CHAPTER ONE

AN INTRODUCTION TO MENTAL ILLNESS

1.1 What is mental health and mental illness?

Good mental health is when an individual can think clearly, solve problems they face in life, enjoy happy relationships and feel spiritually at ease. Mental illness is anything that affects a person's thoughts, emotions or behaviour that results in:

- A negative effect on the person or those around them.
- An obvious change in their personality.
- Friends or relatives feel that what is happening to the person is strange and hard to understand.

However, everybody can experience unusual thoughts, emotions or behaviour especially when sleeping, praying or when alone in the dark. For example, dreams can sometimes be more vivid and realistic than usual. Sometimes people experience strong spiritual feelings when praying or meditating. And occasionally people feel frightened when alone in the dark.

It is important to remember that these experiences are not a sign of mental illness and are completely normal and are nothing to worry about. However, if these experiences had a negative effect on the person, resulted in a change in their personality and confused others, then this may be a sign of mental illness.

THE CONCEPTS OF ABNORMALITY

***Abnormal Psychology, Psychopathology*.** These are terms that continue to fascinate psychologists and other helping professionals, especially those outside of the field. In this chapter we will give a brief overview of abnormal behavior.

If you were to take a poll of most people outside of the helping professions (e.g., psychologists, social workers, and psychiatrists), they would probably tell you that they know abnormal behavior when they see it. Let us look at an example:

You live in a large urban area. One day you hear out of your apartment window a man singing music. You look out the window and watch him walking down the street, singing louder, for everyone to hear. The man is well dressed in a work uniform, appears well kempt, and is not really interacting with other people. The sound of the music fades as he continues down the street. You detect nothing unusual in

his behavior except for the fact that he was singing, and doing so rather loudly. Some people were obviously annoyed; some even crossed the street to avoid him.

Is his behavior abnormal? Does his behavior present a danger to himself or, more importantly, to others? This is the goal of those in the helping professions: to ascertain whether an individual's behavior is indeed abnormal. Therefore, it is important to define abnormal behavior

DEFINING CHILD PSYCHOPATHOLOGY

Several fundamental questions have characterized most discussions concerning how child psychopathology should be defined:

- Should child psychopathology be viewed as a disorder that occurs within the individual child, as a relational disturbance, as a reaction to environmental circumstances, or as some combination of all of these?
- Does child psychopathology constitute a condition qualitatively different from normality (aberration), an extreme point on a continuous trait or dimension, a delay in the rate at which a normal trait would typically emerge, or some combination of the three? How are "sub threshold" problems to be handled?
- Can homogeneous disorders be identified, or is child psychopathology best defined as a configuration of co-occurring disorders or as a profile of traits and characteristics?
- Can child psychopathology be defined as a static entity at a particular point in time, or do the realities of development necessitate that it be defined as a dynamic and ongoing process that expresses itself in different ways over time and across contexts?
- Is child psychopathology best defined in terms of its current expression, or do definitions also need to incorporate non pathological conditions that may constitute risk factors for later problems?

There are currently no definitive answers to these questions. More often, the way in which they are answered reflects theoretical or disciplinary preferences and specific purposes and goals (e.g., defining samples for research studies, or determining program or insurance eligibility).

Generally speaking, we define abnormal behavior by using different perspectives: the statistical frequency perspective, social norms perspective, and maladaptive behavior perspective. Though, a number of simple definitions of abnormality may be proposed, none of which captures the essence of what is generally meant by the term abnormal in the context of mental health problems:

- Statistical abnormality implies that people who are statistically different from the norm are 'abnormal': the further from the norm one is, the greater the abnormality. While this may be true, it does not necessarily imply the presence of a mental disorder. People who are rich or highly attractive, those who engage in dangerous sports or who significantly achieve in their career, all differ markedly from the norm. But none of these would be seen as having a mental health problem.
- ***Psychometric abnormality*** implicates abnormality as a deviation from a statistically determined norm, such as the population average IQ of 100. In this case, an IQ score less than about 70–75 may define someone as having a learning disability and suggests they will have some difficulties coping with life. However, the problems associated with a low IQ differ widely across individuals depending on their life circumstances. So, even when an individual is defined as psychometrically 'abnormal', this tells us little about their actual condition or problems. Furthermore, if one takes the other end of the IQ spectrum, a deviation of 30 points above the mean is generally not considered to be abnormal or to indicate the presence of mental health problems.
- *The Utopian model* suggests that only those who achieve their maximum potential within their lives are free of mental health problems. However, even those who propose this model (e.g. Rogers 1961) accept that only relatively few people truly achieve their maximum potential. Accordingly, this model assumes that the majority of the population deviate from their optimal mental state and experience some degree of mental health problems. Poor mental health may be considered the norm, not the exception.
- *The presence of abnormal or deviant behaviour* is perhaps the closest of the simple models to provide an understanding of abnormality as it relates to mental health problems, because it implies a deviation from normal behaviour in some 'negative 'way. But as a single criterion it is inadequate. Not all people with mental health problems engage in deviant behaviour, and not all deviant behaviours are a sign of mental health problems: stealing a car and 'joy

riding', which places many people in danger, may be considered deviant, abnormal, behaviour by many people, but it is not a sign of a mental health problem.

More complex models of abnormality in the context of mental health consider abnormal behaviour to be a sign of a mental health problem when:

- it is the result of distorted psychological processes
- it causes or is the result of distress and/or is dysfunctional
- it is an out-of-the-ordinary response to particular circumstances

A fourth criterion is that the individual may place them self in danger as a result of a distorted view of the world, although this is relatively infrequent even among those who may be thought of as having a mental health problem. These criteria can perhaps be summarized as the 'four Ds': deviance (from the norm), distress, dysfunctional & dangerous.

- **Deviance**

Abnormal psychological functioning is ***deviant,*** but deviant from what? Alexandra's and Brad's behaviors, thoughts, and emotions are different from those that are considered normal in our place and time. We do not expect people to cry themselves to sleep each night, wish themselves dead, or obey voices that no one else hears.

- **Deviant from cultural norms**

Every culture has certain standards, norms and yardsticks for acceptable behaviors and behavior that deviates or differs markedly from those norms is considered abnormal. The followers of Cultural Criteria perspective argue that we should respect each culture's definition of abnormality for the members of that culture. By doing so we do not impose one culture's standards for behavior on another. The concept of abnormality changes over time, within the same society. Forty years ago, most Americans would have considered men wearing earrings as abnormal but today it's considered as differences in lifestyle rather than as signs of abnormality differ from one society to another and over time within the same society.

In short, behavior, thoughts, and emotions are deemed abnormal when they violate a society's ideas about proper functioning. Each society establishes norms—explicit and implicit rules for proper conduct. Behavior that violates legal norms is called criminal. Behavior, thoughts, and emotions that violate norms of psychological functioning are called abnormal.

Judgments of abnormality vary from society to society. A society's norms grow from its particular culture—its history, values, institutions, habits, skills, technology. A society that values competition and assertiveness may accept aggressive behavior, whereas one that emphasizes cooperation and gentleness may consider aggressive behavior unacceptable and even abnormal.

- **Deviance from Statistical Norms**

The word abnormal means away from the normal or away from the norm. Many characteristics such as height, weight and intelligence cover a range of values, when measured over an entire population. Most people for example fall within the middle range of height and few are abnormally tall or short. Abnormal behavior is statistically infrequent or deviant from the norm. A person who is extremely intelligent or happy would be classified as abnormal. While defining Abnormal Behavior we must consider more than the statistical frequency

- **Dysfunctional**

Abnormal behavior tends to be *dysfunctional;* that is, it interferes with daily functioning. It so upsets, distracts, or confuses people that they cannot care for themselves properly, participate in ordinary social interactions, or work productively. For example, quit from job, left family, and prepared to withdraw from the productive life he once led. Here again one's culture plays a role in the definition of abnormality. Our society holds that it is important to carry out daily activities in an effective, self-enhancing manner.

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Then again, dysfunction alone does not necessarily indicate psychological abnormality. Some people fast or in other ways deprive themselves of things they need as a means of protesting social injustice. Far from receiving a clinical label of some kind, they are widely viewed as admirable people—caring, sacrificing, even heroic.

- **Distress and Disability**

Some conceptions of psychopathology invoke the notions of subjective distress and disability. Subjective distress refers to unpleasant and unwanted feelings such as anxiety, sadness, and anger. Disability refers to restriction in ability. People who seek mental health treatment are not getting what they want out of life and many feel that they are unable to do what they would like to do. They may feel inhibited or restricted by their situation, their fear or emotional turmoil, or by physical or other limitations. Subjective distress and disability are simply two different but

related ways of thinking about adaptiveness and maladaptiveness rather than alternative conceptions of psychopathology

The individuals' subjective feelings of pain, anxiety, depression, agitation, disturbance in sleep, loss ofappetite, numerous aches and pains. Most people who are diagnosed with a mental disorder feel entirely miserable while they may appear normal to the observer.

- Danger

Psychological dysfunctioning is behavior that becomes dangerous to oneself for others. A pattern of functioning that is marked by carelessness, poor judgment, hostility or misinterpretations can jeopardize one's own wellbeing and that of many other people as well. A person may seem to be endangering himself by being least bothered about his diet and health and for others by his collection of arms and guns.

None of these four criteria provide a satisfactory description of abnormal behavior, in most cases; all four criteria are used in diagnosing abnormality.

What is Abnormal Behavior?

By what criteria do we distinguish abnormal behavior from normal behavior?

- The content of the behavior (what a person does?) The content of behavior that causes discomfort, appears weird, and is inefficient.
- The context of the behavior (where and when the person does it?) Does the individual display the behavior in public or privately.

With regard to content, behavior is likely to be judged abnormal by society if it causes

- Discomfort
- Appears bizarre or weird
- Is dysfunctional (distracts, upsets)

People will tolerate a considerable amount of discomfort even bizarreness in themselves and others if the behavior is not so frequent or disruptive that it interferes with the demands of everyday life e.g. a successful businessman was found to have lined all his clothes with newspapers to protect himself against harmful radiation from alien's spaceship. Every one of his office thought that this was bizarre behavior.--

The second criteria used in the practical approach is context where and when the behavior occurs. How would you feel if you were asked to enter a room and stare everybody who was attending a party or to tell jokes at a funeral? You would hesitate. It is because you recognize that these actions would be in appropriate to the situation and your behavior will be labelled as abnormal. According to the second criteria of context of behavior (where and when the behavior takes place) --

What is Normality?

Normality is even more difficult to define as compared to Abnormality

What is Normality? Normality refers to adjustment.

The traits or characteristics of well-adjusted individuals or mentally healthy individuals or psychologically well-adjusted individual are reflected by the followings:

- **Appropriate perception of reality**. Normal individuals are realistic in appraising their reactions, capabilities, and in interpreting in what is going on in the world around them. They do not misinterpret what others say or so they do not overate or underestimate their abilities. They do not avoid difficult tasks.
- **Ability to exercise voluntary control over behavior**. Normal individuals feel confident about their ability to control their behavior.
- **They rarely act impulsively and refrain from aggressive behavior**.
- **Self Esteem and Acceptance:** Normal people have appreciation of their own worth and they feel accepted by those around them. Feelings of worthlessness, alienation and lack of acceptance are prevalent among abnormal.
- **Ability to form affectionate relationships**. Normal individual are able to form close and satisfying relationships with other people. They are sensitive to the feelings of others and do not make excessive demands on others. Abnormal individuals are extremely self- centered; they seek affection but are unable to reciprocate.
- **Productivity**: Well-adjusted people are able to channel their abilities into productive activity. They do not suffer from lack of energy and they do experience excessive fatigue.

Defining Psychological Disorders

- Psychological Disorder is a psychological dysfunction with in an individual that is associated with distress or impairment in functioning and a response that is not typical or culturally expected.

- Psychological dysfunction refers to a breakdown in cognitive, emotional, or behavioral functioning of the individual. A schizophrenic individual exhibits breakdown of cognitive (thinking), emotional (feeling) or behavioral (action) functions. The disorder or behavior must be associated with distress and impairment. It is quite normal to be distressed or upset, if someone close to you dies. This distress and impairment makes you unable to function socially i.e. that is an individual attempts to avoids friends, relatives and even work colleagues. The criterion, that the response be a typical or not culturally expected. At times, something is considered abnormal because it occurs infrequently it deviates from the average say when someone is extremely short or tall or eccentric. So we can conclude that behavioral, emotional or cognitive dysfunction that is unexpected in a culture and associated with personal distress or impairment in functioning is abnormal

A BRIEF HISTORY OF ABNORMAL BEHAVIOR AND TREATMENT

The history of abnormal psychology (or psychopathology; the terms are used interchangeably) dates back hundreds if not thousands of years. Stone Age civilizations (the dates vary, but most agree that this era occurred approximately 2 million years ago in Asia, Africa, and Europe; in the Americas, it began about 30,000 years ago!) evidently believed that serious mental illness or abnormal behavior was due to being possessed by evil spirits (an idea that some people still believe today). Archaeological finds have discovered skulls that have holes bored into them. This process was called *trepanning*. A small instrument was used to bore holes in the skull, the idea being that the holes would allow the evil spirits to leave the possessed person. In later societies exorcisms were performed, usually by a priest. This was a non-invasive way to drive out the evil spirits in the possessed individual. Exorcisms, although rare, are still performed today.

Views on abnormal behavior were significantly advanced by Hippocrates (460 -377 B.C.), the father of modern medicine. He viewed abnormal behavior-and illnesses in general as having internal causes, and thus having biological natures or etiologies. Hippocrates prescriptions for the ill included ***rest, proper diet, sobriety, and exercise***- many prescriptions that are still used today. Hippocrates also had a key belief that if you took care of your body, your mind would also stay well.

During the Middle Ages (approximately the fifth to the fifteenth century),the view that demons were causing mental illnesses in certain people once again became popular, and the ancient Greek and Roman views that saw physiological causes of such behaviors lost favour. Plagues were common during these times, and exorcisms re-emerged as a form of treatment for mental illnesses. One key concept was the idea that evil supernatural forces were to blame; oddly enough, this took some of the responsibility off of the mentally ill.

During the Renaissance (around 1400–1700 A.D.), the treatment of the mentally ill improved significantly. The mentally ill were seen as having sick minds, and, therefore, their minds needed to be treated along with their bodies.

During the early part of the Renaissance, asylums were created. Even though the name connotes bad feelings and scenes of patient abuse today, this was not how they were run at their founding. Their sole purpose was to treat the mentally ill in a humane fashion. Unfortunately, they soon became overcrowded, and the treatment soon turned to punishment and torture. Reforms in mental health treatment really did not occur until the nineteenth and twentieth centuries.

Two important figures arose during the nineteenth century. Philippe Pinel (1745–1826) is seen as one of the early reformers in the proper treatment of mentally ill individuals. Pinel, a Frenchman, advocate that the mentally ill be treated with *sympathy, compassion, and empathy not with beatings and torture.* Dorothea Dix (1802–1887) helped to establish many state mental hospitals in the United States during her nationwide campaign to reform treatment of the mentally ill. She was directly responsible for laws that aimed to reform treatment of this population.

The Twentieth Century

Many changes occurred during the twentieth century. The *DSM* series was created. Physical factors were understood as responsible for mental illnesses. In 1897 the sexually transmitted disease syphilis was discovered by von Kraft- Ebing (1840–1902). This was important because syphilis sufferers demonstrated delusions of grandeur, which *can* be a sign of a mental illness.

For many psychologists the most important figure of the twentieth century began his work in the 1890s in Vienna. Sigmund Freud (1856–1939) was initially a researcher who was studying the reproductive systems of eels.

- Josef Breuer (1842–1925), another Viennese physician, treated patients who suffered from hysteria, which literally means "wandering uterus." Hysteria during the 1890s meant something quite different than it does today: Breuer's patients told him that they had physical illnesses. However, after examination, he discovered that they had no physical symptoms. Breuer, following Anton Mesmer's work, discovered that in some cases their symptoms eased or disappeared once his patients discussed their past with him in a safe environment without censure and while under hypnosis. Breuer discussed these ideas with Freud, who expanded on them and created psychoanalytic theory,thus leading to an entire movement that is still popular today. Freud's basictenet is that unconscious processes, motives, and urges are at the core of many of our behaviors and difficulties.
- Albert Ellis (1913–) takes a somewhatdifferent approach. He believesthat we get depressed and developother mental illnesses because of ourfaulty thinking. He created RationalEmotive Behavior Therapy (REBT)with this concept in mind. For example,Ellis says that some peopleset themselves up to fail because of"masturbation." This means thatyou create a series of mental "musts" that are virtually impossible to satisfy. For example, "Everyone must love me. I must always get any job I apply for. I must always be happy." These are unrealistic goals, and when some of them are not met, the individual gets depressed.

The field of abnormal psychologyreached a major milestone in the early 1950s. During this decade, Henry Laborit (1914–1955) introduced Thorazine (generically known as chlorpromazine1) for the treatment of Schizophrenic Disorders.

Initially this medication was used to tranquilize surgical patients, but Laborit noticed that chlorpromazine managed to calm patients *without*putting them to sleep. This led to its widespread use for the treatment of Schizophrenic Disorders. Thus, the field of psychopharmacology was un officially born, and the nature of mental illness treatment changed forever. Today many mental illnesses are treated with a combination of talk therapy and medications.

A second landmark in the helping professions was the publication of the *Diagnosticand Statistical Manual of Mental Disorders* (*DSM*) in 1952. It contained about60 different disorders and was based on theories of abnormal psychology orpsychopathology. However, the *DSM* and *DSM- II* (1968) were considered tohave many limitations. Arguably, the major limitation was

that the conceptshad not been scientifically tested; in addition, all of the disorders listed wereconsidered to be reactions to events occurring within the individual's environment,and there was really no distinction between abnormal and normalbehavior. In effect, everyone was considered to be abnormal to a certain degree,depending on the severity of their behavior.

The first two *DSM*s also described the differences between neurosis and psychosis. The term *neurosis* is now considered archaic, while *psychosis* is still used.

- If an individual is demonstrating psychosis, that person experiences a break from reality, including hallucinations, delusions, and disorganized or illogical thinking patterns. Schizophrenia is an example of a psychosis.
- A person with a neurosis will be distorting reality without actually breaking (or splitting off) from it. Neuroses are considered milder disorders than psychoses and tend to respond better to treatment. Most of Freud's patients suffered from neuroses. Today we call neuroses Anxiety Disorders; they can also include some of the milder Mood Disorders.

The diagnostic field changed significantly in 1980 with the publication of the *DSM- III*. The psychoanalytic basis for the *DSM*s was abandoned, and the diagnostic criteria were now based on the medical model and on clinical symptoms, not on theories. The five- part multiaxial system was also introduced. The *DSM* was revised twice more, until *DSM- IV- TR* was published in 2000. This volume is heavily research based and includes much information about the etiologies of all of the disorders. The new one is DSM-V.

The *DSM- IV- TR* Multiaxial System

Axis I: Clinical Disorders and Other Conditions that May Be a Focus of Attention

Axis II: Personality Disorders and Mental Retardation

Axis III: General Medical Conditions

Axis IV: Psychosocial and Environmental Problems

Axis V: Global Assessment of Functioning

CHAPTER TWO: BRIEF HISTORICAL OVERVIEW OF CHILD PSYCHOPATHOLOGY

Historical developments surrounding the emergence of child psychopathology as a field of study have been documented in a number of excellent sources. The emergence of concepts of child psychopathology was inextricably related to the broader philosophical and societal changes in the ways children have been viewed and treated by adults over the course of history.

Several overlapping perspectives for conceptualizing and dealing with deviant child behavior emerged, including the religious, the legal, the medical, the social, and the educational.

In ancient Greek and Roman societies, child behavior disorders were believed to result from organic imbalances, and children with physical or mental handicaps, disabilities, or deformities were viewed as sources of economic burden and/ or social embarrassment. As such, they were usually scorned, abandoned, or put to death. This mistreatment, by today's standards, was common throughout the middle Ages (A.D. 500–1300).

In colonial America, as many as two thirds of all children died prior to the age of 5 years, and those who survived continued to be subjected to harsh treatment by adults. For example, the Massachusetts Stubborn Child Act of 1654 permitted a father to petition a magistrate to put a "stubborn" or "rebellious" child to death (fortunately, no sentences were carried out); in Massachusetts and elsewhere, mentally ill children were **kept in cages and cellars into** the mid-1800s (Silk et al., 2000).

The historical record indicates that prior to the 18th century, when references to disordered child behavior were made at all, they were usually presented in terms of the problem child's behavior as inherently evil (Kanner, 1962).

Bizarre behaviors in children were attributed to **Satanic possession and evil spirits** during the Spanish Inquisition, and both John Calvin and Martin Luther viewed mentally retarded children **as filled with Satan**. And, as noted by Rie (1971), "No distinct concept of disordered behavior in children could emerge so long as possession by the devil excluded other notions of causality"

Although nearly all varieties of aberrant behavior in children have existed for millennia, the formal study of such behavior is relatively recent.

Following a comprehensive review of historical developments in child psychopathology, Rie(1971) concluded: “There is a consensus, then, about the absence of any substantial body of knowledge—prior to the twentieth century— concerning disordered behavior in childhood; about the inconsistencies and discontinuities of efforts on behalf of disturbed children; and about the relative absence of those professional specialties which now concern themselves with such problems”.

Rubinstein (1948) noted that

- there was not a single article dealing with insanity in childhood in any of the first 45 volumes of the Journal of Insanity;
- there was no discovery or theory of importance to child psychiatry in the American literature prior to 1900, and no research today stems from any of these writings; and
- the only significant work with children prior to the 20th century focused on the care, treatment, and training of “mental defectives.”

Increased concern for the plight and welfare of children with mental and behavioral disturbances was the result of two important influences.

- First, advances in general medicine, physiology, and neurology led to the re-emergence of the organic disease model and a concomitant emphasis on more humane forms of treatment.
- Second, the growing influence of the philosophies of John Locke, Johann Pestalozzi, and Jean-Jacques Rousseau led to the view that children needed moral guidance and support. With these changing views came an increased concern for
    - moral education,
    - compulsory education, and

- improved health practices.

These early influences also provided the foundation for evolving views of child psychopathology as dependent on both organic and environmental causes.

General Models Used to Conceptualize Child Psychopathology

- **Psychodynamic models:** Inborn drives, intrapsychic mechanisms, conflicts, defenses, psychosexual stages, fixation, and regression.
- **Attachment models:** Early attachment relationships, internal working models of self, others, and relationships in general.
- **Behavioral/reinforcement models:** Excessive, inadequate, or maladaptive reinforcement and/or learning histories.
- **Social learning models:** Vicarious and observational experience, reciprocal parent–child interactions.
- **Interpersonal models:** Interactional styles, social skills deficits, social difficulties, stressful interpersonal environments.
- **Cognitive models** Distorted or deficient cognitive structures and processes.
- **Constitutional/neurobiological models:** Temperament, genetic mutations, neuroanatomy, neurobiological mechanisms.
- **Affective models:** Dysfunctional emotion-regulating mechanisms.
- **Family systems models:** Intra- and intergenerational family systems, and the structural and/or functional elements within families.

Categories of Child Psychopathology

DSM-IV Categories for Developmental and Learning Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

- Mental retardation
- Mild, moderate, severe, profound, severity unspecified

- Learning disorders

- Reading disorder
- Mathematics disorder
- Disorder of written expression
- Learning disorder not otherwise specified
- Motor skills disorder
- Developmental coordination disorder
- Communication disorders
- Expressive language disorder
- Mixed receptive–expressive language disorder
- Phonological disorder
- Stuttering
- Communication disorder not otherwise specified
- Pervasive developmental disorders

- Autistic disorder
- Rett's disorder
- Childhood disintegrative disorder
- Asperger's disorder
- Pervasive developmental disorder not otherwise specified

DSM-IV Categories for Other Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

- Attention-deficit and disruptive behavior disorders
- Attention-deficit/hyperactivity disorder
- Predominantly inattentive type
- Predominantly hyperactive–impulsive type, Combined type
- Attention-deficit/hyperactivity disorder not otherwise specified
- Disruptive behavior disorders
- Conduct disorder
- Oppositional defiant disorder
- Disruptive behavior disorder not otherwise specified
- Feeding and eating disorders of infancy or early childhood
- Pica
- Rumination disorder
- Feeding disorder of infancy or early childhood
- Tic disorders

- Tourette's disorder
- Chronic motor or vocal tic disorder
- Tic disorder not otherwise specified
- Elimination disorders
- Encopresis
- Enuresis
- Other disorders of infancy, childhood, or adolescence
- Separation anxiety disorder
- Selective mutism
- Reactive attachment disorder of infancy or early childhood
- Stereotypic movement disorder
- Disorder of infancy, childhood, or adolescence not otherwise specified

Selected Categories for Disorders of Childhood or Adolescence That Are Not Listed Separately in DSM-IV as Those Usually First Diagnosed in Infancy, Childhood, or Adolescence

- Mood disorders

- Depressive disorders
- Major depressive disorder
- Dysthymic disorder
- Bipolar disorders

- Anxiety disorders
- Specific phobia, social phobia, obsessive–compulsive disorder, posttraumatic stress disorder, acute stress disorder, generalized anxiety disorder, anxiety disorder due to . . . (specific medical condition)
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleep disorders
- Schizophrenia and other psychotic disorders
- Substance-related disorders
- Impulse-control disorders not elsewhere classified
- Adjustment disorders
- Personality disorders

Selected DSM-IV Categories for Other Conditions That May Be a Focus of Clinical Attention during Childhood or Adolescence, but Are Not Defined as Mental Disorders

- *Relational problems*
- Relational problem related to a general mental disorder or general medical condition
- Parent–child relational problem
- Partner relational problem
- Sibling relational problem

- Relational problem not otherwise specified
- *Problems related to abuse or neglect*
- Physical abuse of child
- Sexual abuse of child
- Neglect of child
- *Bereavement*
- *Borderline intellectual functioning*
- *Academic problem*
- *Child or adolescent antisocial behavior*
- *Identity problem*

CHAPTER THREE: ASSESSMENT AND CLASSIFICATION OF ABNORMAL BEHAVIOUR

Assessment of Abnormal Behaviour

Assessment is the process of gathering information from a new patient. It is the systematic collection and analysis of information about a person's characteristics and behaviors.

Clinical assessment and diagnosis are centered to the study of psychopathology. Clinical assessment refers to systematic evaluation and measurement and psychological, biological and social factors in an individual presenting with a possible psychological disorder. Diagnosis is the process of determining whether the particular problem that the individual has needs all the criteria as given in DSM-IV-R in the classification of disorders.

Example A

Suppose your class fellow experiences sensations that make her believe she is having a heart attack. Difficulty in breathing, rapid heartbeat and burden on her chest. She is taken to the emergency of a hospital and she is told that the problem is psychological and physically she is alright.

Example B

Your aunt is depressed, she has lost her husband. She does not eat, does not sleep, and does not go to her work. You are worried. You want her to return to normal.

Example C

A teacher observes that one of her students is disruptive, unpopular with the class. What should be done and how the problem should be treated.

When we frequently come across medical problems, psychological problems, social problems or a combination of either of the two, we frequently ask how we can decide. How can we be sure,

what treatment is needed? How can we differentiate between different types of psychological disorders?

In the mental health field, we describe, classify, explain, select, predict, plan and evaluate to do all these tasks; we need procedures and methods to measure and define psychological disorders.

Tools for Assessment

Assessment is the systematic collection and analysis of information about a person's characteristics and behaviors. There are several assessment procedures, such as:

- Interviews
- Questionnaires
- Psychological tests
- Rating Scales
- Observation
- Behavior samples

Each assessment procedure is to judge according to the following criteria which includes

- Reliability
- Validity
- Standardization
- Utility

- Reliability

Reliability refers to consistency or repeatability of the results. Reliability is computed by several statistical procedures. Reliability is expressed as a matter of degree. Usually, on a continuum of 0 to 1 where one means perfect reliability, this is a rare thing. There are three types of reliability.

- Test Retest
- Internal consistency
- Inter rater reliability

Test retest: is the consistency of a test results over time. The same test questionnaire or an interview should yield the same results, when used on the same person twice (tested on two different occasions). This type of reliability is important when compulsive behavior is being measured or anxiety is being measured.

Split Half (Internal consistency): A type of reliability is internal consistency or correspondence (correlation) between test items. A questionnaire intended to measure potential for child abuse so we focus on the concept of child abuse, now every item of the questionnaire should relate and measure the concept of child abuse. If all the items on the questionnaire contribute to identify this concept then individual item correlation will be high and individual item to total item score will be high.

Inter rater reliability: A type, of reliability is Inter rater reliability or consistency among scorers or observers. Independent judges, who are observing a person's behavior, come to the same conclusion. This kind of reliability evaluates the agreement between two raters administering the same interview, rating the same video of a person's behavior or observing a person's behavior in a particular setting.

High inter rater reliability increases the confidence that the procedure is measuring, what it is supposed to measure. It is clear that an instrument measuring a behavior should be high in reliability if we want to draw conclusions from it. *For example*: an intelligence test demonstrates low test retest reliability. It clearly shows that it is not measuring intelligence. While two observers, observe the same child in the classroom and agree in their ratings that his intelligence should be high.

- Validity

Validity is a method, which means does the test measure, what it has been designed to measure i.e. an intelligence should measure intelligence, a personality test should measure personality then it is a valid measure and it will give valid and accurate results. Suppose that a bag of sugar when put on the scale should read its weight, every time the same bag of sugar is put on the scale should give the same reading. Then the weighing scale is valid.

Kinds of Validity:

- Face validity
- Criterion (Predictive validity and Concurrent validity)
- Content validity
- Construct validity

Face validity does not by itself establish the test's trust worthiness. It simply conveys that the test and its items should appear making sense to the test taker. This is not validity in the real sense.

It's simply means that a test on depression should include questions about how often a depressed individual cry or weeps. So face validity is the apparent sense the test makes to the person who is taking it.

Predictive validity is a test ability to predict a person's future characteristics or behavior. We could establish predictive validity by administering a test to a group of school students and predict their performance for the future senior school i.e. predictive validity makes prediction about the individual's future behavior based on his present behavior. When we ask questions like, Is an individual likely to become anxious or depress in future? We are dealing with the concept of predictive validity.
Concurrent Validity: A test designed to measure student's present or current anxiety state e.g. should produce anxiety scores that agree with school counseling records and parent's reports.

Content validity: A test that displays high content validity reflects that it measures all important aspects of the behavior, skill or quality that it is measuring. All achievements test and intelligence test and all teacher made classroom test should have high content validity. All entrance exams and admission tests should have high content validity (THEY SHOULD BE CONTENT BASED).

Construct validity: Construct validity measures what they are intended to measure and not something else. Do achievement tests measure ability in a given subject area or do they measure something else? Some students do very well on an achievement test and others do very poorly on multiple choice tests. Before any test can be useful, it must meet the requirements of standardization and utility criteria as well.

- Standardization

Standardization is process by which a certain set of standards or norms is determined for a technique in order to make its use consistent across different measurements, e.g. the assessment might be given to a large number of people who differ on important factors, such as age, race, gender, socio economic status and diagnosis, where scores would then be used as a standard or norm for comparison purposes, e.g. if you are an Ethiopian, 22 years old male from a middle class background on your score on a psychological test should be compared to the scores others like you.

- Utility

A final criterion for deciding that an assessment procedure is worth employing is its utility or usefulness. To be useful, the assessment procedure should be valid, reliable, standardized and useful.

- Diagnosing Psychological Disorders

A classification system consists of a list of various types of problems and their associated symptoms. In order to classify the psychological disorders we need a classification system. The term classification refers to process to construct categories and to assign people to these categories on the basis of their attributes or relations. Classification in scientific context refers to taxonomy. It also refers to nomenclature, which describes the names and labels that may make up a particular disorder such as schizophrenia or depression.

Classification is at the heart of every science. If we cannot label and order objects or experiences or behaviors scientists could not communicate with one another and our knowledge will not advance. Therefore, we develop a system with which we could define or classify behavior. Abnormal psychology is based on the assumption that a behavior is part of one category or disorder and not of another one. Different classification systems are not necessarily right or wrong; they are simply more or less useful. Psychologists use three approaches or strategies to classify disorders:

- The categorical approach
- Dimensional approach
- Prototypical approach

The categorical approach

Dimensional Approach

A second strategy is a dimensional approach, in which we note the variety of cognitions, moods, and behaviors with which the patient presents and quantify them on a scale. For example, on a scale of 1 to 10, a patient might be rated as severely anxious (10), moderately depressed (5), and mildly manic (2) to create a profile of emotional functioning (10, 5, 2). Although dimensional approaches have been applied to psychopathology, they are relatively unsatisfactory.

Prototypical approach

A third approach, for organizing and classifying behavioral disorders which is an alternative to the first two. It is called a prototypical approach. It identifies some essential characteristics of a disorder and it also allows for certain non-essential variations that do not necessarily
-change the classification. With this approach classifying the disorder by different possible /eatures or properties any candidate must meet (but not all) of them to fall in that category. In depression, there are five important symptoms such as: *Depressed mood all of the day, Weight loss, Insomnia, Fatigue & Feeling of worthlessness.* For a person might have three or four of the characteristics of the depression but not all five of them. Yet we still diagnose the person as depressed.

From Description to Theory

- Mental disorders are currently classified on the basis of their descriptive features or symptoms.
- We need a classification system for abnormal behavior for two primary reasons
  - First, a classification system is useful to clinicians, who must match their clients' problems with the form of intervention that is most likely to be effective.
  - Second, a classification system must be used in the search for new knowledge.

Brief History of Classifying Abnormal Behavior

Brief Historical Perspective

Currently, two diagnostic systems for mental disorders are widely recognized.

- The *Diagnostic and Statistical Manual (DSM)*—is published by the American Psychiatric Association.

- The *International Classification of Diseases (ICD)*—is published by the World Health Organization.

During the 1950s and 1960s, psychiatric classification systems were widely criticized. One major criticism focused on the lack of consistency in diagnostic decisions. Renewed interest in the value of psychiatric classification grew steadily during the 1970s, culminating in the publication of the third edition of the DSM in 1980.This version of the manual represented a dramatic departure from previous systems.

The DSM-IV-TR System

- More than 200 specific diagnostic categories are described in DSM-IV-TR. These are arranged under 18 primary headings.
- The manual lists specific criteria for each diagnostic category.
- The DSM-IV-TR employs a multiaxial classification system; that is, the person is rated on five separate axes.
- Each axis is concerned with a different domain of information.

  Two are concerned with diagnostic categories and the other three provide for the collection of additional relevant data

CHAPTER FOUR

Behavior Disorder

Children cope with stress in various ways just like adults. Often they do not share their feelings with the adults in their lives because they see how upset the adults are and do not want to upset them further. Therefore, it is up to the adults to help children get through any stressful situation rather than expect the children to ask for what they need. This means understanding where children are developmentally, understanding their general developmental needs, and at the same time, learning about the individual child's needs. To do this, it is important to know how to recognize the children who have developmental disorders and other mental health problems, the family dynamics in which the child has lived, what kinds of treatment are available for children, and how these factors impact on children who come to the attention of the juvenile justice system.

DEVELOPMENTAL DISORDERS

When most people hold their baby in their arms for the first time, they check to make sure that he or she has all the right body parts and, as extra assurance, may even count the number of fingers and toes. Unfortunately, it is not so simple to check for disorders of the brain since those often do not become visible until the infant begins to walk and talk. Usually, the first sign that something is wrong comes when there are delays in the development of behavior and cognition.

In some rare cases, there is trauma at or close to birth that causes problems with the development of the brain and nervous system, such as a stroke causing damage to blood vessels in a specific area of the brain, premature birth causing incomplete maturation of organs such as the lungs preventing sufficient oxygen to the developing brain, or a metabolic disorder that interferes with the development of the endocrine and digestive systems. There are simple blood tests that can be given when the baby is born to help screen for these types of problems, such as the test for Phenylketonuria (PKU test) that indicates a metabolic problem that may then be corrected.

Sometimes, when the parents know that they both come from families with a history of an otherwise rare genetic disorder or something unusual is noted in the prenatal ultrasound test, they can test a fetus' chromosomes through amniocentesis while it is still in the uterus, and make decisions about whether to continue the pregnancy or how to treat the neonate when it is born.

Today it is even possible to perform certain kinds of surgery while the fetus is developing in the uterus.

ATTENTION DEFICIT DISORDERS

- Perhaps the most widely diagnosed mental disorder in children is what is called Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD). These children are frustrating to be with because they cannot regulate their attention and concentration by themselves, yet in other areas appear quite normal.
- Those with ADHD do not solely have concentration problems and stare into space, as do those with ADD; they also fidget, move uncontrollably, have repetitive and annoying behaviors, and disrupt others.
- These children have poorly regulated sleeping and waking patterns, often seen in infancy, but they are not usually seen as problematic until entrance into school where they are expected but unable to conform to the rules and behavioral limits.
- Although those with ADD or ADHD are usually placed in the mental illness classification, it is thought that there is some form of brain dysfunction that contributes to their causation.
- Today, it is becoming more common to see adults who are diagnosed with ADD or ADHD. Although ADHD is thought to have begun in childhood, it is likely that it was undiagnosed or not properly treated and continued into adulthood.

Cardinal Signs and Symptoms: Attention Deficit/Hyperactivity Disorder

- Usually detected in elementary school
- More common in boys or girls
- Often has a learning disability
- May develop substance abuse problems
- No attention to details and careless
- Cannot sustain attention
- Fails to listen
- Cannot follow through on instructions
- Organizational difficulties
- Loses things
- Easily distracted

- Forgetful
- Squirms and fidgets in seat
- Runs about and climbs excessively
- Cannot play quietly
- "on the go and driven
- Excessive talking
- Impulsive

OPPOSITIONAL AND CONDUCT DISORDERS

Oppositional Defiant Disorder

- Children who are persistently oppositional may develop a conduct disorder once they begin school. It is difficult to get these children to respond to discipline because they take every attempt to train them as a challenge to begin another power struggle.
- Children with ***Oppositional Defiant Disorder*** are angry but still engage with the parent or other significant people in their life while those with Conduct Disorder usually are disengaged from others.

Cardinal Signs and Symptoms: Oppositional Defiant Disorder

- Loses temper
- Argues with adults
- Refuses to follow rules
- Deliberately annoys others
- Blames others for mistake
- Easily annoyed by others
- Angry and resentful
- Spiteful and vindictive

Conduct Disorder

- Children with Conduct Disorder often have been (or felt) abandoned and many of them have not had to account for their behavior to anyone. These children or youth are exhausting to

deal with because they are always feeling that they have been cheated or that they are being picked on unfairly. Yet, they do not understand how to actually read the social cues from others, so people do shy away from them.

- Many of those declared delinquent have had conduct disorders from the time they were very young. If they continue to display anti-social behaviors, they may be diagnosed with an Anti-social Personality Disorder as they move into adulthood.

Cardinal Signs and Symptoms: Conduct Disorder

- Aggressive to people and animals
- Bullies & initiates fights with others
- Has used a weapon
- Physically abused animals
- Sexually assaulted someone
- Steals directly from the victim
- Destruction of property and fire-setting
- Lying and theft
- Has entered someone's home & stolen
- Steals items with and without much value
- Runs away overnight
- Truancy from school

Adolescence Substance use Disorder

DRUG-USE STAGES

Drug use can be viewed as a series of developmental stages. Although conceived differently by various experts. We propose these stages: initiation, escalation, maintenance, discontinuation (sometimes including relapse), and recovery. Although most clients evolve sequentially from one stage to another, others do not. Some relapse many times, whereas others bypass relapse altogether

- **INITIATION**

Drug experimentation typically begins during adolescence, in social contexts during middle or high school. Usually offered by acquaintances as gestures of friendship, teens rarely try drugs alone. Alcohol, the first psychoactive drug for most initiates, is often provided in homes by parents, family, or friends as a social gesture.

- **ESCALATION**

When recalling the course of their addiction, chemically dependent clients typically view their drug initiation, not as a single point in time, but a period when they used drugs occasionally. During escalation, a time of increasing preoccupation with psychoactive substances and more frequent socializing with other users, intoxication is thought of as normal and fun—a healthy form of recreation. In this stage, the variety of substances used increases and users typically feel little or no concern about how these drugs might impair their health or future.

- **MAINTENANCE**

Full addiction can occur at any age, and when it does, all other life activities become secondary to obtaining and using drugs. The social fabric of life unravels when using becomes a daily devotion, an obsession.

At the escalation stage, most friends also use drugs, but functional ties are maintained with nonusers; a survival consciousness has not yet developed. In contrast, drug using is no longer just "a lot of fun"; at this stage, it is a necessity.

During the initiation and escalation stages, users take drugs primarily for the social and psychological rewards they offer—that is, to feel euphoric. But, as these highs become more and more difficult to achieve, the quest becomes just to feel normal, to manage personal feelings with various chemicals. As this quest becomes more difficult, life turns into a struggle for survival. For non –addicted people, survival connotes food, shelter, and clothing; but for the addict, survival means obtaining drugs first—a constant preoccupation—then everything else.

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- **DISCONTINUATION AND RELAPSE**

How long or why a person stops using mood-altering chemicals varies. Some stop abruptly due to drug overdoses, death, illness, or family pressure. Others stop temporarily because of incarceration or forced participation in a court mandated treatment program. The downward spiral of loss and adversity—"hitting bottom"—motivates some to seek help, or another person may help them see that drugs are not the *solution* for their problems (the typical misperception), but the *problem.* Despite strong denial, bitter experiences bring them face-to-face with their increasingly desperate circumstances.

Some people break free of addictions on their own. “Several surveys by the Institute for Health and Aging (University of California) show that drinking problems with blackouts almost always disappear before middle age, without medical assistance, as do most teenage drug addictions. Over two-thirds of those who abuse alcohol quit on their own, with no help.

Many addicts, however, require considerable assistance from caring others.

- **RECOVERY**

Recovery, the cessation of all psychoactive substances, occurs when addicted clients acknowledge that the mood-altering substance is not their support, as they had supposed, but the cause of their increasing problems. Though betrayed by their chemical elixir, they grieve the loss of their drug lifestyle. Gradually, one small step at a time, they replace this presumed “best friend” with more healthy activities and networks at home, school, work, church/synagogue/ mosque, and in recreational settings.

Regaining physical health is much easier than recovering lost emotional growth because, to develop emotionally, they must return to the time when they first began using drugs to cope with life’s problems and begin solving problems.

Though middle-aged, emotionally they may be adolescents—the point at which they first started using mood-altering substances and stopped struggling with emotional problems. Even worse, their emotional skills have likely atrophied. Fortunately, struggling with life’s problems without relying on psychoactive chemicals to block out uncomfortable feelings—“clawing oneself back to mental health”—brings accelerated emotional growth. This transition, though initially terrifying, can be exhilarating.

Recovering addicts go through three fairly predictable stages during their recoveries, each with its own challenges and difficulties.

- **EARLY STAGE RECOVERY**

Spanning the first 6 months of sobriety, the risk of relapse is highest during this time. Not only is mental clarity impaired, so is physical health. Clients are beginning to develop new (nonchemical) ways of dealing with daily stressors at work and in personal relationships by building sober support networks, such as those offered by Alcoholics Anonymous or other

support groups. In this phase, they also must experience the accompanying mood swings and depression that can derail treatment.

- **MIDDLE STAGE RECOVERY**

During this time, usually the second 6 months of sobriety, individuals grapple with the physical, social, and psychological adjustments of sobriety. Among other profound emotions, they typically go through a grieving process, mourning for the loss of a best friend and the good times that they "enjoyed" while using drugs. At this stage, individuals begin to re -establish their ability to feel and to deal with their emotions without using drugs.

- **LATE STAGE RECOVERY**

In this stage of recovery, beginning after roughly a year of sobriety, individuals begin to gain confidence in their new support systems and the psychosocial and spiritual tools they have learned in treatment and recovery groups. A time of increasing stability and comfort with their new life, individuals continue to advance in forming healthy support networks and activities (or re-establishing old ones, such as with family members) to replace drug-related ones.

LEVELS OF DRUG USE

At any particular time, individuals may fit any one of these levels of drug involvement: (1) abstainers, (2) social users, (3) drug abusers, (4) addicts who are physically dependent (but not psychologically dependent), and (5) addicts who are both physically and psychological dependent. These categories are *ideal types* (useful for classification); people rarely fit neatly into a single category. A person categorized as an abstainer may, on rare occasions, drink alcohol. Many individuals shift during their lifetime from one category to another. In addition, psychological dependence varies by degree.

Note that these are *not drug stages*, but drug-related *conditions;* individuals do not necessarily move predictably from one condition to another; a person may swing from one extreme to another. For example, a person who experiments with crack cocaine for the first time can go from being an abstainer to full psychological dependence, while an addicted individual (Type 5) may stop using completely.

TYPE 1—ABSTAINERS

Some consciously choose abstinence as a way of life for religious or other reasons. Still others abstain after devastating experiences from a drinking and drugging lifestyle

TYPE 2—SOCIAL USERS

Constituting the majority of people, social users limit their intake of alcohol and other psychoactive drugs to social gatherings where using substances is peripheral, rather than the main purpose or attraction. Alcohol and other mood-altering substances are seen simply as ways to enhance the pleasure of the gathering while accomplishing other social goals.

Although those at Stage 5 (i.e., people that are psychologically as well as physically dependent on substances) often regard themselves as social drinkers/ users, they cannot, like social users, ingest their drug-of-choice intermittently, go long periods without it, or quit at any time. By contrast, social users may enjoy social events that offer psychoactive substances as part of the fare but are not preoccupied with drugs or getting high. Although clients may use alcohol or even marijuana regularly, they are in control of their consumption and experience few, if any, significant adverse consequences at home, work, in social settings or with law enforcement personnel.

TYPE 3—DRUG ABUSERS

Like social users (Type 2), *drug abusers* use psychoactive drugs typically in social settings, but unlike them, their consumption is heavier, and intoxication is usually the purpose of their get-togethers. Unlike addicts (Types 4 and 5), their use is sporadic, usually on weekends. Partying—"getting plastered," or "smashed" with others who enjoy such activities is socially rewarding and a sign of acceptance.

In some circles, especially among college students, it is considered "cool" to binge (i.e., consume more than five servings of beer or five glasses of wine at a single setting). Depending on the drug, tolerance starts to develop—meaning it takes more to produce the desired euphoric effect. Drug abusers may increase their frequency, duration, and intensity of use and move to the next level of addiction.

Aside from social rewards, people have the following motivators to misuse psychoactive drugs:

- A coping strategy to avoid unwanted feelings
- A way to change mood or personality (e.g., be more up and bubbly)
- A way to escape unwanted obligations at home, work, or school (e.g., intoxication and hangovers provide an excuse to avoid undesirable responsibilities)
- A way to enhance social standing with other drug-using peers, to be "cool," hip, avant-garde

- Annoyance at being confronted about the use of alcohol and/or other drugs
- A way to enhance performance (e.g., using stimulants to prepare for exams by studying later into the night, using downers to play mellow music on one's instrument, or to feel relaxed in stressful situations)

TYPE 4—PHYSICALLY BUT NOT PSYCHOLOGICALLY DEPENDENT USERS

Clients inadvertently addicted to drugs prescribed by their doctor or dentist illustrates this type. Although such individuals may eventually come to despise these prescribed drugs—the opposite of psychological dependence—their bodies have gradually developed a tolerance to these substances (i.e., they have developed a physical dependence). Therefore, they must endure the sometimes painful experience of detoxifying, 3 to 5 days for relatively short-acting drugs (e.g., alcohol, heroin, and cocaine) but 2 weeks or longer for long-acting drugs
(e.g., benzodiazepines like Valium or Zanax, or methadone).

TYPE 5—PHYSICALLY AND PSYCHOLOGICALLY DEPENDENT USERS

Unlike Vietnam veterans, individuals in this condition cannot simply walk away from their addictions and resume a normal life. They depend on psychoactive drugs to cope with life. When the reward-pain ratio shifts and unpleasant and disruptive events accelerate, rather than discontinuing the drugs as Type 4 users do, they increase the dosage, switch to other drugs, or try to titrate various substances. Instead of blaming drugs for their spiraling decline, they regard them as the solution and often mourn their loss just as one mourns the death of a loved one.

STAGES OF BEHAVIORAL CHANGE

Behavioral change rests primarily with the motivation of the client, not the counsellor. Since clients come in with varying degrees of motivation, the counsellor should match this motivation with an effective treatment plan. This matching process is critical for achieving positive client change. The six stages of change are (1) Pre-contemplation, (2) Contemplation, (3) Preparation, (4) Action, (5) Maintenance and Relapse Prevention, and (6) Termination.

Success is defined as both a behavioral change and any movement toward change, such as a shift from one stage of change (readiness) to another. A powerful and effective strategy for assessing client motivation, this model helps the counsellor match clients' treatment protocol with their level of motivation

STAGE 1—PRECONTEMPLATION

Clients do not perceive their actions as being problematic. Clients are in this stage of change because of "the Four Rs"—reluctance, rebellion, resignation, and rationalization:

- **Reluctant** pre-contemplators, through inertia or lack of knowledge, do not want to consider change. The real or potential impact of the problem is not yet apparent to them.
- **Rebellious** pre-contemplators have a heavy investment in their behavior and in making their own decisions. They are resistant to being told what to do.
- **Resigned** pre-contemplators have given up concerning the possibility of change and seem overwhelmed by the problem. Many have made numerous attempts to quit or control their addictions.
- **Rationalizing** pre-contemplators have all the answers; they have plenty of reasons why their behavior is not a problem, or why a particular behavior is a problem for others but not for them.

The love and support of family and friends can help clients recognize the need to be concerned about self-defeating behaviours. A structured intervention led by an addiction counsellor may facilitate this recognition. During treatment, professionals can use motivational interviewing to promote awareness.

STAGE 2—CONTEMPLATION

Clients become aware of the risks of present behavior(s), but still struggle with ambivalence. They may realize there is a problem, but feel that they can handle it. With the counsellor's help; clients at this stage often make a risk-reward analysis. They consider the pros and cons of their behavior, together with the pros and cons of change. They may also review prior attempts to stop the problem behavior and evaluate the factors that contributed to past failures.

STAGE 3—PREPARATION

Clients agree there is a problem but are not yet 100% committed to the recovery process. Although not fully motivated, ambivalence is no longer an insurmountable barrier to change. It is important that clients not stay in this stage for more than 30 days since they can slip back to Stage 2 (or even 1) again, and the process must begin anew. Most clients at this stage, however, appear ready and committed to action.

The goal here is to move clients toward the action stage as fast as possible, without irritatingly pushing them. Momentum in moving toward action can be achieved by having clients talk about their potential plans.

STAGE 4—ACTION

Clients are now motivated to improve their lives by following a clearly defined action plan with goals leading to desired outcomes. A client who implements a good action plan begins to experience success, making adjustments along the way. Addiction-related losses begin to be restored, together with hope, self-confidence, and determination to not return to the problem behavior and/or substance. If clients have not done so already, they may enter an outpatient treatment program.

A manageable treatment plan with clear goals is essential. A recovery contract with specified goals and rewards for achieving milestones may be developed to systematically help the client stay motivated.

STAGE 5—MAINTENANCE AND RELAPSE PREVENTION

Clients in this stage have taken action and are now learning the necessary skills to avoid relapse. The longer the client stays on course, the less chance of relapse. Ensure that the treatment plan is always being appropriately revised and updated with new core skills to support the client's on going treatment plan. Relapse often occurs when clients stop paying attention to the details that have kept them free from their particular problem behaviours.

STAGE 6—TERMINATION

Client has developed the core skills needed to move past their addiction and have developed new life habits. Subsequently, they are encouraged to proceed to other life goals.

Education and learning are important for the lifelong development of any person. It is recommended that addiction counsellors assist clients to move forward by developing healthy activities in place of their former addiction. Planning ways to improve the overall quality of one's life is important.

There are many substances that are capable of harming the body or adversely affecting the behavior and mood. The misuse of drugs has become one of the most disabling problems of the society.

The term drug applies to any substance other than food that changes our bodily and mental functioning. Drug misuse may lead to a temporary mental syndrome such as intoxication but chronic excessive use of drugs can lead to a substance use disorder.

There are 2 types of substance related disorders.

- Substance use disorder
- substance induced disorders

Substance use disorder can take two forms

- Substance abuse
- Substance dependence(addiction)

Substance abuse

- Is a maladaptive pattern of substance use resulting in repeated problems and adverse consequences
- Includes only the harmful effect of the substance
- A pattern in which people rely heavily on a drug and they structure their lives around the drug

Criteria for Substance Abuse

The fourth diagnostic and statistical manual (DSM-IV) of the American Psychiatric Association uses the following criteria for substance abuse. If any individual has experienced one or more of the following at any time for at least in the same one-month period:

- Recurrent drug use resulting in failure to fulfil major responsibilities
- Recurrent drug use in physically hazardous situations.
- Recurrent drug –related legal problems.
- Continued use despite drug related social or interpersonal problems.

Substance abuse may lead to dependence.

Substance dependence (addiction)

- In which people show all symptoms of substance abuse plus physical dependence on the drug.

- It is maladaptive pattern of substance use leading to clinically significant impairment occurring at any time during the 12 month period.

The term *addiction* (derived from the Latin root *addicere,* meaning "to adore or surrender oneself to a master") also applies to behaviours beyond drugs and alcohol such as ***sex, work, gambling, buying, eating, and the Internet.*** Although "there is no single definition of addiction and a universally accepted, comprehensive theory of addiction has yet to be developed" (Doweiko, 2002, p. 21), here are the best known models of addiction, some of which share similar characteristics.

MORAL MODEL

Defines an addicted client as weak in character. It is based on the idea that individuals have free choice and are responsible for their behaviors'.

SELF-MEDICATION MODEL

It assumes that people self-medicate to cope with life problems. A person in emotional pain will self –medicate to find relief, and this can eventually lead to addiction. This self-medication hypothesis (Khantzian, 1999) asserts, "Should be considered in parallel with other approaches and not in competition with them" (p. 5

MEDICAL/DISEASE MODEL

Addiction was identified as a disease, rather than a mental disorder or moral failure. *Disease* is defined as a severely harmful, potentially fatal condition that manifests itself in an irreversible loss of control over use of psychoactive substances. Although the disease may go into remission, there is no known cure, and since the disease is progressive and often fatal, complete abstinence is the treatment goal.

SPIRITUALITY MODEL

This model assumes that addictive disorders stem from a lack of spirituality that is, of being disconnected from a "Higher Power," the source of light, truth, love, and wellness. "Every addiction is, in the final analysis, a disease of the spirit," notes Doweiko (2002, p. 49). Alcoholics Anonymous and its many derivatives help participants recover by developing a viable relationship with this Higher Power.

IMPULSE-CONTROL DISORDER

A relatively new definition of addiction, this view assumes that either neurobiological or genetic deficiencies make a person unable to control and regulate impulsive behavior(s). Under certain conditions, such individuals will put themselves at risk and find temporary relief with self-destructive behaviours i.e. drug abuse (Hollander, Buchalter, & De- Caria, 2000).

REWARD DEFICIENCY AND NEUROPHYSIOLOGICAL ADAPTION

This model assumes that chemical imbalance is manifested as one or more behavioral disorders called the "reward deficiency syndrome" (Blum, Cull, Braverman, & Comings, 2000, para. 3). This disorder, and others like it, are linked by a common biological substrate, a "hard-wired system in the brain (consisting of cells and signalling molecules) that provides pleasure in the process of rewarding certain behaviours" (Blum et al., 2000, para. 3). He suggests that this reward deficiency syndrome may cause a predisposition, or vulnerability, to addiction that includes alcohol, cocaine, heroin, nicotine, sugar, pathological gambling, sex, and other behavior disorders.

GENETIC MODEL

Research over the past 20 years has identified a genetic predisposition in some individuals to alcohol, tobacco, and other substances of abuse (Doweiko, 2002).

Epidemiological studies indicate that 40% to 60% of an individual's risk for an addiction to alcohol, opiates, or cocaine is genetic (Kendler, Karkowski, Neale, & Prescott, 2000; Tsuang, Bar, Harley, & Lyons, 2001). A growing number of genetic researchers now believe different classes of substances may be connected to unique genetic preference and may help account for the individual's drug of choice (Blum et al., 2000).

BIOMEDICAL MODEL

The 1990s gave rise to another disease theory of addiction that draws from both the biological and behavioral sciences. "Using drugs repeatedly over time changes brain structure and function in fundamental and long-lasting ways that can persist long after the individual stops using them" (Leshner, 2001, para. 3). Once the addiction impacts the brain, the client is driven behaviourally to support the demands made by the brain to prevent becoming ill from withdrawal.

SOCIAL LEARNING MODEL

Social reinforcement causes individuals to model the drug use behaviours of their parents, older siblings, and peers. Social learning theorist Albert Bandura (1977, 1986) indicates four stages of social learning: (1) Attention—The individual makes a conscious cognitive choice to observe the

desired behavior; (2) Memory—The individual recalls what he has observed from the modelling; (3) Imitation—The individual repeats the actions that he has observed; and (4) Motivation—The individual client must have some internal motivation for wanting to carry out the modelled behavior.

ERRONEOUS THOUGHT PATTERNS

This model assumes that illogical thinking underlies addiction. Ladouceur, Gaboury, Dumont, and Rochette (1988) explain that, to help addicted clients, counsellors must challenge erroneous thinking, correct flawed thinking, and teach them how to reason correctly. For example, when a compulsive gambler thinks, "I have a system that will beat this slot machine; I just need to stick to it long enough," educate the person about the laws of probability and how they are stacked against the gambler. Teach the person that gamblers cannot "beat the odds," and that this flawed repetitive thought leads to addictive problems.

BIOPSYCHOSOCIAL MODEL

Developed in the 1980s, this view holds that addiction vulnerability is affected by the complex interaction between one's *physical status* (functioning of the body), *psychological state* (how one views and perceives the world), and *social dynamics* (how and with whom one interacts). Chiauzzi (1991) points out that looking at addictions through these three windows allows for more flexibility in determining root cause and treatment.

PUBLIC HEALTH MODEL

The Institute of Medicine (1989) defines addiction from a public health perspective, identifying three etiologic factors: (1) *Agents*—the psychoactive drugs; (2) *Hosts*—individuals who differ in their genetic, physiological, behavioral, and sociocultural susceptibility to various forms of chemicals; and (3) *Environment*— the availability and accessibility of the agent (Coombs, 1997, pp. 176–177).

Criteria of substance dependence

Clinical guidelines (ICD- 10) for a definite diagnosis of "dependence" drawn up by WHO require that three or more of the following six characteristic features have been experienced or exhibited:

- A strong desire or sense of compulsion to take the substance;

- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use
- A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses;
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

Dependence can be categorized into psychological and physical dependence.

Psychological dependence is a compulsion that requires periodic or continuous exposure to a substance to produce pleasure or avoid discomfort.

Physical (physiological) dependence is an adaptive state that develops through resetting of homeostatic mechanism to permit normal function despite the continued presence of a substance. Physiological dependence is evidenced by either tolerance or withdrawal syndrome.

- **Tolerance:** is defined as the requirement for an increased amount of the substance to achieve a desired effect or there is a markedly diminished effect with regular use of the same dose. People who need increased doses of drug in order to get its effect

- **Withdrawal syndrome**: is a substance specific syndrome that follows cessation of or reduction in intake of the substance that was previously regularly used by the individual. These symptoms include muscle aches, pains and cramps, vomiting, nausea. This is manifested by Characteristic withdrawal syndrome, and Persistent desire or unsuccessful efforts to cut down

Virtually, all substances that produce dependence can cause varying degree of health, social and economic problems.

The degree of harm produced in general depends on:

- The quantity of a substance consumed per occasion.
- The frequency with which it is consumed at that quantity and
- The duration of consumption in months or years.

Poly Drug Use

- When an individual uses two or more drugs at the same time we label it as poly drug use

Cross Tolerance

- When people take more than one drug at a time and the drugs interact with each other. Some time the two drugs display cross tolerance
- Cross tolerance is that the drugs act similarly on the brain and taking one drug will affect person's tolerance for the other.

Synergistic Effect

- When different drugs enhance each other's effect, they have a combined impact known as a synergistic effect.

Health related problems

The negative economic consequences and the social consequences of substance abuse or dependence

Since substances of dependence should be taken regularly usually at increasing amounts when tolerance develops in order to prevent withdrawal symptoms, the negative economic consequences are evident. Additionally, the abuser spends much of his/her time searching for and then consuming the abused substance.

The negative economic consequences are:-

- Unemployment resulting in decreased national productivity.
- Increased expenditure by drug abusers for buying the substance of abuse.
- Increased cost of violence, accidents and property crimes associated with drug abuse and dependence.
- Proliferation of producers of substance of abuse that may occupy vast areas of the land that otherwise be used for the cultivation of useful crops and food.
- Proliferations of criminal networks that make a huge profit from trafficking substances of abuse most of them being illicit substances

- Transfer of illicitly acquired assets to other countries
- Increased expenditure for health related problems.

- **Depressants:** are substances which slow the activity of central nervous system they include. The important depressants are
    - Alcohol
    - Sedative-Hypnotic drugs
    - Opioids
- **Stimulants:** are substances that increase the activity of the central nervous system, resulting in the increased blood pressure, heart rate, intensified activity, thought processes and alertness. The important stimulants are
    - Cocaine
    - Amphetamines
    - Nicotine
    - Caffeine
- **Hallucinogens:** are substances that cause changes primarily in sensory perception. They include
    - LSD
    - Cannabis drugs

Factors Associated with Substance Abuse and Dependence

Many variables operate simultaneously to influence the likelihood of any given person becoming a drug abuser or an addict. These variables can be organized into three categories: agent (drug), host (user), and environment.

- **Agent/Drug Variables**

Drugs vary in their ability to produce immediate good feelings in the user. Drugs that reliably produce intensely pleasant feelings (euphoria) are more likely to be taken repeatedly. Reinforcement refers to the ability of drugs to produce effects that make the users wish to take them again. The more strongly reinforcing a drug is, the greater the likelihood that the drug will be abused. The abuse liability of a substance is enhanced by its:

- Availability /cost: easily available and low cost substances are likely to be abused.
- Purity/potency: the more potent the drug, the more it is abused.
- Mode of administration
- Speed of onset and termination of effects: Substances that have longer duration of action are more likely to be abused.

- **Host/User Variables**

In general, the effects of substances/drugs vary among individuals. This depends on:

- Genetic predisposition and vulnerability.
- Psychiatric disorders.
- Prior experience or expectation.
- Tendency for risk-taking behaviour
- **Environmental Variables**
- Social setting and community attitude
- Peer influence
- Paucity of other options for pleasure and diversion
- Low employment or educational opportunities

2. Substance induced disorders

Types of substance induced disorder:

- ***Substance intoxication***
- ***Substance withdrawal***
- ***Substances induce delirium***: is included in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section
- ***Substance induced persisting dementia***: is included in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section
- ***Substance induced persisting amnesia:*** is included in the "Delirium, Dementia, and Amnestic and Other Cognitive Disorders" section
- ***Substance induced psychotic disorder:*** is included in the "Schizophrenia and Other Psychotic Disorders" section. (In DSM-III-R these disorders were classified as "organic hallucinosis" and "organic delusional disorder."
- ***Substance induced mood disorder:*** is included in the "Mood Disorders" section.
- ***Substance induced anxiety disorder:*** is included in the "Anxiety Disorders" section.
- ***Substance induced sexual disorder:*** is included in the "Sexual and Gender Identity Disorders" section.
- ***Substance induced sleep disorder:*** is included in the "Sleep Disorders" section.

Treatment for substance abuse disorders

Treatment for substance abuse disorders include

- Biological therapy
- Insight therapy
- Behavioral techniques (Aversive therapy and Relapse prevention training)
- Self- help groups
- Therapeutic communities

The goals of treatment for substance use disorders are a matter of controversy.

- Some clinicians believe that the only acceptable goal is total absence from drinking or drug use.
- Others have argued that, for some people, a more reasonable goal is the moderate use of legal drugs.
    - **Biological Therapy**
        - **Detoxification**
- Alcoholism and related forms of drug abuse are chronic conditions and their treatment is typically accomplished in a sequence of stages, beginning with a brief period of **detoxification**—the removal of a drug on which a person has become dependent—for 3 to 6 weeks.
        - **Medications**
- Following the process of detoxification, treatment efforts are aimed at helping the person to maintain a state of remission.
- Several forms of medication are used to help the person refrain from drinking.
- If a person who is taking medicine consumes even a small amount of alcohol, he or she will become severely ill.

    - **Insight Therapy**
- Insight therapies try to help the clients become aware of and address the psychological factors that contribute to their pattern of drug use.
    - **Behavioral Techniques**
    - **Cognitive Behavior Therapy**

- Cognitive behavior therapy teaches people to identify and respond more appropriately to circumstances that regularly precipitate drug abuse.
- One element of cognitive behavior therapy involves training in the use of social skills, which might be used to resist pressures to drink heavily.
- Most people who have been addicted to a drug will say that quitting is the easy part of treatment.
- The more difficult challenge is to maintain this change after it has been accomplished.

- **Relapse Prevention Model**

- The relapse prevention model addresses several important issues that confront the addict in trying to deal with the challenges of life without drugs.
- Another important feature of the relapse prevention model is concerned with the guilt and perceived loss of control that the person feels whenever he or she slips and finds himself or herself having a drink (or a cigarette or whatever drug is involved) after an extended period of absence.

- **Aversive Therapy**

Aversive conditioning in which an unpleasant stimulus is paired with the drug that the person is taking

- **Self-Help Groups:**

Alcoholics Anonymous

- Alcoholics Anonymous (AA) is maintained by alcohol abusers for the sole purpose of helping other people who abuse alcohol become and remain sober.
- AA is not officially associated with any other form of treatment or professional organization.
- The viewpoint espoused by AA is fundamentally spiritual in nature.
- In this 12 step procedure in which the first step is the person must acknowledge that he or she is powerless over alcohol and unable to manage his or her drinking.
- The remaining steps involve spiritual and interpersonal matters such as accepting “a Power greater than ourselves” that can provide the person with direction; recognizing and accepting personal weaknesses; and making amends for previous errors, especially instances in which the person’s drinking caused hardships for other people.

- **Therapeutic communities**

- Therapeutic communities or residential therapeutic communities where addicts live work and socialize in a drug free environment.
- There is social and cultural disapproval and unacceptability for drinking, smoking and use of drugs because it has become one of the most disabling problems of the society.
- Just say no to drugs.
- It feels good.

YOU can get help in saying no to drugs from your own self, family, friends and others

CHAPTER FIVE

Emotional and Social Disorder

- **Childhood Anxiety Disorder**

Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. *Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat*. Obviously, these two states overlap, but they also differ, with fear more often associated with:

- surges of autonomic arousal necessary for fight or flight,
- thoughts of immediate danger, and escape behaviors,

And anxiety more often associated with:

- Muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviors.

Sometimes the level of fearor anxiety is reduced by pervasive avoidance behaviors. Panic attacks feature prominentlywithin the anxiety disorders as a particular type of fear response. Panic attacks are not limitedto anxiety disorders but rather can be seen in other mental disorders as well.

The anxiety disorders differ from one another

- In the types of objects or situations that induce fear, anxiety, or avoidance behavior, and
- The associated cognitive ideation.

Thus, while the anxiety disorders tend to be highly co morbid with each other, they can be differentiated by close examination of the types of situations that are feared or avoided and the content of the associated thoughts or beliefs.

Anxiety disorders differ from transient fear or anxiety, often stress-induced, by being persistent (e.g., typically lasting 6 months or more), although the criterion for duration is intended as a general guide with allowance for some degree of flexibility and is sometimes of shorter duration in children (as in separation anxiety disorder and selective mutism).

While normal fear is adaptive and prevents people from entering threatening situations, with anxiety disorders:

- People develop irrational fears of situations which do not threaten their survival.
- They also develop non-adaptive behavioral patterns associated with avoidance of feared situations or experiences.

  Types of anxiety disorders

- **Separation Anxiety:** the individual with separation anxiety disorder is fearful or anxious about separation from attachment figures to a degree that is developmentally inappropriate. There is persistent fear or anxiety about harm coming to attachment figures and events that could lead to loss of or separation from attachment figures and reluctance to go away from attachment figures, as well as nightmares and physical symptoms of distress. Although the symptoms often develop in childhood, they can be expressed throughout adulthood as well.

Cardinal signs and symptoms

- Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:
- Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
- Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
- Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
- Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
- Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
- Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
- Repeated nightmares involving the theme of separation.

- Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.
- Lasting at least 4 weeks in children &adolescents and typically 6 months or more in adults.
- The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
- **Selective Mutism:** it is characterized by a consistent failure to speak in social situations in which there is an expectation to speak (e.g., school) even though the individual speaks in other situations. The failure to speak has significant consequences on achievement in academic or occupational settings or otherwise interferes with normal social communication.

  Cardinal signs and symptoms

  - Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
  - The disturbance interferes with educational or occupational achievement or with social communication.
  - The duration of the disturbance is at least 1 month (not limited to the first month of school).
  - The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
  - The disturbance is not better explained by a communication disorder (e.g., childhood onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.
- **Phobic Disorder**
- **Specific Phobia**: individuals with specific phobia are fearful or anxious about or avoidant of circumscribed objects or situations. A specific cognitive ideation is not featured in this disorder, as it is in other anxiety disorders. The fear, anxiety, or avoidance is almost always immediately induced by the phobic situation, to a degree that is persistent and out of proportion to the actual risk posed. There are various types of specific phobias: animal; natural environment; blood-injection-injury; situational; and other situations.

Cardinal signs and symptoms

- Marked fear or anxiety about a specific object or situation (e.g., flying, heights, and animals, receiving an injection, seeing blood).

Note: In children, the fear or anxiety may be expressed by crying, irritabilities, cold, or clinging.

- The phobic object or situation almost always provokes immediate fear or anxiety.
- The phobic object or situation is actively avoided or endured with intense fear or anxiety.
- The fear or anxiety is out of proportion to the actual danger posed by the specific objector situation and to the socio-cultural context.
- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- The fear, anxiety, or avoidance causes clinically significant distress or impairment insocial, occupational, or other important areas of functioning.
- **Social Anxiety Disorder (Social Phobia):** in social anxiety disorder (social phobia), the individual is fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinized. These include social interactions such as meeting unfamiliar people, situations in which the individual may be observed eating or drinking, and situations in which the individual performs in front of others. The cognitive ideation is of being negatively evaluated by others, by being embarrassed, humiliated, or rejected, or offending others.

Cardinal signs and symptoms

- Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking) and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

- The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing: will lead to rejection or offend others).
- The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

- The social situations are avoided or endured with intense fear or anxiety.
- The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the socio-cultural context.
- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- **Agoraphobia:** individuals with agoraphobia are fearful and anxious about two or more of the following situations: using public transportation; being in open spaces; being in enclosed places; standing in line or being in a crowd; or being outside of the home alone in other situations. The individual fears these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms. These situations almost always induce fear or anxiety and are often avoided and require the presence of a companion.

Cardinal signs and symptoms

Marked fear or anxiety about two (or more) of the following five situations:

- Using public transportation (e.g., automobiles, buses, trains, ships, planes).
- Being in open spaces (e.g., parking lots, marketplaces, bridges).
- Being in enclosed places (e.g., shops, theatres, cinemas).
- Standing in line or being in a crowd.
- Being outside of the home alone.

- **Panic Disorder**: in panic disorder, the individual experiences recurrent unexpected panic attacks and is persistently concerned or worried about having more panic attacks or changes his or her behavior in maladaptive ways because of the panic attacks (e.g., avoidance of exercise or of unfamiliar locations). Panic attacks are abrupt surges of intense fear or intense discomfort that reach a peak within minutes, accompanied by physical and/or cognitive symptoms. Limited-symptom panic attacks include fewer than four symptoms. Panic attacks may be expected, such as in response to a typically feared object or situation, or unexpected, meaning that the panic attack occurs for no apparent reason. Panic attacks function as a

marker and prognostic factor for severity of diagnosis, course, and co morbidity across an array of disorders, including, but not limited to, the anxiety disorders (e.g., substance use, depressive and psychotic disorders). Panic attack may therefore be used as a descriptive specified for any anxiety disorder as well as other mental disorders.

Cardinal signs and symptoms

- Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four(or more) of the following symptoms occur;
    - Palpitations, pounding heart, or accelerated heart rate
    - Sweating
    - Trembling or shaking
    - Sensations of shortness of breath or smothering
    - Feelings of choking
    - Chest pain or discomfort.
    - Nausea or abdominal distress.
    - Feeling dizzy, unsteady, light-headed, or faint.
    - Chills or heat sensations.
    - Derealization (feelings of unreality) or depersonalization (being detached from oneself).
    - Fear of losing control or "going crazy."
    - Fear of dying.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

- Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
- A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situ
- **Generalized Anxiety Disorder**: the key features of generalized anxiety disorder are persistent and excessive anxiety and worry about various domains, including work and school performance that the individual finds difficult to control. In addition, the individual

experiences physical symptoms, including restlessness or feeling keyed up or on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; and sleep disturbance.

Cardinal signs and symptoms

- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- The individual finds it difficult to control the worry.
- The anxiety and worry are associated with three (or more) of the following six symptoms(with at least some symptoms having been present for more days than not for the past 6 months);

Note: Only one item is required in children.

  - Restlessness or feeling keyed up or on edge.
  - Being easily fatigued.
  - Difficulty concentrating or mind going blank.
  - Irritability
  - Muscle tension.
  - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

- **Post-Traumatic Stress Disorder (PTSD)**: it occurs in many people following a catastrophic trauma which the individual perceived to be potentially life-threatening for themselves or others. In PTSD, there are recurrent intrusive memories of the trauma which lead to intense anxiety. The person attempts to avoid this by suppressing the memories and avoiding situations that remind them of the trauma.
- Exposure to traumatic event - experiencing, witnessing, or confronting stressful event, which leads to development of intense fear, helplessness or horror

Cardinal Signs and Symptoms: Posttraumatic Stress Disorder

- Person exposed to an event that involved actual or threatened death orinjury to themselves or others
- Person responded with fear and helplessness
- Re-experiencing the event in recollections, dreams, flashbacks
- Intense distress when exposed to stimuli that symbolize the event

- Efforts to avoid any activities that aid in recalling event
- Inability to remember the trauma
- Loss of interest in activities
- Detachment from others
- Blunted affect
- Sleep disturbance
- Irritability and anger
- Concentration impairments
- Hypervigilence

- **Obsessive-Compulsive Disorder (OCD)**: is a condition typically characterized by distressing obsession thoughts or impulses, on the one hand, and compulsive rituals which reduce the anxiety associated with the obsessions, on the other.

Obsession - recurrent and persistent thoughts, impulses, or images

- Experienced as intrusive and inappropriate(ego dystonic) - Person attempts to ignore or suppress
- Mainly aggressive, sexual, religious, metaphysical -philosophical topics

Compulsion - repetitive behavior like Hand washing, ordering things, checking or repetitive mental acts like praying, counting, repeating words silently

- The behavior or mental acts - aimed at preventing or reducing distress or dreaded event
- Patient recognize them as excessive or unreasonable

Cardinal Signs and Symptoms: Obsessive-Compulsive Disorder

- Recurrent thoughts, images or impulses that are intrusive, inappropriate and causes distress
- Person tries to ignore or neutralize them with other thoughts or behavior
- Person recognizes that thoughts are product of their own mind
- Repetitive behaviors that person is driven to perform like counting or hand washing
- The behaviors are ways to reduce distress or some feared event but are nonrealistic

- These obsession and compulsions impair a person's daily functioning

CHILDHOOD MOOD DISORDERS

Our mood involves a pervasive and sustained emotion that colors our perceptions of the world. We feel sadness and joy, anger and anxiety in reaction to our interaction with others, to successes and failures we experience, and in reaction to our internal, psychological self -explorations. Emotions like sadness and joy occur as part of everyday life and occur in reaction to normal life events such as the loss of loved ones, failures and disappointments as well as successes that all of us encounter at some time in our lives. First Responders who face life and death situations on a daily basis are at risk for exaggerated emotional reactions after involvement in a shooting incident, after witnessing catastrophic accidents, or after losing a victim that they have tried to save.

Grief or mild depressive reactions in these situations may result in feelings of guilt, sadness, sleeplessness and restlessness that are quite predictable and likely to resolve quickly. We may experience the "blues," feeling "bummed out" or simply "down" in response to some conflict or frustration in our lives or in reaction to a holiday or anniversary that ignites memories of an earlier sad or traumatic time. All of these reactions and emotions, including sadness and joy, are quite normal and universal and do not usually result in a clinical mood disorder. However, when these mood states are **exaggerated, persistent and recurrent**, when they occur in the absence of any environmental event or stressor, and/or **result in significant social, occupational or interpersonal impairment,** they rise to the level of a clinical and diagnosable disorder.

The Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition (DSM-IV-TR) lists five major mood disorders including:

- Major Depressive Disorder
- Dysthymic Disorder
- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder.

These categories are in addition to depression and mania that are the direct result of certain substances or a general medical

- **MAJOR DEPRESSIVE DISORDER**

The most serious and debilitating depression are called *Major Depressive Disorder* (MDD). Persons suffering from MDD complain of pervasive feelings of sadness and depression that last for a minimum of two weeks and result in significant impairment in daily functioning.

Cardinal Signs and Symptoms: Major Depressive Episode

- *Depressed mood*
- *Loss of pleasure in all activities(anhedonia)*
- *Appetite, sexual and sleep disturbance*
- *Psychomotor agitation or retardation*
- Feelings of worthlessness, hopelessness, frequent crying spells,
- Withdraw from relationships with others, avoid work, and lose all motivation
- Insomnia and disturbed sleep patterns as well as decreased appetite
- Weight loss
- Fatigue and total loss of energy
- *Guilt*
- *Cognitive impairments (i.e. concentration, memory), inability to make decisions*
- *Suicidal thoughts*
- *Impairment in daily functioning*
- *Signs and symptoms for at least 2 weeks*

Some individuals with more severe depressions may experience **psychotic symptoms** during a depressive episode with ***hallucinations (false perceptions) and/or delusions (false beliefs).*** Patients may hear God condemning them for their grave sins or insist that they suffer from poverty when, in fact, they are financially well off.

- ***DYSTHYMIC DISORDER***

Another milder form of depression is called Dysthymic Disorder. This is considered a chronic condition in which the mood problems last a minimum of 2 years with no relief for more than two months at a time. The symptoms are qualitatively the same as in major depression but are not as severe and do not include psychotic episodes, anhedonia, or suicidal preoccupation.

Having dysthymic disorder does not guarantee that individuals will not at some point develop a major depressive episode. In those cases we refer to the clinical picture as “double depression.”

Cardinal Signs and Symptoms: Dysthymic Disorder

- Depressed mood
- Sleep and appetite disturbance
- Fatigue/low energy
- Low self esteem
- Cognitive impairments
- Feelings of hopelessness
- Impairment in daily functioning
- Signs and symptoms for at least 2 years

Dysthymia	**Major depressive episode**
• 2 years in duration • Depressed mood • 2 additional symptom • More cognitive symptom • Onset mild	• 2 weeks in duration • Depressed mood • 4 additional symptom • More vegetative symptom • Onset may be severe

BIPOLAR DISORDERS

Major depression and Dysthymia are often referred to as unipolar mood disorders in contrast to bipolar disorders in which the individual may cycle between different mood states. Once referred to as manic-depressive illness, Bipolar Disorder is characterized by shifts in mood between serious depression and mania, in which the individual experiences feelings of elation, grandiosity, expansiveness or irritability.

When encountering an individual experiencing a manic episode, you are likely to see someone who is extremely talkative, has racing thoughts, and engage in behaviors that are highly pleasure-seeking, including gambling, spending sprees, excessive and indiscriminate sexuality, all of which represents extremely poor judgment. Individuals suffering from mania do not typically feel a need for sleep and are highly distractible. It is difficult to stop or derail them from their activities.

Some people in a manic state engage in criminal behavior, fuelled by their need for immediate gratification, expansive feelings that they can do no wrong, and their overwhelming poor judgment. In some cases individuals may be so disorganized that they experience delusions and or hallucinations.

The DSM-IV-TR recognizes three major types of bipolar spectrum disorders:

- Bipolar I,
- Bipolar II, and
- Cyclothymic Disorders.

In all three, individuals will at some point in the course of their illness experience both ***depressed and elevated or irritable moods***. These differ primarily ***in the severity of the symptoms as well as the degree of impairment in functioning*** the persons may suffer. ***Bipolar I disorder*** requires that individuals must have at least ***one manic episode*** at some point in the course of their lives and that this episode must last ***one week or more***. Even if the person never has another manic episode or all future episodes involve major depression, the diagnosis remains the same.

Bipolar II involves the presence of major depressive episodes in addition to at least one ***hypo manic episode.*** According to the DSM-IV-TR, no manic episode can occur in Bipolar II disorder.

- **Bipolar I Disorder, Manic Episode**

Signs and Symptoms: Bipolar I Disorder, Manic Episode

- Inflated self- esteem or grandiosity
- Decreased need for sleep

- Highly talkative- pressure to talk
- Racing thoughts
- Distractibility- attention to easily drawn
- Flight of ideas or thought racing
- Increased in goal directed activity or psychomotor agitation
- Psychomotor agitation
- Excessive involvement in pleasurable activities with probability of negative consequence

- **Hypomania**

A hypo manic episode is similar to a manic episode, but is:

- Less severe,
- involves no impairment of functioning or psychotic symptoms, and
- Must last at least four days

- **Bipolar II Disorder**

- Presence (or history) of one or more major depressive episodes.
- Presence (or history) of at least one hypo manic episode.
- There has never been a manic episode or a mixed episode.
- 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.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- ***Cyclothymic disorder***

- Is characterized by numerous mild depressed andhypomanic episodes that persist for at least 2 years with no history ofthe more severe manic or major depressive episodes.
- We may describean individual with Cyclothymic disorder as "moody" with no extendedperiods in which they experienced "normal" or euthymic mood.
- Manyindividuals with cyclothymia will go on to develop a full blown bipolardisorder at some point in their lives.

SCHIZOPHRENIA

Schizophrenia is undoubtedly the most well known and most severely debilitating of all the psychiatric illnesses known to people. It will typically have devastating impact on the individual, on his or her family and, indirectly, on society and its gatekeepers.

The general public has many misconceptions about this illness that often lead to increased stigmatization.

- One of the most serious misconceptions is that all persons with schizophrenia are dangerous and violent. The reality is that when properly medicated, treated, and free of alcohol and drugs, persons with this disorder are no more violent or aggressive than anyone else in the general population.
- A second common belief is that schizophrenic patients have a "split personality." Schizophrenia is a term, literally translated as "split mind." It was ***coined by a psychiatrist named Eugen Bleuler*** who was referring to the fact that the schizophrenic's thinking, emotions and behavior are "split" and not integrated, resulting in their often incoherent speech and disorganized behavior. **Split personality more accurately describes what we now call Dissociative Identity Disorder or multiple personality disorder**.

Some mental health professionals reject the unitary term "schizophrenia" and suggest that it represents many different disorders, referring to them as "the schizophrenias" or schizophrenia spectrum disorders. For most patients, however, the disorder results in fluctuating, gradually deteriorating, or relatively stable disturbances in thinking, behavior, and perception.

These disturbances include the presence of the following "**positive" symptoms**

- **Delusions**

A delusion is a false, illogical or bizarre belief about the world that has absolutely no basis in reality. We generally associate mental illness with this type of symptom that may reflect ***paranoid, grandiose, somatic, persecutory or religious*** themes. Schizophrenic delusions are generally bizarre, meaning that it would be impossible for them to be true.

<u>Non-Bizarre Delusions</u>

- **Erotomanic (delusion of love):** Someone with this type of delusional disorder believes that another person, often someone important or famous, is in love with him or her. The person might attempt to contact the object of the delusion, and stalking behavior is not uncommon.
- **Grandiose**: A person with this type of delusional disorder has an over-inflated sense of worth, power, knowledge, or identity. The person might believe he or she has a great talent or has made an important discovery.
- **Jealous:** A person with this type of delusional disorder believes that his or her spouse or sexual partner is unfaithful.
- **Persecutory:** People with this type of delusional disorder believe that they (or someone close to them) are being mistreated, or that someone is spying on them or planning to harm them. It is not uncommon for people with this type of delusional disorder to make repeated complaints to legal authorities.
- **Somatic:** A person with this type of delusional disorder believes that he or she has a physical defect or medical problem.
- **Nihilistic**
- **Mixed:** People with this type of delusional disorder have two or more of the types of delusions listed above.

Bizarre Delusions

Thought insertion, thought withdrawal, thought broadcasting, delusion of control – passivity phenomena

- **Hallucinations**

Hallucinations: in contrast to delusion, hallucination is a false perception of the world in the absence of any physical sensory input. Hallucinations can involve any of the five sensory modalities although ***auditory hallucinations are the most characteristic of schizophrenic patients.***

When patients report false perceptions involving kinesthetic or tactile sensations, olfactory (smell) or even visual hallucinations, the First Responder should consider the possibility that the individual is suffering from an organic or purely physical problem rather than a schizophrenic disorder. Auditory hallucinations often involve:

- voices engaging in a running commentary about the person's behavior
- two or more voices arguing or discussing with one another
- voices criticizing or taunting the individual or
- a voice commanding that the person engage in some behavior.

Command hallucinations are often potentially dangerous when the voice, often God or the Devil, commands that the individual kill himself or someone else.

- **Disorganized Speech And Thought**

Thinking processes and speech are typically disturbed in persons with schizophrenia. Often, schizophrenia has been described as a ***"thought disorder***" as a result of the fact that these individuals think and reason in ways that appear ***incoherent, illogical or impossible to understand.*** First Responders will find that these patients are difficult or impossible to interview. Not only do they lack insight into their difficulties and often deny that they are ill, but they display a variety of characteristic thought disturbances that result in utter confusion for anyone trying to understand them or elicit information.

Common thought disorders

- **Pressured speech:** Rapid speech, which is typical of patients with manic disorder.
- **Poverty of speech:** Minimal responses, such as answering just "yes or no."
- **Blocking:** Sudden cessation of speech, often in the middle of a statement.
- **Flight of ideas:** Accelerated thoughts that jump from idea to idea, typical of mania.
- **Loosening of associations:** Illogical shifting between unrelated topics.
- **Tangentially:** Thought that wanders from the original point.
- **Circumstantiality:** Unnecessary digression, which eventually reaches the point.
- **Echolalia:** Echoing of words and phrases.
- **Neologisms:** Invention of new words by the patient.
- **Clanging:** Speech based on sound, such as rhyming and punning rather than logical connections.
- **Perseveration:** Repetition of phrases or words in the flow of speech.

- **Ideas of reference:** Interpreting unrelated events as having direct reference to the patient, such as believing that the television is talking specifically to them.
    - **Disorganized or catatonic motor behavior**: stupor, mannerism, posturing, echopraxia, e
    - **Incongruity of affect** - smile, giggle for no reason

And negative symptoms

- **Alogia** – poverty of speech – amount, content
- **Affective flattening**
- **Anhedonia** – inability to experience pleasure
- **Asociality** – few social contact social(withdrawal)
- **Avoliton/Apathy** – lack of energy, decreased motivation
- **Attentional impairment** - absentmindedness

The **"positive" symptoms** are what we generally understand to represent the "psychotic" state. It is important to understand that while persons diagnosed with this disorder are likely to suffer chronically from schizophrenia, when stabilized they will not be "psychotic." In other words, psychosis is a "state" that is often present in this as well as other serious psychiatric and medical disorders, but it is not synonymous with them.

The description of the positive symptoms above is usually associated with the psychotic disorganization that frequently will bring the individual with schizophrenia to the attention of the First Responder. Some patients may initially appear stable but, with the stress of the crisis situation, may later decompensate. It is in this state or the active phase of the illness that persons can be dangerous to themselves and a threat to other citizens or so disabled that they are unable to care for themselves.

Negative symptoms sometimes referred to as the "defect state," involve characteristics that reflect the absence or insufficiency of normal behavior. The ***"negative" symptoms*** tend to be more chronic, more difficult to treat and more seriously debilitating in terms of social, occupational and interpersonal functioning.

Social and occupational deterioration

- Work inhibition
- Poor interpersonal relationship, social withdrawal
- Poor self-care – unkempt, bizarre clothing
- Decreased level of achievement –academic etc.
- Breaking social rules – table manner, obscenities, collecting garbage

Criteria "A" of schizophrenia: Two or more:

- Delusions
- Hallucinations
- Disorganized speech (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior
- Negative symptoms, i.e., affective flattening, alogia, or avolition

Criteria "B" of schizophrenia

***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
    - when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement

Criteria "C" of schizophrenia

***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

Subtypes of Schizophrenia

In order to better understand and treat schizophrenia, clinicians and researchers have developed subtypes of this disorder, each with its distinct signs and symptoms, yet all sharing much of the core clinical picture described above.

The fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-TR) lists five subtypes of schizophrenia:

- paranoid,
- disorganized
- catatonic,
- undifferentiated, and
- Residual.