Unit 10 Mental Disorders and Their Treatment

Overview

In Units 8 and 9 you were presented with contemporary theoretical perspectives outlining the reasons for abnormal psychology and mental disorders. These explanations included biological, psychological, socio-cultural and biopsychosocial. Emphasis was placed in Unit 8 on stress, crisis, coping and the role of **stressors** as risk factors in producing abnormal behaviour that might represent an expression of a mental disorder. In Unit 9 a detailed overview was given of the cause, classification and assessment of mental disorders. The relevance of the tool kits for diagnosis and treatment outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the International Statistical Classification of Diseases and Related Health Problems (ICD-10) were documented in the preceding unit. In Unit 10 the spotlight will be on mental disorders and their treatment and this will be covered in three sessions. This is a very expansive area so the approach taken in this unit is to document in Session 10.1 the common groups of non-psychotic mental disorders (anxiety disorder, somatoform disorder, and dissociative disorder) and to review their treatment options; to discuss common groups of psychotic disorders (antisocial personality disorder, schizophrenic, and mood disorder) in Session 10.2 and to outline the recommended treatments offered by health care professionals; and to briefly document in Session 10.3 common disorders that are associated with specific phases of the human lifespan.

An early thinking among psychologists was that the terms 'normal' and 'abnormal' behaviour were to some extent subjective and there was a very thin line separating the two. In the 1980's the term 'abnormal' was replaced by the term 'deviant behavior'. As a result "deviant behaviour passes under various names, *behaviour pathology, behaviour disorder, mental disorder, abnormal behaviour* – and *psychopathology too* – all carrying the implications of a deviance or departure from normality." (Kimble, Garmezy & Zigler, 1980, p. 422) In this unit the above terms will appear but the key point to remember is that the manifested behaviour causes concern for health care professionals. Interestingly there is a temporal dynamic to classifications of what is regarded as mental disorder. Kimble (1980) stated that homosexuality as a broad term has been a source of great dispute among psychiatrists as to whether or not to consider it a psychosexual disorder. It was excluded from the earlier DSM classifications such as the DSM-III although Kimble noted that, "..ego-dystonic homosexuality has been included to provide a classification of individuals who seek heterosexuality but have little or no arousal under such stimulation, but who do not have homosexual arousal which for them is both unwanted and distressing." (Kimble, 1980, p. 423)

The academic literature identifies various options for treatment such as insight psychotherapies, behaviour therapy, cognitive behaviour therapy and biological treatments. You will have the opportunity to view several YouTube presentations relating to treatment options; for example, psychotherapy and cognitive behaviour therapy (CBT). One of the presentations is given by a cognitive behaviour therapist who explains the type of clients who are most likely to benefit from CBT treatment. Although this Unit is titled 'mental disorders and their treatment' one should bear in mind that there is often no quick, easy or one-off treatment that one could recommend. Different individuals respond in different ways to the same treatment so that there might be an element of trial and error before a health care professional is able to identify the most 'successful' program, intervention or therapy that could reliably improve an affected person's functioning. Above all, cooperation of the patient is crucial to the success of any treatment or intervention as there must be a strong sense that the patient and the therapist are collaborating well as a team to treat a disorder. Most of the academic writers on the topic of mental illness or mental disorders stress that there are few quick and easy therapies particularly for behaviour that is described as 'severely disturbed behaviour'. In the final analysis, there is no magic route for curing mental illness or disorders. Instead, therapists use a variety of approaches to manage dysfunctional behaviour in a mental health context or criminal behaviour in a correctional facility or prison. Moreover, the treatments that clinicians offer invariably reflect the therapist's training in tandem with the theoretical approach that informed the cause of mental disorder. In other words, a psychotherapist is more likely to use a counselling approach and less likely to rely on drug therapy to treat a patient.

An important aim of Session 10.3 is to help you to link your knowledge of developmental psychology, presented in Part III of this course, with the topic of abnormal psychology. Therefore, the focus in this brief session will be on synthesizing the information from Sessions 10.1 and 10.2 on abnormal behaviour and general disorders with the specific disorders that are likely to manifest themselves in various phases of the human lifespan. Nevid, Rathus and Greene (2011) stated that the nature of the psychological disorders that are most prevalent in childhood and adolescence tend to revolve around learning disabilities and attention-deficit/hyperactivity disorder. This was introduced in Unit 9. Child sexual and physical abuse is linked to depression, anxiety and in extreme cases suicide or attempted suicide. The disorders that are most common with ageing are depression which occurs with the loss of a life partner, and amnestic disorders such as dementia and Alzheimer's Disease. There is emerging evidence of the bipolar kid; that is, children who suffer from bipolar disorder. Autism is better known than pervasive developmental disorder which is marked by impairment in multiple areas of development. An understanding of how disorders emerge and are manifested in the adolescence phase of human development would facilitate learners who are enrolled in the Youth Development Work and Social Work degree options. There are tangible benefits from knowing what to expect from youths with special needs and what treatment options are available for them. These can then be integrated into targeted policies and interventions.

The learning objective of Unit 10 is to provide the requisite knowledge, skills-set and critical thinking ability associated with competencies YDWCYP0263 'Enable young people to become active and responsible citizens; YDWCYP0293 'Contribute to the development and implementation of a national youth policy', 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).

Competencies

1. YDWCYP0263: Enable young people to become active and responsible citizens.
2. YDWCYP0293: Contribute to the development and implementation of a national youth policy.
3. YDWCYP0513: Plan and implement programmes to promote healthy lifestyles among youth.

Key Concepts in Unit 10: abnormal behaviour, diagnosis, self-harm, para-suicide, evaluation, trauma, neurotic disorder, anxiety, phobic disorder, social phobia, dissociation, psychotic, non-psychotic, psychosis, psychotherapy, cognitive behaviour therapy, post traumatic stress, disorder; pervasive development disorder; autism; Asperger's disorder; childhood disintegrative disorder; mental retardation; dyslexia; learning disorder.

Structure of the Unit

This Unit is divided into three sessions as follows:

Session 10.1: Non-psychotic Disorders and Treatments

Common groups of non-psychotic mental disorders and their treatments:

- anxiety disorder
- somatoform disorder
- dissociative disorder

Session 10.2: Psychotic Disorders and Treatments

Common groups of psychotic disorders and their treatments:

- anti social personality disorder
- schizophrenic disorder
- mood disorder

Session 10.3: Abnormal Behaviour and Disorders in Childhood, Adolescence and Adulthood

- Pervasive development disorder
- Mental retardation
- Learning Disorders
- Communication disorders
- Attention-Deficit and Disruptive Behaviour disorder
- Anxiety and Mood disorder
- Elimination Disorders

Unit 10 Learning Objectives

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

1. Recognize the core characteristics, treatment and therapy options of selected mental disorders documented in the unit notes and apply them to the reflective activities in the unit;
2. List some of the disorders discussed in the unit that are prevalent during various phases in the human lifespan;
3. Suggest ways in the discussion forum in which abnormal psychology and the discipline's treatment options can promote protective factors and minimize risk factors;
4. Explore in tutorials how the diagnostic tools mentioned in the unit can be used to frame policies for transforming 'at risk' persons into functional and civic-minded citizens;
5. Recognize the salient features of selected disorders (e.g. self-harm and depression) and recommend interventions in tutorials to improve the circumstances of persons with these disorders;
6. Appreciate the need to work in ways that are socially and culturally sensitive when recommending interventions and programs for persons with mental disorders who require special support systems.

Session 10.1

Non-Psychotic Mental Disorders and Treatment Options

Introduction

It is useful to have an expansive view of mental disorders, particularly those disorders that are likely to be manifested in daily life because of stress and illness. You would recall the discussion in Unit 8 on stress, conflict, crisis and coping in which it was noted that stress and stressors can precipitate mental disorders. Nevid, Rathus and Greene (2011) expanded upon the role of stress on mental wellbeing. They noted that stress is implicated in a wide range of physical and psychological illnesses as well as disorders. Included in the category of disorders is **adjustment disorder** which is a maladaptive reaction to stress and it is regarded as amongst the mildest of disorders. The key identifier of this type of disorder is that the nature of the stressor is known. This may be the death of a loved one or the break up of a relationship. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM) an adjustment disorder is a maladaptive reaction to an identified stressor that develops within a few months of the onset of the stressor. The maladaptive reaction is characterized by significant impairment in social, occupational, or academic functioning or by states of emotional distress that exceed those normally induced by the stressor. There is a fine line between adjustment disorder and anxiety disorder. The issue of adjustment disorder also reminds us that there is a grey area between the definition of normal and abnormal behaviour particularly because adjustment disorders represent reactions that exceed our normal expectations. The domain of normal expectations is itself a murky area. Fortunately psychologists and evidence from the DSM offer guidance for recognising adjustment disorders and their chief features. This checklist is displayed in Table 10.1.

Disorder	Chief Features
Adjustment disorder with depressed mood	Sadness, crying, and feelings of hopelessness
Adjustment disorder with anxiety	Worrying, nervousness, and jitters (or in children, fear of separation from primary attachment figures)
Adjustment disorder with mixed anxiety and depressed mood	A combination of anxiety and depression

Adjustment disorder with disturbance of conduct	Violation of the rights of others or violation of social norms appropriate for one's age. Sample behaviours include vandalism, truancy, fighting, reckless driving, and defaulting on legal obligations (e.g. stopping alimony payments)
Adjustment disorder with mixed disturbance	Both emotional disturbance, such as depression or anxiety, and conduct disturbance (as described above)
Adjustment disorder unspecified	A residual category that applies to cases not classifiable in one or the other subtypes

Table 10.1: Subtypes of Adjustment Disorders (Cited in Nevid, Rathus and Greene (2011:141)

Another type of disorder that you are likely to be familiar with because of the attention given to it in the media is **post traumatic stress disorder** (PTSD). PTSD is described in the literature as a prolonged maladaptive reaction to a traumatic event. This can include the severe physical or emotional trauma that occurs from the experiencing of natural disasters or a terrorist incident such as 9/11 attacks in the USA. Thoughts, feelings and behaviour patterns become seriously affected by flashbacks of the event in the short term or in the very long term such as months or even years after the incident. Increasing occurrences of mass killings by psychotic individuals or sociopaths haven given rise to the term terrorism-related trauma. An example of this is the case of the Norwegian killer Andres Behring Breivik who was described by one newspaper as a laughing gun man who shot at least 77 youths at a summer camp in Norway in 2011 and wounded at least 200 others in his combined bomb and shooting attacks. You will have the opportunity to profile Andres Behring Breivik and to share your thoughts about his behaviour in one of your Unit 10 activitites.

In Session 10.1 the emphasis will be on the common groups of non-psychotic disorders. The Oxford Dictionary of Psychology defines **psychotic** as, "relating to, denoting or suffering from a psychosis or a psychotic disturbance." **Psychosis** refers to, "A severe form of disturbed behaviour characterized by impaired ability to interpret reality and difficulty meeting the demands of daily life." (Nevid, Rathus & Greene, 2011, p. 558) Therefore, non-psychotic disorders are those that are not characterized by psychotic disturbances. As we proceed through the unit material and activity sessions you would be provided with the diagnostic tools to develop your understanding of non-psychotic disorders and their related signs and symptoms. Treatment options include psychodynamic therapy, behaviour therapy, humanistic therapy, cognitive therapy, cognitive-behavioural therapy, eclectic therapy, as well as group family and couple therapy. The treatment options for each disorder discussed in this Session and in the overall unit will be presented and evaluated. It is appropriate to commence the discussion with a tabular summary of the major types of psychotherapies for your reflection and consideration. The major types of professionals who can administer treatment include clinical psychologists, counseling psychologists, psychiatrists, clinical or psychiatric social workers, psychoanalysts, counselors, and psychiatric nurses.

Therapy	Major Figure	Goal	Treatment Length	Therapist's Approach	Major Technique
Classical Psychoanalysis	Sigmund Freud	Gaining insight and resolving unconscious psychological conflicts	Lengthy, typically lasting several years	Passive, interpretive	Free association, dream analysis, interpretation
Modern Psychodynamic Approaches	Various	Focus on developing insight, but with greater emphasis on ego functioning, current interpersonal relationships, and adaptive behaviour than traditional psychoanalysis	Briefer than traditional psychoanalysis	More direct probing of client defenses; more back- -and- forth discussion	Direct analysis of client's defenses and transference relationships
Behaviour Therapy	Various	Directly changing problem behaviour through use of learning-based techniques	Relatively brief, typically lasting 10 to 20 sessions	Directive, active problem-solving	Systematic desensitization, gradual exposure, modeling, reinforcement techniques
Humanistic, Client-Centered Therapy	Carl Rogers	Self acceptance and personal growth	Varies, but briefer than traditional psychoanalysis	Non-directive, allowing client to take the lead, with therapist serving as an empathic listener	Use of reflection, creation of a warm, accepting therapeutic relationship
Ellis's Rational Emotive Behaviour Therapy	Albert Ellis	Replacing irrational beliefs with rational alternatives beliefs; making adaptive behavioural changes	Relatively brief, typically lasting 10 to 20 sessions	Direct, sometimes confrontational challenging of client's irrational beliefs	Identifying and challenging irrational beliefs; behavioural homework assignments

Beck's Cognitive Therapy	Aaron Beck	Identify and correcting distorted of self-defeating thoughts and beliefs; making adaptive behavioural changes	Relatively brief typically lasting 10 to 20 sessions	Collaboratively engaging client in process of logically examining thoughts and beliefs and testing them out	Identifying and correcting distorted thoughts; behavioural homework; including reality testing
Cognitive-Behavioural Therapy	Various	Use of cognitive and behavioural techniques to change maladaptive behaviours and cognitions	Relatively brief, typically lasting 10 to 20 sessions	Direct, active problem solving	Combination of cognitive and behavioural techniques

Table 10.2: Overview of the major types of psychotherapies (Adapted from Nevid, Rathus and Greene, 2011, p. 113)

The discussion format will focus on the common groups of non-psychotic disorders; namely, anxiety disorders, somatoform disorders and dissociative disorders. There will be a heavy reliance on tabular summaries, YouTube video presentations and mydevelopmentlab.com activities to illustrate the technical and textual material in the Unit. There is much more that could be said about the treatment of mental disorders than is documented in Unit 10. You are encouraged to read as extensively as possible by exploring the vast array of literature in the Open Campus Library and by reading the relevant sections in your course textbook Boyd, D. & Bee, H. (2012) *Life-span development*.

Session 10.1 Objectives

By the end of this session you should be able to:

1. Recognize the core features of the non-psychotic mental disorders documented in this session;
2. Discuss examples of non-psychotic mental disorders using the cases cited in the session;
3. Identify from the session notes the appropriate treatments that can be applied to non-psychotic mental disorders;
4. Suggest policies in tutorials that can help to promote protective factors for those persons who show the 'high risk' risk factors discussed in the session notes;
5. Link the realization of life goals and development plans to the promotion of healthy lifestyles among citizens and post your comments in the discussion forum.

Common Groups of Non-Psychotic Mental Disorders and Their Treatment

1. Anxiety Disorders

Psychologists define **anxiety** in many ways but the most common features are, "A feeling of intense and painful apprehension, worry and fear. It is often accompanied by (1) physiological signs such as increased heart rate, sweating, and dizziness; (2) doubts about the nature and reality of what is threatening; and (3) doubts about the self." (Newman & Newman, 1983, p. 467) The website of the American Psychological Aassociation (APA) states that people with anxiety disorders usually have recurring intrusive thoughts or concerns. They may avoid certain situations out of worry and this avoidance behaviour creates problems if it clashes with job duties or family responsibilities. Affected persons can display physical symptoms such as sweating, trembling, dizziness or a rapid heartbeat. The APA cautions that some amount of anxiety is perfectly normal and may not necessarily be maladaptive. For instance, stressful situations such as preparing for an examination or meeting a work-related deadline can induce heightened levels of stress, fear and a sense of nervousness. Some individuals claim that they work better under pressure and psychologists explain this trend by noting that, "Experiencing mild anxiety may help a person become more alert and focussed on facing challenging or threatening circumstances. But individuals who experience extreme fear and worry that does not subside may be suffering from an anxiety disorder. The frequency and intensity of anxiety can be overwhelming and interfere with daily functioning. The APA indicates that those who suffer from untreated anxiety disorder are likely to suffer from other psychological disorders such as depression; they are at increased risk for indulging in alcohol use and drug abuse; and their relationships with friends and family become strained. Fortunately, the majority of people with an anxiety disorder improve considerably by getting effective psychological treatment." (Source http://www.apa.org/helpcenter/anxiety-treatment.aspx)

The choice of treatment for anxiety can be selected from the options outlined in Table 10.2 but the APA indicated that based on research evidence cognitive-behaviour therapy (CBT) is highly effective. CBT helps clients to identify and learn to manage the triggers or factors that contribute to the anxiety disorder, panic attack or phobia. You will have the opportunity to see a video on the CBT in Session 10.2, Activity 10.2.

Anxiety disorders can be manifested in many ways such as phobic disorders. The primary characteristic of a phobic disorder is an irrational, persistent fear of an object, situation or activity. A phobia can be so strong that it forces a person to avoid the object or situation that is the target of the behaviour. Newman and Newman (1983) suggested that many people have at least one or more irrational fears so you are in good company if you experience some form of short-term anxiety. These fears are not regarded as phobias if they do not impede the normal, everyday functioning of life. An example of a disruptive phobia is social phobia. A **social phobia** is a fear of situations where one could be observed or evaluated by others. The phobia is characterized by an individual's sense of fear that s/he will behave in a way that will cause embarrassment or degradation. Examples of social phobias include fear of eating in front of others, using public restrooms and speaking in public.

Why do people develop phobias? According to psychoanalytic theory phobias represent an attempt to limit anxiety. An individual experiences general anxiety when unconscious impulses threaten to break into consciousness. To relieve the general anxiety, fear is focused on a single target (e.g. a fear of weapons – known as weapons phobia) and the individual only experiences anxiety in the presence of the target. In other words, the threat is projected onto the frightening object so the person does not have to confront his or her impulses. The behavioural-learning approach offers another explanation for the development of phobias. This theoretical approach suggests that avoidance of an object (e.g. a gun) reduces the fear of the object. Moreover, one does not have to be previously shot to develop a fear of guns; merely watching the reaction of people who have been shot and who either died or were wounded can create a weapons phobia. Biological explanations of mental disorders are premised on the notion that there is an evolutionary basis to some fears, described as aversive conditioning. For instance, a snake phobia (ophidiophobia) perhaps evolved because people were unable to discriminate between poisonous and non-poisonous snakes. Hence all snakes were viewed as dangerous, they were feared and the goal was to kill them on sight. You can obtain more information about phobias by watching the video *Phobias* on mydevelopmentlab.com (Boyd & Bee, 2011, p. 348)

You can read more about the various types of anxiety disorders and their treatment options from the APA's website listed under e-resources. Some of the APA's information is re-produced in this section for your reflection and consideration. In addition to phobias and post-traumatic stress disorder (PTSD), there are other types of anxiety disorders. First, generalized anxiety disorder is displayed by persons who have recurring fears of financial stability, health or other daily issues. The maladaptive response is that these fears prevent persons from concentrating on their daily tasks. Second, panic disorder involves sudden, intense fears about certain objects or situations. For example, performance anxiety might emerge when an individual is about to write an examination, to make a presentation in front of a large audience, or is facing a job interview. People who suffer from this disorder generally develop strong fears about when and where their next panic attack will occur consequently they tend to restrict their everyday activities. Third, obsessive-compulsive disorder is characterized by persistent, uncontrollable and unwanted feelings and thoughts —classified as obsessions– and routines or rituals —classified as compulsions– in which individuals engage to try to prevent or to rid themselves of these thoughts. Examples of common compulsions identified by the APA include excessive washing of hands or body hygiene, excessive cleaning of one's home for fear of germs, or checking work repeatedly for errors. Treatment for these disorders can be via the CBT which help people identify and learn to manage the factors that contribute to their anxiety. Behavioural therapy involves techniques to stop or reduce the undesired behaviours associated with anxiety disorders. The APA recommends training patients in relaxation and deep breathing techniques to counteract the biological manifestations (e.g. breathing difficulty, dizziness) of anxiety and panic. Through cognitive therapy patients are taught how their thoughts contribute to their anxiety and they are trained to alter their thoughts in ways that would eliminate or minimize their anxiety. How long does psychological treatment take? The APA suggests that the large majority of people who suffer from an anxiety disorder are able to reduce or eliminate the symptoms of their anxiety and to return to normal functioning after several months of appropriate psychotherapy.

2. *Somatoform Disorders*

Somatoform disorders are physical disorders that seem to have physical causes, but their actual causes are psychological or due to conflicts. The word *somatoform* is derived from the Greek *soma*, meaning "body". Hence patients have physical 'somatic' symptoms without an identifiable physical cause. Nevertheless, patients' problems are perceived to be real and the manifestations of the disorder are not under the patient's control. Nevid, Rathus and Greene (2011) offered a very good summary of somatoform disorders and these are outlined in Table 10.3. The key points to remember are first, the main characteristics of somatoform disorders are multiple, recurring physical complaints that have lasted for several years despite medical evidence of no physical causes for the complaints and the symptoms. Second, Newman and Newman (1983) noted that somatoform disorders occur most often in females and they are rarely diagnosed in males. However, Newman and Newman's view may be a contentious one. The authors observed a family link in the manifestation of the disorder as the symptoms are more common in families where it has been diagnosed in another family member. Third, anxiety, depression, antisocial behaviour, marital difficulties, as well as occupational difficulties may arise as a result of somatoform disorders.

Type of Disorder	Description	Associated Features
Conversion Disorder	Change in or loss of a physical function without medical cause	• Emerges in context of conflicts or stressful experiences, which lends credence to its psychological origins • May be associated with la belle indifference (indifference to symptoms)
Hypochondriasis	Preoccupation with the belief that one is seriously ill	• Fear persists despite medical reassurance • Tendency to interpret physical sensations or minor aches and pains as signs of serious illness
Somatization Disorder	Recurrent, multiple complaints about physical symptoms that have no clear organic basis	• Symptoms prompt frequent medical visits or cause significant impairment of functioning
Body Dysmorphic Disorder	Preoccupation with an imagined or exaggerated physical defect	• Person may believe that others think less of him or her as a person because of the perceived defect • Person may engage in compulsive behaviours, such as excessive grooming, that aim to correct the perceived defect

Pain Disorder	Persistent physical pain believed to be associated with psychological factors	• Pain severe and persistent enough to interfere with daily functioning; medical conditions and psychological factors may play important roles in accounting for the pain

Table 10.3: Overview of somatoform disorders (Adapted from Nevid, Rathus & Greene, 2011, p. 226)

Explanations for somatoform disorder vary. Nevid et al. (2011) cited the work of Guze (1993) to support their view that although not much is known about the biological underpinnings of somatoform disorders a genetic link seems plausible based on evidence that the disorder tends to run in families, primarily among female members of a family. However, Nevid et al. cautioned that one could not rule out the possibility that social influences contributed to a familial association. According to psychodynamic theory, hysterical symptoms are functional. They allow the person to achieve *primary gains* and *secondary gains*. The primary gain of the symptoms is to allow the individual to keep internal conflicts repressed. The person is aware of the physical symptom but not of the conflict it represents. As a result, "The hysterical paralysis of an arm might symbolize and also prevent the individual from acting on repressed unacceptable sexual or aggressive impulses." (Nevid, Rathus, & Greene, 2011, p. 235) Secondary gains from the symptoms are those that allow the individual to avoid burdensome responsibilities and to gain the support – as opposed to the condemnation– of persons in their environment including friends and relatives.

Freud pioneered psychoanalysis as the preferred treatment option for conversion disorder, which was previously termed hysteria. Psychoanalysts seek to bring to conscious awareness the unconscious forces and conflicts that occurred in childhood that lead to the manifestation of conversion disorder. It is assumed that once the conflict is recognised, aired and dealt with in the counselling session, the symptom is no longer needed and therefore disappears. In contrast, the behavioural approach to treating conversion disorder, and other forms of somatoform disorders, is to focus on removing the secondary reinforcement or secondary gains that accompany the disorders. For instance, if a person with a somatoform disorder uses illness as a reason not to shoulder family responsibilities then the therapist will work with the family members to encourage them to give the affected client some responsibilities and to reward them when they do so. Nevid et al. believed that the best established treatment for somatoform disorders is the use of cognitive-behavioural therapy (CBT) although some forms of drug therapy include giving anti-depressants to affected clients.

3. Dissociative Disorder

Dissociative disorder is characterized by disruption, or dissociation of identity, memory or consciousness. Dissociative disorder is more popularly known as 'multiple personality' and it is viewed as the most perplexing of all psychological disorders. The following quotation in the box below labelled **Learning Activity 10.1** and the YouTube video documentary depicting a woman with 15 personalities, collectively illustrates the

manifestations of dissociative disorder and the difficulties that a therapist might face in offering treatment.

LEARNING ACTIVITY 10.1 •

"Elania is a licensed clinical therapist. Connie is a nurse. Sydney is a delightful little girl who likes to collect bugs in an old mayonnaise jar. Lynn is shy and has trouble saying her I's, and Heather – Heather is a teenager trying hard to be grown-up. We are many different people but we have one very important thing in common: We share a single body….

We have dozens of different people living inside of us, each with our own memories, talents, dreams, and fears. Some of us "come out" to work or play or cook or sleep. Some of us only watch from inside. Some of us as still lost in the past, a tortured past full of incest and abuse. And there are many who were so damaged by this past and who have fled so deep inside, we fear we may never reach them…

Many of our Alter personalities were born of abuse. Some came because they were needed, others came to protect.

Leah came whenever she heard our father say, "Come lay awhile with me." If she came, none of the other Alters would have to do those things he wanted. She could do them for us, and protect us from that part of our childhood."

Source: From the "Quiet Storm," a pseudonym used by a woman who claims to have several personalities residing within her (Cited in Nevid et al., 2011, p. 209)

View the YouTube presentation Multiple Personality disorder – documentary – woman with 15 personalities

Mansor, H. (2011, Mar 29). Multiple Personality Disorder - Documentary. [Video file]. Retrieved from http://www.youtube.com/watch?v=B0LNyXsErb8&feature=related

Discuss the key features of Multiple Personality disorder in your tutorial discussion. **Learning activity 10.1 is due by Week 12.**

Dissociative disorders occur in various forms as shown in Table 10.4 This table contains a description of the disorder and the associated features accompanying the disorder.

Type of Disorder	Description	Associated Features
Dissociative Identity Disorder	Emergence of two or more distinct personalities	• Alternatives may vie for control • May represent a psychological defense against severe childhood abuse or trauma
Dissociative Amnesia	Inability to recall important personal material that cannot be accounted for by medical causes	• Information lost to memory is usually of traumatic or stressful experiences • Subtypes include localized amnesia, selective amnesia, and generalized amnesia
Dissociative Fugue	Amnesia 'on the run'; the person travels to a new location and is unable to remember personal information or reports a past filled with false information not recognized as false	• Person may be confused about his or her personal identity or assume a new identity • Person may start a new family or business
Depersonalization Disorder	Episodes of feeling detached from one's self or one's body or having a sense of unreality about one's surroundings (derealization)	• Person may feel as if he or she were living in a dream or acting like a robot • Episodes of depersonalization are persistent or recurrent and cause significant distress

Table 10.4: Overview of dissociative disorders (Adapted from Nevid, Rathus & Greene, 2011, p. 210)

Theoretical explanations for dissociative disorder range from psychodynamic though social-cognitive theory, brain dysfunction and the diathesis-stress model. Treatment options are aligned to the theoretical explanation that the therapist accepts as the causative reason for the dissociative disorder.

According to Nevid et al. (2011) psychodynamic theorists believe that dissociative disorders involve the use of repression which in turn results in the 'splitting off' from consciousness of unacceptable impulse and painful memories. For example, dissociative amnesia may serve an adaptive function of disconnecting or disassociating one's conscious self from awareness of traumatic experiences. Persons with multiple personalities may express unacceptable impulses through the development of Alters; that is, alternative personalities. Social-cognitive theorists believe that dissociative disorders represent a learned response that allows the affected person to acquire psychological distance from

disturbing emotions or memories. The relief offered by the 'distancing process' reinforces the need for the patient to indulge the dissociative disorder. Another explanation for dissociative disorder is brain dysfunction. There is preliminary evidence that there are structural differences in the brain areas that are responsible for memory and emotion between persons suffering from dissociative disorders and those of healthy persons (Vermetten et al., 2006 as cited in Nevid et al, 2011, p. 222). Finally, the diathesis-stress model suggests that certain personality traits – such as the tendency to fantasize and to be suggestible to hypnosis – may predispose individuals to develop dissociative experiences in the face of traumatic abuse. With respect to treatment options, clinicians believe that stress and anxiety are the foundation of dissociative disorders so they focus on treating or managing stress and anxiety in affected persons. Psychoanalysts try to help clients with dissociative disorder uncover the source of the childhood conflicts and traumas. Moreover, this form of therapy encourages getting in touch with the various Alters in order to assist the client.

Session 10.1 Summary

Review

In Session 10.1 the main learning objectives were to train learners to recognize the core characteristics of selected disorders, to list examples of non-psychotic mental disorders, and to become familiar with treatment options for selected disorders. Three types of non-psychotic disorders were reviewed: There were anxiety disorders, somatoform disorders and dissociative disorders. Within each disorder there were subtypes. For example, somatoform disorders include subtypes such as conversion disorder (a change in or loss of a physical function without medical cause); hypochondriasis (preoccupation with the belief that one is seriously ill); somatization disorder (recurrent complaints about illnesses that have no physical basis); body dysmorphic disorder (preoccupation with an imagined or an exaggerated physical defect); and pain disorder (persistent physical pain believed to be associated with psychological factors).

Reflect

SELF-ASSESSMENT EXCERISE

Discuss, with examples how treatment options for specific disorders relate to the theoretical explanation of that specific disorder

In Session 10.2 the focus will be on identifying and explaining various psychotic disorders.

Session 10.2

Common Psychotic Mental Disorders and Treatment Options

Introduction

In Session 10.1 various non-psychotic disorders were document along with a range of treatment options that are generally available for all mental disorders. In Session 10.2 the spotlight switches to the critical examination of the types and characteristics of common groups of psychotic disorders; namely, anti-social personality disorder, schizophrenia and mood disorder. Psychotic disorders were so named because the signs and symptoms displayed by affected persons revealed severe forms of disturbed behaviour that were characterized by an impaired ability to interpret reality and difficulty meeting the demands of daily life. The end result is maladaptive behaviour.

Session 10.2 Objectives

By the end of this session you should be able to:

1. Distinguish between the psychotic and non-psychotic mental disorders presented in the unit notes;
2. List examples of psychotic mental disorders using the unit notes and the recommended resources;
3. Explain why psychotic mental disorders occur in your tutorial sessions;
4. Recognize the appropriate treatments that can be applied to psychotic disorders and apply them to the exercises outlined in the reflective activities;
5. Incorporate the treatment options for improving mental health documented in this unit to the framing of policies to promote protective factors for those most vulnerable to developing mental disorders in your country of residence.

Common Groups of Psychotic Disorders and Their Treatment Options

1. Anti-social personality disorder

You would recall that anti-social personality disorder (ASPD) was covered in Unit 7 which was titled 'Personality, Plasticity and Self'. According to Boyd and Bee (2012) the key features are difficulty forming borderline attachment; lack of empathy; little regard for the rights of others; being self-centered; and willingness to violate the law or social rules to

achieve a desired objective. Similar features are identified by Nevid et al. (2011) included chronic anti-social behaviour, callous treatment of others, irresponsible behaviour, and lack of remorse for wrong doing. Nevid et al. estimated that 3-6% of American men and 1 % of American women suffer from anti-social personality disorder. The authors also revealed that clinicians previously used the term *psychopath* or *sociopath* to refer to people today who have been assessed as possessing anti-social personalities. There is an increased link to criminality by persons with ASPD.

LEARNING ACTIVITY 10.2 • Summative Assessment/Assignment 5

Examine the e-resources cited below of the Norwegian mass killer Andres Behring Breivik who shot at least 77 youths in Norway in 2011. He was found sane by the Court and sentenced to 21 years in prison on 24th August, 2012.

- Daily Mail Reporter. (2012, Aug 13). Norway could have prevented Anders Breivik's slaughter if existing security plans had been acted upon, damning official report claims. *Mail Online* Retrieved from http://www.dailymail.co.uk/news/article-2187734/Anders-Behring-Breivik-word-Norway-mass-murder-trial-rant-Sex-City.html?ito=feeds-newsxml
- Meo, N. Alexander, H. & Mendick, R. (2011, July 24). Norway killings: The laughing gunman who shot 85 young victims, one by one. *The Telegraph*. Retrieved from http://www.telegraph.co.uk/news/worldnews/europe/norway/8657475/Norway-killings-The-laughing-gunman-who-shot-85-young-victims-one-by-one.html
- RT. (2012, April 16). Breivik trial video: 'Norway killer' claims self-defense, cries in court. [Video file]. Retrieved from http://www.youtube.com/watch?v=lGwRKY0NzKM
- ABC News. (2011, Jul 25). Anders Behring Breivik: Video manifesto has camp shooting motive. [Video file]. Retrieved from http://www.youtube.com/watch?v=oql83SSwpY8&feature=related
- Sfidlv09. (2007, Jul 6). Antisocial Personality Disorder. [Video file]. Retrieved from http://www.youtube.com/watch?v=WftbmbVYiCk

From the discussions of the profile of this killer, your knowledge of the course material covered in units 1-10, your own internet investigations and relevant literature from the Open Campus Library answer the following questions.

1. How does your knowledge of social psychology describe the actions of Andres Behring Breivik? (5 marks) (400 words)
2. What does the discipline of developmental psychology state about the behaviour Andres Behring Breivik? (5 marks) (400 words)
3. How does your knowledge of abnormal psychology explain the actions of Andres Behring Breivik? (5 marks) (400 words)
4. What, if any, preventative measures could have been taken to prevent the actions of Andres Behring Breivik? You are required to source and cite two relevant peer reviewed published academic articles to discuss your views. (5 marks, 400 words)

LEARNING ACTIVITY 10.2 • Summative Assessment/Assignment 5 Cont'd

This assignment is worth a maximum of 25 marks and you must not write less than 1600 words. **Your Course Coordinator/ Tutor will indicate to you the date by which your word file with your response for assignment 5 should be uploaded to the drop box in the course site.** Your score will contribute to your final course mark. Further rubrics for this assignment will also be posted in the Learning Exchange.

In terms of explanations for and treatment of ASDP there are some diagnostic difficulties in separating the symptoms and symptoms of anti-social personality disorder and mood disorder. Specifically, "One nagging question is whether personality disorders can be reliably differentiated from Axis I clinical symptoms such as anxiety or mood disorders. For example, clinicians often have difficult distinguishing between obsessive-compulsive disorder and obsessive-compulsive personality disorder." (Nevid et al., 2011, p. 444)

Explanations for ASDP vary across theoretical domains and within theoretical domains. For instance, Otto Kernberg (1975) a leading psychodynamic theorist felt that personality disorder resulted from the failure in early childhood to develop a sense of consistency and unity in one's image of one's self and others. Consequently, affected persons shift in their views of people as either 'all good' or 'all bad'. Margaret Mahler (1977) another modern day psychodynamic theorist explained borderline personality disorder in terms of childhood separation from the mother figure. Psychodynamic theories provide a useful starting point for understanding the development of several types of personality disorders but these theories are limited because they are based on inferences drawn from behaviour and retrospective accounts of adults rather than on observation of children's behaviour.

Learning perspectives focus on maladaptive behaviour instead of highlighting personality disorders. In contrast to the views of the psychodynamic theorists, learning theorists believe that childhood experiences shape the pattern of maladaptive habits of relating to others that constitute personality disorders. Nevid et al. suggested that children who are regularly discouraged from speaking their minds or exploring their environments may develop a dependent behaviour pattern while excessive parental discipline may lead to obsessive-compulsive behaviours. The biological perspective indicates a genetic link to many personality disorders such as antisocial, narcissistic, paranoid and borderline types.

The treatment of personality disorders is difficult as people with personality disorders are typically highly resistant to change possibly because, "People with personality disorders usually see their behaviours, even maladaptive, self-defeating behaviours, as natural parts of themselves. Even when unhappy and distressed, they are unlikely to perceive their own behaviour as causative." (Nevid et al., 2011, p. 456) One reason why treatments can fail, as suggested by Nevid et al., is the view that affected persons may grudgingly agree to treatment at the urging of concerned friends and relatives but the affected persons usually drop out of treatment programs or fail to co-operate with their therapist. Some promising results have been reported using psychodynamic therapy (e.g. Paris, 2008; Clarkin et al. 2007 as cited in Nevid et al. 2011, p. 456). Psychodynamic therapy seeks to raise the awareness of affected persons of how their problems cause problems in their close relationships. The cognitive-behavioural approach to addressing personality problems focuses on changing maladaptive behaviour and dysfunctional

thought, rather than changing the personality of affected persons. Nevid et al. revealed that some antisocial adolescents have been placed, often by court order, in residential and foster-care programs that consist of behavioural treatment components. These programs have concrete rules and rewards for obeying these rules. An example of how cognitive behaviour therapy (CBT) can be beneficial is demonstrated in Activity 10.2

LEARNING ACTIVITY 10.3 •

Please view the YouTube presentation on Cognitive Behaviour Therapy below and post your responses to the following issues in the Wiki.

NHS Choices. (2008, Jun 26). CBT expert. [Video file]. Retrieved from http://www.youtube.com/watch?v=JSO6iAFekPw

1. What are the key elements of the CBT?
2. What types of disorder can be treated with CBT?
3. What did you learn from the CBT that could enable you to empower youths with behavioural problems?

This assignment constitutes part of your formative assessment and you will receive feedback from your tutor on your performance. You will be required to post a 400 word summary of your responses to the questions in the Wiki. Learning activity 10.3 is due by Week 12.

2. *Schizophrenic*

The relevant information that you need to know about schizophrenia can be obtained from the two e-resources identified below. You are encouraged to view them and to make your notes with respect to (1) the features of disorder; (2) the explanations for it; and (3) the treatment options. Please read the relevant material on schizophrenia in your course text Boyd, D. & Bee, H. (2012) *Life-span development*, 6th Ed. Pearson Education, Inc.

Reading & Resources 10.1

TheMentallight. (2010, May 11). Schizophrenia – ABC 20-20 Documentary Part 1. [Video file]. Retrieved from http://www.youtube.com/watch?v=74vTftboC_A&feature=topics

Alzheimer and Dementia in mydevelopmentlab.com (Boyd & Bee, 2012, p. 446).

3. *Mood Disorder*

Mood disorder is of particular relevance to learners who work with vulnerable adults and at risk young people because mood disorders are often linked to suicide or para-suicide (attempted suicide).What exactly is a mood disorder? How can it be differentiated from moodiness which most of us experience at one time or another? Nevid et al. (2011) defined **mood disorder** as a psychological disorder characterized by unusually severe or prolonged disturbances of mood. Moods are feeling states that add colour and spice to our daily existence. For example, one might speak of being in a happy mood, a depressed mood or a relaxed mood. Experiencing negative moods are regarded as perfectly normal.

If an ambitious student obtains a low summative grade on a class assignment he or she is likely to feel disappointed and sad rather than happy or unconcerned about the incident. People with mood disorder experience severe and lengthy disturbances in moods. They can become depressed even when events are going rather well for them. They generally ride an emotional roller coaster while the rest of society can be on an even keel about life's occurrences. In table 10.5 an overview is provided of the various types of mood disorders, their major features or symptoms, and general comments about the disorders. Some of the terms in the bold font in the table are explained in the glossary. Special mention is made of season affect disorder (SAD) which generally occurs in temperate countries as residents complain that they feel glum on wintery grey gloomy days and happy on warm bright days. There is evidence that mood and temperament vary with the seasons and with climate change. Affected persons are usually encouraged to take a vacation to warmer climates while others benefit from 'light therapy' or phototherapy which is the therapeutic use of bright artificial lights to relieve depression caused by SAD.

Type of Disorder	Major Feature or Symptom	Additional Comments
Depressive Disorder		
1. Major Depression	Episodes of severe depression characterized by downcast mood, feelings of hopelessness and worthlessness, change in sleep patterns or appetite, loss of motivation, loss of pleasure in usual activities	Following a depressive episode, the person may return to his or her usual state of functioning, but recurrences are common. Seasonal affect disorder (SAD) is a major type of depression.
2. Dysthymic Disorder	A chronic pattern of mild depression	Person feels 'down in the dumps' most of the time, but is not as severely depressed as in major depression.
Bipolar Disorder		
1. Bipolar Disorder	Periods of shifting moods between **mania** and depression, perhaps with intervening periods of normal mood; two general sub-types are bipolar I disorder (i.e. history of manic episode possible major depressive episode and **hypomanic** episode)	Manic episodes are characterized by pressured speech; flight of ideas, poor judgment, high levels of restlessness and excitability, and inflated mood and sense of self.
	Mood swings that are milder in severity than those in bipolar disorder	

2.	**Cyclothymic Disorder**	Cyclothymia usually begins in late adolescence or early adulthood and tends to persist for years.

Table 10.5: Overview of mood disorders (Adapted from Nevid, Rathus & Greene, 2011, p. 244)

Causative explanations for mood disorder include the complex interaction between biological factors and psychosocial factors. Many of the explanations for depression – such as stressful life events, break up of a relationship, loss of loved one, living in distressed circumstances such as poverty and abuse– are similar to those proposed for the existence of bipolar disorder. According to the website of the (APA) **bipolar disorder** is a serious mental illness in which common emotions become intensely and often unpredictably magnified. Individuals with bipolar disorder can quickly swing from extremes of happiness, energy and clarity to sadness, fatigue and confusion. These shifts can be so devastating that individuals may choose suicide. All people with bipolar disorder have manic episodes — abnormally elevated or irritable moods that last at least a week and impair functioning. But not all become depressed.

Other explanations for bipolar disorder relate to "cognitive deficits in persons with bipolar disorder in recognizing facial cues in emotions of others –deficiencies that appear tied to abnormalities in the workings of the brain's prefrontal cortex and limbic system." (Izard et al. 2009, as cited in Nevid et al., 2011, p. 266) Evidence from a 2008 study conducted with a Swedish sample demonstrated a connection between a higher risk of bipolar disorder and greater paternal age at birth, especially in father's age 55 years and older (Frans et al., 2008, as cited in Nevid et al., 2011, p. 266) There is an important role of psychosocial factors in the treatment of bipolar patients. For example, social support from family members and friends often enhances the functioning of affected persons as it provides them with the social buffer or support against stress and anxiety that contributes to their illness. The treatment options for bipolar disorder are similar to the treatments offered for depression: psychodynamic theory, behaviour therapy, and cognitive therapy although targeted biological approaches involving the use of antidepressant medication or electroconvulsive therapy (ECT) sometimes called shock therapy play a key role. Drug therapy reports positive effects particularly the use of lithium and mood stabilizers.

Food for Thought

Diagnosis and treatment of bipolar disorder located at website

For updates and additional information about bipolar disorder please refer to the two articles below and current articles via the website of the American Psychological Association as indicated below

- Krehbiel, K. (2000). Diagnosis and treatment of bipolar disorder. American Psychological Association. Vol. 31. No. 9. http://www.apa.org/monitor/oct00/bipolar.aspx
- Author unknown. (2008). Consistent routines may ease bipolar disorder. American Psychological Association. Vol. 39. No. 2. http://www.apa.org/monitor/feb08/consistent.aspx

Information from the 2008 article is cited below for your perusal and consideration.

Sleep patterns and consistent daily routines—may provide relief to the nearly 6 million American adults diagnosed with bipolar disorder. In a study of 175 adults with the disorder, clinical psychologist Ellen Frank, PhD, found that patients who participated in a behavioral therapy designed to help them improve regularity in their daily routines averted new manic or depressive episodes longer than patients whose therapy focused just on regulating their mood symptoms and medication.

In the study, the clinicians treated the patients with bipolar disorder once a week until they achieved a stable remission of symptoms. One-half of patients were given interpersonal and social rhythm therapy, in which they used a monitoring device to track their sleep/wake cycles, meal times and physical activity. The other patients went through intensive clinical management, which offered them educational sessions on the disorder, medications and tips on basic sleep hygiene. All patients were also treated with medication-typically lithium-over the course of the 2.5-year study. Frank found that the interpersonal and social rhythm therapy may ease the symptoms of bipolar disorder because it works to regulate the daily routines of these patients, who are often found to have more sensitive circadian clocks. Disruptions in sleep and routine may spur bouts of mania or depression, says Frank, a psychiatry and psychology professor at the University of Pittsburgh, School of Medicine.

A related study by biologist Colleen McClung, PhD, further elucidated the relationship between the circadian system and bipolar disorder. McClung, a psychiatry professor at the University of Texas Southwest Medical Center, studied mice engineered to lack key circadian genes. She found that they behaved similarly to people in a manic state, exhibiting hyperactivity and shortened sleep cycles. It was argued that the circadian system is fundamental to understanding the basic symptomatology of bipolar and unipolar disorders.

The manic depressive episodes that are embedded in bipolar disorder can increase the risk of patients' thoughts or actions that end in suicide or para suicide. How can one identify persons who are at risk of committing suicide? Researchers report that most people who commit suicide give prior indication of their intentions or they previously consulted a heath care provider about their concerns (Luoma, Martin, & Pearson, 2002 as cited in Nevid et al., 2011, p. 280). Most people who attempt suicide (para suicide) may feel hopeless, but they are not insane. They are also not out of touch with

reality. These persons merely lack effective problem solving skills and cannot find alternatives other than suicide or attempted suicide to deal with their concerns. An open discussion of suicide with a depressed person does not prompt the person to attempt suicide but in most cases the discussion can prevent it. Generally people who commit suicide will have made previous unsuccessful attempts. Women are more likely than men to commit suicide but men succeed more than women because they select more lethal means. Nevid et al. (2011) noted that it is the elderly – rather than the young–who are more likely to commit suicide. Despite these academic beliefs about who is at risk it is vital to remember than any person who signals their intention to take their life or who expresses repeated claims of the hopelessness of life should be attended to, offered support and referred to a specialist for counselling.

Session 10.2 Summary

In Session 10.2 the emphasis was on identifying key psychotic disorders and explaining why they occur. The psychotic disorders were grouped into anti social personality disorder; schizophrenic disorder and mood disorder. The detailed information presented contributed to three essential learning goals that enabled you to (1) distinguish between psychotic and non-psychotic mental disorders; (2) list examples of psychotic mental disorders; and (3) recognize and discuss the appropriate treatments that can be applied to psychotic disorders. Treatment options for each psychotic disorder discussed were offered for your consideration. Collectively the information presented in Session 10.1 and Session 10.2 sets the stage for your understanding of the information that will be presented in Session 10.3; namely, identifying some of the disorders that tend to be manifested in specific phases of the human lifespan. For example, learning difficulties first appear in childhood and early adolescence while amnestic disorders such as dementia and Alzheimer's Disease are confined to late adulthood.

Reflect

Reflection

Reflect on what you know about Cognitive Behaviour Therapy by viewing the YouTube Presentation cited below

Pucci, A. (2009, Sep 22). Cognitive-Behaviour Therapy – the ABC of emotions: how our emotions actually work. [Video file]. Retrieved from http://www.youtube.com/watch?v=1AYAJcOcXFE&feature=related

Add the information from the video to your Unit notes as you will be tested on it during a multiple choice on-line quiz.

SELF-ASSESSMENT EXCERISE

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

1. What does the acronym ASPD represent?.....
2. What does the acronym CBT represent? ……
3. List two types of mood disorders.....
4. What does the biological explanation for bipolar disorder state?.....
5. List one treatment option for ASPD……
6. How can the CBT help persons affected with a mood disorder?…….....
7. How can you assist someone who appears to be suicidal?.....
8. What school or other policies are in place in your country of residence to screen children and youths for mental disorders and illnesses?

Session 10.3

Abnormal Behaviour and Disorders In Childhood, Adolescence and Adulthood

Introduction

During the early formative years of the human lifespan individual differences in children determine the pace at which they learn, grow, develop and mature. Because of these differences in development recognising problems related to abnormal behaviour or mental disorder is challenging as parents may believe that a child will eventually 'grow out of it' or that the child is a 'late developer'. It is therefore useful to know what to expect as children mature because undiagnosed problems in childhood will emerge as fully developed disorders in adolescence and early adulthood. In this session an overview will be given for **pervasive development disorder**, mental retardation, learning disorders, communication disorders, **attention-deficit and disruptive behaviour disorder**, anxiety and mood disorder, and elimination disorders. This discussion highlights the disorders that occur in late adulthood as these often relate to the mental and cognitive deficits that accompany the ageing process. By merging the sub-disciplines of developmental and abnormal psychology and addressing the common disorders that are prevalent in childhood, adolescence and late adulthood the insights gained can be used to improve the quality of life of citizens. By the end of this session learners would be in a better positioned to help people and at risk youths to plan and to implement programs (competency YDWCYP0323) to promote healthy lifestyles (competency YDWCYP0513).

Session 10.3 Objectives

By the end of this session you should be able to:

1. Recognize from the session notes the types of disorders that are prevalent during various phases in the human lifespan;
2. Discuss in tutorials the treatment options that might work for disorders that are specific to children, adolescents or adults;
3. Link your knowledge of abnormal psychology and youth development work by recommending relevant policies and intervention programs mentioned in this unit to deal with at risk youths who suffer from mental disorders and posting these in the discussion forum;
4. Incorporate the session resources into the reflective activities on why some disorders are more prevalent in specific phases of the lifespan than throughout the entire lifespan.

Common Disorders in Childhood, Adolescence and Late Adulthood

Childhood and Adolescence

Sessions 10.1 and 10.2 provided you with the foundational knowledge to assist your understanding of the discussion in Session 10.3. For example, you would recall the earlier discussion on social phobias which was defined as a fear of situations where one could be observed or evaluated. Newman and Newman (1983) observed that social phobias begin in late childhood or early adolescence. The authors described the condition as chronic and it produces a cycle that escalates in intensity if untreated. With respect to anxiety disorders, the APA website suggests that although they may begin at any time, anxiety disorders often surface in adolescence or early adulthood. There is some evidence that anxiety disorders run in families and genes as well as early learning experiences within families seem to make some people more likely than others to experience these disorders. However, there appears to be a range of specific disorders that signal their presence in childhood and adolescence. The description and associated features of these disorders are summarised in Table 10. 6

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

Table 10:6: Overview of disorders of childhood and adolescence (Adapted from Nevid, Rathus & Greene, 2011, p. 472)

The treatment options for pervasive developmental disorders vary. Unfortunately, scientists are unsure what causes autism but they agree that there is no cure for autism. Academics believe that, "Early intensive behavioural treatment programs that apply learning principles can significantly improve learning and language skills and socially adaptive behaviour in autistic children." (e.g. Nevid et al., 2011, p. 478; Eikeseth, 2009 as cited in Nevid et al. 2011, p. 478) Biomedical treatments are limited to the use of psychiatric

drugs to control disruptive behaviour. Mental retardation is diagnosed by low IQ scores of 70 and below; impaired functioning in the performance of tasks that are expected of individuals of a particular age; and development of the disorder before the age of 18 years. The cause of mental retardation has been largely attributed to Down Syndrome (formerly called Down's Syndrome) which is characterized by an extra chromosome on the 21st pair of chromosome, resulting in 47 rather than the normal complement of 46. Interventions for mental retardation depend on the severity of the retardation as children with severely disruptive or aggressive behaviour are often institutionalized. A consequence of mental retardation is the development of other psychiatric disorders such as anxiety and depression. Learning disorders are usually treated with specialist fluency therapy to improve either speech or reading while psychological counseling is recommended for anxiety and other emotional problems linked to learning disorders. Attention-deficit disorders are discussed in great detail below. Although all children experience some amount of fear and anxiety while growing up, excessive anxiety or fears leading to phobias require intervention and treatment. Children who are physically, verbally or sexually abused are particularly at risk of developing fears, anxiety, and depression. Treatment options can range from counseling, drug therapy and the use of cognitive-behaviour therapy – previously mentioned in this Unit.

The academic literature lists additional disorders than those that are summarized by Nevid et al. You are encouraged to read as extensively as possible about these topics using the information from the website of the APA. Activity 10.3 on 'Child of Rage – Reactive Attachment Disorder' illustrates the key points that you should note when reading or viewing the video material relating to childhood disorders. The key points relate to first, what are the underlying features of the disorder; second, what explanations are offered by the experts for the disorder; and third, how can the disorder be treated.

LEARNING ACTIVITY 10.4 • Tutorial Discussion

Please view the YouTube presentations cited below.

Rivetingtalechap. (2009, Sep 27). Child of rage- The documentary (Part 1). [Video file]. Retrieved from http://www.youtube.com/watch?v=ME2wmFunCjU&feature=related

Rivetingtalechap. (2009, Sep 27). Child of rage- The documentary (Part 2). [Video file]. Retrieved from http://www.youtube.com/watch?v=H55Oz92Kh-A

Discuss in your tutorial group.

1. The key points presented in the video.
2. Link the material presented in any of the units of this course to the information presented in the video.
3. Document using the ideas from the video presentation the relevant information that could inform a policy designed to improve the behaviour of children labelled as 'disruptive' in the schools in your country of residence. **Learning activity 10.4 is due by Week 12.**

Special consideration is also given to Attention-Deficit Hyperactive Disorder (ADHD) because of the increasing incidence of this disorder among children and adults in the Caribbean region. Please click on the following e-resources if you would like to read more about incidence of ADHD in the region.

Useful Link/Resources

Caribbean Centre for Child Development http://www.caribbeancenter.org/

Pottinger, A.M., La Hee, F., & Asmusm K. (2009). Students admitted to university who fail: hidden disabilities affecting students' performance. *West Indian Medical Journal*,58 (2). Retrieved from http://caribbean.scielo.org/scielo.php?script=sci_arttext&pid=S0043-31442009000200005&lng=en&nrm=iso

American Psychological Association. (year unknown). What Parents Should Know About Treatment of Behavioral And Emotional Disorders in Preschool Children. Retrieved from http://www.apa.org/pubs/info/brochures/kids-meds.aspx#

A short summary of ADHD is presented below.

Attention-deficit hyperactivity disorder (ADHD)

ADHD is a behavioral condition that makes focusing on everyday requests and routines challenging. The APA's website is very informative and provides updates to the disorder. The notes cited from the APA below are accompanied by the e-references.

"People with ADHD typically have trouble getting organized, staying focused, making realistic plans and thinking before acting. They may be fidgety, noisy and unable to adapt to changing situations. Children with ADHD can be defiant, socially inept or aggressive. Families considering treatment options should consult a qualified mental health professional for a complete review of their child's behavioral issues and a treatment plan. One form of drug therapy that is being used is Ritalin but it is not without controversy as discussed below.

Although some worry that medications like Ritalin are being over-prescribed, research shows that they help kids with ADHD. The most common treatment for attention-deficit hyperactivity disorder (ADHD) in both children and adults is stimulant medication, such as Ritalin. Taking this medication typically results in fast—but temporary—improvements in both performance and social interaction. Most people with ADHD need extra help, however. In addition to medication, they can benefit from parent education, family therapy and supportive interventions. In up to 90 percent of cases, stimulant medication helps children improve their approach to schoolwork, get more focused and organized, think before acting, get along better with others and break fewer rules. They often seem happier, too. Despite these benefits, some concerns remain. Some worry that medication sends the wrong message, discouraging children and their parents from focusing on building problem-solving skills. Others note that as eligibility criteria expand, the number of prescriptions are skyrocketing—suggesting that some children are being misdiagnosed. In the end, the cost/benefit analysis favors the use of stimulant treatment for children with ADHD. There is little evidence of harm. And the treatment is effective." Source: http://www.apa.org/topics/adhd/ritalin-debate.aspx

Is there a gender differences in ADHD? Source http://www.apa.org/topics/adhd/gender.aspx

> **"Girls with ADHD aren't usually hyperactive. Instead, they tend to have the attention-deficit part of the disorder.** *The stereotype of someone with attention-deficit hyperactivity disorder (ADHD) is a hyperactive little boy. The reality? ADHD also affects girls and even adult women. Parents, teachers and others often overlook ADHD in girls, because their symptoms differ from those of boys. Girls with ADHD aren't usually hyperactive, for example. Instead, they tend to have the attention-deficit part of the disorder. According to researchers,* **girls with untreated ADHD are at risk** *for low self-esteem, underachievement and problems like depression and anxiety. They're also more likely to get pregnant and start smoking while still in middle or high school. What's worse, girls with untreated ADHD typically carry their problems into adulthood.* **Women with untreated ADHD** *are also more likely to have children with ADHD. In fact, many women finally receive a diagnosis when their children are diagnosed.* **Treatment options** *for women with ADHD include a combination of stimulant medication and ADHD-focused therapy. For girls, stimulant medication, family therapy and other intervention also help."*

Adulthood and Late Adulthood

Boyd and Bee (2012) stated that based on empirical evidence emotional disturbance is higher in early adulthood than in middle age. They attribute this trend to the fact that in early adulthood individuals have the highest expectation of their lives. Falling short of achieving expectations or the goals set out for self actualization can lead to anxiety and depression. In addition the higher levels of role conflict and role strain that occur as new roles are acquired (e.g. spouse, partner, employee) can be accompanied by stressors associated with these new roles. With ageing the disorders that occur are depression and anxiety brought on by the death of a spouse or life partner. More about this can be clicking Watch the Videos *Death of a Spouse* in mydevelopmentlab.com (Boyd & Bee, 2012, p. 507) and Watch the Videos *Depression in Later Life* in mydevelopmentlab.com (Boyd & Bee, 2012, p. 448). Other disorders that occur in late adult hood include amnestic disorders such as dementia and Alzheimer's Disease. Watch the video *Alzheimer and Dementia* in mydevelopmentlab.com (Boyd & Bee, 2012, p. 446).

LEARNING ACTIVITY 10.5 • Tutorial Discussion

Please view the following video presentations which provide examples of disorders that occur during late adulthood.

1. TheMentallight. (2010, May 11). Schizophrenia – ABC 20-20 Documentary Part 1. [Video file]. Retrieved from http://www.youtube.com/watch?v=74vTftboC_A&feature=topics
2. *Alzheimer and Dementia* in mydevelopmentlab.com (Boyd & Bee, 2012, p. 446).
3. University of California Television. (2011, Jan 20). Neuropsychological testing and cognitive aging, University of California. [Video file]. Retrieved from http://www.youtube.com/watch?v=yVnap3TKyF4&feature=related
4. *Death of a Spouse video* in mydevelopmentlab.com (Boyd & Bee, 2012, p. 507)
5. *Depression in Later Life video* in mydevelopmentlab.com (Boyd & Bee, 2012, p. 448)

LEARNING ACTIVITY 10.5 • Tutorial Discussion Cont'd

Students in each tutorial group must be divided into sub-groups. Each sub-group must view any one of the five video presentations and be prepared to make a presentation to the tutorial group based on the three statements listed below. After the discussions, one member of the group must post a 300 word summary for the video viewed. **Learning activity 10.5 is due by Week 12.**

1. The key points presented in the video.
2. Link the material presented in the video to any of the theories, concepts, and findings outlined in the previous units of this course; that is, Units 1-9.
3. Document using the ideas from the video presentation the relevant information that could inform a policy designed to improve the quality of life and care of the citizens in your country of residence.

Session 10.3 Summary

Reflect

To help you to think critically about the potential for abnormal psychology to explain both normal and abnormal behaviour and to inform policy creating and evaluation critically think about the following questions.

- ◊ Why is it necessary to consider the academic literature on abnormal behaviour and disorders as explanations for children labeled 'troublesome' or 'disruptive' in our nation's schools?
- ◊ How can your knowledge of developmental and abnormal psychology be used to inform national policies on physical and mental well being?

Review

Key Points

1. To distinguish between children's abnormal behaviour and their normal range of growing up experiences consult the check list present in Table 10.6 that provided a description and lists the major features of some common disorders that occur in childhood and adolescence.
2. The major disorders associated with childhood and adolescence that were covered in Session 10.3 were pervasive development disorder, mental retardation, learning disorders, communication disorders, attention-deficit and disruptive behaviour disorder, anxiety and mood disorder, and elimination disorders. Information on Attention-deficit hyperactivity disorder (ADHD), reactive attachment disorder.
3. A multi-media approach was used to present information related to schizophrenia, Alzheimer and dementia; the latter are normally manifested in late adulthood.

Key Points

4. Although there are universalities in the underlying psychological mechanisms and subjective experiences of some of the abnormal behavioural and disorders discussed, culture and gender play a role in the behavioral manifestations of these behaviors and disorders. For example, the universal symptoms of schizophrenia include lack of insight, auditory and verbal hallucinations, and ideas of reference. Cross-cultural differences occur in the domains of rate of recovery and in the manifestations or the expressions of symptoms. The discussion on ADHD highlighted gender differences in how the disorder is manifested in males and females.

Unit Summary

Unit 10 comprised three sessions during which the focus of attention was on non-psychotic mental disorders, psychotic mental disorders, and their respective treatment options. The use of a multi media approach was adopted to convey technical information and concepts that are unique to abnormal psychology and to encourage you to think critically, reflectively and constructively about abnormal psychology. The incorporation of YouTube videos into the Unit discussion was designed to bring the topic of abnormal psychology to life, to demonstrate how the signs and symptoms of specific mental disorders are manifested in particular stages of the human life span, and to present contemporary perspectives on treatments, their successes and limitations.

In Session 10.1 the discussion began by identifying the major type of professionals (e.g. clinical psychologists, counselling psychologists, psychiatrists, psychoanalysts, psychiatric nurses and social workers) who are trained to apply the various classifications of mental disorders documented in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Some of the features of particular disorders and abnormal behaviours were documented throughout Units 8, 9 and 10 so learners are also equipped to recognise these disorders and abnormal behaviour. An overview of the major types of psychotherapies and their approaches was provided. This comprised classical psychoanalysts, modern psychodynamic approaches, behaviour therapy, humanistic client-centred therapy, Ellis's rational emotive behaviour therapy, Beck's cognitive therapy and the popular cognitive-behavioral therapy (CBT). The knowledge of treatment options was incorporated into the discussion of the common groups of non-psychotic disorders: Anxiety disorders, somatoform disorder, and dissociative disorders.

In Session 10.2 the focus of attention was placed on common psychotic disorders, their causes, treatments and some of the difficulties in their diagnoses. The disorders presented were antisocial personality disorder, schizophrenic disorder, and mood disorder. Mention was made of the link between mood disorder and suicide as well as para suicide or attempted suicide. Two main types of mood disorder were reviewed; namely, depressive disorders comprising major depression and dysthymic disorder and bipolar disorders comprising bipolar disorder and the less severe version labeled cyclothymic disorder or cyclothymia.

In Session 10.3 the goal was to illustrate the link between developmental psychology and abnormal psychology by listing and reviewing some of the major disorders and abnormal behaviour that the academic literature identifies as being associated with specific stages of the life span. An overview was presented of the disorders that are common in childhood and adolescence. These are pervasive developmental disorders, mental retardation, learning disorders, communication disorders, attention-deficit and disruptive behaviour disorders, anxiety and mood disorders, and finally elimination disorders. With respect to the stage of late adulthood, video presentations were given on dementia and Alzheimer.

Throughout Unit 10 the approach taken was to link theory and practice. The theoretical perspectives in Sessions 10.1 and 10.2 were linked to contemporary issues such as controversial treatment options, new data on mental health issues that concern the Caribbean region particularly the increasing incidence of ADHD in adults and children. Mydevelopmentlab.com activities and readings from electronic resources were incorporated in the Unit. This multi-media approach to course delivery served to bring the text material to life, to help learners to understand and to remember key points and concepts, and most importantly to relate the main ideas to real world situations.

The key learning objectives of Unit 10 served to provide the competencies, skills set and knowledge base to allow learners to assist all citizens, particularly youths and vulnerable persons, to become active and responsible citizens (competency YDWCYP0263). Learners will now be able to work with other professionals in their field to contribute to the development and implementation of a national youth policy (competency YDWCYP0293) and to plan and implement programmes to promote healthy lifestyles among youth (competency YDWCYP0513). There is much more that could be written and discussed about abnormal psychology. You are strongly encouraged to continue to explore and to read the rich relevant literature that is available in the Open Campus Library and in your course text book, Boyd, D. & Bee, H. (2012) *Life-span development*, 6th Ed. Pearson Education, Inc.

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Glossary of Terms Used in Unit 10

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.
Adjustment Disorder	A maladaptive reaction to an identified stressor, characterized by impaired functioning or emotional distress that exceeds what would normally be expected.
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.
Anxiety	An emotional state characterized by physiological arousal, unpleasant feelings of tension, and a sense of apprehension or foreboding.
Anxiety Disorder	A class of psychological disorders characterized by excessive or maladaptive anxiety reactions.
Asperger's Disorder	A pervasive development disorder characterized by social deficits and stereotyped behaviour but without the significant language or cognitive impairment associated with autism.
Autism	A pervasive developmental disorder characterised by failure to relate to others, lack of speech, disturbed motor behaviours, intellectual impairment, and demands of sameness in the environment.
Childhood Disintegrative Disorder	A pervasive developmental disorder involving loss of previously acquired skills and abnormal functioning following a period of apparently normal development during the first 2 years of life.
Conflict	An incompatibility of motives or goals.

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.
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.
Dissociative Amnesia	A dissociative disorder in which a person experiences memory loss without any identifiable organic cause
Dissociative Fungue	A dissociative disorder in which one suddenly flees from one's life situation, travels to a new location, assumes a new identity, and has amnesia for personal material
Dissociative Identity Disorder	A dissociative disorder in which a person has two or more distinct, or alter personalities. It is assumed that multiple personalities emerge within the same person, with each having its own well-defined traits and memories.
Hypomania	A relatively mild state of mania
Hysteria	A condition characterized by paralysis or numbness that cannot be explained by any underlying physical cause.
Major Depressive Disorder	A severe mood disorder characterized by major depressive episodes
Mania	A state of unusual elation, energy and activity.
Mood Disorder	Psychological disorders characterized by unusually severe or prolonged disturbances of mood.
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
Pervasive Developmental Disorders	A class of developmental disorders characterized by significantly impaired behaviour or functioning in multiple areas of development
Phobia	Is a persistent irrational fear of an object, situation, or activity that the person feels compelled to avoid.
Post Traumatic Stress Disorder	A prolonged maladaptive reaction to a traumatic event.

Psychopathology	The scientific study of mental disorders; features of people's mental health considered collectively such as ageism, family discord, domestic abuse.
Psychotherapy	A structured form of treatment derived from a psychological framework that consists of one or more verbal interactions or treatment sessions between a client and a therapist.
Psychotic	Relating to, denoting or suffering from a psychosis or a psychotic disturbance.
Psychosis	This refers to a severe form of disturbed behaviour characterized by impaired ability to interpret reality and difficulty meeting the demands of daily life.
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.
Social Phobia	A fear of situations where one could be observed or evaluated.
Somatoform Disorders	Disorders characterized by complaints of physical problems and symptoms that cannot be explained by physical causes.
Stressor	This represents any unusual or intense demand.
Stress Response	The non-specific response of the body to any demand.
Trauma	Mental and physical injury