CHALIMBANA UNIVERSITY

Integrity, Service, Excellence.

DIRECTORATE OF DISTANCE EDUCATION

PYS 2200: ABNORMAL PSYCHOLOGY

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COURSE AIMS

The aim of this course is to equip students with an understanding of causes, symptoms and treatment of various disorders.

COURSE OUTCOMES

By the end of the course, students should be able to:

- evaluate criteria for abnormal behavior and specific psychological disorders
- diagnose common psychological disorders,
- describe common explanations for the etiology of psychological disorders, Analyse effective treatments for psychological disorders.
- Demonstrate an understanding of the origin, development, nature, basic concepts, theoretical and methodological issues in abnormal psychology.

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Study skills

As an adult learner, your approach to learning will be different to that of your school days you will choose when you want to study. You will have professional and/or personal motivation for doing so and you will most likely be fitting your activities around other professional or domestic responsibilities.

Essentially you will be taking control of your learning environment. As a consequence, you will need to consider performance issues related to time management, goals setting, stress management, etc. perhaps you will also need to reacquaint yourself in areas such as essay planning, coping with examinations and using the internet as a learning source.

Your most significant considerations will be time and space i.e. the time you dedicate to your learning and the environment in which you engage in that learning. It is recommended that you take time now before starting your self-study to familiarise yourself with these issues. There are a number of excellent resources on the web. A few suggested links are: http://www.how-to-study.com/ and http://www.ucc.vt.edu/stdysk/stdyhlp.html

Time frame

You are expected to spend at least three terms of your time to study this module. In addition, there shall be arranged contact sessions with lecturers from the University during residential possibly in April, August and December. You are requested to spend your time carefully so that you reap maximum benefits from the course. Listed below are the components of the course, what you have to do and suggestions as to how you should allocate your time to each unit in order that you may complete the course successfully and no time.

Course Materials

Text books and module.

Need help

In case you have difficulties in studying this module don't hesitate to get in touch with your lecturers. You can contact them during week days from 08:00 t0 17:00 hours. Mr Moono Maurice mmoono.75@gmail.com Tutorial Room 3,. You are also free to utilise the services of the University Library which opens from 08:00 hours to 20:00 hours every working day.

Assessment

Continuous	50%
One Assignment	25%

One Test	25%
Final Examination	50%
Total	100%

UNIT 1: HISTORICAL VIEWS OF ABNORMAL BEHAVIOR

1.1 Introduction

Abnormal Psychology is one of the most important and popular sub-field of Applied Psychology. This unit describes how the subject originated and how it evolved and developed. The purpose of this unit is to provide an insight into the historical trajectory of Abnormal Psychology. You will also learn about four major approaches to the study of abnormal behaviour.

This branch of psychology has a very fascinating history and so many people have tried

to explain and control abnormal behavior for thousands of years. As the results, historically, there have been three main models and five main Eras to Abnormal Behavior. We will now take you through the historical eras of abnormal psychology. As you read through pay particular attention to different eras and their understanding of abnormal behaviour.

1.2 Learning outcomes

By the end of this unit, you are expected to:

- Discuss different perspectives in the study of studying abnormal behavior
- Describe various disorders
- Explain the diagnosis, treatment of psychological disorders
- Analyze the history of abnormal Psychology

1.3 Historical Eras:

We will now take you through various eras of explanations of abnormal behaviour as you read through, critically evaluate each era in your note pad discuss your observations with your friend.

1.3.1 Super natural Model (Demonology, Gods, and Magic)

References to abnormal behavior in early writings show that the Ancient Chinese, Ancient Egyptians, Ancient Hebrews, and Ancient Greeks often attributed such behavior to a demon, Spirits or god who had taken possession of a person.

The decision as to whether the "possession" involved good spirits or evil spirits usually depended on an individual's symptoms. If a person's speech or behavior appeared to have a religious or mystical significance, it was usually thought that he or she was possessed by a good spirit or god. Such people were often treated with considerable awe and respect, for it was thought that they had supernatural powers.

Most possessions, however, were considered to be the work of an angry god or an evil spirit, particularly when a person became excited or overactive and engaged in behavior contrary to religious teachings. Do you agree with this explanation if not why?

The primary type of treatment for demonic possession was Trephining and exorcism, which included various techniques for casting an evil spirit out of an afflicted person. These techniques varied considerably but typically included magic, prayer, incantation, noisemaking, and the use of various horrible-tasting concoctions, such as purgatives made from sheep's dung and wine. More sever measures, such as starving or flogging, were sometimes used in extreme cases to make the body of a possessed person such an unpleasant place that an evil spirit would be driven out. Exorcism is one of the ancient methods to release evil spirits from patient's body. Exorcism was originally the task of healers or persons regarded as having healing powers. In this historical period, human skull have been found from as long as ago as the stone age with areas removed by a method of surgery that involved making circular holes in the skull with stone tools, that method was "Trephining" was a performed on those who had mental illness to literally cut the evil spirits out of the victims body. What do you think were the dangers of this type of exorcism of demons? Do you think these practices still exist in Zambia?

As you can see from the above explanations in the super natural tradition also called as the demonological method, abnormal behavior is attributed to the agent outside human bodies and according to this model abnormal behaviors are caused by demons.

1.3.2 Biological Model (Somatogenic) / Hippocrates, Early Medical Concept

We will now look at the second approach to the explanation of abnormal behavior. Hippocrates denied that gods and demons intervened in the development of illnesses and insisted that mental disorders had natural causes and required treatments like other diseases. He believed that the brain was the central organ of intellectual activity and that mental disorders were due to brain pathology. He also emphasized the importance of heredity and predisposition and pointed out that injuries to the head could cause sensory and motor disorders.

Hippocrates classified all mental disorder into three general categories-mania, melancholia, and phrenitis (brain fever) – and gave detailed clinical descriptions of the specific disorders included in each category. For the treatment of melancholia, for example, he prescribed a regular and tranquil life, sobriety and abstinence from all excesses, a vegetable diet, celibacy, exercise short of and bleeding if indicated. Pause here and check in the dictionary the meaning of melancholia, mania and phrenitis. Now that you know the meaning of these word continue following the argument of Hippocrates.

Hippocrates had little knowledge of physiology. He believed that hysteria (the appearance of physical illness in the absence of organic pathology) was restricted to women and was caused by the uterus wandering to various parts of the body, pining for children. for this “disease”, Hippocrates recommended marriage as the best remedy. He also believed in the existence of four bodily fluids or humors – blood, black bile, yellow bile, and phlegm.
After reading Hippocrates’ views do you think his thinking has some scientific backing?

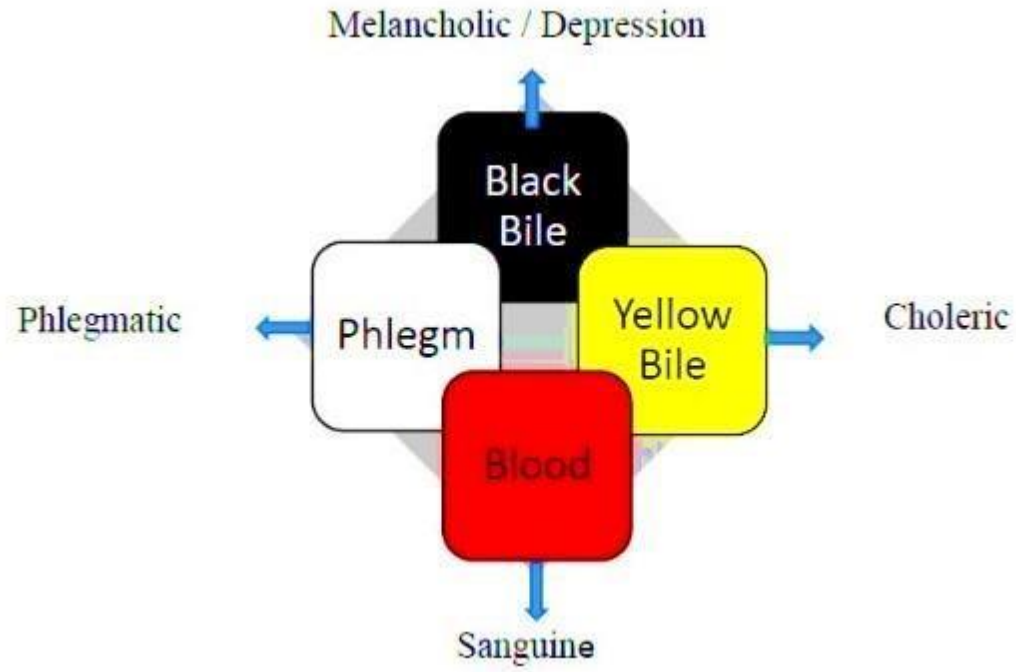
1.3.3 Later Greek and Roman Thought

Hippocrates’ work was continued by some of the later Greek and Roman physicians. Pleasant surroundings were considered of great therapeutic value for mental patients, who were provided with constant activities, including parties, dances, walks in the temple gardens, rowing along the Nile, and musical concerts.

One of the most influential Greek physicians was Galen (A.D 130-200), who practiced in

Rome. He made a new theory as "the humoral theory of abnormal behavior" it was based Hippocrates believes and after that Galan also believed abnormal behaviors are based on these four humor.

Illustration of Galan four humors explained above



Moreover, Galan made a Number of original contributions the anatomy of the nervous system. Galen also maintained a scientific approach to the field, dividing the causes of psychological disorders into physical and mental categories. Among the causes he named were injuries to the head, alcoholic excess, shock, fear, adolescence, menstrual changes, economic reverses, and disappointment in love.

Roman physicians wanted to make their patients comfortable and thus used pleasant physical Therapies, such as warm baths and massages. They also followed the principle of *contraries* (opposite by opposite) – for example, having their patients chilled wine they were in a warm tub. **"**Dark Ages**"** in the history of abnormal psychology began much earlier, with Galen's death in A. D. 200. The contributions of Hippocrates and the later Greek and Roman physicians were soon lost in the welter of popular superstition.

1.3.4 Views of Abnormality During The Middle Ages

During the Middle Ages, the more scientific aspects of Greek medicine survived in the Islamic Countries of the Middle East. The first mental hospital was established in Baghdad in A. D 792; it was soon followed by others in Damascus and Aleppo (Polvan, 1969). In these hospitals, the mentally disturbed individuals received humane treatment. The outstanding figure in Islamic medicine was Avicenna from Arabia (c. 980-1037), called the "prince of physicians" (Campbell, 1926) and author of *The Canon of Medicine,* perhaps the most widely studied medical work ever written. In his writings, Avicenna frequently referred to hysteria, epilepsy, manic reactions, and melancholia.

During the Middle Ages in Europe (c. 500- 1500), scientific inquiry into abnormal behavior was limited, and the treatment of psychologically disturbed individuals was more often characterized by ritual or superstition than by attempts to understand an individual's condition.

Mental disorders were quite prevalent throughout the middle Ages in Europe. During this time, supernatural explanations of the causes of mental illness grew in popularity.

During the last half of the middle Ages in Europe, a peculiar trend emerged in efforts to understand abnormal behavior. It involved mass madness- the widespread occurrence of group behavior disorders that were apparently cases of hysteria. Whole groups of people were affected simultaneously. Dancing Manias (epidemics of raving, jumping, dancing, and convulsions) were reported as early as the tenth century. One such episode, occurring in Italy early in the thirteenth century was known as tarantism. This dancing mania later spread to Germany and the rest of Europe, where it was known as Saint Vitus's dance**.**

Isolated rural areas were also afflicted with outbreaks of Lycanthropy- a condition in which people believed themselves to be possessed by wolves and imitated their behavior.

Exorcism and Witchcraft, in the middle Ages in Europe, management of the mentally disturbed was left largely to the clergy. During the early part of the medieval period, the mentally disturbed were, for the most part, treated with considerable kindness.
"Treatment" consisted of prayer, holy water, sanctified ointments, the breath or spittle of the priests, the touching of relics, visits to holy places, and mild forms of **exorcism.**

1.3.5 Toward Humanitarian Approaches

During the latter part of the Middle Ages and the early Renaissance, scientific questioning Reemerged and a movement emphasizing the importance of specifically human interests and concerns began-a movement (still with us today) that can be loosely referred to as humanism.

1.3.6 The Resurgence of Scientific Questioning in Europe

Paracelsus, a Swiss physician (1490-1541), was an early critic of superstitious beliefs about possession. He insisted that the dancing mania was not a possession but a form of disease, and that it should be treated as such. Although Paracelsus rejected demonology, his view of abnormal

Behavior was colored by his belief in astral influence (lunatic is derived from the Latin word *Luna* or "moon"). He was convinced that the moon exercised a supernatural influence over the brain an idea, incidentally, that persists among some people today.

During the sixteenth century, Teresa of Avila (1515-1582) a Spanish nun who was later canonized, made an extraordinary conceptual leap that has influenced thinking to the present day. Teresa, in charge of a group of cloistered nuns who had become hysterical and were therefore in danger from the Spanish Inquisition, argued convincingly that her nuns were not possessed but rather were "as if sick" (*comas enfermas).* Apparently, she did not mean that they were sick of body. Rather, in the expression 'as if," we have what is perhaps the first suggestion that a mind can be ill just as a body can be ill?

Johann Weyer (1515-1588), a German physician and writer who wrote under the Latin name of Joannus Wirus, was so deeply disturbed by the imprisonment, torture, and burning of people accused of witchcraft that he made a careful study of the entire problem. About 1563 he published a book, *The Deception of Demons,* which contains a step- by-step rebuttal of the *Malleus Malefic arum,* a witch-hunting handbook published in 1486 for use in recognizing and dealing with those suspected of being witches. Weyer was one of the first physicians to specialize in mental disorders.

1.3.7 The Establishment of Early Asylums and Shrines

From the sixteenth century on, special institutions called **asylums**, meant solely for the care of the mentally ill grew in number. Although the scientific inquiry into understanding abnormal behavior was on the increase, bearliest asylums, often referred to as madhouses, were not pleasant places or storage places for the insane.

These early asylums were primarily modifications of penal institutions, and the inmates were treated more like beasts than like human beings.

1.3.8 Humanitarian Reform

The humanitarian treatment of patients received great impetus from the work of Philippe Pinel (1745-1826) in France.

Pinel's Experiment

In 1792, shortly after the first phase of the French Revolution, Pinel was placed in charge of LaBicetre in Paris. In this capacity, he received the grudging permission of the Revolutionary Commune to remove the chains from some of the inmates as an experiment to test his views that mental patients should be treated with kindness and consideration-as sick people, not as vicious beasts or criminals. Had his experiment proved a failure, Pinel might have lost his head, but fortunately, it was a great success. Chains were removed; sunny rooms were provided; patients were permitted to exercise on the hospital grounds; and kindness was extended to these poor beings, some of whom had been chained in dungeons for 30 years or more. Jean Esquirol (1772- 1840), continued Pinel's good work at La Salpetriere and, in addition, helped establish ten new mental hospitals.

William Tuke's Work in England

At about the same time that Pinel was reforming La Bicetre, an English Quaker named William Tuke (1732-1822) established the York Retreat, a pleasant county house where mental patients lived, worked, and rested in a kindly religious atmosphere.

Benjamin Rush and Moral Management in America

The success of Pinel's and Tuke's humanitarian experiments revolutionized the treatment of mental patients throughout the Western world. In the United States, this revolution was reflected in the work of Benjamin Rush(1745-1813), the founder of American psychiatry, Rush encouraged more humane treatment of the mentally ill; wrote the first systematic treatise on psychiatry in America, *Medical Inquiries and Observations upon the Diseases of the Mind (1812); and was the first American to organize a course in Psychiatry.*

During the early part of this period of humanitarian reform, the use of **moral management**– a wide-ranging method of treatment that focused on a patient's social, individual, and occupational needs-became relatively widespread.

Dorathea Dix and the Mental Hygiene Movement

Dorothea Dix (1809-1887) was an energetic New England schoolteacher who became a champion of poor and "forgotten" people in prisons and mental institutions for decades during the nineteenth century.

1.3.9 Nineteenth-Century Views of the Causes and Treatment of Mental Disorders

In the early part of the nineteenth century, mental hospitals were controlled essentially by lay persons because of the prominence of moral management in the treatment of "lunatics." Medical professionals-or *alienists,* as psychiatrists were called at this time in reference to treating the "alienated", or insane-had a relatively inconsequential role in the care of the insane and management of the asylums of the day. Effective treatments for mental disorders were unavailable, however, during the latter part of the century, alienists gained control of the insane asylums and incorporated the traditional moral management therapy into their other rudimentary physical-medical procedures.

Changing Attitudes Toward Mental Health in the Early Twentieth Century

In America, the pioneering work of Dix was followed by that of Clifford Beers (18761943), whose book *A Mind That Found Itself was published in* 1908.

1.3.10 The Beginning of the Modern Era

1.3.10.1 Brain Pathology as a Causal Factor

With the emergence of modern experimental science in the early part of the eighteenth century, knowledge of anatomy, physiology, neurology, chemistry, and general medicine increased rapidly. These advances led to the gradual identification of the biological, or organic, pathology underlying many physical ailments Scientists began to focus on diseased body organs as the cause of physical ailments. It was only another step for these researchers to assume that mental disorder was an illness based on the pathology of an organ-in this case, the brain.

1.3.10.2 The Beginnings of a Classification System

Emil Kraepelin (1856-1926) played a dominant role in the early development of the biological viewpoint. The most important of these contributions was his system of classification of mental disorders, which became the forerunner of today's DSM-V.

1.3.10.3 Establishing the Psychological Basis of Mental Disorder

Despite the emphasis on biological research, understanding of the psychological factors in mental disorders was progressing, too, with the first major steps being taken by Sigmund Freud (1856- 1939), generally acknowledged as the most frequently cited psychological theorist of the twentieth century. Freud developed a comprehensive theory of psychopathology that emphasized the inner dynamics of unconscious motives (often referred to as *psychodynamics*) that are at the heart of the psychoanalytic perspective. The methods he used to study and treat patients came to be called psychoanalysis.

Mesmerism our efforts to understand the psychological causation of mental disorder start with Franz Anton Mesmer (1734-1815), an Austrian physician who further developed Paracelsus' ideas about the influence of the planets on the human body. Mesmer believed that the planets affected a universal magnetic fluid in the body, the distribution of which determined health or disease. In attempting to find cures for mental disorders, Mesmer concluded that all people possessed magnetic forces that could be used to influence the distribution of the magnetic fluid in other people, thus effecting cures.

The Beginnings of psychoanalysis the first systematic attempt to answer this question was made by Sigmund Freud (1856-1939). Freud directed his patients to talk freely about their problems while under hypnosis. The patients usually displayed considerable emotion, and on awakening from their hypnotic states felt a significant emotional release, which was called a catharsis. This simple innovation in the use of hypnosis proved to be great significance. It was this approach that thus led the discovery of the unconscious- that portion of the mind that contains experience of which a person is unaware-and with it the belief that processes outside of a person's awareness can play an important role in the determination of behavior. Two related methods allowed him to understand patients' conscious and unconscious thought processes. One method, free association**,** involved having patients talk freely about themselves, thereby providing information about their feelings, motives, and so forth. A second method, dream analysis**,** involved having patients record and describe their dreams. These techniques helped analysts and patients gain insights and achieve a more adequate understanding of emotional problems.

The Early Psychological Laboratories in 1879 Wilhelm Wundt established the first experimental psychology laboratory at the University of Leipzig. Lightner Witmer (18671956), combined research with application and established the first American psychological clinic at the University of Pennsylvania. Witmer, considered to be the founder of clinical psychology (McReynolds, 1996, 1997), was influential in encouraging others to become involved in the new profession.

The behavioral perspective is organized around a central theme; the role of learning in human behavior.

Classical Conditioning The origins of the behavioral view of abnormal behavior and its treatment are tied to experimental work on the form of learning known as **classical** conditioning. This work began with the discovery of the conditioned reflex by Russian physiologist Ivan Pavlov. Watson thus changed the focus of psychology to the study of overt behavior, an approach he called behaviorism.

Operant Conditioning While Pavlov and Watson studying antecedent stimulus conditions and their relation to behavioral responses, E. L. Thorndike (1874-1949) and subsequently B.F. Skinner (1904-1990) were exploring a different kind of conditioning – one in which the

consequences of behavior influence behavior. Behavior that operates on the environment may be instrumental in producing certain outcomes, and those outcomes, in turn, determine the likelihood that the behavior will be repeated on similar occasions.

This is how the abnormal Psychology has evolved gradually from time to time through various epochs and schools, and it has become the most popular and essential branch.

1.3.11 Summary

In this unit, we have taken you through the history of abnormal psychology. We have discussed the super model, the Biological model, views of the Greek and Roman thought of explaining causes of abnormal behaviour. You have also learnt about the views of abnormality during the middle ages and the contributions of Pinel, William Turke, Benjamin Rush and Dorothea Dix were also adequately explained**.** It is hoped that at this stage you are able to trace the history of abnormal psychology. In the next unit you will learn about different anxieties that people go through.

1.3.12 Activities

1. Discuss different approaches to the understanding of abnormal behaviour.
2. Analyze major views of William Turke and Dorothea Dix to the explanation of abnormal behaviour.

   Reflection

   Which approach to the development of abnormal psychology do you think had scientific backing?

UNIT 2: ANXIETY DISORDERS

2.1 Introduction

In this unit, you are going to learn about causes, symptoms and treatment of some anxiety disorders. You may be aware that experiencing occasional anxiety is a normal part of life. However, people with anxiety disorders frequently have intense, excessive and persistent worry and fear about everyday situations. Often, anxiety disorders involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks). These feelings of anxiety and panic interfere with daily activities, are difficult to control, are out of proportion to the actual danger and can last a long time. You may avoid places or situations to prevent these feelings. Symptoms may start during childhood or the teen years and continue into adulthood.

2.2 Learning Outcomes

By the end of this unit, you are expected to:

- Discuss various types of anxieties
- Analyse causes and symptoms of anxiety
- Develop treatment plan for people facing different types of anxiety.

2.3 Types of anxiety disorders

We will now look at each anxiety disorder in details, as you read through pay attention to the causes, symptoms and treatment.

2.3.1 Agoraphobia

Agoraphobia is a type of anxiety disorder that causes people to avoid places and situations that might cause them to feel: trapped, helpless, panic, embarrassed and scared. People with agoraphobia often have symptoms of a panic attack, such as a rapid heartbeat and nausea, when they find themselves in a stressful situation. They may also experience these symptoms

before they even enter the situation they dread. In some cases, the condition can be so severe that people avoid doing daily activities, such as going to the bank or grocery store, and stay inside their homes most of the day. Have you heard any one with such symptoms?

The National Institute of Mental Health (NIMH) estimates that 0.8 percent of American adults have agoraphobia. About 40 percent of cases are considered severe. When the condition is more advanced, agoraphobia can be very disabling. People with agoraphobia often realize their fear is irrational, but they're unable to do anything about it. This can interfere with their personal relationships and performance at work or school.

If you suspect you have agoraphobia, it's important to receive treatment as soon as possible. Treatment can help you manage your symptoms and improve your quality of life. Depending on the severity of your condition, treatment may consist of therapy, medications, and lifestyle remedies.

2.3.1.1 Symptoms Agoraphobia

People with agoraphobia are typically:

- afraid of leaving their home for extended periods of time.
- afraid of being alone in the social situation.
- afraid of losing control in a public place.
- afraid of being in places where it would be difficult to escape, such as a car or elevator.
- detached or estranged from others
- anxious or agitated

Agoraphobia often coincides with panic attacks. Panic attacks are a series of symptoms that sometimes occur in people with anxiety and other mental health disorders. Panic attacks can include a wide range of severe physical symptoms, such as: chest pain, a racing heart, shortness of breath, dizziness, trembling, choking, sweating, hot flashes, chills, nausea, diarrhoea, numbness and tingling sensations.

People with agoraphobia may experience panic attacks whenever they enter a stressful or uncomfortable situation, which further enhances their fear of being in an uncomfortable situation.

2.3.2 Attacks Symptoms and Signs of Panic disorder

Panic attacks are a symptom of an anxiety disorder, which include a discrete period of intense fear, distress, nervousness, or discomfort. Panic attacks can be frightening but are fortunately not physically harmful. They can occur suddenly, unexpectedly, unprovoked, and can be disabling. Panic attacks may occur for no known reason or after a person is exposed "trigger". They can intensity to a peak rapidly and also go away with or without medical intervention.

2.3.2.1 Symptoms of panic attacks may include:

palpitations, pounding heart, fast heart rate, sweating, trembling and shaking, sensations of shortness of breath or smothering, feelings of choking, chest pain or discomfort, nausea, upset stomach, dizziness, unsteadiness, lightheadedness, fainting, feelings of unreality or being detached from oneself, fear of losing control or going crazy, fear of dying, numbness or tingling sensations, chills, or hot flashes.

2.3.3 Generalized anxiety disorder (GAD)

Anxiety is a word that describes feelings of apprehension, concern, fear, nervousness, restlessness, or worry. Normal feelings of anxiety often serve as an “alarm system” that alerts you to danger. Your heart may beat fast. Your palms may get sweaty. Anxiety can provide an extra spark to help you get out of danger. It can also give you the energy to get things done in more normal but busy situations.

Anxiety can be a general feeling of worry, a sudden attack of panicky feelings, or a fear of a certain situation or object. Sometimes, anxiety can be out of control. You may feel a sense of dread and fear for no apparent reason. This kind of anxiety can disrupt your life.

Generalized anxiety disorder is ongoing anxiety that isn’t related to a particular event or situation. It can also be anxiety that is not “normal” about a situation. For instance, a person who has GAD may constantly worry about something that is unlikely to happen. They let these worries interfere with ability to function.

Women are more likely to have GAD than men. It usually begins to affect people when they are in their teens and early 20s.

2.3.3.1 Symptoms of generalized anxiety disorder

Most people worry from time to time. These occasional worries are normal. They don't mean that you have GAD. If you have GAD, you worry so much that it interferes with your day-today life. You feel tense and worried more days than not. Other signs of GAD include:

- trouble falling or staying asleep
- muscle tension
- irritability
- trouble concentrating
- getting tired easily
- restlessness, or feeling "keyed up" or on edge
- trembling
- shortness of breath
- fast heartbeat
- dry mouth
- dizziness nausea.

If you feel tense most of the time and have some or all of these symptoms, talk to your doctor. They will ask questions to make sure that something else isn't causing your symptoms. He or she will also perform a physical examination.

2.3.3.2 What causes generalized anxiety disorder?

Suppose the fire alarm goes off in your home. You race around frantically to find the fire. Instead, you find that there is no fire. The alarm just isn't working properly.

It's the same with anxiety disorders. Your body mistakenly triggers your alarm system when there is no danger. This may be due to a chemical imbalance in your body. It may also be related to:

- An unconscious memory, A side effect of a medicine and an illness.

Sometimes, certain kinds of medicine may cause GAD. You could also have symptoms if your thyroid gland is too active. Depression can also cause them. GAD sometimes runs in families.

2.3.3.3 How generalized anxiety disorder diagnosed

Doctors ask patients about symptoms and health history. He or she will perform a physical examination to make sure a physical or medical condition is not causing your symptoms. If the doctor doesn't find any other reason for a patient's symptoms, the patient may need to be treated for GAD.

2.3.3.4 Can generalized anxiety disorder be prevented or avoided?

There is not a specific cause for GAD. This means it can't be prevented or avoided. The best thing to do is to address the symptoms as soon as possible. Then the patient can get started on a treatment plan and live a normal day-to-day life.

2.3.3.5 Generalized anxiety disorder treatment

People who have GAD must learn ways to cope with anxiety and worry. Doctors can help them form a plan to develop skills to cope with your anxiety. The plan may include counselling, medicine, or both. Counselling can help patients figure out what's making them so tense. The doctor may prescribe medicine to help them feel less anxious. They can recommend the treatment that is right for you.

2.3.3.6 Living with generalized anxiety disorder

People who have GAD can get better. If they take medicine for it, a patient may be able to stop taking it at some point in the future. A Doctor may tell the patient if it's OK to stop taking the medicine.

The most important things are to talk about it, seek help, and take action. Action can help the affected person to gain a sense of control. The following are some tips on coping with anxiety:

Control worries. The affected person must choose a place and time to do the worrying and must make it the same place and time every day. Must spend 30 minutes thinking about his/her concerns and what he can do about them. He/she should not dwell on what "might" happen but must focus more on what's really happening. Then let go of the worry and go on with his/her day and must learn ways to relax. These may include activities such as yoga or a walking around the block.

Must breathe deeply. Follow these steps to take a break during the day to just breathe: Lie down on a flat surface. Place one hand on your stomach, just above your navel. Place the other hand on the chest. Must breathe in slowly and try to make the stomach rise a little. Must hold the breath for a second. Breathe out slowly and let the stomach go back down.

Relax muscles, start by choosing a muscle and holding it tight for a few seconds. Then relax the muscle. Do this with all of your muscles, one part of your body at a time. Try starting with the feet muscles and working your way up your body. Exercise regularly, People who have anxiety often quit exercising. But exercise can give you a sense of well-being and help decrease feelings of anxiety.

The affected person must get plenty of sleep. Sleep rests the brain as well as the body. It can improve general sense of well-being and the mood.

Alcohol abuse and drug abuse must be avoided. It may seem that alcohol or drugs relax the affected person, but in the long run, they make anxiety worse and cause more problems. The suffering from this anxiety must cut down on caffeine. Caffeine is found in chocolate, coffee, soft drinks, and tea. Caffeine may increase the sense of anxiety because it stimulates the nervous system. Must also avoid over-the-counter diet pills and cough and cold medicines that contain a decongestant. The affected person must confront the things that have made him/her anxious in the past. He or she must begin by just picturing himself or herself confronting these things. Then can get used to the idea of confronting the things that make him/her anxious.

The use of medicine can help reduce anxiety while one learns new ways to respond to the things that make him/her anxious.

2.3.4 Separation Anxiety Disorder Symptoms & Causes

What causes separation anxiety disorder?

Nearly all children experience brief feelings of anxiety about being away from a parent and display clingy behavior. Typically, these normal bouts occur when a child is between 18 months and 3 years old, although older children can have passing feelings of separation anxiety during times of stress. The difference between these normal feelings of anxiety and a disorder like SAD is that a child with separation anxiety disorder will experience an extended and extensive period of fear and distress about being apart from familiar people and places and the degree of anxiety or fear is notably out of proportion to the reality of the situation.

Anxiety disorders like SAD are linked to biological, family and environmental factors.

2.3.4.1 Causes of separation anxiety disorder

Biological factors

The brain has special chemicals, called neurotransmitters, that send messages back and forth to control the way a person feels. Serotonin and dopamine are two important neurotransmitters that, when "out of whack," can cause feelings of anxiety.

Family factors

Just as a child can inherit a parent's hair color, a child can also inherit that parent's anxiety. In addition, anxiety may be learned from family members and others who are noticeably stressed or anxious around a child. Parents can also contribute to their child's anxiety without realizing it by the way they respond to their child. For example, allowing a child to miss school when they are anxious about going, likely causes the child to feel more anxious the next school day.

Environmental factors

A traumatic experience (such as a divorce, illness, or death in the family) may also trigger the onset of separation anxiety disorder.

Who is affected by separation anxiety disorder?

Research shows that about 4 % of younger children have SAD, while the estimate for adolescents is slightly lower. Girls are affected more often than boys.

2.3.4.2 The symptoms of separation anxiety disorder

Separation Anxiety Disorder (SAD) is a condition that causes a child to feel intense worry and fear at the prospect of being away from family members, other people, and even places (most commonly home) that he cares about. Children with SAD can't just "put their worries aside" no matter how hard they try. They feel much more anxious, and for a much longer period of time, than other children in the same situations.

Common fears experienced by children with SAD Include:

- Worry about separation
- Worry about death or harm to a loved one
- Worry about something bad happening to herself
- Worry about being alone

- Worry about sleep and nightmares

The consistent factor in any worry associated with SAD is that the child's fear is unrealistic. What she fears will happen is usually very unlikely to happen.

Physical symptoms usually occur when there is a separation or anticipated separation. They may include:

- Nausea/ vomiting
- Quick breathing or difficulty catching one's breath
- Muscle aches (especially stomach and headaches)
- Fatigue

How common are anxiety disorders? Anxiety disorders are among the most common mental, emotional and behavioural problems affecting children. About 13 out of every 100 children ages 9 to 17 years old experience some kind of anxiety disorder, such as separation anxiety disorder. Approximately 4% of children suffer from separation anxiety disorder.

How can you tell if a child has separation anxiety disorder?

All kids experience some separation anxiety. For infants and toddlers, it is a normal stage of development which is connected to developing an attachment to parents and other caregivers. In older children, certain separation fears and worries are typical for their age. For example, let's say your child is starting his first day of kindergarten. He is likely to show some anxiety and discomfort when getting up and ready for school and going into the school for the first time. He may even cry when he comes home and say he wants to stay home and not return to school. If this period of anxiety is minor (he is comforted by reassurance), lasts only a few days, and is replaced by a return to his normal mood and activities, this is probably normal separation anxiety. However, if your child remains significantly distressed about being away from you during the school day (to the point where he is physically ill, can't focus, isn't soothed, and is disrupted in other activities), this may be separation anxiety disorder.

What is the difference between separation anxiety disorder in children and in adults?

Separation Anxiety Disorder is uncommon in adults. With anxiety in general, children usually don't realize how intense or abnormal their feelings of anxiety have become. It can be difficult for a child to know that something is "wrong." How can you prevent separation anxiety disorder?

While anxiety disorders such as SAD cannot be prevented altogether, seeking treatment as soon as you notice that the child has a problem can reduce the severity of the problem and improve your child's quality of life. Some other tips include:

- Stay calm in front of the child, as she often looks to you for how to react in new and uncertain situations.
- Avoid providing an excessive amount of reassurance since this may signal more, not less, to worry about.
- Teach the child how to problem solve, cope, and reassure himself/herself.
- Limit the avoidance of activities. Though avoidance may temporarily reduce distress, it will allow the anxiety to grow and make things more difficult for the child in the future.
- Provide support and praise for small victories in separation rather than consequences for the difficulties, since consequences tend to increase anxiety.

What is the long-term outlook for a child with a separation anxiety disorder?

With proper treatment, the majority of children diagnosed with separation anxiety disorder experience a reduction or elimination of symptoms. Symptoms of SAD can recur when new developmental challenges emerge. When treatment is started early and involves the parent as well as the child, the child's chance of recovery without multiple recurrences improves.

2.3.5 Medication-Induced Anxiety Disorder

Substance or medication-induced anxiety disorder is the diagnostic name for severe anxiety or panic which is caused by alcohol, drugs, or medications. While it is normal to have some feelings of anxiety in stressful situations, and even the transient feelings of anxiety, paranoia or panic that can happen spontaneously during intoxication or withdrawal from alcohol or drugs, substance-induced anxiety feels much worse and goes on a lot longer. For some people, it can significantly upset their enjoyment in life.

Unfortunately, the same drugs that many people use to try and boost their confidence, help them relax, and lower their inhibitions are the ones most prone to causing substance-induced anxiety disorder or panic attacks. In some cases, people don't even realize that it is alcohol, drugs or medications that are causing the anxiety because they only associate those substances with feeling good.

2.3.5.1 Diagnosis of Substance/Medication-Induced Anxiety Disorder

When physicians or psychologists give a diagnosis of substance/medication-induced anxiety disorder, they check to make sure that the anxiety wasn't there before the use of alcohol, drugs or medications thought to be responsible.

This is because there are several different types of anxiety disorders, and if the symptoms were there before the substance use, it isn't diagnosed as substance/medication-induced anxiety.

How Soon Anxiety Can Be Induced After Taking the Drug?

In some cases, anxiety or panic can occur straight away. There is even a category "with onset during intoxication," which means that the anxiety episode actually started when the individual was drunk or high on the drug. It can also occur during withdrawal, during which symptoms of anxiety are common.

However, with anxiety which is simply a symptom of withdrawal, the person's symptoms will generally resolve within a few days of discontinuing alcohol or drug use, while with substance-induced anxiety disorder, it can start during withdrawal, and continue or get worse as the person moves through the detox process.

How Long Do Withdrawal Symptoms Last?

Generally, the diagnosis isn't given if the person has a history of anxiety without substance use, or if the symptoms continue for more than a month after the person becomes abstinent from the alcohol, drugs or medication.

For the diagnosis of Substance/Medication-Induced Anxiety Disorder to be given, the symptoms have to be causing a great deal of emotional upset or significantly affecting the person's life, including their work or social life, or another part of their life that is important.

2.3.5.2 Drugs That Cause Substance/Medication-Induced Anxiety Disorder

A wide variety of psychoactive substances can cause substance-induced anxiety, including:

- Alcohol-induced anxiety disorder

- Caffeine-induced anxiety disorder
- Cannabis-induced anxiety disorder
- Phencyclidine-induced anxiety disorder
- Other hallucinogen-induced anxiety disorder
- Inhalant-induced anxiety disorder
- Amphetamine-induced anxiety disorder
- Other stimulant-induced anxiety disorder
- Cocaine-induced anxiety disorder
- Other substance-induced anxiety disorder
- Unknown substance-induced anxiety disorder

Medications known to cause substance-induced anxiety include:

- Anesthetic-induced anxiety disorder
- Analgesic-induced anxiety disorder
- Sympathomimetic or other bronchodilator-induced anxiety disorder
- Anticholinergic-induced anxiety disorder
- Insulin-induced anxiety disorder
- Thyroid preparation-induced anxiety disorder
- Oral contraceptive-induced anxiety disorder
- Antihistamine-induced anxiety disorder
- Antiparkinsonian-induced anxiety disorder
- Corticosteroid-induced anxiety disorder
- Antihypertensive and cardiovascular medication-induced anxiety disorder
- Anticonvulsant-induced anxiety disorder
- Lithium carbonate-induced anxiety disorder
- Antipsychotic-induced anxiety disorder
- Antidepressant-induced anxiety disorder

2.4 S**ummary**

In this unit, you have learnt about various forms of anxiety disorders, their causes, symptoms and treatment. It is hoped that you are not in a position where you can diagnose these disorders in people. In the next unit, we take you through mood disorder, their symptoms, causes and treatment**.**

2.5 Activity

1. Discuss the symptoms of the following disorders;
    a) Generalized anxiety disorder
    b) Agora phobia disorder
2. Explain the anxiety disorders that can result from drug and substance abuse.

Reflection

Do you think people who have anxiety disorders are properly diagnosed and treated in Zambia?

UNIT 3: MOOD DISORDER: SYMPTOMS, CAUSES AND TREATMENT

3.1 Introduction

In this unit we will take you through mood disorder, their symptoms, causes and treatment. You may be aware that people have different mood on different occasions. you may also know that certain moods are not ordinary but disorders and that they may need treatment. The following are the mood disorders you will learn about in this unit: depressive affective disorder, bipolar affective disorder, cyclothymic disorder. We believe that you will enjoy reading about these disorders because they are a common occurrence in our everyday life.

Mood disorders are constant changes in mood. Just 60 seconds ago, the man was at the peak of joy and bliss, and now he is in deep depression, and can't get rid of it without the help of others. Usually, a person in this state badly controls himself in an area he or she is currently engaged in. Then the depression again shifts to the euphoria, and these alterations occur systematically and depend on the state of each patient. Depending on the severeness of symptoms, psychology distinguishes three types:

- depressive affective disorder;
- bipolar affective disorder (this is endogenous mental illness, manifested by emotional dysfunction); and
- cyclothymia (a state of chronic instability of the mood with a large number of episodes of mild depression and mild elevation).

3.2 Learning Outcomes

By the end of this unit, you are expected to:

- Discuss causes of mood disorder
- Analyze symptoms of various mood disorder
- Identify people with different mood disorders
- Evaluate mood disorder Questionnaire

3.3 Causes of mood disorders

According to psychiatrists, between one and three percent of the adult population suffers from various classes of mood disorders. Unfortunately, today, scientists have not established

the exact cause of the adjustment disorder with depressed mood. The most common among psychiatrists is the theory of uncontrolled hormonal background of brain cells, which causes mood swings. Often the diagnosis is determined in the age of 15-30 years. Scientists do not exclude hereditary predisposition to this disease, although they assure that genetics is not the only risk factor.

Some of the causes of mood disorders

1. Genetic causes (genes can be inherited from parent)

2. Biochemical (violation of the activity of the exchange of neurotransmitters, their number decreases with depression (serotonin) and increases with mania, the deficiency is observed in the depression cycle).

3. Neuroendocrine (violation of the functioning of the hypothalamic-pituitary, limbic system and epiphysis).

4. Stress (death of a loved one, loss of work, social contacts).

3.4 Symptoms Mood disorders

The leading hints of depressive disorders are persistent mood oppression, a pessimistic tint of thinking, a decrease in overall activity. Earlier to the indicated symptoms were counted also stable unmotivated anxiety, but in modern classifications, it is considered separately. Manic conditions are predominantly characterized by inadequate mood elevation or irritation, hyperactivity, accelerated thinking with ideas of revaluation of own significance. Mood disorder symptoms list:

- Melancholy (sorrow, anxiety, mental oppression, a pessimistic view of life).
- Difficulty or slowness of mental acts.
- Depressive state: a feeling of hopelessness, the futility of life.
- Increased anxiety, obsessive, manic ideas.
- Frequent mood swifts.
- Lush ideas.
- Induced thinking.
- Indifference to the surrounding environment.

- Unreasonable movements.
- Disruptive mood dysregulation disorder

A new pathology has been introduced that is imperceptibly different from the mood disorder for children and teenagers under the age of 18, that was given a name disruptive mood dysregulation disorder. Exhibited in case of prolonged (during the year minimum), daily changed behavior of the child – rage, mood swings, uncontrolled outbreaks of irritability, difficulties in socialization. The main symptoms of DMDD that distinguish it from other mental states include:

- strong hysterics manifested in shouts, aggression to people around or to things in the room;
- temper tantrum, not inherent in the child's age, occurring approximately three or more times a week;
- irritability and anger;
- nerve storm occurs in different environments.

Such a violation arise in the child and at home, at school and in the store.

3.5 Disruptive mood dysregulation disorder

Helping children with DMDD may involve psychotherapy or behavioral interventions, medications, or a combination of both. Note that, drug treatment should not be given without clear assessment. However, after assessment drugs that include antidepressants, stimulants, and atypical antipsychotic drugs are used. There are different approaches that are commonly used for various mental health problems for children.

3.6 Mood disorder questionnaire

Here is a brief mood disorder definition test to check out the main symptoms of the disease:

- From time to time you undergo abrupt changes in mood/energy levels.
- During the day, you feel a tide of energy, then full apathy.
- Friends and folks consider your behavior to be strange and unpredictable.
- You often shout and quarrel.
- You can easily distract from the task, and then it's difficult for you to concentrate.

- You're risky (e.g. drive faster, drink lots, play casino). □ You feel sexual vigor.

If most of the test answers of mood disorder test are affirmative, this signals that it's the right moment to visit the doctor.

3.7 Mood disorder treatment

According to physicians, those patients who started treatment at an early stage, and also combine substance intake with rehabilitation, have the best chances of a complete recovery at least remission. Early diagnosis is a serious problem, and its solution requires state assistance for registration in the psychoneurological dispensary.

The therapy is very long and complex. Medications for mood disorder are prescribed by a physician-psychotherapist, bearing in mind the results of diagnosis and individual symptoms of the disease. Drug treatment (for example, antidepressants) is usually combined with psychotherapy (cognitive, family and group therapy). Lisdexamfetamine, sulbutiamine, centrophenoxine, and Adderall are one of the most effective medicine to treat the state.An equally important tool for nursing is the support of the patient. Long-term concrete communication with a psychotherapist, friends' aid and relatives, personal setting for a positive outcome, can help completely cure.

3.8 Summary

In this unit you have learnt about, depressive affective, bipolar, cyclothymia disorders. You also looked at their causes, symptoms and treatment. We hope at this stage you clearly understand these disorders to a point where you can tell a person exhibiting them in everyday life. In the next unit we will present to you, somatoform and dissociative disorders. We hope you will enjoy learning more about them.

3.9 Activity

1. Discuss causes of mood disorders
2. Evaluate mood disorder Questionnaire
3. Analyze symptoms of bipolar affective disorder

UNIT 4: SOMATOFORM AND DISSOCIATIVE DISORDERS

4.1 Introduction

You may have heard people who complain of chronic pain in one or more areas of their body that has no identifiable cause. Others accuse witches for such strange pain. In this unit we are going to expose you to somatoform and dissociative disorders which may cause such unique pain in human beings after going through this unit you will have a very clear understanding of these disorders.

4.2 Learning Outcomes

By the end of this unit, you are expected to:

- Discuss various types of samatoform disorders
- Discuss various types of psychotic disorders
- Analyse causes and symptoms of somatoform and psychotic disorder Asses treatment options for people with somatoform disorder.

Somatoform disorders cause physical symptoms to appear even though there isn't a medical condition to cause them. The psychological nature of the pains and symptoms can cause people to continually seek treatment even when there is nothing medically wrong with them. Symptoms include insisting on getting medical tests, and real or imagined pain that has no obvious source.

4.3 Types of Somatoform Disorders

These are the main types of somatoform disorders:

1. Somatization Disorder - Continual complaints of physical symptoms when no physical condition exists to cause the symptoms.
2. Somatoform Autonomic Dysfunction - This type centres around problems with a specific organ or section of the body.
3. Conversion Disorder - This usually occurs after a traumatic event, and causes impairment of movement or senses that is only psychological in nature.

3. Pain Disorder - Chronic pain in one or more areas of the body that has no identifiable cause.
4. Hypochondriasis - A belief that physical symptoms (either real or imagined) are signs of a serious illness, even when medical tests show otherwise.
5. Body Dysmorphic Disorder - A constant obsession with a physical flaw - real or imagined - that can cause side effects.
6. Unspecified Somatoform Disorder - A disorder that shows symptoms from two or more other types of somatoform disorders.
7. Undifferentiated Somatoform Disorder - Physical complaints of pain that can't be attributed to a medical condition and last more than six months.

4.3.1 Symptoms of Somatoform Disorders

The exact symptoms that appear with somatoform disorders will depend on the specific disorder, but in general they revolve around physical pains that are not caused by a medical reason. Many people will insist on a barrage of tests, even when they come back negative. Others may go from doctor to doctor, insisting that they have a problem. In others, symptoms may appear as a fear of getting a serious illness that lasts more than a few months. A preoccupation with pain and medical conditions is a good sign that a somatoform disorder may be a problem. If the symptoms do appear, getting treatment can help avoid the dangers of somatoform disorders.

- Insistence on testing
- Unexplained medical symptoms
- Chronic complaints about pain or other symptoms
- Extreme fear of having a medical illness that lasts more than six months
- Loss of voluntary motor abilities or a sensory function that is not due to medical illness
- Constant pain in one or more anatomical spots
- Preoccupation with an imagined defect

4.3.2 Dangers of Somatoform Disorders

One of the dangers that come with somatoform disorders is the possibility of financial problems due to numerous unnecessary medical tests. Another risk associated with these disorders is that a person will try to make their illness or pain more real by mutilating or harming themselves

to mimic symptoms of various diseases or medical conditions. There are various other physical and psychological risks depending on the part affected.

One can get help from trained therapists who specialize in somatoform disorders. They can help give the guidance and support needed to effectively deal with these types of disorders.

4.4 Dissociative disorders

Dissociative identity disorder, previously known as multiple personality disorder, is a type of dissociative disorder. Along with dissociative amnesia and depersonalization-derealization disorder, it's one of the three major dissociative disorders.

Dissociative disorders can be found in people of all ages, races, ethnicities, and backgrounds. The National Alliance on Mental Illness (NAMI) estimates that about 2 percent of people experience dissociative disorders.

4.4.1 What are the symptoms of dissociative identity disorder?

The most recognizable symptom of dissociative identity disorder (DID) is a person's identity being involuntarily split between at least two distinct identities (personality states). Other symptoms might include:

- Dissociative amnesia**.** This is a type of memory loss — beyond forgetfulness — that's not associated with a medical condition.
- Dissociative fugue**.** A dissociative fugue is an episode of amnesia that involves not having memory of certain personal information. It may include wandering off or a detachment from emotion.
- Blurred identity**.** This occurs when you feel like there are two or more people talking or living in your head. You might even feel like you're possessed by one of several other identities.

It's important to note that according to the Diagnostic and Statistical Manual of Mental Disorders, many cultures around the globe include possession as part of a normal spiritual ritual or practice. This isn't considered a dissociative disorder.

4.4.2 Interacting with someone with dissociative identity disorder

If you believe someone you know has DID, you may get the impression that you're communicating with not one, but several different people, as the person switches between personalities.

Often, each identity will have their own name and characteristics. They'll each commonly have an unrelated detailed background with obvious differences in age, gender, voice, and mannerisms. Some might even have individual physical characteristics such as a limp or poor vision that requires glasses.

There are often differences in each identity's awareness and relationship — or lack thereof — to the other identities.

4.4.3 Causes of dissociative personality disorder

Dissociative identity disorder — along with other dissociative disorders — usually develop as a way to deal with some type of trauma they've experienced. According to the American Psychiatric Association, 90 percent of people with dissociative identity disorder in the United States, Canada, and Europe have experienced childhood neglect or abuse.

4.4.4 What types of treatment are there for DID?

The primary treatment for DID is psychotherapy. Also known as talk therapy or psychosocial therapy, psychotherapy is focused on talking with a mental health professional about your mental health. The goal of psychotherapy is to learn how to cope with your disorder and to understand the cause of it. Hypnosis is also considered by some to be a useful tool for DID treatment. Medication is sometimes used in the treatment of DID, as well. Although there are no medications specifically recommended for the treatment of dissociative disorders, your doctor might use them for associated mental health symptoms.

Some commonly used medications are: anti-anxiety medications, antipsychotic drugs and antidepressants.

When to see a doctor

If someone can identify with any of the following, he/she should make an appointment to see your doctor:

- You are aware — or others observe — that you involuntarily and unwillingly have two or more personalities or identities that have a distinctly different way of relating to you and the world around you.
- You experience beyond ordinary forgetfulness, like extensive gaps in your memory for important personal information, skills, and events.
- Your symptoms aren't caused by a medical condition or from the use of alcohol or drugs.
- Your symptoms are causing you problems or stress in important areas such as your personal life and at work.

If your friend or a loved one is displaying the common symptoms, you should encourage them to seek help.

4.5 Summary

In this unit you have learnt about the following somatoform disorders; somatization disorder, somatoform, Autonomic dysfunctional, conversion disorder pain disorder, hypochondriasis and body dysmorphic disorder. You have also learnt about dissociative amnesic, dissociation forge, blurred, identity. We hope you now understand their causes and their symptoms. In the next unit, we will take you through schizophrenia and psychotic disorder.

4.6 Activity

1.Differentiate between somatoform and dissociative disorder.

3. Discuss causes and symptoms of dissociative amnestic and autonomic dysfunction.
4. Discuss causes of somatoform disorders.
5. Explain the treatment you can give a person who has somatoform disorder.

Reflection

Think of other ways that can be used to help people with somatoform disorders. Do you think enough research has been done to find better ways of helping such people?

UNIT 5: SCHIZOPHRENIA AND PSYCHOTIC DISORDERS

5.1 Introduction

In your community you may have come across people who hear voices, people who are suspicious of others and some community members usually call them mad. Such people may have disorders called Schizophrenia and psychotic disorders. This unit presents various Schizophrenia and Psychotic Disorders, as you read ensure that you understand the causes, symptoms and treatment these disorders.

5.2 Learning Outcomes

By the end of this Unit, you are expected to:

- Describe various Schizophrenia disorders
- Discuss psychotic disorder
- Analyze causes and symptoms of Schizophrenia and psychotic disorders
- Explain treatment available for Schizophrenia and psychotic disorders

Each person with schizophrenia falls under a subtype of schizophrenia defined by a unique indicator. This indicator may be one dominant symptom only or a combination of positive and negative symptoms.

For example, schizoaffective disorder exhibits schizophrenia alongside another mental disorder. Undifferentiated schizophrenia can be thought of as "general" schizophrenia, as it doesn't display any one dominant symptom. Below are the different types of schizophrenia and their characteristics.

Paranoid schizophrenia represents the most common of the many sub-types of the debilitating mental illness known collectively as schizophrenia. People with all types of schizophrenia become lost in psychosis of varying intensity, causing them to lose touch with reality. Untreated, people with psychotic disorders lose their ability to function in daily life.

5.3 Paranoid Schizophrenic – Drowning in Suspicion and Obsession

Typically, a paranoid schizophrenic experiences auditory hallucinations along with deluded thought processes and beliefs. They often believe others plot and conspire against them or their family members. People with paranoid schizophrenia tend to fare better than those

suffering from one of the other subtypes. They experience fewer issues with concentration, memory, and emotional apathy, allowing them to function better in everyday life.

5.3.1 Paranoid Schizophrenia Symptoms

Patients often describe life with paranoid schizophrenia as a dark and fragmented world – a life marked by suspicion and isolation where voices and visions torment them in a daily waking nightmare.

Common paranoid schizophrenia symptoms may include:

- Auditory disturbances – hearing things that are not real (more on hallucinations and delusions)
- Unexplained anger
- Emotional disconnectedness
- Severe anxiety and agitation
- Argumentative behavior
- Violent tendencies (more on violent behaviors and schizophrenia)
- Delusions of grandeur – self-importance and believing he or she possesses special powers
- Frequent suicidal thoughts and behavior

While all the above symptoms of paranoid schizophrenia can occur across the different types of schizophrenia, two, in particular, set it apart from the other sub-types – paranoid delusions and auditory disturbances.

Paranoid Delusions – When suffering from paranoid schizophrenia, one feels that others are conspiring against him/herself. As these paranoid thoughts intensify, the affected person may behave aggressively or commit violence in self-defence against those they believe plan to cause harm to them or a loved one. They may also think they possess special powers, such as the ability to breathe underwater or fly like a bird. they may believe they are famous or that a famous person wants to date you. Even though others present contrary evidence, they hold onto these beliefs anyway.

Auditory hallucinations that are unpleasant and cruel – Imagine sitting in your living room. You hear voices in the room, but no one else can hear them. You might hear one person's voice or two or more people conversing. They may talk to you or about you amongst each other. They criticize you; cruelly poke fun at your real or perceived flaws. Suddenly, one of

the voices orders you to hurt someone else or yourself. Although not real, to you they absolutely are.

5.3.2 Causes of Paranoid Schizophrenia Symptoms

Researchers do not have a clear understanding of the causes of paranoid schizophrenia symptoms or those associated with any of the sub-types. Although experts believe that brain dysfunction has a role in causing the onset of most types of the disorder, they don't know what causes the dysfunction initially. Research indicates that both genetics and environmental triggers work together to trigger the onset.

Think of any genetic predisposition for developing psychotic disorders as rows of levers or switches. People and events represent your environment. If a person, event, or combination of these flips your switches at certain of times and in a particular order, you develop signs of paranoid schizophrenia. These initial signs signal the onset of the disorder. Research studies indicate that an imbalance of brain chemicals contributes to the onset of the first psychotic episode, leading to paranoid schizophrenia symptoms.

Risk factors that increase chances of a paranoid schizophrenia diagnosis include:

- family history of psychotic disorders
- exposure to a viral infection in the womb
- fetal malnutrition
- stress in early childhood
- sexual or physical abuse
- older parental age
- use of psychoactive drugs during adolescence

5.3.3 Treatment of Paranoid Schizophrenia

Treatment of paranoid schizophrenia involves a lifelong commitment; no cure for schizophrenia exists. Treatment, essentially the same for all types of the disorder, varies based on symptom intensity and severity, patient medical history, age, and other individually relevant factors.

Treatments for paranoid schizophrenia require a team of medical and mental health professionals as well as social workers. Treatment strategies may include one or more of several options: antipsychotic medications (both traditional and atypical), psychotherapy for

schizophrenia for patient and family, hospitalization, electroconvulsive therapy (ECT), and social skills development training.

For psychotherapeutic and other non-pharmaceutical interventions to work, doctors must first control paranoid schizophrenia symptoms. They accomplish this by prescribing one or more antipsychotic drugs. For the drugs to do their work effectively, the patient must comply with the physician orders by closely adhering to dosing instructions and schedule.

Medication non-compliance represents a significant problem in the efficacy of treatment and eventual recovery of paranoid schizophrenic patients. A high percentage of patients choose to stop taking their medications during the first year of treatment, allowing psychosis to return and the debilitating clutches of the disorder to take over once again.

5.4 Disorganized schizophrenia

This is a f subtype of schizophrenia, a chronic mental illness.

Disorganized schizophrenia, or hebephrenia, refers to incoherent and illogical thoughts and behaviors related to schizophrenia. However, hebephrenia is no longer considered a distinct form of schizophrenia. The change in status happened because keeping the different types separate did not appear to help with diagnosis.

5.4.1 Fast facts on disorganized schizophrenia

Here are some key points about disorganized schizophrenia.

Schizophrenia is a serious, lifelong mental disorder that can involve disorganized and illogical thinking and behavior.

Disorganized schizophrenia, or hebephrenia, used to be a subtype, but since 2013, it has been included under the heading "schizophrenia5."Treatment is available, and if a person adheres to it, it can enable them to cope with everyday life. The complications of schizophrenia can be severe, but support from family and friends may help a person avoid some of the. Symptoms. The signs of schizophrenia fall into the following key symptom categories of all psychotic disorders:

Delusions: The patient has false beliefs of persecution, guilt, or grandeur. It is not uncommon for people with schizophrenia to describe plots against them, or to believe they have extraordinary powers and gifts. Some patients may hide to protect themselves from an imagined persecutor.

Hallucinations: These involve seeing, feeling, tasting, or smelling things which are not there. Hearing voices is the most common hallucination.

Disorganized speech and thoughts: The patient is unable to form coherent or logical thoughts, and this is signified by disorganized speech. During a conversation, the individual will be unable to stick to the subject. They will leap from one topic to another. In severe cases, speech may be perceived by others as unintelligible garble.

Disorganized or catatonic behavior: Behaviors may vary from being child-like and silly, to aggressive and violent. There may be unprovoked agitation, or sexual behavior in public. Excessive movement, bizarre actions, freezing in place, or a lack of response to instructions or conversation are other ways this symptom can manifest.

Negative symptoms: This refers to the inability to function normally and can include symptoms such as a lack of personal hygiene, social withdrawal, and an inability to show emotion such as avoiding eye contact or speaking in a monotone voice.

5.5 **Catatonic schizophrenia**

Catatonic schizophrenia is much rarer than it used to be thanks to improved treatments. Catatonic states are now more likely to be found in types of mental illness other than schizophrenia, such as neurodevelopmental (conditions that affect children during the development of their nervous system), psychotic bipolar, or depressive disorders.

Individuals with catatonia may flip between decreased and excessive motor activity.

With modern treatments, patients with catatonic schizophrenia can manage their symptoms easier, making the likelihood of leading a happier and healthier life much greater.

The clinical picture of catatonia is dominated by at least three of the following symptoms:

- Stupor - no psychomotor activity, no interaction with the environment
- Catalepsy - includes adopting unusual postures
- Waxy flexibility - if an examiner places the patient's arm in a position, they will maintain this position until it is moved again
- Mutism - limited verbal responses
- Negativism - little or no response to instructions or external stimuli
- Posturing - actively holding a posture against gravity

- Mannerism - carrying out odd, exaggerated actions
- Stereotypy - repetitive movements without an apparent reason
- Agitation - for no known reason
- Grimacing
- Echolalia - mimicking another person's speech
- Echopraxia - mimicking another person's movements

Without proper treatment, a catatonic episode can persist for days or even weeks.

Apart from the above, the patient may also have the following symptoms of schizophrenia:

Delusions - The patient may believe they are being persecuted. Alternatively, they may think they have extraordinary powers and gifts.

Hallucinations - particularly hearing voices (auditory hallucination), but hallucinations can include visual (seeing things that aren't there) or hallucinations involving any other sensory system.

Thought disorder - when speaking, the person can jump from one subject to another for no logical reason. The patient's speech might be muddled and impossible to understand.

Lack of motivation (avolition) - the patient loses their drive. They give up on everyday activities, such as washing and cooking.

Poor expression of emotions - they may not respond to happy or sad events, or may react inappropriately.

Social withdrawal - when a patient with schizophrenia withdraws socially it is often because they believe somebody is going to harm them.

Unaware of illness (also referred to as "poor insight") - because the hallucinations and delusions seem so real to the patient, many do not believe they are ill.

Cognitive difficulties - the patient's ability to concentrate, remember things, plan ahead, and to organize is affected and communication becomes more difficult.

Patients with the symptoms of catatonic schizophrenia are not usually able to get medical help on their own. Often, it is a family member or friend who seeks medical help.

5.6 Residual Schizophrenia

Residual schizophrenia is one of the 5 types of schizophrenia that is characterized by a longterm history of negative symptoms (i.e. psychomotor slowing), with very infrequent or rare occurrences of positive symptoms. To meet the criteria for diagnosis, the person must have experienced positive symptoms (e.g. hallucinations/delusions/etc.) at some point. With that said, the person may go years without experiencing any further positive or psychotic symptoms.

Individuals with residual-type schizophrenia may exhibit an array of symptoms during the active phase. Although this is considered one of the 5 main subtypes, there's really no predictable set of symptoms – it varies depending on the person. Certain individuals with residual-type may experience an isolated schizophrenic episode or two, but may have gone months without symptoms.

Typically, this subtype is considered the least severe and least debilitating of all unless psychomotor slowing becomes overwhelming. This type of schizophrenia may also be characterized as having "waxing" and "waning" phases. During the waxing phase, the symptoms increase in overall intensity. During the waning phase, the symptoms slowly decline in intensity and may completely disappear. However, most individuals still have to find ways to cope with the prevalence of the negative symptoms.

5.6.2 Residual Schizophrenia Symptoms

The symptoms experienced in this subtype are generally considered of less intensity and lower severity than others. This subtype generally involves a person experiencing minimal positive symptoms of the illness, with more negative symptoms, and in some cases, more cognitive symptoms. Below are some symptoms that a person with residual schizophrenia may experience if they have been formally diagnosed with this subtype.

1 year of minimal/reduced symptoms: In order to be diagnosed with residual schizophrenia, the person must undergo a period of at least one full year in which their symptoms are substantially reduced or are of minimal intensity. During this time the person may experience symptoms, but they may hardly be noticeable and may not impair functioning too much. The person may not experience many delusions, hallucinations or even notice negative symptoms.

It is this long period of time with minimal or no symptoms (e.g. remission) that distinguishes residual from other subtypes.

Absence of dementia / other diseases and disorders: In order to properly diagnose the condition, the person must first be cleared of any neurodegenerative disease such as dementia. They must also have major depression with psychotic features ruled out. In other words, all other medical conditions must be ruled out before the diagnosis of residual schizophrenia can be assumed.

Negative symptoms: Although positive symptoms may be more common, a person with residual-type may experience negative symptoms. These symptoms include things like slowed psychomotor functioning, flat affect (i.e. inability to feel emotion), poverty of speech (or monotone speech), poor communication, social isolation, poor hygiene, and an overall slowness.

- *Flat affect*: The person may be incapable of showing or expressing their emotions. They may appear to have no emotion, and may appear to have an expressionless, blank look while talking in monotone.
- *Psychomotor slowing*: The person's psychomotor activity is significantly slowed. This means they have a difficult time thinking, staying motivated, and active. They may become completely apathetic if there is too much slowing.
- *Inactivity*: The person may sit in one position for long periods of time or become under-active. In other words, they will appear lazy, lethargic, and without any motivation or energy to complete basic tasks.
- *Passivity*: The individual may become completely passive to his or her environment.
- *Poor communication*: The individual may not be able to communicate properly or exhibit deficiencies in speech. Not only does verbal communication suffer, but nonverbal cues such as eye contact, facial expressions, and posture also suffer.
- *Poor hygiene*: The person may neglect basic habits such as brushing their teeth, cleaning, bathing, doing the dishes, etc.

Psychotic episode: The person will have experienced at least one psychotic episode at some point in their past. This episode may be characterized by hallucinations, delusions, etc. Most individuals with the residual subtype have experienced at least one episode of psychosis.

- *Delusions*: The person may experience false beliefs that other people are out to get them and/or that they are being followed or that the government is spying on them. These are false beliefs that the person with schizophrenia believes to be true even though there is significant evidence to the contrary. These aren't experienced very often in people with residual subtypes.
- *Hallucinations*: The person may hear voices and/or see things that aren't based in reality. The voices may tell them hurtful things and may encourage the person to engage in violence or self-harm. Typically, the person with residual subtype does not experience hallucinations very often.

5.6.3 Residual Schizophrenia Causes

Currently it is unknown as to what causes schizophrenia. Individuals with other subtypes such as: catatonic, disorganized, paranoid, or undifferentiated may go on to develop residual schizophrenia. As long as the illness goes into a long-term period of remission, the individual that was diagnosed could be classified as having "residual schizophrenia." There are no known causes for this specific subtype or another subtype for that matter.

Some hypothesize that dopamine levels, glutamate levels, and traumatic experiences early in life may play a role in the development of this disease. Others believe that it is the result of biopsychosocial factors. Depending on the particular subtype that you have, there could be a number of different "causes." For example, if you have the catatonic subtype, the symptoms of catatonia are largely due to problems with the GABA neurotransmitter. If you have paranoid schizophrenia, it could be a result of overactive dopamine receptors.

5.6.4 Residual Schizophrenia Treatment

In order to properly treat residual schizophrenia, it is highly recommended that to see a psychiatrist. They can help to find medication or multiple medications that work to reduce symptoms and prevent symptom relapse. The following are type of medications that are used to treat residual schizophrenia.

1. Antipsychotic medications: The first line of treatment for all types of schizophrenia is antipsychotic drugs. These medications target dopamine activity and can significantly reduce positive symptoms. Unfortunately, they do come with a lot of side effects including weight gain and motor problems. The newer "atypical" class of these medications is thought to have less side effects than the older "typical" class.
2. Antidepressants: In some cases, an antidepressant medication may be prescribed to help treat the negative symptoms. The most commonly prescribed class of medications is that of SSRI's. However, doctors may also consider TCA's and MAOI's if they do not have an interaction with the antipsychotic. Antidepressants are sometimes used as an augmentation strategy when antipsychotics are not helping reduce negative symptoms.
3. Hospitalization: In some cases, people with this subtype may be hospitalized for a period of time when symptoms get severe. A hospital visit may involve the injection of antipsychotic medication and behaviors may be closely monitored by a professional.
4. Natural supplements: In some cases, people may have success when using natural remedies for schizophrenia. These include things like antioxidants, amino acids, etc.
5. Psychotherapy: Usually the individuals with residual schizophrenia go into remission. During this phase of remission or "waning" of the illness, they may be able to benefit from therapy sessions. Therapy may provide the person with social and emotional support, help them better understand their symptoms, and learn how to better function in society.
6. Social support network: A social support network of family, acquaintances, and friends may improve the symptoms in people with residual schizophrenia. This will help guide them during times when they are struggling. Individuals with social support tend to have a better long term prognosis than those who become isolated from society.

7. Vocational skills training: If the schizophrenia is severe enough to impair the individual from getting a job, they may enroll in some sort of vocational skills training. This will help the person learn a skill and possibly qualify for a job. This will help them stay productive and contribute to society.

5.6.5 Residual Schizophrenia Prognosis

The prognosis for people with this subtype varies depending on the individual. People that have experienced episodes at a young age with more significant cognitive and negative symptoms may have a worse prognosis than someone who experiences a late onset. Most individuals will end up having a difficult time during their schizophrenic episodes, but when the symptoms “wane” people can function pretty normally in society.

In general, individuals that have a higher level of mental performance before the onset of this illness tend to have a better long-term prognosis. In general, more favorable outcomes tend to be linked with people who just experience “brief” episodes of symptoms. Women tend to not be as severely affected by symptoms as men. Individuals with structural brain abnormalities also tend to have a worse prognosis.

It's not known what causes schizophrenia, but researchers believe that a combination of genetics, brain chemistry and environment contributes to development of the disorder.

Problems with certain naturally occurring brain chemicals, including neurotransmitters called dopamine and glutamate, may contribute to schizophrenia. Neuroimaging studies show differences in the brain structure and central nervous system of people with schizophrenia. While researchers aren't certain about the significance of these changes, they indicate that schizophrenia is a brain disease.

5.6.6 Risk factors

Although the precise cause of schizophrenia isn't known, certain factors seem to increase the risk of developing or triggering schizophrenia, including:

- Having a family history of schizophrenia
- Increased immune system activation, such as from inflammation or autoimmune diseases
- Older age of the father

- Some pregnancy and birth complications, such as malnutrition or exposure to toxins or viruses that may impact brain development
- Taking mind-altering (psychoactive or psychotropic) drugs during teen years and young adulthood

5.6.7 Complications

If left untreated, schizophrenia can result in severe problems that affect every area of life. Complications that schizophrenia may cause or be associated with include:

- Suicide, suicide attempts and thoughts of suicide
- Self-injury
- Anxiety disorders and obsessive-compulsive disorder (OCD)
- Depression
- Abuse of alcohol or other drugs, including tobacco
- Inability to work or attend school
- Legal and financial problems and homelessness
- Social isolation
- Health and medical problems
- Being victimized
- Aggressive behavior, although it's uncommon

5.6.8 Prevention

There's no sure way to prevent schizophrenia, but sticking with the treatment plan can help prevent relapses or worsening of symptoms. In addition, researchers hope that learning more about risk factors for schizophrenia may lead to earlier diagnosis and treatment.

5.7 Psychotic Disorders

Psychotic disorders represent the types of mental illnesses that feature a break with reality. The resulting odd behaviors, perceptions, thoughts, and emotions, such as hearing voices or seeing things that are not there. When a mental health condition has psychosis as a primary symptom, it is then classified as a psychotic disorder. About 3.5% of the population will experience psychosis at some point. Although psychotic disorders are among the most complex mental health disorders to treat, with a comprehensive approach to treatment, an individual with a psychotic disorder can learn to manage many of the symptoms.

The cause of psychotic disorders is still mainly unknown, although there are some theories exists to explain the cause. These include neurological malfunctioning, certain viruses, extreme trauma or prolonged excessive stress, certain drugs of abuse, and genetics.

5.7.1Types of Psychotic Disorders

Within the spectrum of psychotic disorders are several specific types of psychosis. These types include:

- Schizophrenia, which may involve hearing or seeing things that are not there, delusional thoughts, erratic behavior, angry outbursts and moodiness.
- Schizoaffective disorder**,** which combines features of schizophrenia with a mood disorder involving depressive or manic episodes.
- Schizophreniform disorder, is like schizophrenia but is a temporary disorder lasting one-six months in duration, and tends to affect teens and young adults.
- Brief psychotic disorder, is a short-lived disorder that is sometimes triggered by a traumatic event, such as the death of a loved one or a car accident, that lasts less than one month.
- Delusional disorder**,** is characterized by false beliefs that the individual truly believes are true, such as thinking someone is out to murder you or your spouse is having an affair, for example, which lead to impairing behaviors.
- Shared psychotic disorder, is one that involves two people who both believe in a delusional situation, such as a husband and wife who both believe the same absurd delusion.
- Substance induced psychotic disorder, is the presence of hallucinations or delusions occurring as a withdrawal symptom for several drugs, including alcohol, LSD, opioids, cocaine, benzodiazepines, amphetamines, and PCP.

5.7.2 Signs of a Psychotic Disorder

While the specific symptoms for a certain type of psychotic disorder will vary, there are some general signs that individuals will experience upon onset of a psychotic disorder. These include:

- Persistent feelings of being watched.
- Strange or disorganized speech or writing
- Seeing or hearing things that are not really there
- Inappropriate behavior
- Avoidance of social situations
- Decline in academic or work performance
- Unusual body positioning or movement
- Insomnia
- Suspicious or paranoid behavior
- Unusual preoccupation and fears
- Irrational or angry behaviors
- Inability to concentrate
- Loss of interest in appearance and hygiene
- Personality changes

5.7.3 Treatment for Psychotic Disorders

In many cases, someone with a psychotic disorder may first need inpatient intervention to become stabilized, referred to as acute stabilization services. During an acute psychotic event the individual will be closely monitored, medications reviewed and adjusted, and therapy initiated. Generally, a residential setting provides a more intensive and tailored treatment approach in a setting that is safe and offers 24-hour support.

Treatment primarily involves psychotherapy and drug therapy. While in a residential treatment the individual will be involved in various types of psychotherapy. The focus for therapy involves helping the individual recognize irrational thoughts and behaviors and to replace those with healthy thought-behavior patterns. Individual therapy, group therapy, and family therapy are all provided in a residential program.

Medications, such as anti-psychotic drugs and antidepressants, can help stabilize the most severe symptoms, such as hallucinations, cognitive issues, and delusions. For some individuals with a psychotic disorder, these medications will necessary to help manage daily living and should be taken for a lifetime.

5.8 Summary

This unit has exposed you to paranoid, disorganized, catatonic and un differentiated sschizophrenia. You have also learnt about episodes of psychosis such as delusions, hallucinating causes and possible treatment to these disorders were also explained. It is hoped that by this time you clearly understand he causes and symptoms of the above disorder. We will now teach you about use abuse disorders in the next unit.

5.9 Activity

1. Discuss the treatment of residual Schizophrenia
2. Discuss causes and symptoms of disorganized Schizophrenia.
3. Discuss psychotic disorder.

Reflection

Explain how you can handle some of the disorders in this unit in the absence of medication.

UNIT 6: SUBSTANCE USE DISORDERS

6.1 Introduction

In this unit you are going to learn about substance use disorder. The following substance abuse disorders will be discussed: substance induced psychotic disorder, substance induced bipolar and relaxed disorder and substance induced delirium and many others. It is hoped that you will enjoy interacting with this unit.

6.2 Learning Outcomes

By the end of this unit, you are expected to:

- Discuss the various substance induced disorders
- Analyze causes and symptoms of substance abuse disorders
- Explain the treatment of substance abuse disorders

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, often called the DSM-V or DSM 5, is the latest version of the American Psychiatric Association's goldstandard text on the names, symptoms, and diagnostic features of every recognized mental illness—including addictions.

The DSM 5 criteria for substance use disorders are based on decades of research and clinical knowledge. This edition was published in May 2013, nearly 20 years after the original publication of the previous edition, the DSM-IV, in 1994.

6.3 What Are Substance Use Disorders?

The DSM 5 recognizes substance-related disorders resulting from the use of 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (phencyclidine or similarly acting arylcyclohexylamines, and other hallucinogens, such as LSD); inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants (including amphetamine-type substances, cocaine, and other stimulants); tobacco; and other or unknown substances. Therefore, while some major groupings of psychoactive substances are specifically identified, the use of other or unknown substances can also form the basis of a substance-related or addictive disorder.

The activation of the brain's reward system is central to problems arising from drug use; the rewarding feeling that people experience as a result of taking drugs may be so profound that they neglect other normal activities in favor of taking the drug. While the pharmacological mechanisms for each class of drug are different, the activation of the reward system is similar across substances in producing feelings of pleasure or euphoria, which is often referred to as a "high."

The DSM 5 recognizes that people are not all automatically or equally vulnerable to developing substance-related disorders and that some people have lower levels of self-control that predispose them to develop problems if they're exposed to drugs.

There are two groups of substance-related disorders: substance-use disorders and substanceinduced disorders.

Substance-use disorders are patterns of symptoms resulting from the use of a substance that you continue to take, despite experiencing problems as a result.

Substance-induced disorders, including intoxication, withdrawal, and other substance/medication-induced mental disorders, are detailed alongside substance use disorders.

6.4 Criteria for Substance Use Disorders

Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria1:

- Taking the substance in larger amounts or for longer than you're meant to.
- to cut down or stop using the substance but not managing to.
- Wanting Spending a lot of time getting, using, or recovering from use of the substance.
- Cravings and urges to use the substance.
- Not managing to do what you should at work, home, or school because of substance use.
- Continuing to use, even when it causes problems in relationships.
- Giving up important social, occupational, or recreational activities because of substance use.

- Using substances again and again, even when it puts you in danger.
- Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
- Needing more of the substance to get the effect you want (tolerance).
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.

6.5 The Severity of Substance Use Disorders

The DSM 5 allows clinicians to specify how severe or how much of a problem the substance use disorder is, depending on how many symptoms are identified. Two or three symptoms indicate a mild substance use disorder1; four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder. Clinicians can also add “in early remission,” “in sustained remission,” “on maintenance therapy,” and “in a controlled environment.”

6.7 Intoxication

Substance intoxication, a group of substance-induced disorders, details the symptoms that people experience when they are "high" from drugs. Disorders of substance intoxication include:

- Marijuana intoxication
- Cocaine intoxication
- Methamphetamine intoxication (stimulants)
- Heroin intoxication (opioids)
- Acid intoxication (other hallucinogen intoxication or "acid trip")
- Substance intoxication delirium

6.8 Substance/Medication-Induced Mental Disorders

Substance/medication-induced mental disorders are mental problems that develop in people who did not have mental health problems before using substances, and include:

- Substance-induced psychotic disorder
- Substance-induced bipolar and related disorders

- Substance-induced depressive disorders
- Substance-induced anxiety disorders
- Substance-induced obsessive-compulsive and related disorders
- Substance-induced sleep disorders
- Substance-induced sexual dysfunctions
- Substance-induced delirium
- Substance-induced neurocognitive disorders

6.9 Summary

In this unit you have studied various types of substance abuse disorders such as substance induced neurocognitive disorder, substance sexual dysfunction and substance induced sleep disorders. We hope that you have clearly studied the causes and symptoms of the substance abuse disorders so that you can apply this knowledge in everyday life.

6.10 Activity

1. Discuss he following substance abuse disorders

a) Substance induced obsessive-compulsive disorder

b) Substance induced delirium disorder

2. Discuss general symptoms of substance abuse disorder

Reflection

Why do you think drug abuse is common among adolescents?

UNIT 7: PERSONALITY DISORDER SYMPTOMS, CAUSES AND EFFECTS

7.1 Introduction

Human beings have different personalities. Other types of personalities are offensive while others are not. In this unit we are going to look at different types of personality disorder. We will particularly discuss causes and symptoms of personality disorder. We will conclude the unit by looking at treatment of the people with different personality disorders.

7.2 Learning Outcomes

- Describe characteristics of carious personality disorder
- Identify causes of personality disorders
- analyze symptoms of various personality disorders.

7.3 Types of Personality Disorders

Several broad categories of personality disorders exist, each with a defining characteristic. Disorders can co-occur, and symptoms can blur together. Personality disorders can lead to suicide; according to the National Institute of Mental Health, 90 percent of people who commit suicide have a diagnosable mental disorder. The New York Times lists the types of personality disorders as follows:

7.3.1 Paranoid Personality Disorder

Individuals affected by paranoid personality disorder have a general suspicion that everyone is out to mistreat them. The condition usually does not extend into full-on psychosis such as schizophrenia.

7.3.2 Schizoid Personality Disorder

This condition tends to cause patients to avoid social interaction and be indifferent to social cues. The disorder extends beyond introversion; introverts occasionally enjoy socializing.

7.3.4 Antisocial Personality Disorder

People with antisocial personality disorder have a noted disregard for the rights and feelings of others, often performing criminal acts for personal gain.

7.3.5 Borderline Personality Disorder

Borderline personality disorder causes patients to have unstable emotions and mood swings. Unlike bipolar disorder, it does not usually occur in cycles.

7.3.6 Histrionic Personality Disorder

This condition is characterized by acting in an overly dramatic or emotional way, usually as a bid to draw attention.

7.3.7 Narcissistic Personality Disorder

Named for the figure from Greek mythology, narcissistic personality disorder causes patients to have an inflated view of self or their importance, often at the expense of others.

7.3.8 Avoidant Personality Disorder

People with avoidant personality disorder are often extremely shy and harbor feelings of inadequacy. They are very hesitant to confront others about their problems or to express their feelings.

7.3.9 Dependent Personality Disorder

People who have dependent personality disorder have difficulty functioning without the aid or encouragement of others.

7.3.10 Obsessive-Compulsive Personality Disorder

This condition is characterized primarily by a compulsion to engage in repetitive behaviors and repetitive thought patterns.

7.4 What Causes a Personality Disorder?

Personality disorders are caused by a mixture of genetic factors, such as a family history of disorders and upbringing. People who have a dysfunctional home life in early childhood and

adolescence can develop personality disorders in later life. For example, a lack of constructive criticism or excessive praise could foster narcissistic personality disorder. It takes knowledge of a person's background and family history to pinpoint what causes a personality disorder, and it is not an exact science.

7.5 What Are the Signs of a Personality Disorder?

Personality disorders are classified in three types of behaviors: eccentric behavior, dramatic or erratic behavior, and anxious or fearful behavior. Displaying atypical behaviors can be a sign of a disorder, but professional evaluation will offer a more accurate diagnosis.

7.6 Emotional Symptoms of Personality Disorders

The emotional symptoms of personality disorders vary between disorders and express themselves to varying degrees with each person. For example, people with avoidant personality disorder have an extreme aversion of conflict, allowing others to take advantage of them. Other symptoms can include poor impulse control and a propensity for substance abuse.

7.7 Physical Symptoms of Personality Disorders

Personality disorders affect the mind, but they can drive people to neglect their physical health as well. Someone affected by schizophrenia or a similar condition, for example, may neglect personal hygiene or suffer from insomnia due to fearful thoughts, while a person who is obsessive-compulsive may have raw skin from excessive washing. Because a personality disorder is difficult to diagnose by someone who lacks the necessary medical background, a detailed psychiatric evaluation is usually required.

7.8 Short-Term and Long-Term Effects of a Personality Disorder

Personality disorders have several effects on the psyche over time, both in the short- and long-term. They include, but are not limited to, the following:

- Difficulty in relationships
- Increased withdrawal from socialization
- Mood swings
- Depression

- Suicidal thoughts
- Attempted suicide
- Decline in physical health due to lack of care

Is There a Test or Self-Assessment You Can Do?

Self-diagnosis of a psychological disorder is usually unfeasible simply because a person may have an inherent bias and will be unable to accurately report his or her own symptoms. Even if he/she attempted to diagnose someone else, biasness is likely to occur too. Moreover, it's necessary to have face-to-face interaction with a psychologist who can diagnose disorders, using an interview and long-term observation. Although numerous tests exist on the Internet, none of them can give you a definitive or accurate result.

7.9 Medication: Personality-Modifying and Mood-Stabilizing Drug Options

Medications exist to assist with treatment of personality disorders. Medications should only be taken under the supervision of a physician.

7.10 Personality-Stabilizing Drugs: Possible Options

Mood stabilizers can help deal with the more extreme symptoms of personality disorders, but they will not take effect immediately, and the patient is also likely to require behavioral or cognitive therapy. Several types of medication are available via prescription. Selective serotonin reuptake inhibitors and monoamine oxidase inhibitors are both used to treat depression. Common brand names include Prozac, Paxil and Zoloft. Mood stabilizers such as lithium supplements are also used.

7.11 Medication Side Effects

Personality disorder medication can have several side effects, including, but not limited, to:

- Changes in libido
- Weight loss or gain
- Insomnia
- Fatigue
- Agitation

7.12 Drug Addiction, Dependence and Withdrawal

Drug addiction can exacerbate the symptoms of a personality disorder or create an entirely separate problem. Someone whose disorder causes them to lose contact and damage relationships with loved ones may turn to drugs as a source of comfort. An individual suffering from a personality disorder may resort to drugs abuse as an outlet for the stresses of daily life, but when that person tries to stop drug use, withdrawal symptoms may set in because of the body's previous dependence on the drug.

Medication Overdose: as a person becomes more accustomed to using drugs, such as prescription drugs, they will likely begin taking a gradually higher dose to get the same effect. In extreme cases, this can lead to death. According to the National Center for Health Statistics, 38,329 people died of prescription drug overdoses in 2010, with many of them due to opioid-based painkillers.

7.13 Depression and Personality Disorders

Depression can be a component of several types of personality disorders, or it can be a secondary symptom. A lack of social interaction or a loss of interest in hobbies can lead to depression. It often co-occurs with other personality disorders, such as avoidant personality disorder or phases of bipolar disorder.

7.14 Dual Diagnosis: Addiction and Personality Disorders

Substance abuse and addiction often coexist with a personality disorder. BioMed Central published a study that showed that 46 percent of people with a substance use disorder suffer from at least one personality disorder; however, symptoms can overlap and can be hard to diagnose. If the patient is admitted to a drug rehab facility, the staff will often conduct dual diagnosis assessments to identify the presence of a comorbid condition and to determine the best course of personality disorder treatment.

People will usually not seek help for a personality disorder on their own until the consequences are dire or until someone intervenes. This is due to the inherent bias involved in self-diagnosing personality disorders; some may simply be in denial about their emotional problem, while others may see their struggles as a natural part of their personality rather than an illness.

Medication is one component of treatment, but many personality-altering medications are available by prescription only. You will need to consult a physician or mental health professional for an evaluation. After this, you or your loved one will be prescribed the appropriate medication and placed on a regimen.

The other part of treatment deals with thought processes. Negative thought processes can be dealt with through behavioral therapy or by attending support groups of people with similar disorders who are recovering from them.

7.15 Summary

In this unit you have learnt about paranoid, antisocial, borderline, Histrionic, Narassistic, avoidant dependent and obsessive personality. I hope you are now able to explain their causes, symptoms and possible treatment. since you now understand personality disorder go straight to the next unit where you will learn about sexual disorder another interesting topic**.**

Reflection

What do you think you can do to help people who have substance use disorders in your community?

UNIT8: SEXUAL DISORDERS

8.1 Introduction

In this unit we will take you through sexual disorders. We will specifically talk about female and male sexual dysfunctions. We will also discuss causes of sexual dysfunction and their possible treatment, signs of sexual disorder will also be discussed.

8.2 Learning Outcomes

By the end of this unit, you are expected to:

- Discuss sexual disorders
- Evaluate treatment methods of sexual disorders
- Analyze causes and symptoms of sexual disorders**.**

8.3 Types of sexual dysfunctions

8.3.1 Sexual Desire Disorder

Sexual desire disorder is a psychiatric condition marked by a lack of desire for sexual activity over a prolonged period. In the DSM-5, Sexual Desire Disorder has been broken down into two separate conditions: Female Sexual Interest/Arousal Disorder and Male Hypoactive Sexual Desire Disorder. Both of these refer to a low level of sexual interest resulting in a failure to initiate or respond to sexual intimacy. This can include an absence of sexual thoughts or fantasies, reduced or absent pleasure during sexual activity, and absent or reduced interest in internal or external erotic cues. Neither of these conditions can be diagnosed if the main problem is a "desire discrepancy" in which one partner desires more sexual activity than the other; rather, the conditions are diagnosed when symptoms have been present for a minimum of six months and cause clinically significant distress for the individual.

Female Sexual Interest/Arousal Disorder and Male Hypoactive Sexual Desire Disorder can both be diagnosed as generalized, meaning they may be a general attitude toward any potential partner or situation. These conditions can also be diagnosed as being situational, meaning symptoms are only present with certain types of stimulation, situations, or partners. Female Sexual Interest/Arousal Disorder was known as Sexual Arousal Disorder in previous versions of the DSM, although this diagnosis has been replaced by gender-specific conditions in the DSM-5.

The prevalence of Female Sexual Interest/Arousal Disorder is unknown, although some older women report less distress about experiencing low sexual desire than younger women. In men, it is estimated that 6 percent of younger men (ages 18-24) and 41 percent of older men (ages 66-74) have some problems with sexual desire. Only 1.8 percent of men ages 16-44, however, experience persistent problems lasting more than six months.

8.3.2 Symptoms of female sexual interest

Symptoms for Female Sexual Interest/Arousal Disorder include the following:

- Absent or reduced interest in sexual activity
- Absent or reduced sexual thoughts or fantasies
- Reduced or no initiation of sexual activity
- Absent or reduced sexual excitement or pleasure during most sexual activity
- Absent or reduced sexual interest or arousal in response to internal or external cues, such as a partner's attempts to initiate sexual activity
- Absent or reduced genital or nonessential sensations during sexual activity

To meet criteria for Female Sexual Interest/Arousal Disorder, the symptoms must be present for at least six months and cause significant distress to the individual.

Symptoms for Male Hypoactive Sexual Desire Disorder include the following:

- Reduced or absent sexual thoughts or fantasies
- Reduced or absent desire for sexual activity

Similar to Female Sexual Interest/Arousal Disorder, the symptoms must also be present for at least six months and cause significant distress to the individual.

Both of these conditions can be diagnosed as a lifelong problem or an acquired problem that emerged after a period of normal sexual activity.

8.3.3 Causes of sexual desires

Changes in sexual desire are natural and may come and go depending on personal events or partner-related issues. When the lack of interest in sexual activity lasts longer than six months and causes distress, however, the criteria for a sexual desire disorder may be met.

Some risk factors for developing a sexual desire disorder include:

- Negative attitudes about sexuality

- Relationship difficulties (poor communication or abuse)
- Partner sexual functioning
- Childhood stressors
- Medical conditions (such as, diabetes mellitus, thyroid dysfunction)
- Endocrine disorders (hyperprolactinemia)
- Erectile dysfunction
- History of emotional or physical abuse
- Other psychiatric diagnosis (depression, anxiety)
- Medication side effects
- Stressors (job loss, bereavement)
- Alcohol use

8.3.4 Treatment of sexual disorders

Treatment for a sexual desire disorder may include psychotherapy and medication. In 2015, the FDA approved a medication called Addyi (flibanserin) to treat acquired, generalized hypoactive sexual desire disorder (HSDD) in premenopausal women. The medication has faced controversy, and research is underway to evaluate its efficacy.

Treatment must be individualized—some couples will need relationship or marital therapy prior to focusing directly on enhancing sexual activity. Of course, many couples may need to focus on the sexual relationship itself, and through education and assignments they can expand the variety and time devoted to sexual activity. When problems with sexual arousal or performance are factors, these sexual dysfunctions will need to be addressed.

8.3.5 Prevention of sexual dysfunctions

One helpful way to prevent issues with sexual desire is setting aside time for nonsexual intimacy. Couples who reserve time for one-on-one conversations are more likely to experience sexual desire. Also, reserving time before exhaustion sets in will encourage closeness and sexual desire. Couples might mentally separate sex and affection, so that neither one is afraid to be affectionate daily.

Reading books or taking courses in couple's communication may also encourage feelings of closeness. For some couples, reading novels or viewing movies with romantic or sexual content may also serve to encourage sexual desire.

Low sexual desire may be a barometer of the emotional health of the relationship. In the case of a loving relationship, low sexual desire may cause a partner to repeatedly feel hurt and rejected, leading to eventual feelings of resentment and emotional distance.

Sex is something that, for most couples, either bonds their relationship or creates a wedge that gradually drives them apart. When one partner is significantly less interested in sex than their companion, professional help is recommended before the relationship becomes strained.

What Are Sexual Arousal Disorders?

Not to be confused with sexual desire disorders, sexual arousal disorders are commonly described as the inability to achieve the necessary physical arousal to engage in sexual intercourse. For men, this can commonly be thought of as the inability to achieve an erection. As an erection is necessary for sexual intercourse to occur, sexual arousal disorders can pose significant obstacles for men wishing to engage in routine sexual activity with their partner.

Sexual health and performance disorders affect a large number of men in the United States annually, allow a significantly lower number of individuals dealing with these problems choose to confront and remedy them. The causes for this can be explained best by examining perceived societal expectations placed upon men, commonly defining them as the “provider” and “dominant” sexual force in a relationship. Any physiological or psychological factors causing a man’s sexual health or performance may therefore become a source of embarrassment or shame, which most often leads them to conceal their medical issues. For men who are willing to confront their sexual performance issues, including sexual arousal disorders, treatments and remedies for their particular conditions can be found quite easily.

8.3.6 Orgasmic Disorder

Orgasmic disorder, now referred to as female orgasmic disorder, is the difficulty or inability for a woman to reach orgasm during sexual stimulation. This disturbance must cause marked distress or interpersonal difficulty for it to be diagnosed. The diagnosis for men is erectile dysfunction, premature ejaculation, or delayed ejaculation.

As cataloged by the DSM-5, female orgasmic disorder is characterized by difficulty experiencing orgasm and/or markedly reduced intensity of orgasmic sensations. Women show wide variability in the type or intensity of stimulation that elicits orgasm. Similarly,

subjective descriptions of orgasm are varied, suggesting that it is experienced in different ways.

For a woman to have a diagnosis of female orgasmic disorder, clinically significant distress must accompany the symptoms. If interpersonal or significant contextual factors, such as severe relationship distress, intimate partner violence, or other significant stressors, are present, then a diagnosis of female orgasmic disorder would not be made.

Many women require clitoral stimulation to reach orgasm, and a relatively small number of women report that they always experience orgasm during intercourse. It's also important to consider whether orgasmic difficulties are the result of inadequate sexual stimulation and not related to female orgasmic disorder.

8.3.6.1Treatment of orgasmic dysfunction

1. To treat orgasmic dysfunction, the underlying medical condition, medication, or mood disorder needs evaluation and treatment. The role of hormone supplementation in treating orgasmic dysfunction is controversial and the long-term risks remain unclear. If other sexual dysfunctions (such as lack of interest and pain during intercourse) co-occur, these need to be addressed as part of the treatment plan.
2. Relationship difficulties sometimes play a role, so treatment may sometimes need to include communication training and relationship enhancement work. A series of exercises to practice communication, more effective stimulation, and playfulness can help.
3. Incorporating clitoral stimulation into sexual activity may be all that is necessary for a woman to achieve orgasm. Masturbation when the partner is not present (which could cause inhibition) usually results in success. Working with a partner to decrease performance anxiety and maximize communication can make it possible for a woman to achieve orgasm with a partner.
4. It is also important to ascertain that the problem is only one of orgasmic disorder, and not a coexisting problem with inhibited sexual desire.
5. Data on success rates in sex therapy indicates that these interventions are helpful in 65 to 85 percent of cases. In primary orgasmic dysfunction, treatment is usually successful in 75 to 90 percent of cases. A positive prognosis is usually associated with being younger, emotionally healthy, and having a loving, affectionate relationship with a partner.

8.3.7 Sexual Pain Disorders

Sexual pain disorders are characterized by feelings of pain during sexual intercourse. However, the pain can occur from any sort of genital stimulation, even when it is not sexual in nature. Dyspareunia is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as "recurrent or persistent genital pain associated with sexual intercourse." It adds that this can occur in both men and women. However, these disorders almost always occur in women. With dsypareunia, the person feels pain during sexual intercourse or activities. With vaginismus, a separate sexual pain disorder, a woman has involuntary spasms or contractions of the vaginal muscles which impedes intercourse.

There are several similarities between vaginismus and dyspareunia. Both involve a pain reaction during sexual intercourse but, while those suffering from dyspareunia are able (even if not particularly eager) to have engage in sexual relations, those who are diagnosed with vaginismus are not. Vaginismus is defined by the DSM-IV as "a recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse."

Clinicians believe that women experiencing these symptoms have the conscious desire to enjoy sex, but the unconscious need to prevent a penis from entering their bodies. The memory of a sexual trauma during which a penis was, in fact, wielded like a weapon, returns and causes a woman's body to forcibly refuse penetration. Even emotional abuse can elicit this reaction; the abuser is rejected without a word being spoken.

8.3.7.1 Causes of Sexual Pain Disorders

While the pain may have originated in a biological condition or a disease, sexual pain disorders cannot be diagnosed if the only reason for the pain is a medical condition. Sexual pain disorders are psychological, not physical.

Causes of Sexual Pain Disorders

While the pain may be linked to a biological condition or disease, sexual pain disorders cannot be diagnosed if the only reason for the pain is a medical condition. Sexual pain disorders are psychological, not physical.

Research suggests that the pain is almost never “psychogenic” (in the mind). Pain can have multiple psychological components. This theory has been proven in cases of depression. Depressed people often cite that they feel chronic physical pain as well as emotional pain.

There are several possible reasons for dyspareunia, but the most common physical cause is injury to the vagina, cervix, uterus and/or pelvic ligaments during the course of childbirth. Others possible causes include: episiotomy scarring, vaginal infection, pelvic diseases, tumors, cysts, allergic reactions to contraceptive creams, latex condoms and/or protein found in semen. Masters and Johnson, the well-known 1950s sex researchers, blamed environmental factors such as: stringent religious beliefs, low self-esteem, focus on physical appearance, anxiety personal trauma such as rapes and fear for causing pain during intercourse.

For example: A woman who was raped may consciously or subconsciously remember the traumatic event of the rape during sexual activities. Once she starts to remember the rape, her vaginal muscles will involuntary contract causing pain. In addition, the memory of a trauma can cause a decrease in vaginal lubrication, which can make sexual intercourse not only difficult, but also painful.

Sexual pain disorders have been linked to anxiety disorders, meaning that they occur as a result of anxiety related to sex or intimate relationships.

What Treatments Are Available for Sexual Pain Disorders?

Physical and psychological therapies can be very helpful if you suffer from a sexual pain disorder. Treatment typically begins with a frank and open discussion with a medical professional. In cases of vaginismus, you should seek a referral to see a pelvic floor therapist. The group of muscles, ligaments and tissues that support the internal organs can be an important factor when assessing the cause of the pain. A pelvic floor therapist can teach you effective pelvic floor exercises, the use of vaginal dilators and relaxation techniques. You may also be advised to avoid the use of potentially irritating detergents and feminine products and advised to switch to natural fiber undergarments.

Other possible treatments for sexual pain disorder include: estrogen and progestin therapies to increase vaginal lubrication. Estrogen and progestin will balance your hormones, increase lubrication and ease the pain associated with sex. Antibiotics can be used if a doctor suspects that the sexual pain is a result of an infection.

Psychotherapy will not only help you explore the possible causes of your pain, but also help you manage your disorder and have a healthy sex life.

8.4 Summary

In this unit we have discussed the following disorders: female sexual interest disorder, male hypoactive sexual desire disorder, erectile dysfunction, orgasm disorder. We further looked at causes symptoms and treatment of these disorders. We hope you now have a clear understanding of these disorders.

Activity

- Discuss any two male and two female sexual dysfunctions you have learnt in this unit.

Reflection

Imagine you have a friend who has one of the sexual disorders discussed in this unit, explain how you can help him/her to seek treatment**.**

UNIT9: DISORDERS OF CHILDHOOD AND ADOLESCENCE

9.1 Introduction

This unit presents disorders of childhood and adolescence. The childhood disorder we will look at are, attention deficit hyperactivity disorder, autistic disorder, conduct disorder, conduct and oppositional defiant disorder, learning disorder, mental retardation, Tourette's disorder. The causes, symptoms and treatment of these disorders will also be explained in this unit.

9.2 Learning Outcomes

By the end of this unit, you are expected to:

- Discuss various childhood and adolescence disorders
- Establish treatment plans for childhood and adolescence disorder
- Discuss symptoms of childhood and adolescence disorders

- Attention-Deficit/ Hyperactivity Disorder (ADHD)
- Autistic Disorder
- Conduct Disorder and oppositional Defiant Disorder
- Learning Disorders
- Mental Retardation
- Tourette's Disorder

Child psychiatric assessment requires attention to details of a child's stage of development, family structure and dynamics, and normative age-appropriate behavior. Consulting with parents and obtaining information from schools, teachers, and other involved parties (e.g., Department of Social Services/Youth Services) are essential to proper assessment.

Children, especially young children, usually express emotion in a more concrete (less abstract) way than adults. Consequently, child interviews require more concrete queries (Do you feel like crying? instead of Are you sad?). Playing games, taking turns telling stories, and imaginative play are often used to gain insight into the child's emotional and interpersonal life. During play, observations are also made regarding activity level, motor skills, and verbal

expression. Children are much more Likely than adults to have comorbid mental disorders, making diagnosis and treatment more complicated.

The complexities of diagnosis in child psychiatry often require the use of psychological testing. Tests of general intelligence include the Stanford-Binet Intelligence Scale (one of the first intelligence tests developed and often used in young children) and the Wechsler Intelligence Scale for Children-Revised (WISC-R). The WISC-R is the most widely used intelligence test for assessing school-age children. It yields a verbal score, a performance score, and a full-scale score (both verbal and performance) or intelligence quotient (IQ).

9.3 Prevalence of Child and Adolescent Mental Disorders

Four million children and adolescents in this country suffer from a serious mental disorder that causes significant functional impairments at home, at school and with peers. Of children ages 9 to 17, 21 percent have a diagnosable mental or addictive disorder that causes at least minimal impairment.

Half of all lifetime cases of mental disorders begin by age 14. Despite effective treatments, there are long delays, sometimes decades, between the first onset of symptoms and when people seek and receive treatment. An untreated mental disorder can lead to a more severe, more difficult to treat illness and to the development of co-occurring mental illnesses.

9.4 **Autistic Disorder**

It is characterized by the triad of impaired social interactions, impaired ability to communicate, and restricted repertoire of activities and interests.

9.5 Anxiety disorders in youth

During the past decade, the results of international epidemiologic surveys have revealed that anxiety disorders are the most, prevalent, class of mental disorders in adults. Similar to community studies of adults, anxiety disorders are also quite prevalent in the general population of children and adolescents. The median prevalence rate of all anxiety disorders in a recent review was 8% with an extremely wide range of estimates (eg, 2% to 24%). Current, or 12-month rates of anxiety disorders range from 2.2% in North Carolina youth to 9.5% in Puerto Rico. Generalized Anxiety Disorder (GAD) and Social Anxiety Disorder (SAD) are

the two most prevalence disorders in youth. In contrast, panic disorder and obsessivecompulsive disorder (OCD) are both quite rare in children under 12.

Similar to the gender ratio for adults, girls tend to have more of all subtypes of anxiety disorders, irrespective of the age composition of the sample. However, it has also been reported that, despite the greater rates of anxiety in girls across all ages, there is no significant difference between boys and girls in the average age at onset of anxiety.

Comorbidity between anxiety disorders and other mental disorders is already apparent in childhood and adolescence. Anxiety disorders are associated with all of the other major classes of disorders, including mood disorders, disruptive behaviors, eating disorders, and substance use disorders. The co-occurrence of anxiety disorders and mood disorders is so common that there is emerging evidence that anxiety disorders may be part of the developmental sequence in which anxiety is expressed early in life followed by depression in adulthood.

Autistic disorder is familial. Genetic studies demonstrate incomplete penetrance (36% concordance rate in monozygotic twins), although a specific genetic defect has not been discovered. A small percentage of those with autistic disorder have a fragile X chromosome, and a high rate of autism exists with tuberous sclerosis.

Kids can get depressed and disorders ranging from major depression to bipolar disorder are increasingly diagnosed in children, whose symptoms are especially likely to include irritability. Psychotherapy is often highly effective, although drug treatment may also be needed.

9.6 Attention-Deficit/ Hyperactivity Disorder (ADHD)

ADHD is characterized by a persistent and dysfunctional pattern of over activity, impulsiveness, inattention, and distractibility.

The disorder runs in families and cosegregates with mood disorders, substance use disorders, learning disorders, and antisocial personality disorder.

Families with a child diagnosed with ADHD are more likely than those without ADHD offspring to have family members with the above-mentioned disorders

According to the World Health Organization (WHO), mental health disorders are one of the leading causes of disability worldwide. Three of the ten leading causes of disability in people between the ages of 15 and 44 are mental disorders, and the other causes are often associated with mental disorders. Both retrospective and prospective research has shown that most adulthood mental disorders begin in childhood and adolescence. This highlights the importance of gaining understanding of the magnitude, risk factors, and progression of mental disorders in youth.

9.7 **Learning Disorders**

Learning disorders are characterized by performance in a specific area of learning (e.g., reading, writing, arithmetic) substantially below the expectation of a child's chronologic age, measured intelligence, and age-appropriate education. The (DSM-IV) identifies three learning disorders: reading disorder, mathematics disorder, and disorder of written expression.

Specific learning disorders often occur in families. They are presumed to result from focal cerebral injury or from a neurodevelopmental defect.

Mental health disorders in children and adolescents are caused by biology, environment, or a mix of both. Examples of biological factors are genetics, chemical imbalances in the body, and damage to the central nervous system, such as a head injury. Many factors in a young person's environment can affect his or her mental health, such as exposure to violence, extreme stress, and loss of an important person. Caring families and communities working together can help children and adolescents with mental disorders. A broad range of services often is necessary to meet the needs of these young people and families.

Following are descriptions of some of the mental, emotional, and behavior problems that can occur during childhood and adolescence. All of these disorders can have a serious impact on a child's overall health. Some disorders are more common than others, and conditions can range from mild to severe. Often, a child has more than one disorder.

Anxiety disorders are the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety disorders include:

Depressive disorders, which include major depressive disorder (unipolar depression), dysthymic disorder (chronic, mild depression), and bipolar disorder (manic-depression), can have far-reaching effects on the functioning and adjustment of young people.

Major depression is manifested by a combination of symptoms (see symptom list) that interfere with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life. Dysthymia involves long-term (two years or longer) but less severe symptoms that do not disable, but keep one from functioning well or from feeling good. Many people with dysthymia also experience major depressive episodes at some time in their lives. Bipolar disorder is not nearly as prevalent as other forms of depressive disorders and is characterized by mood changes: severe highs (mania) and lows (depression). Sometimes the mood switches are dramatic and rapid, but most often they are gradual. When in the depressed cycle, an individual can have any or all of the symptoms of a depressive disorder. When in the manic cycle, the individual may be overactive, overly talkative, and have a great deal of energy. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment.

Some forms of depressive disorder exhibit slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include: Psychotic depression, which occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality, hallucinations, and delusions. Seasonal affective disorder (SAD) is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer.

- Phobia - an unrealistic and overwhelming fear of some abject or situation;
- Generalized anxiety disorder - a pattern of excessive, unrealistic worry not attributable to any recent experience.
- Panic disorder - terrifying panic attacks that include physical symptoms such as rapid heartbeat and dizziness;
- Obsessive compulsive disorder - being trapped in a pattern of repeated thoughts and behaviors such as counting or hand washing; and

- Post-traumatic stress disorder - a pattern of flashbacks and other symptoms that occurs in children who have experienced a psychologically distressing event such as physical or sexual abuse, being a victim or witness of violence, or exposure to some other traumatic event such as a bombing or hurricane.

Major depression is recognized more and more in young people. Years ago, many people believed that major depression did not occur in childhood. But we now know that the disorder can occur at any age. Studies show that up to 6 out of every 100 children may have depression. Some adolescents or even elementary school children with depression may not place any value on their own lives, which may lead to suicide. The disorder is marked by changes in:

- Emotion - the child often feels sad, cries, looks tearful, feels worthless;
- Motivation - schoolwork declines, the child shows no interest in play;
- Physical well-being - there may be changes in appetite or sleep patterns and vague physical complaints; and
- Thoughts - the child believes that he or she is ugly, that he or she is unable to do anything right, or that the world or life is hopeless.

- Bipolar disorder (manic-depressive illness) in children and adolescents is marked by exaggerated mood swings between extreme lows(depression) and highs (excited ness or manic phases). Periods of moderate mood occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct disorder causes children and adolescents to act out their feelings or impulses toward others in destructive ways. Young people with conduct disorder repeatedly violate the basic rights of others and the rules of society. The offenses that these children and adolescents commit often get more serious over time. Examples include lying, theft, aggression, truancy, fire setting, and vandalism. Children and adolescents with conduct disorder usually have little care or concern for others. Current research has yielded varying estimates of the number of young people with this disorder; most estimates range from 4 to 10 of every 100 children and adolescents.

Eating disorders can be life threatening. A young person with anorexia nervosa, for example, cannot be persuaded to maintain a minimally normal body weight. This child or adolescent is intensely afraid of gaining weight and doesn't believe that he or she is underweight. Anorexia affects 1 in every 100 to adolescent girls and a much smaller number of boys.

Youngsters with bulimia nervosa feel compelled to binge (eat huge amounts of food at a time). Afterward, to prevent weight gain, they rid their bodies of the food by vomiting, abusing laxatives, taking enemas, or exercising obsessively. Reported rates vary from 1 to 3 out of 100 young people.

9.8 Summary

In this unit you have learnt about disorders of childhood and adolescence. We hope by this time you are able to discuss and explain the causes, symptoms and treatment of these disorders.

Activity

1. Explain how to can help a child who has an Autistic disorder to learn how to use language.

Reflection

Explain how you can know that some children that perform poorly at school do not necessarily have learning disorders.

UNIT10: ADJUSTMENT DISORDERS

10.1 Introduction

In this unit, we will go through children adjustment disorders. We will take you through different types of adjustment disorders, their causes, symptoms and how you can diagnose and treat such disorders. As you read through this unit ensure that you pay particular attention to the key aspects of the topic. It is our hope that this module has helped you understand various disorders that have been discussed.

10.2 Learning Outcomes

By the end of this unit, you are expected to:

- Identify symptoms of adjustment disorders
- Discuss causes of adjustment disorder
- Discuss types of adjustment disorders

10.3 Adjustment disorders

This is a group of conditions that can occur when you have difficulty coping with a stressful life event. These can include the death of a loved one, relationship issues, or being fired from work. While everyone encounters stress, some people have trouble handling certain stressors. The inability to adjust to the stressful event can cause one or more severe psychological symptoms and sometimes even physical symptoms. There are six types of adjustment disorders, each type with distinct symptoms and signs.

These disorders are treated with therapy, medication, or a combination of both. With help, you can usually recover from an adjustment disorder quickly. The disorder typically doesn't last more than six months, unless the stressor persists.

10.4 Recognizing the symptoms of adjustment disorder

The mental and physical symptoms associated with adjustment disorder usually occur during or immediately after you experience a stressful event. While the disorder lasts no longer than

six months, your symptoms may continue if the stressor isn't removed. Some people have just one symptom. Others may experience many symptoms.

The mental symptoms of adjustment disorders can include:

- rebellious or impulsive actions
- anxiousness
- feelings of sadness, hopelessness, or being trapped
- crying
- withdrawn attitude
- lack of concentration
- loss of self-esteem
- suicidal thoughts

There is one type of adjustment disorder that is associated with physical symptoms as well as psychological ones. These physical symptoms can include:

- insomnia
- muscle twitches or trembling
- fatigue
- body pain or soreness
- indigestion

10.5 Types of adjustment disorder

Following are the six types of adjustment disorder and their symptoms:

10.5.1 Adjustment disorder with depressed mood

People diagnosed with this type of adjustment disorder tend to experience feelings of sadness and hopelessness. It's also associated with crying. A person may also find that he/she no longer enjoy activities that he/she did formerly.

10.5.2 Adjustment disorder with anxiety

Symptoms associated with adjustment disorder with anxiety include feeling overwhelmed, anxious, and worried. People with this disorder may also have problems with concentration and memory. For children, this diagnosis is usually associated with separation anxiety from parents and loved ones.

10.5.3 Adjustment disorder with mixed anxiety and depressed mood

People with this kind of adjustment disorder experience both depression and anxiety.

10.5.4 Adjustment disorder with disturbance of conduct

Symptoms of this type of adjustment disorder mainly involve behavioral issues like driving recklessly or starting fights.

Teens with this disorder may steal or vandalize property. They might also start missing school.

10.5.5 Adjustment disorder with mixed disturbance of emotions and conduct

Symptoms linked to this type of adjustment disorder include depression, anxiety, and behavioral problems.

10.5.6 Adjustment disorder unspecified

Those diagnosed with adjustment disorder unspecified have symptoms that aren’t associated with the other types of adjustment disorder. These often include physical symptoms or problems with friends, family, work, or school.

10.5.7 Causes of adjustment disorders

A variety of stressful events can cause an adjustment disorder. Some common causes in adults include:

- death of a family member or friend
- relationship issues or divorce
- major life changes
- illness or a health issue (in you or someone you're close with)
- moving to a new house or place
- sudden disasters
- money troubles or fears

Typical causes in children and teenagers include:

- family fights or problems
- problems in school
- anxiety over sexuality

10.6 Who is at risk of developing adjustment disorder?

Anyone can develop an adjustment disorder. There isn't any way to tell who out of a group of people experiencing the same stressor will develop one. People social skills and methods for coping with other stressors may determine whether or not they develop an adjustment disorder.

10.7 How adjustment disorders is diagnosed

In order to be diagnosed with an adjustment disorder, a person must meet the following criteria:

- experiencing psychological or behavioral symptoms within three months of an identifiable stressor or stressors occurring in your life.
- having more stress than would be ordinary in response to a specific stressor, or stress that causes issues with relationships, in school or at work, or experiencing both of these criteria.

- the improvement of symptoms within six months after the stressor or stressors are removed.
- symptoms that aren't the result of another diagnosis.

10.8 Treatment of adjustment disorders

If one receives an adjustment disorder diagnosis, one would probably benefit from treatment. A person may require only short-term treatment or may need to be treated over an extended period of time. Adjustment disorder is typically treated with therapy, medications, or a combination of both.

10.8.1 Therapy

Therapy is the primary treatment for an adjustment disorder. A doctor or healthcare provider may recommend the affected person see a mental health professional. The affected person may be referred to a psychologist or mental health counselor. However, if the doctor thinks that the condition requires medication, they may refer them to a psychiatrist or psychiatric nurse practitioner.

Going to therapy may enable the affected person to return to a regular level of functioning. Therapists offer emotional support and can assist the affected person in understand the cause of their adjustment disorder. This may help them develop skills to cope with future stressful situations.

There are several kinds of therapies used to treat adjustment disorders. These therapies include:

- psychotherapy (also called counseling or talk therapy)
- crisis intervention (emergency psychological care)
- family and group therapies
- support groups specific to the cause of the adjustment disorder

- cognitive behavioral therapy, or CBT (which focuses on solving problems by changing unproductive thinking and behaviors)

interpersonal psychotherapy, or IPT (short-term psychotherapy treatment)

10.8.2 Medication

Some people with adjustment disorders also benefit from taking medications. Medications are used to lessen some of the symptoms of adjustment disorders, such as insomnia, depression, and anxiety. These medications include:

benzodiazepines, such as lorazepam (Ativan) and alprazolam (Xanax)

nonbenzodiazepine anxiolytics, such as gabapentin (Neurontin) SSRIs or

SNRIs, such as sertraline (Zoloft) or venlafaxine (Effexor XR)

10.9 How to prevent adjustment disorders?

There's no guaranteed way to prevent an adjustment disorder. However, learning to cope and be resilient can help you deal with stressors. Being resilient means being able to overcome stressors. A person can increase his/her resilience by:

- developing a strong network of people to support you
- looking for the positive or humor in hard situations
- living healthfully
- establishing good self-esteem

10.10 Summary

Unit ten is the last unit in this module. We hope you have understood the content of this module. In case you have a question do not hesitate to ask your course lecturer. Go back to all other unit as you start your revision for your examination.

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