help. Eighty-seven percent of people with a diagnosable mental disorder have not received treatment in the past year, including many people with common, severe, and treatable disturbances.

Therapists working within the biological, psychodynamic, cognitive behavioral, and humanistic paradigms would approach treatment and evaluate a mentally ill person in very different ways.

3.3.1 Pharmacological Approaches To Treatment

*Psychopharmacology*—the study of the use of medications to treat psychological disturbances—has been the most promising avenue of biological treatment. In recent years, scientists have developed new medications that have increasingly specific effects on emotional states and mental disorders.

There are a variety of *psychotropic medications*, chemical substances that affect psychological state. The success of psychopharmacology is evident in the expanding development and use of psychotropic medications. Evidence indicates that medication often is an effective and safe treatment for many mental disorders.

Although psychotropic medications do not cure underlying causes, symptom alleviation is extremely important. All medications have side effects, some of which are very unpleasant. Partly as a result of unpleasant side effects, many patients do not take their medication as prescribed, and they may experience a relapse as a result.

Many psychotropic drugs must be taken for long periods of time. Despite the effectiveness of many psychotropic medications, we share some concerns that we sometimes look to medication to solve problems that may have psychological or social roots.
3.3.2 Antipsychotic Drugs

Used to treat psychotic disorders such as schizophrenia and psychotic mood disorders. The key therapeutic benefit is their ability to alleviate or reduce the intensity of delusions and hallucinations. They do this by blocking dopamine receptors.

The half-life is the time it takes for the level of active drug in the body to be reduced by 50%. Advantages of a long half-life include less frequent dosing, less variation in the concentration of the drug in the plasma and less severe withdrawal. Disadvantages include the risk of the drug accumulating in the body as well as increased sedation and psychomotor impairment during the day.

One side effect is tardive dyskinesia, which is a movement abnormality from taking antipsychotic medication. A more serious side effect is a potentially life threatening drop of white blood cells.

3.3.3 Antidepressant Drugs

3.3.3.1 Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs work by inhibiting the reuptake of the neurotransmitter serotonin following its release into the synapse. They have fewer side effects and are generally not found to be fatal in overdose as tricyclics can be. Side effects include nausea, diarrhea, nervousness, insomnia and sexual problems.

3.3.3.2 Monoamine Oxidase (MAO) Inhibitors

They inhibit the activity of monoamine oxidase, and enzyme present in the synaptic cleft that helps break down the monoamine neurotransmitters that have been released into the cleft. Patients taking MAO inhibitors must avoid foods rich in acid tyramine.

3.3.3.3 Tricyclic Antidepressants

They inhibit the reuptake of norepinephrine and serotonin once these have been released into the synapse.

3.3.3.4 Other Antidepressants

Trazodone (Desyrel) inhibits reuptake of serotonin. It has heavy sedating properties that limit its uses.

Bupropion (Wellbutrin) increases noradrenergic function. Mirtazapine (Remeron) and Cymbalta facilitate serotonin and norepinephrine neurotransmission. The side effect of Remeron is weight gain and Cymbalta is decreased appetite and weight loss.
3.3.4 Anti Anxiety Drugs

Benzodiazapine

At low doses they help quell anxiety, at higher doses they act as sleep inducing agents and can be used to treat insomnia. One problem is that patients become psychologically and physiologically dependent on them.

3.3.5 Lithium and other Mood-Stabilizing Drugs

The biochemical basis of lithium’s therapeutic effect is unknown. It used to treat manic-depression. Side effects may include increased thirst, gastrointestinal difficulties, weight gain, tremor and fatigue. Lithium can be toxic if the dose is exceeded.

3.3.6 Electroconvulsive Therapy

Electroconvulsive therapy (ECT) involves deliberately inducing a seizure by passing electricity through the brain. Approximately 100 volts of electric current is passed through a patient’s brain in bilateral ECT, where electrodes are placed on the left and right temples, and the current passes through both brain hemispheres. In unilateral ECT, the electric current is passed through only one side of the brain, the nondominant hemisphere. ECT can be effective in treating severe depressions that do not respond to other treatments, especially for a patient at high risk for suicide.

3.3.6 Neurosurgery

Psychosurgery is a controversial biological treatment, as it involves the surgical destruction of specific regions of the brain.

Prefrontal lobotomy is a procedure in which the frontal lobes of the brain are surgically and irrevocably severed. The procedure has limited effectiveness and causes frequent and severe side effects, including a significant mortality rate, excessive tranquility, and the absence of emotional responsiveness. Although prefrontal lobotomies are no longer performed, some forms of highly circumscribed psychosurgery are used today to treat severe disorders.
3.3.7 Psychological Approaches To Treatment

3.3.7.1 Behavior Therapy

Behavior therapy is a direct and active treatment that recognizes the primacy of behavior, acknowledges the role of learning, and includes thorough assessment and evaluation.

3.3.7.2 Exposure Therapy

Systematic desensitization is a technique for eliminating fears that has three key elements. The first is relaxation training using progressive muscle relaxation, a method of inducing a calm state through the tightening and subsequent relaxation of all of the major muscle groups.

The second is the construction of a hierarchy of fears ranging from very mild to very frightening, a ranking that allows clients to confront their fears gradually. The third part of systematic desensitization is the learning process, namely, the gradual pairing of ever-increasing fears in the hierarchy with the relaxation response.

Systematic desensitization involves imagining increasingly fearful events while simultaneously maintaining a state of relaxation. Evidence shows that systematic desensitization can be an effective treatment for fears and phobias, but it is not clear whether classical conditioning accounts for the change.

Although many factors contribute to effective cognitive behavior therapy, most investigators agree that exposure is the key to fear reduction.

In vivo desensitization involves gradually confronting fears in real life while simultaneously maintaining a state of relaxation. Imaginal exposure is when the fear confronted is imaginary.

Flooding involves helping clients to confront their fears at full intensity.

3.3.7.3 Aversion Therapy

The goal in aversion therapy is use classical conditioning to create, not eliminate, an unpleasant response. The technique is used primarily in the treatment of substance use disorders such as alcoholism and cigarette smoking. Aversion treatments often achieve short-term success, but relapse rates are high.
3.3.7.4 Modeling

The client learns new skills by imitating another, a therapist, who performs the behavior to be acquired. A younger client may be exposed to behaviors and then be encouraged to imitate and practice the new responses.

3.3.7.5 Systematic Use Of Reinforcement

Often referred to as contingency management, it is an operant conditioning technique that directly changes rewards and punishments for identified behaviors. A contingency is the relationship between a behavior and its consequences; thus, contingency management involves changing this relationship.

The goal of contingency management is to reward desirable behavior systematically and to extinguish or punish undesirable behavior.

Positive reinforcement is often used in response sharpening, establishing by gradual approximation a response that is actively resisted or not initially in an individual's behavior repertoire.

3.3.7.6 Token Economies

The token economy is an example of contingency management that has been adopted in many institutional settings. In a token economy, desired and undesired behaviors are clearly identified, contingencies are defined, behavior is carefully monitored, and rewards or punishments are given according to the rules of the token economy. Research shows that contingency management successfully changes behavior for diverse problems such as institutionalized clients with schizophrenia and juvenile offenders in-group homes. However, improvements often do not generalize to real life situations where the therapist cannot control rewards and punishments.

3.3.7.7 Social Skills Training

The goal of social skills training is to teach clients new ways of behaving that are both desirable and likely to be rewarded in everyday life.

The goal of assertiveness training is to teach clients to be direct about their feelings and wishes. Social problem solving is a multi-step process that has been used to teach children and adults ways to go about solving a variety of life's problems.

The first step involves assessing and defining the problem in detail, breaking a complex difficulty into smaller, more manageable pieces. "Brainstorming" is the second step in
social problem solving. The third step involves carefully evaluating the options generated during brainstorming. Finally, the best solution is chosen and implemented, and its success is evaluated objectively.

If the option does not work, the entire process can be repeated until an effective solution is found.

3.3.7.8 Cognitive and Cognitive-Behavioral Therapy

Cognitive behavior therapy involves teaching new ways of thinking, acting, and feeling using different, research-based techniques. In contrast to the psychodynamic approach, cognitive behavior therapists focus on the present and on behavior, adhering to the truism, “Actions speak louder than words.”

The beginnings of behavior therapy can be traced to John B. Watson's behaviorism. Watson viewed the behavior therapist's job as being a teacher. The therapeutic goal is to provide new, more appropriate learning experiences. More recently, behavior therapy has been extensively influenced by the findings of cognitive psychology.

Cognitive behavior therapy is a practical approach oriented to changing behavior rather than trying to alter the dynamics of personality. One of the most important aspects of cognitive behavior therapy is its embrace of empirical evaluation.

3.3.7.9 Cognitive Techniques

All of the cognitive behavior therapies we have discussed so far have foundations in either classical or operant conditioning. More recent techniques are rooted in cognitive psychology.

One example is attribution retraining, which is based on the idea that people are “intuitive scientists” who are constantly drawing conclusions about the causes of events in their lives.

These perceived causes, which may or may not be objectively accurate, are called attributions. Attribution retraining involves trying to change attributions, often by asking clients to abandon intuitive strategies. Instead, clients are instructed in more scientific methods, such as objectively testing hypotheses about themselves and others.

Self-instruction training is another cognitive technique that is often used with children. In Meichenbaum's self-instruction training, the adult first models an appropriate behavior while saying the self-instruction aloud. This procedure is designed as a structured way of developing internalization, helping children to learn internal controls over their behavior.
3.3.7.10 Rational Emotive Behavior Therapy

Albert Ellis's rational–emotive behavior therapy (RET) is also designed to challenge cognitive distortions. According to Ellis, emotional disorders are caused by irrational beliefs, absolute, unrealistic views of the world.

The rational–emotive behavior therapist searches for a client’s irrational beliefs, points out the impossibility of fulfilling them, and uses any and every technique to persuade the client to adopt more realistic beliefs. RET aims at increasing and individual’s self-worth and clearing the way for self-actualization by removing false beliefs.

3.3.7.11 Beck’s Cognitive Therapies

Aaron Beck’s cognitive therapy was developed specifically as a treatment for depression.

Beck suggested that depression is caused by errors in thinking. The errors leave them:

- To perceive the world as harmful while ignoring evidence to the contrary
- To over generalize on the basis of limited examples
- To magnify the significance of undesirable events
- To engage in absolutistic thinking

Beck’s cognitive therapy involves challenging these negative distortions by gently confronting clients’ cognitive errors in therapy, and asking clients to see how their thinking is distorted based on their own analysis of their life.

Integration and Research

What unites cognitive behavior therapists is a commitment to research, not to a particular form of treatment. Cognitive behavior therapists have been vigorous in conducting psychotherapy outcome research, and they generally embrace any treatment with demonstrated effectiveness.

For this reason, we envision what is now called cognitive behavior therapy as becoming the integrated, systems approach to treatment, as more and more therapists offer eclectic but effective treatments for different disorders.

3.3.7.12 Humanistic-Experimental Therapies

Humanistic psychotherapy originally was promoted as a “third force” in psychotherapy. Humanistic therapists believe that that each of us has the responsibility for finding
meaning in our own lives. Therapy is seen only as a way to help people to make their
own life choices and resolve their own dilemmas.
To help clients make choices, humanistic therapists strive to increase emotional awareness.
Given the emphasis on emotional genuineness, humanistic psychotherapists place a great
deal of importance on the therapist–client relationship.
Most other approaches also recognize the importance on the therapist–client relationship,
but they view the relationship primarily as a means of delivering the treatment. In
humanistic therapy, the relationship is the treatment.

3.3.7.13 Client-Centered Therapy

Carl Rogers and his client-centered therapy provide a clear example of the humanistic focus
on the therapeutic relationship. Rogers wrote extensively about the process of fostering a
warm and genuine relationship between therapist and client.

He particularly noted the importance of empathy, or emotional understanding. Empathy
involves putting yourself in someone else’s shoes and conveying your understanding of
that person’s feelings and perspectives.

The client-centered therapist does not act as an “expert” who knows more about the
client than the client knows about himself or herself. Rather, the therapeutic goal is to
share honestly in another human’s experience.

Rogers encouraged self-disclosure on the part of the therapist, intentionally revealing
aspects of the therapist’s own, similar feelings and experiences as a way of helping the
client. Rogers also felt that client-centered therapists must be able to demonstrate
unconditional positive regard involves valuing clients for who they are and refraining
from judging them. Because of this basic respect for the client’s humanity, client-centered
therapists avoid directing the therapeutic process.

According to Rogers, if clients are successful in experiencing and accepting themselves,
they will achieve their own resolution to their difficulties. Thus client-centered therapy is
non directive.

3.3.7.15 Gestalt Therapy

The term gestalt means whole and gestalt therapy emphasizes unity of the mind and
body, placing strong emphasis on the need to integrate thought, feeling and action. The
main goal is to increase the individual’s self-awareness and self-acceptance.

3.3.7.16 Process-Experiential Therapy

This treatment emphasizes the experiencing of emotions during therapy. Clients are
asked to reflect on their emotions and are encouraged to create meaning for them. Like
other humanistic therapies, relationship with the therapist is regarded as extremely
important.
A Means, Not an End?

Psychotherapy process research shows that the bond or therapeutic alliance between a therapist and client is crucial to the success of therapy—no matter what approach is used. A therapist’s caring, concern, and respect for the individual are important to the success of all treatments for psychological disorders.

3.3.7.17 Psychodynamic Therapies

An early influence on the psychodynamic approach to therapy was Joseph Breuer, who used hypnosis to induce troubled patients to talk freely about problems in their lives. Upon awakening from a hypnotic trance, many patients reported relief from their symptoms.

Breuer attributed their improvement to catharsis, the release of previously unexpressed feelings, pent up emotion that Breuer assumed was responsible for his patients’ psychological problems.

Freudian Psychoanalysis

Breuer’s collaborator, Sigmund Freud, adopted the hypnotic method for a time, but he soon concluded that hypnosis was not necessary to encourage open expression.

Freud used a method called free association, in which he simply told his patients to speak freely about whatever thoughts crossed their mind. This method, became a cornerstone of Freud’s famous treatment, psychoanalysis.

The true benefit of free association, in Freud’s view, was that it revealed aspects of the unconscious mind. Freud also believed that dreaming and slips of the tongue (now called Freudian slips) provided especially revealing information about the unconscious. Thus, according to Freud, free association, dreams, and slips of the tongue are valuable because they serve as “windows into the unconscious.”

The ultimate goal of psychoanalysis is to bring formerly unconscious material into conscious awareness. This is what Freud called insight. Freud asserted that insight is sufficient for curing psychological disorders. The analyst’s main tool for promoting insight is interpretation. In offering an interpretation, the analyst suggests hidden meanings to patients’ accounts of their past and present life.

One essential element in probing the unconscious mind and offering interpretations is therapeutic neutrality. Psychoanalysts maintain a distant stance toward their patients in order to minimize their influence on free association.

During the process of free association the individual may evidence resistance, an unwillingness to talk about certain thoughts, motives or experiences.

The analyst’s distant stance is thought to encourage transference, the process whereby patients transfer their feelings about some key figure in their life onto the shadowy figure of the analyst. Insight into the transference relationship presumably helps patients understand how and why they are relating to the analyst in the same dysfunctional manner in which they related to a loved one.
A common misconception about psychoanalysis is that the ultimate goal of insight is to rid the patient of all defenses. According to Freud, defenses are essential for the functioning of a healthy personality. Thus, rather than ridding the patient of defenses, one goal of psychoanalysis is to replace them.

Defenses such as denial and projection are confronted because they distort reality dramatically, whereas “healthier” defenses, such as rationalization and sublimation, are left unchallenged. A second goal of psychoanalysis is to help patients become more aware of their basic needs or drives so that they may find socially and psychologically appropriate outlets for them.

The Decline of Freudian Psychoanalysis

Because psychoanalysis requires substantial time, expense, and self-exploration, it is accessible only to people who are relatively well functioning, introspective, and financially secure. In many respects, psychoanalysis now is viewed as a process of self-understanding, not a treatment for specific emotional disorders. Although Freudian psychoanalysis has declined greatly, the approach spawned numerous therapeutic variations broadly referred to as psychodynamic psychotherapy. Psychodynamic psychotherapists often are more engaged and directive in therapy, and treatment may be relatively brief in comparison to psychoanalysis.

3.3.7.18 Ego Analysis

Ego analysis originated in the work of a number of therapists trained in psychoanalysis but who developed somewhat different theories and techniques. Whereas Freud emphasized the role of the id, these new theorists focused much more on the ego.

The patient’s past and present interpersonal relationships are of greatest importance according to Harry Stack Sullivan, an influential ego analyst.

Other influential ego analysts include Erik Erikson and Karen Horney. Horney’s lasting contribution was her view that people have conflicting ego needs: to move toward, against, and away from others. Erikson introduced the argument that an individual’s personality is not fixed by early experience but continues to develop as a result of predictable psychosocial conflicts throughout the life span.

John Bowlby’s attachment theory perhaps has had the greatest effect on contemporary thought about interpersonal influences on psychopathology. Unlike Freud, Bowlby elevated the need for close relationships to a primary human characteristic.

The approaches of the ego analysts seek to uncover hidden motivations and emphasize the importance of insight. However, psychodynamic psychotherapists are much more actively involved with their patients. They are more ready to direct the patient’s recollections, to focus on current life circumstances, and to offer interpretations quickly and directly.
Short-term psychodynamic psychotherapy is a form of treatment that uses many psychoanalytic techniques. Therapeutic neutrality is typically maintained, and transference remains a central issue, but the short-term psychodynamic therapist actively focuses on a particular emotional issue rather than relying on free association.

3.3.7.19 Marital and Family Therapy

Marital Therapy

Couples therapy involves seeing intimate partners together in psychotherapy. The goal of couples therapy typically is to improve the relationship, and not to treat the individual.

Couples therapists typically help partners to improve their communication and negotiation skills. Research shows that couples therapy can improve satisfaction in marriages. When couples therapy is used in conjunction with individual treatment, the combined approach often is more effective than individual therapy alone.

Traditional behavioral couple therapy is based on a social-learning model and views marital satisfaction and marital distress in terms of reinforcement. Integrative behavioral couple therapy focuses on acceptance and includes strategies that help each other come to terms with and accept some of the limitations of his or her partner.

Family Therapy

Family therapy might include two, three, or more family members in a treatment designed to improve communication, negotiate conflicts, and perhaps change family relationships and roles.

Parent management training is an approach that teaches parents new skills for rearing troubled children. As with individual and couples therapy, there are many different theoretical approaches to family therapy.

Structural family therapy holds that if the family context has changed, then the individual members will have altered experiences in the family and will behave differently in accordance with the changed requirements of the new family context. Many approaches to family therapy are distinguished, however, by their longstanding emphasis on systems theory. In applying systems theory, family therapists emphasize interdependence among family members and the paramount importance of viewing the individual within the family system.

A common goal in systems approaches to family therapy is to strengthen the alliance between the parents, to get parents to work together and not against each other.
3.3.7.20 Group Therapy

Group therapy involves treating a collection of several people who are facing similar emotional problems or life issues. Psychoeducational groups are designed to teach group members specific information or skills relevant to psychological well-being.

In experiential group therapy the relationships formed between group members in a unique setting become the primary mode of treatment. In an encounter group, group members may question self-disclosure when it is "phony" but support more honest appraisals of oneself.

Self-help groups bring together people who face a common problem and who seek to help themselves and each other by sharing information and experiences. Technically, self-help groups are not therapy groups, because typically a professional does not lead them.

Available evidence suggests that self-help groups can be beneficial even when they are delivered by paraprofessionals—people who do have limited professional training, but who have personal experience with the problem.

3.3.7.21 Biological Treatments

General paresis is an example not only of the hope of the biological approach to etiology and treatment but also of the medical model of research.

First, a diagnosis is developed and refined. Second, clues about causes are put together like pieces of a puzzle to form a picture of the specific etiology of the disease. Third, scientists experiment with various treatments for preventing or curing the disorder until they find an effective treatment.

Most mental disorders appear to be caused by many factors. Because of this, scientists often search for biological treatments without knowing a disorder's specific cause. These treatments focus on symptom alleviation, reducing the dysfunctional symptoms of a disorder but not eliminating its root cause.
3.4 MEASURING SUCCESS IN PSYCHOTHERAPY

The client’s gains in therapy generally depend on one or more of the following sources of information:

- A therapist's impression of changes that have occurred.
- A client's report of change.
- Reports from the client's family or friends.
- Comparison of pretreatment and post-treatment scores on personality tests or other instruments designed to measure relevant facets of psychological functioning.
- Measures of change in selected overt behaviors.

3.4.1 Research on Psychotherapy

Psychotherapy outcome research shows that psychotherapy does work—for many people and for many problems.

Psychotherapy process research indicates that most approaches to psychotherapy share many "active ingredients" and these commonalities contribute to making most types of treatment at least somewhat helpful.

Contemporary research demonstrates more and more that different treatments are more effective for helping different disorders.

3.4.2 Does Psychotherapy Work?

Psychotherapy outcome research examines the outcome, or result, of psychotherapy—its effectiveness for relieving symptoms, eliminating disorders, and/or improving life functioning. Hundreds of studies have compared the outcome of psychotherapy with alternative treatments or with no treatment at all.

In order to summarize findings across all of these studies, psychologists have invented a new statistical technique called meta-analysis, a statistical procedure that allows researchers to combine the results from different studies in a standardized way. Meta-analysis indicates that the average benefit produced by psychotherapy is .85 standard deviation units.

The statistic indicates that the average client who receives therapy is better off than 80 percent of untreated persons. A .85 standard deviation change also shows that roughly two-thirds of clients who undergo psychotherapy improve significantly, whereas about one-third of people who receive no treatment improve over time.

Thus, we can conclude that therapy "works," but you should remember a very important qualification: Research shows that many benefits of psychotherapy diminish in the year or two after treatment ends.
3.4.3 Do People Improve without Treatment?

Psychologists widely accept that about two-thirds of clients improve in the short term as a result of psychotherapy.

Some skeptics have suggested, however, that far more than one-third of untreated emotional disorders have a spontaneous remission, that is, the problems may improve without any treatment at all. It is hard to know how many people with psychological problems improve without treatment. Researchers have found that as many as one-half of people seeking psychotherapy improve as a result of simply having unstructured conversations with a professional.

3.4.3.1 The Placebo Effect

Placebos are any type of treatment that contains no known active ingredients for treating the condition being evaluated. The placebo effect, the powerful healing produced by apparently inert treatments, has been demonstrated widely and repeatedly in psychotherapy, dentistry, optometry, cardiovascular disease, cancer treatment, and even surgery.

Experts agree that many of the benefits of physical and psychological treatments are produced by placebo effects, which apparently are caused by the recipient’s belief in a treatment and expectation of improvement. Research shows that the “active ingredients” in placebos include heightened expectations for improvement and classical conditioning owing to past, successful treatment.

3.4.3.2 Placebo Control Groups

The ultimate goal of treatment research is to identify therapies that produce change above and beyond placebo effects. Many investigations in medicine and psychotherapy include placebo control groups in which patients are given treatments that are intentionally designed to have no active ingredients. The double-blind study is a study in which neither the physician nor the patient knows whether the prescribed pill is the real medication or a placebo. Unfortunately, a double-blind study cannot be used in psychotherapy outcome research.

3.4.4 Efficacy and Effectiveness

Tightly controlled experiments provide important information about the efficacy of psychotherapy, that is, whether the treatment can work under prescribed circumstances. However, such studies provide little information about the effectiveness of the treatment—whether the therapy does work in the real world.

The magazine Consumer Reports (1995, November) surveyed nearly 3,000 readers who had seen a mental health professional in the past three years, and the respondents generally rated psychotherapy highly. Of the 426 people who were feeling “very poor” at the beginning of treatment, 87 percent reported feeling “very good,” “good,” or at least “so-so” when they were surveyed.
3.4.5 When Does Psychotherapy Work?

What predicts when treatment is more or less likely to be effective? The most important predictor is the nature of a client’s problems—the diagnosis. If therapy is going to be effective, it usually will be effective rather quickly.

Clients’ background characteristics also predict outcome in psychotherapy. The acronym YAVIS was coined to indicate that clients improve more in psychotherapy when they are “young, attractive, verbal, intelligent, and successful.” This finding has caused considerable concern, for it seems to indicate that psychotherapy works best for the most advantaged members of our society.

Another concern is that men are considerably less likely than women to seek therapy. The masculine role seems to discourage appropriate help seeking.

3.4.6 Psychotherapy Process Research

Psychotherapy process research is an approach that examines what aspects of the therapist–client relationship predict better outcome. A classic study by Sloane and colleagues found that the different paradigms share some surprising similarities.

In this study, 90 patients who had moderate difficulties with anxiety, depression, or similar problems were assigned at random to receive either psychodynamic psychotherapy, behavior therapy, or no treatment. All three groups, including the no-treatment group, improved over time, but the treated groups improved significantly more than the untreated group.

Behavior therapy was more effective in a few instances, but on most measures, there were no differences between the two treatment groups. Much of the effectiveness of different forms of psychotherapy is explained by common factors.

3.4.6.1 Therapy as Social Support

The therapist–client relationship is one essential common factor across different approaches to therapy. Carl Rogers argued that warmth, empathy, and genuineness formed the center of the healing process, and research on psychotherapy process indicates that a therapist’s supportive ness is related to positive outcomes across approaches to treatment.

Objective indicators of a therapist’s support are less potent predictors of successful outcome than are a client’s rating of the therapist. Clients may perceive different therapeutic stances as supportive, depending on the particular types of relationships with which they are most comfortable.
3.4.6.2 Therapy as Social Influence

Psychotherapy is a process of social influence as well as of social support. Jerome Frank, an American trained in psychology and psychiatry, argued that, in fact, psychotherapy is a process of persuasion—persuading clients to make beneficial changes in their emotional lives.

Psychotherapy process research clearly demonstrates the therapist's social influence. Psychotherapy is not value free. There are values inherent in the nature of therapy itself—for example, the belief that talking is good. Moreover, the values of individual therapists about such topics as love, marriage, work, and family necessarily influence clients.

3.4.6.3 Prevention

Community psychology is one approach within clinical psychology that attempts to improve individual well-being by promoting social change.

Primary prevention tries to improve the environment in order to prevent new cases of a mental disorder from developing. Secondary prevention focuses on the early detection of emotional problems in the hope of preventing them from becoming more serious and difficult to treat.

Tertiary prevention may involve any of the treatments discussed in this chapter, because the intervention occurs after the illness has been identified.

In addition to providing treatment, however, tertiary prevention also attempts to address some of the adverse, indirect consequences of mental illness. Many prevention efforts face an insurmountable obstacle: We simply do not know the specific cause of most psychological disorders.

3.4.7 Specific Treatments for Specific Disorders

Contemporary psychotherapy researchers are advancing knowledge by studying factors common to all therapies. The ultimate goal of treatment research, however, is to identify different therapies that have specific active ingredients for treating specific disorders. The identification of effective treatments for specific disorders is necessary if clinical psychology is to fulfill its scientific promise. The challenge for the mental health professional is to approach treatment both as a scientist and as a practitioner.
1. Expressing an uninhibited flow of thoughts and feelings is called ______.

2. Which treatment approach focuses on memories of early relationships with parents and significant others?

3. After a year in analysis, Mark realizes that his therapist reminds him of his older sister, who guided and protected him after his mother’s death. Mark’s reaction is an example of _____________.

4. Recovered memories are ________.

5. People who are susceptible to hypnosis typically have ________.

6. Client-centered therapy is an example of which approach to therapy?

7. Which type of therapist believes their main task is to frustrate their clients, to help clients express strong emotions, and fight out conflicts with authority?

8. Which approach to therapy emphasizes changing unrealistic or irrational thoughts?

9. Interpersonal therapy was originally designed for people suffering from ______.

10. Meta-analysis is a method of ________.

11. Token economies use the principles of ________.

12. Shaping, fading, extinction, and punishment are all procedures used in ________.

13. The use of homework, role-playing, programmed activities, and attempting to identify and modify unrealistic thoughts are techniques of ________.

14. In contrast to flooding, exposure therapy involves ________.

15. Rick has been watching his father fib on his income tax form and has decided to lie to his parents about how much allowance his friends get. Rick’s behavior is an example of ________.

16. What does the family therapist encourage the family to do as part of the therapy?

17. Why are control groups used in therapy outcome studies?

18. Which drug would likely be prescribed for a person diagnosed with bipolar disorder?

19. Which drug is likely to be prescribed to treat anxiety disorders?

20. Marital therapy is viewed as a subtype of ________.
Required Reading


Check your answers

1. free association.
2. psychodynamic.
3. positive transference.
4. repressed memories.
5. heightened suggestibility.
6. humanistic.
7. Gestalt.
8. cognitive.
9. depression.
10. combining the results of many studies.
11. operant conditioning.
12. behavior therapy.
13. cognitive-behavioral therapy.
14. gradual approach to the feared stimulus.
15. live modeling.
16. obtain a balance between being individuals and being a group.
17. to rule out the possibility of alternative explanations of positive outcomes.
18. Lithium.
19. benzodiazepines.
20. family therapy.
Unit 4

Stress and Stress-Related Disorders

LEARNING OUTCOME

At the end of this topic you will able to:

1. Describe the psychological factors in health and illness
2. Describe stress and the stress response
3. Describe the signs of Trauma-Related Stress.
4. Explain the significance of stress factors in health and illness, paying special attention to the role of the immune system.
5. Explain what the general adaptation syndrome means.
6. Explain the connection between psychological factors and physical disorders.
INTRODUCTION

Scientists define stress as any challenging event that requires physiological, cognitive, or behavioral adaptation. Scientists once thought that stress contributed only to a few physical diseases like ulcers, migraine headaches, hypertension (high blood pressure), asthma, and other psychosomatic disorders, a term indicating that a disease is a product of both the psyche (mind) and the soma (body).

Today, the term “psychosomatic disorder” is old-fashioned. Medical scientists now view every physical illness—from colds to cancer to AIDS—as a product of the interaction between the mind and body. Thus, there is no longer a list of “psychosomatic disorders” in the DSM-IV-TR or elsewhere.

Behavioral medicine is a multidisciplinary field that includes both medical and mental health professionals who investigate psychological factors in the symptoms, cause, and treatment of physical illnesses.

Psychologists who specialize in behavioral medicine often are called health psychologists. Learning more adaptive ways of coping, responses aimed at diminishing the burden of stress, can limit the recurrence or improve the course of many physical illnesses.

4.1

PSYCHOLOGICAL FACTORS IN HEALTH AND ILLNESS

4.1.1 What Is Stress?

Stress has typically been used to refer both to adjuvative demands placed on an organism’s internal biological and to the organism’s internal biological and psychological response to such demands.

Stressors are the adjuvative demands and coping strategies are the efforts to deal with stress. Stress can be broken down to eustress (positive stress) and distress (negative stress).
4.1.2 Factors Predisposing a Person to Stress

4.1.2.1 The Nature of the Stressor

Most minor stressors may be dealt with a matter of course; however, stressors that involve important aspects (death, divorce) of a person’s life tend to be highly stressful.

Key stressors in a person’s life center on a continuing, difficult life situation are considered chronic or long lasting. Encountering a number of stressors at the same time also makes a difference.

4.1.2.2 The Experience of Crisis

Crisis is used to refer to times when a stressful situation approaches to refer to times when a stressful situation approaches or exceeds the adaptive capacities of a person or group.

The difference between stress and crisis is that a crisis overwhelms a person’s ability to cope, whereas stress does not necessarily do so. Crisis intervention is providing psychological help in times of severe and special stress.

4.1.2.3 Stress as a Life Event

Researchers often define stress as a life event—a difficult circumstance regardless of the individual’s reaction to it. For example, Holmes and Rahe’s Social Readjustment Rating Scale (SRRS) assigned stress values to life events based on the judgments of a large group of normal adults. The SRRS views stressors that produce more life change units as causing more stress.

Researchers consistently link stress ratings on the SRRS and similar instruments to a variety of physical illnesses. The same stressor does have different meanings for different people. Because of this variability, many experts believe stress must be defined by the combination of an event plus each individual’s reaction to it.

4.1.2.4 A Person’s Perception of the Stressor

Richard Lazarus defined stress by the individual’s appraisal of a challenging life event. The appraisal approach recognizes that the same event is more or less stressful for different people, but runs the risk of being an exercise in circular logic.

Your primary appraisal is your evaluation of the challenge, threat, or harm posed by a particular event. Your secondary appraisal is your assessment of your abilities and resources for coping with that event.
4.1.2.5 The Individual’s Stress Tolerance

The term stress tolerance refers to a person’s ability to withstand stress without becoming seriously impaired. An individual’s prior history of major depression is a risk factor.

Children are particularly vulnerable to severe stressors. Early traumatic experiences can leave a person especially vulnerable to certain stressors.

4.1.2.6 A Lack Of External Resources and Social Supports

Positive social and family relationships can moderate effects of stress on a person. Conversely, lack of external support either personal or material can make a stressor more potent and weaken a person’s capacity to cope with it.

ACTIVITY 4.1

(a) Distinguish among stressors, stress and coping strategies.
(b) How can the nature of the stressor, the individual’s perception of it, his or her stress tolerance, and his or her external resources and supports modify the effects of stress?
4.2 STRESS AND THE STRESS RESPONSE

The renowned American physiologist Walter Cannon, one of the first and foremost stress researchers, recognized the adaptive, evolutionary aspects of stress. Cannon viewed stress as the activation of the fight or flight response.

The fight or flight response has obvious survival value. Cannon observed, however, that fight or flight is a maladaptive reaction to much stress in the modern world such as being reprimanded by your boss or giving a speech before a large audience.

4.2.1 Biological Cost of Stress

When we are stressed our allostatic load will be higher. The general adaptation syndrome finds that the body’s reaction to sustained and excessive stress occurs in three major phases, alarm, resistance, and exhaustion.

The stage of alarm occurs first and involves the mobilization of the body in reaction to threat.

The stage of resistance comes next and is a period of time during which the body is physiologically activated and prepared to respond to the threat.

Exhaustion is the final stage, and it occurs if the body’s resources are depleted by chronic stress. Selye viewed the stage of exhaustion as the key in the development of physical illness from stress. At this stage, the body is damaged by continuous, failed attempts to reactivate the GAS.

Stress may create physical illness in both ways, but a third mechanism may be as important. Because the stress response uses so much energy, the body may not be able to perform many routine functions, such as storing energy or repairing injuries. The result is greater susceptibility to illness.

4.2.2 Stress And The Immune System

Physiologically, the fight or flight response activates your sympathetic nervous system. Your heart and respiration rates increase, blood pressure rises, your pupils dilate, blood sugar levels elevate, and your blood flow is redirected in preparation for muscular activity.

When a perceived threat registers in the cortex, it signals the amygdala, the brain structure primarily responsible for activating the stress response, which in turn secretes corticotropin-releasing factor (CRF).

CRF stimulates the brainstem to activate the sympathetic nervous system. In response to the sympathetic arousal, the adrenal glands release two key hormones.
• One is epinephrine (commonly known as adrenaline), which acts as a neuromodulator, and leads to the release of norepinephrine and epinephrine into the bloodstream. This familiar “rush of adrenaline” further activates the sympathetic nervous system.

• The second key adrenal hormone is cortisol, often called the “stress hormone” because its release is so closely linked with stress. One function of cortisol is “containment” of pathogens in the body.

The release of cortisol and CRF also cause immunosuppression, the decreased production of immune agents. In fact, research in this area has spawned a new field of study, psychoneuroimmunology (PNI), the investigation of the relation between stress and immune function.

PNI research shows that particularly vulnerable to stress are T cells, one of the two major types of lymphocytes, white blood cells that fight off antigens, foreign substances like bacteria that invade the body. Decreased T cell production makes the body more susceptible to infectious diseases during times of stress.

Recent evidence suggests that stress may both inhibit and enhance immune functioning. Short-term stressors and physical threats enhance certain immune responses, particularly aspects of immune functioning that respond quickly, require little energy, and may contain infection due to an injury.

However, stress impairs other aspects of immune function, particularly actions that drain energy from the fight or flight response, and chronic stressors and losses (as opposed to threats) also create immunosuppression.

When repeated over time, your physiological reactions to stress can leave you susceptible to illness.

Cannon hypothesized this occurs because intense or chronic stress overwhelms the body’s homeostasis (a term he coined), the tendency to return to a steady state of normal functioning. He suggested that, over time, the prolonged arousal of the sympathetic nervous system eventually damages the body, because it no longer returns to its normal resting state.

4.2.2.1 Psychological Factors And Immune Functioning

Acquired immune deficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which attacks the immune system and leaves the patient susceptible to infection, neurological complications, and cancers that rarely affect those with normal immune function.

Behavioral factors play a critical role in the transmission of AIDS. Scientists and policymakers have launched large-scale media campaigns to educate the public about HIV and AIDS and to change risky behavior.

Recent evidence has linked increased stress with a more rapid progression of HIV, and the availability of social support is associated with a more gradual onset of symptoms.
There is a strong causal inference concerning the role of stress in reducing immunocompetence. Immunosuppression can be caused by short term threats to our well-being.

4.2.3 COPING WITH STRESS

In reviewing certain general principles of coping with stress, it is helpful to conceptualize three interactional levels:

1. On a biological level, there are immunological defenses and damage repair mechanisms.
2. On a psychological level and interpersonal level, there are learned coping patterns, self-defenses, and support from family friends.
3. On a sociocultural level, there are labor unions, religious organizations and law enforcement agencies.

In coping with stress, a person is confronted with two challenges:

- Meeting the requirements of the stressor
- Protecting self from psychological or physical damage and disorganization.

4.2.3.1 Task-Oriented Coping

Involves making changes in one’s self, one’s surroundings depending on the situation. May be overt or covert.

4.2.3.2 Defense Oriented Coping

There are two common types of defense-oriented responses. The first consist of responses such as crying and mourning that seem to function as psychological damage-repair mechanisms. The second consists of the ego-defense including denial and repression.

Repression is one form of emotion-focused coping that can be maladaptive physically. Psychophysiological reactions to stress also are greater for “defensive deniers” — people who report positive mental health but whom clinicians judge to have emotional problems.

4.2.3.3 Problem-focused coping and Emotion-focused coping

Two general coping strategies are problem-focused and emotion-focused coping.

- Problem-focused coping involves attempts to change a stressor.
- Emotion-focused coping is an attempt to alter internal distress.

Studies of animals and humans show that predictability and control can dramatically reduce stress. Even the illusion of control can help to alleviate stress in humans.
However, the perception of control can increase stress when people believe they can exercise control but fail to do so, or when they lose control over a formerly controllable stressor. In short, control alleviates stress when it can be exercised or even when it is illusory, but failed attempts at control intensify stress.

4.2.3.4 Attitudes and Health

Optimism is a basic key to effective coping. People with an optimistic coping style have a positive attitude toward dealing with stress, even when it cannot be changed, while pessimists are defeated from the outset.

Positive thinking is linked with better health habits and less illness in general, and for those with heart disease, AIDS, and other serious physical illnesses.

For many people, religious and philosophical beliefs are essential to coping with stress. Emerging evidence demonstrates the health value of religious practices; for example, mortality risk is lower among those who attend church services, probably as a result of improved health behavior.

New research also is shattering some misconceptions about religious coping. For example, a recent study of 200 Latinos with arthritis found that greater religious coping predicted improved psychological well-being. Some view religious beliefs as promoting acceptance of one's lot in life, but in this study religious coping predicted active, not passive, coping efforts.

**ACTIVITY 4.1**

(a) What physiological mechanisms are involved in autonomic nervous system arousal?
(b) Describe the relation between stress and the immune system.
(c) How does a person's attitude and outlook on life affect health maintenance and deterioration?
4.3 LIFESTYLE FACTORS IN HEALTH AND ILLNESS

Stress may also cause illness indirectly by disrupting healthy behavior. Health behavior is action that promotes good health, including positive efforts like eating, sleeping, and exercising adequately and avoiding unhealthy activities such as cigarette smoking, excessive alcohol consumption, and drug use.

Stress may also be related to the very important health behavior of following medical advice, something that as many as 95 percent of all patients fail to do fully.

Illness behavior—behaving as if you are sick—also appears to be stress related. Considerable research indicates that increased stress is correlated with such illness behaviors as making more frequent office visits to physicians or allowing chronic pain to interfere with everyday activities.

The fact that many people consult physicians for psychological rather than physical concerns underscores the value of social support in coping with stress. Social support not only can encourage positive health behavior, but research shows that social support can have direct, physiological benefits. Of all potential sources of social support—or conflict—a good marriage may be most critical to physical health.

4.3.1 Cardiovascular Disease

Cardiovascular disease (CVD) is a group of disorders that affect the heart and circulatory system. The most important of these illnesses are hypertension (high blood pressure) and coronary heart disease (CHD). The most deadly and well-known form of coronary heart disease is myocardial infarction (MI), commonly called a heart attack.

Hypertension increases the risk for CHD, as well as for other serious disorders, such as stroke. Cardiovascular disorders are the leading cause of mortality not only in the United States, where they account for over one-third of all deaths, but also in most industrialized countries.

An individual’s risk for developing CVD, and particularly CHD, is associated with a number of health behaviors, including weight, diet, exercise, and cigarette smoking. In addition to health behavior, personality styles, behavior patterns, and forms of emotional expression appear to contribute directly to the development of CVD.
4.3.1.1 Symptoms of Hypertension and CHD

Hypertension is often referred to as the "silent killer" because it produces no obvious symptoms. The measurement of blood pressure includes two readings. Systolic blood pressure is the highest pressure that the blood exerts against the arteries. This occurs when the heart is pumping blood.

Diastolic blood pressure is the lowest amount of pressure that the blood creates against the arteries. This occurs between heartbeats. Generally, a systolic reading above 140 and/or a diastolic reading above 90 when measured while the patient is in a relaxed state define hypertension.

The most notable symptom of CHD is chest pain. Typically, the pain is centralized in the middle of the chest, and it often extends through the left shoulder and down the left arm. In less severe forms of the disorder, the pain is mild, or it may be sharp but brief. The pain of myocardial infarction typically is so intense, however, that it is crippling.

4.3.1.2 Diagnosis of CVD

Myocardial infarction and angina pectoris are the two major forms of coronary heart disease. Angina pectoris involves intermittent chest pains that are usually brought on by some form of exertion. Attacks of angina do not damage the heart, but the chest pain can be a sign of underlying pathology that puts the patient at risk for a myocardial infarction.

MI (heart attack) does involve damage to the heart, and as noted, it often causes sudden cardiac death, which is usually defined as death within 24 hours of a coronary episode. Hypertension can be primary or secondary.

Secondary hypertension results from a known problem such as a diagnosed kidney or endocrine disorder. It is called secondary hypertension because the high blood pressure is secondary to—that is, a consequence of—the principal physical disorder.

Primary or essential hypertension is the major concern of behavioral medicine and health psychology. In the case of essential hypertension, the high blood pressure is the principal disorder. Multiple physical and behavioral risk factors contribute to the elevated blood pressure.

4.3.2 Frequency of CVD

Men are twice as likely to suffer from CHD as are women, and sex differences are even greater with more severe forms of the disorder. For men, risk for CHD increases in a linear fashion with increasing age after 40. For women, risk for CHD accelerates more slowly until they reach menopause and increases sharply afterwards.
Rates of CHD also are higher among low-income groups, a finding that likely accounts for the higher rates of CHD among black than among white Americans. Finally, a positive family history is also linked to an increased risk for CHD, due at least in part to genetic factors.

The risk for CHD is two to three times greater among those who smoke a pack or more of cigarettes a day.

Obesity, a fatty diet, elevated serum cholesterol levels, heavy alcohol consumption, and lack of exercise also increase the risk for CHD. CHD also is associated with psychological characteristics, including depression.

About 30 percent of all U.S. adults suffer from hypertension, and many of the same risk factors that predict CHD also predict high blood pressure, including genetic factors, a high-salt diet, health behavior, and lifestyle factors.

Hypertension is more common in industrialized countries; and in the United States, high blood pressure is found with greater frequency among men, African Americans, low-income groups, and people exposed to high levels of chronic life stress.

### 4.3.3 Causes of CVD

The immediate cause of CHD is the deprivation of oxygen to the heart muscle. No permanent damage is caused by the temporary oxygen deprivation (myocardial ischemia) that accompanies angina pectoris, but part of the heart muscle dies in cases of myocardial infarction.

Oxygen deprivation can be caused by temporarily increased oxygen demands on the heart, for example, as a result of exercise. More problematic is when atherosclerosis causes the gradual deprivation of the flow of blood (and the oxygen it carries) to the heart.

**Atherosclerosis** is the thickening of the coronary artery wall that occurs as a result of the accumulation of blood lipids (fats) with age, and which also may be caused by inflammation resulting from stress.

The most dangerous circumstance is when oxygen deprivation is sudden, as occurs in a coronary occlusion. Coronary occlusions result either from arteries that are completely blocked by fatty deposits or from blood clots that make their way to the heart muscle.

The immediate biological causes of hypertension are less well understood, as are the more distant biological causes of both hypertension and CHD.

A positive family history is a risk factor for both hypertension and CHD, and most experts interpret this as a genetic contribution. However, research using animal models of CVD suggests that heritable risk interacts with environmental risk.

The most important of the known psychological contributions to CVD are the wide variety of health behaviors that (1) have a well-documented association with heart disease; (2) decrease the risk for CVD when they are modified; and (3) often are difficult to change.
Improved health behavior—including avoiding or quitting smoking, maintaining a proper weight, following a low-cholesterol diet, exercising frequently, monitoring blood pressure regularly, and taking antihypertensive medication as prescribed—can reduce the risk of heart disease.

Stress also contributes to CVD, in two different ways. First, stress taxes the cardiovascular system through increased heart rate and blood pressure and can precipitate immediate symptoms or broader episodes of CHD. Second, over the long run, the heart may be damaged by constant stress.

We consider four areas that this can happen: cardiovascular reactivity to stress, actual exposure to life stress, characteristic styles of responding to stress, and depression and anxiety.

Increased blood pressure and heart rate are normal reactions to stress, but researchers have long observed that different people exhibit different cardiovascular reactivity to stress—greater or lesser increases in blood pressure and heart rate—when exposed to stress in the laboratory.

In a study of patients with coronary artery disease, patients who reacted to mental stress in the laboratory with greater myocardial ischemia (oxygen deprivation to the heart) had a higher rate of fatal and nonfatal cardiac events over the next 5 years in comparison to their less reactive counterparts.

In fact, mental stress was a better predictor of subsequent cardiac events than was physical stress (exercise testing). Research shows that exposure to chronic stress increases risk for cardiovascular disease.

Several studies have found a relationship between job strain and CHD. Such strains are not limited to employment, but include work that is performed in other life roles.

Characteristic styles of responding to stress may also increase the risk for CVD, particularly the Type A behavior pattern—a competitive, hostile, urgent, impatient, and achievement-striving style of responding to challenge. Type B individuals, in contrast, are more calm and content. Type D individuals have a tendency to experience negative emotions (insecure and anxious) have higher stress.

The National Blood, Heart, and Lung Institute concluded in 1981 that Type A was a risk factor for CHD, independent of other risks, for example, diet. Many studies conducted since 1980 have failed to support earlier findings. Hostility predicts future heart disease better than other aspects of Type A behavior or the pattern as a whole.

Depression is three times more common among patients with CHD than in the general population, and depression doubles the risk for future cardiac events.

Anxiety seems to be associated with one crucial aspect of CHD: sudden cardiac death. Heart-focused anxiety, preoccupation with heart and chest sensations, is another important concern.

Social factors can influence the risk for CVD in many ways. Friends and family members can encourage a healthy—or an unhealthy—lifestyle.
Interpersonal conflict can create the anger and hostility that can increase the risk for coronary heart disease, whereas a spouse's confidence in coping with heart disease predicts patients' increases survival over 4 years.

Economic resources, being married, and/or having a close confidant all predict a more positive prognosis among patients with coronary artery disease.

Finally, societal values, such as attitudes about health behaviors like smoking and cultural norms about competition in the workplace also can affect the risk for CVD. Recognizing the importance of interpersonal and societal influences, many efforts have been directed toward structuring the social ecology—the interrelations between the individual and the social world—to promote health.

CVD is an excellent example of the value of the systems approach. CVD is caused by a combination of genetic makeup, an occasional structural defect, maintenance in the form of health behavior, and how hard the heart is driven by stress, depression, coping, and societal standards.

4.3.4 Prevention and Treatment of CVD

Several medications known as antihypertensives are effective treatments for reducing high blood pressure. Other drugs, called beta-blockers, reduce the risk of myocardial infarction or sudden coronary death following a cardiac episode.

Numerous public service advertisements attempt to prevent CVD by encouraging people to quit smoking, eat well, exercise, monitor their blood pressure, and otherwise improve their health behavior.

The treatment of essential hypertension is one of the most important attempts at the secondary prevention of CHD. Treatments of hypertension fall into two categories. One focuses on improving health behavior, and the other emphasizes stress management, attempts to teach more effective coping skills.

The major form of stress management used to treat hypertension is behavior therapy, particularly relaxation training and biofeedback. Biofeedback uses laboratory equipment to monitor physiological processes that generally occur outside conscious awareness and to provide the patient with conscious feedback about these processes. Biofeedback tries to teach the person to control the functions of their autonomic nervous system.

Both relaxation training and biofeedback produce reliable, reductions in blood pressure. Unfortunately, the reductions are small, often temporary, and considerably less than those produced by antihypertensive medications.

Overall, stress management appears to improve quality of life but has little effect on disease. Biofeedback is a particularly dubious treatment; one that some well-respected investigators suggest should be abandoned as a treatment for hypertension.

The Trials of Hypertension Prevention (TOHP) is an important ongoing study of whether stress management and health behavior interventions succeed in lowering high blood pressure.
Results from Phase I of the study indicated that only the weight reduction and the salt reduction programs were successful in lowering blood pressure over a follow-up period of up to 11.2 years.

Findings from Phase II of the TOHP underscored the importance of weight loss, as even a modest reduction in weight lowered produced clinically significant reductions in blood pressure.

The Multiple Risk Factor Intervention Trial (MRFIT) is another important investigation, of over 12,000 men at risk for CHD who were assigned at random to intervention and control groups.

Carefully developed intervention programs, including both education and social support, produced improved health behavior, including reduced smoking and lower serum cholesterol. However, the men randomly assigned to the treatment groups did not have a lower incidence of heart disease during the 7 years following intervention.

Tertiary prevention of CHD targets patients who have already had a cardiac event, typically a myocardial infarction. The hope is to reduce the incidence of recurrence of the illness.

Exercise programs are probably the most common treatment recommended for cardiac patients, but evidence of their effectiveness is limited. The most effective programs are individualized for each patient.

Some of the most optimistic evidence on the treatment of CHD comes from studies of interventions designed to alter the Type A behavior pattern, a somewhat surprising circumstance given the controversies about the risk research on Type A.

Some valuable treatments focus on the effects of heart disease on life stress rather than the other way around. The link between stress and physical health clearly is a reciprocal one.

**ACTIVITY 4.3**

(a) What is essential hypertension and what are some factors that contribute to its development?

(b) What are the clinical manifestations of, and potential risk factors for, coronary heart disease (CHD)?
4.4 PSYCHOLOGICAL REACTIONS TO STRESSORS

4.4.1 PSYCHOLOGICAL REACTIONS TO COMMON LIFE STRESSORS

A person's reaction is considered maladaptive if he or she is unable to function as usual or if the person's reaction to the particular stressor is excessive.

In adjustment disorder, the person's maladjustment lessens or disappears when:
- The stressor has subsided
- The individual learns to adapt to the stressor.

4.4.2 PSYCHOLOGICAL REACTIONS TO CATASTROPHIC EVENTS

The DSM-IV-TR provides two major classifications for post-traumatic stress disorder: acute stress disorder and post-traumatic stress disorder. For both of these disorders, the stressor is unusually severe.

Where the disorders differ is in timing and duration of the symptoms. Acute stress occurs within 4 weeks of the traumatic event and lasts for a minimum of 2 days and a maximum of 4 weeks. The latter is for symptoms that last for at least a month.

If the symptoms begin more than 6 months after the reaction is considered acute. If it begins more than 6 months after the tragedy the reaction is considered delayed.

4.4.2.1 Criteria for Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   i. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others.
   ii. The person's response involved intense fear, helplessness or horror.

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
   i. A subjective sense of numbing, detachment, or absence of emotional responsiveness.
   ii. A reduction in awareness of his or her surroundings.
   iii. De-realization
   iv. Depersonalization
   v. Dissociative amnesia (inability to recall an important aspect of the trauma)
C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic events.

D. Marked avoidance of stimuli that arouse recollections of the trauma.

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hyper-vigilance)

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual’s ability to pursue some necessary tasks, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance last for a minimum of 2 days and maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to direct physiological effects of a substance or a general medical condition, is not better accounted for by the Brief Psychotic Disorder, and is not merely and exacerbation of a preexisting Axis I or Axis II disorder.

4.4.2.2 Criteria for Post-Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which: they experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others; and the person’s response involved intense fear, helplessness or horror

B. The traumatic event is persistently re-experienced in one (or more of the following):
   i. Recurrent distressing dreams of the event; acting or feeling as if the traumatic event were recurring.
   iii. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
   iv. Psychological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance stimuli associated with the trauma and numbing of general responsiveness, as indicated by three (or more) of the following:
   i. efforts to avoid thoughts, feelings or conversations associated with the trauma
   ii. efforts to avoid activities, places, or people that arouse recollections of the trauma
   iii. inability to recall an important aspect of the trauma
   iv. markedly diminished interest or participation in significant activities
   v. feelings of detachment or estrangement from others
   vi. restricted range of affect (e.g., unable to have loving feelings)
   vii. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
D. Persistent symptoms of increased arousal (that were not present before the trauma), as indicated by the following:
   i. Difficulty falling or staying asleep
   ii. Irritability or outburst of anger
   iii. Difficulty concentrating
   iv. Exaggerated startle response

E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
- Acute: if duration of symptoms is less than 3 months;
- Chronic: if duration is 3 months or more

Specify if:
- With delayed Onset: if onset symptoms is at least 6 months after the stressor.

4.4.2.3 Prevalence of PTSD in the General Population

Nearly half of the adults in US will experience a traumatic event in their lives but only 10% of women and 5% of men will develop post-traumatic disorder.

Most people who are exposed to plane crashes, automobile accidents, explosions, fires, earthquakes, tornadoes, sexual assaults or other terrifying experiences show psychological shock reactions such as confusion and disorganization.

4.4.2.4 Causal Factors in Post-Traumatic Stress

Personality plays a role in reducing vulnerability to stress when the stressors are severe. The key causal factor seems to be conditioned fear or the fear associated with the traumatic experience.

4.4.2.5 Causal Factors In Combat Stress Problems

To understand traumatic reaction to combat, we need to look at factors such as constitutional predisposition, personal maturity, loyalty to one’s unit, and confidence in one’s officers as well as the actual stress experienced.
4.4.2.6 Prevention And Treatment Of Stress Disorders

Prevention of Stress Disorders

Stress-inoculation training prepares people to tolerate an anticipated threat by changing the things they say to themselves before the crisis.

A three-stage process is employed. In the first stage, information is provided about the stressful situation and about ways people can deal with the danger. In the second stage, self-statements that promote effective adaptation are rehearsed. In the third stage, the person practices making such self-statements while being exposed to a variety of ego threatening or pain threatening stressors.

Treatment For Stress Disorders

- **Short Term Crisis Therapy**
  - Short-term crisis therapy is of brief duration and focuses on the immediate problem.

- **Direct-Exposure Therapy**
  - The client is exposed or reintroduced to stimuli that have come to be feared or to be associated with the traumatic event. This procedure involves repeated or extended exposure either in vivo or imaginal.

- **Telephone Hotlines**
  - There are specific hotlines for those undergoing stress, usually for rape victims and runaways who need help.

- **Psychotropic Medication**
  - Antidepressants are sometimes helpful in alleviating PTSD symptoms of depression, intrusion, and avoidance.

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<tr>
<th>ACTIVITY 4.4</th>
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<tr>
<td>(a) What are the main differences between acute stress disorder and post-traumatic stress disorder?</td>
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<td>(b) What strategies are useful for preventing or reducing maladaptive responses to stress?</td>
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1. Stress is a function of how people appraise situations and how they rate their _____.

2. Composure, experience, and self-confidence are important and necessary components because ______.

3. What technique pairs relaxation training with a hierarchy of anxiety-producing stimuli?

4. What are the two broad types of stress-arousing conditions that might require adjustment?

5. What does research reveal concerning the effects of strong family ties?

6. Approximately 80 to 90 percent of people who experience chest pain attribute the pain to indigestion rather than a heart attack. What type of response to stress does this example represent?

7. A United Nations Peacekeeper witnesses extensive shelling and the abuse of prisoners. When he returns to France, he has difficulty concentrating, has recurring nightmares about the war, and cries easily. What is the most likely diagnosis of the symptoms of his distress?

8. What are the two major types of posttraumatic stress disorder listed in DSM-IV-TR?

9. Which disorders have been found to occur at elevated rates among people who develop posttraumatic stress disorder?

10. Some victims of the effects of PTSD exhibit maladaptive reactions to the trauma that may involve alterations between

11. Under which condition is recovery from posttraumatic stress disorder likely to be most complete?
Required Reading:


Self-check

1. ability to cope.
2. These factors contribute to appraisals of and responses to stressful situations.
3. systematic desensitization
4. developmental transition and situations that arise in life
5. They encourage self-reliance.
6. denial
7. a posttraumatic stress disorder
8. acute and delayed
9. alcohol abuse and depression
10. intrusive thinking and denial.
11. symptoms appear soon after the trauma
Unit 5

Panic, Anxiety, and Their Disorders

LEARNING OUTCOME

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

1. Define anxiety generally and understand its historical connection with the term neurosis.
2. Define, describe, and contrast specific phobia, social phobia, and agoraphobia.
3. Define and describe panic disorder, and explain the differences between panic attacks and other forms of anxiety.
4. Define and describe generalized anxiety disorder.
5. Define and describe obsessive-compulsive disorder.
6. Describe the features of acute and posttraumatic stress disorder.
7. Explain various theoretical perspectives on the anxiety disorders.
8. Explain the various treatment approaches for anxiety disorders.
INTRODUCTION

Taken together, the various forms of anxiety disorders—including phobias, obsessions, compulsions, and extreme worry—represent the most common type of abnormal behavior.

Anxiety disorders share several important similarities with mood disorders. From a descriptive point of view, both categories are defined in terms of negative emotional responses.

Stressful life events seem to play a role in the onset of both depression and anxiety. Cognitive factors are also important in both types of problems. From a biological point of view, certain brain regions and a number of neurotransmitters are involved in the etiology of anxiety disorders as well as mood disorders.

5.1 THE FEAR AND ANXIETY RESPONSE PATTERNS

5.1.1 Fear

Fear is experienced in the face of real, immediate danger. It involves activation of the fight or flight response of the sympathetic nervous system. Fear and panic have three basic components: cognitive/subjective components, ph

5.1.2 Anxiety

In contrast to fear, anxiety involves a more general or diffuse emotional reaction—beyond simple fear—that is out of proportion to threats from the environment. Rather than being directed toward the person’s present circumstances, anxiety is associated with the anticipation of future problems. Anxiety can be adaptive at low levels, because it serves as a signal that the person must prepare for an upcoming event. A pervasively anxious mood is often associated with pessimistic thoughts and feelings. The person’s attention turns inward, focusing on negative emotions and self-evaluation rather than on the organization or rehearsal of adaptive responses that might be useful in coping with negative events.
5.2 OVERVIEW OF THE ANXIETY DISORDERS
AND THEIR COMMONALITIES

Anxiety disorders all have unrealistic, irrational fears or anxieties of disabling intensity. DSM-IV-TR recognizes seven primary anxiety disorders.
- Phobic disorders
- Panic disorder
- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder

People with these varied disorders differ from one another both in terms of relative preponderance of fear/panic versus anxiety symptoms they experience. There are many commonalities across the effective treatments for these different anxiety disorders.

5.3 SOCIOCULTURAL CAUSAL FACTORS FOR ALL ANXIETY DISORDER

People in Western societies often experience anxiety in relation to their work performance, whereas in other societies people may be more concerned with family issues or religious experiences.

Anxiety disorders have been observed in preliterate as well as Westernized cultures. Of course, the same descriptive and diagnostic terms are not used in every culture, but the basic psychological phenomena appear to be similar.
5.4 SPECIFIC PHOBIAS

Phobias are persistent, irrational, narrowly defined fears that are associated with a specific object or situation. A fear is not considered phobic unless the person avoids contact with the source of the fear or experiences intense anxiety in the presence of the stimulus. Phobias are also irrational or unreasonable.

The most straightforward type of phobia involves fear of specific objects or situations. Some people experience marked fear when they are forced to engage in certain activities, such as public speaking, initiating a conversation, eating in restaurants, or using public rest rooms, which might involve being observed or evaluated by other people.

A specific phobia is defined in DSMIV-TR as “a marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation.”

Frequently observed types of specific phobia include fear of heights, small animals, tunnels or bridges, storms, illness and injury, being in a closed place, and being on certain kinds of public transportation.

5.4.1 Criteria for Specific Phobia

A. Marked or persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation.
B. Exposure to phobic stimulus almost invariably provokes an immediate anxiety response or panic attack.
C. Person recognizes that the fear is excessive or unreasonable.
D. Phobic situation avoided or endured with intense anxiety or distress.
E. Symptoms interfere significantly with normal functioning, or there is marked distress about the phobia.
F. Duration of at least 6 months.

5.4.2 Blood-Injection-Injury Phobia

Affected people tend to experience at least as much disgust as fear and also show a unique physiological response when confronted with the sight of blood and injury.

Women are three times as likely as men to experience specific phobias. Animal phobias tend to begin in childhood and claustrophobia and driving phobia tend to begin in adolescence or early adulthood.
5.4.3 Psychosocial Causal Factors

5.4.3.1 Phobias As Learned Behavior
The fear response can be conditioned to previously neutral stimuli when these stimuli are paired with traumatic or painful events. Some of these traumatic conditioning events were simply uncued panic attacks, which are known to effectively conditioned fear.

5.4.3.2 Vicarious Conditioning of Phobic Fears
Simply watching a phobic person behaving fearfully with his or her phobic object can be distressing to the observer and can result in fear being transmitted from one person to another through vicarious or observational classical conditioning.

5.4.3.3 Sources of Individual Differences
Life experiences among individuals strongly affect whether or not conditioned fears or phobias develop. Some of these life experiences may make certain people more vulnerable to phobias and serve as protective factors to others.

5.4.3.4 Evolutionary Preparedness for the Development of Fears and Phobias
Our evolutionary history has affected which stimuli we are most likely to come to fear. Humans seem to be evolutionary prepared to rapidly associate certain objects with frightening or unpleasant events.
This preparedness occurs because over the course of evolution humans who have rapidly acquired fears of certain objects or situations that posed real threats to our early ancestors may have enjoyed a selective advantage.

5.4.3.5 Genetic and Temperamental Causal Factors
Several studies suggest modest genetic contributions to the development of specific phobias. Depending on their temperament or personality, people are more likely to acquire phobias.
5.4.4 Treating Specific Phobias

Exposure therapy involves controlled exposure to the stimuli or situations that elicit phobic fear. Situational exposure is used to treat agoraphobic avoidance. In this procedure, the person repeatedly confronts the situations that have previously been avoided.

Participant modeling is often more effective than modeling alone. Here the therapist calmly models ways of interacting with the phobic stimulus or situation. The clients learn that these situations are not as frightening as they had thought and their anxiety will gradually disappear.

5.5 SOCIAL PHOBIA

The DSM-IV-TR definition of social phobia is almost identical to that for specific phobia, but it includes the additional element of performance. A person with a social phobia is afraid of (and avoids) social situations.

These situations fall into two broad headings: doing something in front of unfamiliar people (performance anxiety) and interpersonal interactions (such as dating and parties). Fear of being humiliated or embarrassed presumably lies at the heart of the person’s discomfort.

5.5.1 Criteria for Social Phobia

A. Marked or persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny of others.
B. Exposure to feared social situations almost invariably provokes anxiety of panic.
C. Person recognizes that the fear is excessive or unreasonable.
D. Feared social or performance situation avoided or endured with great distress or anxiety.
E. Symptoms interfere significantly with person’s normal routine, or occupational or social functioning.
5.5.2 Interaction of Psychosocial and Biological Causal Factors

5.5.2.1 Social Phobias as Learned Behavior
Social phobias seem to originate from simple instances of direct or vicarious classical conditioning such as experiencing or witnessing a perceived social defeat or humiliation or being or witnessing the target of anger or criticism.

People with social phobia may be especially likely to have grown up with parents who were socially isolated and avoidant and who devalued sociability.

5.5.2.2 Social Fears and Phobias in an Evolutionary Context
Social fear and phobias involve fears of members of one’s own species. Dominance hierarchies are established through aggressive encounters between members of a social group and defeated individual typically displays fear and submissive behavior but only rarely attempts to escape the situation completely.

Humans have an evolutionary predisposition to acquire fears of social stimuli that signal dominance and aggression from other humans.

5.5.2.3 Genetic Factors
A family study of social phobia has demonstrated that the generalized form of this disorder (where the person is fearful in most types of social situations) is also familial in nature and etiologically distinct from other types of anxiety disorder. Research results suggest that the nongeneralized form of social phobia is not influenced by genetic factors.

5.5.2.4 Perceptions of Uncontrollability and Unpredictability
Perceptions of uncontrollability and unpredictability often lead to submissive and unassertive behavior. People with social phobia have diminished sense of personal control over their lives.

5.5.2.5 Cognitive Variables
People with social phobias tend to expect that other people will reject or negatively evaluate them. This leads to a sense of vulnerability around people who might pose a threat.
5.5.3 Treating Social Phobias

There are very effective forms of behavior therapy and cognitive-behavioral therapy. Social Phobias can be treated with antidepressants and the SSRIs. Benzodiazepines have been shown to be effective in the treatment of generalized anxiety disorders and social phobias.

5.6 PANIC DISORDER WITH AND WITHOUT AGORAPHOBIA

5.6.1 Panic Disorder

A panic attack is a sudden, overwhelming experience of terror or fright. Whereas anxiety involves a blend of several negative emotions, panic is more focused. Some clinicians think of panic as a normal fear response that is triggered at an inappropriate time.

To meet the diagnostic criteria for panic disorder, a person must experience recurrent, unexpected panic attacks. Panic disorder is divided into two subtypes, depending on the presence or absence of agoraphobia.

Descriptively, panic can be distinguished from anxiety in two other respects: It is more intense, and it has a sudden onset. Panic attacks are defined largely in terms of a list of somatic or physical sensations, ranging from heart palpitations, sweating, and trembling to nausea, dizziness, and chills.

People undergoing a panic attack also report a number of cognitive symptoms. They may feel as though they are about to die, lose control, or go crazy. Some clinicians believe that the misinterpretation of bodily sensations lies at the core of panic disorder.
Panic attacks are further described in terms of the situations in which they occur, as well as the person’s expectations about their occurrence. An attack is said to be expected, or "cued," if it occurs only in the presence of a particular stimulus.

5.6.1.1 Criteria for Panic Attack

A discrete period of intense fear in which four or more of the following symptoms develop abruptly and reach a peak within 10 minutes:

A. Palpitations or pounding heart.
B. Sweating.
C. Trembling or shaking.
D. Sensations of shortness of breath or being smothered.
E. Feeling of choking.
F. Chest pain or discomfort.
G. Nausea or abdominal distress.
H. Feeling dizzy, lightheaded, or faint.
I. Derealization (feeling of unreality) or depersonalization (being detached from oneself).
J. Fear of losing control or going crazy.
K. Fear of dying.
L. Paresthesias (numbness or tingling sensations).
M. Chills or hot flashes.

5.6.1.2 Criteria for Panic Disorder without Agoraphobia

A. Both (1) and (2):
   (1) Recurrent, unexpected panic attacks.
   (2) At least one of the attacks followed by 1 month or more of:
      i. Concern about having another one.
      ii. Worry about consequences of an attack.
B. Absence of agoraphobia.
C. Panic attack not due to physiological effects of a substance or medical condition.
D. Panic attacks not better explained by another mental disorder such as social or specific phobia.

5.6.2 Agoraphobia

The most complex and incapacitating form of phobic disorder is agoraphobia, which literally means "fear of the marketplace (or places of assembly)" and is usually described as fear of public spaces.
DSM-IV-TR defines agoraphobia in terms of anxiety about being in situations from which escape might be either difficult or embarrassing. This approach is based on the view that agoraphobia is typically a complication that follows upon the experience of panic attacks.

People with agoraphobia are frequently afraid that they will experience an "attack" of symptoms that will be either incapacitating or embarrassing, and that help will not be available to them.

5.6.2.1 Criteria for Agoraphobia

A. Anxiety about being in places from which escape might be difficult/embarrassing, or in which help may not be available in the event of a panic attack.
B. Situations are avoided or endured with marked distress or anxiety about having a panic attack.
C. Anxiety or avoidance not better accounted for by another anxiety disorder.

5.6.2.2 Criteria for Panic Disorder with Agoraphobia

A. Both (1) and (2):
   (1) Recurrent, unexpected panic attacks.
   (2) At least one of the attacks followed by 1 month or more of:
       i. Concern about having another one.
       ii. Worry about consequences of an attack.
B. Presence of agoraphobia.
C. Panic attack not due to physiological effects of a substance or medical condition.
D. Panic attacks not better explained by another mental disorder such as social or specific phobia.

5.6.2.3 The Timing of a First Panic Attack

The first one frequently occurs following feelings of distress or some highly stressful life circumstances. Not all people who have a panic attack following a stressful event go on to develop full-blown panic disorder.
5.6.3 Biological Causal Factors

5.6.3.1 Genetic Factors
Family studies indicate that the relatives of people with panic disorder show an elevated risk of panic disorder themselves but not an elevated risk of generalized anxiety disorder.

5.6.3.2 Biochemical Abnormalities
Panic attacks are alarm reactions caused by biochemical dysfunction. People with panic attacks are exposed to a variation of biological challenge procedures. There is a broad range of these so-called panic provocation agents.

The alternative explanations stems from observation that biological challenge procedures put stress on certain neurobiological systems which in turn produce intense physical symptoms (increased heart rate, respiration, and blood pressure).

5.6.3.3 Panic In The brain
Laboratory studies of fear conditioning in animals have identified specific pathways in the brain that are responsible for detecting and organizing a response to danger.

Studies with animals have shown that artificial stimulation of the amygdala can produce different effects, depending in large part on the environmental context in which the animal is stimulated. Anger, disgust, and sexual arousal are all emotional states that are associated with activity in pathways connecting the thalamus, the amygdala, and their projections to other brain areas.

The brain regions that have been identified in studies of fear conditioning seem to play an important role in panic disorder. The locus ceruleus, a small area located in the brain stem, has also been the focus of considerable emphasis in research on panic disorder. Research with monkeys has demonstrated that the firing rate of neurons in the locus ceruleus increases dramatically when a monkey is frightened. Furthermore, electrical stimulation of the locus ceruleus triggers a strong fear response that resembles a panic attack.

ACTIVITY 5.2
(a) Describe the major diagnostic features of both panic disorder and agoraphobia and explain how they are thought to be related.
(b) Compare and contrast the learning theory and cognitive models of panic disorder.
5.6.4 Behavioral and Cognitive Causal Factors

5.6.4.1 Comprehensive Learning Theory of Panic Disorders
According to this theory, initial panic attacks become associated with initially neutral internal (interoceptive) and external cues through a conditioning process. Typical interoceptive cues might be palpitations. This theory also underscores why not everyone who experiences an occasional panic attack goes on to develop a panic disorder. Instead people with certain genetic, temperamental or cognitive-behavioral vulnerabilities will show stronger conditioning of both anxiety and panic attacks.

5.6.4.2 The Cognitive Theory of Panic
An earlier cognitive theory of panic proposed that panic clients are hypersensitive to their bodily sensations and are very prone to giving them the direst possible interpretation. Very frightening thoughts may cause more physical symptoms of anxiety leading to a panic attack.

5.6.4.3 Anxiety Sensitivity and Perceived Control
Several researches have shown that people who have high levels of anxiety sensitivity are more prone to developing panic attacks and perhaps panic disorder. Anxiety sensitivity is a trait-like belief that certain bodily symptoms may have harmful consequences.

Several important studies have shown that simply having a sense of perceived control reduces anxiety and even blocks panic. If a person with panic disorder has a safe person with her or him when s/he undergoes panic provocation procedure, s/he is likely to show reduced distress, lowered physiological arousal, and reduced likelihood of panic relative to people who came alone.

5.6.4.4 Safety Behaviors and the Persistence of Panic
After experiencing hundreds or thousands of panic attacks, one would think, from the cognitive perspective, that this catastrophic thought would have been proven wrong so many times that it finally go away. However, evidence suggests that such disconfirmation does not occur because people with panic disorder frequently engage in safety behaviors before or during an attack. They then mistakenly tend to attribute the lack of the catastrophe to their having engaged in this safety behavior rather than to the idea that panic attacks actually do not lead to heart attacks.
5.6.4.5 Cognitive Biases and the Maintenance of Panic

Many studies have shown that people with panic disorder are biased in the way they process threatening information. Such people not only interpret ambiguous bodily sensations as threatening but also other ambiguous situations as more threatening than do controls.

5.6.5 Treating Panic Disorder and Agoraphobia

5.6.5.1 Medication

Many people with panic disorder are prescribed minor tranquilizers from the benzodiazepine category such as alprazolam (Xanax) or clonazepam. These people frequently show some symptom relief many can function more effectively.

Many patients with panic disorder and agoraphobia relapse if they discontinue taking medication.

These drugs reduce many symptoms of anxiety, especially vigilance and subjective somatic sensations, such as increased muscle tension, palpitations, increased perspiration, and gastrointestinal distress. They have relatively less effect on a person's tendency toward worry and rumination.

Common side effects of benzodiazepines include sedation accompanied by mild psychomotor and cognitive impairments. The most serious adverse effect of benzodiazepines is their potential for addiction.

The selective serotonin reuptake inhibitors (SSRIs) have become the preferred form of medication for treating almost all forms of anxiety disorder. Reviews of controlled outcome studies indicate that they are at least as effective as other, more traditional forms of antidepressants in reducing symptoms of various anxiety disorders. They also have fewer unpleasant side effects, they are safer to use, and withdrawal reactions are less prominent when they are discontinued.

5.6.5.2 Behavioral and Cognitive Behavioral Treatments

Cognitive therapy is used extensively in the treatment of anxiety disorders. Therapists help clients identify cognitions that are relevant to their problems; recognize the relation between these thoughts and maladaptive emotional responses (such as prolonged anxiety); examine the evidence that supports or contradicts these beliefs; and teach clients more useful ways of interpreting events in their environment.

In the case of anxiety disorders, cognitive therapy is usually accompanied by additional behavior therapy procedures.
5.7

GENERALIZED ANXIETY DISORDER

Excessive anxiety and worry are the primary symptoms of generalized anxiety disorder (GAD). The person must have trouble controlling these worries, and the worries must lead to significant distress or impairment in occupational or social functioning.

In order to distinguish GAD from other forms of anxiety disorder, DSM-IV-TR notes that the person’s worries should not be focused on having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), or being contaminated (as in obsessive-compulsive disorder).

5.7.1 Criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry occurring more days than not for at least 6 months about a number of events or activities.
B. Person finds it difficult to control worry.
C. Anxiety and worry associated with 3 or more of the following 6 symptoms for more days than not:
   • Restlessness or feeling keyed up
   • Being easily fatigued
   • Difficulty concentrating
   • Irritability
   • Muscle tension
   • Sleep disturbance
D. Anxiety and worry not confined to features of another Axis I disorder.
E. Symptoms cause clinically significant distress or impairment in functioning.

5.7.2 Prevalence, Age of Onset and Comorbidity

GAD is twice as common in women as men. Although GAD is quite common, most people with this disorder manage to function in spite of their high level of worry and low perceived well-being.

60 to 80 percent of people with GAD remember having being anxious all their lives. GAD occurs more often in older adults where it is the most common anxiety disorder. GAD often co-occurs with other Axis I disorders, especially panic disorder, phobia and PTSD.
5.7.2 Psychosocial Causal Factors

5.7.2.1 The Psychoanalytic Viewpoint
Generalized anxiety results from an unconscious conflict between ego and id impulses that is not adequately dealt with because the person's defense mechanisms have either broken down or have not developed.

5.7.2.2 The Role of Unpredictable and Uncontrollable Events
Researchers hypothesize that people with GAD may have a history of experiencing many important events in their lives as unpredictable or uncontrollable. There is some evidence that people with GAD may be more likely to have had several other anxiety disorders. Some of their uncertainty may stem from their lack of safety signals in their environment.

5.7.2.3 The Central Role of Worry and Its Positive Functions
When people with GAD worry, their emotional and physiological responses to aversive imagery are actually suppressed. This suppression may serve to reinforce the process of worrying. It ends up insulating the person from fully experiencing or processing the topic that is being worried about.

5.7.2.4 The Negative Consequences of Worry
Worry itself can lead to a greater sense of danger and anxiety. People who worry tend to have more negative thoughts than people who do not. There is now considerable evidence that attempts to control thoughts and worry may paradoxically lead to increased experience of intrusive thoughts and enhanced perception of being unable to control them.

5.7.2.5 Cognitive Biases For Threatening Information
Not only do people with GAD have frequent frightening thoughts, they process threatening information in a biased way. Studies have shown that generally anxious people tend to preferentially allocate their attention to threatening cues when both threat and nonthreat cue are present in the environment. Generally anxious people also have a much stronger tendency to interpret ambiguous information in a threatening way.
5.7.3 Biological Causal Factors

5.7.3.1 Genetic Factors
It does seem that there is a modest heritability, although smaller than for most anxiety disorders. The most recent twin study estimated the heritability of GAD to be about 15 to 20 percent.

5.7.3.2 A Functional Deficiency of GABA
It appears that highly anxious people have a kind of functional deficiency in GABA, which ordinarily plays an important role in the way our brain inhibits anxiety in stressful situations. Researchers have also found that serotonin is also involved in modulating generalized anxiety.

5.7.3.3 The Corticotrophin-Releasing Hormone System and Anxiety
When activated by a perceived threat, CRH stimulates the release of ACTH (adrenocorticotropic hormone) from the pituitary gland, which in turn causes the release of the stress hormone cortisol from the adrenal gland. Cortisol helps the body deal with stress.

5.7.3.4 Neurobiological Differences Between Anxiety and Panic
Fear and panic involve the activation of the fight-or-flight response, and brain areas strongly implicated in these emotional responses are the amygdala and the neurotransmitters serotonin and norepinephrine.

Generalized anxiety is a more diffuse emotional state involving arousal and preparation for impending threat, and the brain areas, neurotransmitters, and hormones most strongly implicated are the limbic system.

5.7.4 Treating Generalized Anxiety Disorder
Most often in such cases, medication such as from the benzodiazepine (anxiolytic) category such as Valium are used. A newer medication called buspirone seems effective and it is neither sedative nor addictive. The disadvantage is that patients do not experience relief from severe anxiety symptoms as quickly with buspirone as they do with benzodiazepines. Several antidepressant medications are also useful in the treatment of GAD.
Cognitive-behavioral therapy (CBT) has also become increasingly effective. It usually involves a combination of behavioral techniques as well as reducing catastrophizing about minor events.

**Activity 5.3**

(a) What are the key characteristics of GAD and what is the typical age of onset?
(b) Compare and contrast the biological and cognitive-behavioral treatments for GAD.

### 5.8 Obsessive-Compulsive Disorder

DSM-IV-TR defines obsessive-compulsive disorder (OCD) in terms of the presence of either obsessions or compulsions. Most people who meet the criteria for this disorder actually exhibit both of these symptoms. The DSM-IV-TR definition requires that the person must attempt to ignore, suppress, or neutralize the unwanted thoughts or impulses.

**Obsessions** are repetitive, unwanted, intrusive cognitive events that may take the form of thoughts or images or impulses. They intrude suddenly into consciousness and lead to an increase in subjective anxiety.

Obsessive thinking can be distinguished from worry in two primary ways:
- Obsessions are usually experienced as coming from “out of the blue,” whereas worries are often triggered by problems in everyday living; and
- The content of obsessions most often involves themes that are perceived as being socially unacceptable or horrific, such as sex, violence, and disease/contamination, whereas the content of worries tends to center around more acceptable, commonplace concerns, such as money and work.

**Compulsions** are repetitive behaviors or mental acts that are used to reduce anxiety. In contrast to the obsessions described by people who are not in treatment, those experienced by clinical patients occur more frequently, last longer, and are associated with higher levels of discomfort than normal obsessions.
Compulsions reduce anxiety, but they do not produce pleasure. Thus some behaviors, such as gambling and drug use, that people describe as being "compulsive" are not considered true compulsions according to this definition. The two most common forms of compulsive behavior are cleaning and checking.

5.8.1 Criteria for Obsessive-Compulsive Disorder

A. Either obsessions of compulsion

Obsessions as defined by (all 4 required)
(1) recurrent and persistent thoughts, impulses or images that are experienced at some time as intrusive and cause marked anxiety
(2) thoughts, impulses, or images are not simply excessive worries about real life problems.
(3) Person attempts to ignore or suppress or neutralize them with some other thought or action.
(4) Person recognizes they are a product of his or her own mind.

Compulsions as defined by (1 and 2)
(1) repetitive behaviors (hand washing, ordering, checking) or mental acts (praying, counting, etc.) the person feels driven to perform in response to an obsession, or according to rigid rules.
(2) Behaviors or mental acts aimed at preventing or reducing distress or preventing some dreaded event situation.

B. At least at some point person recognizes the obsessions or compulsion are excessive or unreasonable.

C. Obsessions or compulsions caused marked distress, are time-consuming (more than an hour a day), or interfere significantly with normal functioning.

5.8.2 Prevalence, Age of Onset and Comorbidity

The average 1-year rate of OCD was 1 percent and the average lifetime prevalence was 1.6 percent. There is little or no gender difference in adults. Although the disorder generally begins in late adolescence or early adulthood, it is not uncommon in children.

Obsessive-compulsive disorder usually co-occurs with other mood and anxiety disorders. Depression, phobia, panic disorder, GAD and PTSD are especially common.
5.8.3 Psychosocial Causal Factors

5.8.3.1 The Behavioral Viewpoint

According to O.H. Mowrer’s two-process theory of avoidance learning, neutral stimuli become associated with frightening thoughts or experiences through classical conditioning and come to elicit anxiety. Once learned, such avoidance responses are extremely resistant to extinction. Moreover, any stressors that raise anxiety levels can lead to compulsive rituals in humans.

5.8.3.2 OCD and Preparedness

The human’s obsession with dirt and contamination and certain other potentially dangerous situations of conflict have evolutionary roots. Displacement activities that many species of animals engage in under situations of conflict resemble compulsive rituals of OCD.

5.8.3.3 The Effects of Attempting to Suppress Obsessive Thoughts

Two studies showed that if thought suppression occurs during a negative mood, a connection is made between the thought and the negative mood. When the negative mood occurred again later, the thought was more easily experience and vice versa. Thought suppression leads to a more general increase in OCD symptoms.

5.8.3.4 Appraisal of Responsibility for Intrusive Thoughts

Thought-action fusion is the inflated sense of responsibility for the harm a person may cause and motivates compulsive behaviors to reduce the likelihood of anything harmful happening.

**ACTIVITY**

(a) Summarize the major symptoms of obsessive-compulsive disorder.

(b) Describe the major treatment approaches for OCD and their relative advantages and disadvantages.
5.8.4 Biological Causal Factor

5.8.4.1 Genetic Influence
A moderate genetic contribution to OCD seems to exist, although it may be a rather nonspecific neurotic predisposition.

5.8.4.2 Abnormalities In Brain Function
The overreaction of the orbital frontal cortex, combined with a dysfunctional interaction among the corpus striatum, the orbital frontal cortex and the thalamus may be the central component of the brain dysfunction of OCD. This in turn prevents people with OCD from showing the normal inhibition of sensations, thoughts and behaviors that would occur if the circuit was functioning properly.

5.8.4.3 The Role Of Serotonin
Current evidence suggests that increased serotonin activity and increased sensitivity of some brain structures to serotonin are involved in OCD symptoms.

5.8.5 Treating Obsessive-Compulsive Disorder

Behavioral treatment that combines exposure and response prevention may be the most effective approach to OCD. This involves having clients repeatedly expose themselves to stimuli of that will provoke their obsession and prevent them from engaging in their compulsive rituals.

Medications that affect the serotonin seem to be the primary class of medication that has good effects on OCD. These medications alter the functioning of the serotonin system such as clomipramine (Anafranil) and fluoxetine (Prozac) appear to reduce the symptoms by 50 to 70 percent. The disadvantage is that relapse rates are generally high once the medication is discontinued.

One third of those who performed neurosurgery respond quite well to it. It is designed to destroy brain tissue in one of the areas implicated
1. Fear differs from anxiety in that fearful people can

2. How long must anxiety and worry last before someone can be diagnosed as having generalized anxiety disorder?

3. Maria describes recurrent, sudden anxiety attacks where she experiences terror and dread. Her sister presents with anxiety but she can identify the cause of the anxiety. Maria has a ______, while her sister would be diagnosed with a ______.

4. Panic disorders differ from generalized anxiety disorders in terms of the

5. Fear of a panic attack is called

6. Research on the effectiveness of imipramine has provided evidence that which two conditions might have different sources?

7. What are involuntary, seemingly inexplicable fears that are out of proportion to reality

8. Fear of heights is also known as:

9. Dennis is terrified of dogs and is claustrophobic. Dennis would have a diagnosis of:

10. The three general categories of phobias in DSM-IV-TR are specific phobias, social phobias, and

11. Why do social phobics avoid contact with other people?

12. Fear of open spaces, traveling, and being in crowds is called

13. In contrast to compulsions, obsessions concern

14. What is the irresistible urge to perform a particular act over and over again?

15. Which anxiety disorder is equally common among men as among women and men in the U.S.?
Required Reading:

Self-check

1. identify the source of their fears.
2. 6 months
3. panic disorder; phobic disorder
4. suddenness of onset.
5. anticipatory anxiety.
6. panic disorder and anticipatory anxiety
7. phobias
8. acrophobia
9. specific phobia
10. agoraphobia.
11. They fear making a mistake and being criticized.
12. agoraphobia.
13. thoughts.
14. compulsion
15. obsessive-compulsive disorder
Unit 6

Mood Disorders and Suicide

LEARNING OUTCOME

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

1. Distinguish between normal and abnormally depressed moods and define the term "mood disorder." Unipolar Disorders.
2. Describe the features of major depressive disorder and dysthymic disorder and distinguish between them.
3. Discuss seasonal affective disorder and postpartum depression.
4. Discuss the prevalence of major depressive disorder, with particular attention to ethnic and gender differences and changes in prevalence rates worldwide.
5. Differentiate between reactive and endogenous depression.
6. Describe the features of bipolar disorder and cyclothymic disorder and distinguish between them.
7. Discuss the relationships between stress and mood disorders.
8. Discuss psychoanalytic, behavioral, cognitive, and biological perspectives on the
9. Discuss integrative models for understanding depression.
10. Discuss the incidence of suicide and theoretical perspectives on its causes.
WHAT ARE MOOD DISORDERS?

- **Emotion** refers to a state of arousal that is defined by subjective states of feeling.
- **Affect** refers to the pattern of observable behaviors, such as facial expression, that are associated with these subjective feelings.
- **Mood** refers to a pervasive and sustained emotional response that, in its extreme form, can color the person's perception of the world.

Two key moods involved in mood disorders are **mania** often characterized by intense and unrealistic feelings of excitement and euphoria and depression, which usually involve feelings of extraordinary sadness and dejection.

**Mood disorders** are defined in terms of **episodes**—discrete periods of time in which the person's behavior are dominated by either a depressed or manic mood.

- **Unipolar mood disorder** is a mood disorder in which the person experiences only episodes of depression.
- **Bipolar mood disorder** is a mood disorder in which the person experiences episodes of mania as well as depression.

Mood disorders can be differentiated by severity (number of dysfunctions experienced and relative degree of impairment in those areas) and duration (chronic, acute or intermittent).

The most common form of mood episode is a major depressive episode; a person must be markedly depressed for most everyday for at least 2 weeks. He or she should also experience three or four other symptoms.

A manic episode shows markedly elevated, euphoric, or expansive mood often interrupted by burst of irritability, this must persist for at least a week before a diagnosis can be made.

In contrast to the cognitive slowness associated with depression, manic patients commonly report that their thoughts are speeded up. Manic patients can also be easily distracted, responding to seemingly random stimuli in a completely uninterpretable and incoherent fashion.

Grandiosity and inflated self-esteem are also characteristic features of mania. Many people experience self-destructive ideas and impulses when they are depressed. Interest in suicide usually develops gradually and may begin with the vague sense that life is not worth living.

The **somatic symptoms** of mood disorders are related to basic physiological or bodily functions. They include fatigue, aches and pains, and serious changes in appetite and sleep patterns. In the midst of a manic episode, a person is likely to experience a drastic reduction in the need for sleep. Some patients complain of frequent headaches and muscular aches and pains.

The term **psychomotor retardation** refers to several features of behavior that may accompany the onset of serious depression.
The most obvious behavioral symptom of depression is slowed movement. Patients may walk and talk as if they are in slow motion. Others become completely immobile and may stop speaking altogether.

Some depressed patients pause for very extended periods, perhaps several minutes, before answering a question. In marked contrast to periods when they are depressed, manic patients are typically gregarious and energetic.

In the syndrome of depression, which is also called clinical depression, a depressed mood is accompanied by several other symptoms, such as
- Fatigue,
- Loss of energy,
- Difficulty in sleeping, and
- Changes in appetite.

Manic symptoms that frequently accompany an elated mood include
- Inflated self-esteem,
- Decreased need for sleep,
- Distractibility,
- Pressure to keep talking, and
- The subjective feeling of thoughts racing through the person's head faster than they can be spoken.

6.1 The Prevalence of Mood Disorders

Lifetime prevalence of unipolar major depressive disorder is nearly 17 percent. Rates for unipolar depression is much higher among women than men. Bipolar disorder is much less common with a lifetime prevalence of 0.4 to 1.6 percent and there is no discernable difference in prevalence rates among the sexes.

Women are two or three times more vulnerable to depression than men are. The increased prevalence of depression among women is apparently limited to unipolar disorders. Possible explanations for this gender difference have focused on a variety of factors, including sex hormones, stressful life events, and childhood adversity as well as response styles that are associated with gender roles.

Comparisons of emotional expression and emotional disorder across cultural boundaries encounter a number of methodological problems. One problem involves vocabulary.

Cross-cultural differences have been confirmed by a number of research projects that have examined cultural variations in symptoms among depressed patients in different countries.

These studies report comparable overall frequencies of mood disorders in various parts of the world, but the specific type of symptom expressed by the patients varies from one culture to the next.
In Chinese patients, depression is more likely to be described in terms of somatic symptoms, such as sleeping problems, headaches, and loss of energy. Depressed patients in Europe and North America are more likely to express feelings of guilt and suicidal ideas.

These cross-cultural comparisons suggest that, at its most basic level, clinical depression is a universal phenomenon that is not limited to Western or urban societies.

They also indicate that a person’s cultural experiences, including linguistic, educational, and social factors, may play an important role in shaping the manner in which he or she expresses and copes with the anguish of depression.

Data from the ECA project suggest that mood disorders are most frequent among young and middle-aged adults.

Prevalence rates for major depressive disorder and dysthymia were significantly lower for people over the age of 65. The frequency of bipolar disorders was also low in the oldest age groups. The frequency of depression is much higher among certain subgroups of elderly people.

The prevalence of depression is particularly high among those who are about to enter residential care facilities. Elderly people in nursing homes are more likely to be depressed in comparison to a random sample of elderly people living in the community.

6.2

UNIPOLAR MOOD DISORDERS

6.2.1 Depressions That Are Not Mood Disorders

6.2.1.1 Loss and The Grieving Process

Grief often has certain qualities; there are usually four phases of normal response to the loss of a spouse or close family member:

1. Numbing disbelief that may last for a few hours to a week and may be interrupted by outburst of intense distress, panic and anger.
2. Yearning and searching for the dead, may last for weeks or months.
3. Disorganization and despair that set in after yearning and searching diminish.
4. Some level of reorganization when people gradually begin to rebuild their lives.
6.2.1.2 Postpartum “Blues”

Postpartum depression sometimes occurs in new mothers (and occasionally fathers) after the birth of a child. The symptoms often include emotional liability, crying easily, and irritability often intermixed with happy feelings. Such symptoms occur in as many as 30 to 70 percent of women within 10 days of birth and usually subside on their own.

6.2.1.3 Important Considerations in Distinguishing Clinical Depression from Normal Sadness

1. The mood change is pervasive across situations and persistent over time.
2. The mood change may occur in the absence of any precipitating events, or it may be completely out of proportion to the person’s circumstances.
3. The depressed mood is accompanied by impaired ability to function in usual social and occupational roles.
4. A cluster of additional signs and symptoms, including cognitive, somatic, and behavioral features accompanies the change in mood.
5. The nature or quality of the mood change may be different from that associated with normal sadness.

6.2.2 Dysthymic Disorder

Dysthymia differs from major depression in terms of both severity and duration. In order to fulfill DSM-IV-TR criteria for this disorder, the person must, over a period of at least 2 years, exhibit a depressed mood for most of the day on more days than not.

If at any time during the initial 2 years the person met criteria for a major depressive episode, the diagnosis would be major depression rather than dysthymia.

6.2.2.1 Criteria for Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, for at least two years (1 year for children and adolescents).

B. Two or more of the following symptoms must also be present for a diagnosis of dysthymia:
   a. Poor appetite or overeating
   b. Insomnia or hypersomnia
   c. Low energy or fatigue
   d. Low self-esteem
   e. Poor concentration or difficulty making decisions
   f. Feelings of hopelessness
C. During the 2-year period of the disturbance, the person has never been without a symptoms in Criteria A or B for 2 months at a time.

D. No Major Depressive Disorder has been present during the first 2 years of the disturbance.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met Cyclothymic Disorder.

F. The symptoms cause clinically significant distress or impairment in functioning.

6.2.3 Major Depressive Disorder

In order to meet the criteria for major depressive disorder, a person must experience at least one major depressive episode (initial or single, or recurrent) in the absence of any history of manic episodes.

An affected person must experience markedly depressed moods or marked loss of interest in pleasurable activities most of every day, nearly every day for at least 2 consecutive weeks. The person must experience at least three or four additional symptoms during the same period. These symptoms include:

- Cognitive symptoms (worthlessness, guilt, thoughts of suicide)
- Behavioral symptoms (fatigue, physical agitation)
- Physical symptoms (changes in appetite and sleep pattern)

As in the case of major depressive disorder, the presence of a manic episode would rule out a diagnosis of dysthymia.

The distinction between major depressive disorder and dysthymia is somewhat artificial because both sets of symptoms are frequently seen in the same person. In such cases, rather than thinking of them as separate disorders, it is more appropriate to consider them as two aspects of the same disorder, which waxes and wanes over time.

6.2.3.1 Specifiers For Major Depression

Additional patterns of symptoms or features are called specifiers. One such specifier is major depressive episode with melancholic features, it is applied when in addition to criteria for major depression, and a patient has lost interest or pleasure in almost all activities. The patient must experience at least three of the following:

A. Early morning awakenings
B. Depression being worse in the morning
C. Marked psychomotor retardation or agitation
D. Significant loss of appetite and weight
E. Inappropriate or excessive guilt
F. Depressed mood that is different from sadness
Severe major depressive episode with psychotic features are marked by loss of contact with reality and delusions or hallucinations, may be accompanied by other symptoms of major depression.

Major depressive episode with atypical features include pattern symptoms characterized by mood reactivity. In addition the patient must show two or more of the following:

A. Significant weight gain or increase in appetite
B. Hypersomnia
C. Leaden-paralysis
D. Long-standing pattern of being acutely sensitive to interpersonal rejection

Double depression is major depression coexisting with dysthymia. People with double depression are depressed on a chronic basis but undergo increased problems from time to time.

Most unipolar patients will have at least two depressive episodes. The mean number of lifetime episodes is five or six. When a person’s symptoms are diminished or improved, the disorder is considered to be in remission, or a period of recovery.

6.2.3.2 Depression as a Recurrent Disorder
Depressive episodes are usually time-limited; the average duration of an untreated episode is about 6 months. If a case of major depression does not remit for over 2 years, chronic depressive disorder is diagnosed. In recent years, recurrence has been distinguished from relapse, where the latter term refers to the return of symptoms within a fairly short period of time. The proportion of patients who will exhibit a recurrence of major depressive disorder is very high.

6.2.3.3 Seasonal Affective Disorder
According to the DSM-IV-TR, the person must have had at least two episodes of depression of depression in the past 2 years occurring at the same time of the year, and full remission must have occurred in the same year. In addition, the person cannot have any other, nonseasonal depressive episodes in the same 2-year period and most of the person’s lifetime depressive episodes must have been seasonal.
6.2.4 Causal Factors In Unipolar Mood Disorders

6.2.4.1 Biological Causal Factors

**Genetic influences**

Family studies have shown that prevalence of mood disorders is 3 times higher among blood relatives of persons diagnosed with unipolar depression than the population at large. Twin studies suggested that about 31 to 42 percent of variance in liability to major depression is due to genetic influences. Adoption studies show that about seven times more often in biological relatives of the severely depressed adoptees than in the biological relatives of control adoptees.

Serotonin-transporter gene is involved in transmission and reuptake of serotonin. Two different alleles are involved, short allele (s) and the long allele (l). Studies suggest that having ss alleles might predispose depression relative to ll alleles.

**Neurochemical Factors**

A large body of evidence suggests that various medications that are often used to treat severe mood disorders affect concentrations or the activity of neurotransmitters at the synapse.

The monoamine hypothesis suggests that depression was at least due to an absolute or relative depletion of on of these neurotransmitters (norepinephrine, dopamine, serotonin) at important receptors in the brain.

However, some studies have shown exactly the opposite, net increases in norepinephrine activities in depressed patients. Only a minority of patients has lowered serotonin activities.

**Abnormalities of Hormonal Regulatory System**

The majority of attention has been focused on the hypothalamic-pituitary-adrenal (HPA) axis, and in the particular hormone cortisol. Sustained levels of cortisol can result from increased CRH activation, increased secretion of ACTH or failure of feedback mechanisms.

One line of evidence suggest the failure of feedback mechanisms, a potent suppressor of plasma cortisol, dexamethasone, either fails entirely to suppress cortisol or fails to sustain its suppression.

Recent findings show that depressed patients with elevated cortisol also tend to show memory impairments and problems with abstract thinking and complex problem solving. This may be related to findings showing that prolonged elevations in cortisol result in cell death in the hippocampus.

Cushing's syndrome is a disease associated with the adrenal glands that results in abnormally high concentrations of the hormone cortisol in the bloodstream. Approximately half of all patients with Cushing's syndrome are also clinically depressed. After Cushing's
syndrome is corrected, most patients also recover from their depression. This pattern suggests that abnormally high levels of cortisol may lead to the onset of depression.

**Neurophysiological and Neuroanatomical Influences**
Research has shown that damage to the left anterior or prefrontal cortex often leads to depression. A low level of activation in the anterior cingulated cortex has been shown in depressed patients. Prolonged depression usually leads to decreased hippocampal volume, which could be due to cell atrophy or death. The amygdala tends to show increased activation in individuals with depression.

**Sleep and Other Biological Rhythms**
Depressed patients show a variety of sleep problems ranging from early morning awakening, periodic awakening during the night, and difficulty falling asleep. Research using EEG recordings has shown that many depressed patients enter first period of REM after only 60 minutes or less of sleep and also show greater amounts of REM sleep early in the night. The depressed person also gets a lower-than-normal deep sleep.

Research has found some abnormalities in the circadian rhythms of all depressed patients. Two current theories are (1) that the size or magnitude of the circadian rhythms is blunted, or (2) the various circadian rhythms become desynchronized or uncoupled.

A majority of patients become depressed in fall and winter but normalize in the spring and summer. Research on patients with seasonal affective disorder supports the therapeutic use of controlled exposure to light, which may work by reestablishing normal biological rhythms.

**6.2.4.2 Psychosocial Causal Factors**

**Stressful life events as causal factors**
Most of stressful life events involved in precipitating depression involve the loss of loved one, serious threats to important close relationships or to one’s occupation or severe economic or serious health problems. Losses that involve and element of humiliation can be especially potent.

An important distinction has been made between stressful life events that are independent of the persons’ behavior and personality (independent life events) and events that have been at least partially generated by the depressed person’s behavior or personality (dependent life events). Evidence suggests that dependent life events play an even stronger role in the onset of major depression than do independent life events.

Research is complicated by the fact that depressed people have a distinctively negative view of themselves and the world around them.

Research shows that severely stressful life events play a causal role in about 20 to 50 percent of cases. Moreover, depressed people who have experienced a stressful life event tend to
show more severe depressive symptoms. It is estimated that 70 percent of people with first
onset of depression have had a recent major stressful event, whereas about 40 percent with a
recurrent episode have had a recent major life event.

*Mildly stressful events and chronic stress*
Studies have not found minor stressful events to be associated with the onset of clinical
depression. In a number of good studies, chronic stress has been associated with increased
risk for the onset and maintenance of major depression.

*Individual differences in responses to stressors: vulnerability and invulnerability
factors*
Women (and perhaps men) at genetic risk for depression not only experience more stressful
life events, but also are also more sensitive to them. Conversely those at low genetic risk are
more invulnerable to effects of major stressors. Specifically, individuals with two short
alleles are twice as likely to develop depression following stressful life events compare to
those with two long alleles.

Four factors were associated with not becoming depressed:
A. Having an intimate relationship with a spouse or lover
B. Having no more than three children at home
C. Having a job outside the home
D. Having a serious religious commitment

Conversely not having these and having lost a parent by death before the age of 11 were
strongly associated with the onset of depression following a major life event.

6.2.5 Different Types of Vulnerabilities For Unipolar Depression

6.2.5.1 Personality and Cognitive Diathesis
Researchers have concluded that neuroticism is the primary personality variable that serves
as a vulnerability factor for depression. Limited evidence show that high levels of
introversion may serve as a vulnerability factor for depression.

The cognitive diathesis that have been studied generally focus on particular negative
patterns of thinking that make people who are prone to depression more likely to become
depressed once faced with stressful life events.
6.2.5.2 Early Adversity and Parental Loss as a Diathesis

The incidence for depression is three times higher in women who had lost their mothers before the age of 11. A number of studies have shown that early parental loss produces a vulnerability to depression. In cases where the child continues to receive good parental care, and there are not too many disruptions to the child’s environment, a vulnerability to depression is not usually created.

Research has revealed that a range of other adversities in the early environment can also create a long-term vulnerability to depression. Such factors operate by increasing an individual’s sensitivity to stressful life events in adulthood. The long-term effects may be mediated by biological variables and psychological variables.

6.2.5.3 Psychodynamic Theories

Freud noted the important similarity between the symptoms of clinical depression and the symptoms seen in people mourning the loss of a loved one. Freud hypothesized that when a loved one dies, the mourner regresses to the oral stage of development and interjects and incorporates the lost person, feeling all the same feelings toward the self as toward the loss person.

Freud also hypothesized that depression could also occur in response to imagined or symbolic losses. Freud also hypothesized that someone who experienced the loss of a mother or whose parents did not fulfill the infant’s need for nurturance and love develops a vulnerability to depression.

6.2.5.4 Beck’s Cognitive Theory

Beck hypothesized that the cognitive symptoms of depression often precede and cause the affective or mood symptoms rather than vice versa. Beck’s theory has become somewhat more elaborate over the years while retaining its tenets.

First, there are underlying depressogenic schemas or dysfunctional beliefs, which are rigid, extreme and counter productive. Such a belief would predispose the person holding it to develop depression if he or she perceived social rejection.

These depression producing beliefs or schemas are thought to develop during childhood and adolescence as a function of one’s negative experiences with one’s parents and significant others, and are thought to serve as a vulnerability.

Although they might lie dormant for years in absence of dysfunctional stressors, when dysfunctional beliefs are activated by current stressors, they tend to fuel the current thinking pattern, creating a pattern of negative automatic thoughts, thoughts that often occur just below the surface of awareness and involve unpleasant pessimistic predictions.

These pessimistic predictions, tend to center on three themes of what Beck calls the negative cognitive triad:

A. Negative thoughts about self
B. Negative thoughts about one’s experiences and the surrounding world
C. Negative thoughts about one's future

The negative cognitive field also tends to be maintained by a variety of negative cognitive biases or errors. Each of these involves biased processing of negative self-relevant information. Examples are:

- Dichotomous or all-or-none reasoning, which involves a tendency to think in extremes.
- Selective abstraction, which involves a tendency to focus on one negative detail of a situation while ignoring other elements of the situation.
- Arbitrary inference, which involves jumping to a conclusion based on minimal or no evidence.

6.2.5.5 Evaluating Beck's Theory as a Descriptive Theory

Depressed patients of all the subtypes are considerably more negative in their thinking, especially about themselves or issues highly relevant to the self. Depressed persons do think more negatively about themselves, the world around them and their future. Depressed people show better or biased recall of negative information and negative autobiographical memories. In addition, depressed people are more likely to draw negative conclusions that go beyond the information presented in a scenario and to underestimate the positive feedback they received.

6.2.5.6 The Helplessness and Hopelessness Theories of Depression

Martin Seligman first proposed the laboratory phenomenon as learned helplessness. He noted that laboratory dogs that were first exposed to uncontrollable shock later acted in a passive and helpless manner when they were in a situation where they could control the shocks.

The hypothesis states that when animals or humans have no control over aversive events, they may learn that they are helpless, which in turn makes them unmotivated to try to respond in the future.

6.2.5.7 The Reformulated Helplessness Theory

Abramson proposed that when people are exposed to uncontrollable negative events, they ask themselves why, and the kinds of attributions that people make are in turn central to whether or not they become depressed.

Investigators proposed three critical dimensions on which attributions are made:

- Internal/external
- Global/specific
- Stable/unstable

They proposed that a depressogenic or pessimistic attribution for a negative is an internal, stable and global one.

Abramson proposed that people who have a relatively stable and consistent pessimistic attributional style have a vulnerability for depression when face with uncontrollable life events.
6.2.5.8 The Hopelessness Theory of Depression

Abramson proposed that having a pessimistic attributional style in conjunction with one or more negative life events was not sufficient to produce depression unless one first experienced a state of hopelessness.

Hopelessness expectancy was defined by the perception that one had no control over what was going to happen and by absolute certainty that an important bad outcome was going to occur or that a highly desired good outcome was not going to occur.

6.2.6 Interpersonal Effects of Mood Disorders

Interpersonal problem and social-skills deficits may well play a causal role in at least some cases of depression. In addition, depression creates many interpersonal difficulties.

The manner in which a person responds to the onset of a depressed mood seems to influence the duration and the severity of the mood.

Two different response styles have been emphasized in this work. In the ruminative style people respond to feelings of depression by turning their attention inward, contemplating the causes and implications of their sadness. People employing a distracting style work on hobbies, play sports, or otherwise become involved in activities that draw their attention away from symptoms of depression.

A ruminative response style is relatively stable over time and tends to be associated with longer and more severely depressed moods. Furthermore, women are more likely than men to exhibit a ruminative coping style in response to the onset of a depressed mood.

The development of depression must be understood in terms of several stages: vulnerability, onset, and maintenance. Cognitive factors and interpersonal skills play an important role within each stage.

Vulnerability to depression is influenced by experiences during childhood, including events such as being repeatedly neglected or harshly criticized by parents. The onset of depression is most often triggered by life events and circumstances. The stressful life events that precipitate an episode frequently grow out of difficult personal and family relationships.

The impact of these experiences depends on the meanings that people assign to them. Persistent interpersonal and cognitive problems also serve to maintain a depressed mood over an extended period of time and help it escalate to clinical proportions.
6.2.6.1 Lack of Social Support and Social Skills Deficits

Many studies have supported that people who are socially isolated or lack social support are more vulnerable to becoming depressed and that some depressives have social skills deficits.

6.2.6.2 The Effects of Depression on Others

Depressive behavior can elicit negative feelings and rejection in other people including strangers, roommates and spouses. Social rejection may be especially likely if the depressed person engages in excessive reassurance seeking.

6.2.6.3 Marriage and Family Life

A significant proportion of couples experiencing marital distress have at least one partner with clinical depression and there is a high correlation between marital dissatisfaction and depression for both women and men. A person whose depression clears up is likely to relapse if he or she has an unsatisfying marriage.

Parental depression puts children at high risk for many problems especially depression. Many studies have documented the damaging effects of negative interactional patterns between depressed mothers and their children. Young children are given multiple opportunities for observational learning of negative cognitions, depressive behavior, and depressed affect.

ACTIVITY 6.3

(a) Summarize the biological causal factors for unipolar depression, including hereditary, biochemical, neuroendocrine and neurophysiological factors.

(b) What are the major features that differentiate dysthymic and major depressive disorder?
6.3  

BIPOLAR DISORDERS

All three types of bipolar disorders involve manic or hypomanic episodes. The mood disturbance must be severe enough to interfere with occupational or social functioning. A person who has experienced at least one manic episode would be assigned a diagnosis of bipolar I disorder.

Hypomania refers to episodes of increased energy that are not sufficiently severe to qualify as full-blown mania.

A person who has experienced at least one major depressive episode, at least one hypomanic episode, and no full-blown manic episodes would be assigned a diagnosis of bipolar II disorder. The differences between manic and hypomanic episodes involve duration and severity.

The symptoms need to be present for a minimum of only 4 days to meet the threshold for a hypomanic episode (as opposed to 1 week for a manic episode). The mood change in a hypomanic episode must be noticeable to others, but the disturbance must not be severe enough to impair social or occupational functioning or to require hospitalization.

6.3.1 Cyclothymic Disorder

Cyclothymia is considered by DSM-IV-TR to be a less severe version of major bipolar disorder, minus certain extreme symptoms and psychotic features, such as delusions and minus the marked impairment cause by full-blown manic or major depressive disorders.

In order to meet criteria for cyclothymia, the person must experience numerous hypomanic episodes and numerous periods of depression (or loss of interest or pleasure) during a period of 2 years.

There must be no history of major depressive episodes and no clear evidence of a manic episode or mixed episode during the first 2 years of the disturbance. The symptoms also cause clinically significant distress or impairment in functioning.

6.3.2 Bipolar Disorders (I and II)

The first widely accepted the German physician Emil Kraepelin proposed classification system. Kraepelin divided the major forms of mental disorder into two categories: dementia praecox, which we now know as schizophrenia, and manic-depressive psychosis.

He based the distinction on age of onset, clinical symptoms, and the course of the disorder (its progress over time). The manic-depressive category included all depressive syndromes, regardless of whether the patients exhibited manic and depressive episodes or simply
depression. In comparison to dementia praecox, manic-depression typically showed an episodic, recurrent course with a relatively good prognosis.

Onset of bipolar mood disorders usually occurs between the ages of 28 and 33 years, which is younger than the average age of onset for unipolar disorders. The average duration of a manic episode runs between 2 and 3 months. Several studies that have followed bipolar patients over periods of up to 10 years have found that 40 to 50 percent of patients are able to achieve a sustained recovery from the disorder.

Bipolar I disorder is distinguished from major depressive disorder by at least one episode of mania or a mixed episode. A mixed episode is characterized by symptoms of both full-blown manic and major depressive episodes for at least 1 week, whether the symptoms are intermixed or alternate rapid every few days. Moreover, many patients in a manic episode have some symptoms of depressed mood, anxiety, guilt and suicidal thoughts even if these are not severe enough to qualify as a mixed episode.

6.3.2.1 Criteria for Bipolar I disorder:

A. Presence (or history) of one or more Manic or Mixed Episodes
B. Presence (or history) of one or more Major Depressive Episodes (not necessary)
C. The symptoms for criteria A or B are not better accounted for by another disorder
D. The symptoms cause clinically significant distress or impairment in functioning
E. Specify if current or most recent episode is:
   a. Hypomanic
   b. Manic
   c. Mixed
   d. Depressive

DSM-IV-TR identifies a distinct form of bipolar disorder called Bipolar II disorder, in which the person does not experience full-blown manic episodes but has experienced clear-cut hypomanic episodes as well as major depressive episodes. In two thirds of cases, the manic episodes either immediately preceed or follow a depressive episode.

6.3.2.2 Features of Bipolar Disorder

The symptoms of the depressive episodes of bipolar disorder are usually clinically indistinguishable from unipolar major depressive disorder. One recent study has shown that people presenting initially with a major depressive disorder who have a history of creative achievements, professional instability, multiple marriages, and flamboyant behavior may be especially likely to be diagnosed later with Bipolar II disorder.

On average, people with bipolar disorder suffer from more episodes during their lifetimes than do persons with unipolar disorder. As many as 5 to 10 percent of persons with bipolar disorder experience at least four episodes every year, known as rapid cycling.

Overall, the probability of full recovery from bipolar disorder is discouraging. The long-term course of bipolar disorder is even more severe for patients who have comorbid substance abuse or dependence disorders.
6.3.3 Causal Factors In Bipolar Disorder

6.3.3.1 Biological Causal Factors

*Genetic Influences*
There is greater genetic contribution to bipolar disorder than to unipolar disorder. About 8 to 9 percent of the first degree relatives of a person with bipolar illness can be expected to have bipolar disorder relative to 1 percent of the general population.

Family studies begin with the identification of an individual who has been diagnosed as having a mood disorder—the proband. Researchers obtain as much information as possible about the proband’s relatives, through personal interviews, family informants, or mental health records.

The comparison of monozygotic (MZ) and dizygotic (DZ) twin pairs provides a more rigorous test of the possible influence of genetic factors. Several twin studies of mood disorders have reported higher concordance rates among MZ than among DZ twins.

Twin studies also tell us that environmental factors influence the expression of a genetically determined vulnerability to depression.

The results of these analyses are expressed in terms of *heritability*, which can range from 0 percent (meaning that genetic factors are not involved) to 100 percent (meaning that genetic factors alone are responsible for the development of the trait in question). These analyses indicate that genetic factors are particularly influential in bipolar mood disorders, for which the heritability estimate is 80 percent.

*Neurochemical Factors*
According to the monoamine hypothesis, if depression is caused by deficiencies of norepinephrine and/or serotonin, then perhaps excesses of these neurotransmitters cause mania. Evidence shows increased levels of norepinephrine during manic episodes and lowered levels during depressive episodes. However, serotonin activity appears to be low in both depressed and manic phases.

Evidence for the role of dopamine stems from research showing that increased dopaminergic activity may be related to manic symptoms of hyperactivity, grandiosity and euphoria.

*Other Biological Causal Factors*
Some neurohormonal research on bipolar depression has focused on the hypothalamic-pituitary-adrenal axis. Cortisol levels are elevated in bipolar depression. Bipolar depressed patients show evidence of abnormalities on the dexamethasone suppression test (DST). During manic phases, their rate of DST abnormalities has generally been found to be lower.
It has been observed that blood flow to the left prefrontal cortex is reduced during depression and during mania it is reduced in the right frontal and temporal regions. There are deficits in activity in the solateral prefrontal cortex. However, structural imaging studies suggest that certain subcortical structures are enlarged in bipolar disorder. Studies using fMRI also find increased activation in bipolar patients in subcortical brain regions involved in emotional processing such as the amygdala and thalamus.

There is considerable evidence regarding disturbance in biological rhythms such as circadian rhythms in bipolar disorder. During manic episodes, patients tend to sleep very little. During depressive episodes, they tend toward hypersomnia.

6.3.3.2 Psychosocial Causal Factors

Some studies have found that the weeks preceding the onset of a manic episode are marked by an increased frequency of stressful life events. The kinds of events that precede the onset of mania tend to be different from those that lead to depression.

While the latter include primarily negative experiences involving loss and low self-esteem, the former include schedule-disrupting events (such as loss of sleep) as well as goal attainment events. Some patients experience an increase in manic symptoms after they have achieved a significant goal toward which they had been working.

Aversive patterns of emotional expression and communication within the family can also have a negative impact on the adjustment of people with bipolar mood disorders. Bipolar patients who have less social support are more likely to relapse and recover more slowly than patients with higher levels of social support.

Stressful life events can also delay recovery from an episode of depression in bipolar patients. The social environment in which the person is living can influence the course of bipolar mood disorder.

6.3.3.3 Socio-Cultural Factors Affecting Unipolar And Bipolar Disorders

Cross-Cultural Differences in Depressive Symptoms

Although depression occurs in all cultures that have been studied, the form it takes differs widely as does its prevalence.

In some non-Western cultures where rates of depression are relatively low, many of the psychological symptoms of depression are often not present. Several possible reasons for these symptoms stem from Asian beliefs in the unity of mind and body, a lack of expressiveness about emotions and the stigma attached to mental illness.
ACTIVITY 6.2

(a) Describe the symptoms and clinical features of cyclothymia and bipolar disorder.
(b) Summarize the major biological causal factors for bipolar disorder, including hereditary, biochemical and other biological factors.

6.4 TREATMENTS AND OUTCOMES

6.4.1 Pharmacotherapy

The types of medication that are used most frequently in the treatment of unipolar mood disorders fall into four general categories: selective serotonin reuptake inhibitors (SSRIs), tricyclics (TCAs), monoamine oxidase inhibitors (MAO-Is), and "other," more recently developed drugs.

Among patients who respond positively to antidepressant medication, improvement is typically evident within 4 to 6 weeks, and the current episode is often resolved within 12 weeks.

The selective serotonin reuptake inhibitors (SSRIs) were developed in the early 1980s and are now the most frequently used form of antidepressant medication, accounting for more than 80 percent of all prescriptions written for that purpose.

SSRIs were synthesized in the laboratories of pharmaceutical companies on the basis of theoretical speculation regarding the role of serotonin in the etiology of mood disorders. The SSRIs inhibit the reuptake of serotonin into the presynaptic nerve ending and thus promote neurotransmission in serotonin pathways by increasing the amount of serotonin in the synaptic cleft. The most troublesome side effects associated with SSRIs are sexual dysfunction and weight gain.

The tricyclics (TCAs), such as imipramine (Tofranil) and amitriptyline (Elavil), have been in relatively widespread use since the 1950s, but their use has declined since the introduction of the SSRIs because they have more side effects. Common reactions include blurred vision, constipation, drowsiness, and a drop in blood pressure. The TCAs affect brain functions by blocking the uptake of neurotransmitters (especially norepinephrine) from the synapse.

The antidepressant effects of monoamine oxidase inhibitors (MAO-Is), such as phenelzine (Nardil), were discovered at about the same time as those of the tricyclic drugs.
These drugs have not been used as extensively as tricyclics, however, primarily for two reasons. First, patients who use MAO-I and also consume foods containing large amounts of the compound tyramine, such as cheese and chocolate, often develop high blood pressure. Second, some early empirical evaluations of antidepressant medications suggest that MAO-I is not as effective as tricyclics.

More recent studies have shown that MAO inhibitors are indeed useful in the treatment of depressed patients. They can be used safely when the patient avoids foods such as cheese, beer, and red wine.

Considerable time and energy have been devoted to the evaluation of psychological and pharmacological treatments for depression. The bottom line in this lengthy debate—based on extensive reviews of the research literature—is that cognitive therapy and antidepressant medication are both effective forms of treatment for people who suffer from unipolar depression. In actual practice, many experts recommend treatment with a combination of psychotherapy and medication.

In 1949, the Australian psychiatrist John Cade discovered that the salt lithium carbonate was effective in treating bipolar mood disorders. Lithium carbonate is an effective form of treatment in the alleviation of manic episodes, and it remains the first choice for treating bipolar disorders. It is also useful in the treatment of bipolar patients who are experiencing a depressive episode.

Perhaps most importantly, bipolar patients who continue to take lithium between episodes are significantly less likely to experience a relapse. Unfortunately, there are also some limitations associated with the use of lithium.

Many bipolar patients, perhaps 40 percent, do not improve when they take lithium. Compliance with medication is also a frequent problem; at least half the people for whom lithium is prescribed either fail to take it regularly or stop taking it against their psychiatrist’s advice; usually because of negative side effects such as nausea, weight gain, memory problems and impaired coordination.

Often, bipolar patients who do not respond to lithium are prescribed anticonvulsant drugs, particularly carbamazepine (Tegretol) or valproic acid (Depakene). Outcome data suggest that slightly more than 50 percent of bipolar patients respond positively to these drugs. Common side effects include gastrointestinal distress (nausea, vomiting, and diarrhea) and sedation.

### 6.4.2 Alternative Biological Treatments

#### 6.4.2.1 Electroconvulsive Therapy

The procedure known as electroconvulsive therapy (or ECT) has proved beneficial for many patients suffering from unipolar or bipolar mood disorders. ECT is an invasive procedure that should usually be reserved for patients who have been resistant to other forms of intervention, such as medication and cognitive therapy.

Nevertheless, it remains a viable and legitimate alternative for some severely depressed patients, especially those who are so suicidal that they require constant supervision to
prevent them from harming themselves. Rapid cycling bipolar patients and depressed patients with psychotic symptoms may also be more responsive to ECT than to medication.

6.4.2.2 Transcranial Magnetic Stimulation (TMS)
TMS is a noninvasive technique allowing focal stimulation of the brain in the patients who are awake. Brief but intense pulsating magnetic fields that induce electrical activity in certain parts of the cortex are delivered. The procedure is painless and occurs 5 days a week for 2 to 6 weeks.

Studies have shown it to be quite effective, comparable to unilateral ECT and antidepressant medications.

6.4.2.3 Bright Light Therapy
This was originally used in the treatment of seasonal affective disorder, but it has now shown to be effective in nonseasonal depression as well.

6.4.3 Psychotherapy

6.4.3.1 Cognitive-Behavioral and Behavioral Activation Therapy
Cognitive-behavioral therapy (CBT) is a relatively brief form of treatment that focuses on here-and-now problems rather than on the more remote causal issues that psychodynamic psychotherapy often address. They are also taught to identify and correct their biases or distortions in information processing and to uncover and challenge their underlying depressogenic assumptions.

When compared to pharmacotherapy, it is at least as effective when delivered by well-trained cognitive therapist. It also seems to have a special advantage in preventing relapse.

A relatively new and promising treatment for unipolar depression is called behavioral activation treatment. This treatment focuses intensively on getting patients to become more active and engaged with their environment and with their interpersonal relationships.

One study found that moderately to severely depressed patients who received behavioral activation treatment did as well as those on medication and slightly better than those who received cognitive therapy.

Mindfulness-based cognitive therapy is based on findings that people with recurrent depression are likely to have negative thinking patterns activated when they are simply in a depressed mood. This group thinking involves training in mindfulness meditation techniques aimed at developing patients’ awareness of their unwanted thoughts and feelings.
and sensations so they learn to accept them for what they are, thoughts occurring in the moment rather than a reflection of reality.

For those who have had three or more recurrences of depression and have been treated with antidepressants, this form of treatment has been shown to reduce further recurrences.

6.4.3.2 Interpersonal Therapy

Interpersonal Therapy (IPT) focuses on current relationship issues, trying to help the person understand and change maladaptive interaction patterns. Interpersonal therapy can also be useful in long term follow up for individuals with severe recurrent unipolar depression.

A variation on interpersonal therapy, known as “interpersonal and social rhythm therapy” has been developed for use with bipolar patients. It is based on the recognition that a repeated episode of either mania or depression is often precipitated by one of the following factors: stressful life events, disruptions in social rhythms (the times of day in which the person works, sleeps, and so on), and failure to take medication. Therapists help patients learn to lead more orderly lives, especially with regard to sleep-wake cycles, and to resolve interpersonal problems effectively.

6.4.3.3 Family and Marital Therapy

For married people who have unipolar depression and marital discord, marital therapy (focusing on the marital discord rather than on the depressed spouse alone) is as effective as cognitive therapy in reducing unipolar depression for the depressed spouse.

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**Activity 6.3**

(a) Evaluate the effectiveness of antidepressant medications, electroconvulsive therapy and mood stabilizing drugs in the treatment of unipolar and bipolar disorders.

(b) Describe the three major forms of psychotherapy that have been shown to be effective for treating depression.
6.5

SUICIDE

The risk of suicide, taking one’s own life is a significant factor in all types of depression. Depressed people are 50 times more likely to commit suicide than nondepressed people.

6.5.1 Classification of Suicide

The most influential system for classifying suicide was originally proposed in 1897 by Emile Durkheim (1858–1917), a French sociologist who is one of the most important figures in the history of sociology.

In his book *Suicide*, Durkheim (1897/1951) argued that the rate of suicide within a group or society would increase if levels of social integration and regulation are either excessively low or excessively high. Durkheim identified four different types of suicide, which are distinguished by the social circumstances in which the person is living.

- **Egoistic suicide** (diminished integration) occurs when people become relatively detached from society and when they feel that their existence is meaningless. Egoistic suicide is presumably more common among groups such as people who have been divorced and people who are suffering from mental disorders.

- **Altruistic suicide** (excessive integration) occurs when the rules of the social group dictate that the person must sacrifice his or her own life for the sake of others.

- **Anomic suicide** (diminished regulation) occurs following a sudden breakdown in social order or a disruption of the norms that govern people’s behavior. Anomic suicide explains increased suicide rates that occur following an economic or political crisis or among people who are adjusting to the unexpected loss of a social or occupational role.

- **Fatalistic suicide** (excessive regulation) occurs when the circumstances under which a person lives become unbearable. A slave, for example, might choose to commit suicide in order to escape from the horrible nature of his or her existence.

Durkheim’s system for classifying types of suicide has remained influential, but it does have some limitations. For example, it does not explain why one person commits suicide while other members of the same group do not. Another problem with Durkheim’s system is that the different types of suicide overlap and may, in some cases, be difficult to distinguish.
6.4.2 The Clinical Picture and the Causal Pattern

6.4.2.1 Who Attempts and Who Commits Suicide?

Suicide attempts were most common in people between 25 and 44 but it is now people between 18 and 24 who have the highest rates. In the United States, women are about three times as likely to attempt suicide and people who are separated or divorced are three or four times as likely.

Completed suicides are four times more likely in men. The highest rate of completed suicides is in the elderly. People who live alone and people from socially disorganized areas are also at heightened risk. Certain highly creative or successful scientist, health professionals, businesspeople, composers, writers and artist are at higher-than-average risk.

6.4.2.2 Suicide in Children

For children between the ages of 5 and 14 suicide is rare in absolute terms, but nevertheless the 7th leading cause of death in the United States for this age group. Children are at increased risk for suicide if they have lost a parent or been abused. Several forms of psychopathology, depression, antisocial behavior, and high impulsivity, are known to be risk factors for suicide.

6.4.2.3 Suicide in Adolescents and Young Adults

Suicide ranks as the third most common cause of death in the United States for 15 to 24 year olds. Several surveys of high school students estimated the rates of self-reported suicide attempts to be an alarming 10 percent, with about twice considering it. One large survey found that about 10 percent of college students had seriously contemplated suicide in the past year and most of these had some sort of plan.
6.4.2.4 Known Risk Factors For Adolescent Suicide

Studies have shown that mood disorder, conduct disorder and substance abuse are relatively more common in both completers and nonfatal attempters. Among those with two or more of these disorders, the risk for completion increases.

Exposure to suicide through the media, where they are often portrayed in dramatic terms, has also contributed to these increases in suicide. Many college students are vulnerable to suicide. The combined stressors of academic demands, social interaction problems and career choices make impossible for some students to continue making the adjustments their life situations demand.

6.4.2.5 Other Psychosocial Factors Associated With Suicide

Some believe the common denominator for suicide may be either that these events lead to the loss of a sense of meaning in life and/or hopelessness about the future which can both produce a mental state that looks to suicide as a possible way out.

Other symptoms include severe psychic anxiety, panic attacks, severe anhedonia, global insomnia, delusions and alcohol abuse. Schneidman views suicide as an escape from unbearable psychological pain.

People who become suicidal often come from backgrounds in which there was some combination of a good deal of family psychopathology, child maltreatment and/or family instability. These early experiences are in turn associated with the child having low self-esteem, hopelessness, and poor problem solving skills.

6.4.2.6 Biological Causal Factors

There is strong evidence that suicide runs in families and that genetic factors may play a role in the risk for suicide.

Serotonin dysfunction has also been linked to depressive disorders. Difficulty in regulating serotonin systems has been found among people who attempted suicide, and it has also been found among people who have shown other types of violent and aggressive behavior, such as criminals convicted of murder.

6.4.2.7 Sociocultural Factors

Durkheim's data and subsequent research by other investigators have provided support for the notion that social structures do represent one important consideration with regard to suicide.

One study found that religious affiliation is significantly related to suicide rates. Both Catholicism and Islam condemn suicide and suicide in Catholic and Islamic countries are correspondingly low.

Japan is one of the few societies in which suicide has been socially approved under certain circumstances, such as conditions that bring disgrace to an individual or group.
Social policies regulating access to firearms, especially handguns, also have an effect on suicide rates.

6.4.2.8 Communication of Suicidal Intent

One review of many studies conducted revealed that 40 percent of people who have committed suicide communicated their intent in very clear and specific terms and another 30 percent had talked about death or dying. These communications were usually made to several people and occurred a few weeks or months before the suicide.

6.4.3 Suicide Prevention and Intervention

Efforts to avoid the tragic consequences of suicidal behavior can be organized at several levels. One approach would focus on social structures that affect an entire society. Most treatment programs that are concerned with suicidal behavior have been directed toward individual persons and their families.

Treatment of mental disorders, especially depression and schizophrenia, is usually the most important element of intervention with suicidal clients. The use of various types of medication is often an important part of these treatment efforts.

People who appear to be on the brink of committing suicide are often hospitalized, either with their permission or involuntarily. The primary consideration in such cases is safety. In many cases, commitment to a hospital may be the best way to prevent people from harming themselves.

6.4.3.1 Crisis Intervention

Many communities have established crisis centers and telephone hot lines to provide support for people who are distraught and contemplating suicide. The primary problem faced by suicide prevention programs is this: The people who they are trying to serve are, by definition, very difficult to reach.

Here the primary objective is to help these people regain their ability to cope with their immediate problems quickly. Emphasis is usually placed on:
- Maintaining supportive and often highly directive contact with the person over a short period of time
- Helping the person realize that acute distress is impairing his or her ability to assess the situation accurately and to see that there are better ways of dealing with the problem
- Helping the person to see that the present distress and emotional turmoil will not be endless

Psychological interventions with people who are suicidal can take many forms. These include all the standard approaches to psychotherapy, such as cognitive, behavioral, psychoanalytic, and family therapy. These methods address underlying problems that have set the stage for the person’s current problems.
The following recommendations cover special considerations that are particularly important when clients have expressed a serious intent to harm themselves:

- Reduce lethality.
- Negotiate agreements.
- Provide support.
- Replace tunnel vision with a broader perspective.

6.4.3.2 Focus on High-Risk Groups and Other Measures

Many investigators have emphasized the need for broad-based prevention programs aimed at alleviating the life problems of people who are in groups at high risk of suicide.

Required Reading:

SELF TEST

1. Dysthymia, major depressive disorder, cyclothymic disorder, and the bipolar disorders are classified as ________.

2. Which of the following is not a reason why people do not seek treatment for mood disorders?

3. Which disorder occurs at a much higher rate among women than men?

4. People who have experienced one or more episodes of major depression, but no episodes of mania or hypomania, are classified as having ________.

5. One explanation for the higher rates of depression among women is that women experience more stress associated with ________.

6. Which mood disorder has sometimes been considered a personality disorder?

7. Which disorder is most likely to occur with dysthymic disorder?

8. Which psychotic symptom often occurs with severe depression?

9. What is the most likely biological basis for depression?

10. What effect does monoamine oxidase have on serotonin levels?

11. What is the biological effect of the tricyclic antidepressants?

12. In what part of the world are seasonal affective disorders most prevalent?

13. Why is electroconvulsive therapy sometimes used instead of antidepressant medication in the treatment of severe depression?

14. Interpersonal therapy is a variation of what form of therapy?

15. In which disorder is the most severe mania experienced?

16. Elevated mood, psychomotor agitation, and flight of ideas are all characteristic of ________.

17. Which mood disorder has the highest risk of suicide?
Self-check

1. mood disorders.
2. high cost related to treatment
3. major depressive disorder
4. unipolar depression.
5. providing social support.
6. dysthymia
7. major depressive disorder
8. delusions
9. abnormal levels of neurotransmitters in the brain
10. decreases amount of serotonin in the synapse
11. They block reuptake of serotonin.
12. near the poles
13. It works more quickly.
14. psychodynamic
15. bipolar I disorder
16. mania
17. bipolar II disorder
Unit 7

Somatoform and Dissociative Disorders

LEARNING OUTCOME

At the end of this topic, you will learn about:

1. Differentiate between psychophysiological disorders and somatoform disorders.
2. State the criteria for identifying a cluster of symptoms as somatization disorder.
3. Distinguish between conversion disorder and hysteria.
4. Describe the cluster of symptoms in hypochondriasis and the three major characteristics.
5. Suggest several reasons why cognitive-behavioral therapy is effective with body dysmorphic disorders.
6. Differentiate between somatization disorder and dissociative disorders.
**INTRODUCTION**

The somatoform disorders are a group of conditions that involve physical symptoms and complaints suggesting the presence of a medical condition but without any evidence of physical pathology to account for them.

The dissociative disorders are a group of conditions involving disruptions in a person’s normally integrated functions of consciousness, memory, identity or perception. The term dissociation refers to the human mind’s capacity to engage in complex mental activity in channels split from, or independent of mental awareness.

**7.1 SOMATOFORM DISORDERS**

Soma means body and somatoform disorders involve patterns in which individuals complain of bodily defects that suggest the presence of medical problems but for which no organic basis can be found that satisfactorily explains the symptoms. Such individuals are typically preoccupied with their state of health with various presumed disorders or diseases of bodily organs. Affected patients have no control over their symptoms and are not intentionally faking symptoms or attempting to deceive others.

DSM-IV-TR lists five major subcategories of somatoform disorders: (1) hypochondriasis, (2) somatization disorder, (3) pain disorder, (4) conversion disorder, and (5) body dysmorphic disorder.

**7.1.1 Hypochondriasis**

According to DSM-IV-TR, people with hypochondriasis are preoccupied either with fears of contracting a serious disease or with the idea that they actually have such a disease even though they do not.

Hypochondriasis is much more serious than normal and fleeting worries. The preoccupation with fears of disease extends over long periods of time. In addition, in hypochondriasis, a thorough medical evaluation or examination does not alleviate the fear of the disease.

Hypochondriasis may be the most commonly seen somatoform disorder, with prevalence at between 2 to 7 percent. It occurs about equally often in men and women and can start at any age.
7.1.1.1 Criteria for Hypochondriasis:

A. Preoccupation with fears of contracting, or the idea that one has, a serious disease, based on misinterpretation of bodily symptoms.
B. Preoccupation persists despite appropriate medical evaluation and reassurance.
C. Preoccupation causes clinically significant distress or impairment.
D. Duration for at least 6 months.

7.1.1.2 Theoretical Perspectives on Causal Effects

Cognitive behavioral views are the most widely accepted and have as a central tenet that hypochondriasis is a disorder of cognition and perception. It is believed that an individual’s past experiences with illness lead to the development of a set of dysfunctional assumptions about symptoms and diseases that may predispose a person to developing hypochondriasis.

Because of these dysfunctional assumptions, individuals with hypochondriasis seem to focus excessive attention on symptoms; these individuals have an informational bias for illness-related information. They also perceive their symptoms as more dangerous than they really are and judge a particular disease as more dangerous. Once they have misinterpreted a symptom, they tend to look for confirming evidence and to discount they are in good health. They also perceive their probability of being able to cope with the illness as extremely low and see themselves as weak and unable to tolerate physical effort or exercise.

7.1.1.3 Treatment of Hypochondriasis

Studies have shown that cognitive-behavioral treatment is very effective. The cognitive component involves assessing the patient’s belief about illness and modifying misinterpretations of bodily sensations. The behavioral techniques include having patients induce innocuous symptoms by intentionally focusing on parts of their body so they can learn that selective perception of bodily sensations plays a major role in their symptoms. There is evidence that certain antidepressants (especially SSRIs) may be effective in treating hypochondriasis.

7.1.2 Somatization Disorder

Somatization disorder is characterized by a history of multiple somatic complaints in the absence of organic impairments. In order to be diagnosed with somatization disorder, the patient must complain of at least eight physical symptoms and must involve multiple somatic systems.

Patients with somatization disorders sometimes present their symptoms in a histrionic manner—a vague but dramatic, self-centered, and seductive style. Patients also may exhibit la belle indifference (“beautiful indifference”), a flippant lack of concern about the physical symptoms.
7.1.2.1 Criteria for Somatization Disorder:

A. History of many physical complaints before age 30 that occur over several years result in treatment being sought, or significant impairment in functioning.

B. Each of the following criteria must be met at one time during the disturbance:
   (1) Four pain symptoms in different sites or functions.
   (2) Two gastrointestinal symptoms other than pain.
   (3) One sexual symptom/reproductive system symptom.
   (4) One pseudoneurological symptom.

C. Either (1) or (2):
   (1) After appropriate investigation, each of the symptoms under criterion B cannot be fully explained by a medical condition.
   (2) When there is general medical condition, the physical complaints are in excess of what would be expected.

D. Symptoms not intentionally produced or feigned.

7.1.2.2 Demographics, Comorbidity and Course of Illness

Somatization disorder usually begins at adolescence and is believed to be about three times more common among women than among men. The lifetime prevalence of somatization disorder in the United States is only 0.2 percent. In the United States, somatization is more common among lower socioeconomic groups and people with less than a high school education.

Finally, somatization disorder has frequently been linked with antisocial personality disorder, a lifelong pattern of irresponsible behavior that involves habitual violations of social rules. Somatization disorder commonly co-occurs with other disorders including major depression, panic disorder, and generalized anxiety disorder.

7.1.2.3 Causal Factors in Somatization Disorder

There is evidence that it runs in families and that there is a familial linkage between antisocial personality disorder in men and somatization disorder in women. Other contributory causal factors probably include an interaction of personality, cognitive and learning variables.

7.1.2.4 Treatment of Somatization Disorder

Certain types of medical management and cognitive-behavioral treatments may be helpful. A physician will integrate the patient’s care by seeing the patient on regular visits and provide physical exams focused on new complaints. At the same time, the physician avoids unnecessary diagnostic testing and makes minimal use of medications or other therapies.
7.1.3 Pain Disorder

Pain disorder is characterized by the experience of persistent and severe pain in one or more areas of the body. Complaints seem excessive and apparently are motivated at least in part by psychological factors. As with hypochondriasis and somatization disorder, pain disorder can lead to the repeated, unnecessary use of medical treatments.

7.1.3.1 Criteria For Pain Disorder:

A. Pain in one or more sites as primary focus of clinical presentation
B. Pain causes significant distress or impairment in functioning.
C. Psychological factors judged to have an important role in the pain.
D. Symptom or deficit is not intentionally provoked or feigned.

DSM-IV-TR specifies two coded subtypes:
- Pain disorder associated with psychological factors.
- Pain disorder associated with both psychological factors and a general medical condition.

Pain disorder is quite common among patients at pain clinics. It is diagnosed more frequently in women than in men and is frequently comorbid with anxiety and/or mood disorders.

7.1.3.4 Treatment of Somatoform Pain Disorder

Cognitive behavioral techniques have been widely used in the treatment of both physical and psychogenic pain syndromes. These include relaxation training, support and validation that the pain is real, scheduling of daily activities, cognitive restructuring and reinforcement of no-pain behaviors. Antidepressant medication, (especially tricyclic antidepressants) have been shown to reduce pain intensity.

7.1.4 Conversion Disorder

The symptoms of conversion disorder often mimic those found in neurological diseases, and they can be dramatic. “Hysterical” blindness or “hysterical” paralysis are examples of conversion symptoms.

Although conversion disorders often resemble neurological impairments, they sometimes can be distinguished from these disorders because they make no anatomic sense. The term conversion disorder accurately conveys the central assumption of the diagnosis—the idea that psychological conflicts are converted into physical symptoms.

7.1.4.1 Criteria for Conversion Disorder:

A. One or more symptoms affecting voluntary motor or sensory function that suggest a neurological or other medical condition.
B. Psychological factors judged to be associated with the symptoms because conflicts or other stressors preceded them.
C. Symptom or deficit cannot be fully explained by a general medical conditioning.
D. Symptom or deficit causes distress or impairment in functioning.

Freud suggested that most people with conversion disorder showed very little anxiety and fear known as la belle indifference. However, this only occurs in 30 to 50 percent of patients with conversion disorder. Freud used the term conversion hysteria for these disorders because he believed that the symptoms are an expression of repressed sexual energy.

7.1.4.2 Precipitating Circumstances, Escape and Secondary Gains

The primary gain for conversion symptoms is continued escape or avoidance of a stressful situation. Because it is unconscious the symptoms go away only if the stressful situation has been removed or resolved. Secondary gain refers to advantages that the symptom bestowed beyond the primary gain. Generally any external circumstance such as attention from loved ones or financial compensation.

7.1.4.3 Range of Conversion Disorder Symptoms

There are four categories:

A. Sensory Symptoms or Deficits - Usually deficits in the visual (blindness, tunnel vision), auditory (deafness) or sensitivity (anaesthesia) system.
B. Motor Symptoms or Deficits - Conversion paralysis, speech related conversion disturbance (aphonia) or difficulty swallowing.
C. Seizures – Involve pseudoseizures, which resemble epileptic seizures.
D. Mixed presentation form the first three categories.

7.1.4.4 Important Issues in Diagnosing Conversion Disorder

Several criteria are commonly used to distinguish between conversion disorder and true organic disturbances:
- The frequent failure of the dysfunction to conform clearly to the symptoms of the particular disease or disorder simulated.
- The selective nature of the dysfunction.
- Under hypnosis or narcosis the symptoms can usually be removed, shifted or reinduced by of the therapist.

7.1.4.5 Distinguishing Conversion Disorder from Malingering and from Factitious Disorder

The malingering person is intentionally producing or grossly exaggerating physical symptoms and is motivated by external incentives. In factitious disorder, the person intentionally produces psychological or physical symptoms but there are no external incentives.
By contrast persons who are feigning symptoms are inclined to be defensive, evasive and suspicious when asked about them.

### 7.1.4.6 Criteria for Factitious Disorder

- A. Intentional production or feigning of physical or psychological signs or symptoms.
- B. Motivation for the behavior is to assume the sick role
- C. There are no external incentives for the behavior.

In factitious disorder by proxy, the person seeking medical help or consulting a mental health professional falsely reports, or even induces, medical or psychological symptoms in another person who is under his or her care.

A rare, repetitive pattern of factitious disorder is sometimes called Munchausen syndrome, named after Baron Karl Friedrich Hieronymus von Munchausen, an eighteenth-century writer known for his tendency to embellish the details of his life.

### 7.1.4.7 Treatment of Conversion Disorder

Some hospitalized patients with motor conversional symptoms have been successfully treated with a behavioral approach in which specific exercises are prescribed in order to increase movement and then reinforcements are provided when patients show improvement.

### 7.1.5 Body Dysmorphic Disorder

Body dysmorphic disorder is officially classified in DSM-IV-TR as a somatoform disorder because it involves preoccupation with certain aspects with certain aspects of their body. People with BDD are obsessed with some perceived or imagined flaw or flaws in their appearance.

#### 7.1.5.1 Criteria for Body Dysmorphic Disorder:

- A. Preoccupation with an imagined defect in appearance
- B. Preoccupation causes significant distress or impairment.

Most people with BDD have compulsive checking behaviors and avoid usual activities because of fear that other people will be repulsed. Another common feature is that people with BDD frequently seek reassurance from friends and family about their defects.
The preoccupation typically focuses on some facial feature, such as the nose or mouth, and in some cases may lead to repeated visits to a plastic surgeon. Preoccupation with the body part far exceeds normal worries about physical imperfections.

### 7.1.5.2 Prevalence, Gender and Age of Onset

Some leading researchers estimate that it is not a rare disorder, affecting perhaps 1 to 2 percent of the general population, 8 percent of people with depression. The prevalence seems to be approximately equal in men and women. The age of onset is usually adolescence.

People with BDD very commonly have a depressive diagnosis (50 percent) or social phobia or obsessive-compulsive disorder.

### 7.1.5.3 A Biopsychosocial Approach to BDD

It seems likely that there is a partially genetically based personality predisposition that people with BDD may share with people who have OCD and other anxiety disorders. BDD seems to be occurring in a sociocultural context that places great value on attractiveness and beauty.

### 7.1.5.4 Treatment of Body Dysmorphic Disorder

There is some evidence that antidepressant medications from the selective serotonin reuptake inhibitor category often produce moderate improvement in patients with BDD. A form of cognitive-behavioral treatment emphasizing exposure and response prevention has shown to produce a marked improvement in 50 to 80 percent of patients.

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**ACTIVITY 7.1**

(a) What are the primary characteristics of hypochondriasis and how does the cognitive-behavioral viewpoint explain their occurrence?

(b) What are the symptoms of somatization disorder and pain disorder?

(c) What are sources of primary and secondary gains involved in conversion disorder and how is conversion disorder distinguished from malingering and factitious disorder?

(d) What are the primary symptoms of body dysmorphic disorder and how are they related to obsessive-compulsive disorder?
7.2 DISSOCIATIVE DISORDERS

Dissociative disorders are characterized by persistent, maladaptive disruptions in the integration of memory, consciousness, or identity—verge on the unbelievable. The person with a dissociative disorder may be unable to remember many details about the past; he or she may wander far from home and perhaps assume a new identity, or two or more personalities may coexist within the same person.

Contemporary psychologists generally agree that unconscious processes do exist and that they play a role in both normal and abnormal emotion and cognition. Contemporary cognitive scientists continue to debate the importance of unconscious mental events.

Contemporary cognitive scientists insist that hypotheses about unconscious mental processes must be tested in research. In fact, scientists have created new research techniques to study unconscious processes, for example, the distinction between explicit and implicit memory. Explicit memory is the conscious recollection of a past event. Implicit memory is indicated by changes in behavior apparently based on a memory of a prior event but with no conscious remembering of the event.

Like somatoform disorders, dissociative disorders appear mainly to be ways of avoiding anxiety and stress and managing life problems that threaten to overwhelm the person’s usual coping techniques.

7.2.1 Hysteria and the Unconscious

Dissociative disorders once were viewed as expressions of hysteria. In Greek, *hystera* means “uterus,” and the term *hysteria* reflects ancient speculation that these disorders were caused by frustrated sexual desires, particularly the desire to have a baby.

According to the theory, the uterus becomes detached from its normal location and moves about the body, causing a problem in the location where it eventually lodges. Variants of this somewhat sexist view continued throughout Western history, and as late as the nineteenth century many physicians erroneously believed that hysteria occurred only among women.

New speculation about the etiology of hysteria emerged toward the end of the nineteenth century. Jean Charcot, who used hypnosis both to treat and to induce hysteria, was particularly influential.

Janet was a French philosophy professor who conducted psychological experiments on dissociation and who later trained as a physician in Charcot’s clinic. Both Janet and Freud were eager to explain and treat hysteria, and the problem led both of them to develop theories about unconscious mental processes.

Janet saw dissociation as an abnormal process. To Janet, detachment from conscious awareness occurred only as a part of psychopathology.
In contrast, Freud considered dissociation as a normal process, a routine means through which the ego defended itself against unacceptable unconscious thoughts. Freud saw dissociation and repression as similar processes, and, in fact, he often used the two terms interchangeably. Thus Freud viewed dissociative and somatoform disorders to be merely two of many expressions of unconscious conflict.

7.2.2 Depersonalization Disorder

Depersonalization disorder is a less dramatic problem that is characterized by severe and persistent feelings of being detached from oneself. Depersonalization experiences include such sensations as feeling as though you were in a dream or were floating above your body and observing yourself act. In derealization one’s sense of reality of the outside world is temporarily lost.

7.2.2.1 Criteria for Depersonalization Disorder:

A. Persistent or recurrent experiences of feeling detached from one’s mental process or body.
B. During this experience, reality testing remains intact.
C. Causes significant distress or impairment in functioning.

Occasional depersonalization experiences are normal and are reported by about half the population. In depersonalization disorder, however, such experiences are persistent or recurrent, and they cause marked personal distress.

The onset of the disorder commonly follows a new or disturbing event, such as drug use. Unlike other dissociative disorders, depersonalization disorder involves only limited splitting between conscious and unconscious mental processes, and no memory loss occurs. In a study of 30 cases there were elevated levels of comorbid anxiety and mood disorders, as well as avoidant, borderline and obsessive-compulsive disorders. The disorder had an average of onset of 23.

7.2.3 Dissociative Amnesia and Fugue

Retrograde amnesia is the partial or total inability to recall or identify previously acquired information or past experiences. Anterograde amnesia is the partial or total inability to retain new information.

Brain injury or disease can cause amnesia, but psychogenic (psychologically caused) amnesia results from traumatic stress or other emotional distress. Psychogenic amnesia may occur alone or in conjunction with other dissociative experiences. It is widely accepted that fugue and psychogenic amnesia are usually precipitated by trauma, thus providing another link between dissociation and traumatic stress disorders.

Dissociative amnesia involves a sudden inability to recall extensive and important personal information that exceeds normal forgetfulness. Dissociative amnesia typically is characterized by a sudden onset in response to trauma or extreme stress and by an equally sudden recovery of memory.
The most common form of amnesia in dissociative disorders is **selective amnesia**, in which patients do not lose their memory completely but instead are unable to remember only selected personal events and information, often events related to a traumatic experience. Localized amnesia is where a person remembers nothing that happened during a specific period, most commonly the first few hours or days of a traumatic event.

In typical dissociative amnesiac reactions, individuals cannot remember certain aspects of their personal life history or important facts about their identity. Yet basic habit patterns remain intact. When only a particular type of memory is affected, it is referred to as episodic or autobiographical memory. Semantic, procedural and short-term storage seem usually to remain intact.

**Dissociative fugue** is characterized by sudden and unexpected travel away from home, an inability to recall the past, and confusion about identity or the assumption of a new identity.

### 7.2.3.1 Memory and Intellectual Deficits in Dissociative Amnesia and Fugue

These individual’s semantic knowledge seem to be intact. The primary deficit is their compromised episodic or autobiographical memory. However, some cases have suggested that implicit memory is generally intact.

### 7.2.4 Dissociative Identity Disorder (DID)

Dissociative identity disorder (DID), formerly known as multiple personality disorder, is when a patient manifest two or more distinct identities that alternate in some way in taking control of behavior.

#### 7.2.4.1 Criteria for Dissociative Identity Disorder:

A. Presence of two or more distinct identities, each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self.

B. At least two of the identities recurrently take control of the person’s behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

The original personality especially is likely to have amnesia for subsequent personalities, which may or may not be aware of the “alternates.”

In most cases, the one identity that is most frequently encountered and that carries the person’s real name is the host identity. The alter identities may differ in striking ways including gender, ages and general knowledge.

In sum, DID is a condition in which normally integrated aspects of memory, identity and consciousness are no longer integrated. Other symptoms include depression, self-mutilation and frequent suicide attempts.

The disorder usually starts in childhood, although most patients are in their twenties or thirties at time of diagnosis. Approximately three to nine times more women than men are
diagnosed with this disorder. Recent estimates show that about 50 percent now show over ten identities with some claiming as many as a hundred.

7.2.4.2 Causal Factors and Controversies About DID

Is DID real or faked?
The issue of possible factitious or malingering origins of DID has dogged diagnosis of DID for at least a century. One obvious situation in which this issue becomes critical is when it has been used by defendants and their attorneys to escape punishment for crimes.

If DID is not faked, how does it develop: Post traumatic theory or sociocognitive theory?
The original theory of how DID develops is post-traumatic theory. The vast majority of patients with DID (over 95%) report memories of severe and horrific abuse as children. According to this view, DID starts from the child’s overwhelming sense of hopelessness and powerlessness in the face of repeated traumatic abuse. Lacking other resources or routes of escape the child may dissociate and escape into a fantasy becoming someone else. This escape may occur like a self-hypnosis and if it helps alleviate pain, it will be reinforced and occur again in the future. Children who are prone to fantasy and/or those who are easily hypnotizable may have a diathesis for developing DID.

The sociocognitive theory claims that DID develops when a highly suggestible person learns to adopt and enact the roles of multiple identities mostly because clinicians have inadvertently suggested, legitimized and reinforced them and because their personalities are geared towards their personal goals.

Are recovered memories of abuse in did real or false?
One way to document that particular recovered memories are real might be if some reliable physiological test could be developed to distinguish between them. Another way is to have independent verification that the abuse had actually occurred such as through a physician, hospital and police records.

7.2.4 General Sociocultural Causal Factors in Dissociative Disorders

DSM-IV-TR has noted that people who enter trance or possession voluntarily because of cultural norms may develop distress or impairment, in such cases they may be diagnosed with dissociative trance disorder. Trance is said to occur when someone experiences a temporary marked alteration in a state of consciousness or identity. A possession trance is similar except the alteration of consciousness or identity is replaced by a new identity that is attributed to the influence of a spirit deity or power.
Amok is often thought as a rage disorder. Amok occurs when a dissociative episode leads to violent, aggressive or homicidal behavior. It occurs mostly in men and is often precipitated by a perceived slight or insult.

Evidence that DID can be diagnosed in the general population in Turkey, where there is no public awareness of the disorder, leads us to conclude that DID is a real but rare problem.

7.2.5 Treatment and Outcome in Dissociative Disorders

Some think that hypnosis, including training in self-hypnosis techniques may be useful because patients can learn to dissociate and then reassociate thereby gaining some sense of control over their depersonalization and derealization experiences.

In dissociative amnesia and fugue, it is important for the person to be in a safe environment and simply removing him or her from what is perceived as a threatening situation sometimes allows for spontaneous recovery of memory. Hypnosis as well as drugs such as benzodiazepines, barbiturates, sodium pentobarbital and sodium amobarbital often facilitate recall of repressed memories. After memories are recalled, it is important to work through the memories with the therapist so that the experiences can be reframed in new ways.

For DID patients, most current therapeutic approaches are based on the assumption of post-traumatic theory. Most therapists set integration of the previously separate alters, together with their collective merging into the host personality as the ultimate goal of treatment. When successful integration occurs the patient eventually develops a unified personality although it is not uncommon for only partial integration to be achieved.

**Activity 7.2**

(a) Describe the symptoms known as depersonalization and derealization.

(b) Describe dissociative amnesia and dissociative fugue, and indicate which aspects of memory are affected.

(c) What are the primary symptoms of dissociative identity disorder and why is its prevalence thought to have been increasing?
1. Somatization, conversion disorder, pain disorder, and hypochondriasis are all classified by DSM-IV-TR as

2. What are the two categories of pain disorder listed in DSM-IV-TR?

3. Michael is always complaining of aches, pains, and other symptoms. He focuses on slight changes in his heartbeat, is convinced he always has a fever, and frequently sees a physician. What is his most likely diagnosis?

4. How long must a person have the persistent belief that he or she has a serious illness despite medical reassurance in order to meet the criteria for hypochondriasis?

5. Omar’s statement that “I immediately get upset if something is wrong with me”, and he drives to the doctor’s office is associated with:

6. What term is used for repeated, conscious simulation of disease for the sole purpose of assuming the role of a patient?

7. Which disorders are characterized by disruptions of identity, consciousness, and memory?

8. What is the most common pattern of onset and outcome in dissociative disorders?

9. Seth has been diagnosed with dissociative amnesia. He has difficulty remembering events associated with his post-graduate studies. Seth has:

10. Rod is involved in a near-death collision. Afterwards he cannot remember any of the details of the collision. Rod’s condition is known as

11. Joe has lost his sense of identity, wandered to another state and set up a new life, calling himself “Pete”. What is the most likely diagnosis?

12. What is another name for multiple personality disorder?

13. John was recently diagnosed with dissociative amnesia. What therapeutic approach is appropriate?

14. Which treatment approach involves learning new internal dialogues along with new ways of viewing situations and oneself?
Required Reading:

Self-check

1. somatoform disorders.
2. acute and chronic
3. somatization disorder
4. six months
5. hypocondriasis
6. Munchausen syndrome
7. dissociative
8. abrupt onset and abrupt recovery
9. selective amnesia
10. localized amnesia.
11. dissociative fugue
12. dissociative identity disorder
13. supportive therapy
14. cognitive modification
Unit 8

➤ Eating Disorders and Obesity

LEARNING OUTCOME

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

1. Describe the features of anorexia and bulimia and the medical complications associated with each.
2. Explain the etiological similarities and differences between anorexia and bulimia.
3. Describe the features of binge-eating disorder and how it differs from bulimia.
4. Discuss treatments for anorexia, bulimia, and binge-eating disorder.
5. Discuss the prevalence and causes of obesity.
6. Discuss ethnic and socioeconomic differences in obesity.
CLINICAL ASPECTS OF EATING DISORDERS

According to DSM-IV-TR, eating disorders are characterized by a severe disturbance in eating behaviors.

8.1 ANOREXIA NERVOSA

8.1.1 Criteria for Anorexia Nervosa:

A. Refusal to maintain a body weight that is normal for the person’s age and height.
B. Intense fear of gaining weight or becoming fat even though underweight.
C. Distorted perception of body shape and size.
D. Absence of at least three consecutive menstrual periods or diminished sexual appetite and lowered testosterone levels in men.

There are two types of anorexia nervosa, the restrictive type and the binge-eating/purging type. In the restrictive type, every effort is made to limit how much food is eaten and caloric intake is tightly controlled. Patients often try to avoid eating in the presence of people. When they do eat, they eat excessively slowly, cut their food into small pieces and secretly dispose of it.

The binge-eating/purging type differs because they either binge, purge or binge and purge. A binge involves the out-of-control eating of amounts of foods that are far greater than what most people eat in the same amount of time and under the same circumstances. These binges may be followed by efforts to purge, or remove from their body’s food they have eaten. Approximately 30 to 50 percent of patients transition from restricting type to the binge-eating/purging type during the course of their disorder.

The mortality rate for females with anorexia nervosa is more than 12 times higher than the mortality rate for females aged 15 to 24 in the general population. When death occurs it is usually the result of the physiological consequences of starvation or suicidal behavior. This is the contrast between bulimia nervosa where death as a direct outcome of the disorder is rare.
8.2 BULIMIA NERVOSA

Bulimia nervosa is characterized by binge eating and by efforts to prevent weight gain using such inappropriate behaviors as self-induced vomiting, and excessive exercising.

8.1.2 Criteria for Bulimia Nervosa:

A. Recurrent episodes of binge eating. Binges involve eating in a fixed period of time amounts of food that are far greater than anyone might eat under normal circumstances.
B. Recurrent and inappropriate efforts to compensate for the effects of binge eating.
C. Self-evaluation is excessively influenced by weight and body shape.

The difference between a person with bulimia nervosa and a person with binge-eating/purging type of anorexia is weight. By definition a person with anorexia nervosa is severely underweight. This is not true for a person with bulimia nervosa.

DSM-IV-TR distinguishes bulimia nervosa between purging and nonpurging types. The purging type is the most common (80 percent). In the nonpurging type, the person may fast of exercise excessively but not vomit or use diuretics to counteract the effects of binging.

8.1.3 Age of Onset and Gender Differences

Pathological patterns of eating date back several centuries, but did not attract much attention until the 1970s and 1980s. Anorexia nervosa is most likely to develop in 15- to 19-year-olds. Bulimia nervosa is most likely to develop in women aged 20-24. There are 10 females for every male with an eating disorder.

8.1.4 Medical Complications of Anorexia Nervosa and Bulimia Nervosa

Anorexia can lead to death from heart arrhythmias, kidney damage or renal failure. Bulimia can lead to Electrolyte imbalances, Hypokalemia (low potassium) or damage to hands, throat, and teeth from induced vomiting.
8.3 OTHER FORMS OF EATING DISORDERS

The DSM-IV-TR includes the diagnosis eating disorder not otherwise specified (EDNOS). This diagnostic category is for patterns of eating disorder that do not fit the criteria for any of the more specific diagnosis. Binge-eating disorder is similar to bulimia without any form of compensatory behavior.

8.3.1 Prevalence of Eating Disorders

The prevalence of anorexia nervosa at any one time is about 0.3 percent with a lifetime prevalence of 0.5 percent. For bulimia the point of prevalence is around 1 percent and the lifetime prevalence 1 to 3 percent. For binge-eating disorders community-based estimates indicate a prevalence of 2 to 3 percent in general population and 8 percent for obese people.

8.3.2 Eating Disorders Across Cultures

Eating disorders are becoming a problem worldwide. The attitudes that lead to eating disorders are more common in Whites and Asians than African Americans.

8.3.2 Course and Outcomes

Löwe and colleagues (2001) looked at the clinical outcomes of patients with anorexia nervosa 21 years after they had first sought treatment. Reflecting the high morbidity rate associated with anorexia nervosa, 16 percent of the patients were no longer alive, 10 percent were still anorexic and a further 21 percent had partially recovered. However 51 percent were fully recovered at the time of the follow up.

With regard to bulimia nervosa, the long-term mortality rate is lower, at around 0.5 percent. A study shows that about 70 percent of bulimic women were in remission and no longer met diagnostic criteria for any eating disorder. The remaining 30 percent continued to have problems with their eating.

**Activity 8.1**

(a) What are the major clinical differences between patients with anorexia nervosa and patients with bulimia nervosa?

(b) What kinds of medical problems do patients with eating disorders suffer from?
RISK AND CAUSAL FACTORS IN EATING DISORDERS

8.4 BIOLOGICAL FACTORS

8.4.1 Genetics

The tendency to develop an eating disorder runs in families. Whether this is due to genetic influence has yet to be determined. In one large family study, the risk of anorexia nervosa was 11.4 times greater than for the relatives of the healthy controls. The risk for bulimia nervosa was 3.7 times greater.

There is also evidence for a gene on chromosome 1 that may be linked to susceptibility to the restrictive type of anorexia nervosa. Recent evidence suggested that susceptibility to bulimia nervosa might be linked to chromosome 10. Eating disorders have also been linked to genes that are involved in the regulation of neurotransmitter serotonin.

8.4.2 Set Points

Set-point theory (the idea that our bodies resist marked variation) may play a role. As we lose more weight, hunger may rise to extreme levels, encouraging eating, weight gain, and a return to the state of equilibrium. For patients with bulimia, these hunger driven impulses may lead to uncontrollable binge eating.

8.4.3 Serotonin

Serotonin is a neurotransmitter that has been implicated in obsessiveness, mood disorders, and impulsivity. It also modulates appetite and feeding behavior. People with anorexia nervosa who are underweight have low levels of 5-HIAA, which is a major metabolite of serotonin. The same is true for bulimics.
8.5

SOCIOCULTURAL FACTORS

8.5.1 Peer and Media Influences

Sociocultural influences such as fashion magazines idealize extreme thinness. Women often internalize the thin ideal. Social pressures toward thinness may be particularly powerful in higher-SES backgrounds from where a majority of girls and women with anorexia nervosa appear to come.

8.5.2 Family Influences

Families of anorexics are described as showing the following characteristics:
- Limited tolerance of disharmonious affect or psychological tension
- An emphasis on propriety and rule-mindedness
- Parental overdirection of the child or subtle discouragement of autonomous strives
- Poor skills in conflict resolution
- Preoccupations regarding the desirability of thinness, dieting, and good physical appearance

8.5.3 Individual Risk Factors

8.5.3.1 Internalizing The Thin Ideal

The extent to which people internalize the thin ideal is associated with a range of problems that are thought to be risk factors for eating disorders. These include body dissatisfaction, dieting, and negative affect.

8.5.3.2 Body Dissatisfaction

Body dissatisfaction is associated with dieting and negative affect. Simply put, if we don’t like how we look we are likely to feel bad about ourselves. We may also try to lose weight to look better.

8.5.3.4 Dieting

Some researchers regard dieting as a risk factor for the development of anorexia nervosa and bulimia nervosa in young women. The people who self-report that they often diet or try to restrain their eating may be people who are dissatisfied with their bodies. There is a
difference between a supervised diet that is monitored by therapist and going on a self-started diet that might be characterized between periods of fasting and overeating.

8.5.3.5 Negative Affect

Negative affect is a causal risk factor for body dissatisfaction. When we feel bad, we tend to become self-critical. We may focus on our limitations and shortcomings and magnify our flaws and defects. This seems to be especially true of people who have eating disorders. People with eating disorders tend to exhibit distorted ways of thinking and of processing information received from the environment.

8.5.3.6 Perfectionism

Perfectionism has long been considered a risk for eating disorders. This is because people who are perfectionist may be more likely to subscribe to the thin ideal and relentlessly pursue the perfect body. It has also been suggested that perfectionism helps maintain bulimic pathology through a rigid adherence to dieting that then derives to the binge/purge cycle.

8.5.3.7 Childhood sexual abuse

One possibility is that being sexually abused increases the risk of developing other known risk factors such as having negative body image or high levels of negative affect. In other words, the causal pathway from early abuse to later eating disorder may be an indirect one.

(Activity 8.2)

(a) What individual characteristics are associated with increased risk for eating disorders?
(b) What role do sociocultural factors play in the development of eating disorders?
TREATMENT OF EATING DISORDERS

8.6 TREATING ANOREXIA NERVOSA

The most immediate concern with patients who have anorexia nervosa is to restore their weight to a level that is no longer life threatening. In severe cases, this requires hospitalization and extreme measures such as tube feeding. This is followed by rigorous control of the patients eating and progress toward a targeted range of normal weight gain.

8.6.1 Medications

Antidepressants as well as antipsychotic medications (to help with disturbed thinking) are sometimes used.

8.6.2 Family Therapy

The therapist will work with the parents to help them with their anorexic child to begin to eat again. Randomized controlled trials have shown that patients treated with family therapy for a year do better than patients who are assigned for a control treatment.

8.6.3 Cognitive-Behavioral Therapy

This involves changing behavior and maladaptive styles of thinking have proved to be very effective with bulimia. Because anorexia nervosa shares many features with bulimia, CBT is often used with anorexic patients too. The treatment is about 1 to 2 years. A major focus of the treatment involves modifying distorted beliefs about the self that may have contributed to the disorder.
8.7 TREATING BULIMIA NERVOSA

8.7.1 Medications

Antidepressants seem to decrease the frequency of binges as well as improving patients mood and their preoccupation with shape and weight.

8.7.2 Cognitive-Behavior Therapy

The behavior component of CBT for bulimia focuses on normalizing eating patterns. This includes meal planning, nutritional education, and ending binging and purging cycles by teaching the person to eat small amounts of food more regularly.

The cognitive element of the treatment is aimed at changing the cognitions and behaviors that initiate or perpetuate a binge cycle. Challenging the dysfunctional thought patterns usually present in bulimia such as the all or nothing thinking does this.

8.7 Treating Binge-Eating Disorder

Antidepressant medications are sometimes used. Other categories of medications such as appetite suppressants and anticonvulsant medications are also being explored.

In general, a well-planned program of CBT together with corrective and factual information on nutrition and weight loss is often helpful.

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**Activity 6.3**

(a) Compare the treatment approaches that are used for anorexia nervosa and bulimia nervosa.

(b) What factors make eating disorders so difficult to treat?
OBESITY

8.7

Risk and Causal Factors in Obesity

In the United States, 20% of men and 25% of women are morbidly obese. Obesity is defined on the basis of the body mass index, having a BMI of 30 or more is considered obese.

Obesity seems to be related to social class, occurring six times more often in lower SES adults and nine times higher in lower SES children. Children who were neglected have a greater risk of obesity in young adulthood. Low parental education is also a risk factor.

Obesity can be a life-threatening disorder, it results in conditions such as diabetes, joint disease, high blood pressure, coronary artery disease, sleep apnea and certain kinds of cancer. From a diagnostic perspective, obesity is not an eating disorder. Many clinicians regard the central problem as the habit of overeating.

8.7.1 The Role of Genes

Genes associated with thinness and leanness has been found in certain animals. Twin studies further suggest that genes play a role both in the development of obesity and in the tendency to binge.

8.7.2 Hormones Involved in Appetite and Weight Regulation

Leptin is a hormone that acts to reduce our intake of food and is produced by fat cells. Increased body fat leads to increased levels of leptin, which lead to decreased food intake. When body fat levels decrease, leptin production decreases and food intake is stimulated. Rare genetic mutations result in an inability to produce leptin is associated with morbid obesity.

Grehlin is a recently discovered hormone that is produced by the stomach. Grehlin is a powerful appetite stimulator. Under normal circumstances, grehlin levels rise before a meal and go down after we have eaten. People with a rare condition called Prader-Willi syndrome have chromosomal abnormalities that create many problems, one of them is very high levels of grehlin.
8.7.3 Sociocultural Influences

This implicates environmental factors in the development of extreme problems with weight. Particularly problematic is a culture that encourages consumption and discourages exercise.

8.7.4 Family Influences

In some families high-fat, high-calorie diet or an overemphasis on food may produce obesity in many or all family members. In other families, eating becomes a habitual means of alleviating emotional distress. It is possible that overfeeding infants and young children causes them to develop more adipose cells and may thus predispose them to weight problems in adulthood.

8.7.5 Stress and Comfort Food

Foods that are high in fat or carbohydrates are the foods that console us when we are feeling bad. Certainly many people with obesity experience psychological problems such as depression. One study reported 26 percent of patients seeking help with weight loss were diagnosed as having mood disorders and that 55 percent had at least one diagnosis of mood disorder during their lifetime.

8.7.6 Pathways to Obesity

The association between binge eating and obesity suggest we should pay close attention to binge eating.

Research suggests one pathway to binge eating may be via social pressure to conform to the thin ideal. Being heavy often leads to dieting, which may lead to binge eating. Another pathway may operate through depression and low self-esteem.

8.8 TREATMENT OF OBESITY

8.8.1 Weight Loss Groups

These programs provide education, encourage record keeping in the form of food diaries and also provide support and encouragement.
8.8.2 Medications
Drugs that are use to promote weight loss fall into two categories, medications that suppress appetite and medications that prevent some of the nutrients in food from being absorbed.

8.8.3 Gastric Surgery
One increasingly popular method for treating obesity involves bariatric or gastric bypass surgery. This involves placing lines of staples in the intestines to develop a holding pouch for food that is ingested. Binge eating becomes virtually impossible.

8.8.4 Psychological Treatment
Considerable support for treatment of binge eating using cognitive-behavioral methods have been found. Research also suggests that highly motivated people can lose weight and keep it off.

8.8.5 The Importance of Prevention
Once people become obese, it is difficult for them to lose weight and maintain their new low weight. Therefore, prevention is important. Suggestions for prevention are:
- Improving opportunities for physical exercise.
- Regulating food advertising aimed at children.
- Prohibiting the sale of fast food and soft drinks in schools.
- Subsidizing the sale of healthful foods.

(a) What biological factors are implicated in obesity?
(b) In what ways might negative emotional states contribute to the development of obesity?
(c) What treatment approaches are used to help obese patients?
SELF TEST

1. What philosophy do the fields of behavioral medicine and health psychology have in common?

2. What cutoff in DSM-IV-TR separates normal weights from those that suggest the presence of anorexia nervosa?

3. What is the primary feature of anorexia nervosa?

4. Individuals who are attempting to become extremely thin by refusing to eat suffer from ________.

5. Anorexia nervosa can lead to cardiac arrest due to low levels of ________.

6. Darla is suffering from anorexia nervosa and currently weighs 70% of the weight that is average for her age and height. What treatment would be recommended in this case?

7. Bulimia nervosa is characterized by ________.

8. During an episode of binge eating, a person with bulimia nervosa typically consumes large quantities of ________.

9. How is obesity defined?

10. Which hormones are involved in appetite and weight regulation?
Required Reading:


Self-check

1. an emphasis on personal responsibility for health
2. 85% of normal weight
3. obsessive preoccupation with losing weight
4. anorexia nervosa.
5. potassium.
6. inpatient hospital treatment
7. binge eating followed by purging.
8. high calorie foods.
9. having a BMI of over 30.
10. leptin and grehlin.
Unit 9  Personality Disorders

**LEARNING OUTCOME**

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

1. Define the essential features of personality disorders and why they are classified as Axis II disorders.
2. Describe the three research clusters of personality disorders and features of each personality disorder contained within the clusters.
3. Discuss problems in the classification of personality disorders, including their reliability, validity, and sexist biases.
4. Discuss theoretical perspectives on personality disorders including the psychodynamic, learning, family, biological, and sociocultural perspectives.
5. Consider issues of comorbidity with Axis I disorders and other Axis II disorders.
6. Conceptualize societal factors that may influence the prevalence and etiology of personality disorders, such as childhood abuse.
CLINICAL FEATURES OF PERSONALITY DISORDERS

According to DSM-IV-TR criteria for diagnosing a personality disorder, the person’s enduring pattern of behavior must be pervasive and inflexible as well as stable and of long duration. It must also cause clinical distress or impairment in functioning, and may be manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning or impulse control.

Personality disorders typically do not stem from debilitating reactions to stress. Rather, these disorders stem from the gradual development of inflexible and distorted personality and behavioral patterns that result in persistently maladaptive ways of perceiving, thinking about and relating to the world.

9.1 DIFFICULTIES DOING RESEARCH ON PERSONALITY DISORDERS

9.1.1 Difficulties in Diagnosing Personality Disorders

One problem is that the diagnostic criteria for personality disorders are not as sharply defined as for most Axis I diagnostic categories, so they are not often very precise or easy to follow or practice. A second problem is that the diagnostic categories are not mutually exclusive: people often show characteristics of more than one personality disorder.

The five-factor model is used to help understand the commonalities and distinction between the different personality disorders by assessing how these individuals score on the five basic personality traits.

It is also necessary to measure the six different facets or components of each of the five personality traits. By assessing whether a person scores high or low, it is easy to see how this system can account for an enormous range of personality disorders.

9.1.2 Difficulties in Studying the Causes of Personality Disorders

One major problem in studying causes of personality disorders stems from the high level of comorbidity among them. Another problem in drawing conclusions about causes occurs because researchers have more confidence in prospective studies.
CATEGORIES OF PERSONALITY DISORDERS

The DSM-IV-TR personality disorders are grouped in three clusters on the basis of similarities of features among these disorders.

- Cluster A: Includes paranoid, schizoid, and schizotypal personality disorders. People with this disorder often seem odd or eccentric, with unusual behavior ranging from distrust and suspiciousness to social detachment.
- Cluster B: Includes histrionic, narcissistic, antisocial and borderline personality disorders. Individuals tend to be dramatic, emotional, and erratic.
- Cluster C: Includes avoidant, dependent and obsessive-compulsive personality disorders. Individuals tend to be anxious and fearful.

PARANOID PERSONALITY DISORDER

Individuals with paranoid personality disorder have a pervasive suspiciousness and distrust of others, leading to numerous interpersonal difficulties. They tend to see themselves as blameless, instead blaming others for their own mistakes and failures.

9.2.1 Criteria for Paranoid Personality Disorder:

A. Evidence of pervasive distrust or suspiciousness of others present in at least four of the following ways.
   a. Pervasive suspiciousness of being deceived, harmed, or exploited.
   b. Unjustified doubts about loyalty or trustworthiness of friends and associates.
   c. Reluctance to confide in others because of doubts of loyalty or trustworthiness.
   d. Hidden demeaning or threatening meanings read into benign remarks or events.
   e. Bears grudges; does not forgive injuries, insults or slights.
   f. Recurrent suspicions of regarding fidelity of spouse or sexual partner.

B. Does not occur exclusively during course of Schizophrenia, Mood Disorder with Psychotic Features or other psychotic disorder.

It is also important to bear in mind that paranoid personalities are not usually psychotic although they may experience transient psychotic symptoms during periods of stress.
9.2.2 Causal Factors

Genetic transmission might occur through the heritability of high levels of antagonism and neuroticism that are primary traits in paranoid personality disorder. Psychosocial causal factors suspected include parental neglect or abuse and exposure to violent adults.

9.3 SCHIZOID PERSONALITY DISORDER

Individuals with schizoid personality disorder are unusually unable to form social relationships and are unable to do so. In terms of the five-factor model they show high levels of introversion and are low on openness to feelings.

9.3.1 Criteria for Schizoid Personality Disorder:

A. Evidence of a pervasive pattern of detachment from social relationships and a restricted range of expressions of emotions in interpersonal settings shown in at least four of the following ways:
   a. Neither desires nor enjoys close relationships,
   b. Almost always chooses solitary activities,
   c. Has little if any interest in sexual experiences with another person,
   d. Takes pleasure in few if any activities,
   e. Lacks close friends or confidants,
   f. Appears indifferent to the praise or criticism of others,
   g. Shows emotional coldness, detachment or flat effect.

B. Does not occur exclusively during course of Schizophrenia, Mood Disorder with Psychotic Features or other psychotic disorder or a Pervasive Developmental Disorder.

9.3.2 Causal Factors

Cognitive theorists propose that individuals with schizoid personality disorder exhibit cool and aloof behavior because of the maladaptive underlying schemas that lead them to view themselves as self-sufficient loners and others as intrusive.
9.4 SCHIZOTYPAL PERSONALITY DISORDER

Individuals with Schizotypal Personality Disorder are excessively introverted and have pervasive social and interpersonal deficits, but in addition they have cognitive and perceptual distortions and eccentricities.

9.4.1 Criteria for Schizotypal Personality Disorder:

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with and reduced capacity for close relationships as well as cognitive or perceptual distortions and behavioral eccentricities as indicated by at least five of the following:
   b. Odd beliefs or magical thinking.
   c. Unusual perceptual experiences.
   d. Odd thinking and speech.
   e. Suspiciousness or paranoid ideation.
   f. Inappropriate or constricted affect.
   g. Behavior or appearance that is odd, eccentric or peculiar.
   h. Lack of close friends or confidants.
   i. Excessive social anxiety that does not diminish with familiarity.

B. Does not occur exclusively during course of Schizophrenia, Mood Disorder with Psychotic Features or other psychotic disorder or a Pervasive Developmental Disorder.

9.4.2 Causal Factors

The genetic relationship to schizophrenia has been long suspected. This disorder appears to be part of a spectrum of schizophrenia that often occurs in some of the first-degree relatives of people with schizophrenia.
9.5

Histrionic Personality Disorder

Excessive attention-seeking behavior and emotionality are the key characteristics of individuals with histrionic personality disorder. Usually they are considered self-centered, vain and excessively concerned about the approval of others.

9.5.1 Criteria for Histrionic Personality Disorder:

A pervasive pattern of excessive emotionality and attention seeking as indicated by at least five of the following:

1. Discomfort in situations where s/he is not the center of attention.
2. Inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has an excessively impressionistic style of speech.
7. Is overly suggestible.
8. Considers relationships to be more intimate than they actually are.

The prevalence of this disorder in the general population is estimated at 2 to 3 percent, occurring more in women than men.

9.5.2 Causal Factors

There is some evidence for a genetic link with antisocial personality disorder. In terms of the five-factor model, there are very high levels of extraversion and neuroticism and high on openness to fantasy.

Cognitive theorist emphasizes the importance of maladaptive schemas revolving around the need for attention to validate self-worth.

(a) List three DSM criteria that must be met before an individual is diagnosed with histrionic personality disorder and cite the additional personality traits that define psychopathy.

(b) What biological factors contribute to these disorders?
9.6 Narcissistic Personality Disorder

Individuals with narcissistic personality disorder show an exaggerated sense of self-importance, a preoccupation with being admired and a lack of empathy for the feelings of others.

9.6.1 Criteria for Narcissistic Personality Disorder:

A pervasive pattern of grandiosity (in fantasy and behavior), need for admiration, and lack of empathy as indicated by at least five of the following:

2. Preoccupation with fantasies or unlimited success, power, brilliance, or beauty.
3. Belief that s/he is special and unique.
4. Excessive need for admiration.
5. Sense of entitlement.
6. Tendency to be interpersonally exploitative.
7. Lacks empathy.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes.

Most clinicians believe that people with narcissistic personality disorder have a very fragile and unstable sense of self-esteem. This may be why they are often so preoccupied with what others think and with fantasies of outstanding achievement.

From the perspective of the five-factor model, individuals with narcissistic personality disorder are characterized by low agreeableness, low altruism, and tough mindedness. They also show high levels of fantasy proneness, angry-hostility and self-consciousness.

Studies show that it is more common in men than women and occurs in about 1 percent of the population.

9.6.2 Causal Factors

Heinz Kohut argued that all children go through the phase of grandiosity during which they think all events and needs revolve around them. Kohut and Kernberg proposed that narcissistic personality disorder is likely to develop if parents are neglectful, devaluing, or unempathetic to the child; this individual will be perpetually searching for affirmation of an idealized sense of self.

From a different theoretical standpoint, narcissistic personality disorder comes from unrealistic parental overvaluation.
9.7  ANTISOCIAL PERSONALITY DISORDER AND PSYCHOPATHY

The outstanding characteristic of people with antisocial personality disorder is their tendency to persistently disregard and violate the rights of others. Individuals with antisocial personality disorder (ASPD) continually violate and show disregard for the rights of others through deceitful, aggressive, or antisocial behavior; typically without remorse or loyalty to anyone.

9.7.1 Criteria for Antisocial Personality Disorder

A. A pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by at least three of the following:
   a. Failure to conform to social norms and repeated law breaking.
   b. Deceitfulness.
   c. Impulsivity or failure to plan ahead.
   d. Irritability and aggressiveness.
   e. Reckless disregard for safety of self or others.
   f. Consistent irresponsibility.
   g. Lack of remorse.

B. The individual is at least 18 years of age.

C. There is evidence of Conduct Disorder with onset before age 15.

9.7.2 Psychopathy and ASPD

In addition to the defining features of antisocial personality, psychopathy includes such affective and interpersonal traits such as lack of empathy, inflated and arrogant self-appraisal, and glib and superficial charm.

The prevalence of ASPD in the general population is about 3 percent for males and 1 percent for females.

9.7.3 Two Dimensions of Psychopathy

There are two related but separable dimensions of psychopathy, each predicting different types of behavior:

- The first dimension involves the affective and interpersonal core of the disorder and reflects traits such as lack of remorse or guilt, callousness/lack of empathy, glibness/superficial charm, grandiose sense of self-worth, and pathological lying.
The second dimension reflects behavior - the aspects of psychopathy involving antisocial, impulsive and socially deviant lifestyle.

9.7.4 The Clinical Picture in Psychopathy and Antisocial Behavior

9.7.4.1 Inadequate Conscience Development
Psychopaths appear unable to understand and accept ethical values except on a verbal level. In short, their conscience development is severely retarded.

9.7.4.2 Irresponsible and Impulsive Behavior
Psychopaths have learned to take rather than earn what they want. Prone to thrill seeking, they often break the law impulsively and without regard for the consequences. Studies have shown that antisocial personalities and some psychopaths have high rates of alcohol abuse and dependence.

9.7.4.3 Ability to Impress and Exploit Others
Some psychopaths are often charming and likable, with a disarming manner that easily wins friends. They seem to have good insight into people's needs and weaknesses and are good at exploiting them. These frequent liars seem sincerely sorry if caught in a lie and promise to make amends, but will not do so.

9.7.5 Causal Factors in Psychopathy and Antisocial Behavior

9.7.5.1 Genetic Influences
Twin studies of some of the personality traits elevated in psychopathy show moderate heritability. Researchers also note that strong environmental influences interact with genetic predisposition to determine which individuals become criminals or antisocial personalities.

The gene known as monoamine oxidase-A gene (MAO-A gene) may be involved. It is involved in the breakdown of neurotransmitters like norepinephrine, dopamine and serotonin. Researchers found that individuals with low MAO-A activity were far more likely to develop ASPD if they had experienced maltreatment.
9.7.5.2 The Low-Fear Hypothesis and Conditioning

Research evidence indicates that psychopaths who are high on egocentric, callous and exploitative dimension have low trait anxiety and show poor conditioning of fear. The deficient behavioral inhibition system has been proposed to be the neural system underlying anxiety. It is also the neural system responsible for learning to inhibit responses to cues that signal punishment.

Psychopaths also seem to be unaffected by the fear-potentiated startle. The behavioral activation system activates behavior in response to cues for reward as well as cues for active avoidance of threatened punishment. The behavioral activation system is thought to be normal or even overactive in psychopaths.

This system seems to account for three features of psychopathy:
- The psychopath’s deficient conditioning of anxiety to signals for punishment.
- Their difficulty learning to inhibit responses that may result in punishment.
- Their normal or hypernormal active avoidance of punishment when threatened with punishment.

People with psychopathy also have a dominant response to reward. Their excessive focus is thought to interfere with their ability to use punishment or other contextual cues or information to modulate their responding when rewards are no longer forthcoming at the same rate they once were.

9.7.5.3 More General Emotional Deficits

Psychopaths show less significant physiological reactivity to distress cues. However, they were not underresponsive to unconditioned threat cue.

9.7.5.4 Early Parental Loss, Parental Rejection and Inconsistency

In addition to genetic factors and emotional deficits, slow conscience development and aggression are influenced by the damaging effects of parental rejection, abuse and neglect accompanied by inconsistent discipline.

9.7.6 A Developmental Perspective on Psychopathy and Antisocial Personality

Early antisocial symptoms are associated with a diagnosis of conduct disorder. Children with and early history of oppositional defiant disorder, characterized by a pattern of hostile and defiant behavior toward authoritarian figures begins at 6, followed by conduct disorder at 9 are likely to develop conduct disorder as adults.

When ADHD occurs with conduct disorder this leads to a high likelihood that person will develop ASPD and possibly psychopathy. Children who have great difficulty learning to regulate their emotions and show high levels of emotional reactivity including aggressive
and antisocial behaviors when responding to stress and negative emotions are more likely to develop ASPD.

9.7.6.1 Sociocultural Causal Factors And Psychopathy

The prevalence of the disorder seems to vary with sociocultural influences that either encourage or discourage its development. One primary symptom where cultural variations occur is the frequency of aggressive and violent behavior. Cultures can be classified along a dimension distinguishing between collectivist and individualistic societies. Individualistic societies promote some of the behavioral characteristics of psychopathy.

9.7.7 Treatments and Outcomes in Psychopathic and Antisocial Personality

A few studies of individual treatment programs led to as many as 60 percent of individuals showing significant improvement in psychopathic symptoms and decreases in recidivism.

There have been some promising results using antidepressants from the SSRI category. However, none of the biological treatments were has any substantial impact on the disorder as a whole.

9.7.7.1 Cognitive-Behavioral Treatments

Common targets of cognitive behavioral treatment include the following:

- Increasing self-control, self-critical thinking, and social perspective training.
- Teaching anger management.
- Changing antisocial attitudes.
- Curing drug addiction.

It focuses on improving moral and social behavior by examining self-serving dysfunctional beliefs that psychopaths tend to have.

9.7.8 Prevention of Psychopathy and Antisocial Personality Disorder

For young children, Patterson, Dishion, Reid and colleagues have developed programs that target the family environment and teach effective parental discipline and supervision. Such interventions can prevent psychopathy in high-risk children.
9.8 BORDERLINE PERSONALITY DISORDER

Individuals with borderline personality disorder (BPD) show a pattern of behavior characterized by impulsivity and instability in interpersonal relationships, self-image and instability.

9.8.1 Criteria for Borderline Personality Disorder:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity as indicated by at least five of the following:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships.
3. Identity disturbance characterized by a persistently unstable self-image or sense of self.
4. Impulsivity in at least two potentially self-damaging areas.
5. Recurrent suicidal behavior, gestures or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood.
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger.
9. Transient, stress related paranoid ideation or severe dissociative symptoms.

Estimates are that only 1 to 2 percent of the population qualifies for BPD. 75 percent are women.

9.8.2 Comorbidity With Other Axis I and Axis II Disorders

BPD commonly co-occurs with a variety of Axis I disorders ranging from mood and anxiety disorders to substance abuse and eating disorders. There is also substantial co-occurrence of BPD with other personality disorders.

9.8.3 Causal Factors

Genetic factors play a significant role in the development of BPD. This heritability may be partly a function of the fact personality traits of impulsivity and affective instability are themselves partially heritable.

People with BPD often appear to be characterized by lowered functioning of the neurotransmitter serotonin. Patients with BPD also show disturbances in the regulation of noradrenergic neurotransmitters.

Many studies have found that people with this disorder usually report a large number of negative or traumatic events in childhood. These experiences include abuse and neglect.
Paris proposes that people who have high levels of impulsivity and affective instability may have a diathesis for this disorder, but only in the presence of certain psychological risk factors such as trauma, loss and parental failure.

### 9.9 AVOIDANT PERSONALITY DISORDER

Individuals with avoidant personality disorder show extreme inhibition and introversion leading to lifelong patterns of limited social relationships and reluctance to enter into social interactions.

#### 9.9.1 Criteria for Avoidant Personality Disorder:

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation as indicated by at least four of the following:

1. Avoids occupational activities that involve significant interpersonal contact.
2. Unwillingness to get involved with people unless certain of being liked.
3. Restraint within intimate relationships because of the fear of being shamed or ridiculed.
4. Preoccupation with being criticized or rejected.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept or inferior to others.
7. Extreme reluctance to take personal risks or engages in any new activities for fear of embarrassment.

#### 9.9.1 Causal Factors

Some research suggests that avoidant personality may have its origins in an innate inhibited temperament. Avoidant personality disorder is heritable; introversion and neuroticism are both elevated and are also moderately inheritable. This genetic and biologically based inhibition may often serve as the diathesis that leads to avoidant personality disorder.
9.10  DEPENDENT PERSONALITY DISORDER

Individuals with dependent personality disorder show an extreme need to be taken care of, which leads to clinging and submissive behavior.

9.10.1 Criteria for Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation as indicated by at least five of the following:

1. Difficulties making everyday decisions without excessive advice and reassurance from others.
2. Needs others to take responsibility for most major areas of life.
3. Difficulty expressing disagreement with others because of fear of loss of support or approval.
4. Difficulty initiating projects or doing things on his or her own.
5. Goes to excessive lengths to obtain nurturance and support from others.
6. Feels uncomfortable or helpless when alone because of fears of being unable to care for self.
7. Urgently seeks another relationship for care and support when a close relationship ends.
8. Unrealistic preoccupation with fears of being left to take care of himself or herself.

Estimates are that dependent personality disorder occurs in 2 to 4 percent of the population and is more common in women than men. Some features overlap with those of borderline, histrionic and avoidant personality behaviors.

9.10.2 Causal Factors

Some evidence shows that there might be a small genetic influence on dependant personality disorder. It is possible that people with these partially genetically based predispositions to dependence and anxiousness may be especially prone to the adverse parents who are authoritarian and overprotective. Cognitive theorist describes the underlying maladaptive schemas as involving core beliefs about weakness and incompetence.
9.11 OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

Perfectionism and excessive concern with maintaining order and control characterize individuals with obsessive-compulsive personality disorder (OCPD).

9.11.1 Criteria for Obsessive-Compulsive Personality Disorder:

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control as indicated by at least five of the following:

1. Preoccupation with details, rules, order or schedules to the extent that the major point of an activity is lost.
2. Extreme perfectionism that interferes with task completion.
3. Excessive devotion to work to the exclusion of leisure and friendships.
4. Overly inflexible and over conscientious about matters of morality, ethics or values.
5. Inability to discard worn-out or worthless objects.
6. Reluctance to delegate tasks or work with others unless others do exactly the same things.
7. Miserliness in spending style toward both self and others.
8. Shows rigidity and stubbornness

9.11.2 Causal Factors

According to the five-factor approach, these individuals have excessively high levels of conscientiousness, which leads to extreme devotion to work, perfectionism and excessive controlling behavior. They are also high on assertiveness and low on compliance.

(a) What are the general characteristics of the three clusters of personality disorders?
(b) Describe and differentiate among the following Cluster A personality disorders: paranoid, schizoid, and schizotypal.
(c) Describe and differentiate among the following Cluster B personality disorders: histrionic, narcissistic, antisocial and borderline.
(d) Describe and differentiate among the following Cluster C personality disorders: avoidant, dependent and obsessive-compulsive.
TREATMENTS AND OUTCOMES

People with personality disorders have rigid ingrained personality traits that often lead to poor therapeutic relationships and additionally make them resist doing things that would help improve their condition.

9.12 ADAPTING THERAPEUTIC TECHNIQUES TO SPECIFIC PERSONALITY Disorders

Therapeutic techniques must often be modified. Traditional individual psychotherapy tends to encourage dependence in people who are already dependent. For people with more severe personality disorders, therapy may be more effective in situations where acting-out behavior is constrained.

9.13 TREATING BORDERLINE PERSONALITY DISORDER

Treatment often involves use of both psychological and biological treatment methods.

9.12.1 Biological Treatments

Antidepressant medications from the SSRI category are considered most safe and useful for treating rapid mood shifts, anger and anxiety. Low doses of antipsychotic medication have modest but significant effects that are broad-based. Mood-stabilizing drugs may be useful in reducing irritability, suicidality and impulsive aggressive behavior.
9.12.2 Psychosocial Treatment

The primary goal of psychodynamic therapy is to strengthen weak egos with a particular focus on their primary primitive defense mechanism of splitting.

Dialectical behavior therapy is a problem-focused treatment based on a clear hierarchy of goals:
- Decreasing suicidal and other self-harming behavior.
- Decreasing behaviors that interfere with therapy.
- Decreasing escapist behaviors that interfere with a stable lifestyle.
- Increasing behavioral skills in order to regulate emotions, to increase interpersonal skills.
- Other goals the patient chooses.

9.14 TREATING OTHER PERSONALITY DISORDERS

9.13.1 Treating Other Cluster A and B Disorders

Low doses of antipsychotic drugs may result in modest improvements, and antidepressants from the SSRI category may be useful.

9.13.2 Treating Cluster C Disorders

Significant improvement can be found in patients using a form of short-term psychotherapy that is active and confrontational. Cognitive-behavioral treatment with avoidant personality disorder has reported significant gains. Antidepressants from the MAO inhibitor and SSRI categories may sometimes help in the treatment of avoidant personality disorder.

ACTIVITY 9.2

(a) Why are personality disorders especially resistant to therapy?
(b) Under what circumstances do individuals with personality disorders generally get involved in psychotherapy?
1. When is a personality style considered maladaptive?

2. What is the major difference between Axis I and Axis II disorders?

3. A patient who cannot stand to be alone; exhibits intense, unstable moods and interpersonal relationships; and is chronically angry is most likely to receive the diagnosis of _________.

4. The three types of personality disorders are (1) anxious or fearful behavior; (2) dramatic, emotional, or erratic behavior; and (3) _________.

5. Which personality disorder is characterized by unwarranted feelings of suspiciousness, mistrust of other people, and hypersensitivity?

6. Withdrawal from social contact is characteristic of _________.

7. Schizotypal individuals have an elevated risk for what disorder?

8. On what basis is a person with histrionic personality disorder likely to make important decisions?

9. Greg, a successful actor, contacted a therapist because he was having trouble playing a character who was grieving. Greg could not understand how someone could be so wrapped up in someone else, nor could he understand why someone as gifted as himself was having any difficulty with the role. Which personality disorder is most consistent with the symptoms Greg exhibits?

10. What do borderline personality disorder and histrionic personality disorder have in common?

11. Low levels of which neurotransmitter has been implicated in the development of antisocial personality disorder?

12. Which characteristic of antisocial personality disorder usually interferes with successful psychotherapy?

13. What do dependent personality disorder and borderline personality disorder have in common?

14. An inability to grasp the "big picture" due to a preoccupation with rules and details is characteristic of which personality disorder?
Required Reading:


Self-check

1. if the person will not change
2. Axis I disorders are symptom disorders, and have some flexibility with regard to prognosis which Axis II disorders are near-permanent.
3. borderline.
4. odd or eccentric behavior.
5. paranoid
6. schizoid personality disorder.
7. schizophrenia
8. hunches
9. narcissistic
10. attention seeking behaviors
11. serotonin
12. lack of empathy
13. difficulty being alone
14. obsessive-compulsive
Unit 10  |  Substance Related Disorders

**LEARNING OUTCOME**

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

1. Distinguish between psychological and physiological dependence.
2. Describe and explain alcohol abuse and dependence.
3. Describe and explain drug abuse and dependence.
4. Discuss biological, learning, cognitive, psychodynamic, and sociocultural perspectives of substance abuse and dependence.
5. Discuss approaches to treating substance abuse and dependence including detoxification, disulfiram, antidepressants, nicotine replacement, methadone maintenance, and naloxone/naltrexone.
6. Discuss the need for, methods of, and limitations of relapse prevention training.
7. Understand genetic and environmental contributions to substance abuse and dependence.
INTRODUCTION TO SUBSTANCE RELATED DISORDERS

Addictive behavior is behavior based on the pathological need for substance or activity, may involve abuse of substances such as nicotine, alcohol or cocaine.

The most commonly used problem substance are those drugs that affect mental functioning or psychoactive drugs: alcohol, nicotine, barbiturates, tranquilizers, heroin, Ecstasy and marijuana.

Addictive or substance related disorders are divided into two categories:

1. Those conditions that involve organic impairment form prolonged and excessive ingestion of psychoactive substances.

2. Substance-induced organic mental disorders and symptoms.

These conditions stem from toxicity, the poisonous nature of the substance or physiological changes in the brain due to vitamin deficiency.

Substance abuse generally involves a pathological use of a substance resulting in:

- Potentially hazardous behavior.
- Continued use despite a persistent social, psychological occupational or health problem.

Substance dependence disorders includes more severe form of substance-use disorders and usually involves marked physiological needs need for increasing amounts of a substance to achieved the desired effect.

Tolerance is the need for increased amounts of a substance to achieve the desired effects. Withdrawal symptoms are physical symptoms such as sweating, tremors, and tension that accompany abstinence from the drug.

10.1 ALCOHOL ABUSE AND DEPENDENCE

Alcohol dependence syndrome is a state, psychic and usually also physical resulting from taking alcohol characterized by behavioral and other responses that always include compulsion to take alcohol on a continuous basis in order to experience its psychic effects and sometimes to avoid discomfort of its absence, tolerance may or may not be present.
10.1.1 The Prevalence, Comorbidity And Demographics Of Alcohol Abuse And Dependence

Heavy drinking is associated with vulnerability to injury and becoming involved in intimate partner violence. The life span of the average person with alcohol dependence is about 12 years shorter. Alcohol significantly lowers performance on cognitive tasks. Organic impairment including brain shrinkage occurs in a high proportion of people with alcohol dependence.

Over 37 percent of alcohol abusers suffer from at least one coexisting mental disorder. Alcohol abuse is associated with over half the deaths and major injuries suffered in automobile accidents each year and about 40 to 50 percent of all murders.

Most problem drinkers are male. Marriage, high levels of education and being older are associated with a lower incidence of alcoholism.

10.1.2 The Clinical Picture of Alcohol Abuse and Dependence

10.1.2.1 Criteria for Substance-Dependence and Substance-Abuse Disorders

Substance-Dependence Disorder
A maladaptive pattern of substance use leading to clinically significant distress or impairment as manifested by at least three of the following at any time in the same 12-month period:

A. Tolerance as defined by either a need for increased amounts of substance to achieve intoxication or desired effect, or diminished effect with continued use of the same amount of substance.
B. Withdrawal as manifested by either the characteristic withdrawal syndrome for the substance or same or closely related substance is taken to relieve or avoid withdrawal symptoms.
C. Substance is often taken in larger amounts or over a longer period than intended.
D. Persistent desire or unsuccessful effort to cut down or control substance use.
E. The person spends a great deal of time engaging in activities necessary to obtain the substance, use the substance or recover from its effects.
F. The person has given up or reduced the amount of important social, occupational or recreational activities because of substance abuse.
G. Continued substance use despite persistent or recurrent physical or psychological problems caused or exacerbated by the substance.
Substance-Abuse Disorder
A. A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by at least one of the following occurring within a 12 month period:
   a. Recurrent substance use that results in a failure to fulfill some major role obligations at work, school or home.
   b. Recurrent substance use in situations where it is physically hazardous.
   c. Recurrent substance-related legal problems.
   d. Continued substance use despite persistent or recurrent social or interpersonal problems caused by the substance.
B. Person has never had symptoms or problems that have met the criteria for Substance Dependence in this class of substance.

Several physiological effects such as lowered sexual inhibition and black outs. Another phenomenon is the hangover characterized by headache, nausea and fatigue.

10.1.2.2 Alcohol’s Effect On The Brain
At lower levels, alcohol stimulates certain brain cells and activates the brains pleasure areas that release endogenous opioids that are stored in the body. At higher levels, alcohol depresses brain functioning, inhibiting one of the brain’s excitatory neurotransmitters, glutamate which slows down activities in parts of the brain.

Inhibition of glutamate in the brain impairs the organisms’ ability to learn, judgment and self-control. Some degree of motor uncoordination becomes apparent and discomfort is dulled.

When the blood alcohol content reaches 0.08 percent, the individual is considered intoxicated. The effects of alcohol vary for different drinkers, depending on their physical condition, the amount of food in their stomach and duration of drinking.

Development of Alcohol Dependence
Excessive drinking can be viewed as progressing insidiously from early to middle to late stage alcohol abuse disorder. For pregnant women any alcohol is dangerous and may cause fetal alcohol syndrome (FAS), which results in birth defects such as mental retardation.

The Physical Effects of Chronic Alcohol Use
Alcohol that is taken must be assimilated into the body, except for about 5 to 10 percent. The liver may be seriously overworked and may suffer irreversible damage. 15 to 30 percent of heavy drinkers develop cirrhosis of the liver.

Because of its high-calorie nature, alcohol reduces a drinker’s appetite for food, which may lead to malnutrition. Heavy drinking also impairs the body’s ability to utilized nutrients. Many alcohol abusers experience increased gastrointestinal symptoms such as stomach pains.
Psychosocial Effects of Alcohol Abuse and Dependence

In addition to various physical problems, an excessive drinker usually suffers from chronic fatigue, over sensitivity and depression. The excessive use of alcohol eventually becomes counterproductive and can result in impaired reasoning, poor judgment and gradual personal deterioration.

Psychoses Associated With Severe Alcohol Abuse

Psychotic reactions may develop in people who have been drinking excessively for a long period of time or who have a reduced tolerance for alcohol for other reasons. Such acute reactions usually last only a short time and generally consist of confusion, excitement and delirium. These disorders are often called alcoholic psychoses because they are marked by temporary loss of contact with reality.

Among those who drink excessively for a long time, alcohol withdrawal delirium may occur during withdrawal. Slight noises or suddenly moving objects may cause considerable excitement or agitation. Full-blown symptoms include:

- Disorientation for time and place.
- Vivid hallucinations, particularly of small, fast moving animals.
- Acute fear in which these animals may change in form, size or color in terrifying ways.
- Extreme suggestibility, in which a person can be made to see almost any animal if its presence is suggested.
- Marked tremors of the hands tongue and lips.
- Other symptoms include perspiration, fever, a rapid and weak heartbeat, a coated tongue and foul breath.

The delirium last from 3 to 6 days and is generally followed by a day of sleep. When a person awakes, few symptoms remain, but frequently the individual is badly scared and may not resume drinking for months.

A second alcohol related psychosis is alcohol amnestic disorder. The outstanding symptom is a memory defect, which is sometimes accompanied by falsification of events. These individuals may appear to be delirious, delusional and disoriented for time or place. Such a reaction usually occurs in older alcoholics after years of drinking. The symptoms of alcohol amnestic disorder are now thought to be due to vitamin B deficiency.
10.1.3 Biological Factors in the Abuse of and Dependence on Alcohol and Other Substances

10.1.3.1 The Neurobiology of Addiction

Drugs differ in their biochemical properties as well as how rapidly they enter the brain. There are several routes of administration, oral, nasal and intravenous.

The mesocorticolimbic dopamine pathway (MCLP) is the center of the psychoactive drug activation in the brain. This connects to the brain. This neuronal system is involved in such functions as control of emotions, memory and gratification. Alcohol produces euphoria by stimulating this area. Drug ingestion or behaviors that lead to activation of the brain reward system are reinforced so further use is promoted.

10.1.3.2 Genetic Vulnerability

Many experts agree that genetics plays an important role in developing sensitivity to the addictive powers of drugs. They found that for males, having one alcoholic parent increased the rate of alcoholism from 12.4 percent to 29.5 percent and having two alcoholic parents increased the rate to 41.2 percent.

An alcohol-risk personality has been described as an individual who has inherited predisposition toward alcohol abuse and who is impulsive, prefers taking high risks and is emotionally unstable.

Some ethnic groups such as Asians and Native Americans have abnormal physiological reactions, a phenomenon referred to as alcohol flush reaction. This results in a hypersensitive reaction including flushing of the skin, a drop in blood pressure, heart palpitations, and nausea following ingestion of alcohol.

10.1.3.3 Genetic Influences and Learning

The development of alcohol-related problems involves living in an environment that promotes initial as well as continuing use of the substance. People become conditioned to stimuli and tend to respond in particular ways as a result of learning. Research has also shown that psychoactive drugs contain intrinsic rewarding properties.

10.1.4 Psychosocial Causal Factors in Alcohol Abuse and Dependence

10.1.4.1 Failures in Parental Guidance

Children who have parents who are extensive alcohol or drug abusers are vulnerable to developing substance abuse and related problems. Children who are exposed to negative role models and family dysfunction early in their lives or experience other negative circumstance often falter on the difficult steps they must take in life.
10.1.4.2 Psychological Vulnerability

Investigators found many potential alcohol abusers to be emotionally immature, expect a great deal of the world, require and inordinate amount of praise and appreciation, react to failure with marked feelings of hurt and inferiority, have low frustration tolerance and feel inadequate and unsure of their abilities to fulfill expected male and female roles.

Persons at high risk for developing alcohol-related problems are significantly more impulsive and aggressive. About half of the persons with schizophrenia have either alcohol or drug abuse or dependence as well. About 70 to 80 percent of antisocial personality can be related to addictive disorders. There is a strong association of depression with alcohol abuse especially among women.

10.1.4.3 Stress, Tension Reduction and Reinforcement

The typical alcohol abuser is discontented with his or her life and is unable or unwilling to tolerate tension or stress and use alcohol to relax.

Cox and Clinger and Cooper describe a motivational model of alcohol use. According to this view, the final common pathway of alcohol use is motivation. Alcohol is consumed to bring about affective changes such as the mood altering effects. In short, alcohol is consumed because it is reinforcing.

10.1.4.4 Expectations of Social Success

Many people, especially young adolescents, expect that alcohol use will lower tension and anxiety and increase sexual desire and pleasure. According to the reciprocal model, adolescents begin drinking as a result of expectations that using alcohol will increase their popularity and acceptance by peers. However, time and experience do have moderating influences on these alcohol expectancies.

10.1.4.5 Marital and Other Intimate Relationships

Adults with less intimate and supportive relationships tend to show greater drinking following sadness or hostility. Excessive drinking often begins during crisis periods of marital or other intimate personal relationships. The marital relationship may actually serve to maintain the pattern of excessive drinking.

10.1.5 Sociocultural Factors

Alcohol use is a pervasive component is the social life in Western civilization. Social events often revolve around alcohol use, and alcohol use before and during meals is commonplace. Alcohol is often seen as a social lubricant or tension reducer that enhances social events.
Muslims, Mormons and Orthodox Jews have traditionally limited its use and the incidence of alcohol abuse among these groups is minimal.

10.1.6 Treatment Of Alcohol Abuse Disorders

In general, a multidisciplinary approach to the treatment of drinking problems is often complex, requiring flexibility and the individualization of treatment procedures. Treatment objectives usually include detoxification, physical rehabilitation, control over alcohol abuse behavior and the individual realizing that he or she can cope with the problems of living and lead a much more rewarding life without alcohol. Some programs promote abstinence and others controlled drinking. Relapse is common.

10.1.6.1 Use of Medications in Treating Alcohol Abuse

Biological approaches include a variety of treatment measures such as medications to reduce craving, to ease the detoxification process and to treat co-occurring health and mental health problems that underlie the drinking behavior.

10.1.6.2 Medications to Block The Desire to Drink

Disulfiram (Antabuse), a drug that causes violent vomiting when followed by ingestion of alcohol may be administered to prevent and immediate return to drinking. Naltrexone an opiate antagonist that helps reduce cravings by blocking the pleasure producing effects of alcohol.

10.1.6.3 Medications to Reduce the Side Effects of Withdrawal

Drugs like Valium overcome motor excitement, nausea and vomiting, prevent withdrawal delirium and convulsions and help alleviate tension and anxiety associated with withdrawal.

10.1.6.4 Psychological Treatment Approaches

Detoxification is optimally followed by psychological treatment including family counseling and the use of community resources to related to employment and to other aspects of a person’s readjustment.

10.1.6.5 Group Therapy

In the confrontational give-and-take of group therapy, alcohol abusers are often forced to face their problems and their tendencies to deny or minimize them. Often, this paves the way to learning more effective ways of coping and other positive steps toward dealing with their drinking problem.

In the case of family therapy, the abuser is seen as a member of a disturbed family and all the members have a responsibility for cooperating in treatment.
10.1.6.6 Environmental Intervention

Simply helping people with alcohol-abuse problems learn more effective coping techniques may not be enough if their social environment remains hostile. For those who have been hospitalized, halfway houses designed to assist them in their return to family and community are often important adjuncts to their total treatment program.

10.1.6.7 Behavioral and Cognitive-Behavioral Therapy

One behavioral therapy is aversive conditioning, which involves a wide range of noxious stimuli with alcohol consumption in order to suppress drinking behavior.

The cognitive behavioral approach combines cognitive-behavioral strategies of intervention with social learning and modeling of behavior. The approach, referred to as a skills training program, is usually aimed at a younger problem drinkers. This approach relies on such techniques as imparting specific knowledge about alcohol, developing coping skills in situations with increased risk of alcohol use, modifying cognitions and expectations, acquiring stress-management skills and providing training in life skills.

Self-control training techniques, involve getting alcoholics to reduce alcohol intake without abstaining.

10.1.6.8 Alcoholics Anonymous

Alcoholics Anonymous operates primarily as a self-help counseling program in which both person-to-person and group relationships are emphasized. To ensure anonymity only first names are used. Meetings are devoted partly to social activities, but they consist mainly of discussions of the participants’ problems with alcohol often with testimonials from those who have stopped drinking.

An important aspect of AA’s rehabilitation program is that it appears to lift the burden of personal responsibility by helping that alcoholism is bigger than they are.

10.1.6.9 Outcomes Studies and Issues in Treatment

Results range from low rates of success for hard-core substance abusers to recovery rates of 70 to 90 percent where modern treatment and aftercare procedures are used. Substance abusers who are also diagnosed with personality or affective disorders tended to have poorer outcomes.

Having a positive relationship with the therapist was associated with better treatment outcome. One important new treatment strategy is aimed at reinforcing treatment motivation and abstinence early in the treatment process by providing check-up follow-ups on drinking behavior.
10.1.6.10 Relapse Prevention

In relapse prevent treatment, clients are taught to recognize the apparently irrelevant decisions that serve as early warning signs for relapse. Clients are also trained not to become discouraged if they do relapse. Some cognitive-behavioral therapists have incorporated a planned relapse phase into the treatment.

ACTIVITY 10.1

(a) What is the difference between alcohol abuse and alcohol dependence?
(b) What are the three major physiological effects of alcohol?
(c) What are five major psychosocial factors that may contribute to alcohol dependence?
(d) Describe four psychosocial interventions used to treat alcohol dependence.

10.2 DRUG ABUSE AND DEPENDENCE

Aside from alcohol, the psychoactive drugs most commonly associated with abuse and dependence appear to be:

- Narcotics such as opium and heroin
- Sedatives such as barbiturates
- Stimulants such as cocaine and amphetamines
- Anti-anxiety drugs such as benzodiazepines
- Pain killers such as OxyContin
- Hallucinogens such as LSD and PCP

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

An estimated 28 million people worldwide incur significant health risks by using various psychoactive substances other than alcohol, tobacco and volatile solvents. Among those who abuse drugs, behavior patterns vary markedly, depending on type, amount, and duration of drug use; on the physiological and psychological makeup of the individual and in some instances the social setting in which the drug experience occurs.
10.2.1 Caffeine And Nicotine

The DSM-IV-TR includes addictions to two legally available and widely used substances: caffeine and nicotine. Although these substances do not represent the extensive self-destructive problems found in drug and alcohol disorders, they create important physical and mental health problems in our society for several reasons:

- These drugs are easy to abuse.
- These drugs are readily available to anyone who wants to use them, in fact, because of peer pressure, it is usually difficult to avoid.
- Both caffeine and nicotine have clearly addictive properties.
- It is difficult to quit using these drugs both because their addictive properties and they are so embedded in the social context.
- The extreme difficulty most people have in dealing with the withdrawal symptoms.
- The health problems and side effects of these drugs.

10.2.1.1 Caffeine

As described in the DSM-IV-TR, caffeine-induced organic mental disorder involves symptoms of restlessness, nervousness, excitement, insomnia, muscle twitching, and gastrointestinal complaints. The amount of caffeine that results in intoxication varies among individuals. Withdrawal doesn't produce severe symptoms other than headache.

10.2.1.2 Nicotine

The nicotine withdrawal syndrome results from ceasing or reducing intake of nicotine-containing substances after an individual has developed physical dependence on them. The diagnostic criteria include:

A. The daily use of nicotine for at least several weeks.
B. The following symptoms after nicotine ingestion is stopped or reduced:
   - Craving for nicotine
   - Irritability, frustration or anger
   - Anxiety, difficulty concentrating, restlessness and decreased heart rate
   - Increased appetite or weight gain

Several other physical concomitants are associated with withdrawal from nicotine including decreased metabolic rate, headaches, insomnia, tremors, increased coughing and impairment of performance on tasks requiring attention.

These withdrawal symptoms usually continue for several days to several weeks, depending on the extent of the nicotine habit.

10.2.1.3 Treatment of Nicotine Withdrawal

Numerous programs have been developed to help smokers quit. Such programs use many different methods including social support groups, various pharmacological agents that replace cigarette consumption with safer forms of nicotine, self-directed changes, and professional treatment.
The average rates of these programs are 20 to 25 percent. The highest self-reported quit rates for smokers were reportedly among patients who were hospitalized for cancer, cardiovascular disease or pulmonary disease.

10.2.2 Opium And Its Derivatives (Narcotics)

Opium is a mixture of about 18 chemical substances known as alkaloids. Morphine was found to be a bitter-tasting powder that could serve as a powerful sedative and pain reliever. Heroin proved to be an even more dangerous drug than morphine acting more rapidly and more intensely and being equally if not more addictive.

In one survey, 2.4 million Americans acknowledged having tried heroin and almost a quarter million people admitted using it within the past few months. In 2000, heroin overdose accounted for 16 percent of all drug-related emergency room admissions.

10.2.2.1 Biological Effects of Morphine and Heroin

Morphine and heroin are commonly introduced into the system by smoking, snorting, eating or via hypodermic injection.

Among the immediate effects of mainlined or snorted heroin is a euphoric spasm. However, vomiting and nausea have also been known to be part of the immediate effects of heroin and morphine use. This rush is followed by a high, during which the addict is in a lethargic withdrawn state in which bodily needs are diminished and pleasant feelings of relaxation, euphoria and reverie tend to dominate. These effects last from 4 to 6 hours.

The use of opium derivatives over a period of time generally results in a physiological craving for the drug if used continually over 30 days. Users become physiologically dependent and feel ill when they do not take it. Users of opium derivatives gradually build up tolerance to the drug.

When people addicted to opiates do not get a dose of the drug within approximately 8 hours, the start to experience withdrawal symptoms. These vary on the amounts of the narcotic habitually used, the intervals between doses, the duration of the addiction and especially the addict’s health and personality.

Withdrawal from heroin is not always dangerous or very painful. However, it can be agonizing for some, with symptoms including runny nose, tearing eyes, perspiration, restlessness, increased respiration rate and an intensified desire for the drug.

As time passes, the symptoms become less severe, resulting in chilliness alternating with flushing and excessive sweating, vomiting, diarrhea, abdominal cramps, pains in the back, severe headache, marked tremors and varying degrees of insomnia. Beset by these discomforts, an individual might refuse food and water resulting in dehydration and weight loss.

Occasionally, symptoms include delirium, hallucinations and manic activity. If morphine is administered, the subjective distress experience temporarily ends and physiological balance is quickly restored.
Withdrawal symptoms are usually on the decline by the third or fourth day and by the seventh or eighth day have completely disappeared. After withdrawal symptoms subside, tolerance is reduced, as a result there is a risk that taking the former large dosage may result in overdose.

10.2.2.2 Social Effects of Morphine and Heroin

Typically, the life of a narcotics addict becomes so increasingly centered on obtaining and using drugs, so the addiction usually leads to socially maladaptive behaviors. Many resort to petty theft and prostitution.

The use of unsterile equipment may also lead to various problems including liver damage from hepatitis and transmission of AIDS. Injection of too much can cause coma or death. Women who use heroin may end up with premature babies who are addicted to heroin and vulnerable to a number of diseases.

The ill health and general personality deterioration often found in opium addiction do not result directly from the pharmacological effects of the drug but rather are products of the sacrifices of money, proper diet, social position and self-respect as an addict becomes more desperate to procure the required daily dosage.

10.2.2.3 Causal Factors in Opiate Abuse and Dependence

The three most frequently cited reasons for beginning to use heroin were pleasure, curiosity and peer pressure. Heavy opiate use may in some part be influenced by a genetic inheritance, perhaps thought the inheritance of personality characteristics.

Other reasons such as a desire to escape life stress, personal maladjustment and sociocultural conditions also play a part.

10.2.2.4 Neural Bases for Physiological Addiction

The repeated use of opiates results in changes to the neurotransmitter systems that regulate/incentive motivation and the ability to manage stress. The human body produces endorphins in a response to stimulation and are believed to play a role in an organisms' reaction to pain. Research of the role of endorphins in drugs has generally been inconclusive.

10.2.2.5 Addiction Associated with Psychopathy

A high incidence of antisocial personality has been found among heroin addicts. Researchers found that opiate addicts were highly impulsive and unable to delay gratification. About 68 percent of heroin abusers were also diagnosed as having a personality disorder.

10.2.2.6 Addiction Associated with Sociocultural Factors

The majority of illicit drug injectors are undereducated and unemployed individuals from minority groups. Most young addicts become easily withdrawn, indifferent to their friends (except those in the drug group), and apathetic about sexual activity. They are likely to
abandon scholastic and athletic endeavors and show a marked reduction in competitive and achievement strivings.

Most of these addicts appear to lack clear sex-role identification and to experience feelings of inadequacy when confronted with the demands of adulthood. They feel progressively isolated from the broader culture at the same time they come to view drugs as both a means of revolt and a device for alleviating personal anxieties and tensions.

10.2.2.7 Treatments and Outcomes

Treatments for narcotics addiction involve building up an addict both physically and psychologically and providing help through the withdrawal period. After physical withdrawal has been completed, treatment focuses on helping a former addict make an adequate adjustment to his or her community and abstain from further use of narcotics.

A key target in treatment of heroin addiction is the alleviation of craving. This may involve the use of the drugs methadone or buprenorphine in conjunction with a rehabilitation program directed toward the total resocialization of addicts.

Methadone hydrochloride is useful because it satisfies an addict’s craving for heroin without producing serious psychological impairment if administered as treatment in a formal clinical context. Buprenorphine operates as a partial antagonist to heroin and produces the feelings of contentment associated with heroin use without the physical dependence.

10.2.3 Cocaine And Amphetamines

Cocaine and amphetamines stimulate the action of the central nervous system.

10.2.3.1 Cocaine

Crack is the street name that is applied to cocaine that has been processed from cocaine hydrochloride to a free base for smoking. In 2003, there were an estimated 2.3 people using cocaine. In 2000, cocaine related admissions were 23 percent of all drug related admissions.

Like the opiates, cocaine may be ingested by sniffing, swallowing or injecting. It precipitates a euphoric state for about 4 to 6 hours during which a user experiences feelings of confidence and contentment, which is preceded by headache, dizziness and restlessness. When cocaine is chronically abused, acute toxic psychotic symptoms may occur including frightening visual, auditory and tactile hallucinations similar to those with acute schizophrenia.

Unlike the opiates, cocaine stimulates the cortex of the brain, inducing sleeplessness and excitement as well as stimulating and accentuating sexual feelings. Acute tolerance has now been demonstrated and some chronic tolerance may also occur. Cognitive impairment associated with cocaine abuse is likely to be an important consideration in the long-term effect of the drug.
A new disorder is described, cocaine withdrawal, that involves symptoms of depression, fatigue, disturbed sleep and increased dreaming. Employment, family and legal problems are more likely to occur among cocaine users.

Women who use cocaine during pregnancy place their babies at risk for both health and psychological problems. These children are at risk of being maltreated and losing their mother during infancy.

**Treatment and Outcomes**

The effective cocaine abuse treatment includes the medications such as desipramine and naltrexone to reduce cravings and psychological therapy to ensure treatment compliance and disulfiram to reduce alcohol use. The feelings of tension and depression that accompany absence of the drug have to be dealt with during the immediate withdrawal period.

The problems clinicians face is cocaine abusers dropping out and that many of these patients have antisocial problems, resulting in treatment resistance or are psychosis prone personalities.

### 10.2.3.2 Amphetamines

The earliest amphetamine to be use was Benzedrine or amphetamine sulfate found in inhalant. Two newer amphetamines were introduced in the 1930s, Dexedrine (dextroamphetamine) and Methadrine (methamphetamine).

Today amphetamines are occasionally used medically for curbing appetite, for treating narcolepsy and for hyperactive children. Amphetamines are sometimes prescribed for alleviating mild feelings of depression, relieving fatigue, and maintaining alertness for sustained periods of time. Amphetamines are typically used for recreational reasons.

**Effects of Amphetamine Abuse**

Amphetamines are psychologically and physically addictive and the body rapidly builds tolerance to them. For a person who exceeds the prescribed dosage, amphetamine consumption results in heightened blood pressure, enlarged pupils, unclear or rapid speech, profuse sweating, tremors, excitability, loss of appetite, confusion and sleeplessness. In large quantities, Methadrine can cause death.

Chronic abuse of amphetamines can result in a wide range of psychopathology known as amphetamine psychosis, which appears to be similar to paranoid schizophrenia. Suicide, homicide, assault and various other acts of violence are associated with amphetamine abuse.

**Treatments and Outcomes**

In some cases, abrupt withdrawal from the chronic, excessive use of amphetamines can result in cramping, nausea, diarrhea, and even convulsions. Abrupt abstinence commonly results in feelings of weariness or depression. The depression usually peaks in 48 to 72
hours, often remains intense for a day or two and tends to lessen gradually over a period of time.

Mild feelings of depression and lassitude may persist for weeks or months. If brain damage has occurred, the residual effects may include impaired ability to concentrate, learn and remember with resulting social, economic and personality deterioration.

10.2.4 Barbiturates (Sedatives)

10.2.4.1 Effects of Barbiturates

Barbiturates were once used widely by physicians to calm patients and induce sleep. Shortly after taking barbiturates, an individual experiences a feeling of relaxation in which tensions seem to disappear, followed by a physical and intellectual lassitude and a tendency toward drowsiness and sleep.

Strong doses produce sleep almost immediately; excessive doses are lethal because they result in paralysis of the brain's respiratory centers. Impaired decision-making and problem solving, sluggishness, slow speech, and sudden mood shifts are also common effects of barbiturates.

Excessive use of barbiturates leads to increased tolerance as well as physiological and psychological dependence. It can also lead to brain damage and personality deterioration. Tolerance does not increase over time and users can easily ingest fatal overdoses.

10.2.4.2 Causal Factors in Barbiturate Abuse and Dependence

The people who become dependent on barbiturates tend to be middle-aged and older people who often rely on them as sleeping pills and who do not commonly see other classes of drugs.

10.2.4.3 Treatments and outcomes

With barbiturates, withdrawal symptoms are more dangerous, sever and long-lasting than opiate withdrawal. The patient becomes anxious, apprehensive and manifests coarse tremors of the hands and face; additional symptoms include insomnia, weakness, nausea, vomiting, abdominal cramps, rapid heart rate, elevated blood pressure, and loss of weight.

An acute delirious psychosis may develop.

For persons taking large dosages, withdrawal symptoms may last as long as a month but usually tend to abate after a week. The withdrawal symptoms in barbiturate addiction can be minimized by administering increasingly small dose of the barbiturate itself or another drug that produces similar effects.
10.2.5 LSD and Related Drugs (Hallucinogens)

The hallucinogens are thought to induce hallucinations

10.2.5.1 LSD

The most potent of the hallucinogens, the odorless, colorless and tasteless LSD can produce intoxication with an amount smaller than a grain of salt. After taking LSD, a person typically goes through 8 hours of changes in sensory perception, mood swings, and feelings of depersonalization and detachment. The LSD experience is not always pleasant. It can be extremely traumatic, and the distorted objects and sounds, the illusory colors and the new thoughts can be menacing and terrifying.

An interesting and unusual phenomenon that may occur is the flashback, an involuntary recurrence of perceptual distortions or hallucinations week or even months after the individual has taken the drug.

10.2.5.2 Mescaline and Peyote

Two are hallucinogens are mescaline, derived from mescal buttons on the top of the peyote cactus and psilocybin, obtained from Mexican mushrooms (Psilocybe mexicana). Both drugs have mind altering and hallucigenic properties but their principal effect appears to be enabling an individual to see, hear and otherwise experience events in unaccustomed ways, transporting him into a realm of nonordinary reality.

10.2.6 Ecstasy

The drug Ecstasy or MDMA (3,4-methylenedioxymethamphetamine) is both a hallucinogen and a stimulant. Usually after 20 minutes of ingesting Ecstasy, a person experience a rush sensation, followed by a feeling of calmness, energy and well being. The effects of Ecstasy can last several hours. People who take the drug report an intense experience of color and sound and mild hallucinations in addition to the high levels of energy and excitement.

MDMA is addictive, yet not as addictive as cocaine. Use of the drug is accompanied by a number of adverse consequences such as clenching of teeth, muscle cramps, blurred vision and hallucinations.

As with other illicit drugs, the recreational use of Ecstasy has been associated with personality characteristics of impulsivity and poor judgment. Ecstasy users are more likely to use marijuana, engage in binge drinking, smoke and have multiple sexual partners. Naive partygoers also use ecstasy as a means of staying up.
10.2.7 Marijuana

Marijuana is a mild hallucinogen that comes from the leaves and flowering tops of the Cannabis plant. Marijuana is related to a stronger drug, hashish derived from the resin exuded by the cannabis plant and made into a gummy powder.

In 2004, over 3.1 million people over 12 years reportedly used marijuana daily and in 2004, 34.9 percent of high school seniors had used marijuana within the past 12 months.

10.2.7.1 Effects of Marijuana

The specific effects of marijuana vary greatly, depending on the quality and dosage of the drug, the personality and mood of the user, the user’s past experiences with the drug, the social setting and the user’s expectations. The result is a state of mild euphoria distinguished by increased feelings of well-being, heightened perceptual acuity and pleasant relaxation. Sensory inputs are intensified.

Marijuana has the effect on the brain of altering one’s internal clock. Often a person’s sense of time is stretched and distorted, so that an event that lasts only a few seconds may seem to cover a much longer span. When smoked, marijuana is rapidly absorbed and its effects appear within seconds to minutes but seldom last for more than two hours.

Marijuana may lead to unpleasant experiences. If a person uses the drug while in an unhappy mood, these feelings may be magnified. Higher dosages and with certain unstable or susceptible individuals, marijuana can produce extreme euphoria, hilarity and overtalkativeness, but it can also produce intense anxiety and depression as well as delusions, hallucinations and other psychotic like experience.

Marijuana’s short-range physiological effects include a moderate increase in heart rate, a slowing reaction time, a slight contraction of pupil size, bloodshot and itchy eyes, a dry mouth and increased appetite. Marijuana induces memory dysfunction and a slowing of information processing. Continued use of high dosages over time tends to produce lethargy and passivity along with reduced life success. In such cases marijuana appears to have a depressant and hallucinogenic effect.

As with other addictive drugs, there may be among the users many individuals with serious antisocial or psychosis prone personalities. Relapse Prevention and Support Group resulted in substantial reduction in marijuana use in the 12 months following treatment.

(a) What are the major physical and psychological effects of morphine and heroin use?

(b) What is methamphetamine? What are the major health factors related to methamphetamine use?
SELF TEST

1. What term, which is not used in DSM-IV-TR, describes the harmful effects of excessive reliance on drugs for pleasure and relief of tension?

2. Tolerance, withdrawal, and compulsive use are associated with ______ while psychological problems and maladaptive behavior are associated with ______.

3. Cognitive, physiological, and ______ symptoms are the factors which define it’s the condition of substance dependence.

4. The need for markedly increased amounts of a substance to achieve the desired effect is called ______.

5. The three major criteria for the diagnosis of substance dependence are tolerance, withdrawal, and ______.

6. Which psychoactive substance produces withdrawal symptoms that are less apparent than those produced by most other substances?

7. Substance intoxication affects which nervous system?

8. Your friend misses work and has serious family difficulties because he uses drugs. However, he is not “addicted” to drugs. What DSM-IV-TR diagnosis would be made in this case?

9. What do alcohol, tranquilizing drugs, amphetamines, and heroin have in common?

10. Which part of the brain is affected first by alcohol consumption?

11. Which part of the brain is affected by continued consumption of alcohol?

12. What are the primary risks to the infant if the child develops fetal alcohol syndrome?

13. How does alcohol act as a positive reinforcer for drinking?

14. How do proponents of Alcoholics Anonymous view alcoholism?

15. What do barbiturates and tranquilizing drugs have in common?

16. What do we call opioids that are manufactured by the brain?

17. Using amphetamines to alter performance on intellectual tasks typically leads to an increase in ______.
Required Reading:


Self-check

1. addiction
2. substance dependence; substance abuse
3. behavioral
4. tolerance.
5. compulsive use.
6. cocaine
7. central nervous system
8. substance abuse
9. Overdose can result in death.
10. frontal lobes
11. cerebellum
12. mental retardation and physical malformations
13. produces pleasant sensations
14. a disease
15. They are central nervous system depressants.
16. endorphins
17. quantity of work, but not quality.
Unit 11

Sexual Variants, Abuse and Dysfunctions

LEARNING OUTCOME

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

1. Describe sociocultural factors involved in classifying sexual behaviors as normal or abnormal.
2. Describe the features of sexual and gender variants.
3. Describe the process of gender reassignment and discuss the outcomes of the procedures undergone.
4. Define and describe the features of various sexual dysfunctions.
5. Discuss theoretical perspectives on sexual dysfunctions and ways of treating them.
6. Define and describe the features of various paraphilias.
7. Discuss theoretical perspectives on the paraphilias and ways of treating them.
8. Discuss the effectiveness of sex therapy techniques.
9. Define sexual abuse and rape, their subtypes, and prevalence.
10. Describe the features of sexual abuse and rape.
11. Describe the psychological, physical, and societal costs of sexual abuse and rape.
12. Discuss the sociocultural factors associated with sexual abuse and rape.
INTRODUCTION

Brief Historical Perspective

Early medical and scientific approaches to sexual behavior were heavily influenced by religious doctrines and prevailing cultural values.

The exclusive purpose of sexual behavior was assumed to be biological reproduction; anything that varied from that narrow goal was considered a form of psychopathology and was usually subject to severe moral and legal sanctions.

The period between 1890 and 1930 saw many crucial changes in the ways in which society viewed sexual behavior. A significant number of people were beginning to think of sex as something other than a simple procreative function. If the purpose of sexual behavior was to foster marital intimacy or to provide pleasure, then interference with that goal might become a legitimate topic of psychological inquiry.

Changes in prevailing social attitudes led to a change in the focus of systems for the classification of sexual problems. Over the course of the later twentieth century and into the twenty-first, there has been a trend toward greater tolerance of sexual variation among consenting adult partners and toward increased concern about impairments in sexual performance and experience.

Several leading intellectuals influenced public and professional opinions regarding sexual behavior during the first half of the twentieth century.

The work of Alfred Kinsey, a biologist at Indiana University, was especially significant. In keeping with his conscious adherence to scientific methods, Kinsey adopted a behavioral stance, focusing specifically on those experiences that resulted in orgasm.

The incredible diversity of experiences reported by Kinsey's subjects led him to reject the distinction between normal and abnormal sexual behavior. He argued that differences among people are quantitative rather than qualitative.

SOCIOCULTURAL INFLUENCES ON SEXUAL PRACTICES AND STANDARDS

Despite the substantial variability in sexual attitudes and behavior in different times and places, people typically behave as though the sexual standards of their time and place are obviously correct, and they tend to be intolerant of sexual nonconformity.

Homosexuality and American Psychiatry

Homosexuality as a Sickness

The view that homosexual people were mentally ill was relatively tolerant compared to some earlier views, for example, the idea that homosexual people were criminals in the need of
incarceration. British and American cultures have long taken punitive approaches to homosexual behavior.

During the 19th and early 20th centuries, prominent sexologist such as Havelock Ellis and Magnus Hirschfeld suggested that homosexuality is natural and consistent with psychological normality.

**Homosexuality as a Nonpathological Variation**

Around 1950, the view of homosexuality as a sickness began to be challenged by both scientist and homosexuals. Scientific blows to the pathology position included Alfred Kinsey’s finding that homosexual behavior was more common than had been previously believed.

### 11.1 SEXUAL AND GENDER VARIANTS

#### 11.1.1 The Paraphilias

People with paraphilia have recurrent intense sexually arousing fantasies, sexual urges or behaviors that generally involve:

- Non human objects
- The suffering or humiliation of oneself or one’s partner
- Children or other nonconsenting persons

To meet DSM-IV-TR criteria, the patterns must last at least 6 months. Five of these conditions can be diagnosed simply if the person has acted on his fantasies or urges, even if the person does not experience significant distress or impairment. A paraphilic person is diagnosed by the insistence and relative exclusivity with which his sexuality focus on the acts or objects in question, without which orgasm is often impossible. Paraphilias are often have a compulsive quality

#### 11.1.1.1 Criteria for Several Different Paraphilias

A. **Fetishism**
   - For at least 6 months, recurrent, intense sexual arousing fantasies, urges or behaviors involving the use of nonliving objects.
   - The fantasies, urges or behaviors cause distress or impairment in functioning.

B. **Transvestic Fetishism**
   - For at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, urges or behaviors involving cross dressing.
   - The fantasies, urges or behaviors cause distress or impairment in functioning.
C. Voyeurism
   • For at least 6 months, recurrent, intense sexual arousing fantasies, urges or behaviors involving the act of observing an unsuspecting person, who is naked, in the process of disrobing or engaging in sexual activity.
   • The person has acted on these sexual urges or fantasies cause marked distress or impairment.

D. Exhibitionism
   • For at least 6 months, recurrent, intense sexual arousing fantasies, urges or behaviors involving the exposure of one's genitals to an unsuspecting stranger.
   • The person has acted on these sexual urges or fantasies cause marked distress or impairment.

E. Sexual Sadism
   • For at least 6 months, recurrent, intense sexual arousing fantasies, urges or behaviors involving real acts in which the psychological or physical suffering of the victim is sexually exciting to the person.
   • The person has acted on these sexual urges or fantasies cause marked distress or impairment.

F. Sexual Masochism
   • For at least 6 months, recurrent, intense sexual arousing fantasies, urges or behaviors involving the real act of being humiliated, beaten, bound or otherwise made to suffer.
   • The person has acted on these sexual urges or fantasies cause marked distress or impairment.

G. Pedophilia
   • For at least 6 months, recurrent, intense sexual arousing fantasies, urges or behaviors involving sexual activity with a prepubescent child or children (generally age 13 or younger).
   • The person has acted on these sexual urges or the sexual urges cause distress or impairment.
   • The person is at least age of 16 and 5 years older than the child.

11.1.1.1 Fetishism

In psychopathology, fetishism refers to the association of sexual arousal with nonliving objects. The person may be unable to become sexually aroused in the absence of the fetish object.

The range of objects that can become associated with sexual arousal is virtually unlimited, but fetishism most often involves women's underwear, shoes and boots, or products made out of rubber or leather. People who fit the description of fetishism typically masturbate while holding, rubbing, or smelling the fetish object. In addition to holding or rubbing the object, the person may wear, or ask his sexual partner to wear, the object during sexual activity.
11.1.1.2 Transvestic Fetishism
In DSM-IV-TR, transvestic fetishism is defined as cross-dressing for the purpose of sexual arousal or autogynephilia. It has been described primarily among heterosexual men and should not be confused with the behavior of some gay men known as drag queens (for whom cross-dressing has a very different purpose and meaning).

People who engage in transvestic fetishism usually keep a collection of female clothes that are used to cross-dress. For some men, transvestism may eventually lead to feelings of dissatisfaction with being male.

They may eventually want to live permanently as women. These men, who develop persistent discomfort with their gender role or identity, would be assigned a subtype diagnosis of transvestic fetishism with gender dysphoria.

11.1.1.3 Frottuerism
In frottuerism, a person who is fully clothed becomes sexually aroused by touching or rubbing his genitals against other, nonconsenting people. The frotteur usually chooses crowded places, such as sidewalks and public transportation, so that he can easily escape arrest. He either rubs his genitals against the victim’s thighs and buttocks or fondles her genitalia or breasts.

11.1.1.4 Voyeurism
The focus of sexual arousal in voyeurism is the act of observing an unsuspecting person, usually a stranger, who is naked, in the process of disrobing, or engaging in sexual activity.

Voyeurs are not aroused by watching people who know that they are being observed. In fact, the secret nature of the observation and the risk of discovery may contribute in an important way to the arousing nature of the situation.

11.1.1.5 Exhibitionism
This behavior is also known as indecent exposure. Many different patterns of behavior fit into this category.

Their intent usually involves a desire to shock the observer, but sometimes they harbor fantasies that the involuntary observer will become sexually aroused. Exhibitionism is almost exclusively a male disorder.

11.1.1.6 Sadism
Someone who derives pleasure by inflicting physical or mental pain on other people is called a sadist.
DSM-IV-TR defines sexual sadism in terms of intense, sexually arousing fantasies, urges, or behaviors that involve the psychological or physical suffering of a victim. Sadistic fantasies often involve asserting dominance over the victim; the experience of power and control may be as important as inflicting pain.

Extreme sexual sadist may mentally replay their torture scenes while masturbating. Serial killers, who tend to be sexual sadist sometimes record or videotape their sadistic acts. Some of the men reported that the God-like sense of being in control of another human being was exhilarating.

11.1.1.7 Masochism

People who become sexually aroused when they are subjected to pain or embarrassment are called masochists.

DSM-IV-TR defines sexual masochism as recurrent, intense sexually arousing fantasies, urges, or impulses involving being humiliated, beaten, bound, or otherwise made to suffer.

Many people who engage in masochistic sexual practices are highly educated and occupationally successful. Masochists tend to be disproportionately represented among the privileged groups in society.

This pattern leads to the suggestion that masochism may be motivated by an attempt to escape temporarily from the otherwise constant burden of maintaining personal control and pursuing self-esteem. One particularly dangerous form of masochism, called autoerotic asphyxias involves strangulation to the point of oxygen deprivation.

11.1.1.2 Causal Factors and Treatments For Paraphilias

Neurological abnormalities may also be involved in the development of paraphilias.

The high rate of overlap among paraphilias indicates that the etiology of these behaviors might be most appropriately viewed in terms of common factors rather than in terms of distinct pathways that lead exclusively to one form of paraphilia or another.

The epidemiological evidence suggests another important pattern that must be explained by any theory of paraphilias: They are more prevalent among men than among women. The exception to this rule seems to be masochism, which may be equally common in both genders.

Some studies of convicted sexually violent offenders have found evidence of elevated levels of testosterone. These reports must be viewed with some skepticism, however, for two reasons. First, the participants in these studies are invariably convicted sexual offenders. Thus, it is not clear that the findings can be generalized to all people with paraphilias. Second, there is a high rate of alcoholism and drug abuse among men convicted of sexual crimes.

For that reason, we do not know whether the biological abnormalities observed in these men are causes of their deviant sexual behavior or consequences of prolonged substance abuse. Based on available evidence it seems reasonable to conclude that some cases of paraphilia are
caused, at least in part, by endocrine and neurological abnormalities, but the relations among these factors are not entirely clear.

Some types of paraphilias seem to be distortions of the normal mating process when viewed in a broad, evolutionary context.

John Money has described the development of paraphilias using a geographic metaphor that he calls a *lovemap*. A lovemap is a mental picture representing a person’s ideal sexual relationship. Children learn their lovemaps during sexual play, by imitation of their parents and other adults and through messages that they digest from the popular media. The lovemap can be distorted, according to Money’s metaphor, if the child learns that romantic attachment and sexual desire are incompatible—that these feelings cannot be directed toward the same person. The inability to integrate these aspects of the lovemap lies at the heart of Money’s explanation of paraphilias.

### 11.1.1.3 Treatments For Paraphilias

Most people with paraphilias do not enter treatment voluntarily. They are often referred to a therapist by the criminal justice system after they have been arrested for exposing themselves, peeping through windows, or engaging in sexual behaviors with children. Their motivation to change is, therefore, open to question.

For several decades, the most commonly used form of treatment for paraphilias was aversion therapy. In this procedure, the therapist repeatedly presents the stimulus that elicits inappropriate sexual arousal in association with an aversive stimulus, such as repulsive smells, electric shock, or chemically induced nausea.

Revolting cognitive images are sometimes used instead of tangible aversive stimuli. Whatever the exact procedure, the rationale is to create a new association with the inappropriate stimulus so that the stimulus will no longer elicit sexual arousal.

Some studies suggested that aversion therapy produces positive effects. This treatment has more recently fallen into disfavor, however, because the studies that were used to evaluate it suffered from design flaws.

Current behavioral treatment programs for paraphilic behaviors reflect a broader view of the etiology of these conditions. There is considerable reason to believe that paraphilias are based on a variety of cognitive and social deficits. Data suggest that broad-based cognitive and social treatment procedures may ultimately be most useful in the treatment of paraphilias and sexual disorders. Unfortunately, research results regarding the effectiveness of psychological treatment for sexual offenders are discouraging.

Another approach to the treatment of paraphilias involves the use of drugs that reduce levels of testosterone, on the assumption that male hormones control the sexual appetite. However, one review of this literature concludes that treatment programs should never rely exclusively on the use of medications that reduce levels of testosterone. Antidepressants and anti-anxiety drugs have also been used to treat paraphilias. Case studies as well as some small uncontrolled outcome studies indicate that the SSRIs can have beneficial effects for some male patients.
11.1.2 Gender Identity Disorders

Our sense of ourselves as being either male or female is known as gender identity.

11.1.2.1 Criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification. In children four of the following must also be present:
   a. Repeatedly stated desire to be, or insistence one is the other sex.
   b. In boys, preference for cross-dressing in feminine attire, in girls, insistence on wearing stereotypical masculine clothing.
   c. Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
   d. Intense desire to participate in the stereotypical games and pastimes of the other sex.
   e. Strong preference for playmates of the other sex.

In adolescents and adults, the disturbance is manifested by symptoms such as stated desire to be of the other sex, frequent passing as the other sex and/or desire to live or be treated as the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness of the gender role of that sex.

In boys, this could be in the form of assertion that penis or testes are disgusting or that it would be better not to have a penis or rejection of stereotypical male toys, games and activities.

In girls, rejection of urinating in a sitting position, assertion that she will grow a penis, or assertion that she does not want to grow breast and menstruate.

In adolescents and adults, preoccupation with getting rid of primary and secondary sex characteristics by procedures to physically alter sexual characteristics to simulate the other sex.

11.1.2.2 Gender Identity Disorder in Childhood

Gender identity almost always reflects the child's physical anatomy. Gender identity is usually fixed by the time a child reaches 2 or 3 years of age.

Gender identity must be distinguished from sex roles, which are characteristics, behaviors, and skills that are defined within a specific culture as being either masculine or feminine.

Boys with gender identity disorder show a marked preoccupation with traditionally feminine activities which is opposite for girls with gender identity disorder.
The most common outcome of boys with gender identity disorder seems to be homosexuality (40 to 60 percent) rather than transexualism (10 to 20 percent). For women 35 to 45 percent had a desire for sex reassignment surgery and half were homosexual.

**Treatment**

Children with gender identity disorder are often brought for psychotherapy. Children with gender identity disorders often have other general behavioral problems such as anxiety and mood disorders.

Therapists try to improve their peer and parental relations by teaching such children how to reduce their cross-gender behavior. Gender dysphoria is treated psychodynamically.

### 11.1.2.3 Transsexualism

**Transsexualism** is also known as *gender dysphoria*. Most transsexuals report that they were aware of these feelings very early in childhood.

Gender identity disorders should be distinguished from transvestic fetishism, which is a form of paraphilia in which a heterosexual man dresses in the clothing of the other gender in order to achieve sexual arousal. These are, in fact, very different conditions.

Transvestic fetishists do not consider themselves to be women, and transsexuals are not sexually aroused by cross-dressing. Homosexual transsexual men are generally very feminine and are attracted to men.

Gender identity disorders are rare in comparison to most of the other disorders that we have considered. Male-to-female transsexuals are apparently more common than female-to-male transsexuals, at least based on the numbers of people who seek treatment at clinics. Deeply ingrained cross-gender behaviors and attitudes among children occur infrequently in the general population.

Very little is known about the origins of gender identity in normal men and women, so it is not surprising that the etiology of gender identity disorders is also poorly understood.

There is some reason to believe that gender identity is strongly influenced by sex hormones, especially during the prenatal period.

**Treatment**

There are two obvious solutions to problems of gender identity: Change the person's identity to match his or her anatomy, or change the anatomy to match the person's gender identity.

Various forms of psychotherapy have been used in an effort to alter gender identity, but the results have been fairly negative.
One alternative to psychological treatment is sex-reassignment surgery, in which the person’s genitals are changed to match the gender identity. The results of sex-reassignment surgery have generally been positive.

ACTIVITY II

(a) Define paraphilia and cite eight paraphilias recognized in the DSM, along with their associated features.
(b) What two components characterize gender identity disorders?

11.2 SEXUAL ABUSE

Sexual abuse is sexual contact that involves physical or psychological coercion or at least one individual who cannot reasonably consent to the contact.

11.2.1 Childhood Sexual Abuse

Prevalence of Childhood Sexual Abuse

Depending on which definition used, prevalence figures have ranged from less than 5 percent to more than 30 percent.

Consequences of Childhood Sexual Abuse

The most common short-term consequences are fears, post-traumatic stress disorders, sexual inappropriateness and poor self-esteem. Approximately one-third of sexually abused children show no symptoms.

A number of studies found associations between reports of childhood abuse and adult psychopathology including borderline personality disorder, somatization disorder with dissociative symptoms, and dissociative identity disorder. A wide variety of sexual symptoms have been alleged to result from early sexual abuse.
11.2.2 Pedophilia

Pedophilia entails recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child (generally age 13 years or younger). In order to qualify for a diagnosis of pedophilia in DSM-IV-TR, the person must be at least 16 years of age and at least 5 years older than the child.

The terms pedophile and child molester are sometimes used interchangeably, but this practice confuses legal definitions with psychopathology. A child molester is a person who has committed a sexual offense against a child victim. Therefore the term depends on legal definitions of "sexual offense" and "child victim," which can vary from one state or country to another.

Pedophilia usually begins in adolescence and persists over a person’s life. Many engage in work with children or youth so they have extensive access to children. Pedophilia includes a great variety of behaviors and sexual preferences.

11.2.3 Incest

Incest refers to sexual activity between close blood relatives, such as father–daughter, mother–son, or between siblings.

The definition may also be expanded to include stepchildren and their stepparents in reconstituted families.

Many incest perpetrators would not be considered pedophiles, either because their victims are post-pubescent adolescents or because they are also young themselves (such as male adolescents molesting their younger sisters).

11.2.4 Rape

The legal definition of rape includes “acts involving nonconsensual sexual penetration obtained by physical force, by threat of bodily harm, or when the victim is incapable of giving consent by virtue of mental illness, mental retardation, or intoxication.”

Some rapes are committed by strangers, but many others—known as acquaintance rapes—are committed by men who know their victims. Rapes are committed by many different kinds of people for many different reasons.

11.2.4.1 Is Rape Motivated By Sex or Aggression?

Current efforts to classify sexual offenders attempt to distinguish between those for whom deviant sexual arousal contributes to the act and those whose behavior is motivated primarily by anger or violent impulses.
Raymond Knight and his colleagues have developed a classification system for convicted rapists who were imprisoned at an institution for sexually dangerous persons.

They identified four different types of rapists. Two categories include men whose motivation for sexual assault is primarily sexual in nature:

**Sadistic rapists** exhibit features that are close to the DSM-IV-TR definition of a paraphilia. Their behavior is determined by a combination of sexual and aggressive impulses. The non-sadistic category also includes men who are preoccupied with sexual fantasies, but these fantasies are not blended with images of violence and aggression.

The other two categories describe men whose primary motivation for rape is not sexual. **Vindictive rapists** seem intent on violence directed exclusively toward women. Their aggression is not erotically motivated, as with sadistic rapists. **Opportunistic rapists** are men with an extensive history of impulsive behavior in many kinds of settings and who might be considered psychopaths. Their sexual behavior is governed largely by immediate environmental cues. They will use whatever force is necessary to ensure compliance, but they express anger only in response to the victim's resistance.

### 11.2.4.2 Rape and Its Aftermath

In addition to the physical trauma on a victim the psychological trauma may be severe. Apart from post-traumatic disorder, there is a possibility of pregnancy or of contracting a sexually transmitted disease.

### 11.2.4.3 Rapist and Causal Considerations

In terms of personality, rapist is very often characterized by impulsivity, quick loss of temper, lack of personally intimate relationships and insensitivity to social cues or pressures. Many rapists show deficits in social and communication skills as well as their cognitive appraisal of women's feelings and intentions. In addition they have difficulty-decoding women's negative cues during social interactions and often interpret friendly behavior as flirtatious or sexually provocative.

### 11.2.5 Treatment and Recidivism of Sex Offenders

Recidivism rates are higher among sex offenders with deviant sexual preferences. The recidivism rates for rapists steadily decrease with age, but the rate for child molesters does not decline much until after age 50.

#### 11.2.5.1 Psychotherapies and Their Effectiveness

Therapies for sex offenders typically have at least one of the following goals:
- To modify patterns of sexual arousal
- To modify cognitions and social skills to allow more appropriate sexual interactions with adult partners
- To change habits or behavior that increases the chance of reoffending
- To reduce sexual drive.
Attempts to modify sexual arousal patterns usually involve aversion therapy. An alternative version is electric aversion or covert sensitization, in which the patient imagines a highly aversive stimulus while viewing or imagining a paraphilic stimulus or assisted covert sensitization in which a foul odor is introduced at the peak of arousal.

Cognitive restructuring attempts to eliminate sex offenders' cognitive distortions. In addition, social-skills training aims to help sex offenders learn and process social information more appropriately.

The U.S. Congress and all 50 states have passed laws that are intended to protect society from people who have been convicted of violent or repeated sexual offenses. These laws fall into two categories. The first includes community notification laws (such as "Megan's Law"), which require the distribution of information to the public regarding the presence of child molesters and sexually violent offenders when they are released from prison or placed on parole. The second category includes sexual predator laws, which are designed to keep some criminals in custody indefinitely.

11.2.5.2 Biological and Surgical Treatments

Both surgical and chemical castration lowers the testosterone level, which in turn lowers the sex drive, allowing the offender to resist any inappropriate impulses.

**ACTIVITY 11.3**

(a) Define pedophile, incest and rape and summarize the major clinical features of the perpetrators of these crimes.

(b) Identify the main goals of treatment of sex offenders, and describe the different treatment approaches.
10.3 SEXUAL DYSFUNCTIONS

Inhibitions of sexual desire and interference with the physiological responses leading to orgasm are called sexual dysfunctions. Problems can arise anywhere, from the earliest stages of interest and desire through the climactic release of orgasm.

William Masters, a physician, and Virginia Johnson, a psychologist, were undoubtedly the best-known sex therapists and researchers in the United States during the second half of the twentieth century. Masters and Johnson described the human sexual response cycle in terms of a sequence of overlapping phases: excitement, orgasm, and resolution.

Sexual excitement increases continuously from initial stimulation up to the point of orgasm. Among the most dramatic physiological changes during sexual excitement are those associated with vasocostriction—engorgement of the blood vessels of various organs, especially the genitals.

The experience of orgasm is usually distinct from the gradual buildup of sexual excitement that precedes it. This sudden release of tension is almost always experienced as being intensely pleasurable, but the specific nature of the experience varies from one person to the next.

The female orgasm occurs in three stages, beginning with a “sensation of suspension or stoppage,” which is associated with strong genital sensations. The second stage involves a feeling of warmth spreading throughout the pelvic area. The third stage is characterized by sensations of throbbing or pulsating, which are tied to rhythmic contractions of the vagina, the uterus, and the rectal sphincter muscle.

The male orgasm occurs in two stages, beginning with a sensation of ejaculatory inevitability. This is triggered by the movement of seminal fluid toward the urethra. In the second stage, regular contractions propel semen through the urethra, and it is expelled through the urinary opening.

During the resolution phase, which may last 30 minutes or longer, the person’s body returns to its resting state. Men are typically unresponsive to further sexual stimulation for a variable period of time after reaching orgasm. This is known as the refractory period.

Women, on the other hand, may be able to respond to further stimulation almost immediately.

Sexual dysfunctions can involve a disruption of any stage of the sexual response cycle. Many sexual problems are best defined in terms of the couple rather than each partner individually. Although problems in sexual behavior clearly involve basic physiological responses and behavioral skills, each person’s thoughts about the meaning of sexual behavior are also extremely important.
11.3.1 Criteria For Different Sexual Dysfunctions

11.3.1.1 General Criteria for All Dysfunctions

A. The disturbance causes marked distress or interpersonal difficulty.
B. The sexual dysfunction is not better accounted for by another Axis I disorder and is not due to direct effects of a substance or a general medical condition.
C. Specifiers include: Lifelong vs. Acquired Types and Generalized vs. Situational Types.

11.3.1.2 Specific Criteria for Different Dysfunctions

A. Sexual Desire Disorders:
   a. Hypoactive Sexual Desire Disorder - Persistently or recurrently deficient or absent sexual fantasies and desire for sexual activity. Thus judgment of deficiency or absence is made by the clinician taking into account such factors as age and context of a person’s life.
   b. Sexual Aversion Disorder - Persistent or recurrent extreme aversion to and avoidance of all (or almost all) genital contact with a sexual partner.

B. Sexual Arousal Disorders:
   a. Female Sexual Arousal Disorder – Persistent or recurrent to attain or to maintain until completion of the sexual activity an adequate lubricating or swelling response of sexual excitement.
   b. Male Erectile Disorder – Persistent or recurrent inability to attain or to maintain until the completion of the sexual activity an adequate erection.

C. Orgasmic Disorders:
   a. Female Orgasmic Disorder – Persistent of recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Diagnosis is made based on clinicians’ judgment that the woman’s orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.
   b. Male Orgasmic Disorder – Persistent or recurrent delay in, or absence of orgasm following normal sexual excitement phase during sexual activity that the clinician, taking into account the person’s age, judges to be adequate in focus, intensity and duration.
   c. Premature Ejaculation – Persistent or recurrent ejaculation with minimal sexual stimulation before or shortly after penetration and before the person wishes it. The clinician must take into account factors such as age, novelty of the sexual partner or situation and recent frequency of sexual activity.

D. Sexual Pain Disorders:
   a. Dyspareunia – Recurrent or persistent genital pain associated with sexual intercourse in either a male or female.
   b. Vaginismus – Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.
11.3.2 Dysfunctions Of Sexual Desire

Inhibited, or hypactive, sexual desire is defined in terms of subjective experiences, such as lack of sexual fantasies and lack of interest in sexual experiences. The absence of interest in sex must be both persistent and pervasive to be considered a clinical problem.

The absolute frequency with which a person engages in sex cannot be used as a measure of inhibited sexual desire because the central issue is interest—actively seeking out sexual experiences—rather than participation.

The fact that hypactive sexual desire is listed in DSM-IV-TR as a type of disorder should not lead us to believe that it is a unitary condition with a simple explanation. It is, in fact, a collection of many different kinds of problems.

People who suffer from low levels of sexual desire frequently experience other mental and medical disorders. Some people develop an active aversion to sexual stimuli and begin to avoid sexual situations altogether. Some people avoid only certain aspects of sexual behavior, such as kissing, intercourse, or oral sex. This reaction is stronger than a simple lack of interest.

Fear of sexual encounters can occasionally reach intense proportions, at which point it may be better characterized as sexual aversion disorder. This problem might be viewed as a kind of phobia because it extends well beyond anxiety about sexual performance.

Sexual interest depends in part on testosterone. The sexual desire problems increases with age in part due to declining levels of testosterone. Hypoactive sexual disorder appears to be the most common female dysfunction.

11.3.3 Dysfunctions Of Sexual Arousal

11.3.3.1 Male Erectile Disorder

Many men experience difficulties either in obtaining an erection that is sufficient to accomplish intercourse or maintaining an erection long enough to satisfy themselves and their partners during intercourse. Both problems are examples of erectile dysfunction.

Men with this problem may report feeling subjectively aroused, but the vascular reflex mechanism fails, and sufficient blood is not pumped to the penis to make it erect. This phenomenon is called impotence, but the term has been dropped because of its negative implications. Erectile dysfunctions can be relatively transient, or they can be more chronic.

Erectile problems occur in as many as 90 percent of men on certain antidepressant medications. These problems are also a common consequence of aging. For young men, one cause of erectile disorder is having had priapism, an erection that will not diminish even after a couple of hours.
Treatment

A variety of treatments have been employed, often when behavioral-behavioral treatments have failed. These include:

- Medications such as yohimbine
- Injections of smooth-muscle-relaxing drugs into the penile erection chambers
- And even a vacuum pump

Viagra works by making nitric oxide, the primary neurotransmitter involved in penile erection more available.

11.3.3.3 Female Sexual Arousal Disorder

A woman is said to experience inhibited sexual arousal if she cannot either achieve or maintain genital responses, such as lubrication and swelling that are necessary to complete sexual intercourse. The desire is there, but the physiological responses that characterize sexual excitement are inhibited.

Possible reasons for this inhibition of sexual feelings range from early sexual traumatization, to excessive and distorted socializations about the evils of sex to dislike of or disgust with a partner’s current sexuality.

Treatment

Clinical experience suggests that psychotherapy and sex therapy may play important roles. The widespread use of vaginal lubricants may effectively mask and treat the disorder in women. In addition, there has been great interest in the possibility that Viagra, Levitra and Cialis would have positive effects in women.

11.3.4 Orgasmic Disorders

11.3.4.1 Premature Ejaculation

Many men experience problems with the control of ejaculation. They are unable to prolong the period of sexual excitement long enough to complete intercourse. This problem is known as premature ejaculation. Once they become intensely sexually aroused, they reach orgasm very quickly.

Treatment

The pause-and-squeeze technique requires the man to monitor his sexual arousal during sexual activity. When arousal is intense enough that the man feels that ejaculation might occur soon, he pauses, squeezes the head of the penis until the feeling of pending ejaculation passes.
Antidepressants such as paroxetine (Paxil) and setraline (Zoloft) have been found to prolong significantly ejaculatory latency in men with premature ejaculation.

### 11.3.4.2 Male Orgasmic Disorder

Sometime called retarded ejaculation or inhibited male orgasm, male orgasmic disorder refers to the persistent inability to ejaculate during intercourse. Retarded ejaculation can be related to specific physical problems such as multiple sclerosis or the use of certain medications.

### 11.3.4.3 Female Orgasmic Disorder

Women who experience orgasmic difficulties may have a strong desire to engage in sexual relations, they may find great pleasure in sexual foreplay, and they may show all the signs of sexual arousal. Nevertheless, they cannot reach the peak erotic experience of orgasm.

Women whose orgasmic impairment is generalized have never experienced orgasm by any means. Situational orgasmic difficulties occur when the woman is able to reach orgasm in some situations but not in others.

Orgasmic disorder in women is somewhat difficult to define in relation to inhibited sexual arousal because the various components of female sexual response are more difficult to measure than are erection and ejaculation in the male.

Women with this disorder report that when engaging in intercourse they do not have difficulty lubricating and experience no pain. However, they report no genital sensations (hence the term genital anesthesia) and do not appear to know what sexual arousal is.

Most of these women seek therapy because they have heard from others or have read that they are missing something, rather than because they themselves feel frustrated.

#### Treatment

Masters and Johnson were pioneers in developing and popularizing a short-term, skills-based approach to the treatment of sexual dysfunctions. Psychological treatments for sexual dysfunction address several of the causes discussed earlier, especially negative attitudes toward sexuality, failure to engage in effective sexual behaviors, and deficits in communication skills.

Sex therapy centers around three primary types of activity: sensual focus and scheduling; education and cognitive restructuring; and communication training. The cornerstone of sex therapy is known as sensate focus, a procedure developed by Masters and Johnson.

Sensate focus involves a series of simple exercises in which the couple spends time in a quiet, relaxed setting, learning to touch each other. The rationale for sensate focus hinges on the recognition that people with sexual problems must learn to focus on erotic sensations rather than on performance demands.
The goal is to help them become more comfortable with this kind of physical sharing and intimacy, to learn to relax and enjoy it, and to talk to each other about what feels good and what does not.

Another facet of psychological approaches to treating sexual dysfunction involves scheduling. This is, in fact, closely related to sensate focus because the technique of sensate focus requires that people schedule time for sex.

A third aspect of sex therapy involves education and cognitive restructuring—changing the way in which people think about sex. The final element of psychological treatment for sexual dysfunction is communication training.

11.3.5 Dysfunctions Involving Sexual Pain

11.3.5.1 Vaginismus

Some women find that whenever penetration of the vagina is attempted, the muscles around the entrance to the vagina snap tightly shut, preventing insertion of any object.

This involuntary muscular spasm, known as vaginismus, prevents sexual intercourse as well as other activities, such as vaginal examinations and the insertion of tampons. Many women experience genital pain during sexual stimulation other than intercourse.

11.3.5.2 Dyspareunia

Some people experience persistent genital pain during or after sexual intercourse, which is known as dyspareunia. The problem can occur in either men or women, although it is considered to be much more common in women.

**Activity 11.3**

(a) Compare and contrast the symptoms of the dysfunctions of sexual desire, arousal and orgasm in men and women.

(b) What are the most effective treatments for male erectile disorder and premature ejaculation and for female orgasmic disorder?
1. What do all of the sexual dysfunctions covered by DSM-IV-TR have in common?

2. Ed’s wife reports he has lost interest in sexual activity. He is not responsive, and she is considering divorce. Ed has a ________.

3. What are the three major categories of sexual dysfunctions in DSM-IV-TR?

4. What is the most common sexual problem for which men seek treatment?

5. Which disorder could possibly lead to a panic attack with feelings of terror?

6. Vaginismus is characterized by ________.

7. Gender identity refers to a person’s ________.

8. What is the difference between gender identity and sexual preference?

9. In contrast to transvestites, transsexuals are characterized by ________.

10. What is a paraphilia?

11. What term do we use for sexual attraction to a nonliving object?

12. What disorder is associated with men and involves exposing their genitals?

13. What is the root of the sexual disorder called voyeurism?

14. Robert has intense and recurrent sexual urges regarding children. What is Robert’s diagnosis?

15. To be classified as a pedophile, a person must have acted on urges to engage in sexual activity with a child OR ________.
Required Reading:


Self-check

2. They cause distress or interpersonal difficulty
3. sexual dysfunction
4. desire, arousal, orgasm
5. erectile dysfunction
6. sexual aversion disorder
7. involuntary spasms of the outer portion of the vagina.
8. sense of being male or female.
9. Gender identity involves whether a person views themselves as male or female; sexual preference involves attraction to either a male or a female.
10. a desire to live as a member of the opposite sex.
11. sexual attraction to something deviant
12. fetishism
13. exhibitionism
14. It is derived from a French word meaning watcher.
15. pedophilia
16. be very distressed by the urges.
Unit 12  ■ Schizophrenia and Other Psychotic Disorders

LEARNING OUTCOME

At the end of this topic you will learn about:

1. Distinguish among the disorganized, catatonic, paranoid, Type I, and Type II types of schizophrenia.
2. Review the disturbances in thought, speech, attention, perception, emotions, and other types of impairment associated with schizophrenia.
3. Distinguish between positive and negative symptoms and their subtypes.
4. Discuss theoretical perspectives on schizophrenia, including the psychodynamic, learning, biological, and family theories in the development of schizophrenia.
5. Discuss biological, psychodynamic, learning-based, psychosocial-rehabilitation, and family intervention treatments of schizophrenia.
6. Describe the diagnostic features of brief psychotic disorder, schizophreniform disorder, delusional disorder, and other schizophrenic-spectrum disorders.
INTRODUCTION

The Epidemiology of Schizophrenia

One of the most informative ways of examining the frequency of schizophrenia is to consider the lifetime morbidity risk—that is, the proportion of a specific population that will be affected by the disorder at some time during their lives. Most studies in Europe and the United States have reported lifetime morbidity risk figures of approximately 1 percent.

The vast majority of cases of schizophrenia begin in late adolescence and early childhood. The period of risk for the development of a first episode is considered to be between the ages of 15 and 35. Most epidemiological studies have reported that across the life span men and women are equally likely to be affected by schizophrenia.

The average age at which schizophrenic males begin to exhibit overt symptoms is younger by about 4 or 5 years than the average age at which schizophrenic women first experience problems. Male patients are more likely than female patients to exhibit negative symptoms, and they are also more likely to follow a chronic, deteriorating course.

Schizophrenia has been observed in virtually every culture that has been subjected to careful scrutiny. Two large-scale epidemiological studies, conducted by teams of scientists working for the World Health Organization (WHO), indicate that the incidence of schizophrenia is relatively constant across different cultural settings.

Origins of the Schizophrenia Construct

Descriptions of schizophrenic symptoms can be traced far back in history, but they were not considered to be symptoms of a single disorder until late in the nineteenth century.

At that time, Emil Kraepelin, a German psychiatrist, suggested that several types of problems that previously had been classified as distinct forms of disorder should be grouped together under a single diagnostic category called dementia praecox. This term referred to psychoses that ended in severe intellectual deterioration (dementia) and that had an early or premature (praecox) onset, usually during adolescence.

Kraepelin argued that these patients could be distinguished from those suffering from other disorders (most notably manic-depressive psychosis) largely on the basis of changes that occurred as the disorder progressed over time, primarily those changes involving the integrity of mental functions.

In 1911, Eugen Bleuler published an influential monograph in which he agreed with most of Kraepelin’s suggestions about this disorder. He did not believe, however, that the disorder always ended in profound deterioration or that it always began in late adolescence.

Kraepelin’s term dementia praecox was, therefore, unacceptable to him. Bleuler suggested a new name for the disorder—schizophrenia. This term referred to the splitting of mental associations, which Bleuler believed to be the fundamental disturbance in schizophrenia.
12.1 THE CLINICAL PICTURE IN SCHIZOPHRENIA

12.1.1 Criteria For The Diagnosis Of Schizophrenia:

- Two or more of the following symptoms, present for a significant portion of time during a 1-month period (less if successfully treated):
  1. Delusions
  2. Hallucinations
  3. Disorganized speech
  4. Grossly disorganized or catatonic behavior
  5. Negative symptoms

- Dysfunctions in work, interpersonal relations or self care.

- Signs of disturbance for at least 6 months, with at least 1 month of symptoms listed above.

The problems of most patients can be divided into three phases of variable and unpredictable duration: prodromal, active, and residual. Symptoms such as hallucinations, delusions, and disorganized speech are characteristic of the active phase of the disorder.

- The **prodromal phase** precedes the active phase and is marked by an obvious deterioration in role functioning as a student, employee, or homemaker. Prodromal signs and symptoms are similar to those associated with schizotypal personality disorder.

  They include peculiar behaviors (such as talking to one’s self in public), unusual perceptual experiences, outbursts of anger, increased tension, and restlessness. Social withdrawal, indecisiveness, and lack of willpower are often seen during the prodromal phase.

- The **residual phase** follows the active phase of the disorder and is defined by signs and symptoms that are similar in many respects to those seen during the prodromal phase. At this point, the most dramatic symptoms of psychosis have improved, but the person continues to be impaired in various ways.

  Negative symptoms, such as impoverished expression of emotions, may remain pronounced during the residual phase.
12.1.1 Delusions

Many schizophrenic patients express delusions, or idiosyncratic beliefs that are rigidly held in spite of their preposterous nature. Delusions have sometimes been defined as false beliefs based on incorrect inferences about reality. This definition has a number of problems, including the difficulty of establishing the ultimate truth of many situations.

In the most obvious cases, delusional patients express and defend their beliefs with utmost conviction, even when presented with contradictory evidence. Delusional patients typically are unable to consider the perspective that other people hold with regard to their beliefs.

Common delusions include the belief that thoughts are being inserted into the patient's head, that other people are reading the patient's thoughts, or that the patient is being controlled by mysterious, external forces. Many delusions focus on grandiose or paranoid content.

12.1.2 Hallucinations

Hallucinations are sensory experiences that are not caused by actual external stimuli.

Although hallucinations can occur in any of the senses, those experienced by schizophrenic patients are most often auditory.

Hallucinations should be distinguished from the transient mistaken perceptions that most people experience from time to time. Hallucinations strike the person as being real, in spite of the fact that they have no basis in reality. They are also persistent over time.

12.1.3 Disorganized Speech

One important set of schizophrenic symptoms, known as disorganized speech, involves the tendency of some patients to say things that don't make sense.

Signs of disorganized speech include making irrelevant responses to questions, expressing disconnected ideas, and using words in peculiar ways.

This symptom is also called thought disorder, because clinicians have assumed that the failure to communicate successfully reflects a disturbance in the thought patterns that govern verbal discourse.

Common features of disorganized speech in schizophrenia include shifting topics too abruptly, called loose associations or derailment; replying to a question with an irrelevant response, called tangentiality; or persistently repeating the same word or phrase over and over again, called perseveration.
12.1.4 Disorganized and Catatonic Behavior

Thinking disturbances and bizarre behavior represent a third symptom dimension, which is sometimes called disorganization. Goal-oriented activity is almost universally disrupted in schizophrenia. The impairment occurs in areas of routine daily functioning.

Schizophrenic patients may exhibit various forms of unusual motor behavior.

- **Catatonia** most often refers to immobility and marked muscular rigidity, but it can also refer to excitement and overactivity.
- Catatonic posturing is often associated with a *stuporous state*, or generally reduced responsiveness.
- Another kind of bizarre behavior involves affective responses that are obviously inconsistent with the person’s situation. The most remarkable features of inappropriate affect are incongruity and lack of adaptability in emotional expression.

12.1.5 Negative Symptoms

Negative symptoms of schizophrenia are defined in terms of responses or functions that appear to be missing from the person’s behavior. In that sense, they may initially be more subtle or difficult to recognize than the positive symptoms of this disorder.

Negative symptoms tend to be more stable over time than positive symptoms, which fluctuate in severity as the person moves in and out of active phases of psychosis.

- **Blunted affect**, or affective flattening, involves a flattening or restriction of the person’s nonverbal display of emotional responses.
- Another type of emotional deficit is called anhedonia, which refers to the inability to experience pleasure.
- Many people with schizophrenia become socially withdrawn. The withdrawal seen among many schizophrenic patients is accompanied by indecisiveness, ambivalence, and a loss of willpower.
- This symptom is known as avolition. A person who suffers from avolition becomes apathetic and ceases to work toward personal goals or to function independently.
- Another negative symptom involves a form of speech disturbance called alogia, which refers to impoverished thinking. In one form of alogia, known as poverty of speech, patients show remarkable reductions in the amount of speech.
- In another form, referred to as thought blocking, the patient’s train of speech is interrupted before a thought or idea has been completed.
12.2 SUBTYPES OF SCHIZOPHRENIA

12.2.1 Paranoid Schizophrenia

The patient with paranoid schizophrenia show a history of increasing suspiciousness and severe difficulties in interpersonal relationships. Persecutory delusions are the most frequent and may involve and wide range of bizarre ideas and plots. Delusions of grandeur are also common in paranoid schizophrenia.

Criteria for Paranoid Schizophrenia

A. Preoccupations with delusions or frequent auditory hallucinations.
B. No evidence of marked disorganized speech, disorganized or catatonic behavior, flat or inappropriate affect.

Patients with the paranoid subtype of schizophrenia tend to function at a higher level overall and also to have more intact cognitive kills than patients with other subtypes.

12.2.2 Disorganized Type

The disorganized type of schizophrenia is characterized by disorganized speech, disorganized behavior, and flat or inappropriate affect.

Very gradually, the person becomes more reclusive and preoccupied with fantasies. As the disorder progresses, the clinical picture is one of emotional indifference and infantile behavior.
Patients with disorganized schizophrenia may have severe disruptions in their abilities to take care of themselves and be unable to perform routine tasks. They sometimes show peculiar mannerisms and other bizarre forms of behavior.

**Criteria for Disorganized Schizophrenia**

A. Disorganized speech  
B. Disorganized behavior  
C. Flat or inappropriate affect  
D. No evidence of catatonic schizophrenia

The prognosis is generally poor for individuals who develop disorganized schizophrenia. At this stage of deterioration, no form of treatment intervention yet discovered has a high likelihood of effecting more than modest gains.

### 12.2.3 Catatonic Type

The catatonic type is characterized by symptoms of motor immobility (including rigidity and posturing) or excessive and purposeless motor activity.

Some of these patients are highly suggestible and will automatically obey commands or echopraxia (imitate the actions of others) or echolalia (mimic their phrases).

Ordinarily, patients in a catatonic stupor may stubbornly refuse to change their position, may become mute, resist all attempts at feeding and refuse to comply to even the slightest request. Catatonic patients may pass suddenly from extreme stupor to a state of great excitement and may become violent.

**Criteria for Catatonic Schizophrenia:**

In catatonic schizophrenia, the clinical picture is dominated by at least two of the following:

a. Immobile body or stupor.  
b. Excessive motor activity that is purposeless and unrelated to outside stimuli.  
c. Extreme negativism (resistance to being moved or to follow instructions) or mutism.  
d. Assumptions to bizarre positions, or stereotyped movements or mannerisms.  
e. Echolalia or echopraxia.

### 12.2.4 Undifferentiated Type

A person meets the usual criteria for schizophrenia – including delusions, hallucinations, disordered thoughts and bizarre behaviors – but does not clearly fit into one of the other types because of a mixed-symptom picture.
Criteria for Undifferentiated Schizophrenia:
Symptoms of schizophrenia that do not meet criteria for the Paranoid, Disorganized and Catatonic types.

12.2.5 Residual Type
The residual type includes patients who no longer meet the criteria for active phase symptoms but nevertheless demonstrate continued signs of negative symptoms or attenuated forms of delusions, hallucinations, or disorganized speech. They are in “partial remission.”

Criteria for the Residual Type of Schizophrenia
A. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.
B. Continued evidence of schizophrenia or mild psychotic symptoms.

12.2.6 Other Psychotic Disorders

12.2.6.1 Schizoaffective Disorder
Schizoaffective disorder is defined by an episode in which the symptoms of schizophrenia partially overlap with a major depressive episode or a manic episode.

Criteria for Schizoaffective Disorder
A. An illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode that co-occurs with symptoms of Schizophrenia.
B. During the illness, there must be a period of at least 2 weeks where delusions and hallucinations have been present without mood symptoms.
C. The mood symptoms are present for a substantial proportion of the total illness time.
12.2.6.2 Schizophreniform Disorder

This category is reserved for schizophrenia-like psychoses that last at least a month but do not last for 6 months so do not warrant a diagnosis of schizophrenia.

Criteria for Schizophreniform Disorder:
A. Symptoms for schizophrenia.
B. An episode of the disorder that lasts at least a month but less than 6 months.

12.2.6.3 Delusional Disorder

People with delusional disorder do not meet the full symptomatic criteria for schizophrenia, but they are preoccupied for at least 1 month with delusions that are not bizarre.

Criteria for Delusional Disorder:
A. Nonbizarre delusions that last for at least a month.
B. No evidence of full-blown schizophrenia.
C. Apart from the delusion, the person's functioning is not markedly impaired; neither is behavior obviously odd or bizarre.

12.2.6.4 Brief Psychotic Disorder

Brief psychotic disorder is a category that includes those people who exhibit psychotic symptoms—delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior—for at least 1 day but no more than 1 month.

Criteria for Brief Psychotic Disorder:
A. Presence of one or more of the following: delusions, hallucinations, disorganized speech or grossly disorganized or catatonic behavior.
B. The episode last for at least 1 day but less than 1 month, with an eventual full return to normal functioning.
C. A diagnosis of Mood Disorder with Psychotic Features; Schizoaffective Disorder or Schizophrenia is ruled out.
12.2.6.5 Shared Psychotic Disorder

Shared Psychotic Disorder or folie a deux, is a delusion that develops in someone who has a very close relationship with another person who is delusional. Over time, this second individual comes to believe in the delusions of the other person.

Criteria for Shared Psychotic Disorder:
A. A delusion develops in the context of a close relationship with another person who already has an established delusion.
B. The delusion is similar in content to that of the person who has already established the delusion.
C. Other Psychotic Disorders ruled out.

Activity 22.3
(a) What are the five major subtypes of schizophrenia recognized by the DSM?
(b) What are the major differences between schizophrenia and (a) schizoaffective disorder and (b) schizophreniform disorder?
12.3 WHAT CAUSES SCHIZOPHRENIA?

12.3.1 Genetic Aspects

Research evidence points clearly toward some type of genetic influence in the transmission of schizophrenia. The family history data are consistent with the hypothesis that the transmission of schizophrenia is influenced by genetic factors.

Twin Studies

Several twin studies have examined concordance rates for schizophrenia. Although the specific rates vary somewhat from study to study, all of the published reports have found that MZ twins are significantly more likely than DZ twins to be concordant for schizophrenia.

Adoption Studies

Several adoption studies have been concerned with schizophrenia, and all reach the conclusion that genetic factors play a role in the development of the disorder.

Results from adoption and twin studies have also provided interesting clues regarding the boundaries of the concept of schizophrenia.

The overall pattern of results suggests that vulnerability to schizophrenia is sometimes expressed as schizophrenia-like personality traits and other types of psychosis that are not specifically included in the DSM-IV-TR definition of schizophrenia.

Molecular Genetics

One of the most exciting areas of research on genetics and schizophrenia focuses on the search for genetic linkage. Studies of this type are designed to identify the location of a specific gene that is responsible for the disorder (or some important component of the disorder).

Linkage analysis has not been able to identify a specific gene for schizophrenia, but it has implicated regions on a small number of chromosomes that may contribute to the etiology of the disorder. For example, reports of positive linkage on regions of chromosomes 6, 8, 13, and 22 have been verified by more than one laboratory.
12.3.2 Prenatal Exposures

People with schizophrenia are more likely than the general population to have been exposed to various problems during their mother’s pregnancy and to have suffered birth injuries.

Problems during pregnancy include the mother’s contracting various types of diseases and infections. Birth complications include extended labor, breech delivery, forceps delivery, and the umbilical cord wrapped around the baby’s neck. These events may be harmful, in part, because they impair circulation or otherwise reduce the availability of oxygen to developing brain regions.

It is not clear whether the effects of pregnancy and birth complications interact with genetic factors. Dietary factors may also play a role in the etiology of the disorder.

Some speculation has focused on the potential role that viral infections may play in the etiology of schizophrenia. One indirect line of support for this hypothesis comes from studies indicating that people who develop schizophrenia are somewhat more likely than other people to have been born during the winter months.

Some clinicians interpret this pattern to mean that, during their pregnancies, the mothers were more likely to develop viral infections, which are more prevalent during the winter. Exposure to infection presumably interferes with brain development in the fetus.

12.3.3 Genes and Environment in Schizophrenia: Synthesis

In the cases of a person who develops schizophrenia, the predisposing genetic factors must have combined in additive and interactive ways with environmental factors, that operate prenatally, perinatally, and also postnatally.

A genetic liability to schizophrenia may predispose an individual to suffer more damage from environmental insults than would be the case in absence of genetic predisposition.

12.3.4 A Neurodevelopmental Perspective

The idea here is that vulnerability to schizophrenia stems from a brain lesion that occurs very early in development, perhaps even before birth. This lesion lies dormant until normal maturation of brain shows the problems that result from the lesion. This may not occur until the brain is fully mature.
Developmental Precursors of Schizophrenia

One of the most consistent findings from high-risk research is that children with a genetic risk for schizophrenia are more deviant than control children on research tasks that measure attention.

Adolescents at risk for schizophrenia are also rated lower in social competence than adolescents at risk for affective illness. Early motor abnormalities are an especially strong predictor for schizophrenia.

Endophenotypes are discrete, measurable traits that are thought to be linked to specific genes that might be important in schizophrenia. Endophenotypic risk markers for schizophrenia include abnormal performance on measures of cognitive functioning.

12.3.5 Biological Aspects

Brain Volume

Most MRI studies have reported a decrease in total volume of brain tissue among schizophrenic patients.

Another consistent finding is that some people with schizophrenia have mildly to moderately enlarged lateral ventricles, the cavities on each side of the brain that are filled with cerebrospinal fluid.

The structural changes seem to occur early in the development of the disorder and therefore may play a role in the onset of symptoms.

Several studies have reported decreased size of the hippocampus, the parahippocampus, the amygdala, and the thalamus, all of which are parts of the limbic system.

Specific Brain Areas

Schizophrenia seems to affect many different regions of the brain and the ways in which they connect or communicate with each other.

The results of functional brain imaging studies suggest dysfunction in various neural circuits, including some regions of the prefrontal cortex and several regions in the temporal lobes.

The primary conclusion that can be drawn from existing brain imaging studies is that schizophrenia is associated with diffuse patterns of neuropathology.

The most consistent findings point toward structural as well as functional irregularities in the frontal cortex and limbic areas of the temporal lobes, which play an important role in cognitive and emotional processes. The neural network connecting limbic areas with the frontal cortex may be fundamentally disordered in schizophrenia.
**Neurochemistry**

Scientists have proposed various neurochemical theories to account for the etiology of schizophrenia.

The most influential theory, known as the dopamine hypothesis, focuses on the function of specific dopamine pathways in the limbic area of the brain. A dysregulation and exaggerated response of certain dopamine pathways is certainly involved in schizophrenia, at least for some patients.

On the other hand, experts now agree that several other neurotransmitters also play an important role. Several studies have found decreased serotonin receptor density in cortical areas of schizophrenic patients.

Brain imaging studies that point to problems in the prefrontal cortex have also drawn attention to glutamate and GABA (gammaaminobutyric acid), the two principal neurotransmitters in the cerebral cortex.

**12.3.6 Neurocognition**

Many investigators have pursued the search for signs of vulnerability by looking at measures of cognitive performance in which schizophrenic patients differ from other people.

Considerable emphasis has been focused on one aspect of cognitive functioning known as working memory, or the ability to maintain and manipulate information for a short period of time. Working memory problems seem to be a stable characteristic of patients with schizophrenia; they do not fluctuate over time.

Another promising line of work involves impairments in eye movements — specifically, difficulty in tracking the motion of a pendulum or a similarly oscillating stimulus while the person’s head is held motionless.

When people with schizophrenia are asked to track a moving target, like an oscillating pendulum, with their eyes, a substantial number of them show dysfunctions in smooth-pursuit eye movement.

**12.3.7 Psychosocial and Cultural Aspects**

*Do Bad Families Cause Schizophrenia?*

Research that taught us that disturbances and conflict in families that in clued an individual with schizophrenia might well be caused by having a severely ill and psychotic person in the family. However, adverse family environments and communication deviations probably have little pathological consequence if the child who is exposed has no risk for schizophrenia.
Families and Relapse Rates

The family environment does have a significant impact on the course (as opposed to the etiology) of schizophrenia. Studies that point to this conclusion do not address the original onset of symptoms. Instead, they are concerned with the adjustment of patients who have already been treated for schizophrenic symptoms.

This effect was discovered by people who were interested in the adjustment of patients who were discharged after being treated in a psychiatric hospital.

Men with schizophrenia were much more likely to return to the hospital within the next 9 months if they went to live with their wives or parents than if they went to live in other lodgings or with their siblings. The patients who relapsed seemed to react negatively to some feature of their close relationship with their wives or mothers. Subsequent research confirmed this initial impression.

Relatives of schizophrenic patients were interviewed prior to the patients' discharge from the hospital, and many of the relatives made statements that reflected negative or intrusive attitudes toward the patient. These statements were used to create a measure of expressed emotion (EE).

For example, many of the relatives expressed hostility toward the patient or repeatedly criticized the patient's behavior. Such comments would be considered to be high in expressed emotion.

Other family members appeared to be overprotective or too closely identified with the patient. These phenomena are also rated as being high in expressed emotion.

Patients who returned to live in a home with at least one member who was high in EE were more likely than patients from low EE families to relapse in the first 9 months after discharge. This result has been replicated many times.

Approximately half of schizophrenic patients live in families that would be rated as being high in EE. Close contact with relatives increases the risk of relapse for schizophrenic patients living with a high EE relative.

The opposite pattern is seen in low EE families, where increased contact with relatives seems to have a protective influence.

Patients with mood disorders, eating disorders, panic disorder with agoraphobia, and obsessive–compulsive disorder are also more likely to relapse following discharge if they are living with a high EE relative.

Cross-cultural evidence suggests that high EE may be more common in Western or developed countries than in non-Western or developing countries.

Urban Living

Being raised in an urban environment seems to increase a person's risk for schizophrenia by 2.75 times. Although the reasons for the link between urban living and later development of schizophrenia are not clear, studies of this kind raise the possibility that some cases of schizophrenia may have environmental causes.
Immigration

The findings showing that urban living raises a person’s risk for developing schizophrenia suggest that stress or social adversity might be an important factor to consider with respect to this disorder. Research is also showing that recent immigrants have much higher risks of developing schizophrenia.

One possibility is that immigrants are more likely to receive this diagnosis because of cultural misunderstandings. Another hypothesis is that people who are genetically predisposed to develop schizophrenia are more likely to move to live in another country.

There is a possibility that experiences of being discriminated against could lead some immigrants to develop a paranoid and suspicious outlook on the world, which could set the stage for development of schizophrenia.

Another possibility is that the stress that results from social disadvantage and social defeat may have an active effect on dopamine release or dopamine activity in key neural areas.

Integration and Multiple Pathways

Paul Meehl proposed a theory of schizophrenia that provides a useful guide to understanding this complex disorder. According to Meehl, individuals who are predisposed to schizophrenia inherit a subtle neurological defect of unknown form. Meehl referred to this condition as schizotaxia.

As a result of the interaction between this defect and inevitable learning experiences, schizotaxic individuals develop odd or eccentric behaviors, which he called schizotypic signs. Only a small proportion of schizotypic persons will eventually become overtly schizophrenic.

**Activity 12.3**

(a) What evidence supports a genetic contribution to schizophrenia?

(b) What role does family play in the development of schizophrenia?

(c) What is the dopamine hypothesis? Describe the current status of this explanation for schizophrenia.
12.4 TREATMENT AND CLINICAL OUTCOME

Clinical Outcome

The most recent studies of clinical outcome show that 15 to 25 years after developing schizophrenia, around 36 percent of patients have a generally favorable outcome and can be thought of as recovered. For a minority of patients (around 12 percent) long-term institutionalization is necessary.

Patients who live in less industrialized countries do better than those who live in more industrialized countries.

12.4.1 Pharmacological Approaches

12.4.1.1 First-Generation Antipsychotics

Classical antipsychotics are also known as neuroleptic drugs because they also induce side effects that resemble the motor symptoms of Parkinson's disease. Double-blind, placebo-controlled studies have confirmed the effectiveness of antipsychotic medication in the treatment of patients who are acutely disturbed.

The great majority of schizophrenic patients continue to take medication after they recover from psychotic episodes, although usually at lower dosages, to reduce the likelihood of relapse.

In the case of classical or first-generation antipsychotic drugs, the most obvious and troublesome side effects are called extrapyramidal symptoms (EPS) because they are mediated by the extrapyramidal neural pathways that connect the brain to the motor neurons in the spinal cord. These symptoms include an assortment of neurological disturbances, such as muscular rigidity, tremors, restless agitation, peculiar involuntary postures, and motor inertia.

Additional drugs, such as benztropine (Cogentin), can be used to minimize the severity of EPS during the first few months of treatment.

Prolonged treatment with classical antipsychotic drugs frequently leads to the development of tardive dyskinesia (TD). This syndrome consists of abnormal involuntary movements of the mouth and face, such as tongue protrusion, chewing, and lip puckering, as well as spasmodic movements of the limbs and trunk of the body.
In rare cases, there is a toxic reaction to the medication that is called neuroleptic malignant syndrome. This condition is characterized by high fever and extreme muscle rigidity and if left untreated can be fatal.

12.4.1.2 Second-Generation Antipsychotics

Atypical antipsychotics are less likely than the classical antipsychotics to produce unpleasant motor side effects.

Clinical trials indicate that atypical antipsychotics are at least as effective as the first-generation drugs for the treatment of positive symptoms of schizophrenia, and they are generally more effective than classical antipsychotics in the treatment of negative symptoms.

Patients are more compliant with medication and less likely to drop out of treatment when taking one of the atypical antipsychotic drugs because of their decreased motor side effects. Atypical antipsychotics also produce side effects, such as weight gain and obesity.

All antipsychotic medications—both traditional and atypical forms—act by blocking dopamine receptors in the cortical and limbic areas of the brain. They also affect a number of other neurotransmitters, including serotonin, norepinephrine, and acetylcholine. In rare cases, clozapine also causes a life-threatening drop in white blood cells known as agranulocytosis.

12.4.2 Psychosocial Approaches

12.4.2.1 Family Therapy

Family treatment programs attempt to improve the coping skills of family members, recognizing the burdens that people often endure while caring for a family member with a chronic mental disorder.

There are several different approaches to this type of family intervention. Most include an educational component that is designed to help family members understand and accept the nature of the disorder.

At a practical level, this generally involves working with families to educate them about schizophrenia, to help them improve their coping and problem-solving skills, and to enhance communication skills.

12.4.2.2 Case Management

Case managers help patients find the services they need in order to function in the community. Typically case management involves multidisciplinary teams with limited caseloads to ensure that discharged patients don’t get overlooked and lost in the system. The team delivers all the services to the patients needs.
12.4.2.3 Social-Skills Training

Patients with schizophrenia have very poor interpersonal skills. Social learning programs, sometimes called token economies, can be useful for these patients.

In these programs specific behavioral contingencies are put into place for all of the patients on a hospital ward. The goal is to increase the frequency of desired behaviors, such as appropriate grooming and participation in social activities, and to decrease the frequency of undesirable behaviors, such as violence or incoherent speech.

Instead of teaching specific skills, the new emphasis is on helping patients deal with their neurocognitive deficits through cognitive remediation training in hope that these improvements might translate to better overall functioning.

12.4.2.4 Cognitive-Behavioral Therapy

Various forms of cognitive therapy have been used to treat schizophrenia. In some cases, these interventions have focused on the use of standard cognitive therapy procedures that are designed to help patients evaluate, test, and correct distorted ways of thinking about themselves and their social environments.

The goal of these treatments is to decrease the intensity of positive symptoms, reduce relapse and decrease social disability.

12.4.2.5 Individual Treatment

Personal therapy is a nonpsychodynamic approach that equips patients with a broad range of coping techniques. Overall, this treatment seems to be very effective in enhancing the social adjustment and social role performance of discharge patients.

ACTIVITY 12.4

(a) What kinds of clinical outcomes are associated with schizophrenia? Is full recovery possible?
(b) Describe the major psychological approaches used in treating schizophrenia.
SELF TEST

1. Schizophrenic disorders are part of the category of mental disorders known as ______.

2. Cecilia believes her thoughts are broadcast straight from her mind through electrical appliances so everyone around can hear them. This delusional belief is most likely part of which DSM-IV-TR diagnosis?

3. What types of symptoms distinguish the paranoid subtype of schizophrenia from other subtypes of schizophrenia?

4. Which type of schizophrenia is characterized by psychomotor disturbances?

5. Incoherence in expression, flat affect, aimless behavior, and childish disregard for social norms are symptoms of ______.

6. Maria receives a diagnosis of schizophrenic disorder of the residual type. What does this mean?

7. What are "positive" symptoms of schizophrenia?

8. What term is used for faulty interpretations of reality that cannot be shaken despite clear evidence to the contrary?

9. ______ occur in the early stages of schizophrenia while ______ are more prominent in the later stages of schizophrenia.

10. What is the most common type of hallucination that occurs in schizophrenia?

11. Scanning techniques have shown that some people with schizophrenic disorders have significantly larger ______.

12. Why are antipsychotic drugs effective in the treatment of schizophrenia?

13. What type of people are studied in high-risk research on schizophrenia?

14. What is tardive dyskinesia?

15. Cognitive behavior therapy helps people suffering from schizophrenia ______.
Required Reading:


Self-check

1. psychotic disorders.
2. schizophrenia
3. cognitive
4. catatonic
5. disorganized schizophrenia
6. Maria had previously met the criteria for schizophrenia but no longer has prominent positive symptoms.
7. distortions or excesses of normal functions
8. delusions
9. positive symptoms; negative symptoms
10. auditory
11. cerebral ventricles.
12. They block dopamine receptors.
13. children with a strong family history of the disorder
14. involuntary movements
15. recognize internal cues.
Unit 13  ➤ Cognitive Disorders

**LEARNING OUTCOME**

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

1. Describe the major features of the dissociative disorders including dissociative identity, dissociative amnesia, dissociative fugue, and depersonalization disorder.
2. Recount various theoretical perspectives on the dissociative disorders.
3. Describe various methods for treating dissociative disorders.
4. Describe the features of somatoform disorders including conversion disorder, hypochondriasis, body dysmorphic disorder, and somatization disorder.
5. Discuss theoretical perspectives on somatoform disorders.
6. Distinguish delirium, dementia, amnestic syndrome from disorders involving head injury.
INTRODUCTION TO COGNITIVE DISORDERS

Dissociative disorders involve changes or disturbances in identity, memory, or consciousness that affect the ability to maintain an integrated sense of self. Dissociative disorders include dissociative identity disorder, dissociative amnesia, dissociative fugue, and depersonalization disorder:

- In dissociative identity disorder, two or more distinct personalities, each possessing well-defined traits and memories, exist within the person and repeatedly take control of the person’s behavior.

- Dissociative amnesia involves loss of memory for personal information. There are five types of dissociative amnesia: localized, selective, generalized, continuous, and systematized.

- In dissociative fugue, the person travels suddenly away from home or place of work, shows a loss of memory for his other personal past, and experiences identity confusion or takes on a new identity.

- Depersonalization disorders involve persistent or recurrent episodes of depersonalization that are of sufficient severity to cause significant distress or impairment in functioning.

Psychodynamic theorists view dissociative experiences as a form of psychological defense by which the ego defends itself against troubling memories and unacceptable impulses by blotting them out of consciousness. There is increasing documentation of a link between dissociative disorders and early childhood trauma, which lends support to the view that dissociation may serve to protect the self from troubling memories.

To learning and cognitive theorists, dissociative experiences involve ways of learning not to think about certain troubling behaviors or thoughts that might lead to feelings of guilt or shame. Relief from anxiety negatively reinforces this pattern of dissociation.

Within the diathesis-stress model, dissociative identity disorder may be explained in terms of a diathesis consisting of psychological traits such as a rich inner fantasy life and high levels of hypnotizability interacting with traumatic stress in the form of severe childhood abuse.

Treatment of dissociative disorders from the biological approach focuses on the use of drugs to treat the anxiety and depression often associated with the disorder; but drugs have not been able to bring about reintegration of the personality. Learning perspectives focus on the use of behavioral methods of reinforcement of the most well-adjusted personality.

In somatoform disorders, there are physical complaints that cannot be accounted for by organic causes. Thus the symptoms are theorized to reflect psychological rather than organic factors. Four types of somatoform disorders are considered: conversion disorder, hypochondriasis, body dysmorphic disorder, and somatization disorder.
In **conversion disorder**, symptoms or deficits in voluntary motor or sensory functions occur which suggest an underlying physical disorder but no apparent medical basis for the condition can be found.

- **Hypochondriasis** is a preoccupation with the fear of having, or the belief that one has, serious medical illness, but no medical basis for the complaints can be found and fears of illness persist despite medical reassurances.

- People with **body dysmorphic disorder** are preoccupied with an imagined or exaggerated physical defect in their appearance.

- **Somatization disorder**, formerly known as Briquet's syndrome, involves multiple and recurrent complaints of physical symptoms that have persisted for many years and began prior to the age of 30, but most typically during adolescence.

The psychodynamic view holds that conversion disorders represent the conversion into physical symptoms of the leftover emotion or energy that is cut off from unacceptable or threatening impulses that the ego has prevented from reaching awareness. The symptom is functional, allowing the person to achieve both primary and secondary gains.

Learning theorists focus on the reinforcements that are associated with conversion disorders, such as the reinforcing effects of adopting a "sick role." A learning theory view likens hypochondriasis to obsessive-compulsive behavior. Cognitive factors in hypochondriasis include self-handicapping strategies and cognitive distortions.

Psychoanalysis seeks to uncover and bring to the level of awareness the unconscious conflicts, originating in childhood, that are believed to be at the root of the problem. Once the conflict is uncovered and worked through, the hysterical symptom should disappear because it is no longer needed as a partial solution to the underlying conflict.

Behavioral approaches focus on removing sources of reinforcement that may be maintaining the abnormal behavior pattern. Behavior therapists may also work more directly to help people with somatoform disorders learn to handle stressful or anxiety-arousing situations more effectively. Cognitive techniques such as cognitive restructuring have been very helpful in treating hypochondrias and body dysmorphic disorder.

### 13.1 BRAIN IMPAIRMENT IN ADULTS

Prior to the revision of DSM-IV, most of the disorders considered to be in this section were called organic mental disorders. This term was designed to convey that there was some identifiable pathology that was a cause to the problem. In contrast, functional mental disorders were brain disorders that were considered not to have an organic basis.

By the time the DSM-IV was published, however, it was apparent that it was wrong to assume that psychiatric disorders had no organic component. The terms functional and organic were dropped and it is now called Delirium, Dementia and Amnestic and other Cognitive Disorders.
13.1.1 Clinical Signs of Brain Damage

When brain injury occurs in an older child or adult, there is loss in established functioning. This loss can be painfully obvious to the victim, adding an often pronounced psychological burden of having the lesion. In other cases the impairment may extend to the capacity for realistic self-appraisal (anosognosia), leaving these patients relatively unaware of their losses and hence poorly motivated for rehabilitation.

Damage or destruction of brain tissue may involve only limited behavioral deficits or a wide range of psychological impairments depending on:

- The nature, location and extent of neural damage.
- The premorbid (predisorder) competence and personality of the individual.
- The individual's life situation.
- The amount of time since the first appearance of the condition.

13.1.2 Diffuse versus Focal Damage

In contrast to diffuse damage, focal brain lesions involve circumscribed areas of abnormal change in the brain structure. This kind of damage might occur with a sharply defined traumatic injury or interruption of blood to a specific part of the brain. The location and extent of damage determine problems the patient will have.

Damage to certain parts of the brain may cause different impairments:

1. Left hemisphere: serial processing of familiar information
2. Right hemisphere: grasping overall meanings in novel situations, reasoning on a nonverbal, intuitive level and appreciation of spatial relations.
3. Frontal areas: behavioral inertia, passivity, apathy and preservative thought or impulsiveness or distractibility.
5. Left parietal area: language function.
7. Occipital lobe: visual impairments
13.1.3 Impairments Associated with Brain Disorders:

The following types of difficulties are often the consequences of brain disease, disorder or damage:

1. Impairment of memory – trouble remembering recent events and events of the remote past, with a tendency to confabulate.

2. Impairment of orientation – unable to locate himself or herself correctly.

3. Impairment of learning, comprehension and judgment – thinking becomes clouded, sluggish or inaccurate, may lose ability to plan with foresight or to understand abstract concepts and process complex information.

4. Impairment of emotional control or modulation – manifests emotional overreactivity.

5. Apathy or emotional blunting – manifests emotional underreactivity.

6. Impairment in the initiation of behavior – lacks self-starting capability and may have to be reminded repeatedly about what to do next.

7. Impairment of controls over matters of propriety and ethical conduct – manifest a marked lowering of personal standards in areas such as appearance, personality, sexuality or language.

8. Impairment of receptive and expressive communication – may be unable to comprehend written or spoken language or may be unable to express thoughts orally or in writing.

9. Impaired visuospatial ability – difficulty coordinating motor activity with the characteristics of the visual environment.

13.1.4 The Neuropsychology/Psychopathology Interaction

Most people who have a neuropsychological disorder do not develop psychopathological symptoms, but many show at least mild deficits in cognitive processing and self-regulation.

The psychopathological symptoms that do sometimes accompany brain impairment are not always predictable and can reflect individual nuances with the patient’s age, her or his prior personality and the total psychological situation confronting the patient.

People with more favorable life situations tend to fare better after brain injury than people whose lives are more disorganized or disadvantage. Intelligent, well-educated, mentally active people have enhanced resistance to mental and behavioral deterioration following significant brain injury.
13.2 DELIRIUM

13.2.1 Clinical Presentation

Delirium is an acute confusional state that lies between normal wakefulness and stupor or coma. It has a sudden onset and involves a fluctuating state of reduced awareness. Information-processing capacities are impaired impairing basic functions. Hallucinations and delusions are quite common and the person may have a disturbed sleep cycle.

Criteria for Delirium:

- Disturbance of consciousness.
- A change in cognition that is not related to dementia.
- The disturbance develops over a short period of time and tends to fluctuate over the course of the day.

Delirium can occur at any age but the elderly are at particularly high risk because of brain changes caused by normal aging that lead to reduced brain reserve. Children are also at high risk because their brains are not yet fully developed.

Delirium may result from head injury, infection or more commonly drug intoxication or withdrawal.
13.2.2 Treatment and Outcome

Most cases are reversible except when the delirium is caused by a terminal illness or by severe brain trauma. Treatment includes medication, environmental manipulation and family support.

The medications that are used are mostly cases are neuroleptics. For delirium caused by alcohol or drug withdrawal, benzodiazepines are used. Orienting techniques and environmental modifications can be helpful.

13.2 DEMENTIA

Dementia implies loss and is characterized by a decline from a previously attained level of functioning.

Criteria for Dementia:

- The development of multiple cognitive deficits manifested by both:
  1. Memory impairment.
  2. One or more of the following disturbances:
     a. Aphasia (language disturbances)
     b. Apraxia (impaired ability to carry out motor tasks despite having the motor ability to do so).
     c. Agnosia (failure to recognize or identify objects despite intact sensory function)
     d. Disturbance in executive functioning

- The cognitive deficits cause significant impairment in functioning and represent a significant decline from a previous level of functioning.
- The onset of the disorder is gradual and there is cognitive decline.
Causes of Dementia:
At least 50 different disorders are known to cause dementia. They include degenerative diseases (Huntington's and Parkinson's), strokes, certain infectious disease (syphilis, meningitis, and AIDS), intracranial tumors and abscesses, certain dietary deficiencies (especially of the B vitamins), severe or repeated brain injury, anoxia and the ingestion of toxic substances (lead or mercury). The most common cause of dementia is Alzheimer's disease.

13.2.1 Parkinson's Disease
Parkinson's disease is a form of shaking palsy. The cause of Parkinson's disease is not clear although both genetic and environmental factors are suspected. Parkinson's is more common in men than women and usually develops in people aged 50 to 70 years old.

13.2.2 Huntington's Disease
Huntington's disease is a rare degenerative disorder of the central nervous system. The illness begins in midlife and affects men and women in equal numbers. Huntington's disease is characterized by a chronic, progressive chorea.

Patients eventually develop dementia and death usually occurs 10 to 20 years of first developing the illness. Huntington's disease is caused by an autosomal dominant gene on chromosome 4.

13.2.3 Alzheimer's Disease
Alzheimer's Disease (AD) is the most common cause of dementia and is referred to as dementia of the Alzheimer's type. Alzheimer's disease is associated with a characteristic dementia syndrome that has an imperceptible onset and a usually slow but progressively deteriorating course, terminating in delirium and death.

The Clinical Picture of AD
The diagnosis of AD is made on the basis of a thorough clinical assessment but cannot be absolutely confirmed until after the patient's death. An autopsy must be performed to see the amyloid plaques and neurofibrillary tangles that are distinctive signs of Alzheimer neuropathology.

In living patients, the diagnosis are normally given only after all other potential causes of dementia are ruled out by case and family history, physical examination and laboratory tests. Neuroimaging techniques are now being explored as a way to facilitate early diagnostic assessment of patients suspected to have AD.
Alzheimer’s disease usually begins about after age 45 and is characterized by multiple cognitive deficits. There is a gradual declining course that involves slow mental deterioration. AD often begins with the person’s gradual withdrawal from active engagement with life. There is a narrowing of social activities and interest, a lessening of mental alertness and adaptability and a lowering tolerance of new ideas and changes in routine.

Often thoughts and activities become self-centered and childlike. As these changes become more severe, additional symptoms such as impaired memory for recent events, empty speech, messiness, impaired judgment, agitation and periods of confusion make their appearance. The clinical picture is by no means uniform until the terminal stages, when the patient is reduced to vegetative level. Damage to the temporal lobes of the brain, delusions are also found in some patients.

With appropriate treatment, which may include medication and the maintenance of a calm, reassuring and unprovocative social environment, many people with Alzheimer’s disease show some alleviation of symptoms. In general, deterioration continues its downward course over a period of months or years. It is typically taught that patients with AD live about 7 to 10 years after they are diagnosed.

**Prevalence of AD**

For all of us, the brain starts to decrease in size after about age 18, by 80; our brain has lost about 15 percent of its original weight. About 1 to 2 percent of the population in the age range of 65 to 74 has AD and 25 percent of people older than 85 have the disease.

Women seem to have a slightly higher risk of developing AD than men. It is suspected that a high-fat, high-cholesterol diet and high levels of amino acids called homocysteine can increase a person’s risk of developing Alzheimer’s disease.

**Genetic and Environmental Aspects of AD**

Cases of early-onset Alzheimer’s disease appear to be caused by rare genetic mutations. So far three mutations have been identified. One involves the APP gene, which is located on chromosome 21. Other cases of even earlier onset appear to be associated with mutations on chromosome 14 called presenilin 1 (PS1) and with a mutation of the presenilin 2 (PS2) gene on chromosome 1.

A gene that may play greater role in cases of late onset Alzheimer’s disease is the APOE (apolipoprotein) gene on chromosome 19. This gene codes for a blood protein that helps carry cholesterol through the bloodstream. Three such alleles have been identified, and everyone inherits two of them. One of these alleles, the APOE-E4 allele, significantly enhances risks for late-onset AD. Another such allele, APOE-E2 seems to convey protection against late-onset AD.

Environmental factors such as exposure and experiencing head trauma should also be taken under consideration. Exposure to nonsteroidal anti-inflammatory drugs such as ibuprofen may be protective and lead to lower risk of AD.
Neuropathology

There are a number of brain abnormalities known to be characteristic to the disease. These are:

- Senile plaques
- Neurofibrillary tangles
- Abnormal appearance of small holes in neuronal tissue (granulovacuoles)

Senile plaques are made of deformed nerve cell terminals. At their core, they contain a sticky protein substance called beta amyloid. Having the APOE-E4 gene may also facilitate aggregation of amyloid in the brain. Moreover, beta amyloid has shown to be neurotoxic, causing cell death.

Neurofibrillary tangles are webs of abnormal filaments within a nerve cell. These filaments are made of a protein called tau. Neurofibrillary tangles may be caused by an increasing burden of amyloid in the brain.

Another notable alteration in AD occurs the neurotransmitter acetylcholine (ACh). This neurotransmitter is important in the mediation of memory. The reduction in brain ACh activity in patients with AD is correlated with the extent of neuronal damage that they have sustained.

Treatments and Outcome in AD

We currently have no treatment for AD that will restore functions once they have been destroyed or lost. We only have palliative measures that can diminish patient and caregiver distress and relieve as far as possible those complications of the disorder such as combattiveness that increase the difficulties of management.

Behavioral treatments can help with patients wandering off, incontinence, inappropriate sexual behavior and inadequate self-care skills. Administering drugs such as tacrine (Cognex) and donepezil (Aricept) may help by inhibiting the production of acetylcholinesterase, the principal enzyme involved in the metabolic breakdown of ACh. Another drug, Namenda, regulates the activity of the neurotransmitter glutamate by partially blocking NMDA receptors.

13.2.4 Dementia from HIV-1 Infection

The HIV virus is capable of inducing neurological disease that can result in dementia. This can happen two ways:

- Because the immune system is weakened, people with HIV are more susceptible to rare infections caused by parasites and fungi.
- The virus also appears capable of damaging the brain more directly resulting in neuronal injury and destruction of brain cells.

Neuropathology involving dementia involves various changes in the brain, among them generalized atrophy, edema, inflammation, and patches of demyelination. No brain area may be entirely spared, notably the central white matter, the tissue surrounding the
surrounding ventricles and deeper gray matter structures such as the basal ganglia and thalamus.

The neuropsychological features of AIDS, which tend to appear as a late phase of HIV infection, usually begin with mild memory difficulties, psychomotor slowing and diminished attention and concentration.

### 13.2.5 Vascular Dementia

Vascular Dementia (VAD) is a series of circumscribed cerebral infarcts – interruptions of the blood supply to minute areas of the brain because of arterial disease – cumulatively destroy neurons over expanding brain regions. The affected regions become soft and may degenerate over time leaving only cavities. The progressive loss of cells leads to brain atrophy and behavioral impairments that ultimately mimic those of AD.

VAD tends to occur after the age of 50 and affects more men than women. Abnormalities of gait may be an early predictor of this condition. Accompanying mood disorders are more common in VAD than AD, perhaps because more subcortical areas are affected.

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**AC T I V I T Y 1.0.3**

(a) What is dementia? How is it different from delirium?
(b) Describe some major risk factors for Alzheimer’s disease.
(c) What kinds of neuropathological abnormalities are typical of the Alzheimer’s brain?
10.3 AMNESTIC SYNDROME

The characteristic feature of amnestic syndrome is strikingly disturbed memory. Short-term memory is typically so impaired that the person is unable to recall events that took place only a few minutes previously. To compensate patients tend to confabulate.

Overall cognitive functioning may remain relatively intact. The affected person may thus be able to execute a complex task if it provides its own distinctive cues for each stage.

Criteria for Amnestic Disorder:

- The development of memory impairment.
- The memory disturbance causes significant impairment in functioning and represents a decline from a previous level of functioning.
- The memory disturbance does not occur exclusively during the course of a delirium or dementia.

Most commonly, amnestic syndrome is caused by chronic alcohol use and associated deficiency in vitamin B1. Another common cause is head trauma. Stroke, surgery in the temporal lobe area of the brain, hypoxia and some forms of brain infections can also lead to amnestic disorder.

Because procedural memory is often preserved in patients with amnesia, even patients without memory for specific personal experiences can still be taught to perform tasks that might help them reenter the workforce.

Activity 13.4

(a) What is the most striking clinical features of amnestic syndrome?
(b) What are some of the major causes of amnestic syndrome?
10.4 DISORDERS INVOLVING HEAD INJURY

Traumatic brain injury (TBI) occurs frequently, commonly caused by motor vehicle accidents. Men aged 15 to 24 are at highest risk for brain injury. Disorders that result from traumatic injuries are more common than from any other forms of neurological disease except headache. In DSM-IV-TR, brain injuries that have notable, long-term effects on adaptive functioning are coded on Axis I using the appropriate syndromal descriptive phrase, with the qualifier due to head trauma.

10.4.1 The Clinical Picture

Clinicians distinguish three types of TBI because the clinical pictures and residual problems vary somewhat among them:

- Close-head injury, in which the cranium remains intact
- Penetrating head injury, in which the cranium, as well as the underlying brain are penetrated by some object.
- Skull fracture, with or without compression of the brain by fragmented bone concavity.

Neuropsychologically significant head injuries usually give rise to immediate acute reactions such as unconsciousness and disruption of circulatory, metabolic and neurotransmitter regulation. Normally, if head injury is severe enough to result in unconsciousness, the person experiences retrograde amnesia. Apparently such trauma interferes with the brain’s capacity to consolidate into long-term storage the events that were still being processed at the time of the trauma.

Large numbers of relatively mild close-head brain concussions and contusions occur every year. Temporary loss of consciousness and postimpact confusion are the most common and salient immediate symptoms. A recent study has shown that older individuals or individuals who have TBI share several changes in information-processing speed. The presence of APOE-E4 genetic risk factor was associated with more chronic neurological deficits.

10.4.1 Treatments and Outcomes

Common after effects of moderate brain injury include chronic headaches, injury, anxiety, irritability, dizziness, easy fatigability and impaired memory concentration. Where brain damage is extensive, a patient’s general intellectual level may be markedly reduced. Some 24 percent of TBI cases overall develop post-traumatic epilepsy. For decades after a head injury, there is also a risk of depression as well as other disorders such as substance abuse, anxiety disorders and personality disorders. Personality changes may also occur.
Treatment of TBI requires careful and continuing assessment of neuropsychological functioning and the design of interventions intended to overcome the deficits that remain. Often, a treatment goal is to provide patients with new techniques to compensate for losses that may be permanent. Research is now showing that patients with TBI may also benefit from treatment with donepezil.

Predictors of Clinical Outcome after Traumatic Brain Injury

Outcome is more favorable when:

- only a short period of unconsciousness or post-traumatic anterograde amnesia,
- minimal cognitive impairment,
- a well-functioning preinjury personality,
- higher educational attainment,
- a stable preinjury work history,
- motivation to recover or make the most of residual capacities,
- a favorable life situation to which to return,
- early intervention, and
- an appropriate program of rehabilitation and retraining.
1. How do cognitive impairment disorders differ from most other DSM-IV-TR categories?

2. Clinical neuropsychologists are particularly interested in understanding changes in behavior due to ________.

3. A positron emission tomography (PET) scan provides information about ________.

4. Denzel is disoriented and confused. He has difficulty focusing and shifting attention. What is Denzel’s diagnosis?

5. Dementia is primarily characterized by loss of ________.

6. Typically, the onset of dementia is ________.

7. What term is used to designate degeneration of brain tissue?

8. Treatment of dementia focuses on ________.

9. What is the most common form of presenile dementia?

10. What is the average time between the diagnosis of Alzheimer’s disease and the person’s death?

11. What are plaques?

12. Alzheimer’s disease is associated with lowered amounts of what substance in the brain?

13. What is the cause of Huntington’s disease?

14. Which psychological symptoms are often associated with Huntington’s disease?

15. Parkinson’s disease is thought to be caused by a deficiency of ________.
Required Reading:


Self-check

1. They are due to known medical conditions or substances.
2. brain lesions.
3. biochemical changes in the brain.
4. delirium
5. intellectual abilities
6. gradual.
7. atrophy
8. reducing patient distress, improving behavior and cognitive function, reducing family distress
9. Alzheimer’s disease
10. 8 years
11. disintegrated nerve cell branches
12. acety/choline
13. a dominant gene
14. depression, obsessions, and compulsions
15. thiamine.
Unit 14

 Disorders of Childhood and Adolescence

LEARNING OUTCOME

At the end of unit you will be able to:

1. Discuss ways of determining what is normal and what is maladaptive in childhood and adolescence.
2. Define common developmental disorders of childhood and adolescence.
3. Discuss features, theoretical perspectives, and treatments of autism.
4. Discuss features, theoretical perspectives, and treatments of Asperger's Disorder and distinguish it from autism.
5. Discuss features and causes of mental retardation including chromosomal, genetic, prenatal, and cultural-familial causes.
6. Distinguish between the levels of mental retardation and perspectives on the possible environmental causes of some cases of mild retardation.
7. Discuss types, theoretical perspectives, and interventions for learning disorders.
8. Describe types, features, theoretical perspectives, and treatments of communication disorders.
9. Discuss types, features, theoretical perspectives, and treatments of attention-deficit and disruptive behavior disorders.
10. Discuss features and treatment of anxiety disorders and depression in childhood and adolescence.
11. Discuss prevalence of childhood and adolescent suicide.
12. Discuss factors associated with increased risk of suicide, such as gender, age, geography, race, depression, previous suicidal behavior, familial discord, stressful life events, substance abuse, and social contagion/suicide clusters.
INTRODUCTION TO DISORDERS OF CHILDHOOD AND ADOLESCENCE

Maladaptive Behavior In Different Life Periods
It is important to view a child’s behavior in reference to normal childhood development. We cannot consider a child’s behavior to be abnormal without determining whether the behavior is appropriate for a child’s age.

Varying Clinical Pictures
Some of the emotional disturbances of childhood may be relatively short-lived and less specific than those occurring in adulthood. However, some childhood disorders severely affect future development.

Special Vulnerabilities of Young Children
In evaluating the presence or extent of mental health problems in children, one needs to consider the following:

1. They do not have as complex and realistic a view of themselves and their world as they will have later, they have less self-understanding, and they have not yet developed a stable sense of identity or a clear understanding of what is expected of them and what resources they might have to deal with problems.

2. Immediately perceived threats are tempered less by considerations of the past and future and thus tend to be seen as disproportionately important. As a result, children have more difficulty than adults in coping with stressful events.

3. Children’s limited perspectives, lead them to use unrealistic concepts to explain events.

4. Children also are more dependent on other people than are adults. Although in some ways this dependency serves as a buffer against other dangers, because the adults around might protect a child against stressors in the environment, it also makes the child highly vulnerable to experiences of rejection, disappointment and failure if these adults ignore the child.

5. Children lack experience in dealing with adversity can make manageable problems seem insurmountable. On the other hand, although their inexperience and lack of self-sufficiency make them easily upset by problems that seem minor to the average adult, children typically recover more rapidly from their other hurts.
COMMON DISORDERS OF CHILDHOOD AND ADOLESCENCE

14.1 ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Attention-Deficit/Hyperactivity Disorder (ADHD) is characterized by difficulties that interfere with effective task-oriented behavior in children—particularly impulsivity, excessive or exaggerated motor activities and difficulties sustaining attention.

Perhaps as a result of their behavioral problems, hyperactive children often have lower intelligence, usually about 7 to 15 IQ points below average. Hyperactive children also tend to talk incessantly and to be socially intrusive and immature.

14.1.1 Criteria for Attention-Deficit/Hyperactivity Disorder

Either of the following criteria would enable diagnosis of ADHD:

1. If six or more of the following symptoms of inattention have persisted for at least 6 months and are maladaptive for the child’s developmental level:
   a. Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
   b. Often has difficulty attending in tasks or play activities.
   c. Often does not seem to listen when spoken to directly.
   d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.
   e. Often has difficulty organizing tasks and activities.
   f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.
   g. Is often easily distracted by extraneous stimuli.
   h. Is often forgetful in daily activities.

2. If six or more of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive:
   a. Hyperactivity
   b. Often fidgets with hands or feet or squirms in seat.
   c. Often leaves seat in classroom or in other situations in which remaining seated is expected.
   d. Often runs about or climbs excessively in situations, which it is inappropriate.
   e. Often has difficulty playing or engaging in leisure activities quietly.
   f. Is often on the go or often acts as driven by a motor.
   g. Often talks excessively.
h. Impulsivity
   i. Often blurts out answers before questions have been completed.
   j. Often has difficulty awaiting turn.
   k. Often interrupts or intrudes on others.

Hyperactive children often have problems getting along with their parents and peers because of their behavior. They usually do poorly in school and often show specific learning disabilities such as difficulties in reading or learning other basic school subjects.

Hyperactive children are the most frequent psychological referrals to mental health and pediatric facilities and the disorder is thought to occur in about 3 to 5 percent of school-age children. One study reported a much higher prevalence rate of 16.1 percent for ADHD.

The disorder occurs most frequently among preadolescent boys, it is six to nine times more prevalent among boys than girls. ADHD occurs with the greatest frequency before age 8 and tends to become less frequent and involve brief episodes thereafter. ADHD seems comorbid with oppositional defiant disorder.

14.1.2 Causal Factor in Attention-Deficit Disorder

Many researchers believe that biological factors such as genetic inheritance will turn out to be important precursors to the development of ADHD. One study suggested family pathology, particularly parental personality problems, leads to hyperactivity in children. There is general agreement that there are processes operating in the brain that disinhibit the child’s behavior, and some recent research has found different EEG patterns occurring in children with ADHD.

14.1.3 Treatments and Outcomes

Research has shown that prescribing amphetamines have a quieting effect on children. For hyperactive children, such medication decreases overactivity and distractibility and at the same time, increases alertness.

It is concluded that Ritalin can lower the amount of aggressiveness in hyperactive children. The possible effects of Ritalin however, are numerous: decrease blood flow to the brain, disruption of growth hormone, insomnia, psychotic symptoms and others.

The behavioral intervention techniques that have been developed for ADHD include selective reinforcement in the classroom and family therapy. Another effective approach involves the use of behavior therapy techniques featuring positive reinforcement and the structuring of learning materials and tasks in a way that minimizes error and maximizes immediate feedback and success.
14.1.4 ADHD Beyond Adolescence

Some hyperactive children retain ADHD into early adulthood or go on to have other psychological problems such as overly aggressive behavior or substance abuse in their late teens and early adulthood.

14.2 OPPORTIONAL DEFIAINT DISORDER AND CONDUCT DISORDER

The next group of disorders involves a child's or adolescent's relationship to social norms and rules of conduct. Oppositional defiant disorder is usually apparent at about age 8 and conduct disorder ends to be seen by age 9. Oppositional defiant disorder and conduct disorder involve misdeeds that may or may not be against the law (juvenile delinquency).

14.2.1 The Clinical Picture in Oppositional Defiant Disorder And Conduct Disorder

Oppositional Defiant Disorder

An important precursor in antisocial behavior seen in children who develop conduct disorder is now called oppositional defiant disorder. The essential feature is a recurrent pattern of negativistic, defiant, disobedient and hostile behavior toward authority figures that persists for at least 6 months. This disorder usually begins at 8. The risk factors for this disorder include family discord, socioeconomic disadvantage and antisocial behavior in parents.

Conduct Disorder

The essential symptomatic behavior in conduct disorder involves a persistent, repetitive violation of rules and a disregard for the rights of others. In general, they manifest such characteristics such as overt or covert hostility, disobedience, physical and verbal aggressiveness, quarrelsome, vengefulness and destructiveness. Lying, stealing and temper tantrums are common.
14.2.2 Criteria For Conduct Disorder

A. This disorder is a repetitive and persistent pattern of behavior in which the basic rules of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three or more of the following criteria in the past 6 months:

a. Aggression to People and Animals
   • Often bullies, threatens, or intimidates others
   • Often initiates physical fights
   • Has used a weapon that can cause serious physical harm to other
   • Has been physically cruel to people
   • Has been physically cruel to animal
   • Has stolen while confronting a victim
   • Has forced someone into sexual activity

b. Destruction of Property
   • Has deliberately engaged in firesetting with the intention of causing serious damage
   • Has deliberately destroyed others' property

c. Deceitfulness or Theft
   • Has broken into someone else's house, building, or car
   • Often lies to obtain goods or favors or to avoid obligations
   • Has stolen items of nontrivial value without confronting a victim

d. Serious Violations of Rules
   • Often stays out at night despite parental prohibitions beginning before age of 13 years
   • Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period
   • Is often truant from school, beginning before age 13 years

The disturbance in behavior causes clinically significant impairment in social, academic or occupational functioning. If the individual is age 18 or older, criteria are not met for Antisocial Personality Disorder. The severity of the disorder should be specified as follows:

Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others.

Moderate: number of conduct disorders and effect on other intermediate between mild and severe.

Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others.
14.2.3 Causal Factors in Oppositional Disorder and Conduct Disorder

A Self-Perpetuating Cycle

Evidence has accumulated that a genetic predisposition leading to low verbal intelligence, mild neuropsychological problems and difficult temperament in these children. This can set the stage for early onset conduct disorder through a set of self-perpetuating mechanisms:

- The child’s difficult temperament may lead to an insecure attachment.
- In addition, the low verbal intelligence and/or mild neuropsychological deficits in many of these children may help set the stage for a lifelong course of difficulties.

Age of Onset and Links to Antisocial Personality Disorder

- Children who develop conduct disorder at an earlier age are much more likely to develop psychopathy or antisocial personality disorder as adults than are adolescents who develop conduct disorders suddenly in adolescence.

- Most individuals who develop conduct disorders in adolescence do not go on to become adult psychopaths or antisocial personalities but instead have problems limited to the adolescent years.

Environmental Factors

Having a confused relationship with the primary caregiver can result in disorganized early attachment. This can signal later aggression in the child.

Children who are aggressive and socially unskilled are often rejected by their peers, leading them to antisocial behavior. Severe conduct disorder can lead to other mental health problems as well.

The family setting of a conduct-disordered child is typically characterized by

- ineffective parenting, rejection, harsh and inconsistent discipline, and often parental neglect.
- the parents may have an unstable marital relationship
- either of the parents may emotionally disturbed or sociopathic
- their parents do not provide them with consistent guidance, acceptance or affection.

Low socioeconomic status, poor neighborhoods, parental stress and depression all appear to increase the likelihood that a child will be enmeshed in this cycle.
14.1.4 Treatments and Outcomes

Treatment for oppositional defiant disorder and conduct disorder often focus on dysfunctional family pathology and on finding ways to alter the child’s aggressive or otherwise maladaptive behaviors.

Cohesive Family Model

In this family-group-oriented approach, parents of children with conduct disorder are viewed as lacking in parenting skills and as behaving in inconsistent ways, thereby reinforcing inappropriate behavior and failing to socialize the children.

In extreme cases, the circumstances may call for the child to be removed from home and placed in foster care, with the expectation of a later return to the home if intervening therapy with the parents appears to justify it.

Behavioral Techniques

Teaching control techniques to the parents is particularly important. This is to enable them to function as therapist in reinforcing desirable behavior and modifying the environmental conditions that have been reinforcing maladaptive behavior.

The changes are brought about when parents consistently accept and reward their child’s positive behavior. In addition, they will stop focusing on negative behavior, resulting in a change in their perception of and feelings toward the child. This will lead to the basic acceptance that the child needs.

14.2 ANXIETY DISORDERS OF CHILDHOOD AND ADOLESCENCE

Children with anxiety disorders tend to be oversensitive, have unrealistic fears, are shy and timid, have pervasive feelings of inadequacy, sleep disturbances and fear school. Generally, about ten percent of a community-based school sample meet the diagnostic criteria for anxiety-based disorder and is more common in girls than in boys.

14.2.1 Separation Anxiety Disorder

Separation anxiety disorder is the most common of the childhood disorders, occurring in 2 to 4 percent of children. Children with separation anxiety disorder exhibit unrealistic fears, oversensitivity, self-consciousness, nightmares, and chronic anxiety. They lack self-confidence, are apprehensive in new situations and tend to be immature for their age. Typically, they are overly dependent.
14.2.1.1 Criteria for Separation Anxiety Disorder

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached as evidenced by three or more of the following:
   - Recurrent excessive distress when separation from home or major attachment figure occurs or is anticipated.
   - Persistent and excessive worry about losing, or about possible harm befalling, major attachment figures.
   - Persistent and excessive worry that an untoward event will lead to separation from a major attachment figure.
   - Persistent reluctance or refusal to go to school or elsewhere because of fear of separation.
   - Persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings.
   - Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home.
   - Repeated nightmares involving the theme of separation.
   - Repeated complaints of physical symptoms when separation from major attachment figures occurs or is anticipated.

B. The duration of the disturbance is at least 4 weeks;

C. The onset is before 18 years; and

D. The disturbance causes clinically significant distress or in social, academic occupational or other important areas of functioning.

Selective Mutism

Selective mutism is a condition that involves the persistent failure to speak in specific social situations that is considered to interfere with educational or social adjustment. Selective mutism should only be diagnosed if the child actually knows the language. Moreover, in order of this condition to be diagnosed, the condition must have lasted for a month and must not be limited to the first month of school.

Both biological and learning factors have been cited as possible causal factors underlying the disorder. It is reported that specific auditory nerve activity were found among children with selective mutism.

One study reported that the symptoms were reduced substantially with fluoxetine and another successful report involved a drug called moclobemide as an MAO inhibitor. However, family-based psychological treatment is the most commonly used therapeutic approach.
14.2.1.2 Causal Factors in Anxiety Disorders

Parental behavior has been particular noted as a potential influential factor in the origin of anxiety disorders in children, however broader cultural factors are also important considerations.

Anxious children often manifest and unusual constitutional sensitivity that makes them easily conditionable to aversive stimuli. They have a harder time calming down. They can become anxious because of early illness, accidents or losses that involved pain and discomfort.

Overanxious children often have the modeling effect of an overanxious and protective parent who sensitzes a child to the dangers and threats of the outside world. Indifferent, detached or rejecting parents also foster anxiety in their children. The child may not feel adequately supported in mastering essential competencies and gaining a positive self-concept. Repeated experiences of failure, stemming from poor learning skills may lead to subsequent patterns if anxiety or withdrawal in the face of threatening situations.

The role that social-environmental factors might play in the development of anxiety based disorders, though important is not clearly understood. Several studies have found a strong association between exposure to violence and a reduced sense of security and psychological well-being.

14.2.1.3 Treatments and Outcomes

**Biologically Based Treatments**
Fluoxetine has proven to be useful in treating anxiety-based disorders.

**Psychological Treatment**
Behavior therapy includes assertiveness training to provide help with mastering essential competencies and desensitization to reduce anxious behavior. Manual-based cognitive-behavioral treatment (well-defined procedures using positive reinforcement to enhance coping strategies to deal with fears) has been successful in treating children with anxiety disorders.
14.2.2 Childhood Depression

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

The point of prevalence of major depressive disorder had been estimated between 0.4 and 2.5 percent for children and between 4.0 and 8.3 for adolescents. The lifetime prevalence for major depressive disorders in adolescents is between 15 and 20 percent.

14.2.2.1 Causal Factors in Childhood Depression

Biological Factors

There appears to be an association between parental depression and behavioral and mood problems in children. This is particularly the case when the parent’s depression affected the child through less-than-optimal interactions.

Other biological factors include biological changes in the neonate as a result of alcohol intake by the mother during pregnancy.

Learning Factors

There are likely to be learning or cultural factors in the expression of depression. Children who have experienced past stressful events are susceptible to states of depression.

Intense or persistent sensitization of the central nervous system in response to severe stress might induce hyperreactivity and alteration of the neurotransmitter system. This causes the child to be more vulnerable to later depression.

Depressed mothers do not respond effectively to their children. Depressed mothers tend to less sensitively attuned to and more negative toward their infants. Depression in fathers has also been related to depression in children.

Depressive symptoms are positively correlated with the tendency to attribute positive events to external, specific and unstable causes. Negative events are correlated with internal, global, and stable causes; with fatalistic thinking and with feelings of hopelessness.

The tendency to develop distorted mental representations are an important cause of disorders such as depression and conduct disorder.

14.2.2.3 Treatments and Outcomes

Recent studies have shown fluoxetine to be effective in the treatment of depression along with cognitive-behavioral therapy. Recent attention is being paid to the increased potential of suicide ideation and behavior in children and adolescents who are taking SSRIs.
14.3 PERVERSIVE DEVELOPMENTAL DISORDERS

Pervasive development disorders (PDDs) are a group of severely conditions that make up about 3.2 percent of cases in in-patient settings. They are considered to be the result of some structural differences in the brain that are usually evident at birth or become as the child begins to develop.

Asperger's disorder is a severe and persistent impairment in social interaction that involves marked stereotypic behavior and inflexible adherence to routines. Asperger's disorder shares many features of social impairment disorder, restricted interest and repetitive behaviors with autism.

14.3.1 Autism

Autism is a mental disorder that involves a wide range of problematic behaviors including deficits in language, and perceptual and motor development; defective reality testing and inability function in social settings.

14.3.1.1 Criteria for Autistic Disorder:

A. Six or more of the following criteria form (1), (2) and (3), with at least two from (1) and of each from (2) and (3):

1. Qualitative impairment in social interaction, as manifested by at least two of the following:
   - Marked impairment in the use of multiple nonverbal behaviors.
   - Failure to develop peer relationships appropriate to developmental level.
   - A lack of spontaneous seeking to share enjoyment, interests or achievements with other people.
   - Lack of social or emotional reciprocity.

2. Qualitative impairments in communication as manifested by at least one of the following:
   - Delay in, or total lack of, the development of spoken language.
   - In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others.
   - Stereotyped and repetitive use of language or idiosyncratic language.
   - Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

3. Restricted repetitive impairments and stereotyped patterns of behavior, interests and activities as manifested by at least one of the following:
   - Encompassing preoccupation with one or more stereotyped and restricted patterns or interest that is abnormal either in intensity or focus.
UNIT 14  DISORDERS OF CHILDOHOOD AND ADOLESCENCE

- Apparently inflexible adherence to specific, nonfunctional routines or rituals.
- Stereotyped and repetitive motor mannerisms.
- Persistent preoccupation with parts of objects.

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to 3 years:
   1. Social interaction
   2. Language as used in social communication
   3. Symbolic or imaginative play

Autism is usually identified before a child is 30 months old and may be suspected in early weeks of life. One study found that autistic behavior such as lack of empathy, inattention to others and inability to imitate is shown as early as 20 months.

14.3.1.2 The Clinical Picture in Autism Disorder

A Social Deficit

Typically, autistic children do not show any need for affection or contact with anyone, and they usually do not even seem to know or care who their parents are. The inability of autistic children to respond to other is a lack of social understanding. The autistic child is thought to have mind blindness, an inability to take the attitude of others or to see things as others do. Additionally, autistic children show deficits in attention and in locating and orienting to sounds in their environment.

An Absence of Speech

Autistic children have been considered to have an imitative deficit and do not effectively learn by imitation. This dysfunction might explain their characteristic absence or severely limited speech (echolalia).

Self-Stimulation

Self-stimulation usually takes the form of repetitive movements, which may continue for an hour. Autistic children seem to actively arrange the environment on their own terms in an effort to exclude or limit variety and intervention from other people, preferring instead a limited and solitary routine. Autistic children often show and active aversion to auditory stimuli.

Intellectual Ability

Compared with the performance of other groups of children on cognitive or intellectual tasks, autistic children often show marked impairment. Some autistic children are quite skilled at fitting objects together. Even in the manipulation of objects, however, difficulty with meaning is apparent.
Maintaining Sameness

Many autistic children become preoccupied with and form strong attachments to unusual objects. When their preoccupation with the object is disturbed, or when anything familiar in the environment is altered even slightly, these children may have a violent temper tantrum or a crying spell that continues until the familiar situation is restored.

14.3.1.3 Causal Factors in Autism

Many investigators believe that autism begins with some type of inborn defect that impairs an infant's perceptual-cognitive functioning. Evidence has accumulated that defective genes or damage from radiation or other conditions during prenatal development may play a significant role.

Twin studies have consistently shown higher concordance rates among monozygotic than dizygotic twins. The conclusion from family and twin studies is that 80 to 90 percent of the variance in autism is based on genetic factors. Some investigators have pointed to existence of a possible genetic defect known as fragile X, a constriction or breaking off of the end portion of the long arm of the X sex chromosome that appears to determined by a specific gene.

14.3.1.4 Treatment and Outcomes of Autism

Medical Treatment

The drug most often used in treatment of autism is haloperidol (Haldol), an antipsychotic medication. More recently, clonidine, an antihypertensive medication has been used with reportedly moderate effects in reducing severity of symptoms.

Behavioral Treatment

Behavior therapy in an institutional setting has been used successfully in the elimination of self-injurious behavior, the mastery of the fundamentals of social behavior, and the development of some language skills.

Some impressive results with autistic children have also been obtained in projects that involve parents at home. Treatment contracts with parents specify the desired behavior changes in their child and spell out the explicit techniques for bringing about these changes.

The Effectiveness of Treatment

The prognosis for autistic children, particularly for children showing symptoms before the age of 2 is poor. Commonly, the long-term results of autism treatments have been unfavorable.
One important factor limiting treatment success is the difficulty that autistic children have in generalizing behavior outside the treatment context. Less than one-fourth of autistic children who receive treatment attain even marginal adjustment in later life.

Some make substantial improvement during childhood. They only deteriorate, showing symptom aggravation at the onset of puberty.

**ACTIVITY 14.1**

(a) Distinguish among conduct disorder, oppositional defiant disorder, and juvenile delinquency.
(b) Describe two common anxiety disorders found in children and adolescents.
(c) How do the symptoms of childhood depression compare to those seen in adult depression?
(d) What is known about the causes and treatments of autistic disorder?

### 14.4 LEARNING DISABILITIES AND MENTAL RETARDATION

#### 14.4.1 Learning Disabilities

The inadequate development found in learning disabilities, a term that refers to retardation, disorder, or delayed development, may be manifested in language, speech, mathematical or motor skills and it is not due to any reliably demonstrable physical or neurological effect.

In dyslexia, the individual manifest problems in word recognition and reading comprehension, often he or she is markedly deficient in spelling as well. On assessments of reading skills, these persons routinely omit, add and distort words and their reading is typically painfully slow and halting.

The diagnosis of learning disability or disorder is restricted to those cases in which there is clear impairment in school performance or in daily living activities not due to mental retardation or to a PDD. Significantly more boys are diagnosed as learning disabled.
Typically, these children have overall IQs, family backgrounds and exposure to cultural norms and symbols that are consistent with at least average achievement in school. They do not have obvious crippling emotional problems, nor do they seem to be lacking in motivation, cooperativeness or eagerness to please their teachers and parents.

14.4.1.1 Causal Factors in Learning Disabilities

These disabilities are thought to result from some sort of immaturity, deficiency or deregulation limited to those brain functions. These brain functions were supposed to mediate the cognitive required.

Portions of the left hemisphere normally mediated the language function. For unknown reasons, they appear to remain relatively underdeveloped in many dyslexic individuals.

Dyslexic individuals may have a deficiency of physiological activation in a brain center believed to be involved with rapid visual processing. Identification of the gene region for dyslexia on chromosome 6 has been reported.

14.4.1.2 Treatments and Outcomes

Many informal and single-case reports claim success with various treatment approaches, but direct instruction strategies often do not succeed in transforming these children’s abilities, and there are few well-designed and well-executed outcome studies on specific treatments for LD.

Two studies of college students with LD suggested that as a group they continue to have problems, academic, personal and social.

14.4.2 Mental Retardation

Mental retardation is defined as significantly subversive age general intellectual functioning that is accompanied by significant limitations in adaptive functioning in certain skill areas such as self-care, work, health and safety.

For the diagnosis to apply, these problems must have begun before age 18. Initial diagnoses of mental retardation occur very frequently at ages 5 to 6, peak at age 15 and drop off sharply after that.

During early childhood, individuals with only a mild degree of intellectual impairment who constitute the vast majority of the mentally retarded, often appear normal. Following the school years, they usually make more or less acceptable adjustment in the community and thus lose the identity of being retarded.
14.4.2.1 Mild Mental Retardation

Mildly retarded individuals constitute the largest number of those diagnosed as mentally retarded. People in this group are considered educable and their intellectual levels, as adults are comparable to those of average 8 to 11 year olds.

The social adjustments of mildly retarded people often approximate that of adolescents. However, they tend to lack normal adolescent's imagination, inventiveness and judgment.

With early diagnosis, parental assistance, and special education programs, the great majority of borderline and mentally retarded individuals can adjust socially. They can also master simple academic and occupational skills, and become self-supporting citizens.

Moderate Mental Retardation

Moderately retarded individuals are likely to fall in the educational category of trainable. In adult life, these individuals attain intellectual levels similar to those of average 4 to 7 year old children.

Some can be thought to read and write a little and might manage to achieve a fair command of spoken language. However, their rate of learning is slow. Their level of conceptualizing is also extremely limited.

They usually appear clumsy and ungainly and they suffer from bodily deformities and poor motor coordination. In general, with early diagnosis, parental help, and adequate opportunities these individuals can achieve partial independence in daily self-care, acceptable behavior and economic sustenance in family or other sheltered environment.

Severe Mental Retardation

Severely retarded individuals are sometimes referred to as dependent retarded. In these individuals, motor and speech development are severely retarded. Sensory defects and motor handicaps are common.

They can develop limited levels of personal hygiene and self-help skills, which somewhat lessen their dependency. Whichever the case, they are always dependent on others for care. Yet, many profit to some extent from training and can perform simple occupational tasks under supervision.

Profound Mental Retardation

Most of these people are severely deficient in adaptive behavior. They unable to master any but the simplest tasks. Useful speech, if it develops at all, is rudimentary. Severe physical deformities, central system pathology and retarded growth are typical. Convulsive seizures, mutism, deafness and other physical anomalies are also common.

These individuals must be under custodial care all their life. They show a marked impairment of overall intellectual functioning.
14.4.2.2 Brain Defects in Mental Retardation

Genetic-Chromosomal Factors

Genetic-chromosomal factors play a much clearer role in the etiology of relatively infrequent but more severe types of mental retardation such as Down's syndrome and a heritable condition known as fragile X. In such conditions, genetic aberrations are responsible for metabolic alterations that adversely affect the brain's development.

Genetic defects leading to metabolic alterations may involve other developmental anomalies besides mental retardation such as autism. In general, mental retardation associated with known genetic chromosomal defects is moderate to severe.

Infections and Toxic Agents

Mental retardation may be associated with a wide range of conditions due to infections such as viral encephalitis or genital herpes. If a pregnant woman is infected with syphilis or HIV-1 or if she gets German measles, her child may suffer brain damage.

A number of toxic agents such as carbon monoxide and lead may cause brain damage during fetal development after birth. In rare instances, immunological agents such as antitetanus serum or typhoid vaccine may lead to brain damage.

Similarly, if taken by a pregnant woman, certain drugs, including an excess of alcohol may lead to congenital malformations. In rare cases, brain damage results from incompatibility in blood types between mother and fetus.

Trauma (Physical Injury)

Although the fetus is normally well protected by its fluid-filled bag during gestation and although its skull appears to resist delivery stresses, accidents do happen during delivery after birth. Difficulties in labor due to malposition of the fetus or other complications may irreparably damage the infant's brain.

Bleeding within the brain is probably the most common result of such birth trauma. Hypoxia is another type of birth trauma that may damage the brain.

Ionizing Radiation

Radiation may act directly on fertilized ovum or may produce gene mutations in the sex cells, which may lead to defective offspring. Sources of harmful radiation was once limited to high energy X-rays used in medicine for diagnosis of therapy, but the list has grown to include nuclear weapon testing and leakages of nuclear power plants.
14.4.2.3 Malnutrition and Other Biological Factors

Malnutrition may affect mental development more indirectly by altering a child’s responsiveness, curiosity and motivation to learn. According to this hypothesis, these losses would then lead to a relative retardation of intellectual facility.

Organic Retardation Syndromes

No. 18 Trisomy Syndrome

The symptoms include a peculiar pattern of multiple congenital anomalies, the most common being low-set malformed ears, flexion of fingers, small jaw, and heart defects. The cause is an autosomal anomaly of chromosome 18.

Tay-Sachs Disease

The symptoms include hypertonicity, listlessness, blindness, progressive spastic paralysis, and convulsions. The cause is a disorder of lipid metabolism, carried by a single recessive gene.

Turner's Syndrome

This appears in females only, the symptoms are webbing of the neck, increased carrying angle of forearm, and sexual infantilism. The cause is a sex chromosome anomaly (XO), mental retardation may occur but is infrequent.

Klinefelter’s Syndrome

This appears in males only and features vary from case to case, the only constant finding is being small testes after puberty. The cause is a sex chromosome anomaly (XXY).

Niemann-Pick’s Disease

The onset is usually in infancy; the symptoms are loss of weight, dehydration, and progressive paralysis. The cause is a disorder of the lipid metabolism.

Bilirubin Encephalopathy

The symptoms are abnormal levels of bilirubin in the blood and frequent motor incoordination. The cause is often an Rh (ABO) blood group incompatibility between mother and fetus.

Rubella, congenital

The symptoms are visual difficulties with cataracts and retinal problems occurring together and with deafness and anomalies in the valves and septa of the heart. The cause is the mother’s contraction of rubella during the first few months of pregnancy.
Down Syndrome

Down Syndrome is best known of the clinical conditions associated with moderate and severe retardation. About 1 in every 1000 babies is diagnosed as having Down syndrome, a condition that creates irreversible limitations on survivability, intellectual achievement and competence in managing life tasks.

The availability of amniocentesis and of chorionic villus sampling has made it possible to detect in utero the extra genetic material involved in Down syndrome, which is most often trisomy of chromosome 21, yielding 47 instead of 46.

The Clinical Picture of Down Syndrome

- The eyes appear almond shaped.
- The skin of the eyelids tends to be abnormally thick.
- The face and nose are often flat and broad, as is the back of the head.
- The tongue, which seems too large for the mouth, may show deep fissures.
- The iris of the eye is frequently speckled.
- The neck is often short and broad as are the hands.
- The fingers are stubby, and
- The little finger is often more noticeably curved than the other fingers.

Despite their problems, children with Down syndrome are usually able to learn self-help skills, acceptable social behavior and routine manual skills that enable them to be of assistance in a family or institutional setting. In general, the quality of a child’s social relationship depends on both IQ level and a supportive home environment.

Children with Down syndrome remain relatively unimpaired in their appreciation of spatial relationships and in visual-motor coordination. Their greatest deficits are in verbal and language related skills.

The reason for the trisomy of chromosome 21 is not clear, but the defect seems to be related to parental age at conception.

Phenylketonuria

In phenylketonuria (PKU), the baby appears normal at birth. But they lack a liver enzyme needed to break down phenylalanine, an amino acid found in many foods. The genetic error results in retardation only when significant quantities of phenylalanine are ingested. This disorder occurs in about 1 to 12,000 births.

If the condition is not detected, the amount of phenylalanine in the blood increases and eventually produces brain damage. The disorder becomes apparent between 6 to 12 months after birth. Earlier symptoms, such as vomiting, a peculiar odor, infantile eczema and seizures might occur.

Lack of motor coordination and other neurological problems caused by brain damage are also common. Often, the eyes, skin and hair of untreated PKU patients are very pale. Patients with PKU are typically advised to follow a restricted diet over their life span in order to prevent cognitive impairment.
Cranial Anomalies

Microcephaly

The term microcephaly means small headedness. It is associated with a type of mental retardation resulting from impaired development of the brain and a consequent failure of the cranium to attain normal size.

The most obvious symptom is the small head (circumference of 17 inches). These children are short in stature. They have relatively normal musculature and sex organs.

Microcephalic children fall within the moderate, severe and profound categories of mental retardation. Most show little language development. They are also extremely limited in mental capacity.

Microcephaly may result from a wide range of factors that impair brain development including intrauterine infections and pelvic irradiation during the mother’s early months of pregnancy. Treatment is ineffective once fault development has occurred.

Hydrocephaly

Hydrocephaly is a relatively rare condition in which the accumulation of an abnormal amount of cerebrospinal fluid within the cranium causes damage to the brain tissues and enlargement of the skull. In congenital cases, the head is either already enlarged at birth or begins to enlarge soon after.

The disorder can also arise in infancy or early childhood following the development of a brain tumor, subdural hematoma, meningitis, or other conditions. In these cases, the condition appears to result from blockage of the cerebrospinal pathways and an accumulation of fluid in certain brain areas.

The damage leads to intellectual impairment and to other effects as convulsions and impairment or loss of sight and hearing. The degree of intellectual impairment varies, being severe or profound in advanced cases. Hydrocephaly can be treated by a procedure in which shunting devices are inserted to drain cerebrospinal fluid.

14.4.2.4 Treatments, Outcomes and Prevention

Treatments Facilities and Methods

In general children who are institutionalized fall into two groups:

1. Those who, in infancy and childhood, manifest severe mental retardation and associated physical impairment and who enter an institution at an early age.
2. Those who have no physical impairments but show relatively mild mental retardation and a failure to adjust socially in adolescence, eventually being institutionalized chiefly because of delinquency of other problem behavior.

Many families are not in a position to help teenagers with retardation achieve a satisfactory adjustment. For these teenagers, community-oriented residential care seems to be effective alternative. During the 1970s, there was a rapid increase in alternative forms of care for the mentally retarded.

Alternative forms of care included the use of decentralized regional facilities for short-term evaluation and training and small private hospitals specializing in rehabilitative technique.

Others forms of care included group homes or halfway houses integrated into the local community, nursing homes for the elderly retarded and the placement of severely retarded children in more enriched foster home environments. Varied forms of support in alternative modes of support for the family for own home care and employments are also available.

**Education and Inclusion Programming**

Typically, educational and training procedures involve mapping out target areas of improvement. These procedures comprise personal grooming, social behavior, basic academic skills, and simple occupational skills.

Within each area, specific skills are divided into simple components that can be learned. The skills are also reinforced before more complex behaviors are required.

Many mildly retarded children fare better when they attend regular classes for much of the day. This approach called mainstreaming requires careful planning, a high level of teacher skill and facilitative teacher attitudes.

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**Exhibit 14.3**

(a) In what ways do learning disorders differ from mental retardation?

(b) Compare the mild, moderate, severe and profound mental retardation.

(c) Describe some of the physical characteristics of children born with Down syndrome. What is the cause?
14.5  PLANNING BETTER PROGRAMS TO HELP CHILDREN AND ADOLESCENTS

14.5.1 Special Factors Associated with Treatment for Children and Adolescents

The Child’s Inability to Seek Assistance

Most emotionally disturbed children who need assistance are not in a position to ask for help themselves or to transport themselves to and from child treatment clinics. Adults should realize when a child needs professional help and take the initiative in obtaining it.

The law identifies four areas in which treatment without parental consent is permitted:

- In the case of mature minors
- In the case of emancipated minors
- In emergency situations
- In situations where a court orders treatment

Many children, or course come to the attention of treatment agencies as a consequence of school referrals, delinquent acts or parental abuse.

Vulnerabilities That Place Children at Risk for Developing Emotional Problems

Children and youth who experience or are exposed to violence are at increased risk for developing psychological disorders. In addition, many families provide an undesirable environment for their growing children.

Disruptive childhood experiences have been found to be a risk factor for adult problems. Parental substance abuse has also been found to be associated with vulnerability for children to develop psychological disorders.

High-risk behaviors or difficult life conditions need to be recognized and taken into consideration. Moreover, physical or sexual abuse, parental divorce, family turbulence and homelessness can place young people at great risk for emotional distress and subsequent maladaptive behavior.

Need for Treating Parents as Well as Children

Because many of the behavior disorders specific to childhood appear to grow out of pathogenic family interactions and result from having parent with psychiatric problems themselves, it is often essential for the parents as well as the child to receive treatment.
Possibility of Using Parents as Change Agents

In essence, parents can be used as change agents by training them in techniques that enable them to help their child. Typically, such training focuses on helping the parents understand the child’s behavior disorder and teaching them to reinforce adaptive behavior while withholding reinforcement for undesirable behavior.

Problem of Placing a Child Outside the Family

Depending on the home situation and the special needs of the child, he or she will later be either returned to his or her parents or placed elsewhere. In the latter instance four types of facilities are commonly relied on:

- Foster homes
- Private institutions for the care of children
- County or state institutions
- The homes of relatives

The quality of the child’s new home is a crucial determinant of whether the child’s problems will be alleviated or made worse, and there is evidence to suggest that foster-home placement has more positive effects than group home placement.

Some cases of child abuse, child abandonment, or serious child behavior problems are beyond parental control. In these cases, the only feasible option is to take the child out of the home and to find a temporary substitute.

Taking children out of their home and placing them in an institution may not be a suitable option. These children are likely to feel rejected by their parents, unwanted by their new caretakers, rootless, constantly insecure, lonely and bitter.

The trend today is toward permanent planning. First, every effort is made to hold a family together and to give parents the support and guidance for childrearing. If that is impossible, then efforts are made to free the child legally for adoption and to find an adoptive home as soon as possible.

ACTIVITY 14.3

(a) What special factors must be considered in providing treatment for children and adolescents?
(b) Why is therapeutic intervention a more complicated process with children than adults?
Value of Intervening Before Problems Become Acute

Investigators found that children of parents who had a chronic medical problem were vulnerable to developing internalizing problems and avoidant behavior. The case was more severe when the parent-child relationship was weak.

Investigators concluded that clinicians might be able to reduce the impact of parental chronic illness by

- strengthening the parent-child relationship, and
- decreasing the child’s use of avoidant strategies.

Early intervention has the double goal of reducing stressors in a child’s life and strengthening the child’s coping mechanism. It can often reduce the incidence and intensity of later maladjustment, thus averting problems for both the individuals concerned and the broader society.
1. Inattention, hyperactivity, and impulsivity are symptoms associated with ________.

2. Why is Attention-Deficit/Hyperactivity Disorder (ADHD) difficult to diagnose in children younger than 4 or 5?

3. Why are girls less likely to be referred for ADHD than boys?

4. What is the most common treatment for hyperactive children?

5. Young children who are diagnosed with conduct disorder are at high risk for the later development of:

6. Mark, a 10-year-old boy, is often in trouble for hurting his neighbor’s pets, setting fires, and getting money with his parents’ bank card. His behavior is consistent with what diagnosis?

7. Aggressive children are more likely than nonaggressive children to interpret the causes of ambiguous social situations as ________.

8. Separation anxiety disorder is diagnosed if a child expresses extreme distress at most separations from a caregiver over a period of at least ________.

9. What is the most typical type of treatment for childhood fears and phobias?

10. What type of sleep-related changes are likely to occur among adolescents experiencing depression?

11. What is the basic premise of family therapy?

12. What are the three major categories of the symptoms that define autistic disorder?

13. The cognitive skills in autistic disorders are primarily in the area of ________.

14. What is the most common degree of mental retardation?

15. What is the cause of phenylketonuria?

16. Down syndrome is caused by ________.
Required Reading:


Self-check

1. attention-deficit/hyperactive disorder
2. Many ADHD type behaviors are normal for this age.
3. Boys show aggressive-impulsive behavior where girls are primarily inattentive.
4. stimulant drugs and behavior therapy.
5. antisocial personality disorder
6. conduct disorder
7. hostile
8. four weeks
9. cognitive-behavioral therapy
10. sleeping excessive amounts of time
11. the system of family interactions is disturbed
12. activities, communication, and social interaction
13. factual memory
14. mild
15. a gene mutation
16. a chromosomal abnormality.
Unit 15

Contemporary and Legal Issues

LEARNING OUTCOME

At the end of this topic you will learn about:

1. Define, compare, and contrast perspectives on prevention: voluntary and involuntary commitment and types of commitment, such as, civil commitment, psychiatric commitment, and criminal commitment.
2. Describe controversial legal issues and the mentally disordered, the legal procedures for psychiatric commitment and the safeguards to prevent abuses of psychiatric commitment.
3. Discuss the controversy concerning psychiatric commitment.
4. Discuss the problem faced by psychologists and other professionals who are given the task of attempting to predict dangerousness.
5. Distinguish among the legal standards of competency to stand trial, the insanity plea, not guilty by reason of insanity, and guilty but mentally ill.
6. Evaluate the legal basis of the right to treatment, the right to refuse treatment, the right to the least restrictive environment, and similar laws associated with the legal rights of those with mental illness.
7. Discuss the organized efforts for mental health.
15.1 PERSPECTIVES ON PREVENTION

Prevention efforts are now categorized into three subcategories:

- **Universal interventions**: Efforts that are aimed at influencing the general population.
- **Selective interventions**: Efforts that are aimed at a specific subgroup of the population considered at risk for developing mental health problems.
- **Indicated interventions**: Efforts that are directed to high-risk individuals who are identified as having minimal but detectable symptoms of mental disorder but who do not meet the criteria for mental disorder.

15.1.1 Universal Interventions

Universal interventions perform two key tasks:

1. Altering conditions that can cause or contribute to mental disorders.
2. Establishing conditions that foster positive mental health.

Universal prevention is very broad and includes biological, psychosocial and sociocultural efforts. Virtually any effort that is aimed at improving the human condition would be considered as part of a universal prevention of mental disorder.

**Biological Strategies**

Biological based universal strategies begin with promoting adaptive lifestyles. Efforts geared toward improving diet, establishing a routine of physical exercise, and developing overall good health habits can do much to improve physical well-being. Physical illness always produces some kind of psychological stress that can result in problems such as depression.

**Psychosocial Strategies**

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

The second requirement for psychosocial health is that a person acquires an accurate frame of reference to build his or her identity. We have seen repeatedly that when people’s assumption about themselves or their world are inaccurate, their behavior is likely maladaptive.

The third requirement for psychosocial health is that a person be prepared for types of problems likely to be encountered during given life stages.
Sociocultural Strategies

Without a supportive community, the individual is stifled. At the same time, without responsible, psychologically health individuals, the community will not thrive, and therefore cannot be supportive.

15.1.2 Selective Interventions

An Illustration of Selective Prevention Strategies

In this section we will look at the mobilization of prevention resources aimed at curtailing or reducing the problem of teenage alcohol and drug use. There are three broad strategies to prevent drug use in the US:

1. Interdicting and reducing the supply of drugs available
2. Providing treatment services for those who develop drug problems.
3. Encouraging prevention.

Education Programs

Many drug and alcohol education programs are school based and predicted on the idea that children are made aware of the drugs and alcohol, they will choose not to begin to use them.

Intervention Programs for High-Risk Teens

Intervention programs identify high-risk teens and take special measures to circumvent their further use of alcohol or potentially dangerous drugs. Programs such as these are often school-based efforts and are not strictly prevention programs.

Parent Education and Family-Based Intervention Programs

Through their own drinking or through verbalizations about alcohol, parents may encourage or sanction alcohol use among teens. Some research has shown that parental involvement and monitoring involves substance use among adolescents.

Peer Group Influences

Peers exert a powerful influence on teenagers in every aspect of their lives including drug and alcohol abuse. Programs designed to help youngsters overcome negative pressure from peers focus on teaching social skills and assertiveness.
Programs to Increase Self-Esteem

Programs designed to increase a sense of self-worth attempt to ensure that young people will be able to fend for themselves with more confidence and not fall into dependent negative relationships with stronger and more dominant peers.

One such program provided teenagers with social-skills training and the modeling of appropriate behaviors to reduce drug use and related negative behaviors such as truancy. Another program relied on cognitive-behavioral intervention techniques to enhance teenagers' feelings of competency in basic life skills and to improve their problem-solving skills.

Mass Media and Modeling Programs

Most youngsters are bombarded with drug or alcohol related stimuli in movies and the TV commercials that are aired at those times when children are most likely to use them. Some legal prohibitions of such exploitation are now in place.

Several efforts have been aimed at de glamorizing or counteracting these messages by showing commercials that graphically depict the negative aspects of alcohol and drug use.

15.1.3 Indicated Interventions

Indicated interventions emphasize the early detection and prompt treatment of maladaptive behavior in a person’s family and community setting.

The Mental Hospital as a Therapeutic Community

In cases where individuals might be considered dangerous to themselves or others or where their symptoms are so severe that they are unable to care for themselves in the community, psychiatric hospitalization may be required.

All the ongoing activities are brought into the total treatment program and the environment or milieu is a crucial part of therapy. This approach is often referred to as milieu therapy. Three general therapeutic principles guide this approach to treatment:

1. Staff expectations are clearly communicated to patients. Both positive and negative feedback are used to encourage appropriate verbalizations and actions by patients.

2. Patients are encouraged to become involved in all decisions made, and all actions taken concerning them. A self-care, do-it-yourself attitude prevails.

3. All patients belong to social groups on the ward. The group cohesiveness that results gives the patients support and encouragement, and the related process of group pressure helps shape their behavior in positive ways.

In a therapeutic community, as few restraints as possible are placed on patient’s freedom and patients are encouraged to take responsibility for their behavior and encouraged to take responsibility for their behavior and participate actively in their treatment programs.
Another successful method is the social-learning programs. Such programs normally make use of learning principles and techniques such as token economies to shape more socially acceptable behavior.

**Aftercare Programs**

Even where hospitalization has successfully modified maladaptive behavior and patient has learned need occupational and interpersonal skills, readjustment into the community following release may still be difficult.

Community-based treatment programs, now referred to, as aftercare programs are live-in facilities that serve as a home base for former patients as they make the transition back to adequate functioning in the community. Sometimes aftercare includes a halfway period in which a released patient makes a gradual return to the outside world in what were formerly termed halfway houses.

**Deinstitutionalization**

Deinstitutionalization is the movement to close down mental hospitals and to treat persons with severe mental disorders in the community. Some authorities consider the emptying of the mental hospitals a positive expression of society’s desire to free previously confined persons. They maintain that deinstitutionalized patients show significant improvement compared to those who remain hospitalized.

Others speak of the abandonment of chronic patients to cruel and harsh existence, which for many includes homelessness, violent victimization or suicide. Many citizens, too, complain of being harassed, intimidated and frightened by obviously disturbed persons wandering the streets.

**ACTIVITY 1.5**

1. Discuss the three intervention efforts and decide which would be most effective and give reasons why.
2. Discuss the effectiveness of education programs on high-risk individuals.
15.2 CONTROVERSIAL LEGAL ISSUES AND THE MENTALLY DISORDERED

The subject matter of forensic psychology or forensic psychiatry are related to the legal status of mentally ill people and center on the rights of patients and the rights of members of society to be protected from disturbed individuals.

15.2.1 Important Court Decisions for Patient Rights

Several important court decisions have helped establish certain basic rights for individuals suffering from mental disorders:

- Right to treatment.
- Freedom from custodial confinement.
- Right to compensation for work.
- Right to live in a community.
- Right to less restrictive treatment.
- Right to legal counsel at commitment hearings.
- Right to refuse treatment.
- The need for confinement must be shown by clear, convincing evidence.
- Limitation on patient's rights to refuse psychotropic medication.

15.2.2 The Commitment Process

People who are judged to be potentially dangerous because of their psychological state may, after civil commitment procedures, be confined to mental institutions. The steps in the commitment process vary slightly depending on state law, the locally available community mental health resources and the nature of the problem.

A person's being mentally ill is not sufficient grounds for placing that person in a mental institution against his or her will. In brief, such individuals must be judged to be:

- Dangerous to themselves or to others and/or
- Incapable of providing for their basic physical needs and/or
- Unable to make responsible decisions about hospitalization and
- In need of treatment or in care in a hospital

Typically, filing a petition for a commitment hearing is the first step in the process of committing a person voluntarily. When such a petition is filed, a judge appoints examiners to evaluate the proposed patient. The patient is asked to appear voluntarily for psychiatric examination before the commitment hearing. The law requires that the court-appointed examiners interview the patient before a hearing.

When a person is committed to a mental hospital for treatment, the hospital must report to the court within 60 days on whether the person needs to be confined any longer. If the
hospital indicates that the person needs further treatment, then the commitment period becomes intermediate, subject to periodic reevaluations.

Assessment of Dangerousness

A history of violent behavior and some classes of mental disorder appear to be associated with violence. The disorders that have an increased risk for violent behavior include schizophrenia, mania, personality disorder, substance abuse and the more rare conditions of organic brain injury and Huntington’s disease. Practitioners are called upon to evaluate the possibility that a patient might be dangerous.

Attempts to Predict Dangerousness

The goal of a warning system in mental health is to maximize the number of people who take appropriate and timely actions for the safety of life and property. Violent acts are difficult to predict because they are apparently determined as much by situational circumstances as by an individual’s personality traits or violent predispositions. One obvious and significantly predictive risk factor is past history violence.

15.2.3 The Duty to Protect: Implications of the Tarasoff Decision

Today in most states in the US, the therapist not only can violate confidentiality with impunity but also may be required by the law to take action to protect people from the threat of imminent violence against them. The duty-to-warn ruling (the Tarasoff decision), spelled out a therapist’s responsibility in situations where there has been an explicit threat on specific a person’s life, but it left other areas of application unclear.

15.2.4 The Insanity Defense

Some who are being tried for murder use the insanity defense – also known as the NGRI plea (not guilty by reason of insanity) – in an attempt to escape the legally prescribe consequences of their crimes.

In technical legal terms, they invoke the ancient doctrine that their acts, while guilty ones (actus rea), lacked moral blameworthiness because they were not intentional since the defendants did not possess their full mental faculties at the time of the crime and did not know what they were doing (mens rea) – the underlying assumption being that insanity somehow precludes or absolves the harboring of guilty intent.

Established precedents that define the insanity defense are as follows:

1. The M’Naghten Rule (1843) – which is often referred to as the “knowing right from wrong” rule. Under this ruling, people are assumed to be sane unless it can be proved that at the time of committing the act, they were laboring under such a defect of reason that they did not know the nature and quality of the act they were doing.
Otherwise, if they did know they were committing the act, they did know what they were doing was wrong.

2. The Irresistible Impulse Rule (1887) – This view holds that accused persons might not be responsible for their acts, even if they knew that what they were doing was wrong, if they had lost the power to choose between right and wrong. They could not avoid doing the act in question because they were compelled beyond their will to commit the act.

3. The Durham Rule – Under this rule, which is often referred to as the product test, the accused is not criminally responsible if his or her unlawful act was the product of mental disease or mental defect.

4. The American Law Institute (ALI) Standard (1962) – Often referred to as the substantial capacity test for insanity. This test combines the cognitive aspect of M'Naghten with the volitional focus of irresistible impulse. It holds that the perpetrator is not legally responsible if at the time of the act he or she, owing to mental disease or defect, lacked substantial capacity either to appreciate its criminal character or to conform his or her behavior to the law’s requirement.

5. The Federal Insanity Defense Act (IDRA) – This act abolished the volitional element to the ALI standard and modified the cognitive one to read unable to appreciate thus bringing the definition quite close to M’Naghten. IDRA also specified that the mental disorder involved must be a severe one and shifted the burden of proof from the prosecution to the defense. That is, the defense must clearly and convincingly establish the defendant’s insanity. In contrast, the prior requirement that the prosecution clearly and convincingly demonstrate the defendant have been sane when the prohibited act was committed.

One study found that a NGRI plea was most likely to be successful if one or more of the following factors were present:
- A diagnosed mental disorder, particularly a major mental disorder
- A female defendant.
- The violent crime was other than murder.
- There had been prior mental hospitalization.

States have adopted the optional plea/verdict of guilty but mentally ill (GBMI). In these cases, a defendant may be sentenced but placed in a treatment facility rather than a prison.

Activity 152
(a) Explain the basic rights for individuals suffering with a mental disorder.
(b) Discuss the insanity defense. How appropriate is it use in court?
15.3 ORGANIZED EFFORTS FOR MENTAL HEALTH

15.3.1 Efforts for Mental Health

In 1946, aware of the need for more research, training and services in the field of mental health, Congress passed its first comprehensive mental health bill, the National Mental Health Act. In that same year, the National Institute of Mental Health (NIMH) was formed. The agency was to serve as a central research and training center and as headquarters for the administration of a grant-in-aid program designed to foster research and training elsewhere in the nation and to help state and local communities expand and improve their own mental health services.

The NIMH:
- Conducts and supports research on the biological, psychosocial, and sociocultural aspects of mental disorders;
- Supports the training of professional and paraprofessional personnel in the mental health field;
- Helps communities plan, establish, and maintain more effective mental health programs;
- Provides information on mental health to the public and to the scientific community.

Professional Organizations and Mental Health

A key function of professional organizations is the application of insights and methods to contemporary social problems. Professional mental health organizations are in a unique position to serve as consultants on mental health problems and programs.

Another important function of these organizations is to set and maintain high professional and ethical standards within their special areas. This function may include:
- Establishing and reviewing training qualifications for professional and paraprofessional personnel;
- Setting standards and procedures for the accreditation of undergraduate and graduate training programs;
- Setting standards for accreditation of clinics, hospitals, or other service operations and carrying out inspections to see that the standards are followed;
- Investigating reported cases of unethical or unprofessional conduct and taking disciplinary action when necessary.

The Role of Volunteer Organizations and Agencies

The National Mental Health Association (NMHA) works for the improvement of services in community clinics and mental hospitals, it helps recruit, train, and place volunteers for service in treatment and aftercare programs and it works for enlightened mental health
legislation and for provision of need facilities and personnel. The NMHA has bee actively involved in many court decisions affecting patient’s rights.

The National Association for Retarded Children (NARC) works to reduce the incidence of mental retardation, to seek community and residential treatment centers and service for the retarded and to carry on a program of education aimed at a better public understanding of retarded individuals and greater support for legislation on their behalf.

*Mental Health Resources in Private Industry*

The National Institute for Occupational Safety and Health (NIOSH) recognizes psychological disorders as one of the ten leading work-related health problems, and work related health problems risk factors may be increasing with changes in the economy, in technology and in demographics in the workforce.

Since passage of the Americans with Disabilities Act, people with psychiatric problems cannot be discriminated against in the workplace. Employers are encouraged to alter the workplace, as needed, to accommodate the needs of persons with mental illness.

**15.3.2 International Efforts for Mental Health**

*The World Health Organization*

The World Health Organization has always been keenly aware of the close interrelationships among physical, psychosocial and sociocultural factors. Another important contribution of WHO has been its International Classification of Disease (ICD), which enables clinicians and researchers in different countries to use a uniform set of diagnostic categories.

*The World Federation for Mental Health*

Its purpose is to promote international cooperation among governmental and nongovernmental mental health agencies.
1. What is an example of alternative housing for the mentally ill?
2. What is one of the clearest consequences of deinstitutionalization?
3. What is the process of placing a person in a psychiatric hospital without their consent?
4. What is the most serious problem with forced institutionalization?
5. Under which set of circumstances is criminal commitment of an individual to a mental hospital most likely to occur?
6. The legal concept of insanity refers to the person’s state of mind at what point in time?
7. Which principle refers to a person’s ability to distinguish right from wrong?
8. Which principle holds that a person is not criminally responsible if a criminal act was the product of mental disease or mental defect?
9. All civil commitment laws involve a judgment about whether an individual is suffering from a disabling mental illness and whether he or she is
10. A clinical psychologist is treating a young man who made several threats against his former girlfriend during therapy sessions. According to the Tarasoff decision, what is the psychologist’s responsibility in this case?
Required Reading:


Self-check

1. group homes
2. There are now more re-admissions to hospitals.
3. civil commitment
4. The individual is deprived of basic human rights.
5. he or she has committed a criminal act that is legally declared to be a result of insanity
6. at the time the act was carried out
7. M’Naghten rule
8. Durham rule
9. dangerous
10. The psychologist has a responsibility to the threatened person and must call the police or take other reasonable action.