1. Details of Module and its structure

Module Detail	
Subject Name	Psychology
Course Name	Psychology 03 (Class XII, Semester - 1)
Module Name/Title	Psychological Disorders – Part 3
Module Id	lepy_10403
Pre-requisites	Classification of Psychological Disorders & Various factors underlying the disorder.
Objectives	After going through this lesson, the learner would be able to: • Understand the types of psychological disorders. • Understand Trauma – Stress Related Disorders • Somatic Symptom and Related Disorders • Dissociative Disorders • Depressive Disorders • Bipolar and Related Disorders • Schizophrenia spectrum and other Psychotic Disorders
Keywords	Trauma and Stressor Related Disorders, Post–Traumatic Stress Disorder, Somatic Symptom and Related Disorders, Illness Anxiety disorder, Conversion Disorders, Dissociative Disorders, Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder, Depersonalisation/ Derealisation Disorder, Depressive Disorders, Depression, Bipolar and Related Disorders, Schizophrenia Spectrum and other Psychotic Disorders

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Trauma- and Stressor-Related Disorders

Very often people who have been caught in a natural disaster (such as tsunami) or have been victims of bomb blasts by terrorists or been in a serious accident or in a war-related situation, experience **post-traumatic stress disorder (PTSD).** PTSD symptoms vary widely but may include recurrent dreams, flashbacks (involuntary recurrent dreams of the past), impaired concentration, and emotional numbing (a loss of interest in important activities and feeling distant from others.) Adjustment disorders and Acute stress disorder are also included under this category.

Introduction

Adjustment Disorders:

Adjustment disorders are disorders in which a person experiences more stress than normal in response to a stressful event. Work problems, relationship problems, terminal illness, death of a family member, a natural disaster or any number of changes can cause stress to people.

When people continue to have emotional or behavioural symptoms in reaction to a stress or, it leads to adjustment disorder. These disorders are associated with increased risk of suicide attempt.

Acute Stress Disorder:

It is developed when a person is exposed to traumatic events. The symptoms may develop after an individual experiences/ witnesses a disturbing event, like a threat or actual death, serious injury or sexual violation. This disorder is characterised by the presence of symptoms like intrusive memories, negative mood, dissociation, avoidance or arousal during the first month after a traumatic event.

Somatic Symptom and Related Disorders

Meena, a 53 year old married, unemployed woman with unspecified pain syndrome of the nose was transferred to the hospital after a suicide attempt. For 3 years prior to her suicide attempts the patient had been experiencing constant tearing and bilateral pain from the surface of the nose.

The patient sought professional medical help but her pain symptoms did not reduce. Slowly, her ability to function drastically declined and she discontinued her once beloved athletic endeavours because she felt limited by pain, had minimal appetite, low energy, reduced ability to concentrate and remained passive. One psychiatrist diagnosed her pain as psychogenic in nature.

As one can identify from the above case, Somatic Symptom and Related Disorders are conditions in which there are physical symptoms in the absence of a physical disease. In these disorders, the individual has psychological difficulties and complains of physical symptoms, for which there is no biological cause. These include Conversion disorders, Somatic symptom disorder, and Illness Anxiety disorder among others.

Somatic symptom disorder involves a person having persistent body-related symptoms which may or may not be related to any serious medical condition. People with this disorder tend to be overly preoccupied with their symptoms and they continually worry about their health and make frequent visits to doctors. As a result, they experience significant distress and disturbances in their daily life.

Illness anxiety disorder involves persistent preoccupation about developing a serious illness and constantly worrying about this possibility. This is accompanied by anxiety about one's health. Individuals with illness anxiety disorder are overly concerned about undiagnosed disease, negative diagnostic results, do not respond to assurance by doctors, and are easily alarmed about illness such as on hearing about someone else's ill-health or some such news. In general, both Somatic symptom disorder and Illness Anxiety disorder are concerned with medical illnesses. But the difference lies in the way this concern is expressed. In the case of Somatic symptom disorder, this expression is in terms of physical complaints while in case of Illness Anxiety disorder, as the name suggests, it is the anxiety which is the main concern.

Conversion Disorders: a case vignette

A boy of 15 was referred for investigation with varying symptoms of nausea, weakness, abrupt sleep pattern and inability to use the right hand. He had not attended school since the onset of his illness and had undergone extensive investigation. He was noted to walk in a staggering manner. His right hand was rendered unmovable. Systematic detailed clinical examination showed no neurological abnormality. A tentative diagnosis of conversion disorder was made. Slowly before the onset of his illness he had not been able to achieve high academic expectations and his favourite subject teacher had humiliated him by rejecting classwork he had done and throwing his workbook on the floor. Psychotherapy was then iniated with gradual improvement and he became confident and well-enough to return school.

The symptoms of **conversion disorders** are the reported loss of part or all of some basic body functions. Paralysis, blindness, deafness and difficulty in walking are generally among the symptoms reported. These symptoms often occur after a stressful experience and may be quite sudden.

Dissociative Disorders

a) Dissociation can be viewed as severance of the connections between ideas and emotions. Dissociation involves feelings of unreality, estrangement (alienation), depersonalisation, and sometimes a loss or shift of identity. Sudden temporary alterations of consciousness that blot out painful experiences are a defining characteristic of dissociative disorders. Conditions included in this are **Dissociative Amnesia, Dissociative Identity Disorder, and Depersonalisation/Derealisation Disorder**.

SALIENT FEATURES OF SOMATIC SYMPTOM AND RELATED DISORDERS AND DISSOCIATIVE DISORDERS

Salient Features of Somatic Symptom and Related Disorders and Dissociative Disorders	
Somatic Symptom and Related Disorders	*Dissociative Disorders*
Somatic Symptom Disorder : The person experiences body-related symptoms in the absence of any medical condition (or even if medical condition is present, it is not as serious as the symptoms presented).	*Dissociative amnesia* : The person is unable to recall important, personal information often related to a stressful and traumatic report. The extent of forgetting is beyond normal.
Illness Anxiety Disorder : The person experiences worry about the possibility of developing a serious medical condition.	*Depersonalisation/Derealisation Disorder* : The person experiences a change in the person's sense of reality and perception of self.
Conversion : The person suffers from a loss or impairment of motor or sensory function (e.g., paralysis, blindness, etc.) that has no physical cause but may be a response to stress and psychological problems.	*Dissociative identity (multiple personality) Disorder* : The person exhibits two or more separate and contrasting personalities, generally associated with a history of abuse.

Dissociative amnesia is characterised by extensive but selective memory loss that has no known organic cause (e.g., head injury). Some people cannot remember anything about their past. Others can no longer recall specific events, people, places, or objects, while their memory for other events remains intact. A part of dissociative amnesia is **dissociative fugue**. Essential feature of this could be an unexpected travel away from home and workplace, the assumption of a new identity, and the inability to recall the previous identity. The fugue usually ends when the person suddenly 'wakes up' with no memory of the events that occurred during the fugue. This disorder is often associated with an overwhelming stress.

Case:

A man called B vanished without a trace, two weeks later, looking more like a teenager in boxer shorts wearing a child-like cap, he was found by the police in a nearby township. The wife back home was summoned to the police station, on seeing the wife he asked, 'Who are you'? He did not remember anything of his life that was two weeks ago. Through psychotherapy he recalled that he had left the town with enough money to buy a ticket to his hometown of childhood.

Dissociative Identity Disorder, often referred to as multiple personality, is the most dramatic of the dissociative disorders. It is often associated with traumatic experiences in childhood. In this disorder, the person assumes alternate personalities that may or may not be aware of each other.

Depersonalisation / Derealisation disorder involves a dreamlike state in which the person has a sense of being separated both from self and from reality. In depersonalisation, there is a change of self-perception, and the person's sense of reality is temporarily lost or changed.

Depressive Disorders

One of the most widely prevalent and recognised of all mental disorders is depression. Depression covers a variety of negative moods and behavioural changes. Depression can refer to a symptom or a disorder. In day-to-day life, we often use the term depression to refer to normal feelings after a significant loss, such as the break-up of a relationship, or the failure to attain a significant goal. Major depressive disorder is defined as a period of depressed mood and/or loss of interest or pleasure in most activities, together with other symptoms which may include change in body weight, constant sleep problems, tiredness, inability to think clearly, agitation, greatly slowed behaviour, and thoughts of death and suicide. Other symptoms include excessive guilt or feelings of worthlessness.

Factors Predisposing towards Depression:

- Genetic make-up, or heredity is an important risk factor for major depression and other depressive disorders.
- Age is also a risk factor. For instance, women are particularly at risk during young adulthood, while for men the risk is highest in early middle age.
- Similarly gender also plays a great role in this differential risk addition. For example, women in comparison to men are more likely to report a depressive disorder.
- Other risk factors are experiencing negative life events and lack of social support.

Bipolar and Related Disorders

Bipolar I disorder involves both mania (mental illness marked by periods of great excitement or euphoria, delusions and over-activity) and depression, which are alternately present and

sometimes interrupted by periods of normal mood. Manic episodes rarely appear by themselves; they usually alternate with depression.

Bipolar mood disorders were earlier referred to as Manic-Depressive Disorders.
Some examples of types of bipolar and related disorders include Bipolar I Disorder (Manic Depressive Disorder), Bipolar II disorder (is similar to Bipolar I with mood cycling between high and low. However, it is less intense) Cyclothymic Disorder (a relatively mild mood disorder. The low and high mood swings never reach the severity or duration of major depressive or full mania episodes.)

Case:

Mrs M was first admitted to a mental hospital at age 38, even as a child she had experienced extreme mood swings. At 30, just before the birth of her first child, she had become very depressed but soon after the child was born, she became euphoric and agitated. She bought an apartment and piled up loans. Over the years the phases of mania and depression continued to increase and finally she needed hospitalization.

Severe depression and few other psychological disorders can cause individuals to want to end their lives, but every suicide is a misfortune. Suicide is a result of complex interface of biological, genetic, psychological, sociological, cultural and environmental factors. Some other risk factors are having mental disorders (especially depression and alcohol use disorders), going through natural disasters, experiencing violence, abuse or loss and isolation at any stage of life. Previous suicidal attempt is the strongest risk factor.

Often, suicidal behaviour indicates difficulties in problem-solving, stress management, and emotional expression. Suicidal thoughts lead to suicidal action only when acting on these thoughts seems to be the only way out of a person’s difficulties. These thoughts are heightened under acute emotional and other distress. The ramifications of suicide on social circle and communities tend to be devastating and long-lasting. The stigma surrounding suicide continues despite recent advances in research in this field. Due to this, many people who are contemplating or even attempting suicide do not seek help thus, preventing timely help from reaching them.

If someone threatens suicide, then:

What to do	**What not to do**
Ask direct straightforward questions in a calm manner	Do not ignore warning signs.
Be a good listener	Do not refuse to talk about suicide if the person concerned wants to talk about it.
Take every suicide threat very seriously	Do not react with horror or disapproval
Encourage person to seek professional help.	Do not abandon the person after the crisis passes or even after professional counselling has started.

Therefore, improving identification, referral, and management of behaviour are crucial for preventing suicide. We need to identify vulnerability; comprehend the circumstances leading to such behaviour and accordingly plan interventions as suicides are preventable. There is a need for comprehensive multi-sectoral approach where the government, media and civil society all play important role as stakeholders.

Some measures suggested by WHO include:

1. Limiting access to the means of suicide;
2. Reporting of suicide by media in a responsible way;
3. Bringing in alcohol-related policies;
4. Early identification, treatment and care of people at risk;
5. Training health workers in assessing and managing for suicide;
6. Care for people who attempted suicide and providing community support.

Identifying students in distress: Any unexpected or striking change affecting the adolescent's performance, attendance or behaviour should be taken seriously, such as:

1. Lack of interest in common activities
2. Declining grades
3. Decreasing effort
4. Misbehaviour in the classroom
5. Mysterious or repeated absence
6. Smoking or drinking, or drug misuse

Strengthening students' self-esteem: Having a positive self-esteem is important in face of distress and helps in coping adequately. In order to foster positive self- esteem in children the following approaches can be useful:

i. Accentuating positive life experiences to develop positive identity. This increases confidence in self.
ii. Providing opportunities for development of physical, social and vocational skills.
iii. Establishing a trustful communication.
iv. Goals for the students should be specific, measurable, achievable, relevant, to be completed within a relevant time frame.

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia (translates roughly as "splitting of the mind") is the descriptive term for a group of psychotic (severe mental disorders) disorders in which personal, social and occupational functioning deteriorate as a result of disturbed thought processes, strange perceptions, unusual emotional states, and motor abnormalities. It is a debilitating disorder. The social and psychological costs of schizophrenia are tremendous, both to patients as well as to their families and society.

Symptoms of Schizophrenia

The symptoms of schizophrenia can be grouped into three categories, viz. **positive symptoms** (i.e. excesses or exaggeration of thought, emotion, and behaviour, where the person can't tell what's real form what isn't), **negative symptoms** (i.e. deficits or absence of thought, emotion, and behaviour), and **psychomotor symptoms**.

Positive symptoms are 'pathological excesses' or 'bizarre additions' to a person's behaviour. Delusions, disorganised thinking and speech, heightened perception and hallucinations, and inappropriate affect are the ones most often found in schizophrenia.

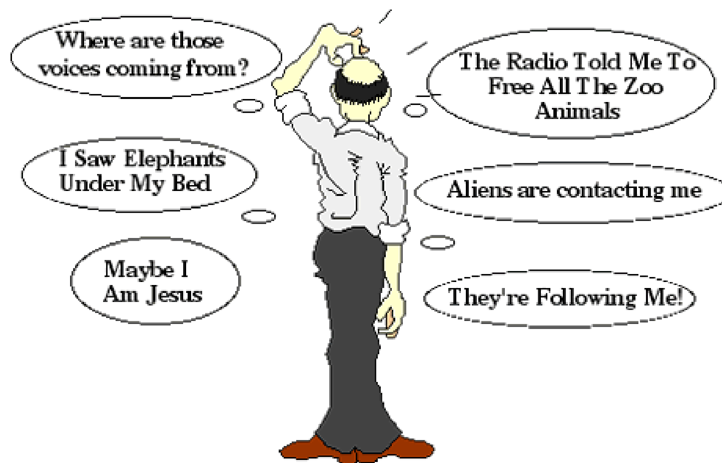
Many people with schizophrenia develop **delusions**. A delusion is a false belief that is firmly held on inadequate grounds. It is not affected by rational argument and has no basis.

Delusions of persecution are the most common in schizophrenia. People with this delusion believe that they are being plotted against, spied on, slandered (false spoken statement about someone that damages ones reputation), threatened, attacked or deliberately victimised.
People with schizophrenia may also experience **delusions of reference** in which they attach special and personal meaning to the actions of others or to objects and events.

In delusions of grandeur, people believe themselves to be specially empowered persons and in **delusions of control**, they believe that their feelings, thoughts and actions are controlled by others.

People with schizophrenia may not be able to think logically and may speak in peculiar ways. These formal thought disorders can make communication extremely difficult. These include rapidly shifting from one topic to another so that the normal structure of thinking is muddled and becomes illogical (loosening of associations, **Derailment**), inventing new words or phrases (**neologisms**), and persistent and inappropriate repetition of the same thoughts (**perseveration**).

People with schizophrenia may develop **hallucinations**, i.e. perceptions that occur in the absence of external stimuli. **Auditory hallucinations** are most common in schizophrenia. Patients hear sounds or voices that speak words, phrases and sentences directly to the patient (second-person hallucination) or talk to one another referring to the patient as s/he (third-person hallucination). Hallucinations can also involve the other senses. These include **tactile hallucinations** (i.e. forms of tingling, burning), **somatic hallucinations** (i.e. something happening inside the body such as a snake crawling inside one's stomach), **visual hallucinations** (i.e. vague perceptions of colour or distinct visions of people or objects), **gustatory hallucinations** (i.e. food or drink taste strange), and **olfactory hallucinations** (i.e. smell of poison or smoke). People with schizophrenia also show **inappropriate affect**, i.e. emotions that are unsuited to the situation.



Negative symptoms are 'pathological deficits' and include poverty of speech, blunted and flat affect, loss of volition, and social withdrawal. People with schizophrenia show **alogia** or poverty of speech, i.e. a reduction in speech and speech content. Many people with schizophrenia show less anger, sadness, joy, and other feelings than most people do. Thus, they have **blunted affect**. Some show no emotions at all, a condition known as **flat affect**. Also, patients with schizophrenia experience **avolition,** or apathy and an inability to start or complete a course of action. People with this disorder may withdraw socially and become totally focused on their own ideas and fantasies.

People with schizophrenia also show psychomotor symptoms. They move less spontaneously or make odd grimaces and gestures. These symptoms may take extreme forms known as catatonia. People in a catatonic stupor remain motionless and silent for long stretches of time. Some show catatonic rigidity, i.e. maintaining a rigid, upright posture for hours. Others exhibit catatonic posturing, i.e. assuming awkward, bizarre positions for long periods of time.