CLINICAL PSYCHOLOGY

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CHAPTER 1

HISTORY OF CLINICAL PSYCHOLOGY

1.1: ABNORMALITY

While many definitions of abnormality have been proposed over the years, none is universally accepted (Boysen, 2007). Still, most of the definitions have certain features in common, often called "the four Ds": deviance, distress, dysfunction, and danger. That is, patterns of psychological abnormality are typically deviant (different, extreme, unusual, perhaps even bizarre), distressing (unpleasant and upsetting to the person), dysfunctional (interfering with the person's ability to conduct daily activities in a constructive way), and possibly dangerous. These criteria offer a useful starting point from which to explore the phenomena of psychological abnormality.

1.2: ANCIENT VIEWS AND TRETMENTS ON ABNORMALITY

People in prehistoric societies apparently believed that all events around and within them resulted from the actions of magical, sometimes sinister, beings who controlled the world. In particular, they viewed the human body and mind as a battleground between external forces of good and evil. Abnormal behavior was typically interpreted as a victory by evil spirits, and the cure for such behavior was to force the demons from a victim's body.

This supernatural view of abnormality may have begun as far back as the Stone Age, a half-million years ago. Some skulls from that period recovered in Europe and South America show evidence of an operation called **trephination**, in which a stone instrument, or trephine, was used to cut away a circular section of the skull. Some historians have concluded that this early operation was performed as a treatment for severe abnormal behavior—either hallucinations, in which people saw or heard things not actually present, or melancholia, characterized by extreme sadness and immobility. The purpose of opening the skull was to release the evil spirits that were supposedly causing the problem (Selling, 1940).

In recent decades, some historians have questioned whether Stone Age people actually believed that evil spirits caused abnormal behavior. The treatment for abnormality in these early societies was often exorcism. The idea was to coax the evil spirits to leave or to make the person's body an uncomfortable place in which to live. A shaman, or priest, might recite

prayers, plead with the evil spirits, insult the spirits, perform magic, make loud noises, or have the person drink bitter potions. If these techniques failed, the shaman performed a more extreme form of exorcism, such as whipping or starving the person.

1.3: THE RENAISSANCE AND RISE OF ASYLUMS

During the early part of the Renaissance, a period of flourishing cultural and scientific activity (about 1400–1700), demonological views of abnormality continued to decline. German physician **Johann Weyer** (1515–1588), the first physician to specialize in mental illness, believed that the mind was as susceptible to sickness as the body was. He is now considered the founder of the modern study of psychopathology.

The care of people with mental disorders continued to improve in this atmosphere. In England such individuals might be kept at home while their families were aided financially by the local parish. Across Europe religious shrines were devoted to the humane and loving treatment of people with mental disorders. Perhaps the best known of these shrines was at Gheel in Belgium. Beginning in the fifteenth century, people came to it from all over the world for psychic healing. Local residents welcomed these pilgrims into their homes, and many stayed on to form the world's first "colony" of mental patients. Gheel was the forerunner of today's community mental health programs, and it continues to demonstrate that people with psychological disorders can respond to loving care and respectful treatment (van Walsum, 2004; Aring, 1975, 1974). Many patients still live in foster homes there, interacting with other residents, until they recover.

Unfortunately, these improvements in care began to fade by the mid-sixteenth century. Government officials discovered that private homes and community residences could house only a small percentage of those with severe mental disorders and that medical hospitals were too few and too small. More and more, they converted hospitals and monasteries into asylums, institutions whose primary purpose was to care for people with mental illness. These institutions began with every intention of providing good care. Once the asylums started to overflow, however, they became virtual prisons where patients were held in filthy conditions and treated with unspeakable cruelty.

1.4: REFORM AND MORAL TREATMENT IN 19th CENTURY

As 1800 approached, the treatment of people with mental disorders began to improve once again (Maher & Maher, 2003). Historians usually point to **La Bicêtre** as the first site of asylum reform. In 1793, during the French Revolution, **Philippe Pinel** (1745–1826) was named the chief physician there. He argued that the patients were sick people whose illnesses should be treated with sympathy and kindness rather than chains and beatings (van Walsum, 2004). He unchained the patients and allowed them to move freely about the hospital grounds; replaced the dark dungeons with sunny, well-ventilated rooms; and offered support and advice. Pinel's approach proved remarkably successful. Many patients who had been shut away for decades improved greatly over a short period of time and were released. Pinel later brought similar reforms to a mental hospital in Paris for female patients, **La Salpetrière**. Meanwhile an English Quaker named William

Tuke (1732–1819) was bringing similar reforms to northern England. In 1796 he founded the York Retreat, a rural estate where about 30 mental patients lived as guests in quiet country houses and were treated with a combination of rest, talk, prayer, and manual work (Charland, 2007; Borthwick et al., 2001).

1.5: CURRENT TRENDS IN CLINICAL PSYCHOLOGY

It would hardly be accurate to say that we now live in a period of great enlightenment about or dependable treatment of mental disorders. The past 50 years have brought major changes in the ways clinicians understand and treat abnormal functioning. More theories and types of treatment exist, as do more research studies, more information, and, perhaps for these reasons, more disagreements about abnormal functioning today than at any time in the past.

In the 1950s researchers discovered a number of new psychotropic medications— drugs that primarily affect the brain and alleviate many symptoms of mental dysfunctioning. They included the first antipsychotic drugs, which correct extremely confused and distorted thinking; antidepressant drugs, which lift the mood of depressed people; and antianxiety drugs, which reduce tension and worry.

When given these drugs, many patients who had spent years in mental hospitals began to show signs of improvement. Hospital administrators, encouraged by these results and pressured by a growing public outcry over the terrible conditions in public mental hospitals, began to discharge patients almost immediately. Since the discovery of these medications,

mental health professionals in most of the developed nations of the world have followed a policy of **deinstitutionalization**, releasing hundreds of thousands of patients from public mental hospitals.

CHAPTER 2

PERSPECTIVES ON ABNORMAL BEHAVIOUR

2.1: PSYCHODYNAMIC PERSPECTIVE

Freud believed that three central forces shape the personality—instinctual needs, rational thinking, and moral standards. All of these forces, he believed, operate at the unconscious level, unavailable to immediate awareness, and he further believed them to be dynamic, or interactive. Freud called the forces the id, the ego, and the superego.

2.1.1: The id

Freud used the term id to denote instinctual needs, drives, and impulses. The id operates in accordance with the pleasure principle; that is, it always seeks gratification. Freud also believed that all id instincts tend to be sexual, noting that from the very earliest stages of life a child's pleasure is obtained from nursing, defecating, masturbating, or engaging in other activities that he considered to have sexual overtones. He further suggested that a person's libido, or sexual energy, fuels the id.

2.1.2: The ego

During our early years we come to recognize that our environment will not meet every instinctual need. Like the id, the ego unconsciously seeks gratification, but it does so in accordance with the reality principle, the knowledge we acquire through experience that it can be unacceptable to express our id impulses outright. The ego, employing reason, guides us to know when we can and cannot express those impulses.

The ego develops basic strategies, called ego defense mechanisms, to control unacceptable id impulses and avoid or reduce the anxiety they arouse. The most basic defense mechanism, repression, prevents unacceptable impulses from ever reaching consciousness. There are many other ego defense mechanisms, and each of us tends to favor some over others

2.1.3: The Superego

According to Freud, the psychological force that represents a person's values and ideals.

The superego grows from the ego, just as the ego grows out of the id. As we learn from our parents that many of our id impulses are unacceptable, we unconsciously adopt, or introject, our parents' values. Judging ourselves by their standards, we feel good when we uphold their values; conversely, when we go against them, we feel guilty.

According to Freud, these three parts of the personality—the id, the ego, and the superego—are often in some degree of conflict. A healthy personality is one in which an effective working relationship, an acceptable compromise, has formed among the three forces. If the id, ego, and superego are in excessive conflict, the person's behavior may show signs of dysfunction.

2.2: BEHAVIOURISTIC PERSPECTIVE

Learning theorists have identified several forms of conditioning, and each may produce abnormal behavior as well as normal behavior. In operant conditioning, for example, humans and animals learn to behave in certain ways as a result of receiving rewards—any satisfying consequences—whenever they do so. In modeling, individuals learn responses simply by observing other individuals and repeating their behaviors.

In a third form of conditioning, classical conditioning, learning occurs by temporal association. When two events repeatedly occur close together in time, they become fused in a person's mind, and before long the person responds in the same way to both events. If one event produces a response of joy, the other brings joy as well; if one event brings feelings of relief, so does the other.

Abnormal behaviors, too, can be acquired by classical conditioning. Consider a young boy who is repeatedly frightened by a neighbor's large German shepherd dog. Whenever the child walks past the neighbor's front yard, the dog barks loudly and lunges at him, stopped only by a rope tied to the porch. In this unfortunate situation, the boy's parents are not surprised to discover that he develops a fear of dogs. They are stumped, however, by another intense fear the child displays, a fear of sand. They cannot understand why he cries whenever they take him to the beach and screams in fear if sand even touches his skin. It turns out that a big sandbox is set up in the neighbor's front yard for the dog to play in. Every time the dog barks and lunges at the boy, the sandbox is there too. After repeated pairings of this kind, the child comes to fear sand as much as he fears the dog.

2.3: HUMANISTIC-EXISTENTIAL PERSPECTIVE

Humanistic and existential theorists are usually grouped together—in an approach known as the humanistic-existential model—because of their common focus on these broader dimensions of human existence. At the same time, there are important differences between them.

Humanists, the more optimistic of the two groups, believe that human beings are born with a natural tendency to be friendly, cooperative, and constructive. People, these theorists propose, are driven to self-actualize—that is, to fulfill this potential for goodness and growth. They can do so, however, only if they honestly recognize and accept their weaknesses as well as their strengths and establish satisfying personal values to live by. Humanists further suggest that self-actualization leads naturally to a concern for the welfare of others and to behavior that is loving, courageous, spontaneous, and independent.

Existentialists agree that human beings must have an accurate awareness of themselves and live meaningful lives in order to be psychologically well adjusted. These theorists do not believe, however, that people are naturally inclined to live constructively. They believe that from birth we have total freedom, either to face up to our existence and give meaning to our lives or to shrink from that responsibility. Those who choose to "hide" from responsibility and choice will view themselves as helpless and weak and may live empty, inauthentic, and dysfunctional lives as a result.

2.4: COGNITIVE PERSPECTIVE

According to cognitive theorists, abnormal functioning can result from several kinds of cognitive problems. Some people may make assumptions and adopt attitudes that are disturbing and inaccurate.

Illogical thinking processes are another source of abnormal functioning, according to cognitive theorists. Beck, for example, has found that some people consistently think in illogical ways and keep arriving at self-defeating conclusions (Beck & Weishaar, 2008). Beck has identified a number of illogical thought processes regularly found in depression, such as **overgeneralization**, the drawing of broad negative conclusions on the basis of a single insignificant event.

2.5: DIATHESIS-STRESS MODEL

A predisposition toward developing a disorder is termed a diathesis. It can derive from biological, psychological, or sociocultural causal factors. Many mental disorders are believed to develop when some kind of stressor operates on a person who has a diathesis or vulnerability for that disorder.

The diathesis is a relatively distal necessary or contributory cause, but it is generally not sufficient to cause the disorder. Instead, there generally must be a more proximal undesirable event or situation (the stressor), which may also be contributory or necessary but is generally not sufficient by itself to cause the disorder except in someone with the diathesis.

Stress is the response or experience of an individual to demands that he or she perceives as taxing or exceeding his or her personal resources. It usually occurs when an individual experiences chronic or episodic events that are undesirable and lead to behavioral, physiological, and cognitive accommodations.

Researchers have proposed several different ways that a diathesis and stress may combine to produce a disorder. Mainly there are two models namely (1) **additive model** and (2) **interactive model.**

In the additive model, individuals who have a high level of a diathesis may need only a small amount of stress before a disorder develops, but those who have a very low level of a diathesis may need to experience a large amount of stress for a disorder to develop. In other words, the diathesis and the stress sum together, and when one is high the other can be low, and vice versa; thus, a person with no diathesis or a very low level of diathesis could still develop a disorder when faced with truly severe stress.

In the interactive model, some amount of diathesis must be present before stress will have any effect. Thus, in the interactive model, someone with no diathesis will never develop the disorder, no matter how much stress he or she experiences, whereas someone with the diathesis will show increasing likelihood of developing the disorder with increasing levels of stress.

CHAPTER 3

ANXIETY, OBSESSION AND PANIC DISORDERS

Anxiety involves a general feeling of apprehension about possible future danger, and fear is an alarm reaction that occurs in response to immediate danger. There has never been complete agreement about how distinct the two emotions of **fear and anxiety** are from each other. Historically, the most common way of distinguishing between the fear and anxiety response patterns has been whether there is a clear and obvious source of danger that would be regarded as real by most people. **When the source of danger is obvious, the experienced emotion has been called fear** (e.g., "I'm afraid of snakes"). **With anxiety, however, we frequently cannot specify clearly what the danger** is (e.g., "I'm anxious about my parents' health").

1. Generalized Anxiety Disorder (GAD)
2. Obsessive-Compulsive Disorder
3. Panic Disorder
4. Phobias

3.1: GENERALIZED ANXIETY DISORDER (GAD)

Most of the people worry and get anxious occasionally, and anxiety is an adaptive emotion that helps to plan and prepare for possible threat. But for some people, anxiety and worry about many different aspects of life (including minor events) becomes chronic, excessive, and unreasonable. In these cases, generalized anxiety disorder (GAD) (formerly known as free-floating anxiety) may be diagnosed. The worry must occur more days than not for at least 6 months and that it must be experienced as difficult to control. The worry must be about a number of different events or activities, and its content cannot be exclusively related to the worry associated with another concurrent Axis I disorder, such as the possibility of having a panic attack.

The general picture of people suffering from generalized anxiety disorder is that they live in a relatively constant future-oriented mood state of anxious apprehension, chronic tension, worry, and diffuse uneasiness that they cannot control. They also frequently show marked vigilance for possible signs of threat in the environment and frequently engage in certain subtle avoidance activities such as procrastination, checking, or calling a loved one frequently to see if he or she is safe. The nearly constant worries of people with generalized anxiety disorder leave them continually upset and discouraged. People with GAD have no

appreciation of the logic by which most of us conclude that it is pointless to torment ourselves about possible outcomes over which we have no control.

GAD is approximately twice as common in women as in men. Although GAD is quite common, most people with this disorder manage to function. They are less likely to go to clinics for psychological treatment than are people with panic disorder or major depressive disorder, which are frequently more debilitating conditions. However, people with GAD do frequently show up in physicians' offices with medical complaints (such as muscle tension or gastrointestinal and/or cardiac symptoms) and are known to be over users of health care resources.

3.2: OBSESSIVE-COMPULSIVE DISORDER (OCD)

Diagnostically, obsessive compulsive disorder (OCD) is defined by the **occurrence of unwanted and intrusive obsessive thoughts or distressing images; these are usually accompanied by compulsive behaviors performed to neutralize the obsessive thoughts or images or to prevent some dreaded event or situation.**

More specifically, **obsessions** involve persistent and recurrent intrusive thoughts, images, or impulses that are experienced as disturbing, inappropriate, and uncontrollable. People who have such obsessions actively try to resist or suppress them or to neutralize them with some other thought or action. **Compulsions** can involve either overt repetitive behaviors that are performed as lengthy rituals (such as hand washing, checking, or ordering over and over again) or more covert mental rituals (such as counting, praying, or saying certain words silently over and over again).

The variety of obsessive-compulsive rituals and thoughts is practically unlimited, but investigators have identified four broad types of preoccupations namely: **(1) Checking, (2) Cleaning, (3) Slowness and (4) Doubting and Conscientiousness.** A person with OCD usually feels driven to perform this compulsive, ritualistic behavior in response to an obsession, and there are often very rigid rules regarding how the compulsive behavior should be performed. The compulsive behaviors are performed with the goal of preventing or reducing distress or preventing some dreaded event or situation. OCD is often one of the most disabling mental disorders in that it leads to a lower quality of life and a great deal of functional impairment.

In addition, the person must recognize that the obsession is the product of his or her own mind rather than being imposed from without. However, there is a continuum of "insight"

among persons with obsessive-compulsive disorder about exactly how senseless and excessive their obsessions and compulsions are.

3.3: PANIC DISORDER

Diagnostically, panic disorder is defined and characterized by the occurrence of panic attacks that often seem to come "out of the blue" (accidentally). For the diagnosis of panic disorder, the person must have experienced recurrent, unexpected attacks and must have been persistently concerned about having another attack or worried about the consequences of having an attack for at least a month.

Panic attacks are often "unexpected" or "uncued" in the sense that they do not appear to be provoked by identifiable aspects of the immediate situation. Indeed, they sometimes occur in situations in which they might be least expected, such as during relaxation or during sleep (known as nocturnal panic). In other cases, however, panic attacks are said to be situationally predisposed, occurring only sometimes while the person is in a particular situation such as while driving a car or being in a crowd.

Researchers found that **agoraphobia** (fear of public or open places) usually develops as a complication of having panic attacks in one or more such situations. Concerned that they may have a panic attack or get sick, people with agoraphobia are anxious about being in places or situations from which escape would be physically difficult or psychologically embarrassing, or in which immediate help would be unavailable if something bad happened.

3.4: SPECIFIC PHOBIA

A person is diagnosed as having a **specific phobia** if she or he shows strong and persistent fear that s/he realizes is excessive or unreasonable and is triggered by the presence of a specific object or situation. When individuals with specific phobias encounter a phobic stimulus, they often show an immediate fear response that often resembles a panic attack except for the existence of a clear external trigger as photographs or television images. This avoidance of phobic stimulus is a cardinal characteristic of phobias; it occurs both because the phobic response itself is so unpleasant and because of the phobic person's irrational appraisal of the likelihood that something terrible will happen.

If people who suffer from phobias attempt to approach their phobic situation, they are overcome with fear or anxiety, which may vary from mild feelings of apprehension and distress (usually while still at some distance) to full-fledged activation of the fight-or-flight response. Regardless of how it begins, phobic behavior tends to be reinforced because every time the

person with a phobia avoids a feared situation his or her anxiety decreases. In addition, the secondary benefits derived from being disabled, such as increased attention, sympathy, and some control over the behavior of others, may also sometimes reinforce a phobia.

Other common phobias are **Acrophobia** (fear of heights), **Agoraphobia** (Fear of open spaces and unfamiliar settings), **Aquaphobia** (fear of water), **Claustrophobia** (fear of closed spaces) and **Xenophobia** (fear of strangers).

3.5: SOCIAL PHOBIA

Social phobia (or social anxiety disorder), is characterized by disabling fears of one or more specific social situations (such as public speaking, urinating in a public bathroom, or eating or writing in public). In these situations, a person fears that she or he may be exposed to the scrutiny and potential negative evaluation of others or that she or he may act in an embarrassing or humiliating manner. Because of their fears, people with social phobias either avoid these situations or endure them with great distress. Intense fear of public speaking is the single most common type of social phobia.

CHAPTER 4

SOMATOFORM AND DISSOCIATIVE DISORDERS

4.1: SOMATOFORM DISORDERS

The somatoform disorders are a group of conditions that involve physical symptoms and complaints suggesting the presence of a medical condition but without any evidence of physical pathology to account for them (APA, 2000). In other words, they involved medically unexplained physical symptoms.

Soma means "body," and somatoform disorders involve patterns in which individuals complain of bodily symptoms or defects that suggest the presence of medical problems but for which no organic basis can be found that satisfactorily explains the symptoms such as paralysis or pain. Such individuals are typically preoccupied with their state of health and with various presumed disorders or diseases of bodily organs. Equally key to these disorders is the fact that the affected patients have no control over their symptoms. They are also not intentionally faking symptoms or attempting to deceive others. For the most part, they genuinely and sometimes passionately believe something is terribly wrong with their bodies and so they frequently show up in the practices of primary-care physicians, who then have the difficult task of managing their complaints, which have no known medical basis.

Mainly there are 5 types of somatoform disorders namely: (1) **hypochondriasis**, (2) **somatization disorder**, (3) **pain disorder**, (4) **conversion disorder**, and (5) **body dysmorphic disorder.**

4.1.1: Hypochondriasis

People with hypochondriasis are preoccupied either with fears of contracting a serious disease or with the idea that they actually have such a disease even though they do not. Their very distressing preoccupations are all based on a misinterpretation of one or more bodily signs or symptoms (e.g., being convinced that their slight cough is a sign of lung cancer). Of course the decision that a hypochondriacal complaint is based on a misinterpretation of bodily signs or symptoms can be made only after a thorough medical evaluation does not find a medical condition that could account for the signs or symptoms. Another defining criterion for hypochondriasis is that the person is not reassured by the results of a medical evaluation; that is, the fear or idea of having a disease persists despite medical reassurance. Indeed, these individuals are sometimes disappointed when no physical problem is found. Finally, the

condition must persist for at least 6 months for the diagnosis to be made so as to not diagnose relatively transient health concerns.

4.1.2: Somatization Disorder

Somatization disorder is characterized by many different complaints of physical ailments, over at least several years beginning before age 30, that are not adequately explained by independent findings of physical illness or injury and that lead to medical treatment or to significant life impairment. Not surprisingly, therefore, somatization disorder is seen most often among patients in primary medical care settings in cultures all over the world (Guerje et al., 1997; Iezzi et al., 2001). Indeed, patients with somatization disorder are enormously costly to health care systems because they often have multiple unnecessary hospitalizations and surgeries.

4.1.3: Pain Disorder

The pain disorder is characterized by the experience of persistent and severe pain in one or more areas of the body that is not intentionally produced or feigned. Although a medical condition may contribute to the pain, psychological factors must be judged to play an important role. The pain disorder may be acute (duration of less than 6 months) or chronic (duration of over 6 months). In approaching the phenomenon of somatoform pain disorder, it is very important to remember that the pain that is experienced is very real and can hurt as much as pain with purely medical causes. It is also important to note that pain is always, in part, a subjective experience that is private and cannot be objectively identified by others.

4.1.4: Conversion Disorder

Conversion disorder involves a pattern in which symptoms or deficits affecting sensory or voluntary motor functions lead one to think that a patient has a medical or neurological condition. However, upon a thorough medical examination, it becomes apparent that the pattern of symptoms or deficits cannot be fully explained by any known medical condition. A few typical examples include partial paralysis, blindness, deafness, and pseudoseizures. In addition, psychological factors must be judged to play an important role in the symptoms or deficits because the symptoms usually either start or are exacerbated by preceding emotional or interpersonal conflicts or stressors. Finally, the person must not be intentionally producing or faking the symptoms.

4.1.5: Body Dysmorphic Disorder

Body dysmorphic disorder (BDD) is a somatoform disorder because it involves preoccupation with certain aspects of the body. People with BDD are obsessed with some perceived or imagined flaw or flaws in their appearance to the point they firmly believe they are disfigured or ugly. This preoccupation is so intense that it causes clinically significant distress and impairment in social or occupational functioning. Although it is not considered necessary for the diagnosis, most people with BDD have compulsive checking behaviors (such as checking their appearance in the mirror excessively or hiding or repairing a perceived flaw). Another very common symptom is avoidance of usual activities because of fear that other people will see the imaginary defect and be repulsed. In severe cases they may become so isolated that they lock themselves up in their houses and never go out even to work.

4.2: DISSOCIATIVE DISORDERS

Dissociative disorders are a group of conditions involving disruptions in a person's normally integrated functions of consciousness, memory, identity, or perception (APA, 2000). Included here are some of the more dramatic phenomena in the entire domain of psychopathology: people who cannot recall who they are or where they may have come from, and people who have two or more distinct identities or personality states that alternately take control of the individual's behavior.

4.2.1: Depersonalization Disorder

Two of the more common kinds of dissociative symptoms are derealization and depersonalization. In **derealization** one's sense of the reality of the outside world is temporarily lost, and in **depersonalization** one's sense of one's own self and one's own reality is temporarily lost. As many as half of us have such experiences in mild form at least once in our lives, usually during or after periods of severe stress, sleep deprivation, or sensory deprivation. But when episodes of depersonalization (and derealization) become persistent and recurrent and interfere with normal functioning, depersonalization disorder may be diagnosed. In this disorder, people have persistent or recurrent experiences of feeling detached from (and like an outside observer of) their own bodies and mental processes. They may even feel they are, for a time, floating above their physical bodies, which may suddenly feel very different—as if drastically changed or unreal.

4.2.2: Dissociative Amnesia

Dissociative amnesia (or psychogenic amnesia) is usually limited to a failure to recall previously stored personal information (retrograde amnesia) when that failure cannot be accounted for by ordinary forgetting. The gaps in memory most often occur following intolerably stressful circumstances— wartime combat conditions, for example, or catastrophic events such as serious car accidents, suicide attempts, or violent outbursts. In this disorder, apparently forgotten personal information is still there beneath the level of consciousness, as sometimes becomes apparent in interviews conducted under hypnosis or narcosis (induced by sodium amytal, or so-called truth serum) and in cases where the amnesia spontaneously clears up. Several types of dissociative amnesia are recognized by DSM-IV-TR. One is **localized amnesia** (a person remembers nothing that happened during a specific period, most commonly the first few hours or days following some highly traumatic event). Another **is selective amnesia** (a person forgets some but not all of what happened during a given period).

Usually amnesic episodes last between a few days and a few years, and although many people experience only one such episode, some people have multiple episodes in their lifetimes. In typical dissociative amnesic reactions, individuals cannot remember certain aspects of their personal life history or important facts about their identity. Yet their basic habit patterns—such as their abilities to read, talk, perform skilled work, and so on—remain intact, and they seem normal aside from the memory deficit. Thus the only type of memory that is affected is episodic (pertaining to events experienced) or autobiographical memory (pertaining to personal events experienced). The other recognized forms of memory— semantic (pertaining to language and concepts), procedural (how to do things), and short-term storage—seem usually to remain intact.

4.2.3: Dissociative Fugue

A person may retreat still further from real-life problems by going into an amnesic state called a dissociative fugue, which, as the term implies (the French word fugue means "flight"), is a defense by actual flight—a person is not only amnesic for some or all aspects of his or her past but also departs from home surroundings. This is accompanied by confusion about personal identity or even the assumption of a new identity (although the identities do not alternate as they do in dissociative identity disorder). During the fugue, such individuals are unaware of memory loss for prior stages of their life, but their memory for what happens during the fugue state itself is intact. Their behavior during the fugue state is usually quite normal and unlikely to arouse suspicion that something is wrong. However, behavior during the fugue state

often reflects a rather different lifestyle from the previous one (the rejection of which is sometimes fairly obvious). Days, weeks, or sometimes even years later, such people may suddenly emerge from the fugue state and find themselves in a strange place, working in a new occupation, with no idea how they got there. In other cases, recovery from the fugue state occurs only after repeated questioning and reminders of who they are. In either case, as the fugue state remits, their initial amnesia remits—but a new, apparently complete amnesia for their fugue period occurs.

4.2.4: Dissociative Identity Disorder

Dissociative identity disorder (DID), formerly called multiple personality disorder (MPD), is a dramatic dissociative disorder in which patient manifests two or more distinct identities that alternate in some way in taking control of behavior. There is also an inability to recall important personal information that cannot be explained by ordinary forgetting. Each identity may appear to have a different personal history, self-image, and name, although there are some identities that are only partially distinct and independent from other identities. In most cases the one identity that is most frequently encountered and carries the person's real name is the host identity. Also in most cases, the host is not the original identity, and it may or may not be the best-adjusted identity. The alter identities may differ in striking ways involving gender, age, handedness, handwriting, sexual orientation, prescription for eyeglasses, predominant affect, foreign languages spoken, and general knowledge.

CHAPTER 5

MOOD DISORDERS

5.1: MOOD DISORDERS: AN OVERVIEW

Mood disorders involve much more severe alterations in mood for much longer periods of time. In such cases the disturbances of mood are intense and persistent enough to be clearly maladaptive and often lead to serious problems in relationships and work performance.

The two key moods involved in mood disorders are **mania**, often characterized by intense and unrealistic feelings of excitement and euphoria, and **depression**, which usually involves feelings of extraordinary sadness and dejection. Some people with mood disorders experience only time periods or episodes characterized by depressed moods. However, other people experience manic episodes at certain time points and depressive episodes at other time points. Normal mood states can occur between both types of episodes. Manic and depressive mood states are often conceived to be at opposite ends of a mood continuum, with normal mood in the middle.

5.2: UNIPOLAR MOOD DISORDERS

5.2.1: Dysthymic Disorder (Persistent Depressive Disorder)

Dysthymic disorder is generally considered to be of mild to moderate intensity, but its primary hallmark is its chronicity. To qualify for a diagnosis of dysthymic disorder (or dysthymia), a person must have a persistently depressed mood most of the day, for more days than not, for at least 2 years (1 year for children and adolescents). In addition, individuals with dysthymic disorder must have at least two of six additional symptoms when depressed. Periods of normal mood may occur briefly, but they usually last for only a few days to a few weeks (and for a maximum of 2 months). These intermittently normal moods are one of the most important characteristics distinguishing dysthymic disorder from major depressive disorder, which typically occurs in more discrete major depressive episodes. Nevertheless, in spite of the intermittently normal moods, because of its chronic course people with dysthymia show poorer outcomes and as much impairment as those with major depression.

5.2.2: Major Depressive Disorder

The diagnostic criteria for major depressive disorder (also known as major depression) require that the person exhibit more symptoms than are required for dysthymia and that the symptoms be more persistent (not interwoven with periods of normal mood). To receive a diagnosis of major depressive disorder, a person must be in a major depressive episode (single

if initial, or recurrent) and never have had a manic, hypomanic, or mixed episode. An affected person must experience either markedly depressed moods or marked loss of interest in pleasurable activities most of every day, nearly every day, for at least 2 consecutive weeks. In addition to showing one or both of these symptoms, the person must experience at least three or four additional symptoms during the same period (for a total of at least five symptoms). In addition to the obvious emotional symptoms, these symptoms also include cognitive symptoms (such as feelings of worthlessness or guilt, and thoughts of suicide), behavioral symptoms (such as fatigue or physical agitation), and physical symptoms (such as changes in appetite and sleep patterns).

5.2.2.1: Depression as a recurrent disorder

When a diagnosis of major depressive disorder is made, it is usually also specified whether this is a first, and therefore single (initial), episode or a recurrent episode (preceded by one or more previous episodes). This reflects the fact that depressive episodes are usually time limited; the average duration of an untreated episode is about 6 to 9 months. In a large untreated sample of women with depression, certain predictors pointed to a longer time to spontaneous remission of symptoms: having financial difficulties, severe stressful life events, and high genetic risk.

Although most depressive episodes remit (which is not said to occur until symptoms have largely been gone for at least 2 months), depressive episodes often recur at some future point. In recent years, recurrence has been distinguished from relapse, where the latter term refers to the return of symptoms within a fairly short period of time, a situation that probably reflects the fact that the underlying episode of depression has not yet run its course.

5.2.3: Beck's Cognitive Theory

Beck's theory, a diathesis-stress theory, first, there are the underlying dysfunctional beliefs, known as **depressogenic schemas**, which are rigid, extreme, and counterproductive. An example of a dysfunctional belief (that a person is usually not consciously aware of) is, "If everyone doesn't love me, then my life is worthless." According to cognitive theory, such a belief would predispose the person holding it to develop depression if he or she perceived social rejection. Beck did not maintain that simply having these dysfunctional beliefs is sufficient to make someone depressed; instead, he maintained that these dysfunctional beliefs need to be activated by the occurrence of some form of stress (e.g., perceiving social rejection or feeling like a failure).

These depression-producing beliefs or schemas are thought to develop during childhood and adolescence as a function of one's negative experiences with one's parents and significant others, and they are thought to serve as the underlying diathesis, or vulnerability, to developing depression. Although they may lie dormant for years in the absence of significant stressors, when dysfunctional beliefs are activated by current stressors or depressed mood, they tend to fuel the current thinking pattern, creating a pattern of **negative automatic thoughts**—thoughts that often occur just below the surface of awareness and involve unpleasant, pessimistic predictions. These pessimistic predictions tend to center on the three themes of what Beck calls the negative cognitive triad: (1) **negative thoughts about the self** ("I'm ugly"; "I'm worthless"; "I'm a failure"); (2) **negative thoughts about one's experiences and the surrounding world** ("No one loves me"; "People treat me badly"); and (3) **negative thoughts about one's future** ("It's hopeless because things will always be this way".

5.3: BIPOLAR DISORDERS

Bipolar disorders are distinguished from unipolar disorders by the presence of manic or hypomanic episodes, which are nearly always preceded or followed by periods of depression. A person who experiences a manic episode has a markedly elevated, euphoric, and expansive mood, often interrupted by occasional outbursts of intense irritability or even violence—particularly when others refuse to go along with the manic person's wishes and schemes. These extreme moods must persist for at least a week for this diagnosis to be made. In addition, three or more additional symptoms must occur in the same time period. There must also be significant impairment of occupational and social functioning, and hospitalization is often necessary during manic episodes. Hypomanic episodes can also occur; these involve milder versions of the same symptoms and last at least 4 days. Although the symptoms listed are the same for manic and hypomanic episodes, there is much less impairment in hypomania, and hospitalization is not required.

5.3.1: Cyclothymic Disorder

Cyclothymia is defined as a less serious version of full-blown bipolar disorder because it lacks certain extreme symptoms and psychotic features such as delusions and the marked impairment caused by full-blown manic or major depressive episodes. In the depressed phase of cyclothymic disorder, a person's mood is dejected, and he or she experiences a distinct loss of interest or pleasure in customary activities and pastimes. In addition, the person may show other symptoms such as low energy, feelings of inadequacy, social withdrawal, and a

pessimistic, brooding attitude. Essentially, the symptoms are similar to those in someone with dysthymia except without the duration criterion.

Symptoms of the hypomanic phase of cyclothymia are essentially the opposite of the symptoms of dysthymia. In this phase of the disorder, the person may become especially creative and productive because of increased physical and mental energy. There may be significant periods between episodes in which the person with cyclothymia functions in a relatively adaptive manner. For a diagnosis of cyclothymia, there must be at least a 2-year span during which there are numerous periods with hypomanic and depressed symptoms (1 year for adolescents and children), and the symptoms must cause clinically significant distress or impairment in functioning. Because individuals with cyclothymia are at greatly increased risk of later developing full-blown bipolar I or II disorder it recommends that they be treated.

5.3.2: Bipolar I Disorder

Bipolar I disorder is distinguished from major depressive disorder by at least one manic episode or mixed episode. A mixed episode is characterized by symptoms of both full-blown manic and major depressive episodes for at least 1 week, whether the symptoms are intermixed or alternate rapidly every few days. Such cases were once thought to be relatively rare but have increasingly been recognized as relatively common.

Even though a client may be exhibiting only manic symptoms, it is assumed that a bipolar disorder exists and that a depressive episode will eventually occur. Thus, there are no officially recognized unipolar manic or hypomanic counterparts to dysthymia or major depression.

5.3.3: Bipolar II Disorder

Bipolar II disorder, in which the person does not experience full-blown manic (or mixed) episodes but has experienced clear-cut hypomanic episodes as well as major depressive episodes as in bipolar I disorder. Bipolar II disorder is equally or somewhat more common than bipolar 1 disorder.

Bipolar disorder occurs equally in males and females (although depressive episodes are more common in women than men) and usually starts in adolescence and young adulthood, with an average age of onset of 18 to 22 years. Bipolar II disorder has an average age of onset approximately 5 years later than bipolar I disorder. Both bipolar I and II are typically recurrent disorders, with people experiencing single episodes extremely rarely (Kessler et al., 2007). In about two thirds of cases, the manic episodes either immediately precede or immediately follow

a depressive episode; in other cases, the manic and depressive episodes are separated by intervals of relatively normal functioning.

5.3.3.1: Features of Bipolar Disorder

The duration of manic and hypomanic episodes tends to be shorter than the duration of depressive episodes, with typically about three times as many days spent depressed as manic or hypomanic. Research clearly indicates that major depressive episodes in people with bipolar disorder are, on average, more severe than those seen in unipolar disorder, and, not surprisingly, they also cause more role impairment. Because a person who is depressed cannot be diagnosed with bipolar I disorder unless he or she has exhibited at least one manic or mixed episode in the past, many people with bipolar disorder whose initial episode or episodes are depressive (about 50 percent) are misdiagnosed at first and possibly throughout their lives (for instance, if no manic episodes are observed or reported, or if they die before a manic episode is experienced). Misdiagnoses are unfortunate because there are somewhat different treatments of choice for unipolar and bipolar depression.

On average, people with bipolar disorder suffer from more episodes during their lifetimes than do persons with unipolar disorder. As many as 5 to 10 percent of persons with bipolar disorder experience at least four episodes (either manic or depressive) every year, a pattern known as **rapid cycling.** People who develop rapid cycling are slightly more likely to be women, to have a history of more episodes (especially more manic or hypomanic episodes), to have an earlier average age of onset, and to make more suicide attempts.

CHAPTER 6

SCHIZOPHRENIA

6.1: SCHIZOPHRENIA

Schizophrenia occurs in people from all cultures and from all walks of life. The disorder is characterized by an array of diverse symptoms, including extreme oddities in perception, thinking, action, sense of self, and manner of relating to others. However, the hallmark of schizophrenia is a significant loss of contact with reality, referred to as psychosis.

It is the German psychiatrist Emil Kraepelin who is best known for his careful description of what we now regard as schizophrenia. Kraepelin used the Latin word, ***dementia praecox*** to refer to a group of conditions that all seemed to feature mental deterioration beginning early in life.

It was a Swiss psychiatrist named Eugen Bleuler (1857–1939) who gave us the diagnostic term we still use today. In 1911, Bleuler used schizophrenia (from the Greek roots of sxizo, pronounced "**schizo" and meaning "to split or crack," and phren, meaning "mind"**) because he believed the condition was characterized primarily by disorganization of thought processes, a lack of coherence between thought and emotion, and an inward orientation away (split off) from reality.

6.2: CHARACTERISTICS OF SCHIZOPHRENIA

The most important characteristics of schizophrenia are (1) delusions, (2) hallucinations, (3) disorganized speech and behavior, (4) positive symptoms and (5) negative symptoms.

6.2.1: Delusions

Delusion can be defined as false belief about reality maintained in spite of strong evidence to the contrary.

A delusion is essentially an erroneous belief that is fixed and firmly held despite clear contradictory evidence. People with delusions believe things that others who share their social, religious, and cultural backgrounds do not believe. A delusion therefore involves a disturbance in the content of thought. Not all people who have delusions suffer from schizophrenia. However, delusions are common in schizophrenia, occurring in more than 90 percent of patients at some time during their illness.

In schizophrenia, certain types of delusions or false beliefs are quite characteristic. Prominent among these are beliefs that one's thoughts, feelings, or actions are being controlled by external agents (**made feelings or impulses**), that one's private thoughts are being broadcast indiscriminately to others **(thought broadcasting**), that thoughts are being inserted into one's brain by some external agency (**thought insertion**), or that some external agency has robbed one of one's thoughts (**thought withdrawal**). Also common are delusions of reference, where some neutral environmental event (such as a television program or a song on the radio) is believed to have special and personal meaning intended only for the person. Other strange propositions, including delusions of bodily changes (e.g., bowels do not work) or removal of organs, are also not uncommon.

6.2.2: Hallucinations

Hallucinations can be defined as the false perception such as things seen or heard that are not real or present. In other words, *hallucination is a sensory experience that seems real to the person having it, but occurs in the absence of any external perceptual stimulus*.

Hallucinations can occur in any sensory modality (auditory, visual, olfactory, tactile, or gustatory). However, auditory hallucinations (e.g., hearing voices) are by far the most common. Even deaf people who are diagnosed with schizophrenia sometimes report auditory hallucinations.

6.2.3: Disorganized Speech

Disorganized speech, is the external manifestation of a disorder in thought form. Basically, an affected person fails to make sense, despite seeming to conform to the semantic and syntactic rules governing verbal communication. The failure is not attributable to low intelligence, poor education, or cultural deprivation.

In disorganized speech, the words and word combinations sound communicative, but the listener is left with little or no understanding of the point the speaker is trying to make. In some cases, completely new, made-up words known as neologisms (literally, "new words") appear in the patient's speech.

6.2.4: Disorganized Behaviour

Disorganized behavior can show itself in a variety of ways. Goal-directed activity is almost universally disrupted in schizophrenia. The impairment occurs in areas of routine daily functioning, such as work, social relations, and self-care, to the extent that observers note that the person is not himself or herself anymore. For example, the person may no longer maintain

minimal standards of personal hygiene or may exhibit a profound disregard of personal safety and health. In other cases, grossly disorganized behavior appears as silliness or unusual dress (e.g., wearing an overcoat, scarf, and gloves on a hot summer day).

Catatonia is an even more striking behavioral disturbance. The patient with catatonia may show a virtual absence of all movement and speech and be in what is called a *catatonic stupor*. At other times, the patient may hold an unusual posture for an extended period of time without any seeming discomfort.

6.2.5: Positive Symptoms and Negative Symptoms

Positive symptoms are those that reflect an excess or distortion in a normal repertoire of behavior and experience, such as delusions and hallucinations.

Negative symptoms, reflect an absence or deficit of behaviors that are normally present. Important negative symptoms in schizophrenia include flat affect, or blunted emotional expressiveness, and **alogia**, which means very little speech. Another negative symptom is **avolition**, or the inability to initiate or persist in goal-directed activities.

Although most patients exhibit both positive and negative symptoms during the course of their disorders, a preponderance of negative symptoms in the clinical picture is not a good sign for the patient's future outcome.

Statistical procedures have further indicated that some symptoms like disordered speech and disorganized behavior that were previously thought to reflect positive symptoms might be better separated from "true" positive symptoms like hallucinations and delusions. A disorganized symptom pattern is now also recognized.

6.3: SUBTYPES OF SCHIZOPHRENIA

What we call schizophrenia probably encompasses a variety of disordered processes of varied etiology, developmental pattern, and outcome—perhaps more so than is the case for any other psychiatric diagnosis. Reflecting this, attempts have been made to identify meaningful subtypes of schizophrenia. The subtypes of schizophrenia include (1) Paranoid Schizophrenia, (2) Catatonic Schizophrenia (3) Residual Schizophrenia (4) Disorganized Schizophrenia and (5) Undifferentiated Schizophrenia

6.3.1: Paranoid Schizophrenia

Paranoid schizophrenia is marked by delusions and sustained extreme suspiciousness. Preoccupation with delusions or auditory hallucination, little or no disorganized speech,

disorganized or catatonic behavior, or inappropriate or flat affect etc are the characteristics of paranoid schizophrenia.

6.3.2: Catatonic Schizophrenia

Catatonic schizophrenia is characterized by psychomotor disturbances that may range from immobility or stupor to excessive motor activity that seems purposeless and unconnected to what is going on in the environment. A person with this type of schizophrenia may refuse to speak and remain stiffly immobile or may be extremely agitated. Waxy flexibility is an extreme form of immobility in which the person's arm of legs remains passively in the position in which it is placed. In contrast a person with agitated catatonic behavior shows extreme psychomotor excitement such as continuous talking or shouting.

6.3.3: Residual Schizophrenia

If someone has previously met the diagnostic criteria for schizophrenia and no longer has prominent positive symptoms, but still continues to have negative symptoms or very mild positive symptoms, then he or she is classified as having schizophrenic disorder of the residual type. People with this pattern may continue to display blunted or inappropriate emotions, as well as social withdrawal, eccentric behavior, and some illogical thinking.

6.3.4: Disorganized Schizophrenia

The central symptoms of disorganized type of schizophrenia are confusion, incoherence, and flat or inappropriate affect. Attention and perception problems, extreme social withdrawal, and odd mannerisms are common. So is flat or inappropriate affect. Silliness, in particular, is common; some patients giggle constantly without apparent reason. Such people behave actively but aimlessly, and they may show a childish disregard for social conventions and may resists wearing clothes, or urinate or defecate in inappropriate places. Usually the long-term outlook for recovery is poor. Not surprisingly, people with disorganized schizophrenia are typically unable to take good care of themselves, maintain social relationships, or hold a job.

6.3.5: Undifferentiated Schizophrenia

When people with this disorder do not fall neatly into one of the other categories, they are diagnosed with undifferentiated type of schizophrenia. Because this category is somewhat vague, it has been assigned to a wide assortment of unusual patterns over the years. Many clinicians believe that it is in fact overused.

CHAPTER 7

PERSONALITY DISORDERS

7.1: CLUSTER A PERSONALITY DISORDERS

The cluster A personality disorders consists of the paranoid, schizoid, and schizotypal personality disorders. People with these disorders typically display odd or eccentric behaviors that are similar to but not as extensive as those seen in schizophrenia, including extreme suspiciousness, social withdrawal, and peculiar ways of thinking and perceiving things. Such behaviors often leave the person isolated. Some clinicians believe that these personality disorders are actually related to schizophrenia, and they call them schizophrenia-spectrum disorders. In support of this idea, people with these personality disorders often qualify for an additional diagnosis of schizophrenia or have close relatives with schizophrenia (Bollini & Walker, 2007; APA, 2000). Clinicians have learned much about the symptoms of the odd personality disorders but have not been so successful in determining their causes or how to treat them. In fact, people with these disorders rarely seek treatment (Mittal et al., 2007).

7.1.1: Paranoid Personality Disorder

People with paranoid personality disorder deeply distrust other people and are suspicious of their motives (APA, 2000). Because they believe that everyone intends them harm, they shun close relationships. Their trust in their own ideas and abilities can be excessive. They find "hidden" meanings, which are usually belittling or threatening, in everything. In a study that required individuals to role-play, participants with paranoia were more likely than control participants to read hostile intentions into the actions of others. In addition, they more often chose anger as the appropriate role-play response (Turkat et al., 1990).

People with this disorder are critical of weakness and fault in others, particularly at work. They are unable to recognize their own mistakes, however, and are extremely sensitive to criticism. They often blame others for the things that go wrong in their lives, and they repeatedly bear grudges. Between 0.5 and 3 percent of adults are believed to experience this disorder, apparently more men than women (O'Connor, 2008; Mattia & Zimmerman, 2001).

7.1.2: Schizoid Personality Disorder

People with schizoid personality disorder persistently avoid and are removed from social relationships and demonstrate little in the way of emotion (APA, 2000). Like people with paranoid personality disorder, these individuals do not have close ties with other people.

The reason they avoid social contact, however, has nothing to do with paranoid feelings of distrust or suspicion; it is because they genuinely prefer to be alone.

People with schizoid personality disorder, often described as "loners," make no effort to start or keep friendships, take little interest in having sexual relationships, and even seem indifferent to their families. They seek out jobs that require little or no contact with others. When necessary, they can form work relations to a degree, but they prefer to keep to themselves. Many live by themselves as well. Not surprisingly, their social skills tend to be weak. If they marry, their lack of interest in intimacy may create marital or family problems.

People with schizoid personality disorder focus mainly on themselves and are generally unaffected by praise or criticism. They rarely show any feelings, expressing neither joy nor anger. They seem to have no need for attention or acceptance; are typically viewed as cold, humorless, or dull; and generally, succeed in being ignored. This disorder is estimated to be present in fewer than 1 percent of the population (Mittal et al., 2007; Samuels et al., 2002). It is slightly more likely to occur in men than in women, and men may also be more impaired by it (APA, 2000).

7.1.3: Schizotypal Personality Disorder

People with schizotypal personality disorder display a range of interpersonal problems marked by extreme discomfort in close relationships, very odd patterns of thinking and perceiving, and behavioral eccentricities (APA, 2000). Anxious around others, they seek isolation and have few close friends. Many feel intensely lonely. The disorder is more severe than the paranoid and schizoid personality disorders.

The thoughts and behaviors of people with schizotypal personality disorder can be noticeably disturbed. These symptoms may include ideas of reference— beliefs that unrelated events pertain to them in some important way—and bodily illusions, such as sensing an external "force" or presence. A number of people with this disorder see themselves as having special extrasensory abilities, and some believe that they have magical control over others. Examples of schizotypal eccentricities include repeatedly arranging cans to align their labels, organizing closets extensively, or wearing an odd assortment of clothing. The emotions of these individuals may be inappropriate, flat, or humorless.

People with schizotypal personality disorder often have great difficulty keeping their attention focused. Correspondingly, their conversation is typically digressive and vague, even sprinkled with loose associations (O'Connor, 2008). They tend to drift aimlessly and lead an

idle, unproductive life (Skodol et al., 2002). They are likely to choose undemanding jobs in which they can work below their capacity and are not required to interact with other people. It has been estimated that 2 to 4 percent of all people—slightly more males than females—may have a schizotypal personality disorder (Bollini & Walker, 2007; Mattia & Zimmerman, 2001).

7.2: CLUSTER B PERSONALITY DISORDERS

The cluster B personality disorders includes the antisocial, borderline, histrionic, and narcissistic personality disorders. The behaviors of people with these problems are so dramatic, emotional, or erratic that it is almost impossible for them to have relationships that are truly giving and satisfying.

These personality disorders are more commonly diagnosed than the others. However, only the antisocial and borderline personality disorders have received much study, partly because they create so many problems for other people. The causes of the disorders, like those of the odd personality disorders, are not well understood. Treatments range from ineffective to moderately effective.

7.2.1: Histrionic Personality Disorder

People with histrionic personality disorder, once called hysterical personality disorder, are extremely emotional—they are typically described as "emotionally charged"— and continually seek to be the center of attention (APA, 2000). Their exaggerated moods can complicate life considerably.

People with histrionic personality disorder are always "on stage," using theatrical gestures and mannerisms and grandiose language to describe ordinary everyday events. They keep changing themselves to attract and impress an audience, and in their pursuit they change not only their surface characteristics—according to the latest fads—but also their opinions and beliefs. In fact, their speech is actually scanty in detail and substance, and they seem to lack a sense of who they really are.

People with this disorder may draw attention to themselves by exaggerating their physical illnesses or fatigues. They may also behave very provocatively and try to achieve their goals through sexual seduction. Most obsess over how they look and how others will perceive them, often wearing bright, eye-catching clothes. They exaggerate the depth of their relationships, considering themselves to be the intimate friends of people who see them as no

more than casual acquaintances. Often, they become involved with romantic partners who may be exciting but who do not treat them well.

7.2.2: Narcissistic Personality Disorder

People with narcissistic personality disorder are generally grandiose, need much admiration, and feel no empathy with others (APA, 2000). Convinced of their own great success, power, or beauty, they expect constant attention and admiration from those around them.

The Greek myth has it that Narcissus died enraptured by the beauty of his own reflection in a pool, pining away with longing to possess his own image. His name has come to be synonymous with extreme self-involvement, and indeed people with narcissistic personality disorder have a grandiose sense of self-importance. They exaggerate their achievements and talents, expecting others to recognize them as superior, and often appear arrogant. They are very choosy about their friends and associates, believing that their problems are unique and can be appreciated only by other "special," high-status people. Because of their charm, they often make favorable first impressions. Yet they can rarely maintain long-term relationships (Shapiro & Bernadett-Shapiro, 2006).

People with narcissistic personality disorder are seldom interested in the feelings of others. Many take advantages of others to achieve their own ends, perhaps partly out of envy; at the same time, they believe others envy them (O'Connor, 2008; Sperry, 2003). Though grandiose, some of these individuals react to criticism or frustration with bouts of rage or humiliation (Levy et al., 2007). Others may react with cold indifference. And still others become extremely pessimistic and filled with depression.

7.2.3: Antisocial Personality Disorder

Sometimes described as "psychopaths" or "sociopaths," people with antisocial personality disorder persistently disregard and violate others' rights (APA, 2000). Aside from substance-related disorders, this is the disorder most closely linked to adult criminal behavior. DSM-IV-TR stipulates that a person must be at least 18 years of age to receive this diagnosis; however, most people with antisocial personality disorder displayed some patterns of misbehavior before they were 15, including truancy, running away, cruelty to animals or people, and destroying property.

People with antisocial personality disorder lie repeatedly (Patrick, 2007). Many cannot work consistently at a job; they are absent frequently and are likely to quit their jobs altogether. Usually they are also careless with money and frequently fail to pay their debts. They are often impulsive, taking action without thinking of the consequences (Blair, Mitchell, & Blair, 2005) (see A Closer Look on the next page). Correspondingly, they may be irritable, aggressive, and quick to start fights.

7.2.4: Borderline Personality Disorder

People with borderline personality disorder display great instability, including major shifts in mood, an unstable self-image, and impulsivity. These characteristics combine to make their relationships very unstable as well (Paris, 2005; APA, 2000).

People with borderline personality disorder swing in and out of very depressive, anxious, and irritable states that last anywhere from a few hours to a few days or more. Their emotions seem to be always in conflict with the world around them. They are prone to bouts of anger, which sometimes result in physical aggression and violence. Just as often, however, they direct their impulsive anger inward and inflict bodily harm on themselves. Many seem troubled by deep feelings of emptiness.

People with borderline personality disorder frequently form intense, conflict-ridden relationships in which their feelings are not necessarily shared by the other person. They may come to idealize another person's qualities and abilities after just a brief first encounter. They also may violate the boundaries of relationships (Skodol et al., 2002). Suicidal threats and actions are also common.

7.3: CLUSTER C PERSONALITY DISORDERS

The cluster of "anxious" personality disorders includes the avoidant, dependent, and obsessive-compulsive personality disorders. People with these patterns typically display anxious and fearful behavior. Many of the symptoms of these disorders are similar to those of the anxiety and depressive disorders.

7.3.1: Avoidant Personality Disorder

People with avoidant personality disorder are very uncomfortable and inhibited in social situations, overwhelmed by feelings of inadequacy, and extremely sensitive to negative evaluation (APA, 2000). They are so fearful of being rejected that they give no one an opportunity to reject them—or to accept them either.

People with avoidant personality disorder actively avoid occasions for social contact. At the center of this withdrawal lies not so much poor social skills as a dread of criticism, disapproval, or rejection. They are timid and hesitant in social situations, afraid of saying something foolish or of embarrassing themselves by blushing or acting nervous. Even in intimate relationships they express themselves very carefully, afraid of being shamed or ridiculed.

People with this disorder believe themselves to be unappealing or inferior to others. They exaggerate the potential difficulties of new situations, so they seldom take risks or try out new activities. They usually have few or no close friends, though they actually yearn for intimate relationships, and frequently feel depressed and lonely. As a substitute, some develop an inner world of fantasy and imagination (Millon, 1990).

7.3.2: Dependent Personality Disorder

People with dependent personality disorder have a pervasive, excessive need to be taken care of (APA, 2000). As a result, they are clinging and obedient, fearing separation from their parent, spouse, or other person with whom they are in a close relationship. They rely on others so much that they cannot make the smallest decision for themselves.

People with dependent personality disorder constantly need assistance with even the simplest matters and demonstrate extreme feelings of inadequacy and helplessness. Afraid that they cannot care for themselves, they cling desperately to friends or relatives.

People with avoidant personality disorder have difficulty initiating relationships. In contrast, people with dependent personality disorder have difficulty with separation. The individuals feel completely helpless and devastated when a close relationship ends, and they quickly seek out another relationship to fill the void. Many clings persistently to relationships with partners who physically or psychologically abuse them. Many people with dependent personality disorder feel distressed, lonely, and sad; often they dislike themselves. Thus, they are at risk for depressive, anxiety, and eating disorders (Bornstein, 2007). Their fear of separation and their feelings of helplessness may leave them particularly prone to suicidal thoughts, especially when they believe that a relationship is about to end (Kiev, 1989).

7.3.3: Obsessive – Compulsive Personality Disorder

People with obsessive-compulsive personality disorder are so preoccupied with order, perfection, and control that they lose all flexibility, openness, and efficiency. Their concern for doing everything "right" impairs their productivity.

People with this personality disorder set unreasonably high standards for themselves and others. They can never be satisfied with their performance, but they typically refuse to seek help or to work with a team, convinced that others are too careless or incompetent to do the job right. Because they are so afraid of making mistakes, they may be reluctant to make decisions.

These individuals also tend to be rigid and stubborn, particularly in their morals, ethics, and values. They live by a strict personal code and use it as a yardstick for measuring others. They may have trouble expressing much affection, and their relationships are sometimes stiff and superficial. In addition, they are often stingy with their time or money. Some cannot even throw away objects that are worn out or useless (APA, 2000).

CHAPTER 8

CHILDHOOD AND ADOLESCENT DIORDERS

8.1: PERVASIVE DEVELOPMENTAL DISORDERS

The pervasive developmental disorders (PDDs) are a group of severely disabling conditions that are among the most difficult to understand and treat. They are considered to be the result of some structural differences in the brain that are usually evident at birth or become apparent as the child begins to develop. Two major pervasive developmental disorders are, **autism**, one of the most severe and puzzling disorders occurring in early childhood, and **Asperger's disorder**, which is a severe and persistent impairment in social interaction that involves marked stereotypic (repetitive) behavior and inflexible adherence to routines and also appears in childhood.

8.1.1: Autism

One of the most disabling of the pervasive developmental disorders is autistic disorder, which is often referred to as autism, childhood autism or autism spectrum disorder. It is a developmental disorder that involves a wide range of problematic behaviors including deficits in language and perceptual and motor development; defective reality testing; and an inability to function in social situations.

8.8.1.1: Clinical Picture in Autism

Children with autism show varying degrees of impairments and capabilities. A cardinal and typical sign is that a child seems apart or aloof from others, even in the earliest stages of life. Mothers often remember such babies as never being cuddly, never reaching out when being picked up, never smiling or looking at them while being fed, and never appearing to notice the comings and goings of other people.

- **A Social Deficit**

Typically, children with autism do not show any need for affection or contact with anyone, and they usually do not even seem to know or care who their parents are.

- **An Absence of Speech**

Children with autism do not effectively learn by imitation. This dysfunction might explain their characteristic absence or severely limited use of speech. If speech is present, it is almost never used to communicate except in the most rudimentary fashion, such as by saying

"yes" in answer to a question or by the use of **echolalia**—the parrot-like repetition of a few words.

- **Self-stimulation**

Self-stimulation is often characteristic of children with autism. It usually takes the form of such repetitive movements as head banging, spinning, and rocking, which may continue by the hour. Other bizarre repetitive behaviors are typical.

- **Intellectual Ability**

Compared with the performance of other groups of children on cognitive or intellectual tasks, children with autism often show marked impairment.

- **Maintaining Sameness**

Many children with autism become preoccupied with and form strong attachments to unusual objects such as rocks, light switches, or keys. In some instances, the object is so large or bizarre that merely carrying it around interferes with other activities. When their preoccupation with the object is disturbed—for example, by its removal or by attempts to substitute something in its place— or when anything familiar in the environment is altered even slightly, these children may have a violent temper tantrum or a crying spell that continues until the familiar situation is restored. Thus children with autism are often said to be "obsessed with the maintenance of sameness."

8.1.2: Asperger's Disorder

This disorder, often referred to as an autistic spectrum disorder, was first described by Hans Asperger in 1944. According to the DSM-IV-TR, the essential features of Asperger's disorder involve both severe and sustained impairment of interpersonal interactions, including impairment of facial expressions, body postures, and gestures, and people with Asperger's fail to develop peer relationships. Interestingly, in contrast to autism, in Asperger's disorder there are usually no clinically significant delays in early language or age-appropriate self-help skills. However, several researchers have described the high rate of suicide during adolescence among persons with Asperger's disorder.

Patients with Asperger's disorder are often treated with psychotropic medication including antidepressants, antipsychotic (thioridazine and haloperidol), and mood stabilizers such as lithium . A number of behavioral treatment approaches to improve the functioning of Asperger patients have also been used. For example, Bock (2007) found that a social behavioral

learning strategy intervention was effective at reducing problem behavior and improving cooperative learning activities with peers.

8.2: ATTENTION DEFICIT HYPERACTIVITY DISORDER

Attention-deficit/hyperactivity disorder (ADHD), often referred to as hyperactivity, is characterized by difficulties that interfere with effective task-oriented behavior in children - particularly impulsivity, excessive or exaggerated motor activity such as aimless or haphazard running or fidgeting, and difficulties in sustaining attention. Children with ADHD are highly distractible and often fail to follow instructions or respond to demands placed on them. Perhaps as a result of their behavioral problems, children with ADHD are often lower in intelligence, usually about 7 to 15 IQ points below average. Children with ADHD also tend to talk incessantly and to be socially intrusive and immature. Recent research has shown that many children with ADHD show deficits on neuropsychological testing that are related to poor academic functioning.

Children with ADHD generally have many social problems because of their impulsivity and overactivity. Hyperactive children usually have great difficulty in getting along with their parents because they do not obey rules. Their behavior problems also result in their being viewed negatively by their peers. In general, however, hyperactive children are not anxious, even though their overactivity, restlessness, and distractibility are frequently interpreted as indications of anxiety. They usually do poorly in school and often show specific learning disabilities such as difficulties in reading or in learning other basic school subjects. Hyperactive children also pose behavior problems in the elementary grades.

8.3: OPPOSITIONAL DEFIANT DISORDER AND CONDUCT DISORDER

This group of disorders involves a child's or an adolescent's relationship to social norms and rules of conduct. In both oppositional defiant disorder and conduct disorder, aggressive or antisocial behavior is the focus. As we will see, oppositional defiant disorder is usually apparent by about age 8, and conduct disorder tends to be seen by age 9. These disorders are closely linked.

8.3.1: Clinical Picture in Oppositional Defiant Disorder

An important precursor of the antisocial behavior seen in children who develop conduct disorder is often what is now called oppositional defiant disorder (ODD). The essential feature is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months. This disorder usually begins by the age of 8, whereas full-blown conduct disorders typically begin from middle childhood through adolescence.

8.3.2: Clinical Picture in Conduct Disorder

The essential symptomatic behavior in conduct disorder involves a persistent, repetitive violation of rules and a disregard for the rights of others. Children with conduct disorder show a deficit in social behavior. In general, they manifest such characteristics as overt or covert hostility, disobedience, physical and verbal aggressiveness, quarrelsomeness, vengefulness, and destructiveness. Lying, solitary stealing, and temper tantrums are common. Such children tend to be sexually uninhibited and inclined toward sexual aggressiveness. Some may engage in cruelty to animals, bullying, fire setting, destruction, robbery, and even homicidal acts.

8.4: MENTAL RETARDATION

Mental retardation can be defined as "**significantly subaverage general intellectual functioning, that is accompanied by significant limitations in adaptive functioning**" in certain skill areas such as self-care, work, health, and safety. For the diagnosis to apply, these problems must begin before the age of 18. Mental retardation is thus defined in terms of level of performance as well as intelligence.

8.4.1: Levels of Mental Retardation

DSM-IV-TR divides mental retardation into four levels namely, (1) **Mild mental retardation,** (2) **Moderate mental retardation** (3) **Severe Mental Retardation** and (4) **Profound Mental Retardation.**

8.4.1.1: Mild Mental Retardation

The IQ level of the persons having mild mental retardation will be in between 50 to 55 to approximately 70. Approximately 85% mentally retarded people included in mild mental retardation type. The mild mentally retarded children are often not distinguishable from other children until school age and they may attain 5^{th} to 6^{th} grade level of academic skills. The social adjustment of people with mild mental retardation often approximates that of adolescents, although they tend to lack normal adolescents' imagination, inventiveness, and judgment.

Ordinarily, they do not show signs of brain pathology or other physical anomalies, but often they require some measure of supervision because of their limited abilities to foresee the consequences of their actions. With early diagnosis, parental assistance, and special educational programs, the great majority of borderline and individuals with mild mental retardation can adjust socially, master simple academic and occupational skills, and become self-supporting citizens.

8.4.1.2: Moderate Mental Retardation

The moderate mentally retarded people have their IQ level from 35 - 40 to 50-55 and approximately 10% of people are included in this category among mentally retarded population. They may attain 2nd grade level of academic skills. Individuals with moderate mental retardation are likely to fall in the educational category of trainable, which means that they are presumed able to master certain routine skills such as cooking or minor janitorial work if provided specialized instruction in these activities. Although some can be taught to read and write a little and may manage to achieve a fair command of spoken language, their rate of learning is slow, and their level of conceptualizing is extremely limited. They usually appear clumsy, and they suffer from bodily distortions and poor motor coordination.

In general, with early diagnosis, parental help, and adequate opportunities for training, most individuals with moderate mental retardation can achieve partial independence in daily self-care, acceptable behavior, and economic sustenance in a family or other sheltered environment.

8.4.1.3: Severe Mental Retardation

The severe level of mentally retarded people has their IQ level from 20-25 to 30-35 and approximately 3 to 4% of people included in this level among total mentally retarded population. In individuals with severe mental retardation, motor and speech development are severely retarded and sensory defects and motor handicaps are common. They can develop limited levels of personal hygiene and self-help skills, which leads them to be always dependent on others for care. However, many profit to some extent from training and can perform simple occupational tasks under supervision. they may learn to read “survival” words such as STOP, MEN, WOMEN etc.

8.4.1.4: Profound Mental Retardation

The profound level of mentally retarded people have their IQ level below 20 -25 and approximately 1to 2% people included in this category among the total mentally retarded population. Most individuals with profound mental retardation are severely deficient in adaptive behavior and unable to master any but the simplest tasks. Useful speech, if it develops at all, is rudimentary. Severe physical deformities, central nervous system pathology, and retarded growth are typical; convulsive seizures, mutism, deafness, and other physical anomalies are also common. These individuals must remain in custodial care all their lives. They tend, however, to have poor health and low resistance to disease and thus a short life expectancy. Severe and profound cases of mental retardation can usually be readily diagnosed in infancy because of the presence of obvious physical malformations, grossly delayed development (e.g., in taking solid food), and other obvious symptoms of abnormality.

CHAPTER 9

EATING DISORDERS

During the past three decades we have also witnessed an increase in two eating disorders that have at their core a morbid fear of gaining weight. Sufferers of anorexia nervosa, are convinced that they need to be extremely thin, and they lose so much weight that they may starve themselves to death. People with bulimia nervosa go on frequent eating binges, during which they uncontrollably consume large quantities of food, and then force themselves to vomit or take other extreme steps to keep from gaining weight.

9.1: ANOREXIA NERVOSA

Anorexia nervosa is an eating disorder marked by the pursuit of extreme thinness and by extreme loss of weight. People with this disorder refuses to maintain more than 85 percent of their normal body weight, intensely fears becoming overweight, has a distorted view of their weight and shape.

At least half of the people with anorexia nervosa reduce their weight by restricting their intake of food, a pattern called restricting-type anorexia nervosa. First they tend to cut out sweets and fattening snacks; then, increasingly, they eliminate other foods (APA, 2000). Eventually people with this kind of anorexia nervosa show almost no variability in diet. Others, however, lose weight by forcing themselves to vomit after meals or by abusing laxatives or diuretics, and they may even engage in eating binges, a pattern called binge-eating/purging-type anorexia nervosa, which you will observe in more detail in the section on bulimia nervosa (APA, 2000).

People with this disorder are afraid of becoming obese, of giving in to their growing desire to eat, and more generally of losing control over the size and shape of their bodies. In addition, despite their focus on thinness and the severe restrictions they may place on their food intake, people with anorexia are preoccupied with food. They may spend considerable time thinking and even reading about food and planning their limited meals (Herzig, 2004; King et al., 1991). Many reports that their dreams are filled with images of food and eating (Knudson, 2006; Levitan, 1981).

Persons with anorexia nervosa also think in distorted ways. They usually have a low opinion of their body shape, for example, and consider themselves unattractive (Eifert et al., 2007; Kaye et al., 2002). In addition, they are likely to overestimate their actual proportions. Approximately 90 to 95 percent of all cases of anorexia nervosa occur in females (Zerbe, 2008;

Freeman, 2005). Although the disorder can appear at any age, the peak age of onset is between 14 and 18 years (APA, 2000).

9.2: BULIMIA NERVOSA

People with bulimia nervosa—a disorder also known as binge-purge syndrome—engage in repeated episodes of uncontrollable overeating, or binges. A binge occurs over a limited period of time, often an hour, during which the person eats much more food than most people would eat during a similar time span (Stewart & Williamson, 2008; APA, 2000). In addition, people with this disorder repeatedly perform inappropriate compensatory behaviors, such as forcing themselves to vomit; misusing laxatives, diuretics, or enemas; fasting; or exercising excessively (Kerr et al., 2007). If the compensatory behaviors regularly include forced vomiting or misuse of laxatives, diuretics, or enemas, the specific diagnosis is purging-type bulimia nervosa. If individuals instead compensate by fasting or exercising frantically, the specific diagnosis is non- purging-type bulimia nervosa.

Like anorexia nervosa, bulimia nervosa usually occurs in females, again in 90 to 95 percent of the cases (Stewart & Williamson, 2008). It begins in adolescence or young adulthood (most often between 15 and 21 years of age) and often lasts for several years, with periodic letup. The weight of people with bulimia nervosa usually stays within a normal range, although it may fluctuate markedly within that range (APA, 2000). Some people with this disorder, however, become seriously underweight and may eventually qualify for a diagnosis of anorexia nervosa instead. Clinicians have also observed that certain people, a number of them overweight, display a pattern of binge eating without vomiting or other inappropriate compensatory behaviors.

10: REFERENCES

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#Disclaimer: This note is prepared for learning the basics of Clinical Psychology and based on the PG entrance pattern only. It is not a complete collection of Clinical Psychology principles.