Classification of Mental Disorders
Block 1

CLASSIFICATION OF MENTAL DISORDERS

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Expert Committee

Prof. Vimala Veeraraghavan (Chairperson)
Former Emeritus Professor
Discipline of Psychology
IGNOU, New Delhi

Prof. R. K. Chadda
Dept. of Psychiatry, AllIMS
Ansari Nagar, New Delhi

Prof. Dinesh Kataria
Dept. of Psychiatry
Lady Hardinge Medical College
New Delhi

Prof. Ram Ghulam
Head, Dept. of Psychiatry
M.G.M. Medical College Indore, M.P.

Superintendent -Mental Hospital Indore

Prof. T. B. Singh
Professor, Clinical Psychology
Institute of Behavioural Sciences
Gujarat Forensic Sciences University
Gujarat

Prof. B. S. Chavan
Head, Dept. of Psychiatry
Govt. Medical College, Chandigarh

Prof. R. C. Jiloha
Head, Dept. of Psychiatry
G.B. Pant & Maulana Azad Medical College
New Delhi

Dr. Rajeev Dogra
Clinical Psychologist
Dept. of Psychiatry, PGIMS
Rohtak

Prof. M. Thirunavukkarasu
President, Indian Psychiatric Society
Head, Dept. of Psychiatry, SRM Medical College
Hospital & Research Center, Chennai

Dr. Swati Patra
(Programme Coordinator)
Associate Professor, Discipline of Psychology
IGNOU, New Delhi

Programme Coordinator

Dr. Swati Patra
Associate Professor, Discipline of Psychology
SOSS, IGNOU, New Delhi

Course Coordinator

Dr. Monika Misra
Assistant Professor, Discipline of Psychology
SOSS, IGNOU, New Delhi

Course Writers

Unit 1 & 4
Prof. R. K. Chadda, Department of Psychiatry
All India Institute of Medical Sciences
New Delhi 110029

Unit 2 & 3
Dr. Mamta Sood, Associate Professor
Department of Psychiatry
All India Institute of Medical Sciences
New Delhi

Unit 5
Dr. Yatan Pal S. Balhara
Assistant Professor
Department of Psychiatry
Lady Hardinge Medical College
New Delhi

Material Production

Mr. Manjit Singh
Section Officer (Publication)
School of Social Sciences
IGNOU

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The Course on “Mental Disorders” is the second course in the P.G. Diploma in Mental Health (PGDMH) programme of IGNOU. This course will orient you towards the various group of mental disorders and their epidemiology. It further deals with the clinical picture, course and outcome of the mental disorders. The identification and assessment of the mental disorders are also described in this course.

As part of this course, you’ll have continuous evaluation through assignment and a term-end examination at the end of the year.

The course has four theory Blocks as follows:

The Blocks

Block 1 is on “Classification of Mental Disorders”. This Block focuses on the classification system of mental disorders. It provides you understanding about the different types of mental disorders such as the psychotic and neurotic group of disorders. It talks about their clinical features, course and outcome, identification and assessment, and treatment procedures. After studying this Block, you will be able to describe the classification systems for various mental disorders and point out their various aspects in terms of symptoms, clinical characteristics, diagnosis, causes and treatment.

Block 2 is titled “Epidemiology and Prevalence of Mental Disorders”. The Block talks about the epidemiological methods. You will also learn about the epidemiology of mental disorders in India. Further, you will understand the global burden of mental illness and the impact of mental disorders on the society. After going through this Block, you will be able to describe the epidemiology of mental disorders and the adverse effect of mental disorders on the society.

Block 3 is on “Clinical Manifestations, Course and Outcome of Mental Disorders”.

This Block will help you understand the clinical manifestations of the mental disorders in its cognitive, conative and affective aspects. Further, you will also learn about the course and outcome of the mental disorders. After studying this Block, you will be able to describe the mental disorders in terms of the disturbances in cognitive, affective and behavioural aspects; and depict their course and outcome.

Block 4 is on “Identification and Assessment of Mental Disorders”. This Block delineates the process of identification and assessment of mental disorders through interview and case history taking. You will learn about the steps followed in the assessment and the role of physical investigation and psychological assessment in the diagnosis of mental disorders. After going through this Block, you will develop an understanding of the procedure for identification and assessment of mental disorders.

How Will This Course Help You

The course will provide you knowledge and understanding about the various mental disorders. It will help you develop awareness and understanding of the mental disorders in its various aspects such as classification, identification, assessment, clinical manifestations, course, aetiology and treatment.
BLOCK 1    CLASSIFICATION OF MENTAL DISORDERS

In MPC-051 you have learned about the fundamentals of mental health, including the concept of mind, schools of psychology, concepts of normality and abnormality, and role of family and culture in mental health. In MPC-052, we will be discussing about the mental disorders, their classification, clinical manifestations and assessment of mental disorders.

Here in Block 1 of MPC-052, we will be focusing on the classification of Mental Disorders.

Unit 1 deals with the “Classification of Mental Disorders: Need, Historical Perspective and the Modern System of Classification”. It defines mental disorder and highlights the need and importance of having a classification system for mental disorders. The modern system of classification used are described in detail.

Unit 2 deals with “Schizophrenia and other psychotic disorders”. Schizophrenia, a major mental disorder is described in this unit in terms of its clinical features and diagnosis. Further, the etiology and treatment for schizophrenia are also explained. A few other related mental disorders are also mentioned in this Unit.

Unit 3 describes “Mood Disorders”, most commonly observed in the field of mental health. The clinical features of manic episode, depressive episode and mixed episode are explained. The Unit also describes the classification of mood disorders and the treatment of mood disorders. The Unit will help you be familiar with the common mood disorders.

Unit 4 is “Neurotic Group of Disorders”. It describes the anxiety related disorders, stress related disorders found frequently in the population. The Unit also deals with somatoform disorders and dissociative disorders. In all these disorders, the clinical picture, symptoms and the treatment options are elaborated.

Unit 5 is on “Other Disorders which do not fall in above categories of Psychiatric Disorders.” In this Unit, various other mental disorders are described such as sleep disorders, personality disorders, psychosexual disorders and eating disorders. The etiology, symptoms and the treatment options of these disorders are also described.
UNIT 1  CLASSIFICATION OF MENTAL DISORDERS: NEED, HISTORICAL PERSPECTIVE AND THE MODERN SYSTEM OF CLASSIFICATION

Structure
1.0  INTRODUCTION
1.1  Objectives
1.2  Definition of Mental Disorder
1.3  Need for Classification of Mental Disorders
1.4  Historical Perspective of Classification of Mental Disorders
1.5  Principles of Classification of Mental Disorders
1.6  Modern Systems of Classification of Mental Disorders
   1.6.1  Diagnostic and Statistical Manual (DSM)
   1.6.2  International Classification of Diseases (ICD)
1.7  Categories of Mental Disorders
1.8  Let Us Sum Up
1.9  Answers to Self Assessment Questions
1.10  Unit End Questions
1.11  References
1.12  Suggested Readings

1.0  INTRODUCTION

There is one important difference between mental illness and physical illness. In most of the mental illnesses unlike the physical illnesses, the exact etiology is not known. For example, we know that hypertension, a physical illness, is a result of increased blood pressure due to various reasons. In acute bronchitis, another physical illness, there is inflammation of bronchi due to various causes. Ulcerative colitis and bronchial asthma, two common physical illnesses, are characterised by changes in the colon and lungs respectively. But we are not aware of the exact pathological changes accompanying the mental illnesses, though on advanced imaging studies some patients show changes in specified brain areas, but these are not uniform.

Mental illnesses are a result of disturbance of the psychological functioning due to various reasons, and hence the term ‘disorder’ is commonly used instead of disease, whenever we are referring to a mental illness. The term ‘mental illness’ and ‘mental disorder’ are used synonymously, but the current classification systems prefer the term ‘mental disorder’, indicating a disturbance of functioning.

In this Unit, we will discuss about the concept of mental disorder, need for classifying the mental disorders, historical developments in the classification of mental disorders, and the modern classification systems.
1.1 OBJECTIVES

After studying this Unit, you will be able to:

- define a mental disorder;
- explain the need and purpose of classification of mental disorder;
- describe the history of classification of mental disorders; and
- explain the modern systems of classifications of mental disorders.

1.2 DEFINITION OF MENTAL DISORDER

Before we proceed further, it is important to define mental disorder and distinguish it from normal. Whether or not a problem is considered a disorder has implications in terms of deciding treatment, legal aspects, and also for medical insurance reimbursements. In comparison to most medical illnesses, mental disorders are manifested by a quantitative deviation in behaviour, ideation, and emotion from a normative concept. The debate remains which behaviours, ways of thinking, or emotional states could be considered abnormal or deviant to indicate mental disorder.

The 10th edition of the World Health Organisation’s International Classification of Diseases (ICD 10) does not define mental disorder, but refers to the term ‘disorder’, using it to imply the existence of a clinically recognisable set of symptoms or behaviours, associated with distress or interference with personal functions. It further mentions that social deviance or conflict alone, without personal dysfunction, does not constitute mental disorder (World Health Organisation, 1992).

The Mental Health Act of India does not define mental disorder or illness, but defines a mentally ill person as a person who is in need of treatment by reason of any mental disorder other than mental retardation.

American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV), defines mental disorder as a “clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.” The syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever be the original cause, the disturbance is considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (e.g., political, religious, or sexual) nor conflicts that are primarily between an individual and the society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above (American Psychiatric association, 2000).

Thus in simple words, mental disorder can be conceptualised as a disturbance in psychological functioning expressing itself in the form of psychological or behavioural disturbance, which is associated with significant distress to self or others or dysfunction in different areas of functioning.

Self Assessment Questions 1

Note: i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.
1. Differentiate between mental disorder and mental illness.

2. How do you define a mental disorder?

1.3 NEED FOR CLASSIFICATION OF MENTAL DISORDERS

There is a wide range of mental disorders with different kinds of manifestations. Hence it becomes important to arrange them into specific categories, based on some established criteria for different purposes. The classification serves this purpose and can be defined as the process by which the complexity of phenomena is reduced by grouping them into categories as per some defined criteria.

The ultimate purpose of classification is to improve the treatment and prevention of illnesses. Ideally, a classification of any illness group should be based on its etiology or pathophysiology because this increases the likelihood of improving treatment and prevention. Since, exact etiology or pathophysiology of most of the mental disorders is not known; the disorders are grouped into various classes on the basis of some shared phenomenological characteristics.

Classification of mental disorders serves the purpose of communication, control, and comprehension.

- Communication refers to communicating information about the illness and the diagnosis. Thus when a clinician diagnoses a mental disorder as a specific category (e.g. generalised anxiety disorder) as per a particular classification system, and puts it on an outpatient prescription or the case records; another clinician would understand the clinical symptoms of the patient on seeing the diagnosis in the records. Thus it has served the purpose of communication.

- Control refers to developing the strategies for modifying the course of illness with treatment and also planning preventive strategies. A definition of disorder as per some classification would make it easy to develop control methods.

- Comprehension refers to understanding about the illness. Classification has a potential to improve understanding of an illness and hence also the causes and the processes involved in the development of illness and its maintenance.

Self Assessment Questions 2

Note:  i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.
1) What is classification?

2) Why do we need to classify mental disorders?

3) Describe the purposes of classification of mental disorders.

1.4 HISTORICAL PERSPECTIVE OF CLASSIFICATION OF MENTAL DISORDERS

Historically, there are evidences of description of some mental disorders as early as 3000 BC. The syndromes of melancholia and hysteria find mention in Egyptian and Sumerian literature of 2600 BC. Ayurveda, the Indian system of medicine had included a classification of psychiatric disorders under medical illnesses in 1400 BC. In the modern system of medicine, Hippocrates (460-370 BC) is generally credited for bringing the concept of psychiatric illnesses to medicine. He classified mental illness into delirium, mania, paranoia, hysteria, melancholia resulting from four basic temperaments.

In the modern psychiatry, the first major attempt of classifying mental disorders was made by Emil Kraepelin (1856-1926), who used three approaches towards classification of mental disorders: clinical-descriptive, the somatic, and the course. His primary classifications were manic depressive psychosis and dementia praecox. Thus, Kraepelin brought manic and depressive disturbances together into one illness, and distinguished it from the chronic deteriorating illness called dementia praecox, on the basis of its periods of remission. Later Eugen Bleuler renamed dementia praecox as schizophrenia, a diagnostic term which is in use even after 100 years of its introduction. Kraepelin also differentiated paranoia from dementia praecox, delirium from dementia, and, also introduced the concepts of psychogenic neuroses and psychopathic personalities. Sigmund Freud (1856-1939) made important contributions towards the classification of neuroses and personality disorders. Kraepelin’s classification could be taken as a forerunner of the modern official classification system.

For the purpose of census, certain classification system had been in use in the 19th century and in the first half of the 20th century in the USA and certain other countries. In the current scientific world, there are two official classification systems: World Health Organisation’s International Classification of Diseases (ICD) and the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). We will be discussing about these in detail.
1.5 PRINCIPLES OF CLASSIFICATION OF MENTAL DISORDERS

The development of classification system and their subsequent revisions reflect the contemporary understanding of the mental illness. The classification of psychiatric disorders has been primarily based on the clinical presentation of the illness and its course, since we are not aware of their exact etiology and pathophysiology. Clustering of different clinical symptoms in different areas of psychological functioning, their severity, and the course often form the basis of the categorisation, as also historically used by Kraepelin.

At the simplest, the mental disorders are divided into organic and functional, and then into psychotic and neurotic disorders. This dichotomy, though still used sometimes, is not valid in the current classificatory systems. But for historical reasons and for understanding purpose, it is important to understand these terms. If in a psychiatric patient there is an evidence of a structural or functional disturbance in brain on taking history, clinical examination or investigations, the disorder is termed as ‘organic’. If there is no such evidence, the illness is called ‘functional’. The functional illnesses are further broadly categorised into psychoses (psychotic disorders) and neuroses (neurotic disorders).

The term ‘psychoses’ refers to severe psychiatric disorders characterised by grossly disturbed behaviour, loss of contact with reality, lack of insight and inability to meet the general demands of life, whereas the ‘neuroses’ are psychiatric disorders of lesser severity, where anxiety is the predominant feature which may be experienced directly or on being altered into some other symptoms by mental defence mechanisms. The patient usually retains insight and contact with reality in neuroses. The traditional dichotomy between neuroses and psychoses is not followed in the current classificatory systems e.g. ICD 10 and DSM IV. In both, the disorders are arranged in groups according to major common themes or descriptive likenesses, making it more convenient to use.

<table>
<thead>
<tr>
<th>Self Assessment Questions 3</th>
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</thead>
<tbody>
<tr>
<td><strong>Note:</strong> i) Read the following questions carefully and answer in the space provided below.</td>
</tr>
<tr>
<td>ii) Check your answer with that provided at the end of this unit.</td>
</tr>
<tr>
<td>1) What is Kraepelin’s contribution to classification of mental disorders?</td>
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<tr>
<td>2) What is the principle used in classification of mental disorders?</td>
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<tr>
<td>3) What are the differences between psychoses and neuroses?</td>
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</table>
As introduced earlier, there are currently two official classification systems which are recognised internationally. Both have been in use now for more than 60 years. The two systems are the WHO’s International Classification of Diseases (ICD) and American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). Both the systems have undergone a number of revisions and also expansions since their initial introduction. Though initially, there were many differences between the two systems, their latest editions (ICD 10 of 1992 and DSM IV of 1994) with revisions in their respective editions over the years, the two are now quite similar in basic principle. Both are recognised internationally. DSM IV is the official diagnostic system of USA and its latest version is of 2000, called DSM IV-TR (DSM IV- Text Revision). WHO’s ICD10 has got acceptance all over the world and is also the official diagnostic system in India. Both ICD 10 as well as DSM IV are in the process of a final revision to ICD 11 and DSM V, which are expected in another 2-3 years.

Let us now discuss both DSM and ICD classification.

### 1.6.1 Diagnostic and Statistical Manual (DSM)

The DSM-IV (TR) recommends clinicians to assess an individual’s mental state across five factors or axes. Together the five axes provide a broad range of information about the individual’s functioning, not just a diagnosis. The system contains the following axes.

1) **Axis I: Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention**

This axis incorporates a wide range of clinical syndromes, including anxiety disorders, mood disorders, schizophrenia and other psychotic disorders, adjustment disorders, and disorders usually first diagnosed during infancy, childhood, or adolescence (except for mental retardation, which is coded on Axis II). Axis I also includes relationship problems, academic or occupational problems, and bereavement, conditions that may be the focus of diagnosis and treatment but that do not in themselves constitute definable psychological disorders. Also coded on Axis I are psychological factors that affect medical conditions, such as anxiety that exacerbates an asthmatic condition or depressive symptoms that delay recovery from surgery. The Axis I clinical disorder categories are as follows:

1) Disorders usually first diagnosed in Infancy, Childhood, or Adolescence
2) Delirium, Dementia, and Amnestic and other Cognitive Disorders
3) Mental Disorders due to a General Medical Condition not elsewhere Classified
4) Substance Related Disorders
5) Schizophrenia and other Psychotic Disorders
6) Mood Disorders
7) Anxiety Disorders
8) Somatoform Disorders
9) Factitious Disorders
10) Dissociative Disorders
11) Sexual and Gender Identity Disorders
12) Eating Disorders
13) Sleep Disorders
14) Impulse Control Disorders not elsewhere Classified
15) Adjustment Disorders
16) Other Conditions that may be a focus of Clinical Attention

2) Axis II: Personality Disorders and Mental Retardation

Personality disorders are enduring and rigid patterns of maladaptive behaviour that typically impair relationships with others and social functioning. These include antisocial, paranoid, narcissistic, and borderline personality disorders. Mental retardation, which is also coded on Axis II, involves pervasive intellectual impairment. People may be given either Axis I or Axis II diagnoses or a combination of the two when both apply. For example, a person may receive a diagnosis of an anxiety disorder (Axis I) and a second diagnosis of a personality disorder (Axis II).

This axis include following disorders:

1) Paranoid Personality Disorder
2) Narcissistic Personality Disorder
3) Schizoid Personality Disorder
4) Avoidant Personality Disorder
5) Schizotypal Personality Disorder
6) Dependent Personality Disorder
7) Antisocial Personality Disorder
8) Obsessive-Compulsive Personality Disorder
9) Borderline Personality Disorder
10) Personality Disorder Not Otherwise Specified
11) Histrionic Personality Disorder
12) Mental Retardation

3) Axis III: General Medical Conditions

All medical conditions and diseases that may be important to the understanding or treatment of an individual’s mental disorders are coded on Axis III. For example, if hypothyroidism were a direct cause of an individual’s mood disorder (such as major depression), it would be coded under Axis III. Medical conditions that affect the understanding or treatment of a mental disorder (but that are not direct causes or the disorder) are also listed on Axis III. For instance, the presence of a heart condition may determine whether a particular course of drug therapy should be used with a depressed person.

4) Axis IV: Psychosocial and Environmental Problems

The psychosocial and environmental problems that affect the diagnosis, treatment, or outcome of a mental disorder are placed on Axis IV. These include job loss, marital separation or divorce, homelessness or inadequate housing, lack of social support, the death or loss of a friend, or exposure to war or other disasters. Some positive life events, such as a job promotion, may also be listed on Axis IV, but only when they create problems for the individual, such as difficulties adapting to a new job. Table 1 lists examples from this axis.
### Table 1: Psychosocial and Environmental Problems

<table>
<thead>
<tr>
<th>Problem Categories</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with primary support group</td>
<td>Death of family members; health problems of family members; marital disruption in the form of separation, divorce, or estrangement; sexual or physical abuse within the family; child neglect; birth of a sibling</td>
</tr>
<tr>
<td>Problems related to the social environment</td>
<td>Death or loss of a friend; social isolation or living alone; difficulties adjusting to a new culture (acculturation); discrimination; adjustment to transitions occurring during the life cycle, such as retirement</td>
</tr>
<tr>
<td>Educational problems</td>
<td>Illiteracy; academic difficulties; problems with teachers or classmates; inadequate or impoverished school environment</td>
</tr>
<tr>
<td>Occupational problems</td>
<td>Work-related problems including stressful workloads and problems with bosses or co-workers; changes in employment; job dissatisfaction; threat of loss of job; unemployment</td>
</tr>
<tr>
<td>Housing problems</td>
<td>Inadequate housing or homelessness; living in an unsafe neighbourhood; problems with neighbours or landlord</td>
</tr>
<tr>
<td>Economic problems</td>
<td>Financial hardships or extreme poverty; inadequate welfare support</td>
</tr>
<tr>
<td>Problems with access to health care services</td>
<td>Inadequate health care services or availability of health insurance; difficulties with transportation to health care facilities</td>
</tr>
<tr>
<td>Problems related to interaction with the legal system/crime</td>
<td>Arrest or imprisonment; becoming involved in a lawsuit or trial; being a victim of crime</td>
</tr>
<tr>
<td>Other psychosocial problems</td>
<td>Natural or human-made disasters; war or other hostilities; problems with caregivers outside the family, such as counselors, social workers, and physicians; lack of availability of social service agencies</td>
</tr>
</tbody>
</table>

Source: Adapted from the DSM-IV-TR (APA, 2000)

5) **Axis V: Global Assessment of Relational Functioning (GARF)**

The clinician rates the client’s current level of psychological, social, and occupational functioning using a 0-100 scale (see Table-2). The clinician may also indicate the highest level of functioning achieved for at least a few months during the preceding year. The level of current functioning indicates the current need for treatment or intensity of care. The level of highest functioning is suggestive of the level of functioning that might be restored. The GARF Scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship (APA. 2000).
Table 2: Global Assessment of Functioning (GAF) Scale

<table>
<thead>
<tr>
<th>Code</th>
<th>Severity of Symptoms</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-100</td>
<td>Superior functioning across a wide variety of activities of daily life</td>
<td>Lacks symptoms, handles life problems without them “getting out of hand”</td>
</tr>
<tr>
<td>81-90</td>
<td>Absent or minimal symptoms, no more than everyday problems or concerns</td>
<td>Mild anxiety before exams, occasional argument with family members</td>
</tr>
<tr>
<td>71-80</td>
<td>Transient and predictable reactions to stressful events, or no more than slight impairment in functioning</td>
<td>Difficulty concentrating after argument with family, temporarily falls behind in schoolwork</td>
</tr>
<tr>
<td>61-70</td>
<td>Some mild symptoms, or some difficulty in social, occupational, or school functioning, but functioning pretty well</td>
<td>Feels down, mild insomnia, occasional truancy or theft within household</td>
</tr>
<tr>
<td>51-60</td>
<td>Moderate symptoms, or moderate difficulties in social, occupational, or school functioning</td>
<td>Occasional panic attacks, few friends, conflicts with co-workers</td>
</tr>
<tr>
<td>41-50</td>
<td>Serious symptoms, or any serious impairment in social, occupational, or school functioning</td>
<td>Suicidal thoughts, frequent shoplifting, unable to hold job, has no friends</td>
</tr>
<tr>
<td>31-40</td>
<td>Some impairment in reality testing or communication, or major impairment in several areas</td>
<td>Speech illogical, depressed man or woman unable to work, neglects family, and avoids friends</td>
</tr>
<tr>
<td>21-30</td>
<td>Strong influence on behavior of delusions or hallucinations, or serious impairment in communication or judgment, or inability to function in almost all areas</td>
<td>Grossly inappropriate behavior, speech sometimes incoherent, stays in bed all day, no job, home, or friends</td>
</tr>
<tr>
<td>11-20</td>
<td>Some danger of hurting self or others, or occasionally fails to maintain personal hygiene, or gross impairment in communication</td>
<td>Suicidal gestures, frequently violent, smears feces Largely incoherent or mute</td>
</tr>
<tr>
<td>1-10</td>
<td>Persistent danger of severely hurting self or others, or persistent inability to maintain minimal personal hygiene, or seriously suicidal act with clear expectation of death</td>
<td>Serious suicidal attempt, recurrent violence</td>
</tr>
</tbody>
</table>

Source: Adapted from the DSM-IV-TR (APA, 2000)
1.6.2 International Classification of Diseases (ICD)

ICD 10 is developed by WHO. The current version being followed is the 10th version of ICD (ICD-10) that was published in 1992. ICD10 follows an alphanumeric coding scheme, based on codes with a single letter followed by two numbers at the three character level (A00- - Z99). Further detail is then provided by decimal numeric subdivisions at the four character level. There are a total of 21 chapters in ICD-10, of which the fifth chapter, i.e. Chapter V (F) of ICD-10 deals with mental and behavioural disorders and has 100 categories F00-F99. On the other hand, DSM IV retained the coding of the earlier edition called International Classification of Diseases, Clinical Modification (ICD-CM) - 291.00 to 319. ICD 10 is the official diagnostic system in India.

The version of ICD 10 used by mental health professionals for clinical purposes is called the Clinical Description and Diagnostic Guidelines version. Other versions of the ICD-10, which are all mutually compatible, are depicted in the table below:

<table>
<thead>
<tr>
<th>S.No.</th>
<th>ICD 10 Version</th>
<th>Description</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clinical description and diagnostic guidelines</td>
<td>Contains basic description of each disorder</td>
<td>Mainly for clinicians</td>
</tr>
<tr>
<td>2</td>
<td>Diagnostic criteria for research</td>
<td>Each disorder contains specific criteria for diagnosis</td>
<td>Mainly for researchers</td>
</tr>
<tr>
<td>3</td>
<td>Primary care version</td>
<td>Contains only 27 main categories, with brief notes on management and referral</td>
<td>Mainly for general physicians who work in the primary care setting</td>
</tr>
</tbody>
</table>

As mentioned earlier, mental and behavioural disorders of ICD-10 are given code “F”. ICD 10 has grouped various mental disorders into 10 groups, coded as F00 to F99, as below.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>F00-F09</td>
<td>Organic, including symptomatic, mental disorders</td>
</tr>
<tr>
<td>F10-F19</td>
<td>Mental and behavioural disorders due to psychoactive substance use</td>
</tr>
<tr>
<td>F20-F29</td>
<td>Schizophrenia, Schizotypal and delusional disorders</td>
</tr>
<tr>
<td>F30-F39</td>
<td>Mood (affective) disorders</td>
</tr>
<tr>
<td>F40-F49</td>
<td>Neurotic, stress related and somatoform disorders</td>
</tr>
<tr>
<td>F50-F59</td>
<td>Behavioural syndromes associated with physiological disturbances and physical factors</td>
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<td>F60-F69</td>
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<tr>
<td>F90-F99</td>
<td>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence</td>
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Self Assessment Questions 4

**Note:**

i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Discuss briefly the international classification systems of mental disorders currently in use.

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1.7 CATEGORIES OF MENTAL DISORDERS

This section gives salient features of various mental disorders, as these are described in ICD 10. The categories are broadly similar to those of DSM IV, though there are minor differences in diagnostic guidelines or in the precise grouping of the diagnostic categories. All the disorders as enumerated below are discussed in details in subsequent chapters.

As mentioned earlier, the following mental disorders are included under ICD 10:

- Organic, including symptomatic, mental disorders
- Mental and behavioural disorders due to psychoactive substance use
- Schizophrenia, schizotypal and delusional disorders
- Mood [affective] disorders
- Neurotic, stress-related and somatoform disorders
- Behavioural syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behaviour
- Mental retardation
- Disorders of psychological development
- Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- Unspecified mental disorder

Characteristics of some important illnesses in each category are briefly discussed.

1) Organic, including symptomatic, mental disorders

Organic mental disorders, also known as organic brain disorders, are a group of disorders, characterised by a demonstrable etiology in the brain in form of a cerebral disease, brain injury or some other insult leading to cerebral dysfunction. The illness may be primary, where the pathology involves the brain directly or secondary, where the brain is affected as secondary consequence of another systemic disease, which has involved the brain as one of the multiple organs or systems. For example, the brain is the primary organ involved in Alzheimer’s disease, Parkinson’s disease, head injury or
common mental disorders include dementia, delirium, organic amnestic syndrome, organic delusional disorder, organic mood disorder, organic personality disorder, mild cognitive disorder, post encephalitic disorder, etc.

**Dementia** is a syndrome resulting from disease of brain, usually of chronic or progressive nature, which is characterised by a global impairment of higher mental functions, such as memory, intelligence, comprehension, cognition, learning capacity, judgement, reasoning, language, orientation and personality, occurring as a result of degenerative changes in the brain. Consciousness is not affected. Alzheimer’s disease is the commonest type of dementia. Other types include vascular dementia, sub cortical dementia, dementia due to Parkinson’s disease. A large number of neurological and systemic illnesses can lead to dementia.

**Delirium** is an organic mental disorder of acute onset, characterised by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion and sleep-wake cycle. It is usually transient and runs a fluctuating course. Delirium is a result of some disturbance in the cerebral functioning, which can be due to a large number of cerebral and non cerebral systemic causes.

**Organic amnestic disorder** is characterised by an impairment of recent and remote memory. While immediate recall is preserved, ability to learn new material is markedly reduced, resulting in anterograde amnesia and disorientation in time.

Any kind of psychiatric symptomatology characterised by psychotic symptoms, mood symptoms, personality disturbances or others can occur due to an organic cause and comes under the broad category of organic mental disorders.

2) **Mental and behavioural disorders due to psychoactive substance abuse**

Abuse of various psychoactive substances like alcohol, opioids, stimulants or other such substances, can result in a wide variety of psychiatric conditions, such as acute intoxication, harmful use, dependence syndrome, withdrawal phenomena, amnestic syndrome and disorders resembling functional psychiatric conditions like schizophrenia, depression, mania, amnestic syndrome or others. Common substances that are abused include alcohol, opioids, cannabinoids, sedatives and hypnotics, hallucinogens, cocaine, stimulants, tobacco and volatile solvents.

Acute intoxication is a transient disturbance which occurs following the administration of a psychoactive substance and is characterised by disturbances in consciousness, cognition, perception, affect or behaviour, or in other psychophysiological functions and responses. The condition is usually transient.

Harmful use refers to a pattern of psychoactive substance abuse, which can cause damage to the physical or mental health of the person using the substance.

Dependence syndrome is characterised by a cluster of physiological, behavioural and cognitive phenomena, in which, the use of a substance takes on a much higher priority for an individual than other behaviours, which have a greater value. There is a strong desire or an urge (craving) to take the psychoactive substance, appearance of withdrawal symptoms on reducing or stopping the substance, need to take increasing amounts of the substance to achieve the desired effect, and persisting with substance use despite
clear evidence of overtly harmful consequences. Often there is accompanying impairment in various areas of psychosocial functioning such as personal neglect, neglect of family, and impairment in job performance.

Withdrawal syndrome refers to a group of symptoms of variable clustering and severity that occur on stopping or reducing the amount of intake of the psychoactive substance after repeated and prolonged use of that substance.

3) **Schizophrenia, schizotypal and delusional disorders**

This group includes schizophrenia, schizotypal disorder, persistent delusional disorder, acute transient psychotic disorder, schizoaffective disorder and other psychotic disorders.

*Schizophrenia* is characterised by disturbances in thinking, emotion, perception, behaviour and personality disorganisation, and often runs a chronic deteriorating course. The patient may present with delusions, hallucinations, disorganised thinking, disorganised behaviour, inappropriate and blunted affect, and personality deterioration.

*Schizotypal disorder* is characterised by eccentric behaviour and anomalies of thinking like odd beliefs, suspiciousness, vague circumstantial, stereotyped thinking inappropriate or constrained affect and occasional transient quasi-psychotic episodes. But characteristic symptoms of schizophrenia like delusions, hallucinations or disorganised behaviour are lacking.

In *delusional disorders*, the patient presents with long standing delusions in the absence of any other characteristic psychopathology suggestive of schizophrenia, mania or any other psychiatric disorder.

*Schizoaffective disorders* are characterised by the presence of prominent schizophrenic as well as affective symptoms within the same episode of illness. The illness has an episodic pattern and its relationship with schizophrenia as well as the mood disorders is still uncertain.

*Acute and transient psychotic disorders* are a group of disorders, characterised by symptoms of excitement, perplexity, confusion, irrelevant talk, delusions and hallucinations of acute onset. The clinical presentation may mimic schizophrenia or may have an affective colouring but the illness is mostly short lasting. Some cases may go on to develop into schizophrenia.

4) **Mood (affective) disorders**

Mood disorders are characterised by a primary disturbance of mood or affect. Most of the other symptoms are secondary and can be easily understood in the context of the primary mood disturbance. Most of these disorders run an episodic course. The episodes can be of mania, depression or of mixed type. In inter episodic periods the patients may not have any symptoms.

The patient in mania is euphoric or elated, excited, overenergetic, grandiose, and has increased libido and decreased need for sleep. There is pressure of speech or flight of ideas. The patient may make extravagant and impractical schemes, spend money recklessly, or may become paranoid, aggressive and violent.

In the depressive phase, the patient feels sad, dejected and low. There is loss of interest in day to day activities, decreased sleep, decreased appetite and lack of energy. Psychomotor activity is usually decreased, but sometimes agitation may be present. Ideas of guilt, hopelessness, helplessness, worthlessness and suicide are often present.
Classification of Mental Disorders

Sometimes, there occur mixed kind of episodes with a mixture of manic and depressive symptoms.

Hypomania and dysthymia are relatively milder forms of manic and depressive episodes respectively. Cyclothymia is a condition, in which there occur alternating phases of hypomania and dysthymia.

5) **Neurotic, stress related and somatoform disorders**

The group of neurotic, stress related and somatoform disorders includes a large number of conditions, which were earlier included under the broad group of neuroses, and stress related symptoms. Most such patients present with anxiety symptoms, or somatic symptoms without an organic basis. Stress related disorders like post traumatic stress disorder and dissociative disorders also grouped in this broad category.

*Neurotic disorders* include phobic anxiety disorder, panic disorder, generalised anxiety disorder, obsessive compulsive disorder and dissociative disorders.

The central feature in *phobic anxiety disorder* (earlier known as phobic neurosis) is phobia. Phobia is a persistent, unrealistic and intense fear of an object, activity or a situation, which is considered irrational by the person. Common types of phobia are agoraphobia, social phobia and specific phobias.

*Generalised anxiety disorder* is characterised by the presence of generalised and persistent anxiety. The presenting symptoms include feelings of nervousness, muscular tension, sweating, light-headedness, palpitations, dizziness, epigastric discomfort and tremulousness.

In *panic disorder*, there occur recurrent brief episodes of severe anxiety (panic). The episodes occur suddenly and spontaneously and are not restricted to any particular situation or set of circumstances (unlike phobias), and usually last for minutes, though may be longer in some cases.

*Obsessive compulsive disorder* is characterised by obsessions and compulsions. An obsession is a persistent and recurrent idea, image or impulse, which enters the individual’s mind against one’s wish, is considered absurd by the person, is anxiety provoking and cannot be eliminated from the consciousness by any amount of reasoning or logic. It is recognised as one’s own thought or impulse. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. The individual often views them as preventing some objectively unlikely event or performs it in response to an obsession. Behaviour is considered purposeless by the person and person may feel compelled to perform it.

*Dissociative (conversion) disorders* are characterised by the presence of psychological or physical symptoms, presumed to result from partial or complete loss of normal integration (dissociation) between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. The term conversion refers to the mechanism by which an unpleasant affect, resulting from a conflict is transformed into the symptoms. Psychological presentations include amnesia, fugue states, stupor, possession states, multiple personality, etc. Physical presentations include disorders of movement and sensation, convulsions and dissociative anaesthesia or loss of sensation. The conversion disorder with presentation of physical symptoms is grouped under somatoform disorders in DSM IV.

In *somatoform disorders*, the patient presents with physical symptoms suggesting a physical illness, though there is none. Even if a physical pathology is present, it is not
sufficient to explain the symptoms. The patient repetitively requests for medical investigations, in spite of repeated negative findings and reassurances from the doctors that the symptoms have no physical basis. Psychological factors are responsible or are presumed to be responsible for the symptoms. Even when the onset and continuation of the symptoms bear a close relationship with unpleasant life events or with difficulties or conflicts, the patient usually resists attempts to discuss the possibility of psychological causation. The category of somatoform disorders includes somatization disorder, hypochondriacal disorder, undifferentiated somatoform disorder, somatoform autonomic dysfunction and persistent somatoform pain disorder.

In stress related disorders, the genesis of illness is related to stress. The illness may occur either immediately following the stress or with a delayed onset. These include acute stress reaction, post traumatic stress disorder and adjustment disorders.

*Acute stress reaction* is a transient disorder occurring in response to exceptional physical or mental stress, which usually subsides within hours or days. The clinical picture is often changing, starting with a daze and later characterised by depression, anxiety, anger, despair, overactivity or withdrawal. Stressor may be an overwhelming traumatic experience posing serious threat to the security or physical integrity of the person (e.g. a criminal assault, natural catastrophe, rape, accident, etc.)

*Post traumatic stress disorder (PTSD)* is characterised by a delayed or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature (e.g., natural or man-made disasters, serious accidents, wars, torture, terrorism) which is likely to cause pervasive distress in almost all the affected population. Symptoms include repeated reliving of the trauma in flashbacks or dreams, sense of numbness, detachment from other people, unresponsiveness to others, a state of hyper arousal with hyper vigilance and avoidance of activities and situations reminiscent of trauma.

*Adjustment disorders* are characterised by subjective distress and emotional disturbance, occurring in the period of adaptation to a significant life change. Symptoms usually interfere with social functioning and performance, and include a range of depressive, anxiety or behavioural disturbances.

6) **Behavioural syndromes associated with physiological disturbances and physical factors**

This group includes eating disorders, non organic sleep disorders, sexual dysfunctions, mental and behavioural disorders associated with puerperium (not classified elsewhere), psychological and behavioural factors associated with disorders and diseases classified elsewhere and abuse of non dependence producing substances.

*Eating disorders* include anorexia nervosa, bulimia nervosa, overeating and others. Anorexia nervosa is characterised by deliberate weight loss, induced and/or sustained by the patient and is usually seen in adolescent girls and young women, and is associated with body image distortions and endocrine disturbances like amenorrhea. In bulimia nervosa, there occur repeated bouts of overeating and an excessive preoccupation with the control of body weight, leading to episodes of self induced vomiting, purgative abuse, diuretics or appetite suppressants.

*Non organic sleep disorders* include non organic insomnia, non organic hypersonomnia, disorder of sleep wake schedule, sleepwalking, sleep (night) terrors and nightmares.

*Sexual dysfunctions* (not caused by organic disorder or disease) or psychosexual disorders include a range of dysfunctions like failure of genital response (erectile impotence in males), premature ejaculation, retarded ejaculation, excessive sexual drive,
lack or loss of sexual desire, orgasmic dysfunction, vaginismus, dyspaerunia and sexual aversion.

7) Disorders of adult personality and behaviour

This group includes personality disorders, habit and impulse disorders, gender identity disorders, disorders of sexual performance, factitious disorder and other related disorders.

*Personality disorders* are deeply ingrained and inflexible lifelong maladaptive patterns of behaviour, generally recognisable by adolescence and continuing throughout most of the adult life. There is significant functional impairment and the patient may be subjectively distressed, but denies his or her problems and refuses psychiatric help. There are many types of personality disorders, which include paranoid personality disorder, schizoid personality disorder, dissocial personality disorder, histrionic personality disorder, narcissistic personality disorder, avoidant personality disorder and others.

*Habit and impulse disorders* are characterised by repeated performance of certain acts, generally of harm to one’s and others’ interests. There is no clear rational motivation, but the behaviour is associated with impulses which cannot be controlled. The group includes pathological gambling, pathological fire setting (pyromania), pathological stealing (kleptomania), trichotillomania and others.

*Gender identity disorders* are characterised by persistent feelings of discomfort with one’s biological sex or gender role of one’s biological sex. These include transsexualism and transvestism.

*Disorders of sexual preference* include deviant sexual practices like sadism, masochism, fetishism, transvestism, voyeurism, exhibitionism, paedophilia, zoophilia, etc. The key feature is that the deviant sexual behaviour is often the preferred sexual practice by the person.

*Factitious disorder* is characterised by repeated feigning of physical or psychological symptoms. The patient may even self inflict cuts or abrasions to induce bleeding or self inject toxic substances to produce pathology. There is no apparent motivation except for an unconscious desire to assume a sick role or to be ill.

8) Mental retardation

Mental retardation is a developmental condition, characterised by significantly subaverage general intellectual functioning in various areas like cognitive, language, motor and social abilities, resulting in or associated with concurrent impairment in adaptive behaviour. The condition is usually manifested during the developmental period. The cause may lie in arrested or incomplete development of the mind due to a congenital or hereditary cause or brain insult due to a birth injury, pre or post natal event or in the early childhood. Depending on the IQ or the severity, it is categorized as mild, moderate, severe or profound.

9) Disorders of psychological development

These include specific developmental disorders of speech and language, scholastic skills and motor function, mixed specific developmental disorders and pervasive developmental disorders.

*Specific developmental disorders* of speech and language are characterised by a delay in the normal patterns of language acquisition from the early stages of development.
The delay is not a result of any neurological or speech mechanism abnormalities, sensory impairment, mental retardation or environmental factors. There could be a delay in speech articulation, expressive language, receptive language, acquired aphasia with epilepsy (Landau Kleffner syndrome) or other related disorders.

**Specific developmental disorders of scholastic skills** are characterised by delay in the normal patterns of development of a specific skill acquisition, which may include reading, writing, spellings or arithmetic skills. Conceptually, it is similar to the specific developmental disorder of speech and language. The disorder is thought to result from some abnormalities in cognitive processing because of some biological dysfunction, and is not simply a consequence of a lack of opportunity to learn or some acquired brain trauma or disease.

**Specific developmental disorder of motor function** is characterised by serious impairment in the development of motor coordination, which cannot be explained in terms of general intellectual retardation or some neurological disorder.

In **pervasive developmental disorders**, qualitative abnormalities are seen in reciprocal social interactions and in patterns of communication, accompanied by restricted and stereotyped repetitive repertoire of interests and activities. The developmental problems are mostly evident starting from infancy and the condition becomes manifest in the first 5 years of life. The group includes autism, Rett’s syndrome, childhood disintegrative disorder, Asperger’s syndrome and other related disorders.

10) **Behavioural and emotional disorders with onset usually occurring in childhood and adolescence**

This group includes hyperkinetic disorders, conduct disorders, mixed disorders of conduct and emotions, emotional disorders with onset specific to childhood, disorders of social functioning, tic disorders, enuresis, encopresis and other related disorders.

**Hyperkinetic disorders** (Attention deficit hyperactivity disorder in DSM IV) have onset usually in the first five years of life and are characterised by overactivity, impaired attention, and behavioural disturbance, which are manifest in different situations.

**Conduct disorders** are characterised by a repetitive and persistent pattern of dissocial, aggressive and defiant behaviour, which is more than the usual childish mischief or adolescent rebelliousness. Such behaviours include excessive fighting or bullying, cruelty to animals, severe destructiveness to property, fire setting, stealing, truancy from school, repeated lying, etc.

**Emotional disorders** specific to childhood include separation anxiety disorder, phobic anxiety disorder, social anxiety disorder and sibling rivalry disorder.

**Disorders of social functioning** are characterised by some abnormalities of social functioning with onset during developmental period. These include elective mutism, reactive attachment disorder and disinherited attachment disorder.

11) **Unspecified mental disorder**

This includes conditions which cannot be diagnosed under any of the above categories.
Self Assessment Questions 5

Note:  
i) Read the following questions carefully and answer in the space provided below.
ii) Check your answer with that provided at the end of this unit.

1) What are the different major diagnostic categories under the section of mental disorders in ICD 10?

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2) Discuss the main difference between schizophrenia and mood disorder?

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3) What are disorders of psychological development?

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1.8 LET US SUM UP

- Mental disorder is conceptualised as a disturbance in psychological functioning expressing itself in form of psychological or behavioural disturbance, associated with significant distress to self or others or dysfunction in different areas of functioning.

- Classification serves the purpose of communication, control and comprehension.

- ICD 10 and DSM IV are the two official classification systems used for classification of mental disorders.

- ICD 10 is the official classification system of India.

1.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Mental disorder and mental illness are used synonymously; however, the current classification system prefers the use of the term ‘mental disorder’, indicating a disturbance of functioning.

2) Mental disorder can be defined as a disturbance in psychological functioning, expressed in the form of psychological or behavioural disturbance, and that is associated with significant present distress or disability or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.
Self Assessment Questions 2
1) Classification is the process by which a phenomena is grouped into categories as per some defined criteria.

2) We need to classify mental disorders in order to provide for better treatment and prevention of illnesses.

3) The purposes of classification of mental disorders are three-fold: communication, control and comprehension.

Self Assessment Questions 3
1) Kraepelin was the first psychiatrist to classify mental disorders, and used three approaches towards the classification of mental disorders, namely (i) clinical-descriptive, (ii) the somatic, and (iii) the course.

2) The classification of mental disorders is primarily based on the clinical presentation of the illness and its course.

3) The difference between psychoses and neuroses lies in the severity of the disorder. Psychoses refer to severe psychotic disorders characterised by grossly disturbed behaviour and loss of contact with reality; whereas neuroses are of milder form with anxiety being the predominant feature.

Self Assessment Questions 4
1) Currently there are two types of international classification systems of mental disorders that are in use. These are Diagnostic and Statistical Manual (DSM – IV – Text Revision) and International Classification of Diseases (ICD – 10). The former is the official diagnostic system of USA whereas India follows the latter classification system.

Self Assessment Questions 5
1) The major diagnostic categories under the section of mental disorders in ICD 10 are as follows:
   i) Organic including symptomatic, mental disorders
   ii) Mental and behavioural disorders due to psychoactive substance use
   iii) Schizophrenia, schizotypal and delusional disorders
   iv) Mood, affective disorders
   v) Neurotic, stress related and somatoform disorders
   vi) Behavioural syndromes associated with physiological disturbances and physical factors
   vii) Disorders of adult personality and behaviour
   viii) Mental retardation
   ix) Disorders of psychological development
   x) Behavioural and emotional disorders with onset usually occurring in childhood and adolescence.

2) Schizophrenia is characterised by disturbed thought and perception with delusions and hallucinations; whereas mood disorders are characterised by a primary disturbance of mood or affect.
3) Disorders of psychological development include specific developmental disorders of speech and language, scholastic skills and motor function, mixed specific developmental disorders and pervasive developmental disorders.

1.10 UNIT END QUESTIONS

1) What are the purposes of classification?

2) What is the basis of classification of mental disorders in the modern classification systems?

3) Discuss historical development of classification of mental disorders.

4) What are the different major diagnostic categories in the mental disorder section of the ICD 10?

1.11 REFERENCES


1.12 SUGGESTED READINGS


UNIT 2  SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

Structure

2.0  Introduction
2.1  Severe Mental Illness
2.2  Classification of Schizophrenia and other Psychotic Disorders
2.3  Schizophrenia
   2.3.1  Epidemiology
   2.3.2  Clinical Features
   2.3.3  Diagnosis
   2.3.4  Etiology
      2.3.4.1  Genetic Factors
      2.3.4.2  Environmental Factors
   2.3.5  Treatment
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      2.3.5.2  Psychosocial Treatment
      2.3.5.3  Rehabilitation
   2.3.6  Course and Prognosis
2.4  Persistent Delusional Disorder
2.5  Acute and Transient Psychotic Disorders
2.6  Schizoaffective Disorder
2.7  Other Psychotic Disorders
2.8  Let Us Sum Up
2.9  Answers to Self Assessment Questions
2.10  Unit End Questions
2.11  Suggested Readings

2.0  INTRODUCTION

In the previous Unit, you have learnt about historical perspective of mental disorders and need for their classification. In this Unit, we shall learn about schizophrenia and other psychotic disorders. Worldwide, schizophrenia and other psychotic disorder represent a major health problem and result in huge burden on the individual, family and society.

Objectives

After studying this unit, you will be able to:

- define severe mental illness;
- describe the classification of schizophrenia and other psychotic disorders;
- describe clinical features of schizophrenia;
- explain the causes of schizophrenia;
discuss the prognosis and treatment of schizophrenia; and

mention other important psychotic disorders in this Unit.

2.1 SEVERE MENTAL ILLNESS

Schizophrenia and related psychotic disorders are a group of severe mental illnesses. In severe mental illness, a person has mental health problems that are persistent, result in moderate to severe disability and may require treatment for long time. One of the ways in which mental health problems, in severely mentally ill persons manifest is psychosis.

Psychosis is a psychiatric condition in which a person has hallucinations, delusions, disorganised behaviour and impaired reality testing. Hallucinations are false perceptions without any stimulus which means s/he may perceive something that does not exist in reality e.g., s/he may start hearing voices of people talking when there is no one around. These can occur in all five senses like sound, sight, smell, touch and taste and are called auditory, visual, olfactory, tactile and gustatory hallucinations. Delusions are firmly held false beliefs that cannot be corrected by any amount of reasoning or evidence to the contrary. These beliefs cannot be explained by the person’s educational, social and cultural background. Delusions may be of many types e.g. delusion of persecution, grandiosity etc. Persons with psychosis are unaware that their experiences could be imaginary and they cannot differentiate real from unreal. There is severe disturbance in social and personal functioning.

Self Assessment Questions 1

Note:  
i) Read the following questions carefully and answer in the space provided below.
ii) Check your answer with that provided at the end of this unit.

1) What is severe mental illness?

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2) What is psychosis?

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2.2 CLASSIFICATION OF SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

You have already learnt in the previous chapter that in India, Chapter V (F) of tenth revision of International Classification of Diseases (ICD -10) is used for making diagnosis of psychiatric disorders. A psychiatric disorder is a syndrome where a group of signs and symptoms occur together to make up a recognisable psychiatric condition.
In ICD-10, schizophrenia and other psychotic disorders are classified under F20-F29 and contain all types of psychoses which are not due to organic causes, abuse of psychoactive substances or mood disorders. These are as follows:

F20  Schizophrenia
F21  Schizotypal disorder
F22  Persistent delusional disorders
F23  Acute and transient psychotic disorders
F24  Induced delusional disorder
F25  Schizoaffective disorder
F28  Other non-organic psychotic disorder
F29  Unspecified non-organic psychosis

Schizophrenia is the commonest and most important disorder of this group and will be discussed in detail.

### Self Assessment Questions 2

**Note:**

i) Read the following question carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Which classificatory system is used for making diagnosis of psychiatric disorders in India?

### 2.3 SCHIZOPHRENIA

The term schizophrenia was introduced by the Swiss psychiatrist Eugene Bleuler at the beginning of last century.

#### 2.3.1 Epidemiology

People have conducted studies worldwide and reported that persons with schizophrenia are present across all geographical locations and societies in the world. In adults, incidence rates per year (proportion of new cases in one year) is 0.1-0.4 per 1000 population. Life time prevalence (proportion of existing cases, both old and new) of schizophrenia is about 1%. To understand it better, let us consider a locality where 10,000 adults reside. In that locality, every year about 1-4 new persons will have schizophrenia. However, in their life time, about 100 persons may have schizophrenia. Therefore, although incidence of schizophrenia is low, due to persistence of symptoms, the prevalence is relatively high. Schizophrenia most commonly occurs in young people. The age of onset is 15-35 years and it occurs often earlier in men than in women although men and women are affected equally.

#### 2.3.2 Clinical Features

Before proceeding with this section let us see how a hypothetical case of schizophrenia presents.
Mr. S., a 30-year-old married, 10th passed salesman with no past or family history of psychiatric disease with good work record and stable interpersonal relationships, was brought by his parents with 2 months history of abnormal behavior. He was fine till about 2 months back when a gradual change in his behavior was noticed. After coming back from work, he would remain in his room instead of talking to family members, watching TV, eating dinner with them which was his usual routine. He also looked preoccupied and interacted less with family members. At times he would not eat his meals. He was noticed to have less sleep and would pace up and down in his room. When asked by family members why he remained lost, he told them that there were cameras fitted in their house to spy on him. He also told them that this was done by their neighbors. Their neighbors were being paid by his colleagues in the office who were planning to implicate him in a false case. He would also insist on keeping the lights switched off so that cameras were not able to catch what they were doing. His family members tried to argue with him that he always had good relationship with neighbors and his colleagues but he would not be convinced. He also told that in the streets, people were talking about him. He started remaining self-absorbed and was seen muttering and smiling to self and would give no reason for the same. Family members would coax him to take bath and change clothes. He stopped going for work and stopped meeting his friends. He would become angry on trivial matters. Later, he started accusing family members that they were helping his colleagues and stopped talking to them and would abuse them without reason.

There was no history of alcohol/drug abuse and any physical disease. On physical examination no abnormality was detected.

Psychiatric evaluation revealed ill-kempt, ill-groomed individual. He was muttering to self. He told the doctor that his colleagues were planning to kill him and had recruited many people to help them. His food was poisoned, his neighbors discussed about him all the time and called him names and threatened him. Though he heard their voices clearly, he could not see them in the vicinity. He also told that they had fitted a camera and a sensor in his house through which they were constantly emitting electric waves which hit him like current against his will. He denied that he had any problem and did not see any point in taking treatment.

What is the problem with Mr. S.? Mr. S. has schizophrenia. This case highlights the main clinical features of schizophrenia. We will discuss about findings of this case once you have understood the signs and symptoms of schizophrenia.

In schizophrenia, there are characteristic disturbances of thinking, perceptions and emotions that affect the most basic functions in persons with schizophrenia. Consciousness remains clear and intellectual capacity is usually maintained, although certain cognitive deficits may also be noticed.

The knowledge of these typical changes helps in making diagnosis of schizophrenia by eliciting symptoms in history from the informants/patients and the signs on psychiatric examination. This is in contrast to a physical illness like tuberculosis where simple laboratory tests confirm the diagnosis; there are no laboratory tests available for detecting schizophrenia.

**Symptoms in history from the informants/patients**

The changes in behavior are generally noticed by people who are in close contact with the patients like family members, friends or teachers. These behavioural changes may develop rapidly over a period of days to weeks (acute onset) or gradually over months.
The recognition of symptoms is easier if the behavioural changes are marked and develop suddenly.

Initially, very few changes may be noticed like sleep disturbances, irritability, remaining preoccupied or appearing different from his/her usual self. Some of the patients may not answer relevantly to the questions asked. Their speech may be difficult to understand because of lack of proper connections between sentences or phrases or words. They may speak very less or may not speak at all. However, some patients may continue to speak relevantly and coherently.

The patients may express thoughts which are false and do not correspond to the reality. They may remain convinced about these beliefs even on the face of opposite evidence, e.g. they may believe that there is a conspiracy against them, strangers are talking about them, their actions/emotions being controlled by others/some external force etc.

They may laugh or cry without any apparent reason, mutter or talk or shout loudly to self and may make apparently meaningless gestures in the air. It may appear as if they are talking/communicating with someone. This is generally in response to hearing voices of people talking whereas in reality, no one is talking. These voices may talk to the patient in second or third person, give command to the patient or may comment on his/her actions. The content of the voices may be abusive, threatening or neutral.

They may appear depressed, anxious, irritable or fearful or alternatively may show lack of emotions and emotional reactivity. They may remain emotionally indifferent and may not participate in the family events like festivals, death, marriage etc. Sometimes, they may show inappropriate emotional reactions.

They may become restless or alternatively, their body movements may become slow and awkward, and they may remain in same position for long periods e.g. standing at one place for hours.

They may appear shabby as they neglect their personal care. They need to be reminded for doing activities of daily living like brushing teeth, taking bath, changing clothes, taking food etc. Their functioning at home, school or job may deteriorate. They may lose interest in the activities which they earlier used to be fond of like watching TV, reading newspaper, dressing, etc. They may avoid company and stop interacting with family members, friends and others. They may withdraw from world around them and start believing in the reality of their imaginary experiences. They are reluctant to seek medical help as they believe that there is nothing wrong with them. They are also at increased risk of having alcohol and drug problems and suicide.

**Signs on psychiatric examination**

**Psychosis:** In the section 2.1, you have already learnt that psychosis is characterised by hallucinations, delusions, disorganised behaviour and impaired reality testing. These may be present for long time before others notice them. Auditory hallucinations are the most common type of hallucinations in schizophrenia. Some of the typical auditory hallucinations are running commentary (voices comment on behaviour of the patient), commanding (voices command to do certain actions), third person (voices talk to each other about the patient), thought echo (patients hear aloud what they think). In some patients, visual, tactile, olfactory and gustatory hallucinations may also be present. Somatic passivity is special type of hallucination in which the patient believes that he/she is passive recipient of the bodily sensations caused by an external agency e.g. may report that electric sensations in his/her body are being sent by neighbours. Typical delusions seen in patients with schizophrenia are:
- Delusion of control: The patients believe that their emotions, behaviour or sensations are under the control of some external agency.

- Bizarre delusions: absurd and implausible beliefs.

- Delusions of thought withdrawal and insertion: believe that their thoughts are withdrawn or new thoughts are being inserted into their mind

- Delusion of thought broadcast: believe that their thoughts are known to others without their speaking them aloud.

- Delusional perception: patient attributes a new meaning, usually in the sense of self-reference, to a normally perceived object.

- Delusion of reference: believe that people are talking about them or are laughing at them. They may believe that people are talking about them on television, radio and newspaper and

- Delusions of persecution: believe that they are being cheated, harassed or poisoned. They may also report that people/agency is spying and plotting against them or their close associates.

Formal thought disorder: In some patients with schizophrenia, speech may appear vague and woolly. It may be incomprehensible, irrelevant and incoherent. There may be break in thoughts which manifest as loss of apparent connection between sentences, phrases or words and is because of difficulty in organising their thoughts. Neologism is use of new words with special meaning for the patient.

Catatonic signs: Some patients with schizophrenia may show problems in motor movements called catatonic signs. Their body movements may become odd and clumsy like maintaining same and awkward postures for long time, grimace or show unusual mannerisms and mimic movements (echopraxia) or speech (echolalia) of others, run without purpose or become completely immobile. Some patients may become mute (not speaking at all) and have stupor (complete absence of movements).

Negative signs: In some patients, especially in those with long duration of illness, there may be loss/decrease in mental functions, these are called negative signs. Some of the negative signs seen in patients with schizophrenia are anhedonia (loss of interest in previously pleasurable activities), apathy (lack of emotions, poor reactivity to any event), alogia (minimal/no speech), avolition (decreased/absent motivation to initiate or maintain activities) and asociality (minimal/no interaction with others)

The negative signs are more difficult to identify than positive signs. The family members may incorrectly assume that patients with negative symptoms are lazy and do not want to do any work.

Cognitive impairment: It is now believed that patients with schizophrenia have problems in cognitive functions like attention, memory, decision-making, motor skills, executive functions and intelligence. Cognitive deficits are most difficult to recognise but have the most disabling impact on day to day normal functioning.

Self Assessment Questions 3

Note:  

i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.
1) What is a hallucination?
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2) What is a delusion?
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3) What are the signs of schizophrenia?
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2.3.3 Diagnosis

As has been discussed earlier, for making diagnosis of schizophrenia, diagnostic guidelines are given by International Classification of Diseases – tenth revision (ICD-10). These guidelines require the symptoms to be present for duration of at least one month. Diagnostic Guidelines for Schizophrenia as per ICD-10 are:

- At least one of the following must be present most of the time for a month:
  a) Thought echo, thought withdrawal, thought insertion, or thought broadcast.
  b) Delusions of control for the movements of the body or extremities, specific thoughts, acting or feelings, delusional perception.
  c) Hallucinatory voices; running commentary, discussing the patient in third person, or voices coming from some parts of the patient’s body.
  d) Bizarre or culturally inappropriate delusion.

OR

- At least two of the following first three must be present most of the time for a month; or last one symptom for 2 years:
  e) Persistent daily hallucinations accompanied by delusions
  f) Formal thought disorder (incoherent speech)
  g) Catatonic symptoms
  h) Negative symptoms

AND

- A significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.
Such symptoms should not be due to organic causes or due to psychoactive substance use.

If there is indication in history towards the presence of organic (physical/medical diseases) causes and psychoactive substance use responsible for symptoms of schizophrenia, further physical examination and investigations should be done to rule these out. The pointers towards presence of organic causes are:

- Sudden appearance of symptoms in previously healthy person
- Elderly
- Presence of fever
- Presence of altered consciousness and inattentiveness
- Presence of confusion, memory problems
- Presence of urinary and/or bowel incontinence
- Reversal of sleep wake cycle i.e. sleeping in the time and remaining awake in the night
- Presence of visual hallucinations
- History of any other medical condition.

Schizophrenias have been further classified into paranoid, hebephrenic, catatonic and undifferentiated types.

**Paranoid schizophrenia:** The patients may have persecutory, referential or grandiose delusions with relatively less effect on speech, behaviour and affect.

**Hebephrenic schizophrenia:** The patients may show shallow and inappropriate emotions and ill organised, fleeting delusions or hallucinations.

**Catatonic schizophrenia:** The patients show predominantly catatonic signs.

**Undifferentiated schizophrenia:** The patients may have all above mentioned symptoms and signs with no specific features.

Now, let us go back to Mr S. On psychiatric examination, he had delusions of persecution, delusional perception (criteria b) and third person auditory hallucinations (criteria c) with derogatory content and he lacked insight into these problems. He had these symptoms for more than 1 month and had significant dysfunction. His physical examination was normal and there was no history of drug/alcohol abuse or medical disease. Therefore, his illness had no organic basis. Mr S. has Schizophrenia. As he had persecutory delusions, he has paranoid schizophrenia.

### Self Assessment Questions 4

**Note:**

i) Read the following question carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) How many types of schizophrenias are there?

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2.3.4 Etiology

There is no known single cause for schizophrenia like malaria is caused by malarial parasite. It is considered a biological disease which results from interplay of multiple factors like genetic and environmental factors.

2.3.4.1 Genetic Factors

Genetic vulnerability to schizophrenia has been found to be multifactorial which is caused by interaction of several genes. Role of genetic factors has been demonstrated by family, adoption and twin studies. People who have a close relative with schizophrenia are more likely to develop the disorder than the people who have no relatives with the illness. The genetic closeness and genetic loading to the person with schizophrenia increases the risk for schizophrenia. If both parents are affected, the risk in children of having schizophrenia is 50%. The risk is about 10% in siblings of patients with schizophrenia. Twin studies show that rate of having schizophrenia in non identical and identical twin of patients with schizophrenia is 8-12% and 50% respectively.

2.3.4.2 Environmental Factors

The environmental factors like poverty, lower socioeconomic class, residence in rural area have been linked to higher rates of schizophrenia. In the mothers of patients with schizophrenia, smoking, poor nutrition and infections during pregnancy have been reported. Further, complications during delivery and such as hypoxia (low oxygen levels) before, at, or immediately after birth may also be a risk factor for causing schizophrenia. The family members of patients with schizophrenia show high expressed emotions in the form of critical comments, emotional over involvement and hostility.

The changes in neurotransmitters like dopamine, serotonin and nor-epinephrine, have also been associated with schizophrenia. Brain-imaging studies (CT scan, MRI scan etc.) have shown certain structural changes in the brain like enlarged ventricles, reduction of cerebral blood flow, volume and cortical grey matter. Prenatal risk factors such as pre-natal stress, Pre-natal malnutrition and pre-natal infection have also been implicated as causal factors of schizophrenia. Various infections during childhood such as influenza, polio, measles etc. have been correlated with later development of schizophrenia.

Self Assessment Questions 5

Note:  
1) Read the following questions carefully and answer in the space provided below.

2) Check your answer with that provided at the end of this unit.

1) What is the risk for schizophrenia in immediate family members of patient with schizophrenia?

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2.3.5 Treatment

Management of patients with schizophrenia involves use of antipsychotic drugs and psychosocial interventions. The goal of the treatment is to help patients with schizophrenia
to function well and lead productive lives. The treatment is planned according to the specific needs of the patients and their families. Use of the antipsychotic drugs is the mainstay of treatment as these help in relieving the symptoms and prevent further relapse. Psycho-education helps patients and families cope with the illness. Rehabilitation is important for restoring educational and occupational functioning of the patient.

2.3.5.1 Pharmacological Treatment

The drug treatment can be prescribed only by a qualified physician. Most of the patients with schizophrenia can be treated with antipsychotic drugs at their homes. The antipsychotic drugs have to be started as soon as possible as improvement in symptoms takes place gradually. First sleep, appetite and agitated behaviour improve followed by improvement in psychotic symptoms and negative symptoms take long time to improve. These drugs are started at low dosage and gradually increased depending on the improvement. A drug should be tried for minimum of 4-6 weeks in adequate dosage. An important thing to remember is that the drug should not be stopped soon after improvement and should be continued for a long period, beyond the point of recovery, to prevent relapses or deterioration. The drug treatment should only be stopped on the advice of treating physician. Majority of patients show improvement on antipsychotic drugs.

The family members should be educated about the chances of recurrence and characteristic symptoms with which illness presents in the patient. The drugs need to be restarted in case of a recurrence. In about 20% of cases, relapses occur even if they are on continuous medicines. Even if a recurrence occurs while on medicines, the intensity of the symptoms and the frequency of the relapses is less.

In some situations, hospitalisation usually for 4-6 weeks, is indicated like when patient shows grossly disorganised or inappropriate behaviour, has suicidal ideations, is violent and unmanageable.

Drug compliance, the extent to which patients follow the recommended treatment, is an important issue in the treatment of schizophrenia. Poor drug compliance may lead to no improvement in symptoms or relapse in improved patients. There are many reasons for poor drug compliance. Family members and patients may have negative view about medications e.g. may consider these to be addicting. Patients may believe that they are not ill and therefore may not take medications. Prescribing physician may not have explained the treatment plan and side effects adequately. Family members and patients may not understand the instructions correctly so may unintentionally take drugs in wrong dose/timing or may incorrectly stop treatment when the patient is feeling better.

For improving the drug compliance, family members and patients should be adequately educated about the prescribed medications. Most of these drugs can be given in a single night time dosage and can be scheduled according to the patient’s daily routine and work. Oral intake of these medicines by patients needs to be carefully observed as some of them may not swallow the tablets and later on throw away the tablets. Some drugs are available as long-acting depot injections which may be repeated at an interval of 2-4 weeks.

2.3.5.2 Psychosocial Treatment

Schizophrenia afflicts people when they are young, the time for getting education, training for vocation and making new relationships. Therefore, many of them may not complete their education, may lack vocational skills required to work on any job and may not have skills to build friendships/intimate relationships. The psychosocial interventions
are non medical interventions which help in dealing with difficulties in personal and socio-occupational functioning. We shall be considering only two types of psychosocial interventions: Psychoeducation and rehabilitation.

**Psychoeducation**

Psychoeducation aims at improving the treatment compliance, reducing risk of relapse and admission rates. In India, families are the primary care givers for 95% of the persons with schizophrenia and experience significant burden and stigma. They should be engaged early in the treatment. The psychoeducation also helps in decreasing the burden and stigma experienced by their families.

The families and patients are educated over multiple sessions about the schizophrenia. Common misconception about schizophrenia, especially in the rural areas, is that it is due to curse/black magic/sins of previous births and should be treated by faith healers. They have to be educated that it is a biological disease like heart disease/diabetes mellitus with multi factorial causation and should be treated with drugs prescribed by a qualified physician. They are also explained about various drug treatments available, their side effects, and schedule of how to take these drugs. They may have apprehensions about use of antipsychotic drugs in the treatment. Some may worry that the antipsychotic drugs are addicting and turn the patient into a zombie. It has to be explained that these drugs are not addicting as these do not produce joy or drug seeking behaviour. Also, they may believe that these drugs act as a kind of mind control by sedating the patient. Though sedating effect of these drugs can be useful but it is their ability to diminish the hallucinations, agitation, confusion, and delusions which is curative. They have to be explained that although medications do have some side-effects, their beneficial effects far outweigh the side effects. They should keep a record of name of medications, side effects and effectiveness of the medications. They need to be psycho-educated about issue of drug compliance in these patients as about 50% of outpatients and 20% of inpatients fail to take prescribed medications. So ensuring drug compliance is very important. They are also sensitized to the variations in chances of recovery.

Sometimes there are misconceptions that these patients are violent, lazy, unproductive and that their illness is incurable. Most of these patients prefer to remain alone and are not violent; some especially those with drug/alcohol abuse may become violent in response to auditory hallucinations with derogatory/threatening content or persecutory delusions. Such incidents should be handled in a calm reassuring manner without fear. Due to the negative and cognitive symptoms, they may appear lazy and unproductive.

Certain myths and facts related to schizophrenia are given below:

<table>
<thead>
<tr>
<th>Myths</th>
<th>Facts</th>
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</thead>
<tbody>
<tr>
<td>Schizophrenia is caused by sins of previous life or black magic</td>
<td>Schizophrenia is a biological disease with multi factorial causation</td>
</tr>
<tr>
<td>Anti-psychotic drugs will make the person into a zombie</td>
<td>Anti-psychotic drugs help in reducing the symptoms of schizophrenias such as delusions, confusion etc.</td>
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<tr>
<td>Drugs will develop addiction</td>
<td>Rather, drugs are curative</td>
</tr>
<tr>
<td>Schizophrenia is not treatable</td>
<td>Can be treated with proper diagnoses &amp; early start of treatment</td>
</tr>
</tbody>
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The patients should be encouraged to follow structured daily activity schedule and to
perform simple tasks around the house. Appreciation of the smallest task and achievements of the patients helps to boost their self confidence and productivity. The family members have to be tolerant and supportive. Emotional reactions to patients should be kept at low level and feelings must be expressed in a matter-of-fact way. Efforts should be made to engage patients in conversation, express interest in what they are talking and prolong normal conversation. The family members should not make derogatory statements. Talk to the patients and show an interest in what they are doing, even if they sound dull and repetitive. Ignore deluded or abnormal talk, appear interested and prolong normal talk and conversation.

A checklist of symptoms of the patient’s illness can be provided to the family to help them identify signs of relapse at the earliest like sleeplessness, increased restlessness, irritability, return of hallucinations, etc. The patient should be taken to a psychiatrist immediately so that medications may be restarted/adjusted.

### 2.3.5.3 Rehabilitation

In rehabilitation, the core intervention is training patients with schizophrenia to perform the skills required for improved personal and socio-occupational functioning. Principles of behavioural theories are used for training. Along with the training of patients, environment support should also be increased. Training must be tailored to the needs of individual patients as they present different combinations of social abilities and deficiencies and have varying degrees of support from their environment.

The methods used for rehabilitation are social skills training, vocational counseling, job training, problem-solving and money management skills, use of public transportation, etc.

Training is provided in doing daily activities such as bathing, cleaning, cooking, buying groceries and making financial transactions in bank. Social skills such as making friends, engaging in conversation and communicating with family and friends can also be taught.

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<thead>
<tr>
<th>Self Assessment Questions 6</th>
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</table>
| **Note:** i) Read the following questions carefully and answer in the space provided below.  
  
   ii) Check your answer with that provided at the end of this unit.  

1) **What steps can be taken to improve the drug compliance in patients with schizophrenia?**  

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2) **Highlight the points used in psychoeducation.**  

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2.3.6 Course and Prognosis

The typical course of schizophrenia is one of exacerbations and remission and outcome is reported to be better in developing rather than developed world. After the first episode patients generally recover, many function normally for a relatively long period. Usually pattern of illness during first 5 years after diagnosis generally indicates the future course. With each relapse, there is further worsening in patient’s baseline functioning.

It is difficult to predict course of schizophrenia in an individual patient. However, presence of certain factors confers good prognosis, these are: female gender, late age of onset, good premorbid social functioning and work histories, acute presentation with positive symptoms, married, history of maintaining stable job, good support system and family history of mood disorders. Some of the factors related to poor prognosis are: young onset, no precipitating factors, insidious onset, poor premorbid social functioning and work histories, single divorced or widowed, family history of schizophrenia, poor support system, negative symptoms, presence of neurological signs and symptoms, history of perinatal trauma, no improvement in 3 years, many relapses and history of assaultive behaviour.

Self Assessment Questions 7

Note: i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the factors which predict good prognosis in patients with schizophrenia?

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2.4 PERSISTENT DELUSIONAL DISORDER

Persistent delusional disorder is characterised by the development of a single delusion or a set of related delusions which are usually persistent and sometimes lifelong. These delusions can be persecutory, grandiose, jealous, or hypochondriacal. A person having hypochondriacal delusion firmly and falsely believes that he/she is suffering from serious disease. On psychiatric examination, apart from well systematized delusions, their mood, speech, and behaviour are normal. They may seem odd and eccentric because of actions related to their delusions.

It is an uncommon disorder, and prevalence is about 0.025-0.03%. The mean age of onset is about 40 years. It is slightly more common in females.

For making diagnosis on ICD 10, following criteria should be fulfilled.

- The presence of a delusion or a set of related delusions other than those listed as typically schizophrenic delusions
- The delusions must be present for at least three months.
- The general criteria for schizophrenia are not fulfilled.
- Persistent hallucinations in any modality must not be present.
Exclude evidence of brain disease or a psychotic disorder due to psychoactive substance use or secondary to mood disorder.

The disease runs waxing and waning course. The treatment is with antipsychotic drugs and psychosocial therapies including psycho education.

### 2.5 ACUTE AND TRANSIENT PSYCHOTIC DISORDERS

In this, psychosis occurs in association with an acute stress. The patient may present with hallucination, delusions, rapid emotional changes, and schizophrenic symptoms. Acute stress means that the first psychotic symptoms occur within 2 weeks of one or more events that would be regarded as stressful to most people. Common events are bereavement, unexpected loss of partner or job, marriage, or the psychological trauma of combat, terrorism, and torture. Long-standing problems like chronic financial problems, marital difficulties should not be included as a source of stress in this context.

For making diagnosis on ICD 10, following criteria should be fulfilled:

- An acute onset of delusions, hallucinations, incomprehensible or incoherent speech, or any combination of these.
- The time interval between the first appearance of any psychotic symptoms and the presentation of the fully developed disorder should not exceed two weeks.
- Transient states of bewilderment, misidentification, or impairment of attention and concentration are present.
- The disorder does not meet the criteria for manic episode, depressive episode.
- No evidence of brain disease or a psychotic disorder due to psychoactive substance use or serious metabolic disorder.

The treatment is with antipsychotics. Complete recovery usually occurs within 2 to 3 months, often within a few weeks or even days, and only a small proportion of patients with these disorders develop persistent illness.

### 2.6 SCHIZOAFFECTIVE DISORDER

It is an episodic disorder in which both affective and schizophrenic symptoms are present within the same episode. It may be of schizo-depressive type or schizo-maniac type depending on the type of affective symptoms present in the episode. The treatment is with antipsychotic medications and mood stabilizers and needs to be planned on long term basis.

Self Assessment Questions 8

**Note:**

1. Read the following questions carefully and answer in the space provided below.
2. Check your answer with that provided at the end of this unit.

1) What are other important disorders included under the section schizophrenia and related disorders?

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2.7 OTHER PSYCHOTIC DISORDERS

These are very uncommon.

F21 Schizotypal disorder: It is characterised by odd beliefs, eccentric behaviour, tendency to social withdrawal, appear cold, suspicious ideas, vague, overelaborate, stereotyped thinking and odd speech. The individual has no definite and characteristic abnormalities like schizophrenia. There is no definite onset and it runs a chronic course with fluctuations of intensity and its evolution and course are usually those of a personality disorder. It is more common in individuals genetically related to patients with schizophrenia.

F24 Induced delusional disorder: In this condition, a delusional disorder is shared by two or more people with close emotional links. Only one of them has a genuine psychotic disorder and the delusions are induced in the other/others. The delusions in the other person disappear when the persons are separated.

F28 Other nonorganic psychotic disorders: Psychotic disorders that do not meet the criteria for schizophrenia, persistent delusional disorder or for psychotic types of mood disorders and persistent delusional disorder are included under this category.

F29 Unspecified nonorganic psychosis: This category should be used for psychosis of unknown etiology

2.8 LET US SUM UP

- In severe mental illness, a person has mental health problems that are persistent, result in moderate to severe disability and may require treatment for long time. Mental health problems in severely mentally ill persons manifest as psychosis. In psychosis, a person has hallucinations, delusions, disorganised behaviour and impaired reality testing.

- In ICD-10, schizophrenia and other psychotic disorders are classified under F20-F29. Schizophrenia is the most studied of these conditions.

- Lifetime prevalence of schizophrenia is about 1% and incidence rates per year is 0.1-0.4 per 1000 population.

- Schizophrenia is characterised by typical delusions and hallucinations. Formal thought disorder, negative and catatonic signs and cognitive impairment. These should be present for one month for making diagnosis of schizophrenia.

- Schizophrenias have been further classified into paranoid, hebephrenic, catatonic and undifferentiated types.

- There is no known single cause for schizophrenia; considered a biological disease which results from interplay of multiple factors like genetic and environmental factors as in many physical diseases, such as heart diseases.

- Management of patients with schizophrenia involves use of antipsychotic drugs and psychosocial interventions. Use of the antipsychotic drugs is the mainstay of treatment as these help in relieving the symptoms and prevent further relapse. Psycho-education helps patients and families cope with the illness. Rehabilitation is important for restoring educational and occupational functioning of the patient.

- Drug compliance, the extent to which patients follow the recommended treatment,
is an important issue in the treatment of schizophrenia. For improving the drug compliance, family members and patients should be adequately educated about the prescribed medications.

- Psychoeducation of the persons with schizophrenia and their families should be part of the treatment. It involves educating them about symptoms of schizophrenia, treatment options available, clearing misconceptions, ensuring drug compliance, encouragement and motivation by family members, following daily structured routine, course of schizophrenia, identifying signs of relapse.

- The typical course of schizophrenia is one of exacerbations and remission and outcome is reported to be better in developing rather than developed world. After the first episode patients generally recover, many function normally for a relatively long period. Usually pattern of illness during first 5 yrs after diagnosis generally indicates the future course. With each relapse, there is further worsening in patient’s baseline functioning.

- Other important conditions included under the section schizophrenia and related disorders are persistent delusional disorders, acute and transient psychotic disorders and schizo-affective disorders.

2.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Severe mental illness refers to mental health problems that are persistent, result in moderate to severe disability and may require treatment for long time. Mental health problems in severely mentally ill persons manifest as psychosis.

2) Psychosis is a psychiatric condition in which a person has hallucinations, delusions, disorganised behaviour and impaired reality testing.

Self Assessment Questions 2

1) International Classification of Diseases (ICD -10)

Self Assessment Questions 3

1) Hallucination is false perception without any stimulus which means a person may perceive something that does not exist in reality e.g., he/she may start hearing voices of people talking when there is no one around. These can occur in all five senses like sound, sight, smell, touch and taste and are called auditory, visual, olfactory, tactile and gustatory hallucinations.

2) Delusion is firmly held false belief that cannot be corrected by any amount of reasoning or evidence to the contrary. This belief cannot be explained by the person’s educational, social and cultural background. Delusions may be of many types e.g. delusion of persecution, grandiosity etc.

3) Signs seen on psychiatric examination of schizophrenia are:

   i) Psychosis: typical auditory hallucinations are running commentary, commanding, third person and thought echo and typical delusions are bizarre delusions, delusion of control, delusions of thought withdrawal and insertion, delusion of thought broadcast and delusional perception.

   ii) Formal thought disorder.
iii) Catatonic signs: odd and awkward postures, grimacing, mannerisms, echolalia, echopraxia, mute, stupor.

iv) Negative signs: anhedonia, apathy, alogia, avolition, and asociality.

v) Cognitive impairment.

**Self Assessment Questions 4**

1) The types of schizophrenias are paranoid, hebephrenic, catatonic and undifferentiated types.

**Self Assessment Questions 5**

1) The risk is about 10% in siblings of patients with schizophrenia. If both parents are affected, the risk in children of having schizophrenia is 50%. Twin studies show that rate of having schizophrenia in non identical and identical twin of patients with schizophrenia is 8-12% and 50% respectively.

**Self Assessment Questions 6**

1) For improving the drug compliance, following steps can be taken:
   - Family members and patients should be adequately educated about the prescribed medications.
   - Most of these drugs can be given in a single night time dosage and can be scheduled according to the patient’s daily routine and work.
   - Oral intake of these medicines by patients needs to be carefully observed as some of them may not swallow the tablets and later on throw away the tablets.
   - Some drugs are available as long-acting depot injections which may be repeated at an interval of 2-4 weeks.

2) Psycho education involves educating them about symptoms of schizophrenia, treatment options available, clearing misconceptions, ensuring drug compliance, encouragement and motivation by family members, following daily structured routine, course of schizophrenia, identifying signs of relapse.

**Self Assessment Questions 7**

1) The presence of certain factors confer good prognosis, these are: female gender, late age of onset, good premorbid social functioning and work histories, acute presentation with positive symptoms, married, history of maintaining stable job, good support system and family history of mood disorders.

**Self Assessment Questions 8**

1) Persistent delusional disorders, Acute and transient psychotic disorders and Schizo-affective disorders

**2.10 UNIT END QUESTIONS**

1) Discuss in detail the clinical features of schizophrenia.

2) Examine the myths related to schizophrenia. How can the awareness regarding these facilitate the treatment and rehabilitation of schizophrenic patients?

3) Discuss the treatment for schizophrenia.
2.11 SUGGESTED READINGS


UNIT 3  MOOD DISORDERS

Structure

3.0  Introduction
3.1  Mood and Mood Disorders
3.2  Epidemiology of Mood Disorders
3.3  Clinical Features
    3.3.1  Manic Episode
    3.3.2  Depressive Episode
    3.3.3  Mixed Episode
3.4  Diagnosis
3.5  Classification of Mood Disorders
3.6  Etiology
    3.6.1  Genetic Factors
    3.6.2  Environmental Factors
3.7  Treatment of Mood Disorder
    3.7.1  Pharmacological Treatment
    3.7.2  Psychosocial Treatment
3.8  Course and Prognosis
3.9  Let Us Sum Up
3.10 Answers to Self Assessment Questions
3.11 Unit End Questions
3.12 Suggested Readings

3.0  INTRODUCTION

In the last Unit, you have learnt about schizophrenia and other psychotic disorders. In this Unit, we shall discuss another group of serious mental illnesses called mood disorders.

Objectives

After studying this Unit, you will be able to:

● define mood and mood disorders;
● list the common mood disorders;
● describe the identification and diagnosis of mood disorders;
● mention the types of mood disorders;
● explain the causes of mood disorders;
● describe the treatment options; and
● describe the prognosis.

3.1  MOOD AND MOOD DISORDERS

The term ‘mood’ is commonly used in English language to mean ‘frame of mind’,
‘temper’, etc. However, the term mood in the context of a psychiatric illness is used in a different way. ‘Mood’ and a related term ‘affect’ are used to describe emotions and feelings. Mood is a sustained feeling state that is experienced internally and influences a person’s behaviour and awareness of the world. Affect is external expression of mood and is known by the facial expressions. Mood can be normal, cheerful, depressed, irritable, anxious etc.

In mood disorders, the fundamental disturbance is change in mood or affect, usually to depression or to cheerfulness. The mood change is accompanied by the change in the overall activity of a person. These changes are persistent (last for prolonged period of time, usually for weeks), pervasive (affect all aspects of person’s life) and have an effect on personal, biological and socio-occupational functioning of a person.

According to the Diagnostic and Statistical Manual (DSM-IV-TR) of Mental Disorders, mood disorders refer to a group of diagnosis where a disturbance in the person’s mood is hypothesized to be the main underlying feature. Mood disorders are emotional disturbance consisting of prolonged periods of excessive sadness, excessive joyousness or both. Thus there may be intense sadness, termed depression or intense elation, termed mania, or it can be a combination of both depression and mania, called bipolar disorder.

Depression can also be classified as mild (dysthymia), moderate and severe based on number of complaints and the degree of resulting dysfunction.

**Check List for identifying mood disorders**

- Depressed state or feeling blue/down throughout the day or for most part of the day for the last two weeks.
- Unable to enjoy the things used to enjoy earlier for the last two weeks.
- Loss of interest in most of the things during the last two weeks.
- Feeling of sadness or depressed state for the last two years.
- A very high level of energy, excitement, and a feeling of ‘High’ as ‘Very Good’ — which is not the usual self of the person.

If the above are present in a client, then there may be the presence of mood disorders which need to be confirmed following the diagnostic criteria given by ICD – 10.

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<th>Self Assessment Questions 1</th>
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<td>ii) Check your answer with that provided at the end of this unit.</td>
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<tr>
<td>1) Define mood.</td>
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<tr>
<td>2) What is a mood disorder?</td>
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3.2 EPIDEMIOLOGY OF MOOD DISORDERS

Mood disorders are common psychiatric disorders. They have been found to affect people of all ages, socio-economic status, race, caste, religion or country. Studies have been carried out to know the epidemiology of mood disorders globally and in India. Depressive disorders are more common than bipolar disorders. The lifetime risk (risk of developing a disease during one’s lifetime) for bipolar disorder is 0.3-1.5% and for depressive disorders is 8-20%. The annual incidence is less than 1% for bipolar disorders and about 2% for depressive episode. Bipolar disorder has an equal prevalence among men and women. There is twofold greater prevalence of depressive disorders in women than in men. The reason for increased prevalence of depression among women is believed to be due to hormonal changes, the effects of childbirth and psychosocial stressors for women.

The bipolar disorder commonly occurs between the ages of 18-24 years with mean age of onset at 21 years and depressive disorder occurs between the ages of 20-50 years with mean age of onset at 40 years; cases are reported in children as well as elderly.

A higher proportion of patients with bipolar disorder are found among the persons with upper socioeconomic status. No correlation is seen between socioeconomic status and depressive disorders. The lifetime risk of dysthymia (mild depression) is about 3%. Rates are higher in women, divorced and single persons, and persons belonging to low income group.

Self Assessment Questions 2

Note: i) Read the following questions carefully and answer in the space provided below.

   ii) Check your answer with that provided at the end of this unit.

1) How common are mood disorders?

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2) Why is there increased prevalence of mood disorders among women?

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3.3 **CLINICAL FEATURES**

Before proceeding with the clinical features of an episode of mania and depression, let us discuss two patients.

**Case 1** Mr. K., 20 yr old student of BA 1st year, unmarried male with no family or past history of psychiatric disease was brought by his family members with 15 days history of sleeping less. Unlike his usual self, he would get up at 4 AM, go out for jogging and visit nearby temple where he would chant ‘bhajans’ at loud volume. He would talk excessively and would express new ideas for upgrading their family business and his studies. He would change clothes 3-4 times in a day and would demand for good food. He would talk at length to even strangers. He would remain cheerful and would sing songs. However, for last 5 days, he had become very restless and agitated and become irritable/abusive whenever he was stopped from doing whatever he wanted to do. His sleep had reduced to 1-2 hours at night. He stopped going to college and started missing his meals. He believed that he had powers of Lord Hanuman and could do even impossible tasks like bringing rains etc. Once he had gone out of the house on motorbike and was trying to ride it without holding the handles.

There was no history of any psychoactive substance abuse and he had no physical disease. Physical examination showed no problems. Psychiatric examination revealed that the patient was dressed in very bright clothes, and he started thumping on the table with his fist and demanded an explanation for his coming to hospital. He left his seat many times, and moved around in the room examining various articles, singing songs. He was cheerful. He started speaking spontaneously in loud volume and tone. He reported that he was full of brilliant ideas to improve education system of the country. He boasted of being disciple of Lord Hanuman and had power to stop the Sun from rising. His family members did not share his beliefs. He also heard voice of Lord Hanuman blessing him. He denied that he had any problems and need for any treatment.

**Case 2** Mrs. S., 35yr old female graduate, married housewife with no past or family history of psychiatric disorder was brought by family members with two months history of getting tired easily and not doing her household work as before. She would sleep poorly. She also had lost interest in previously enjoyable activities like watching television, chatting with neighbors etc. She would feel gloomy almost all day and felt like crying for no apparent reason. She would worry excessively about welfare and future of her children. Gradually, she had stopped going out of her house and meeting her friends. Her appetite reduced and she neglected her personal hygiene. She would express death wishes, would blame herself for being a burden on her husband. She also expressed that she would never become alright as there was no cure for her problems. She would remain in the bed, most of the day complaining of tiredness even on doing some minor work.

There was no history of alcohol/drug use or any other physical disease. Her physical examination was within normal limits and showed no problems.

Psychiatric examination revealed poorly groomed woman sitting with downcast eyes. She took long time to answer the questions asked and spoke in low tone and volume. Her affect was sad and she started crying, while expressing ideas of guilt. She also had ideas of hopelessness and helplessness.

We will come back to Mr. K. and Mrs. S. in the subsequent section.

The most important consideration in this section is to be able to differentiate between transient day-to-day feelings of being depressed/ cheerful and depression/cheerfulness as a part of distinct psychiatric disorder.
You are already familiar with the fact that the change in mood accompanied by change in the activity is the core feature of mood disorder. Most other symptoms arise out of and can be understood in the context of these changes. The knowledge of characteristic features of episodes of depression and mania helps in making diagnosis of a mood disorder. The clinical interview is the best method to elicit symptoms in history from the informants/patients and the signs on psychiatric examination. The information from history is corroborated with findings on psychiatric examination to make diagnosis. In the following section, we will discuss about symptoms and signs of mania and depression.

### 3.3.1 Manic Episode

**Symptoms in history from the informants/patients**

The changes in behaviour develop rapidly and are noticed by people who are in close contact with the patients. The patients may get up early in the morning and appear active and cheerful. They may start many activities together. They may start talking excessively. They are full of new and exciting ideas/plans like buying a new vehicle, helping others, earning more money, etc. They have increased self esteem and feel confident. They may buy new clothes and eat fancy foods. They like to go out, and meet people, may talk on telephone for long time. They feel fresh and energetic even after sleeping for less time.

When the illness becomes severe, they may become very restless and be easily distractible. They talk constantly and often intrude into others’ conversation. They become irritated when others don’t agree with them or try to interrupt them. They indulge in many pleasurable activities. They may spend money without any need, sometimes incurring heavy financial losses. They wear clothes and jewellery of bright colors in unusual or eccentric combinations. They may talk with strangers as if they know them well and talk about their big ideas and plans to them. They may show socially disinhibitory behaviour like talking rudely to elders, inappropriate advances towards opposite sex and may indulge in increased and indiscriminate sexual activities. They plan/start risky and reckless ventures, schemes and business enterprises. They may act impulsively and make rash decisions that can affect their jobs, relationships, money, health, etc. They may start or increase use of alcohol or illegal drugs. They may believe that they have special powers and abilities, often with themes of religion, politics or money. They turn angry and abusive especially when others try to counter their special ideas and plans.

If episode is not treated, patients may become severely disturbed. Their beliefs of special abilities and merits may become so fixed that they may act and behave accordingly. The mental and physical activity may become so severe that it may lead to their becoming aggressive and assaultive. Their personal care, sleep, appetite, social behaviour and interpersonal relationships, occupational functioning may be severely disturbed.

**Signs on psychiatric examination**

The mode of onset is often acute (within days or weeks); sometimes it may be abrupt (within 48 hours). They may be restless, move around more than usual, use lot of gestures to express themselves and may be easily distractible. The patients with mania show increased psychomotor activity. They may appear over familiar. They report of feeling unusually well, fresh and energetic despite sleeping less, and physical and mental overactivity. Their mood is typically cheerful/elevated/ecstatic and may have infectious quality. Mood may also be irritable or labile (rapid fluctuations). They may speak spontaneously even when not asked a question and excessively. They may speak nonstop, in loud voice on any topic which comes to their mind or pick up from clues from
environment. In extreme cases, patients may have flight of ideas (jump from topic to topic) and pressure of speech (difficult to interrupt) and their speech may be full of embellishments like singing, rhyming, punning etc. They also report that their mind is full of ideas and experience subjective racing of thoughts. They are grandiose and boast of their special abilities, worth and powers; in severe cases these ideas may reach delusional level. They may have delusions of persecution, reference and auditory hallucinations. In severe cases, their judgment may be impaired and may deny any need for treatment.

3.3.2 Depressive Episode

Symptoms in history from the informants/patients

The changes in behaviour are initially noticed by people who are in close contact with the patients like family members, friends or teachers and are minimal like difficulty in falling asleep or getting up early, missing appointments/meals, not attentive to day to day tasks. They start feeling sad and the sadness does not get better in response to change in circumstances and may be worse in the morning. Sometimes patients may be anxious or irritable. They worry about trivial matters and have negative thinking. They express that they are incapable of doing anything, worthless and nothing good is going to happen in future. They may express guilt about their past acts/decisions. They lose interest in day to day activities and do not enjoy previously pleasurable activities like watching television, reading newspaper, etc.

They feel tired even without doing much activity and have difficulty in carrying out day to day tasks. They complain of memory loss which is due to poor concentration. Their speech, walk and other actions become slow. They also start withdrawing from social interactions and prefer to stay alone. They express doubts regarding their capabilities to finish a task. They have recurrent thoughts of death and are preoccupied with death and dying. They complain of physical complaints like body aches, headache, sensation of nausea, dizziness, problems of indigestion like constipation and belching. It has been observed in various studies that people from Asian countries tend to report more of physical symptoms rather than low mood when they are suffering from depressive disorder. Along with difficulties in sleeping, they also have loss of appetite and weight. They often complain of constipation. Their interest in sexual activity decreases.

As the illness progresses, above mentioned symptoms get aggravated and they get almost confined to bed. They may start actively contemplating of ending their lives as they believe that they can’t be cured or helped in any way and may plan/attempt suicide. About two thirds of all depressed patients have suicidal ideas, and about 10-15% may commit suicide. They may also start expressing false beliefs that they have been responsible for the hardships faced by self, family and even the world, have turned poor, their body parts have decayed, or they have died. They may also report of hearing voices accusing them. In severe cases, the patient may not speak or move at all, that is, there is severe psychomotor retardation.

In children, school refusal, decreased interest in playing and excessive clinging to parents may be suggestive of depression. In adolescents, in addition to usual symptoms of depression, symptoms like poor scholastic performance, irritability, sexual promiscuity, and truancy may be suggestive of depression. In elderly, physical complaints may be the first symptom of depression.

Signs on psychiatric examination

They have decreased psychomotor activity. They may take long time to answer the questions asked; their speech may be of low volume, slow and monotonous. They
describe their mood as depressed with distinct quality, may feel numb and devoid of all feelings. Sometimes mood may be anxious or irritable. They may appear tearful and start crying. They have anhedonia (reduced/loss of interest or pleasure in previously enjoyable activities). They have anergia (reduced or no energy, marked tiredness even on slight effort). They express ideas of hopelessness, helplessness and worthlessness; this triad is known as depressive cognitions. They may have ideas of guilt. They may also express death wishes and suicidal ideas.

In severe cases, different types of delusions congruent with the theme of depressed mood may be present. The ideas of guilt may be held with conviction and fulfill criteria of a delusion. They may have delusions of poverty that they have become poor, of nihilism that they do not exist or of ill health. They may also have persecutory and referential delusions. They may also have auditory and visual hallucinations. Some patients may show catatonic features like mutism and stupor. In severe cases, their judgment may be impaired and may deny any need for treatment as they may believe that nothing can help them.

### 3.3.3 Mixed Episode

During this episode, the person may exhibit symptoms of both depression and mania together, or there may be rapid alternation of both symptoms.

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<tr>
<td>1) What are the signs observed on psychiatric examination of a patient with manic episode?</td>
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<td>2) What are the signs observed on psychiatric examination of a patient with depressive episode?</td>
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<td>3) Describe the symptoms and characteristic features of Mania.</td>
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<td>4) Describe the symptoms and characteristic features of depression.</td>
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3.4 DIAGNOSIS

Now you are familiar with the clinical features of manic and depressive episodes, and can identify the symptoms and signs in a given patient.

For making diagnosis of manic episode, following criteria are given in ICD -10:

- The symptoms should last for at least 1 week.
- It should be severe enough to disrupt ordinary work and social activities more or less completely.
- The mood may be elevated, expansive or irritable and is definitely abnormal for the individual concerned.
- The change in mood should be sustained and should be accompanied by increased energy and several of the following symptoms:
  - increased activity
  - increased talkativeness (pressure of speech)
  - subjective experience of thoughts racing
  - decreased need for sleep
  - inflated self esteem or grandiosity
  - excessive optimism
  - distractibility
  - constant changes in activity or plans
  - loss of normal social inhibitions resulting in behaviour which is inappropriate to the circumstances
  - reckless behaviour without understanding the risks of such behaviour like spending sprees, foolish enterprises, reckless driving
  - marked sexual energy or sexual indiscretions
- The episode is not attributable to psychoactive substance use or any organic mental disorder

In Unit 2 in Section 2.3.3, you have already learnt how to rule out organic diseases and psychoactive substances use as cause for schizophrenia. In similar fashion, these causes are to be ruled out for mania as well.

The severity of the symptoms can vary from mild to severe. In ICD-10, three degrees of severity are included: hypomania, mania without psychotic symptoms and mania with psychotic symptoms. Hypomania is milder form of mania. In hypomania, there is mild cheerfulness (for at least several days), increased energy and activity, feelings of increased physical and mental efficiency, increased sociability, talkativeness, over familiarity, increased sexual energy, and a decreased need for sleep. But these changes may not result in functional disruption as seen in mania. However, patients are still at risk of making rash and dangerous decisions.

For making diagnosis of depressive episode, following criteria are given in ICD -10:

- The symptoms should be present for at least 2 weeks
At least 2 out of the 3 most typical symptoms must be present:

- Sustained depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances
- Loss of interest or pleasure in activities that are normally pleasurable (anhedonia)
- Decreased energy or increased fatigability (anergia)

- Should be accompanied by several other symptoms like:
  - Reduced concentration and attention
  - Reduced self-esteem and self-confidence
  - Ideas of guilt and unworthiness (even in a mild type of episode)
  - Bleak and pessimistic views of the future
  - Ideas or acts of self-harm or suicide
  - Disturbed sleep.

- There should not be episode of hypomania, mania or mixed episode in the past

- This episode should not be attributable to psychoactive substance use or to any organic mental disorder

Depressive episode can be mild, moderate or severe based on the number of symptoms and functional impairment.

- For mild depressive episode, two of the most typical and at least two other symptoms should be present. There may be subjective distress but with some difficulty, the individual will continue functioning.

- For moderate depressive episode, two of most typical and at least three (preferably four) other symptoms should be present. The person will usually have considerable difficulty in continuing with social, work or domestic activities.

- For severe depressive episode, all three of most typical and at least four of other symptoms must be present and it is very unlikely that the person will be able to continue with social, work, or domestic activities, except to a very limited extent. In severe depressive episode with psychotic features, delusions and hallucinations are present.

Now let us go back to our two patients Mr. K and Mrs. S described in previous section.

On psychiatric examination, Mr. K. had increased psychomotor activity and was distractible. His affect was cheerful. He was distractible and spoke spontaneously in high tone and volume. He had delusion of grandiosity and auditory hallucination and lacked insight. He had these symptoms for more than 1 week and had significant dysfunction. His physical examination was normal and there was no history of drug/alcohol abuse or medical disease. Therefore, his illness had no organic basis. Mr. K. has manic episode.

On psychiatric examination, Mrs. S. had decreased psychomotor activity and her affect was sad. She spoke in low tone and volume. She had ideas of guilt, depressive cognitions
and death wishes. She also had anhedonia and anergia. She had these symptoms for
more than 2 weeks. Mrs. S. has depressive episode.

### Self Assessment Questions 4

**Note:**

i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) How do we diagnose manic episode?

2) How is depression episode diagnosed?

3) Discuss the three types of depressive episode.

### 3.5 CLASSIFICATION OF MOOD DISORDERS

As you have already studied in Unit 1, in India, Chapter V (F) of tenth revision of
International Classification of Diseases (ICD -10) is used for making diagnosis of
psychiatric disorders.

Mood disorders present as episodes (with identifiable beginning and ending). They
may present as single episode only or may be recurrent (two or more episodes). There
are two types of episodes: manic and depressive episodes. In manic episode, the central
feature is elevated mood accompanied by increase in the physical and mental activity.
Hypomania is less severe form of mania. In depressive episode, the central feature is
depressed mood and there is decrease in physical and mental activity.

Mood disorders are classified according to number and types of episodes, the severity
and duration of symptoms. A patient may have depressive and/or manic types of episodes
and severity and duration of the symptoms may vary in each episode.

So when a patient presents to you, first step is to conduct clinical interview to collect
detailed information on history and conduct psychiatric examination. If organic diseases/
psychoactive substance is not the case of presenting problems, the presence of typical
signs and symptoms help in making a diagnosis of mania or depression according to
diagnostic guidelines. After ascertaining diagnosis of episode of mania or depression and its severity, the final diagnosis is made according to the type of mood disorder as given in ICD-10. In ICD-10, mood disorders are classified under section F30-39 as follows:

**F30 Manic episode:** There is only single episode of mania and level of severity of symptoms can be from hypomania to severe mania.

**F31 Bipolar affective disorder:** This is characterised by repeated episodes (at least two) of either mania or hypomania only or episodes of both depression and hypomania/mania.

These are of two types: bipolar I and bipolar II. In bipolar I, patient may have only episodes of mania or of both depression and mania. In bipolar II, patient may have episodes of hypomania only or of both depression and hypomania.

**F32 Depressive episode:** There is only single episode of depression and the level of severity of symptoms can be mild to severe.

**F33 Recurrent depressive disorder:** This is characterised by repeated (at least two) episodes of depression.

**F34 Persistent mood disorder:** In these types of disorders, persistent, longstanding fluctuating mood is present. The symptoms are rarely, if ever, sufficiently severe to be diagnosed as mild depression or hypomania.

Dysthymia is characterised by persistent, long standing low grade depressive symptoms and in cyclothymia patients may have persistent, long standing frequent mood swings of mild depression and mild cheerfulness.

**F38 Other mood disorder:** Mixed affective episode and recurrent brief depressive disorder are classified here. In mixed affective episode, the patient may experience either a mixture or a rapid alternation (usually within a few hours) of hypomanic, manic, and depressive symptoms. In recurrent brief depressive disorder, patient may experience recurrent (every month) depressive episodes of shorter duration (< 2 weeks).

**F39 Unspecified mood disorder** is diagnosed when diagnostic guidelines of any of the categories mentioned above are not met with.

If a person has four episodes of mania, hypomania or depression per year, it is called rapid cycling mood disorder.

### Self Assessment Questions 5

**Note:**

i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) **What are different types of mood disorders?**

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2) Discuss the characteristic features of bipolar disorder.

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3) Describe Hypomania.

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3.6 AETIOLOGY

As discussed in the previous chapter, like schizophrenia, for mood disorders also, no known single cause has been demonstrated. It is considered a biological disease which results from interplay of multiple factors like genetic and environmental factors.

3.6.1 Genetic Factors

Several family, adoption, and twin studies have demonstrated that the predisposition or susceptibility to develop the mood disorder is inherited. People who have a close relative with mood disorder are more likely to develop the disorder than the people who have no relatives with the illness. The more the number of members affected in a family, the greater is the risk to the child. The risk is greater if the affected family members are first-degree relatives rather than distant relatives. If one parent has a mood disorder, the child will have a risk of 10 – 25% for developing a mood disorder and the risk doubles if both parents are affected. The twin studies show that rate of having mood disorder in non identical and identical twin of patients with mood disorders is 70-90% and 16-35% respectively. Changes in neurotransmitters like serotonin, nor epinephrine, dopamine and histamine have been reported in brains of patients with mood disorder e.g. in patients with depression, decrease in norepinephrine, serotonin and dopamine activity have been reported and increase in norepinephrine and dopamine have been reported in mania. In some patients with suicidal impulses, low concentrations of serotonin metabolite in the cerebrospinal fluid have been reported. These neurotransmitters are modified by drugs used to treat mood disorders. Elevated hypothalamo-pituitary axis activity has been reported in patients with depressive disorders. Thyroid hormone abnormalities have been reported in patients with mood disorders.

3.6.2 Environmental Factors

It has been observed that stressful life events like loss of job, death of loved one etc. are seen more often before the onset of an episode of mood disorder. Recent stressful events are the most powerful predictors of the onset of a depressive episode. Cognitive theory of depression suggests that specific distortions (cognitive triad - a negative attitude towards self, environment, and future) in thinking result in depression in susceptible persons.
3.7 **TREATMENT OF MOOD DISORDER**

Management of patients with mood disorder involves use of pharmacological and psychosocial interventions. The goal of the treatment of patients with mood disorders is to reduce the symptoms, attain early recovery, decrease the dysfunction, and to prevent occurrence of future episodes. The treatment is planned according to the specific needs of the patients and their families.

3.7.1 **Pharmacological Treatment**

Mood stabilizer drugs are the mainstay of treatment for mood disorders and are treatment of choice for therapeutic treatment (treatment of an individual episode) and for prophylactic (prevention of future episodes) treatment of mood disorders. However, for an episode of depression, antidepressant drugs are used and antipsychotic drugs are used for rapid control of mania.

Most of the patients with mood disorders can stay at home and be treated on outpatient basis. Short term hospitalisation (2-6 weeks) is indicated for patients with severe illness who may refuse to eat or take medicines, are at increased suicidal risk, show grossly disorganised or inappropriate behaviour and are unmanageable and violent.

The treatment of mood disorders should be started immediately. In case of mania, presence of poor judgment, impulsivity, and aggressiveness may put the patient and others at risk and in case of depression, the delay leads to prolongation of misery. Some of the patients with mood disorders may not want to be treated because of poor judgment; e.g., in mania due to elated mood and grandiose ideas, the patient may not feel the need for treatment; and in depression, the patient may not want treatment because of ideas of hopelessness.

Large numbers of drugs are available for use and should be prescribed by a qualified physician. There is delay in onset of effect of antidepressant and mood stabilizer drugs; it may take 2-3 weeks before their effect builds up fully. However, antipsychotic drugs for treatment of mania show rapid effect and the improvement starts within a week. The improvement takes place gradually. First sleep, appetite and personal care improve followed by improvement in mood and distorted thinking. A drug should be tried for minimum of 4-6 weeks in adequate dosage before changing it. Substance abuse like alcohol, cannabis interferes with the effectiveness of treatment and may also result in stopping the medications. It should be ensured that patients do not consume these substances.
In patients with first episode of mania or depression, only therapeutic use of the drugs is recommended. After improvement, the drugs should not be stopped but should be continued for a period of minimum 6 - 12 months or more after the symptoms have disappeared. However, if there is no recurrence, the drugs should be gradually decreased and stopped.

In patients with multiple episodes, and incomplete improvement, long term prophylactic treatment is indicated. As chances of recurrence are high in patients with bipolar disorder, prophylactic treatment is recommended after the second episode. However in patients with first episode mania, with positive family history of mood disorders and very severe illness, the prophylactic treatment is recommended. In patients with multiple episodes of depression or incomplete improvement, prophylactic treatment is recommended.

The blood levels of mood stabilizer drugs in the blood should be monitored periodically as low dose has little effect on symptoms and high dose results in more side-effects.

Issues of compliance with drug treatment, reasons for poor drug compliance and how to improve it, have been discussed in detail in the chapter on schizophrenia and other psychotic disorders. You may please refer back to sub-section 2.3.5.1 of the previous Unit.

### 3.7.2 Psychosocial Treatment

The research indicate that a combination of pharmacotherapy with psychosocial interventions work best for patients with mood disorders. Many types of psychological interventions are available.

#### 3.7.2.1 Psychoeducation

The goal of psychoeducation is to empower the patients and their families by providing relevant information about mood disorders in simple and clear language and help them apply this information to their own situation. They are educated about the nature of illness and treatment options available. They are also encouraged to develop support mechanisms to deal with problems encountered. Psycho education is simple and can be imparted by trained health workers.

Family members have myths about the mood disorders and its treatment. Hence they are educated about the symptoms of mood disorders. Common myth about depression is that it is due to character weakness of the person or he/she is pretending. It is also believed that the patients lack will power to perform their tasks and are not trying enough to become alright. Common myths surrounding the drugs are that they are addicting and control the mind. These should be dispelled by emphasizing that it is an illness similar to other well known illnesses and are treatable.

Available treatment options and rationale of their use, side effects and dosage of drugs is also informed to the patient and family members. They are told about both benefits and side effects of treatment so that choice, mode and duration of treatment can be made as team effort. It is explained that although medications do have some side-effects, their beneficial effects far outweigh the adverse effects. Family members and the patients need to be told about ensuring drug compliance. Supervision of medications is required as there is a risk that they may not take drugs due to negative thinking, they might believe that treatment may not help them or may take over dosage of medicines as a way of suicidal attempt. They are advised to keep a record of name of medications, side effects and effectiveness of the medications. Family members are encouraged to check on the progress regularly after patients become alright, when they go back to work or study to prevent a sudden and unexpected relapse.
The persons with bipolar disorders should have regular daily and sleep routine and should avoid illicit substances. Role of family members in encouraging and being supportive to the patients is also discussed. Family members are told about the course and outcome of illness with and without treatment.

Family members should make a list of symptoms as this helps in identifying early signs of relapse. The patient should be taken to a psychiatrist immediately so that medication may be adjusted and a relapse prevented if these signs are noticed. Patients should also themselves learn to identify early subjective signs of relapse. Also they should have a plan in advance about what to do if such subjective symptoms are noticed.

The patient should be educated to delay any major decisions about relationships, jobs, or money until he/she is well again. During a mood episode, particularly during manic episode, they might sell or donate properties; ask for divorce etc. due to poor judgment.

3.7.2.2 Counseling

Counseling is directed at a specific problem, identified to be a trigger/reason for poor improvement of the mood episode, or making it worse e.g. marital problems, sexual problems, problems at work place, etc.

3.7.2.3 Supportive Psychotherapy

Supportive psychotherapy aims at extending rapport to the patents and their family during and also after the course of illness. Guidance and report is offered at each and every step aimed at improving the condition of the patient as well as to prevent relapse after recovery. Supportive psychotherapy is very important as it conveys to the patient and family that help and support is available whenever there is a need for it. It offers guidance and reassurance which is important for preventing relapse.

3.7.2.4 Interpersonal and Social Rhythm therapy for Bipolar Disorder

Interpersonal and social rhythm therapy helps the patients with bipolar disorder to regularize their daily routines and sleep-wake cycles. It also helps them to understand the relationship between mood and interpersonal events. Sleep deprivation has been recognised as trigger for an episode of mania. Patients should be advised to modify their life styles and stick to new lifestyle. They should have regular social and sleep routines; should avoid illicit substances. Also, the focus is on resolving interpersonal issues and problems that may directly impact a person’s routines and the patients are encouraged to build better and healthier interpersonal relationships and skills.

3.7.2.5 Cognitive-behaviour therapy (CBT) for Depression

Cognitive behaviour therapy is short term, problem focused and goal directed therapy. It is based on the premise that faulty ways of thinking can trigger depression. It helps people to achieve changes in the way they think, feel and behave. It focuses on the here and now difficulties. It is carried over weekly sessions for 15-25 weeks. The cognitive techniques involve eliciting automatic thoughts, testing them, identifying maladaptive assumptions and testing the validity of maladaptive assumptions. The behavioural techniques help the patients understand the inaccuracy of their cognitive assumptions and learn new ways of dealing with it. ‘Home work’ is given between sessions. Patients are asked to follow structured daily routine. Once these techniques are taught, the persons have to use these whenever symptoms occur. For mild to moderate depression, cognitive behaviour therapy works well.
3.7.2.6 Physical Exercise for Depression

Regular exercise helps to improve symptoms of mild depression. A typical exercise programme for mild depression is three sessions per week of moderate duration (45-60 minutes) for 10-12 weeks. Exercises like jogging, brisk walking, swimming, etc are useful.

Self Assessment Questions 7

Note:  
i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the treatment options available for mood disorders?

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2) What do you understand by therapeutic and prophylactic use of drugs?

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3) Highlight the salient points used in psychoeducation of families and patients with mood disorder.

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3.8 COURSE AND PROGNOSIS

In patients with bipolar disorder, most have both depressive and manic episodes, although 10-20% experience only manic episodes. In 60-75% of cases, it starts with depression and after first manic episode, 90% of the patients are likely to have another episode. An untreated manic episode lasts for about 3 months; therefore drugs should not be stopped before that. Patients may have 2-30 numbers of manic episodes, the mean number is about nine and about 5-15% are rapid cyclers. One third of all patients with bipolar disorder have chronic symptoms. Patients with bipolar disorder have a poorer prognosis than do patients with major depressive disorder. Factors related to good prognosis of bipolar disorders are short duration of manic episodes, late age of onset and few coexisting psychiatric or medical problems. Factors related to poor prognosis are an early age of onset, presence of substance/alcohol abuse and poor psychosocial support.

Depressive disorder tends to be chronic, and about 50-75% of patients have other episode of depression within first 5 years. Over a 20-year period, the mean number of
episodes is five or six. Some of the patients with depressive disorder may have manic episode and turn into bipolar disorder after several years. An untreated depressive episode lasts for about 6-13 months, lasts for longer duration in elderly people. The withdrawal of antidepressants before this period almost always results in the return of the symptoms. Factors related to good prognosis are mild episodes, absence of psychotic symptoms, late age of onset, short hospital stay, history of stable family and social functioning for the 5 years preceding the illness. Factors related to poor prognosis are presence of coexisting dysthyemic disorder, abuse of alcohol/illicit substances, anxiety disorder, history of more than one previous depressive episode, and men are more likely to experience a chronically impaired course.

If a mood disorder is left untreated, a patient experiences more number of episodes, the time between the episodes decreases, and the severity and duration of each episode increases. However with prophylactic treatment, number, duration and severity of individual episode decrease and interval between the episodes increases.

Self Assessment Questions 8

Note:  
1) Read the following questions carefully and answer in the space provided below.
2) Check your answer with that provided at the end of this unit.

1) If untreated, how long a mood episode will last?

2) What is the average number of mood episodes a person with mood disorder is likely to have?

3) What is the effect of prophylactic treatment on the course of mood disorders?

3.9 LET US SUM UP

- Mood is a sustained feeling state that is experienced internally and influences a person’s behaviour and awareness of the world. Affect is a related term which is external expression of mood and is known by the facial expressions.
Classification of Mental Disorders

- Mood disorders are characterised by persistent and pervasive change in mood or affect accompanied by the change in the overall activity of a person and affect personal, biological and socio-occupational functioning of a person.

- The lifetime risk for bipolar disorder is 0.3-1.5% and for depressive disorders is 8-20%. There is twofold greater prevalence of depressive disorders in women than in men.

- The clinical interview is the best method to elicit symptoms in history from the informants/patients and the signs on psychiatric examination. The information from history is corroborated with findings on psychiatric examination to make diagnosis.

- Manic episode is characterised by sustained mood elation, increased energy, increased activity, increased talkativeness, subjective experience of thoughts racing, decreased need for sleep, and inflated self esteem, loss of normal social inhibitions resulting in behaviour which is inappropriate to the circumstances and disruption of functioning. These symptoms should last for at least 1 week. Hypomania is less severe form of mania.

- Depressive episode is characterised by sustained mood of depression, anhedonia, anergia, depressive cognitions, ideas of guilt, suicidal ideas, poor sleep and weight. These symptoms should be there for at least 2 weeks.

- Bipolar affective disorder characterised by repeated episodes (at least two) of either mania or hypomania only or episodes of both depression and hypomania/mania. Recurrent depressive disorder is characterised by repeated (at least two) episodes of depression.

- It is considered a biological disease which results from interplay of multiple factors like genetic and environmental factors.

- The goal of the treatment of patients with mood disorders is to reduce the symptoms, attain early recovery, decrease the dysfunction, and to prevent occurrence of future episodes.

- Management of patients with mood disorder involves use of pharmacological and psychosocial interventions.

- Mood stabilizer drugs are the mainstay of treatment for mood disorders. However, for an episode of depression, antidepressant drugs are used and antipsychotic drugs are used for rapid control of mania. The mood stabilizer drugs are used for therapeutic treatment and are treatment of choice for prophylactic treatment of mood disorders.

- Psychoeducation is simple and can be imparted by trained health workers. It consists of providing relevant information about mood disorders in simple and clear language and help family members apply this information to their own situation. Cognitive behaviour therapy has also been found helpful.

- Patients with bipolar disorder have poorer prognosis than do patients with major depressive disorder. About 90% of the patients with bipolar disorder are likely to have another episode. An untreated manic episode and depressive episode last for about 3 months and 6-13 months respectively.
3.10 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Mood is a sustained feeling state that is experienced internally and influences a person’s behaviour and awareness of the world. Mood can be normal, cheerful, depressed, irritable, anxious etc.

2) In mood disorders, the fundamental disturbance is change in mood or affect, usually to depression or to cheerfulness. The mood change is accompanied by the change in the overall activity of a person. These changes are persistent (last for a prolonged period of time, usually for weeks), pervasive (affects all aspects of person’s life) and have an effect on personal, biological and socio-occupational functioning of a person.

Self Assessment Questions 2

1) Depressive disorders are more common than bipolar disorders. The lifetime risk (risk of developing a disease during one’s lifetime) for bipolar disorder is 0.3-1.5% and for depressive disorders is 8-20%.

2) The increased prevalence of mood disorders among women is due to hormonal changes, the effects of child birth and psychosocial stresses for women.

Self Assessment Questions 3

1) The signs on psychiatric examination of a patient with mania episode are:
   - Increased psychomotor activity, over familiar, easily distractible.
   - Cheerful/elevated/ecstatic mood, it may also be irritable and labile (rapid fluctuations).
   - Spontaneous speech, increased rate, tone and volume of speech.
   - Flight of ideas (jump from topic to topic).
   - Pressure of speech (difficult to interrupt).
   - Subjective racing of thoughts.
   - Idea/delusions of grandiosity.
   - Delusions of persecution, reference and auditory hallucinations.
   - In severe cases, their judgment may be impaired.

2) The signs on psychiatric examination of a patient with depressive episode are:
   - Decreased psychomotor activity.
   - Depressed mood, sometimes mood may be anxious or irritable.
   - Anhedonia (reduced/loss of interest or pleasure in previously enjoyable activities).
   - Anergia (reduced or no energy, marked tiredness even on slight effort).
   - Ideas of hopelessness, helplessness and worthlessness; this triad is known as depressive cognitions.
- Ideas of guilt.
- Suicidal ideas, death wishes.
- Delusions of guilt, poverty, nihilism, persecution, reference.
- Auditory and visual hallucinations.
- Catatonic features in some patients: mutism and stupor.
- Judgment may be impaired in severe cases.

3) The characteristic features of mania include excessive activeness and cheerfulness. The person talks incessantly, full of new ideas and have increased self esteem. They are restless, irritable, impulsive and easily distractible. They believe that they have special powers and abilities.

4) The characteristic feature of depression include excessive sadness, worrying, negative thinking and feelings of worthlessness. The symptoms also include difficulty in sleep, tiredness, loss of appetite and weight, loss of memory and concentration.

**Self Assessment Questions 4**

1) Manic episode is diagnosed based on the following criteria as given in ICD – 10:
   
   i) The symptom should last for at least one week.
   
   ii) Should be severe enough to disrupt ordinary work and social activities more or less completely.

   iii) The mood may be elevated, expansive or irritable and is definitely abnormal for the individual concerned.

   iv) Change in mood should be sustained and be accompanied by increased energy and several of the following symptoms:

   - increased activity.
   - increased talkativeness (pressure of speech).
   - subjective experience of thoughts racing.
   - decreased need for sleep.
   - inflated self esteem or grandiosity.
   - excessive optimism.
   - distractibility.
   - constant changes in activity or plans.
   - loss of normal social inhibitions resulting in behaviour which is inappropriate to the circumstances.
   - reckless behaviour without understanding the risks of such behaviour like spending sprees, foolish enterprises, reckless driving.
   - marked sexual energy or sexual indiscretions.

   v) The episode is not attributable to psychoactive substance use or any organic mental disorder.
2) Depression episode is diagnosed as follows according to ICD 10:

- The symptoms should be present for at least 2 weeks.
- At least 2 out of the 3 most typical symptoms must be present.
  - Sustained depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances.
  - Loss of interest or pleasure in activities that are normally pleasurable (anhedonia).
  - Decreased energy or increased fatigability (anergia).
- Should be accompanied by several other symptoms like:
  - Reduced concentration and attention.
  - Reduced self-esteem and self-confidence.
  - Ideas of guilt and unworthiness (even in a mild type of episode).
  - Bleak and pessimistic views of the future.
  - Ideas or acts of self-harm or suicide.
  - Disturbed sleep.
- There should not be episode of hypomania, mania or mixed episode in the past.
- This episode should not be attributable to psychoactive substance use or to any organic mental disorder.

3) The three types of depressive episode are mild, moderate and severe depressive episode.

Self Assessment Questions 5

1) In ICD-10, mood disorders are classified taking into consideration number and types of episodes, the severity and duration of symptoms as follows: Manic episode, Depressive episode, Mixed episode, Bipolar affective disorder, Recurrent depressive disorder, Persistent mood disorder, Other mood disorder, Unspecified mood disorder.

2) Bipolar disorder is characterised by repeated episodes (at least two) of either mania or hypomania only, or episodes of both depression and mania/hypomania.

3) Hypomania is less severe form of mania.

Self Assessment Questions 6

1) Mood disorders result from an interplay of genetic as well as environmental factors. Genetic factors underline the role of inheritance and neurotransmitters. Environmental factors include stressful events coupled with negative attitude towards self, environment and the future.

Self Assessment Questions 7

1) Two types of treatment options are available for mood disorders: pharmacological and psychosocial.
2) Mood stabilizer drugs are the mainstay of treatment for mood disorders. However, for an episode of depression, antidepressant drugs are used and antipsychotic drugs are used for rapid control of mania.

3) Treatment of an individual episode is called therapeutic use and treatment used for prevention of future episode is called prophylactic use. Mood stabilizer drugs are treatment of choice for therapeutic and prophylactic treatment of mood disorders.

4) The salient points used in psychoeducation for mood disorders are:
   - Psycho education is simple and can be imparted by trained health workers.
   - Providing relevant information about mood disorders in simple and clear language and help family members apply this information to their own situation.
   - Nature of illness.
   - Educated about the symptoms.
   - Clearing common misperceptions about mood disorders.
   - Available treatment options and rationale of their use, side effects and dosage of drugs.
   - A record of name of medications, side effects and effectiveness of the medications.
   - Drug compliance.
   - Watch for early signs of relapse and the patient should be taken to a psychiatrist immediately so that medication may be adjusted and a relapse prevented.
   - Family members are encouraged to check on the progress regularly after patients become alright, when they go back to work or study to prevent a sudden and unexpected relapse.
   - Regular daily and sleep routine.
   - Avoid use of illicit substances.
   - Role of family members in encouraging and be supportive to the patients.
   - Course of illness i.e. how long it lasts and its outcome with treatment and without treatment is discussed.
   - Delay any major decisions about relationships, jobs, or money until he/she is well again.

Self Assessment Questions 8

1) An untreated manic episode lasts about 3 months and an untreated depressive episode lasts for about 6-13 months, lasts for longer duration in elderly people.

2) Patients with bipolar disorder may have 2 – 30 numbers of manic episodes, the mean number is about nine and the mean number of episodes is five or six in patients with recurrent depressive disorders.

3) With prophylactic treatment, number, duration and severity of individual episode decrease and interval between the episodes increases.
3.11 UNIT END QUESTIONS

1) Describe the identification and diagnosis of mood disorders.

2) Explain the aetiology and treatment for mood disorders.

3.12 SUGGESTED READINGS


UNIT 4  NEUROTIC GROUP OF DISORDERS

Structure

4.0 Introduction
4.1 Objectives
4.2 Definition and Classification
4.3 Anxiety Disorders
  4.3.1 Generalised Anxiety Disorder
  4.3.2 Panic Disorder
  4.3.3 Phobic Anxiety Disorder
  4.3.4 Obsessive Compulsive Disorder
4.4 Stress Related Disorders
  4.4.1 Acute Stress Reaction or Acute Stress Disorder
  4.4.2 Post Traumatic Stress Disorder
  4.4.3 Adjustment Disorders
4.5 Somatoform Disorder
  4.5.1 Somatization Disorder
  4.5.2 Hypochondriasis
  4.5.3 Somatoform Pain Disorder
  4.5.4 Undifferentiated Somatoform Disorder
  4.5.5 Somatoform Automatic Dysfunction
  4.5.6 Treatment of Somatoform Disorder
4.6 Dissociative Disorders
4.7 Let Us Sum Up
4.8 Answers to Self Assessment Questions
4.9 Unit End Questions
4.10 References
4.11 Suggested Readings

4.0 INTRODUCTION

We have discussed about schizophrenia and mood disorders in the previous Units. Schizophrenia and mood disorders come under the group of severe mental illnesses. In this Unit, we will be discussing a much broader and also a more common group of illnesses, which come under the broad rubric of neurotic group of disorder. The term neurosis is not used now-a-days. But the category F 40-49 of the ICD 10 included the term neurotic in its heading as “neurotic, stress-related and somatoform disorders”. This Unit will discuss the group of disorders included under this broad heading.

4.1 OBJECTIVES

After studying this unit, you will be able to:

- describe the clinical features of anxiety, somatoform, stress related, adjustment and related disorders;
- understand the Classification of neurotic, stress-related and somatoform disorders;
identify and diagnose these disorders;

describe the course and outcome of neurotic, stress-related and somatoform disorders; and

discuss the methods of treatment available for these disorders.

4.2 DEFINITION AND CLASSIFICATION

In Unit 1, we discussed about the classification of the “Neurotic, stress related and somatoform disorders”. Before going into further details, it is important to know what neurosis is and what anxiety is. In the Unit 1, we understood conceptually ‘neuroses’ as the psychiatric disorders of lesser severity, where anxiety is the predominant feature which may be experienced directly or on being altered into some other symptoms by mental defence mechanisms. The term is no longer used in the current scientific literature and has more of historical relevance.

Let us now try to understand, what anxiety is. Anxiety is in the background of a large number of psychiatric disorders. In the English language, anxiety means worrying or feeling uneasy. Anxiety is a part of everyday life, and can be both, normal as well as abnormal. It is one of the commonest clinical manifestations of psychiatric illnesses. Anxiety can be defined as an unpleasant emotion, characterised by constant apprehension, which can be extremely distressing and unbearable, and is accompanied by psychological, somatic, physiological, biochemical, autonomic and behavioural changes. Anxiety has also been termed as a fear of unknown, and is related to a feeling of threat which has minimal or no objective basis.

However, there is difference between fear and anxiety. Fear involves a real threatening situation which gives rise to the flight or fight response by the individual. Thus fear involves cognition of the threatening object, subjective cognition of being in danger, physiological responses like sweating or increased blood pressure, and behavioural components of running away or hitting back. Similarly, anxiety also involves physiological changes and behavioural responses. However, unlike fear, there is no immediate threat; though the person perceives the threat as being imminent. Thus anxiety involves subjective perception of threat.

Whenever a person becomes anxious, he or she may resort to different manoeuvres to reduce anxiety, such as discussing problem with others, going for a stroll, smoking, going to sleep, taking a pill, resorting to alcohol, eating, etc. When anxiety is excessive, it may not get relieved by such measures and can be termed as ‘pathological’.

In a normal situation, anxiety acts as a “drive” to overcome, eliminate or resolve threat and re-establish homeostasis. This is also called “signal anxiety”, implying a subjective warning that something needs to be done. For example, in a person who has to appear in an examination or interview, anxiety acts as a drive motivating him to prepare for the event. An optimum level of anxiety is essential for achieving highest level of performance. However, a further increase in anxiety does not improve performance, and later starts deteriorating it.

The abnormal or pathological anxiety differs from normal anxiety by being:

- Excessive; not relieved by the usual stress relieving manoeuvres resorted to in day to day life.
- Distressing
- Adversely affecting the performance
Anxiety can be a presenting symptom in a wide variety of psychiatric disorders and sometimes even in physical disorders. It can be primary or secondary to other symptoms, as is the case when it is occurring as a part of symptom complex of other psychiatric disorders or as a reaction to physical illness. But in anxiety disorders, it is the predominant presenting symptom which may be generalised and present all the time as in generalised anxiety disorder; episodic as in panic disorder; or related to specific situations, objects or activities as in phobic anxiety disorder.

DSM IV includes generalised anxiety disorder, panic disorder, phobic disorders, obsessive compulsive disorder, acute stress disorder and post traumatic stress disorder under the broad group of anxiety disorders, since in all these illnesses anxiety is the predominant manifestation. However, ICD 10 does not use the term anxiety disorders as a broad group. This unit discusses the generalised anxiety disorder, panic disorder, phobic disorders and obsessive compulsive disorder under the section on anxiety disorders, and acute stress disorder and post traumatic stress disorder under the section on stress related disorders.

Self Assessment Questions 1

Note:  
i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What do you mean by anxiety?

2) What is the difference between normal and abnormal anxiety?

3) How does one cope with anxiety?

4) Mention the different types of anxiety disorders.
4.3 ANXIETY DISORDERS

4.3.1 Generalised Anxiety Disorder

The generalised anxiety disorder (GAD) was earlier known by the name anxiety neurosis or anxiety states. The disorder is more commonly seen in primary care settings or in internal medicine clinics rather than in psychiatric practice.

GAD is characterised by unrealistic and/or excessive anxiety which is generalised and persistent, present all the time, and is not restricted to certain situations or exposure to certain objects. The disorder has a prevalence of 2-5 percent and is twice more common in females as compared with males. Onset is usually in 20s, although persons of any age can be affected.

Only one-third of patients who have GAD seek psychiatric help. Many go to the general practitioners, internists and cardiologists.

Clinical picture

The patient presents with psychological, autonomic and motor symptoms of anxiety, described as below:

1) Psychological symptoms. Psychological symptoms of GAD include constant feelings of worries, apprehension, feeling on “edge”, difficulty in concentration or mind going blank because of anxiety, irritability and difficulty sleeping. The difficulties in concentration lead to complaints of forgetfulness.

2) Symptoms of increased motor tension. Persistent anxiety is associated with increased muscular tension, which can lead to symptoms like tremulousness, feeling shaky, muscle tension, generalised aches, pain in the chest, backache, pain in extremities, muscle soreness, restlessness, easy fatigability, etc.

3) Symptoms of sympathetic overactivity. Increased sympathetic activity associated with anxiety leads to shortness of breath, palpitations, sweating or cold clammy hands, dry mouth, dizziness or light-headedness, nausea, diarrhoea, abdominal distress, hot flushes or chills, frequent urination, trouble in swallowing or lump in throat.

Symptoms in GAD may sometimes occur in the background of chronic environmental stress. Many times, the illness runs a chronic and fluctuating course, but response to treatment is good. Mild depressive symptoms are often an associated feature.

Treatment

Main treatment of GAD is on psychotherapeutic lines. Both supportive psychotherapy as well as cognitive behaviour therapy (CBT) can be used. CBT requires specialised training. Psychotherapies are discussed in detail in Unit 2 of Block 3 of MPC 054.

Supportive psychotherapy includes empathetic listening to the patient’s problems, identifying the stressors in the environment, identification of the patients’ strengths and reassurance to the patient. The therapist should appreciate and encourage the patient’s positive strengths and qualities by which he has been managing his life.

Muscular relaxation exercises, breathing exercises, meditation, yoga, biofeedback, regular physical exercise and lifestyle modification help in reducing anxiety.

A number of antianxiety medications are also available, which include benzodiazepines(diazepam, lorazepam, clonazepam, etc.), selective serotonin uptake
inhibitors—SSRIs (sertraline, paroxetine, escitalopram), venlafaxine and buspirone. All are effective and should be used under strict medical care. The benzodiazepines are associated with abuse potential and hence are not used beyond 6-8 weeks.

4.3.2 Panic Disorder

Panic disorder is characterised by spontaneous recurrent episodes of severe anxiety (panic) which are not restricted to any particular situation or set of circumstances, and are therefore unpredictable.

Panic disorder is also a common psychiatric illness with a life time prevalence of 1-2% and annual prevalence of 0.5-1.5%. It is twice more common in females as compared to that in males.

Clinical picture

The patient presents with episodes of sudden onset of anxiety, palpitations, chest pain, choking sensation, dizziness and feelings of unreality (depersonalization and derealization), invariably accompanied by a secondary fear of dying, losing control or going mad. Individual attacks usually last for minutes only, sometimes longer. During a panic attack, the patient develops such a fear and severe autonomic symptoms that he has to go out of the place wherever he is. A panic attack is often followed by a persistent fear of having another attack. Depressive symptoms are often an associated feature.

Patients of panic disorder suffer recurrent attacks of panic. Diagnosis of panic disorder is made, if a person suffers several such attacks within a period of one month. According to DSM IV TR, a person is diagnosed as having panic disorder if she had experienced recurrent unexpected attacks and is persistently concerned with having another attack. This condition should be there for at least one month. Further, the person must have at least four of the following symptoms during the panic attack:

a) palpitation or pounding heart
b) sweating
c) trembling or shaking
d) feeling of choking
e) chest pain or discomfort
f) shortness of breath
g) feeling dizzy
h) nausea
i) fear of dying
j) derealisation or depersonalization
k) fear of losing control or going crazy
l) paresthesias
m) chill or hot flushes

Patients with panic disorder often also present with agoraphobia, a fear of being alone especially in situations in which a rapid exit is not possible. The person is afraid of public places such as shopping malls, cinema hall, train etc. where a large number of
people gather. This fear may develop secondary to the initial panic attacks, when the person starts avoiding the other situations.

There is a related condition of “hyperventilation syndrome”, which sometimes can be confused with panic disorder. In hyperventilation syndrome, respiration is characterised by an irregular sighing pattern or rapid shallow regular breathing. Breathing is high thoracic rather than diaphragmatic breathing. The hyperventilation attack can be provoked by voluntary respiration and controlled by specific breathing regulation exercises such as breathing in a paper bag and also by relaxation exercises.

**Treatment**

Treatment of panic disorder includes psychological treatment as well as medications. Psychological treatments like exposure and cognitive behaviour therapy are used commonly. The patient and the family members need to be reassured that the illness is not physical, is not serious, and the episodes remit spontaneously after a short period of 15-30 minutes. The patient should not avoid various situations, where such an episode has occurred. Just a rest for a short time is enough and there is no need to rush to a doctor or a hospital. One of course needs to follow the advice of the psychiatrist or the treating doctor.

Some patients are helped by breathing exercises, and can easily learn to control hyperventilation which is associated with most panic attacks.

A number of effective medications are also available for panic disorder. Selective serotonin uptake inhibitors – SSRI (fluoxetine, sertraline, paroxetine, escitalopram) are often the preferred medication. Other medicines, which can also be used for treatment of panic disorder, include benzodiazepines like clonazepam and alprazolam, and imipramine, a tricyclic antidepressant.

However, cognitive technique has been found to be more effective in long term maintenance of cure. It helps in identifying the catastrophic thoughts in the individual which become automatic thoughts that non-consciously result in the panic attack, e.g., increase in heart beat may be thought of as leading to a heart attack. The individual is helped to identify the triggering cues and take a realistic view.

**Self Assessment Questions 2**

**Note:**

i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the clinical features of generalised anxiety disorder?

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2) Discuss psychological treatment of generalised anxiety disorder.

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3) What is the difference between a panic attack and panic disorder?

4) How does hyperventilation syndrome differ from panic attacks?

4.3.3 Phobic Anxiety Disorder

In phobic anxiety disorder, the patient develops severe anxiety or fear on exposure to certain well defined situations, objects or activities, which are external to the individual, resulting in avoidance of such situations or objects. The patient considers the fear as irrational, but is unable to control it.

The phobic anxiety is indistinguishable subjectively, physiologically and behaviourally from other forms of anxiety and may vary in severity from mild unease to terror. The affected person is aware that the particular situation, object or the activity is not to be feared upon, but is unable to control the fear and face it.

Phobias are different from normal fears which occur in most young children and many adults in some form. Mild fears of heights, lifts, darkness, aeroplanes, lizards, spiders, rats, etc. are within cultural norms and do not usually lead to total avoidance of such objects. When such fears become too distressing, leading to avoidance of the phobic stimuli and, interfering into the day-to-day functioning, these can be termed phobias.

Phobic disorders are not commonly seen in psychiatric practice, though they are quite prevalent.

Phobias are broadly of 3 types: agoraphobia, social phobias and specific phobias.

i) Agoraphobia: Agoraphobia is the fear of being in places or situations from where escape to a safe place (usually home) might be difficult or embarrassing, or in which help may not be available in the event of suddenly developing symptoms that could be incapacitating or extremely embarrassing. It includes fears of leaving home alone, entering shops, crowds and public places, or of travelling alone in trains, buses or planes.

Onset of agoraphobia is in 20s. It has a life time prevalence of 0.6% and is about 3 times more common in women than in men.

Symptoms of agoraphobia include those of acute anxiety occurring in phobic situations. Agoraphobia is the most incapacitating of the phobic disorders and some sufferers may become house-bound. Many patients of agoraphobia develop secondary depressive symptoms. Some may also develop obsessions and others may also have social anxiety.
ii) **Social Phobia or Social Anxiety Disorder**: Social phobia or social anxiety disorder is characterised by a fear of scrutiny by other people in comparatively small groups (as opposed to crowds like in agoraphobia), leading to avoidance of social situations. Social phobia affects 3-5 percent of the population and is seen equally in both sexes. Social phobias may be discrete (i.e., restricted to public speaking, eating in front of others, being unable to urinate in a public lavatory, trembling of hands while writing in presence of others, and not being able to answer questions in social situations) or diffuse, involving almost all social situations outside the family circle.

Social phobias are usually associated with low self esteem and fear of criticism. The patient may present with complaints of blushing, shakiness or tremors of hands, nausea or urgency of micturition. Symptoms may progress onto panic attacks. Avoidance is often marked, and in extreme cases may result in complete social isolation.

iii) **Specific Phobias or Simple Phobias**: Specific phobias, also called simple phobias, are characterised by an irrational fear of specific objects or situations, e.g., fear of fire (pyrophobia), fear of closed space (claustrophobia), fear of blood (haemophobia), fear of heights (acrophobia) and fear of spiders (arachnophobia). There is also fear of thunder, darkness, flying, eating certain foods or fear of exposure to certain diseases, such as sexually transmitted diseases, AIDS or radiation, etc.

Thus specific phobias can be divided into the following subtypes such as:

a) animal-related, e.g., fear of dogs, spiders, rats etc.
b) situation-related, e.g., fear of driving, closed spaces etc.
c) natural environment-related, e.g., water, storms
d) medical-related, e.g., blood, injury
e) others e.g., vomiting, choking.

Patients with specific phobias only occasionally present for treatment. Six months prevalence of specific phobias is 5-12%. Onset is usually in childhood or early adult life. Specific phobias that start in childhood usually remit spontaneously.

**Treatment**

Phobic disorder responds best to psychological treatment. It can be psychoanalytical therapies, behavioural or cognitive behavioural therapies.

Psychoanalytic therapies focus on finding out the past unresolved conflicts and learn to deal with it in an appropriate manner.

Behaviour therapy is the treatment of choice for most of the phobic disorders, as phobias are considered to be learned behaviours. Treatment of agoraphobia is similar to that of panic disorder.

Behavioural techniques like systemic desensitisation, exposure in vivo, flooding and modeling, relaxation techniques are used for treatment of simple phobias. In systemic desensitization, the patient is first taught to be relaxed completely. Then he is exposed serially to a predetermined list of anxiety provoking stimuli graded in a hierarchy from the least to the most frightening. Flooding or exposure therapy involves putting the client straightaway in the feared situation. Modelling is also another behavioural techniques used in treatment of phobic disorders.
Systemic desensitisation is also effective in social phobias. Drugs like SSRIs (paroxetine, sertraline, escitalopram), clonazepam, alprazolam and beta blockers like propranolol have also been found to be effective in social phobia. Propranolol is especially helpful in reducing performance anxiety.

Cognitive behavioural therapies has also been found to be useful in case of social phobia. It explores the erroneous automatic thoughts of the individual and helps in gaining new perspective.

### 4.3.4 Obsessive Compulsive Disorder

Obsessive compulsive disorder (OCD) is characterised by the presence of obsessions and compulsions. Obsessions are recurrent and persistent ideas, images, doubts, impulses or ruminations, that enter the individual’s mind repeatedly, considered irrational or senseless by the person and are anxiety provoking. The sufferer often tries, though unsuccessfully, to resist them. The thoughts are recognised by the individual as own thoughts and not attributed to others (unlike delusions).

Compulsions are the motor counterpart of obsessions. These are recurrent behaviours, such as counting, checking, washing, touching or avoiding, usually performed as a response to an obsession or to neutralize some dreaded event. The compulsions may or may not be connected in a realistic way with what it is designed to neutralize or prevent, and are clearly excessive.

Thus compulsions are repetitive acts which the person carries out despite knowing that they are meaningless, or excessive. In both obsessions and compulsions, the client knows that these are meaningless, unnecessary and excessive. They are distressing and affect the day to day functioning. Client is not able to ignore or control it. Obsessions usually provoke anxiety whereas compulsions reduce anxiety, even thought temporarily.

OCD has a lifetime prevalence of about 3 percent and is equally seen in males and females. Onset is usually in adolescence or early adulthood, though in some cases, it may be traced to childhood. The illness often tends to run a chronic course and can be highly disabling. There is often a marked delay between onset and treatment seeking, as the illness remains unrecognized in the earlier period.

#### Clinical Picture

Patients present with multiple obsessions and compulsions. Obsessions may be of different types like of contamination with dirt, repetitive doubts like not having locked the door properly, aggressive impulses, excessive need to have things in particular order, distressful images of sexual nature or related to blasphemous thoughts. Obsessions of contamination are often followed by compulsions like excessive hand washing, bathing; and the doubts are followed by repetitive checking of doors, locks, taps etc. Often the patients present with multiple obsessions and compulsions, but sometimes, obsessions and compulsions may occur alone. The nature of obsessions and compulsions may also change over the course of illness.

Patients with OCD often suffer secondary depressive symptoms in form of low mood, generalised disinterest, hopelessness, helplessness, disturbed sleep.

#### Treatment

Treatment of OCD includes behaviour therapy and medications. The behavioural technique of exposure and response prevention (popularly known as ERP) is used for treatment. The basic principle of ERP is that the patient is exposed to the obsessional
stimuli like the dirt or asked to do the action generating anxiety, and is not allowed to do the neutralising behaviour like washing or checking. Treatment goes on for multiple sessions, which may be spread over few weeks to months. The sessions may be taken initially 2-3 times a week and later less frequently. Patient is also given homework. Other behavioural techniques include exposure in vivo and thought stopping technique.

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<td>1) Define phobia. What are different types of phobias?</td>
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<td>2) Describe treatment of phobic disorder.</td>
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<td>3) What is the difference between obsessions and compulsions?</td>
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<td>4) Describe clinical picture of obsessive compulsive disorder.</td>
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<td>5) What treatment is prescribed for OCD?</td>
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Neurotic Group of Disorders
A number of effective medications are also available for treatment of OCD, which include SSRIs (fluoxetine, fluvoxamine, sertraline, paroxetine, escitalopram) and clomipramine. Treatment often needs to be continued for long period, which may go beyond 2-3 years. Though the patient may show significant response in the initial 2-3 months, maintenance treatment needs to be continued.

4.4 STRESS RELATED DISORDERS

The term, ‘stress’, is used very commonly in day to day life. For example, we often say that ‘so and so person is under stress’, or ‘stress leads to so many problems’, or ‘life is full of stress’. In medical and behavioural sciences, the term has been used interchangeably to describe aversive stimuli of excessive intensity; the physiological, behavioural and subjective responses to them; in context of an encounter between an individual and the stressful stimuli; or all of the above as a system. Thus stress can be conceptualised as a stimulus i.e., the cause, or a response, i.e., the result. Stress refers to a real or perceived threat to the individual that results in physiological and behavioural responses.

Stress can give rise to a wide range of medical and psychiatric disorders. It has an important role to play in causation of most of the psychiatric disorders, may precipitate or advance the onset or interfere in improvement. Certain psychiatric disorders are known to have a specific relation with stress. These disorders develop as a direct consequence of an acute severe stress or continued trauma. The stressful event and its accompanying circumstances are the primary and overriding causal factor, and the disorder would not occur, if the stressful event had not occurred.

The stress related disorders include:
- Acute stress reaction
- Post traumatic stress disorder
- Adjustment disorders

All the stress related disorders can be considered as maladaptive responses to severe or continued stress.

4.4.1 Acute Stress Reaction or Acute Stress Disorder

Acute stress reaction is a transient disorder occurring in response to an exceptional physical or mental stress.

Prevalence of acute stress reaction is likely to vary depending on the kind of stressor. Incidence has been reported to be ranging from 14% in motor vehicle accident survivors to 33% in witnesses of a mass shooting.

Clinical Picture

The patient presents with severe anxiety symptoms in response to a severe stressful event. There is usually an initial phase of daze accompanied by some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli and disorientation. A subjective sense of numbness, low mood, irritability, anger and despair with the stressor and its immediate consequences, and autonomic arousal may be present, though no one symptom predominates for long. The patient may be anxious, restless and overactive or become withdrawn.

The stressors may include natural catastrophes, accidents, criminal assault, rape, multiple bereavements, domestic fire, war, etc. The stressors involve sudden and threatening change in the social position of the person.
Symptoms may appear within minutes of facing the stressor, begin to diminish after 24-48 hours and are minimal after about 3 days. Sometimes, symptoms may resolve within hours if the patient can be removed from the stressful environment.

**Treatment**

Treatment mainly consists in providing psychological support in form of reassurance. The patient should be encouraged to speak about his problem and ventilate his feelings. Critical incident stress debriefing is a specific technique used in acute stress reaction, conducted within 24-72 hours of the trauma. Debriefing has been claimed to prevent the development of PTSD, though some studies have not found any significant effect in preventing the subsequent development of PTSD. Cognitive behavioural techniques such as education about trauma reactions, progressive muscular relaxation, prolonged exposure and cognitive restructuring of the fear related beliefs have also been found to be helpful.

Benzodiazepines, such as diazepam, lorazepam, clonazepam or alprazolam can be used to relieve the distress. Treatment is usually not required beyond 2-3 days.

### 4.4.2 Post Traumatic Stress Disorder (PTSD)

PTSD occurs as a delayed response to stressful events of threatening or catastrophic nature that would lead to severe or pervasive distress in nearly all the persons. The stressors may include natural or manmade disasters, such as wars, floods, earthquakes and famines, serious accidents, witnessing violent deaths of others, being victim of torture, terrorism or rape, etc. Re-experiencing of trauma through intruding thoughts or dreams and emotional numbing to other events are the characteristic features of PTSD.

Post traumatic stress disorder can broadly be categorised as arising out of the following:

- Natural disasters such as flood, earthquake, cyclone, tsunami; and
- **Manmade disasters:** can again be subdivided into trauma arising out of military combat, e.g., war, terrorist attack; and trauma due to severe threat to personal security and safety, e.g., incidents of rape, accidents, domestic violence, abuse, torture, kidnapping etc.

Life time prevalence of PTSD has been reported to be 5% in men and 10.4% in women, whereas past month prevalence is reported to be 1.2% in men and 2.74% in women. Following a traumatic event, nearly 50-80% of the people affected may develop the disorder.

**Clinical Picture**

Symptoms appear within six months of the traumatic event. There occur episodes of repeated reliving of the trauma in form of flashbacks, intrusive recollections or distressing dreams of the event. There is a general feeling of emotional numbness or emotional detachment from other people, unresponsiveness to the surrounding environment, anhedonia, and avoidance of activities and situations reminiscent of the trauma. The patient reports intense distress on exposure to events which resemble the concerned stressor and on anniversaries of the stressor. A state of autonomic hyperarousal with hypervigilance is often present. Sleep and appetite are disturbed. Anxiety and depressive symptoms are often present. Alcohol or drug abuse may occur as a complication.

Thus PTSD can said to have three main clinical characteristics:

- Persistent re-experiencing and reliving the traumatic event (e.g., flashbacks, dreams, nightmares)
Persistent avoidance of stimuli associated with trauma

Experiencing symptoms of increased autonomic arousal (not present before the trauma), such as irritability, excessive display of anger, increased heart beat, difficulty in falling asleep or staying asleep, sweating, excessive vigilance of the environment.

In most of the cases, the symptoms begin immediately after the traumatic event, though there may be a delayed onset in a small number of cases. Prospective follow up studies have shown that a large proportion of the patients with PTSD recover on their own. About one third to one half of the subjects may not recover even after many years.

**Treatment**

Psychological treatments in form of cognitive behaviour therapy, stress management and supportive therapy are helpful.

Cognitive behaviour therapy for PTSD includes psychoeducation about common reactions to trauma, and rationale for interventions. Trauma focussed CBT with elements of exposure and cognitive therapy is indicated. Cognitive therapy focuses on the identification and modification of the misinterpretations that lead the patient to overestimate the threat. Patients with PTSD sometimes may feel guilty and blame themselves. For example, a rape victim may blame herself for the event or a war survivor may have survivor guilt. These feelings need to be addressed in the therapy.

Stress management techniques like progressive muscular relaxation, training in slow abdominal breathing, thought stopping of unwanted thoughts and training in positive thinking may be helpful.

SSRIs like sertraline, fluoxetine, escitalopram have been found to be effective in controlling the symptoms of PTSD. Benzodiazepines like lorazepam, clonazepam can be used for immediate control of anxiety symptoms.

Steps for prevention of PTSD can also be taken through Stress Inoculation Technique which will provide all the information to the person regarding the situation and the stress likely to be experienced, and accordingly prepare him to face it.

However, since one cannot be prepared for all types of disasters or traumas, it is important that the treatment should focus on providing ways to integrate the trauma experiences into the daily life of the person by gradually exposing to the memories of trauma and teaching appropriate coping skills to integrate them into one’s life.

Family therapy is also important in the treatment of PTSD. Since the trauma affects the individual’s relationship with others and disrupts the family functioning, it is essential to take the family as a whole and help them come to terms with the traumatic event and enable members to offer support and help to each other.

Existential therapy is another approach which tries to bring in a new perspective and look for meaning in one’s existence.

**4.4.3 Adjustment Disorders**

Adjustment disorders may be understood as stress related phenomena, in which stress precipitates the maladaptation and symptoms are time limited. The person recovers, when the stressor diminishes or is eliminated or a new state of adaptation is reached.

Adjustment disorders are a group of disorders that occur in the period of adaptation to a significant life change, or following a stressful life change, a stressful life event or a
serious physical illness. Such changes may include marriage, marital discord, divorce, birth of child, death of a near one, serious or disabling illness, change of job or residence, financial crisis, etc. Clinical picture may be dominated by emotional or behavioural symptoms in response to a psychosocial stressor. Symptoms may be in the form of anxiety, depression, disturbances of conduct or mixed disturbances. Individual predisposition or vulnerability plays an important role in development of the disorder and shaping of clinical picture. It is assumed that the condition would not have occurred in the absence of stressors.

Exact prevalence of adjustment disorders is not known, as the community based epidemiological studies do not give any estimates. Some studies have shown a prevalence varying from 2.3-5 % in outpatient and inpatient psychiatric settings respectively.

Clinical Picture

Onset is usually within one month of the stressful event, situation or the life crises. Symptoms usually do not exceed 6 months. If these exceed 6 months, diagnosis may need to be changed except in cases with depressive symptoms, where the diagnosis changes to prolonged depressive reaction.

Clinical manifestations may include depressed mood, anxiety, worrying too much, a feeling of inability to cope and plan ahead, medically unexplained physical symptoms and some degree of disability in performance of daily routine. Mixed anxiety and depressive symptoms are more common, as compared with other symptom patterns. Sometimes, the patient may present with intense anger and aggressive or dissocial behaviour. None of the symptoms is of sufficient severity to justify a more specific diagnosis like of an anxiety disorder or depressive episode. In children, regressive phenomena, such as return to bed wetting, babyish speech or thumb sucking may be seen. As per the presenting symptom, the diagnosis could be

- Brief depressive reaction
- Prolonged depressive reaction
- Mixed anxiety and depressive reaction
- With predominant disturbance of other emotions
- With predominant disturbance of other conduct
- With mixed disturbance of emotions and conduct

Prognosis is good with appropriate treatment. Most of the patients return to their premorbid level of functioning within few months. Some patients may progress on to develop other disorders, such as depression. Adolescents usually take longer time to recover than the adults.

Treatment

Treatment includes psychotherapy and drugs. Psychotherapy is the treatment of choice. Both individual and group therapies can be used. In individual therapy, it is important to explore the meaning of the stressor for the patient and also his reaction. The patient is helped in adjusting or adapting to the new situation or role. Group therapy is especially used in patients who have faced similar stressors, for example, a group of retired persons.

Medications are usually not indicated. When the anxiety or depressive symptoms are severe, an appropriate antianxiety or antidepressant medication may be prescribed.
### Self Assessment Questions 4

**Note:**
1. Read the following questions carefully and answer in the space provided below.
2. Check your answer with that provided at the end of this unit.

1) What is stress?

2) What are different stress related disorders?

3) What is acute stress disorder? Describe its characteristic features.

4) Discuss clinical presentation of PTSD.

5) What are adjustment disorders? Describe the clinical presentation of adjustment disorders.

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### 4.5 SOMATOFORM DISORDERS

Somatoform disorders are a group of disorders, which are characterised by presence of physical symptoms suggesting a physical illness (hence called somatoform) but there is no evidence of a physical illness on history, clinical assessment or investigations. Even if a physical illness is present, it is not sufficient to explain the symptoms. Thus these are called “medically unexplained symptoms”. There is a positive evidence or a strong presumption that the symptoms are linked to psychological factors.
The patients often request for investigations despite repeated negative findings and reassurances by the doctor that symptoms have no physical basis. In many cases, the onset of symptoms may be traced back to some stressful or unpleasant event in the past, but the patient resists attempts to discuss the possibility of psychological causation.

Most of the patients with somatoform disorders present in primary care or to the general physicians, rather than the psychiatrists who see only a small proportion of such patients, often on being referred.

Somatoform disorders include somatization disorder, hypochondriasis, somatoform pain disorder, undifferentiated somatoform disorder and somatoform autonomic dysfunction.

Treatment of the somatoform disorders is described at the end of this section.

4.5.1 Somatization Disorder

Somatization disorder is characterised by the presence of multiple, recurrent and frequently changing physical symptoms from different bodily systems for several years duration. There is a long and complicated medical history of contact with both primary and specialist medical services during which many negative investigations or fruitless operations may have been carried out.

Prevalence of somatisation disorder is about 1% in general population and 1-6% in primary care settings. The age of onset is usually in early 20s or 30s. The illness tends to be chronic and poses substantial burden on the families as well as the heath care resources.

Clinical Picture

The patient presents with multiple physical symptoms belonging to different bodily systems. The predominant symptoms at a particular time may vary from time to time. The patient often uses colourful language to describe the symptoms and appears too much distressed. Common symptoms referring to different body systems are:

Gastrointestinal symptoms: Abdominal pain, nausea, vomiting, belching, regurgitation, etc.

Pain symptoms: Pain in various body parts like extremities, back or joints.

Neurological symptoms: Pseudoseizures, fainting, incoordination, loss of voice, difficulty in swallowing, etc.

Cardiopulmonary symptom: Pain chest, palpitations, breathlessness, etc.

Sexual and menstrual disturbances: Dysmenorrhea, dyspaerunia, menorrhagia, etc.

History is usually vague, imprecise, inconsistent and disorganised. The patients often describe their complaints in a dramatic, emotional and exaggerated fashion, using vivid and colourful language. Marked anxiety and depressive symptoms may be present.

4.5.2 Hypochondriasis

Hypochondriasis is characterised by a persistent preoccupation with having one or more serious and progressive physical illness. The belief is based on misinterpreting the normal or commonplace sensations or appearances as abnormal and distressing, indicating presence of a serious physical illness.

Hypochondriasis usually occurs as a symptom in the course of other psychiatric disorders, such as depression, schizophrenia or anxiety disorders. A diagnosis of hypochondriacal
disorder is made only if hypochondriacal symptoms are occurring in the absence of other psychiatric disorders.

Exact prevalence of hypochondriasis is not known, though the hypochondriacal symptoms are seen in 3-14% of patients in general practice settings. It is seen equally in both sexes.

**Clinical Picture**

The patient usually presents with a detailed and exhaustive history of multiple complaints and explanations for the symptoms. Often he has a full file of medical records, having consulted a number of doctors and undergone a variety of diagnostic procedures. Pain and related symptoms referring to gastrointestinal and cardiovascular systems is the most common presentation. Symptoms usually run a waxing and waning course.

Hypochondriasis can be differentiated from somatization disorder by the emphasis which the patient lays on presence of a serious physical illness rather than on symptoms, as seen in somatization disorder.

### 4.5.3 Somatoform Pain Disorder or Psychogenic Pain Disorder

Somatoform pain disorder is characterised by the presence of severe and prolonged pain for which there is no adequate medical explanation. It is presumed that psychological factors are important in causation even though evidence for them might not be readily apparent in each case.

Exact prevalence is not known but there are estimates that 10-50% of patients with chronic pain of chest, abdomen and pelvis have pain of psychogenic or idiopathic origin. It is twice more common in women as compared with men.

Peak age of onset is in fourth and fifth decades. Patients present with persistent, severe, and distressing pain, which may involve any body area such as back, chest, face, abdomen or pelvis. Pain is constant and does not vary from day to day. Pain is often inconsistent with neurological innervation of the area involved. The patients often show dramatic display in describing the painful experience. There can be history of drug abuse and doctor shopping. Psychosocial factors such as pain contingent financial compensation or some other benefits may be apparent in some of the cases.

### 4.5.4 Undifferentiated Somatoform Disorder

Undifferentiated somatoform disorder can be described as a minor form of somatization disorder. The disorder is characterised by multiple, varying and persistent somatic symptoms but the typical clinical picture of somatization disorder is not present, for example, the forceful and dramatic manner of complaints may be lacking, complaints may be fewer in number, duration may be shorter, and the associated impairment of social and family functioning may be totally absent.

Anxiety and depressive symptoms are a frequent accompaniment. The disorder is quite common in general clinical practice rather than in psychiatric practice and is equally seen in both sexes. It is less disabling than somatization disorder and has a better prognosis than somatization disorder.

### 4.5.5 Somatoform Autonomic Dysfunction

Somatoform autonomic dysfunction is characterised by the presence of symptoms of autonomic arousal which may involve cardiovascular, gastrointestinal or respiratory systems.
The illness has been given different names over the period depending on the bodily system involved. Some common presentations are given as below:

- **Cardiac neurosis**: Symptoms refer to the cardiovascular system in form of pain chest, palpitations, etc.
- **Psychogenic hyperventilation, psychogenic hiccough**: Symptoms refer to the respiratory system in from of hyperventilation, recurrent hiccups, and breathlessness.
- **Gastric neurosis, nervous diarrhea**: Symptoms involve gastrointestinal system in form of recurrent nausea, vomiting, diarrhea, etc.

There is a constant preoccupation and distress about the possibility of a serious illness of the stated organ or system which does not respond to repeated explanations and reassurance by doctors. No evidence of significant disturbance of structure or function of the stated system or organ is found.

### 4.5.6 Treatment of Somatoform Disorders

As you must have understood by now that somatoform disorders involve the person reporting physical complaints/characteristics of bodily dysfunction. However, physical investigation usually does not find any actual physical deficit/problem. Hence the management of the somatoform disorders is mainly on psychological lines. Supportive psychotherapy is the mainline of treatment. Some basic principles of the therapy have also been outlined in the earlier sections.

The patient should preferably maintain contact with a single physician (usually the family physician) which may be aided by a liaison with a psychiatrist, especially if psychosocial problems are predominant. Supportive regularly scheduled visits with the treating doctor are preferable, that are not on as needed basis or based on development of new or exacerbation of existing symptoms.

Often there are underlying stressors, which need to be identified and focused on. One should listen carefully and sympathetically, and be reassuring and non-critical. The therapist needs to acknowledge that the symptoms really exist, as the symptoms are real for the patient, though they are a communication of emotional distress. One may provide satisfactory explanation and simple examples: eg, once a person is nervous, heart beats faster; constant stretching or tension can lead to pain; relaxation relieves these symptoms. One needs to act on the aggravating factors (situations, lifestyle factors, diet, etc.)

Activity scheduling, i.e., maintaining a regular schedule of physical activity like regular physical exercise or morning or evening walk is often helpful. Progressive muscular relaxation exercises are also helpful.

If significant anxiety and depression are present, antianxiety or antidepressant agents may be used.

Cognitive therapy is also used along with the Supportive therapy. It focuses on using cognitive restructuring to challenge the secondary gains from the disorder.

### Self Assessment Questions 5

**Note:**

i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.
1) What are somatoform disorders?

2) Describe clinical features of hypochondriasis.

3) Outline management of somatoform disorders.

4.6 DISSOCIATIVE DISORDERS

Dissociative disorders refer to what was earlier known as hysterical neurosis. The decision to abandon the term ‘hysteria’ has been taken primarily because of its multiple meanings leading to vagueness and creating confusion. The term ‘hysteria’ has been used in the past to describe a psychiatric disorder, a personality type and a type of behaviour, as a psychoanalytic term, as a diagnosis in general medicine when all laboratory tests and examinations have proved that the symptoms cannot be explained on organic basis, and as a pejorative term.

The disorder may present with physical or psychological symptoms as a result of partial or complete loss of normal integration (dissociation) between memories of the past, awareness of identity and immediate sensations, and control of bodily movements.

The symptoms are a manifestation of some underlying psychological conflict or need. Anxiety accompanying the conflict gets transformed into the symptom by the mental mechanism of conversion leading to freedom from anxiety due to the conflict—called primary gain. As a result of development of symptoms which may be incapacitating, the patient gets attention, care, sympathy, and advantages from his family, relations, etc.—called secondary gain. This secondary gain is many times responsible for prolongation of the symptoms.

Whenever clinical presentation is of physical symptoms, the disorder is termed as conversion disorder and when the symptoms are psychological, it is called dissociative disorder. However, ICD-10 has grouped the two under one category, giving reason that both share the common defence mechanism of dissociation. The disorder is more common in females.
**Conversion symptoms:** Common conversion symptoms are paralysis of extremities, aphonia, abnormal movements, gait disturbances or weakness of a particular body area. Sensory symptoms, such as patchy or diffuse anaesthesia or paraesthesia, loss of vision, deafness, etc. can also occur as conversion symptom. The patient appears indifferent to the symptom, i.e., the expected concern or anxiety for the symptom is absent (also called *la belle indifférence*). The symptoms do not follow the neurological distribution pattern.

**Dissociative symptoms:** Pseudoseizures, dissociative stupor and possession states are common presentation in Indian setting. Pseudoseizure is characterised by erratic movements of the upper and lower extremities and neck without complete loss of consciousness. The person remains aware of the surroundings. The episodes may last from 15-20 minutes to few hours and occur while the person is awake and in presence of others. There is no injury, tongue bite or urinaruy incontinence unlike the true epileptic seizures. Dissociative stupor is characterised by profound diminution or absence of voluntary movements and minimal response to external stimuli in the presence of normal respiration and cardiovascular function with apparent presence of consciousness. Possession states are the other common presentations in our country. Dissociative amnesia, fugue and multiple personality are other dissociative symptoms but are not common. In routine clinical practice, mild anxiety symptoms are commonly seen. The patient may have mild to moderate anxiety symptoms.

Course is most often of short duration with sudden onset and complete resolution. Recurrences are common. Precipitating factors can often be elicited if a thorough history is taken from the patient and the family. The disorder has shown a decreasing trend in the West in the last 50-60 years and now there are reports even from India that it is on decline.

**Treatment:** Treatment is primarily psychological. A thorough physical examination should be done. If no medical cause is found, as is often the case, the patient can be reassured that the symptoms will subside, as there is no serious cause for the symptoms. Telling such patients that their symptoms are imaginary (which is not true, since there is a definite psychological cause) often makes things worse rather than better.

If the symptoms are such that are interfering with the patient’s day to day activities, and appear too distressing, immediate removal is indicated by suggestion, hypnosis, medication and assisted interview. Abreaction are used to remove the symptom and to understand the underlying stressors.

One should try to remove or modify the stressful environment taking the help of the family. Once the symptoms have subsided, psychotherapy is resorted to find out the cause or the conflict, which should be dealt appropriately. Secondary gains should be curtailed by telling the family that there is nothing serious and the extra concern would only prolong the problem. The patient should be encouraged to resume or carry out his or her full responsibilities.

Improvement can be maintained by letting the patient see the reasons into his or her illness. Discussions can be done with the patient to find out the reason. Suggestions can be given but not forced. A reassuring and sympathetic approach is to be followed.

Antianxiety drugs for short periods and behavioural relaxation exercises can be used in patients who are excessively anxious.
Self Assessment Questions 6

**Note:**

i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Discuss clinical features of dissociative disorders.

2) Briefly discuss the treatment of dissociative disorders.

4.7 LET US SUM UP

- Neurotic group of disorders are a broad group of disorders.
- Anxiety is the central feature of anxiety disorders, which may be generalised as in generalised anxiety disorder, episodic as in panic disorder, restricted to exposure to some situations, objects or activities as in phobic disorder, or to thoughts as in obsessive compulsive disorder.
- Patients with neurotic groups of disorders more often present in primary care or to physicians.
- Exceptional stress can lead to disorders like acute stress disorder or PTSD, which has a delayed onset.
- Adjustment disorders occur as a result of a stressful life situation.
- Somatoform and dissociative disorders present with a range of physical or dissociative symptoms, for which there is an underlying psychological cause.

4.8 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Anxiety refers to worrying and feelings of uneasiness. It is an unpleasant emotion that is part of our everyday life. Anxiety has also been termed as the fear of unknown, and is related to a feeling of threat having minimal or no objective basis.

2) The abnormal anxiety differs from the normal anxiety by being:

   i) excessive
ii) distressing

iii) adversely affecting the performance.

3) Anxiety usually involves the fight or flight response in the individual. When a person faces anxiety, he or she tries to cope with it by various means such as discussing the problem with others, going for a stroll, sleeping, taking a pill, eating, resorting to smoking or alcohol etc.

4) Anxiety disorders include Generalised anxiety disorder, Panic disorder, Phobic disorders, obsessive compulsive disorder, acute stress disorder and post traumatic stress disorder.

Self Assessment Questions 2

1) Clinical features of generalised anxiety disorder include Psychological symptoms (feelings of apprehension, irritability, difficulty in concentration etc.); Symptoms of increased motor tension (tremulousness, muscle tension, easy fatiguability etc.); and Symptoms of sympathetic overactivity (shortness of breath, dry mouth, dizziness, abdominal distress, hot flushes or chills, frequent urination & easy fatiguability).

2) Psychological treatment of generalised anxiety disorder consists of supportive psychotherapy, cognitive behaviour therapy, muscular relaxation exercises, breathing exercises, meditation, yoga and biofeedback.

3) Panic attack refers to a single episode of attack whereas panic disorder includes recurrent attack of panic.

4) Hyperventilation syndrome differs from panic attacks in terms of respiration and breathing pattern.

Self Assessment Questions 3

1) Phobias are intense fears which are irrational, leading to avoidance of the phobic stimuli and interferes in the day-to-day functioning of the individual. The different types of phobias are Agoraphobia, Social phobias and Specific phobias.

2) Treatment of phobic disorders is mostly psychological. Psychoanalytic therapies with a focus on the past unresolved conflicts; behavioural therapy which includes systematic desensitisation, modeling, relaxation techniques; and cognitive behavioural therapies have been found to be more effective.

3) Obsessions are recurrent and persistent ideas, thoughts that are considered irrational by the person and are anxiety-provoking. Whereas compulsions are the recurrent behaviours, usually performed as a response to an obsession.

4) There may be multiple obsessions and compulsions or it may occur alone. Obsessions may be with regard to repetitive doubts, aggressive impulses or excessive need to have things in a particular order. Obsessions of contamination are often followed by compulsions like excessive hand washing.

5) Treatment for OCD includes behaviour therapy and medication. The most widely used technique is Exposure and Response Prevention (ERP). Thought stopping and in viv techniques are also used.
Self Assessment Questions 4

1) Stress refers to aversive stimuli of excessive intensity which poses a real or perceived threat to the individual and results in physiological and behavioural responses.

2) The stress related disorders are Acute stress reaction, Post traumatic stress disorder and Adjustment disorders.

3) Acute stress disorder is a transient disorder occurring in response to an exceptional physical or mental stress. The characteristic features include disorientation, inability to comprehend stimuli, narrowing of attention. There is also low mood, irritability, anxiety and despair.

4) The clinical presentation of PTSD includes three main characteristics:
   i) persistent re-experiencing and reliving the traumatic event (eg. Flashbacks, dreams, nightmares)
   ii) persistent avoidance of stimuli associated with trauma
   iii) experiencing symptoms of increased autonomic arousal (not present before the trauma), such as irritability, excessive display of anger, increased heart beat, difficulty in falling asleep or staying asleep, sweating, excessive vigilance of the environment

5) Adjustment disorders are a group of disorders that occur in the period of adaptation to a significant life change or a stressful change, for example, marriage, divorce, birth, death or serious illness etc.

   The clinical presentation of adjustment disorders include anxiety, depressed mood, medically unexplained physical symptoms, excessive worrying, and inability to cope and plan for future.

Self Assessment Questions 5

1) Somatoform disorders refer to a group of disorders characterised by presence of physical symptoms suggesting a physical illness, but there is no evidence of a physical illness on history, clinical assessment or investigations. Thus these are also called “medically unexplained symptoms”.

2) Hypochondriasis is characterised by a persistent preoccupation with having one or more serious and progressive physical illness. The patient usually presents with a detailed and exhaustive history of multiple complaints and explanations for the symptoms. Pain and related symptoms referring to gastrointestinal and cardiovascular systems is the most common presentation.

3) The mainline of treatment for Somatoform disorders is supportive psychotherapy.

Self Assessment Questions 6

1) Dissociative disorders may present with physical or psychological symptoms as a result of partial or complete loss of normal integration (dissociation) between memories of the past, awareness of identity and immediate sensations, and control of bodily movements.

2) The treatment of dissociative disorders is primarily psychological.
4.9 UNIT END QUESTIONS

1) Discuss the classification and important clinical features of anxiety disorders?
2) What are phobias? Describe clinical features of various phobic disorders?
3) What are important differences between anxiety disorders and somatoform disorders?
4) What is stress? What is stress related disorders?
5) Describe classification, clinical features and treatment of somatoform disorders.
6) Discuss clinical features and treatment of adjustment disorders?
7) Describe clinical features and treatment of dissociative disorders.

4.10 REFERENCES


4.11 SUGGESTED READINGS


UNIT 5 OTHER DISORDERS WHICH DO NOT FALL IN ABOVE CATEGORIES OF PSYCHIATRIC DISORDERS

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5.0 INTRODUCTION

The earlier units in this block have dealt with severe mental disorders (e.g. schizophrenia, bipolar disorders) and common mental disorders (e.g. anxiety disorders including OCD,
generalised anxiety disorder, phobias etc.). There are other psychiatric disorders that are associated with significant distress and disability. The current unit presents an overview of some of these disorders.

These various disorders can be described under four headings such as sleep disorders, psychosexual disorders, personality disorders and eating disorders.

### 5.1 OBJECTIVES

After studying this Unit, you will be able to:

- identify clinical features of sleep disorders, psychosexual disorders, personality disorders, eating disorders;
- describe the approach to diagnosis of these disorders; and
- outline the management of these disorders.

### 5.2 SLEEP DISORDERS

#### 5.2.1 Normal Sleep

Before we discuss disorders of sleep it is important to understand normal sleep. Sleep is a reversible state of reduced awareness of and responsiveness to the environment. Sleep serves multiple purposes including energy conservation, restoration of cellular energy stores, emotional regulation, consolidation of memory, discharge of emotions, brain growth and other various biological functions including maintenance of immune systems.

Sleep is made up of two physiological states: non-rapid eye movement (NREM) sleep and rapid eye movement (REM) sleep. NREM is further divided into four stages (stage I, II, III & IV). There is change in pattern of brain activity during the different phases of sleep. This activity can be recorded using electroencephalogram (EEG).

Stage I occurs at sleep onset. The electroencephalogram (EEG- a record of electrical activity of brain) is low voltage with mixed frequencies and reduced alpha activity compared with the awake state. Stage II contains more slow activity, sleep spindles and K complexes. Stage III contains yet more slow EEG activity. Stage IV is characterised by the slowest brain activity. The combination of Stages III and IV is called slow-wave sleep (SWS) or delta sleep. Brain metabolism is highest in REM stage of sleep with a low voltage, mixed frequency, non-alpha EEG. Heart rate, blood pressure, and respiration are variable. Most dreams, including nightmares, occur in REM sleep.

Sleep has a cyclical nature. A REM period occurs about every 90 to 100 minutes during the night. The first REM period tends to be the shortest, usually lasting less than 10 minutes. Later REM periods may last 15 to 40 minutes each.

#### 5.2.2 Types of Sleep Disorders

Sleep disorders can be classified in different ways. According to DSM IV (Diagnostic and Statistical Manual of Mental Disorders IV), sleep disorders are classified as dyssomnias and parasomnias. Dyssomnias include disorders of quantity or timing of sleep. Insomnia and hypersomnia are examples of dyssomnias. Parasomnias are abnormal behaviours during sleep or the transition between sleep and wakefulness. A third group of sleep disorders is known as sleep-wake schedule disturbance (circadian rhythm sleep disorders).
ICD 10 (International Classification of Diseases 10) has classified sleep disorders (given in the box below) as Insomnia, Hypersomnia, Circadian rhythm sleep disorders, Sleep apnea, Narcolepsy and Cataplexy, Parasomnia, Sleep related movement disorders and Sleep disorder unspecified.

ICD 10 Classification of Sleep Disorders

Sleep Disorders G47

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<thead>
<tr>
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<th>Diagnosis</th>
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<tr>
<td>G47.0</td>
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<td>G47.1</td>
<td>Hypersomnia</td>
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<td>G47.2</td>
<td>Circadian rhythm sleep disorder</td>
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<td>G47.3</td>
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<td>Parasomnia</td>
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<tr>
<td>G47.6</td>
<td>Sleep related movement disorders</td>
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</table>

5.2.3 Epidemiology of Sleep Disorders

Insomnia is the most common sleep disorder with a 1-year prevalence rate of 30 to 45% in adults. Hypersomnia is found among 5% of adult population.

5.2.4 Clinical Features of Sleep Disorders

Insomnia is a perceived disturbance in the quantity or quality of sleep. It includes difficulty initiating or maintaining sleep. Insomnia can be further divided into primary insomnia and secondary insomnia. Primary insomnia is the result of disturbance in the inherent mechanisms by which sleep is regulated. Inadequate sleep hygiene is a common cause of primary insomnia. Psycho-physiological insomnia is a long standing disturbance of sleep induction in which the patient typically ruminates about issues on his or her mind while lying in bed before sleep. In sleep state misperception (also known as subjective insomnia) there is dissociation between the patient’s experience of sleeping and the objective measures of sleep (such as EEG).

In secondary insomnia the disturbance in sleep is secondary to some medical or psychiatric disorder. Disturbance in sleep induction or maintenance can occur in various medical (e.g. painful or uncomfortable condition, sleep apnoea syndromes, nocturnal myoclonus and restless legs syndrome, substance interactions, endocrine or metabolic diseases, infectious diseases, neoplasms or other diseases) and psychiatric disorders (e.g. anxiety, depression, circadian rhythm sleep disorder, posttraumatic stress disorder, schizophrenia).

Hypersomnia manifests as excessive amounts of sleep, excessive daytime sleepiness (somnolence), or sometimes both. The patient does not awaken refreshed even after the excessive sleep. Like insomnia, hypersomnia can also be further classified as primary or secondary. Primary hypersomnia is also called as idiopathic hypersomnia. Secondary hypersomnia is seen in various medical conditions (e.g. Kleine-Levin syndrome, menstrual-associated somnolence, metabolic or toxic conditions) and psychiatric conditions (e.g. alcohol and depressant medications, withdrawal from stimulants, depression).
Periodic limb movement syndrome (PLMS) (also known as nocturnal myoclonus) is a dysomnia characterised by periodic stereotyped movements of the limbs (usually the legs) during sleep. The individual is neurologically normal while awake. It is associated with renal disease, as well as iron and vitamin B12 anaemia.

Restless limbs syndrome (RLS) is an uncomfortable subjective sensation of the limbs (usually legs) experienced as ants walking on the skin. It tends to be worse at night and is relieved by moving about. RLS appears in pregnancy, iron or vitamin B12 deficiency anaemia, and renal disease.

Parasomnias include nightmare disorder, sleep terror disorder, sleep walking disorder (somnambulism), sleep talking (somniloquy), REM sleep behaviour disorder and sleep related bruxism. In nightmare disorder individual experiences vivid dreams that become progressively more anxiety producing. These occur during REM sleep. The individual is able to recollect these dreams. Sleep terror disorder occurs during deep NREM (stages III and IV) sleep. Typically, patients sit up in bed with a frightened expression, scream loudly, and sometimes awaken immediately with a sense of intense terror. However there is little, if any, recollection of the episode next morning.

Narcolepsy is a sleep disorder characterised by excessive sleepiness as well as other symptoms such as sleep attacks (episodes of irresistible sleepiness, leading to perhaps 10 to 20 minutes of sleep, after which the patient feels refreshed), cataplexy (sudden onset of weakness of the weight-bearing muscles, lasting for a minute or less and occurring in association with the expression of emotion, such as anger or laughter), sleep paralysis (a brief period of paralysis that occurs as the patient is drifting off to sleep or awakening in the morning) and hypnagogic hallucinations (vivid dream-like experiences that occur when the patient is drifting off to sleep or is in the process of awakening in the morning). It usually begins in adolescence and young adulthood.

Sleep-wake schedule disturbance disorders (circadian rhythm sleep disorders) are characterised by misalignment between desired and actual sleep periods. These include delayed sleep-phase syndrome (in which sleep and wake times that are later than desired), advanced Sleep Phase Syndrome (in which sleep and wake times that are earlier than desired), jet lag type (sleepiness and alertness that occur at an inappropriate time of day relative to local time, occurring after repeated travel across more than one time zone) and shift work sleep disorder (insomnia during the major sleep period or excessive sleepiness during the major awake period associated with night shift work or frequently changing shift work).

5.2.5 Diagnosis
A good sleep history is an integral component in assessment of sleep disorders. Sleep History Questionnaire can be used for this purpose. Ideally additional information should be obtained from the bed partner or other relative. The patient should be asked about the typical 24 hour sleep–wake schedule. Enquiry should also be made about sleep hygiene of the patient. Maintaining a sleep diary helps obtain an unbiased information about sleep problem. Possible medical or psychiatric causes for sleep disorder should be excluded by history, examination and relevant investigations. Physiological sleep studies (called polysomnography) are necessary for diagnosis in some sleep disorders. It includes EEG, an electro-oculogram (to record electrical activity of eyes), and an electromyogram (to record electrical activity of muscles).

5.2.6 Treatment
Treatment of sleep disorders includes a combination of non-pharmacological and

Other Disorders which do not Fall in above Categories of Psychiatric Disorders
Classification of Mental Disorders

pharmacological measures. Explain the problem to the patient and reassure. It is important to ensure good sleep hygiene in all patients with sleep disorder. Box 1 provides an overview of different aspects of sleep hygiene. Cognitive relabeling can help in psychophysiological insomnia. Similarly relaxation therapy can be used to address anxiety associated with sleep disorders. It is important to manage the underlying medical and psychiatric causes of sleep disorders, if any.

**Box 1: Components of sleep hygiene**

- Maintain comfortable sleeping conditions.
- Wake up at the same time daily.
- Discontinue/reduce central nervous system stimulants as well as depressants (caffeine, nicotine, alcohol, stimulants).
- Improve physical fitness by means of a graded program of vigorous exercise early in the day.
- Avoid daytime naps.
- Avoid evening stimulation.
- Avoid large meals near bedtime.
- Practice evening relaxation routines.

Hypnotics (benzodiazepines as well as non-benzodiazepines) and melatonin are commonly used for insomnias. Stimulants are used for daytime sleepiness. Modafinil is a commonly used medication for narcolepsy. It is important to ensure rational and supervised prescription of these medications as these are liable to be abused.

Benzodiazepines, levodopa and quinine are effective to some extent for PLMS. It is important to investigate patients with RLS for anaemia and treat it, if found. Ropinirole, combination of L-dopa and carbidopa, bromocriptine and pergolide are effective in reducing the symptoms.

Treatment of parasomnias consists primarily of educating and reassuring the patients. Medical intervention is rarely needed. Medications such as tricyclic drugs that suppress REM sleep reduce the frequency of nightmares. Use of diazepam in small doses at bedtime improves night terrors.

Sleep phase rescheduling and light therapy have been used for circadian rhythm sleep disorders.

**Self Assessment Questions 1**

*Note: i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.*

1) Enumerate various stages of normal sleep.

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2) What are the different types of sleep disorders?

3) What are the treatments for sleep disorders?

5.3 PSYCHOSEXUAL DISORDERS

5.3.1 Definition

Psycho-sexual disorder includes a wide array of disorders categorised as sexual dysfunctions and paraphilias. Sexual dysfunction refers to a lack of desire or of pleasure or physiological inability to begin, maintain, or complete sexual interaction. Paraphilias are sexual stimuli or acts that are deviations from normal sexual behaviours, but are necessary for some individuals to experience arousal and orgasm.

This section also includes gender identity disorders which include conditions characterised by a strong, persistent preference for living as a person of the other sex as the main feature.

5.3.2 Epidemiology

Studies have reported variable rates of various psycho-sexual disorders. According to one of the most frequently cited study conducted among adult males and females, 33% of females had a lack of interest in sex, 17% had difficulty with arousal, 24% were unable to reach orgasm, 21% reported sex not being pleasurable, and 14% complained of pain during coitus. Among males, 16% reported a lack of sexual interest, 10% reported erectile difficulties, 29% complained of premature ejaculation and 17% acknowledged anxiety about performance.

Paraphilias are practiced by only a small percentage of the population. These are seen more commonly in males.

Prevalence of gender identity disorders has been estimated to be 1 in 30,000 men and 1 in 100,000 women. It is more common in men as compared to women with a ratio of 3-5:1.

5.3.3 Causes

Both biological (e.g. neurotransmitters) as well as psychological (interpersonal conflicts, quality of prior sexual experiences, anxiety, fears of impregnation, rejection by a sex partner, feelings of guilt about sexual impulses) factors have been implicated in causation of various psycho-sexual disorders. Functional neuroimaging studies have found altered
Classification of Mental Disorders

Brain activation in areas controlling genital response in some of these disorders. Additionally, most of the psycho-sexual disorders occur in combination with other psychiatric disorders. Various psychodynamic formulations have been given to conceptualise these conditions. Cultural factors have also been implicated.

These conditions can be lifelong or acquired, generalised or situational, and due to psychological factors, physiological factors, or a combination thereof.

According to classical psychoanalysis, persons with a paraphilia have failed to complete the normal developmental process toward heterosexual adjustment. Studies have reported a higher prevalence of abnormal hormone levels, chromosomal abnormalities, seizures, abnormal electroencephalograms, major mental disorders, and mental retardation in persons with paraphilias.

Testosterone (a sex steroid hormone) affects brain neurons that contribute to the masculinisation of the brain. A disturbance in this action of testosterone has been implicated as a possible contributor to development of gender identity disorders. Disturbance in development of gender identity during childhood and adolescence has been attributed to interaction of various psychological and environmental factors.

5.3.4 Clinical Features of Psycho-sexual Disorders

Various sexual dysfunctions include sexual desire disorders, sexual arousal disorders, orgasm disorders, sexual pain disorders, sexual dysfunction due to a general medical condition and substance-induced sexual dysfunction. These disorders are related to one or more of the four phases of physiological sexual response i.e. desire, excitement, orgasm and resolution.

Sexual desire disorders include hypoactive sexual desire disorder and sexual aversion disorder. As the name would suggest, hypoactive sexual desire is characterised by a deficiency or absence of sexual fantasies and desire for sexual activity. Sexual aversion disorder is characterised by an aversion to, and avoidance of, genital sexual contact with a sexual partner or by masturbation.

Sexual arousal disorders can be divided into female sexual arousal disorder and male erectile disorder. Female sexual desire disorder is characterised by the persistent or recurrent partial or complete failure to attain or maintain the lubrication-swelling response of sexual excitement phase until the completion of the sexual act. In male erectile disorder there is recurrent and persistent partial or complete failure to attain or maintain an erection to perform the sex act.

Orgasmic disorders include female orgasmic disorder (also called anorgasmia) and male orgasmic disorder (also called retarded ejaculation). In female orgasmic disorder there is recurrent or persistent inhibition of female orgasm. This is manifested by the recurrent delay in, or absence of, orgasm after a normal sexual excitement phase. In male orgasmic disorder, man achieves ejaculation during coitus with great difficulty or fails to achieve it altogether.

Premature ejaculation is characterised by man persistently or recurrently achieving orgasm and ejaculation before he wishes to.

Sexual pain disorders include dyspareunia and vaginismus. In dyspareunia there is recurrent or persistent genital pain occurring in either men or women before, during, or after intercourse. Vaginismus is characterised by an involuntary muscle constriction of the outer third of the vagina that interferes with penile insertion and intercourse.
Various psychoactive substances, medications, medical conditions and psychiatric disorders have been implicated in causation of different sexual dysfunctions.

Various types of paraphilias have been reported. Paraphilias can range from nearly normal behaviour to behaviour that is destructive or hurtful to the individual, partner or even the community. These include exhibitionism (exposure of one’s genitals), fetishism (use of nonliving objects), frotteurism (rubbing against or touching a nonconsenting person), pedophilia (sexual fantasy preoccupation or sexual activity with pre-pubertal or early pubertal age children), sexual masochism (seeking humiliation or suffering), sexual sadism (inflicting humiliation or suffering), transvestic fetishism (the obligatory use of clothing of the opposite sex to achieve arousal) and voyeurism (arousal through viewing another person’s undressing, toileting or sexual activity).

Gender identity disorders are characterised by individual stating a desire to be of the other sex. These individuals desire to live and be treated as the other sex. They are convinced to have typical feelings and reactions of the other sex. During childhood it might manifest as child involving in game play associated with other sex. For example, a girl might be more interested in sports and show no interest in playing with dolls. During adulthood, it manifests as preoccupation of getting rid of primary and secondary sexual characteristics and the request for hormone therapy, surgery or procedures to alter physically the sexual characteristics. This is done with the aim to simulate the other sex.

5.3.5 Diagnosis

Diagnosis of psycho-sexual disorders requires a structured sexual history. It should cover both recent and past sexual history. The therapist should ask for the specific current sexual complaint, the patient’s sexual practices and pattern of interaction with partners, the patient’s sexual goal and fantasies, the patient’s masturbatory history and the degree of commitment to the marriage or the partner. The sexual orientation of the person being interviewed should be ascertained. High risk sexual behaviours should also be explored. History of other psychiatric disorders and medical disorders must also be taken. It is important to ask for the medications and psychoactive substances being use by the patient. It might be important to involve the partner in evaluation process.

After detailed history we should do a thorough physical examination and mental status examination. Certain specific investigations (e.g. hormone assays) might be required to rule out the possibility of organic causes of psycho-sexual disorders.

5.3.6 Treatment

Both pharmacological and non-pharmacological approaches have been used for management of psycho-sexual disorders.

Dual sex therapy requires involvement of both partners in therapy. This approach, developed by Masters and Johnson, is based on a concept that the couple must be treated when a person with sexual dysfunction is in a relationship. The treatment team comprises of a male therapist, a female therapist and the couple seeking help. Various approaches used include clarification, discussion and working through problems with the couple. Sensate focus exercises are used to distract the couple from obsessive concerns about performance.

Various techniques and exercises are available for individuals with sexual dysfunction. Behaviour therapy (individual as well as group) and psycho-analytically oriented sex therapy are also available.
Sildenafil and its congeners, oral phentolamine, alprostadil are commonly used medications for erectile disorder. The side effects of antidepressants such as SSRIs and tricyclic drugs can be used to prolong the sexual response in patients with premature ejaculation. Androgens (for women) and testosterone (for men) can be used to improve the sexual drive in those having low levels of these hormones. In a small proportion of patients surgical intervention (e.g. vascular surgery) might be of help.

Reduction of sexual drives, treatment of co-morbid psychiatric conditions, cognitive-behavioural therapy and psychodynamic psychotherapy have been used for treatment of paraphilias. Some paraphilias (e.g. paedophilia) are illegal and punishable under law.

There is no effective medication based treatment for gender identity disorder. In children the treatment is directed largely at developing social skills and comfort in the sex role expected by birth anatomy. Sex reassignment surgery and hormonal therapy can be used in carefully selected cases. These individuals must meet the stringent criteria of suitability for a surgical procedure.

**Self Assessment Questions 2**

**Note:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Enumerate various paraphilias.

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2) What is gender identity disorder?

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3) What treatment are prescribed for psychosexual disorders?

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5.4 PERSONALITY DISORDERS

5.4.1 Definition

Personality disorders comprise deeply ingrained and enduring behavioural patterns. These manifest as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviation from the way the average individual in the given culture perceives, thinks, feels and relates to others.
5.4.2 Types of Personality Disorders

Different types of personality disorders include paranoid, schizotypal, schizoid, dissocial, emotionally unstable, histrionic, anankastic (obsessive comp, anxious (avoidant) and dependent personality disorders.

5.4.3 Epidemiology

Prevalence of personality disorders has shown to vary from 10-20% in western studies. An average prevalence rate of 0.6 per 1000 for personality disorders was found in a review of Indian studies.

5.4.4 Causes

Development of personality disorders has been found to be interplay of biological and psychosocial factors. These biological factors include genetic factors, structural abnormalities of brain and neurotransmitters such as dopamine and serotonin. Psychodynamic theory, cognitive theory and interpersonal theory help explain the role of psychosocial factors in development of personality disorders.

5.4.5 Clinical Features and Diagnosis

Patients with paranoid personality disorder see others as ill intentioned. They tend to pick up insults or offences of others where none were intended. They have a strong sense of personal right and a tendency to hold grudges. This may make them litigious.

Patients with schizotypal personality disorder appear distant and aloof. They rarely form intimate relationships. They may express certain beliefs such as those related to premonitions and mystical concerns.

People with schizoid personality disorder are detached in their social relationships and appear emotionally cold. They show little concern for the opinion of others and pursue a lonely course throughout life. They make up for the lack of intimate relationships by an inner world of fantasy.

Individuals with dissocial personality disorder show an aggressive disregard for the rights of others. Punishment seems to have little effect on them and kindness does not seem to move them. Truancy and lying to escape punishment may be common. They have no guilt or remorse for harming or exploiting others.

Attitudes and feelings of individuals with emotionally unstable personality disorder about themselves and others are subject to dramatic and sudden changes. Their relationships with others are intense and often stormy. They may be unclear about their goals and internal preferences.

People with histrionic personality disorder are dramatic and colorful. They constantly seek to draw attention to themselves by their speech, dress and behaviour.

People with anankastic personality disorder are typically rigid and perfectionist. They give undue attention to details, rules and schedules. These individuals are moralistic and scrupulous.

Individuals with anxious (avoidant) personality disorder fear disapproval, criticism, rejection and worry about embarrassment. Because of this fear they are unwilling to become involved with others.

People with dependent personality disorder appear weak-willed. They avoid...
responsibility and lack self-reliance. They need a lot of reassurance and assistance from others with their work.

5.4.6 Management

Clinical evaluation for personality disorders should include information from multiple sources. It is not uncommon for these individuals to seek help for their personality problems on their own. Usually they present with complaints of associated psychiatric co-morbidity. Also significant others can bring them for help because of difficulties they face with them. A number of assessment instruments for the diagnosis and measurement of personality disorders are available. These include International Personality Disorder Examination (IPDE), Personality Disorder Questionnaire (PDQ), Personality Assessment Inventory and Millon Clinical Multiaxial Inventory.

Prevalence of psychiatric co-morbidity is high among individuals having personality disorders. It is important to assess these individuals for co-morbid psychiatric disorders.

Non-pharmacological therapies are the mainstay of treatment for personality disorders. Psychodynamic therapy and cognitive behaviour therapy are commonly used therapies for this purpose. Dialectical behaviour therapy has been developed for individuals suffering from emotionally unstable personality disorder. Crisis intervention and supportive psychotherapy are of help to tide over a crisis situation.

Mood stabilisers (such as sodium valproate) and antidepressants such as SSRIs have been used with some success in management of certain features associated with personality disorders.

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<th>Self Assessment Questions 3</th>
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| **Note:** i) Read the following questions carefully and answer in the space provided below.  
   ii) Check your answer with that provided at the end of this unit. |
| 1) List various types of personality disorders. |
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5.5 EATING DISORDERS

5.5.1 Definition

Eating disorders are disorders of eating behaviour. The underlying pathology is an overvaluation of the desirability of weight loss that results in functional medical, psychological, and social impairment. Anorexia nervosa and bulimia are two of the most common eating disorders.

5.5.2 Epidemiology

Anorexia nervosa occurs 10 to 20 times more often in females than in males. It is estimated to occur in about 0.5 to 1% of adolescent girls. Estimated prevalence of bulimia nervosa ranges from 2 to 4% of young women. Earlier eating disorders were
considered to be restricted to western societies. However with increasing westernisation and globalisation these conditions are being reported from other countries as well.

The most common ages of onset of anorexia nervosa are the mid teens, but up to 5% of anorectic patients have the onset of the disorder in their early 20s. Bulimia is more common than anorexia nervosa.

5.5.3 Causes

Glamorisation of and preoccupation with a thin body frame has been found to affect eating and body shape attitudes of children and adolescents. Exposure to adverse life events including sexual abuse during childhood is reported by a high proportion of individuals suffering from eating disorders. Genetic factors, lesions of hypothalamus (region of the brain involved in regulation of appetite), and serotonin have been hypothesised to play a role in pathogenesis of eating disorders.

5.5.4 Clinical Features and Diagnosis

Anorexia nervosa is characterised by a set of three essential criteria. These include self-induced starvation to a significant degree, a relentless drive for thinness or a morbid fear of fatness and presence of medical signs and symptoms resulting from starvation. These individuals usually have associated disturbances of body image. Starvation in these individuals can also lead to amenorrhea as a result of hormonal imbalance. With increasing weight loss other clinical features such as hypothermia (reduction in body temperature), edema, bradycardia (decrease in heart rate), hypotension (decrease in blood pressure), and lanugo (appearance of neonatal-like hair) appear. Anorexia nervosa could either be food-restricting type or binge-eating or purging type.

Bulimia is characterised by frequent episodes of binge eating followed, in majority, by compensatory behaviours to prevent weight gain. These include self-induced vomiting and abuse of laxatives, diuretics & emetics. The individual has a morbid fear of fatness. However, weight is not severely lowered as in anorexia nervosa.

Additionally, these individuals can have other psychiatric co-morbidities, especially depression.

5.5.5 Management

In anorexia nervosa it is important to restore nutritional state, dehydration, starvation, and electrolyte imbalances. The patient might require hospitalisation during the initial phase. A combination of behavioural management approach, individual psychotherapy, family education remain the mainstay of treatment. These non-pharmacological approaches have been found to be effective for bulimia as well. Amitriptyline, clomipramine, pimozide, chlorpromazine and fluoxetine are some medications that have been found to be effective in management of anorexia nervosa. Similarly, imipramine, desipramine, trazodone, monoamine oxidase inhibitors (MAOIs) and fluoxetine have been used in management of bulimia.

Self Assessment Questions 4

Note:  

i) Read the following questions carefully and answer in the space provided below.

   ii) Check your answer with that provided at the end of this unit.

1) What are the main clinical features of anorexia nervosa?
Classification of Mental Disorders

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2) What are the main clinical features of bulimia?
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5.6 LET US SUM UP

Insomnia is a perceived disturbance in the quantity or quality of sleep. It includes difficulty initiating or maintaining sleep. Hypersomnia manifests as excessive amounts of sleep, excessive daytime sleepiness (somnolence), or sometimes both. Parasomnias include nightmare disorder, sleep terror disorder, sleep walking disorder (somnambulism), sleep talking (somniloquy), REM sleep behaviour disorder and sleep related bruxism. Narcolepsy is a sleep disorder characterised by excessive sleepiness as well as other symptoms that represent the intrusion of aspects of REM sleep into the waking state. Sleep-wake schedule disturbance disorders (circadian rhythm sleep disorders) are characterised by misalignment between desired and actual sleep periods. A good sleep history is an integral component in assessment of sleep disorders. Treatment of sleep disorders includes a combination of non-pharmacological and pharmacological measures.

Sexual dysfunction refers to a lack of desire or of pleasure or physiological inability to begin, maintain, or complete sexual interaction. Paraphilias are sexual stimuli or acts that are deviations from normal sexual behaviours, but are necessary for some persons to experience arousal and orgasm. Gender identity disorders are conditions characterised by a strong, persistent preference for living as a person of the other sex as the main feature. Both biological as well as psychological factors have been implicated in causation of various psycho-sexual disorders. Diagnosis of psycho-sexual disorders requires a structured sexual history. Both pharmacological and non-pharmacological approaches can be used for management of psycho-sexual disorders.

Personality disorders comprise deeply ingrained and enduring behavioural patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. The different types of personality disorders include paranoid, schizotypal, schizoid, dissocial, emotionally unstable, histrionic, anankastic, anxious (avoidant) and dependent personality disorders. Development of personality disorders has been found to be interplay of biological and psychosocial factors. Non-pharmacological therapies are the mainstay of treatment for personality disorders.

Eating disorders are disorders of eating behaviour. Anorexia nervosa and bulimia are two most common eating disorders. Anorexia nervosa is characterised by self-induced starvation to a significant degree, a relentless drive for thinness or a morbid fear of fatness and presence of medical signs and symptoms resulting from starvation. Bulimia is characterised by frequent episodes of binge eating followed, in majority, by compensatory behaviours to prevent weight gain.
5.7 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Normal sleep is made up of two states such as Non-Rapid Eye Movement (NREM) sleep and Rapid Eye Movement (REM) sleep.

2) According to ICD 10, the different types of sleep disorders are insomnia, hypersomnia, circadian rhythm sleep disorder, sleep apnea, narcolepsy and cataplexy, parasomnia and sleep related movement disorders.

3) Treatment for sleep disorders include both pharmacological and non-pharmacological measures. Sleep hygiene, relaxation therapy, cognitive relabeling, educating the patients etc. are used for the treatment of sleep disorders.

Self Assessment Questions 2

1) Various types of paraphilias are exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, and voyeurism.

2) Gender identity disorder refers to the strong and persistent desire for living as a person of the other sex.

3) Psychosexual disorders involve both pharmacological and non-pharmacological treatment approach. Dual sex therapy and behaviour therapy are used under psychological therapies.

Self Assessment Questions 3

1) The various types of personality disorders are paranoid, schizoid, dissocial, emotionally unstable, histrionic, anankastic, anxious and dependent personality disorders.

Self Assessment Questions 4

1) Anorexia nervosa has three essential clinical features:
   i) self induced starvation
   ii) a morbid fear of fatness
   iii) presence of medical signs and symptoms resulting from starvation

2) Bulimia is characterised by frequent episodes of binge eating followed by compensatory behaviours to prevent weight gain.

5.8 UNIT END QUESTIONS

1) What is narcolepsy?

2) What are the sleep disorders due to disturbance of circadian rhythm?

2) List various sexual dysfunctions.

3) Briefly describe dual sex therapy.

4) Describe the main clinical features of different personality disorders.

5) What are the main differences between anorexia nervosa and bulimia?
5.9 GLOSSARY

Anorexia nervosa: An eating disorder characterised by self-induced starvation to a significant degree, a relentless drive for thinness or a morbid fear of fatness and presence of medical signs and symptoms resulting from starvation.

Bulimia: An eating disorder characterised by frequent episodes of binge eating followed, in majority, by compensatory behaviours to prevent weight gain.

Hypersomnia: A dyssomnia characterised by excessive amounts of sleep, excessive daytime sleepiness (somnolence), or sometimes both.

Insomnia: A dyssomnia characterised by a perceived disturbance in the quantity or quality of sleep.

Narcolepsy: A sleep disorder characterised by excessive sleepiness as well as other symptoms that represent the intrusion of aspects of REM sleep into the waking state.

Paraphilias: Sexual stimuli or acts that are deviations from normal sexual behaviours, but are necessary for some persons to experience arousal and orgasm.

Personality disorders: Deeply ingrained and enduring behavioural patterns. These manifest as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviation from the way the average individual in the given culture perceives, thinks, feels and relates to others.

Premature ejaculation: A type of sexual dysfunction characterised by man persistently or recurrently achieving orgasm and ejaculation before he wishes to.

Sexual dysfunction: A lack of desire or of pleasure or physiological inability to begin, maintains, or completes sexual interaction.

Sleep: A reversible state of reduced awareness of and responsiveness to the environment.

Sleep-wake schedule disturbance disorders: Sleep disorders characterised by misalignment between desired and actual sleep periods.
5.10 SUGGESTED READINGS AND REFERENCES


# Mental Disorders

## Block 1: Classification of Mental Disorders

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