Unit 9 Cause, Classification and Assessment of Mental Disorder

Overview

In Unit 8 the foundations for understanding abnormal psychology and abnormal behaviour were provided. Abnormal psychology was defined as the branch of psychology that deals with the description, causes, and treatment of abnormal behaviour patterns. (Nevid, Rathus & Greene, 2011) Nevid et al. noted that abnormal psychology also extends to diagnosable mental and psychological disorders and this is the subject of attention in this unit. Unit 8 provided a working definition of a disorder as "An inflexible pattern of behaviour that leads to difficulty in social, educational, and occupational functioning." (Boyd & Bee, 2012, p. 348) The authors identified some of the reasons why personality disorders occur. Among these are the stresses of young adulthood, presumably in combination with some biological factors, resulting in serious disturbances in cognitive, emotional and social functioning that are not easily treated. Other stressors or stress factors may cause the onset of the disorder. These stressors include the break-up of a long term relationship. Physical illness can cause abnormal behaviour and some cultural practices may cause personality disorders. In Unit 8 learners were presented with a critical review of the four main abnormal psychological theories: biological, psychological (including psychodynamic, learning, humanistic, and cognitive), socio-cultural and biopsychosocial.

Unit 9 contains two sessions and in this Unit further details will be provided about the classification of abnormal behaviour including the criteria for classification as outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV;DSM –V*), the multi-axial system of classification as well as the strengths and limitation of using a classification system to diagnose mental illness and mental disorders. Various methods of assessment and some clinical scales are also presented in Session 9.1. Session 9.1concludes with an examination of socio-cultural effects on assessment.

In Session 9.2 the focus of attention switches to a few practical issues that relate to the classification and assessment of mental illness. Specifically, consideration will be given to three themes. First, consideration of how developments in infancy and early childhood can be responsible for abnormal behaviour in young persons. More importantly, the consequences of these being disordered are explored through evidence from the academic literature such as the *Journal of Abnormal Psychology*, *Journal of Abnormal Child Psychology* and recent statistical reports such as those published by the *Centers for Disease Control and Prevention* in the USA. Second, the psycho-social reasons for abnormal behaviour, including the impact of substance abuse on the development of mental illness will be

documented. Finally, the connection between mental disorder and crime will be explored. The discussion in the Session 9.2 will be informed by a summary of the key findings in relevant peer-reviewed journals and the course text book (Boyd & Bee, 2012). Collectively, the information in Session 9.1 and Session 9.2 provides the foundation block for the detailed discussion of mental disorders and their treatment options in Unit 10, the final unit of this course. In Unit 10 you will be provided with the necessary diagnostic tools that will allow you to recognize the core characteristics of non-psychotic disorders such as anxiety disorder, somatoform disorder, and dissociative disorder. The spotlight will also be placed on psychotic disorders (e.g. anti-social personality disorder, schizophrenic disorder, and mood disorder) and their treatment options.

Session 9.1 and Session 9.2 supplement the discussion initiated in Unit 8 regarding the nature and diagnosis of mental disorders. The material presented may appear to be technical and detailed but it will be summarized and presented in a user-friendly way and enlivened by YouTube videos and mydevelopmentlab.com activities located in your course text Boyd and Bee (2012). The learning objectives of this unit are aligned to several course competencies. For example, the provision of the requisite knowledge, skills-set and critical thinking ability associated with competencies YDWCYP0263 'Enable young people to become active and responsible citizens; YDWCYP0323 'Assist young people with their personal development plans', YDWCYP0513 'Plan and implement programs to promote healthy lifestyles'.

You are reminded to continue to look up any terms or concepts that you do not understand using your course textbook Boyd and Bee (2012) and the free-access on-line psychology dictionaries cited in the references.

Competencies

1. YDWCYP0263: Enable young people to become active and responsible citizens.
2. YDWCYP0323: Assist young people with their personal development plans.
3. YDWCYP0513: Plan and implement programmes to promote healthy lifestyles among youth.

Key Concepts in Unit 9: abnormal behaviour, diagnosis, multiaxial evaluation, trauma, neurotic disorder, anxiety, phobic disorder, social phobia, dissociation, psychotic, non-psychotic.

Structure of the Unit

This Unit is divided into two sessions as follows:

Session 9.1: Classifying and Assessing Abnormal Behaviour

- Approaches to explaining mental disorder (psycho-analytic; behavioural-learning; biological and socio-cultural)
- Classification of abnormal behaviour: criteria for classification, merits and demerits; multi-axial system; standards of assessment, methods of assessment, clinical scales

- Socio-cultural effects on assessment

Session 9.2: Applied Issues Related to Assessment: Evidence rrom The Scientific Literature

- Abnormal developments in infancy and childhood and the consequences for young persons.
- Psycho-social factors, including substance abuse, for abnormal behaviour
- Mental disorder and crime.

Unit 9 Learning Objectives

By the end of this unit learners would be able to:

1. Discuss the causes of mental disorders documented in the unit and identify in the reflective activities tangible ways to promote healthy lifestyles among citizens and particularly at risk young people and vulnerable adults;
2. Suggest in the discussion forum ways in which knowledge of the disorders discussed in the unit can inform policies to maximize protective factors and minimize risk factors;
3. Explore the diagnostic tools identified in the unit and reflect on policies for transforming 'at risk' persons into functional and civic-minded citizens;
4. Recognize the core characteristics of the disorders discussed in the unit and apply them to the activities cited in this unit;
5. Appreciate the need to work in ways that are socially and culturally sensitive when recommending interventions and programs in the discussion forum for persons with mental disorders who require special support systems;
6. Reflect on the impact of substance abuse on mental health as discussed in the unit and the recommended readings.

Session 9.1

Classifying and Assessing Abnormal Behaviour

Introduction

Why is it important to examine and explore the topic mental disorder? You would recall the definition by Boyd and Bee (2012) that a disorder is an inflexible pattern of behaviour that leads to difficulty in social, educational, and occupational functioning. This suggests that persons with mental disorders will have reduced capacities to function as active, responsible citizens and they are unlikely to lead healthy lifestyles. Therefore, special consideration is usually given to such persons who appear as defendants in law – they are assumed to have diminished responsibility and may even be declared unfit for trial. In general, persons with mental illness and mental disorders are likely to require special support systems by governments including medical facilities and welfare assistance such as disability grants. This financial cost must be integrated into the design plans for national human development.

Throughout Unit 8 reference was made to the reasons why mental disorders occur. In this unit the focus is on the cause, classification and assessment of mental disorders and additional information is provided to supplement previous discussions. It should be borne in mind that the causes of mental disorder are difficult to diagnose because (1) the causative agents can be varied; (2) a disorder itself is accompanied by a range of signs or symptoms, and (3) the symptoms can be manifested in different ways in each individual suffering from a mental disorder. In other words, there may be a unique response to disorders and this can make diagnosis difficult. Very often professionals may disagree in their **diagnosis** of the same individual.

A quick review of the four major approaches (psychoanalytic approach, behavioural-learning approach, biological approach and the socio-cultural approach) to explaining mental disorders follows. You are urged to link the current discussion to the previously presented details of these four major approaches outlined in earlier units of this course.

1. *The Psychoanalytic approach* – within this framework mental disorders are explained by events such as the occurrence of a traumatic childhood event that disrupts ego development, stress factors or unhealthy family interactions such as cases of incest and abuse. Newman and Newman (1983) noted that strong emotions such as fears or internal conflicts lead to **fixation** at an early stage of development. It is assumed that developmental trauma sets the stage for later **psychopathology** if the person in adulthood comes under some major stress or a stress similar to the original trauma. The earlier the source of **trauma**, the more disorganized the personality will be. Maladaptive behaviour patterns are viewed as an outlet for unacceptable

impulses. Sometimes these maladaptive behaviour can lead to the commission of crimes and being incarcerated as a prisoner upon conviction for these cries. Within the psychoanalytic approach disorders can only be cured by bringing the unconscious conflicts into awareness and helping the affected person to learn to view these conflicts as acceptable.

2. *The Behavioural-learning approach* – according to this perspective maladaptive behavior is the result of learning bad habits or failing to learn good ones. The social learning approach engages cognitive processes. When individuals develop negative, inaccurate notions of life their self esteem and self confidence will be low. Maladaptive behaviours can be manifested as (1) **learned helplessness** a condition created by the inability to escape aversive conditions and this leads to apathy and inability to cope effectively in new situations; and (2) the inability of an individual to predict which behaviours are appropriate in a given situation. The behavioural-learning approach offers treatments for mental disorders by ways of re-shaping new behaviours in a manner that is adaptive and reality oriented.

3. *The Biological approach* – The causes of mental disorders are viewed as having their origins in the hormonal system, the nervous system, genetic background, the effects of neurotransmitters on emotion and thought, and the effects of substance and alcohol abuse. The latter assumes primary importance in light of information that the number of drugs addicts and alcoholics regionally and internationally is growing exponentially. The link between mental disorders and substance abuse is elaborated upon in Session 9.2. Boyd and Bee stated that, "The choices that teenagers make about substance use can have lifelong consequences."(Boyd & Bee, 2012, p. 286). The consequences include dangerous driving and lifelong addition. For a better understanding of the effects of alcohol use on young people please watch the video on *Teen Alcoholism* on mydevelopmentlab.com (Boyd & Bee, 201, p. 288) The rising incidence of teenage pregnancies means that teen moms are at risk to underage drinking and there is conclusive empirical evidence of the detrimental effects of alcohol on prenatal fetal development. More about this is explained when you watch the video on *Fetal Alcohol Damage* on mydevelopmentlab.com (Boyd & Bee, 2012, p. 68) Children who suffered fetal alcohol damage are diagnosed with fetal alcohol syndrome (FAS) with physical symptoms such as being smaller than average with smaller brains, heart defects, hearing loss, and intelligence test scores which depict mild mental retardation. FAS children who do not have mental retardation usually display learning and behavioural difficulties that sometimes continue into adolescence and adulthood.

4. *The sociocultural approach* – this approach is centered on the social environment and the cultural definitions of normality to understand mental disorders. It is assumed that the labeling process itself can produce deviant, unusual and abnormal behaviour.

Session 9.1 Objectives

By the end of this session learners would be able to:

1. Be aware of the purpose and function of the DSM using the session notes;
2. State in tutorials the problems that may arise when trying to diagnose mental illness or mental disorder individuals;
3. Elaborate upon what is meant by the multi-axial system of classification in tutorial discussions;
4. Apply the unit notes to the reflection activities;
5. Appreciate the need to work in ways that are socially and culturally sensitive when recommending interventions and programs in the discussion forum for persons with mental disorders who require special support systems.

Classification

It is not sufficient for society to label a person 'mad', 'insane' or 'disturbed' for that person to be treated as a mentally ill person. An individual may be aware that a particular aspect of their behaviour is a source of concern, for example, an obsession with cleanliness. However, these perceptions in themselves do not officially constitute mental disorder. Instead diagnosis by a trained health care professional —such as a clinical psychologist, counseling psychologist, psychiatrist, clinical or psychiatric social worker, psychoanalyst, counselors or psychiatric nurses– is required. These professionals would assess a patient's feelings and behaviour using a scientific process and internationally accepted classifications of mental disorders. In Unit 8 it was noted that the 19th Century German psychiatrist Emil Kraepelin was the first modern theorist to develop a comprehensive model of classifications based on the distinctive signs and symptoms of various abnormal behaviours. Kraepelin's work influenced the most commonly used classification today called the DSM which is discussed below. In the DSM, abnormal behaviour patterns are classified as "mental disorders" and these mental disorders "involve either emotional distress (typically depression or anxiety), significantly impaired functioning (difficulty meeting responsibilities in at work, in the family, or in society at large), or behaviour that places people at risk for personal suffering, pain, disability, or death (e.g. suicide attempts, repeated use of harmful drugs." (Nevid, Rathus & Greene, 2011, p. 68)

The DSM classifications are identified and documented in the American Psychiatric Association's 1994 publication *Diagnostic and Statistical Manual of Mental Disorders –IV (DSM-1V)* with the updated DSM-5 due in May 2013. The first DSM was introduced in 1952 but it is not the only diagnostic tool. Another common classification published by the World Health Organization is the *International Statistical Classification of Diseases and Related Health Problems (ICD-10)*. You can read more about the DSM and the ICD via the hyperlinks:

http://www.psych.org/practice/dsm

http://www.dsm5.org/Pages/Default.aspx

http://apps.who.int/classifications/icd10/browse/2010/en

Some information from the web-links about the DSM is cited in the box.

"The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations. It can be used by a wide range of health and mental health professionals, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors. It is also a necessary tool for collecting and communicating accurate public health statistics. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text.

Diagnostic Classification

The diagnostic classification is the list of the mental disorders that are officially part of the DSM system. "Making a DSM diagnosis" consists of selecting those disorders from the classification that best reflect the signs and symptoms that are exhibited by the individual being evaluated. Associated with each diagnostic label is a diagnostic code, which is typically used by institutions and agencies for data collection and billing purposes. These diagnostic codes are derived from the coding system used by all health care professionals in the United States, known as the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM).

Diagnostic Criteria Sets

For each disorder included in DSM, a set of diagnostic criteria indicate what symptoms must be present (and for how long) as well as symptoms, disorders, and conditions that must not be present in order to qualify for a particular diagnosis. Many users of DSM find these diagnostic criteria particularly useful because they provide a concise description of each disorder. Furthermore, use of diagnostic criteria has been shown to increase diagnostic reliability (i.e., likelihood that different users will assign the same diagnosis to an individual). However, it is important to remember that these criteria are meant to be used as guidelines informed by clinical judgment and are not meant to be used in a cookbook fashion.

Descriptive Text

Finally, the third component of DSM is the descriptive text that accompanies each disorder. The text of DSM-IV systematically describes each disorder under the following headings: "Diagnostic Features"; "Subtypes and/or Specifiers"; "Recording Procedures"; "Associated Features and Disorders"; "Specific Culture, Age, and Gender Features";"Prevalence"; "Course"; "Familial Pattern"; and "Differential Diagnosis.""

Merits and Demerits of a Classification System

Classifications are useful and necessary but the DSM is descriptive not explanatory. According to Carlson (1990) the primary advantage is that the recognition of a specific diagnostic category precedes the development of successful treatment for that disorder.

A secondary advantage of a classification system is that it allows the clinician to give a prognosis. With a good prognosis the patient is likely to improve without a recurrence of the problem. The nature of the prognosis can reassure the patient and the patient's family about the future and allow them to plan for any special support systems that may be required. In sum, the DSM facilitates the classification of specific mental disorders in accurate and reliable ways. However, a cautionary note must be given about the absolute reliance on the criteria outlined in the DSM and this is highlighted in yellow in the box above. Carlson also noted that there are dangers associated with classifying a person's mental disorder primarily because, "No classification scheme is perfect, and no two people with the same diagnosis will behave in exactly the same way. Yet once people are labeled, they are likely to be perceived as having all the characteristics assumed to accompany that label; their behaviour will probably be perceived selectively and interpreted in terms of the diagnosis. Mental health professionals, like other humans, tend to simplify things by pigeonholing people." (Carlson, 1990, p. 566) This negative stereotyping of people who are identified as mentally ill is known as **sanism**. The difficulty in diagnosing and treating with persons who may exhibit symptoms of mental disorder is illustrated in a Trinidad case which is cited in the e-articles documented in Activity 9.1. At the end of activity 9.1 you would realize why standards of assessment are necessary safeguards in diagnosis and treatment. The information presented in Table 9.1 would assist you in completing Activity 9.1 because it provides an overview of the focus of interest for clinicians.

Axis	Type of Information	Brief Description
Axis I	Clinical Disorder.	The patterns of abnormal behaviour (mental disorders) that impair functioning and are stressful to the individual.
	Other Conditions That May Be A Focus Of Clinical Attention.	Other problems that may be the focus of diagnosis or treatment but do not constitute mental disorders, such as academic, vocational, or social problems, and psychological factors that affect medical (such as delayed recovery from surgery due to depressive symptoms).
Axis II	Personality Disorders	Personality disorders involve excessively rigid, enduring, and maladaptive ways of relating to others and adjusting to external demands.
	Mental Retardation	Mental retardation involves a delay or impairment in the development of intellectual and adaptive abilities.
Axis III	General Medical Conditions	Chronic and acute illnesses and medical conditions that are important to the understanding or treatment of the physiological disorder or that play a direct role in causing the psychological disorder.

Axis IV	Psychosocial And Environment Problems	Problems in the social or physical environment that affect the diagnosis, treatment and outcome of psychological disorders.
Axis V	Global Assessment Of Functioning	Overall judgment of current functioning with respect to psychological, social, and occupational functioning; the clinician may also rate the highest level of functioning occurring for a least a few months during the past year.

Table 9.1: The Multiaxial Classification System of the DSM-IV-TR (adapted from Nevid, Rathus & Greene, 2011, p. 70)

LEARNING ACTIVITY 9.1 • Tutorial Discussion

Please read the following articles and use them as the basis for your tutorial discussion.

Express Editorial. (2012, April 4). The bizarre case of Cheryl Miller. *Trinidad Express*. Retrieved from http://www.trinidadexpress.com/commentaries/The_bizarre_case_of_Cheryl_Miller-146206245.html

Seelal, N. (2012, April 3). 'Cheryl not mad'. *Newsday*. Retrieved from http://www.newsday.co.tt/news/0,157904.html

Lord, R. (2012, April 7). 'Cheryl Miller goes home'. *Trinidad Guardian*. Retrieved from http://www.guardian.co.tt/news/2012-04-07/cheryl-miller-goes-home

Based on your course notes on (1) abnormal behaviour, (2) the current discussion on labeling, and (3) the difficulties in classification what comments would you make on the events described in the newspaper articles? Discuss each of the three sub-areas identified. Your comments should be informed ones based on theories, concepts and evidence that you acquired from PSYC 1000, any other course in your degree option, and the scientific readings and resources available in the Open Campus Library. You are also encouraged to add any other relevant information that you may have from your professional experience. **Learning activity 9.1 is due by Week 11**

Standards of Assessment

In light of the important and life changing decisions that need to be made when a person is diagnosed with either mental illness or a mental disorder, standards of assessment must be reliable and valid. You would recall from the discussion in Unit 2 titled '*Scientific Methods: How Psychologists Do Research* that reliability and validity were key concepts. Like the reliability of data collected using a research method, the reliability of an assessment, like that outlined in the DSM diagnostic system, refers to its consistency. A reliable measure of abnormal psychology or mental disorder must yield the same results on different occasions. More importantly, different people should be able to check their symptoms against the same classification and be reliably evaluated. This can only be achieved if the

measurements that are used, for example a depression scale, has internal consistency. In other words, each part of the scale must be reliably correlated with each other. Another key element is inter-rater reliability. This means that raters who are evaluating the reliability of a scale by testing it out on a sample of persons must demonstrate a high level of agreement in their ratings. You would recall from the articles cited in Activity 9.1 that there was some element of disagreement in the opinions of the various health care professionals who evaluated Ms Cheryl Miller.

Validity means that the instruments or the scales that are used for assessment must measure what they actually seek to measure. If one is seeking to measure depression, the instrument or scale must actually measure depression rather than some other aspect of abnormal behaviour such as psychopathology. An example of a test labeled the Edinburgh Post Natal Depression Scale (EPNDS) can be found at the hyperlink http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf Please click on the link, follow the on-line instructions and you will be able to take the test or to administer it to someone. The scores are also included in this e-resource.

To ensure that an instrument or scale is valid there must be (1) content validity, (2) criterion validity and (3) construct validity. Content validity is the degree to which the contents of the scale represent the behaviours associated with the trait or behaviour being measured. From the EPNDS you would recognize that some of the signs of depression are sadness and refusal to participate in activities the person once enjoyed. In order to have content validity scales must seek to assess and measure depression this should include question items or indicators that address these areas. For example, reduced social involvement is an indicator of depression on a depression scale. Criterion validity represents the degree to which the assessment technique correlates with an independent, external criterion or standard of what the technique is intended to assess. Predictive validity is a form of assessment criterion validity in which a test or assessment technique shows good predictive validity if it can be used to predict future performance or behaviour. Construct validity is the degree to which a test corresponds to the theoretical model of the underlying construct or trait it purports to be measure. Returning to the example of the post-natal depression scale, depression is a theoretical construct with some indicators of the mental state of the person. For instance, the behavioural aspect might include weeping rather than smiling and an attitudinal change might include withdrawing from a circle of friends and family members.

Methods of Assessment

Clinicians use various methods of assessment which are thoroughly reviewed by Nevid, Rathus and Greene (2011) and summarized below. The ones reviewed below do not represent a finite list and you are encouraged to read more extensively about the themes in unit 9 using the link http://www.apa.org/. Remember to add your notes to the information documented in this unit. Some assessment methods are identified below.

1. *Clinical interview* –this is the most widely used assessment technique. It involves face-to-face contact with the clinician or health care professional. The client is first asked to describe the nature of the problem. For example, "Can you describe to me the problem that you have been having lately?" The clinician will then probe the answers given by the client to ascertain behavioural problems, feelings of

discomfort, the circumstances surrounding the onset of the problem, history of past episodes, and how the problem affects the client's daily functioning. During the clinical interview the health care professional will explore the possible precipitating events of the problem, changes in life circumstances such as marriage, divorced, or being recently widowed. The clinician is attuned to both the client's verbal and non-vernal behaviour. At the end of the session the clinician is likely to arrive at a diagnostic impression of the nature of the problem.

2. *Computerized interviews* –this format option proves that interviews may not necessarily have to be conducted in person and with a life clinician. The example previously provided of the Edinburgh Post Natal Depression Scale is an example of a simple test that can be administered in a virtual environment via email, video-conferencing and the internet. On-screen tests are officially referred to as computerized assessment protocols (CAP). Delivery formats can be based on the **structured interview, the semi-structured interview** or the **unstructured interview.** Nevid et al. (2011) noted one advantage of the CAP over the clinical interview. For example, some people are more likely to respond to questions that might be of an embarrassing nature such as their psychological symptoms, deepest fears, matters related to sexual concerns on-screen or on-line, and less likely to discuss personal or sensitive details in person. In addition to revealing more information a patient may feel less pressured if afforded the opportunity to take as much time as possible to report their concerns via computer data entry rather than feeling pressured to report the information while facing the clinician in a personal interview in which a patient may be assigned 1 hour or 30 minutes for a professional visit. Nevid et al. identified some other advantages of the computerized interview: it is less expensive to administer than a clinical interview and it is more efficient in data collection and analysis than note-taking during a clinical interview. However, the key point to remember is that the patient's choice of selecting either the clinical interview or the computerized interview to report a concern to a heath care professional is a matter of personal preference. A disadvantage of the CAP is that there are still a number of clients who remain reassured by the presence of their health care professional being in the same room with them during a consultation visit. For these clients the 'interview' becomes more of a friendly interactive discussion which affords clients the opportunity to ask questions and to get immediate feedback about their concerns and queries.

3. *Psychological tests* – In their review of the psychological test as a form of assessment Nevid et al. noted that this is a structured method of assessment that is used to evaluate reasonably stable traits such as intelligence and personality. An example of a personality test 'The Five Factor Personality Test' can be found at the hyperlink http://www.personalitytest.org.uk/

Nevid et al. (2011) provided a summary of the clinical scales of the MMPI-2 displayed. This summary is presented in Table 9.2. An important feature of Table 9.2 is the description of the core characteristics of common disorders such as depression and hysteria. Tests are usually standardized on large numbers of subjects and provide norms that compare a client's scores with the expected average. The primary advantage of this method of

assessment is that by comparing test results from samples of people who are free of psychological disorders with the test results from clients with diagnosable disorders, psychological tests allow medical professionals to gain insights into the types of response patterns that are indicative of abnormal behaviour. Other psychological assessments include **projective tests** which unlike objective tests, offers no clear specified response options. Clients are presented with ambiguous stimuli, such as inkblots, and asked to respond to them. The word projective is used because these personality tests derive from psychodynamic beliefs that people impose or project their psychological needs, drives and motives, much of which reside in the domain of the unconscious, onto their interpretation of ambiguous stimuli. An example of this test can be viewed at the hyperlink http://www.inkblottest.com/tag/projective-test/

Scale Number	Scale Label	Items similar to those found on MMPI Scale	Sample Traits of High Scores
1	Hypochondriasis	My stomach frequently bothers me. At times, my body seems to ache all over.	Many physical complaints, cynical defeatist attitudes, often perceived as whiny, demanding.
2	Depression	Nothing seems to interest me anymore. My sleep is often disturbed by worrisome thoughts.	Depressed mood, pessimistic, worrisome, despondent, lethargic.
3	Hysteria	I sometimes become flushed for no apparent reason. I tend to take people at their word when they're trying to be nice to me.	Naïve, egocentric, little insight into problems, immature, develops physical complaints in response to stress.
4	Psychopathic Deviate	My parents often dislike my friends. My behaviour sometimes got me into trouble at school,	Difficulties incorporating values of society, rebellious, impulsive, antisocial tendencies, strained family relationships, poor work and social history.
5	Masculinity-Femininity	I like reading about electronics (M) I would like to work in the theatre (F)	Males endorsing feminine attributes: have cultural and artistic interests, effeminate, sensitive, passive. Females endorsing male interests: aggressive, masculine, self-confident, active, assertive, vigorous.

6	Paranoia	I would have been more successful in life but people didn't give me a fair break. It's not safe to trust anyone these days.	Suspicious, guarded, blames others, resentful, aloof, may have paranoid delusions.
7	Psychasthenia	I'm one of those people who have to have something to worry about. I seem to have more fears that most people I know.	Anxious, fearful, tense, worried, insecure, difficulties concentrating, obsessional, self-doubting.
8	Schizophrenia	Things seem unreal to me at times. I sometimes hear things that other people can't hear.	Confused and illogical thinking, feels alienated and misunderstood, socially isolated or withdrawn, may have blatant psychotic symptoms such as hallucinations or delusional beliefs, or may lead detached, schizoid lifestyle.
9	Hypomania	I sometimes take on more tasks than I can possibly get done. People have noticed that my speech is sometimes pressured or rushed.	Energetic, possibly manic, impulsive, optimistic, sociable, active, flighty, irritable, may have overly inflated or grandidose self-image or unrealistic plans.
10	Social Introversion	I don't like loud parties. I was not very active in school activities.	Shy, inhibited, withdrawn, introverted, lacks self-confidence, reserved, anxious in social situations.

Table 9.2: Clinical Scales of the MMPI-2 (adapted from Nevid, Rathus & Greene, 2011, p. 84)

4. *Neuropsychological assessment* – this involves the use of tests to help determine whether psychological problems reflect underlying neurological impairment or brain damage. When clinicians suspect that neurological impairment is suspected they might be advised by a neurologist (a medical doctor who specializes in disorders of the nervous system) to undertake a neurological evaluation. Hence a neuropsychologist may be consulted to administer the neuropsychological assessment in the hope of revealing possible brain damage. These tests would supplement data provided by scans such as the Magnetic Resonance Image (MRI) and computed tomography (CT). The merit of the neurological assessment is that it can not only suggest whether or not patients suffer from brain damage but the

result of these specialized tests can point to the parts of the brain that may be affected. Two main neuropsychological tests are the Bender Visual Motor Gestalt Test and the Halstead-Reitan Neuropsychological Battery. You can learn more about neuropsychological evaluation by viewing the following video presentation. WWRC Virginiagov. (2009, April 6). WWRC Psychological Evaluation. [Video file]. Retrieved from http://www.youtube.com/watch?v=bbS36bI-hOg

5. *Behavioural assessment* – it is alleged that traditional personality tests such as the MMPI as well as the inkblot test, such as the ones designed by Rorchach, are limited in their assessment because they were designed to measure underlying psychological traits and dispositions. In contrast, **behavioural assessment** treats test results as samples of behaviour that occur in specific situations rather than as signs of underlying personality traits. Nevid et al. (2011) stated that the focus of the behavioural approach to diagnosis is premised on the view that behaviour is primarily determined by environmental or situational factors such as stimulus cues and reinforcement, not by underlying traits. Moreover, behavioural assessment aims to sample an individual's behaviour in settings that are, as far as possible, similar to real-life environments such as at school, at home or in the workplace. In the clinic or laboratory the clinician may simulate real-life situations by using vignettes (e.g. short stories, case studies or scenarios) and ask clients to make judgments or to give their views on the events described in the vignettes. In the behavioural assessment approach the health care professional usually focuses on functional analysis – that is an analysis of the problem behaviour in relation to the antecedents or what caused the problem, the consequences of the problem behaviour and possible reinforcements or what factors lead to the maintenance of the behaviour under examination. Other measurement strategies include observation of the client's behaviour as well as asking clients to keep a diary of events in their lives that can give clinicians clues about the antecedents, stimulus and consequences of problem behaviour. This data collection strategy is called **self monitoring** and it involves training clients to record or monitor the problem behaviour in their daily lives. Clients also assume responsibility for assessing the problem behaviour in the settings in which they naturally occur. There are some simple behaviours that are suitable or self-monitoring by clients and these include food intake, sleep patterns and duration, cigarette taking, alcohol or drug use, study periods and engagement in social activities. There are some disadvantages with self monitoring and these largely relate to clients' willingness to actually undertake the self-monitoring task reliably and accurately for the length of period that is required for the clinician to accurate assess the problem behaviour. In addition, clients may be very reluctant to record undesirable behaviour such as their deviant sexual activity or possible criminal behaviour such as physical abuse of their children or petty theft to fund a drug addiction.

6. *Cognitive* assessment – this refers to the measurement of thoughts, beliefs, and attitudes that may be associated with emotional problems. Cognitive therapists believe that clients who possess self-defeating or dysfunctional cognitions are at a greater risk of developing emotional problems such as depression in the face of

adversity than individuals who do not have these negative thoughts. Assessment strategies may require clients to enter into their daily diary the reasons and consequences of their behaviour. Nevid et al. referred to these diaries as a 'thought diary' as the client is required to enter all conscious emotions and responses to their negative thoughts, beliefs and attitudes that disrupt normal thinking and lead to abnormal behaviour. **Cognitive assessment** opens up a new domain of information for psychologists that can facilitate both assessment and treatment.

7. *Physiological measurement* – this relates to the study of people's physiological responses. Nevid et al. noted that anxiety is associated with the arousal of the sympathetic division of the autonomic nervous system so that anxious people display elevated heart rates and blood pressure during situations that generate anxiety for the affected individuals. These physical responses can be easily assessed using equipment designed to measure electrodermal response or galvanic skin response (GSR). The constant development of new technologies such as electroencephalograph (EEG) used to measure brain activity by attaching electrodes or sensors to the brain scalp or the use of Magnetic Resonance Image (MRI) have provided rich and valuable data. Computed tomography (CT) scans are another popular option.

Sociocultural and Ethnic Factors in Assessment

Researchers and clinicians must keep sociocultural and ethic factors in mind when assessing personality traits and psychological disorders. One must bear in mind that most assessment tests originated and were refined in the developed world with primarily Caucasian patients. There must be careful translation of some of the tests so that it can be successful applied across all countries and cultures. In particular, language, slangs, dialect and vocabulary assume relevance when clinicians interpret what their patients' record or report about their behaviour. You would recall the discussion in Unit 8 on culture and abnormal psychology and this has relevance for both assessment and treatment. Table 9.3 provides some examples of culture-bound syndromes from various countries. You are encouraged to explore the available resources on this topic that is cited in the Internet and to include the additional information in your notes. You can commence your exploration of this topic by reading the University of the West Indies article by Alea, Thomas, Manickchand, Ramirez-Cole, Renaud-Simon and Bacchus (2010) *The Emotional Quality of Childhood Memories and Depression in Trinidadian Older Adults.* This article provides empirical evidence of the research methods and methods of assessment psychologists use to evaluate issues such as depression symptomology and the research findings offer an insight into the social context underlying depression.

Culture-bound syndrome	Description
Amok	A disorder principally occurring in men in Southeastern Asian and Pacific Island cultures as well as in Puerto Rican and Navajo cultures in the West, it describes a dissociative episode (a sudden change in consciousness or self-identity) in which an otherwise normal person suddenly goes berserk and strikes out at others, sometimes killing them. During these episodes, the person may have a sense of acting automatically. Violence may be directed at people or objects and is often accompanied by perceptions of persecution. A return to the person's usual state of functioning follows the episode. In the West, we use the expression "running amuck" to refer to an episode of losing oneself and running around in a violent frenzy. The word amuck is derived from the Malaysian word amoq, meaning "engaging furiously in battle." The word passed into the English language during colonial times when British colonial rulers in Malaysia observed this behaviour among the native people.
Attack of nerves (Ataque de nervous)	A way of describing states of emotional distress among Latin American and Latin Mediterranean groups, it most commonly involves features such as shouting uncontrollably, fits of crying, trembling, feelings of warmth or heat rising from the chest to the head, and aggressive verbal or physical behaviour. These episodes are usually precipitated by a stressful event affecting the family (e.g. receiving news of the death of a family member) and are accompanied by feelings of being out of control. After the attack, the person returns quickly to his or her usual level of functioning, although there may be amnesia for events that occurred during the episode.
Dhat syndrome	A disorder affecting males, found principally in India, that involves intense fear or anxiety over the loss of semen through nocturnal emissions, ejaculations or excretion with urine (despite the folk belief, semen doesn't actually mix with urine). In Indian culture, there is a popular belief that loss of semen depletes the man of his vital natural energy.
Falling out or blacking out	Occurring principally among southern U.S. and Caribbean groups, the disorder involves an episode of sudden collapsing of fainting. The attack may occur without warning or be preceded by dizziness or feelings of "swimming" in the head. Although the eyes remain open, the individual reports an inability to see. The person can hear what others are saying and understand what is occurring but feels powerless to move.

Ghost sickness	A disorder occurring among American Indian groups, it involves a preoccupation with death and with the "spirits" of the deceased. Symptoms associated with the condition include bad dreams, feelings of weakness, loss of appetite, fear, anxiety, and a sense of foreboding. Hallucinations, loss of consciousness, and states of confusion may also be present, among other symptoms.
Koro	Found primarily in China and some other South and East Asian countries, the syndrome refers to an episode of acute anxiety involving the fear that one's genitals (the penis in men and the vulva and nipples in women) are shrinking and retracting into the body and that death may result.
Zar	A term used in a number of countries in North Africa and the Middle East to describe the experience of spirit possession. Possession by spirits is often used to these cultures to explain dissociative disorders (i.e. sudden changes in consciousness or identity) that may be characterized by periods of shouting, banging the head against a wall, laughing, singing, or crying. Affected people may seem apathetic or withdrawn or refuse to eat or carry out their usual responsibilities.

Table 9.3: Culture-bound syndromes from other cultures (adapted from Nevid, Rathus & Greene, 2011, p. 74)

Reflect and Review

SELF-ASSESSMENT EXCERISE

What response would you give to the following questions or statements?

1. What do you understand by the term psychopathology?.....
2. What does CAP represent? …….
3. Define mental disorder…….....
4. Give an example of a mental disorder cited in Session 9.1 and state why it is a mental disorder.....
5. List two criteria for consideration in standards of assessment for mental disorder…….
6. Give two examples of methods of assessment that health care professionals would used to diagnose a mental disorder……..
7. What do you understand by the term semi-structured interview?.....
8. What is a social phobia?……..
9. List two traits of the psychopathic deviate……
10. List two traits associated with paranoia……

Key Points

1. There are four major approaches used to explain mental disorders. These are the psychoanalytic approach, behavioural-learning approach, biological approach and the socio-cultural approach.
2. A classification is a diagnostic tool that is intended to be applicable in a wide array of contexts by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems) and across clinical settings (such as inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care). Two primary classifications are the DSM-IV and the ICD-10.
3. Standards of assessment must include (1) content validity, (2) criterion validity and (3) construct validity.
4. Common methods of assessment used by clinicians or health care professionals to diagnose behavioural problems or mental disorders include the clinical interview, computerized interview, psychological tests, neuropsychological assessment, behavioural assessment, cognitive assessment, and physiological measurement.

Session 9.2

Applied Issues Related to Assessment: Evidence from The Scientific Literature

Introduction

In Session 9.1 attention was placed on outlining the nature and purpose of assessment and the merits and demerits of using the DSM for clinical evaluations. It was necessary to devote this degree of detail to the classification and assessment of mental disorders because a working knowledge of mental illness and mental disorders is useful for various reasons. Healthy individuals need to avoid stressors which impair their mental capacities. Health care professionals and those who interface with 'at risk' persons need to be familiar with the core characteristics of specific disorders so that affected persons can be referred to the relevant clinicians. Policy makers, legislators and politicians need a sound knowledge of the extent of the mental health population in their country in order to provide the requisite diagnostic and rehabilitative services to the population. In Session 9.2 we will consider how developments in infancy and early childhood can be responsible for abnormal behaviour in young persons. One of the negative consequences of being disordered or mentally ill is the inability or limited ability of the affected person to achieve sustainable relationships and sustainable employment. This is largely due to impairments in the person's intellectual, cognitive or emotional development. A discussion of the psycho-social reasons for abnormal behaviour, including the effects of substance abuse, on mental health follows. Session 9.2 will conclude with an examination of the relationship between mental disorder and crime. The coverage area of Session 9.2 draws upon information that you have from Units 1-8 and it also provide an introduction into what you can expect in Unit 10. The issues discussed will help you to further develop the necessary skills sets and knowledge base for the acquiring competencies identified in Session 9.1 of Unit 9 namely YDWCYP0263 'Enable young people to become active and responsible citizens; YDWCYP0323 'Assist young people with their personal development plans', YDWCYP0513 'Plan and implement programs to promote healthy lifestyles'.

Session 9.2 Objectives

By the end of this session learners would be able to:

1. Incorporate the session notes into a tutorial discussion of the impact of childhood disorders on behaviour later in the human lifespan;
2. Discuss in the reflective activities how substance abuse can lead to the development of mental disorders;

3. Apply the evidence from the session notes to the framing of interventions to promote healthy lifestyles among citizens and particularly at risk young people and vulnerable adults.

Abnormal Development in Infancy and Early Childhood and Consequences for The Future

The types of disorders that can occur in childhood, a description of their core characteristics and their associated features are summarized in Table 9. 4 The information in this table is explained in detail in Unit 10. However, the enclosed information provides useful background material for understanding the link between abnormal behaviour in childhood and continued abnormality during other stages of the human lifespan if successful treatment is not provided to affected persons. What is directly relevant for the discussion in Session 9.2 is a discussion of the ways in which childhood abnormalities and their associated features can have negative repercussions for human development, quality of life, forming attachments and engaging in sustainable employment during adulthood.

Table 9.4: Overview of disorders of childhood and adolescence (Adapted from Nevid, Rathus & Greene, 2011, p. 472)

Type of Disorder	Description	Associated Features
Pervasive Developmental Disorder	Marked impairment in multiple areas of development	• Autism : major deficits in relating to others, impaired language and cognitive functioning, and restricted range of activities and interests • Asperger's disorder: Poor social interactions and stereotyped behaviours but without the significant language or cognitive deficits of autism
Mental Retardation	A broad-based delay in the development of cognitive and social functioning	• Diagnosed on the basis of low IQ score and poor adaptive functioning
Learning Disorders	Deficiencies in specific learning abilities in the context of at least average intelligence and exposure to learning opportunities	• Mathematics disorder: Difficulty understanding basic mathematical operations • Disorder of written expressions: Grossly deficient writing skills • Reading disorder (Dyslexia): Difficult recognizing words and comprehending written text

Communication Disorders	Difficulties in understanding or using language	• Expressive language disorder: Difficulty using spoken language • Mixed receptive/expressive language disorder: Difficulty understanding and producing speech • Phonological disorder: Difficulty articulating the sound of speech • Stuttering: Difficulty speaking fluently without interruption
Attention-Deficit and Disruptive Behaviour Disorder	Patterns of disturbed behaviour that are generally disruptive to others and to adaptable social functioning	• ADHD: Problems of impulsivity; inattention, and hyperactivity • Conduct disorder: Antisocial behaviour that violates social norms and the rights of others • Oppositional defiant disorder: Pattern of noncompliant, negativity, or oppositional behaviour
Anxiety and Mood Disorder	Emotional disorders affecting children and adolescents (E.g. separation-anxiety disorder; specific phobia; social phobia; generalized anxiety disorder; major depression; bipolar disorder)	• Anxiety and depression often have similar features in children as in adults, but some differences exist • Children may suffer from school phobia as a form of separation anxiety • Depressed children may fail to label their feelings as depressed or may show behaviours such as conduct problems and physical complaints, that mask depression
Elimination Disorders	Persistent problems with controlling urination or defecation that cannot be explained by organic causes	• Enuresis: Night-time only enuresis (bed-wetting) is the most common type • Encopresis: Occurs most often during daytime hours

After reading Table 9.4 you would realize that disabilities can vary from moderate to extreme and that some disorders —such as pervasive developmental disorder, mental retardation and learning disorders– have life-long consequences for affected persons. For example, the effects of bipolar disorder in young children include difficulty functioning in school and in forming attachments as well as relationships. Additionally, "Autistic children appear to have failed to develop a differentiated self-concept, a sense of themselves as

distinct individuals." (Nevid et al., 2011, p. 477) These challenges would in turn severely impair the ability of children to obtain a level of literacy and education that is necessary for sustainable employment or to acquire the social skills to form sustainable relationships. In many countries mental illness is regarded as a disability and state grants are provided for affected persons to allow them to meet their needs. The prospects for children who exhibit the symptomology listed in Table 9.4 depend on early screening and diagnosis during infancy and early childhood along with a constant supply of appropriate clinical interventions to affected children as well as dedicated support services to the parents and caregivers of these affected children.

For more information and statistics regarding mental illness in children ages 3-16 years please click on the hyperlink to the e-report in Activity 9.2. As you read this e-report bear in mind the following message.

> *The term childhood mental disorder means all mental disorders that can be diagnosed and begin in childhood (for example, attention-deficit/hyperactivity disorder (ADHD), Tourette syndrome, behavior disorders, mood and anxiety disorders, autism spectrum disorders, substance use disorders, etc.). Mental disorders among children are described as serious changes in the ways children typically learn, behave, or handle their emotions. Symptoms usually start in early childhood, although some of the disorders may develop throughout the teenage years. The diagnosis is often made in the school years and sometimes earlier. However, some children with a mental disorder may not be recognized or diagnosed as having one. (Centre for Disease Control and Prevention, 2013)*

When reading and reflecting on the article it is important to recognize that children who are severely impaired may become depressed and suicidal, they may be the victim of child abuse, susceptible to bullying and have an increase chance of become 'at risk' young people. Therefore, they must be offered protection and support by legislation and targeted interventions. The e-report offers very useful tips for treating and managing childhood mental disorders.

LEARNING ACTIVITY 9.2 •

CDC. (2013). Children's Mental Health - New Report. USA: Centers for Disease Control and Prevention. http://www.cdc.gov/features/childrensmentalhealth/

As you read the article reflect on the incidence of mental illness and disorders in children in your country of residence and how their circumstances can be improved by your country's government and non-governmental agencies. This article will facilitate your understanding of discussion in the next subsection.

The Role of Psycho-Social Factors in Human Development and The Development of Abnormal Behaviour

In the CDC article cited in Activity 9.2 reference was made to psycho-social factors. The term **psycho-social** was referred to in previous units of this course. As a reminder, psycho-social factors generally refer to the psychological and social factors that influence human growth and development. These psycho-social factors are linked to the model of development outlined by Erik Erikson who proposed that development result from the interaction between internal drives and cultural demands. This occurs in psycho-social

stages in which chronological age is associated with a specific stage. There are unique positive characteristics gained as well as typified activities in each of the 8 psycho-social stages. For example, from birth to 1 year the psycho-social stage is trust versus mistrust. The attendant characteristics and activities include trust in the primary care giver of the infant and security of attachment.

Psychosocial factors include peer pressure, environmental influences and parental support. They impact upon both physical and mental health. It is important to recognize that psycho-social factors can be both positive and negative

The effects include the following. Children's early expose to parental depression and hostile parenting are associated with increased stress and the development of oppositional behaviour in children, particularly after the first two years of life (Dougherty, Tolep, Smith, & Rose, 2013). The study was conducted with a sample of 165 pre-school age children from the Washington, DC area in the USA with an average age of 49.9 months or around 4 years of age. Among the indicators used by the researchers to assess oppositional behaviour in children were:

1. The degree to which children showed willingness to listen to the parent's suggestions and to comply to parental requests.
2. Children's negativity towards the parent, which captures a child's expression of anger, dislike, or hostility toward the parent (s).

The researchers stated that their findings highlighted the critical influence of early environmental experiences, particularly parenting and the mother-child relationship, on the development and functioning of young children's neuroendocrine system. The neuroendocrine system regulates the body in many ways, including the ability to cope with stress. The findings of the study support major psychological theories. For example,

> *Consistent with a social-learning perspective, this finding suggests that children's oppositional behavior may emerge as a result of repeated exposure to maladaptive learning experiences, which likely involve a coercive parent–child interaction style (Dougherty et al., 2013, p. 1308).*

The article by Dougherty et al. is available from the Unit 9 reading folder in the course site. You are not expected to understand all the technical details but when you read the article you will gain an overall impression of the key points identified by the authors. When reading the article please note the research methods used by Dougherty et al. (2013) as they will give you an additional insight into the methods of inquiry that psychologists use to gather information and to test their theories.

There is Caribbean empirical evidence of the harmful effects of negative psycho-social influences on human development. For example, "…anger associated with childhood memories plays a unique role in predicting depressive symptoms in adulthood." (Alea, Thomas, Manickechand, Ramirez-Cole, & Renaud-Simon, 2010) Alea et al. described how repressed memories of unpleasant events impeded adult development. This is particularly relevant in light of the dangers that children and young adults are exposed to in our societies. These include verbal, sexual and physical abuse, exploitation for labour or other nefarious purpose such as the sex trade.

In addition to the psycho-social influences on impressionable young minds, young persons exposed to substance abuse, either through the consumption of alcohol or drugs, often show symptoms of abnormal behaviour. Substance abuse is a pattern of behaviour in which a person continue to use a substance even though it interferes with psychological, occupational, educational and social functioning (Boyd & Bee, 2012). Abnormal behaviours that have been scientifically proven to result from substance abuse include depression, anxiety, hallucinations, and hyperactivity. The course text *Lifespan development* (Boyd & Bee, 2012) contains details of the effects of negative psycho-social influences on abnormal behaviour and disorders and you are encouraged to read this scientific evidence on this topic as it leads on to the next sub-section, mental disorder and crime. Substance abusers often commit crime to fund their drug habits or because they are disordered or disillusioned they harm themselves and others in their environment.

Mental Disorder, Criminal Conduct and Crime

The link between mental disorder and crime has been extensively studied with startling evidence. Politicians and policy makers acknowledge the interconnection between abnormal psychology, criminology, criminal justice and forensic mental health. Andrews and Bonta (2006) provided an overview of the psychology of criminal conduct noting that, "The phrase 'criminal conduct' more strongly implies the violation of deeply held and widely shared norms than does the phrase 'criminal behaviour'(Andrews & Bonta, 2006, p. 3) Psychologists and psychiatrists are often called into the courtroom to testify about an accused's competency to stand trial or they may be required to provide rehabilitative treatment to convicted prisoners. They often speak to the issue of mental disorder and maladjustment as possible reasons for the behaviour of defendants.

Andrews and Bonta (2006) identified some criminal subtypes such as sex offenders, batterers who assault others either because of provocation or while under the influence of drugs and diminished reasoning, drug offenders such as drug users and traffickers, murderers. In line with the discussion in the preceding subsection, it should be noted that the relationship between substance abuse and criminal behaviour is complex. Citing evidence from published research it can be said that substance abuse may influence criminal behaviour through the disinhibition of behavioural controls (e.g. the effects of alcohol abuse discussed by Giancola, 2004 as cited in Andrews & Bonta, 2006, p. 406). High risk abusers and those who perpetrate family violence may be caught up in the cycle of violence in which they were or may presently be victims as well perpetrators. In the clinical psychological literature depressive symptomology was strongly correlated with the propensity to commit violence (Andrews & Bonta, 2006, p. 415).

Special emphasis in this sub-section is given to the mentally disordered offender (MDO) whose behaviour appears to be incomprehensible and almost always violent. One of the problems in assessing a defendant is that the legal system and the mental health system need to agree that the actions of the defendant or culprit were due to diminished responsibility or committed during a period of insanity. The DSM-IV and DSM-V (discussed in earlier units of this course) offer the classification and symptomology needed for assessment. Examples of defendants whose actions were deemed to be caused by psycho-social factors or mental illness can be in law reports. The examples used in this sub-section are taken

from Supreme Court transcripts collected for the study by Hood and Seemungal (2006) on murder and capital punishment in Trinidad and Tobago.

Case 1

The High Court of Trinidad and Tobago, No. 27 of 2000, The State against Sherwin Joseph for Manslaughter, Sentencing on 13th November, 2001

The defendant was an outpatient of St. Anns (the sole mental hospital in Trinidad and Tobago) and he had a medical mental history and medical evidence revealed that he had a dissociative disorder (a disorder characterized by disruption, or disassociation, of identity, memory or consciousness). He was a patient at St. Anns for three months and continued to be an outpatient at the time the murder of his wife, Cheryl Ann Joseph, occurred on 5th September, 1996. His defence counsel stated that this disorder and a medical condition of sickle cell anaemia had a great effect on his mind and his state of being. The judge stated,

> *"You left the body of your wife in the home that you had found her in for some 17 hours roughly. At 8.00 am in the morning, when it is that you admitted committing the unlawful act, you did absolutely nothing to see whether there might have been a chance that you could have saved her.*
>
> *You then went on a mission of seeking to cover up your unlawful act. You waited until 1.00 am, on your admission, and you dragged the body of your wife into the bushes, into an open field, where you placed her in the area of a ravine and there you turned your back on her remains, leaving it to the elements, including what Professor Dr. Chandu Lal suggests might be animals including dogs, corbeau and other animals.*
>
> *She was allowed to remain there and to putrefy, to decompose while you went about your legitimate business, telling you [your] landlord that she had gone to Carlsen Field, lying to him. Eventually, some boys came upon her skull and later the police came upon her maggot-infested body. That is the woman who you, as a human being, no doubt shared your bed with as your wife. It shows that you are a callous human being, little regard for even the dead." (The Honourable Justice Volney, 2001, p. 21 as cited in The State v. Sherwin Joseph for Manslaughter No. 27 of 2000)*

Case 2

The High Court of Trinidad and Tobago, No. 120 of 2002, The State V Gopaul Juman for Manslaughter, Sentencing on 8th July, 2003

At sentencing the judge stated,

> *"Mr. Juman, on the 3rd of July, you pleaded not guilty to murder but guilty of manslaughter. This plea was accepted by the State on the basis of provocation.*
>
> *A synopsis of the facts given is that about a year before this tragic incident, your common law wife left you and formed a relationship with the deceased. During this year there were frequent altercations between yourself and the deceased. On the material day you, armed with a cutlass, approached the deceased and fired one chop to his neck. You then ran in front of the yard and began pelting stones and calling out to the deceased to fight.*
>
> *The post mortem report stated that the cause of death as the chop wound to the neck. The State also submitted that you are an out-patient of the St. Ann's Hospital. You were first admitted in 1988 with subsequent admissions in '89, '90, '96 and '97. You have been diagnosed as suffering with a cannabis induced psychotic disorder, reactive depression, schizophrenia and substance induced psychotic illness." (The Honourable Madame Justice Elder, 2003, p. 2 as cited in The State v Gopaul Juman for murder No. 120 of 2002)*

You would realize that the link between drug use and mental illness was mentioned in case 2 and this point was established in this unit. In sending a signal to society Madame Justice Elder cautioned, "…users of illicit drugs should be aware that even if their ability to exercise restraint is weakened by the use of these drugs, this would not exonerate them from punishment." (The Honourable Madame Justice Elder, 2003, p. 3 as cited in The State v Gopaul Juman for murder No. 120 of 2002)

Case 3

The High Court of Trinidad and Tobago, No. 162 of 2002, The State against Curtis O'Garro for Murder, Sentencing on 10th November, 2004

The judge in deciding on the state of mind of the defendant at the time of the murder said,

> *"Now, in making the assessment, to be sure for my own self that the accused was, in fact, suffering from an abnormality of mind, I make reference back to the psychiatric report dated 9th of December, 2003 under the hand of Dr. Iqbal Ghany, consultant psychiatrist at the Forensic Unit at the St. Ann's Hospital. Out of that report, these are the following ones which would have attracted my attention in terms of their relevance to the matter before us: It indicates that in the year 2001 the accused would have attempted suicide by drinking a poisonous substance. Further, he found that it would appear that while in adolescence the accused experienced depression and feelings of inferiority, and it would appear that he was depressed and under the influence of drugs at the time of the alleged incident. Further on in the report he says, 'It would appear that at the time of the incident he was depressed and under the influence of drugs, and these would have caused abnormality of mind and of such a degree to affect his mental responsibility and judgement for his acts." (The Honourable Justice Holdip, 2004, p. 3 as cited in The State against Curtis O'Garro Juman for murder No. 162 of 2002)*

Collectively these three cases demonstrate the intersections of criminal justice, psychology and mental illness. The coverage area in the cases also speaks to the key themes in Unit 9 namely, approaches to explaining mental disorder, in particular the biological approach; the assessment of abnormal behaviour; abnormal behaviour and consequences for young people; and finally, the role of psycho-social factors, including substance abuse on the development of abnormal behaviour and disorders.

Key Points

1. Congenital and psycho-social factors in infancy and early childhood can be responsible for the development of abnormal behaviour and disorders during later stages in the human lifespan.
2. The disorders that are more likely to emerge during the early stages of development –childhood and adolescence – include pervasive development disorder, mental retardation, learning disorders, communication disorders, attention-deficit and disruptive behaviour disorders, mood and anxiety disorders, and elimination disorders.
3. The role of psycho-social factors in the development of abnormality of the mind and behaviour was explained.
4. Erik Erikson's 8 stages of psycho-social development emphasized the interaction between internal drives and cultural demands. Chronological age is associated with a specific stage and each stage has unique positive characteristics gains and typical activities.

Unit Summary

In keeping with the title of Unit 9 '**Cause, Classification and Assessment of Mental Disorder'** Session 9.1 commenced by defining a disorder as an inflexible pattern of behaviour that leads to difficulty in social, educational, and occupational functioning. The cause of mental disorder can be explained using four major approaches, the psychoanalytic approach which locates the development of mental disorders in events such as the occurrence of a traumatic childhood event that disrupts ego development, stress factors or unhealthy family interactions. The behavioural-learning approach views maladaptive behavior as the result of learning bad habits or failing to learn good ones. The biological approach believes that mental disorders originate in the hormonal system, the nervous system, genetic background, the effects of neurotransmitters on emotion and thought, and the effects of substance and alcohol abuse. Finally, the socio-cultural approach differs from the aforementioned three approaches because it is centered on the social environment and the cultural definitions of normality to understand mental disorders. It is assumed that the labeling process itself can produce deviant, unusual and abnormal behaviour. The methods of assessment include, but are not limited to, the clinical interview, computerized interview, psychological tests, neuropsychological assessment, behavioural assessment, cognitive assessment, and physiological measurement. You would realize that the theoretical approach that is used to explain the disorder offers a clue as to the nature of the method of assessment that will be used to obtain the details of the client's problem. Hence clinicians working within a biological approach are likely to utilize physiological assessment techniques such as magnetic resonance images or computed tomography.

The explanations for mental disorder to some extent reflect the diagnostic specialization of a patient's heath care professional. For example, a clinical or psychiatric social worker is expected to have earned at least a Master's degree in social work (M.S.W.) and this professional would use their knowledge of community agencies and organisations to help people with severe mental disorders receive the services they need. For example, they may help people with schizophrenia make a more successful adjustment to the community once they leave the hospital. Clinical social workers usually practice psychotherapy or other specific forms of therapy such as marital or family therapy. The basis of this form of diagnosis and treatment is reflected of the psycho-analytic approach and the socio-cultural approach for explaining mental disorders.

In Session 9.2, the aims of the discussion were to link the material presented in Session 9.1 to a practical approach to explaining assessment issues and illustrate how current disorders and abnormalities in adults have their genesis in earlier stages of human development, namely childhood and adolescence. Several disorders common to childhood and adolescence were mentioned specifically, pervasive development disorder, mental retardation, learning disorders, communication disorders, attention-deficit and disruptive behaviour disorders, mood and anxiety disorders, and elimination disorders. A description of the associated features of each group of disorders was summarized in Table 9.4. This information provided the contextual information for illustrating how childhood experiences, events and neglect can impact upon a person in ways that places the individual 'at risk' in society. These high risk factors can lead to a life of crime or it can trigger an exaggerated response to a situation by a mentally ill person such as the

commission of a homicide. The details of three cases from the Supreme Court of Trinidad and Tobago were presented as a way that allowed you to reflect on the way in which psychology interacts with law. These were outlined in the sub-sections on psycho-social factors and abnormal development as well as mental disorders and crime.

A key learning objective of Unit 9 was to provide a scientific understanding of mental disorder which would in turn enable learners to empower young people and adults in their care to become active and responsible citizens. Collectively, the information presented paves the way for understanding the types of mental disorders that exist and more importantly what treatment options might be available. This session was comprehensive because it provided the structural framework for understanding related themes in Unit 10 which is titled "Common mental disorders across the lifespan and their treatment options." In Unit 10 we will explore in more detail the common groups of non-psychotic mental disorders – such as anxiety disorders, somatoform disorders, and dissociative disorders. A review of some common psychotic disorders such as antisocial personality disorder, schizophrenic and mood disorders will be undertaken. You can read in advance about common disorders that occur at various stages in the lifespan in the course text by Boyd and Bee; for example, at page 347.

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Glossary of Terms Used in Unit 9

Source: A Dictionary of Psychology, Andrew M.Coleman, Oxford University Press, 2nd ed. 2006.

Other free access on-line psychology dictionaries are available at the following links http://allpsych.com/dictionary/ and http://www.merriam-webster.com/dictionary/psychology

The American Psychological Association website is a powerhouse of information. http://www.apa.org/topics.index.aspx

Abnormal Behaviour	This represents behaviour that is distressful to the person and impairs functioning.
Affective Disorders	Serious mood disturbances, especially elation or depression, involving intense emotions that are not clearly related to events in the person's life.
Antisocial Personality Disorder	A personality disorder characterized by a consistent pattern of such behaviours as truancy, delinquency, lying, promiscuity, drunkenness or substance abuse, theft, vandalism, and fighting.
Behavioural Assessment	The approach to clinical assessment that focuses on the objective recording and description of problem behaviour.
Biopsychosocial Model	An integrative model for explaining abnormal behaviour in terms of the interaction of biological, psychological, and socio-cultural factors.
Cognitive Assessment	Measurement of thoughts, beliefs and attitudes that may be associated with emotional problems.
Conditional Positive Regard	Means valuing other people on the basis of whether their behaviour meets one's approval.
Conflict	An incompatibility of motives or goals.
Coping	Efforts to reduce stress and to find new solutions to life challenges.
Crisis	An event or period that brings rapid change, usually involving more than one area of functioning.
Critical Thinking	This refers to the adoption of a questioning attitude and the careful scrutiny of claims and arguments in light of evidence.
Defence Mechanism	In psycho-analytic theory, techniques which attempt to alleviate anxiety caused by the conflicting theories of the id and superego (e.g. repression, projection, displacement).

Dementia Praecox	The term given by the German physician to the disorder now called schizophrenia
Depression	A state of extreme sadness, usually characterized by slow thoughts and movements but sometimes by restless agitation.
Diagnosis	Identifying a disorder from its signs and symptoms.
Diathesis	This is a vulnerability or predisposition to a particular disorder.
Diathesis-Stress Model	This model contends that abnormal behaviour problems involve the interaction of a vulnerability or a predisposition and stressful life events or experiences.
Dispositional Factors	A cause of behaviour that is related to one's personality characteristics and preferences.
Dissociation	Some aspect of psychological functioning seems separated from a normal, integrated state. Memory, emotion, or identity may be separated from the other elements of functioning.
Distress	A threatening unpleasant demand
Downward Drift Hypothesis	The theory that explains the link between low socio-economic status and behaviour problems by suggesting that problem behaviours lead people to drift downward in social status.
Emotional Inoculation	The ability to work through feelings of anxiety or threat in anticipation of a stressful event
Fixation	In psychoanalytic theory, continued use of pleasure-seeking or anxiety-reducing behaviours appropriate to an earlier stage of development
Heredity	The proportional contribution of genetic factors to the total variance of a trait.
Hysteria	A condition characterized by paralysis or numbness that cannot be explained by any underlying physical cause.
Medical Model	A biological perspective in which abnormal behaviour is viewed as symptomatic of underlying illness.
Personality	The integrated and organized characteristics and behaviour tendencies of a person that determine the unique ways the person interacts with his or her environment.
Personality Disorders	Impairment in work or social behaviour due to rigid, maladaptive personality traits

Phobia	Is a persistent irrational fear of an object, situation, or activity that the person feels compelled to avoid.
Physiological Assessment	Measurement of physiological responses that may be associated with abnormal behaviour.
Projective Tests	Psychological tests that present ambiguous stimuli onto which the examinee or client is thought to project his or her personality and unconscious motives.
Psychodynamic Model	The theoretical model of Freud and his followers, in which abnormal behaviour is viewed as the product of clashing forces within the personality.
Psychopathology	The scientific study of mental disorders; features of people's mental health considered collectively such as ageism, family discord, domestic abuse
Sanism	The negative stereotyping of people who are identified as mentally ill.
Schizophrenia	This is characterized by severely disturbed behaviour, thinking, emotions, and perceptions involving a break with reality (psychosis). It is caused by biological factors, including genetic factors, neurotransmitters, irregularities, and brain abnormalities and/or by psychosocial factors interacting with genetic factors. It can be treated with antipsychotic drugs; learning based treatments, such as the token economy and social skills training; psychosocial rehabilitation services such as residential treatment facilities; and family intervention programs to improve communication and reduce conflicts.
Scientific Method	A systematic method of conducting scientific research in which theories or assumptions are examined in light of evidence.
Self Monitoring	The process of observing or recording one's own behaviour, thoughts, or emotions.
Semi-Structured Interview	This represents an interview in which the clinician follows a general outline of questions designed to gather essential information but is free to ask them in any order and to branch off in other directions.
Social Phobia	A fear of situations where one could be observed or evaluated.
Stressor	This represents any unusual or intense demand.
Stress Response	The non-specific response of the body to any demand.

Structured Interview	Interview that follows a preset series of questions in a particular order.
Trauma	Mental and physical injury
Unconditional Positive Regard	This means valuing other people as having basic worth regardless of their behaviour at a particular time.
Unstructured Interview	An interview in which the clinician his or her own style of questioning rather than following any standard format.