

Psychopathology I

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INVESTICE DO ROZVOJE VZDĚLÁVÁNÍ

Meaning of the Icons in the Text



Objectives

A list of objectives is provided at the beginning of each chapter.



Time Demands

An estimate of how much time you will need to study the chapter.



Terms to Remember (Key Words)

A list of important terms and main points that the student should not omit when studying the topic.



Practical Application of the Subject – Tasks, Activities

Miscellaneous less important or clarifying information in a note.



Review Questions

Verifying to what extent the student has understood the text and the issue and remembers fundamental and important information.



Summary

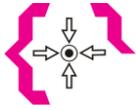
A summary of the topic.



Literature

Used in the text and to complement and further one's knowledge.

1 Introduction to Psychopathology



Objectives

After studying this chapter you will be able to formulate criteria to determine the normalities and abnormalities of human behaviour and lived experience. You will learn the theories on the causes of mental disorders.



Terms to Remember (Key Words)

- maladaptation
- stigmatisation
- normality
- abnormality
- statistical norm
- social norm

1.1 The Subject of Psychopathology

Psychopathology deals with the description of abnormal manifestations of the human psyche and categorises mental illnesses and their symptoms. It is the study of pathological mental phenomena dealing with the symptoms and classification of mental illnesses.

Psychopathology focuses on disorders of the **psyche**, which, under optimal conditions, serves for successful **adaptation** of a person to life's demands. Mental disorders occur in connection with a lower or insufficient ability to adapt. In such cases, we talk about **maladaptation** – the failure of the organism to create effective interactions with its surroundings during ontogeny.

1.2 Defining the Norm

The border between 'normal' and 'abnormal' psychological behaviour is quite fluid. Everyone has probably experienced something unusual, has behaved inappropriately, or has shown some symptoms from the field of psychopathology.



Atkinson (2000) says that almost half of Americans experience, at least once in their lifetimes, a serious mental or emotional problem that could be diagnosed as a mental disorder.

The determination of a diagnosis of a certain mental disorder can lead to **stigmatisation**:

- The society creates prejudices towards people with a mental-disorder diagnosis, assigns them negative characteristics, and assesses them negatively.
- The person identifies with his/her diagnosis.

Experts working with people suffering from mental disorders should avoid the general categorisation of patients into groups of e.g. 'schizophrenics', 'phobics', etc., as these labels lead to the distorted notion that all people with a certain diagnosis are the same in all aspects of life. No matter how well defined it may be, a disorder says hardly anything about the person as a sufferer of the disorder, about his/her personality, lifestyle, or the environment he/she lives in (Smolík, 2002).

1.2.1 Defining Normality

Normality can be defined as a set of characteristics indicating mental health (Atkinson, 2000):

- **Adequate perception of reality:** The person is quite realistic when estimating his/her reactions and abilities and interpreting things happening around him/her.
- **Ability to control one's behaviour:** Behaviour is not a result of uncontrollable impulses; the person has his/her behaviour under control.
- **Self-respect and acceptance:** Well-adapted people have adequate self-confidence and feel accepted by the people around them.
- **Ability to create emotional relationships:** The person creates close and satisfying relationships, is perceptive of the feelings of



other people, and does not place excessive demands on others to satisfy his/her needs.

- **Activeness:** The ability to apply one's abilities in a meaningful activity; the person likes life and does not need to be forced to fulfil the demands of a normal life.

A norm can be perceived as a certain **optimal condition** or a kind of **ideal** whose achievement we strive for. The concept of a norm as an ideal condition defines the best possible option that seems available and is realistically achievable. The ideal becomes the objective of where one is headed, but we cannot take it as an evaluating criterion when assessing a person's common behaviour.

1.2.2 Defining Abnormality

The definition of abnormality can be determined with respect to various criteria (Atkinson, 2000):

- **Deviation from the statistical norm:** Abnormal behaviour is statistically rare and is different from the prevailing average of the majority. The use of the statistical norm can be misleading, because an exceptionally intelligent or exceptionally happy person could be classified as abnormal.
- **Deviation from the social norm:** Every society creates criteria for acceptable behaviour and creates social norms. Behaviour deviating from these norms is considered abnormal. Behaviour considered normal in one society (e.g. women have their hair uncovered in public) may not be tolerated in another. What is deemed abnormal also changes over time; several decades ago, homosexuality was considered a deviation that had to be treated, while society today allows same-sex couples to enter into a registered partnership.
- **Maladaptive behaviour:** This criterion determines abnormality by assessing how behaviour affects the well-being of an individual or a social group. Abnormal behaviour is maladaptive, has an adverse effect on an individual or society, and does not fulfil its purpose. Normal behaviour is considered to be appropriate for the situation and brings the desired effect.



- **Personal difficulties:** This criterion involves subjective feelings. There can be a missing feeling of harmony in life, mental suffering, anxiety, etc.

When assessing abnormality, it is necessary to consider all of the abovementioned criteria, because none of them used on their own can reliably determine abnormality.

According to the American Psychiatric Association definition, the behaviour of an individual is considered a manifestation of a mental disorder if it fulfils all of the three conditions below (Kassin, 2004):

1. The individual is experiencing strong pain or anxiety, is unable to work, and is threatened with an increased risk of death or loss of freedom in important areas of life.
2. The source of difficulties is in the individual or caused by biological factors, acquired habits or mental processes, and it is not a common reaction to specific life events, such as the death of a loved one.
3. It is not a purposeful behaviour in reaction to a situation that includes poverty, prejudices, governmental policy or other difficult topics discussed in the society in question.

If we want to evaluate any strange behavioural manifestation, we also have to take into account (Vágnerová, 2004):

- **The personality of the individual:** People perceive identical situations differently and react differently to them in a way that is typical to themselves.
- **The situation:** According to the context of the situation, the same behaviour could be considered normal in one case and inappropriate in another.
- **The environment in which the person lives:** Through social learning, people acquire the behavioural patterns which they commonly meet in their immediate environment and which they consider normal. However, in another environment they may seem ineffective or even maladaptive.



1.3 Developmental Mechanism of Mental Disorders

The development of mental characteristics and functions and their common, less common and pathological versions depends on many factors, particularly on the interaction of congenital disposition and the effect of environmental influences.

1.3.1 Heredity

One's genetic endowment (**genotype**) determines the extent of the risk of a mental deviation, and its particular manifestation (**phenotype**) depends more or less on external environmental effects.

For all mental disorders, the extent of genetic predisposition, or **heritability**, is important. In general, the more serious the genetic conditioning, the less environmental influences will apply. In some disorders it is very hard to determine the extent of heritability, as particular psychological behaviours are always the result of long-term relationships between a set of hereditary dispositions and external environmental factors.

A disposition toward the onset of a mental disorder can stem from several possible genotypical factors, e.g. **types of heredity** (Vágnerová, 2004):

- disorder of the number or structure of chromosomes,
- disorder of the function of one gene pair,
- polygenic inheritance which is linked to the joint effect of a larger, not exactly determined number of genes.

The heredity of many mental disorders can be labelled as **heterogeneous**, i.e. various genes can contribute to their onset and the method of hereditary transmission can also be different.

An increased disposition toward a mental illness, so-called **vulnerability**, will more likely contribute to the onset of a disorder:

- increased vulnerability,
- stable congenital sensitivity or a disposition toward a certain way of processing stressors, respectively,



- a risk factor for the onset of mental disorders.

1.3.2 Environmental Influences

Environmental influences are realised by the mechanism of **learning**, i.e. by acquiring experience. They also include the effects of the environment's physical and chemical makeup, which can affect physical development. In terms of time, they can be divided into (Vágnerová, 2004):

- **Pre-natal effects**, known as **teratogenic** if harmful to the development of the foetus, with the effect of the teratogen being the most severe in the first three months of pregnancy;
- **Post-natal effects**, affecting the mental development of the child after his/her birth. The mental development of the child in the post-natal period is affected primarily by the **social environment**, i.e. by people among whom the child is growing up, in particular the family, peer group, school, and the environment of the child's place of residence.

The social environment affects the child through interpersonal contact and relationships which can be the source of **stressful** (negative) and **protective** influences. The significance of the family is higher in childhood than in adulthood, because during this period the possibility of choosing the environment in which the individual lives is limited. Due to their dependence and defencelessness, children can easily become victims of a pathological family system. On the other hand, a satisfactory family environment can lessen the risk of mental illness.

1.3.3 Theories on the Causes of Mental Disorders

There are various views on the mechanism of the development of mental disorders, and individual theories explain the causes of mental disorders in a different way (Atkinson, 2000):

The biological view or the medical model emphasises the idea that mental disorders are caused by physical disorders, including genetic deviations, abnormalities in specific parts of the brain, neurotransmitter disorders, and problems in the functioning of the autonomous nervous system. The



proponents of the biological view prefer using medication for the purposes of treatment.

The proponents of the medical model have proven in several studies that in people suffering from depression, there can be abnormalities in the number of receptors of nerve cells and their sensitivity to serotonin and noradrenalin can be lower, in particular in the areas of the brain that contribute to the regulation of emotions. Therefore, medical treatment focuses on the utilisation of preparations that increase the level of serotonin, resulting in the promotion of a better mood.

The psychoanalytical view emphasises the significance of unconscious conflicts that usually stem from early childhood. A person coping with anxiety caused by suppressed impulses and emotions uses unconscious defence mechanisms. Moving conflicts and emotions from unconsciousness to consciousness should remove the maladaptive use of defence mechanisms and thus the mental disorder.

Psychoanalytical theories interpret depression as a reaction to a loss. Regardless of the essence of the loss (loss of a loved one, loss of social standing), a depressed person reacts to it so intensely because the current situation brings forward the suppressed worries about earlier losses the person experienced in childhood, in particular the worry of losing the love of his/her parents. For some reason, the individual's need for love and care was not satisfied in childhood. The person regresses back to the period when the original loss happened in which he/she felt helpless and dependent. Therefore, the behaviour of a depressed person partially represents a crying out for love – he/she shows helplessness and a desire for love and safety.

The behavioural view investigates how fear is conditioned in specific situations and what role the strengthening of the reaction plays in the origin and persistence of maladaptive behaviour. The behavioural approach views mental disorders in terms of the theory of learning and assumes that maladaptive behaviours are learned and therefore can be unlearned or relearned using suitable techniques.

For instance, behaviourists explain the cause of phobias with classical and operant conditioning. Many phobias begin after experiencing a traumatic event, e.g. a phobia of dogs begins after being attacked by a dog. Originally a neutral stimulus (dog) is connected to a traumatic event (attack) which causes anxiety.



Through classical conditioning, the originally neutral stimulus can cause an anxious reaction. A person generalises this experience and starts avoiding the subject of the phobia (dogs), because then the anxiety is not increased. Some phobias are the result of social learning or imitating. Anxious parents tend to have anxious children, as by observing their parents, the children learn to react fearfully without having their own negative experience with the subject of the phobia.

The cognitive view suggests that the causes of some mental disorders are based on disrupted conscious cognitive processes. It is important how people think, how they perceive and evaluate stressful situations, and what strategies they use to cope with these situations. Mental disorders can be alleviated by changing the erroneous cognitive processes.

An example of the cognitive approach is rational emotive therapy by Albert Ellis, according to whom the decisive factor of the mental disorder is not the stressful situation (splitting from a partner), but how the event is perceived and interpreted by the person ('no one will ever love me again', 'I don't deserve love', or 'my whole life is in ruins, it will never be better'). The therapy is based on discussions about these irrational beliefs during which people think about themselves in a self-deprecating manner and which cause emotional disturbance (anxiety, depression). During treatment, the client creates a rational, healthy set of opinions leading to a change in thinking about him/herself and subsequently to a change in behaviour and experiencing the world (Prochaska and Norcross, 1999).

Each approach focuses on mental disorders from a different viewpoint, but none satisfactorily explains them fully. However, the theories on the causes of mental disorders are a starting point for various **therapeutic techniques**. In practice, therapists often experience that a treatment based on one theory is insufficient or does not work as it should according to the theoretical assumptions. The solution is to integrate individual approaches into a comprehensive view of the client's problem in which various treatment methods (medication, psychotherapy, adaptive behaviour training, etc.) are combined.



Review Questions

1. If you had certain unusual experiences, when would you seek professional help?



2. Explain the term 'maladaptation'.
3. What criteria can we use when assessing normality (mental health)?
4. With what mechanism does the environment influence the cause of mental disorders?
5. Explain the cause of phobias according to the behavioural view. Is this theory in accordance with your own personal experience?



Literature

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2 Disorders of Individual Mental Functions



Objectives

After studying this chapter you will have an overview of the disorders of individual mental functions, you will learn to discern between psychological symptoms and syndromes, and you will learn a large number of the psychopathological terms.



Terms to Remember (Key Words)

- | | | |
|-----------------|---------------------|-----------------------|
| ▪ symptoms | ▪ thought disorders | ▪ emotional disorders |
| ▪ syndromes | ▪ speech disorders | ▪ behavioural |
| ▪ consciousness | ▪ attention | |



- | | | |
|------------------------|------------------------|------------------------------|
| disorders | disorders | disorders |
| ▪ perception disorders | ▪ volitional disorders | ▪ instinct control disorders |
| ▪ memory disorders | | |

2.1 Types of Disorders and Their Causes

Partial mental-function disorders are **symptoms** which are usually not present on their own, but combined with various other symptoms make up **syndromes** that are typical representatives various mental illnesses. In the following sections, we will describe the individual partial symptoms.

2.1.1 Consciousness Disorders

Consciousness is the essential mental function which enables the origination and functioning of other mental phenomena. It is manifested as an extension of vigilance, the ability to receive stimuli, be aware of them and react to them. A good state of consciousness is conditioned by the functioning of a large number of brain structures and connections. Its disorders can be divided into quantitative and qualitative (Svoboda, 2006).

Quantitative consciousness disorders represent various degrees of loss of vigilance until its complete absence.

- **Somnolence** is a state of lower vigilance accompanied by hypersomnia.
- **Sopor** is manifested by a deep sleep from which it is very difficult to be roused. This can be done only through intensive stimuli and for a short period of time, after which the patient falls back asleep.
- **Coma** is a state of unconsciousness from which one cannot be roused and during which the basic reflexes are absent. Its depth is assessed by a neurologist.

In **qualitative consciousness disorders**, the disruption of some mental functions with preserved vigilance is typical. They are manifested by changes in lucidity, disorientation, confusion, or a loss of control over one's reactions.



- **Amentia (confusion)** is disorientation caused by disturbed perception and thinking.
- **Delirium (acute mental confusion)** is a state caused by organic damage to the brain. It manifests itself in an overall disturbance of mental function, disquiet (or inhibition), and disorientation with regard to memory and one's own experiences. Delirium tremens is a typical condition, a symptom of withdrawal syndrome in chronic alcoholics.
- **Obnubilation (syncope state)**, contrary to delirium, begins and ends suddenly. The patient tends to be active or numb, disoriented, cannot control his/her behaviour, and usually does not remember having an episode (amnesia). This disorder is typical of epilepsy or after a head injury.

2.1.2 Attention Disorders

Attention is a function that promotes focused consciousness and is a condition for the efficient operation of other, particularly cognitive, functions. Its disorders lie in the inability to concentrate adequately on a stimulus.

- **Hypoprosexia** is a limited focus of attention. It is usually present in depressed individuals and in people in the beginning stages of dementia.
- **Hyperprosexia** is a pathologically increased focus of attention on a certain area. It is rarer, for instance in paranoid disorders (Vágnerová, 2004).

2.1.3 Perception Disorders

In perception, a physical stimulus is transferred in a piece of information called a **percept**. Different individuals can process the same stimulus into a completely different percept based on many individual characteristics that influence their perception: an individual's past experience, the state of neural pathways and the respective brain centre, emotions, memory and fantasy. The respective perception disorders have various causes and varying degrees of severity (Svoboda, 2006).

- **Illusions** represent the distorted perception of realistically acting stimuli. Typically they appear during exhaustion and some emotions (fear), but also in serious mental disorders (the illusion of an impostor). In children, they



are quite often combined with magical thinking (fairy-tale figures appear in the dim light of the bedroom).

- **Hallucinations** are apparent (false) percepts that originate without a realistic stimulus affecting a sensory organ. They are a serious psychiatric symptom that substantially deforms the perception of reality. They are common in psychotic illness, for instance in schizophrenia. However, they can appear in alcohol and drug intoxication and in some unusual situations (artificially caused – by sensory deprivation or hypnotic suggestion; 50% of widowed people hear the voice of their deceased partner; after amputation, people feel phantom pain in the amputated limb). Hallucinations can be classified according to the sensory modalities the disorder relates to:
 - ✓ **Auditory** hallucinations are often colloquially called 'voices' by patients. This is a condition where the patient hears his thoughts as voices and believes that they come to him/her 'from the outside'. The 'voices' are often of an imperative character and are typical mainly in psychotics.
 - ✓ **Visual** hallucinations often appear in psychoses, brain disorders, migraines, alcohol withdrawal (for instance, alcoholics experiencing delirium tremens typically have hallucinations of small rodents and dwarves), and intensified captivation of religious followers (a vision of the Virgin Mary on an altar).
 - ✓ **Tactile** hallucinations can for instance be in the form of an insect crawling over the body (during alcohol withdrawal in alcoholics or from cocaine intoxication). In schizophrenic disorders, hallucinations of sexual intercourse can appear.
 - ✓ **Olfactory and gustatory** hallucinations are frequent in organic disorders (lesions on the temporal lobe are associated with hallucinations of being burned). In psychotics they are present in combination with persecution or paranoid delusions (they smell poisonous gases, taste poisons in food, and are convinced that someone wants to poison them).
 - ✓ **Pseudohallucinations** are hallucinations where a person is aware that they are the product of his/her ill psyche and not reality.
- **Gnostic or recognition disorders** are displayed by the inability to recognise stimuli despite an undamaged analyser. A person often sees an object, but cannot recognise what it is. The disorder is either partial



(dysgnosia) or full (agnosia) and is usually the result of an injury or cerebrovascular accident.

2.1.4 Memory Disorders

Memory is the ability to receive, store and recall past experiences. Its disorders can happen at various stages of the memory process and have various causes. **Registration disorders** can be caused by a lower quality of consciousness or attention, anxiety, fatigue, depression, intoxication or psychosis. **Retention disorders** (preserving information in memory) can be the result of an organic disorder, dementia or alcoholism. **Recall disorders** can be related to a head injury, dementia or mental shock. According to the degree and quality of impairment, one can discern between the following recall disorders (Vágnerová, 2004):

- **Hypomnesia** is a decrease in memory performance.
- **Amnesia** is a total loss of memory.
 - ✓ **Partial amnesia** is a loss of memory for a limited period of time. Examples include memory gaps after a concussion or a 'blank' (palimpsest) after alcohol intake.
 - ✓ **Full amnesia** is rare, usually occurring in dementia.
 - ✓ **Anterograde amnesia** is the inability to recall the events before a head injury.
 - ✓ **Retrograde amnesia** is a loss of memory of the events between the time of injury and regained consciousness.
- **Paramnesia** refers to memory deviations in terms of inaccuracies or too much certainty. We encounter it particularly in children or in witness testimonies.
- **Confabulation** is the replacement of memory loss with fabricated events. This disorder is common among dementia patients.
- **Hypermnesia** relates to the deepening of a certain memory. These are usually unpleasant, evil or humiliating thoughts that frequently return and repeatedly force themselves into consciousness (e.g. pangs of conscience).



2.1.5 Thought Disorders

We can discern between quantitative and qualitative disorders. **Quantitative thought disorders** are displayed by a change of pace or focus of thought (Svoboda, 2006).

Thought pace disorders include:

- **Bradypsychism** is a slower thought pace connected with slow recall, difficulty concentrating and tiring easily. It is typical in depression, the mentally handicapped, and organic brain disorders.
- **Tachypsychism** refers to faster thinking which can accelerate into **racing thoughts**. The pace of speech usually cannot keep up with such quick thinking, which creates the impression of distorted thinking (qualitative disorder). It appears in manias or after drug intoxication.

In **thought focus disorders**, people cannot follow a primary theme. These disorders appear in some epilepsy patients, the mentally retarded and individuals suffering from dementia.

- **Circumstantial thinking** involves the inability to tell the difference between the important and the unimportant. It is not distorted, but is very lengthy and protracted.
- **Perseverative thinking** is manifested by the permanent return and repetition of one idea or word.

Qualitative thought disorders are characterised by the distortion of content appropriateness.

- **Delusion** is the most serious qualitative thought disorder. It involves erroneous beliefs based on incorrect premises. Delusion is accompanied by a feeling of its obviousness, strongly affects the behaviour of the patient, cannot be disproved, and can have a pathological influence on the behaviour of the patient. It appears in schizophrenics. According to their content, delusions can be divided into:

- ✓ **Macromaniacal**, manifested as a belief in having a special ability or being of noble origin;



- ✓ **Micromaniacal**, a belief in one's own inability or a looming catastrophe, hypochondriacal or self-accusatory;
 - ✓ **Paranoid**, a belief in persecution (persecutory delusion), morbid jealousy (delusional jealousy) or in being loved by a famous person (erotomaniac).
- **Obsessive thinking** is a disorder during which the mind of the patient is repeatedly 'infiltrated' by certain threatening thoughts against his/her will. Even though the patient is aware of their nonsensicality, he/she cannot suppress them and will try to cope with them. The situation is usually resolved through multiple stereotypical repetitions of various tasks (compulsion). This thinking is typical for obsessive-compulsive disorder.
 - **Incoherent thinking** is composed of incoherent, unrelated thoughts that do not logically follow each other. It appears in schizophrenics.
 - **Autistic (derealistic) thinking** is displayed by ignoring reality. This type of thinking is controlled by fantasy. It is considered pathological if a person cannot recognise the difference between fantasy and reality.
 - In **magical thinking**, words or acts have a special significance and power. It is typical in pre-schoolers, but also in schizophrenics.

2.1.6 Speech Disorders

According to Vágnerová (2004), speech disorders can be divided into receptive speech disorders and expressive speech disorders.

An example of a **receptive speech disorder** is

- **Receptive aphasia**, in which the patient cannot understand the spoken form of a language. This disorder results from damage to certain areas of the cerebral cortex.

Expressive speech disorders are further divided into speech content disorders and formal speech disorders.

Speech content disorders include:

- **Expressive aphasia**, the inability to express oneself through speech. The cause is again damage to certain areas of the cerebral cortex.



- **Agrammatism** is the inability to express oneself in a grammatically correct form. This disorder appears in the mentally handicapped.
- **Neologisms** are newly created words to label phenomena and experiences for which there are often no words. They are often present in schizophrenics' descriptions of their experiences.

Formal speech disorders include:

- **Mutism**, which is usually a temporary muteness, a loss of the ability to communicate. It usually originates as a result of psychological trauma in childhood, and also appears in hysteria and schizophrenia.
- **Dysarthria**, a disorder of the motor functions of the speech organ, which results in the inability to articulate properly.
- **Balbuties (stuttering)** is a speech-flow disorder appearing in neurotic patients.
- **Logorrhea** is rapid speech which is connected with accelerated thought pace and rapid thoughts. It is spoken at an incoherent, difficult-to-understand rate. It appears in manic disorders.

2.1.7 Emotional Disorders

Emotions are an expression of a person's relationship to the world and him/herself. They serve for orientation and the subsequent regulation of behaviour. Emotional disorders can be distinguished in terms of the emotional experience's intensity, length and quality (Vágnerová, 2004).

Affect disorders are very intense and short-lasting.

- **Pathic affect** is a very strong emotional outburst connected to a short-term consciousness disorder. A person in affect can even commit an act of violence (killing) which he/she will not be aware of and therefore also not remember. A tendency to affects is usually strengthened by alcohol or drug intake. An increased risk of occurrence is also present in patients with organic brain damage.
- **Phobias** are intrusive pathological fears whose intensity does not correspond to the stimulus that causes them. Despite being aware of the nonsensicality of his/her fear, the patient cannot control it with his/her will.



Phobias are frequently a problem of neurotics. They can have various contents (anthropophobia – a fear of people; claustrophobia – a fear of confined spaces; nosophobia – a fear of diseases; arachnophobia – a fear of spiders).

Compared to the aforementioned disorders, **mood disorders** are usually less intense, but last much longer.

- **Manic mood** is inappropriately optimistic and cheerful and is connected with increased activation. It is a typical symptom of a manic syndrome within the framework of bipolar affective disorders.
- **Euphoric mood** involves elation or bliss without activation. It appears in certain types of dementia.
- **Depressive mood** is an extremely sad mood accompanied by general inhibition. It can be seen in depressive disorders, but also in schizophrenia.
- **Anxious mood** is dominated by inappropriate worries about certain non-specific threats. The patient feels increased tension and has a tendency to react inappropriately.
- **Explosive mood** is related to a tendency to get angry and enraged and is manifested with a tendency to be aggressive. One can encounter it in chronic alcoholics or people with a dissociative identity disorder.
- **Apathetic mood** is characterised by an overall listlessness and disinterest in anything.

2.1.8 Volitional disorders

To a great extent, volition is an acquired ability of auto-regulation which directs a person's behaviour purposefully or in a required way. Volitional disorders represent a disrupted ability to control one's behaviour and can be divided into active volitional disorders and passive volitional disorders (Svoboda, 2006).

Active volitional disorders involve a loss of decisiveness.

Passive volitional disorders involve a lack of perseverance and are manifested in the inability to implement one's decisions.



According to the degree of impairment, one can discern between three forms:

- **Hypobulia** is manifested by a lower competence of the will.
- **Abulia** is escalated hypobulia, with a complete lack of volitional effort. It is typical in depression.
- **Hyperbulia** is an inappropriate increase in decisiveness related to excessive activity. It frequently accompanies a manic mood.

2.1.9 Behavioural Disorders

Conduct is purposeful, thought-out behaviour. It is usually disturbed as a result of other mental or physical functions, for instance emotions, thought, consciousness, etc. Behavioural disorders can be classified as quantitative and qualitative (Vágnerová, 2004).

Quantitative behavioural disorders can have two forms:

- **Hypoagility** is an overall lowering or deprivation of activities.
- **Hyperagility** is manifested in excessive activity.

Qualitative behavioural disorders include:

- **Impulsive act**, which happens based on momentary pathological ideas without any consideration of the possible consequences. The behaviour is not usually accompanied by any emotional experience. It appears in schizophrenics, for instance, with patients suddenly jumping out a window.
- **Raptus** is nonsensical and sudden aggressive behaviour towards other people which is often preceded by severe anxiety. It is typical in schizophrenics.
- **Catatonic disorders** are inappropriate motor manifestations. They are either **stuporous**, in which movement is inhibited until complete stupor, or **productive**, manifesting in an excessive number of purposeless movements (e.g. grimacing). These disorders are also typical in schizophrenia.
- **Compulsive act** is manifested by the urgent tendency to repeat an activity. Despite the fact that the patient perceives the activity as



nonsensical or even unpleasant, he/she cannot stop doing it, as it helps him/her lower psychological tension. This behaviour is a key symptom of obsessive-compulsive disorder.

2.1.10 Instinct Control Disorders

Instincts are congenital tendencies to behave in a certain way whose goal is to preserve the individual or to preserve the existence of a family. Their disturbance accompanies some mental disorders (Svoboda, 2006).

Eating disorders present themselves in two forms than can be combined.

- **Bulimia** is a pathologically increased need to eat.
- **Anorexia** is a pathologically lower need to eat or aversion to food.

Self-preservation instinct disorders can have two degrees.

- **Automutilation (self-harm)** is manifested, for instance, by cutting one's arms. It appears in schizophrenia and depression.
- **Suicidal** behaviour has two types, according to its objective.
 - ✓ **Demonstration suicide** is usually a call for help; the person does not intend to successfully commit suicide.
 - ✓ **Balance suicide** is the result of a reasoned decision to end one's life.

Sexual instinct disorders are deviations from the norm in terms of intensity, orientation or method of satisfaction.

- **Deviation in intensity** is manifested as a lower or higher need for sexual satisfaction. An example could be **nymphomania**, an excessive need for sexual satisfaction.
- **Deviation in orientation** relates to the objects through which one is satisfied. An example is paedophilia, sexual orientation towards children.
- **Deviation in the method of sexual satisfaction** could, for example, be demonstrated as **sadism** or **sadomasochism**.



Parental instinct disorder presents itself as:

- **Disinterest in one's offspring.**
- **Neglecting or abusing one's own children.**



Review Questions

1. Explain the difference between a symptom and a syndrome.
2. Name at least seven mental functions.
3. What is the general difference between qualitative and quantitative consciousness disorders?
4. What do the prefixes a-, hypo- and hyper- usually indicate in psychopathology?
5. Clarify the difference between an illusion and a hallucination.
6. What are anterograde amnesia and retrograde amnesia usually related to?
7. What is a delusion and how does it manifest itself in an individual's experience and his/her behaviour?
8. Describe the difference between receptive aphasia and expressive aphasia. What is their origin?
9. What is the essence of a pathic affect?
10. How do affects differ from moods in general?
11. Which mental function sub-disorder includes grimacing?
12. What are the two types of suicide? What, in general, is the difference between them?



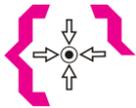
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3 Classification of Mental Illnesses



Objectives

After studying this chapter you will know the classification system used by experts when diagnosing mental disorders. You will get an overview of the individual categories of mental disorders according to ICD-10.



Terms to Remember (Key Words)

- ICD-10
- DSM-IV

3.1 International Classification of Diseases

The internationally recognised **International Classification of Diseases (ICD-10)** classification system is used in psychopathology and psychiatry the world over. The WHO coordinates its continual updates. In 1992, its 10th revision was done and currently a new revision is being prepared, whose introduction was declared for 2015 by the WHO.

To describe mental disorders, one uses the **ICD-10** section entitled '**Mental and Behavioural Disorders**'. Generally, the ICD-10 corresponds to the fourth edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)**, which is used by experts in the United States.

The classification system enables a more exact definition of problems and makes communication between individual experts easier. On the other hand, having a diagnosis assigned alone does not explain the causes of problems and can lead to a more simplified perception of an individual's problems (Atkinson, 2009).



3.2 Mental Disorder Categories According to ICD-10

In this section, an overview of categories is provided into which mental disorders are currently sorted by the International Classification of Diseases (ICD-10, 2010). Mental disorders are sorted into categories according to their resulting behaviours, not according to their causes, as it is based on the assumption that the causes are never fully known in any mental disorder. For each category, there is a description of the relevant problems.

The classification includes **10 basic categories** that include numerous sub-categories. Each diagnostic unit has been assigned its own code which combines a letter and digits.

F00-F09 Organic, including symptomatic, mental disorders – worsening of cognitive functions as a result of a brain injury or disease, e.g. Alzheimer's disease, delirium, or organic amnesia.

F10-F19 Mental and behavioural disorders due to use of psychoactive substances – abuse of psychoactive substances (alcohol, illegal drugs or medication) and addiction to them.

F20-F29 Schizophrenia, schizotypal and delusional disorders – disorders for which distorted thinking and perception are common, with hallucinations and delusions appearing at a certain stage of the disease.

F30-F39 Mood (affective) disorders – disorders of normal mood, depression, manic conditions, switching between depression and mania.

F40-F49 Neurotic, stress-related and somatoform disorders – disorders for which excessive anxiety is typical; disorders which are to a large extent caused by stress; changes in consciousness and identity as a result of emotional problems.

F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors – eating disorders (anorexia nervosa, bulimia), sleep disorders, sexual dysfunction and disorders, and post-partum disorders.



F60-F69 Disorders of adult personality and behaviour – long-term personality traits present which lead to disturbed patterns of behaviour and social adaptation disorders.

F70-F79 Mental retardation – mental retardation which is present from early childhood and lasts one's whole life, resulting in low intellectual abilities which are below an IQ of 70.

F80-F89 Disorders of psychological development – disorders with onset in childhood affecting the development of an individual, e.g. speech disorders, learning disorders, autism.

F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence – hyperkinetic disorders, behavioural disorders, emotional disorders.

Many categories include very different disorders, e.g. disorders of psychological development (F80-F89) include both dyslexia and childhood autism, which are completely different problems in terms of their causes, the severity of the consequences on the development of a child, and the utilised educational and therapeutic procedures.

Due to this heterogeneity, this study text is outlined somewhat differently in some places and does not strictly follow the individual ICD-10 categories. Still, there are references in the text to the respective categories so that the student can place the disorder discussed in the text within the context of this internationally recognised and generally known classification.

At the same time, the study text cannot include a description of all of the mental disorders that are included in the ICD-10 and instead focuses on the most frequently occurring problems. The F70-F79 mental retardation category and some sub-categories (specific developmental learning disorders, hyperkinetic disorders and behavioural disorders) are described in the following study text, *Psychopathology II*.



Review Questions



13. In what year was the 10th revision of the International Classification of Diseases carried out?
14. Under which organisation's auspices are the introduction of and updates to the ICD-10 provided?
15. Which classification system of mental disorders is used by experts in the United States?
16. Think about why it is important to gradually update the classification of diseases.



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4 Organic Mental Disorders



Objectives

After studying this chapter you will have an overview of organic mental disorders. You will be able to define dementia and describe the symptoms and types of dementia. You will learn the specifics of dementia in childhood. You will be able to formulate the objectives of dementia treatment.



Terms to Remember (Key Words)

- organic mental disorders
- dementia
- atrophic-degenerative dementia
- secondary dementia



4.1 Definition of Organic Mental Disorders According to ICD-10

ICD-10 puts mental disorders whose common characteristic is the **connection of the illness with a brain injury or other damage** leading to cerebral dysfunction (ICD-10, 2010) in this category.

Typical representatives of such disorders are **dementias (F0)**:

- dementia in Alzheimer's disease (F00),
- vascular dementia (F01),
- dementia in diseases classified elsewhere (F02),
- dementia in Pick's disease,
- dementia in Creutzfeldt-Jakob disease,
- dementia in Huntington's disease,
- dementia in Parkinson's disease,
- dementia in HIV infection.

In the category of organic mental disorders, ICD-10 also defines other problems caused by brain damage, e.g. **personality and behavioural disorders due to brain disease, damage and dysfunction (F07)**:

- organic personality disorder (change in behaviour, emotions, needs and impulses as a result of brain damage),
- postencephalitic syndrome (after recovery from either viral or bacterial encephalitis),
- postconcussional syndrome (a syndrome occurring after head trauma – headache, dizziness, fatigue, difficulty in concentration, impairment of memory, reduced tolerance to stress), etc.

4.2 Dementia

Dementia is an acquired impairment caused by **organic brain damage** during which a loss of already developed cognitive functions occurs. It can only happen after achieving a certain degree of intellectual development, and



therefore dementia can be diagnosed only after the second year of life; before then the impairment is considered to be mental retardation. Dementia is a chronic disease, and its course and prognosis depend on the cause, type and severity of the basic impairment or illness.

Dementia primarily affects the older population. Approximately 5% of people over 65 years of age suffer from dementia, with up to 30% of people over the age of 85 affected. However, dementia can occur at any age, including in childhood. It is more often caused by injury in younger people and by a degenerative disease of the central nervous system (CNS) in older people (Vágnerová, 2004).

4.2.1 Dementia Symptoms

The clinical symptoms of dementia include (Vágnerová, 2004):

- **Memory function disorder:** At first, short-term memory is affected, manifested by the inability to learn anything new; later, long-term memory functions worsen, and at an advanced stage this leads to the inability to recall one's own name or recognise one's loved ones.
- **Disrupted attention:** The patient has problems staying focused, contributing to restrictions in his/her performance.
- **Decline in thinking:** The ability to think in the abstract disappears first; concrete thinking is preserved longer; patients are not able to make plans or decisions, have problems understanding context, perceive many problems as insurmountable, cannot get oriented in new situations, and gradually may not be able to perform tasks that were once simple for them.
- **Decline in criticality:** At an advanced stage of the illness, patients are no longer aware of the incorrectness of their thoughts or the inappropriateness of their behaviour.
- **Disrupted orientation:** There is a loss of orientation in time, space, people, and, in the end, in oneself. One can even lose one's identity – the patient does not know who he/she is.



- **Speech disorders:** The ability to understand the spoken word and the ability to express oneself verbally decrease; even the ability to read or express oneself in writing can be affected.
- **Emotional disorders:** The ability to control and contain one's emotions worsens, with emotional reactions becoming less appropriate. Higher emotional tension and anxiety or depression, emotional numbness or apathy may appear.
- **Conspicuous behaviour:** Behaviour is usually inappropriate to the situation form-wise and content-wise, the level of activity can fluctuate, and gradually all activity ceases and the patient spends most of his/her time lying down.
- **Apraxia:** There is a decline in acquired motor skills and the ability to use daily required objects (e.g. cutlery) is lost; patients stop being able to take care of themselves and become dependent on others for care.
- **Personality decline:** Some personality traits can be accentuated, and patients can become inconsiderate, egocentric, distrustful, intolerant or even aggressive.

4.2.2 Types of Dementia

Dementias can be divided into two basic groups according to the etiology of the impairment (Vágnerová, 2004):

Atrophic-degenerative dementia is a result of a degenerative brain disease.

An example of an atrophic-degenerative illness is **Alzheimer's disease**, which accounts for 50–70% of all dementias. Early-onset (before the age of 65) and late-onset (after the age of 65) versions are distinguished. Alzheimer's disease affects around 6% of the population at age 70 and 12% at age 75. It is a neurodegenerative illness characterised by a loss of neurons and synapses in the cerebral cortex and certain subcortical regions. The disease develops slowly and gradually, mental functions are affected equally, and their decline is complex. The disease lasts five to eight years on average and ends in death.

Alzheimer's disease is the most common type of dementia, and as the average human lifespan is increasing it is becoming an ever more urgent social problem (www.alzheimers.org.uk).



Secondary dementia occurs as a consequence of a different primary disorder which damages the CNS in a certain way. Dementia can be a consequence of a cardiovascular disease or can occur due to metabolic, infectious, toxic or post-injury causes.

*One of the secondary dementias is **vascular dementia**, which is caused by a vascular disease that, after several small infarctions or one larger cerebral event, causes a decline in cognitive functions. Mental functions are not affected equally, and the impairment depends on the location and the extent of damage to the brain tissue.*

4.2.3 Dementia Stages

The course of the disease can be divided into four stages for which a certain extent of impairment of individual mental functions is typical (Vágnerová 2004):

Mild dementia stage: Mild disorders of short-term memory, verbal skills and thinking appear; patients try to compensate for the decline in their abilities by using old skills and fixed ways of behaviour and by avoiding new or difficult situations. At this stage, patients need to be checked on and occasionally helped by others.

Medium dementia stage: Memory disorders already affect long-term memory as well; patients are disoriented in time and space, have problems resolving common situations, and lose sound judgement. Patients are unable to behave appropriately in social situations, their personal hygiene declines, incontinency appears, and they need supervision and permanent help.

Severe dementia stage: Patients are completely disoriented in time, space and themselves; there is limited communication and apraxia leads to a loss of the majority of common skills. Patients fully depend on the care of others.

Terminal stage: Patients are confined to bed, do not communicate, lose the ability to be active in any way, and fully depend on caretakers.

The patient's personality changes and decline in abilities become a burden for his/her family, because it is difficult to accept the worsening of the condition and the change in the personality of a loved one. At the same time, caring for a



person affected by dementia is very demanding, and it is frequently necessary to institutionalise the patient.

4.2.4 Specifics of Dementia in Childhood

Intelligence only develops during childhood, and therefore clinical symptoms of dementia depend on the developmental level which the child has achieved before the onset of the illness. The severity of the impairment can vary; the development can stagnate, slow down and regress. It is also hard to determine a prognosis, especially if the impairment is a result of brain injury, infection or tumour.

In younger children, their further development is positively affected by their plasticity and compensation skills.

In older children, the higher level of abilities and skills acquired pre-morbidly is an advantage (Vágnerová, 2004).

The course of dementia in children differs from that of dementia in adults; after a varyingly long period of stagnation or regression, the development usually continues again, though mostly at a slower pace (Říčan, Krejčířová et al., 2006).

4.2.5 Dementia Treatment

Apart from the rather less frequent cases of dementia that develop from curable basic diseases, the course of dementia can at best be alleviated but not fundamentally changed.

Treatment focuses on coping with the disease, slowing down degenerative processes, and alleviating or quietening the individual symptoms of the disease. It is also important to preserve the patient's self-sufficiency and the quality of his/her life. The main objectives of treatment include (Rahn and Mahnkopf, 2000):

- educating the patient and his/her relatives,
- training cognitive skills,
- perceiving and using preserved skills,



- encouraging activity,
- verbalising subjective experiences,
- broadening communication,
- preserving independence,
- boosting self-confidence,
- creating a supportive environment,
- supporting family members,
- ensuring dignified behaviour by caretakers and protecting from resignation.



Review Questions

1. What do organic mental disorders have in common?
2. Explain the term 'dementia'.
3. Give an example of a disease which involves atrophic-degenerative dementia.
4. What are the typical symptoms of dementia?
5. Can dementia also affect children?



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5 Mental Disorders due to Psychoactive Substance Use



Objectives

After studying this chapter you will be able to describe the types, causes and development of addictions to psychoactive substances and the basic principles of addiction treatments.



Terms to Remember (Key Words)

- psychoactive substances
- acute intoxication
- harmful use
- dependence syndrome
- withdrawal state
- addiction medicine

5.1 Definition of Mental Disorders due to Psychoactive Substance Use According to ICD-10

This ICD-10 group includes various disorders that originate through **using one or more psychoactive substances**, which can or do not have to be prescribed by a physician (ICD-10, 2010).

- Disorders due to the use of alcohol (F10.-)
- Disorders due to the use of opioids (F11.-)
- Disorders due to the use of cannabinoids (F12.-)
- Disorders due to the use of sedatives or hypnotics (F13.-)
- Disorders due to the use of cocaine (F14.-)
- Disorders due to the use of other stimulants, including caffeine (F15.-)
- Disorders due to the use of hallucinogens (F16.-)



- Disorders due to the use of tobacco (F17.-)
- Disorders due to the use of volatile solvents (F18.-)
- Disorders due to multiple drug use and the use of other psychoactive substances (F19.-)

5.2 Division of Psychoactive Substances According to Their Effect on Mental and Physical Functions

Psychoactive substances (substances that change a person's mental state) can be divided into groups according to their pharmacological characteristics, which have specific effects on mental and physical functions (Rahn and Mahnkopf, 2000):

Alcohol – causes euphoric mood, relaxation and reduces social inhibition, while at the same time diminishing intellectual and motor functions and slowing reactions and the ability to appropriately assess a situation.

Pharmaceuticals – anti-anxiety drugs are most frequently abused, leading to relaxation and calming. They are inhibiting and induce sleep.

Opioids – (opium, morphine, heroin, methadone) induce a feeling of harmony and euphoria that, however, disappears again after prolonged use. Addicts then use opioids to prevent unpleasant withdrawal symptoms.

Stimulants – (pervitin, ecstasy) are used to improve concentration and performance and to induce euphoria, however, they have negative side effects, such as panic, depressiveness and regular psychotic attacks. Physiologically, they cause unsteady walking, dry mouth, arrhythmia, etc. After the drug's effect wears off, dizziness, muscle contractions and headache appear.

Hallucinogens – (LSD) cause exogenous psychosis with corresponding changes in perception, thinking and affect. There is a thin line between their desired and undesired effects, the desired ones usually being changes in perception in the sense of optical hallucinations and changes in experiencing space and time. At the same time, fear, depressiveness and mood changes appear. After the acute intoxication wears off, concentration disorders may persist, sometimes even for weeks.



Cocaine – when used, euphoria and increased activity and attention appear first, while the need to eat and sleep is reduced. With prolonged use, feelings of fear, moodiness and psychotic phenomena appear.

Cannabis – (hashish, marijuana) belongs, in addition to alcohol and nicotine, among the most frequently used substances; it induces changes in mood and perception, feelings of happiness and slower perception of time, and creates strongly associative thought processes. When used over a longer period, one can lose touch with reality, the ability to manage everyday tasks is weakened, and concentration and memory disorders or psychotic reminiscences (flashbacks) can appear.

Volatile solvents – (toluene, trichloroethylene, benzene) induce euphoria and changes in consciousness. Intoxication lasts only about 30 minutes, but the substances are highly toxic. Soon the brain atrophies, concentration and the ability to think are weakened, and disorders of consciousness and orientation occur.

5.3 Consequences of Using Psychoactive Substances

When determining a diagnosis, it is important to determine what clinical picture is presented. According to ICD-10, the following can occur as a result of using psychoactive substances:

- acute intoxication,
- harmful use,
- dependence syndrome,
- withdrawal state,
- withdrawal state with delirium,
- psychotic disorder,
- amnesic syndrome,
- residual and late-onset psychotic disorder,
- other mental and behavioural disorders.

Acute intoxication is a temporary condition usually lasting several hours following the use of a psychoactive substance. Intoxication severity differs



according to the type and amount of the used substance, while the intoxicated person's current tolerance of the used substance is also important.

Harmful use includes a pattern of behaviour which results in health, mental or social damage. Harmful use is often criticised by the social environment and causes various negative social consequences.

Dependence syndrome is characterised by a set of psychological and somatic changes that occur as a result of the repeated use of a psychoactive substance. It is diagnosed if at least three or more of the following phenomena occur for the duration of at least one month or repeatedly:

- a strong desire or urge to use the drug,
- a lower ability to control the beginning and end of use as well as the amount of the drug,
- physiological withdrawal syndrome when terminating or lessening use of the drug,
- increases in dose are necessary to achieve the drug's effect,
- gradual neglect of other activities and interests, more time spent on obtaining the drug, taking the drug or recovering from its effects,
- persistent use of the drug, even though the addicted person knows that use of the substance has harmful consequences.

Withdrawal state includes symptoms of varying severity that occur when a substance's use is discontinued. The onset and course of the withdrawal state are time-limited and depend on the type and amount of the substance that was used immediately before abstinence. Withdrawal state is one of the indicators of dependence syndrome. It can be complicated by convulsions and accompanied by delirium.

***Delirium tremens** is a short but sometimes life-threatening episode of confusion with associated physiological problems that occurs in alcohol addiction. The classical symptoms are clouded consciousness and confusion, vivid hallucinations and illusions, severe tremors, agitation, insomnia, and increased autonomous activity.*



Psychotic disorder occurs during or immediately after drug use and is characterised by vivid, typically auditory hallucinations, mistaking people for others, delusions, egotism, psychomotor disturbances (restlessness or stupor) and an abnormal affect that may range from intense fear to ecstasy. The disorder will disappear (at least partially) within one month, and completely within six months.

The diagnosis of a psychotic disorder is not made if perception disorders or hallucinatory experiences are present in an individual and if substances with primarily hallucinogenic effects (e.g. LSD) are being used. In such cases, these are symptoms of acute intoxication.

Amnesic syndrome is associated with chronic prominent memory impairment. Other cognitive functions are usually well preserved and the amnesic defects are out of proportion to other disturbances.

Residual and late-onset psychotic disorder is a disorder in which changes to cognitive functions, emotions, personality or behaviour last for a longer period than the expected direct intoxication effect of the drug. It can be divided into several sub-groups:

- psychotic reminiscences (flashbacks),
- personality or behavioural disorder,
- residual affective disorder,
- dementia,
- other mild forms of persisting impairment of cognitive functions,
- late-onset psychotic disorder.

5.4 Development of Addiction to Psychoactive Substances

An addiction to psychoactive substances develops gradually, but drug addiction occurs much faster than alcohol addiction. **The development of the origins of drug addiction** can be divided into four stages (Vágnerová, 2004):

Experimentation and casual use stage – the drug produces the desired feelings, enables the achievement of necessary activation, and rids the person



of anxiety, fear and uncertainty, and therefore one tends to use it again. The impulses to try drugs can include boredom, curiosity, a need for unusual experiences, peer pressure, or a need to escape from one's problems.

Regular use stage – the person uses the drug more frequently but denies the risk involved in his/her actions and does not want to admit it to him/herself. He/she tries to convince those around him/her that his/her drug use is under control and if he/she wanted to, he/she could stop at any time. This illusion of control is typical in the beginning stages of addiction.

Addicted use stage – as the addiction progresses, indifference to everything that is not drug-related increases, changes in values and a loss of motivation occur, the person is unable to perform his/her daily tasks, and he/she stops caring for his/her relationships with friends and family or cannot maintain them and they are disrupted or fall apart. The addicted person uses the drug primarily to prevent withdrawal symptoms, as he/she cannot live without it.

Terminal stage – use of the drug leads to overall personality decline and a disintegration of social relations. The addicted person's only interest is to get the necessary dose of the drug regardless of the way he/she gets it.

The development of alcohol addiction usually occurs relatively inconspicuously, with typical gradual changes (a gradual increase in alcohol tolerance and a gradual change of control over alcohol use). At the same time, in the beginning also inconspicuously, changes in thinking and behaviour occur that are fixed as these are the defence mechanisms of the alcoholic, who needs to cope with the problems caused by his/her drinking. In the beginning, the alcoholic uses them to hide and later to explain and defend (rationalise) his/her drinking. Symptoms of a developed addiction are a change in tolerance (the need to increase the amount of alcohol used to achieve the desired effect), the need for 'morning sips' to top up the alcohol level immediately after waking up, and memory disturbances (blanks). As the addiction progresses, alcohol tolerance is lowered significantly, i.e. even a small amount of alcohol can cause symptoms of heavy inebriation. An irreversible loss of the ability to control one's drinking is characteristic of alcohol addiction, and therefore the basic condition for treatment is permanent, life-long abstinence (Raboch, Zvolský et al., 2001).

Disorders due to tobacco use. Acute nicotine intoxication can cause vomiting, sweating, tachycardia, arrhythmia or sleep disturbances. The body takes in 5–10 mg of nicotine from one cigarette, which stimulates specific



receptors in the CNS. Even though nicotine is highly toxic, a tolerance to it develops quickly with a subsequent physiological addiction that occurs in up to 85% of consumers. Its origin is significantly influenced by one's personal environment (smoking in the family or in a peer group) and often occurs in combination with addiction to other drugs. The treatment of nicotine addiction focuses on complete abstinence and usually combines behavioural therapy (particularly motivational training) and substitutional treatment (patches, chewing gums).

5.5 Pathological Gambling (F63.0)

Pathological gambling belongs among the addictive diseases and is included among the *Disorders of Adult Personality and Behaviour* in ICD-10 (F63 Habit and impulse disorders). The principle for treating gambling is similar to other addictive disorders and usually requires a stay of several weeks in an addiction treatment facility with subsequent visits to an outpatient facility over the longer term. Similarly to drug addictions, repeated relapses and subsequent abstinence attempts can occur. It is due to its similarity to psychoactive-substance disorders that this section on gambling was included in this chapter.

The disorder is characterised by repeated gambling episodes on gambling machines. Gambling dominates the life of the affected person and leads to a disruption of family, social, work and material values. Gamblers have an uncontrollable urge to gamble, are unable to stop gambling of their own volition, and continue to gamble despite its negative consequences, such as debts, loss of work, disrupted family relations, etc. Several stages of the disorder's development are described (Raboch, Zvolský et al., 2001):

Winning stage – the individual only gambles sometimes, wins outnumber losses, there is excitement before and during gambling, gradually bets are increased, and gambling occurs more often. There are fantasies about a big win, which sometimes actually occurs, followed by euphoria, boasting about the win, and gambling alone.

Losing stage – the gambler thinks mainly of gambling and cannot stop gambling during a long losing period. He/she borrows money, keeps gambling in secret, lies, is inconsiderate to his/her family, is absent from work, and delays paying off debts. There are personality changes (irritation, restlessness, introversion) and family life is seriously disturbed. This is followed by large loans and the inability to pay off debts.



Desperation stage – criminal prosecution for fraud occurs as do unpaid debts, a damaged reputation, and estrangement from family and friends. The majority of time is spent gambling, with the gambler losing more and more, accusing others, having pangs of conscience, and committing crimes. Panic, hopelessness, suicidal thoughts and collapse appear.

5.6 Treatment of Drug Addictions and Habit Disorders

The science focusing on addictions, their prevention, causes, treatments, research, consultation and other related issues is called **addiction medicine**. More narrowly, it focuses on addictive-substance addictions. Clinical addiction medicine works only with individual clients.

The course and prognosis of addiction depend on the type of psychoactive substance, the addict's motivation for treatment, family support, and many other factors. Approximately one-third of addicts will become permanently abstinent, even though minor relapses (returns to the drug) occur in them. Other addicts have permanent, more or less strong social, physiological and mental problems, with premature mortality also being high.

The objectives of addiction treatment can be divided into several categories (Rahn and Mahnkopf, 2000):

1. detoxification,
2. motivation and preparation of subsequent therapeutic steps,
3. creation of alternative life plans (withdrawal), creation of an abstinent lifestyle,
4. modification of the social and physiological consequences of the addiction, integration into family and employment.

The 12-step programme of Alcoholics Anonymous (www.alcoholics-anonymous.org.uk) is a traditional and generally widespread approach to treating drug addictions. This organisation works on the principle of self-help groups. Many addicts discover that they have similar experiences and that they can initiate abstinence with the help of the group.



There are other therapeutic approaches that can be used for the treatment of drug addictions (Walters and Rotgers, 2011):

- psychodynamic approach,
- marital/family therapy,
- behavioural approach,
- motivation boosting.



Review Questions

1. What types of psychoactive substances can we discern?
2. What consequences of psychoactive substance use does ICD-10 discern?
3. Define 'harmful use' of psychoactive substances.
4. Describe the development of an addiction to psychoactive substances.
5. What disorders can be caused by using tobacco?
6. How are gambling and psychoactive-substance addiction similar?
7. In the recommended sources, find the '12 Steps of AA' and in the individual steps look for reasons as to why they could help in the treatment of people addicted to alcohol.



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6 Schizophrenia



Objectives

After studying this chapter you will be able to define the term schizophrenia. You will be able to name its causes, manifestations and individual types. You will be able to outline its treatment and to characterise the manifestations of schizophrenia in children.



Terms to Remember (Key Words)

- schizophrenia
- psychosis
- affective disorder
- paranoid schizophrenia
- simple schizophrenia
- hebephrenic schizophrenia
- catatonic schizophrenia
- positive symptoms
- negative symptoms
- psychotherapy
- sociotherapy
- prodromal stage
- attack
- remission
- stigmatisation

6.1 Classification of Schizophrenia in the Personality Disorder System

As opposed to neurotic disorders and personality disorders, psychotic disorders (or psychoses) represent a deep disruption of one's relation to reality. There is a fundamental change in the way one experiences him/herself, other people and the world he/she lives in. The affected person becomes introverted; the common world fades into the background and is replaced by a world of delusions and fantasies. The patient retreats inside this world and avoids interaction with other people. On the outside, he/she comes across as strange. Another, very serious difference between psychosis and neurosis is the fact that



psychotics do not have an insight into their illness. They admit that they are not without problems, but they do not think psychiatric treatment is necessary.

Schizophrenia, schizoaffective psychoses and **affective disorders** (earlier called manic-depressive psychoses) in particular are classified as psychotic disorders. Schizoaffective psychosis is an illness that includes symptoms of schizophrenia and affective disorders. The next chapter will focus on affective disorders. Here we will focus on schizophrenia.

6.2 Causes of Schizophrenia

Schizophrenia is a disorder that affects around 1% of the population. Its onset is most often at a younger age, between 15 and 35 years, but somewhat later in women than in men. There is not just one cause of the onset of the disease; a combination of a larger number of negative influences, heredity, changes in the structure and function of brain cells, and psychosocial factors plays a role (Vágnerová, 2004).

Experts believe that **a higher number of genes** can participate in causing this disorder, but it is still unclear what type of heritability is concerned.

Due to deviations in genetic information, there are **changes in the structure of the brain tissue**, which causes disrupted brain function. A loss of cerebral cortex in certain regions has been described, primarily in the prefrontal region and the left hemisphere, as have changes in the structure of a whole array of organs under the cerebral cortex, such as the hippocampus, basal ganglia, limbic system, thalamus, etc.

In terms of the function of the brain tissue, one generally speaks of a change in brain metabolism in the case of schizophrenia. As a result of changes and an imbalance in a larger number of various neurotransmitters (dopamine, serotonin and glutamate), there is an erroneous, disrupted transmission of information.

External influences contributing to the onset of schizophrenic psychosis can be divided into **prenatal**, which occur during intrauterine foetal development (e.g. hypoxia, foetal malnutrition), perinatal (mechanical brain injury, hypoxia), and postnatal, which are related to the closest relatives of the individual and



the family's way of life. The following families can be considered risky in terms of having an increased risk of the onset of a psychotic disorder (Rahn and Mahnkopf, 2000):

- more often closed and isolated from their environment,
- with conflicted and/or cold or hostile relations between the parents,
- with non-standard roles and positions of individual family members,
- with disrupted communication and conspicuousness in terms of structure and content,
- with an inability to define and resolve problems,
- with an inability to cope with negative emotions.

Another factor is the experiencing of long-term and/or recurring situations of stress. These external influences contribute to the increased sensitivity and vulnerability of the individual and decrease his/her ability to react appropriately to various life events. They can become the 'trigger' of the psychosis, but they should not be considered its cause (Kalina, 2001). We all encounter these situations, but only in more vulnerable individuals can such a psychological disorder start as a result of them.

6.3 Clinical Symptoms of Schizophrenia

This disorder can have various forms (see below) and within the framework of one form various symptoms can appear. In general, one can discern **positive symptoms**, i.e. excessive or distorted manifestations of functions as a result of the hyperactivity of some parts of the brain (e.g. hallucinations, delusions, speech disorders, behaviour control disorders, and catatonic symptoms), and **negative symptoms**, which result from the inhibition of some parts of the brain (e.g. apathetic behaviour, poverty of speech, bradypsychism, blunted affect, volitional disorders, and a tendency to withdraw socially), in the behaviour of the affected person.

A very typical symptom signalling the onset of the disease is a perception disorder called **hallucination**. In the beginning, hallucinations can take the form of illusions. Most frequent are auditory hallucinations, which the affected person refers to as 'voices' or 'loud thoughts'. The 'voices' can talk directly to the patient and accuse him/her or threaten him/her, tell him/her off, forbid



him/her, or order him/her. In a milder form, they comment on the behaviour of the patient or talk about the patient as if 'behind his/her back'. Very often they appear together with **delusion**, which is a qualitative thought disorder. Delusion is an erroneous way of thinking that is developed as a method of resolving feelings of anxiety and dealing with uncomfortable situations the person finds him/herself in. According to Kalina (2001), a delusion appears when there is a strong increase in pathological anxiety and the patient cannot defend him/herself with other mechanisms. The content of the delusional belief is related to real situations in the life of the patient which are, however, processed into a bizarre form. In the delusion, the patient is the centre of all the action, which often is the opposite of the real situation.

The typical features of a delusion are its irrefutability, its strong feeling of obviousness, and the nonsensicality of its content. The patient is so strongly convinced of the truthfulness of his/her delusion that he/she can be dangerous to him/herself and those around him/her. However, any efforts to refute it will only cause another anxious or aggressive reaction. Therefore, during these intense symptoms, it is suitable to admit the patient to a closed psychiatry ward and modify his/her condition with the appropriate medication.

Every time some girl looked at me, I looked away, feeling terrible, embarrassed and nervous. Then I started to feel that girls were observing me, keeping an eye on me... I then had even stronger stage fright and was upset at my mother for deliberately ironing or washing my clothes badly. In the end I suspected her of ironing something into them so that girls would not like me. In these looks, there was some sexual challenge that was destroying me. I started to be even more afraid and then I understood that this was a conspiracy against me plotted by my former female boss... I had terrible conflicts with her. She looked like my mother. I believed she was connected with her and that she might be her double. (Kalina, 2001, p. 33)

Schizophrenia is also typically accompanied by thought-pace disorders. The pace can be **slower (bradypsychism)** and take the form of '**thought blocking**' during which the patient is unable to advance in his/her thoughts and sticks to one thought. On the other hand, the pace can be **faster (tachypsychism)** and achieve such a rate that the speech pace cannot keep up (**rapid thoughts**). Speech thus becomes incomprehensible and incoherent (**logorrhea**). In its extreme form, incoherent speech is called a **word salad**, with individual consecutively expressed words having no logical context.

Thinking is also formally disrupted. Its logical structure disappears and thoughts are disorganised and without the ability to abstract. New expressions,



neologisms, appear which the patient uses to define his/her experience. These are usually illogical and bizarre word formations.

Another typical manifestation is a conspicuous **withdrawal into isolation**, into a world of one's own thoughts (autism). It is a consequence of the **inability to understand the world** around, which seems strange and incomprehensible (derealisation), and the problems in the person's relationship with the environment.

Emotional disorders are usually manifested differently in the acute and later stages of the psychosis. In the beginning, **inappropriate reactions, oversensitivity and strong emotional lability** appear in the affected person. Emotional ambivalence is also frequent, with the patient experiencing ambivalent, contradicting and incompatible feelings towards the people around him/her and towards all phenomena including his/her own behaviour. Later, **emotional insensibility**, apathy and inhibition occur.

Kalina (2001) describes personality as an awareness of the integral content of one's self, including one's own mental processes, the image of one's own body and the surrounding environment. A healthy person has interconnected images of his/her own psychological self and physiological self that appear within a defined space, are internally cohesive (integrated), and are connected to the awareness of one's own existence of the type 'this is really me'. In psychosis, the borders of the content of one's own personality fade, and **feelings of depersonalization** appear during which one's own thoughts seem strange, inserted by someone, unreal, and remote. Similarly, through this collapsed border, happenings from variously remote surroundings penetrate into the experience of the self, from which the affected person loses his/her distance and experiences them acutely in an essential relationship with his/her personality. This experience of the collapse of one's own integrity and identity is very painful, accompanied by tremendous anxiety and fearful panic, from which the affected person tries to 'rescue' him/herself by producing delusions that explain the condition.

6.4 Types of Schizophrenia

Traditionally, four basic types are distinguished: paranoid, hebephrenic, catatonic and simple. However, in practice, one can encounter combinations of these possibilities (Vágnerová, 2004):



- **Paranoid schizophrenia** is characterised in particular by the paranoid content of delusions and hallucinations. The affected person believes he/she is being persecuted or cheated on (morbid jealousy).
- **Hebephrenic schizophrenia** usually starts at a younger age, between 15 and 25 years. It takes the form of a protracted puberty with strange thinking and conspicuous silly and uncouth behaviour. Its typical manifestation is 'philosophising', incoherent thinking related to the creation of new words (neologisms). This form is also often manifested by a lack of social inhibition, inappropriate joking, rudeness or vulgarity. The affected person also tends to wander, run away and neglect his/her outward appearance.
- **Catatonic schizophrenia** is manifested by conspicuous changes in motor activity. There are two possibilities:
 - ✓ **Productive form**, within the framework of which motor activity is excessively increased. The patient continuously repeats certain words or movements (echolalia or echopraxia).
 - ✓ **Stuporous form**, on the contrary, is characteristic for its overall motor inhibition. The affected person stays in a certain position for a long time without any movement. He/she is negativistic and tends to have paradoxical reactions (does the contrary of what he/she is asked to). Waxy flexibility (*flexibilitas cerea*) is also typical for this form, during which the patient stays in the position into which he/she is put.
- **Simple schizophrenia** usually appears at a younger age and is less conspicuous compared to the aforementioned types. In the beginning, the affected person is lazy and asocial, starts to wander and tends to be apathetic and autistic. Thinking gradually worsens down to the level of dementia.

6.5 Course and Prognosis

The stage before the actual onset of the disease is called **prodromal**. During this period, one can observe some conspicuousness in the affected persons. Somewhat atypical symptoms appear from which a psychotic disease develops



later. Vágnerová (2004) provides the following list of prodromal symptoms of schizophrenia:

- increased vulnerability and ego weakness,
- conspicuous introversion,
- limited ability to gain independence (increased dependency on one's loved ones),
- problems in interpersonal relations (increased criticality or hostility towards loved ones),
- lower performance,
- physiological complaints of an uncertain nature (fatigue, sleeplessness).

The course of the disease varies. Often it takes the form of **repeated alternation between attacks** of the disease (full of the disease's manifestations) **and remissions** (periods without the disease's symptoms or only with some of them).

The disease can also have an **episodic course**, where an attack appears just once, after which the health condition stabilises.

The **malignant course** of the disease is manifested by rapid personality deterioration.

The **chronic (residual) course** is characterised by the persistence of some (usually negative) symptoms, resulting in the gradual loss of some competencies.

Schizophrenia also has a social aspect. One speaks about the **stigmatisation of the patient**. Due to a lack of information about the characteristics of the disease, the social environment usually has negative attitudes towards the affected persons. The patient's conspicuous behaviour may cause uncertainty and threat. The social environment tends to assign the manifestations of the disease in schizophrenic patients to their character. With regard to the age in which the disease starts and to the characteristics of the impairment, the majority of the affected persons do not live in a partnership.

The patient's family's coping with this disease is also a difficult process. It is related to the necessity to understand the characteristics of this disease and its treatment and to the new organisation of relations within the family so that the affected person is supported. However, the families of schizophrenic patients



also need support. Ways of caring for the closest relatives include family psychotherapy and self-help groups.

6.6 Therapy

It is possible to treat this serious disorder despite the fact that there is not always a complete recovery. In any case, therapy is a factor that significantly improves the quality of life of the patient. Usually a combination of several therapeutic approaches is used (Vágnerová, 2004):

Psychopharmacological treatment focuses on quietening the patient, increasing resistance, and alleviating positive symptoms, tension and anxiety. Narcoleptics are usually deployed. The regular use of pharmaceuticals prescribed by a physician is one of the most important conditions for the improvement of the patient's condition. They usually also have to be taken after an attack of the disease subsides, thus significantly decreasing the risk of the onset of a new stage of the disease.

- **Psychotherapy** supports the affected person in coping with the disease and in the training of social skills.
- **Sociotherapy** has the objective of achieving acceptable social adaptation and the reintegration of the affected person into society (housing, employment).

6.7 Specifics of Schizophrenia in Childhood

Paediatric schizophrenia is a schizophrenic disease which starts before the age of 10 (Vágnerová, 2004). The disease occurs very rarely, affecting only 0.02% of the population in a ratio of 2 to 1 (boys to girls). The disease takes a more serious course in boys. In general, the earlier a schizophrenic disease appears, the worse its prognosis. A child's immature psyche is more vulnerable and affected at all levels. The disease usually develops slowly with a gradual worsening of cognitive and social functions. In its pre-morbid stage, these children are usually emotionally labile or detached, motorically inept and unfocused.



Emotional experiences are dominated by an **extinguished ability to have positive experiences** (apathy or flattened affect) or **oversensitivity and ambivalence**.

Cognitive functions are significantly disrupted, which is manifested primarily by the **inability to receive and process information, the impairment of rational judgment, and poverty of thought**. Such children have difficulty orienting themselves and have **feelings of depersonalization** and problems defining the borders between self and non-self. Resistance to change is also typical. The external world is considered threatening and evil. In its acute stage, **auditory and visual hallucinations occur**, and in children over seven years of age **delusions** appear. The expression of thoughts is problematic; expression is fragmented and full of neologisms.

The most significant behavioural changes take place in the activity level (**hyperactivity or hypoactivity**) and conspicuous motor activities (e.g. a strange gait).

The child has **disrupted relations with people**, loses the ability to be empathetic, and has little interest in contact. The child has problems understanding social norms and with appropriate communication.



Review Questions

1. How are psychotic disorders different from neurotic disorders? Name at least two ways.
2. Apart from schizophrenia, what other disorders are classified among the psychotic disorders?
3. What are the positive symptoms through which schizophrenia manifests itself? What is meant by the word 'positive' in this definition?
4. In general, how do positive symptoms differ from negative symptoms in schizophrenia?
5. What does 'depersonalization' mean? What are its consequences for the affected person?
6. What types of schizophrenia do we distinguish?



7. What is typical for hebephrenic schizophrenia?
8. Through what symptoms does schizophrenia manifest itself during the prodromal stage?
9. What two stages often alternate in schizophrenia? What is their content?
10. How can a person suffering from schizophrenia be socially stigmatised?
11. What are the specifics of schizophrenia in childhood?



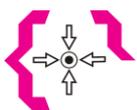
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7 Affective Disorders



Objectives

After studying this chapter you will be able to recognize the symptoms of depression and mania. You will learn how these diseases present physiologically and how they most threaten the affected person. You will learn the specifics of these diseases in childhood.



Terms to Remember (Key Words)

- affective disorder
- endogenous
- bipolar
- affective



- depression
 - masked depression
 - somatic syndrome
 - self-harm
 - anaclitic depression
- depression
 - cognitive depression
 - inhibition depression
 - recurrent depressive disorder
- disorder
 - manic mood
 - hypomania
 - hypermania
 - cyclothymia
 - dysthymia

7.1 Characteristics of Affective Disorders

The basic manifestation of any of the affective disorders is a pathological mood which does not correspond to the actual life situation of the affected person and disturbs his/her thinking, behaviour and somatic functions (Vágnerová, 2004).

An affective disorder affects approximately 25% of the population at least once in life, with depressions occurring more often than manias. According to various authors, depressions occur in 1–20% of adults and affect women twice as much as men.

Several mutually interacting factors can contribute to the onset of an affective disorder: a set of hereditary dispositions, developmentally conditioned changes, and various present stressors. The incidence of depression is also influenced by climatic conditions; in countries where there is less light and it is colder, depression is more frequent. Depressive disorders show a certain dependence on the season and are present the least during the summer months (Vágnerová, 2004).

7.2 Types of Affective Disorders

7.2.1 Depression

Depression belongs among the most frequent mental illnesses. The use of the term 'depression' can be traced back to the end of the 19th century when psychiatrists used it to replace the term 'melancholia' (Smolík, 2002).



According to the International Classification of Diseases (1992), an individual in a **depressive stage** suffers from a lowering of mood, a reduction in energy and a decrease in activity. The capacity for enjoyment is reduced, interest in activities is lower, and marked tiredness after even a minimum of effort is common. The lowered mood varies little from day to day and does not correspond to the affected person's life circumstances. Other common symptoms of depression include a reduction in concentration, lowered self-confidence and self-esteem, feelings of guilt and worthlessness, a sad and pessimistic outlook for the future, and thoughts of self-harm and suicide.

Depression is also usually accompanied by a **somatic syndrome** whose symptoms include a loss of joy from normally pleasurable activities and waking up in the morning two (or more) hours earlier than usual. Depression is worse in the morning, and loss of appetite, weight loss (5% or more of body weight in the past month) and significant loss of libido occur.

Despite the fact that the affected person lacks appetite, movement or sexual activity, they can suffer from physiological problems of various kinds, such as feelings of heaviness, chest pain, a racing heart, headache or stomach ache, digestive problems, sleep disorders, etc. If the primary depression symptoms are missing from the patient's clinical picture and mainly somatic problems occur, **masked depression** can be considered during which a sad mood is transformed into physiological symptoms (Vágnerová, 2004).

Vágnerová (2004) lists the following **clinical manifestations of depression**:

- A depressed person cannot react emotionally in the usual way to the stimuli that commonly cause emotions; instead he/she is indifferent to them. An affective stupor can even occur, i.e. the loss of the ability to have emotional experiences and feelings of emptiness.

During his stay at the psychiatric ward, a depressed patient whose son was arrested for alleged activity against the state did not react to this event in any way and continued to focus on his own thoughts. This reaction can be perceived as a defence mechanism, as a depressed individual defies other stressors in that he/she does not accept them at all. (Vágnerová, 2004, p. 376)

- A depressive mood, particularly in a severe depressive episode, affects all lived experience very strongly. Depression is also



connected with a tendency to experience things with anxiety, with feelings of guilt, hopelessness, desperation and helplessness appearing.

- An overall slowdown in and inhibition of cognitive functions occurs. The ability to focus and to recall necessary data from memory is impaired and the inability to think and make decisions appears.
- Depression leads to a deformation of the content of thoughts towards pessimism, to an emphasis of life's negative aspects, to overestimation of one's own mistakes and to an inappropriate generalisation of negative experience. From the patient's point of view, everything is bad and nothing good will ever come his/her way. The affected person sees him/herself as incapable; he/she will not achieve anything and does not deserve anything good either.
- Depression manifests itself with a reduction in psychomotor pace (limp body posture, slow gait), slower reactions and monotonous, quiet speech. The patient feels tired, as if without energy, and shows only minimal activity. In the extreme, a depressive stupor may appear, during which the affected person does not move, does not speak and does not react to anything.

According to the depth of the depression and the severity of its symptoms, ICD-10 distinguishes several degrees of depressive episodes:

- **Mild depressive episode** manifests itself with a depressive mood, increased tiredness and a loss of interest and enjoyment. The individual is bothered by these symptoms to such an extent that he/she has certain difficulties doing normal work and social activities, but probably will not stop functioning altogether.
- The symptoms of a **moderate depressive episode** are of such a degree that the individual is able to continue his/her social, work-related and domestic activities only with great difficulty.
- **Severe depressive episode** is manifested by all of the typical symptoms (depressive mood, increased tiredness, loss of interest and enjoyment) and, in addition, loss of self-respect and feelings of worthlessness and guilt come to the fore. It is assumed that a somatic syndrome is almost always present during a severe



depressive episode. During this episode, it is improbable that the affected person will be able to continue his/her ordinary activities and if he/she is, then only very restrictedly. In especially severe cases, there is an obvious risk of suicide.

- **Severe depressive episode with psychotic symptoms** includes, apart from the symptoms of a severe depressive episode, delusions, hallucinations or depressive stupor. Delusions usually include thoughts of sin, poverty or impending doom, for which the patient feels responsible. Auditory hallucinations have the form of slanderous or accusing voices, for instance.

In depression, people have an increased tendency towards **self-harm and suicidal behaviour**. Many people suffering from depression long for death, which would liberate them from their mental torment, but they do not attempt suicide as they do not have enough energy to carry out the act. Paradoxically, the risk of a suicide attempt appears when the patient's condition improves and he/she is no longer as inhibited and has a sufficient activation level (Vágnerová, 2004). Suicide attempts occur three times more often in women than in men, which can be explained by the higher incidence of depression in this sex. People who have not completed their suicide attempt list depression, loneliness, illness, marital problems, financial problems, and problems at work as the most frequent reasons for attempting suicide. The elderly, even though their number is dropping, belong among the most frequent suicide victims. On the other hand, there is an increasing number of suicides among adolescents and young adults (Atkinson et al., 2003).

7.2.1.1 Manifestations of Depression in Childhood

Compared to an earlier opinion that stated this disorder was untypical in childhood, depression is currently recognised a disorder from which children suffer at least as often as adults. Its basic manifestations include (Kocourková in: Říčan, Krejčířová et al., 2006):

- sad mood, feelings of hopelessness, apathy,
- loss of interest in and enjoyment of ordinary activities,
- eating disorders (loss of appetite or overeating),
- sleep disorders (particularly sleeplessness),



- inhibited movements or agitation,
- fatigue, loss of energy,
- loss of feeling of one's own worth,
- inappropriate feelings of guilt,
- impaired concentration,
- thoughts of death.

In the text below we will pay attention to the specific manifestations of this disorder in the individual developmental periods of childhood.

- Depression in the **suckling period** appears as a result of long-term dissatisfaction with having its basic biological needs met. From six months of age, **anaclitic depressions** are most typical in this period, i.e. reactions of the child to separation from the mother. The child goes through certain typical stages during which it first cries and seeks out the mother, then becomes apathetic, does not react to the social environment and refuses food and contact.
- In the **toddler period**, depressions are manifested as sleep and eating disorders, more frequent autostimulation behaviour, disinterest in playing, negativism, and increased dependence on the mother.
- In **pre-school age**, depression manifestations are dominated, due to the inability to self-reflect, by physiological symptoms (headache and stomach ache), loss of interest in and enjoyment of playing, isolation from peers, aggressiveness, destruction, and frequent daydreaming about pain and death.
- Depression in a child of **school age** is accompanied by low self-valuation and feelings of guilt and helplessness; playing often deals with depressing topics (injury, shame, loss of a loved one, rejection by others, or critique). The child loses interest in learning and his/her classmates, has difficulties concentrating on learning, and worsens significantly. Physiologically, there is either inhibition or hyperactivity. The risk of suicide is real during this period.
- **Puberty and adolescence** are periods in which a certain degree of emotional instability is common. However, it is necessary to



quickly detect possible pathological depression, as the risk of suicide is extraordinarily high. It is manifested by a marked mood disorder, loss of energy, tiredness, and a tendency towards withdrawal. Lower self-valuation is common as are feelings of hopelessness, which the adolescent may start resolving with alcohol, drugs or promiscuity. Other manifestations of depression can be in the form of suddenly worse school results, changes in behaviour or physiological problems.

Depression during adolescence can be present in two basic syndromes. **Cognitive depression** is based on the change of perceiving oneself, one's present situation and the future negatively. Low self-valuation, feelings of uselessness, helplessness and guilt, and rejection by the social environment appear. Irritability and suicidal thoughts are often present.

The second syndrome is **endogenous** or **inhibition** depression and is characteristic for its inhibition, depressive mood and inability to become enthusiastic about anything.

The main causes of depression include hereditary and psychosocial factors. Even though the currently valid classification of diseases (ICD-10 and DSM-IV) no longer makes a distinction between 'neurotic' and 'psychotic' depressions, it is possible to use this now invalid classification as a basis for the assessment of a depressive disorder's causes, depth and therapy. Thus, depressions can be divided into 'reactive' and 'endogenous'.

The 'reactive' type of depression is caused as a consequence of negative environmental influences and compared to the 'endogenous' type is manifested by less severe symptoms and milder changes in psychomotor pace. The cause of the 'endogenous' type of depression is connected to genetic disposition and its manifestations include increased anxiety and self-pity. Most frequently, depression in childhood occurs as a reaction to the loss of a loved one and other traumatising events. It is often present in children with a learning disorder (up to 40% of children) and probably is a consequence of academic failure and excessive criticism by the social environment. Therefore, it is necessary to keep these risks in mind and focus on them when working with children.



The 'endogenous' type of depression is less frequent in children and can be accompanied by psychotic symptoms, such as hallucinations (particularly auditory, so-called 'voices') and delusions.

In **bipolar affective disorder**, depressive and manic episodes alternate and in this form it appears only during adolescence. In pre-school age and younger school age, however, some deviations are already present, particularly emotional lability, irregular physiological functions and the overall maladaptivity of the child. Depressive manifestations are more frequent than manic in younger children. In childhood these can take the form of a feeling of omnipotence, excessively increased activity or moodiness. In children of a younger school age, the episodes typically do not alternate, but the disorder is chronic and there are very quick switches between depression and mania, even several times per day.

7.2.2 Mania

The basic symptom of a **manic mood** is a pathologically elated, convulsive mood connected with hyperactivity, expansive behaviour and cheerfulness. However, it is not just about escalated merriment, as the individual is also tense and his/her conspicuously good mood does not seem very natural. Subjectively, a manic episode can be more pleasant than depression, but from the viewpoint of the social environment it is the other way round. The patient is uncritical, too optimistic, lacks judgement and cannot estimate danger, yet his/her mental activity is faster and increased, so the individual's conduct is imprudent, e.g. he/she spends excessively, closes strange deals or makes unrealistic plans. Hyperactivity can be combined with irritation, and therefore there is a higher risk of various conflicts and disruptions in interpersonal relations, particularly in the family (Vágnerová, 2004).

Similarly to depression, mania is also reflected in a change in physical functions. The **somatic syndrome in the manic episode** is manifested by excessive appetite and increased sexual appetite, and the affected person has excessively activated somatic processes, does not need much sleep and still feels fresh.

The patient's thoughts are also faster (tachypsychism) and change into rapid thoughts, with the speech pace lagging behind, and therefore the individual's verbal manifestations are seemingly incoherent to the outside. A patient in a manic episode is convinced that he/she is focusing very easily, but his/her



attention is distracted, or is convinced that he/she understands very easily and that there is nothing he/she could not resolve. In reality, however, this is a disrupted evaluation of one's own capabilities, not a real improvement of intellectual functions.

Just a month ago, Tony was a normal, sensitive, quiet man, but then his behaviour significantly changed. He worked as a bus driver in Philadelphia. Once, he suddenly stopped the bus at an intersection, turned to face his passengers and started to sing. When he was asked about this at home, Tony replied that he had decided to become a lounge singer and that he was happy about being laid off, as he would have more time for his singing career. Tony has hardly any musical talent, but two weeks ago he went to Las Vegas where he approached a few casino managers and tried to persuade them to let him sing at their clubs. When they threw him out, he started to threaten them. That's why he was arrested in the end. Then he decided to open his own casino in Philadelphia (even though gambling is prohibited in this city) so as to be able to sing every evening. To implement his plan, he withdrew all the family savings from the bank and put the house up for sale. (Atkinson, 2003, p. 541)

The International Classification of Diseases (1992) specifies three degrees of an illness whose common denominator is elated mood and increased physical and mental activity:

- **Hypomania** is a lower degree of mania, with persistent mood elevation, increased energy and activity, and marked feelings of well-being and physical and mental efficiency lasting for at least several days. Often present are increased sociability, talkativeness, over-familiarity, increased sexual energy and a decreased need for sleep, but not to the extent that they would seriously disrupt the individual's ordinary activities. Attention focus can be disrupted, decreasing the ability to work, relax or be entertained.
- **Mania** is manifested by a mood that is elevated out of proportion with the patient's circumstances. Elation is accompanied by increased energy. The individual loses social inhibitions and has inflated self-esteem. Pressure of speech appears as do grandiose ideas and over-optimistic thoughts. The affected person can venture into unrealistic and impractical plans, spend money in a carefree way or be aggressive, enamoured or jovial in inappropriate circumstances. The first episode most often appears between 15 and 30 years of age, but can also appear anytime between late childhood and old age.



- **Mania with psychotic symptoms** has all the characteristics of a manic mood. In addition, inflated self-esteem and grandiose thoughts can develop into delusions, while irritation and suspiciousness can develop into persecution delusions.

The affected person is convinced of his/her importance and uniqueness. Delusions of grandeur are sometimes connected with feelings of injustice, with a need to prove one's alleged worth to other people. The patient feels like the saviour of all humankind, discovers a cure for cancer, etc. He/she has a need to be involved in all that is happening and to influence the world which – in his/her opinion – does not fully appreciate him/her. (Vágnerová, 2004, p. 384)

7.3 Course of Affective Disorders

With regard to the course of affective disorders, the International Classification of Diseases (1992) distinguishes the following individual categories:

- **Manic episode** is diagnosed in the case of a single episode that has to last at least two weeks and after ending is followed by no additional affective episodes, be they manic or depressive.
- **Bipolar affective disorder** is characterised by repeated episodes that disrupt the mood and activity level. This disorder is sometimes manifested by elation and increased energy and activity (mania or hypomania) and at other times by a lower mood and decreased activity (depression). Remission (a period without a mood disruption) between these episodes is usually complete. The frequency of episode alternation can vary greatly; however, over time, remissions tend to be shorter and depressive episodes tend to be more frequent and last longer after middle age is achieved. The incidence of this disorder is approximately the same in both sexes, as opposed to other mood disorders. The first episode can appear at any age between childhood and old age. This disorder used to be called manic-depressive psychosis.
- **Depressive episode** is diagnosed in the case of a single episode. This form is more frequent than its manic counterpart, but in half the patients depression occurs repeatedly during their lives and then belongs in a different diagnostic category.



If an individual suffers from repeated depressive episodes, this condition is diagnosed as a **recurrent depressive disorder**. Individual depressive episodes last three to 12 months (six months on average), are often caused by stressful life events, and are twice as frequent in women as in men. Depressive episodes are separated by a period of several months without a significant mood disruption.

- **Persistent mood disorders** are long-term and usually fluctuating disorders of mood, during which individual episodes are exceptionally severe enough to be described as manic or depressive episodes. As they can persist for several years and sometimes for a larger part of an individual's adult life, they result in his/her subjective distress and disability.
- **Cyclothymia** is a persistent instability of mood with numerous periods of mild depression and mild elation (elated, excessively cheery mood). This instability is usually developed in early adulthood and has a chronic course, even though sometimes the mood can be normal and stable for several months. The individual usually sees that the fluctuations of his/her mood are not connected to life events.
- **Dysthymia** is a chronic depression of mood. The affected person goes through days or weeks in which he/she feels good, but most of the time he/she feels tired and depressed. However, he/she usually manages all of the basic requirements of daily life.

7.4 Affective Disorder Therapy

Medication has a fixed place in the treatment of affective disorders and is used in combination with psychotherapeutic strategies, complementing each other mutually.

Treatment of depression can never be underestimated, in particular with regard to suicide risk. The following psychotherapeutic methods have been proven effective (Rahn and Mahnkopf, 2000):

- cognitive behavioural therapy,
- interpersonal psychotherapy,



- psychoanalytical treatment,
- couples and family therapy.

Combined with antidepressants, the aforementioned methods affect both the lessening of depression symptoms and the risk of relapse. Psychotherapy is effective primarily in terms of its long-term influence on the depressive syndrome.

Manic episodes also require treatment by psychopharmaceuticals, with a host of effective medications available.

The treatment of bipolar disorder is managed according to the prevailing symptoms. When manic and depressive episodes alternate quickly, the pharmacological treatment must be adjusted to the present condition and requires good co-operation from the patient. It is also suitable to combine this treatment with psychotherapy in these cases.



Review Questions

1. How frequent is the incidence of affective disorders in the population? What sex is affected more often?
2. What primary symptoms constitute the basis of a depressive disorder?
3. How does the somatic syndrome manifest itself in depression?
4. What is the essence of masked depression?
5. How does masked depression threaten the affected person the most?
6. What are the specifics of childhood depression?
7. What is the essence of mania?
8. How does the somatic syndrome manifest itself in mania?



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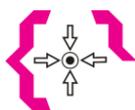
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8 Neurotic Disorders



Objectives

After studying this chapter you will be able to distinguish the respective types of neurotic, stress-related and somatoform disorders.



Terms to Remember (Key Words)

- neurotic disorders
- phobic anxiety disorders
- OCD
- stress-related disorders
- somatoform disorders

8.1 Definition of Neurotic, Stress-Related and Somatoform Disorders According to ICD-10



These three groups of disorders are classified in the same category in ICD-10 with regard to their historic connection with the term **neurosis** and with regard to the fact that the vast majority of these disorders are connected with psychological causes of origin (ICD-10, 2010).

The category of *Neurotic, Stress-Related and Somatoform Disorders* includes various disorders in which several common denominators can be described (Vágnerová, 2004):

- persistent disproportionate anxiety which becomes maladaptive and causes purposeless behaviour,
- anxiety can be accompanied by physical manifestations,
- the extent of impairment is so large that it limits the patient's functioning in various life roles (work, family, partner),
- to a large extent environmental influences contribute to the cause of these disorders,
- the patient usually knows about the inappropriateness of his/her reactions but cannot control them.

The incidence of all disorders from this group is only estimated. It seems that an increase has occurred in recent decades (1960s around 15%, now 35–40%). We have more exact data from studies in the population about only some disorders (generalised anxiety disorder around 8%, social phobia around 14%, panic disorder around 3%, agoraphobia around 6%, specific phobias around 15%, obsessive-compulsive disorder around 5%, and post-traumatic stress disorder around 8%). The majority of these disorders are more frequent in women than in men (Vágnerová, 2004).

The causes of this group of disorders are usually multifactorial. To a certain extent, readiness for the development of anxiety is congenital; however, childhood upbringing is also important (the problems seem to be premature separation from care providers, rejection, excessive punishment, criticism and abuse, but also anxious parents, conflicts between parents, and problems in groups of children). The combination of congenital vulnerability and negative childhood influences leads to the creation of vulnerability to a future neurosis. Persistent stress, stressful life events, conflicts or excessive demands in later life then lead to the development of neurotic problems in more vulnerable individuals.



8.2 Phobic Anxiety Disorders (F40)

This group involves disorders in which anxiety is caused by certain well-defined situations or objects that are normally not dangerous. Phobic anxiety disorders are manifested in the form of irrational, abnormal fear of objects and phenomena which do not cause fear in healthy people. In essence, this is a reaction that has developed from an originally unspecified anxiety and that is manifested by an escalated reaction of fear of a certain stimulus.

The affected person tries to avoid the dreaded objects, which can, as a result, lead to restricted functioning.

A person suffering from a phobia usually sees the illogicality of his/her worries and reactions, but cannot control him/herself. The anxiety is not alleviated, even though he/she is aware of the fact that other people do not consider the situation in question dangerous or threatening. The mere thought of an individual that he/she would be in contact with the subject of the phobia causes feelings of anxiety.

ICD-10 distinguishes three basic groups of phobias:

Agoraphobia (F40.0) is characteristic for its abnormal fear of open spaces. It appears in situations when the affected person is outside his/her home (e.g. in a shop or in means of transportation). It is connected to fear of losing control and panic. Such places are avoided and this can lead to a situation where he/she does not leave home at all.

Social phobia (F40.1) is manifested by an abnormal fear of social contact and situations, primarily during which the individual is the centre of attention, feels embarrassed and fears criticism and ridicule. These feelings are followed by a physical accompaniment in the form of blushing, tremor, sweating, nausea, or an inability to react.

Specific (isolated) phobias (F40.2) are characterised by a fear of individual stimuli. For example, they include:

- claustrophobia (fear of closed spaces),
- acrophobia (fear of heights),



- nyctophobia (fear of darkness),
- zoophobia (fear of animals),
- arachnophobia (fear of spiders),
- mysophobia (fear of dirt and bacterium), etc.

Social phobias and specific phobias belong among the most common types of anxiety disorders (www.mentalhealth.com).

8.3 Other Anxiety Disorders (F41)

These are disorders in which the major symptom is the manifestation of anxiety that is (as opposed to phobic disorders) not restricted to any particular situation.

8.3.1 Panic Disorder (F41.0)

Panic disorder includes attacks of panic anxiety which occur without an obvious cause, which are not limited to a certain situation or a set of circumstances, and which cannot be predicted. The attack takes the form of a sudden, very intense fear of short duration. The affected person feels he/she cannot control his/her anxiety. It can be a single attack or attacks can also be recurrent.

During the attack, the affected person experiences strong feelings of terror, hopelessness and helplessness. Other accompanying feelings include a feeling of strangeness toward oneself and the world around, a fear of going mad and of dying, and a tendency towards an irrational interpretation of one's problems. This is accompanied by worries about another possible attack, and thus the affected person tries to avoid places where he/she has been stricken with panic and places where there are a lot of people and from which he/she would have difficulties escaping in case of panic.

This disorder is also reflected in physical symptoms. Vágnerová (2004) includes the following somatic manifestations among the most frequent: palpitations, rapid pulse, sweating, tremor, switching between flushes and chills, feelings of nausea, dizziness, not feeling one's own body, and feelings of suffocation. The affected person often believes that these are symptoms of serious heart, lung or brain diseases. As a result, the patients observe themselves more, which



repeatedly produces a condition of anxious tension and increases the probability of other attacks.

8.3.2 Generalised Anxiety Disorder (F41.1)

This disorder's symptoms primarily include abnormally high anxiety in the form of various worries and premonitions that cannot be controlled by the affected person.

Anxiety also changes one's way of thinking and one's attitude towards the world around. Increased attention to stimuli is developed that can cause anxiety, so-called anticipatory anxiety, which results in the patient being worried not only about certain situations, but also of his/her own anxious reaction to them. The patient has a persistent, certain way of thinking about him/herself and those around him/her. Negative expectations and pessimistic evaluations of past situations prevail. Anxiety usually negatively influences the level of concentration and memory performance. This is also one of the reasons for impaired self-valuation, with common feelings of inferiority and abnormal concerns about criticism.

Repeated experiences of uncertainty and loss of control result in often purposeless behaviour with a tendency towards escalated reactions, when the patient for instance suddenly runs away or is incapable of any reaction. Threats connected with these manifestations are often the cause of evasive acts through which the affected person tries to escape from threatening conflicts.

This disorder also includes somatic symptomatology. Patients suffer from sleep disorders, feelings of tiredness, palpitations, tremor, increased sweating, dizziness, breathing and digestive problems, etc. These are often a reason to visit a physician. Anxiety is also reflected in the patient's appearance and in his movements (Vágnerová, 2004).

8.4 Obsessive-Compulsive Disorder (F42)

The abbreviation 'OCD' is commonly used when referring to obsessive-compulsive disorder. Recurrent obsessive thoughts (obsessions) or compulsive acts (compulsions) are the essential feature of this disorder.



Obsessions are thoughts, ideas or images that repeatedly enter the patient's mind in a stereotypical way. They almost always cause anxiety, as they are perceived as unacceptable, nonsensical and threatening. The affected person tries to suppress them, usually unsuccessfully.

Compulsions are manifested by repeated purposeless acts that the affected person carries out with the aim of averting danger. Compulsive acts are experienced as unpleasant but necessary by the affected person. They are considered a lesser evil than the anxiety that precedes them. The patient is aware of their purposelessness and nonsensicality but cannot control them. The effort to suppress them is accompanied by increased anxiety.

There are five types of symptoms that occur most frequently in people with OCD (Hort et al., 2000):

1. **Fear of contamination, connected with washing rituals.** The patient is afraid of dirt, microbes and body secretions. He/she stays for hours in the bathroom washing him/herself, does not touch anything, and avoids anything considered 'dirty'.
2. **Pathological doubts connected with rituals of control** (e.g. switches, windows, locked doors).
3. **Persistent thoughts of an unacceptable nature** (usually having an aggressive or sexual content), which the affected person tries to prevent by repeating a certain activity over and over.
4. **Obsessions of exactness, symmetry and order** connected with rituals of orderliness, organisation and tidiness in accordance with certain rules.
5. **Primary obsessive slowdown** prevents the patient from functioning normally as he/she carries out rituals all day long (e.g. it takes him/her hours and hours to put his/her clothes on).

8.5 Adjustment Disorders and Reaction to Severe Stress (F43)

This category includes disorders that can be identified not only on the basis of their symptoms but also on the basis of the connection of the problems to an exceptionally stressful life event or a significant life change. In these disorders, it is assumed that they are always a direct consequence of acute, severe stress:



- acute stress reaction (F43.0),
- post-traumatic stress disorder (F43.1),
- adjustment disorders (F43.2).

8.6 Dissociative (Conversion) Disorders (F44)

The common themes of the disorders included in this group are a partial or complete loss of normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. Dissociative disorders are a result of psychological defences being erected against experienced emotional stress. This group of disorders includes:

- dissociative amnesia (memory loss),
- dissociative fugue (running away from home),
- dissociative stupor (rigidity, absence of movement),
- trance and possession disorders,
- dissociative motor and sensory loss disorders (paralysis, convulsions, loss of vision),
- dissociative identity disorder.

Dissociative identity disorder (also called multiple personality disorder) is manifested by the existence of two or more different personalities in one individual which take turns controlling his/her behaviour. Each personality usually has his/her own name, age, memories and behaviour patterns. The attitudes and behaviours of the alternating personalities are very different. In almost all cases, one personality cannot recall what is happening with the other personalities.

Cases of dissociative identity disorders always attract a lot of attention, although they are rare. One of the most famous cases, which was depicted in the 1957 film 'The Three Faces of Eve' and in more detail in the autobiography 'I'm Eve', was the case of Chris Sizemore. Three personalities developed in this woman: Eve White – an obedient housewife; Eve Black – a sexually promiscuous woman; and Jane – something like a combination of the two former personalities. In the end, this woman had developed 22 different personalities in order to cope with the traumatic experiences she had had to cope with at two years of age. (Kassin, 2004)



Individuals suffering from a dissociative identity disorder often claim they were physically or sexually abused in childhood. The basic hypothesis about the onset of this disorder assumes that a multiple personality is developed as a defence against traumatic childhood experiences. The child copes with painful experiences by separating memories from consciousness. The existence of multiple identities allows the other personalities to not be aware of the abuse, as if it was happening to someone else. As soon as the affected person realises that the creation of another personality has brought him/her relief from emotional pain, he/she has a tendency to create other identities in the future, should he/she encounter emotional problems (Atkinson, 2000).

8.7 Somatoform Disorders (F45)

Somatoform disorders are characterised by feelings of physical symptoms or subjective belief of one's own illness, which, however, is not confirmed by an objective medical examination. The physical symptoms are caused by psychological problems.

Somatization describes a process where a physical reaction is caused under the influence of an emotional experience and is connected with non-standard (or even pathological) behaviour. Usually, these include problems with the regulation of the functioning of bodily organs when a person, for instance, has a stomach ache or feels short of breath, despite the fact that there is no organic cause as a result of physical strain or anger. These physical problems take on a certain significance, e.g. they prevent the individual from activities he/she is afraid of or which he/she resists. However, the affected person does not admit the possibility of psychological influences and repeatedly requests an examination by a specialist to clarify his/her problems. The affected person is not pretending; he/she really does not feel well (Vágnerová, 2004).

The category of somatoform disorders includes somatization disorder, hypochondriacal disorder, somatoform autonomic dysfunction, persistent somatoform pain disorder, and others.



8.7.1 Somatization Disorder (F45.0)

Somatization disorder manifests itself in repeated multiple and often changing physical symptoms, with its course being chronic and fluctuating, and is often associated with the long-term disruption of social behaviour. The affected person refuses to accept the assurances of even several different physicians that there is no medical explanation for his/her symptoms.

8.7.2 Hypochondriacal Disorder (F45.2)

Hypochondriacal disorder is diagnosed in patients who are persistently preoccupied with the possibility of having one or more serious physical disorders or who believe that they are disfigured, even though it is not objectively the case. The individual is excessively focused on his/her own physical sensations. Normal, common sensations are often interpreted as symptoms of a disease. Some patients control and manipulate their family and social environment with their symptoms.

8.8 Other Neurotic Disorders

8.8.1 Neurasthenia (F48.0)

The essence of this disorder emphasises tiredness, weakness and worries of the individual about his/her lower mental and physical performance.

There are two main types of neurasthenia:

- In the first type, the main feature is complaints of increased fatigue after mental effort, often accompanied by a decrease in occupational performance or coping efficiency in daily tasks. Mental fatiguability is described as generally ineffective thinking and difficulty in concentrating.
- In the second type, the affected person complains about feelings of bodily weakness and exhaustion after minimal effort, accompanied by a feeling of aching muscles.



In both types, other unpleasant feelings are common, e.g. dizziness, headaches, tension, sleep disorders and irritability.

8.8.2 Depersonalization-Derealization Syndrome (F48.1)

In this disorder, the affected person complains that his/her own mental activity, body and surroundings change in their quality so as to be unreal, remote or automatized. The individual can have a feeling that:

- he/she has lost emotions,
- he/she does not create his/her own thoughts, imagination or memories,
- his/her movements and behaviour are not his/her own,
- his/her body seems lifeless, distant,
- the surroundings lack colour and life and seem artificial,
- he/she looks at him/herself from a distance or as if he/she is dead.

Depersonalization-derealization syndrome often appears in connection with depression, a phobic disorder or obsessive-compulsive disorder.

Elements of this syndrome can appear in mentally healthy individuals when they are tired, suffering sensory deprivation, or intoxicated by hallucinogens.

8.9 Neurotic Disorder Therapy and Resocialisation

In the treatment of these disorders, pharmacological, psychotherapeutic and sociotherapeutic approaches are combined (Vágnerová, 2004).

- **Pharmacological** treatment tries to alleviate the feelings of anxiety and depression and calm the patient down.
- **Psychotherapy** uses various approaches that lead primarily to relaxation and weakening the influences of trigger mechanisms (e.g. supportive psychotherapy, relaxation techniques, hypnosis, behavioural therapy) and also to the acquisition of a new



perspective on and interpretation of the disorder (insight-oriented therapy, cognitive therapy).

- **Family therapy** is a specific form of psychotherapy that works with the entire family system. Its essence lies in the fact that the patient cannot be treated separately from the environment in which he/she lives. Mostly, it tries to remove possible negative influences and to increase the family members' understanding of the patient's problems. However, the problems of other family members are also considered, with the overall objective being family members' support of the patient, education in terms of suitable behaviour toward the patient, and the resolution of relationship problems in the family.
- **Sociotherapy** is dominated by the effort to include the patient in the wider social environment and supporting his/her fulfilment of social roles.



Review Questions

1. What groups of phobias does ICD-10 distinguish?
2. What is obsessive-compulsive disorder and what are its symptoms?
3. Explain the term 'somatization' and give some examples of somatoform disorders.
4. What approaches are used in the treatment of neurotic disorders?
5. Have you personally experienced any of the symptoms typical of neurotic disorders?
6. In the recommended sources, find examples of important personalities who suffered from some type of mental disorder.



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9 Behavioural Syndromes Associated with Physiological Disturbances and Physical Factors



Objectives

After studying this chapter you will have an overview of the eating disorders. You will be able to characterise them and determine their symptoms and course.



Terms to Remember (Key Words)

- anorexia
- bulimia
- BMI

9.1 Eating Disorders

Eating disorders take one of two basic forms – anorexia nervosa and bulimia nervosa. Anorexia nervosa affects around 0.5–0.8% of the population and bulimia around 2–4%. Girls and women are primarily affected, with the sex ratio being 10:1 in anorexia and 20:1 in bulimia (Rahn and Mahnkopf, 2000).



The International Classification of Diseases lists the following symptoms of these disorders.

9.2 Symptoms of Anorexia Nervosa

- Body weight is kept at least 15% below the optimal weight, or the BMI is 17.5 or less. Pre-pubescent patients do not meet the expected weight gain while growing.
- The BMI is an abbreviation of Quetelet's body mass index and can be calculated by dividing one's weight (in kg) by the square of one's height (in m).
- The patients induce their weight loss themselves by avoiding food and using one or more of the following means: induced vomiting, induced defecation, use of anorectics and diuretics, excessive exercise.
- A persistent dread of fatness, a distorted idea about one's own body, and a striving for low weight.

9.3 Symptoms of Bulimia Nervosa

- A persistent preoccupation with food, an uncontrollable desire to eat, and overeating episodes during which large portions of food are eaten within a short time.
- Efforts to suppress the effect of the food through the following means: induced vomiting, abuse of purgatives, alternating periods of fasting, using medication such as anorectics, thyroid preparations or diuretics.
- The patients have a pathological fear of fatness and define an exactly determined weight threshold that is lower than their optimal weight. Often, but not always, their anamnesis includes an earlier episode of anorexia nervosa.

The effort to sustain a low weight gradually leads to the development of a wide range of subsequent physiological, psychological and social complications (Raboch, Zvolský et al., 2001):



- **Physiological complications** – changes in the digestive tract and cardiovascular system, hormonal disorders, and delayed or stopped symptoms of adolescence (no menstruation or secondary sex characteristics).
- **Psychological complications** – interests restricted to dieting, concentration problems, black-and-white thinking, no confidence in oneself or others, shame, self-accusation, emotional lability, depression, anxiety.
- **Social complications** – social isolation, loss of the ability to cope with daily duties (unfinished studies, loss of work), problems in relationships, economic problems.

The factors that affect the disorder's onset, course and result can be divided into predisposition, triggering and maintaining factors. Eating disorders are most frequently present in countries of the western world with values oriented towards individualism, success and performance. The negative influence of the social perception of slimness as the desired norm related to youth, health, success and independence is also important. Families with problematic interactions are a risk factor; these families are often closed and rigid, and emphasise perfectionism and performance. Difficult separation processes are also significant. The most important triggering factors of the disease are the development requirements of and tasks during adolescence, problems gaining independence during adolescence, experiences connected with a breach of the family balance, threat to self-valuation, somatic disease, and sexual abuse (Říčan, Krejčířová et al., 2006).

The treatment of eating disorders combines several measures (Rahn and Mahnkopf, 2000):

- **Information about the disease and treatment possibilities:** Patients are informed about all aspects of nutrition and know about the pathological character of anorexia nervosa or bulimia nervosa. The treatment information helps ease the patient's worries about the loss of control over their eating habits and about them being 'fattened up' during the treatment. By naming the objectives of the treatment, the therapy becomes more transparent and removes the tendency of the patient to covertly fight for power with his/her physician.



- **Ensuring physiological health:** Mainly in the case of anorexia, patients can reach a state in which their life is threatened. The patient and the physician agree on a weight limit below which the physician will insist on force-feeding. An explicit agreement on the value below which the weight should not drop is advantageous in therapy because one does not have to discuss the patient's weight and eating habits all the time.
- **Agreement on the treatment progress and its objective:** Treatment objectives are not only limited to gaining the target weight and the normalisation of eating behaviour. After the patient is able to break the vicious circle of fasting and overeating, they will have enough space to deal with other aspects of life. It is important to emphasise one's own responsibility, which strengthens the patient's autonomy.
- **Psychotherapy:** A host of effective psychotherapeutic approaches has been created, with behavioural therapy, psychodynamic techniques and family therapy being used. According to these approaches, there are inpatient and outpatient treatment programmes which consist of various elements. All these programmes usually include individual and group therapy, body-oriented techniques (dance therapy), and approaches that support self-awareness (relaxation, music therapy).
- In approximately 80% of patients, the eating disorder is cured. Some 5% to 15% of the affected persons die of the consequences of the disease, and in a number of patients the disorder becomes chronic (Rahn and Mahnkopf, 2000).



Review Questions

1. What does the abbreviation BMI denote?
2. What are the main symptoms of anorexia nervosa?
3. What are the main symptoms of bulimia nervosa?
4. What are some subsequent complications in persons affected by anorexia nervosa or bulimia nervosa?
5. What is the prognosis for these diseases?





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10 Personality Disorders



Objectives

After studying this chapter you will have an overview of the different types of personality disorders. You will be able to name them and describe each individual type in terms of its causes and course.



Terms to Remember (Key Words)

- personality
- personality disorder
- personal well-being
- social adaptation
- paranoid disorder
- histrionic disorder
- negativistic disorder
- emotionally unstable disorders
- narcissistic disorder
- avoidant disorder
- schizoid disorder
- asocial disorder
- anankastic disorder
- resocialisation

10.1 Definition of the Term Personality

Personality is an integrated set of all mental phenomena. According to Vágnerová (2004, p. 70), its main features are:

- internal unity and structure of partial components,



- individual specificity (its difference from other personalities),
- developmental continuity (relative stability of the constellation of the individual components throughout its development).

A **personality disorder** can be defined as a **persistent and difficult-to-influence condition of personality traits that deviate from the sociocultural norm**. It is manifested by the persistent presence of some negative and extremely accentuated personality traits, by **disturbed personal well-being** (relationship with oneself, evaluation of oneself and one's own conduct), and by **impaired social adaptation** (relationship with the world, other people and the society).

Some general criteria can indicate the presence of a personality disorder (ICD-10, 1992):

- it is a persistent condition which, with certain fluctuations, lasts one's whole life,
- it is manifested by strange, maladaptive or grossly disturbing behaviour which results in the suffering of the affected person and his/her social environment and which increases the risk of conflicts,
- due to lowered stress tolerance, inappropriate reactions occur easily,
- insight into the inappropriateness of one's own behaviour, thinking and attitudes is insufficient,
- the affected person is resistant to change and is unable to learn from his/her experience.

Despite the fact that some symptoms are obvious as early as in childhood, a personality disorder can be **diagnosed only as of adolescence**.

10.2 Incidence and Causes of Onset

Personality disorders affect 5–13% of the population, with problems related to a disharmonic personality structure occurring in 10–18% of the population. The incidence of individual disorders is as varied as their representation in terms of



sex. The most frequent disorders are anxiety (1–10% of the population), schizoid (2.5–7.5%) and anankastic (1.7–6.4% of the population) (Vágnerová, 2004).

Various factors can contribute to the onset of personality disorders, from hereditary dispositions through developmentally conditioned fluctuations to social stress.

10.3 Clinical Symptoms

Overall, a personality disorder can be characterised as an **imbalanced structure of personality traits and peculiarities** (extreme traits, abnormal attitudes and behaviour) **and the inability to socially adapt** (Svoboda, 2006).

- **The cognitive function** is not impaired in terms of having lower intelligence, but in the way a person evaluates situations and him/herself. Thinking is egocentric and situations are evaluated with touchiness and mostly emotionally. Self-valuation is also impaired, being either abnormally increased or resulting in an inferiority complex. Insight into the inappropriateness of one's attitudes and behaviour is missing. The affected persons are unable to accept their share of responsibility for their problems, which they usually blame on those around them. They are unable to learn from their past mistakes.
- **Emotionality** differs in its quality and intensity and its lack of propriety. In some types of personality disorders, oversensitivity (paranoid personality disorder) is typical, while in others emotional withdrawal (schizoid disorder) or shallow emotions (histrionic personality) are typical. A typical symptom of the personality disorders is a lack of empathy and of altruism.
- **Behaviour** is generally maladaptive. Problems of self-control and the absence of empathy and of altruism constitute a very serious part of these disorders. The affected persons have a lower tolerance of stress and tendencies towards self-destructive behaviour (abuse of psychoactive substances, eccentric sexual behaviour, dangerous self-stimulation, etc.).



10.4 Types of Personality Disorders

In accordance with ICD-10 and DSM-IV, the following basic types of personality disorders are distinguished:

10.4.1 Paranoid Personality Disorder

Typical symptoms of this disorder are inappropriate **suspiciousness of other people** and **excessively sensitive self-valuation**.

The affected person has a **tendency to emphasise him/herself** and mainly his/her **personal rights**, the enforcement of which he/she devotes a lot of energy and time to. In relationships with other people, **suspiciousness and touchiness** are conspicuous. The affected persons have a tendency to evaluate the behaviour and attitudes of those around them as deliberately hostile. They are unable to forgive real or alleged injustice. These individuals also have problems at work and in their private lives because of their attitudes. Their social environment evaluates them as unpleasant and unjust and they are often rejected. Fanatic personalities can also be included in this category.

As an example, Vágnerová (2006) states the case of a jealous 38-year-old man who constantly checks on his wife by phone, asks her to not stop anywhere and to go directly home from work. If the wife gets delayed, he reacts with insults, reproaches and physical violence. He considers his wife's female friends unwanted; he does not want her to meet them as they allegedly incite her against him. He assesses his behaviour as normal and explains it as his reaction to the conduct of his wife, who 'would like to just use him and cheat on him – one cannot trust her'. (p. 520)

10.4.2 Schizoid Personality Disorder

In this disorder, **conspicuous introversion** (introversion, focus on own's own experiences and thoughts), **emotional withdrawal** and **disinterest in the outside world** are typical.

A person suffering from this disorder **is unable to experience and show emotions**, in particular satisfaction, love and tenderness. He/she remains closed in his/her own internal world and focuses on his/her own thoughts and fantasies. He/she uses his/her own logic, which is hard to influence due to the



person's lack of interest in the opinions and assessments of those around him/her.

In their relationships with other people, the affected persons are **cold** and **detached** and try to avoid contact, as it disturbs them. They usually do not have partners or friends. They adapt to social norms and habits only with difficulty.

Praško et al. (2003) provide an example in the case of 37-year-old Martin, who is single and has lost his job. He sees a psychiatrist due to his social phobia. In childhood, only a few words were said at home. His father did clerical work and brought his job home with him. He hardly spoke to his mother, who did not go to work, did not meet other people and studied history books all day long. He does not remember anyone playing with him or touching him. His parents were not interested in his school results. However, he usually did well in his studies, because he was interested in them. He was less interested in his classmates. As far as he remembers, he was extremely introverted and did not meet his peers. He never had a friend, but he also did not have enemies. He collected labels from safety-match boxes and built model airplanes. He never dated a girl. He likes women, but it would be too complicated to date them. He does not know what else apart from sex they could give him. He graduated from the department of mathematics and physics. For some time after graduation, he tried to teach, but was put off by the students' disinterest. Despite his education, he eventually found work in an archive where he could study all day long and did not have to meet anyone. Similarly to his mother, he was interested in history, in particular the history of war, and philosophical logic. He worked there for six years and avoided contact with people. He only went shopping. Half a year ago, his position was terminated. Now he is in a quandary. He has lost the possibility to read for days on end and experiences emptiness. He would like to learn to be among people in order to find a job. However, he does not want to work with people. He does not miss them. (edited)

10.4.3 Dissocial (Asocial) Personality Disorder

The most marked symptoms of this disorder are strong **egocentrism, a lack of concern for others, and an inability to dampen and control one's own reactions.**

Individuals suffering from this disorder are **emotionally immature.** They are unable to put off their own satisfaction, are quite **unrestrained,** and have a **need for strong excitement** (they have a hard time enduring boredom). They cannot empathise with other people.

They do not recognise generally valid norms and their conscience is only weakly developed. They are not able to appropriately assess situations and themselves (they see the world in extremes; they do not have a problem with themselves). Their low tolerance of stress often leads to **affective explosions, aggressiveness, violence and other kinds of criminal**



behaviour. In their relationships with people, they are unstable, unreliable and inconsiderate. Their behaviour is not easily influenced by experience.

Milan was born to a family of a police officer and a lawyer. His father was often not at home and when he was, he was mean, very strict and cruel. His mother was 'hysterical', she often quarrelled with his father, and his father sometimes beat her, too. She died of breast cancer when Milan was seven. From then on, his sister, who was three years older, took care of him most of the time. When Milan was beaten by a clique of older boys and confided in his father, he laughed at him and told him he was a coward. Soon, the tenet 'an eye for an eye, a tooth for a tooth' became his credo. He finished secondary school with great difficulty but thanks to bribes graduated in medicine. However, he had repeated problems with alcohol at work. He had to repeatedly leave his post as a physician after a series of problems with alcohol, absences and fights in pubs. In the meantime, his wife and child left him – 'she found someone more successful'. He is convinced that he has to seize every opportunity that presents itself. He considers the majority of people to be 'ignorants' who 'do not know how to work the system'. His main goal is 'to earn a lot, have a good time and have a lot of women'. He does not like 'all the morality talk, people just say things, but they are still interested in their own benefit like I am'. He devotes his leisure time to sports, he goes to the gym every day, and his main hobby is 'women', who he seduces at various occasions. (Praško et al., 2003, edited)

10.4.4 Emotionally Unstable Personality Disorder

This disorder is further divided into two types – impulsive and borderline.

10.4.4.1 Impulsive Type of Emotionally Unstable Personality

The most typical symptoms of this disorder include **impulsiveness, explosiveness and emotional instability.**

These individuals **cannot plan** or think of the future. They act impulsively and without consideration of the consequences. They have a **tendency towards egocentric thoughts** and are distrustful of other people. They often make things up and promise things that they do not fulfil.

The emotions of such affected persons are **changeable and unpredictable.** They are not able to put off satisfaction or control their behaviour. Their relationships with people are very shallow.



They are unable to **fulfil their duties** and cannot work systematically. They tend to be **undisciplined** and **intolerant**, and often cause conflict and rejection in their social environment. The **risk of asocial behaviour** is also increased in this disorder.

Doctor, I'm something. When I see a policeman, I see red and start looking for something to hit him with. I also hate gypsies when I see them. I immediately start a fight. I have already had many problems because of it, but I can't control myself. I don't have to be drunk; it's enough when they tell me something or want something from me. My last stint was five years for gross bodily harm. I would never steal something or mug someone, though. (Vágnerová, 2006, p. 526)

10.4.4.2 Borderline Type of Emotionally Unstable Personality

The essence of this type is **ambivalence and instability of self-concept together with disturbed emotional experience and thinking**.

Emotional emptiness, mood swings and affective reactions to minor stimuli are typical. Usually, **negative mood**, depression and anxiety are present.

Having an **unclear idea of oneself** is very typical; the affected person is not clear about who he/she is. This can also apply to sexual orientation when one is not sure whether one is homosexual or heterosexual. This disturbance results in the **inability to find some aim** or activity and related frequent feelings of boredom and emotional emptiness. The **tendency to think in black and white** about other people, who are either completely good or completely bad, is also characteristic.

Impulsive acts are a frequent reaction to the feelings of emptiness. Relationships with people are unstable and unsatisfactory. The affected persons can only love or hate and are unable to have a more sophisticated experience or a neutral relationship. They have **tendencies towards self-harm, excessive use of alcohol or psychoactive substances, and suicidal behaviour**.

A 32-year-old woman has chronic problems in interpersonal relations of all kinds. Her relatives see her as moody and unpredictable and hard to get on with. No one ever knows how she will behave in a certain situation. Often she is hot-tempered and angry without reason. For others, her tendency to keep on attracting attention and to force things when her demands are not met is also unpleasant. Her evaluation of her own relationships and the problems related to them is in the extremes of idealisation and complete condemnation of her 'terrible relatives who are inconsiderate and selfish'. She



does not have a partner or close friends. She has been through many, more or less random, short-term relationships that usually fall apart very quickly. She establishes contact quickly and in the beginning is enthusiastic and talks about the person in superlatives, but the relationship does not develop further. She is convinced that she 'has bad luck with bad people'. She attempted suicide several times and thus ended up in the care of a psychiatrist. (Vágnerová, 2006, p. 527)

10.4.5 Histrionic Personality Disorder

Egocentrism, exaggerated expression of emotions and the need to seek attention are typical symptoms of this disorder.

Despite this disorder's quite theatrical outward manifestations, the affected person's internal emotional experience is very shallow. Mood lability, a high level of vulnerability, and marked suggestibility are also typical. Due to persisting feelings of dissatisfaction, these individuals are excessively motivated to seek excitement.

Their **thoughts are controlled by emotions**. **Pathological lying** is often present, with the affected person making up various stories in which they play the main characters.

They have a tendency to start **shallow relationships** which are full of tension and conflict. They tend to be **selfish and unreliable** partners.

A 40-year-old clerk has recurring problems at work. They stem mostly from her tendency to tell made-up stories that lead to conflict and from her tendency to enter into relationships with various men. These are mostly short-term, outwardly demonstrated relationships that end in some affective scene. With regard to the fact that she is considered a very attractive woman and a very good manipulator, the first conflict at work did not result in her learning a lesson. The same situation is repeated at regular intervals. After the problems escalated, her colleagues of both sexes rejected her and demanded her dismissal or transfer to a different workplace. She reacted with a dramatic suicide attempt and by emphasising her role as a victim of evil people. (Vágnerová, 2006, edited)

10.4.6 Narcissistic Personality Disorder



Excessive egocentrism and oversensitivity connected with insensitivity towards those around are the essence of this disorder.

- Persons with this disorder have a **low frustration tolerance** as a result of which they are **excessively vulnerable**. They feel **moody** even as a result of relatively neutral stimuli **and react with anger**.
- In these individuals, impaired self-valuation is manifested in the **overestimation of the significance of themselves**, for whom, according to them, different norms apply than for others. Their dreams of their own exceptional qualities are often completely unrealistic. On the other hand, they also succumb to **inappropriate underestimation**. They cannot accept the opinion of or criticism from others.
- Their strong need for others to be in awe of them leads to problems in their relationships with those around them. Other people are a means to confirm their own exceptionality. Such a personality lacks empathy in relationships and behaves **arrogantly and inconsiderately**. Promiscuity and a lack of social restraint can be related to the **inability to enter into a satisfactory emotional relationship**.

An example of a person with narcissistic personality disorder is a 33-year-old divorced physician working as a plastic surgeon. He is an only child and both of his parents have university degrees – his father is an engineer and his mother a teacher. The partnership between the parents was competitive, often tense and silent. The father was exacting, the mother admiring. His upbringing was strict, he had to attend various after-school activities, and his parents demanded excellent academic results. He felt isolated among his classmates and felt he did not fully belong. In puberty, he took up athletics and because he did well, he felt the awe of his classmates and started to be proud of 'his exceptionality'. He was only shy with girls; he felt that they had 'superficial' interests, but at the same time he tried to get close to them. He finished his medicine studies and found friends with whom he went to the gym, but he did not want to commit himself to a partner. He visits a psychotherapist because of his depressive moodiness in connection with repeated failures in his partnerships. From his partners, he requires expressions of love in a way they refuse, he is excessively jealous of them, and there are quarrels to which he reacts with depressive moods. He chooses similar types – exclusive, attractive ladies. However, they do not understand him and do not see the social status he is offering to them as a physician in an attractive field. He is not attracted to less-beautiful women and would be ashamed of them. (Praško et al., 2003, edited)



10.4.7 Anankastic Personality Disorder

This disorder is characterised primarily by **indecisiveness, rigidity of emotional experience, and a need for excessive control.**

- With regard to emotions, **gloominess, anxiety or anger** prevails. The affected persons are unable to experience feelings of joy or well-being.
- With regard to thoughts, increased feelings of **doubt, indecisiveness and low self-trust** are typical. Another frequent manifestation is **rigid thinking and a routine resolution of problems**. The affected persons often become stuck on details of little importance and fundamental things can escape their notice. In terms of critique, they are very dependent on the opinions of those around them and tend to be extremely critical and self-critical.
- The ability to adapt to change is restricted. They have a tendency to **thoroughly respect social norms** and to meet demands, which probably fulfils the function of lowering uncertainty. They tend to be unpopular in relationships; their partners evaluate them as inadaptable, unattractive, boring, and without a sense of humour.

An example of this type of personality is a 46-year old divorced university graduate employed in the laboratory of a research institute. He is conspicuously careful and orderly and requires the same from others, and therefore sometimes has conflicts with his colleagues. In most cases they have known him for a long time and a method of mutually respectful co-existence has been created. He works very thoroughly, often beyond working hours, and is reliable. His colleagues sometimes use this character of his, but on the other hand they mind not knowing when he will finish his work. Sometimes there are problems, in particular when there is a deadline to be met. He does not have friends and does not care much about having any either. He only participates in a conversation when it is focused on an expert problem. He divorced his wife after two years of mutually unsatisfactory co-habitation, because 'she was unreliable, disorderly, and was damaging the linoleum in the kitchen with her high heels'. Now he has been living on his own for a long time and has created a certain system of taking care of the household and shopping, which is run according to a schedule; he does something every day. If his schedule is interrupted, he is displeased. He is unwilling to adapt even for something serious, such as the illness of his mother.



He does not feel dissatisfied; he is convinced that the life of an adult should not be full of merrymaking, but work and duties. (Vágnerová, 2006, p. 531)

10.4.8 Passive-Aggressive (Negativistic) Personality Disorder

The essence of this disorder is an **inappropriate way of coping with the demands of the social environment and the inability to openly express negative emotions.**

- Emotionally, a **gloomy mood and feelings of anger** dominate. The affected persons **avoid open conflicts** and show their negative feelings in an immature way.
- They consider the demands placed on them by the people around them excessive and unsubstantiated and complain of their inconsiderateness. **They cannot show their needs or demands** and expect that these should be clear to others.
- Due to their inability to express disagreement outwardly, they vent their feelings and demands through **hidden negation and blocking**, e.g. working at a slow pace, putting off duties, forgetting, not meeting deadlines, or incorrect execution. Their conduct often causes conflict.

An example is the behaviour of a 21-year-old shop assistant who believes her boss checks on her and criticises her without justification. On the other hand, she is pleased that she keeps her boss from doing something else and burdens the boss with the necessity to check on her work. She deliberately works slowly and makes mistakes to punish the boss for assumedly holding her in disfavour. She criticises and humiliates her in front of others. She behaves in a similar, passive-resistant way towards her colleagues as well. When they ask her for something, she agrees, but something always happens that prevents her from keeping her promise: she forgets, cannot manage because she has some problems, does the opposite because she made a mistake, etc. She believes that these complications are not her fault and that she has bad luck. Others' opinions of her are not unanimous; on the one hand, some colleagues pity her because she cannot do anything properly, but on the other hand many think that she is essentially conniving and lazy. (Vágnerová, 2006, p. 534)



10.4.9 Anxious (Avoidant) Personality Disorder

This disorder is characterised primarily by **anxious experience and a tendency to avoid any threat.**

- Emotional experience is disrupted, and the affected persons live in persistent tension and **worry about dangers.**
- Self-valuation and valuation of the social environment are disrupted. The affected persons suffer from a lack of self-respect, **feelings of inferiority and excessive concerns about criticism or rejection.** Even completely neutral reactions from those around them are assessed as unpleasant and lead to a **further withdrawal into isolation.**
- They avoid any risk of non-acceptance, failure or criticism. This often socially isolates them. In relationships they have **problems maintaining appropriate borders.** As opposed to other disorders, they suffer from their problems.

Such manifestations can also be conspicuous to colleagues, even though they do not lead to conflicts. Other people usually stop paying attention to an anxious individual and consider him/her strange. Sometimes they feel sorry for him/her because they know he/she is suffering, but that is all. This is the position a 38-year-old clerk is in at her workplace. She does not communicate with anyone; when she does not have to she does not participate in any social activities and avoids others. She works carefully, her boss is satisfied with her, and others have grown accustomed to her behaviour. In the beginning, some of them tried to talk to her, but gradually gave up their attempts. She is single, lives with her widowed mother and sometimes visits her married sister. She has neither female friends nor a boyfriend; she believes she cannot meet anyone and refuses the attempts of her relatives to arrange contact with a potential partner in advance. The idea of any communication with a strange man scares her; she does not know what she should say and she is afraid that she would embarrass herself in the end anyway. (Vágnerová, 2006, p. 536)

10.4.10 Dependent Personality Disorder

This disorder typically manifests itself by one's inability to become independent, **increased reliance on another person, and concerns of abandonment.**

- Emotionally, pessimism, anxiety and **excessive worry** prevail most often.



- The affected persons have **low self-valuation and do not like to make decisions on their own**. They usually conform and adapt to another person.
- They are **increasingly reliant on another person**. They cannot assert themselves and avoid responsibility and independence. They are unpleasant companions due to their excessive fixation and persistent enforcement of guarantees. A break-up is less acceptable for them than abuse, and therefore they can quite easily become **victims of violence or abuse**.

Lída is a 21-year-old single nurse, without a job, living with her older sister at their parents'. She had a hard time starting kindergarten, got used to school and had a strong relationship with an older female teacher. She was a very diligent pupil popular with her teachers. However, contact with her classmates was problematic; she spent a lot of time on her own and got on better with her mother and sister. She always had a hard time making decisions and needed confirmation from her parents or sister. She does not feel experienced enough to make decisions about important things. She graduated from nursing secondary school with flying colours and her parents picked a bachelor's study programme for her out of town. However, she was unable to commute there and interrupted her studies, which she now holds against herself. She has been interested in boys since puberty, has an easy time meeting them and feels safe in the company of men. However, the majority of her relationships end when she starts reproaching her partners for not spending more time with her. In the last two years, she has begun shunning society, is afraid of being embarrassed and has been unable to use public transportation or go shopping. Now she cannot go anywhere on her own. If she faces such situations, she sweats, has palpitations, is dizzy and lacks an appetite. (Praško et al., 2003, edited)

10.5 Treatment and Resocialisation of Personality Disorders

Attempts to treat personality disorders are not very successful and are usually without more significant permanent changes. The main cause is the missing willingness to co-operate with a physician, who is usually contacted by those around the affected person. Effective therapy should be complex, long-term and focused on the individual needs of the patient. In general, one can distinguish the following elements of a therapeutic approach (Vágnerová, 2004):

- **Pharmacotherapy**, the use of psychopharmaceuticals in order to affect some symptoms, e.g. anxiety or depression.



- **Psychotherapy** is usually deployed in order to gain insight into the cause of the patient's problems. Cognitive behavioural therapy is usually used.
- **Resocialisation** is aimed at the renewal of the ability to cope with problems in interpersonal relationships. It is carried out through family or group psychotherapy.



Review Questions

1. Define 'personality'.
2. What does the term 'personality disorder' mean?
3. How do personality disorders differ from other mental disorders, e.g. from affective, psychotic and neurotic disorders?
4. In what type of personality disorders does introversion prevail?
5. People with what type(s) of personality disorder(s) most frequently have conflicts with the law?
6. In what types of personality disorders does impaired self-valuation dominate? How do these types differ from each other?



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11 Psychological Development Disorders





Objectives

After studying this chapter you will be able to define the individual types of psychological development disorders. You will learn to distinguish specific developmental disorders of speech and language, scholastic skills disorders, motor function disorders and pervasive developmental disorders.



Terms to Remember (Key Words)

- psychological development disorders
- developmental dysphasia
- specific developmental disorders of scholastic skills
- pervasive developmental disorders
- childhood autism

11.1 Definition of Psychological Development Disorders According to ICD-10

Psychological development disorders have the following common characteristics (ICD-10, 2010):

- they appear in early childhood, in the first years of life,
- the impairment of or delay in functional development is closely related to the biological maturation of the CNS, which is not progressing as it should be,
- the course is persistent, the problems are constant and they do not worsen.

The following sections are devoted to the categorisation of these disorders.

11.2 Specific Developmental Disorders of Speech and Language (F80)



Speech disorders in children can be divided into developmental and acquired in terms of their etiology and period of onset (Říčan, Krejčířová et al., 2006).

Developmental speech disorders have an organic etiology (deviations in the development of the brain structures important for speech), but in particular cases the cause remains unknown. They affect some 2% of children in total, with an incidence of up to 19% in a group of pre-school children, if we also factor in milder articulation defects.

Acquired speech disorders can be diagnosed at the earliest when the child is two years old, i.e. at a time when the basics of normal speech have already developed. The causes of acquired speech disorders are CNS malignancies, neural infections, head injuries, vascular events or epilepsy.

ICD-10 distinguishes the following disorders of speech and language:

- **Specific speech articulation disorder (F80.0)** – includes developmental dysarthria and dyslalia.
- **Expressive language disorder (F80.1)** – includes developmental dysphasia or aphasia, expressive type (i.e. disorders of active language, disorders of the ability to express oneself verbally).
- **Receptive language disorder (F80.2)** – includes developmental dysphasia or aphasia, receptive type (i.e. disorders related to understanding of language).
- **Acquired aphasia with epilepsy (Landau-Kleffner syndrome) (F80.3)** – a disorder during which the child, who has been making normal progress in speech development, loses his/her receptive and expressive language abilities, but general intelligence remains at the same level. The onset of the disorder is accompanied by EEG abnormalities and in the majority of cases by epileptic seizures. Typical onset begins between the ages of three and seven, but can also appear earlier or later in childhood.

11.2.1 Developmental Dysphasia

Developmental dysphasia is a disorder in the acquisition of spoken language. Usually, spoken language is not completely missing but its development has



been severely delayed, and we observe qualitative deviations in some aspects of speech. This delay cannot be explained by hearing impairment, mental retardation, physical handicap, deprivation or other negative influences of the environment.

The following symptoms are typical for developmental dysphasia (Říčan, Krejčířová et al., 2006):

- a significant difference between the level of understanding of language, which is good, and active speech, which stagnates,
- a discrepancy between relatively good vocabulary and bad language comprehension; the child has articulation problems, even though oral motor function is undisturbed, and has difficulties recalling and creating words,
- an inability to create sentences and to apply grammatical rules, even though the child has good vocabulary,
- a low ability to apply spoken language; the child does not use it for common communication purposes, does not use words to express his/her feelings or wishes, has difficulties creating answers to questions, etc.,
- the child has marked problems recalling even known words.

The **expressive** type of developmental dysphasia primarily affects active language, while the **receptive** type is characterised by a lower ability to understand heard language. However, active speech does not develop normally either in the receptive type, as it is always created based on understanding.

11.2.2 Articulation Disorders

In the initial stages of speech development, inexact or less comprehensible articulation is a normal phenomenon in children. Around the age of seven, the basic development of speech concludes, which is related to the maturation of the central nervous system. Therefore, one can consider incorrect articulation as a developmental phenomenon until the age of seven, and later unambiguously as a disorder. Until this age, articulation is open to changes and can be influenced more easily, but after the age of seven all acquired speech



habits are fixed. However, one recommends starting speech therapy earlier; when there is a higher number of incorrectly articulated speech sounds, when the child does not know the speech sounds, omits them or replaces them with others, it is suitable to start around the age of four-and-a-half. If the child starts to suffer from rhotacism or lisping, it is possible to attempt to stop the incorrect development even earlier. One has to start working on correcting the incorrect articulation of 'l', 'r' and 'ř' when the child turns five at the latest (Kutálková, 1996).

Dyslalia is manifested by the incorrect articulation of one or more speech sounds (most often 'r', 'ř', sibilants and 'l'). Articulation errors of this type are part of a child's development at an early age, usually adjusting spontaneously by the age of four or five; when they persist longer, it is time for speech therapy.

Awkward articulation is an articulation disorder where the child articulates all respective speech sounds correctly, but the articulation is incorrect in longer or more difficult words (e.g. 'nejnebezpečnější').

More severe and persistent articulation disorders appear in connection with oral motor function disorders (Říčan, Krejčířová et al., 2006):

Developmental dysarthria is a developmental speech articulation disorder in which the child has significant problems articulating, even though he/she understands the language and his/her vocabulary is good. However, in the most severe cases, the development of expressive language can also be limited in terms of vocabulary.

Dysarthria, as a secondary disorder, is most frequently common in children with an overall physiological handicap (cerebral palsy) or another type of neurological disease. Articulation deviations appear already at an early age (during vocalisation and babbling), and the impaired oral motor function is also reflected in impaired swallowing, chewing, breathing, etc. The child's speech develops with a delay and is hard to comprehend for some time, even when the child's vocabulary is good.



11.2.3 Educational Approach to Children Affected by Speech Disorders

Educators who deal with children affected by a speech disorder can be inspired by some principles for managing the physiological development of speech and by specific guidelines for the respective speech disorders (Kutálková, 1996):

Appropriate stimulation – the child should not be deprived of or overloaded with stimuli focusing on speech development. If we press the child too much, we force him/her into inappropriately frequent or long practice and the child's organism defends itself either by protective inhibition (the child falls asleep, yawns, loses interest or is restless) or by aggression (anger, crying or negativism). An overload of the nervous system can also manifest itself through a disorder in another sphere (stutter, tics, sleep disorder, etc.).

Respect for the age and achieved degree of the child's development – based on knowledge of the achieved skill level, we choose appropriate methods for the further development of speech. It is better to have smaller demands with which the child experiences success than more difficult tasks with a low probability that the child will master them.

Use of the child's interests – if we want to teach the child something, we should choose a game or activity that would be interesting and enjoyable for the child.

Praise – it is necessary to be aware that we strengthen what we emphasise and point out and we lose what we do not pay attention to. Therefore, we praise good efforts and do not comment on failures or mistakes in speech.

Patience – speech, similarly to other activities, needs practice. When we are learning something, it is only natural to make mistakes and try again and again. The impatience of the child's social environment complicates matters – he/she tries to speak quickly so as not to delay people, does not manage to articulate precisely or find a suitable word, and loses confidence.

A dialogue requires two people – speech primarily has a communication function, and therefore the relationship we succeed at creating with the child is very important. If the child trusts us and feels confident, he/she has the optimal conditions to attempt verbal expression. The child should not be afraid of



talking with us and the communication should be pleasing and meaningful to him/her.

When approaching children with **articulation disorders**, the basic approach is the deliberate use of imitative reflex, not correction of the child's articulation. If we want to correct the child, we use the echo method. Without any comment or any non-verbal hint at the fact that the child has made a mistake, we repeat the word after the child and inconspicuously point out the speech sound that needs improving. The child either spontaneously corrects him/herself or at least tries it one more time. Even if the child does not repeat the word, he/she will take the correct version of the word into account.

11.3 Specific Developmental Disorders of Scholastic Skills (F81)

This group includes disorders in which the normal acquisition of scholastic skills is impaired as a result of relatively minor cognitive-process deviations that can be largely derived from some type of biological dysfunction. The category of specific developmental disorders of scholastic skills includes:

- specific reading disorder (F81.0) – i.e. dyslexia,
- specific spelling disorder (F81.1) – i.e. dysgraphia and dysorthography,
- specific disorder of arithmetical skills (F81.2) – i.e. dyscalculia,
- mixed disorder of scholastic skills (F81.3).

These disorders are also labelled, using an older term, as **specific developmental learning disorders**. A separate, more detailed chapter is devoted to learning disorders in the study text *Psychopathology II*.

11.4 Specific Developmental Disorder of Motor Function (F82)

This title includes **developmental dyspraxia** (also called 'clumsy child syndrome') during which motor coordination is impaired.



Children suffering from this disorder are not conspicuous at first sight, but show their 'clumsiness' in various situations, for instance they cannot catch a ball and thus spoil the game for others. They become objects of ridicule for their motor clumsiness, can have problems belonging to a collective, suffer from an inferiority complex, etc. (Kirby, 2000).

The development of a child suffering from dyspraxia has to be stimulated so that it is directed towards development according to the common rules of neuropsychological development and follows the level achieved by the child. Re-education focuses on these areas: gross motor skills, fine motor skills, graphomotor skills, motor skills of the articulation organs, body schema, visual and auditory perception, sensory integration, space orientation and right-left orientation.

11.5 Pervasive Developmental Disorders (F84)

Pervasive developmental disorder is a common denominator for more severe disorders whose onset begins already in early childhood. This group of disorders is characterised by severe and complex impairment of the psychological development of the affected children. Usually, a certain degree of overall cognitive impairment, qualitative abnormalities in social interactions and methods of communication, and a stereotypical repertoire of interests and activities are present.

Childhood autism (F84.0) is a typical pervasive developmental disorder, with the main symptoms being impaired social understanding, interpersonal relations and communication, and conspicuous stereotypical behaviour.

The development of the autistic child is often affected by generally restricted intellectual abilities, as approximately 75% of autistic children suffer from mental retardation and only a small number of them have an intelligence quotient within the range of the broader norm and are not that severely handicapped (5–20%). This type is called **high-functioning autism**. In addition to this, there are autistic people who are very talented in one specific area, for instance they have a disposition for numerical mathematical operations or an excellent mechanical memory (Vágnerová, 2004).



To determine a diagnosis of childhood autism, the developmental abnormalities must be present in the first three years of life. The incidence of childhood autism is probably four times higher in boys than in girls; overall there are 2–20 autistic children per 10,000 children. The diagnosis of childhood autism also includes **Kanner syndrome**, named after American psychiatrist Leo Kanner who described childhood autism for the first time in 1943.

Atypical autism (F84.1) differs from childhood autism either in its time of onset (abnormal development is shown only after reaching the age of three) or in its missing one or two of the three psychopathological areas required to diagnose autism (disturbed social interaction, disturbed communication and stereotypical behaviour).

Rett syndrome (F84.2) is a genetically conditioned neurodegenerative disease which is very rare and only affects girls (0.007% of girls). The initial development of a girl with Rett syndrome is normal; however, in the period between the sixth and twelfth month, head growth decelerates and there is a gradual loss of previously acquired skills. Gradually, the condition deteriorates down to the level of severe mental retardation.

Other childhood disintegrative disorder (F84.3) is defined by a period of entirely normal childhood development, at least until the age of two, which is followed by a loss of previously acquired skills. Usually, speech regression or loss and a lower level of playing, social skills and adaptive behaviour appear; encopresis and enuresis are often present, and sometimes movement control worsens. In essence this is early dementia and the prognosis is unfavourable. This disorder is also called **Heller syndrome** and is approximately ten times less frequent than autism.

Asperger syndrome (F84.5) differs from childhood autism in that there is no general delay in language or cognitive development. The intelligence of the majority of affected persons is within the norm and problems appear primarily in social adaptation. This disorder affects 0.4% of children, again prevailingly boys.

The syndrome is named after the Viennese paediatrician Hans Asperger who in 1944 published his first case studies on autistic children who manifested a severe social-interaction and communication disorder despite having well-developed language and normal or high intelligence. Furthermore, they



presented restricted, stereotypical interests and motor clumsiness (Hrdlička, Komárek et al., 2004).

Bringing up and educating a child with autism requires an expert in special education. An emphasis is put on structured learning, during which clearly defined space has been created for the child, he/she is given clearly defined tasks in a visual way, and the organisation of time is also visual (how many tasks are ahead, what will follow, etc.). The meeting of even common expectations is done through communication and these children have to have a different, special way of communicating and learning. It is necessary to make the world more comprehensible to them, and therefore maximum emphasis is put on clear space and time structuring which gives them certainty. In learning, completely concrete, mainly visual stimuli are used, and the teaching of children with autism is always connected with concrete situations and people and requires the close cooperation of many people, primarily from a special school and the family. Their school teachers should always have special training (Říčan, Krejčířová et al., 2006).

The TEACCH (Treatment and Education of Autistic and Related Communication Handicapped Children) programme, which was created 30 years ago at the University of North Carolina, has become a generally followed approach. For children who cannot communicate through spoken language, the Picture Exchange Communication System (PECS) was designed as an alternative communication system which allows them to spontaneously express their needs and to communicate with those around them through pictures (Kerig, Ludlow and Wenar, 2012).

When integrating such affected children into normal schools, it is necessary to provide conditions where the situation is more transparent and more comprehensible to them. It is necessary to work according to individual education programmes and to have a personal or pedagogical assistant present.



Review Questions

1. What is the difference between developmental speech disorders and acquired speech disorders?



2. Describe the symptoms of developmental dysphasia.
3. What principles belong to the educational approach to children with a speech disorder?
4. Explain the term 'developmental dyspraxia'.
5. Which diseases belong among the pervasive developmental disorders?
6. Describe the specifics of bringing up and educating a child with autism.



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12 Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence



Objectives

After studying this chapter you will be able to distinguish individual behavioural and emotional disorders with onset usually occurring in childhood and



adolescence. You will learn about the issues involved with emotional disorders and social functioning disorders.



Terms to Remember (Key Words)

- anxiety
- fear
- separation anxiety disorder
- phobic anxiety disorder
- social anxiety disorder
- sibling rivalry disorder
- nonorganic enuresis
- nonorganic encopresis
- elective mutism
- stuttering

12.1 Definition of Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence According to ICD-10

This group of disorders is characterised by typical onset in childhood or adolescence and includes a wide range of diverse disorders (ICD-10, 2010):

- hyperkinetic disorders (F90),
- conduct disorders (F91),
- mixed disorders of conduct and emotions (F92),
- emotional disorders with onset specific to childhood (F93),
- social functioning disorders with onset specific to childhood and adolescence (F94),
- tic disorders (F95),
- other behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F98).

A separate chapter is devoted to the issue of hyperkinetic disorders and conduct disorders in the study text *Psychopathology II*. The following section deals with emotional disorders and social functioning disorders in more detail.



12.2 Emotional Disorders with Onset Specific to Childhood

Anxiety and fear belong among the frequently experienced adaptive developmental phenomena. Under normal circumstances they signal looming danger to the child.

Anxiety does not have a concrete source and is manifested as non-concrete feelings of worry, threat and tension.

Fear is also bound to concrete objects and situations (e.g. a fear of an exam).

In each age period there are typical fears and anxieties that are connected with the developmental tasks of the period in question and are part of normal development (Říčan, Krejčířová et al., 1997):

- fear of strangers appears in the suckling period (around the eighth month),
- separation anxiety appears in the suckling and toddler periods and is a common reaction of the child to separation from the mother,
- we can observe a high number of temporary fears and phobias (e.g. of insects, animals, darkness, thunderstorms, monsters, etc.) in the majority of children of pre-school age,
- an overall increase in anxiety appears between the ages of nine and eleven as the child matures towards full comprehension of the term death, he/she begins to be scared when alone or in darkness, and social fears are also characteristic for this period,
- tumultuous and changeable emotional reactions, which can be caused by even very minor (insignificant from the observer's point of view) stimuli, are typical for adolescence.

Pathological anxiety is excessive with regard to the situation, has a tendency to persist, and limits the child in normal functioning and in the fulfilment of the developmental tasks for his/her age.

During the toddler and pre-school periods, excessive anxiety is manifested either by passivity and a lack of activity or by restlessness. Both forms limit the



child's ability to receive stimuli and experience the world to an appropriate extent.

In pre-school age, excessive anxiety can also be manifested by eating and sleep disorders and by neurotic habits (thumb sucking, nail biting, pulling hair out).

In older children, anxiety disorders usually have specific manifestations corresponding to the individual emotional disorder categories defined by ICD-10. In a child of school age, some types of anxiety disorder (e.g. phobia, generalised anxiety disorder) or affective disorder (depression) can develop which we have already covered in previous sections of this text.

However, there are also emotional disorders whose typical onset occurs primarily in childhood. According to ICD-10, **emotional disorders with onset specific to childhood** (F93) include:

- separation anxiety disorder of childhood (F93.0),
- phobic anxiety disorder of childhood (F93.1),
- social anxiety disorder of childhood (F93.2),
- sibling rivalry disorder (F93.3),
- other childhood emotional disorders (F93.8) that include, for example, overanxious disorder.

12.2.1 Separation Anxiety Disorder of Childhood (F93.0)

In toddlers and pre-schoolers, it is normal that a certain feeling of **anxiety from being separate from one's loved ones** appears. Separation anxiety disorder differs from normal separation anxiety in its degree of severity, its persisting beyond the normal age period, and its negative impact on common social functioning. Anxiety can take any of the following forms:

- unrealistic worry that something will happen to those closest to the child emotionally or that they will leave and will not come back,
- unrealistic persistent worry that some unpleasant event will separate the child from the emotionally closest person,



- persisting hesitation or refusal to go to school due to fear of separation,
- persisting hesitation or refusal to go to sleep if the child is not next to or close to an emotionally favoured person,
- persisting unsubstantiated fear of being at home alone or without the emotionally closest person during the day,
- recurring nightmares related to separation,
- recurring incidence of somatic symptoms (stomach ache, headache, vomiting) in situations where the child separates from an emotionally close person, e.g. when leaving home to go to school,
- excessive recurring fear manifested by anxiety, crying, outbursts of anger, suffering, apathy or social withdrawal when being separated from an emotionally close person or immediately afterwards.

It is necessary to distinguish rejection of school or fear of school as a result of separation anxiety from genuine **school phobia**, where the child is afraid of specific situations or conflicts at school, e.g. his/her own failure, teachers, or contact with other children, but copes well with all other separations (summer camps, etc.). In such cases, it is necessary to consider whether the child's fear is not fully substantiated, as it can be a reaction to, for instance, fear of bullying or fear of a hypercritical teacher (Říčan, Krejčířová et al., 1997).

12.2.2 Phobic Anxiety Disorder of Childhood (F93.1)

In pre-school age, a number of fears temporarily appear which disappear over time, if not strengthened by negative influences. At the same age, pathological, persisting fears and phobias appear as well.

Phobic anxiety disorder is manifested by an excessively strong anxiety reaction caused by a certain situation or object. Its onset is at an age appropriate to the developmental period, but the problem persists for too long a time, leads to inappropriate, avoidant behaviour, and lowers the child's ability to adapt to common demands.



In children, phobias are often bound to fear of animals in general (zoophobia), of dogs (cynophobia) and cats (ailurophobia), of snakes (ophidiophobia), of spiders (arachnophobia), of insects (entomophobia), of dirt, parasites and microbes (mysophobia), of blood (haemophobia), of darkness (nyctophobia), of small and closed spaces (claustrophobia), of heights (acrophobia), of fire (pyrophobia), etc. (Hort et al., 2000).

12.2.3 Social Anxiety Disorder of Childhood (F93.2)

The main symptom is the pathological persistence of fear of strangers, which should, under normal circumstances, subside by the age of three at the latest. Fear of contact with strangers becomes a hindrance to the normal development of relations with peers and other social relations and to the acquisition of social skills. Usually, this disorder adjusts itself during puberty. In a small number of children, it can escalate into a social phobia or, in adulthood, grow into an anxious (avoidant) personality disorder (Říčan, Krejčířová et al., 2006).

12.2.4 Sibling Rivalry Disorder (F93.3)

In the majority of young children, a certain emotional reaction to the birth of a younger sibling appears. In some cases, the rivalry or jealousy which occurs after the birth of the sibling may persist and be manifested by long-term, excessive competition with the sibling for parental attention and love. In order for this to be considered abnormal, it should be connected with an unusual intensity of negative feelings toward the sibling. In severe cases, this can be accompanied by open hostility, maliciousness and even bodily harm.

12.3 Disorders of Social Functioning with Onset Specific to Childhood and Adolescence (F94)

This is a diverse group of disorders in which social functioning deviations are the common trait.



12.3.1 Elective Mutism (F94.0)

Elective mutism is categorised in the International Classification of Diseases as a social functioning disorder, as it is not a disorder of speech itself, but rather its use.

In some situations, the child speaks well and can even be talkative, but does not speak in certain environments or with certain people, most frequently at school, or with all strangers or sometimes even with strange children.

There are rarer cases where the child does not speak at home, but does speak in other situations and with other people; usually this indicates a highly dysfunctional family.

Among the causes, personality influences are important, such as increased shyness, anxiousness, or a tendency towards oppositional behaviour and negativism. Family factors, such as an overprotective upbringing, are also important.

Treatment is usually long-term and it is optimal to combine individual and family psychotherapy, which should continue even after overcoming the mutism with the aim of the child developing a more balanced personality (Říčan, Krejčířová et al., 2006).

If a child stops communicating altogether, even though until now it had communicated quite normally, we talk about **total mutism**, a total loss of voice and language. It usually appears as a result of a shock during injury or of a psychological trauma. As opposed to elective mutism, the child tries to talk and make him/herself understood. In children who stop talking as a result of a shock, mutism can subside after several hours, but speech can return with symptoms of stuttering. If mutism appears as a result of injury, it is necessary to undergo an examination by a specialist to distinguish neurotic symptoms from a loss of speech as a result of brain damage (Kutálková, 1996).

The more we force children suffering from **elective mutism** to speak, the later they usually start to speak. Therefore, we should not force such a child to speak; we must accept his/her behaviour as normal and inconspicuously try to initiate non-verbal contact at least. It is necessary to bear in mind that the child will gradually adapt to the person with whom or the situation in which he/she does not want to speak. Similarly to children suffering from stuttering,



questions should be formulated in such a way as to offer an easy answer, even a non-verbal one. If the child does not reply, we reply ourselves so that the 'dialogue' continues without interruption. Elective mutism usually subsides spontaneously once certainty in a new situation is gained.

12.3.2 Reactive Attachment Disorder in Childhood (F94.1)

This disorder is characterised by persistent abnormalities in the social relations of the child, which are connected with an emotional disorder and which are a reaction to changes in living conditions. Fearfulness, hyper-vigilance, poor social interaction with peers, and aggression towards oneself and others are typical.

This syndrome is a direct consequence of severe parental neglect, abuse or maltreatment.

12.3.3 Disinhibited Attachment Disorder in Childhood (F94.2)

This is a special type of abnormal social integration which appears in the first five years of life and which has a tendency to persist, despite any changes in the child's conditions. At around age two, attachment behaviour and indiscriminate affection towards the people around him/her appear in the child. At around age four, the child's affection remains diffuse and attention-seeking and uncritically friendly behaviour appear. At a later age, selective relations may or may not develop, but attention-seeking often persists. The child has difficulties creating close, intimate relations with his/her peers. According to the circumstances, there may be an affiliated emotional or behavioural disorder.

It is assumed that the syndrome appears as a result of a lack of opportunities to develop selective relations (e.g. institutional upbringing, frequent changes of carers).

12.4 Other Behavioural and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence (F98)



12.4.1 Nonorganic Enuresis (F98.0)

This disorder is characterised by involuntary voiding of urine by day and/or by night which is abnormal in relation to the child's mental age and which is not a consequence of a somatic dysfunction.

Enuresis may develop as an abnormal prolongation of normal toddler incontinence or can appear after a certain period of already acquired bladder control. The later-onset option usually begins around the age of five to seven. Enuresis may be associated with a more widespread emotional or behavioural disorder. Emotional problems may also arise as a consequence of the difficulties related to the stigma the child develops as a result of the enuresis.

Enuresis should not usually be diagnosed in a child under the age of five.

12.4.2 Nonorganic Encopresis (F98.1)

This difficulty is related to bowel-control problems which may be a continuation of normal childhood incontinence. Encopresis can also mean a loss of control over the stool caused by a somatic dysfunction. It can also be deliberate defecation in inappropriate places in spite of being capable of normal physiological bowel control.

12.4.3 Feeding Disorders of Infancy and Childhood (F98.2)

Feeding disorders in childhood include the refusal of food and extremely finicky behaviour in the presence of an adequate food supply provided by caregivers.

Minor problems with food intake are quite common in infancy (in the form of finicky behaviour, alleged insufficient food intake or overeating). These manifestations should not be considered signs of a disorder of their own. A disorder should only be diagnosed if the degree of difficulties exceeds the normal range, if the character of the problem with food intake is of a qualitatively different character, or if the child does not gain weight or loses weight over a period of at least one month.



12.4.4 Stuttering (F98.5)

Stuttering (*balbuties*) belongs among the speech flow disorders, with the speech being conspicuous due to repetition or prolongation of syllables or words and due to pauses that also disrupt the speech flow.

Stuttering symptoms include (Kutálková, 1996):

- **repetition** – repetition of syllables or entire words,
- **sound prolongation** – the child has problems pronouncing the first syllable, gets stuck there and only after overcoming the cramp does he/she utter the entire word; often even the rest of the sentence is fluent.
- However, it is rare that only repetition or sound prolongation appear in the speech. It is much more frequent that these symptoms are combined, and therefore we speak about **repeated and prolonged speech sounds**.
- Stuttering is also connected with **involuntary muscle movements** – somatic symptoms such as cramped grimacing in the face, twitches in some muscles, shuffling around or fist clenching, which usually appear immediately before the beginning of speech.
- Apart from involuntary muscular movements, a person suffering from stuttering sometimes creates a situation through which he/she delays the beginning of speech to get time to overcome the cramp. These cover-up manoeuvres, which can be in the form of a common behaviour but sometimes look quite odd, are known as **blocks**.
- In many children who suffer from stuttering, there are also marked vegetative symptoms (they blush, turn pale or sweat), or various tics or neurotic manifestations appear.

The onset or escalation of neurotic symptoms related to stuttering most frequently occurs secondarily. School-age children in particular have a very hard time coping with the negative reactions of their social environment, such as ridicule or caricatural imitation, and experience this disorder, which prevents



them from joining the collective of their peers, very depressively. In the majority of cases, the speech of school-age children who suffer from stuttering is significantly better in the family environment than in a group of their peers or in a school group focused on performance. Repeated problems with communication and peer ridicule can lead to a fear of speech – **logophobia** – in children. The treatment of stuttering should be performed by a team of specialists consisting of a speech therapist, a psychologist and a phoniatriest (Říčan, Krejčířová et al., 2006).

In the case of **stuttering**, it is first important to look for causes related to the beginning of the disorder and to try to remove them. We should focus on the inconspicuous development of speech pace with the help of poems and songs. In speech, we thoroughly avoid haste and impatience and try to make speech as easy as possible for the child. We never force the child to correct him/herself, to repeat the word again and properly, and we never show displeasure over an unsuccessful sentence. It is suitable to give the child hints about words that he/she is missing and to complete the sentence for the child, by which we keep the conversation fluent, and after overcoming his/her problems, the child joins us again and continues talking. We can help by formulating questions that already include a possible answer (we do not ask: 'What do you want for a snack?' but instead ask: 'Do you want an apple or a bun?'). We try to continuously identify the situations in which the child has a harder time speaking and we avoid them; we do not unnecessarily expose the child to sudden changes and new situations he/she is not ready for (Kutálková, 1996).

12.4.5 Cluttering (F98.6)

Cluttering (*tumultus*) is a speech pace disorder characterised by its conspicuous quickening pace; the speech is not fluent, but it is without repetitions and hesitations. The child produces a quick, dysrhythmic, jerky flow of speech, his/her tongue often slips, articulation becomes unclear, and the speech is hard to understand. In children who suffer from cluttering, an organic cause for the disorder is often found, a minor or an explicitly abnormal EEG finding. Overall, one can consider cluttering a symptom of minimal brain dysfunction. This disorder manifests itself mainly at the beginning of school attendance or later.



Cluttering can be detected and distinguished from stuttering when we ask the child to speak more slowly because we do not understand him/her well. A child suffering from cluttering usually slows down and the comprehensibility improves significantly; however, his/her speech will gradually start to quicken in pace again, as the child can only control him/herself for a while. If a child suffering from stuttering is given the same instruction, he/she starts to speak significantly worse, and it is not proper to issue such an instruction to a thus affected child (Kutálková, 1996).



Review Questions

1. Which mental disorders have a typical onset in childhood and adolescence?
2. Give an example of a developmentally conditioned anxiety which can be considered age-appropriate.
3. Describe the symptoms of separation anxiety disorder.
4. What is elective mutism?
5. Describe the typical symptoms of stuttering.
6. In the recommended literature, find therapeutic approaches used in the treatment of enuresis.



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