

Block

3

MENTAL DISORDERS -II

UNIT 11

Neurotic Disorders	7
---------------------------	----------

UNIT 12

Personality Disorders	53
------------------------------	-----------

UNIT 13

Depression, Grief and Suicide	73
--------------------------------------	-----------

UNIT 14

Disorders of Childhood and Adolescence — Developmental, Behavioural and Emotional	104
--	------------

EXPERT COMMITTEE

Prof. V.N. Rajasekharan Pillai (Chairperson)

Vice Chancellor

IGNOU, New Delhi

Prof. Girishwar Misra
Department of Psychology
University of Delhi, New Delhi

Prof. Mathew Verghese
Head, Family Psychiatry Centre
NIMHANS, Bangalore

Prof. Manju Mehta
Department of Psychiatry
AIIMS, New Delhi

Prof. Shagufa Kapadia
Head, Department of Human
Development and Family Studies
The M.S. University of Baroda
Vadodara

Prof. Reeta Sonawat
Head, Department of Human
Development, SNDT Women's
University, Mumbai

Prof. Ahalya Raghuram
Department of Mental Health
and Social Psychology,
NIMHANS, Bangalore

Dr. Rajesh Sagar
Associate Professor,
Deptt. of Psychiatry, AIIMS &
Secretary, Central Mental Health
Authority of India, Delhi

Prof. Aruna Broota
Department of Psychology
University of Delhi
New Delhi

Prof. Anisha Shah
Department of Mental Health
and Social Psychology,
NIMHANS, Bangalore

Prof. Rajni Dhingra
Head, Department of Human
Development
Jammu University, Jammu

Prof. T.B. Singh
Head, Department of Clinical
Psychology, IHBAS, New Delhi

Prof. Sudha Chikkara
Department of Human
Development and Family Studies
CCS HAU, Hisar

Prof. Minhotti Phukan
Head, Deptt. of HDFS
Assam Agricultural University
Assam

Mrs. Vandana Thappar
Deputy Director (Child
Development), NIPCCD
New Delhi

Dr. Indu Kaura
Secretary, Indian Association for
Family Therapy, New Delhi

Dr. Jayanti Dutta
Associate Professor of HDCS,
Lady Irwin College, New Delhi

Ms. Reena Nath
Practising Family Therapist
New Delhi

Dr. Rekha Sharma Sen
Associate Professor
(Child Development), SOCE
IGNOU, New Delhi

Prof. Vibha Joshi
School of Education
IGNOU, New Delhi

Prof. C.R.K. Murthy
STRIDE
IGNOU, New Delhi

Mr. Sangmeshwar Rao
Producer, EMPC, IGNOU
New Delhi

Prof. Neerja Chadha
(Programme Coordinator)
Professor of Child Development
School of Continuing Education
IGNOU, New Delhi

Dr. Amiteshwar Ratra
(Convenor & Programme
Coordinator)
Research Officer, NCDS
IGNOU, New Delhi

Acknowledgment:

We acknowledge our thanks to Prof. Omprakash Mishra, Former PVC, IGNOU; Prof. C.G. Naidu, Former Director (I/c) P&DD and Head, Nodal Unit; and Dr. Hemlata, Former Director (I/c), NCDS for facilitating the development of the programme of study.

PROGRAMME COORDINATORS – M.Sc. (CFT) / PGDCFT

Dr. Amiteshwar Ratra
Research Officer
NCDS, IGNOU, New Delhi

Prof. Neerja Chadha
Professor of Child Development
SOCE, IGNOU, New Delhi

COURSE COORDINATORS

Dr. Amiteshwar Ratra
Research Officer
NCDS, IGNOU, New Delhi

Prof. Neerja Chadha
Professor of Child Development
SOCE, IGNOU, New Delhi

COURSE WRITERS

Unit 11 Dr. Suresh Bada Math, Assistant Professor, Dept. of Psychiatry, NIMHANS, Bangalore
&

Dr. Nitin Anand, Dept. of Mental Health and Social Psychology, NIMHANS, Bangalore.

Unit 12 Dr. J.P. John, Assistant Professor, Dept. of Psychiatry, NIMHANS, Bangalore
&

Mr. Mohammed Kalathil Shakeel, NIMHANS, Bangalore

Unit 13 Dr. PSVN Sharma, Prof. & Head, Dept. of Psychiatry, Kasturba Hospital, Manipal

Unit 14 Prof. Manju Mehta, Dept. of Psychiatry, AIIMS, New Delhi

BLOCK EDITORS

Dr. Rajesh Sagar
Associate Professor
Department of Psychiatry, AIIMS,
New Delhi

Dr. Amiteshwar Ratra
Research Officer
NCDS, IGNOU, New Delhi

Prof. Neerja Chadha
Professor of Child Development
SOCE, IGNOU, New Delhi
*Course Editing by the Programme
Coordinators involved Content Editing,
Language Editing, Unit Formating and
Transformation of the units.

Acknowledgement :

We acknowledge our thanks to Ministry of Health and Family Welfare for providing inputs for cover design.

September, 2010

© Indira Gandhi National Open University, 2010

ISBN:

All rights reserved. No part of this work may be reproduced in any form, by mimeograph or any other means, without permission in writing from the Indira Gandhi National Open University, New Delhi.

Further information on Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi- 110 068 or the official website of IGNOU at www.ignou.ac.in.

Printed and published on behalf of Indira Gandhi National Open University by Registrar, MPDD.

Laser Composed by: Rajshree Computers, V-166A, Bhagwati Vihar, (Near Sector-2, Dwarka),
Uttam Nagar, New Delhi-110059

Printed by:

BLOCK 3 MENTAL DISORDERS-II

Introduction

The Block 3 is “*Mental Disorders-II*” which is in continuation with the previous Block. This Block will acquaint you with the various types of mental disorders like neurotic disorders, personality disorders, depression, grief and suicide. The Block also provides knowledge on developmental, behavioural and emotional disorders of childhood and adolescence stage of human life span. The Block consists of four Units.

Unit 11 entitled “*Neurotic Disorders*” describes various types of neurotic disorders and their management. The Unit begins with classification of neurotic disorders, and differentiates between neurosis and psychosis. Further, the Unit explains the epidemiology of neurotic disorders and the possible causes of these disorders. Social anxiety disorder is also called as social phobia. The epidemiology and types of social phobias are discussed in detail, in this Unit. Generalised anxiety disorder is another type of neurotic disorder. The Unit explains the characteristics and epidemiology of generalised anxiety disorder. The other neurotic disorders like obsessive-compulsive disorders, panic disorder, agoraphobia, somatoform disorder, post traumatic stress disorder and adjustment disorder are also discussed in detail, in this Unit. The characteristics and epidemiology of these neurotic disorders are explained. At the end of this Unit, management of neurotic disorders is described. It includes assessment, medication management, stress management, supportive therapy, grief therapy, exposure therapy, cognitive restructuring technique, psychoanalytic therapy and working with the family. The Unit helps you to understand various types of neurotic disorders and explain their management.

Unit 12 is “*Personality Disorders*.” The focus of this Unit is on various types of personality disorders. The Unit begins with the definitions of personality and personality disorders. Further, the Unit outlines the unique characteristics of different personality disorders. The personality disorders may be developed due to certain biological as well as psychosocial factors. The Unit explains the contribution of these factors in development of personality disorders. The alternative views on personality disorders are also discussed in this Unit. The Unit further outlines the methods of formal assessment of personality disorders. The course and outcome of personality disorders are also described in this Unit. In the end of this Unit, the general principles of management of personality disorders are explained. The management of personality disorder should include a collaborative approach between different professionals and optimal combination of pharmacological and non-pharmacological interventions. The Unit will help you in understanding various personality disorders.

Unit 13 is “*Depression, Grief and Suicide*.” The Unit has three parts. The first part of Unit deals with depression, its types and causes. The Unit begins with the introduction and manifestations of depression. The Unit explains how depression affects the individual. The depression is of several types like anxious depression, retarded depression, hostile depression, recurrent depressive disorders etc. These subtypes of depression are well explained in this Unit. The epidemiology of depression is also given in this Unit. The various causes and risk factors responsible for the development of depression are discussed including the course of depression. The evaluation process and

possible treatment of depression is also discussed at the end of the first part. The second part of the Unit deals with the grief. It explains the features of normal grief like sense of disbelief on shock, sense of anger, bargaining, process of depression and acceptance. It also describes the features of abnormal grief like sense of presence, mummification or anniversary reaction. The Unit further distinguishes grief from depression. The Unit provides knowledge on socio-cultural correlates of grief and various interventions used to overcome abnormal grief. The last part of this Unit deals with suicide. The part begins with definitions of various terms related to suicide. Further, the epidemiology of suicide is also discussed. The Unit acquaints you with the causation and theoretical models of suicides. Various risk factors involved and assessment of risk of suicide is explained in this Unit. At the end of this Unit, the invention and post-intervention for suicide is discussed.

Unit 14 is “Disorders of Childhood and Adolescence — Developmental, Behavioural and Emotional.” As the name suggests, the Unit acquaints you with the developmental, behavioural and emotional disorders during childhood years and adolescence stage. The Unit begins with the classification of childhood and adolescent disorders which also includes the criteria to identify a child suffering from such disorders. Further, the Unit provides knowledge on developmental disorders which broadly includes mental retardation, specific learning disability, pervasive developmental disorders, specific developmental disorders and habit disorders. The behavioural problems like attention deficit hyperactivity disorder (ADHD), conduct disorder, oppositional defiant disorder and substance abuse are also explained in detail. Some of the major emotional disorders like anxiety disorders, phobias, somatoform disorder, obsessive-compulsive disorder and depression can affect the children during childhood and adolescent years. The Unit acquaints you with the knowledge of these emotional disorders. Schizophrenia and manic depressive disorder are childhood psychotic disorders which have been discussed in this Unit. The later part of this Unit deals with the causes of childhood and adolescent psychiatric disorders. The Unit will help you to identify children with developmental behavioural and emotional disorders and understand the methods of assessment of child and adolescent disorders.

UNIT 11 NEUROTIC DISORDERS

Structure

- 11.1 Introduction
- 11.2 Neurotic Disorders
 - 11.2.1 Classification of Neurotic Disorders
 - 11.2.2 Neurosis and Psychosis
 - 11.2.3 Epidemiology of Neurotic Disorders
 - 11.2.4 Causes of Neurotic Disorders
 - 11.2.5 Co-existing Mental Illness
- 11.3 Social Anxiety Disorder (Social Phobia)
 - 11.3.1 Types of Social Phobias
 - 11.3.2 Epidemiology
- 11.4 Generalised Anxiety Disorder
 - 11.4.1 Characteristics of Generalised Anxiety Disorders
 - 11.4.2 Epidemiology
- 11.5 Obsessive Compulsive Disorder
 - 11.5.1 Characteristics of Obsessions and Compulsions
 - 11.5.2 Epidemiology
- 11.6 Panic Disorder
 - 11.6.1 Characteristics
 - 11.6.2 Epidemiology
- 11.7 Agoraphobia
 - 11.7.1 Characteristics
 - 11.7.2 Epidemiology
- 11.8 Somatoform Disorder
- 11.9 Post Traumatic Stress Disorder
- 11.10 Adjustment Disorder
- 11.11 Management of Neurotic Disorders
 - 11.11.1 Assessment
 - 11.11.2 Psychoeducation
 - 11.11.3 Medication Management
 - 11.11.4 Stress Management
 - 11.11.5 Supportive Therapy
 - 11.11.6 Grief Therapy
 - 11.11.7 Exposure Therapy
 - 11.11.8 Cognitive Restructuring Technique
 - 11.11.9 Psychoanalytic Therapy
 - 11.11.10 Working with the Family
- 11.12 Let Us Sum Up
- 11.13 Glossary
- 11.14 Answers to Check Your Progress Exercises
- 11.15 Unit End Questions
- 11.16 Further Readings and References

11.1 INTRODUCTION

The term 'neurosis' (its adjective 'neurotic') was coined by William Cullen, a Scottish physician (1769) to describe a specific group of mental disorders. The term 'Neurosis' is derived from the Greek word *neuron* (nerve) with the suffix '-osis' (abnormal condition) to designate physiological disturbances. *Neurotic disorders* are a group of mental disorders without any evident structural basis for the origin of the symptoms, which are distressing to the individual, recognised by her or him as being unacceptable, with good insight into her or his illness, and her or his behaviour does not actively violate gross social norms although it may be quite disabling.

Neurotic disorders are characterised by a variety of symptoms such as anxiety, panic attacks, obsessions, compulsions, multiple body pains, excessive worry and tiredness. These symptoms become so pronounced that they interfere with activities of daily living. Although, the term 'neurosis' and 'neurotic' have completely disappeared from the current diagnostic classificatory system, they still continue to be used in everyday clinical practice as a convenient term for non-psychotic mental disorders. Hence, neurosis can be understood as psychiatric disorders which are neither organic nor psychotic.

In this Unit, we have discussed commonly occurring neurotic disorders. Each neurotic disorder is explained, identifying points are highlighted and further to add clarity to understand these disorders, case vignettes are given.

Objectives

After studying this Unit, you will be able to:

- Define and classify neurotic disorders;
- Understand various types of neurotic disorders; and
- Explain the management of neurotic disorder.

11.2 NEUROTIC DISORDERS

As discussed earlier, neurotic disorders are a group of mental disorders without any evident structural basis for the origin of symptoms, which are distressing to the individual, recognised by her or him as being unacceptable, with good insight to her or his illness and her or his behaviour does not actively violate gross social norms although it may be quite disabling. Now, let us study the various types of neurotic disorders.

11.2.1 Classification of Neurotic Disorders

Neurotic disorders encompass three important domains. They are anxiety disorders, stress related disorders and medically unexplained symptoms domain. For classification of neurotic disorders, please refer to Fig. 11.1.

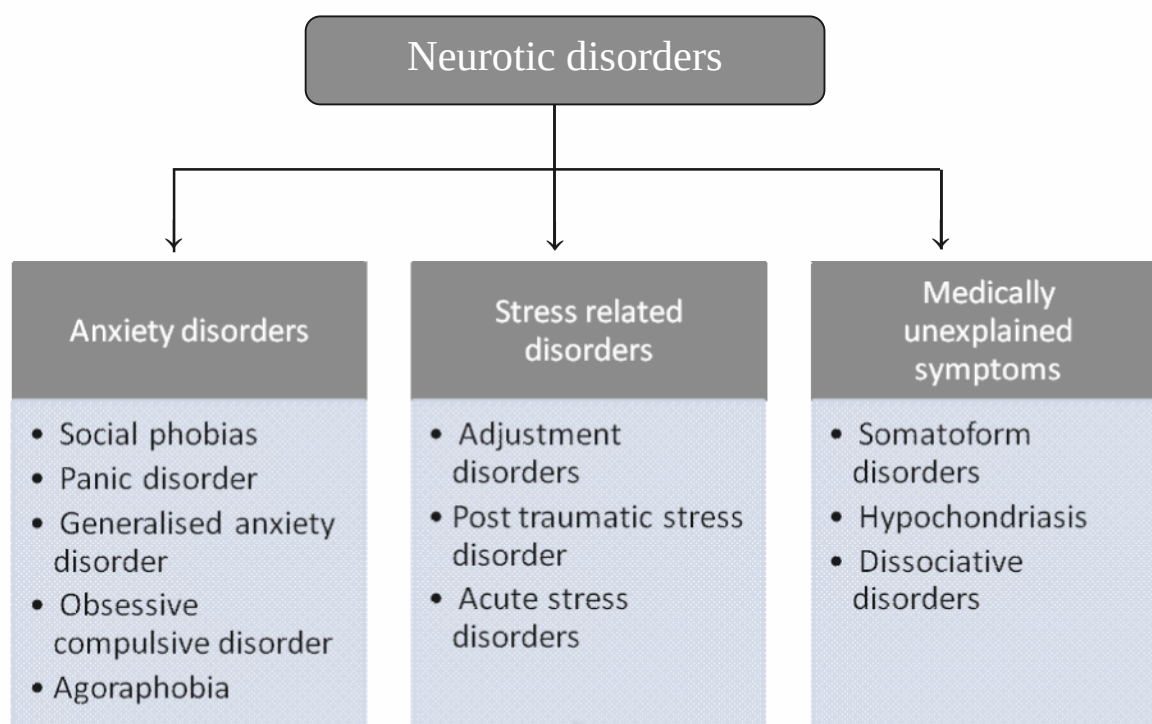


Fig. 11.1: Classification of neurotic disorders

11.2.2 Neurosis and Psychosis

Neurosis differs from psychosis (a severe form of mental illness) by not having any effect on rational thought or behaviour. Neurotic patients recognise their symptoms as unacceptable, irrational, excessive and that they are unable to control them. They will have good insight into their illness. However, majority (more than 60 percent) of the patients with neurotic disorders avoid seeking professional help. Reasons for poor help seeking behaviours are poor knowledge about the nature of neurotic disorders, stigma and non-availability of mental health professionals easily. The main differences between neurotic and psychotic disorders are given in Table 11.1.

Clinical variable	Neurotic disorders	Psychotic disorders
Signs and symptoms	Anxiety symptoms, panic attacks, worry, multiple aches and pains, poor attention and concentration, recurrent thoughts and other stress related symptoms	Delusions, hallucinations and disorganization.
Occurrence	15-20%	Less than 1%
Insight into their illness	Usually present	Usually absent
Behaviour of the patients	Usually does not violate social norms	Usually violates social norms
Rational thinking	Usually present	Usually absent
Disability	Present	Present

Disorders	Phobias, Panic disorder, Obsessive Compulsive disorder, Generalised anxiety disorder, Post Traumatic Stress disorder, Adjustment disorders and Somatoform disorders.	Schizophrenia Acute Psychosis
------------------	--	----------------------------------

Table 11.1 : Differences between neurosis and psychosis

11.2.3 Epidemiology of Neurotic Disorders

Neurotic disorders are the most common group of psychiatric disorders in the general population. The prevalence of neurotic disorders ranges between 15-20 per cent. Approximately one in every five people has a neurotic disorder. Similar to adults, neurotic disorders are the most common mental disorders in children and adolescents. The prevalence of neurotic disorders in primary health care reportedly ranges between 25-30 per cent in developing countries. The prevalence of neurotic disorders in chronic medically ill patients ranges widely from 35-75 per cent. For example, 40-60 per cent of HIV patients are known to develop one or the other neurotic disorders. Similarly 60-70 per cent of cancer patients and 60-80 per cent of chronic renal failure patients are known to develop adjustment disorders, depression and various anxiety disorders.

11.2.4 Causes of Neurotic Disorders

The exact etiology of neurotic disorders is not known. However, various theories have been proposed to understand the origin of neurotic disorders. There are some reports suggestive of genetic factors playing a role in the development of these disorders. At the same time non-genetic factors, such as various stressful life events have been found to play an even more important role in the pathogenesis of these disorders in vulnerable individuals. Several different neurotransmitter systems have been also implicated in the development of these disorders, including the Noradrenergic, GABA amino butyric acid and Serotonin in some parts of the brain.

1. Neurotransmitter Theory

Neurotransmitters are neurochemicals (hormones) which are involved in transmission of impulses from one nerve to the other. There are specific neurotransmitters involved in the mediation of causing fear and anxiety responses which are visible in neurotic disorders and also during stress. These neurotransmitters prepare the individual for facing fear or threat in multiple ways, through increase in attention and vigilance, modulation of memory (maximising utilisation of previous experiences), planning and preparation for action. In addition, these systems also cause increased heart rate and blood pressure. These neurobiological responses to threat or fear are adaptive and are necessary for survival. However, they can have maladaptive consequences, which happen when they become chronically activated due to excessive or prolonged stress. This causes long-term alterations in the function of the neurotransmitter systems and the result is prolonged and persistent responses of fear and anxiety which occur in neurotic patients.

2. Psychoanalytic Theory

All individuals experience certain sexual and aggressive urges which emerge from the *id* (instinctual drive). Some of these sexual and aggressive urges come in conflict with the *superego* (rules, principles and social norms). These urges are repressed (concealed in our unconscious mind) by individuals. The individual cannot consciously think or verbalise about these repressed urges or desires. However, these urges are still present in our unconscious minds and are making attempts to express themselves in the conscious mind but cannot as they are in conflict with the *ego* and *superego* of the individual. This conflict causes the individual to experience fear and anxiety, but at the same time the individual does not know why she or he is fearful of certain people or objects or situations. Anxiety triggers when the individual makes attempts to utilise a range of defense mechanisms to protect oneself or at least decrease the overwhelming anxiety. The neurotic behaviours occur when the defense mechanisms require excessive amounts of the individual's mental energy to such an extent that the ability to function normally becomes significantly impaired.

3. Learning Theory

Every behaviour is learnt based on the model behaviours available, past experience, reinforcement or reward and punishment. For example, the child learns to greet the guest through the parents and the appreciation received from everybody for that act. The child does not repeat the mischief of troubling the mother for the fear of being punished. Lack of rewards and punishments or inconsistent rewards and punishments may lead to confused or inconsistent behaviours in the child. Encouragement by the peer group, the role model behaviours of a movie hero like smoking or drinking and the pleasure (reward) she or he gets from tobacco or alcohol, make the person take to smoking and drinking. Past failures, humiliation, criticism and decreased self esteem, makes the person more anxious or withdrawn.

Mowrer proposed the “*two factor theory of fear and avoidance*”, in which fears are acquired through classical conditioning and are maintained by operant conditioning. The theory states that in the first stage a neutral stimulus becomes associated with fear because of its pairing with an aversive event or experience which provokes anxiety and distress. In stage two, escape or avoidance responses develop (individual avoids facing objects and situations; avoids experiencing thoughts and images associated with aversive experience) and are maintained because they reduce the fears and distress associated with objects, situations, thoughts or images. For example: A person who fails in one examination, may anticipate the same and become fearful in any examination or test situation and hence may avoid going for exams. In this example, in Stage-I ‘exam situation’ became associated with an aversive stimulus ‘failure’ and to reduce distress in exams, the person avoids exams in Stage-II.

4. Social Learning Theory

Social learning theory was proposed by Albert Bandura. He proposed that learning also occurs through observation or imitation in absence of reinforcement. He focused on how individuals learn (being fearful, anxious, nervous, aggressive) from observing others within the environment through

observational learning. Observational learning provides no direct reinforcement to the learner, although it is acknowledged that persistence of the learned behaviour may depend upon reinforcement or at least anticipated reinforcement. This learning usually takes place in a social situation where there is presence of a role model and an imitator. The imitator observes the role model and experiences his or her behaviour and its consequences vicariously. Bandura proposed that through observational learning, individuals learn how to respond in varied situations. For example, if the children grow up experiencing their parents to be submissive, shy, nervous and anxious while conversing with others and displaying avoidance behaviours in social situations such as family or friends get-together, marriages, or religious functions, this will cause children to model their parents during their growing up years and by the time they reach early adulthood they would have behavioural characteristics similar to their parents. This learning persists because of approval of parents or in anticipation of approval. These children in adulthood will have poor social skills and would be at-risk for developing or would develop significant anxiety symptoms in social situations.

5. Cognitive Theory

Cognitive processes (thinking processes) include patterns of evaluating and organizing information about the self and the world, processing information for coping with stressors or for solving problems and methods of predicting and evaluating future events. The individual's cognitions and cognitive processes develop from experiences during childhood and adolescence. This theory proposes that maladaptive behavioural responses and negative emotions occur due to presence of dysfunctional assumptions or irrational beliefs. It is believed that early traumatic experiences cause the formation of dysfunctional assumptions, irrational beliefs and faulty patterns of organising and processing information. This creates a model within the individual, in which problem solving becomes unrealistic and ways of predicting future are faulty. When such an individual faces any traumatic event or a chronic stressor, these irrational beliefs and assumptions are activated which cause the individual to display excessive fear, distress or anxiety in response to certain objects, situations or people. The neurotic behaviours are maintained as the individuals are unable to identify the irrational beliefs which continue to produce maladaptive behaviours and negative emotions.

6. Trauma Theory

Maladaptive behaviours and emotions including dissociation from the reality occur as a part of the psychological and biological response which protects the individual from a life-threatening danger or abuse. The psychobiological response is a protective function which activates the altered state of consciousness that changes perception, pain sensation, sense of time and self. During this altered state of consciousness, the memories relating to the trauma are encoded within the unconscious mind. When the individual returns to conscious state, there is relatively restricted availability to the traumatic information which causes amnesia to individuals who have been exposed to traumatic events. However, the memories which are pushed into the unconscious mind, still seek expression in various forms such as intrusive flashbacks, nightmares and other pain symptoms. This theory suggests that the trauma remains unforgotten but remains relatively inaccessible because

of the individual's difficulty in retrieving information during the dissociative behavioural states and this causes the intrusive images, nightmares and other pain symptoms to continue.

11.2.5 Co-existing Mental Illness

Various studies have reported that 50-60 per cent of the individuals suffering from neurotic disorders, experience two or more comorbid (co-existing) psychiatric conditions such as depression, other anxiety disorders, substance use (alcohol, nicotine, cannabis and benzodiazepines) and personality disorders.

Common co-existing mental illnesses with neurotic disorders

1. Depression,
2. Anxiety disorders, (Specific phobias, Social phobia, Generalised anxiety disorder and Panic disorder),
3. Substance use, (nicotine, alcohol, cannabis and benzodiazepines),
4. Personality disorders, and
5. Somatoform disorders.

It is also well known that neurotic disorders are common in patients with chronic medical conditions. Neurotic disorders are associated with significant disability, poor quality of life, and burden on families. Further association of neurotic disorders with various comorbid psychiatric and medical illnesses will add to burden, disability and poor quality of life.

Check Your Progress Exercise 1

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the major anxiety disorders which are classified under neurotic disorders.

.....

2. Name the theories that explain causes of neurotic disorders.

.....

3. What are the common co-existing mental illnesses with neurotic disorders?

.....

11.3 SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

Social anxiety disorder (also called social phobia) involves fear of being in social situations. The situations usually involve contact with strangers or known seniors or the opposite sex. Social phobias are usually associated with low self-esteem and fear of criticism. Individuals with social phobia usually feel anxious or nervous by themselves in social situations. Social situations include marriages, meetings, parties, presentations, interviews, group discussions and any situation that involves meeting new people. These individuals might in particular have fears about performing certain activities in presence of others, such as speaking, writing, presenting, discussing, meeting and eating. Direct eye-to-eye interaction may be particularly stressful to these people especially with seniors or opposite sex. Avoidance is often marked, and in extreme cases may result in almost complete social isolation.

Predominant irrational fears in social phobia are as follows:

- Fear of scrutiny or evaluation by other people,
- Fear of criticism by other people,
- Fear of rejection by other people, and
- Fear of losing control in front of others.

It is important to note that some amount of anxiety occurs in the majority of normal people during particular developmental stages such as adolescence or after certain lifestyle changes such as joining degree college, joining the first job, shifting to a new occupation and marriage, which brings with itself a new set of demands for engaging in social interactions. Such anxiety should be considered pathological or undesirable when the anxiety prevents the person from participating in desired activities or causes noticeable distress and avoidance or interferes with his or her social and occupational performance.

Predominant anxiety symptoms are:

Blushing, Hand tremor, Nausea, Stammering, Sweating, Becoming blank in mind, Increased heart beat, Palpitation, Urgency of passing urine, Shortness of breath, Choking, Feeling of impending doom and Restlessness.

11.3.1 Types of Social Phobias

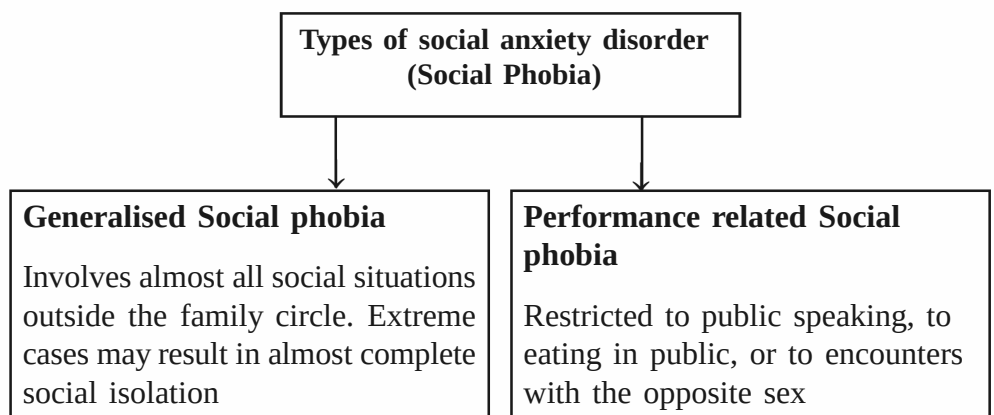


Fig. 11.2: Types of social phobia

As depicted in Fig. 11.2, the social anxiety disorder may be generalised social phobia, or it may be performance related social phobia.

The clinical characteristics for recognising social anxiety disorder are as follows:

- i) The individual has noticeable or persistent fear of one or more social (social get-togethers, marriages) or performance situations (oral presentations, group discussions) in which the person faces possible evaluation by others. The person feels that she or he would behave in a manner or display anxiety symptoms that would be humiliating or embarrassing for her or him.
- ii) When the individuals face these feared social situations, it always provokes anxiety within them. Anxiety symptoms are characterised by increased heart rate, sweating, feeling of shortness of breath, feeling of choking, stammering or discomfort, nausea, numbness, fear of losing control or going crazy.
- iii) The individual avoids the feared social situations or performance situations.
- iv) Social anxiety interferes significantly with occupational functioning or social activities or relationships.

The onset of social phobia is usually in childhood or adolescence causing devastating effect during important phases of life. Onset may abruptly follow a stressful or humiliating experience, or it may be insidious. If untreated, the course is often continuous, although the disorder may decrease in severity or remit during adulthood. The severity of impairment may fluctuate with life stressors and demands. For example, a promotion in job to a position requiring speaking in public may lead to re-emergence of social anxiety disorder in a person who previously never needed to speak in public.

11.3.2 Epidemiology

Social anxiety disorder is a common mental disorder. Community based studies have reported that 4-12 per cent of the general population have social phobia at some point in their life. Though social anxiety disorder is a common illness, many who suffer from this illness do not seek treatment. In general population, most individuals with social phobia report fear of speaking in public or in a social gathering or making oral presentations. Other performance fears such as eating, drinking, or writing in public appear to be less common. Social anxiety disorder is equally common in men and women.

Case vignette of social anxiety disorder

Mr. X, is a final year graduate student pursuing his Bachelor's degree in Management. He had the fear of speaking to others especially in a gathering of friends; he used to avoid attending social get-togethers like birthday parties, class outings, college festivals or marriages. He also had excessive fear of making presentations in the class. He used to experience increased heartbeat, sweating, stammering, shortness of breath, choking sensations, turning blank and fearful of losing control during his presentations. He used to think that he might say something very foolish during his presentations or interactions with his friends and thus it would cause him

embarrassment and people would laugh at him. He knew that his fears were illogical or irrational but he could not get rid of these feelings when he used to face the social situations. This fear would make him to leave the social gatherings early or in most cases he would decline accepting the invitations. Just when his class seminar dates used to get closer, he would experience more of anxious feelings and would remain preoccupied with distress. This illness leads him to have poor scores in class seminars and also he had very limited number of friends throughout his college days. With great difficulty, he attended a job interview and got a job as a human resources development officer. However, because of his social anxiety he was unable to perform his normal duties. Hence, he decided to resign from his job.

Check Your Progress Exercise 2

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. What are the predominant irrational fears in social phobias?

.....

.....

.....

.....

2. Enumerate the main clinical characteristics for recognising social anxiety disorders.

.....

.....

.....

.....

11.4 GENERALISED ANXIETY DISORDER

Generalised anxiety disorder is characterised by patterns of frequent, persistent, excessive worry and anxiety, which is out of proportion to actual events or circumstances. This worry and anxiety is present on most days and is not restricted to any particular set of events or circumstances. This worry is excessive, more prolonged than ordinary worries and concerns of healthy people. Typically, the anxiety and worry involve minor or everyday matters, such as work, finances, relationships, the health or safety of loved ones, and routine tasks. Often, the focus of worry shifts from one concern to another.

Individuals with generalised anxiety disorder may not acknowledge the excessive nature of worries but they are usually preoccupied with the degree of worry and find it difficult to control it. Consequently, the worries often interfere with concentration and performance. This pattern of excessive worrying for trivial matters is usually present for most of the days and the

individuals find it difficult to control their worry and associated free floating anxiety.

'Free floating anxiety' means anxiety not related to any particular set of events or situations. It is prevalent across all situations and tasks.

11.4.1 Characteristics of Generalized Anxiety Disorder

The clinical characteristics for recognising generalised anxiety disorder are as follows:

1. The individual experiences frequent, persistent, excessive worry and anxiety,
2. The individual finds it difficult to control the worry,
3. The individual experiences apprehensive expectation which is typically of negative outcome about a number of events or activities (such as work or school or college or office performance),
4. The individual's anxiety and worry is usually associated with some of the following symptoms which are present on most of the days for at least a period of six months:
 - Restlessness or being unable to relax or feeling of being on edge,
 - Easily fatigued,
 - Difficulty in concentrating on activities,
 - Irritability in most activities,
 - Muscular tension, and
 - Sleep disturbances (difficulty in falling asleep or staying asleep or restless/unsatisfying sleep).
5. The anxiety or worry is not related to any particular set of events or situations and is prevalent across all situations and tasks (free floating anxiety).
6. The individual's anxiety, worry or physical symptoms cause significant amount of distress or lead to impairments in social and occupational functioning.

11.4.2 Epidemiology

The community based studies have reported a lifetime prevalence of generalised anxiety disorder to be ranging from 2 to 5 per cent. The disorder tends to be more common in women and usually has its onset in late adolescence or early adulthood. However, cases are also commonly seen in older adults. Some data suggests that there is a high prevalence of generalised anxiety disorder in primary health care settings. Generalised anxiety disorder has an onset usually in the late adolescence or early adulthood.

Case vignette of generalised anxiety disorder

Mrs. B is a 31 year old, successful, married, business entrepreneur. However, she reports that since 10 months, she has been becoming increasingly worried and anxious and remains so while performing most of the daily office and household tasks. He has been a successful entrepreneur. However, these days she feels anxious, worried and restless for prolonged periods of time, with one or the other daily tasks constantly bothering her. For example, whether her ongoing business transactions will occur correctly, whether the prospective buyers will cancel their site visit, whether company will be able to earn substantial profits. This anxiety and worry continues within the home settings also. Sometimes the preoccupations related to business continue, otherwise other issues become the focus of worry, such as whether the children will be able to pass the exams, will they miss the school bus in the morning, should I sleep early to wake them up early tomorrow, will the cook run away during children's exams, should I enroll my husband for regular health check-ups. These appear to be somewhat daily concerns, but what makes them more than ordinary concerns is that they produce intense anxiety and worry which continue for prolonged periods of time across a number of activities and persist on most occasions throughout the day, on most days. Along with this she also reported that she has been unable to overcome this worry, feels restless and gets easily fatigued irrespective of performing office or household tasks. Her concentration in general had decreased; she always remained irritable and felt that something negative could occur.

Check Your Progress Exercise 3

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. How can you identify that the person is suffering from generalised anxiety disorder?

.....

.....

.....

11.5 OBSESSIVE COMPULSIVE DISORDER

Obsessive-compulsive disorder (OCD) is a common mental illness characterised by obsessions and compulsions. *Obsessions* are understood as repetitive, persistent ideas, thoughts, impulses or images that are experienced by individuals as intrusive and irrational or illogical. These thoughts cause intense anxiety or distress. However, the individual is able to recognise that the obsessions are coming from his or her own mind. The person with obsessions attempts to ignore or suppress such intrusive, repetitive thoughts, images or impulses or attempts to neutralize them with some other repetitive actions called compulsions.

Compulsions are repetitive behaviours or mental acts performed by the individual, the goal of which is to prevent or reduce distress that accompanies an obsession or to prevent some dreaded event or situation and not to provide pleasure or gratification. Some compulsions can be in the form of elaborate ‘rituals’. *Rituals* are a particular sequence of actions, which the person is compelled to carry out. On either changing the sequence, or missing out one of the actions, anxiety increases driving the person to repeat the set of actions all over again.

11.5.1 Characteristics of Obsessions and Compulsions

Table 11.2 depicts the characteristics and symptoms of obsessions and compulsions.

Obsessions	Compulsions
• Repetative thoughts/images/impulses/urges that occur in one’s mind inspite of knowing that they are meaningless, unnecessary or excessive. • Distressing and interfering in normal daily functioning. • Person unable to ignore or suppress them. • Usually provoke anxiety.	• Repetitive acts that the person driven to carry out inspite of knowing that they are meaningless, unnecessary or excessive • Compulsions are usually in response to obsessions. • Person unable to ignore or suppress them. • Distressing and interfering in normal daily functioning. However they reduce anxiety at least transiently.

Table 11.2: Characteristics and symptoms of obsessions and compulsions

All repetitive thoughts are not obsessions. The common usage of the word ‘obsession’ as in, “he is obsessed with music” is not obsession as used in the context of OCD. Here the person indulges in the activity with complete will, has control over it and derives pleasure out of the activity. Similarly when one is fired from a job or loses someone close, it is natural to brood over the event. However, these thoughts are not considered as senseless or irrational, though they may cause some discomfort. The above experiences are obviously not obsessions as used in the context of OCD.

Some common obsessions are as follows:

- Repeated thoughts about contamination (individual feels excessively concerned with contamination from dirt, germs, urine, faeces, or other environmental contaminants),
- Repetitive doubts (whether doors, locks, taps, gas stove knobs have been closed properly or not),
- A need to have things in a particular order (excessive need for arranging clothes, shoes, papers and items at home properly and meticulously),
- Aggressive impulses (fearing that they might physically hurt someone), and
- Sexual thoughts or imagery (individual gets personally unacceptable sexual thoughts and images).

Some common compulsions are as follows:

- Washing and cleaning (excessive hand washing, bathing, tooth brushing, grooming, excessive cleaning of items and objects used by others and avoiding to use them),
- Counting (counting number of stairs, number of tiles used for walking over),
- Repetitive checking (doors, locks, taps, gas stove knobs),
- Arranging clothes, shoes, papers, and other items properly and meticulously,
- Repeating daily activities,
- Re-reading, and
- Re-writing.

Let us now take a look at the clinical characteristics for recognising obsessive compulsive disorder

Obsessions have the following characteristics:

1. Obsessions are repetitive, persistent, thoughts, images or impulses,
2. Obsessions experienced are excessive, distressing and/or anxiety provoking,
3. The individual is able to recognise that the obsessions are coming from his or her own mind, and
4. Unable to suppress or ignore obsessions, however, the individual resorts to repeated acts (compulsions) that may provide transient reduction in anxiety/discomfort.

Compulsions have the following characteristics:

1. Compulsions are repetitive behaviours or mental acts that the individual feels driven to perform when obsessions occur,
2. Compulsions are performed for preventing or reducing distress or preventing occurrence of some unfavorable event or situation,
3. Compulsions are recognised by the individuals as excessive, distressing or unreasonable, and
4. Both obsessions and compulsions significantly interfere with the individuals' normal routine, occupational functioning or usual social activities or relationships.

11.5.2 Epidemiology

Obsessive compulsive disorder is one of the most common and severe anxiety disorders. Obsessive compulsive disorder affects 1 to 3 per cent of adult population in their lifetime. It is the fourth most common psychiatric disorder following phobias, substance abuse and major depressive disorder.

Earlier it was considered a rare illness, but studies have now shown that 2 to 3 per cent of the population have OCD at some point in their life. Though OCD is a common illness, many who suffer from this illness do not seek treatment. In the West, less than 50 per cent have contacted a psychiatrist for treatment and in India, even fewer numbers seek treatment for this illness.

It occurs in all age groups. Obsessive compulsive disorder has an onset usually in late adolescence or early adulthood. However, onset in childhood is also common. If untreated, the course is often chronic but fluctuating and the symptoms worsen during stressful situations.

Case Vignette of obsessive compulsive disorder

Mrs. V, a 35 year old housewife, was brought to the hospital with complaints of spending long hours (2-3 hours) in hand washing after urination and defecation. She used to take 30-35 minutes for brushing her teeth as she feared that her teeth were not clean. She would wash her brush before and after use with soap as she feared germs had come into the brush and can spread to other places. She also reported consuming water excessively (25-30 buckets) and taking a long time for bathing (3-4 hours). She reported that she gets repeated thoughts that her hands and body become unclean after urination and defecation. She also avoided touching door handles especially of toilet, bathroom, picking up objects from floor, handling old currency notes, using chairs and stationery items used by others. She reported having repetitive thoughts that germs are there on these objects and hence she avoided touching them. When she had to touch any of these items, she used to repetitively apply soap on hands till she felt satisfied that germs have been washed away completely.

She also revealed that she gets repeated doubts whether she had completed her daily activities properly or not. She used to check the door lock of her residence at least 30-35 times before retiring to bed in the night. She even checked all the electrical appliances and gas stove several times (25-30 times) to ensure that they were switched off properly. She used to count currency notes several times (15-20 times) before handing over the cash to the milk vendor.

Her life and daily activities revolved entirely around her excessive concern with cleanliness and checking. She would be left with no time or very little time to engage in any other activity. Since some months her excessive concern with cleanliness had reached such an extent that she would force her husband to repeatedly wash hands before he engaged in any activity. She reported that she was aware that her preoccupation with cleanliness was irrational and excessive, but however she was unable to control her excessive cleaning behaviours because of intense anxiety that was caused by the repetitive thoughts of being dirty.

Check Your Progress Exercise 4

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the clinical characteristics of obsessive compulsive disorder.

.....

2. Give examples of some common obsessions and compulsions.

.....

.....

.....

11.6 PANIC DISORDER

A *panic attack* is a distinct period in which there is a sudden onset of intense apprehension or fearfulness or discomfort that is often associated with feelings of approaching impending doom. The panic attacks are episodic in nature and the anxiety is crescendo in nature, building to a peak in 10 minutes in most cases. Panic attacks usually last for several minutes, but in some patients they can last for hours. Panic attacks can occur in a variety of anxiety disorders such as stressful situations, dreadful situations, panic disorder, agoraphobia, generalized anxiety disorder, social anxiety disorder, and post traumatic stress disorder.

11.6.1 Characteristics

We shall first take a look at the clinical characteristics for recognising a panic attack. In a panic attack, the following symptoms develop abruptly and reach a peak within 10 minutes of the beginning of the first symptom noticed:

- Increased heart rate or pounding heart or palpitations,
- Sweating,
- Trembling or shaking,
- Sensations of shortness of breath or breathlessness,
- Sensations of choking,
- Feeling dizzy, lightheaded and unsteady,
- Nausea or abdominal discomfort,
- Fear of losing control or going crazy,
- Fear of dying,
- Sensations of numbness or tingling sensations, and
- Restlessness.

There are three distinctive types of panic attacks:

1. **Unexpected panic attacks:** The onset of panic attack is not associated with any particular situation (that is, they occur spontaneously or out of nowhere). This is also called panic disorder.
2. **Expected panic attacks:** The onset of panic attacks is always associated with exposure to or in anticipation of the situational trigger (for example, seeing a snake, dead body, lizard or being subjected to an interview always triggers a panic attack immediately in the individual).

- 3. Panic attacks predisposed to certain situations:** The onset of the panic attack is likely to occur on exposure to a particular situational trigger, but the attack is not always associated with the trigger, and does not immediately occur after exposure to the trigger. For example, attacks are more likely to occur while driving, but there are times when the individual drives and there are no panic attacks or there are times when the panic attack occurs after driving for an hour.

Let us now take a closer look at panic disorder. *Panic disorder* draws its name from the Greek God called 'Pan'. Pan was known for suddenly frightening animals and humans 'out of the blue'. The spontaneous 'out of the blue' character of panic attacks is the principle identifying characteristic of panic disorder and central to its recognition and diagnosis.

Panic attacks are extremely frightening; hence patients usually report an urgent need to escape from the place where the attack is occurring and subsequently avoiding situations associated with panic attacks. For example, if patient had a panic attack in a supermarket then he or she will avoid the supermarket where the panic attack had occurred. Patients also develop worry and anxiety about the possibility of panic attacks recurring which is called, 'anticipatory anxiety'.

The dramatic and emergency presentation of panic disorder is well known. Many patients report to cardiologist particularly in the cardiac emergency or casualty with fear of having a heart attack. Similarly, the involvement of physicians is also well known because of breathlessness or choking sensation. Majority of these patients usually consult non-mental health professionals for treatment.

Let us summarise the clinical characteristics for recognising panic disorder.

Following are the clinical features of panic disorder:

- a) Recurrent panic attacks in circumstances where there is no objective danger.
- b) The unexpected occurrence (panic attacks without any reason) of panic attacks without being confined to known or predictable situations.
- c) A persistent fear of having another panic attack (anticipatory anxiety).
- d) Individual worries about the consequences of a panic attack (for example losing control, having a heart attack or going crazy).

11.6.2 Epidemiology

The epidemiological studies throughout the world consistently indicate the lifetime prevalence of panic disorder to be between 1 and 6 per cent. Conservative estimates of panic disorder in primary care have ranged from 3 to 8 per cent with at least 50 per cent going unrecognized. The presence of panic disorder leads to a three to fourfold increase in the utilisation of general medical services.

Panic disorder has an onset typically in late adolescence or early adulthood. However, onset in childhood and late adulthood also has been reported. Retrospective and clinical research data reveals that panic disorder has a

fluctuating course with varying levels of severity during lifetime. Approximately one-third to one-half of the individuals appear to be living reasonably normal lives despite their fluctuating or recurrent panic symptoms. It is understood that agoraphobia (described in the next section) may develop at any point; however, its onset is usually within the first year of occurrence of repetitive panic attacks. The course of agoraphobia and its relationship to the course of panic attacks are variable. In some individuals, there is a decrease or remission of panic attacks which may be followed by a corresponding decrease in agoraphobic avoidance and anxiety. In some other individuals, agoraphobia may become chronic irrespective of the presence or absence of panic attacks.

Case vignette of panic disorder

Mr. Y is a 22 year old student who had been referred to the psychiatry clinic from a general hospital. He had been evaluated in the general hospital twice in the last 2 weeks.

His first visit to the general hospital occurred when he experienced sudden onset of shortness of breath, which was accompanied by increased heart rate, choking sensations, sweating and fear of losing control. He thought he was having a heart attack and on reporting to the cardiac clinic of the general hospital, detailed investigations revealed no evidence of cardiac illness. He reported again to the cardiac clinic after a week with similar complaints and the investigations revealed normal findings. This time he was referred to the psychiatry clinic, however he refused to accept the psychiatry referral thinking these attacks would not occur again and felt he did not have any psychiatric illness.

Then later he had two such panic attacks again, once while he was in a shopping mall and another when he was in an elevator. This is when he decided to visit the psychiatry clinic, where he was diagnosed as having panic disorder.

Check Your Progress Exercise 5

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the clinical characteristics of a panic attack.

.....

.....

.....

2. How can one identify that a person is suffering from a panic disorder?

.....

.....

.....

11.7 AGORAPHOBIA

Agoraphobia refers to anxiety towards or avoidance of places or situations from which escape might be difficult or embarrassing or in which help may not be available when a panic attack or panic like symptoms occur.

The predominant irrational fears in agoraphobia are:

- Fear of not finding easy escape,
- Fear of losing control in front of others,
- Fear of moving away from home,
- Fear of having dizziness and falling down, and
- Fear of something going wrong and not able to get easy help.

The above irrational fears or apprehensions usually cause avoidance of a variety of situations.

These situations include :

- being alone outside the home,
- being alone at home,
- being alone in the crowd (like market place or cinema hall or train station or bus terminal),
- travelling alone in car, bus, train, or taxi,
- being alone on a bridge, or
- being alone in an elevator.

Fig. 11.2 depicts the fear circuit which confirms the irrational fears and maintains agoraphobia.

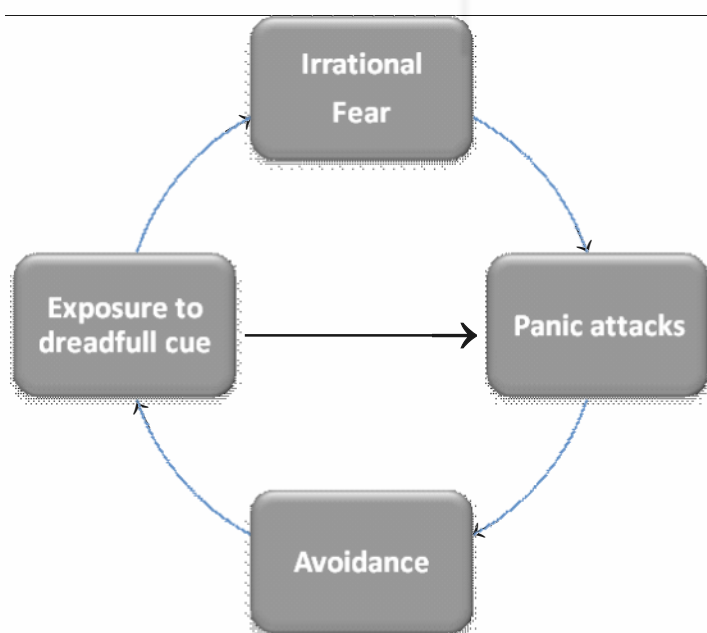


Fig. 11.2: Fear circuit that maintains agoraphobia

Individuals with agoraphobia are better able to expose themselves to feared situations when they are accompanied by a person whom they trust. Individual's avoidance usually causes significant impairment in their ability to perform household responsibilities which include venturing out of the house independently. Severe illness can lead to the individual becoming totally home bound and requiring constant presence of a family member.

11.7.1 Characteristics

Following are the clinical characteristics for recognising agoraphobia:

- a) Individuals experience intense anxiety about being in places or situations from where easy escape might be difficult or embarrassing or in which easy help may not be available when a panic attack occurs,
- b) Agoraphobic fears typically include situations like being alone outside home, being alone in a crowded place, travelling alone in buses, cars and trains, and
- c) Individuals avoid these situations or else, when it is essential, face them in the presence of a person whom they believe to be reliable.

11.7.2 Epidemiology

Epidemiological studies indicate the lifetime prevalence of agoraphobia to be between 2 to 6 per cent. Agoraphobia may develop at any point during the course of panic disorder; however, its onset is usually within the first year of occurrence of repetitive panic attacks. The course of agoraphobia and its relationship to the course of panic attacks are variable. In some individuals, there is a decrease or remission of panic attacks which may be followed by a corresponding decrease in agoraphobic avoidance and anxiety. In some other individuals, agoraphobia may become chronic irrespective of the presence or absence of panic attacks. However, relatively little is known about the course of agoraphobia without history of panic attacks. Some evidence suggests that agoraphobia may persist for many years and is associated with considerable impairment.

Case vignette of agoraphobia

Mr. S is a 34 year old software professional reported to the hospital with complaints of having intense anxiety while travelling in elevators, escalators and being in crowds. He had his office on the sixth floor of the building. He used to wait for one of his colleagues with whom he used to travel in the elevator, whom he believed to be reliable and thought he could save him in the event of an unfavorable situation. If his colleague was on leave, those days he would endure travelling in the elevator alone but his distress was severe and easily noticeable to others. He also had frequent sensations of shortness of breath, increased heart rate and used to experience the fear of losing control or impending trouble.

He also revealed that these symptoms also restricted his capabilities of performing household responsibilities as he always wanted some person to accompany him to departmental stores, malls, railway stations, airports, marriage functions, vegetable markets and so forth. Since some months, his fear had increased so much that he was totally house bound and refused to go outside the house alone.

Check Your Progress Exercise 6

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. What are the predominant irrational fears in agoraphobia?

.....

11.8 SOMATOFORM DISORDER

Somatoform means taking the “form of” or “in soma” (that is, body), which implies that this illness is nonsomatic. Somatoform disorders are usually encountered in primary health care and general hospital settings. In somatoform disorders, a common feature is the presence of multiple physical symptoms (abdominal pain, headaches, back ache, neck pain, joint pains, nausea, vomiting, impaired balance, loss of touch and unusual sensations of pain or discomfort) which cannot be fully explained by presence of general medical conditions or illness. Hence, these symptoms are also called, ‘*medically unexplained symptoms*’. Individuals with somatoform disorders usually describe their physical complaints in an exaggerated and dramatic manner.

All possible laboratory investigations will be normal, however, the symptoms persists. These individuals persistently refuse to accept the reassurances by physicians or medical practitioner that there is no physical cause for the multiple physical symptoms. Hence, these patients dropout and ultimately start doctor shopping. Subsequently, they seek treatment from several physicians simultaneously, which leads to complicated and at times hazardous combination of treatments. These individuals also commonly undergo numerous medical examinations, diagnostic investigations and hospitalisations. However, the investigation results are unable to support the presence of subjective physical complaints or any illness.

The clinical characteristics for recognising somatoform disorder are as follows:

1. These individuals have a history of at least 2 years of multiple physical complaints that cannot be explained by presence of a general medical condition or physical disorders.
2. These individuals are preoccupied with physical symptoms which cause them constant distress and lead them to seek repeated consultations (doctor shopping) or diagnostic investigations with primary health care or specialist physicians.
3. These individuals persistently refuse to accept medical reassurances by physicians or medical practitioners that there is no physical cause for the multiple symptoms.
4. These multiple physical symptoms are not intentionally produced by the individuals.

5. The multiple physical symptoms interfere significantly with the individuals' normal routine, occupational functioning or social activities or relationships.

Epidemiology

Epidemiological studies of somatoform disorders indicate a widely variable lifetime prevalence rate ranging between 0.2 to 2 per cent among women, and less than 0.2 per cent among men. It is more common among individuals who reside in rural areas and who are less educated. Individuals with somatoform disorder seek medical care more than what is required and it causes increased health costs to the medical services. Somatoform disorder has an onset typically before the age of 25 years in ninety per cent of the population with this disorder.

The risk factors for developing somatoform disorders include the following:

- Severe ongoing stressors,
- Marital/family discord,
- Poor social support,
- Financial loss,
- Living with a family member who has the disorder,
- Parental substance abuse, and
- Antisocial personality disorder in a family member.

Somatoform disorder is chronic but has a fluctuating course that rarely remits completely. It is unusual in individuals with this disorder to be free of symptoms or help seeking behaviours for more than one year.

Case vignette of somatoform disorders

Ms. X is a 28 year old employee in government secretarial service. She had been referred to the psychiatry clinic from a general hospital. History revealed that she had been evaluated for her multiple physical complaints by numerous physicians and specialists in various government hospitals and private specialty centres for a duration of over 3 to 3 ½ years. The symptoms reported by her were intermittent dizziness, head ache, pain in hands and legs, joints pains, electric like sensation all over the body followed by twisting like sensation of the trunk, feelings of nausea and intermittent numbness.

Further on detailed evaluation at the psychiatry clinic, she reported that these symptoms had been present on most of the days since she was 22 years of age. However, they had been fluctuating in nature. In addition to these symptoms, she also reported feelings of sadness and decreased interest in activities, including decreased sexual desire. She reported that she has undergone numerous medical examinations and diagnostic investigations; however, most of the physicians and specialists were unable to find any physical cause or disorder which was causing these symptoms. In the psychiatry clinic her recent medical records were reviewed in detail which included medical and neurological opinions. Considering the given details she was diagnosed to be suffering from somatoform disorder. These physical symptoms were causing her significant interference in occupational and social functioning.

Check Your Progress Exercise 7

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. What are the risk factors that are associated with somatoform disorders?

.....

.....

.....

.....

.....

.....

11.9 POST TRAUMATIC STRESS DISORDER

Post traumatic stress disorder (PTSD) is characterised by development and maintenance of behavioural, emotional and anxiety symptoms following exposure to an extremely traumatic event.

A traumatic event involves either direct personal experiencing or witnessing a situation involving actual or threatened bodily injury or death, or threat to physical integrity, accompanied by feeling of being helpless, horrified or terrified during the experience. The individual's response to such traumatic events involves intense fear, helplessness or terror.

Fig. 11.3 depicts common traumatic events.

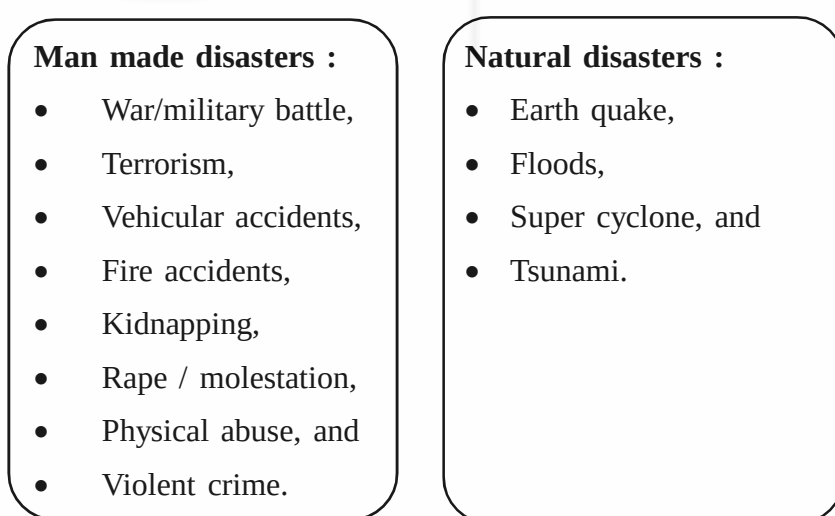


Fig. 11.3: Common traumatic events

It is understood that greater the proximity and intensity of trauma, the greater the probability for developing psychiatric symptoms. Symptoms of post traumatic stress disorder can be easily understood under three domains that are depicted in Fig. 11.4.

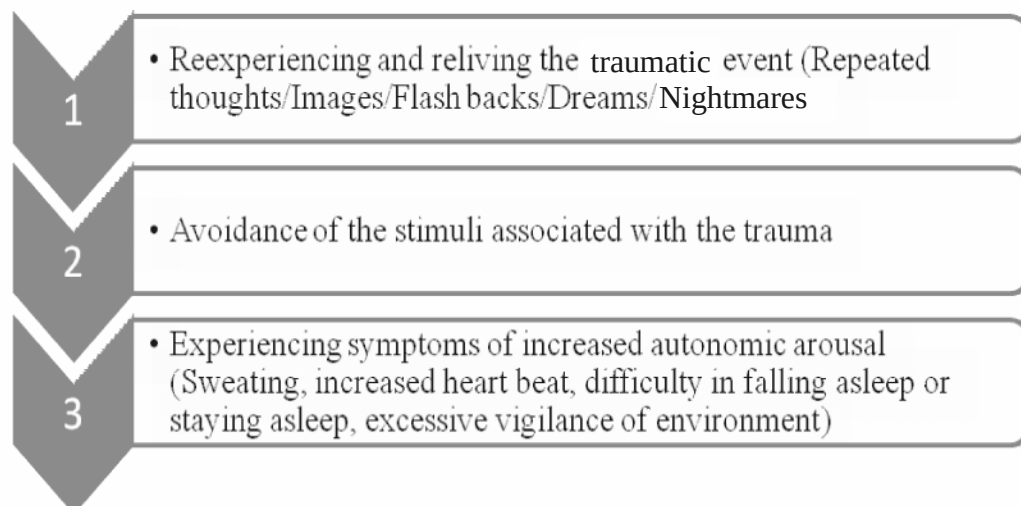


Fig.11.4: Three domains of post traumatic stress disorder

Individuals with post traumatic disorder may also describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive the traumatic event, which is known as, ‘Survivor’s guilt’.

The clinical characteristics for recognizing post traumatic stress disorder are as follows:

1. Exposure to a severe traumatic event.
2. Persistent “*re-experience and reliving the traumatic event*” in one or more of the following ways:
 - Repetitive, intrusive and distressing memories of the traumatic event,
 - Repetitive images and thoughts of the traumatic event,
 - Repetitive and distressing dreams/nightmares of the traumatic event, and
 - Repetitive flash backs.
3. The individual engages in “*persistent avoidance of stimuli*” associated with trauma and experiences numbness in responsiveness which is indicated by the following:
 - Efforts to avoid thoughts, feelings or conversations associated with the traumatic event,
 - Efforts to avoid activities, places, or people that make him or her remember the traumatic event,
 - The individual is unable to recall an important aspect of the trauma,
 - Decreased interest in activities of daily living,
 - The individual is unable to experience any emotions, and
 - Individual feels that his or her future has been shortened (for example, does not expect to have a career, marriage, children or a normal life span).

4. The individual experiences persistent symptoms of increased autonomic arousal (not present before the trauma), as indicated by the following:
 - Difficulty in falling asleep or staying asleep,
 - Irritability or excessive display of anger, and
 - Excessive vigilance towards the environment.
5. These symptoms of “re-experiencing the traumatic event”, “persistent avoidance of stimuli” and increased autonomic arousal cause significant impairment in social and occupational functioning.

Epidemiology

Community based studies of post traumatic stress disorder reveal a lifetime prevalence rate ranging between 1 and 14 per cent. Prevalence rates vary widely as the prevalence depends upon the population being studied. Studies conducted on ‘at-risk’ individuals (for example veteran battlefield soldiers, or victims of criminal violence or exposed to a disaster like tsunami victims) have yielded prevalence rates ranging from 3 to 58 per cent.

Post traumatic stress disorder can have an onset at any age, including childhood. The psychiatric symptoms usually begin within the first three months of the traumatic event, although there may be a delay of months or even years before there is onset. These symptoms of “re-experiencing the traumatic event”, “persistent avoidance of stimuli” and increased autonomic arousal may vary over time. The severity, duration and proximity of an individual’s exposure to the traumatic event are the most important factors which predict the probability of developing this disorder.

Case vignette of post traumatic stress disorder

Mr. Y is a 42 year old engineer, who had a car accident 5 weeks ago, while driving on a rainy day to his site construction office. He developed symptoms such as repetitive, intrusive and distressing memories of the car accident. He would experience intense mental distress on exposure to news of car crashes and would avoid reading those pages in the newspaper where the news of bus, train or car crashes was printed. The car crash was so bad that his car got smashed against the wall of an under bridge and one of his close friends traveling along with him in the same car died on the spot within minutes after the accident. The car doors were jammed and he was trapped inside for 2-2 ½ hours while the mechanics and construction site workers cut through the car doors. He also reported getting nightmares about the accident, used to fear that it could occur again and had unsatisfying sleep. He avoided driving a car for some weeks, and started working from home. He used to feel guilty of losing control over the car while driving, and causing the death of his friend.

He would avoid visiting his friends and relatives as he feared that the accident could occur again. He would not even sit in the passenger seat. He refused to drive the car or board any car as a passenger even after 12 weeks of the car accident. He avoided taking the same route on which the accident had occurred. He would still avoid reading the news of car crashes and would change the television channel when either some news or advertisements about cars or tyres would come. On seeing any reminders of the accident he used to get severe panic attacks and restlessness. Considering his nature of complaints he was diagnosed with post traumatic stress disorder.

Check Your Progress Exercise 8

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. What are the three domains of post traumatic stress disorder?

.....

.....

.....

11.10 ADJUSTMENT DISORDER

The development of transient psychiatric symptoms in the context of stress is virtually a universal experience. An *adjustment disorder* is defined as the development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within a month of onset of the stressor(s) and the duration of symptoms usually does not exceed 6 months, except in the case of a prolonged depressive reaction. These symptoms or behaviours are clinically significant as evidenced by either of the following:

- a) marked distress that is in excess of what would be expected from exposure to the stressor, and
- b) significant impairment in social and occupational functioning.

Let us now take a look at some common stressful events that can trigger adjustment disorders. You are aware that adjustment disorder is characterised by an intense emotional and behavioural response to a stressful event. The stressor usually involves :

- The presence or possibility of serious physical illness (disabling or life threatening),
- Death of loved ones, job loss, business loss,
- Marital/family discord,
- Parental divorce, separation, bereavement,
- Migration or refugee status,
- Breaking up with the girl/boy friend/relationship,
- Child being put to a new school,
- Failure to reach the goal,
- Financial constraint, and
- Natural disasters.

The subjective distress or impairment associated with adjustment disorders is usually manifested as decreased performance at work or school or college

and temporary changes in social relations. The emotional distress and associated symptoms may include anxious or depressive emotions or a disturbance in behaviour. The symptoms usually begin within a few weeks of the onset of stressor and decrease and disappear within 6 months of removal of the stressor. If the symptoms last more than 6 months from the initial onset of the stressful event, then it is defined as a *chronic adjustment disorder*.

Adjustment disorder is not an enduring diagnosis. According to its definition, if the stressful event does not occur, then symptoms do not emerge. People with adjustment disorder may have a wide variety of symptoms. How those symptoms cluster depend on the particular subtype of adjustment disorder and on the individual's personality and psychological defenses.

The clinical characteristics for recognising adjustment disorder are as follows:

- a) The symptoms develop in response to a stressful event or events,
- b) The symptoms emerge within a few weeks of onset of the stressful event,
- c) The individual experiences noticeable distress that is in excess of what would be expected from exposure to the stressful event,
- d) Significant impairment in social or occupational functioning is noted, and
- e) The symptoms usually decrease and disappear within 6 months from the removal or end of the stressful event.

Epidemiology

Prevalence of an adjustment disorder in general population is 2 to 20 per cent. Depending upon the population studied, adjustment disorder prevalence varies. Individuals diagnosed to be suffering from medical illness (like diabetes, hypertension, HIV positive, cancer, psoriasis, burn patients, and so forth) report of wide range of prevalence of adjustment disorder from 15 to 95 per cent. Adjustment disorder affects both genders equally, and can occur at any age. People are particularly vulnerable during normal transitional periods such as adolescence, mid-life and late life. Adjustment disorder includes grief reactions and bereavement.

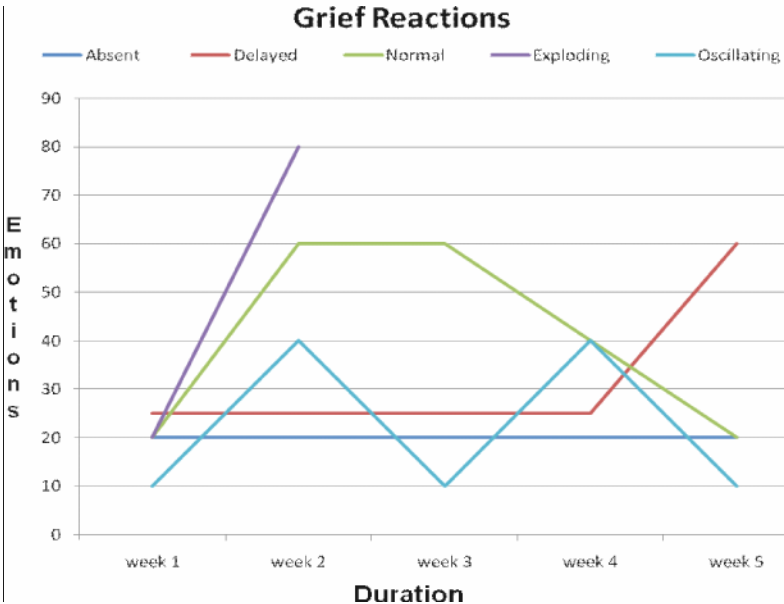
Grief and Bereavement

Loss is a universal experience. During life everybody has to cope with a series of losses, which may range in intensity from the minor loss of a pet to the major loss of a spouse or child. *Bereavement* is the loss of a loved person through death. *Grief* stands for the feelings and associated behaviour (for example crying) precipitated by this death. *Mourning* indicates the social expression of grief, including funerals, visitations and rituals. Grief process occurs through various stages namely shock, denial, anger, bargain, depression and acceptance. It can be classified roughly into three different phases as shown in the Table 11.3.

Table 11.3: Stages of normal grief (Bereavement) First phase: Shock, disbelief, numbness and denial followed by searching behaviours lasting for days to weeks. Second phase: Intense somatic distress, preoccupation with the deceased, anger, restlessness, bargaining, feeling of sadness, guilt, depressive symptoms, helplessness, hopelessness and impairment in functioning lasting for days to weeks. Third phase: Restitution and reorganisation (acceptance) lasting months. Normal grief usually follows the above phases with a possibility of slight variation.

Grief reactions manifest in the form of emotions, thoughts, physical symptoms and behaviours. *Predominant emotions* noted are sense of shock, emotional numbness, sadness, despair, anxiety, fear, anger, guilt and loneliness. *Common thoughts* noted are slow thinking process, helplessness, hopelessness, worthlessness, death wishes, philosophical ideas about life/death and some times suicidal ideas. *Physical symptoms* noted are panic attacks, choking sensation, tightness or heaviness in the chest, nausea, dizziness, headaches, generalised weakness and easy fatigability. Usual *grief behaviors* noted are decreased social interaction, decreased interest in pleasurable activities, decreased appetite, crying spells, self injurious behaviors and excessive consumption of substances like alcohol, cannabis or drugs. These symptoms are often experienced in waves or cycles or episodes with periods of intense and painful emotions that come and go.

Abnormal grief reactions can be grossly classified into delayed grief, absent grief, oscillating grief and exploding grief. It is important to identify abnormal grief as, if undetected, it could lead to various problems like non acceptance of the death of the individual, avoidance of the mention of the deceased, avoidance of the funeral and other associated rituals, holding on to the belongings of the dead, preoccupation with thoughts of the deceased, a strong and continued feeling of the dead person’s presence, illusions or hallucinations of the deceased for a long time.



Graph 11.1: Various patterns of normal and abnormal grief reactions

Mr. Z is a 36 year old married man, working as a mechanic in a private factory. He was very energetic with high aspirations in life and a pleasant disposition. He lived in a nuclear family consisting of his wife and two daughters. One day while returning from his factory, Mr. Z met with an accident, during which he sustained a crush injury to his right leg. He was taken to a private hospital where the orthopaedic and the vascular surgeon tried to do restorative surgery. Unfortunately gangrene set in after the emergency operation. Hence the specialist decided to go in for a below knee amputation. The patient refused to consent for the surgery but later on, left with no options, he agreed for it. Operation went on without any complication. Postoperative period was uneventful and he was discharged within a few weeks.

A week after the discharge, Mr. Z was brought with complaints of feeling uneasy, having decreased sleep, multiple body aches, being withdrawn, irritability on trivial issues, anger outbursts, complaints of being fearful at times, and crying spells. The orthopaedic surgeon did not find any post-operative complications. During the consultation Mr. Z started crying and asked the orthopaedic surgeon for some injection, which will make him die without any pain. On hearing his suicidal ideation the orthopaedic surgeon referred the patient immediately for psychiatric consultation. Psychiatric evaluation revealed that his symptoms had increased since two days when he came to know from his colleague that he might lose his job. Taking into consideration the clear-cut stressors and presentation of both anxiety and depressive symptoms, a diagnosis of Adjustment Disorder was made.

Check Your Progress Exercise 9

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. What are the stages of normal grief?

.....

.....

.....

11.11 MANAGEMENT OF NEUROTIC DISORDERS

11.11.1 Assessment

A detailed evaluation is conducted on the complaints reported by the patient. During the detailed evaluation, each presenting complaint requires to be enquired in the following fashion:

History taking in Neurotic disorders

1. Demographic details
2. History of presenting illness and symptoms

- How they started?
 - When they started? (Duration)
 - How they are progressing? (Increasing/Decreasing/Static)
 - How often they occur? (Frequency and fluctuations of the symptoms)
 - Any precipitating, aggravating and relieving factors to be noted
 - List of avoidance behaviours
 - Attempts for treatment/remedy
 - How disabling the symptoms are in terms of social and occupational functioning?
 - Reason for the present consultation
3. Past history
 4. Family history
 5. Personal history
 6. Premorbid personality
 7. Coping pattern for stress
 8. Mental status examination

The past history of any medical or similar illness requires to be enquired. A detailed family history should be collected along with the primary caregiver and social support pattern. Personal history, personality assessment and coping pattern for stress requires to be briefly assessed. Finally mental status examination, arriving at the diagnosis and plan of management should be arrived at.

11.11.2 Psychoeducation

Psychoeducation refers to educating the patient and patient's family members about the mental illness. Goal of psychoeducation is to improve the patient's compliance with treatment procedures. During psychoeducation following information requires to be conveyed; nature of the symptoms, diagnosis, etiology, prevalence, available treatment options, cost and side-effects of treatment, duration of treatment, course and outcome of the disorder. When family members are unable to come along with the patient, then psychoeducation is provided to the patient alone and at a later time psychoeducation may be scheduled for the family.

Psychoeducation in neurotic disorders

Goal: To improve the patient's compliance with treatment procedures.

Session duration: 45-60mins.

Number of sessions: 3-5 sessions over a period of 1-2 weeks.

Steps of psychoeducation:

- To explore the patient's and the caregiver model of illness.

- To educate the patient and his or her caregiver about the following:
 1. The symptoms and illness (diagnosis),
 2. Possible etiology of the illness,
 3. Prevalence of illness,
 4. Available treatment options, cost and the side-effects of treatment,
 5. Effects of treatment on pregnancy,
 6. Duration of treatment,
 7. Role of family members in treatment of the patient,
 8. Course and outcome of the illness, and
 9. Helping the family members to build their own help seeking network (self help groups).

11.11.3 Medication Management

A group of medications called, selective serotonin reuptake inhibitors have been found to be most effective in treatment of neurotic disorders. In the brain, there are various chemicals or neurotransmitters and serotonin is one of them. These groups of medications function to increase the amount of serotonin available for nerve cells in the brain. These medications have been found effective in reducing or preventing various forms of anxiety disorders including social phobia, obsessive compulsive symptoms, panic, agoraphobia, generalised anxiety and post traumatic stress symptoms.

11.11.4 Stress Management

1. **Stress:** Hans Selye, who is often referred to as ‘The father of stress research’ defined stress as ‘The non-specific response of the body to any demand’. It is also called the *General Adaptation Syndrome (GAS)*. Stress can have a direct effect on our immune, endocrine, gastrointestinal, nervous and cardiovascular system. It can also cause indirect effect by developing maladaptive coping patterns in the face of stressful situations, such as use of alcohol, tobacco and drugs; poor dietary habits and lack of physical exercises.

Many of the neurotic disorders are well known to precipitate during stressful situations. Like any other medical illness, neurotic disorders become uncontrollable and found to worsen during stressful situations. Stress management can be used in primary and also secondary prevention. Reducing excessive debilitating stress after it has begun is called ‘*Secondary prevention*’. Implementing strategies that can prevent before it occurs is called ‘*Primary prevention*’. Main objective of both primary and secondary prevention is to decrease stress and thus the probability of stress-related illnesses.

Stress management

1. Identifying and acknowledging the effect of stress on our body,
2. Healthy life style,
3. Coping with emotions,
4. Creative and critical thinking,
5. Problem solving and decision making,
6. Effective communication skills,
7. Coping skills,
8. Assertiveness skills,
9. Time management,
10. Relaxation techniques,
11. Stress inoculation,
12. Interpersonal and social skills,
13. Enrichment and hobbies, and
14. Socio-cultural, Spiritual (and philosophical) domain.

- 2. Lifestyle and stress:** First step in stress management is to acknowledge that we are going through a stressful situation. Identify the possible sources of stressors and list all the symptoms that occur whenever you are in stressful situation.

Another important issue is to understand the effect of our lifestyle and how it is contributing to stress. Physical exercise, proper diet, maintenance of weight in the normal range, adequate sleep and rest, cessation of smoking and alcohol and overall a healthy lifestyle helps to reduce stress.

Stress and emotions

- Irritable on trivial issues,
- Anger outburst on trivial issues,
- Low frustration tolerance,
- Low tolerance to sound,
- Feeling sad, and
- Anxiety

- 3. Emotions and stress:** Recognising one's feelings or emotions as they occur is an important aspect of stress management. Usually individuals become irritable on trivial issues during stress. The ability to monitor feelings from moment to moment is key to psychological insight and understanding of self. Being aware of one's emotions makes one more confident when making important personal decisions such as whom to marry or what career path to follow. Taking control of emotions helps in thinking logically and to solve the problem in hand.
- 4. Problem solving and decision making:** It is an important aspect of stress management. Structured problem solving is a simple and effective technique for dealing with problems in your life. It is a step-by-step approach for tackling those aspects of a problem that can be changed.

Steps involved in problem solving:

1. Identify the problem,
2. List as many solutions as possible,
3. Discuss the pros and cons of each possible solution,
4. Select the best or most promising solution,
5. Plan how to carry out your chosen solution,
6. Try it out, review what happens and praise all efforts, and
7. Tackle only one problem at a time.

Problem solving and decision making skills are essential to deal constructively with the stressors we face in our lives. This can have consequences for health if young people actively make decisions by choosing healthy life style in coping with stress.

5. **Creative and critical thinking:** Creative thinking contributes to both decision-making and problem solving by enabling us to explore the available alternatives and various consequences of our actions or non-action. It helps us to look beyond our direct experience, and to look for out of box solutions. *Critical thinking* is an ability to analyse information and experiences in an objective manner. Critical thinking can contribute to health by helping us to recognise and assess the factors that influence attitudes and behaviour, such as values, peer pressures and the media.
6. **Effective communication and interpersonal relationship skills:** Effective communication means that we are able to express ourselves, both verbally and non-verbally in ways that are appropriate to our cultures and situations. *Interpersonal relationship skills* help us to relate in positive ways with the people we interact with. This may mean being able to make and keep friendly relationships, which can be of great importance to our mental and social well-being. It may mean keeping good relations with family members, which are an important source of social support. It may also mean being able to end relationships constructively.
7. **Coping:** Coping process refers to cognitive or behavioural efforts to deal with, reduce or tolerate excess demand, internal or environmental (stressors). Coping process can be classified as problem-focussed and emotion-focussed. *Problem-focussed* coping involves efforts to deal with the source of stress, either by changing one's own problem-maintaining behaviour or by changing environmental conditions. *Emotion-focussed coping* is aimed at reducing emotional distress and maintaining a satisfactory internal state for processing information and action.
8. **Assertive behaviour:** Assertive behaviour enables a person to act in his or her own best interest, to stand up for himself or herself without undue anxiety, to express honest feelings comfortably and to exercise personal rights without denying the rights of others.
9. **Significance of time management:** A stressful event can place inordinate demands on time and time management becomes critical. In such circumstances individuals often report feeling that they have lost control of their daily schedule and, as a result of that, they have little or no time to attend to their own needs.

Time management : Steps involved

1. Maintaining dairy on how they spend their time each day,
2. Noting the amount of time spent in important activities such as those in the domain of work, family, exercise, or leisure,
3. Analyzing the substantial difference in the time that they would like to spend on important activities and the amount of time they actually spend on them,
4. Setting priorities on the basis of **urgency** and **importance** in time management for the activities to be done,
5. Goal setting, that is what is to be done? When to do it? How long will it take? and
6. Review how meaningfully the previous day was spent and try to modify and improve on it if required.

10. Progressive muscular relaxation: This technique requires the individual to tense and relax the muscles of the body in a particular sequence. Individual is instructed to tense up his or her muscles as it helps the individual to focus his or her attention on specific muscles or to identify the sensations in the tense muscles. Later on, this focus makes the individual aware of the sensations of relaxation. Relaxation induces physiological changes which are opposite to those induced by stress responses that are part of many emotions. Relaxation causes a decrease in muscular tension, respiration rate, heart rate and blood pressure. It helps in decreasing physiological arousal, emotional tension and causes an increase in the ability to tolerate stress.

11. Stress inoculation training: This technique proposes that emotions, stress and anxiety reflect the interactional pattern of human responding, that is cognitive, physiological and behavioural respectively. This technique involves training the patients in application of specific skills and techniques, and is designed to address the difficulties arising in responding pattern of the individual. In case of experiencing negative cognitions which get triggered in times of stress, the patient learns to identify them and replaces them with a logical thinking pattern. When experiencing physiological sensations under stress, the patient can engage oneself in deep breathing or progressive muscular relaxation. Patients can learn to change behaviour through undergoing role plays and behaviour rehearsal where patient learns new and better ways of responding to stressful situations. All training occurs within the clinical setting and under supervision. The patient starts applying the learned techniques in various anxiety provoking or stressful situations gradually. As the patient attains success in applying these techniques in stressful situations, there is a cognitive change in how the patient processes situations. In other words, the patient's coping skills improve as he or she is able to incorporate new information in his or her mind about the situations which were feared earlier.

12. Social skills training : It helps the patients with social skills deficits (e.g. lack of communication skills, assertiveness skills) to learn social skills through utilisation of techniques like role play and behavioural

rehearsal within the clinical setting and under the therapist's supervision. This training is based on the proposition that some individuals especially patients with social anxiety disorder lack social skills to interact effectively with others. This skills deficit causes them to experience fewer personal rewards and more disappointments, leading them to avoid social interactions when possible, thereby further limiting their opportunities to acquire social skills. When the patients learn these skills through role play and behavioural rehearsals, this can end this cycle of social avoidance and develop meaningful relationships. The therapists usually model these behaviors and then the patients act them out in a role play with the therapists and engage in behavior rehearsals till they become effective.

For example, a patient was always taken for granted by his colleagues, and they used to frequently ask him for favours like taking up their work assignment when they would go on leave (but *vice-versa* was not true), asking for his vehicle, using his laptop for downloading personal files, repeatedly requesting for loans and the like. This patient was unable to refuse because he thought that if he displays non-compliance to their requests, then they will discontinue their friendship with him. However, he used to feel very miserable and angry with the behaviours of his colleagues. But he was unable to express it. He felt helpless as he had no control over most situations. This patient was taught assertiveness, that is, a way of communication in which you express your feelings and thoughts to the other person without making others feel hurt or without violating their rights. The patient during training learned that relationships continue on mutual benefit and if your rights are being violated then you have a right to voice your concern and protect your interests. After engaging in role plays and behaviour rehearsals, he was able to refuse work assignments citing work commitments, declined giving loans asking them to first clear earlier loans, and refused to provide others his vehicle, when it was unnecessary. Simultaneously, he was able to form some new relationships with other colleagues and reportedly his anger and feelings of helplessness had decreased significantly.

11.11.5 Supportive Therapy

This intervention is aimed at helping patients to cope with the occurrence of a sudden or intense stressor which they have been unable to handle by themselves. The goal of therapy is to provide relief from symptoms and help patients attain a level of adaptive functioning that is comparable to their premorbid functioning. It is essential for the therapist to understand the meaning of the stressor from the patient's perspective and why it is associated with the presenting symptoms. Some techniques utilised in supportive therapy are as follows:

- (i) **Guidance:** Therapist provides help in identifying and examining difficulties and suggests appropriate behaviors to adapt to the situation rather than putting efforts in changing problematic situations.
- (ii) **Environmental manipulation:** Therapist provides help in coping with emotional stressor by removing or modifying factors causing stress within the environment.

- (iii) **Externalization of interests:** The patient is encouraged to resume activities which were meaningful to him or her before the emergence of the stressor. This helps in increasing the social interaction and in shifting the focus from oneself to external events.
- (iv) **Reassurance:** Therapist communicates to the patient that his or her illness is curable and there is no reason for becoming hopeless. It is helpful in patients who have fear or doubts regarding their chances of recovery.
- (v) **Persuasion:** This technique aims at modification of attitude against which the patient is rebelling. It simultaneously provides the patient with new life goals and models of adapting to realistic changes.
- (vi) **Ventilation:** Therapist helps in ventilation of fear, hopes, and ambitions by providing uncritical and sympathetic appraisal of the same.

11.11.6 Grief Therapy

In general, the rituals associated with death serve the purpose of mourning. These rituals afford an opportunity for catharsis and reliving, which help the bereaved in getting over the loss. Hence, people should be encouraged to participate in the funeral and mourning rituals.

The grief therapy treatment options include individual therapy or family grief therapy. Sessions are approximately of 60 to 90 minutes duration. Approximately 14 to 16 sessions are required over a period of 2 to 3 months. Grief therapy involves getting the individual to talk about the deceased, recollecting the experiences preceding and succeeding the death, ventilating his or her feelings both right and wrong towards the dead person and finally letting go of the deceased. During the sessions the therapist plays a supportive role and helps in validating and rationalising the patient's feelings towards the deceased one.

It would help to bear in mind that during the process of grief therapy the depressive symptoms of the patient may escalate or worsen for a brief period indicating that the person is grieving. It is at this stage that the patient requires the support of the therapist the most and hence the therapist should take care not to abort or digress from the therapy.

11.11.7 Exposure Therapy

This involves the individual to intentionally confront feared objects, situations, thoughts, memories and physical sensations which are otherwise not dangerous or threatening. The purpose of confronting these fearful stimuli is to reduce the fear reactions associated with same stimuli or similar stimuli. This therapeutic technique works on the principle of habituation and extinction. Habituation (becoming used to) to fear (that is irrational) occurs by facing the objects or situations that cause fear and extinction of fear occurs when we experience that no unfavourable consequences occur when the feared objects or situations were faced. The exposure therapy is divided into three categories; namely in vivo exposure, imaginal exposure and interoceptive exposure.

1. **In vivo exposure:** This exposure technique involves helping the patients to directly confront the feared objects, activities and situations in real

life situations. This exposure is conducted in a graded manner; that is, the patients are made to confront feared objects, activities and situations, starting from the least anxiety provoking or distress causing object or situation and gradually moving towards more distress provoking objects or situations. The patient is able to move towards confronting more distressing situations as habituation and extinction keep occurring simultaneously for feared stimuli. Prior to initiating exposure, a mutually agreed (between therapist and patient) hierarchy of feared objects or situations is made which has items arranged from least to most distressing. For example, a patient who has fear of travelling in elevators, may be initially asked to view pictures of elevators, followed by standing in front of elevators, then later to use elevators in presence of a companion up to the first floor for a few days, later on to increase the time spent in the elevator in presence of a companion, and then gradually asked to travel in elevators alone, and finally sent to buildings other than his or her office building for travelling in elevators alone.

2. **Imaginal exposure:** This exposure technique involves having the patient close his eyes and to imagine feared stimuli as vibrantly as possible. Imaginal exposure is utilized for two purposes. Firstly, it helps the patients confront their feared thoughts, images and memories. For example, in a patient with post traumatic stress disorder, imaginal exposure is used to help the patient confront his or her memory of the traumatic event. The imaginal exposure causes habituation to the traumatic memories and helps the patient to differentiate between the actual traumatic event, which was dangerous, and the current memory of the event which may still be distressing but not dangerous. Another utilization of imaginal exposure is when arranging for in vivo exposure is not possible or when direct exposure to the feared object or situation is not considered to be safe. In this scenario, the patient is instructed to imagine confronting the feared object or situation. After repeated imaginal exposure over sometime, when the anticipatory anxiety has reduced, then in vivo exposure can be considered with the feared object or situation, provided it is safe. For example, with a patient who has fear of flying, imaginal exposure may be used as the real exposure is difficult to be arranged in the clinical setting. However, after imaginal exposure when patient's anticipatory anxiety has reduced then in vivo exposure can be planned where a companion accompanies the patient when he attempts travelling by airplane for the first few times after treatment with imaginal exposure.
3. **Interoceptive exposure:** This exposure involves habituation towards the feared physiological sensations within clinical supervision. This exposure is usually utilized in patients with panic disorder and specific phobia. Patients with panic disorder have fear of experiencing panic symptoms which are physiological sensations such as increased heart rate, sweating, sensations of shortness of breath, dizziness. The patients are instructed to perform specific exercises which induce panic like sensations and over time with repetitive performance of these exercises, the individual gets habituated to physiological sensations which no longer produce fear. Some of the exercises are "step up exercise" in which the patient repeatedly steps up and down on a single step as rapidly as possible, which produces increased heart rate and shortness of breath

and sweating. Spinning exercise; in which patient is made to spin on an office chair, produces symptoms of dizziness, and mild nausea in some people.

11.11.8 Cognitive Restructuring Technique

This technique helps the patients to identify irrational beliefs about self, world and future and to replace them with realistic beliefs. This technique is based on the proposition that individual's problematic emotional reactions such as anxiety or distress are based on irrational interpretations and beliefs. Patients are helped to identify their irrational beliefs, explained how these evoke fear and avoidance towards certain situations, following which irrational beliefs are challenged and modified by substituting more realistic beliefs. This belief change causes changes in patients' thinking and behavioural responses. A common procedure used in processes of cognitive restructuring is behavioural experiments. The aim of behavioral experiments is to examine whether the feared consequences occur, when irrational repetitive behaviours (compulsions) are not performed.

For example, an OCD patient believes that if he does not seek forgiveness from God when aggressive thoughts (my parents will die; I will verbally abuse others; or I might hurt others) occur, then these thoughts can become a reality that is his parents will die; he will abuse others or hit them. An experiment is conducted, and the goal of this is to collect information which disproves the patient's irrational belief. If the patient agrees to test his belief, then he is instructed not to seek forgiveness from God when these aggressive thoughts occur, and experience for himself what follows. He is explained before the experiment, that no unfavourable events will occur, however, anxiety and distress will be experienced which also will decrease within some time. As these aggressive thoughts occur and when the patient experiences the same that without seeking forgiveness from God (compulsion), no unfavourable event happens except experience of anxiety which subsides within some hours. This experiment provides corrective information to the patient. Through this process his irrational belief gets challenged, modified and replaced with a realistic belief.

11.11.9 Psychoanalytic Therapy

In this therapy, the primary aim is to decrease the anxiety and the dysfunctional behaviours seen in neurosis. This is achieved by developing insight into their repressed feelings and conflicts within the mind. The psychoanalyst (therapist) helps the patients to uncover unconscious conflicts and to bring them within conscious experience, so that they can be resolved. This process of facilitating the patient to identify the unconscious conflicts and to resolve them, usually takes a long time, often months to years.

Initially, the psychoanalyst identifies the unconscious conflicts which caused the neurotic behaviour of the patient. The techniques commonly utilized for identifying these unconscious conflicts are free association and dream analysis. In free association the patients are made to lie down on a couch and are instructed to keep telling their thoughts as they occur in one's mind without censorship. In dream analysis, the patient narrates the dream, while the psychoanalyst tries to understand and interpret the urges and conflicts that

are hidden within the unconscious mind. This form of therapy is usually discouraged and not popular because there are no systematic studies to explore the efficacy of this therapy and also because of the long duration of therapy.

11.11.10 Working with the Family

Give essential information to the patient and family, regarding illness. Identify relatives, friends and community resources, who are able to offer support. Encourage the patient to acknowledge the personal significance of the stressful event. Short-term rest and relief from stress may help the patient. Encourage a return to usual activities within a few days to weeks.

Family therapy is often focused on making needed changes within the family system such as improving communication skills and family interactions, as well as increasing family support among the family members. Family therapy may be appropriate for certain individuals, especially if the person presenting with the disorder is an adolescent. This type of therapy also is appropriate when the family is “scapegoating” a particular family member, or there is a clear “identified patient,” when the actual problem is family-systems related. Education related to the disorder is sometimes needed, and the family can be reassured as to the nature and seriousness of the disorder, as well as its prognosis. Couples therapy is appropriate when the disorder is also negatively affecting the romantic relationship.

Family members often want to help their relative who is suffering from these neurotic disorders but may not know how to help them. An important fact to keep in mind is that these disorders are treatable medical conditions. Like any other mental illnesses, neurotic disorders can disturb family and social relationships. It can even cause severe marital discord. Household routines may be disrupted, family can become isolated, family members may develop frustration and sometimes depression. However, family support and encouragement plays an important role in the process of recovery. Family members should learn about the disorder; it helps them understand the nature of the problem and empathize with the sufferer. A common complaint from the patient is that family members do not understand their problems and they are often dismissive of their difficulties. Usual family reactions result in over-involvement in the patient’s illness or critical and hostile attitude toward the patient. Both the responses are not conducive for recovery.

Some practical tips for family members

- Know about the patient’s illness,
- Know about the recovery process (usually it takes time),
- Keep realistic expectations about improvement,
- Keep your social circle (friends/relatives) intact,
- Encourage patients to participate in social activities,
- Family members can act as co-therapists in therapy,
- Recognize and acknowledge small gains/accomplishments in fighting these disorders. Your encouragement motivates the patient to fight against these disorders,

- High motivation is critical and essential for success of any therapy,
- Do not hesitate to discuss about your problems with the treating team. Family members are well known to develop burn-out or caregivers' stress,
- Criticism and hostility can discourage the patient from participating in therapy, and
- Negative comments or criticism from family members often make illness worse while calm, supportive family can help improve the outcome of treatment.

11.12 LET US SUM UP

Neurotic disorders are the most common group of psychiatric disorders in the general population and are also common in patients with chronic medical conditions. Approximately 50 to 60 per cent of the neurotic disorder patients also experience two or more comorbid psychiatric conditions. Neurotic disorder are associated with significant disability, poor quality of life, and burden on families. The exact etiology of neurotic disorders is not known. There are various methods and treatment modalities available — from medication to stress management. Early detection and intervention makes a major impact on the outcome of the illness.

11.13 GLOSSARY

Agoraphobia	: Avoidance of places or situations from which escape might be difficult or embarrassing or in which help may not be available when a panic attack occurs.
Anticipatory anxiety	: Anxiety about the possibility of panic attack recurring.
Bereavement	: Loss of a loved person through death.
Compulsions	: Repetitive behaviours or mental acts performed by the individual, to prevent or reduce distress that accompanies an obsession.
Critical thinking	: Ability to analyse information and experiences in an objective manner.
Free floating anxiety	: Anxiety not related to any particular set of events or situations. It is prevalent across all situations and tasks.
Grief	: Feelings and associated behaviour precipitated by loved person's death.
Mourning	: Social expression of grief, like funerals.

Obsessions	: Repetitive, persistent ideas, thoughts, impulses or images that are experienced by individuals as intensive and irrational or illogical.
Panic attack	: A distinct period in which there is the sudden onset of intense apprehension or fearfulness or discomfort that is often associated with feelings of approaching impending doom.
Psychoeducation	: Educating the patient and patient's family members about the mental illness.
Rituals	: A particular sequence of actions, which the person is compelled to carry out.
Social anxiety disorder	: Fear of being in social situations.
Survivor's guilt	: Painful guilt feelings about surviving when others did not survive or about the things the person had to do to survive the traumatic event.

11.14 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. The major anxiety disorders which are classified under the neurotic disorders are listed below:
 - i) Social phobias,
 - ii) Panic disorder,
 - iii) Generalised anxiety disorder,
 - iv) Obsessive compulsive disorder, and
 - v) Agoraphobia.
2. The theories that explain the causes of neurotic disorders are given below:
 - i) Neurotransmitter theory,
 - ii) Psychoanalytic theory,
 - iii) Learning theory,
 - iv) Social learning theory,
 - v) Cognitive theory, and
 - vi) Trauma theory.

3. The common co-existing mental illnesses with neurotic disorders are listed below:
 - i) Depression,
 - ii) Anxiety disorders, (Specific phobias, Social phobia, Generalised anxiety disorder and Panic disorder),
 - iii) Substance use, (nicotine, alcohol, cannabis and benzodiazepines),
 - iv) Personality disorders, and
 - v) Somatoform disorders.

Check Your Progress Exercise 2

1. The predominant irrational fears in social phobias are given below:
 - i) Fear of scrutiny or evaluation by other people,
 - ii) Fear of criticism by other people,
 - iii) Fear of rejection by other people, and
 - iv) Fear of losing control in front of others.
2. The main clinical characteristics for recognising social anxiety disorders are listed below:
 - i) The individual has noticeable or persistent fear of one or more social (social get-togethers, marriages) or performance situations (oral presentations, group discussions) in which the person faces possible evaluation by others. The person feels that he or she would behave in a manner or display anxiety symptoms that would be humiliating or embarrassing for him or her.
 - ii) When the individuals face these feared social situations, it always provokes anxiety within them. Anxiety symptoms are characterised by increased heart rate, sweating, feeling of shortness of breath, feeling of choking, stammering or discomfort, nausea, numbness, fear of losing control or going crazy.
 - iii) The individual avoids the feared social situations or performance situations.
 - iv) Social anxiety interferes significantly with occupational functioning or social activities or relationships.

Check Your Progress Exercise 3

1. Following are the clinical characteristics to recognised the generalised anxiety disorder:
 - i) The individual experiences frequent, persistent, excessive worry and anxiety,
 - ii) The individual finds it difficult to control the worry,
 - iii) Presence of apprehensive expectation which is typically of negative outcome about a number of events or activities (such as work or school or college or office performance),

- iv) The individual's anxiety and worry is usually associated with some of the following symptoms which are present on most of the days for at least a period of six months.
 - Restlessness or being unable to relax or feeling of being on edge,
 - Easily fatigued,
 - Difficulty in concentrating on activities,
 - Irritability in most activities,
 - Muscular tension, and
 - Sleep disturbances (difficulty in falling asleep or staying asleep or restless/unsatisfying sleep).
- v) The anxiety or worry is not related to any particular set of events or situations and is prevalent across all situations and tasks (free floating anxiety), and
- vi) The individual's anxiety, worry or physical symptoms cause significant amount of distress or lead to impairments in social and occupational functioning.

Check Your Progress Exercise 4

1. The clinical characteristics of obsessive compulsive disorders are described below:
 - i) Obsessions are repetitive, persistent, thoughts, images or impulses,
 - ii) Obsessions experienced are excessive, distressing and/or anxiety provoking.
 - iii) The individual is able to recognise that the obsessions are coming from his or her own mind,
 - iv) Unable to suppress or ignore obsessions, however, the individual performs repeated acts (compulsions) that may provide transient reduction in anxiety/discomfort,
 - v) Compulsions are repetitive behaviours or mental acts that the individual feels driven to perform when obsessions occur,
 - vi) Compulsions are performed for preventing or reducing distress or preventing occurrence of some unfavorable event or situation.
 - vii) Compulsions are recognised by the individuals as excessive, distressing or unreasonable, and
 - viii) Both obsessions and compulsions significantly interfere with the individuals' normal routine, occupational functioning or usual social activities or relationships.
2. Some common examples of obsessions and compulsions are given below.
Some common obsessions are:
 - i) Repeated thoughts about contamination (individual feels excessively

concerned with contamination from dirt, germs, urine faeces, or other environmental contaminants).

- ii) Repetitive doubts (whether doors, locks, taps, gas stove knobs have been closed properly or not).
- iii) A need to have things in a particular order (excessive need for arranging clothes, shoes, papers and items at home properly and meticulously),
- iv) Aggressive impulses (fearing that they might physically hurt someone), and
- v) Sexual thoughts or imagery (individual gets personally unacceptable sexual thoughts and images).

Some common compulsions are as follows:

- i) Washing and cleaning (excessive hand washing, bathing, tooth brushing, grooming, excessive cleaning of items and objects used by others and avoiding to use them),
- ii) Counting (counting number of stairs, number of tiles used for walking over),
- iii) Repetitive checking (doors, locks taps, gas stove knobs),
- iv) Arranging clothes, shoes, papers, and other items properly and meticulously,
- v) Repeating daily activities, and
- vi) Re-reading re-writing.

Check Your Progress Exercise 5

1. The clinical characteristics of a panic attack are given below:
 - i) Increased heart rate or pounding heart or palpitations,
 - ii) Sweating,
 - iii) Trembling or shaking,
 - iv) Sensations of shortness of breath or breathlessness,
 - v) Sensations of choking,
 - vi) Feeling dizzy, lightheaded and unsteady,
 - vii) Nausea or abdominal discomfort,
 - viii) Fear of losing control or going crazy,
 - ix) Fear of dying,
 - xi) Sensations of numbness or tingling sensations, and
 - xi) Restlessness.
2. The following characteristics indicate that the person is suffering from a panic disorder:
 - i) Recurrent panic attacks in circumstances where there is no objective danger,

- ii) The unexpected occurrence (panic attacks without any reason) of panic attacks without being confined to known or predictable situations,
- iii) A persistent fear of having another panic attack (anticipatory anxiety), and
- iv) Individual worries about the consequences of a panic attack (for example losing control, having a heart attack or going crazy).

Check Your Progress Exercise 6

1. The predominant irrational fears in agoraphobia are given below:
 - i) Fear of not finding easy escape,
 - ii) Fear of losing control in front of others,
 - iii) Fear of moving away from home,
 - iv) Fear of having dizziness and falling down, and
 - v) Fear of something going wrong and not being able to get easy help.

Check Your Progress Exercise 7

1. Following are the risk factors that may lead to somatoform disorders:
 - i) Severe ongoing stressors,
 - ii) Marital/family discord,
 - iii) Poor social support,
 - iv) Financial loss,
 - v) Living with a family member who has the disorder,
 - vi) Parental substance abuse, and
 - vii) Antisocial personality disorder in a family member.

Check Your Progress Exercise 8

1. Following are the three domains of post traumatic stress disorder:
 - i) Re-experiencing and re-living the traumatic event (repeated thoughts/images/flash backs/dreams/nightmares);
 - ii) Avoidance of the stimuli associated with the trauma; and
 - iii) Experiencing symptoms of increased autonomic arousal (sweating, increased heart beat, difficulty in falling asleep or staying asleep, excessive vigilance of environment).

Check Your Progress Exercise 9

1. The three stages of normal grief are given below:
 - i) First phase: Shock, disbelief, numbness and denial followed by searching behaviours lasting for days to weeks.
 - ii) Second phase: Intense somatic distress, preoccupation with the deceased, anger, restlessness, bargaining, feeling of sadness, guilt,

depressive symptoms, helplessness, hopelessness and impairment in functioning lasting for days to weeks.

- iii) Third phase: Restitution and reorganisation (acceptance) lasting months.

11.15 UNIT END QUESTIONS

1. How do you differentiate between neurosis and psychosis?
2. Explain the types of social phobia.
3. What are the characteristics of obsessive compulsive disorder?
4. Write a short note on somatoform disorder.
5. Explain the management of neurotic disorders in your own words. Illustrate with the help of examples.

11.16 FURTHER READINGS AND REFERENCES

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. American psychiatric Association, Washington, DC: United States of America.

Carson, R. C., Butcher, J. N. & Mineka, S. (1996). *Abnormal psychology and modern life*. New York: Harper Collins College Publishers.

Comer, R. J. (2005). *Fundamentals of abnormal psychology*. New York: Worth Publishers & W. H. Freeman & Company.

Gelder, M., Mayou, R. & Cowen, P. (2001). *Shorter oxford textbook of psychiatry*. New Delhi: Oxford University Press.

Morgan, C. T., King, R.A., Weisz, J. R. & Schopler, J. (1993). *Introduction to psychology*. New Delhi: Tata Mc Graw-Hill Publishing Company Limited.

Sadock, B.J. & Sadock, V.A. (2007). *Kaplan and Sadock's comprehensive textbook of psychiatry*. Philadelphia: Lippincot Williams and Wilkins.

WHO. (2002). *The ICD-10 Classification of mental and behavioral disorders: Clinical descriptions and diagnostic guideline*. New Delhi World Health Organization, Geneva, A.I.T.B.S Publishers and distributors.

UNIT 12 PERSONALITY DISORDERS

Structure

- 12.1 Introduction
- 12.2 Personality and Personality Disorders
- 12.3 Classification of Personality Disorders
- 12.4 Characteristics of Individual Personality Disorders
- 12.5 Factors Contributing to the Development of Personality Disorders
 - 12.5.1 Biological Factors
 - 12.5.2 Psychosocial Factors
- 12.6 Alternative Views on Personality Disorders
- 12.7 Assessment of Personality and Personality Disorders
- 12.8 Course and Outcome of Personality Disorders
- 12.9 General Principles of Management of Personality Disorders
- 12.10 Let Us Sum Up
- 12.11 Glossary
- 12.12 Answers to Check Your Progress Exercises
- 12.13 Unit End Questions
- 12.14 Further Readings and References

12.1 INTRODUCTION

We talk about the personality of one or another person in our day-to-day life. Generally, personality of any individual includes her or his characteristics, traits, behaviour, thinking process etc. Similarly, when someone behaves or reacts, abnormally by we might assume that she or he has some personality disorder. Earlier, personality disorders were known as character disorders. In this Unit, we will study the scientific definition of personality and personality disorders. Further, we will discuss how the different personality disorders are classified by two different systems, that are, the Diagnostic and Statistical Manual Text. Revision (DSM-IV TR) and International Classification of Diseases (ICD) 10th revision. We will also describe the different types of personality disorders in brief. A personality disorder may develop due to some biological and psychosocial factors. In this Unit, we will study about these factors. We will also learn about the tools that help in assessment of the personality and personality disorders. In the end of this Unit, we discuss the general principles of management of personality disorders.

Objectives

After studying this Unit, you will be able to:

- Define personality and personality disorders;
- Enumerate the different personality disorders;

- Outline the unique characteristics of different personality disorders;
- Explain the factors contributing to development of personality disorders;
- Outline the methods of formal assessment of personality disorders;
- Describe the course and outcome of personality disorders; and
- Describe the principles of management of personality disorders.

12.2 PERSONALITY AND PERSONALITY DISORDERS

The term *personality* is derived from the Latin word *persona* which means ‘actor’s mask’. In common usage, we take *personality* to mean a variety of different things, like attractiveness, social effectiveness, etc. We commonly observe that each one of us, in many ways: (1) like all other people, (2) like some other people, and (3) like no one else; and these, taken together, are what constitute our personality. Gordon Allport defined personality as the “dynamic organisation within the individual of those psychophysical systems that determine her or his unique adjustment to her or his environment”. From a structural point of view, it is constituted by *temperament* (basic emotions), *character* (rational concepts about self and interpersonal relations), and *psyche* (intuitive self-awareness and intelligence).

Defining abnormal personality is, however, more difficult. It may be viewed as extremes of normal behaviour, but there is an element of context also involved. A behaviour which may be considered maladaptive in one context (over cautiousness when there is no danger) may be normal in another (over cautiousness when there is some danger). Further, social as well as interpersonal aspects need to be considered when defining abnormal personality. Taking these factors into consideration, the Diagnostic and Statistical Manual-Text Revision (DSM IV-TR) defines *personality disorder* as “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment”.

12.3 CLASSIFICATION OF PERSONALITY DISORDERS

The two internationally accepted classificatory systems — the Diagnostic and Statistical Manual-Text Revision (DSM-IV TR) and International Classification of Diseases (ICD) 10th revision — are not fully in agreement with each other with regard to classification of personality disorders.

The DSM-IV TR describes three broad categories or clusters of personality disorders. These are:

- **Cluster A :** It is characterised by odd or eccentric features; includes paranoid, schizoid and schizotypal (only in DSM-IV) personality disorders.
- **Cluster B:** It is characterised by dramatic, impulsive, and erratic features; includes borderline, antisocial, narcissistic (only in DSM-IV), and histrionic personality disorders.

- **Cluster C** : It is characterised by anxious and fearful features; includes avoidant, dependent and obsessive-compulsive personality disorders.

The DSM-IV TR also includes the proposed categories of depressive personality disorder and passive-aggressive personality disorder in its appendix.

The ICD-10, divides personality disorders as paranoid, schizoid, dissocial, emotionally unstable, histrionic, anankastic, anxious (avoidant) and dependent. Table 12.1 provides descriptions of the different types of personality disorders as detailed in the two classificatory systems.

Table 12.1: DSM-IV and ICD-10 classifications of personality disorders

DSM-IV TR	ICD-10	DESCRIPTION
Paranoid	Paranoid	Suspiciousness of others, preoccupation with “conspiracy theories” of events, and self-referential attitude.
Schizoid	Schizoid	Lack of interest in social relationships, preference of solitary activities, and emotional coldness.
Schizotypal	(classified under <i>schizophrenia and related disorders</i>)	Discomfort in relationships, eccentricities of behaviour, peculiar ideas and appearance.
Antisocial	Dissocial	Disregard for rights of others, law breaking, violent behaviour, and lack of guilt for one’s actions.
	Emotionally unstable—impulsive type	Lack of control over emotions and impulsiveness. Inability to control anger, especially when criticised.
Borderline	Emotionally unstable—borderline type	Intense and unstable relationships, unclear sense of self, threats or acts of self-harm, chronic feelings of emptiness.
Histrionic	Histrionic	Excessive attention seeking, self-dramatisation, egocentricity, and manipulative behaviour.
Narcissistic	—	Sense of grandiosity, lack of empathy, and need for admiration.
Avoidant	Anxious (avoidant)	Persistent tension, self-consciousness, inferiority complex, and social inhibition.
Obsessive-compulsive	Anankastic	Perfectionism, preoccupation with rules and order, and pedantry.
Dependent	Dependent	Submissiveness and clinging behaviour, excessive need for care, feeling helpless when not in a relationship.

Check Your Progress Exercise 1

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. How is 'personality' defined?

.....

.....

.....

2. How are personality disorders classified by DSM-IV?

.....

.....

.....

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

.....

.....

.....

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

.....

.....

.....

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

.....

.....

.....

12.4 CHARACTERISTICS OF INDIVIDUAL PERSONALITY DISORDERS

In this section, we will study some important characteristics of individual personality disorders. These are given below:

1. Paranoid Personality Disorder

Paranoid personality disorder is characterised by an inability to trust others. The individual constantly suspects that others are trying to harm her or him, even when they are close friends or relatives. As a result the person is very secretive because she or he is sure that whatever information she or he might divulge to others will invariably be used against her or him. There is also a tendency to fully remember all the perceived injustice meted out to her or him which is called *injustice collecting* and so the person is often seen as hostile and vengeful towards others. These behaviours take their toll on

family life as there is recurrent suspiciousness about the fidelity of the spouse. What distinguishes paranoid personality from similar conditions like schizophrenia is the absence of other characteristic features of schizophrenia. Persons with this personality disorder have lifelong problems in adjusting with their work and family relationships.

2. Schizoid Personality Disorder

Schizoid personality disorder is characterised mainly by a lack of interest in social relations. Schizoid personalities do not seek, or enjoy the company of other people. They prefer to be alone, often pursuing solitary activities rather than those which require social interaction. They are also seen as indifferent to praise or criticism and show little emotional warmth or attachment. Consequently, they are highly introverted and have few or no friends. Even though schizoid personalities are significantly compromised with regard to social interactions, some of them manage to do well in the professional area as they tend to choose fields which require little human interaction.

3. Schizotypal Personality Disorder

Schizotypal personality disorder is characterised by odd and eccentric behaviour. Such individuals report perceptual and cognitive abnormalities such as *magical thinking* (belief that one's thoughts will cause or prevent events), *bodily illusions* and *paranoid ideation*. They are uncomfortable in social situations, and the discomfort does not reduce with greater familiarity and therefore these personalities lack close friends other than first degree relatives. It is now believed that in some people at least, schizotypal is the premorbid personality before an individual goes on to develop schizophrenia. A substantial minority, however, manage to live normal lives and hold on to a job.

4. Antisocial Personality Disorder

Antisocial personality disorder (called *dissocial personality disorder* in the ICD-10) is characterised by an inability to follow social norms. Most of these individuals, but not all, often take up criminal or antisocial and other law breaking activities. This is accompanied by a lack of regard for the rights of others. The person has little qualms about lying or cheating for her or his own benefit, and has a lack of remorse for one's own actions, which may have adversely impacted the life of others. It is thought that up to 75 per cent of prisoners suffer from antisocial personality disorder. There are also high rates of substance use disorders among antisocial personalities.

5. Borderline Personality Disorder

Borderline personality disorder is characterised by instability in relationships, mood and self-concept. Impulsivity is a characteristic feature, with such individuals spending recklessly, using harmful substances, or being sexually promiscuous. Relationships are intense and unstable, and there are recurrent attempts and threats to kill oneself. People with borderline personality disorder also have a persistently unstable sense of self; vacillating between extremes of being a revengeful aggressor to that of a needy suppliant. Frequent feelings of abandonment in the context of clinging relationships will drive them towards attempts at self-harm. Borderline personalities have a higher than usual incidence of major depressive disorder. This disorder is more commonly seen in women.

6. Histrionic Personality Disorder

Histrionic personality disorder is characterised by excessive attention seeking and dramatisation. Individual with this disorder behave in a flamboyant and colourful manner and try to draw attention by their physical appearance. They are at the same time also self-centered and emotionally shallow. Histrionic personality disorder has a high comorbidity with borderline personality disorder.

7. Narcissistic Personality Disorder

Narcissistic personality disorder is characterised by exaggerated feelings of self-importance and uniqueness. The term is derived from the Greek legend of a very handsome man, Narcissus, who eventually died after falling in love with his own reflection in the water. Narcissistic personalities are not able to empathise with the feelings of others and evidently demonstrate arrogance. However, unlike antisocial personalities, they do not think much of exploiting others for their purposes. Often they face rejection by others and have to suffer disgrace because others do not share their views about their own importance.

8. Avoidant Personality Disorder

Avoidant personality disorder is characterised by high levels of social anxiety. These individuals are not asocial (like schizoid personality), but they feel they are inferior to others and hence will be rejected, if they approach others, and thus, they avoid social situations. There is some speculation that avoidant personality could be a more long lasting variant of generalised social phobia. There is a high comorbidity between avoidant personality and dependent personality disorder. However, many of them do get married and lead normal lives with their families.

9. Dependent Personality Disorder

Dependent personality disorder is characterised by the constant need to cling on to another individual and expecting the other person to take all decisions for oneself. The individual lacks a sense of autonomy and feels uncomfortable when she or he has to make a decision for herself or himself. They tend to always cling onto one relationship or the other as a source of support. They associate with only those people who they can depend on, and there is a tendency to continue in a relationship despite physical and mental abuse. When one relation ends they try to find another. Occupational functioning is impaired as the person finds it difficult to make decisions without help.

10. Obsessive-Compulsive Personality Disorder

Obsessive-compulsive personality disorder is characterised by perfectionism, preoccupation with details, and indecisiveness. Their preoccupation with having everything exactly the way they want leads to incomplete tasks and finding little pleasure in the work itself. They also have an inability to delegate tasks to others unless they conform exactly to their own standards. They are miserly and are of the opinion that money is to be hoarded to avert future catastrophes. Some people with obsessive-compulsive personalities are able to live normal lives, usually choosing jobs which require methodical and detailed work.

Check Your Progress Exercise 2

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. Match the following items:

- | | |
|---------------------------------|---|
| a) Paranoid personality | i) Dramatic and attention-seeking. |
| b) Borderline personality | ii) Odd and eccentric; with referential thinking. |
| c) Anankastic personality | iii) Aloof and emotionally cold. |
| d) Schizotypal personality | iv) Persistent anxiety and feelings of inferiority. |
| e) Schizoid personality | v) Unstable emotionality and interpersonal relationships. |
| f) Histrionic personality | vi) Suspicious and distrustful. |
| g) Anxious-avoidant personality | vii) Preoccupied with perfectionism and rules. |

.....

12.5 FACTORS CONTRIBUTING TO THE DEVELOPMENT OF PERSONALITY DISORDERS

In this section, we will discuss different factors that contribute to the development of personality disorders. Broadly, we can classify these factors under two sub-heads, that is, biological factors and psychosocial factors. Let us first discuss the biological factors that may lead to personality disorders.

12.5.1 Biological Factors

Genetic factors underlying personality traits are reflected as *temperamental characteristics*. The personality trait profiles occur on a continuum with normality; however, these traits when amplified and used in maladaptive ways will contribute to the development of personality disorders. The genetic vulnerability or diatheses as reflected in the temperamental profile interacts with specific environmental conditions that are stressful for the individual, thus leading on to personality pathology, as per the stress-diatheses model of personality disorders. Personality traits have been shown to be heritable, with genetic factors accounting for more than half of the variance. Biological markers linked to personality traits or personality disorder clusters may reflect the influence of underlying genetic factors. For example, abnormal eye tracking is commonly associated with Cluster A personality disorders, while low levels of central serotonin activity as well as prefrontal functional abnormalities have been most robustly linked to impulsivity in Cluster B disorders. Another interesting evidence that points towards a genetic influence

underlying personality traits and Axis I disorders is the observation that first-degree relatives of patients with Cluster A personality disorders have higher prevalence of schizophrenia spectrum disorders; those of patients with Cluster B personality disorders; have impulse dyscontrol and mood disorders; while those of patients with Cluster C personality disorders have predominantly anxiety disorders.

12.5.2 Psychosocial Factors

Some of the major psychosocial factors responsible for the development of personality disorders are as follows:

1. Early Childhood Experiences

Early childhood experiences play a significant role in the development of personality disorders. Research on patients with various personality disorders has shown that early adversities like neglect, childhood physical and sexual abuse make a person more susceptible to personality disorders in later life. It is more often the cumulative effect of multiple events and experiences which put an individual at higher risk. However, resilience to childhood adversity varies among individuals; in fact some individuals go on to live normal lives despite severe emotional trauma during early development. Amongst the developmental antecedents that increase the risk of personality disorders, childhood physical, sexual and emotional abuse, and neglect constitute the most important factors.

Childhood Physical Abuse (CPA) refers to physical injury inflicted on a child. Individuals with antisocial personality disorder and borderline personality disorder report a history of CPA more than other personality disorders.

Child Sexual Abuse (CSA) refers to an adult forcing a child into indulging in sexual activity. Overall, patients with personality disorders are more likely to report having suffered CSA than those with other psychiatric conditions. Those with borderline personality disorder and histrionic personality disorder are especially more likely to have suffered long-term CSA than others. Childhood emotional abuse includes verbal abuse, humiliation, and psychological maltreatment that damage the child's feelings and sense of self worth. Patients with borderline personality disorder report a history of childhood verbal abuse more than others. Childhood emotional abuse is thought to be associated with many personality disorders including narcissistic, obsessive-compulsive, and paranoid personality disorders. It is also associated with suicidality, poor self-esteem and other depressive traits.

Childhood neglect refers to denying the child's basic physical, emotional and psychological needs which are essential for healthy development of personality. Childhood neglect is known to be associated with attachment difficulties, antisocial and self-destructive behaviour. Patients with borderline personality and schizoid personality report higher rates of emotional and physical neglect.

2. Family Factors

As can be inferred from the preceding discussion, the family plays a key role in personality disorders. The developing personality may be adversely

affected by parents who do not show warmth and affection, spend time or communicate adequately with the child. More specifically, lack of parental affection has been shown to be associated with the development of antisocial personality symptoms, while overprotective parenting could be associated with schizoid personality. Parental unavailability, insensitivity and intrusiveness in early childhood might interfere with the establishment of a stable sense of self leading on to the development of borderline personality disorder. Death of a parent, divorce and separation, can all make children susceptible to develop personality disorders in later life. There is a need, therefore, for family interventions as a preventive means of reducing personality disorder. Parents should also be taught more effective child rearing practices. Presence of parental psychiatric disorder and marital discord need to be looked into and treated to ensure better care and social support for the children.

Erik Erikson in 1963, hypothesised that children growing up in supportive environments develop trust in others, autonomy and self-esteem. Thus, the family is, perhaps, the single most important protective factor against development of personality disorders. Parental empathy and support help nurture the personality of the child. When children develop a close and strong relation with their parents, it makes them resilient to stressful events in later life. Outside of the family, teachers, peers and community helps the individual develop adaptive personality traits. Active participation in extra-curricular activities like sports and arts can help nurture self-esteem and resilience, and a sense of self efficacy in the child.

3. Psychological factors

Freud believed that fixation in various psychosexual stages influence the development of maladaptive personality traits. Fixation at the oral, anal and genital stages lead to dependent, obsessional and histrionic personalities, respectively. According to the psychodynamic perspective, the defense mechanism which a person uses to resolve conflicts between the *id*, *ego*, and *superego* determines her or his personality. Paranoid personalities, for instance, use projection, a process of projecting one's feelings on to others resulting in the faultfinding behaviour and excessive sensitivity to criticism. Schizoid personalities use withdrawal and excessive fantasy thinking, wherein they seek satisfaction by creating imaginary friends and lives, thereby becoming aloof and asocial. Histrionic personalities, who are often seen as dramatising and emotionally shallow, use denial as a major defense mechanism whereby the individual 'denies' the existence of unpleasant feelings by substituting them with pleasant ones. Splitting is a defense mechanism used primarily by borderline personalities who tend to classify people as all good or all bad, leading to their vacillating between idealising people and hating them.

Cognitive theory views personality disorders as arising out of maladaptive schemas and beliefs about self, others and the world. Cognitive therapies aim to help the personality-disordered individual change her or his maladaptive schemas and beliefs about herself or himself, others and the world.

Check Your Progress Exercise 3

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Enumerate the psychosocial factors that are responsible for the development of personality disorders.

.....

2. Describe some of the maladaptive defense mechanisms used by personality-disordered individuals.

.....

12.6 ALTERNATIVE VIEWS ON PERSONALITY DISORDERS

The categorical perspective of conceptualising abnormal personality, as epitomised by the DSM-IV and ICD-10 classificatory systems, pre-supposes that personality disorders are “qualitatively distinct clinical syndromes”. However, in clinical practice this assumption has been found to be inaccurate. Many patients meet criteria for multiple personality disorders, while patients within the same diagnostic category might differ substantially from one another. Moreover, the threshold for making a diagnosis of a particular personality disorder in a given individual with maladaptive personality traits is very often arbitrary. This has necessitated the emergence of various alternate conceptualisations of abnormal personality, the most influential of which are the dimensional models. Dimensional approaches such as *Cloninger’s Seven Factor Model* and *Costa & McCrae’s Five Factor Model* conceptualise abnormal personality traits as maladaptive variants of otherwise continuously distributed personality traits.

The *Seven Factor Model*, by Robert Cloninger, assesses normal as well as abnormal personality traits. Cloninger has drawn extensively from psychometric, neuropharmacological and neuroanatomic studies (among others) in developing his hypothesis. He proposed the existence of four ‘temperaments’, which are heritable and remain stable throughout life, and these include novelty seeking (behavioural activation: interest in new experiences), harm avoidance (behavioural inhibition: sensitivity to aversive situations), reward dependence (behavioural maintenance: sensitivity to reinforcement), and persistence (frustration tolerance). Additionally, Cloninger proposed three ‘characters’, which evolve as a function of temperament and individual experiences that include *self-directedness* (goal-focus), *cooperativeness* (helpful empathy) and *self-transcendence* (imaginative unconventionality).

The *Five-Factor Model* (FFM) of Costa and McCrae describes five domains of personality that are, openness to experience, conscientiousness, extraversion or introversion, agreeableness or antagonism and neuroticism (easier remembered by the acronym OCEAN).

12.7 ASSESSMENT OF PERSONALITY AND PERSONALITY DISORDERS

In this section, some of the commonly used interviews and questionnaires used in the assessment of personality disorders according to DSM and/or ICD criteria are described, followed by the two most commonly used instruments for assessment of personality dimensions.

The *Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV)* is a structured interview consisting of 398 items for diagnosis of DSM-IV personality disorders. The interview aims at assessing personality traits during the two years prior to the interview.

The *International Personality Disorders Examination (IPDE)* is a semi structured interview schedule with 537 questions to assess both DSM and ICD criteria for personality disorders. The interviewer first administers a 77 item true-or-false screener and goes on to the proper interview. The questions are organised by area: work, self, interpersonal relationships, affects, reality testing, and impulse control. To meet the criteria, it is necessary that at least some traits should be present before 25 years of age.

The *Structured Interview for DSM-IV Personality Disorders* is a semi-structured interview schedule with 101 items for diagnosis of DSM-IV personality disorders. Each item is rated from 0 (not present) to 3 (strongly present). For a diagnosis to be made, the traits must have been present for a majority of time during the previous 5 years.

Among self-administered questionnaires, the *Millon Clinical Multiaxial Inventory-III (MCMI-III)* is a 175 item true or false questionnaire which tests both Axis I and Axis II disorders. It is one of the most widely used questionnaires in research as well as clinically. *Minnesota Mutiphasic Personality Inventory (MMPI)* is a 154 item true or false questionnaire. Though it is extensively used, it has not yet been coordinated with the DSM classification of personality disorders. Other questionnaires include the *Personality Diagnostic Questionnaire-4 (PDQ-4)* and the *Wisconsin Personality Inventory*.

Temperament and Character Inventory (TCI) is a 240 item self-administered questionnaire based on Robert Cloninger's seven factor dimensional model. Based on the responses of patients to the individual items in this inventory, personality disorders may be reconceptualised along the 4 temperament and 3 character dimensions as mentioned before. For example, dependent personality is characterised by low self-directedness and self-transcendence but high cooperativeness; Cluster A personality disorders are marked by low reward dependence, Cluster B by high novelty seeking, and Cluster C by high harm avoidance.

The *Revised NEO Personality Inventory* is a 240 item self administered questionnaire that assesses the five factor model. This is intended to assess the five factors of personality (according to the five factor model—

neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness—and the six facets of each of these domain. For instance, the facets of neuroticism would include depression, anxiety, angry hostility, self-consciousness, vulnerability, and impulsiveness. Subjects have to respond to items like ‘I often feel tense or jittery’ (neuroticism), ‘I think most people I deal with are honest and trustworthy’ (agreeableness or antagonism), and ‘I really like most people I meet’ (extroversion or introversion). People with schizoid and avoidant personality, for instance, are high on introversion, and borderline personality is most strongly related to neuroticism.

Check Your Progress Exercise 4

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Fill in the blanks:

- (i) The Temperament and Character Inventory for assessment of the 7 dimensions of personality was proposed by
- (ii) Two common diagnostic interviews used for formal assessment of personality disorders are and
- (iii) Two common self-administered questionnaires for assessment of personality dimensions are and

12.8 COURSE AND OUTCOME OF PERSONALITY DISORDERS

DSM-IV defines personality disorder as “an enduring pattern of inner experience”, the ‘endurance’ manifesting in patterns of thought, emotionality, interpersonal and social functioning. Both classificatory systems (DSM and ICD) emphasise the idea that personality disorders are stable. All personality disorders usually emerge in mid to late adolescence, with the behavioural disturbance in adolescence continuing into adulthood. The prevalence of personality disorder varies from 0.5 to 2.5 per cent in the general population, and is more common in men than women. Only rarely do such individuals seek treatment for themselves; often they are brought for treatment by the spouse or referred by employers. Personality disorders usually last very long, but not necessarily for life, and in some, like antisocial personality, the symptoms improve as the person grows older. Paranoid personalities sometimes go on to suffer from schizophrenia. They usually have lifelong problems with work and interpersonal relations. It has been reported that 10 per cent of those with schizotypal personalities eventually committed suicide, though some people still manage to live normal lives, work and run a family. Antisocial and histrionic personalities commonly develop substance use disorders. Borderline personalities usually suffer from comorbid depressive disorders. Narcissistic personalities are very difficult to treat. They often have to suffer due to experiences which do not reinforce their beliefs about themselves. Dependent personalities find it difficult to work as they require

constant supervision and they tend to relate only to people on whom they can depend. Some individuals with obsessive-compulsive disorder go on to live normal lives while in others it is the harbinger of schizophrenia or major depressive disorder.

Longitudinal studies have suggested that Cluster B personality disorders have the highest diagnostic stability while Cluster A personality disorders have the lowest. A recent study has reported that symptomatic improvement in patients with borderline personality disorder may be more than what is generally believed. The Collaborative Longitudinal Personality Disorders Study (of schizotypal, obsessive-compulsive, borderline and avoidant personality disorders) observed that, at 12 months, remission rates ranged from 23 per cent (in the case of schizotypal personality disorder) to 38 per cent (in the case of obsessive-compulsive personality disorder) with all the 4 personality disorders showing improvements over a 2 year period. However, in contrast to symptomatic improvement, these patients showed less significant and more gradual improvement in their social and 'real life' functioning.

12.9 GENERAL PRINCIPLES OF MANAGEMENT OF PERSONALITY DISORDERS

The management of personality disorders should constitute a collaborative approach between the psychiatrists, psychologists, psychiatric social workers and family therapists, involving a judicious and optimal combination of pharmacological and non-pharmacological interventions. No single modality of treatment has been shown to be effective for all personality disorders and in fact, certain therapies are contraindicated in specific personality disorders; therefore, the treatment plan has to be devised according to the needs of the individual patient.

The various treatment approaches include psychopharmacology, cognitive-behavioural approaches such as dialectical behaviour therapy and schema therapy, psychodynamic psychotherapies, psychoanalysis, interpersonal therapies and family therapy. All cognitive-behavioural therapies aim at changing the underlying beliefs which are maladaptive, and training the individual in adaptive behaviours and skills.

12.9.1 Management of Individual Personality Disorders

Management of some of the personality disorders is discussed below:

1. Paranoid Personality Disorder

Pharmacological interventions include low doses of antipsychotics which can help reduce the quasi-delusional thinking. Psychotherapy for paranoid personality requires an understanding of the fact that the patient finds it difficult to trust others, so any effort by the therapist at confronting will be misinterpreted. Instead, the therapist should be professional and non-intrusive. Therapy should be aimed at treating problems like excessive threat perception, which is often a consequence of faulty interpretation of other people's intentions. Paranoid individuals have deficits in certain metacognitive skills such as decentering, or the ability to look at events from other people's perspective. They also have difficulty in distinguishing fantasy and reality, so

an imagined threat gains the same prominence as a real one. The therapist can work on such specific issues in a cognitive therapeutic framework to help the person deal more effectively with situations in her or his occupational and interpersonal areas. Family therapy approaches focus on involving the spouse in treatment to reduce mistrust and suspicion. Marital therapy also aims to enhance positive growth of the couple and to enable the spouse to deal more efficiently with the maladaptive personality traits of the patient.

2. Schizoid Personality Disorder

Some patients benefit from low-dose antipsychotics and/or selective serotonin reuptake inhibitors (SSRIs). Cognitive therapy aims at teaching specific cognitive skills such as perspective taking (being able to look at events from other people's point of view). Social skills training to improve the quality of interaction in interpersonal contexts is important for fostering more effective social interactions.

3. Schizotypal Personality Disorder

Antipsychotic medications can help reduce illusions and referential ideas seen in this disorder. Obsessive-compulsive symptoms tend to would benefit from treatment with SSRIs. Psychotherapy should aim at improving social skills, considering that social ineptitude is one the prominent features of the condition. The patient may be given role playing tasks where they can practise more appropriate behaviours in a supervised setting. One of the most important aspects of therapy in this disorder is to help the patients use the evidence from the environment to evaluate their thoughts rather than relying on their own emotions. This way the patients can be helped to question their irrational thoughts and begin to change them.

4. Antisocial Personality Disorder

Pharmacotherapy is used primarily to counter symptoms of anxiety, rage, etc. Drugs such may be useful in the presence of residual attention-deficit hyperactivity symptoms. Dynamic psychotherapy is contraindicated in patients with a history of long standing, violent behaviour and a total lack of remorse for their actions. Psychotherapy should focus on specific problem solving strategies. The patient can be provided with alternative ways of responding to events; impulse control training and anger management can provide the patient with healthy strategies to replace her or his maladaptive behaviours.

Group therapy and social skills training, especially in settings such as jails can help patients learn healthier behavioural strategies. In family therapy, the therapist should attempt to encourage the family to not collude with the antisocial person in her or his maladaptive behaviours, while improving their ability to provide mutual support in protecting themselves against her or his unpredictable behaviours. The primary aims of family therapy in adolescents with evolving antisocial personality disorder include preventing the family from acting inconsistently with the adolescent. When limits are set and consistently enforced, there are higher chances that antisocial behaviour will reduce.

5. Borderline Personality Disorder

The role of pharmacotherapy in treatment of borderline personality disorder includes treatment of mood fluctuations and impulsivity using antidepressants

and/or anticonvulsant mood stabilisers and treatment of brief-lasting or quasi-psychotic episodes using low-dose antipsychotics. Borderline personalities believe that the world is a dangerous place, that they are helpless and that they will be abandoned by others owing to them being undesirable. Cognitive therapies aim at changing this pattern of thinking by encouraging the patient to test these maladaptive schemas against past experiences and reality. The patient is also trained to challenge the tendency to perceive everything in black and white (dichotomous thinking).

The psychodynamic approach to borderline personality disorder specifies the following five treatment goals: reducing the splitting process; interacting with others as a “whole person”; reducing stereotypic behaviours; resetting external boundaries for intergenerational systems; resetting internal boundaries for parent-child, spousal and sibling subtypes; and limiting intrusiveness of parents and children.

Three common family types have been described in borderline personality disorder. These are over involved family; rejecting family; and idealising or denying family. Therefore, family therapy approaches mainly address the diffuse boundaries that result in repetitive and conflicting communications and the absence of problem solving with the objective of promoting healthy connectedness of the family subsystems. Couples therapy has as its focus the objective of encouraging the partners to become open to the other person’s point of view, respect differences between the partners and arriving at negotiated, mutually accepted solutions.

Dialectical Behaviour Therapy

Dialectic-Behaviour Therapy (DBT), which was introduced by Marsha Linehan, is widely used in the treatment of borderline personality. Borderline personality is viewed as a disorder of dysregulation of behaviour, affect, thought processes and interpersonal behaviour, according to DBT. DBT has three goals as proposed by Linehan: control of extreme emotions and behaviour; tolerating distress; and trusting one’s own thoughts and emotions. The therapy aims at enabling the patients to acquire specific skills such as distress tolerance, emotional regulation, mindfulness and interpersonal effectiveness. Mindfulness trains the individual to remain in the present without any kind of judgement. Because borderline personalities suffer from problems of dichotomous thinking, DBT therapy replaces the “either/or” thinking with “yes/and” type of thinking. The dialectic approach assumes that the patients are doing their best, that they are not responsible for all their problems, and that it is only the therapy (and not the patient) which can fail. Such an approach helps reduce distress of the patients and motivates them to continue in therapy. The theoretical underpinnings of this approach can be traced to Hegel’s philosophy of dialectics. For instance, if a patient likes a job (*thesis*), but is distressed by some of the work it entails (*antithesis*), the aim of the therapy would be to help the person understand that she or he can love her or his job even when disliking parts of it (*synthesis*). Thus, the conflict which the situation produces can be resolved. DBT draws heavily from dialectic philosophy, learning principles and mindfulness techniques in Zen. The learning element involves removal of reinforcers for maladaptive behaviours, and reinforcement of adaptive behaviours.

6. Histrionic Personality Disorder

Pharmacological intervention in histrionic personality targets anxiety and/or depressive symptoms using anxiolytics and antidepressants respectively. Psychotherapy aims to facilitate setting of clear and realistic goals, which counters the histrionic personality's tendency to set vague goals. Self-monitoring of cognition is helpful in controlling impulsivity. The patient is trained in challenging assumptions like beliefs of inadequacy by using problem solving and similar strategies. The patients are also made to think about worst case scenarios, effectively decatastrophising their beliefs about rejection. Social skills training would help patients use more effective skills to improve the quality of social interaction.

7. Narcissistic Personality Disorder

Mood stabilizers can be used in cases where mood swings are present, while antidepressants may be helpful in alleviating depressive symptoms. Psychotherapy aims at helping the patient take responsibility for her or his actions, and reducing cognitive distortions. Systematic desensitisation can be used to reduce the patient's hypersensitivity to criticism and role playing can provide the patient insight into the reactions and feelings of others in response to her or his attitude and behaviours. There are also specific cognitive interventions which target belief systems, such as replacing the patient's usual way of thinking with statements which emphasise the importance of others' feelings too. Relationship enhancement couples therapy is used to help narcissistic personalities acquire skills such as empathy, effective expression, discussion and problem solving/conflict resolution. The therapist demonstrates these skills and the couples have to practise them with each other.

8. Avoidant Personality Disorder

Serotonergic medications (SSRIs) can help reduce social anxiety and rejection sensitivity in anxious-avoidant personalities. There is also some evidence that drugs can increase novelty seeking behaviour in such individuals. Anxiety is a prominent feature of avoidant personalities; so cognitive-behavioural interventions focus on training in relaxation using *Jacobsen's Progressive Muscle Relaxation (JPMR)*, applied relaxation, biofeedback training etc. Cognitive approaches focus on increasing emotional tolerance using desensitisation and reframing, while decatastrophising disapproval and rejection. Social skills training would improve the patient's confidence in enhancing social interactions.

9. Dependent Personality Disorder

Pharmacotherapy largely involves use of anxiolytics and antidepressants. The basic goal of psychotherapy is to increase autonomy and self efficacy. Socratic questioning can be used to help the patients to make their own decisions rather than relying on others. Anxiety management can also help the patients focus on independent decision making. The patient may also benefit from assertiveness and social skills training as they usually perceive themselves as socially inept.

There is evidence for the effectiveness of general techniques to reduce enmeshment between family members, encouraging the patients to socialise and maintain work outside of home.

10. Obsessive-Compulsive Personality Disorder

Selective serotonin reuptake inhibitors (SSRIs) are useful for improving obsessive inflexibility interfering with optimal performance. Cognitive restructuring and other problem-centered approaches will help in bringing down ruminations, procrastination and indecisiveness. Response prevention and desensitisation can also help in treating this disorder.

Check Your Progress Exercise 5

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Indicate whether the following statements are true or false:

(i) Psychoanalysis is useful for treatment of all personality disorders.

.....

(ii) Low dose antipsychotic medications are useful for treatment of Cluster A personality disorders.

.....

(iii) Dialectical Behaviour Therapy is used primarily for treatment of borderline personality disorder.

.....

(iv) Jacobsen's Progressive Muscle Relaxation is used in the treatment of schizoid personality disorder.

.....

12.10 LET US SUM UP

Personality disorders are enduring patterns of deviant inner experiences and behaviour which lead to distress or impairment of social and/or occupational functioning. Depending on the predominating characteristics, the DSM-IV describes three clusters of personality disorders. Cluster A personalities are characterised by behavioural oddities and eccentricities (paranoid, schizoid, and schizotypal); Cluster B personalities show dramatic and impulsive features (borderline, antisocial, narcissistic); and Cluster C personality disorders are characterised by anxious features (avoidant, dependent, obsessive-compulsive). According to the diathesis-stress model of personality disorders, temperamental traits are inherited characteristics which interact with stressful environmental factors resulting in personality disorders. Other factors which contribute to personality disorders include early childhood experiences, family environment and other psychological factors.

Personality disorders are assessed by using structured interviews like the Diagnostic Interview for DSM-IV Personality Disorders and the International Personality Disorder Examination and self-administered questionnaires like Minnesota Multiphasic Personality Inventory and Millon Clinical Multiaxial Inventory-III. Other self-administered questionnaires such as Temperamental and Character Inventory and the Revised NEO Personality Inventory are commonly used to assess personality traits or dimensions. In the general

population, personality disorders are present in 0.5 to 2.5 per cent of the population with an over representation of men among the sufferers. Patients with personality disorders often do not seek help for themselves but are brought by family or friends. Personality disorders usually last very long, but not necessarily for life, and in some, the symptoms improve as the person grows older. Management of personality disorders involves a judicious combination of biological and psychosocial interventions, customised to meet the needs of each individual patient. Pharmacological interventions include the use of anti-depressants, anxiolytics, mood stabilizers or antipsychotics, depending on the requirements of the patient, while psychological interventions include cognitive behaviour therapies, group therapies, anxiety management, social skills training etc.

12.11 GLOSSARY

Character	: Rational concept about self and interpersonal relations.
Childhood neglect	: Denying the child's basic physical, emotional and psychological needs which are essential for healthy development of personality.
Childhood physical abuse (CPA)	: Physical injury inflicted on a child.
Child sexual abuse (CSA)	: An adult forcing a child into indulging in sexual activities.
Injustice collecting	: A tendency to fully remember all the perceived injustice meted.
Magical thinking	: Belief that one's thoughts will cause or prevent events.
Psyche	: Intuitive self awareness and intelligence.
Temperament	: Basic emotions.

12.12 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Personality can be defined as the dynamic organisation of temperamental and character traits within an individual that determines her or his unique adjustment with her or his environment.
2. Depending on the predominating characteristics, the DSM-IV describes three clusters of personality disorders. Cluster A personalities are characterised by behavioural oddities or eccentric features (paranoid, schizoid, and schizotypal); Cluster B personalities show dramatic, impulsive and erratic features (borderline, antisocial, narcissistic and histrionic); and Cluster C personality disorders are characterised by anxious and fearful features (avoidant, dependent and obsessive-compulsive).

3. The characteristic features of Cluster A personality disorders are odd and eccentric features.
4. The characteristic features of Cluster B personality disorders are dramatic, impulsive and erratic features.
5. The characteristic features of Cluster C personality disorders are anxious and fearful features.

Check Your Progress Exercise 2

1. a) vi, b) v, c) vii, d) ii, e) iii, f) i, and g) iv.

Check Your Progress Exercise 3

1. Following are the psychosocial factors that are responsible for the development of personality disorders:
 - i) Early childhood experiences like child physical abuse, child sexual abuse or childhood neglect;
 - ii) Family factors like lack of parental affection, overprotective parenting, parental unavailability, insensitivity or intrusiveness etc.; and
 - iii) Psychological factors.
2. Some of the maladaptive defense mechanisms used by personality-disordered individuals are like paranoid personalities, for instance, use projection, a process of projecting one's feelings on to others resulting in the faultfinding behaviour and excessive sensitivity to criticism. Schizoid personalities use withdrawal and excessive fantasy thinking, wherein they seek satisfaction by creating imaginary friends and lives, thereby becoming aloof and asocial. Histrionic personalities, who are often seen as dramatising and emotionally shallow use denial as a major defense mechanism whereby the individual 'denies' the existence of unpleasant feelings by substituting them with pleasant ones. Splitting is a defense mechanism used primarily by borderline personalities who tend to classify people as all good or all bad, leading to their vacillating between idealising people and hating them.

Check Your Progress Exercise 4

1. (i) Robert Cloninger
 (ii) International Personality Disorders Examination (IPDE) and Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV)
 (iii) Temperament and Character Inventory (TCI) and Revised NEO Personality Inventory

Check Your Progress Exercise 5

1. (i) False
 (ii) True
 (iii) True
 (iv) False

12.13 UNIT END QUESTIONS

1. Describe the principles of management of personality disorders.
2. Describe the course and outcome of any three personality disorders.
3. What are the principles underlying Dialectical Behaviour Therapy in borderline personality disorder?
4. Describe the role of early childhood experiences and family environment in the development of personality disorders.
5. What is the role of marital and family interventions in the management of personality disorders?

12.14 FURTHER READINGS AND REFERENCES

Diagnostic and Statistical Manual of Mental Disorders, Text Revision. (2000). Washington, DC: American Psychiatric Association.

Diamaggio, G. *et al.* (2007). *Psychotherapy of personality disorders*. London: Routledge.

Livesley, W.J. (2003). *Practical management of personality disorders*. New York: Guildford Press.

Magnavita, J.J. (Ed.) (2004). *Handbook of personality disorders*. New Jersey: John Wiley and Sons.

Semple, D. *et al.* (2005). *Oxford handbook of psychiatry*. New York: Oxford University Press.

Sperry, L. (1995). *Handbook of diagnosis and treatment of the DSM-IV personality disorders*. New York: Brunner/Mazel Publishers.

Svarkic, D.M. & Cloninger, C.R. (2005). Personality Disorders. In B.J. Sadock, V.A. Sadock (Eds.), *Comprehensive textbook of psychiatry*. Philadelphia: Lippincott Williams and Wilkins.

UNIT 13 DEPRESSION, GRIEF AND SUICIDE

Structure

13.1 Introduction

13.2 Depression

- 13.2.1 Terminology and Manifestations of Depression
- 13.2.2 How Depression Affects the Individual
- 13.2.3 Sub-types of Depression
- 13.2.4 Epidemiology of Depression
- 13.2.5 Causes, Risk Factors and Course of Depression
- 13.2.6 Evaluation and Treatment of Depression

13.3 Grief

- 13.3.1 Features of Normal Grief
- 13.3.2 Features of Abnormal Grief
- 13.3.3 Distinguishing Grief from Depression
- 13.3.4 Sociocultural Correlates of Grief and Interventions

13.4 Suicide

- 13.4.1 Terminology Related to Suicide
- 13.4.2 Epidemiology of Suicide
- 13.4.3 Causation and Theoretical Models of Suicide
- 13.4.4 Risk Factors and Assessment of Risk
- 13.4.5 Intervention and Postvention

13.5 Let Us Sum Up

13.6 Glossary

13.7 Answers to Check Your Progress Exercises

13.8 Unit End Questions

13.9 Further Readings and References

13.1 INTRODUCTION

Depression is one of the common psychiatric disorders which produce a significant impact on the individual, family and society. It has fairly recognisable clinical features, course, outcome and several tested treatments.

Grief is a universal experience following a significant loss. Sometimes grief can become abnormal and can lead to significant dysfunction and co-morbidity such as depression.

Suicide and attempted suicide may have various causes and contributory factors. From a mental health perspective, it is necessary to be aware of the risk factors of suicide and measures to be taken to mitigate the risk. Risks of suicide are high in depression and grief.

Objectives

After studying this Unit, you will be able to:

- Explain the clinical features of depression;
- Discuss the course, outcome, causes and treatment of depression;
- Understand the features and treatment of grief;
- Learn the approaches to understanding suicide and attempted suicide; and
- Describe the methods of management of suicidality.

13.2 DEPRESSION

Depression is a term that has several meanings in lay usage. It is used to denote a mood, an attitude, a lack of interest etc. Further, people may specifically use the term ‘mental depression’ as against physical forms of depression. Mental health professionals use the term ‘Depression’ to connote a symptom, a sign, a syndrome and a disorder in different contexts. With these multiple meanings attached to the word, much confusion often prevails in the understanding of depression — the disorder.

For our purpose, when we use the term depression we will mean ‘Clinical depression’ or depression — the disorder and its variants. This implies a specified group of symptoms which occur together in the affected individual over a specified period of time forming a condition that is amenable to reliable diagnosis and intervention.

13.2.1 Terminology and Manifestations of Depression

There is general agreement about what constitutes depression in different classifications of mental disorders. The important point is that the mood of sadness is persistent over a period of time (usually defined as at least two weeks) in depression whereas it is transient and evanescent in normal day to day fluctuations of mood. The depressed mood is associated with despair and impairment of functioning in contrast to the normal state of the individual.

The depressed person may experience fatigue, anxiety, worry, irritability and loss of interest or pleasure. Reactivity to positive occurrences appears blunted or lost. Biological functions may be disturbed in that the individual may suffer insomnia typically with early morning awakening, early morning worsening of the mood, impaired appetite, loss of weight, constipation, slowing down, low energy level and loss of libido (these features are also referred to as *melancholic* or *somatic features*).

Thinking is experienced as muddled, with poor concentration, subjective forgetfulness, difficulty in making decisions and ambivalence. The depressed individual often has a low self esteem and may be self critical. Thoughts of feeling worthless, helpless and hopeless are often going through the mind with little or no valid reason. Sometimes the depressed person may also harbour notions of guilt, sin, *death wish* (a passive form of desire to die) and *suicidal thoughts* (actively contemplating or seeking death). Further, suicidal plans may evolve and person may involve in suicidal acts sometimes with fatal consequences.

In the elderly with depression there may also be prominent anxiety and restlessness. There may also be a strong preoccupation with bodily functions, unreasonable fear of disease or impairment of some organs and unexplained physical symptoms like aches, pains despite reassurances to the contrary.

When the depression is severe, the individual may experience certain psychotic symptoms which suggest a significant departure from reality. These may be in the form of *hallucinations* (seeing, hearing, smelling or otherwise perceiving experiences when there is no stimulus to perceive), *delusions* (harbouring false beliefs without basis and despite contrary evidence) or severe disturbance of volition in the form of maintaining odd postures or becoming mute.

In some situations the classical melancholic features of depression may get altered or reversed so that instead of insomnia the patient may suffer hypersomnia, instead of loss of appetite there may be overeating and weight gain. Such patients (usually young depressed or bipolar depressed) may also experience extreme inertia or heaviness of the body (also referred to as leaden paralysis) and heightened sensitivity to perceived rejection by others.

The presentation of depression may change subtly depending on the level of care where the patients consult the doctor. For example, at the primary care level, a sizeable number of patients may present originally with a variety of physical symptoms (headache, body ache, neck pain, burning sensation in different parts of the body, indigestion, 'gas') which seem to have no discernible medical explanation. It is here that appropriate questions should be asked in the interview to elicit the core depressive symptoms. Similarly at a mental hospital or an acute psychiatric care unit one will see cases of classical severe depression. In specialty medical clinics such as cardiology, gastroenterology, urology and neurology, we may come across patients who present with symptoms referable to the system to which the clinic belongs but with no confirmatory investigative evidence of any organ dysfunction or disease. Once again, specific interviewing will reveal the diagnosis of depression. A word of caution here is that depression and medical disorders are not mutually exclusive and both can coexist in the same person, making the diagnosis more difficult.

The International Classification of Diseases-10 (ICD-10) of the World Health Organisation (WHO) uses the following criteria to make a diagnosis of "Depressive episode" (depressive disorder or clinical depression):

- Depressed mood, loss of interest and enjoyment, increased fatiguability are the core features of depression.
- Other symptoms include reduced concentration/attention, reduced self-esteem and self-confidence, ideas of guilt and unworthiness, bleak and pessimistic views of the future, ideas or acts of self-harm or suicide, disturbed sleep and diminished appetite.
- The depressed mood varies little from day to day and is often unresponsive to circumstances. It may show spontaneous diurnal variation.
- The above mentioned symptoms should have been continuously present for a period of at least two weeks.

- The ICD differentiates between mild, moderate and severe depression on the basis of the number of the above mentioned symptoms in the individual.
- Some symptoms are of special significance and are called “*somatic symptoms*” (akin to melancholic symptoms in other classifications). They are — loss of interest or pleasure in activities that are normally enjoyable, lack of emotional reactivity to normally pleasurable surroundings and events, waking in the morning two or more hours before the usual time, depression worse in the morning, psychomotor slowing down or agitation, marked loss of appetite, marked weight loss (5% or more of the normal weight lost in the past month) and marked loss of libido.

Check Your Progress Exercise 1

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List important features of depression.

.....

.....

.....

.....

.....

13.2.2 How Depression Affects the Individual

Depression is perhaps the most painful experience suffered by mankind. People who have been through an episode of depression have used terms such as ‘psychic pain’, ‘cancerous pain of the mind’, ‘bottomless pit of suffering’ and other phrases to describe their agony. Depression has also been described as a ‘pall of gloom which has descended over the mind’.

Although the individual going through depression can feel it, it is obvious to the observer only when the condition is of moderate severity or more. The depressed person perceives a chronic sense of sadness and lack of joy coupled with an often unexplained lack of interest. Things and life start appearing bleak or pointless. Routine activities start appearing burdensome to the individual. Interpersonal contacts appear laboured and unappealing. Uniquely with depression, in the initial stages the individual may recognise what is wrong and want to change it but the illness affects ‘the will’ also and hence we see the situation where the patient finds it difficult to help himself.

With increasing severity of depression, mental abilities seem to lose their sharpness, even the simplest tasks appear onerous and the person suffers a loss of self esteem. With declining functional ability, work, interpersonal contact and even personal care gets affected giving rise to a self critical attitude. With the occurrence of negative thoughts, especially such as hopelessness, wishes of death and suicide start occurring. In moderate to severe depression the individual may find himself isolated and with significant dysfunction.

Sometimes when anxiety is a prominent feature the patient may be agitated and difficult to pacify. When psychotic symptoms intervene, they too would modify behaviour.

Case Vignette 1

Mr. A, a 45 year old male from a middle income household, a factory worker by occupation, was noted to be not actively involved with his assigned work by his supervisor in the work place over several days a month after he had been promoted to a higher grade. He was not interacting with his fellow workers as he used to do earlier and would sit in a place and on enquiry, complained of weakness. After a few weeks he started absenting from work and on enquiry, his family reported that he would stay at home in bed most of the day. He would not do his daily chores unless coaxed. He would complain of feeling tired. He was not paying interest in the daily happenings in the house, would not meet his friends or enquire after the children or their studies. He had a hobby of watching television serials earlier which he now shunned. His eating had reduced and he refused good food, participation in social functions and had a dull or 'sad' look on his face most of the time. His libido had completely disappeared. On occasion he had expressed negative thoughts to his spouse. He felt alone, cutoff and helpless and rarely mentioned that there was no hope for him. He also complained of constipation, bodily aches and sleeplessness. In the mornings he would feel unrefreshed and would be irritable if asked to involve himself in any activity.

There was no evidence of any substance use. Mr. A was previously a well adjusted, hardworking and outgoing individual. There was a family history of depression in his father the details of this were not clear.

He was taken for a consultation to his factory doctor who after examining him and doing routine tests found no medical problems. He was prescribed some sleeping tablets which improved sleep but the other complaints continued. After two months of the onset of the problem Mr. A wanted to quit his job. He also talked repeatedly of his incompetence and felt he was a burden on everyone and hence felt that it was better if he died. He revealed to his spouse that he had been thinking of leaving everything and going away or dying.

Mr. A was taken to a psychiatrist who after interviewing him, established the presence of a pervasive mood of sadness with lack of reactivity, lack of enjoyment of previously pleasurable activities (anhedonia), and anergia for over two months. There was also evidence of melancholic symptoms and ideas of helplessness, worthlessness, hopelessness, death wishes and suicidal ideation. In the absence of any contributory medical disorder or substance use, a diagnosis of depression of moderate severity was made. It was believed that the positive family history contributed to a genetic vulnerability and the recent promotion may have acted as a destabilising life stress.

Mr. A was treated with medications and he and his family was counselled about the illness and its care. Over a period of six weeks he improved sufficiently to resume his work, social and personal roles adequately.

Comment: This case vignette shows the history of an individual who had a familial vulnerability to depression, and who had earlier been well adjusted, but on exposure to a life event had developed a full fledged depression with classical behavioural, cognitive and affective features.

Check Your Progress Exercise 2

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List important ways in which depression affects the individual.

.....

.....

.....

.....

.....

13.2.3 Sub-types of Depression

The description that you have read so far is that of a fairly classical presentation of depression which is referred to in the ICD-10 as 'Depressive episode' and in the Diagnostic and Statistical Manual IV-TR (a US system of classification) as 'Major Depressive Disorder'.

Depression can also present differently and may be referred to by other names. Hence authors have described 'Anxious depression', 'Retarded depression', 'Hostile depression', 'Agitated depression' and so on – the overt presentation being self explanatory from the name given. The central feature in all these is the existence of continuous sad or dysphoric mood with loss of interest and fatigue over several weeks along with the other clinical features described earlier.

Depression which occurs in discrete episodes of several weeks to months with normal intervals in between, lasting months to years is referred to as 'recurrent depressive disorder'.

A similar depression as described so far can also occur in another condition known as '*bipolar affective disorder*'. In this condition the person may suffer depression sometimes and '*mania*' (characterised by hyperactivity, heightened self esteem, excess happiness/irritability, decreased need for sleep, distractibility, excess speech etc.) at other times, with months to years of normality in between.

A somewhat milder but more chronic depression is also recognised and known as '*dysthymia*' or '*dysthymic disorder*'. This is a condition that goes on for two or more years with the presence of depressive symptoms such as poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self esteem, poor concentration or difficulty in making decisions, feeling hopeless on most days of the week for most period of the illness. The young suffering from this condition may have typical features (reversal of usual depressive symptoms as in overeating, hypersomnia, irritability etc).

Dysthymia may have its roots in the personality structure of the individual and factors related to childhood adverse events. It can be superseded by a full fledged depressive episode when the dual condition is called ‘*double depression*’.

Depression can occur in other contexts also as in the days to weeks before the menstrual flow when it is called ‘*premenstrual dysphoric disorder*’, in the aftermath of a schizophrenic episode when it is referred to as ‘*post schizophrenic depression*’, as a sub-syndromal condition mixed with anxiety when it is known as ‘*mixed anxiety-depressive disorder*’, as ‘*minor depressive disorder*’ and a relatively newly recognized condition called ‘*recurrent brief depressive disorder*’.

Depression can occur in the course of other psychiatric disorders such as alcohol or substance use, anxiety disorders, somatoform disorders, personality disorders and psychotic disorders.

The full or partial syndrome of depression can also occur along with various medical disorders such as stroke, dementia, Parkinson’s disease, diabetes, ischemic heart disease, cancer etc., Then it may become difficult to decide whether it is an independent depression, or the depressive symptoms (like fatigue, poor appetite, poor sleep, lack of interest etc.,) are a part of the medical disorder(or its treatments) or the medical disorder (or its treatments) is actually inducing a depression through biological mechanisms or whether the depression is a natural reaction to the occurrence of a significant medical illness.

Hence, although we have seen a universally accepted clinical picture of depression, we should be aware that variations in presentations can occur and the context in which the depressive syndrome occurs is very important for the making of a diagnosis, and therefore, management.

Check Your Progress Exercise 3

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List sub-types of depression.

.....

.....

.....

13.2.4 Epidemiology of Depression

Depression is a common condition in the general population. Although studies vary in the prevalence and incidence rates cited, it is generally believed that women have a lifetime risk of depression of 10 to 25 per cent and men 5 to 12 per cent. The point prevalence of depression in the population is 5 to 9 per cent in women and 2 to 3 per cent in men. Depression is said to be the second highest contributor to Disability Adjusted Life Years (DALYs) worldwide amongst chronic medical illnesses. Women have twice the risk of

developing depression than men. Rates of depression are generally higher in the lower income groups as compared to the higher income groups. In the primary care setting depression may occur in about 5 per cent of patients whereas in the hospital setting amongst medical patients the figure may be above 14 per cent.

Depression may occur in about 5 percent of childhood and adolescent populations. In the elderly, the prevalence may be between 5-10 percent. An overall increase in the rate of depression has been noted over the last five decades worldwide.

13.2.5 Causes, Risk Factors and Course of Depression

It is understandable that a complex disorder like depression which is impacted by personal, social and environmental factors, will have multiple causes. In any given individual, the relevant factors may vary in number and significance in each instance of depression. Indeed in a given individual, different episodes of depression may themselves be determined by different causes. Hence it is common to view depression as a 'multifactorial' condition. The 'biopsychosocial' model of causation is a fruitful starting point to understand the occurrence of depression in a given individual. Such an approach helps us understand the case of Mr. A in the vignette mentioned earlier.

Genetic studies in depression reveal that this condition aggregates in families. Twin studies show evidence for some genetic influences in depression. Some workers have quantified that genetics contribute to about 40 per cent of the liability for depression. Other specific factors in combination with the genetic vulnerability contribute to the occurrence of depression. For example some psychosocial risk factors that seem to play an important role are female gender, limited social support, dependent or neurotic personality types, stressful life events, early parental loss, parental separation, trauma and abuse especially in childhood, past episode of depression and low socioeconomic status to name a few.

There are interesting and influential theories of causation of depression derived from research on animal models. Although there are inherent limitations to transposing animal model data on human behaviour, some models such as the '*learned helplessness*' model of Seligman are theoretically important.

Evidence suggests the involvement of abnormalities in specific neurotransmitter chemicals in our brain during depression. These neurotransmitter disturbances seem to be rectified by the medicines which help in the treatment of depression. Similarly, there is progress in the understanding of the link between depression and important hormonal systems of the body.

The role of significant stressors and life events in the causation of depression has been long studied and debated. A distinction is often made between chronic and acute stress. Similarly, distinction is also made between ambient stress and discrete stress. In a vulnerable person, a moderate stress may contribute to the causation of depression. In an otherwise less vulnerable individual, a massive stress may lead to depression. In the presence of chronic stress or significant levels of ambient stress a moderate additional stress may result in depression in a vulnerable person. Several factors may affect how an individual appraises a given stress and adjusts to it or breaks under it.

Allied to this is the *theory of life events*. Life events can be stressful. They can variously be divided into negative events, positive events, loss events, entry events, exit events etc. Although there are commonalities in how we react to similar life events, there is also sufficient scope for individualised appraisal and response to such events, especially with reference to the origin of depression.

Closely related to the effect of stress is the effect of the personality and coping style of an individual. An individual with *personality predisposition* (maladjustment or poor coping skills) may develop depression with a loss event more easily than one with adequate coping skills.

Psychological and psychosocial formulations of the causation of depression have also been developed over the years by experts. Starting from the early psychoanalytic theory of Sigmund Freud and his associates, there have been several theories which tried to explain the occurrence of depression as a result of intrapsychic conflicts often dating back to the early developmental years.

Influential amongst the psychological theories has been the '*Cognitive*' theory of depression. This theory pre-supposes the existence of a '*cognitive triad*' of negative views of one's self, one's world, the current situation and the future. Cognitive distortions cause and maintain depression. This theory has led to the development of a very effective therapy for depression called '*Cognitive-behavioural therapy (CBT)*'. Another interesting development has been '*Interpersonal theory*' which looks upon depression as a disease derived from specific interpersonal relation deficits. This theory has led to the development of another effective treatment for depression known as '*Interpersonal therapy*'.

There have been several other perspectives of depression such as the sociological perspective, the *existential view*, and the *humanistic theory*. All these can contribute in some way to our understanding of depression in specific situations. However, it needs to be re-emphasised that with our current state of knowledge, the causation of depression is best conceptualised with an interactive *biopsychosocial model*.

For our purpose, in summary, the commonly cited risk factors for the causation of depression are: (i) a history of prior episodes of depression, (ii) family history of depressive disorder especially in first degree relatives, (iii) history of suicide attempts, (iv) female gender, (v) age less than 40 yrs, (vi) postpartum period, (vii) presence of comorbid medical illness, (viii) absence of social support, (ix) negative stressful life events, and (x) alcohol or substance use.

The course of a depressive episode is characterised usually by a gradual onset of symptoms over one to several weeks. Usually the individual may experience anxiety, sleeplessness and worrying before sadness sets in. Usually an untreated episode lasts between six to 24 months. When remission occurs, the person is usually able to return to completely normal functioning especially in the case of the first episode of depression. However, as the number of episodes of recurrence increase, there is a likelihood of only partial remission and residual deficits in some areas of functioning. Persons with partial remissions tend to have more depressive episodes and require more depressive intensive treatment to achieve complete remission. About half the

individuals with one episode are likely to have two or more episodes in future. Almost one fourth of people with depression suffer severe enough illness to keep them home bound and incapacitated. The extent of disability they suffer is similar to any other severe chronic medical illness. Depression also entails the risk of suicide. It is estimated that about 15 per cent of patients with severe depression die by suicide and a much larger number attempt suicide.

Check Your Progress Exercise 4

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with that provided at the end of this Unit.

1. List important causal factors associated with the occurrence of depression.

.....

.....

.....

2. List important risk factors for depression.

.....

.....

.....

13.2.7 Evaluation and Treatment of Depression

The evaluation of an individual with depression should start with establishing a therapeutic relationship and assessing the clinical syndrome of depression including its severity. The suicidality of the individual should be assessed. The presence of other medical or psychiatric morbidity should then be ascertained. It may be helpful to use standard instruments to quantify the depression. Commonly used instruments are the *Beck's Depression Inventory* and the *Hamilton Depression Rating Scale*.

The psychosocial circumstances of the individual, the support system and the risk factors contributing to the depression or mitigating against treatment and recovery need to be assessed for future redressal. It would be very useful to establish a relationship with the caregivers and co-opt them into the treatment programme.

The treatment of depression is focused on achieving complete remission of depressive symptoms and full restitution of function to the premorbid level. Treatment may be located in the community or the clinic in milder forms of depression but when the condition is severe or associated with significant suicidal risk, hospitalisation should be an option.

Several drugs are available for the treatment of depression. The choice of a particular drug is often determined by the age of the individual, presence of associated physical conditions and tolerance of adverse effects. Most of the antidepressant drugs available may take two or more weeks to show some benefit. In the case of severe depression, other measures such as electro

convulsive therapy is also used. Once the patient is relieved of the depression, the medication is usually continued for at least six more months to reduce risk of relapse in the first episode of depression. In subsequent episodes it may be necessary to continue medication for a prolonged period of time.

Along with the above treatment it is necessary to educate the family and patient about the nature of the condition, effects and adverse effects of the medications as well as future course and outcome. After the psychoeducation, the patient and family can be taught simple techniques to improve functional ability and decrease suffering by advocating measures such as activity scheduling, supportive and counselling sessions to manage stress, anxiety relieving measures etc.

When indicated, the patient can also be treated with specific psychosocial treatments such as cognitive-behavioural therapy, interpersonal therapy or other such structured therapies which improve the overall outcome and help in reducing the risk of relapse. When psychosocial stress or personality factors are seen to play a major role in the causation of depression, these should also be addressed through appropriate psychosocial modes of treatment.

Regular monitoring of progress, assessment for adverse effects of medicines and continuing psychoeducation will go a long way in maintaining compliance and reducing relapse.

With adequate treatment, a majority of persons with depression will make a good recovery. However, a subgroup of individuals who do not respond adequately to the first line of management may require additional therapeutic inputs.

Depression is an area of a lot of research effort the world over because of the magnitude of the problem from a public health perspective. Better understanding of the condition and better treatment and perhaps preventive strategies may in future mitigate the suffering of millions of persons afflicted by this illness.

Check Your Progress Exercise 5

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with that provided at the end of this Unit.

1. List major treatment modalities of depression.

.....
.....
.....

13.3 GRIEF

Grief is a universal experience following a significant loss. It signifies a process of coming to terms with the loss (usually of a loved person). The term grief is sometimes also used with reference to the loss of a body part or other object as the process involved appears to be similar to grieving for the loss of an individual.

13.3.1 Features of Normal Grief

Normal or uncomplicated grief occurs in a stepwise fashion till resolution. Initially, after the bereavement, there is a *sense of disbelief* or *shock*. This may last a few weeks. After this is a *variable period* which can extend up to a year when there is a preoccupation with the death, why it occurred, what could have been done to prevent it, associated with recurrent feelings of loneliness. This is the *intermediate phase*. Last is the *recovery phase* where in the bereaved person starts establishing new relationships and resumes normal life activities fully. The time frame of grief may vary from person to person. Some consider the normal period to be as short as two months whereas others consider it as extending up to several years. Whatever the duration, the basic mental mechanisms involved in shoring up defenses and getting over the loss make the process of grief a good example of an '*adjustment effort*' or a '*mental reaction*' to a loss. Bereavement also represents a transition and developmental crisis which in its resolution influences adjustment and further maturation or development of the individual.

We gain our concept of death and its permanence by early adolescence. Prior to this, death does not seem to have an immutable quality in our cognition. After gaining our concept of death, when faced with bereavement we go through several defined mental processes. Initially there may be shock followed by denial of the problem along with isolation. Then there is a *sense of anger* at the loss. This is followed by a process of *bargaining* (mentally) for the lost individual. Next is a *process of depression* followed finally by *acceptance*. All of us seem to go through these processes in a similar or different order and to different degrees after bereavement before we reach acceptance. The extent to which some or all these processes are used may depend upon the nature of the loss and the personality of the individual.

Usually, the individual going through grief will experience sadness which may not be pervasive but more akin to waves of emotion associated with weeping. Memories of past events and surrounding objects associated with the dead individual trigger such waves of emotions. There is recurrent preoccupation with the dead person. Often in the initial stages, the dead person is reflexively referred to as alive or invoked in conversations. The grieving person senses a feeling of emptiness and experiences a profound lack of interest in day to day activities. Ideas of helplessness and philosophisation about existence and one's powerlessness over destiny may be expressed. Sleep onset is delayed and is associated with ruminations about the dead person. Appetite may be significantly reduced and the individual may experience *anergia*. Although suicidal thoughts are less frequent in grief, the sufferers often express death wishes ('Wish I was taken instead of him'). The grieving person is often racked by guilt of perhaps not having done enough to save the dead individual. There may also be associated hostility towards caregivers who attended to the dead person last, suspecting that they did not do enough to save the dead one. Sometimes, when the death is in a young person, sudden, unexpected and in one who had close emotional ties with the bereaved, the grief reaction may be more severe and characterised by a variety of severe emotional and conduct disturbances. In grief, at least in the initial stages, the personal, interpersonal and occupational functioning can be severely impaired.

Death of a spouse seems to cause the most severe grief reactions. The next in order of severity is caused by the death of an offspring. The effect of loss may not lessen in some people with the passage of time although active grief may have remitted. Psychological distress and impaired quality of life may persist long after the loss, especially of the spouse or offspring. Grief is also a predictor of occurrence or worsening of pre-existing medical illnesses like ischaemic heart disease, bronchial asthma, bowel disorders, chronic skin conditions, autoimmune disorders etc. This is especially the case in the first year after bereavement in a widower and in three years in the case of a widow. In situations such as these, we may have to consider whether the individual is developing a full fledged depressive illness over and above the grief.

Check Your Progress Exercise 6

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answers with that provided at the end of this Unit.

1. List features of normal grief.

.....

.....

.....

2. List the processes we go through when confronted with bereavement.

.....

.....

.....

13.3.2 Features of Abnormal Grief

We had seen in the previous sub-section that grief is an experience that all of us go through at some point in time and in a sense it may even be called *normative*. It is a transitional crisis in our life which demands a new adjustment and once that adjustment is made we move on in life.

There are, however, situations when grief does not unfold in the above mentioned manner but is altered. The alteration may be in terms of the time involved for grieving, its recurrence after a period of quiescence, occurrence of additional pathological phenomena in the sufferer and so on. Such a situation is referred to as *abnormal grief*. Abnormal grief can be viewed as a deviation in the process of resolution of grief. It can cause significant psychopathology or distress and predispose one to other physical and psychological problems as well.

Commonly seen in abnormal grief is the prolongation of the grieving process beyond the usual two to six months. Preoccupation with the dead person is associated with persisting sadness and loneliness. The sufferer may frequently experience a '*sense of presence*' as if the dead person is around somewhere or has spoken etc. The bereaved may preserve the home or articles of the dead individual in exactly the way they would be had he or she been alive.

This is known as ‘*mummification*’ and suggests a ritualised denial of the death and an attempt at believing the dead person to be alive. On other occasions the grief reaction may repeat itself at the anniversary of the death. This is often referred to as ‘*anniversary reaction*’. In severe abnormal grief the bereaved may suffer from psychiatric disturbances akin to psychosis.

A few risk factors for developing abnormal grief reactions are — the occurrence of an untimely or unexpected death, death of young person, death occurring away from the bereaved, presence of an enmeshed relationship between the deceased and the bereaved and presence of a personality disorder or other characterological problems in the bereaved.

Case Vignette 2

Mrs. B is a 60 year old lady from a middle socioeconomic background who has been hitherto living with her spouse in a town. Their children have grown up and left home for jobs, and visit them off and on. Both Mrs. B and her spouse were healthy and spent a lot of time of the day doing things together. Their marital relations were very good. They had limited social supports outside their home. One month ago Mrs. B's spouse collapsed one morning with chest pain when she was away in the market. She found him dead on returning home. The children came and the final rites and rituals were performed. Mrs. B went through a difficult phase of feeling sad a lot of the time, frequent weepiness, lack of appetite, lack of sleep and lack of energy. Anything in the house reminded her of the spouse and would induce crying. She often felt that God should have taken her instead of him. She also felt guilty sometimes that she was not there when he needed help and that had she been there she may have saved him. She felt there was no point in life now and although she would talk to visitors, conversations did not hold any interest for her. She was however not suicidal nor did she feel a loss of self worth. There was no contributory family history or a history of substance use or medical disorders.

Comment: This vignette shows the classical picture of grief in a widow who had a close relationship with her spouse and little other social contacts. The spouse dies unexpectedly and grief ensues in the survivor.

Check Your Progress Exercise 7

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List the risk factors of abnormal grief.

.....

.....

.....

13.3.3 Distinguishing Grief from Depression

Depression as discussed in Section 13.2 is often demarcated clearly from the ‘blues’ that one experiences with adverse life circumstances. Depression

usually implies a clear break from the usual self unlike reactions to life circumstances. Further, the pervasive nature of the sadness, the disabling nature of biological and cognitive symptoms, the tendency to recur, the presence of a family history of depression help in distinguishing depression from a depressed reaction to life events. In the case of grief, sadness is seldom pervasive, biological symptoms are not usually as severe, all the cognitive symptoms do not usually occur, and family history is not of relevance in the genetic sense. Melancholic symptoms are not common in grief. Preoccupation with suicidal ideas does not usually occur in grief, instead there is a preoccupation with the dead person. Marked slowing down or psychomotor retardation is rare in grief. Guilt of omitting to do something to save the deceased is common with grief but not the guilt of committing a wrong act. Mummification or severe anniversary reactions are suggestive of abnormal grief or depression.

Continuation of Case Vignette 2

Six months after the death of her spouse, Mrs. B continued to suffer from a sad mood which was now pervasive. She still was preoccupied with his death and her loneliness, and had also started to develop feelings of hopelessness and suicide. Her family found her becoming progressively quieter and slowed down. She often mentioned that she must have done something which led to the death of her husband. She had declining self esteem and a self critical attitude. As her appetite decreased, she lost weight. She lost interest in all day to day activities and barely maintained self care.

Comment: The above vignette shows how Mrs. B suffered grief initially but later the picture changed to that of a full syndrome of depression. This is a common occurrence with grief especially in the older persons.

Check Your Progress Exercise 8

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. How is grief different from depression?

.....
.....
.....

13.3.4 Sociocultural Correlates of Grief and Interventions

The process of grieving at the loss of our loved ones is a universal phenomenon that may extend to some pre-human species also. However, we live in and are conditioned by our unique sociocultural milieu. Elements of our milieu naturally impact how we perceive and handle grief. Religion, culture, values and mores influence the experience of grief and the rituals associated with it in different settings.

Religious practices and rituals related to grieving are invariably nuanced by the philosophy of life and the meaning of death that are subscribed to by any

community. The grieving practices hence evolved in keeping with the above contexts. In that sense it is believed that the grieving practices organic to a community serve the function of helping the bereaved to successfully perform 'grief work' and come to terms with the loss. It is also believed that in situations where there is a decline in the rituals of mourning and grief, the occurrence of pathological grief reactions increases.

As rituals and practices relating to normal grief exist in society, the grieving individual or family is encouraged to participate in these. In addition, if the distress is very severe, anxiety reducing medications may be temporarily used. Appropriate counselling and family therapy relevant to the situation can also be used.

In the case of abnormal grief the interventions may need to be more vigorous. If there is depression or psychosis, appropriate medication and other physical treatments may be required. In addition, several innovative psychotherapeutic techniques have been tried in abnormal grief and found effective in different cultural settings. The central theme of these psychotherapies is a process of taking the bereaved through the stages of grief in a culturally authentic manner, help them adjust to the loss and reintegrate them for normal functioning. The therapy may take several sessions and may adopt dynamic, cognitive, directive and other theories or an eclectic mix of these. Grief therapy may be possible in a group setting also when deemed necessary. It needs to be reiterated that whatever the type of therapy done, it should be rooted in the religiocultural practices of the bereaved individual.

Grief is a universal experience. From a mental health perspective, we need to be aware that grief can take abnormal forms when unresolved; it can be associated with significant medical morbidity. It may also lead to several psychiatric disorders including depression.

13.4 SUICIDE

Suicide is the eleventh leading cause of death in the general population according to Western literature. It is the third common cause of death between ages 15 to 24 years. A majority of people with suicidal intent have a psychiatric diagnosis. People who attempt suicide may or may not communicate their intent to anyone. Suicidality may occur acutely in some people whereas others may feel chronically suicidal. Suicide affects not only the concerned individual but also his family and friends. Helping a person with suicidal intent can be difficult and frightening for the relatives. *Suicide* is referred to as a multi-axial behaviour that is behaviour with several determinants and dimensions. Research into the area of suicide spans a wide variety of disciplines and understanding the phenomenon of suicide requires a wide perspective.

13.4.1 Terminology Related to Suicide

Over the years several terms have been used to describe self harm and self induced mortality. The act of suicide may span *suicidal ideation*, *attempt* and *completion of the act*. Persons belonging to these three categories of suicide related behaviour may share some common characteristics or may constitute distinct subgroups of people with differentiating characteristics.

Completed suicide refers to suicide attempt ending with death. Completed suicides are far outnumbered by attempted suicides. It is the latter group and those at risk to attempt that often come to the attention of health professionals. Much more is known about them than about completers. Further, sub-typing of suicide completers can be made on ethnic or sociodemographic characteristics, the means of suicide, causal factors and several other descriptors.

Nonfatal suicide attempts refers to acts performed by persons who intentionally injure themselves but do not die and are available for intervention. Such persons are also said to have involved in *intentional self harm* (also called *deliberate self harm*).

Suicidal ideations are thoughts about suicide. The ideas can be of different degrees of seriousness in the form of death wishes, or ideas of intent. Intent to die is a most important factor in suicidality but is difficult to measure.

Indirect self-destructive behaviours is a group of habits or life-style characteristics (such as smoking, drinking alcohol, participating in risky sports, stress seeking etc.) which are not always explicit or intentional but are often chronic and perhaps even subconscious. Whether these behaviours should be brought under the broader rubric of suicide is questioned by some researchers.

Parasuicide is a term that applies to non-fatal attempts where intent cannot be evidenced easily. Such attempts may be impulsive, under stressful circumstances, or in a period of confusion and high anxiety.

There can be many types of suicide with different etiologies, causal models and managements. As completers, ideators and attempters themselves may be of several types, there is a need for individualised assessment in understanding a person manifesting suicidality.

Intent or *intentionality* is an important concept. It denotes the will or drive to commit the act. However, its assessment or measurement is based more on circumstantial than direct evidence. Intent is inferred by the nature and elaborateness of the plan, effort made by the individual to conceal his attempt to prevent discovery, the extent to which she or he saw the attempt as a final one and went about tying up the loose ends of her or his life (making final statements to relatives, settling property or financial issues, making suggestive statements) etc.

Lethality of the method is a judgement about the likelihood of that method ending in a lethal outcome.

Check Your Progress Exercise 9

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. What is the meaning of 'intentionality' and 'lethality'?

.....

.....

.....

13.4.2 Epidemiology of Suicide

Annual general population rates for suicide vary but are about 10 to 12 per 100,000. In India, the reported rate is about 11 per 100,000. Within countries and communities there can be a wide variation in suicide rates due to various sociocultural and economic factors. Usually suicide rates rise gradually for males through adolescence and adulthood to old age with peaks in early adulthood and old age. In females the suicide rates increase to a single peak in midlife and then decline.

Non-fatal suicide attempts outnumber completed suicide by 20-200:1. Non fatal suicide attempts have a significant risk of recurrence. About 10 per cent of this population will eventually complete suicide at the rate of about 1 per cent per year. Almost 1/3rd of psychiatric patients and perhaps 1/4th of the general population consider suicide at some point in their lives.

A major problem with the reliability of these rates are under-reporting, non-reporting and misclassification of data.

13.4.3 Causation and Theoretical Models of Suicide

Biological theories discuss factors such as abnormal neurotransmitters as important contributors to suicidality. Stress appraisal and response to it are mediated by specific areas in the brain and certain chemical transmitters such as serotonin appear to be involved in this process. There is a strong correlation between the low levels of this transmitter and violent suicidal attempts suggesting the biological basis of suicide. Similarly family genetic studies also point to a genetic basis for suicidality.

Psychoanalytical theories of suicide, like the biological theories, focus on the reasons for the individual's suicidality. They started with Sigmund Freud's postulation. This was that when there is a loss of an ambivalently loved object, the hostile feelings originally meant towards the loved object are turned inwards, on to the internal representation of the object, that is, a part of the self. The logical conclusion of this would be the suicidal act. Freud also postulated the 'death instinct' as a primary instinctual force which in certain circumstances may be turned inwards to harm the self. Karl Menninger pointed out certain longstanding self-destructive life style (smoking, alcoholism etc.) as really representing suicidal behaviour.

Other theoreticians feel that the tendency to commit suicide is related to the extent of perceived threat to life conditions experienced by the individual, her or his sense of competence and degree of hope. Aaron Beck proposed the important link between 'hopelessness' and suicide.

The important contribution of Emile Durkheim focuses on the sociology of suicide. He proposed that suicide rates were determined by society's level of social integration and social regulation. Low levels of integration and regulation lead to egoistic and anomic suicides and high levels of the same variable predict altruistic and fatalistic suicides.

Other theories of social causation for suicide attribute it to the targeting of aggression by a frustrated person to the frustrating object which may be 'the self'. Social restraint has been proposed as a factor that controls suicide in communities. 'Social stress' theory explains that a lack of or losing of social

ties (as in the single and divorced) may also predict suicide especially when the weakening of social ties occur due to the action of others. These and other theories try explaining suicide as a phenomenon at a societal or community level rather than at the individual level. They reflect the probable pathological factors around us which push vulnerable persons to suicidality.

Suicidality is also strongly predicted by the presence of almost all major psychiatric disorders. Of these, the highest risks occur with depression, substance use disorders, anxiety disorders, certain personality disorders and psychosis.

Life events (both positive and negative) can cause sufficient stress in the individual to induce suicidality. Chronic problems of life including economic deprivation and long standing medical disorders can predispose to suicidality. Facing adverse situations in early life also increases later risk for depression and suicide.

Imitation (as in copycat suicides) and overpowering media influences may also contribute to causation of suicide in the vulnerable person.

Major psychosocial factors reported as leading to suicide attempts in the Indian setting are: family conflicts, presence of an illness, financial problems, marriage related problems and alcohol related problems.

Check Your Progress Exercise 10

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List major theories of suicide.

.....

.....

.....

13.4.4 Risk Factors and Assessment of Risk

Risk factors of suicide are those factors which seem to have a high association or co-occurrence with suicidal attempts. They do not necessarily imply causality, but are a starting point for understanding the occurrence of suicide and for identifying persons at risk for intervention.

Commonly cited risk factors predicting suicide are: male gender, white ethnicity (in Western literature), elderly age, presence of psychiatric disorders like depression and substance abuse, past suicide attempts, access to lethal means, family history of depression and suicide, hopelessness, unemployed status, presence of comorbid medical conditions or chronic pain, failed relationships, divorced or widowed status and media related. However, all these factors may not have the same weight in predicting suicide in all individuals. Suicidality is better understood when seen in the context of its occurrence – the individual's innate vulnerabilities, stress, social factors and psychological factors.

Women attempt suicide more frequently than men (3:1) but men complete suicide more often than women (4:1). This difference may be attributed to different risks in men and women for certain psychiatric disorders like substance abuse and the tendency for women to use non-lethal methods more often than men.

Western studies show a higher risk of completed suicide in whites (both male and female) as compared to other ethnicities. Probably protective factors such as extended close relationships exist in the non-whites. Similar data does not exist in India.

The highest rate for completed suicide in the industrialised countries is amongst the elderly with an attempt to completion ratio of about 4:1. In the industrialising countries highest rates are seen in the 25 to 44 years age group. In the elderly, the occurrence of depression, loneliness, bereavement, loss of function, financial stress and medical illness are risk factors whereas in the middle ages, financial and interpersonal factors appear more important. It is relevant here to note that the spate of agrarian suicides in India occurs in the middle ages in the context of financial and social stress. There is an increasing trend of suicidality amongst children and adolescents worldwide. In this population attempts outnumber completion 20:1. Poor family environment, parental psychiatric problems, low parental monitoring, low social competence, early involvement in sexual activity and alcohol use are considered as risk factors predicting suicide attempts in the young.

The presence of depression increases the risk of suicide 7 to 8 fold over the general population. It is likely that between 5 to 10 per cent of depressives, attempt suicide at some point. Drug and alcohol abuse increases the risk of attempts and completion to a significant extent. One third of patients with alcoholism may attempt suicide at some time. It needs to be remembered that a large number of persons who go on to attempt suicide, do go and meet their physician or psychiatrist in the months prior to the attempt without necessarily referring to their ideas about suicide. This has been construed as an evidence of premeditation of suicide, a covert help seeking behaviour, an expression of ambivalence regarding the forthcoming act etc. The point to remember is that perhaps the mental health worker must be constantly on the look-out for such signals in the persons who seek their consultation in order to pick up the high risk individuals and intervene appropriately.

There is a popular misconception that a person who has made past unsuccessful suicidal attempts will not attempt again. On the contrary, a history of previous attempts is the strongest predictor of future suicidal attempt and completion. The risk for subsequent attempts remains for several years after the initial attempt. Persons with suicidal intent may also use different methods in their different attempts.

Another strong predictor of risk for suicide is the easy availability of the means. One of the reasons for the sudden increase in suicides through poisoning in the Indian agrarian sector has been thought to be the easy availability of pesticides. Similarly the high frequency of attempts with guns in some countries is linked to their easy availability along with lenient fire arm laws. Differential accessibility of the means contributes to the difference in methods employed by males and females.

A positive family history of suicide attempts and psychiatric illnesses like depression are strong risk factors for suicide. A sense of hopelessness about the future is also a strong predictor of suicidality whether occurring with depression or independently. If hopelessness does not remit even after treatment of depression, then it continues to be a predictor of suicidality.

The presence of chronic medical illnesses adds to the risk of suicide. Illnesses such as HIV- AIDS, peptic ulcer, head injury, movement disorder, spinal cord injury and chronic pain, amongst others, are commonly cited examples.

Evidence also suggests that the glorification of suicide with extensive media coverage can induce ‘copycat’ suicides. This is especially the case when celebrity suicides are involved. In regions where editorial policy has deliberately reduced such coverage, the copycat suicide trend has also reduced.

We need to systematically assess suicide risk in the individual in order to intervene appropriately. Very often the person will hesitate to talk about his or her suicidality due to various reservations. It is thus necessary to explore for suicidality in a sensitive and non-threatening manner. The assessment of risk for suicide will need to consider:— the current mental status of the individual for the following indices — suicidal ideation, suicidal counters (factors that help prevent suicide in that given individual), suicide intent, the suicidal plans, presence of sadness and depression, hopelessness, social withdrawal, isolation, anxiety and agitation, impulsivity, insomnia, psychotic symptoms. History should be reviewed for occurrence of previous attempts (especially high lethality attempts), uncommunicativeness or reclusiveness, recent major loss or stress, substance use, untreated mood disorder, psychosis or personality disorder. Such an assessment is necessary in any person presenting with a behavioural or psychiatric problem to a mental health professional. Such an assessment will also be necessary when counselling children, students or other target populations seeking help for emotional disturbances even if not qualifying for a psychiatric diagnosis.

Case Vignette 3

Mr. C was a 24 year old single male working in an MNC as an IT professional. He had recently moved from his parental home and town to a new city due to his job. He had no friends or supports in his new situation and he found his work hours and nature of job demanding and difficult. He found himself lagging behind his co-workers and on occasion earned reprimands from his supervisor. He felt inferior to others but could not change his job due to financial constraints. He started consuming alcohol in the evenings to relieve his ‘tension’. As he was from out of state and by nature a reserved person he did not build up a network. Things got worse over the next six months and his supervisor gave him a final warning for poor performance and threatened to terminate his services if he did not improve in work immediately.

Distraught, he sought the help of a human resources department counsellor in his organisation. On enquiry he revealed that he felt hopeless in his situation. His self image had suffered. He did not know the solution to his problems. He had been drinking heavily and indulging in high risk sexual behaviour under the influence of alcohol. He had on several occasions contemplated killing himself but stopped himself by remembering his parents

and responsibilities. He had planned to buy poison and take it in a distant town in a hotel after leaving a note explaining his behaviour to his parents. The counsellor worked with Mr. C over five sessions of ventilation and guidance to help him discover the reasons for his inadequate professional performance and their solution. He guided him to learn methods to focus better on his work and to develop a network of friends in the workplace. The counsellor obtained help for him regarding the alcohol use and also encouraged him to join yoga classes and a local social organization for likeminded young persons. The outcome of the interventions was a better integrated Mr. C who was able to respond to the challenges of his situation more competently.

Check Your Progress Exercise 11

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List important risk factors for suicide.

.....

.....

.....

13.4.5 Intervention and Postvention

Primary prevention models of suicide are based on public health philosophy. They focus more on intervening at the point of appearance of risk or vulnerability rather than after the disease or illness has occurred. These models target interventions at various levels in the community. They include mechanisms to provide education of the public about suicide and undiagnosed psychiatric disorders, especially depression. Community awareness has to be created about suicide (it needs to be noted that merely talking about suicide does not make people attempt it). Public education about the preventability of suicide, improved access to mental health care for those in distress, improved ability for detection and management of suicidality are among the primary prevention management strategies. Intervention with the media, with guidelines for what should or should not be projected in it and how it has to be projected, is also a primary prevention strategy. Developing intervention programmes for different specific risk groups (adolescents involved in high risk behaviour, or depressed housebound women etc) which are then selectively targeted would be a secondary level preventive intervention. Finally a highly specific targeting of interventions for past attempters would be a third level of intervention.

For the individual in the community who is at risk for suicidal thoughts or behaviours, there should be an individualised help which is easily available and culturally acceptable. Community based 'hotlines' or 'help lines' is an innovation in this direction, which has been tried in several places. This is a readily accessible source of help which maintains anonymity and is easy to reach. The helpline is usually manned by trained lay volunteers who can help the potential suicide attempt on tide over a crisis situation. Subsequently

the helpline can either continue support or arrange referral to an appropriate agency. The efficacy of such help lines is still a matter of debate. Similarly there could be trained counsellors and NGOs working in suicide prevention counselling centres in areas of high need. The model of the centre and its working may be dictated by the needs of the community it intends to serve.

At the individual level, the assessment of risk for which the previously mentioned factors can be kept in mind, is required. A decision regarding hospitalisation (to remove the person from means as well as adverse psychosocial circumstances) or community care will need to be made. If a person is to be hospitalised due to the suicide risk, the risk must be diminished quickly by medical, psychological and administrative measures. Access to means should be denied and levels of observation of the patient in the inpatient setting should be suitably fixed. A multidisciplinary approach may be necessary, especially if the suicidal person had comorbid psychiatric disorders, psychosocial risk factors and other mitigating circumstances requiring a multiplicity of inputs. If the individual is to undergo outpatient treatment, it would be advisable to co-opt a family member into the treatment plan and explain the situation to him or her with the patient's consent. In inpatient and outpatient settings, after the risk reduction goal is achieved, steps should be taken to decrease the vulnerability to suicide through the multidisciplinary approach. It would be helpful to formulate the individual's problem in a multi-theoretical manner in order to understand the unique features at issue.

Psychotherapeutic interventions can prove effective to protect against or reduce suicidal ideation. Common modalities of therapy that may be used singly or in combination (depending on the situation) would be: counseling and guidance, supportive therapy, psycho dynamically oriented brief therapy, crisis intervention, solution focused therapy, cognitive behavioural therapy, dialectical behaviour therapy, family therapy, group therapy etc. Therapy should be tailored towards psychoeducation and medication compliance, improving problem solving abilities, addressing psychosocial risk factors, tackling hopelessness, and working on dysfunctional coping. Wherever necessary, drug or ECT treatment may be combined with the above.

The '*no suicide contract*' is a common intervention between the therapist and the suicidal person. This contract is considered binding in so far as it signifies a therapeutic relationship which is binding, with the mental health professional. Although, it is an important part of managing a suicidal person (after entering into a therapeutic relationship with her or him), it should be remembered that almost a half of patients break the contract and attempt suicide subsequently. This suggests that the contract alone does not suffice, especially with patients with difficult problems and multiple psychiatric diagnoses.

While dealing with suicidal persons, superficial reassurances should be avoided. The suicidal thoughts, urges and emotions should be discussed with the person at length and not brushed aside perfunctorily. The therapist should be a patient listener who is also directive when necessary. It is necessary to mitigate the individual's problem by a judicious mixture of giving advice and helping her or him find appropriate solutions.

At the social level, help in achieving gainful employment and social support with a feeling of 'wantedness' in the community can be addressed through community participation programmes focussing on mental health and suicide prevention interventions. Facilitating care for other non-psychological, day to day life skills problems would also help, and in that sense, a comprehensive and holistic management plan with continuity of care is likely to work best.

Postvention deals with reducing the effects of a traumatic event like completed suicide on the survivors. The survivors may be the family members, friends, treating doctors, peer group (such as batchmates/ workmates/ classmates). In several communities and countries there are organisations and institutions which are devoted to postvention work which starts automatically after the occurrence of a traumatic event. Postvention can take the form of use of different psychological techniques as needed by the specified group characteristic. It can occur at the venue most suited for the survivors; for example, in a school, if a school mate has died or in a factory if a coworker has died.

Postvention helps in resolving the conflicts and psychological reactions the survivor goes through after having been in some way involved with (even peripherally) the suicide of a fellow being.

Suicide is a complex behaviour with multiple determinants. Understanding it and helping persons at risk of suicide needs a holistic and integrated approach with multidisciplinary inputs.

Check Your Progress Exercise 12

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Give examples of primary, secondary and tertiary prevention strategy with reference to suicide.

.....

.....

.....

2. What is postvention?

.....

.....

.....

13.5 LET US SUM UP

In this Unit, we have learnt the clinical presentation, cause and treatment of depression.

We have learnt to recognise grief and differentiate it from depression and learned the management of grief.

We have also learnt about the multiple risk factors associated with suicide, the theories of causation of suicide and the steps in the management of suicide.

13.6 GLOSSARY

Abnormal grief	: Derangement of normal grieving process which leads to dysfunctional coping or behaviours of varying severity.
Biological	: All factors that is attributable directly to biology such as genetics, heredity, physiology etc.
Biopsychosocial model	: An integrated theoretical model recognising the existence and interplay of biological, psychological and social factors in the causation, maintenance and management of a mental disorder.
Cognitive (cognition)	: To do with thought, thought processes.
Cognitive-behavioural therapy	: A psychological form of treatment attempting change in thought and behaviour patterns of an individual in a planned and controlled manner to induce positive change.
Depression (Clinical depression)	: A clinical disorder where sadness is a central but not the only feature. It is characterised by persistence of characteristic symptoms over two weeks or more and persistent dysfunction or distress.
Dysthymia (Dysthymic disorder)	: A chronic low grade depression associated with distress and dysfunction but not amounting to a 'depressive episode'.
Grief	: Normal grief, bereavement, a process of reconciling with and accepting the loss of a loved one involving psychological and behavioural healing, usually a normal process.
ICD-10	: International Classification of Diseases-10 th revision.
Intentional self harm (attempted suicide, deliberate self harm, parasuicide)	: Attempts at harming one's self which have not terminated in fatality. These may be described variously in terms of motivation, description of the act, psychosocial factors in the background of the act etc.

Intentionality	: An assessment of how predominant was the 'intention'. Usually with reference to past suicidal attempts.
Lethality	: An assessment of how lethal the potentially attempt at self-destruction was.
Melancholia (somatic features)	: Features of depression which are considered to be biologically mediated such as early morning awakening, early morning worsening of the mood, impaired appetite, decreased weight, constipation, loss of libido etc.
Primary prevention	: Measure/s to prevent the occurrence of a negative health event.
Psychological	: To do with the working of the mind in terms of its innate attributes, past experiences and sociocultural determinants of the way we perceive, experience, think and behave.
Psychosocial factors	: Intra-psychic psychological attributes and social situations of an individual (past or present) which are of relevance.
Risk factors	: Factors which increase the risk (chance) of occurrence of a particular outcome.
Sadness	: A mood or feeling state that is characterised by feeling low, distraught, negative.
Secondary prevention	: Measure/s to recognise a negative health event as early as possible, when it is occurring and limit its impact by intervention.
Social	: To do with the society, its values, norms, beliefs and mores, including traditions and culture which impact on the way we perceive, evaluate and operate on our environment.
Socio-cultural	: Social and cultural factors (present or past) of importance in the given context.
Suicide (completed suicide)	: An act committed by the self to end one's existence.
Tertiary prevention	: Measure/s to limit the damage/dysfunction/disability that occurs after a negative event has occurred.
Vulnerability factors	: Factors in an individual which may increase her or his risk for the occurrence of a particular outcome.

13.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Following are the important features of depression:
 - i) Persistent sadness,
 - ii) Fatigue,
 - iii) Loss of interest or pleasure,
 - iv) Loss of reactivity to positive occurrences,
 - v) Insomnia,
 - vi) Early morning worsening of mood,
 - vii) Impaired appetite,
 - viii) Loss of weight,
 - ix) Constipation, and
 - x) Thoughts of worthlessness, helplessness and hopelessness.

Check Your Progress Exercise 2

1. Following are the five ways in which depression affects the individual:
 - i) Life appears bleak or pointless,
 - ii) Routine activities appear burdensome,
 - iii) Mental abilities lose their sharpness,
 - iv) There is a decline in functional abilities, and
 - v) Isolation occurs.

Check Your Progress Exercise 3

1. Following are the three sub-types of depression:
 - i) Depressive episode,
 - ii) Dysthymia, and
 - iii) Bipolar depression.

Check Your Progress Exercise 4

1. Following are the five important casual factors associated with the occurrence of depression:
 - i) Genetic factors,
 - ii) Neurotransmitter abnormalities,
 - iii) Stressors and life events, and
 - iv) Personality predisposition.

2. Following are the important risk factors:
 - i) History of prior episode of depression,
 - ii) Family history of depression,
 - iii) History of suicide attempt,
 - iv) Female sex,
 - v) Post-partum period,
 - vi) Age less than 40 years,
 - vii) Presence of comorbid medical illness,
 - viii) Absence of social support,
 - ix) Negative stressful life events, and
 - x) Alcohol or substance use.

Check Your Progress Exercise 5

1. Following are the major treatment modalities of depression:
 - i) Drug treatment,
 - ii) Electroconvulsive therapy,
 - iii) Psychoeducation, and
 - iv) Specific psychosocial therapies.

Check Your Progress Exercise 6

1. Following are the features of normal grief:
 - i) Sadness,
 - ii) Recurrent preoccupation with the dead person,
 - iii) Feeling of emptiness,
 - iv) Lack of interest,
 - v) Ideas of helplessness, and
 - vi) Guilt.
2. The process we go through when confronted with bereavement are:
 - (i) Shock,
 - (ii) Denial,
 - (iii) Anger,
 - (iv) Bargaining,
 - (v) Depression, and
 - (vi) Acceptance.

Check Your Progress Exercise 7

1. Following are the risk factors of abnormal grief :
 - (i) Occurrence of untimely or unexpected death,
 - (ii) Death occurring away from the bereaved,
 - (iii) Death of a young persons,
 - (iv) Presence of an enmeshed relationship between the deceased and the bereaved, and
 - (v) Presence of a personality disorder or other characterological problems in the bereaved.

Check Your Progress Exercise 8

1. The main differences between depression and grief are listed below:
 - (i) Sadness is pervasive in depression and nonpervasive in grief,
 - (ii) Biological and cognitive symptoms are more common in depression than in grief,
 - (iii) Preoccupation with suicide occurs in depression, preoccupation with the dead person occurs with grief,
 - (iv) Slowing is not common in grief, and
 - (v) Cognitive and melancholic symptoms occur more in depression than in grief.

Check Your Progress Exercise 9

1. Intentionality denotes the will or drive to commit the suicidal act, whereas lethality refers to the likelihood of a method ending in a lethal outcome.

Check Your Progress Exercise 10

1. Following are the major theories of suicide:
 - (i) Biological theories of abnormal neurotransmitters and genetics,
 - (ii) Psychoanalytical theories, and
 - (iii) Sociological theories.

Check Your Progress Exercise 11

1. Following are the important risk factors for suicides:
 - i) Male gender,
 - ii) Elderly age,
 - iii) Presence of psychiatric disorders like depression,
 - iv) Past suicide attempts, and
 - v) Access to lethal means.

Check Your Progress Exercise 12

1. The examples of primary prevention strategy are public education and increasing awareness about suicide. The example of secondary prevention

strategy are intervention programmes for specific risk groups. The examples of tertiary prevention intervention strategy is targetting the past attempters.

2. Postvention deals with reducing the effects of a traumatic event like completed suicide on the survivors.

13.8 UNIT END QUESTIONS

1. Describe the features of clinical depression.
2. Describe the important treatment strategies for depression.
3. Describe the features of normal grief.
4. Describe the differences between normal grief and abnormal grief.
5. Describe the measures needed to handle abnormal grief.
6. Describe the factors associated or linked to the causation of suicide.
7. Describe the measures to be taken when confronting a person who has attempted suicide.

13.9 FURTHER READINGS AND REFERENCES

Bauer, M.S. (2003). Mood Disorders: Bipolar (Manic-Depressive) Disorders. In Tasman, A., Kay, J. & Lieberman, J.A. (Eds.), *Psychiatry, Vol. 2*, Edition 2, (pp 1237-1270). England: John Wiley & Sons, Ltd.

Beardslee, W.R. & Vaillant, G. (2003). Grief. In Tasman, A., Kay, J. & Lieberman, J.A. (Eds.), *Psychiatry, Vol. 1*, Edition 2, (pp 171). England: John Wiley & Sons, Ltd.

Brown, G.W. & Harris, T.O. (1989). Depression. In Brown, G.W. and Harris, T.O. (Eds.), *Life Events and Illness* (pp 49-94). New York: Guilford press.

David, L. (1992). *Why people kill themselves: A 1990s summary of research findings on suicidal behaviour*, Edition 3 Charles C Thomas: Springfield IL.

Dawkins, K., Golden, R.N. & Fawcett, J.A. (2003). Therapeutic Management of the suicidal patient. In Tasman, A., Kay, J. & Lieberman, J.A. (Eds.), *Psychiatry, Vol. 3*, Edition 2, (pp 2112-2135). England: John Wiley & Sons, Ltd.

Gabbard, G.O. (1999). Psychodynamic psychotherapies. In Gabbard, G.O. & Atkinson, S.D. (Eds.), *Synopsis of treatments of psychiatric disorders*. Edition 2, (pp 515-522). Chennai: All India Publishers & Distributors Regd.

Gruenberg, A.M. & Goldstein, R.D. (2003). Mood Disorders: Depression. In Tasman, A., Kay, J. & Lieberman, J.A. (Eds.), *Psychiatry, Vol. 2*, Edition 2, (pp1207-1236). England: John Wiley & Sons, Ltd.

Khan, M.M. & Bhugra, D. (2005). Suicide and attempted suicide. In Bhugra D, Ranjith, G. & Patel, V. (Eds.), *Handbook of Psychiatry-A South Asian perspective*. (pp 323-342). New Delhi: Byword viva publishers private limited.

Pathare, S., Shukla, B. & Bhugra, D. (2005). Affective Disorders. In Bhugra D, Ranjith, G. & Patel, V. (Eds.), *Handbook of Psychiatry-A South Asian perspective*. (pp 221-246), New Delhi: Byword viva publishers private limited.

Strain, J.J. & Newcom, J.H. (2003). Adjustment Disorders. In Tasman, A., Kay, J. & Lieberman, J.A. (Eds.), *Psychiatry, Vol. 2*, Edition 2, (pp. 1589-1602). England: John Wiley & Sons, Ltd.

Tanney, B. (1995). After a suicide: A helper's handbook. In Mishara, B.L. (Ed.), *The impact of suicide*. New York: Springer.

Thase, M.E. (1999). Reeducative psychotherapies. In Gabbard, G.O. & Atkinson, S.D. (Eds.), *Synopsis of treatments of psychiatric disorders*. Edition 2, (pp 505-514). Chennai: All India Publishers & Distributors Regd.

World Health Organisation. (1992). *The ICD-10 Classification of Mental and Behavioural Disorders – Clinical descriptions and diagnostic guidelines*. Oxford: Oxford University Press.



UNIT 14 DISORDERS OF CHILDHOOD AND ADOLESCENCE — DEVELOPMENTAL, BEHAVIOURAL AND EMOTIONAL

Structure

- 14.1 Introduction
- 14.2 Classification of Childhood and Adolescent Disorders
- 14.3 Developmental Disorders
 - 14.3.1 Mental Retardation
 - 14.3.2 Specific Learning Disability
 - 14.3.3 Pervasive Developmental Disorders
 - 14.3.4 Specific Developmental Disorders
 - 14.3.5 Habit Disorders
- 14.4 Behavioural Problems
 - 14.4.1 Attention Deficit Hyperactivity Disorder (ADHD)
 - 14.4.2 Conduct Disorder
 - 14.4.3 Oppositional Defiant Disorder
 - 14.4.4 Substance Abuse
- 14.5 Emotional Disorders
 - 14.5.1 Anxiety Disorders
 - 14.5.2 Phobias
 - 14.5.3 Somatoform Disorder
 - 14.5.4 Obsessive-Compulsive Disorder
 - 14.5.5 Depression
- 14.6 Childhood Psychotic Disorders
 - 14.6.1 Schizophrenia
 - 14.6.2 Manic Depressive Disorder
- 14.7 Causes of Childhood and Adolescent Psychiatric Disorders
- 14.8 Assessment of Childhood and Adolescent Disorders
 - 14.8.1 Case History and Mental Status Examination
 - 14.8.2 Cognitive Assessment
 - 14.8.3 Projective Techniques
 - 14.8.4 Rating Scales and Questionnaires
- 14.9 Application of Counselling and Family Therapy in Understanding and Correcting Child and Adolescent Psychiatric Disorders
- 14.10 Let Us Sum Up
- 14.11 Glossary
- 14.12 Answers to Check Your Progress Exercises
- 14.13 Unit End Questions
- 14.14 Further Readings and References

14.1 INTRODUCTION

Child and adolescent disorders are generally related to family environment. Behavioural problems are very common in children, but serious disorders have been reported to be between 10 to 15 per cent in different studies. Recent epidemiological study of child psychiatric disorders in urban and rural areas conducted by ICMR (2001) indicated the overall prevalence of mental and behavioural disorders in children to be 12.5 per cent. In an earlier study by Mehta *et al.* (1990), 13 per cent of children were found suffering from behavioural and emotional disorders. With the changing socio-cultural scenario, child psychiatric disorders are showing an increase. These problems are seen in both genders, but certain disorders are more commonly seen in boys.

Objectives

After studying this Unit, you will be able to:

- Know the prevalence of childhood and adolescent psychiatric disorders;
- Understand the criteria for classification of childhood and adolescent psychiatric disorders;
- Identify children with developmental, behavioural, emotional and psychotic disorders;
- Comprehend causes of child and adolescent psychiatric disorders;
- Understand the methods of assessment of child and adolescent disorders; and
- Know the applications of counselling and family therapy in child and adolescent psychiatric disorders.

14.2 CLASSIFICATION OF CHILDHOOD AND ADOLESCENT DISORDERS

Disorders of childhood can be viewed as a dimension ranging from normal behaviour to maladjustment to serious behavioural and emotional disorders. Some behaviour problems occur during development period, are transient and resolve on their own, whereas some become more complicated and need professional intervention. Behaviour problems arouse negative feelings in others. Behaviour disorders represent violation of universally accepted developmental behavioural norms. The criteria for identifying that the child or adolescent may be having a problem are as follows:

Age: Certain behaviours are normal for a particular age. For example, thumb sucking or enuresis in a two year old child is normal but abnormal for a ten year old.

Frequency: If a particular behaviour occurs once in a while it is normal, but if it occurs very often it is a matter of concern. For example, if a child has abdominal pain every morning before going to school, it is indicative of a problem.

Severity: Even a single episode of high intensity or severity requires professional attention. Examples of this are violent behaviour, fainting, muteness etc.

Effect on development: Some behaviours are persistent and have a negative impact on the growth and development of the child. For example, poor concentration or hyperactivity causes decline in academic performance.

Some behaviours are considered abnormal in all cultures and in all social strata. Serious self-injury and severe anxiety are the examples of this category of disorders, whereas over-activity, shyness and mixing with opposite sex are culture specific; there are different levels of tolerance across cultures.

The range of child and adolescent psychiatric disorders is very extensive. The following classification of disorders is adopted from ICD-10 and DSM-IV TR to describe common disorders.

Table 14.3: Common disorders of childhood and adolescence

Developmental	Behavioural	Emotional	Psychotic
Mental retardation	ADHD	Anxiety disorder	Schizophrenia
SLD	Conduct disorder	Phobias	Manic -
Autism	ODD	Somatoform disorder	Depressive
Enuresis	Substance abuse	OCD	
Encopresis		Depression	
Pica			
Rumination			
Sleep			

All clinical assessments require the examiner to make distinction between what is normal and what is abnormal behaviour in the child. Making such decisions in the case of a child is often difficult as behaviours considered normal at a particular age (for example, temper tantrums at age 4 years) would be considered abnormal at another age (for example, age 10 years). Obviously, knowledge of the normal development of children is a necessary prerequisite for making clinical decisions. Clinically, three definitions of abnormal behaviours have been described in the context of the above discussion (Garber, 1984). First, they can be viewed as deviations from age-appropriate norms (for example, enuresis in a 6 year old). Second, they can be exaggerations (either in frequency or intensity or duration) of normal developmental trends (for example, being rebellious as an adolescent). Third, there can be behaviours that interfere with normal developmental processes (for example, extreme aggressiveness or shyness that interferes with the development of friendships).

Check Your Progress Exercise 1

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. What are the criteria that are commonly adopted for identifying that the child is suffering from some developmental, behavioural or emotional problem?

.....

.....

.....

.....

.....

.....

.....

14.3 DEVELOPMENTAL DISORDERS

Following disorders are included under the broad classification of developmental disorders:

14.3.1 Mental Retardation

Mental retardation refers to sub-average intellectual functioning, which originates in the developmental period and is associated with deficit in cognition, language, motor, social abilities and adaptive behaviour. A person is said to suffer from mental retardation if:

- i) The IQ attained is below 70 on standard psychological tests of intelligence; and
- ii) The adaptive skills of the person are inadequate to cope up with the daily routines. *Adaptation skills* are those behaviours by which an individual makes adjustments and independent living in the society. In childhood years, these are the self-help activities such as eating and dressing independently. Later on the adaptive behaviours are concerned with basic academic skills, coping skills such as telling time, using money, reading and writing at basic level and assuming social responsibilities.

The children with mental retardation can be trained in skilled, unskilled and repetitive vocational tasks. Slowness in intellectual development may be widespread and affect all aspects of cognition.

In our country the problem of mental retardation is quite significant. The studies have shown an incidence of 4 to 5 per 1000 individuals. Mental retardation is categorised in four levels; these are, mild, moderate, severe and profound. Following table gives the characteristics of individuals with mental retardation in the four categories.

Category	IQ	Self help	Academic Skills	Vocational training
Mild	50-69	Can do	Basic reading, writing	Skilled work
Moderate	35-49	Can do	Poor comprehension	Unskilled work
Severe	21-34	Under supervision	Nil	Under supervision
Profound	0-20	Needs constant care	Nil	Nil

Table 14.2 : Characteristics of individuals with mental retardation

Clinical features: Mental retardation may first be identified by delay in the child's motor milestones in the first few months of life. The child will be slow to obtain head control, sit unsupported, stand, walk independently and speak. Large number of mildly retarded children however, show normal motor development and are present with language delay. The child may be thought to be deaf because she or he fails to respond to sounds or is unable to speak single words or word combinations at the appropriate age. Mildly retarded children may not be detected until they enter school, fail in exams, and show progress that is unsatisfactory due to a general slowness of development rather than due to a specific learning disability. Occasionally, mental retardation arises as a result of some postnatal event, such as a head injury or cerebral infection. You will study about this in detail in the Block 4.

Once diagnosed, the clinical features of children with mental subnormality will depend more especially on:

1. The severity of the condition;
2. The presence of associated physical and psychiatric conditions; and
3. The quality of care and education the child receives.

Management should begin with an explanation to the parents of the diagnosis, its probable cause, the way in which the child can be helped, and the likely outcome. It is important to reassure parents that their behaviour has not produced the condition, though this does not mean that, in the future, there is not much they can do to help the child. Children with mental retardation take longer to learn new material and once they have learned something new, they usually forget more easily than the normal. Consequently, they need more help, and more systematic help from parents, teachers and caregivers than others in the acquisition of skills. In particular, they often fail to learn by observation, and therefore, need more structured teaching. The help needs to be provided at an appropriate level for the child. It is useless to try and teach skills too far ahead of the child's present mental age. Parents play an important role in training these children. In the preschool period the main role for family therapists and counsellors, is in helping parents to find ways to stimulate their child's development.

14.3.2 Specific Learning Disability

Specific learning disorders or *dyslexia* refer to a group of disorders characterised by severe deficiencies in the development of skills in the academic, language and motor domains. The term does not include children who have learning problems primarily as a result of visual, hearing, or motor handicaps or mental retardation or emotional disturbance, or of environmental, cultural, or economic disadvantage. It is estimated that 3 to 15 per cent of school age children have some learning disability (Hersen and Ammerman, 1995). Clinic based studies from India report a prevalence of 3 per cent (ICMR, 2001).

The major causes of specific learning disability are as follows:

- Genetic,
- Perinatal trauma or neonatal trauma,
- Low birth weight,
- Maternal smoking and alcohol consumption during pregnancy, or
- Elevated lead levels.

Further, specific learning disorders are classified as given below:

1. Academic Skill (or Learning or Scholastic Skill) Disorders

Academic Skill or Learning or Scholastic Skill Disorders include:

- i) **Developmental reading disorder:** Developmental reading disorder includes significant impairment in reading such as word recognition, decoding skills and comprehension.
- ii) **Developmental arithmetic disorder:** Developmental arithmetic disorder includes marked impairment in arithmetic skills hindering achievement. They make simple calculative mistakes.
- iii) **Developmental expressive writing disorder:** In developmental expressive writing disorder there is severe impairment in spelling, grammar and punctuation skills, and poor paragraph organisation. Their handwriting is untidy and unrecognisable.

2. Language Disorders

Language disorders include four subcategories, which are as follows:

1. Developmental articulation disorder (also called phonological disorder) involves errors in sound production, substitution of one sound for another (For example, use of sound/t/for target/k/sound) or omission of final consonants,
2. Stuttering or stammering,
3. Developmental expressive language disorder includes limited vocabulary, delayed speech development and idiosyncratic word ordering, and
4. Developmental receptive (or mixed receptive-expressive) disorder is inadequate development of the ability to comprehend language.

3. Motor Skill Disorders

Motor skill disorders include the developmental coordination disorder. Child has significantly impaired coordination, which interferes with daily living activities. For example, these children have difficulty in tying shoe laces or knots.

There are associated behavioural problems and co-morbid conditions with children with Specific Learning Disability (SLD). Mild SLD can be modified easily. The management strategies include education of the child and the family regarding the exact nature of the disorder after a detailed assessment has been done. The child must be encouraged to follow the treatment plan. Punishment of the child for mistakes has to be avoided. The child is placed in a structured program of tasks, which are graded on a continuum of increasing difficulty. Behavioural principles of operant conditioning are used to mould behaviour (Levine, 1996).

14.3.3 Pervasive Developmental Disorders

The pervasive developmental disorders are a group of disorders that classify children presenting with impairments and deviances in social interaction, language and communication and play. Autistic spectrum disorders are included under this category and the three conditions are included here, these being autistic disorder, Asperger's disorder, and Rett's disorder.

1. Autistic Disorder

Autism is a behaviour syndrome present from early life and defined by deficient social interaction, language and communication and play.

Children with autism have some of the complaints like speech and language delay, impairment of comprehension of language, fluent but unintelligible jargon, impairment of social interaction, poor eye contact, gaze avoidance, lack of reciprocal social smile, lack of imaginative play, hyperactivity, unusual interest in TV commercials, repetitive compulsive play activities. Flapping of hands, twirling, toe walking, excessive stereotyped play are some of the odd behavioural manifestations. Many of the autistic children are irritable and chronically unhappy.

Seizures are more common in autistic children than in general population. 30 per cent autistic children have an IQ of 70 or more. Some autistic children have "Islands of brilliance". Differential diagnosis should be made with mental retardation, especially, the severe type, developmental language disorder in higher functioning autistic children, schizophrenia, Asperger's syndrome and Rett's syndrome.

Autism remains as the most difficult disability to manage and requires a multidisciplinary approach. This condition causes tremendous impact on couple relationship, hence family therapist can help the family in coping with special needs of the child. Pharmacotherapy is used for control of seizures and hyperactivity. Behaviour modification remains as the most successful and time tested mode of treatment in childhood autism. Parent counselling is the most important part of management of autistic disorders.

Factors favourable to a good prognosis are normal intelligence, good communicative skills (speech and language) at the onset, and absence of seizures. Symptoms that can be improved by therapy are eye contact, cognitive skills and communication. However, social interaction skills in the working place remain elusive. An attitude of hopefulness and continued effort is needed on the part of both the doctor and the parents.

2. Asperger's Disorder

Children with Asperger's disorder are high functioning in learning activities of daily living. They have impairment in social interaction, restricted behaviour and interests as seen in autistic disorder, but there is no evidence for clinically significant delay in language, cognitive functioning or age-appropriate self-help skills (Tantum, 1988). There are quantitative as well as qualitative differences from autism in impairment in social interaction and in restriction of interests and behaviour. Impairment in social interaction is less affected. Also, children diagnosed as Asperger's develop adequate attachment with parents, a feature never seen in autism. Similarly, imaginative play is present in Asperger's syndrome, which is deficient in autism.

The reported prevalence of the disorder is 1 in 10,000 with a male to female ratio of 9:1, and the disorder is frequently not recognised until after the age of 3 years. Etiology of the condition is unknown. It is believed that like autism, Asperger's disorder is a life long condition.

3. Rett's Disorder

Rett's disorder was first described in 1966 by Andreas Rett. The disorder is a progressive encephalopathy that develops between 5 and 48 months of age and is characterised by deceleration of head growth (leading to microcephaly), abnormalities of gait, loss of various functions and skills including language and social relatedness. There is also a loss of purposeful hand movements and midline hand stereotypes including hand wringing and hand wetting with saliva.

The cause of the disorder is unknown. It has an estimated prevalence of 1 in 10,000 males and 1 in 15,000 females (or even lower). Mental retardation is severe to profound and MRI reveals significant reduction in overall brain volume. There is no specific treatment and the course is one of progressive irreversible loss of motor function and cognitive functions.

14.3.4 Specific Developmental Disorders

The specific developmental disorders include the following disorders:

1. Elimination Disorders

Elimination disorders include two major disorders that are discussed below:

i) Enuresis: Enuresis is commonly known as bed-wetting. This is a very common problem in both boys and girls in developmental period. Enuresis is the involuntary voiding of urine not occasioned by a physical condition. The severity is determined by frequency of urination, quantity is not a diagnostic consideration. The child should have a mental age of at least 4 years (ICD-10) or 5 years (DSM-IV TR). While a majority of patients have

nocturnal bed wetting, a diurnal (but during sleep) variety and a combined variety have also been described.

Enuresis has been classified into persistent (primary) type and regressive (secondary type). In primary enuresis, the child has never been dry at night. About 75 per cent belong to this category and it is probably the result of inadequate or inappropriate toilet training (for example, parents do not want to wake up the child in the middle of the sleep). The regressive type is often precipitated by stressful environmental events, such as birth of a sibling, marital conflict in parent, or death of a family member. Bed wetting in this case is transitory and prognosis is better.

Management depends on understanding of possible specific causative factors and appropriate measures to tackle any stressors. Behavioural techniques may also be used. Often a 'bell and pad' instrument, based on principles of classical conditioning, is used with up to 75 per cent. Pharmacological treatment can also be given.

Box 1 : Methods to control enuresis

- Reward the child for dry night.
- Once bed-wetting occurs, older children should be asked to wash their own clothes and soiled bed sheets.
- Children should not be given any fluids after dinner.
- Waking the child 1 to 2 hours after sleep to void urine again may help.
- Punishment and humiliation by parents or siblings should be discouraged.

ii) Encopresis

Encopresis refers to passing of faeces into inappropriate places at any age when bowel control should have been established. Encopresis indicates a more serious emotional disturbance than enuresis and is less common (around 1 per cent of school age children). At present the problem is on increase due to early morning school timings. Some children try to postpone going to the toilet and then control is lost at the wrong place. Management is primarily with behavioural techniques.

2. Eating Disorders

Two major eating disorders of childhood stage are given below:

- i) **Pica:** This disorder involves repeated or chronic ingestion of non-nutrient substances, which may include plaster, charcoal, clay, toothpaste, paint and mud. The age of onset is usually 1 to 2 years. Although tasting or mouthing of objects is normal in infants and toddlers, pica after the second year of life needs investigation. Psychological theories of pica have found evidence for mental retardation, high frequency of maternal and paternal deprivation, family disorganisation, poor supervision and low socioeconomic status. Children with pica are at increased risk for lead poisoning and parasitic infestations. Pica can be treated with a

combination of education and guidance, family counselling and behaviour modification.

- ii) **Rumination disorder:** The main characteristic of this disorder is a weight loss or failure to gain weight at the expected level because of repeated regurgitation of food without nausea or associated gastrointestinal illness. This rare condition occurs more commonly in males and usually appears between 3 and 14 months of age. It is potentially fatal in upto one fourth of affected children. Behavioural treatment is directed towards positively reinforcing correct eating behaviour and negatively reinforcing rumination. Parent counselling and family therapy are often necessary.

3. Sleep Disorder

A substantial portion of children have struggle around bed time due to difficulty in falling asleep. Many use a special treatment to help them fall asleep. Infants who show difficulty in establishing regular night time sleep patterns may also show general fussiness and irritability as a temperamental characteristic. In some households, night time is very hectic due to socialising which causes lack of interest to sleep in children. Sleep difficulty may be a reflection of parental strife or underlying anxiety disorder such as separation anxiety disorder.

Different types of parasomnias have been described below:

- Nightmares are common phenomena occurring in the REM (rapid eye movement) phase of sleep. These occur more often in girls with affective or anxiety disorders.
- Night terrors occur in the stage 4 of non REM sleep. The child usually wakes with a scream, is confused, shows signs of intense autonomic activity (laboured breathing, dilated pupils, sweating, tachypnea or tachycardia) and appears frightened. The patient often does not recall the incident on waking up the next morning. They may be related to a specific developmental conflict or to a precipitating event.
- Sleepwalking or somnambulism occurs in stages 3 or 4 non REM sleep. There may be an associated history of enuresis or family history of sleepwalking. It is usually benign but temporal lobe epilepsy should be ruled out.
- Narcolepsy is characterised by frequent daytime naps, cataplexy, sleep paralysis, and/or hypnologic hallucinations. Polysomnographic studies, showing early onset of REM sleep following sleep onset, are required for definite diagnosis.

Some children talk in sleep of the activities of the day. This is considered normal if it occurs occasionally and does not have an impact on child's functional ability during the day time.

14.3.5 Habit Disorders

Habit disorders include tension-discharging phenomena such as head banging, body rocking, thumb sucking, nail biting, teeth grinding (bruxism) and tics. Let us discuss these habit disorders.

1. Head Banging

Rhythmic head banging or rocking in early life can persist without parental reinforcement, occurring when the child is alone. These movements seem to provide a kind of sensory solace for the child who is otherwise uncared for or under stimulated by human touch or interaction. Such patterns are often seen in children with mental retardation or children suffering from maternal or emotional deprivation.

2. Teeth Grinding

Teeth grinding or bruxism results from tension originating in unexpressed anger or resentment. It may create problems in dental occlusion. Helping the child to find ways to express resentment may relieve the problem.

3. Thumb-sucking

Thumb-sucking is normal in early infancy. It makes the older child appear immature and may interfere with normal alignment of teeth. Like any other rhythmic pattern, it can be seen as a way of securing extra self-nurturance. Parents should ignore the symptom if possible, while giving attention to more positive aspects of the child's behaviour. The child who actively tries to restrain thumb-sucking should be given praise and encouragement.

4. Nail-biting

Nail-biting is common in girls and boys in middle and late childhood. It is often associated with anxiety and nervousness. Keeping the child busy and teaching anxiety management can help in managing this.

5. Temper Tantrums

You would have witnessed a child screaming to get an ice-cream in the market. If her or his demand is not met, she or he starts kicking parents, abusing and becoming violent. As soon as her or his demand is fulfilled she or he becomes quiet. This type of behaviour, known as temper tantrum, usually occurs in children in the age range of 2 to 5 years. The problem increases when child is recovering from an illness, fatigue or when the child is hungry. This occurs in children when parents fail to discipline a child or get manipulated by the child. If this behaviour is persistent, professional intervention is required. Parents are counselled to use time-out strategy to avoid reinforcement of the behaviour, fulfill child's demand only if it is reasonable and before the tantrum starts or when the child becomes quiet.

6. Tics

Tics involve repetitive movement of muscle groups that have no apparent useful function and represent discharges of tension originating in emotional and physical states. Parts of the body most frequently involved are muscles of face, neck, shoulders, trunk and hands. Examples of tics include lip smacking and grimacing, tongue thrusting, eye blinking, throat clearing, and so on. They are not accompanied by any loss of consciousness. They are not seen during sleep and can be controlled voluntarily for short periods of time. Simple tics should be differentiated from involuntary movements, for example dyskinesia.

Gilles de la Tourette syndrome is a special type of tic disorder characterised by multiple motor tics, compulsive barking, grunting or shouting obscene words. Children with Gilles de la Tourette syndrome often suffer from secondary behavioural, emotional and academic problems. Many environmental precipitants have been noted to serve as emotional stressors, which also precipitate or worsen tics and Gilles de la Tourette's syndrome. This condition is mainly managed by pharmacotherapy.

Check Your Progress Exercise 2

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Define mental retardation.

.....

.....

.....

2. List the specific learning disabilities.

.....

.....

.....

3. Name three major pervasive developmental disorders.

.....

.....

.....

4. What are the two specific developmental disorders?

.....

.....

.....

5. List the major habit disorders.

.....

.....

.....

14.4 BEHAVIOURAL PROBLEMS

The major types of behavioural problems are discussed below:

14.4.1 Attention Deficit Hyperactivity Disorder (ADHD)

Symptoms of attention deficit hyperactivity disorder (ADHD) are complex and characterised by poor ability to concentrate, hyperactivity and impulsivity.

These children are fidgety, have a difficult time remaining in their seats in school, are easily distracted, have difficulty awaiting their turn, impulsively blurt out answers to questions, have difficulty in following the instructions and sustaining attention, shift rapidly from one incompleting activity to another task, intrude on others, often seem not to listen to what is being said, lose items frequently and often engage in physically dangerous activities. Due to inattention these children have poor school and social performance. A history of aggression and fears, poor relationships with peers, academic, behavioural problems at school and reaction to authority is also reported.

One of the theories about the cause of ADHD is, that it is due to minimal brain damage but this theory has been disputed. Also, there is no clear relationship between home environment and this syndrome. Excess sugar or food additives are believed to make children hyperactive but this is true only in 5 per cent of the children.

Improvement and good outcome is possible if the parents and teachers provide structured environment to the child and preserve the child's self esteem. Many of these children improve attention span as they grow but remain restless even in adulthood. Recent research indicates, that children with ADHD treated with multiple therapies (medication, and parent counselling) are less likely to present with delinquency in adolescence. The main focus of management would be to organise life and discipline. Parent counselling helps them to understand the problem, accept the child's condition and tell them that the hyperactive behaviour is not intentional. Attempts to change an energetic child into a quiet socially acceptable child may prove to be difficult. The children need to be provided with outdoor activities; play with minimal instruction would be beneficial. These children need to organise to get adequate sleep and rest. A structured home schedule for daily activities like wake up time, meal time, bedtime etc. should be followed with consistency. These children need a carefully planned discipline to be followed. Structured behavioural modification programme for increasing attention span, proper disciplining should be adopted. Teachers should be included in the management to improve class room behaviour.

14.4.2 Conduct Disorder

Conduct disorder is defined as persistent antisocial behaviour of children and adolescents that significantly impairs their ability to function in the social or academic area. Youngsters with this disorder repeatedly violate the age-appropriate rules of society, displaying a lack of concern for the rights and feelings of others. The rate is much higher among boys than the girls (Richter and Cicchetti, 1993).

There is evidence for two clusters of symptoms in conduct disorder, aggressiveness and delinquency. Aggression may be directed towards people (for example, peers) or animals (cruelty towards animals) or objects (destruction of property). Delinquency, on the other hand, includes antisocial behaviours, such as lying, stealing, running away and truancy that do not primarily involve physical attack on others. The onset of these symptoms may be preceded by the presence of a difficult temperament and high level of physical aggression in preschool years.

While evaluating a child for conduct disorder, one must consider whether the reported behaviour is appropriate developmentally for the age of presentation. Defiance and temper tantrums are often used by children between 1½ and 3 years of age when frustrated. This often resolves with time. Similarly, 2 to 4 year old children often use lying as a method of playing with language. By observing the reactions of parents and caregivers, preschoolers learn about expectations for honesty in communication. Almost all children steal something at some point in their lives. It becomes a problem when it happens more than once or twice. Thus, certain behaviours become a symptom only when they occur at a greater frequency or persist beyond a developmentally appropriate age. Unlike the previous behaviours, however, truancy, run-away behaviour, destruction of property (for example, through fire-setting), and repeated aggression against animals or others are never developmentally appropriate.

It is widely accepted that multiple influence and factors contribute to the development and maintenance of child conduct disorder. The risk for conduct disorder is increased among offsprings of parents who had conduct disorder, antisocial personality disorder or substance abuse disorders. Other postulated biological factors include high testosterone levels. This theory was put forward due to the high male to female ratio for the disorder, but there is no conclusive evidence in favour of this theory.

Conduct disorder is strongly associated with abusive, chaotic and neglectful family environments. Several specific risk factors have been identified, including exposure to marital conflict and physical aggression, maternal depression, large family size combined with lower socioeconomic status and early loss of father due to divorce. Parental psychopathology, such as antisocial personality and substance abuse may contribute both genetically and environmentally towards manifestation of conduct disorder in the offspring.

Many different nonpharmacological treatments have been used in the management of conduct disorder. These include individual therapy based on alliance building and behavioural principles. Family therapy designed to improve communication among family members and to elicit underlying conflicts is somewhat effective. Correctional schools can address the educational needs of juvenile delinquents.

Childhood conduct disorder often persists into adolescence and predicts antisocial behaviour and alcohol or substance abuse in adulthood. In general risk factors for poor prognosis are childhood onset (less than 10 year age), high level aggression, low intelligence, early court involvement and peer rejection.

14.4.3 Oppositional Defiant Disorder

This disorder is less severe than the conduct disorder. This is commonly seen in adolescence period, more often in boys. It involves temper tantrums, continuous arguing, defiance of rules, continual blaming of others and frequent use of obscene language. Adolescent has very good relationship with peers and people outside her or his immediate family. It has a better prognosis than conduct disorder. A variety of treatment approaches are commonly employed including behaviour therapy, family therapy and parent management training.

14.4.4 Substance Abuse

Substance abuse and alcohol are increasing like an epidemic in our children and adolescent population. The abuse is often by inhalants like thinner, white fluid, cough syrups, tobacco or *gutka* and *charas* or *ganja*. Twenty per cent of children and adolescents start experimenting with alcohol and drugs by 11 years of age (Rapid Assessment Survey, 2004). There are other psychosocial factors which lead to addiction namely, change in life style, low frustration tolerance, easy availability of drugs and peer pressure. The clinical manifestation of substance use in children is – decline in academic performance, change in behaviour, irritability, decreased interaction with family members, lying and stealing and changes in eating and sleeping behaviour. These children can be assessed on detailed case history, mental status examination and standardised psychological rating scales such as CAGE, teen-addiction severity index, Fagerstrom test for nicotine dependence.

Check Your Progress Exercise 3

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Fill up the blanks
 - i) ADHD is a disorder characterised by poor ability to concentrate, ... and
 - ii) While evaluating a child for conduct disorder, one must consider whether the reported behaviour is for the age of presentation.
2. Define 'conduct disorders'.

.....

.....

.....
3. List the psychosocial factors which lead to substance abuse.

.....

.....

.....

14.5 EMOTIONAL DISORDERS

Emotional disorders include anxiety disorders, phobias, somatoform disorder, obsessive-compulsive disorder and depression. Let us discuss these disorders in detail.

14.5.1 Anxiety Disorders

Anxiety, fearfulness, and worrying are regularly experienced as a part of normal development. When they become disabling to the point that they negatively affect social interactions and development, they are pathologic

and warrant intervention. Separation anxiety disorder, overanxious (generalised anxiety) disorder, obsessive-compulsive disorder, phobias and post-traumatic stress disorder are all defined by occurrence of either diffuse or specific anxiety related to predictable situations. Of these the former two are more specific in their onset at any age. The prevalence of anxiety disorders has been reported to be 6-8 per cent. About one-third of these children were overanxious and another third have specific fears or phobias.

1. Separation Anxiety Disorder

The main characteristic of a child with separation anxiety disorder is excessive anxiety concerning separation from home or a primary caretaker. The antecedent of developmentally normal anxiety initially presents at 7 to 8 months of age as infants begin to differentiate from their primary caregivers.

The prevalence of this disorder has been estimated to be between 3.5 and 4.1 per cent. Sex ratio figures seem to show female predominance of 3 to 1. Children with separation anxiety disorder show intense anxiety, to the point of panic, when they are separated from their primary caretaker. They can have difficulties playing outside of home, staying with babysitters, going to school, or even being alone in a part of their home. Physical symptoms (for example, headache, pain in abdomen, etc) can occur when separation is about to occur (for example, when going to school) or does occur. Sleep disruption can occur with the child requiring someone to stay with them till they fall asleep. They may also refuse to sleep alone. Children can worry about getting lost and never being reunited with parents. Fears about harm to the family may become exaggerated (for example, fears of kidnappers or monsters coming into house).

Mothers of children with separation anxiety disorder very commonly have a history of psychiatric illness, especially an anxiety or a depressive disorder. These children can be managed by behaviour therapy and family therapy.

2. Overanxious Disorder

Children who suffer from this disorder have unrealistic worries about future events, the appropriateness of past behaviour and concerns about competence. They frequently present with somatic complaints (for example sweating, palpitation, chest pain, difficulty in breathing, nausea, etc.) and are markedly self-conscious, need large amounts of reassurance, and have trouble relaxing. These children may be managed with self-control measures like relaxation techniques, yoga and biofeedback.

3. Examination Anxiety

Many children before examination experience feeling of apprehension and anxiety. The anxiety begins with preparation period and becomes intense near examination. Children with this type of anxiety develop poor appetites, recurring abdominal pain, headache and sleep disturbance. Mild case of examination anxiety can be managed by psychological intervention. In severe cases pharmacological treatment is required.

14.5.2 Phobias

Children with phobias are anxious only under specific conditions. They try to avoid specific objects or situations that automatically lead to anxiety (for example, animals, closed or open spaces, heights, etc.). School phobias are

commonly seen in children; in this the child develops irrational fear to some aspects of school situations. The child is not able to attend school inspite of deep interest in studies. Though anxiety is prominent some children also have depressive feelings. Other complaints may be abdominal pain, vomiting, anorexia, headache and giddiness. The symptoms are usually intense or present during the school-going hours. Generally, the cause of school phobia is disturbed family relationships.

The first step in treatment is to help the child to attend school. Behavioural techniques (like graded exposure) are very effective in the management of school phobias. Parents should be given insight into the mechanism involved. Drugs may be considered when anxiety and depression are severe.

14.5.3 Somatoform Disorder

Somatoform disorder or conversion disorder is the most common disorder seen in our child psychiatric clinics. It is the disturbance of voluntary motor or sensory system. Often the symptoms are means to get primary and secondary gains. These patients commonly seek first consultation with the pediatrician as the symptoms are primarily physical, viz, seizures, aches and pains, hyperventilation, vomiting and paralysis. The symptoms are variable, fluctuating and usually do not follow any organic pathway. It occurs in both males and females, generally above the age of eight years.

A variety of methods have been recommended for symptom removal. They include such interventions as reassurance, suggestions, behavioural modification (operant conditioning and aversive therapy), hypnosis, use of placebo, and use of sedatives. Parent counselling is very important to decrease parents' anxiety and to modify their reinforcing behaviour. A simple ABC (Antecedent, Behaviour, Consequence) chart may be maintained by the parents to understand the cause of the symptoms.

14.5.4 Obsessive-Compulsive Disorder

Children with Obsessive-Compulsive Disorder (OCD) present with repetitive thoughts (obsessions) or repetitive rituals or movements (compulsions). *Obsessions* have been defined as intrusive thoughts, fears or images which become imposed on the conscious mind repeatedly and which cause anxiety. Typically, the thoughts or fears are perceived as senseless and the individual tries to resist them but is unsuccessful. Obsessions are concerned with fears of contamination with bodily secretions and wastes or fear that some bad event might happen. The most common compulsions are 'hand-washing', continuous checking of locks and repeated touching. This condition is treated with specialised behavioural techniques (for example, thought stopping, systematic desensitisation or exposure and often drug treatment and behaviour therapy are combined for response prevention).

14.5.5 Depression

Depression has been on rise in children and adolescents. It presents with mood disturbance, anhedonia and vegetative symptoms in children.

The prevalence of depressive disorders in childhood has been estimated to be 0.15 to 2.0 per cent. This is less than the prevalence in adulthood. Girls report significantly more depressive symptoms than boys.

Depressive symptoms vary according to the age and developmental level.

Spitz described the anaclitic depression of infancy. Separation from a primary caregiver after 6 to 7 months of age leads to a sequence of behaviours. The first phase of this sequence is labelled as *protest* (crying, searching, hypermotility of arms and legs, etc). This is followed by the infants *close scrutiny of each approaching adult*, looking for the caregiver. The final phase involves *apathy* in which infant becomes apathetic and hypotonic, exhibiting an obviously sad facial expression.

Depressed school aged children present with sad facial expressions, easy tears, irritability, social withdrawal, vegetative symptoms, anxiety and behavioural disturbances. They have lack of interest in activities liked earlier, there is decline in school performance and decrease in interaction with family members and friends. Delusions are uncommon in psychotically depressed prepubertal children.

Family therapy can be useful in changing parent's interaction with the child or adolescent. Chances of relapse are very high in these children.

Check Your Progress Exercise 4

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. List the major anxiety disorders.

.....

.....

.....

2. Write short note on:

i) Somatoform disorder

.....

.....

ii) Obsessive-compulsive disorder

.....

.....

14.6 CHILDHOOD PSYCHOTIC DISORDERS

14.6.1 Schizophrenia

Schizophrenia with childhood onset refers to the development of mood-incongruent delusions, hallucinations, disorganised speech plus a deterioration in functioning (in academic performance, peer relationships etc.) under 15 years of age. It is an uncommon disorder and prepubertal onset is particularly rare. Epidemiological data regarding childhood onset schizophrenia is lacking.

The current concepts followed in both the major classifications that are ICD-10 and DSM IV TR; prescribe the same diagnostic criteria for schizophrenia regardless of the age of onset — childhood, adolescence or adulthood. Though medication is the main treatment but individual and family therapy is also recommended.

14.6.2 Manic Depressive Disorder

Bipolar illness is defined as either alternating depression and mania or as mania alone. Manic episodes are characterised by excessive activity, euphoria and elation of mood, increased attempts to socialise with peers, excessive speech which is full of boastful or grandiose content, excessive spending and sexually inappropriate behaviour like masturbating in front of others. The illness typically presents in the second and the third decade of life. However, there are some cases beginning before puberty.

Though essentially the features of bipolar disorder of childhood resemble that of adults, manic episodes in childhood are found to have the following distinct features:

- Associated medical or neurological problems are common,
- Unpleasant mood is found as frequently as elevated mood in mania, and
- Convincing entrenched delusions were are rarely seen in prepubertal children.

The earlier the onset of bipolar symptoms, the more susceptible the patient is to suicide, and greater is the frequency of episodes and rapid cycling. Treatment is mainly pharmacological, for both acute mania and bipolar disorder.

14.7 CAUSES OF CHILDHOOD AND ADOLESCENT PSYCHIATRIC DISORDERS

Why a particular child behaves in an abnormal way will depend upon her or his biological factors and environmental factors, which include family, school and society in which she or he lives. The following Table 14.3 summarises these factors.

Biological	Psychosocial		
	Family	School	Culture
Genetic disposition	Attitudes of parents	Stress	Media
Fragile-X	Over protection	Self-esteem	Terrorism
Down syndrome	Rejection	Achievement	Neighbourhood
Brain damage	Child abuse	Peer group	Ethnicity
Intelligence	Discipline	Discipline	
Temperament	Anxiety	Social skills	
Illness	Role model	Antisocial	
Physical Handicap	Expectation		
Fatigue	Time spent with the child		
Malnutrition	Conflict		
	• Parents		
	• Family members		
	• Alcoholism		

Table 14.3: Causes of behaviour and emotional problems

There can be a single factor like fragile X causing autism in the child or multiple factors causing a problem behaviour; like in a child with ADHD, very high intelligence, poor discipline at home and poor social skills in school while interacting with friends. A family counsellor or family therapist has to elicit the causes as this would provide the direction in planning of therapy.

Check Your Progress Exercise 5

Note : a) Read the following questions carefully and answer in the space provided below.

b) Check your answers with those provided at the end of this Unit.

1. Define schizophrenia in childhood.

.....
.....
.....

2. What are the distinct features of child with mania depressive disorder?

.....
.....
.....

3. List the major family factors that may cause behavioural and emotional problems in children.

.....
.....
.....

14.8 ASSESSMENT OF CHILDHOOD AND ADOLESCENT DISORDERS

Examination of the child consists of interviewing the child as well as her or his family. Often a child's understanding of what troubles her or him may be at variance with the reports of her or his parents and teachers. Also, many behaviour problems are situation-specific. For example, a child may have severe temper tantrums only when she or he is with her or his mother, or a child who is obedient at school may be destructive in the home. Therefore, as a general rule, information should be gathered from multiple sources (for example parents, peers and teachers etc.) Child's behaviour and co-operation may vary from time to time. A child may have her or his good days and her or his bad days. A comprehensive assessment would therefore require observing the child serially over several sessions.

Assessment for behaviour problems is carried out in the following steps.

14.8.1 Case History and Mental Status Examination

A detailed case history is taken from the time of conception to the present. This includes beginning of problem behaviour, development of the child, family history, family environment, child's temperament, school performance and interpersonal relationship.

The mental status examination refers to child's current abilities to understand her or his actions and interaction with the environment. The child is observed in a structured situation and standard questions are asked to assess her or his feeling and thoughts. Both case history and mental status examination are important in making diagnosis of the child. The example of case history and mental status examination will be given in Manual for Supervised Practicum of this Course.

14.8.2 Cognitive Assessment

The child's cognitive abilities are assessed on a standardised objective test. These include attention, concentration, verbal and performance intelligence, social maturity, adaptive behaviour, and memory. Attention and concentration can be assessed on digit span test, colour or letter cancellation test.

Standardised tests of intelligence are employed routinely as a part of clinical assessment and for educational purposes. The diagnoses of mental retardation, specific learning disorders and developmental language disorders can be made on the basis of these tests. Intelligence predicts an individual's ability to adapt and integrate in society. Low intelligence may increase vulnerability with respect to the development of specific psychiatric disorders, for example, conduct disorders.

Standard measures of intelligence (for example, Wechsler's Intelligence Scale for Children, WISC; Malin's Intelligence Scale for Indian Children, MISIC) provide 3 scores that are Verbal Intelligence Quotient (VIQ), Performance Intelligence Quotient (PIQ) and full Intelligence Quotient (IQ). The verbal subtests are dependent on verbal comprehension and expression, general awareness and calculation. The scores on subtests are age-corrected and summated to give the VIQ. The performance subtests are dependent on visual analysis, visual motor integration, and motor speed. PIQ is calculated in a manner similar to that of VIQ. The global or full score IQ is obtained as the mean of VIQ and PIQ. Full scale IQ is examined for a general placement of the person on the continuum. The average intelligence range is 90-110. However different assessment methods are used to assess the developmental trends for infants and children below 5 years of age. Vineland social maturity test and adaptive behaviour are very useful scales. These are also adapted for Indian children. Memory is a part of intelligence tests. For specific assessment memory can be assessed on NIMHANS memory tests for children.

14.8.3 Projective Techniques

Projective techniques are unstructured stimulus material on which the child's unconscious conflicts and thoughts are elicited. These tests are very useful in understanding the psychodynamic aspect of child's behaviour and child's interactions with family members. Some of the examples of these types of tests are Draw a Person Test, House-tree-person test, in which a child is asked to draw on a plain sheet of paper with her or his imagination. In children's apperception test, child has to make a story on the pictures given to her or him. Picture frustration test consists of semi-structured situations on which the child has to respond with the very first thought that comes to her or his mind. These tests need training in administration, scoring and interpretation. They are very useful in understanding the psychopathology and planning treatment.

14.8.4 Rating Scales and Questionnaires

Rating scales and questionnaires are objective methods to assess psychopathology and personality of the child. Parents or teachers rate on the rating scales. Self rating scales are used for adolescents. Two well-known checklists for children are – Child Behaviour Checklist (CBCL; Achenbach and Edlebrock, 1979) and Conner’s Teacher Rating Scale (CTRS; Conners, 1969). Examples of self-report instruments are Child Depression Inventory (CDI; Kovacs, 1981) and Perceived Competence Scale (PCS; Harter, 1982). There are Indian standardised rating scales and norms available for the assessment. Some of the Indian rating scales are – Developmental Psychopathology Checklist for Children (Kapur), Childhood Psychopathology Measurement Schedule (Malhotra) and Temperament Measurement Schedule (Malhotra).

Check Your Progress Exercise 6

Note : a) Read the following question carefully and answer in the space provided below.

b) Check your answer with that provided at the end of this Unit.

1. List down the steps to asses the behaviour problem in a child.

.....

.....

.....

14.9 APPLICATION OF COUNSELLING AND FAMILY THERAPY IN UNDERSTANDING AND CORRECTING CHILD AND ADOLESCENT PSYCHIATRIC DISORDERS

Family therapy has significant applications in child and adolescent psychiatric disorders. As you have read in Section 14.7, family environment is very crucial in causation of these disorders. Some maladaptive behaviours are learned or acquired through family members. For example, uncontrolled anger outbursts. Many behavioural and emotional disorders are made worse by social interactions within family. The problem behaviours are learnt through modeling, reinforcement and punishment and learning process that shape and maintain behaviour, both normal and deviant (Bandura, 1986). The parents and other significant members living in the family unknowingly create conditions that cause and support undesirable and inappropriate behaviour. At times, it is a very pitiable situation that parents come with the child for management of particular behaviour, and the interactions and interview shows that parents are at fault; responsible for developing that problem behaviour in the child. One example of this is, initially parents fulfill all demands of the child to avoid child’s crying or throwing of temper tantrums. Later when this behaviour develops into a persistent deviant behaviour they seek intervention. Very often the child is not to be blamed for her or his problems. Another example of this is parents keep pressing their children too much to study. Such children after some time get irritated, are not able to take more

and are driven to commit suicide or behave aggressively with parents. Sometimes anxiety or depression in parents is due to child's behaviour, often not bringing results according to their expectation, getting involved with friends who are not approved by parents and so on. The awareness of disorders will lead to understanding impact of child's problem on the parents and siblings.

You have also learnt in this Unit that in many childhood disorders, family therapy and counselling is used to bring the positive change in child's behaviour. The management has to be focused on changing parent's attitudes and method of interaction with the children. A family therapist can help the parents to understand child's deviant behaviour and help in bringing the desired change in family functioning. In the management of these disorders, the family members may be required to bring change in their behaviour; for example, change their way of reacting to stress or method of disciplining. Family members are also trained to be co-therapist in the therapy sessions.

Thus, knowledge of child and adolescent psychiatric disorders is very important for the counsellors and family therapists.

14.10 LET US SUM UP

During developmental period some behavioural problems are very common in children. These are head banging, thumb-sucking, nail-biting, temper tantrum, rubbing of genital area and tics.

The causes for these disorders are biological as well as environmental. Family environment is very important in bringing up healthy children.

Taking detailed case history, conducting mental status examination and using standardised psychological tests help in carrying out assessment of child and adolescent psychiatric disorders.

Counselling and Family therapy is critical in the management of child and adolescent psychiatric disorders.

14.11 GLOSSARY

ABC	: Antecedent, behaviour, consequence chart.
Adaptive skills	: Behaviours by which an individual makes adjustments and independent living in the society.
Autism	: Behaviour syndrome present from early life that includes deficient social interaction, language and communication and play.
Bruxism	: Teeth grinding.
Encopresis	: Passing of faeces into inappropriate places at any age, when control should have been established.
Enuresis	: Bed-wetting.

Pica	: Repeated or chronic ingestion of non-nutrient substances.
REM	: Rapid eye movement.
Obsessions	: Sustensive thoughts, fears or images which become imposed on the conscious mind repeatedly and which cause anxiety.
OCD	: Obsessive-compulsive disorder.

14.12 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercises 1

- Following are the criteria to identify that the child is suffering from some developmental, behavioural or emotional problem:
 - Age: Certain behaviours are normal for a particular age. For example thumb sucking or enuresis in a two year old child is normal but abnormal for a ten year old;
 - Frequency: If a particular behaviour occurs once in a while it is normal, but if it occurs very often it is a matter of concern. For example, a child having abdominal pain every morning before going to school;
 - Severity: Even a single episode of high intensity or severity requires professional attention. Examples are violent behaviour, fainting, muteness etc.; and
 - Effect on development: Some behaviours are persistent and have a negative impact on the growth and development of the child. For example, poor concentration or hyperactivity causes decline in academic performance.

Check Your Progress Exercises 2

- Mental retardation refers to sub average intellectual functioning, which originates in the developmental period and is associated with deficit in cognition, language, motor, social abilities and adaptive behaviour. A person is said to suffer from mental retardation if:
 - The IQ attained is below 70 on standard psychological tests of intelligence, and
 - His or her adaptive skills are inadequate to cope up with the daily routines.
- Following are the specific learning disabilities:
 - Academic or learning or scholastic skill disorder,
 - Language disorder, and
 - Motor skill disorder.

3. The three major pervasive developmental disorders are given below:
 - (i) Autistic disorder,
 - (ii) Asperger's disorder, and
 - (iii) Rett's disorder.
4. The two specific developmental disorders are:
 - (i) Elimination disorders which include enuresis and encopresis, and
 - (ii) Eating disorders which include pica, rumination disorder and sleep disorders.
5. The major habit disorders are as following:
 - (i) Head banging,
 - (ii) Thumb sucking,
 - (iii) Nail biting,
 - (iv) Temper tantrums, and
 - (v) Tics.

Check Your Progress Exercises 3

1.
 - (i) hyperactivity, impulsivity
 - (ii) appropriate
2. Conduct disorder is defined as persistent antisocial behaviour of children and adolescents that significantly impairs their ability to function in the social or academic area.
3. Psychosocial factors which lead to substance abuse are change in life style, low frustration tolerance, easy availability of drugs and peer pressure.

Check Your Progress Exercise 4

1. Following are the major anxiety disorders:
 - (i) Separation anxiety disorder,
 - (ii) Overanxious disorder, and
 - (iii) Examination anxiety.
2.
 - (i) Somatoform disorder: Somatoform disorder is the disturbance of voluntary motor or sensory system. Often the symptoms are means to get primary and secondary gains. These patients commonly seek first consultation with the pediatrician as the symptoms are primarily physical, viz, seizures, aches and pains, hyperventilation, vomiting and paralysis.
 - (ii) Obsessive compulsive disorder: Obsessive-Compulsive disorder (OCD) presents with repetitive thoughts (obsessions) or repetitive rituals or movements (compulsions). Obsessions have been defined

as intrusive thoughts, fears or images which become imposed on the conscious mind repeatedly and which cause anxiety. Typically, the thoughts or fears are perceived as senseless and the individual tries to resist them but is unsuccessful.

Check Your Progress Exercise 5

1. Schizophrenia in childhood refers to the development of mood-incongruent delusions, hallucinations, disorganised speech plus a deterioration in functioning (in academic performance, peer relationships etc.) under 15 years of age.
2. The distinct features of child with mania depressive disorder are given below:
 - Associated medical or neurological problems are common,
 - Unpleasant mood is found as frequently as elevated mood in mania, and
 - Convincing entrenched delusions are rarely seen in pre-pubertal children.
3. The major family factors that may cause behavioural and emotional problems in children are given below:
 - Attitudes of parents,
 - Over protection,
 - Rejection,
 - Child abuse,
 - Discipline,
 - Anxiety,
 - Role model,
 - Expectation,
 - Time spent with the child,
 - Conflict with parents and family members, and
 - Alcoholism.

Check Your Progress Exercise 6

1. The steps to assess the behaviour problem in a child are given below:
 - i) Case history and mental status examination,
 - ii) Cognitive assessment,
 - iii) Projective techniques, and
 - iv) Rating scales and questionnaires.

14.13 UNIT END QUESTIONS

1. List the criteria to label a particular behaviour as abnormal.
2. What are developmental disorders?

3. How will you differentiate between autism and mental retardation?
4. Define the term 'somatoform disorder' and describe a case you have seen with this disorder.

14.14 FURTHER READINGS AND REFERENCES

Kapur, M. (1995). *Mental health of Indian children*. New Delhi: Sage Publications.

Kapur, M. (1997). *Mental health in Indian school*. New Delhi: Sage Publications.

Kauffman, J.M. (2001). *Characteristics of emotional and behavioural disorders of children and youth*, 7th Edition. New Jersey: Merrill Prentice Hall.

Lewis, M. (2002). *Child and adolescent psychiatry – A comprehensive textbook*. New York: Lippincott Williams & Wilkins.



COURSE COORDINATORS

Dr. Amiteshwar Ratra
Research Officer
NCDS, IGNOU, New Delhi

Prof. Neerja Chadha
Professor of Child Development
SOCE, IGNOU, New Delhi

COURSE WRITERS

Unit 1 Dr. Amiteshwar Ratra, Research Officer, NCDS, IGNOU, New Delhi

Unit 2 Dr. Rashmi Gangamma, Therapist, USA

Unit 3 Dr. Poornima Bhola, Assistant Professor, Dept. of Psychiatry, St. John's Medical College Hospital, Bangalore

Unit 4 Prof. Manju Mehta, Professor, Department of Psychiatry, AIIMS, New Delhi

BLOCK EDITORS

Prof. Girishwar Misra
Department of Psychology
University of Delhi, New Delhi

Prof. Neerja Chadha
Professor of Child Development
SOCE, IGNOU, New Delhi
*Course Editing by the Programme
Coordinators Involved Content Editing,
Language Editing, Unit Formating and
Transformation of the Units.

Dr. Amiteshwar Ratra
Research Officer
NCDS, IGNOU, New Delhi

Acknowledgment:

We express our thanks to all those who have contributed their photo images for the cover page.

January, 2011

© Indira Gandhi National Open University, 2011

ISBN:

All rights reserved. No part of this work may be reproduced in any form, by mimeograph or any other means, without permission in writing from the Indira Gandhi National Open University, New Delhi.

Further information on Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi- 110 068 or the official website of IGNOU at www.ignou.ac.in.

Printed and published on behalf of Indira Gandhi National Open University by Registrar, MPDD.

Laser Composed by: Rajshree Computers, V-166A, Bhagwati Vihar, (Near Sector-2, Dwarka), Uttam Nagar, New Delhi-110059

Printed by: