ABNORMAL PSYCHOLOGY

BSc.Counselling Psychology

VI SEMESTER

ELECTIVE

(CUCBCSS 2014 Admn.Onwards)

UNIVERSITY OF CALICUT

SCHOOL OF DISTANCE EDUCATION

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STUDY MATERIAL

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MODULE 1

CONCEPT OF NORMALITY AND ABNORMALITY

The term 'normal' is extremely subjective and context-dependent. According to Grivas et al (2010), what is accepted to be normal is "the pattern of thoughts, feelings or behaviour that conforms to usual, typical or expected standards in a culture". Then, abnormal is "the patterns of thoughts, feelings or behaviour that is deviant, distressing and dysfunctional in relation to the usual, typical or expected standards in a culture." No single indicator is sufficient enough to define or determine abnormality. Generally, the following factors indicate whether a person has some form of abnormality.

Social Context

What may be considered as normal in one societal makeup or culture is likely to be vastly different to another culture. Thoughts, feelings and behaviours, which are inappropriate or unusual in a culture are regarded as abnormal. For example, in some South-East Asian countries, it is entirely acceptable for one to spit on the ground to clear one's throat – it is normal. However, in Australian culture, this is largely unacceptable and abnormal. Even within cultures or different groups of people, whether something is normal or not depends on the particular situation or context. For example, carrying a fully-loaded rifle may be normal if you are part of the armed forces, but probably not if you are in a restaurant.

Violation of the Standards of Society

When people fail to follow the conventional social and moral rules of their cultural group we may consider their behaviour abnormal. Of course, much depends on the magnitude of the violation and on how commonly the rule

is violated by others. a behaviour is most likely to be viewed as abnormal when it violates the standards of society and is statistically deviant or rare. In contrast, most of us have parked illegally at some point. This failure to follow the rules is so statistically common that we tend not to think of it as abnormal.

Social Discomfort

When someone violates a social rule, those around him or her may experience a sense of discomfort or unease. People who walk the streets looking dirty, making bizarre body movements or shouting at others are widely spotted as 'abnormal'. Such behaviours that make people uncomfortable or cause distress to them are indicative of abnormality. At times, the most important factor, is our evaluation of whether the person can control his or her behaviour. Behaviours that the society views as irrational, unpredictable and dangerous are indicative of abnormality.

Subjective Distress

If people suffer or experience subjective distress it is indicative of abnormality. Depressed people clearly suffer, as do people with anxiety disorders. Such distress include feelings of dissatisfaction, sadness, anxiety or lethargy, physical complaints like nausea or headache, or unwanted thoughts or impulses. Although suffering is an element of abnormality in many cases, it is neither a sufficient condition (all that is needed) nor even a necessary condition (a feature that all cases of abnormality must show) so as to consider something as abnormal.

Impairment of Adaptive Functioning

Maladaptive behaviour is often an indicator of abnormality. Adaptive behaviour may be understood as behaviour that meets the performance requirements or role demands of one's situation. The person with depression may withdraw from friends and family and may be unable to work for weeks or months. Maladaptive behaviour interferes with our well-being and with our ability to enjoy our work and our relationships.

Statistical Deviancy

The word abnormal literally means "away from the normal." But simply considering statistically rare behaviour to be abnormal does not provide us with a solution to our problem of defining abnormality. If something is statistically rare and undesirable (like severely diminished intellectual functioning), we are more likely to consider it abnormal than something that is statistically rare and highly desirable (such as genius) or something that is undesirable but statistically common (such as rudeness).

Abnormality may be thus understood as significant deviation from commonly accepted patterns of behaviour, emotion or thought. Decisions about abnormal behaviour always involve social judgments and are based on the values and expectations of society at large. This means that culture plays a role in determining what is and is not abnormal.

MEANING, DEFINITION AND CLASSIFICATION OF MENTAL DISORDERS

Abnormal psychology is concerned with understanding the nature, causes, and treatment of mental disorders. According to the Diagnostic and Statistical Manual of Mental Disorders, Edition 5 (DSM-5), a mental disorder is defined as a syndrome that is present in an individual and that involves clinically significant disturbance in behaviour, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for

mental functioning. DSM-5 also recognizes that mental disorders are usually associated with significant distress or disability in key areas of functioning such as social, occupational or other activities. However, predictable or culturally approved responses to common stressors or losses (such as death of a loved one) are excluded. In brief, mental disorders are patterns of abnormal behaviour, emotions or thought that significantly interfere with an individual's adaptation to important life demands and often cause distress in the individual or in others.

Diagnosis of mental disorders can lead to effective and efficient treatment and, ideally, cure. Organizing information within a classification system allows us to study the different disorders that we classify and therefore to learn more about their causes, prognosis and treatment. At the most fundamental level, classification systems provide us with a nomenclature (a naming system) and enable us to structure information in a more helpful manner. There are two main systems of mental disorders classification: the categorical approach and the dimensional approach.

The categorical approach uses discrete, distinct categories and sub-categories to order mental disorders. It uses a systematic approach to classification, outlining symptoms based on scientific research. It is consistent and comprehensive, but divisive. It distinctly divides people into groups, which may result in stigmatism and labelling.

The categorical approach utilises two tools to aid in diagnosis: the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Edition 4) and the ICD-10 (International Classification of Diseases and Related Health Problems, Edition 10). Both classify mental disorders, order them categorically and use recognisable symptoms to aid their classification. The DSM-IV has 16 categories, and is widely used by mental health professionals for diagnosis whereas the ICD-10 has 21 chapters, and is generally used by doctors and psychiatrists.

The DSM-IV uses five axes:

- Axis 1: Clinical disorders and other conditions (patient's primary diagnosis)
- Axis 2: Personality disorders and mental retardation
- Axis 3: General medical conditions that might affect the patient psychologically.
- Axis 4: Psychosocial and environmental problems
- Axis 5: Global assessment of functioning, an assessment of the patient's level of functioning

Unlike the categorical approach, the dimensional approach uses scales and continuums to diagnose, quantifying symptoms so that they can be analysed. Strengths of the dimensional approach are more comprehensive diagnosis, unique combinations of mental conditions and non-divisive approach, not leading to labelling and stigmatism. However, due to unique combinations being taken into account, the diagnosis process can become very time-consuming. Also, there are potentially endless combinations, meaning that accurate diagnosis may prove difficult.

MODULE 2

ANXIETY DISORDERS

Anxiety refers to a sense of agitation or nervousness, which is focused on an upcoming potential danger. The anxiety response pattern is a complex blend of unpleasant emotions and cognitions that is more oriented to the future and much more diffuse than fear. It has cognitive/subjective, physiological and behavioural components:

- At the cognitive/subjective level, anxiety involves negative mood, worry about possible future threats or danger, self-preoccupation, and a sense of being unable to predict the future threat or to control it if it occurs.
- At a physiological level, anxiety often creates a state of tension and chronic over-arousal, which lead to risk assessment and readiness for dealing with danger if it occurs.
- At a behavioural level, anxiety may create a strong tendency to avoid situations where danger might be encountered.

The adaptive value of anxiety is that it helps to plan and prepare for possible threat. In mild to moderate degrees, anxiety actually enhances learning and performance. It is maladaptive when it becomes chronic and severe, as in people diagnosed with anxiety disorders.

Anxiety disorders refer to a category of psychological disorders in which the primary symptoms involve extreme anxiety, intense arousal, and/or extreme attempts to avoid stimuli that lead to fear and anxiety. For a person with an anxiety disorder, the anxiety does not go away and can get worse over time. The feelings can interfere with daily activities such as job performance, school work, and relationships. When people perceive a threat, the fight-or-flight response (the automatic neurological and bodily response) arises. This response underlies the fear and anxiety involved in almost all anxiety disorders. When the arousal feels out of control the person may experience panic. In response to

the panic, some people develop a phobia of stimuli related to their panic and anxiety symptoms.

Anxiety disorders frequently co-occur with other psychological disorders, such as depression or substance-related disorders. The high comorbidity of depression and anxiety disorders suggests that the two disorders share some of the same features, specifically high levels of negative emotions and distress, which can lead to concentration and sleep problems and irritability. Mental health clinicians must determine whether the anxiety symptoms are the primary cause of the problem or are the by-product of another type of disorder.

The different types of anxiety disorders are described below.

PHOBIAS

A phobia is a persistent and disproportionate fear of some specific object or situation that presents little or no actual danger but leads to greater avoidance of these feared situations. There are three main categories of phobias:
(1) Specific phobia, (2) social phobia, and (3) agoraphobia.

SPECIFIC PHOBIA

This anxiety disorder is characterized by excessive or unreasonable anxiety or fear related to a specific situation or object. Specific phobias include claustrophobia (fear of small spaces), arachnophobia (spiders), and acrophobia (heights). DSM-IV-TR lists five types or categories of specific phobias as shown below.

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Phobia Type	Examples
Animal	Snakes, spiders, dogs, insects, birds
Natural Environment	Storms, heights, water
Blood-Injection-Injury	Seeing blood or an injury, receiving an injection, seeing a person in a wheelchair
Situational	Public transportation, tunnels, bridges, elevators, flying, driving, enclosed spaces
Other	Choking, vomiting, "space phobia" (fear of falling down if away from walls or other support)

When individuals with specific phobias encounter a phobic stimulus, they often show an immediate fear response, similar to a panic attack. Such individuals also experience anxiety if they anticipate they may encounter a phobic object or situation and hence try to avoid encounters with the phobic stimulus. They even avoid seemingly innocent representations of it such as photographs or television images.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack.
C. The person recognizes that the fear is excessive or unreasonable
D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships
F. In individuals under age 18 years, the duration is at least 6 months.
G. The anxiety, Panic Attacks, or phobic avoidance are not better accounted for by another mental disorder

CAUSAL FACTORS

- Neurotransmitters including GABA, serotonin, acetylcholine, and norepinephrine and role of genes
- Psychological factors include operant conditioning (negative reinforcement of avoiding the feared stimulus), and cognitive biases related to the stimulus (such as overestimating the probability that a negative event will occur following contact with the feared stimulus).
- Observational learning—a social factor—can influence what particular stimulus a person comes to fear.

TREATMENT

- Medication (targeting neurological factors), specifically a benzodiazepine.
- CBT is extremely effective, particularly when exposure is part of the treatment

SOCIAL PHOBIA

Social phobia is an intense fear of public humiliation or embarrassment, together with an avoidance of social situations which may cause this fear. When such social situations cannot be avoided, they trigger panic or anxiety. Social phobia may be limited to specific types of performance-related situations or may be generalized to most social situations. The anxiety about performing poorly and being evaluated by others can, in turn, impair an individual's performance, creating a vicious cycle. The symptoms of social phobia may lead individuals with this disorder to be less successful than they could otherwise be, because they avoid job-related social interactions that are required for advancement.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.
B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack.
C. The person recognizes that the fear is excessive or unreasonable.
D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships
F. In individuals under age 18 years, the duration is at least 6 months
G. The fear or avoidance is not due to the direct physiological effects of a substance or a general medical condition and is not better accounted for by another mental disorder

CAUSAL FACTORS

- Neurological factors include an amygdala that is more easily activated in response to social stimuli, too little dopamine in the basal ganglia, too little serotonin, and a genetic predisposition toward a shy temperament.

- Psychological factors include cognitive distortions and hypervigilance for social threats— particularly about being (negatively) evaluated. Classical conditioning of a fear response in social situations may contribute to social phobia; avoiding feared social situations is then negatively reinforced (operant conditioning).
- Social factors that give rise to social phobia include parents' modelling or encouraging a child to avoid anxiety-inducing social interactions.

TREATMENT

- Medication, specifically, beta-blockers for periodic performance anxiety, and Selective Serotonin Reuptake Inhibitors (SSRIs) or Selective Norepinephrine Reuptake Inhibitors (SNRIs) for more generalized social phobia.
- CBT, specifically, exposure and cognitive restructuring.
- Treatments that target social factors include group CBT and exposure to feared social stimuli.

AGORAPHOBIA

Agoraphobia involves persistent avoidance of situations that might trigger panic symptoms or from which escape would be difficult. Many patients with agoraphobia may avoid places in which it would be embarrassing or hard to obtain help in case of a panic attack. For these reasons, tunnels, bridges, crowded theatres, and highways are typically avoided or entered with difficulty by people with agoraphobia.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.
B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.
C. The anxiety or phobic avoidance is not better accounted for by another mental disorder

Agoraphobia is not a separate DSM-IV-TR disorder. Patients who meet the criteria for agoraphobia are diagnosed with either panic disorder with agoraphobia or agoraphobia without history of panic disorder, depending on the presence or absence of panic disorder. When agoraphobia develops, it usually does so within the first year of recurrent panic attacks. For some individuals, as panic attacks decrease, agoraphobia decreases; for others, there is no such relationship. Because people with agoraphobia avoid situations that are associated with past panic attacks, they do not learn that they can be in such situations without having a panic attack.

PANIC ATTACKS

Panic attack refers to a specific period of intense dread, fear, or a sense of imminent doom, accompanied by physical symptoms of a pounding heart, shortness of breath, shakiness, and sweating. During a panic attack, the symptoms generally begin quickly, peak after a few minutes, and disappear

within an hour. In some cases, panic attacks are cued—they are associated with particular objects, situations, or sensations. In other cases, panic attacks are uncued—they are spontaneous—they come out of the blue, and are not associated with a particular object or situation. Panic attacks can occur at any time, even while sleeping (referred to as nocturnal panic attacks).

Recurrent panic attacks may interfere with daily life (for example, if they occur on a bus or at work) and cause the individual to leave the situation to return home or seek medical help. The symptoms of a panic attack are so unpleasant that people who suffer from this disorder may try to prevent another attack by avoiding environments and activities that increase their heart rates.

A typical panic attack involves a discrete period of intense fear or discomfort, in which at least four of the following symptoms develop abruptly and reach a peak within 10 minutes:

• Palpitations, pounding heart, or accelerated heart rate
• sweating
• Trembling or shaking
• Sensations of shortness of breath or smothering
• Feeling of choking
• Chest pain or discomfort
• Nausea or abdominal distress
• feeling dizzy, unsteady, lightheaded, or faint
• Derealization (feelings of unreality) or depersonalization (being detached from oneself)
• Fear of losing control or going crazy
• Fear of dying
• Paraesthesia (numbness or tingling sensations)
• Chills or hot flushes

PANIC DISORDER

Panic disorder is anxiety disorder characterized by frequent, unexpected panic attacks, along with fear of further attacks and possible restrictions of behaviour in order to prevent such attacks. Panic disorder is most likely to arise during two phases of life: the teenage years or the mid-30s. The frequency of panic attacks varies from person to person and over time. The diagnostic criteria for panic disorder without agoraphobia is given below.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Both (1) and (2): (1) recurrent unexpected Panic Attacks (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following: (a) persistent concern about having additional attacks (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy") (c) a significant change in behaviour related to the attacks
B. Absence of Agoraphobia
C. The Panic Attacks are not due to the direct physiological effects of a substance or a general medical condition
D. The Panic Attacks are not better accounted for by another mental disorder

CAUSAL FACTORS

- Neurological factors that contribute to panic disorder and agoraphobia include a heightened sensitivity to detect breathing changes, involving withdrawal emotions and the right frontal lobe, the amygdala, and the hypothalamus; too much norepinephrine, which increases heart and

respiration rates and other aspects of the fight-or-flight response; and a genetic predisposition to anxiety disorders.

- Psychological factors include conditioning of the bodily sensations of panic or of external cues related to panic attacks; heightened anxiety sensitivity and misinterpretation of bodily symptoms of arousal as symptoms of a more serious problem, such as a heart attack, which can, in turn, lead to hypervigilance and fear of further sensations, causing increased arousal.
- Social factors include greater than average number of social stressors during childhood and adolescence; the presence of a safe person, which can decrease catastrophic thinking and panic; and cultural factors, which can influence whether people develop panic disorder.

TREATMENT

- Medication, specifically benzodiazepines for short-term relief and antidepressants for long-term use.
- CBT is the first-line treatment for panic disorder. Behavioural methods focus on the bodily signals of arousal, panic, and agoraphobic avoidance. Cognitive methods (psychoeducation and cognitive restructuring) focus on the misappraisal of bodily sensations and on mistaken inferences about them.
- Treatments that target social factors include group therapy focused on panic disorder, and couples or family therapy, particularly when a family member is a safe person.

OBSESSIVE COMPULSIVE DISORDER

Obsessive-compulsive disorder (OCD) is the anxiety disorder characterized by one or more obsessions, which may occur together with compulsions. Obsessions are thoughts, impulses, or images that persist or recur,

are intrusive—and therefore difficult to ignore—and are inappropriate to the situation. Compulsions are repetitive behaviours or mental acts that a person feels driven to carry out and that usually correspond thematically to an obsession. The obsession can cause great distress and anxiety, despite a person's attempts to ignore or drive out the intrusive thoughts. The most common types of obsessions and compulsions are listed below.

Type of Obsession	**Examples of obsessions:** People with OCD may be preoccupied with anxiety-inducing thoughts about . . .	**Type of Compulsion**
Contamination	germs, dirt	Washing
Order	objects being disorganized, or a consuming desire to have objects or situations conform to a particular order or alignment	Ordering
Losing control	the possibility of behaving impulsively or aggressively, such as yelling during a funeral	Counting
Doubt	whether an action, such as turning off the stove, was performed	Checking
Possible need	the extremely remote likelihood that they will need a particular object at some undetermined point in the future as part of some unknown need (for instance, that they might need to look up something in today's newspaper in a few years)	Hoarding

People with OCD recognize that their obsessive thoughts do not originate from an external source—for example, the thoughts aren't implanted by aliens from outer space, as some people with psychotic symptoms believe. Instead, they realize that the thoughts arise in their own minds, even though they can't control or suppress the thoughts. Symptoms build gradually until they reach a level that meets the diagnostic criteria. Over the course of a lifetime, symptoms wax and wane, becoming particularly evident in response to stress.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Either obsessions or compulsions: Obsessions as defi ned by (1), (2), (3), and (4): (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress (2) the thoughts, impulses, or images are not simply excessive worries about real-life problems (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind Compulsions as defi ned by (1) and (2): (1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.
B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.
C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or signifi cantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it
E. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

CAUSAL FACTORS

- Neurological factors associated with OCD include disruptions in the normal activity of the frontal lobes, the thalamus, and the basal ganglia; lower than normal levels of serotonin; and genetic vulnerabilities

- Psychological factors include negative reinforcement of the compulsive behaviour, which temporarily relieves the anxiety that arises from the obsession and cognitive biases related to the theme of obsessions.
- Social factors include socially induced stress, which can influence the onset and course of the disorder, and culture, which can influence the particular content of obsessions and compulsions.

TREATMENT

- Medication (such as an SSRI or clomipramine)
- The primary treatment for OCD is exposure with response prevention. Cognitive restructuring to reduce the irrationality and frequency of the patient's intrusive thoughts and obsessions may also be employed.
- Family education or therapy targets social factors.

GENERALIZED ANXIETY DISORDER

Generalized anxiety disorder (GAD) is the anxiety disorder characterized by uncontrollable worry and anxiety about a number of events or activities that are not solely the focus of another Axis I disorder. The worry and anxiety among individuals suffering from GAD primarily focus on family, finances, work, and illness. Their worries intrude into their awareness when they are trying to focus on other thought and they cannot stop worrying. People with GAD feel a chronic, low level of anxiety or worry about many things. Moreover, the fact that they constantly worry in itself causes them distress. Most people with GAD also have comorbid depression. The DSM-IV-TR diagnostic criteria is given below:

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities
B. The person finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (1) restlessness or feeling keyed up or on edge (2) being easily fatigued (3) difficulty concentrating or mind going blank (4) irritability (5) muscle tension (6) sleep disturbance
D. The focus of the anxiety and worry is not confined to features of an Axis I disorder
E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
F. The disturbance is not due to the direct physiological effects of a substance or a general medical condition

CAUSAL FACTORS

- Neurological factors include unusually strong activation in the right front lobe, abnormal activity of serotonin, dopamine, and other neurotransmitters, and a genetic predisposition to become anxious and/or depressed.

- Psychological factors that contribute to GAD include being hypervigilant for possible threats, a sense that the worrying is out of control, and the reinforcing experience that worrying prevents panic.
- Social factors that contribute to GAD include stressful life events

TREATMENT

- medication which targets neurological factors
- CBT (which targets psychological factors), including breathing retraining, muscle relaxation training, worry exposure, cognitive restructuring, self-monitoring, problem solving, psychoeducation, and/or meditation. CBT may be employed in a group format.

POSTTRAUMATIC STRESS DISORDER (PTSD)

Posttraumatic stress disorder (PTSD) is diagnosed when people who have experienced a trauma persistently re-experience the traumatic event, avoid stimuli related to the event, and have symptoms of anxiety and hyperarousal; these symptoms must persist for at least a month. An event is considered traumatic if the individual experienced or witnessed an actual or threatened death or serious injury and responded with intense fear, helplessness, or horror. Types of traumatic events are large-scale events with multiple victims, unintended acts involving smaller numbers of people, and interpersonal violence. Interpersonal violence is more likely to lead to a stress disorder, as are other events in which the trauma is severe, of long duration, and of close proximity.

In PTSD a traumatic event is thought to cause a pathological memory that is at the centre of the characteristic clinical symptoms of the disorder. These memories are often brief fragments of the experience and have events that happened just before the moment with the largest emotional impact.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror
B. The traumatic event is persistently re-experienced in one (or more) of the following ways: (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions (2) Recurrent distressing dreams of the event. (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes) (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma (2) efforts to avoid activities, places, or people that arouse recollections of the trauma (3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities (5) feeling of detachment or estrangement from others (6) restricted range of affect (e.g., unable to have loving feelings) (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following: (1) difficulty falling or staying asleep (2) irritability or outbursts of anger (3) difficulty concentrating (4) hypervigilance (5) exaggerated startle response
E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

CAUSAL FACTORS

- High levels of norepinephrine, abnormal serotonin function and decreased production of cortisol in response to the traumatic event.
- Psychological factors that exist before a traumatic event include a history of depression or other psychological disorders, a belief in being unable to control stressors, the conviction that the world is a dangerous place, and lower IQ. After a traumatic event, classical and operant conditioning contribute to the avoidance symptoms.

- **S**ocial factors include low socioeconomic status and a relative lack of social support for the trauma victim. Culture can influence the ways that individuals cope with traumatic stress.

TREATMENT

- Medication, specifically an SSRI.
- CBT, specifically psychoeducation, exposure, relaxation, breathing retraining, and cognitive restructuring.
- Treatments that target social factors are designed to ensure that the individual is as safe as possible from future trauma and to increase social support through group therapy or family therapy

DISSOCIATIVE DISORDERS

The central feature of dissociative disorders is **dissociation**, the separation of mental processes—such as perception, memory and self-awareness—that are normally integrated. Generally, each individual mental process is not disturbed, but their normal integrated functioning is disturbed. In contrast, with schizophrenia, it is the mental processes themselves, such as the form or pattern of thoughts that are disturbed. Dissociation may arise suddenly or gradually, and it can be brief or chronic.

Four types of dissociative symptoms are noted in DSM-IV-TR.

- **Amnesia,** or memory loss, which is usually temporary but, in rare cases, may be permanent;
- **Identity problems,** in which an individual isn't sure who he or she is or may assume a new identity;
- **Derealization**, in which the external world is perceived or experienced as strange or unreal, and the individual feels "detached from the environment" or as if viewing the world through "invisible filters" or "a big pane of glass".

- **Depersonalization**, in which the perception or experience of self—either one's body or one's mental processes—is altered to the point of feeling like an observer, as though seeing oneself from the "outside".

Occasional dissociating is a part of everyday life. For instance, you may find yourself in a class, but not remember walking to the classroom. In some cases, periods of dissociation are part of religious or cultural rituals, as in possession trance. DSM-IV-TR reserves the category of **dissociative disorders** for cases in which perception, consciousness, memory, or identity are dissociated to the point where the symptoms are pervasive, cause significant distress, and interfere with daily functioning. DSM-IV-TR defines the following types of dissociative disorders.

DISSOCIATIVE AMNESIA

Dissociative amnesia is a dissociative disorder in which the sufferer has significantly impaired memory for important experiences or personal information that cannot be explained by ordinary forgetfulness. The experiences or information typically involve traumatic or stressful events, and the amnesia can come on suddenly. The memory problems in dissociative amnesia can take any of several forms:

- Generalized amnesia, in which the individual can't remember his or her entire life.
- Selective amnesia, in which the individual can remember some of what happened in an otherwise forgotten period of time.
- Localized amnesia, in which the individual has a memory gap for a specific period of time, often a period of time just before the stressful event.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
B. The disturbance does not occur exclusively during the course of another psychological disorder and is not due to the direct physiological effects of a substance or a neurological or other general medical condition
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Researchers have focused on two theories of how cognitive disturbances—especially amnesia—arise with dissociative disorders: dissociation theory and neodissociation theory. Both theories focus on how dissociation can arise in response to traumatic experiences—specifically, how the normal processes of memory and its relation to other cognitive processes might be disrupted. Although neither theory can completely explain the phenomenon of dissociative amnesia, both offer some insight.

Dissociation theory posits that very strong emotions (as occur in response to a traumatic stressor) narrow the focus of attention and also disorganize cognitive processes, which prevent them from being integrated normally. According to this theory, the poorly integrated cognitive processes allow memory to be dissociated from other aspects of cognitive functioning, leading to dissociative amnesia.

In contrast, neodissociation theory proposes that an "executive monitoring system" normally coordinates various cognitive systems, much like a chief executive officer coordinates the various departments of a large company. However, in some circumstances (such as while a person is experiencing a traumatic event) the various cognitive systems can operate independently of the executive monitoring system. When this occurs, the

executive system no longer has access to the information stored or processed by the separate cognitive systems. Memory thus operates as an independent cognitive system, and an "amnestic barrier" arises between memory and the executive system. This barrier causes the information in memory to be cut off from conscious awareness—that is, dissociated.

DISSOCIATIVE FUGUE

The key features of **dissociative fugue** are sudden, unplanned travel and difficulty remembering the past. This combination can lead sufferers to be confused about who they are and sometimes to take on a new identity. A person with dissociative fugue can have an episode that lasts from a few hours to weeks or even months. During a fugue state, an individual generally seems to function normally. Once the fugue state has subsided, however, the individual may not be able to remember what occurred during it. The fugue state begins after a traumatic or overwhelming event, although it is not known how much time typically passes between the event and the onset of the fugue state. Patients usually experience only a single episode, in response to high levels of stress, and recover quickly; however, some people may continue to have amnesia for events that transpired during the fugue state.

Very little is known about the process by which people recover from dissociative fugue. An important fact about dissociative fugue is that it does not arise in all cultures. Syndromes that are similar occur in some cultures. This simple observation implies a larger role for social factors than occurs for many other psychological disorders.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.
B. Confusion about personal identity or assumption of a new identity (partial or complete).
B. The disturbance does not occur exclusively during the course of another psychological disorder and is not due to the direct physiological effects of a substance or a neurological or other general medical condition
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DISSOCIATIVE IDENTITY DISORDER

The central feature of **dissociative identity disorder (DID)** is the presence of two or more distinct alters (personality states or identities), each with its own characteristics and history. These alters take turns controlling the person's behaviour. For example, a person with this disorder might have an "adult" alter that is very responsible, thoughtful and considerate and a "child" alter that is irresponsible, impulsive and obnoxious. Each alter can have its own name, mannerisms, speaking style, and vocal pitch that distinguish it from other alters. Some alters report being unaware of the existence of other alters, and thus they experience amnesia due to the memory gaps. The most compelling characteristic of alters is that, for a given patient, each alter can have unique medical problems and histories: One alter might have allergies, medical conditions, or even EEG patterns that the other alters do not have. Stressful events can cause a

switch of alters, whereby the alter that was the dominant personality at one moment recedes and another alter becomes the dominant personality. Although the number of alters that have been reported ranges from 2 to 100, most people diagnosed with DID have 10 or fewer alters.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
B. At least two of these identities or personality states recurrently take control of the person's behaviour.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

People with DID may also be diagnosed with a mood disorder, a substance-related disorder, PTSD, or a personality disorder. DID may be difficult to distinguish from schizophrenia or bipolar disorder. It can take years to make the diagnosis of DID from the time that symptoms first emerge. Because of this long lag time and the rarity of the disorder, there is no accurate information about the usual age of onset. DID—which is easy to role-play—can be difficult to distinguish from malingering also.

CAUSAL FACTORS OF DISSOCIATIVE DISORDERS

- Neurological factors include damage to the hippocampus causing amnesia, and reduced activation in the frontal lobes implicated in fugue, resulting from increased level of stress hormones. Although

neuroimaging studies of patients with DID find that their brains function differently when different alters are dominant, no definite understanding is present.

- Suggestive of psychological factors, people with dissociative disorders are more hypnotizable and dissociate more readily than others. DID is caused by severe, chronic physical abuse during childhood, which leads to dissociation during the abuse; these dissociated states become alters, with their own memories and personality traits.
- Dissociative disorders generally occur in response to significant stressors that involve social factors, such as combat and abuse. For instance, someone experiencing a dissociative fugue probably experienced a traumatic event beforehand.

Although there are clues as to possible factors that contribute to dissociative disorders, the specific roles these factors may play and how they might influence each other are not known.

TREATMENT FOR DISSOCIATIVE DISORDERS

The goal of treatment for dissociative disorders ultimately is to reduce the symptoms themselves and lower the stress they induce. Treatments that target the psychological factors underlying dissociative disorders focus on three elements: (1) reinterpreting the symptoms so that they don't create stress or lead the patient to avoid certain situations; (2) learning additional coping strategies to manage stress; and (3) for DID patients, addressing the presence of alters and dissociated aspects of their memories or identities. Hypnosis may be used, depending on the therapist's theoretical orientation.

In general, medication is not used to treat the symptoms of dissociative disorders because research suggests that it is not helpful for dissociative symptoms. However, patients may receive medication for comorbid disorders or for anxiety or mood symptoms that arise in response to the dissociative symptoms.

Treatment may also focus on reducing the traumatic stress that can induce dissociative disorders.

SOMATOFORM DISORDERS

Somatoform disorders are psychological disorders characterized by complaints about physical well-being that cannot be entirely explained by a medical condition, substance use, or another psychological disorder. Somatoform disorders are relatively rare in the general population but are the most common type of psychological disorder in medical settings. A third of patients visiting their primary care physician have symptoms that are not adequately explained by a medical condition. Somatoform disorders must be distinguished from factitious disorder, in which people intentionally induce symptoms or falsely report symptoms that they do not have to receive attention from others. Those with a somatoform disorder neither pretend to have symptoms nor intentionally induce physical symptoms for any type of gain. By their very nature, however, somatoform disorders are "rule out" diagnoses, meaning that the clinician must make sure that there aren't medical conditions or other psychological disorders that can better explain the patients' physical symptoms.

Somatoform disorders share two common features:

1. *bodily preoccupation*, which is similar to the heightened awareness of panic-related bodily sensations experienced by people with panic disorder, except that with somatoform disorders the patient can be preoccupied with any aspect of bodily functioning; and
2. *Symptom amplification*, or directing attention to bodily symptoms, which in turn intensifies the symptoms. A common example of symptom amplification occurs when someone with a headache pays attention to the headache–and the pain worsens.

SOMATIZATION DISORDER (SD)

Somatization disorder (SD) is characterized by multiple physical symptoms that are medically unexplained and impair an individual's ability to function. The symptoms are chronic; they may fluctuate in location or in intensity (so that the criteria for SD are no longer met), but symptoms usually never completely disappear. In an effort to minimize their bodily symptoms, people with somatization disorder may restrict their activities. However, inactivity can create additional symptoms (such as back pain) or make existing symptoms worse (such as increased heart rate or difficulty breathing). Many laboratory tests and visits to doctors may be required to rule out other medical and psychological diagnoses, which is necessary before a diagnosis of SD can be made.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.
B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance: (1) four pain symptoms: a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination) (2) two gastrointestinal symptoms: a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhoea, or intolerance of several different foods) (3) one sexual symptom: a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory

dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy) (4) one pseudo neurological symptom: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia [loss of voice], urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)
C. Either (1) or (2): (1) after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or [as] the direct effects of a substance (e.g., a drug of abuse, a medication) (2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings
D. The symptoms are not intentionally feigned or produced (as in Factitious Disorder or Malingering).

Factors that contribute to SD include genes, catastrophic thinking about illness (along with symptom amplification and bodily preoccupation), other people's responses to illness, and the way symptoms function as a means of expressing helplessness.

PAIN DISORDER

Pain disorder occurs when psychological factors significantly affect the onset, severity, or maintenance of significant pain. For a clinician to arrive at a diagnosis of pain disorder, the pain must cause significant distress or impair

functioning, and malingering or factitious disorder must be ruled out. In some cases of pain disorder, examiners cannot identify a medical cause for the pain; in other cases, a medical cause may underlie the pain, but psychological factors contribute significantly to the patient's experience of it. When the pain can be diagnosed as arising predominantly from a medical condition, pain disorder will not be diagnosed on Axis I, but the medical condition will be noted on Axis III, along with the specific location of the pain, such as the lower back

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

. Both pain disorder and somatization disorder involve genuine—as opposed to feigned—pain to which psychological factors are thought to contribute. However, SD requires that the individual have a history of four different locations of significant pain (as well as other types of bodily symptoms), whereas pain disorder requires only one location of significant pain.

CONVERSION DISORDER

Conversion disorder involves sensory or motor symptoms that do not correspond to those that arise from known medical conditions. Conversion disorder is similar to SD in that both involve physical symptoms that are not explained by a medical condition; however, conversion disorder is limited to sensory and motor symptoms that appear to be neurological (that is, related to the nervous system) but, on closer examination, do not correspond to effects of known neurological pathways .A diagnosis of conversion disorder can only be made after physician's rule out all possible medical causes, and this process can take years.

Conversion disorder is characterized by three types of symptoms:

• *Motor symptoms*. Examples include tremors that worsen when attention is paid to them, tics or jerks, muscle spasms, swallowing problems, staggering, and paralysis (sometimes referred to as pseudo paralysis, which may also involve significant muscle weakness).

• *Sensory symptoms*. Examples include blindness, double vision, deafness, auditory hallucinations, and lack of feeling on the skin that doesn't correspond to what is produced by malfunctioning of an actual nerve path.

• *Seizures*. Examples include twitching or jerking of some part of the body and loss of consciousness with uncontrollable spasms of the large muscles in the body, causing the person to writhe on the floor. These seizures are often referred to as pseudo seizures because they do not have a neurological origin and are not usually affected by seizure medication. Pseudo seizures are likely to occur when other people are present; patients don't hurt their heads, bite their tongues, or urinate, as during true seizures.

Symptoms typically emerge suddenly after a significant stressor, such as the loss of a loved one, or a physical injury. They last only a brief period of time.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.
B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.
C. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
D. The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behaviour or experience.
E. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.
F. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

Factors thought to contribute to conversion disorder include abnormal functioning of brain areas that interpret and manage other brain areas that process sensation and pain, self-hypnosis (patients, consciously or unconsciously, “suggesting” to themselves that they have symptoms) and dissociation, and intense social stressors.

HYPOCHONDRIASIS

Hypochondriasis is a somatoform disorder marked by a preoccupation with a fear or belief of having a serious disease, but this preoccupation arises because the individual has misinterpreted his or her bodily sensations or symptoms. Despite the fact that physicians cannot identify a medical problem, patients with hypochondriasis persist in clinging strongly to their conviction that they have a serious disease. Although people with somatisation disorder and those with hypochondriasis share a focus on bodily symptoms, only those with hypochondriasis believe that they have a serious illness despite reassurance from doctors. Moreover, people with hypochondriasis do not see that there are other possible explanations for their sensations. They may or may not realize that their worries are excessive for the situation; when they do not, they are said to have poor insight into their condition.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
B. The preoccupation persists despite appropriate medical evaluation and reassurance.
C. The belief in Criterion A is not of delusional intensity and is not restricted to a circumscribed concern about appearance.
D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The duration of the disturbance is at least 6 months.
F. The preoccupation is not better accounted for by another psychological disorder.

Hypochondriasis, phobias, and panic disorder are all characterized by high levels of fear and anxiety, as well as a faulty belief of harm or danger. However, with hypochondriasis and panic disorder, the perceived danger is from an internal event that is thought to be producing a bodily sensation, whereas with phobias, it is from an external object (such as a snake) or a situation (such as giving a speech). In addition, both patients with hypochondriasis and those with obsessive compulsive disorder (OCD) have obsessions and compulsions. In particular, patients with hypochondriasis obsess about possible illnesses or diseases they believe they might have. They may compulsively ask doctors, friends, or family members for reassurance or compulsively "check" their body for particular sensations. By excessively probing, prodding, or touching certain body parts, he or she can create lumps or bruises, which are then interpreted as a new "symptom" of disease. As Internet use has increased over the last decade, people with some forms of hypochondriasis spend hours compulsively consulting medical Web sites.

The neural basis of hypochondriasis shares much with the neural basis of OCD and panic disorder (particularly the latter), but hypochondriasis has at least some distinct neural events. Parts of the brain involved in attention are more activated than normal, at least in certain circumstances. Psychological factors that contribute to hypochondriasis include bias in attention and catastrophic thinking (along with symptom amplification and bodily preoccupation).

BODY DYSMORPHIC DISORDER

Body dysmorphic disorder (sometimes called dysmorphophobia) is diagnosed when someone is excessively preoccupied with a perceived defect or defects in appearance. The preoccupation is excessive because a defect is either imagined or slight. Common preoccupations for people with body dysmorphic disorder are thinning or excessive hair, acne, wrinkles, scars, complexion (too

pale, too dark, too red, and so on), facial asymmetry, or the shape or size of some part of the face or body. The “defect” (or “defects”) may change over the course of the illness. Body dysmorphic disorder usually begins in adolescence, but it can go undiagnosed for several years if the person does not discuss the symptoms with anyone.

People with body dysmorphic disorder may think that others are staring at them or talking about a “defect.” They may compulsively exercise, diet, shop for beauty aids, pick at their skin, try to hide perceived defects, or spend hours looking in the mirror. Alternatively, people with body dysmorphic disorder may try to avoid mirrors altogether. The preoccupation with—or attempts to hide—a perceived defect can be difficult to control and therefore devastating, consuming up to 8 hours each day. An individual with body dysmorphic disorder may seek reassurance (“How do I look?”), but any positive effects of reassurance are transient; a half-hour later, he or she may ask the same question—even to the same person. Unfortunately, these behaviours, which are intended to decrease anxiety about appearance, end up increasing anxiety.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive.
B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
C. The preoccupation is not better accounted for by another mental disorder

. Individuals who have body dysmorphic disorder may feel so self-conscious about a perceived defect that they avoid social situations, which results in their having few (or no) friends nor a romantic partner. Some try to get medical or surgical treatment for a “defect,” such as plastic surgery, dental work, or dermatological treatment. But surgery often does not help; in fact, the

symptoms of the disorder can actually be worse after surgery. In extreme cases, when some people with body dysmorphic disorder can't find a doctor to perform the treatment they think they need, they may try to do it themselves. Research on body dysmorphic disorder has focused on psychological factors, particularly cognitive biases and catastrophic thinking (along with symptom amplification and bodily preoccupation).A patient's perceived defect tends to be related to bodily attributes that are highly valued in his or her culture or subculture.

TREATMENT FOR SOMATOFORM DISORDERS

CBT is generally the treatment of choice for somatoform disorders; the foci of the cognitive and behavioural methods used in treating each of the disorders vary because each disorder has different symptoms. Cognitive methods focus on identifying and then modifying irrational thoughts and shifting attention away from the body and bodily symptoms. Behavioural methods focus on decreasing compulsive behaviours and avoidance.

Medications, such as SSRI when used, target anxiety-related symptoms. Biofeedback to decrease bodily tension or Electro convulsive therapy (ECT) may be used for somatisation disorder and conversion disorder.

Group and family therapy are generally used as supplementary treatments. For SD and conversion disorder, the therapist strives to understand the context of the symptoms and of their emergence and the way the symptoms affect the patient's interactions with others (Holder-Perkins & Wise, 2001); with these two disorders, treatment may focus on helping the patient communicate more assertively—which can help to relieve the social stressors that contribute to the disorders. Treatment may also focus on the family—educating family members about the disorder and the ways they may have contributed to or reinforced the patient's symptoms. The therapist may teach family members how to reinforce positive change and to extinguish behaviour related to the symptoms. .

MODULE 3

SCHIZOPHRENIA

Schizophrenia is a psychological disorder characterized by psychotic symptoms— hallucinations and delusions—that significantly affect emotions, behaviour, and most notably, mental processes and mental contents. The symptoms of schizophrenia can interfere with a person's abilities to comprehend and respond to the world in a normal way. The term schizophrenia covers a set of related disorders and each variant of schizophrenia has different symptoms, causes, course of development, and, possibly, response to treatments.

The criteria for schizophrenia in* DSM-IV-TR *fall into two clusters:

- positive symptoms, marked by the presence of abnormal or distorted mental processes, mental contents, or behaviours consisting of delusions and hallucinations and disorganized speech and behaviour;
- negative symptoms, marked by the absence or reduction of normal mental processes, mental contents, feelings, or behaviours, including speech, emotional expressiveness, and/or movement.

DSM-IV-TR *specifies the following types of positive symptoms.*

Hallucinations

Hallucinations are sensations so vivid that the perceived objects or events seem real even though they are not. Any of the five senses can be involved in a hallucination, although auditory hallucinations—specifically, hearing voices—are the most common type experienced by people with schizophrenia. These symptoms are distinguished by their extreme quality. From time to time, we all have hallucinations, such as thinking we hear the doorbell ring when it didn't. But the hallucinations experienced by people with

schizophrenia are intrusive—they may be voices that talk constantly or scream at the patient.

Delusions

People with schizophrenia may also experience **delusions**—incorrect beliefs that persist, despite evidence to the contrary. Delusions often focus on a particular theme, and several types of themes are common among these patients. Paranoid delusions involve the theme of being persecuted by others. Delusions of control revolve around the belief that the person is being controlled by other people (or aliens), who literally put thoughts into his or her head, called thought insertion. Another delusional theme is believing oneself to be significantly more powerful, knowledgeable, or capable than is actually the case, referred to as delusions of grandeur. Delusions of reference denote the belief that external events have special meaning for the individual.

Disorganized Speech

People with schizophrenia can sometimes speak incoherently, although they may not necessarily be aware that other people cannot understand what they are saying. Speech can be disorganized in a variety of different ways. One type of disorganized speech is **word salad**, which is a random stream of seemingly unconnected words. Another type of disorganized speech involves many neologisms, or words that the patient makes up.

Disorganized Behaviour

Another positive symptom of schizophrenia is disorganized behaviour, behaviour that is so unfocused and disconnected from a goal that the person cannot successfully accomplish a basic task, or the behaviour is inappropriate in the situation. The category of disorganized behaviour also includes **catatonia** (also referred to as catatonic behaviour), which occurs when an individual remains in an odd posture or position, with rigid muscles, for hours.

DSM-IV-TR specifies three types of negative symptoms: flat affect, alogia, and avolition.

Alogia

A negative symptom of schizophrenia marked by speaking less than most other people and responding slowly or minimally to questions.

Avolition

A negative symptom of schizophrenia marked by difficulty in initiating or following through with activities.

Flat affect

lack of, or considerably diminished, emotional expression, such as occurs when someone speaks robotically and shows little facial expression.

Research studies have indicated that cognitive deficits underlie negative and disorganized symptoms of schizophrenia. Such deficits include problems with attention, working memory, and executive functioning (mental processes involved in planning, organizing, problem solving, abstract thinking, and exercising good judgment)

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): (1) delusions (2) hallucinations (3) disorganized speech (4) grossly disorganized or catatonic behaviour (5) negative symptoms, i.e., affective flattening, alogia, or avolition Note: Only one Criterion A symptom is required if delusions are bizarre or

hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts or two or more voices conversing with each other.
B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

Typically, schizophrenia develops in phases**.** In the premorbid phase, before symptoms develop, some people may display personality characteristics that later evolve into negative symptoms. During the **prodromal phase**, which occurs before the onset of a psychological disorder, symptoms may develop gradually but do not meet all the criteria for the disorder. In the **active phase**, a person has full-blown positive and negative symptoms that meet all of the criteria for the disorder. Over time, the individual may fully recover, may have intermittent episodes, or may develop chronic symptoms that interfere with normal functioning.

SUBTYPES OF SCHIZOPHRENIA

DSM-IV-TR specifies a set of subtypes of schizophrenia, which are based on the presence or absence of particular positive symptoms. Over time, the diagnosis of subtype may change, as the prominence of different symptoms shifts. DSM-IV-TR identifies five subtypes of schizophrenia: paranoid, disorganized, catatonic, undifferentiated, and residual.

Paranoid Schizophrenia

Paranoid schizophrenia is characterized by the presence of delusions and auditory hallucinations that are limited to specific topics that have a coherent paranoid or grandiose theme. An example of a paranoid theme is that the person believes that he or she is being hunted by the police; an example of a grandiose theme is that the person believes that he or she is God. Diagnosing people with paranoid schizophrenia can be difficult because they may seem normal if they don't talk about the topic of their delusions. Although the paranoid subtype has the best recovery rate, it is also the subtype most associated with aggressive behaviour toward either themselves or others.

Disorganized Schizophrenia

Disorganized speech and behaviour and inappropriate emotional expression are typical of the subtype called **disorganized schizophrenia**. People with disorganized schizophrenia may giggle, dress strangely, speak obscenely or incoherently, or urinate or defecate in public. They generally have a poor prognosis and, because of their inability to care for themselves, may require constant care.

Catatonic Schizophrenia

Catatonic schizophrenia is characterized by catatonic (stiff or seemingly "frozen") postures or poses, bizarre jerky movements, or frozen facial

expressions. A person with catatonic schizophrenia also may not speak, may involuntarily and senselessly repeat words or phrases said by others, or may mimic other people's bodily movements. Because they are unable to take care of themselves, such as by eating and washing, people with catatonic schizophrenia require constant care.

Undifferentiated Schizophrenia

When someone's symptoms lead to the diagnosis of schizophrenia but do not completely match those specified for paranoid, disorganized, or catatonic schizophrenia, the individual will be diagnosed with the subtype **undifferentiated schizophrenia**.

Residual Schizophrenia

Regardless of the subtype of schizophrenia that someone has, when the positive (and disorganized) symptoms have subsided but the negative symptoms persist, the full criteria for schizophrenia are no longer met; the person's subtype classification changes to residual schizophrenia, which indicates that there is a residue of (negative) symptoms but the pronounced positive symptoms have faded away. Residual schizophrenia may also be diagnosed when prominent negative symptoms are absent but two or more mild positive symptoms, such as odd beliefs that are not delusional, are present. The diagnosis of residual schizophrenia may apply only during a brief period, for example, during an individual's transition from a psychotic state to remission. Sometimes, though, an individual's symptoms may be such that the diagnosis of residual schizophrenia is assigned indefinitely.

CAUSAL FACTORS

A variety of neurological factors are associated with schizophrenia:

• Abnormalities in brain structure and function in the frontal and temporal lobes, the thalamus, and the hippocampus, and enlarged ventricles, resulting from , maternal malnourishment or illness during pregnancy or to fetal oxygen deprivation.

• abnormalities in dopamine, serotonin, and glutamate activity, as well as a heightened stress response and increased cortisol production.

• genetics is still the strongest predictor that a given individual will develop schizophrenia.

Psychological factors that are associated with schizophrenia and shape the symptoms of the disorder include:

• cognitive deficits in attention, memory, and executive functioning;

• dysfunctional beliefs and attributions; and

• difficulty recognizing and conveying emotions.

Various social factors are also associated with schizophrenia:

• an impaired theory of mind (a theory about other people's mental states-their beliefs, desires, feelings- that allows us to predict how they will react in a given situation), which makes it difficult to understand other people's behaviour, meaning that other people's behaviour routinely appears to be unpredictable;

• A stressful home environment, such as being raised in an orphanage or by a parent with schizophrenia;

• the stresses of immigration—particularly for people likely to encounter discrimination—and economic hardship; and •

TREATMENT FOR SCHIZHOPHRENIA

Treatments that target neurological factors include traditional and atypical antipsychotics; when these medications do not significantly decrease positive

symptoms, ECT may be used. Although antipsychotic medications can decrease positive and, in some cases, negative symptoms, many patients discontinue such treatment because of side effects or because the medication did not help them enough. People who stop taking medication are much more likely to relapse.

• Treatments that target psychological factors include CBT to help patients better manage their psychotic symptoms, cognitive rehabilitation to reduce cognitive deficits, and motivational enhancement to decrease comorbid substance abuse.

• Treatments that target social factors include family education, family therapy to improve the interaction pattern among family members, and group therapy to improve social skills. Depending on the severity of an episode of schizophrenia, a patient may be treated in an inpatient facility or as an outpatient in the community. Community-based interventions include residential care and vocational rehabilitation.

SCHIZOAFFECTIVE DISORDER

Schizoaffective disorder is characterized by the presence of both schizophrenia and a depressive, manic, or mixed mood episode. Because schizoaffective disorder involves mood episodes, negative symptoms such as flat affect are not common, and the diagnosis is likely to be made solely on the basis of positive symptoms. Because of their mood episodes, people with schizoaffective disorder are at greater risk for committing suicide than are people with schizophrenia. The prognosis for recovery from schizoaffective disorder is better than that for recovery from schizophrenia, particularly when stressors or events clearly contribute to the disorder.

DELUSIONAL DISORDER

When a person's sole symptom is that he or she adheres to non-bizarre but demonstrably incorrect beliefs—those that are theoretically plausible, such

as believing that someone is following you—and those beliefs have persisted for more than 1 month, that person is diagnosed with **delusional disorder**. Note that the assessment of the bizarreness of the beliefs distinguishes schizophrenia (bizarre) from delusional disorder (non-bizarre). What is interpreted as being bizarre will vary across clinicians, depending on their experience with people from different subcultures, ethnic groups, or countries; what may seem bizarre to a clinician, though, may be understandable given a particular patient's background and experience.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration
B. Criterion A for Schizophrenia has never been met.
C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behaviour is not obviously odd or bizarre.
D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.
E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Clinicians and researchers have identified the following types of non-bizarre delusions:

• *Erotomania*: The belief that another person is in love with the patient. This delusion usually focuses on romantic or spiritual union rather than sexual attraction. It is common for people with erotomania to try to contact the person who is the object of their delusion.

• *Grandiose*: The belief that the patient has a great (but unrecognized) ability, talent, or achievement.

• *Persecutory*: The belief that the patient is being spied on, drugged, harassed, or otherwise conspired against. Small snubs or slights are magnified in the patient's eyes, and he or she may seek legal action to redress these perceived insults. People with this delusion sometimes become violent against those whom they perceive as harming them.

Somatic: The false belief that the patient is experiencing bodily sensations (such as insects on the skin) or bodily malfunctions (such as a foul odour coming from a body cavity).

• *Jealous*: The belief that the patient's partner is unfaithful. This belief is based on tiny amounts of "evidence," such as the partner's arriving home a few minutes late. The patient is likely to confront his or her partner with the "evidence" and may try to "prevent" further unfaithful acts by following or attacking the partner.

People with delusional disorder—like those with the paranoid subtype of schizophrenia—may appear normal when they are not talking about their delusions: Their behaviour may not be particularly odd nor their functioning otherwise impaired. The prognosis for people with this disorder is mixed. For some, the delusions may ebb and flow, sometimes interfering with daily life and sometimes fading into the background and not having any effect; for others, the delusions may dwindle away and not reappear.

MODULE 4

MOOD DISORDERS

Mood disorders are **p**sychological disorders characterized by prolonged and marked disturbances in mood that affect how people feel, what they believe and expect, how they think and talk, and how they interact with others. DSM-IV-TR distinguishes between two categories of mood disorders: depressive disorders and bipolar disorders. Depressive disorders are mood disorders in which someone's mood is consistently low; in contrast, bipolar disorders are mood disorders in which a person's mood is sometimes decidedly upbeat, perhaps to the point of being manic, and sometimes may be low.

DSM-IV-TR defines four types of episode of a mood disorder: major depressive episode, manic episode, hypomanic episode, and mixed episode. These are the four building blocks for diagnosing bipolar disorders.

1. A major depressive episode involves symptoms of severe depression that lasts for at least 2 weeks.
2. A manic episode involves elated, irritable, or euphoric mood (mood that is extremely positive and may not necessarily be appropriate to the situation).
3. A hypomanic episode involves elated, irritable, or euphoric mood that is less distressing or severe than mania and is different than the individual's non depressed state. That is, how a person behaves during a hypomanic episode is different from his or her usual state. Two key features distinguish manic and hypomanic episodes: (1) Hypomania does not impair functioning; mania does. (2) Symptoms of a hypomanic episode must last for a minimum of 4 days, compared to 1 week for a manic episode.
4. A mixed episode involves symptoms of both a major depressive episode and a manic episode. Prominent symptoms usually include agitation,

insomnia, appetite dysregulation, psychotic features, and suicidal thinking.

The* DSM-IV-TR *criteria for a major depressive episode is given as follows.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (4) Insomnia or Hypersomnia nearly every day (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (6) fatigue or loss of energy nearly every day (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan

for committing suicide
B. The symptoms do not meet criteria for a mixed episode.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.
E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one. The symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

According to DSM-IV-TR, once someone's symptoms meet the criteria for a major depressive episode, he or she is diagnosed as having **major depressive disorder (MDD) or unipolar depression**—five or more symptoms of an MDE lasting more than 2 weeks. But, more than half of those who have had a single depressive episode go on to have at least one additional episode, noted in DSM-IV-TR as MDD, recurrent depression. Some people have increasingly frequent episodes over time, others have clusters of episodes, and still others have isolated depressive episodes followed by several years without symptoms.

The DSM-IV-TR criteria list includes specifiers—specific sets of symptoms that occur together or in particular patterns. Specifiers help clinicians and researchers identify variants of a disorder, which is important because each

variant may respond best to a particular treatment or have a particular prognosis.

- Depression with melancholic features includes complete anhedonia—the patient doesn't feel any better after positive events. When a patient experiences depression with melancholic features, the symptoms usually fluctuate during the day—he or she typically wakes early in the morning, feels worse in the morning, and loses his or her appetite.
- In contrast, atypical depression is characterized by depressed mood that brightens when good things happen, along with at least two of the following: hypersomnia, increased weight gain, heavy feelings in arms or legs, and persistent sensitivity to perceived rejection by others. Atypical depression is likely to respond to different medications than is depression with melancholic features.
- Symptoms of depression may also include catatonic features, which are specific motor symptoms—rigid muscles that hold odd postures for long periods of time, or a physical restlessness.
- Although not common, depression can occur with psychotic features—hallucinations (e.g., in which a patient can feel that his or her body is decaying) or delusions (e.g., in which the patient believes that he or she is evil and living in hell).
- Sometimes recurrent depression follows a seasonal pattern, occurring at a particular time of year. Referred to as **seasonal affective disorder (SAD)**, this disorder manifests itself in two patterns:

  • Winter depression is characterized by recurrent depressive episodes, hypersomnia, increased appetite (particularly for carbohydrates), weight gain, and irritability. These symptoms begin in autumn and continue through the winter months. The symptoms either disappear or are much less severe in the summer. Winter depression often can be treated

effectively with **phototherapy** (also called light-box therapy), in which full-spectrum lights are used as a treatment.

• Summer depression, which is less common, tends to appear in late spring. Symptoms often include poor appetite and weight loss, less sleep, and psychomotor changes. Treatment for summer depression usually includes antidepressant medication.

DYSTHYMIC DISORDER

Dysthymic disorder differs from major depressive disorder in that it involves fewer of the symptoms of a major depressive episode, but they persist for a longer period of time. Specifically, dysthymic disorder is characterized by depressed mood and as few as two other depressive symptoms that last for at least 2 years and that do not recede for longer than 2 months at any time during that period. Because symptoms are chronic, people with dysthymic disorder often incorporate the symptoms into their enduring self-assessment, seeing themselves as incompetent or uninteresting. Whereas people with MDD see their symptoms as happening to them, people with dysthymic disorder view their symptoms as an integral part of themselves. If an individual diagnosed with dysthymic disorder develops a major depressive episode, he or she is considered to have **double depression**.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.
B. Presence, while depressed, of two (or more) of the following: (1) poor appetite or overeating (2) insomnia or hypersomnia (3) low energy or fatigue (4) low self-esteem

(5) poor concentration or difficulty making decisions (6) feelings of hopelessness
C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.
D. No major depressive episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic major depressive disorder, or major depressive disorder, in partial remission.
E. There has never been a manic episode, a mixed episode, or a hypomanic episode, and criteria have never been met for cyclothymic disorder
F. The disturbance does not occur exclusively during the course of a chronic psychotic disorder, such as schizophrenia or delusional disorder
G. The symptoms are not due to the direct physiological effects of a substance or a general medical condition
H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

CAUSAL FACTORS OF DEPRESSION

- Neurological factors related to depression include low activity in the frontal lobes, and implicate abnormal functioning of various neurotransmitters (dopamine, serotonin, and norepinephrine). The stress–diathesis model of depression highlights the role of increased activity of the Hypothalamic- Pituitary –Adrenal (HPA) axis and of excess cortisol

in the blood; an overreactive HPA axis is thought to affect serotonin activity and impair the functioning of the hippocampus. People with atypical depression have the opposite pattern—decreased activity of the HPA axis. Genes can play a role in depression, perhaps by causing a person to have disrupted sleep patterns or by influencing how an individual responds to stressful events, which in turn affects activity of the HPA axis.

- Psychological factors that are associated with depression include a bias toward paying attention to negative stimuli, dysfunctional thoughts (including cognitive distortions related to the negative triad of depression- hopelessness, helplessness, worthlessness), rumination, a negative attributional style (particularly attributing negative events to internal, global, and stable factors), and learned helplessness.
- Social factors that are associated with depression include stressful life events, social exclusion, and problems with social interactions or relationships (particularly for people who have an insecure attachment). Culture and gender can influence the specific ways that symptoms of depression are expressed.
- Neurological, psychological, and social factors can affect each other through feedback loops. According to the stress–diathesis model, abuse or neglect during childhood (a stressor) and increased activity in the HPA axis can lead to overreactive cortisol-releasing cells (a diathesis), which respond strongly to even mild stressors. Psychological factors can create a cognitive vulnerability to depression, which in turn can amplify the negative effects of a stressor and change social interactions.

TREATMENT FOR DEPRESSION

- Biomedical treatments that target neurological factors for depressive disorders are medications (SSRIs, SNRIs, etc) and brain stimulation like Electro convulsive therapy.
- Treatments for depression that target psychological factors include CBT (particularly with behavioural activation).
- Treatments that target social factors include Interpersonal therapy and family systems therapy.

MANIC EPISODE

The hallmark of a **manic episode**, is a discrete period of at least 1 week of abnormally euphoric feelings, intense irritability, or an expansive mood. During an **expansive mood**, the person exhibits unceasing, indiscriminate enthusiasm for interpersonal or sexual interactions or for projects. Typically, a manic episode begins suddenly, with symptoms escalating rapidly over a few days; symptoms can last from a few weeks to several months. Compared to major depressive episode, a manic episode is briefer and ends more abruptly.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree: (1) inflated self-esteem or grandiosity (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep) (3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C. The symptoms do not meet criteria for a mixed episode.
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

The presence of different types of mood episodes—different building blocks—leads to different diagnoses. According to DSM-IV-TR, there are two types of bipolar disorder: bipolar I disorder and bipolar II disorder. The presence of manic symptoms—but not a manic episode—is the common element of the two types of bipolar disorder. The types differ in the severity of the manic symptoms. To receive the diagnosis of the more severe bipolar I disorder, a person must have a manic or mixed episode; a major depressive episode may also occur with bipolar I. Thus, just as major depressive episode automatically leads to a diagnosis of MDD, having a mixed or manic episode automatically leads to a diagnosis of bipolar I.

In contrast, to be diagnosed with bipolar II disorder, a person must alternate between hypomanic episodes and major depressive episodes; bipolar II can be thought of as less severe because of the absence of manic episodes. The DSM-IV-TR criteria for Bipolar II disorder is given as follows.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. Presence (or history) of one or more major depressive episodes.
B. Presence (or history) of at least one hypomanic episode.
C. There has never been a manic episode or a mixed episode.
D. The mood symptoms in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified
E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

CYCLOTHYMIA

Cyclothymia is a more chronic but less intense version of bipolar II disorder. The main feature of **cyclothymic disorder** is a chronic, fluctuating mood disturbance with numerous periods of hypomanic symptoms and numerous periods of depressive symptoms that do not meet the criteria for a major depressive episode. Some people may function particularly well during the hypomanic periods of cyclothymic disorder, but be impaired during depressive periods; this diagnosis is given only if the individual's depressed mood leads him or her to be distressed or impaired. Thus, someone with cyclothymic disorder may feel really upbeat and energetic when hypomanic and

begin several projects at work or volunteer to complete projects ahead of schedule. However, when having symptoms of depression, he or she may have some difficulty concentrating or mustering the energy to work on the projects, and so fall behind on the deadlines. Cyclothymia usually unfolds slowly during early adolescence or young adulthood, and it has a chronic course.

DSM-IV-TR DIAGNOSTIC CRITERIA
A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.
B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.
C. No major depressive episode, manic episode, or mixed episode has been present during the first 2 years of the disturbance.
D. The symptoms in Criterion A are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified
E. The symptoms are not due to the direct physiological effects of a substance or a general medical condition
F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

CAUSAL FACTORS OF BIPOLAR DISORDERS.

- Neurological factors that are associated with bipolar disorders include an enlarged and more active amygdala. Norepinephrine, serotonin, and

glutamate are also involved. Bipolar disorders are influenced by genetic factors, which may influence mood disorders in general.

- Psychological factors include the cognitive distortions and negative thinking associated with depression. Moreover, some people with bipolar I disorder may have residual cognitive deficits after a manic episode is over.
- Social factors that are associated with bipolar disorders include disruptive life changes and social and environmental stressors.
- The different factors create feedback loops that can lead to a bipolar disorder or make the patient more likely to relapse.

TREATMENT FOR BIPOLAR DISORDERS

- Treatments that target neurological factors include lithium and anticonvulsants, which act as mood stabilizers. When manic, patients may receive an antipsychotic medication or a benzodiazepine. Patients with a bipolar disorder who have major depressive episodes may receive an antidepressant along with a mood stabilizer.
- Treatment that targets psychological factors—particularly CBT—helps patients recognize warning signs of mood episodes, develop better sleeping strategies, and, when appropriate, stay on medication.
- Treatments that target social factors include interpersonal and social rhythm therapy (IPSRT), which can increase the regularity of daily events and decrease social stressors; family therapy, which is designed to educate family members about bipolar disorder, improve positive communication, and decrease criticism by family members; and group therapy or a self-help group, which is intended to decrease shame and isolation

PERSONALITY DISORDERS

Personality is understood as enduring traits and characteristics that lead a person to behave in relatively predictable ways across a range of situations. Some people consistently and persistently exhibit extreme versions of personality traits, for example, being overly conscientious and rule-bound or being overly emotional and quick to anger. Those extreme and inflexible traits can become maladaptive and cause distress or dysfunction—characteristics of a personality disorder. Personality disorders reflect persistent thoughts, feelings, and behaviours that are significantly different from the norms in the individual's culture. Specifically, these differences involve the ABCs of psychological functioning:

• Affect, which refers to the range, intensity, and changeability of emotions and emotional responsiveness and the ability to regulate emotions;

• Behaviour, which refers to the ability to control impulses and interactions with others; and

• Cognition *(mental processes and mental contents)*, which refers to the perceptions and interpretations of events, other people, and oneself.

Although an individual m ay exhibit a pattern of problems that indicates a personality disorder, clinicians should take into consideration the individual's ethnicity, social background, and culture. If the individual's pattern of thoughts, feelings, and behaviours are characteristic of people from his or her background, a diagnosis of a personality disorder is not warranted.

DSM-IV-TR CRITERIA FOR A PERSONALITY DISORDER
A. An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas: (1) cognition (i.e., ways of perceiving and interpreting self, other people, and events) (2) affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response) (3) interpersonal functioning (4) impulse control
B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood
E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition

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DSM-IV-TR lists ten personality disorders, divided into three clusters. Each cluster of personality disorders shares a common feature. The clusters, disorders and their characteristic features are shown in the tables below.

CLUSTERS	PERSONALITY DISORDERS
Cluster A involves odd or eccentric behaviours:	Paranoid personality disorder is characterized by mistrust and suspicion of others. Schizoid personality disorder is characterized by few close relationships and a limited range of emotional expression. Schizotypal personality disorder is characterized by few close relationships and eccentric perceptions, thoughts, and behaviours.
Cluster B involves emotional, dramatic, or erratic behaviours:	Antisocial personality disorder is characterized by repeated violation of or disregard for the rights of others. Borderline personality disorder is characterized by rapidly changing emotions, unstable relationships, and impulsivity. Histrionic personality disorder is characterized by exaggerated emotions and excessive attention-seeking behaviours. Narcissistic personality disorder is characterized by an excessive sense of self-importance and difficulty appreciating other people's perspectives
Cluster C involves anxious and fearful behaviours:	Avoidant personality disorder is characterized by a heightened sensitivity to rejection and social inhibition. Dependent personality disorder is characterized by submissive, clingy behaviour intended to elicit care from others, along with dependence on others for decision making and reassurance. Obsessive-compulsive personality disorder is characterized by orderliness, perfectionism, and control at the expense of spontaneity and flexibility.

Personality Disorders	Affect	Behavior	Cognition	Social Functioning
Odd/Eccentric: Cluster A				
Paranoid	Easily feels betrayed and angry	Hypervigilant for betrayal	Distrustful/suspicious of others; reads malevolent meaning into neutral remarks	Generally avoids relationships
Schizoid	Emotionally constricted, detached	Avoids people when possible	Views relationships as messy and undesirable	Indifferent to praise or criticism; generally avoids relationships
Schizotypal	Generally emotionally constricted, but displays inappropriate affect and anxiety	Avoids people whenever possible	Perceptual distortions, ideas of reference, magical thinking	Generally avoids relationships
Dramatic/Erratic: Cluster B				
Antisocial	Aggressive feelings toward others, lack of empathy	Generally poor impulse control	Believes that he or she is entitled to break rules	Dominant in relationships
Borderline	Emotionally expressive, with inappropriately strong and rapid reactions	Poor impulse control	Dramatic shifts between overvaluing and undervaluing others; may develop paranoid thinking under stress	Alternately dominant and submissive in relationships
Histrionic	Rapidly shifting but shallow emotions	Relatively poor impulse control; strives to be center of attention	Some grandiosity, believes that he or she should be admired	Dominant in relationships
Narcissistic	No empathy; haughty towards others	Manipulates others	Grandiosity	Dominant in relationships
Fearful/Anxious: Cluster C				
Avoidant	Anxiety in social situations	Overcontrol of behavior	Excessively negative self-opinion; worries about being rejected or criticized	Submissive in relationships
Dependent	Anxiety about possible separations from others and having to function independently	Overcontrol of behavior	Believes that he or she is helpless and incompetent and so must rely on others	Submissive in relationships
Obsessive-Compulsive	Constricted in expression of emotion to others	Overcontrol of behavior	Perfectionism; rigid thinking; preoccupation with details, rules, and lists	Dominant and somewhat detached in relationships

DSM-IV-TR CRITERIA

Paranoid Personality Disorder

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her

(2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates

(3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her

(4) reads hidden demeaning or threatening meanings into benign remarks or events

(5) persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights)

(6) perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack

(7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during the course of another psychological disorder and is not due to the direct physiological effects of a general medical condition.

Schizoid Personality Disorder

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) neither desires nor enjoys close relationships, including being part of a family

(2) almost always chooses solitary activities

(3) has little, if any, interest in having sexual experiences with another person

(4) takes pleasure in few, if any, activities

(5) lacks close friends or confidants other than first-degree relatives

(6) appears indifferent to the praise or criticism of others

(7) shows emotional coldness, detachment, or flattened affectivity

B. Does not occur exclusively during the course of another psychological disorder and is not due to the direct physiological effects of a general medical condition.

Schizotypal Personality Disorder

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) ideas of reference (excluding delusions of reference)

(2) odd beliefs or magical thinking that influences behaviour and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)

(3) unusual perceptual experiences, including bodily illusions

(4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, over-elaborate, or stereotyped)

(5) suspiciousness or paranoid ideation

(6) inappropriate or constricted affect

(7) behaviour or appearance that is odd, eccentric, or peculiar

(8) lack of close friends or confidants other than first-degree relatives

(9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

B. Does not occur exclusively during the course of another psychological disorder and is not due to the direct physiological effects of a general medical condition.

Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

(1) failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest

(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure

(3) impulsivity or failure to plan ahead

(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults

(5) reckless disregard for safety of self or others

(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations

(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years

C. There is evidence of conduct disorder with onset before age 15 years

D. The occurrence of antisocial behaviour is not exclusively during the course of schizophrenia or a manic episode.

The diagnosis for people who exhibit a similar pattern of symptoms but are younger than 18 is **conduct disorder**, which is characterized by consistently violating the rights of others (through lying, threatening, destructive and aggressive behaviours) or violating societal norms

Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
(1) Frantic efforts to avoid real or imagined abandonment.
(2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) Identity disturbance: markedly and persistently unstable self-image or sense of self

(4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, Substance Abuse, reckless driving, binge eating).
(5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms

The highly fluid and impulsive behaviours that are part of borderline personality disorder arise, in part, because of the patient's strong responses to emotional stimuli. For example, if a patient with borderline personality disorder has to wait for someone who is late for an appointment, the patient often cannot regulate the ensuing powerful feelings of anger, anxiety, or despair, which can last for days. Moreover, the person with this personality disorder is extremely

sensitive to any hint of being abandoned, which also can cause strong emotions that are then difficult to bring under control.

When not in the throes of intense emotions, people with borderline personality disorder may feel chronically empty, lonely, and isolated. When feeling empty, they may harm themselves in some nonlethal way—such as superficial cutting of skin—in order to feel "something"; such behaviour has been called parasuicidal rather than suicidal because the intention is not to commit suicide, but rather to gain relief from feeling emotionally numb. The parasuicidal behaviour usually occurs when the person is in a dissociated state, often after he or she has felt rejected or abandoned. More worrying to clinicians, family members, and friends is when the self-harming behaviour is a suicide attempt.

Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) is uncomfortable in situations in which he or she is not the centre of attention

(2) interaction with others is often characterized by inappropriate sexually seductive or provocative behaviour

(3) displays rapidly shifting and shallow expression of emotions

(4) consistently uses physical appearance to draw attention to self

(5) has a style of speech that is excessively impressionistic and lacking in detail

(6) shows self-dramatization, theatricality, and exaggerated expression of emotion

(7) is suggestible, i.e., easily influenced by others or circumstances

(8) considers relationships to be more intimate than they actually are.

Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack of

empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love

(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)

(4) requires excessive admiration

(5) has a sense of entitlement, i.e., unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations

(6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends

(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others

(8) is often envious of others or believes that others are envious of him or her

(9) shows arrogant, haughty behaviours or attitude

Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection.

(2) is unwilling to get involved with people unless certain of being liked.

(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed.

(4) is preoccupied with being criticized or rejected in social situations.

(5) is inhibited in new interpersonal situations because of feelings of inadequacy.

(6) views self as socially inept, personally unappealing, or inferior to others.

(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.

(2) needs others to assume responsibility for most major areas of his or her life.

(3) has difficulty expressing disagreement with others because of fear of loss of support or approval.

(4) has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).

(5) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.

(6) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.

(7) urgently seeks another relationship as a source of care and support when a close relationship ends.

(8) is unrealistically preoccupied with fears of being left to take care of himself or herself

Obsessive Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost

(2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)

(3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)

(4) is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

(5) is unable to discard worn-out or worthless objects even when they have no sentimental value

(6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things

(7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes

(8) shows rigidity and stubbornness

FACTORS INFLUENCING PERSONALITY DISORDERS

Broadly, neurological factors involve the effects of genes on temperament. Psychological factors include temperament, operant conditioning, and dysfunctional beliefs while social factors include insecure attachment that can result from childhood abuse or neglect. In particular,

- Histrionic and narcissistic personality disorders are theorized to arise from a combination of temperament, maladaptive beliefs and behaviours, and social interactions.
- Antisocial personality disorder is thought to arise from feedback loops among various factors, including genes and temperament, lack of empathy, classical and operant conditioning, abuse or neglect or inconsistent discipline in childhood, parents' criminal behaviour, and attachment style.
- Factors that contribute to borderline personality disorder include the genetic and neurological underpinnings of emotional dysregulation, a relatively low threshold for emotional responsiveness, an easily changeable sense of self, cognitive distortions, and a history of abuse, neglect, or feeling invalidated by others.

TREATMENT FOR PERSONALITY DISORDERS

Treatments for personality disorders include medications for comorbid symptoms, CBT or psychodynamic therapy, and family education and therapy, as well as couples, interpersonal, and group therapy. Specifically,

- People with odd/eccentric personality disorders are reluctant participants in treatment. Treatment may address fundamental issues, such as isolation and suspiciousness. Treatment for schizotypal personality disorder may include antipsychotic medication (although at lower doses than used for psychotic disorders), CBT, social skills training, and family therapy.
- Patients with histrionic and narcissistic personality disorders often drop out of treatment early, in part because they are reluctant to shift from viewing others as the cause of their problems to viewing or acknowledging their own role in creating their problems.
- treatment for antisocial personality disorder focuses on modifying specific behaviours and has some degree of success, at least temporarily, in motivated individuals
- Treatment for borderline personality may include medication, CBT, Dialectical Behaviour Therapy, intensive psychodynamic therapy, and Interpersonal Therapy.