UNIT 1 DEPRESSION

Structure

1.0 INTRODUCTION

Most people at some point in their life experience at least some degree of low mood or depression. It is generally felt as sadness that is a normal response to painful circumstances such as financial losses, the break-up of a relationship or losing a job. However, sometimes the depressed mood continues for a prolonged period of weeks or months. At this stage a psychiatrist might diagnose a depressive disorder.

Depression is a term used to describe a mood state in which the main symptoms or features include prolonged feelings of sadness or emptiness and lack of interest

in previously enjoyed activities. This caused depressed people significant distress, since they lose motivation to participate fully in their lives. Depressed people have difficulty spending time with other people and might lose contact with friends and family, which could deprive them of essential support. They might even lose their job because of poor work performance or attendance.

Depression can also result from medical conditions or other psychological disorders. For example, people suffering from adrenal and thyroid dysfunction display depressive symptoms due to their being either very over or underweight. Similarly, agoraphobics might become depressed because their fear of being vulnerable in public places makes it difficult for them to experience taking part in social activities. This prevents them from having essential, healthy contact with other people. In this unit we will be dealing with depression, define and describe the symptoms, discuss the different types of depression, causes of depression and then the treatment of this disorder.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Define depression;
- Describe the symptoms of depression;
- Explain the causes of depression;
- Elucidate the different types of depression; and
- Describe the various treatment interventions for Depression.

1.2 DEFINITION AND DESCRIPTION OF DEPRESSION

Although depression is often thought of being in an extreme state of sadness, there is a vast difference between clinical depression and sadness. Sadness is a part of being human, a natural reaction to painful circumstances. All of us will experience sadness at some point in our lives. Depression, however, is a physical illness with many more symptoms than an unhappy mood.

The person with clinical depression finds that there is not always a logical reason for his dark feelings. Exhortations from well meaning friends and family for him to “snap out of it” provide only frustration, for he can no more “snap out of it” than a diabetic can will his pancreas to produce more insulin.

Sadness is a transient feeling that passes as a person comes to term with his troubles. Depression can linger for weeks, months or even years. The sad person feels bad, but continues to cope with living. A person with clinical depression may feel overwhelmed and hopeless.

To clarify the differences between normal sadness and depression, there are specific, defined criteria for the diagnosis of major depression:

A person who suffers from a major depressive disorder must either have a depressed mood or a loss of interest or pleasure in daily activities consistently for at least a two week period. This mood must represent a change from the person’s normal mood and impair his functioning in his daily life.

A depressed mood caused by substances such as drugs, alcohol, or medications is not considered a major depressive disorder, nor is one that is caused by a general medical condition.

1.2.1 Signs and Symptoms of Depression – General Terms

- Loss of interest in formerly pleasurable activities
- Dissatisfaction with life
- Withdrawal from social activities
- Loss of energy
- Feeling useless or hopeless
- Irritability
- Great concern with health problems
- Sadness or crying
- Worry and/or self-criticism
- Difficulty concentrating and/or making decisions
- Loss of appetite and weight.

1.2.2 Psychological Symptoms: Feelings, Thoughts and Behaviours

- Feeling sad, blue, depressed, or hopeless most of the day.
- Greatly reduced interest or pleasure in all or almost all activities; inability to think of anything that would be enjoyable to do (health permitting)
- Feelings of excessive guilt or a feeling that one is a worthless person.
- Slowed or agitated movements (not in response to pain or discomfort)
- Recurrent thoughts of dying or of ending one's own life, with or without a specific plan.

1.2.3 Physical or Somatic Symptoms

- Significant, unintentional weight loss and decrease in appetite; or, less commonly, weight gain and increased in appetite.
- Insomnia or excessive sleeping
- Fatigue and loss of energy
- A diminished ability to think, concentrate, or make decisions
- Physical symptoms of anxiety, including dry mouth, cramps, diarrhea, and sweating, ideation, or suicide attempt or plan.

Self Assessment Questions

1) Define and describe depression.

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2) How is normal depression different from pathological depression?

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3) Elucidate the signs and symptoms of depression in general.

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4) What are the psychological symptoms of depression?

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5) Enlist the physical or somatic symptoms of depression.

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1.2.4 Criteria for Formal Diagnosis of Major Depression

The following criteria are taken from the DSM-IV, the Diagnostic and Statistical Manual of Mental Disorders 4th edition, published by the American Psychiatric Association, 1994.

For your convenience, a general listing of signs and symptoms of depression, the translated version, follows the formal diagnostic criteria, for ease in interpreting the symptoms.

For a diagnosis of a major depression:

1) At least 5 of the following symptoms.
2) These symptoms must be present during the same 2 week period.
3) These symptoms must represent a change from a previous level of functioning.

Depressed mood nearly every day during most of the day.

- Marked diminished interest or pleasure in almost all activities.
- Significant weight loss (when not dieting), weight gain, or a change in appetite.
- Insomnia or hypersomnia (excess sleep).
- Psychomotor agitation or psychomotor retardation.
- Fatigue or loss of energy.
- Feelings of worthlessness or inappropriate guilt.
- Impaired ability to concentrate or indecisiveness
- Recurrent thoughts of death, recurrent suicidal
- Someone who has major depressive disorder has experienced one or more major depressive episodes without ever experiencing a manic or hypomanic episode.

1) **Major Depressive Episode:** A major depressive episode is marked by either depressed mood or a loss of interest or pleasure in almost all activities and at least four additional symptoms from the following group.

   - Marked weight loss or gain when not dieting, constant sleeping problems, agitated or greatly slowed down behaviour, fatigue, inability to think clearly, feelings of worthlessness, and frequent thoughts about death or suicide. These symptoms must last at least 2 weeks and represent change from the person's usual functioning.

2) **Recurrent Major depressive Disorder:** At least half of the people who experience a major depressive episode will later have a recurrence of major depression. For many people, an initial episode of major depression will develop over time into a recurrent illness.

3) **Major Depressive Episode with psychotic Features:** About 15% of people with a major depression have some psychotic symptoms usually delusions. The delusions typically include guilt ("It is my fault that she is ill"), punishment ("Iam suffering because Iam a terrible person") or poverty ("I will go bankrupt and starve in my old age"). Sometimes, delusions do not have depressive themes.

1.2.5 Criteria for Dysthymic Disorder

a) Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.

   In children and adolescents, mood can be irritable and duration must be at least one year.

b) Presence, while depressed, of two (or more) of the following:

   1) Poor appetite or overeating
   2) Insomnia or hypersomnia
   3) Low energy or fatigue
   4) Low self-esteem

5) Poor concentration or difficulty making decisions

6) Feelings of hopelessness

c) During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

d) No *Major Depressive Episode* has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic *Major Depressive Disorder*, or *Major Depressive Disorder, In Partial Remission*.

e) There has never been a *Manic Episode*, a *Mixed Episode*, or a *Hypomanic Episode*, and criteria have never been met for *Cyclothymic Disorder*.

f) The disturbance does not occur exclusively during the course of a chronic *Psychotic Disorder*, such as *Schizophrenia* or *Delusional Disorder*.

g) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

h) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Most people who have a dysthymic disorder would tell that they have felt depressed for many years, or for as long as they remember. Feeling depressed seems normal to them. It has become a way of life. They feel helpless to change their lives.

Dysthymic is defined as a condition characterised by mild and chronic depressive symptoms. Periods of dysthymia have been found to last from 2 to 20 or more years, with a median duration of about 5 years. About 3% of the general population and about 30% of those seen at outpatient clinics can be classified as dysthymic.

Some researchers have criticized the DSM-IV criteria because they believe they do not give enough emphasis to what these researchers consider the most characteristic symptoms of dysthymia: *the cognitive symptoms, including low self-esteem, feelings of guilt or thinking about the past, and subjective feelings of irritability or excessive anger.*

Because the depressed mood is long-lasting, dysthymia has sometimes been considered a personality disorder. However, most researchers include it in the group of mood disorders and believe it is biologically related to depression.

Dysthymia and major depressive disorder have been found to have a high degree of comorbidirty. This means that both types of mood disorders are likely to occur in the same individual.

A person with dysthymic disorder develops symptoms of major depression because the criteria for both diagnoses are met. This dual state occurs quite frequently

Although dysthymia seems to make people more vulnerable to major depression, dysthymia itself is different from major depression in terms of the ages at which

people are most likely to be affected. In major depression, rates increase in certain age groups, but in dysthymia, the rate is stable from about age 18 until at least age 64

Dysthymic disorders tend to be chronic, persisting for long periods. In contrast, periods of intense depression are usually described as time-limited, which means that even without treatment the symptoms naturally tend to lessen over time.

1.2.6 Criteria for Bipolar I Disorder

(Most Recent Episode Unspecified)

a) Criteria, except for duration, are currently (or most recently) met for a *Manic*, a *Hypomanic*, a *Mixed*, or a *Major Depressive Episode*.

b) There has previously been at least one *Manic Episode* or *Mixed Episode*.

c) The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

d) The mood symptoms in Criteria A and B are not better accounted for by *Schizoaffective Disorder* and are not superimposed on *Schizophrenia*, *SchizophreniformDisorder, Delusional Disorder*, or *Psychotic Disorder Not Otherwise Specified*.

e) The mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

1.2.7 Criteria for Bipolar II Disorder

a) Presence (or history) of one or more *Major Depressive Episodes*.

b) Presence (or history) of at least one *Hypomanic Episode*.

c) There has never been a *Manic Episode* or a *Mixed Episode*.

d) The mood symptoms in Criteria A and B are not better accounted for by *Schizoaffective Disorder* and are not superimposed on *Schizophrenia Schizophreniform Disorder, Delusional Disorder*, or *Psychotic Disorder Not Otherwise Specified*.

e) The symptoms cause clinically significant distress or impairment in social occupational, or other important areas of functioning.

1.2.8 Criteria for Cyclothymic Disorder

a) For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a *Major Depressive Episode*.

NOTE: In children and adolescents, the duration must be at least 1 year.

b) During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.

c) No *Major Depressive Episode,Manic Episode*, or *Mixed Episode* has been present during the first 2 years of the disturbance.

d) The symptoms in Criterion A are not better accounted for by *Schizoaffective Disorder* and are not superimposed on *Schizophrenia*, *Schizophreniform Disorder*, *Delusional Disorder*, or *Psychotic Disorder Not Otherwise Specified*.

e) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

f) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Self Assessment Questions

1) Delineate the criteria for formal diagnosis of major depression.

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2) What criteria to be followed to diagnose dysthymic disorder?

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3) What criteria do we use to diagnose Bipolar I Disorder?

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4) Describe the criteria to be used for Bipolar disorder II.

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5) Explain the criteria for diagnosing cyclothymic disorder.

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1.3 SEASONAL AFFECTIVE DISORDER (SAD)

Sometimes people can experience depression at particular times of the year, especially in northern countries and typically in winter. This seasonal pattern to the depression is called SAD. People with SAD are often treated with light therapy (exposure to artificial lights that imitate daylight) to lift their depressive episode.

1.3.1 Typical Symptoms

The typical emotions experienced during depression include sadness, guilt and despair. It is also common for a depressed person to experience irritability, agitation and anxiety. People suffering from depression can feel less motivated to participate in activities or interests they previously enjoyed. As the depression becomes worse, they might not bother to eat or cook for themselves, stop going to work or taking care of their appearance. Sometimes depression makes people not want to live and they might contemplate, attempt or even commit suicide.

The effects of depression on a person's thinking include indecisiveness, reduced concentration and decreased speed of thought. People experiencing depression often have negative ideas, including self-criticism, they feel that others do not understand them or punishing them and they do not look forward to the future.

Depression can also cause changes in the sufferer's psychomotor activity. The changes can range from inactivity (psychomotor retardation), such as slowed movements or lack of movement to restless activity (psychomotor agitation) such as pacing up and down.

Depression causes a range of changes in physiological or body functioning such as reduced or increased appetite, fatigue or excessive tiredness and loss of sex drive. Sleep disturbance is very common and has been estimated to affect more than 90% of depressed individuals. Depression can also cause shorter periods of sleep and increasingly broken sleep.

DSM IV outlines the criteria for a major depressive episode and also for the presence of a single episode of depression and recurrent episodes. For a major depressive disorder to be considered recurrent, a period of two months must separate each depressive episode.

1.4 DEPRESSIVE DISORDERS (UNIPOLAR DISORDERS)

1.4.1 Dysthymic Disorders

Most people who have a dysthymic disorder would tell that they have felt depressed for many years, or for as long as they remember. Feeling depressed seems normal to them. It has become a way of life. They feel helpless to change their lives.

Dysthymic is defined as a condition characterised by mild and chronic depressive symptoms. Periods of dysthymia have been found to last from 2 to 20 or more years, with a median duration of about 5 years. About 3% of the general population and about 30% of those seen at outpatient clinics can be classified as dysthymic.

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Dysthymic disorders tend to be chronic, persisting for long periods. In contrast, periods of intense depression are usually described as time-limited, which means that even without treatment the symptoms naturally tend to lessen over time.

Self Assessment Questions

1) What is meant by seasonal affective disorder?

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2) What are the typical symptoms of SAD?

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3) Discuss the symptoms of unipolar disorder.

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1.5 CAUSES OF DEPRESSION

Interpersonal and social factors that might affect the development of depression include social isolation and either separation from a partner or divorce.

Biological factors that might influence the development of depression include changes in neurotransmitter levels within the brain. Neurotransmitters carry chemical messages between neurons and can influence mood and behaviour. Three types of neurotransmitters – serotonin, dopamine and norepinephrine assist in the regulation of emotions including stress, sleep functions and appetite. All three are often found at lower levels in depressed people than in nonsufferers.

1.5.1 Genetic Factors

Researches indicate that people are between one and a half and three times more likely to develop depression if one of their parents or brothers or sisters has the disorder. Twin studies also have shown that if one identical twin develops depression, the chances of the other twin developing the disorder can be as high as 75%. This provides the evidence of the role of genetics in the development of the disorder.

Researchers also considered the possibility that the combination of genes might be involved in the development of a vulnerability to depression, which increases a person's chances of developing depression. Vulnerability to depression does not mean that they will develop the disorder but it means that they develop depression if other factors or situations also occur. Examples include growing up with parents who are overly critical or rejecting, losing friends or jobs or being placed in stressful or traumatic situations.

1.5.2 Psychological Factors

Factors which influence the possibility of developing depression include medical illnesses, traumatic experiences such as abuse, war or accidents, job stress, substance abuse and the adjustment required following serious injury.

Psychological theories of depression consider these factors as important in the development of the disorder. They focus on sufferer's subjective experiences and how they interpret the vents that occur in their lives. The three main theories are psychoanalytic, interpersonal and cognitive.

1.5.3 Psychoanalytical Theories

Sigmund Freud suggested that depression occurs as a result of anger being turned inward, especially after the loss of a valued family member or friend. This loss can be either real such as after the end of a relationship or imagined, for example, people who feel that they will never be loved again.

Freud stated that this internally directed anger leads to self-criticism and blame and that the aim of this treatment is to release this anger. A consistent feature of major depression can be irritability often directed toward family members or close friends.

The criticism levelled against this view is that depression can affect people who have not suffered the loss of a loved one. Freud's theory that depressed people have internalised anger is also not supported by dream analysis research.

Some of the latest psychoanalytic theories of depression have tried to address these limitations. They proposed that depression develops when people believe they have not reached their true potential such as achieving good grades in school or gaining promotion or a pay raise at work. The effects of recognising and accepting that they have not reached heir expected goals affects their ego. The result is a general feeling of helplessness and low self-esteem that leads to depression.

1.5.4 Interpersonal Theories

Theories suggest that depressed people have poorer social skills than people not experiencing depression. Social skills include the ability to relate to other people by making appropriate eye contact, being able to communicate clearly, being able to show empathy and having a positive regard for others. People experiencing depression have also been observed to have poor problem solving skills and make poor day –day decisions. It is also found that people who experience recurrent depression make poor decisions between depressive episodes.

Depressed people are more likely to be rejected by their friends or peers as they have an aversive interpersonal style.

1.5.5 Cognitive Theories

According to these theories depression is caused by the misinterpretations or errors people make about themselves, their world and the future. These errors are negatively focussed. For example, sufferers might see themselves as useless, the world as uncaring and the future as hopeless despite being successful in their jobs and having devoted families.

Beck's Cognitive Triad

He observed that depressed people tend to make specific errors in their thinking. For example, deciding that they are stupid simply because they make one mistake in a test. He suggested that depressed people develop specific beliefs with strong

negative elements based on these thought errors. A number of factors might lead to the development of these beliefs, including critical parents or rejection by friends.

Cognitive Errors or Biases in Depression

1) **Arbitrary inference** – Drawing a conclusion from an event or situation when there is lack of evidence to support this conclusion.

   Situation: Waiters in a restaurant forget to take your dinner order.

   Thought: They are ignoring me. I am obviously not worth their time.

2) **Black and white thinking** – Taking an extreme view of a situation.

   Situation: Getting a test back and achieving 70%.

   Thought: If I don't get 100%, Iam a total failure."

3) **Magnification/ minimisation** – Exaggerating or ignoring a particular aspect of a situation.

   Situation: A woman finds out she hasn't been invited to a friend's party.

   Thought: They obviously don't like me anymore. I must be a bad person.

4) **Overgeneralisation –** A gross generalisation based on a single event.

   Situation: Being unable to answer a question asked by a teacher.

   Thought: I am going to fail the rest of the year.

1.5.6 Helplessness Theories

These theories explore the specific thoughts of an individual when depressed. The concept of learned helplessness was demonstrated by Seligman. He believed that sufferers believe or find that they have little control over their lives and become passive. Theories also use the concept of attribution. Attribution refers to people's explanation of a particular event and their response to it. For example, depressed people might attribute failure to themselves when faced with a situation they have difficulty controlling such as a difficult science test.

Self Assessment Questions

1) Delineate the causes of depression.

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2) State genetic factors as causing depression.

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3) Elucidate the psychological factors causing depression.

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4) What is psychoanalytical explanation for depression?

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5) How do interpersonal theories explain depression?

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6) Explain cognitive theories for depression.

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7) Elucidate the helplessness theory of depression.

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1.6 TREATMENT OF DEPRESSION

1.6.1 Biologically Based Treatment

This approach includes antidepressant medication and electroconvulsive therapy (ECT). This approach is often successful in lessening depression. ECT is faster – acting than antidepressant medication and is often used if an effective medication cannot be found.

There are many types of treatment for depression and some of the most frequently used include:

- antidepressant tablets
- mood stabilising medications
- support with day-to-day matters while ill or recovering.

Treatments that are used less often, but which can also be helpful especially in severe depression, of a specific type or has proved difficult to treat include:

- electroconvulsive therapy (ECT)
- special types of operation (psychosurgery)
- bright light therapy for seasonal affective disorder (SAD).

Lastly, there are potential treatments that are still either experimental or for which more evidence needs to be found before they can be considered truly effective and safe:

- herbal remedies (e.g. St John's wort)
- trans-cranial magnetic stimulation (TMS), which involves applying brief magnetic pulses to the brain. This is done with the patient awake and sitting in a chair. A doctor holds an electric coil near to the head that emits repeated short magnetic pulses. The procedure is painless. At the present time, TMS is still under investigation as a treatment for depression. However, current evidence suggests that it may be as effective as ECT, but safer.

Broadly speaking, treatments for depression can be broken down into two types:

- Firstly, there are those that aim to correct the chemical and biological abnormalities that occur in the illness. These are: antidepressants, mood stabilising medications, ECT and psychosurgery.

- Secondly, there are the psychological ones, talking treatments. These involve regular appointments to talk to a professional person who is skilled in a particular type of counselling or psychotherapy to help with depression.

The biological and psychological treatments are certainly not mutually exclusive and are often used in combination.

Neither group of treatments or therapies should be considered better than the other.

The treatment (or combination of treatments) used should be the one most likely to help a person when all the different factors that have led to their illness are taken into account.

This is the reason that approaching a professional is so important in deciding how best to cope with and treat depression.

Antidepressant Tablets

There are a number of different groups of these and they include:

- Tricyclic antidepressants (TCAs), e.g. amitriptyline, imipramine, lofepramine.
- Selective serotonin reputake inhibitors (SSRIs), eg fluoxetine, paroxetine, citalopram.
- Monoamine oxidase inhibitors (MAOIs), eg moclobemide, phenelzine, tranylcypromine.
- Other medicines that do not quite fit neatly into these groups, but that have effects similar to one or more of these groups (eg venlafaxine, mirtazapine, reboxetine, trazodone).

The oldest antidepressants are the monoamine-oxidase inhibitors (MAOIs) and tricylic antidepressants (TCAs). The TCAs are still in wide use today and remain effective medicines.

The MAOIs require a special diet to avoid unpleasant and potentially serious side-effects, and they can interact with many other medicines.

They are therefore generally used only for people whose depression has not responded to other treatments.

The SSRIs are a much newer group of antidepressants, but they have been widely and successfully used for about twenty of years.

- All antidepressants work by boosting one or more chemicals (called neurotransmitters) in the nervous system. These chemicals may be present in insufficient amounts in depression, resulting in the symptoms of the illness.
- All antidepressants take a minimum of two weeks (and sometimes up to eight weeks) to start to work, and once they have started working the depression recovers gradually.
- It's vitally important, therefore, that if a person is given antidepressants they should keep taking them regularly, even if they don't seem to make much difference to begin with.
- Some antidepressants can cause mild unpleasant effects if they are stopped very suddenly, but even these can normally be avoided if the medicine is tailed off over a period of time.
- A rule of thumb is that antidepressants should be taken for at least six months at the same dose after the person has recovered. This reduces the risk of the depression coming back again.
- A few people whose depression does return every time they come off antidepressants may need to be on treatment on a long-term basis.
- There is no evidence to suggest that any one antidepressant or antidepressant group is better than any other in terms of the number of people who will benefit from it. (Generally around two-thirds of people will find that their symptoms improve on any particular medication).

- But one may be a better choice than another on the grounds of its side effects: for instance a person who finds that their sleep is disturbed may benefit from an antidepressant that is also quite sedative. By contrast someone who is sleeping reasonably and has to be able to listen out for their children would clearly find this effect a problem, and would be better with a non-sedative medication.

- If an antidepressant from one group does not work very well, then there is a good chance that one from another group may work.

Mood Stabilisers

- In depression, these medicines are used to boost the effects of antidepressants.

- The best-known mood stabiliser is lithium. It is also the best-proven one, but one drawback is that regular blood tests are needed to check its level. (Lithium is also used in bipolar affective disorder – 'manic depression'.)

- There are some newer mood stabilisers available now that offer alternatives to lithium, such as sodium valproate (Epilim) or semisodium valproate (Depakote).

Electroconvulsive Therapy

Electroconvulsive therapy (ECT) is a treatment that has been used for many decades for depression. But it is controversial.

The facts are:

- it is a very effective treatment for depression, perhaps the single most effective treatment.
- it is especially effective for severe depression and depression that has a lot of physical symptoms, such as changes in appetite, sleep and concentration.
- it is as safe as any minor procedure that needs a general anaesthetic.
- it can be life saving as it can work more quickly than antidepressant medicines.
- there's no good evidence for any permanent damage to the nervous system.

Like all treatments, ECT does have some side effects. These can include:

- headache
- forgetfulness around the time of treatment.

1.6.2 Psychodynamic Approach to Treatment of Depression

According to Freud, depressed person had a strong and punishing conscience and the reason for it was to control anger and aggressive feelings that otherwise come forth to hurt others. Psychoanalytic theorists have suggested that clinical episodes of depression happen because the events that set off the depression revive dimly conscious, threatening views of the self and others that are based on childhood experience. Bowlby also believed that childhood experiences that contribute to these depressed feelings were not single events but developed from long – term patterns of familial reaction.

This approach helps the client to become aware of their beliefs that originated in childhood. The therapist facilitates the process of transference so that the client

exhibits all his reactions that were suppressed. The therapist helps the client to identify his reactions and help him in alter these reactions.

1.6.3 Interpersonal Psychotherapy

It focuses on teaching people to be more socially effective as a way to improve their relationships with their significant others. It integrates the psychodynamic perspective which emphasises early childhood experiences with the cognitive behavioural perspective which emphasises current psychosocial stressors such as chronic marital discord. This therapy works well when paired with the use of antidepressant medications and has been demonstrated to be effective, both in lessening depressive symptoms and in extending the period of remission for individuals who have a history of recurrent depressions.

1.6.4 Behavioural Therapy

As depressed people lack skills necessary to develop satisfying relationships with others, one behavioural approach to this problem is through social skills training. Social skills' training consists of several parts. First clients are taught basic verbal and nonverbal skills. When these are learned, the clients practice gradually putting the basics together. Then clients are given "homework" assignments in which the goal is to adapt the new skill so it is useful in the everyday environment. Clients are also trained to be more perceptive about cues other people in the environment give and they learn how to change their own behaviour in response. Finally, clients learn to adopt realistic criteria for evaluating their performance and are taught how to be self reinforcing.

Role play is necessary so that the client gets the practice needed to use new behaviours in the real – life situations. The practice gained from these assignments is in turn critical for success in learning new habits.

1.6.5 Cognitive Behavioural Therapy

This therapy makes use of both behavioural and cognitive theoretical perspectives based on the client's skills, degree of depression and on the chosen goals of therapy. The main focus of CBT is to help clients think more adaptively and as a result to experience positive changes in mood, motivation and behaviour.

The more severely depressed the client, the more likely the therapist is to use behavioural techniques at the beginning of the treatment process. Clients are taught how to self – monitor their experiences, noting which gave pleasure and feelings of mastery and which lowered their mood. They are also taught to monitor and record their negative thoughts. Special emphasis is put on *automatic thoughts,* recurring thoughts that come into a person's mind almost as if by habit rather than as a specific response to what is currently going on.

Therapists use several techniques to help clients identify these thoughts, including direct questioning, asking the client to use imagery to evoke the thoughts, or eliciting them by means of a role – play situation. The clients are also asked to keep a daily record of their thoughts. The record includes notes on the situation, emotions, automatic thoughts and the outcome. In this way the client learns that a person's view of reality can be quite different from the reality itself. The therapy can help change dysfunctional thinking and thus alleviate the depression by challenging parts of the client's belief system.

Self Assessment Questions

1) Discuss the biologically based treatment for depression.

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2) What is the psychodynamic approach to treatment of depression?

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3) How does interpersonal psychotherapy function as treatment for depression?

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4) Explain behavioural therapy as treatment of depression.

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5) Elucidate cognitive behavioural therapy as treatment for depression.

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1.7 LET US SUM UP

The term depression is commonly used to refer to normal feelings experienced after significant loss such as the breakup of a relationship or the failure to attain a significant goal. These feelings are not classified as a depressive disorder by DSM –IV. Symptoms of grief over the death of a loved one also are not classified as depression unless they continue for an unusually long period.

Depression can refer to a symptom or disorder. The symptom of depressed mood does not necessarily mean a person has a depressive disorder. Some symptoms of depression occur frequently in people who 'have the blues' but are not clinically depressed. But, those who meet DSM – IV criteria experience symptoms that are more severe.

Depressive disorders include dysthymic disorder and major depressive disorder. Depression is the result of an interaction between biological characteristics, psychological vulnerabilities and stressful events or ongoing stressful life situations. Treatment to depression includes biological, psychodynamic, interpersonal, behavioural and cognitive behavioural approaches.

1.8 UNIT END QUESTIONS

1) Discuss the causes for the occurrence of depression.

2) Explain depressive disorders.

3) Explain the significance of different approaches in treating depression.

1.9 GLOSSARY

Dysthymic disorder : It is a stable condition in which a depressed mood is dominant over long periods of time even if is interrupted by short periods of normal mood.

Major depressive disorder : It is diagnosed when a person has experienced one or more major depressive episodes but has never experienced either a manic or hypomanic episode.

Recurrent major depressive disorder : When a person who has experienced one major depressive episode develops the symptoms again at a later time, the diagnosis is known as recurrent major depressive disorder.

Major depressive episode with psychotic features : If someone experiences delusions or other psychotic symptoms during a major depressive episode, it is diagnosed as major depressive episode with psychotic features.

1.10 SUGGESTED READINGS

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UNIT 2 PERSONALITY DISORDER

Structure

2.0 INTRODUCTION

'Personality' is the characteristics or qualities that form an individual's character. For example the way they feel, behave and their pattern of thoughts all make up someone's personality and this is what makes each person the individual they are. Generally speaking someone's personality does not normally change very much, but it can develop as people go through different experiences in life, and as their circumstances change. People are usually flexible enough to learn from past experiences and change their behaviour to cope with life more effectively, but if someone has a personality disorder they are likely to find this more difficult. In this unit we learn about personality disorders. We start with nature of personality

disorders and follow it up with origin of and different types of personality. Under this we discuss different types of personality even in normal persons. Then we discuss the features of personality disorders followed by causes of personality disorders. Then we present the clusters of personality disorders followed by treatment of personality disorders.

2.1 OBJECTIVES

After completing this unit, you will be able to:

- Define personality and personality disorders;
- Explain Nature of personality disorders;
- Trace the Origin and diagnosis of personality disorders;
- Elucidate the Types of personality disorders; and
- Describe the Treatment for personality disorders.

2.2 NATURE OF PERSONALITY DISORDERS

The term "personality disorder" simply refers to a diagnostic category of psychiatric disorders characterised by a chronic, inflexible, and maladaptive pattern of relating to the world. This maladaptive pattern is evident in the way a person thinks, feels, and behaves. The most noticeable and significant feature of these disorders is their negative effect on interpersonal relationships. A person with an untreated personality disorder is rarely able to enjoy sustained, meaningful, and rewarding relationships with others, and any relationships they do form are often fraught with problems and difficulties.

To be diagnosed with a "personality disorder" does not mean that someone's personality is fatally flawed or that they represent some freak of nature. In fact, these disorders are not that uncommon and are deeply troubling and painful to those who are diagnosed with these disorders. Studies on the prevalence of personality disorders performed in different countries and amongst different populations suggest that roughly 10% of adults can be diagnosed with a personality disorder.

Unlike many types of disorders that are indicated by symptoms that are not usually found in the general population (e.g., seizures), personality disorders cannot be understood independently from healthy personalities. Since everyone has a personality (but not everyone has seizures), personality disorders reflect a variant form of normal, healthy personality. Thus, a personality disorder exists as a special case of a normal, healthy personality in much the same way as a square is a special case of the more general construct of a rectangle. Therefore, it is useful for us to begin our discussion of personality disorders by first discussing the broader, more general construct of personality.

The term *'personality disorder'* describes various clusters of symptoms and slots different groups into separate categories of disorder. There are many different types and it is not uncommon for someone with one type of personality disorder to have other types of personality disorder as well.

Personality disorders are long standing, maladaptive, inflexible ways of relating to the environment. Such disorders can usually be noticed in childhood, or at least by early adolescence, and may continue through adult life. They severely limit an individual's approach to stress – producing situations because his characteristic styles of thinking and behaviour allow for only a rigid and narrow range of responses.

They may have great difficulty controlling their impulses and emotions, and often have distorted perceptions of themselves and others. As a result, these individuals may suffer enormous pain and have significant difficulty functioning at home, work, and in relationships.

Families commonly endure episodes of explosive anger and rage, extreme depression (e.g., person rarely gets out of bed), self-mutilation (self-inflicted cuts and burns), and suicide attempts by family members with personality disorders. These individuals are often referred to treatment by loved ones who recognise a troubling pattern, or who have reached their personal limit in trying to cope with them.

Case 1: Sunitha is 37 years old, married, and the mother of two children. She experiences unstable moods, and has repeatedly cut herself, usually when feeling very stressed or abandoned. She often feels empty and bored. She has abused alcohol and drugs in the past. She is extremely sensitive to criticism, and angrily reacts to perceived rebuffs.

Personality Disorders usually become noticeable in adolescence or early adulthood, but sometimes starts in childhood. It can make it hard for people with a personality disorder to start and keep friendships or other relationships and may find it hard to work effectively with other people.

People with mild personality disorders usually manage to live normal lives but in times of increased stress the symptoms of the personality disorder are likely to impact seriously on how they think and feel and they can find it hard to cope.

2.3 ORIGIN AND DIFFERENT TYPES OF PERSONALITY

A personality disorder, as defined in the *Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision (DSM-IV-TR),* is an enduring pattern of inner experience and behaviour that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Personality disorders are a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances. Ten personality disorders, grouped into 3 clusters (ie, A, B, C), are defined in the *DSM-IV-TR.*

Disordered patterns of behaviour characterised by relatively fixed and inflexible lifelong reactions to stress. Individuals may show repetitive, maladaptive, and frequently self-defeating patterns of behaviour, inadequate handling of impulses, or restricted and inappropriate feelings. The individual has a limited variety of responses to stress, and in the face of failure to cope may show anxiety, denial,

or psychotic behaviour. In the absence of environmental frustration, he tends to show little anxiety or mental or emotional symptoms, and the behaviour patterns are said to be "ego syntonic," i.e., they are felt by the person to be "normal" and "right." Thus, such a person rarely seeks help because of his own anxiety and discomfort; more often he is referred by a family or society with whom he is unable to live in harmony. If the patient seeks help, it usually follows environmental frustrations and he shows typical neurotic symptoms and conflicts.

The maladaptive behaviour patterns seen in personality disorders tend to be exaggerations of mechanisms used at times by, most people. Diagnosis of personality disorders is based on behavioural manifestations and patterns and need not reflect a subjective sense of conflict or distress. Frequently, though, one recognises low self-esteem, paucity or relative superficiality of intimate relationships, difficulty in sustaining interests, low frustration tolerance, difficulty in postponing gratification, and inability to learn from experience.

The causes of these disorders are unknown, but constitutional factors may play a role in some instances (schizoid, cyclothymic, antisocial personalities), In general, it is assumed that patterns of response are a result of early experiences and conditioning, and that early interpersonal relationships are important in establishing modes of defense and their rigidity.

2.3.1 Paranoid Personality

These people tend to be hypersensitive, with an underlying suspicion of others and their motivations. They are often rigid and inflexible in behaviour and react poorly to criticism or suggestions for change. They feel isolated and project onto others harmful motives and blame for misfortune. It is assumed that these traits are the person's ways of dealing with feelings about himself which he regards as unacceptable, demeaning, or dangerous. Often the suspicious attitude leads to aggressive feelings and/or behaviour, with resultant further isolation. The individual's sense of self-adequacy and self-esteem seems particularly impaired.

Often the behaviour of these people is designed to, prove their adequacy, while their sense of worthiness becomes exaggerated and is accompanied by belittlement of others. In many spheres: they may be highly efficient and conscientious, though, lacking flexibility. Positions of power and recognition may be achieved, but frequently at the expense of the ability to relax and to maintain a sense of humor. Often their suspiciousness and hostility bring about rejection by others, which seems to justify their original feelings, but they are unable to see their own part in this cycle. They may be litigious, especially when they feel a sense of righteous indignation.

2.3.2 Cyclothymic Personality

Behaviour is frequently characterised by alternating and recurrent states of depression or elation. While elated, these persons feel active and outgoing; are ambitious, optimistic, and enthusiastic; and may show high levels of energy. At such times they are gregarious and capable of attracting friends who may find them fascinating though unpredictable or eccentric. Periods of depression are characterised pessimism, low levels of energy, and a sense of hopelessness and worry. Moods of cheerfulness and sadness are part of normal behaviour and no doubt there is a continuum with cyclothymic personalities. However, with a cyclothymic disorder, the mood swings are precipitated more by internal than

external events, tend to be more intense, and are apt to be cyclic. At times there is not a regular swing from high to low moods but, rather, a more sustained depression or euphoria. It is uncertain whether the cyclothymic personality disorder lies on a continuum with manic-depressive illness or is a different entity.

2.3.3 Schizoid Personality

These persons are oversensitive, withdrawn, seclusive, and shy, and avoid close or prolonged relationships. They may be characterised as eccentric and their thinking as "autistic" (somewhat idiosyncratic but without loss of reality testing). Daydreaming is common, with difficulty in expressing feelings, and detachment. The range of adaptive responses is limited and withdrawal is the main reaction to stress. Often they develop highly stylised and distinct interests which further separate them from their peers, and, in general, their attention is directed to asocial endeavors.

2.3.4 Explosive Personality

This pattern is characterised by sudden, tantrum like outbursts of rage or verbal or physical aggressiveness. Despite guilty and regretful feelings, these individuals are unable to control their outbursts. They are easily excited by environmental frustrations. Recently, questions have been raised as to whether underlying minor organic brain changes predispose to this explosiveness.

2.3.5 Obsessive Compulsive Personality

Patterns of behaviour are characterised by concern for perfection and orderliness, conformity to social norms, and high personal standards of conscience. Persons with this reaction have difficulty dealing with ambiguous situations; need to define, compartmentalise, and conceptualise problems; and also show some rigidity, inhibition, and difficulty in relaxing. There is a drive to control the situation, and to reduce ambiguity. When faced with new, uncertain, and complex situations, they display anxiety. The quality of compulsiveness is in tune with Western cultural standards, and when the disorder is not too marked these people are often capable of high levels of achievement, especially in the sciences and academic fields where order is desirable. On the other hand, they often feel a sense of isolation and difficulty with interpersonal relationships in which one must rely on others and in which one's feelings are less under strict control and events are less predictable.

2.3.6 Hysterical (Histrionic) Personality

This pattern is characterised by dramatic and attention seeking behaviour, excitability, emotional instability and over-reactivity, self-centeredness, and a provocativeness or sexualisation of nonsexual relationships often combined with sexual frigidity or fears. Though superficially self-assured, such people have major doubts as to their identity and goals. Their difficulty in expressing genuine feelings further prevents intimate relationships. Such relationships are affected by the individual's seemingly insatiable need for affection. Behind their sexually seductive behaviour lies a child-like wish for nonsexual affection and protection.

2.3.7 Asthenic Personality

This category is characterised by lack of enthusiasm, low energy and capability, difficulty in developing a broad sense of enjoyment and pleasure, and a poor

response to even small physical or emotional stresses. These persons never seem to mobilise resources to meet distress and, as a result, feel helpless, wishing they could do more but seemingly unable to feel up to doing it.

2.3.8 Antisocial Personality

This pattern, formerly referred to as "sociopathic," includes those whose behaviour is repetitively in conflict with social mores. Delinquent behaviour is not the sole pattern, but is accompanied by impulsiveness, irresponsibility, either a low sense of guilt or guilt that appears only after an event, callousness toward others, and a superficiality of emotional involvement. These people seem to have a keen capacity for rationalising and explaining their behaviour as a consequence of another's. They also show little foresight. Onset is usually before age 12 to 15. Typical childhood symptoms are theft, lack of discipline, and truancy together with habit disturbances such as enuresis, sleepwalking, and nail-biting. As adults they have continued problems with school, poor work records, and unstable marital histories, besides showing belligerency, social isolation, sexual deviations, and frequently excessive alcohol or drug use. They also complain of anxiety and somatic complaints. The disorder is preponderant in males; there is some evidence to believe that there is a "maturing out" of the disorder between ages 30 and 40, followed by a decrease in gross antisocial behaviour.

2.3.9 Passive Aggressive Personality

This group is subdivided into passive, passive-aggressive, and aggressive types. The passive type is characterised by helplessness, indecisiveness, and a clinging dependency even when given support from others. Such passivity may serve to gain attention and affection, to avoid responsibility, and/or to control others covertly. Passive-aggressive behaviour is characterised by obstinacy, inefficiency, procrastination, and sullenness, often disguised under a superficial compliance. Frequently these people agree to perform a task and then proceed to subtly undermine its completion with complaints and passive obstructionism. The aggressive type is characterised by sullenness, tantrum-like behaviour, provocativeness, and argumentativeness, especially with those in authority. Such behaviour usually serves to deny or conceal marked dependency needs. The behaviour is maladaptive in that, ironically, it drives others away and prevents the individual from receiving even a normal amount of support.

2.3.10 Inadequate Personality

The term describes individuals whose response to any form of stress seems ineffectual. Their behaviour shows poor judgment, ineptness, lack of energy, poor long-range planning, and poor performance. Incentive is lacking, especially to achieve culturally desired levels. These people are marginally involved in social relationships, tend to drift, and take non-demanding jobs. There is no evidence for physical or mental defects. However, there does seem to be some social value-judgment essential to this diagnosis, since those diagnosed as inadequate personalities tend to be in the lower socioeconomic level on the other hand, this may reflect early social, cultural, and experiential deprivation which, together with the repeated experience of failure, leads to passive styles of behaviour. Often these people are welfare recipients or reside in institutions.

2.3.11 Sexual Deviations

This category refers to those who repetitively and somewhat compulsively direct their sexual interests toward objects other than the opposite sex, toward sexual acts not associated with intercourse, or toward intercourse only when associated with stylised behaviour (e.g., sexual sadism). The term carries a moral connotation and is somewhat related to cultural norms. However, it is believed that this behaviour reflects at least developmental difficulties, if not psychopathology, and that "deviant" sexual behaviour is an attempt to achieve some sexual gratification while avoiding fears associated with usual adult sexual practices.

Clinicians use different theories to explain the origin and development of each of these disorders. Some argue that personality disorders are inherited while others suggest that the environment in which we grow up is responsible for our personality traits.

Self Assessment Questions

1) Discuss the nature of personality disorders.

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2) What are the different types of personality that we obtain even in normal persons?

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3) Discuss paranoid, cyclothymic, schizoid and explosive personality.

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4) Elucidate the obsessive compulsive personality, hysgterical ersonality and asthetic personality.

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5) Describe antisocial personality, passive aggressive personality and inadequate personality.

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6) What is sexual deviation?

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2.4 DIAGNOSIS

Personality disorders are diagnosed on DSM-IV's Axis II and they are near *permanent disorders*. On the other hand, Axis I disorders are called symptom disorders which may come and go. Symptom disorders may be triggered by events or environmental factors and may disappear when conditions change. People with Axis I disorders often see themselves as having personal problems (symptoms) that are troublesome and require treatment. People with Axis II disorders are far more likely to say that their difficulties are attributable to the environment and that they do not require clinical treatment.

Clinicians also differ on diagnosis. For example, when a highly unpredictable, exuberant patient walks into a psychiatrist's room, one psychiatrist might diagnose him as having antisocial personality disorder and psychopathy, while another might say that he has borderline personality disorder. This is because the diagnostic methods used such as questionnaires are not very reliable. However, better methods are being devised that might show more of a clear pattern for diagnosis – even across different cultures.

2.5 FEATURES OF PERSONALITY DISORDERS

The features of personality disorders are:

- Early onset: This is evident at least since late adolescence.
- Stability: No significant period when not evident.
- Pervasive: This is evident across a wide range of personal, social and occupational situations
- Clinically significant maladaptation resulting in personal distress or impairment in social and occupational functioning.

2.6 CAUSES OF PERSONALITY DISORDERS

There is no single cause of personality disorder. It is thought that a combination of factors may contribute to people being vulnerable to the development of a personality disorder due to genetic factors. However, it may be related more to the fact that people affected have not had the opportunity to learn at an early age how to act or react and manage their feelings.

A personality disorder may also relate to incidents or traumas in childhood like physical or sexual abuse or where there have been difficulties in parenting. Figures show that around 80% of those diagnosed with borderline personality disorder have been diagnosed as having a childhood trauma.

Dissociative Identity Disorder (previously referred to as 'multiple personality disorder') and other dissociative disorders are now understood to be fairly common side effects of severe traumas in childhood.

Personality disorders are more common when stress levels are high. So treatment tends to focus on coping and learning how to relate to others. This is because people diagnosed with personality disorders have often missed the opportunity in childhood to learn how to cope and manage their feelings.

Many people do not even know they have a personality disorder. They may just think that they are miserable and that their lives are pointless. Part of the problem is they are not able to think about their feelings, so they may even resort to drugs and alcohol, self harm or even overdoses, which make things worse.

The role of causal factors in personality disorders is not known much as these disorders received attention only since the publication of DSM –III and also because they are less amenable to study. One major problem in studying the causes of personality disorders stems from the high level of co morbidity among them i.e. patients who are qualified for one personality disorder diagnosis also qualified for one or more than one other personality disorders. Another problem is that many people with these disorders are never seen by clinical personnel.

2.6.1 Biological Factors

It has been suggested that infant's constitutional reaction tendencies (high or low vitality, behavioural inhibition) may predispose them to the development of particular personality disorders. As most of the personality traits are found to be moderately heritable, there is increasing evidence for genetic contributions to certain personality disorders like paranoid personality disorder, schizotypal

personality disorder, borderline personality disorder and antisocial personality disorder. Some progress is also made in understanding the psychobiological substrate of at least some of the personality disorders. For example, people with borderline personality disorder appear to be characterised by lowered functioning of the neurotransmitter serotonin due to which they show impulsive aggressive behaviour as in parasuicidal acts such as cutting their arms with a knife. Patients with borderline personality disorder may also show disturbances in the regulation of noradrenergic neurotransmitters that are similar to those seen in chronic stress conditions such as PTSD. Moreover, deficits in the dopamine system may be related to a disposition toward transient psychotic symptoms.

2.6.2 Psychological Factors

Early learning experiences are usually assumed to contribute the most in predisposing a person to develop a personality disorder. Numbers of studies have suggested that abuse and neglect in childhood may be related to the development of certain personality disorders. Patients with borderline personality disorder reported significantly higher rates of abuse than patients with other personality disorders.

Psychodynamic theorists also expressed their views on the causes of personality disorders. For example, with regard to narcissistic personality disorder they believed all children go through a phase of primitive grandiosity during which they think that all events and needs revolve around them. For a normal development to occur beyond this phase, parents must do some mirroring of the infant's grandiosity. This disorder is also likely to develop if parents are neglectful, devaluing or unempathetic to the child.

2.6.3 Socio-Cultural Factors

The role of socio-cultural factors is not clearly found. However, the changing culture, emphasis on impulse gratification, instant solutions and pain free benefits are leading more people to develop the self –centered life – styles that we see in more extreme forms in the personality disorders.

Self Assessment Questions

1) How do you diagnose personality disorders?

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2) Delineate the features of personality disorders.

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3) Discuss the biological causative factors of personality disorder.

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4) Elucidate the psychological causes of personality disorder.

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5) What are the socio-cultural factors contributing to personality disorders?

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2.7 CLUSTERS OF PERSONALITY DISORDERS

There are 10 different types of personality disorder. Each one is linked with a different set of attitudes, emotions and behaviours. These personality disorders are grouped into three clusters – A, B and C.

2.7.1 Cluster A Personality Disorders

Cluster A features *odd or eccentric behaviour*. The personality disorders in this cluster include:

1) **Paranoid Personality Disorder**

People with this disorder can be cold and detached and find it hard to form relationships. They are often suspicious in their surroundings and can act angrily towards other people. This distrust and suspiciousness is indicated by four (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1) Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her

2) Preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.

3) Reluctant to confide in others because of unwarranted fear that the information will be used against him or her

4) Reads hurtful or threatening meanings into kind remarks or events

5) Unforgiving of insults or injuries

6) Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily

7) Has recurrent suspicions, without justification, regarding faithfulness of spouse or sexual partner.

2) **Schizoid Personality Disorder**

People diagnosed with this disorder can be cold, distant and reclusive, shying away from closeness or intimacy. They can get caught up in their own thoughts and hold back from getting involved with other people. This pattern is indicated by four (or more) of the following (from DSM-IV, American Psychiatric Association, 1994):

1) neither desires nor enjoys close relationships, including family relationships

2) often chooses activities that don't involve other people.

3) has little interest in having sexual relations with another person

4) enjoys few activities

5) lacks close friends other than immediate family

6) appears indifferent to praise or criticism

7) shows emotional coldness, detachment, or little emotional expression.

3) **Schizotypal Personality Disorder**

It has the same traits as the schizoid personality disorder. But, in addition to the above they can have chaotic thoughts and views and are poor communicators. This disorder is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) ideas of reference, i.e., believes that casual and external events have a particular and unusual meaning that is specific to him or her

2) odd beliefs or magical thinking that influences behaviour and is inconsistent with cultural norms (e.g., belief in superstitions or clairvoyance, telepathy, or "sixth sense"

3) unusual perceptual experiences (e.g., hears a voice murmuring his or her name; reports bodily illusions)

4) odd thinking and speech (e.g., unusual phrasing, speech which is vague, overly elaborate, and wanders from the main point)

5) excessively suspicious thinking

6) inappropriate or constricted emotions (reduced range and intensity of emotion) behaviour or appearance that is odd or peculiar (e.g., unusual mannerisms, avoids eye contact, wears stained, ill-fitting clothes) lack of close friends or confidants other than immediate family excessive social anxiety that remains despite familiarity with people and social situation. The anxiety relates more to suspiciousness about others' motivations than to negative judgments about self.

2.7.2 Cluster B Personality Disorders

Cluster B features *dramatic, emotional or erratic behaviour*. The personality disorders in this cluster include:

a) **Borderline Personality Disorder**

People with this disorder have a shaky, unsure view of themselves and have problems with relationships. They can be moody and see things in black and white. They feel they lost out on nurturing as children and can become very needy and clingy as adults. When their needs are not met, they feel empty, angry and abandoned and may react in a desperate and impulsive way.

This pattern begins by early adulthood, occurs in various contexts, and is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) frantic efforts (excluding suicidal or self-inflicted cuts or burns) to avoid real or imagined abandonment.
2) a pattern of intense and unstable interpersonal relationships that may quickly alternate between extremes of idealisation (the other person may be "put on a pedestal") and devaluation (the other person's negative qualities are now exaggerated).
3) identity disturbance: sudden and dramatic shifts in self-image in terms of shifting values (e.g., sexual identity, types of friends) and vocational goals.
4) impulsiveness in at least two areas that are potentially harmful (e.g., spending, sex, substance abuse, reckless driving, binge eating, excluding suicidal or self-mutilating behaviour).
5) repeated suicidal behaviour or threats, or self-inflicted cuts or burns (e.g., self-mutilating behaviour).
6) significant, sudden changes in mood and observable emotion (e.g., intense periodic sadness, irritability, or anxiety, usually lasting a few hours and rarely lasting more than a few days; extreme reactivity to interpersonal stresses).
7) chronic feelings of emptiness; also may be easily bored.
8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights) temporary, stress-related psychosis (symptoms such as paranoia or grossly distorted body image).

b) **Antisocial Personality Disorder**

People diagnosed with this disorder disregard the feelings, property and authority of others; they often have violent and aggressive behaviours and tend to show a lack of remorse.

Individuals with Antisocial Personality Disorder show a pervasive disregard for, and violation of, the rights of others since age 15 years, as indicated by three (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) repeated acts that are grounds for arrest
2) deceitfulness, i.e., repeated lying, use of aliases, or conning others for personal profit or pleasure
3) impulsiveness or failure to plan ahead
4) irritability and aggressiveness, such as repeated physical fights or assaults
5) reckless disregard for the safety of self or others
6) consistent irresponsibility, i.e., repeated failure to sustain consistent work behaviour or honor financial obligations
7) lack of remorse, as indicated by indifference to, or rationalising having hurt, mistreated, or stolen from another.

To receive this diagnosis, an individual also needs to be at least 18 years old, to show evidence of a conduct disorder (which begins before age 15), and to show antisocial behaviour that does not only occur during a manic episode or the course of schizophrenia.

Case 1: Krishna is 46 years old, divorced, and currently unemployed. He has worked for most of his adult life, and at one time owned a business. He has a history of intense, unstable relationships, and has been violent toward his wives and his children. He experiences periods of rage and frequent fighting. Usually the fights are verbal, but occasionally they are physical. When a neighbor spoke to him rudely, he seriously wounded his neighbour. He is in prison at this time.

c) **People diagnosed with Narcissistic Personality Disorder**

They display an abnormally high opinion of themselves, are oversensitive to criticism and resent those people who do not admire them. This pattern is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) has an inflated sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognised as superior without corresponding achievements)
2) is overly concerned with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4) requires excessive admiration
5) has a sense of entitlement, i.e., unreasonable expectations of very positive treatment or automatic compliance with his or her expectations
6) takes advantage of others to achieve his or her own ends
7) lacks empathy: is unwilling to identify with the feelings and needs of others
8) is often jealous of others or believes that others are jealous of him or her
9) shows arrogant or domineering behaviours or attitudes.

d) People diagnosed with Historic Personality Disorder: are obsessive about their appearance and constantly demand attention. Their behaviour is often seen as over the top and they may be referred to as being 'shallow'. This pattern is suggested by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994)

1) discomfort in situations in which he or she is not the center of attention
2) frequent, inappropriate, seductive or provocative behaviour in interpersonal interactions
3) rapid shifts of emotions, and shallow expression of emotions; emotions often appear to be "turned on and off too quickly" to be deeply felt
4) consistent use of physical appearance to draw attention to self
5) excessively dramatic style of speech that lacks detail; opinions are strongly presented, but underlying reasons may be vague, without supporting facts and details
6) self-dramatic, theatrical, and exaggerated expression of emotion
7) easily influenced by others or circumstances (e.g., fads)
8) views relationships as more intimate than they actually are.

2.7.3 Cluster C Personality Disorders

Cluster C features *anxious or fearful behaviour.* The personality disorders in this cluster include:

a) **Dependant Personality Disorder**

Where people depend on their opinion and judgement. Their insecurity, indecision and lack of self esteem can make it difficult for them to take care of themselves. A person with Dependent Personality Disorder shows an extreme need to be taken care of that leads to fears of separation, and passive and clinging behaviour. This disorder is indicated by five (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) difficulty making daily decisions without an excessive amount of advice and reassurance from others
2) needs others to assume responsibility for most major areas of his or her life
3) difficulty voicing disagreement with others because of fear of loss of support or approval (excluding realistic fears of punishment)
4) difficulty starting projects or doing things on his or her own (because of little self-confidence in judgment or abilities, rather than a lack of motivation or energy)
5) excessively attempts to obtain support from others such that he or she volunteers to do unpleasant tasks
6) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
7) urgently seeks another relationship as a source of support when a close relationship ends
8) overly worried about being left to take care of himself or herself.

b) **Avoidant Personality Disorder**

This disorder causes people diagnosed to avoid situations which can cause conflict because they cannot face the possibility of being rejected. By doing so, however, they make their own situation worse by isolating themselves and avoid forming any relationships.

An individual with Avoidant Personality Disorder typically is socially inhibited, feels inadequate, and is oversensitive to criticism, as indicated by four (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) avoids work-related activities that involve much social contact, because of fears of criticism, disapproval, or rejection
2) is unwilling to get involved with people unless certain of being liked
3) fears of shame or ridicule lead to excessive shyness within intimate relationships
4) is overly concerned with criticism and rejection in social situations
5) is inhibited in new social situations because of feelings of inadequacy
6) views self as socially incompetent, personally unappealing, or inferior to others unusually reluctant to take personal risks or do new activities because of fear of embarrassment
7) People diagnosed with Obsessive Compulsive Personality Disorder are so inflexible in their approach to things that they become anxious and indecisive and normally end up not completing any tasks they have started. They like to be in control and have difficulty in sustaining healthy relationships.

This pattern is indicated by four (or more) of the following (from DSM IV, American Psychiatric Association, 1994):

1) is overly concerned with details, rules, lists, order, organisation, or schedules such that the major point of the activity is lost
2) is unable to complete a project because his or her own overly strict standards are not met
3) excessive emphasis on work and productivity such that leisure activities and friendships are devalued (not accounted for by obvious economic need)
4) is overly conscientious and inflexible about issues involving morality, ethics, or values (not accounted for by cultural or religious identification)
5) is unable to throw out worn-out or worthless objects despite lack of emotional value
6) is reluctant to delegate tasks or work with others unless they agree to exactly his or her way of doing things
7) adopts a stingy spending style toward both self and others; money is seen as something to be gathered for future catastrophes
8) rigidity and stubbornness

There also is a diagnosis known as “Personality Disorders Not Otherwise Specified”, which is separate from the above three groups of disorders.

This diagnosis would be given for disturbed personality functioning that does not meet criteria for any specific personality disorder, but which leads to distress or harm in one or more important areas of functioning (e.g., social or work-related). The clinician also may give this diagnosis if a specific personality disorder that is not included in the DSM IV Classification seems to apply to an individual (e.g., depressive personality disorder, or passive-aggressive personality disorder; DSM IV, American Psychiatric Association, 1994).

Self Assessment Questions

1) Discuss the cluster A personality disorders.

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2) Elucidate the Cluster B personality disorders.

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3) Explain the cluster C personality disorders.

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2.8 TREATMENT OF PERSONALITY DISORDERS

There are various kinds of help available. Family doctor can be a good start as he/she will be to refer you to someone who knows how to offer the best help. Psychological and drug therapies provide some benefit for people with personality disorders. Counselling and psychotherapy give people the chance to talk about their difficulties. Therapy aims at helping people bring their true feelings to the surface, so that they can experience and understand them better. Other forms of help available include Cognitive Behavioural Therapy (CBT) which is a combination of cognitive therapy and behavioural therapy. It helps to weaken the links between upsetting situations and your normal reaction to them, teaching you how to calm your mind and body and feel good. It also helps you to recognise patterns that make you angry, anxious or depressed.

Medical Treatment and Support Groups are also other forms of help available for people suffering from personality disorders.

Treatment will vary depending on the view the clinician holds regarding the origins of personality disorders and will also depend on services available. In the case of psychopathy, it is thought that because people who have this diagnosis feel no emotion, it is impossible to treat them with any kind of talking therapy. The other disorders are mainly treated with a combination of drug and talking therapies.

Treatment of Borderline personality Disorder includes the following steps:

- *Identify disturbances*, chronic feelings of emptiness or boredom and their intolerance of being alone. These people have a strong need for involvement with others and a reliance on external support for self- definition.
- *Affective disturbances*, reflected in their intense, inappropriate anger, emotional instability and unstable interpersonal relationships.
- *Impulsive disturbances*, reflected in their self-damaging acts and impulsive behaviours.

2.9 LET US SUM UP

Personality disorders appear to be extreme or exaggerated patterns of personality traits that predispose an individual to maladaptive behaviour. A number of personality disorders have been delineated in which there are persistent patterns of perceiving, thinking and relating to the environment. Three general clusters of personality disorders have been described – Cluster A which includes individuals with paranoid, schizoid and schizotypal personality disorders who seem odd or eccentric. Cluster B which includes individuals with histrionic, narcissistic, antisocial and borderline personality disorders who share a common tendency to be dramatic, emotional and erratic and Cluster C which includes individuals with avoidant, dependent and obsessive – compulsive personality disorders who show fearfulness or tension as in anxiety – based disorders. Research indicated that constitutional and genetic factors play a role in borderline, paranoid, schizotypal and antisocial personality disorders. Some evidence suggests that early childhood abuse may play a role in causing borderline personality disorder.

Treatment of the Cluster C disorders which includes dependent and avoidant personality disorder seems most promising, although a new form of cognitive-behaviour therapy for borderline personality disorder (dialectical behaviour therapy) also shows considerable promise in treating this very serious condition. Cluster A disorders such as schizotypal and paranoid are most difficult to treat.

2.10 UNIT END QUESTIONS

1) Define personality disorders. Discuss the origin and diagnosis of personality disorders.
2) What are the various personality do we come across?
3) Explain Cluster A, Cluster B and Cluster C personality disorders.

4) Delineate the causes of personality disorders.

5) Discuss the symptoms of Cluster C personality disorders.

6) Explain the strategies to treat personality disorders.

2.11 GLOSSARY

Personality disorders : Gradual development of inflexible and distorted personality and behavioural pattern that result in persistently maladaptive ways of perceiving, thinking about and relating to the world.

Paranoid personality disorders : Pervasive suspiciousness and distrust of others

Histrionic personality disorders : Excessive attention seeking, emotional instability and self – dramatisation.

Narcissistic personality disorders : Exaggerated sense of self importance, preoccupation with being admired and lack of empathy for the feeling of others.

Antisocial personality disorders : Continual violation and disregard for the rights of others through deceitful, aggressive or antisocial behaviour, typically without remorse or loyalty to anyone.

2.12 SUGGESTED READINGS

Carson, R.C. Butcher, J.N. & Mineka, S. (2000). *Abnormal Psychology and Modern Life*. Pearson Education, India.

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UNIT 3 GENDER IDENTITY DISORDER

Structure

3.0 INTRODUCTION

In this unit we will be dealing with gender identity disorder. We start with Definition and description of Gender Identity Disorder and follow it up with Origin of Gender Identity Disorder and Transgender issues. Then we take up Components of Gender Identity Disorder and elucidate Criteria and Diagnosis of Gender Identity Disorder. Then we enlist the Symptoms of Gender Identity Disorder and present the Causes of Gender Identity Disorder. The finally we take up the Treatment of Gender Identity Disorder and indicate the Action Steps in Treatment for Gender Identity Disorder.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe gender identity disorder;
- Trace the Origin of gender identity disorder;
- Elucidate the Components of gender identity disorder;
- Explain the Criteria for diagnosis;
- Delineate the Symptoms of gender identity disorder;
- Discuss the Causes; and
- Describe the Treatment interventions of gender identity disorder.

3.2 DEFINITION AND DESCRIPTION OF GENDER IDENTITY DISORDER

Gender identity, a basic feature of personality, refers to an individual's feeling of being male or female. Children become aware that they are male or female at an early age and once it is formed, their gender identity is highly resistant to change.

Gender identity disorder (GID), is a condition in which a person has been assigned one gender (usually at birth), but identifies as belonging to another gender, or does not conform with the gender role their respective society prescribes to them. It is a psychiatric term for what is widely known by other terms such as transsexuality, transgender, transvestism or cross-dressing.

This disorder is different from transvestism or transvestic fetishism where cross dressing occurs for sexual pleasure, but the transvestite does not identify with the other sex. Transsexualism should also not be confused with the behaviour of drag queens and drag kings. Also, transvestic fetishism usually has little, if anything, to do with transsexualism. As a general rule, transsexual people tend to dress and behave in a manner consistent with the gender with which they identify.

3.3 ORIGIN OF GENDER IDENTITY DISORDER

During the 1950's and 60's, psychologists began studying gender development in young children, partially in an effort to understand the origins of homosexuality which was viewed as a mental disorder at the time. Psychoanalyst Robert Stoller is credited with introducing the term gender identity and behavioural psychologist John Money was also instrumental in the development of early theories of gender identity. His work popularized an interactionist theory of gender identity, suggesting that, up to a certain age, gender identity is relatively fluid and subject to constant negotiation.

Sigmund Freud also had a unique theory for the development of gender identity. He believed it was developed during the phallic stage of development. During this time, young boys develop an Oedipus complex and young girls an Electra complex. Freud believed that during this time, the child has an unconscious sexual desire for the parent of the opposite sex and jealousy or hatred for the same sex parent. That jealousy eventually turns into emulating and the child wants to be like that parent, eventually identifying with it.

The notion of gender identity appeared in the Diagnostic and Statistical Manual of Mental Disorders in its third edition, DSM-III (1980), in the form of two psychiatric diagnoses of gender dysphoria – gender identity disorder of childhood (GIDC), and transsexualism (for adolescents and adults). The 1987 revision of the manual, the DSM-III-R added a third diagnosis – gender identity disorder of adolescence and adulthood, non transsexual type. This later diagnosis was removed in the subsequent revision, DSM-IV (1994), which also collapsed the GIDC and transsexualism in a new diagnosis of gender identity disorder.

3.3.1 Transgender

There are many political points of view in the literature of transgender, but the generally agreed definition of transgender covers everything that does not fall

into society's narrow terms of "man" and "woman." Some of the people who consider themselves as transgendered would include transsexuals (who mayor may not have had sex reassignment surgery), transvestites (who wear clothing and adopt behaviour of the opposite sex), people with ambiguous genitalia, and people who have chosen to perform either an ambiguous gender role or no gender role at all.

There are four main categories in the study of transgender:

1) **Essentialist or naturalist:** This group believes that there is no difference between sex and gender, that there are only two genders, and these cannot be changed.

2) **Social constructivist:** This group believes sex and gender can only be considered as part of a social interaction. In other words, sex and gender are a "construction" assigned by society.

3) **Performance:** Gender performance theorists believe gender is best understood through performance studies and they look at what is revealed from clues such as body position, gesture, facial expression, proximity, voice modulation, speech pattern, social space, clothing, adornment and cosmetics.

4) **Memory and language generation:** This group looks at the body as the expression of the symbols of words, gestures and a larger cultural language. On a gut level, the body has deeper knowledge that may not be registered by the mind.

While transgender theorists do not always agree on definitions and underlying philosophies, this is an emerging field with many avenues for scholarly and political dialogue. As the study of transgender develops, it will influence many other disciplines such as anthropology, psychology, psychiatry, sociology, women's studies, men's studies, and gender studies.

A gender identity disorder causes the person to experience serious discomfort with his/her own biological sex orientation. The gender identity disorder can also causes problems for the person in school, work or social settings. The need for treatment is emphasised by the high rate of mental health problems, including depression, anxiety, and drug and alcohol addiction, as well as a higher suicide rate among untreated transsexual people than in the general population. Many transgender and transsexual activists, and many caregivers, point out that these problems usually are not related to the gender identity issues themselves, but to problems that arise from dealing with those issues and social problems related to them.

3.4 COMPONENTS OF GENDER IDENTITY DISORDER

People with gender identity disorder frequently report their feelings as "having always been there", and the disorder can be evident in early childhood. Most people know whether they have a gender identity problem by the time they reach adolescence, although in some cases it seems to appear in adulthood.

Gender identity disorder is a diagnosis given to persons who meet a certain number of clinical criteria related to feelings of discontent regarding one's biological

sex, and identification with the opposite biological sex. The individual may identify to the point of believing that they are, in fact, a member of the other sex who is trapped in the wrong body.

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis.

i) There must be evidence of a strong and persistent gross-gender identification, which is the desire to be, or the insistence that one is, of the other sex. This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex.

ii) There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.

Gender identity disorder can affect children, adolescents, and adults. Individuals with gender identity disorder have strong cross-gender identification. They believe that they are, or should be, the opposite sex. They are uncomfortable with their sexual role and organs and may express a desire to alter their bodies. While not all persons with gender identity disorder are labelled as transsexuals, there are those who are determined to undergo sex change procedures or have done so, and, therefore, are classified as transsexual.

Adults with gender identity disorder sometimes live their lives as members of the opposite sex. They tend to be uncomfortable living in the world as a member of their own biologic or genetic sex. They often cross-dress and prefer to be seen in public as a member of the other sex. Some people with the disorder request sex change surgery.

Self Assessment Questions

1) Define Gender Identity Disorder.

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2) Describe the features of gender identity disorder.

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3) Trace the origin of gender identity disorder.

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4) What is transgender? Explain

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5) Elucidate the components of Gender Identity disorder.

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3.5 CRITERIA FOR GENDER IDENTITY DISORDER

According to the American Psychiatric Association and the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) the following criteria must be met before a person can be given the official diagnosis of gender identity disorder:

- There must be evidence of strong and persistent cross-gender identification. This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex.
- There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.
- The individual must not have a concurrent physical intersex condition (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia).
- There must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The DSM-IV also provides diagnostic criteria for gender disorders that do not meet the criteria for the general gender identity disorder diagnosis. The following criteria are sufficient for a diagnosis of Gender Identity Disorder in Children as well as for Gender Identity Disorder Not Otherwise Specified (GIDNOS). For

the former diagnosis, criteria must be identified before a person is 18 years of age.

a) **Intersex Conditions**

(e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria

Transient, stress-related cross-dressing behaviour.

Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex, which is known as skoptic syndrome.

Cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1) repeatedly stated desire to be, or insistence that he or she is, the other sex.
2) in boys, preference for cross dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.
3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
4) intense desire to participate in the stereotypical games and pastimes of the other sex.
5) strong preference for playmates of the other sex.
6) In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

b) **Persistent Discomfort with his or her Sex**

Or sense of inappropriateness in the gender role of that sex. In children, the disturbance is manifested by any of the following, as for instance in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough and tumble play and rejection of male stereotypical toys, games, and activities.

In girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

c) **The disturbance is not concurrent with a physical intersex condition.**

d) **The disturbance causes clinically significant distress** or impairment in social, occupational, or other important areas of functioning.

Specify if (for sexually mature individuals):

- Sexually Attracted to Males
- Sexually Attracted to Females
- Sexually Attracted to Both
- Sexually Attracted to Neither

3.6 SYMPTOMS OF GENDER IDENTITY DISORDER

Symptoms

A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1) repeatedly stated desire to be, or insistence that he or she is, the other sex
2) in boys, preference for cross dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4) intense desire to participate in the stereotypical games and pastimes of the other sex
5) strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

The disturbance is not concurrent with a physical intersex condition.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Gender identity disorder in children is often reported as “having always been present,” and persons with the disorder do not remember a time when they were satisfied with their gender.

Other persons with the disorder report that symptoms began in adolescence or adulthood, and seemed to grow in intensity over time.

There is usually strong and persistent preferences for cross sex roles in make believe play or persistent fantasies of being the other sex, an intense desire to participate in the stereotypical games and pastimes of the other sex, and usually a strong preference for playmates of the other sex.

Issues regarding gender identity can manifest in a variety of ways. For example, some people may cross dress, while others may seek a sex change surgery. Below is a list of other common *"symptoms"* of gender identity disorder.

Children

- Express a desire to be the opposite sex
- Find their genitals or indicators of their gender cross
- Believe that they will grow up to become the opposite sex
- Are often rejected by their peers
- Become isolated and shy
- Develop moderate to severe anxiety
- Present low self-esteem
- Drop out of school
- Develop moderate to severe anxiety.

In adolescents there is a preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex).

Adults

- Desire to live as a person of the opposite sex
- Pursue a sex reassignment operation
- Both dress and act in a way that is indicative of the opposite sex
- Become socially isolated or ostracized
- Develop moderate to severe depression
- Develop moderate to severe anxiety.

Some persons with gender identity disorder have genitalia and secondary sex characteristics in line with their biological sex. Others may have ambiguous genitalia, or are hermaphroditic. Not all transsexual persons (persons who dress or act as persons of the opposite gender) have gender identity disorder. Generally homosexuals do not have gender identity disorder. The majority of homosexuals identify strongly with their biological gender. Homosexuality involves only a sexual attraction to persons of the same gender.

Self Assessment Questions

1) What is intersex condition?

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2) What is meant by cross gender identification?

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3) Describe the symptoms of Gender Identity Disorder.

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4) Describe the GID symptoms of children.

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5) Elucidate the symptoms of GID in adolescents and adults.

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3.7 CAUSES OF GENDER IDENTITY DISORDER

John Money has coined a useful term "gender maps" to describe the phenomenon of gender identity. He defined gender map as the entity, template, or schema within the mind and brain that codes masculinity and femininity and androgyny. This map or coding imprint is established very early in life through an interaction of nature and nurture. Because gender map development is highly influenced by hormones emanating from the developing fetus, sex and gender identification are generally closely matched. But like most aspects of being human, there are no guarantees. As a result an individual may, as early as the age of four, find themselves aware of being caught between having the anatomy of one sex but being equipped with a gender map much more typical of an individual of the opposite sex. It is also apparently possible for an individual to have no clear sense of gender whatsoever.

There is no clearly understood cause for Gender Identity Disorder.

The biological theory is based on evidence that high levels of the male hormone testosterone are associated with high levels of aggression in boys and tomboyishness in girls.

Social learning theory proposes that gender typing is the result of a combination of observational learning and differential reinforcement.

Cognitive-Developmental theory, states that gender understanding follows a prescribed time line. The pattern put forth is that children recognise that they are either boys or girls by the age of two or three, followed shortly by recognition that gender is stable over time. By the age of six or seven children understand that gender is also stable across situations.

No matter what theory one adopts, for most children, whose sex and gender map are congruent, this insight typically goes unnoticed. However, if there is sex/ gender map incongruence, the child is left perplexed about his or her gender status and begins a lifelong, often compulsive search for resolution of the discrepancy.

All children naturally comply with the demands of their internal sense of gender. Boys generally express male behaviour and girls generally express female behaviour even when raised in closely monitored gender neutral conditions. If there is any confusion in the child, he or she quickly learns from adults and peers that certain gender expression behaviours are inappropriate for that individual. This is true even of gender dysphoric children. Some gender dysphoric children internalise their dilemma and make heroic efforts to display the gender behaviour expected of them, while expressing their internal sense of gender through secret play, cross-dressing, and cross-gender fantasies. Others may continue to struggle by insisting that they be allowed to openly express maleness or femaleness irrespective of their assigned sex. Either way, the problem becomes subsumed into the child's personality.

The arrival of adolescence increases the difficulties for people who are gender dysphonic. Without fail, the subsequent development of secondary sex characteristics counter to the individual's desires increases anxiety. Often, frustration sets in, and determination to finally resolve the problem becomes the individual's driving force in life. This is especially true for gender dysphoric males. Since the obvious first effort is to accept the physical evidence of their genitalia as reality, it is very common to see many of these people push through these early years of adulthood by engaging in stereotypical, even supermale activities. Since outward behaviour has no permanent influence on internal gender understanding, these activities serve only to complicate the individual's social involvement, resulting in anxiety about expressing his true felt gender.

This anxiety state is characterised by feelings of confusion, shame, guilt, and fear. These individuals are confused over an inability to handle their gender identity problem in the same way they readily handle other problems in life. They feel shame over an inability to control what they believe society considers to be sexually perverse activities. Even though cross dressing and cross gender fantasies provide much needed temporary relief, these activities often leave the individual profoundly ashamed of what she or he has done.

Closely associated with shame is guilt over being dishonest by hiding secret needs and desires from family, friends, and society. For example, people commonly get married and have children without telling their spouse of their gender dysphoria before making the commitment. Typically it is kept secret because they have the mistaken conviction that participation in marriage and parenting will in itself erase their gender dysphoria. All of this then leads to fear of being discovered. With some justification, gender dysphoric people fear being called sick, uncaring, selfish and even being left alone by the people they love the most.

The psychological diagnosis of gender identity disorder (GID) is used to describe a male or female who feels a strong identification with the opposite sex and experiences considerable distress because of his or her actual sex.

Thus, Gender identity disorder can affect children, adolescents and adults. Individuals with gender identity disorder have strong cross-gender identification. They believe that they are, or should be, the opposite sex. They are uncomfortable with their sexual role and organs and may express a desire to alter their bodies.

While not all persons with GID are labeled as transsexuals, some are determined to undergo sex change procedures or to pass socially as the opposite sex. Transsexuals alter their physical appearance cosmetically and hormonally, and may eventually undergo a sex change operation.

Children with gender identity disorder refuse to dress and act in sex stereotypical ways. It is important to remember that many emotionally healthy children experience fantasies about being a member of the opposite sex. The distinction between these children and gender identity disordered children is that the latter experience significant interference in functioning because of their cross gender identification. They may become severely depressed, anxious, or socially withdrawn.

Psychologists who work with children and teens on gender identity note that cross gender behaviours generally become less overt with time and by late adolescence, GID is usually no longer present.

Long term studies of children referred to a specialty clinic for GID show that cross gender behaviour is tolerated in girls to a far greater degree than it is in boys. Thus, parents are quicker to bring boys in for evaluation. The clinicians who conducted the study theorized that girls may be under referred for GID because there is more social tolerance of “tomboys” than there is of “sissies.” While much more research is needed, scientists theorize that there are other social factors in play as well.

It is much more common for males to wish to cross to the female gender, but there are exceptions. In Poland, the ratio of women who wish to change gender is five times the rate of men who wish to change. Researchers theorize that Polish women face unfavourable living conditions and gender related economic and occupational hardships to a degree that they seek relief by changing gender.

The biological causes of gender identity disorder are not known. According to one theory, a prenatal hormonal imbalance may predispose individuals to the disorder. Problems in the individual’s family interactions or family dynamics may play a part.

3.8 TREATMENT OF GENDER IDENTITY DISORDER

Treatment for children with gender identity disorder focuses on treating secondary problems such as depression and anxiety, and improving self esteem. Treatment may also work on instilling positive identifications with the child's biological gender. Children typically undergo psychosocial therapy sessions; their parents may also be referred for family or individual therapy.

Children and adolescents with GID have never been systematically counted, but gender identity disorder is generally regarded as a rare phenomenon. In Europe, there are treatment centers in London, England; Utrecht, the Netherlands and in Frankfurt, Germany. In North America, patients may seek treatment at special centers for gender identity disorder in Toronto; in New York City; at the University of California, Los Angeles; at Johns Hopkins University in Baltimore; and at Case Western University in Cleveland. The larger number of GID patients in North America may be related to a less permissive attitude toward gender nonconformity. Traditionally, Europe is more tolerant of gender nonconformity and parents are less likely to see their children's GID symptoms as requiring treatment.

With adolescents, there are many variations in gender role behaviour and experienced gender identity specialists avoid making premature decisions, particularly when sex reassignment surgery is under consideration. One study described in a review in the American Journal of Psychotherapy showed that a large number of children with GID grow up to be homosexual or bisexual. The concept of treatment for GID children and adolescents has become highly politicized, since some groups fear that treatment of GID is actually a thinly veiled attempt to curb or even prevent homosexuality.

Hormone and Surgical Treatments

Transsexual adults often request hormone and surgical treatments to suppress their biological sex characteristics and acquire those of the opposite sex. A team of health professionals, including the treating psychologist or psychiatrist, medical doctors, and several surgical specialists, oversee this transitioning process. Because of the irreversible nature of the surgery, candidates for sex change surgery are evaluated extensively and are often required tospend a period of time integrating themselves into the cross gender role before the procedure begins. Usually sex reassignment surgery is not offered to anyone under 18. Before surgery can be considered, candidates undergo at least a year of psychotherapy. A "real life" test of living for at least a year as a member of the desired gender is recommended.

A male who has been cleared for surgery will have a vagino plasty, the surgical technique for creating a neo vagina. The penis and testes are removed. Surgeons permanently remove male hair growth and perform corrective plastic surgery on the larynx. For the patient to successfully pass as a woman, the growth of facial and body hair must be suppressed, and this can be accomplished with a drug such as cyproterone acetate. The surgery for changing a man into a woman is simpler than the surgery for changing a woman into a man, and many more men than women undergo sex change operations.

A woman who has been cleared for surgery will undergo surgical removal of the breasts, uterus and ovaries. In some cases, a phallo plasty will be performed, creating a neo phallus. Premenopausal women who receive sex change operations are given a drug such as lynestrenol to suppress menstruation. Long-term follow-up studies have shown positive results for many transsexuals who have undergone sex-change surgery. However, significant social, personal, and occupational issues may result from surgical sex changes, and the patient may require psychotherapy or counselling.

In the ongoing debate on gender stereotypes, new areas of inquiry have opened up. Scholars and activists have sought new responses to the questions of gender dysphoria (dissatisfaction or discomfort with one's biological gender). In the literature on issues of transgender, some scholars point out that gender is a performance that everyone learns from birth. Under this theory, by the time people are old enough to recognise that their gender identity is a kind of performance, it is so ingrained that people do not think of their gender identity as a separate entity.

Treatment of psychological disorders in GID

According to the American Psychological Association, the transgendered suffer from a higher than average rate of depression, anxiety, suicide and self-mutilation, yet rarely seek treatment. Untreated gender identity disorders may manifest in associated disorders and emotional distress that can interfere with the individual's ability to function socially at school and work or in relationships. Treatment helps a patient achieve and maintain a healthy and stable life.

For children with GID, individual and family counseling, along with social and physical interventions are recommended. Children with gender identity disorder may develop symptoms of depression, generalised anxiety and separation anxiety disorder. Adolescents may be at risk for depression, suicidal thoughts or suicide attempts. Counseling should focus on improving self-esteem and treating associated complications.

Parents are encouraged to allow their child to explore fantasies about being a member of the opposite gender in a safe and tolerant environment. Additionally, parents are offered suggestions such as using gender-neutral language, making gay-friendly media available, and encouraging the child to participate in any activities she or he is interested in without judgment.

Other Psychological Techniques

Psychological techniques that attempt to alter gender identity to one considered appropriate for the person's assigned sex have typically been shown to be ineffective. However, *psychological therapy* can help alter the course of gender identity disorder problems and can be critical in helping the person adjust. Today, most medical professionals who provide transgender transition services now recognise that when able to live out their daily lives with both a physical embodiment and a social expression that most closely matches their internal sense of self, transgender and transsexual individuals live successful, productive lives virtually indistinguishable from anyone else.

Counselling individuals with gender identity disorder should include an understanding of the differences between true transsexualism and other disorder

issues such as transvestic fetishism, non-conformity to stereotypical sex role behaviours, gender dysphoria, and homosexuality. Patients and their families need to be educated about the complexities of these issues, the enduring nature of these disorders, and the challenges that gender disorders typically present.

Multifaceted Therapeutic Approach

When GID is diagnosed in an adult, a multifaceted therapeutic approach begins. In addition to support groups and counseling (both individual and couples counselling), patients may choose hormone therapy, undertake a Real-Life Experience (living full time in their desired gender for a year or longer) and gender reassignment surgery. Patients desiring gender reassignment surgery undergo extensive evaluation, therapy and a transition period before they can be approved for surgery.

It is generally accepted that a reasonable and effective course of treatment for transsexual people can be sex reassignment therapy. This can include hormonal treatment and surgery. Sex reassignment surgery consists of procedures which transsexual women and men undergo in order to match their anatomical sex to their gender identity. While genital reassignment surgery (GRS) refers only to surgeries that correct genital anatomy, sex reassignment surgery (SRS) may refer to all surgical procedures undergone by transsexual patients.

Hormone therapy may also be helpful. In male to female individuals, original sex characteristics can be suppressed, and breasts, increased body fat, and a more feminine body shape can be promoted. In female-to-male individuals, facial and body hair promotion may be achieved with testosterone.

"Transgender transition services", the various medical treatments and procedures that alter an individual's primary and/or secondary sexual characteristics, are now considered medically necessary interventions for many transgender persons. Prior to this kind of surgery, the person usually goes through a long period of hormone therapy which attempts to suppress same sex characteristics and accentuate other sex characteristics. For instance, males that have gender identity disorder will be given the female hormone, estrogen.

The estrogen causes the male breasts to enlarge, testes to become smaller, and body hair to diminish. Females with gender identity disorder will be given the male hormone, testosterone, to help them develop a lower voice and possibly a full beard. Following the hormone treatment, the adult will be asked to live in a cross-gender role before surgery to alter their genitalia or breasts is performed. A team of health professionals, including the treating psychologist or psychiatrist, medical doctors, and several surgical specialists, oversee this transitioning process.

Because of the irreversible nature of the surgery, candidates for sex-change surgery are evaluated extensively and are often required to spend a period of time integrating them into the cross-gender role before the procedure begins. Counselling and peer support are also invaluable to transsexual individuals.

Follow up studies have shown positive results for many transsexuals who have undergone sex-change surgery. However, significant social, personal, and occupational issues may result from surgical sex changes, and the patient may require psychotherapy or counseling.

Speech therapy may help individuals use their voice in a manner more appropriate to their preferred sex.

3.8.1 Action Steps in Treatment for Gender Identity Disorder

Treating gender identity disorder can be a slow and complicated process. With gender identity disorder, better recovery outcomes are associated with early diagnosis and treatment.

Step 1: Identify and Challenge Negative Thoughts about One's Biological Sex

First, identify any negative thoughts that are being had in regards to one's gender. For example, a male suffering from gender identity disorder may say, "Men are pigs. They are crude, crass, and uncaring. Unlike me, men are athletic and sportsmanlike. Men don't enjoy art and fashion."

Look at these negative statements and note if there are any "lies" or half-truths that are being said. For example, many men are not crass, are un-athletic, and enjoy art.

Step 2: Find ways that one can identify with one's Biological Sex

A person with gender identity disorder generally believes they cannot identify with their biological sex.

Assess what things are present in one's lives that do correspond with their biological sex. For example, a woman suffering from gender identity disorder may feel that she does not identify with cosmetics. Note these similarities and continue to identify things that one does have in common with others of the same biological sex.

Step 3: Neutralise Physical Issues

Some persons with gender identity disorder have genitalia and secondary sex characteristics in line with their biological sex (meaning they have physically developed normally). However, others may be experiencing either ambiguous genitalia, or a hermaphroditic physical condition.

If the latter is present, consider that even though one's external appearance is different from the average person of a particular sex; genetically one is always fully male or fully female.

This male or female designation does not occur in one's phenotype (the way their body looks externally), it occurs in their genotype, whether they present XX or XY chromosomes.

Confirming one's gender based on genetics, and considering outward biology as only secondary, may be an effective tool in reframing thoughts about gender identity.

Self Assessment Questions

1) What are the causes of GID?

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2) What theories are associated with GID?

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3) Describe the various treatments available for GID?

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4) What are hormonal and surgical treatments for GID?

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5) Describe the psychological treatments for GID.

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6) What are the Action Steps in the treatment of GID?

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3.9 LET US SUM UP

Gender may well be the most basic thing in the elements that make up human personality. In fact, gender is so basic to our identity, most people mistakenly assume our sense of being male or female is defined with absolute certainty by our anatomical sex. Contrary to popular belief, one's sense of gender and one's anatomical sex are two distinct elements – each developing at different times in different parts of the body.

Gender Identity Disorder is a real and serious problem. Although we don't know all of what may be the cause or causes of the problem that these individuals feel toward their assigned sex, we can be reasonably certain that it is connected with either a congenital irregularity, an irregularity that occurs in the first few years of childhood or some combination of the two.

We also know that every individual's sense of gender, once established, is unchangeable over the individual's life time. If the individual's gender dysphoria is a relatively minor one, cross-gender, lifestyle changes in periodic dressing and behaviours may be all that is necessary to ease the anxiety. However, if the individual's dysphoria is profound, a life style change may be insufficient. In this latter case, gender expression moves from a lifestyle problem to a life-threatening imperative.

3.10 UNIT END QUESTIONS

1) Define and describe Gender Identity disorder.
2) Discuss the origin of gender identity disorder.
3) Describe the component factors in GID
4) Explain the symptoms of gender identity disorder.
5) How would you diagnose the existence of gender identity disorder?
6) Explain the various treatments for gender identity disorder.

3.11 GLOSSARY

Gender Identity Disorder : It is defined by strong, persistent feelings of identification with the opposite gender and discomfort with one's own assigned sex.

Gender Dysphoria : When the gender identity of a person makes them one gender, but their genitals suggest a different sex, they will likely to experience this.

Gender map : It is the entity, template, or schema within the mind and brain that codes masculinity and femininity and androgyny.

Sex reassignment surgery : It consists of procedures which transsexual women and men undergo in order to match their anatomical sex to their gender identity.

Genital reassignment surgery : It refers only to surgeries that correct genital anatomy.

3.12 SUGGESTED READINGS

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UNIT 4 EATING DISORDER

Structure

4.0 INTRODUCTION

Eating is one of life's great pleasures. But some people have difficult in controlling their food intake. Eating disorders are relatively recent additions to psychiatric classification systems. The vast majority – more than 90% of those affected with eating disorders are adolescents and young adult women. The reason for women being vulnerable to eating disorders is their tendency to go on strict diets to achieve an "ideal" figure.

Eating disorders are sometimes symptoms of a physical ailment, but they might also be external manifestations of mental disorder. The social causes of mental disorder, the interchange between people and society, and the influence that culture has on our perceptions of reality are probably most clearly demonstrated in the mental disorders anorexia nervosa and bulimia nervosa.

Many news papers and magazines feature glamorous celebrities who devised a special diet and shed pounds to become new, healthy, more confident people. Many psychological and social theorists believe that the influx of media images of thin women, many directed at the young, is a prime cause of the massive increase in eating disorders in the western world. In this unit we are going to deal with eating disorders. First we start with definition and description of eating disorders. This is followed by sociocultural comparison of eating disorders within different parts of America and then follow it up with other countries including India. Then we present different types of eating disorders such as anorexia nervosa, bulimia nervosa, binge eating etc. Then we deal with causes of eating disorders in which we present biological, cultural, family and other theories. This is followed by treatment of eating disorders and the different types of treatment.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define eating disorders;
- Describe the prevalence of this disorder;
- Explain the types of eating disorders;
- Elucidate the Causes of eating disorders; and
- Describe the Treatment for eating disorders.

4.2 DEFINITION AND DESCRIPTION OF EATING DISORDERS

"Eating disorder" is when a person eats, or refuses to eat, in order to satisfy a psychic need and not a physical need. The person does not listen to bodily signals or perhaps is not even aware of them. A normal person eats when hungry and stops eating when the body doesn't need more, when he feels the signal of satisfaction.

Eating disorders are usually classified as anorexia nervosa, bulimia nervosa and binge eating disorders, in accordance with the symptoms. However, a person may have an eating disorder without belonging exactly to any of these categories.

Those who lose weight because of illness, e.g., cancer, are not considered to have an eating disorder.

Eating disorders do not seem to manifest as Anorexia Nervosa and Bulimia in non Western cultures like India, but occur infrequently in milder forms with fewer symptoms, In the absence of the major disorders, standard questionnaires such as the Eating Attitudes Test appropriate for detecting severe disorders, may not be useful in identifying low prevalence milder disorders.

Culture has been identified as one of the etiological factors leading to the development of eating disorders. Rates of these disorders appear to vary among different cultures and to change across time as cultures evolve. Additionally, eating disorders appear to be more widespread among contemporary cultural groups than was previously believed. Anorexia nervosa has been recognised as a

medical disorder since the late 19th century, and there is evidence that rates of this disorder have increased significantly over the last few decades. Bulimia nervosa was only first identified in 1979, and there has been some speculation that it may represent a new disorder rather than one that was previously overlooked (Russell, 1997).

However, historical accounts suggest that eating disorders may have existed for centuries, with wide variations in rates. Long before the 19th century, for example, various forms of self starvation have been described (Bemporad, 1996). The exact forms of these disorders and apparent motivations behind the abnormal eating behaviours have varied.

The fact that disordered eating behaviours have been documented throughout most of history calls into question the assertion that eating disorders are a product of current social pressures. Scrutiny of historical patterns has led to the suggestion that these behaviours have flourished during affluent periods in more egalitarian societies (Bemporad, 1997). It seems likely that the sociocultural factors that have occurred across time and across different contemporary societies play a role in the development of these disorders.

4.2.1 Sociocultural Comparisons with America

Several studies have identified sociocultural factors within American society that are associated with the development of eating disorders. Traditionally, eating disorders have been associated with Caucasian upper socioeconomic groups, with a "conspicuous absence of Negro patients" (Bruch, 1966). However, a study by Rowland (1970) found more lower and middle class patients with eating disorders within a sample that consisted primarily of Italians (with a high percentage of Catholics) and Jews. Rowland suggested that Jewish, Catholic and Italian cultural origins may lead to a higher risk of developing an eating disorder due to cultural attitudes about the importance of food.

More recent evidence suggests that the pre-valence of anorexia nervosa among African Americans is higher than previously thought and is rising. A survey of readers of a popular African American fashion magazine (Table) found levels of abnormal eating attitudes and body dissatisfaction that were at least as high as a similar survey of Caucasian women, with a significant negative correlation between body dissatisfaction and a strong black identity (Pumariega et al., 1994).

It has been hypothesized that thinness is gaining more value within the African American culture, just as it has in the Caucasian culture (Hsu, 1987).

Other American ethnic groups also may have higher levels of eating disorders than previously recognised (Pate et al., 1992). A recent study of early adolescent girls found that Hispanic and Asian American girls showed greater body dissatisfaction than white girls (Robinson et al., 1996). Furthermore, another recent study has reported levels of disordered eating attitudes among rural Appalachian adolescents that are comparable to urban rates (Miller et al., in press).

The notion that eating disorders are associated with upper socioeconomic status (SES) also has been challenged. Association between anorexia nervosa and upper SES has been poorly demonstrated, and bulimia nervosa may actually have an

opposite relationship with SES. In fact, several recent studies have shown that bulimia nervosa was more common in lower SES groups. Thus, any association between wealth and eating disorders requires further study (Gard and Freeman, 1996).

4.2.2 Eating Disorders in Other Countries

Outside the United States, eating disorders have been considered to be much rarer. Across cultures, variations occur in the ideals of beauty. In many non Western societies, plumpness is considered attractive and desirable, and may be associated with prosperity, fertility, success and economic security (Nassar, 1988). In such cultures, eating disorders are found much less commonly than in Western nations. However, in recent years, cases have been identified in nonindustrialised or premodern populations (Ritenbaugh et al., 1992).

Cultures in which female social roles are restricted appear to have lower rates of eating disorders, reminiscent of the lower rates observed during historical eras in which women lacked choices. For example, some modern affluent Muslim societies limit the social behaviour of women according to male dictates. In such societies, eating disorders are virtually unknown. This supports the notion that freedom for women, as well as affluence, are sociocultural factors that may predispose to the development of eating disorders

Cross cultural comparisons of eating disorder cases that have been identified have yielded some important findings. In Hong Kong and India, one of the fundamental characteristics of anorexia nervosa is lacking. In these countries, anorexia is not accompanied by a "fear of fatness" or a desire to be thin; instead, anorexic individuals in these countries have been reported to be motivated by the desire to fast for religious purposes or by eccentric nutritional ideas (Castillo, 1997).

Such religious ideation behind anorexic behaviour also was found in the descriptions of saints from the Middle Ages in Western culture, when spiritual purity, rather than thinness, was the ideal (Bemporad, 1996). Thus, the fear of fatness that is required for the diagnosis of anorexia nervosa in the Diagnostic and Statistical Manual, Fourth Edition (American Psychiatric Association) may be a culturally dependent feature (Hsu and Lee, 1993).

Anorexia nervosa has been described as a possible "culture-bound syndrome," with roots in Western cultural values and conflicts (Prince, 1983). Eating disorders may, in fact, be more prevalent within various cultural groups than previously recognised, as such Western values are becoming more widely accepted. Historical and cross cultural experiences suggest that cultural change, itself, may be associated with increased vulnerability to eating disorders, especially when values about physical aesthetics are involved. Such change may occur across time within a given society, or on an individual level, as when an immigrant moves into a new culture. In addition, cultural factors such as affluence and freedom of choice for women may play a role in the development of these disorders (Bemporad, 1997). Further research of the cultural factors influencing the development of eating disorders is needed.

4.2.3 Eating Disorders in India

Most people in India struggle to get enough to eat and it is estimated that 60% of India's women are clinically malnourished. But psychiatrists in urban areas are reporting cases of anorexia nervosa, the so-called slimming disease that can cause sufferers to starve themselves to death. Most people in India have still not heard of the condition but some psychiatrists are of the view that there is an explosion in anorexia cases over the past few years.

The arrival of cable television and Western fashions and films has given today's teenagers the idea that thin is beautiful. Western fast foods have arrived too but as the young girls at Delhi's pizza and burger bars tuck in, they also say they want to lose weight. The irony is that India's traditional idea of beauty is of healthy, well-fed women with rounded figures.

One report states that there is obsession with physical appearance on rise amongst college going crowd in India. Youngsters in the age group of 12-25 years are using diet pills, fat burners, fasting, resorting to self induced vomiting etc. in order to stay slim and look attractive. They are deeply influenced by modern lifestyles together with ubiquitous show of a perfect 10 figure and airbrushed faces in advertisements & pictures of ramp models, film/sports personalities etc. in newspapers, magazines etc, says ASSOCHAM study.

Kids as young as 12 years old are resorting to severe dieting, consuming fat burners and protein shakes thereby developing serious eating disorders, according to the Chamber study. ASDF team conducted a survey in 10 major cities of Delhi-NCR, Mumbai, Kolkata, Bangalore, Chennai, Hyderabad, Ahmedabad, Chandigarh, Jaipur and Lucknow and interacted with around 2500 young folks (almost equal number of males and females) in the age group of 12-25 years. The study was carried out during October 2010 to March 2011.

According to the ASSOCHAM study, "an interesting aspect that emerged out of the survey was that youngsters in urban India feel the need to diet as they aspire to be thin and beautiful as cine stars, models, celebrities and feel that they will be popular if they are able to attain that 'ideal body image'."

The study stated that today, even the kids are not off limits from the celebrity driven trend of staying slim to look perfect and are dieting and starving themselves to achieve desired results. This trend is equally prevalent both in males and females.

This is likely to have an adverse impact on young people, especially females as they suffer from eating disorder and psychological problems like that of a distorted body image, sense of insecurity and a low self-esteem owing to fear of rejection etc. Parents tend to overlook the strange eating habits of their growing kids without realising that this is robbing them off their childhood.

Youngsters (12-25 years old) in Mumbai topped the chart with around 55 per cent of them admitting to dieting over three days a week and 35 per cent admitting to following a daily diet plan. Youth in Delhi –NCR ranked 2nd with 40 per cent of them admitted to dieting over thrice a week and 30 percent said that they diet daily. Chandigarh ranked third where 25 per cent said that they follow a strict diet regime everyday and 35 per cent said that they diet at least 3 days per week.

Ahmedabad stood on the 4th rung with 30 per cent admitting to dieting over three days a week and 20 per cent said that they diet daily. Figures in Lucknow and Jaipur were almost equal as 25 per cent in said that they diet daily whereas 15 per cent respondents admitted to have been following a daily diet chart.

Majority of respondents agreed to following severe diet regimens but were ignorant about the fact that it was affecting their growth. Besides, ASSOCHAM study has revealed that youngsters obsessed with dieting are becoming anorexic by starving themselves relentlessly and are prone to diseases like depression, anxiety, insomnia etc.

While sharing their views with ASSOCHAM representatives the respondents said that they feel worthless for being over-weight and constantly fear of becoming obese, that's the reason they starve themselves to attain a lean look. Majority of them said admitted that they exercise compulsively, often to the point of exhaustion to compensate for the calorie intake.

Self Assessment Questions

1) Define and describe eating disorders.

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2) Elucidate the prevalence of eating disorders.

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3) Present eating disorders in countries other than USA.

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4) Discuss eating disorders as prevalent in India.

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4.3 TYPES OF EATING DISORDERS

Although there are several different types of eating disorders, psychiatrists and psychologists generally tend to divide them into two broad categories – anorexia nervosa, bulimia nervosa and binge eating.

Anorexia nervosa is a condition characterised by a refusal to maintain a minimal normal body weight, voluntary self starvation and an intense fear of becoming fat. These individuals achieve abnomally low weight by severely dieting fasting and often by exercising compulsively. Most cases are female coming from the upper or middle class.

Bulimia nervosa is characterised by recurrent episodes of binge eating while experiencing a subjective sense of lack of control over the eating, the regular use of extreme weight compensatory methods (for example, self induced vomiting, laxative abuse, diuretic abuse, excessive fasting and compulsive exercise) and dysfunctional beliefs about weight and shape that unduly influence self-evaluation or self worth. 90 per cent of the cases happen to be women. Bulimia nervosa is likely to result from a combination of genetic, familial, psychological, and socio-cultural factors.

Binge eating disorder is characterised by recurrent episodes of binge eating but, unlike bulimia nervosa, no extreme weight control behaviours are present. A decreasing weight goal, increasing criticism of the body, increasing social isolation, disruption of menstruation, reports of purging in the context of dieting are some of the warning signals for parents. Parents are largely responsible for shaping a child's body image and eating lifestyle. It is believed that parents who are themselves preoccupied with body image and weight increase the ranks of childhood anorexics. Parents should communicate with their children and try to maintain a healthy lifestyle at home for the sake of their children.

Depression, stress and genetics are important factors when it comes to eating disorders. It has been observed that those who suffer from anorexia nervosa are usually sensitive, intelligent people who have a tendency to turn into control freaks. On the other hand, Anorexia bulimia is associated with those who are very emotional They then alternate between periods of overeating and then a self-inflicted punishment in the form of starvation.

Since, eating disorders usually begin in teens, parents can play an important role in curbing them. Eating disorders in children can often be a result of unhealthy eating habits at home. Parents should realise that children unconsciously follow most of their dietary habits. For this reason parents have to be careful about their own diet and make sure that they are setting a healthy example for their kids. Second, meal time should be fun. Painful or stressful topics should be kept away from the dinner table. This is not a time to discuss your child's bad performance in exams. Instead, make it a family bonding time. Keep conflicts away from meal time. Parents should also try to make a healthy diet palatable. Incorporate interesting recipes so that eating becomes an enjoyable activity.

A balanced diet consists of adequate amount of carbohydrates, proteins, fats and vitamins. An average Indian meal consisting of chapatis, dal, green vegetables and curd forms an ideal diet. Deviating greatly from this for more than three weeks would be considered as a disorder. There can be several reasons for this.

First, there is tremendous peer pressure on young people to look good. Girls compete with one another to fit into a smaller size as thin is in. The pressure to look attractive is so great that they cut down blindly on the first thing that happens to be in their control, which is their food. In the absence of proper guidance they blindly follow crash diets. Some even deprive themselves of all food. There are others, who only go by calorie count, skip healthy meals and binge on junk foods. In their mind they are not doing anything wrong as long as they do not exceed the calorie count. This lack of information about a balanced diet can lead to severe consequences.

Parents in such a situation should not coerce or nag their children. They, instead have to lead by example. If kids see a healthy and an active lifestyle at home, they will automatically emulate it. Do not sermonise, subtle guidance is the need of the hour.

Sometimes eating disorders are a result of severe emotional stress r depression. Parents have to understand their children and ensure that their emotional needs are being fulfilled. These situations have to be tackled sensitively. In case, you are not able to diagnose the cause, medical help should be considered.

In reality it is difficult to differentiate between the two since there is a lot of overlap in the behavioural characteristics and psychological process of each. Many theorists suggest that people's eating habits and their perception of their own body image lie on a continuum- along a scale that extends from extremely distorted eating habits and an unrealistic body image at one end to no psychological or behavioural distortions at all at the other. Every one stands somewhere within in this range.

Sometimes, we see people who think they are fat and sometimes starve themselves, or who are on permanent diets. This does not necessarily mean that they have an eating disorder, but it does show how anorexia and bulimia might be extreme versions of common occurrences.

4.3.1 Anorexia Nervosa

Anorexia nervosa literally means *"nervous loss of appetite"* yet people with anorexia do not lose their appetites but are often hungry and preoccupied with food. They want to eat but seem to be starving themselves. Anorexics might even love to cook for others. They might read recipe books, prepare meals, shop for food, and even work in restaurants, but they always avoid eating any caloric rich food themselves. They usually have a distorted body image and think they are fat when, in fact, they are wasting away and many anorexic people try to hide their bodies in oversized clothes.

4.3.2 Diagnosis of Anorexia Nervosa

People are diagnosed as anorexic if they weigh less than 85 per cent of the expected weight for their age and height in the normal circumstances. They might look extremely thin and feeble because of their significant weight loss, and they often have other health problems, including low blood pressure, constipation, dehydration, and low body temperature.

4.3.3 Diagnostic Criteria for Anorexia Nervosa (DSM-IV)

- Refusal to keep body weight or above 85% of the generally recognised normal level for age and height.
- Intense fear of gaining weight or becoming fat, even when underweight.
- Disturbance in experience of body weight or shape, undue influence of these factors on self-esteem or denial of the seriousness of the health risks of the current low body weight.
- If menstruation has begun, the absence of three consecutive menstrual cycles.

Two types of anorexia are recognised:

1) The restricting type in which the main focus is on restricting food intake and
2) The binge – eating/purging type in which there is regular binge eating followed by purging by vomiting, laxatives, etc;

4.3.4 Prevalence of Anorexia Nervosa

Anorexia nervosa occurs mainly in women. For every male sufferer there are 15 females who have the disorder. However, there is evidence that the number of men with eating disorders is rapidly increasing, Anorexia usually starts at between 14 and 16 years, although two researchers from Great Ormond Street children's Hospital in London, England, have reported cases of anorexia in children as young as eight year old. It is estimated that between 5 and 15 percent of people with anorexia die from it or from related disorders.

4.3.5 Bulimia Nervosa

Bulimia nervosa is characterised by sporadic episodes of compulsive binge eating. People with bulimia rapidly eat lots of carbohydrate-rich foods in a seemingly uncontrolled way. They eat more than just a load of cookies – they could eat a whole of pizza, a whole tub of ice-cream, several giant packs of potato chips, a whole creamy desert, a whole quiche, or lots of fizzy or milky drinks. They usually choose foods that are soft and easy to eat. The binge usually ends with stomach pains or some kind of purging-either self-induced vomiting or defecating as a result of taking laxatives.

Some people begin their binges by eating coloured marker food so they will be able to tell when they have thrown up all the food they took in. Although many people describe themselves as binge eaters, it is the severity and frequency of the binge eating in bulimia that makes it such a severe disorder. In mild cases a person might binge two or three times a week. In more extreme cases it might occur 30 times a week.

4.3.6 Diagnostic Criteria for Bulimia Nervosa (DSM IV)

Frequently occurring episodes of binge eating that are characterised by both

a) eating an amount of food that is definitely larger than most people would eat within a specific period of time and in similar circumstances; and
b) a sense of lack of control over eating during the overeating episode.

- Recurrent behaviour to compensate for the overeating and prevent weight gain, including vomiting, laxatives, fasting or excessive exercise.
- The occurrence of both the binge eating and the compensatory behaviours atleast twice a week for at least a 3 – month period.
- Self – evaluation that is over influenced by weight and body shape
- Bulimic behaviour that does not occur only during episodes of anorexia nervosa.

Two types of bulimia nervosa are recognised:

1) the purging type, in which vomiting or doses of laxatives are used during the current episode; and
2) the nonpurging type in which fasting or excessive exercise, but not purging is used to prevent weight again.

4.3.7 Impact of Bulimia

The process of bingeing and purging can have all sorts of side effects on the rest of the body.

Bulimia sufferers often have puffy cheeks, a bit like those of a chipmunk. That is because vomiting swells the parotid glands in the lower jaw.

Their tooth enamel can often decay because of the acid that they bring up when vomiting.

You might also notice little calluses on the back of their hands, caused by the rubbing against the upper teeth while sticking their fingers down their throats to make themselves sick.

Bulimia sufferers also have problems with their digestive tract, dehydration, and nutritional balances, and anxiety, depression, and sleep disturbance.

4.3.8 Binge Eating

It is characterised by episodes of bingeing without the use of compensatory behaviours such as purging that are seen in bulimia nervosa. Two common patterns characterise binge eating – compulsively snacking over long intervals (such as all day at work or all evening in front of the computer or television) or a consumption of large amounts of food at one time beyond the requirements to satisfy normal hunger. Binge eating disorder often leads to problems with weight regulation and sometime obesity. In clinical practice, it is difficult to distinguish between a binge eating disorder and nonpurging bulimia nervosa. Some studies found that binge eating women experienced more negative affect (depression and anxiety). This suggests that treatment approaches should focus on helping binge eaters learn to cope more adaptively with poor mood. In addition to mood, situational and cognitive factors often play important roles in binge eating.

4.3.9 Triggers of Binge Eating

- Particular stressful situations
- Particular upsetting thoughts
- Feeling guilt about something one has done
- Feeling socially isolated or excluded

- Worries about responsibilities, problems or the future
- Boredom

Self Assessment Questions

1) What are the various types of eating disorders? Explain

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2) Discuss Anorexia nervosa in terms of symptoms, diagnosis and its prevalence.

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3) Discuss bulimia nervosa in terms of diagnostic criteria and impact.

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4) What is binge eating? Discuss the triggers nof binge eating.

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4.4 CAUSES OF EATING DISORDERS

There is no single theory that can explain why people experience anorexia and bulimia. There are many biological, psychodynamic, family and socio-cultural theories that, when combined, can provide some understanding of what is happening. The theories can lay the foundation for the types of treatment the person might receive, but as yet there is no scientific explanation of why people suffer from eating disorders.

4.4.1 Biological Theories

Some theories have suggested that anorexia is caused by damage to various parts of the *hypothalamus*, the part of the brain that helps balance, monitors bodily functions and control the endocrine system via the pituitary gland. The endocrine system consists of glands such as the hypothalamus, the pituitary, and the adrenal glands. Glands communicate with each other through chemicals called hormones.

To understand the development and maintenance of eating disorders, researchers have developed the concept of the *"weight set point"*. In experiments with laboratory rats they located two different areas in the hypothalamus that control eating. The *lateral hypothalamus* (LH) produces hunger when it is activated. Even when a laboratory rat has recently been fed, it will still eat if the LH is stimulated. The *ventromedial hypothalamus* (VMH) reduces hunger when it is activated. When the VMH is destroyed, the laboratory rat will not stop eating and grows obese.

The theory proposes that the various parts of the hypothalamus work together to create something like a weight thermostat – a weight set point- that predisposes people to stay at their natural body weight. When the set point falls below a certain level, parts of the hypothalamus would also decrease the metabolic rate if a person is expending too much energy. If people exceed their set point, then another point in the hypothalamus is activated that reduces hunger and therefore reduces eating and restores the weight balance.

The set point is thought to be determined by a person's genetic makeup, early eating practices, and the body's need to maintain equilibrium.

The problem with these biological theories is that it is unclear whether brain dysfunction and changes in the neurotransmitters are causes or effects of the eating disorder.

Some people have wondered whether genetics plays a part in the development of eating disorders. Over the years there have been a series of studies of twins that have tried to determine whether anorexia and bulimia are caused by nature or nurture. But with much debate and controversy regarding the research, the conclusion seems to be that genetic factors play a minimal role.

According to some theorists, the distorted perception that anorexics have of their bodies might be connected to a blood-flow deficiency in the anterior temporal lobes of the brain. The anterior temporal lobes interpret vision; and if there is less blood flowing there, it might explain why anorexics see themselves as a fat when they are thin. However, this alone could not cause anorexia- there must be other triggers that lead to the development of the disorder.

4.4.2 Cultural Theories

Many theorists believe that pressures in western societies are mainly responsible for the origin and maintenance of eating disorders. Between 1995 and 1997 Paul Garfinkel and David Garner examined the look of Miss America contestants and playboy centrefold models over a 27 year period and found that average bust, waist, and hip size of the women featured in the magazine decreased significantly over this period. They also looked at articles in various women's periodicals from 1959 to 1970 and found that in the 1960s there was an average of 16 articles a year on dieting. By the 1970s that figure had increased an average of 23 a year.

Society's emphasis on appearance has historically exerted much greater pressure on women than on men. Some sociological theorists believe that this double standard of attractiveness has made women overly interested in their appearance, dieting, and body image. The idea is supported by trends in advertising that have presented and even to some extent defined a desirable male physical form that has led men to become more concerned than before about their own eating habits. The increasing preoccupation of the media and leisure world with male attractiveness seems to correlate to an increase in the number of men who now appear at clinics with eating disorders.

4.4.3 Family Theories

The family functions like mini society and can often be the starting point for the development of eating disorders. Research shows that about half of the families of people with eating disorders have a history of making big issues of thinness, food, and body image. From early childhood food can be powerful tool for communication between parents and children. Systems theorists are scientists and thinkers who see relationships between all sorts of systems, big or small, physical or abstract, scientific or social. Psychologists who subscribe to systems theory take the view that a family will come to set its own level of homeostasis, or balance. They suggest that the presence of someone with an eating disorder in the family is really only an expression of some pre-existing family disturbance.

The family therapist Salvador Minuchin is a leading systems theorist who has suggested that an enmeshed family pattern often leads to the development of an eating disorder in one of the children. Enmeshment occurs when parent and child are overly involved in each other's lives. On the one hand, enmeshment can create affectionate, close, and loyal relationships. On other hand, it can prevent a child or young adult from growing up and becoming independent.

Adolescence can be a real crisis point for enmeshed parents and children since the young are trying to establish themselves in the grown-up and are searching for identity. It can disrupt the balance of the family. The parents might no longer feel needed, the roles need to change, and as the family seeks to regain its balance, the child is moved to take on a sick role. If the family functions to look after the sick child, the pain of growing up and many other potential conflicts are avoided. In such instances family therapy can be used to help the family face the underlying tensions and shift the eating pattern.

Anorexia is prevalent in the middle-class female children from families with high aspirations whose parents have a professional back ground. It is also more common in those who go on to higher education than in those leave school at the earliest opportunity. Anorexia suffers are often A-grade students who give perfection in all they do – including the way the look. The pressure on these young women to succeed might just to be great, and it sends them into a spiral anorexia or bulimia and anxiety or depression.

4.4.4 Other Possible Causes

Cognitive behavioural and psychodynamic theories are derived from the increasingly popular idea that eating disorders are linked with dieting behaviour. It is akin to a stimulus response mechanism.

Anorexics might be striving for perfection and so go on diets to achieve their ideal weight. When they reach this goal, they might well receive admiration from those around them. And this further reinforces their dieting behaviour and so it goes on in a vicious circle. Reward for not eating might come in the form of attention from family and friends. There might also be approval-the anorexic looks like an athlete or a supermodel and gets admired for it. For bulimia sufferers the reinforcement might come from bingeing and purging, which reduce their anxious thoughts.

Psychiatrist Hilde Bruch was particularly influential in cognitive and psychodynamic understandings of anorexia and bulimia. She argued that disturbed mother-child interactions lead to ego deficiencies in the child (poor sense of autonomy and control), and this causes severe perceptual and other cognitive disturbances. According to the theory, parents fail to respond to their children effectively. For instance, a child cries, and rather than trying to understand what the crying is about- the child might be tired, hungry or scared- the parent will give food for comfort. According to Bruch, children treated this way fail to develop cohesive self. They grow up confused and not sure of when they are hungry or when they are tired. As they grow to adolescents, they need to develop and increased sense of autonomy yet become stuck because they are unable to be independent and judge their own sense of self.

Self Assessment Questions

1) Discuss the biological causes of eating disorders.

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2) What are the cultural theories of eating disorders?

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3) Elucidate the family theories as applicable to eating disorders.

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4) Discuss the other possible causes of eating disorders.

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4.5 TREATMENT OF EATING DISORDERS

A wide variety of treatments have been used with eating disorders. Treatments used range from biologically based approaches involving antidepressants, antianxiety drugs and appetite stimulants to psycho therapy and family therapy based on psychodynamic principles, behavioural and cognitive behavioural therapies and educational therapies such as nutritional education. Most of the treatment approaches use a combination of medication and behaviour modification or psychotherapy.

4.5.1 The Biological Treatment

The biological treatments show that in 33% cases there is drop out from the treatment. This when compared to the cognitive therapy, which has only a rate of 5% drop out.

4.5.2 Family Treatment

Treatment includes neither biweekly nor monthly family meetings. Sometimes friends of the client and other people can also attend the meetings. The therapist encourages the family to explore its beliefs and behaviours about the disorder and other related family issues.

Therapists work in pairs or teams. The family is encouraged to do homework tasks. The specific nature of intervention is based on the therapist's working hypothesis.

4.5.3 Cognitive Behavioural Treatment

Weekly to biweekly therapy with cognitive therapist. The therapist focuses on interaction between thoughts, feelings and eating behaviours. Behaviours that creat and maintain thinness are negatively reinforced (reduced) by the removal of anxiety. The client and therapist explore society's perception of physical attractiveness. They also examine the client's beliefs about body image. An educational component of the therapy consists of assessing dietary and physical possibilities. The client's monitoring negative automatic thoughts , keeping food diaries and completing rating scales.

4.5.4 Psychoanalytic Treatment

Weekly to 5 times a week individual therapy. The therapy seeks to make the unconscious motivation as conscious motivation of disordered behaviours. It uses the relationship between the therapist and client to explore important relationships in the client's early life, as for example the one that the client had with his or her parents.

4.6 LET US SUM UP

The prevalence of eating disorders appears to have increased over the past 50 years. The major eating disorders are anorexia nervosa, in which the individual seems obsessed with thinness and loses a great deal of weight. Bulimia nervosa, in which excessive quantities of food are eaten followed by purging and binge eating in which large quantities of food are eaten but there is no purging. Personality, family and cultural factors play significant role in causing these disorders. Most of the treatment approaches use a combination of medication and behaviour modification or psychotherapy. Most of the treatment approaches use a combination of medication and behaviour modification or psychotherapy.

4.7 UNIT END QUESTIONS

1) What are eating disorders? Explain their nature and symptoms.
2) What is the prevalence of eating disorders? Discuss eating disorders as being obtained in India.
3) What are the various types of eating disorders?
4) Elucidate the causes of eating disorders.
5) Differentiate anorexia nervosa and bulimia nervosa.
6) Discuss the treatment methods used in treating eating disorders.

4.8 SUGGESTED READINGS

Carson,R.C. Butcher, J.N. & Mineka, S. (2000). *Abnormal Psychology and Modern Life.* Pearson Education, India.

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