

Understanding Psychological Disorders I

COURSE CODE: B23PY05DC

Undergraduate Programme in Psychology

Discipline Core Course

Self Learning Material



SREENARAYANAGURU
OPEN UNIVERSITY

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The State University for Education, Training and Research in Blended Format, Kerala

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Pathway

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Understanding Psychological Disorders I

Course Code: B23PY05DC

Semester - V

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Self Learning Material
(With Model Question Paper Sets)



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Course Code: B23PY05DC

Semester- V

Discipline Core Course

Undergraduate Programme in Psychology

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Dear learner,

I extend my heartfelt greetings and profound enthusiasm as I warmly welcome you to Sreenarayanaguru Open University. Established in September 2020 as a state-led endeavour to promote higher education through open and distance learning modes, our institution was shaped by the guiding principle that access and quality are the cornerstones of equity. We have firmly resolved to uphold the highest standards of education, setting the benchmark and charting the course.

The courses offered by the Sreenarayanaguru Open University aim to strike a quality balance, ensuring students are equipped for both personal growth and professional excellence. The University embraces the widely acclaimed “blended format,” a practical framework that harmoniously integrates Self-Learning Materials, Classroom Counseling, and Virtual modes, fostering a dynamic and enriching experience for both learners and instructors.

The university aims to offer you an engaging and thought-provoking educational journey. The undergraduate programme in Psychology is designed to match the high standards of top universities across the country. We have included the most up-to-date methods for teaching psychological concepts and ideas in our curriculum. This approach helps spark learners’ interest and encourages them to go deeper into the subject. Our courses cover both theories and real-world examples, giving the learner a well-rounded understanding of psychology. The Self-Learning Material has been meticulously crafted, incorporating relevant examples to facilitate better comprehension.

Rest assured, the university’s student support services will be at your disposal throughout your academic journey, readily available to address any concerns or grievances you may encounter. We encourage you to reach out to us freely regarding any matter about your academic programme. It is our sincere wish that you achieve the utmost success.



Warm regards.
Dr. Jagathy Raj V. P.

01-09-2026

Contents

BLOCK1 Introduction to Mental Disorders	1
UNIT 1 Mental Disorders	2
UNIT 2 Classification and Diagnosis	25
 BLOCK 2 Etiology and Theoretical Perspectives	 47
UNIT 1 Etiology of Mental Disorders	48
UNIT 2 Theoretical Perspectives	64
 BLOCK 3 Neurodevelopmental and Neurocognitive Disorders	 85
UNIT 1 Neurodevelopmental Disorders	86
UNIT 2 Neurocognitive Disorders	105
 BLOCK 4 Dissociative, Somatic Symptom and Trauma & Stressor Related Disorders	 124
UNIT 1 Dissociative Disorder and Somatic Symptom and Related Disorders	125
UNIT 2 Trauma and Stressor-Related Disorders	144
 BLOCK 5 Anxiety and Obsessive-Compulsive Disorders	 162
UNIT 1 Anxiety Disorders	163
UNIT 2 Obsessive-Compulsive and Related Disorders	184
 BLOCK 6 Feeding and Eating Disorders and Elimination Disorders	 203
UNIT 1 Feeding and Eating Disorders	204
UNIT 2 Elimination Disorders	223



BLOCK

Introduction to Mental Disorders



UNIT

Mental Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ◆ discuss and define the concepts of normality, abnormality, well-being, and mental disorders
- ◆ describe the role of vulnerability, resilience, and coping in the development and management of mental disorders
- ◆ analyse the historical evolution of the concept of mental disorders
- ◆ evaluate the key mental health laws, policies, and regulations in the Indian context

Prerequisite

Think of a new mother who, in the weeks following childbirth, experiences a persistent sense of being overwhelmed and emotionally detached from her infant, doubting her capability to provide care. Can you also imagine an individual who, after the profound loss of a lifelong partner, remains socially withdrawn, tearful, and unable to resume professional responsibilities many months later? Considering these scenarios, where would you draw the line between a normal human response to life circumstances and something that might warrant clinical attention? Is emotional distress always an indication of pathology, or can it also represent a meaningful psychological response to change, loss, or disruption? And at what point does distress become clinically significant? Who determines whether a response is proportionate to the situation, and on what basis are such decisions made? How do culture, social norms, and expectations about functioning shape our understanding of these experiences?

Now, consider why individuals respond so differently to comparable challenges. Imagine two people confronted with the same major setback, perhaps the collapse of a long-term business venture or an unexpected career loss. One gradually regains equilibrium through personal strengths, social support, and adaptive coping strategies, while the other experiences enduring hopelessness, anxiety, or maladaptive patterns of behaviour. What explains this divergence? To what extent do vulnerability, resilience, prior experiences, and access to resources influence psychological states? And, beyond these individual differences, how have societies across history understood such conditions? In what ways do contemporary legal and policy frameworks determine rights, care, and protection for persons experiencing psychological distress? Let these questions lead you towards a reflective engagement with the notion of mental disorders as you navigate the unit.

Keywords

Normality, Abnormality, Well-Being, Vulnerability, Coping, Biopsychosocial model, DSM, Advance Directive

Discussion

1.1.1 Definitions

Why is intense grief after a loss considered natural, but intense fear without an identifiable cause may be viewed as a symptom? Why are certain fears treated as usual, while others become symptoms? And just because a thought, emotion, or behaviour is common, does it necessarily make it healthy or normal? Conversely, does being unusual or uncommon necessarily make an experience abnormal? And if a person appears to be 'normal' while silently struggling to function each day, how should such a condition be understood?

What is considered 'normal' is often shaped by cultural, social, and historical context. What one culture considers normal may appear unusual in another. What one historical period calls illness may be understood differently later. Some ways of feeling are accepted as natural, some tolerated as unusual, and some identified as requiring help or treatment. Yet these distinctions are rarely as obvious as they first appear.

This raises an important question. On what basis do we distinguish between normality from abnormality, well-being from distress, and typical variations in human behaviour from mental disorder? The study of mental disorders, therefore, begins not with diagnoses alone, but with an examination of the concepts through which psychological experiences are interpreted and classified. Understanding concepts such as normality, abnormality, well-being, and mental disorders is essential because they shape clinical practice, social attitudes, legal systems, and how individuals understand themselves and others.

1.1.1.1 Normality

In psychology, normality is rarely a straightforward biological fact. It is understood as a pattern of thought, emotions, and behaviours that is typical, culturally acceptable, and allows an individual to function effectively in daily life. For example, grieving a major loss is considered normal



across cultures, and becomes pathologically divergent only if the despair remains so intense that it affects the individual's functioning.

However, defining normality is not as simple as identifying what is common. Certain behaviours may be widespread within a society and yet be psychologically unhealthy, while some uncommon behaviours may reflect creativity, individuality, or cultural difference rather than disturbance. Consequently, psychologists understand normality not merely in terms of frequency, but also in relation to adjustment, functioning, adaptability, and contextual appropriateness, and approach it through three main frameworks.

i. Statistical Approach

The statistical approach defines normality in terms of how the psychological characteristic is distributed in a population. Behaviours, traits, abilities, or other psychological characteristics that occur

frequently or cluster around the population average are considered statistically typical, whereas characteristics that occur relatively infrequently are considered statistically atypical. The normal distribution curve provides the statistical model for this principle, as it represents a pattern in which most scores cluster around the mean, with progressively fewer scores occurring toward either extreme. For example, IQ scores used to assess intelligence are typically distributed in this manner; most individuals score around the average range, while very low or very high scores are less common.

ii. Sociocultural Approach

The sociocultural approach defines normality in terms of the degree to which an individual's behaviour aligns with the institutionalised expectations, values, and roles of their specific cultural context. Because social norms evolve, what is deemed normal changes across eras and regions. For example, hearing voices of ancestors may be interpreted in some Indigenous

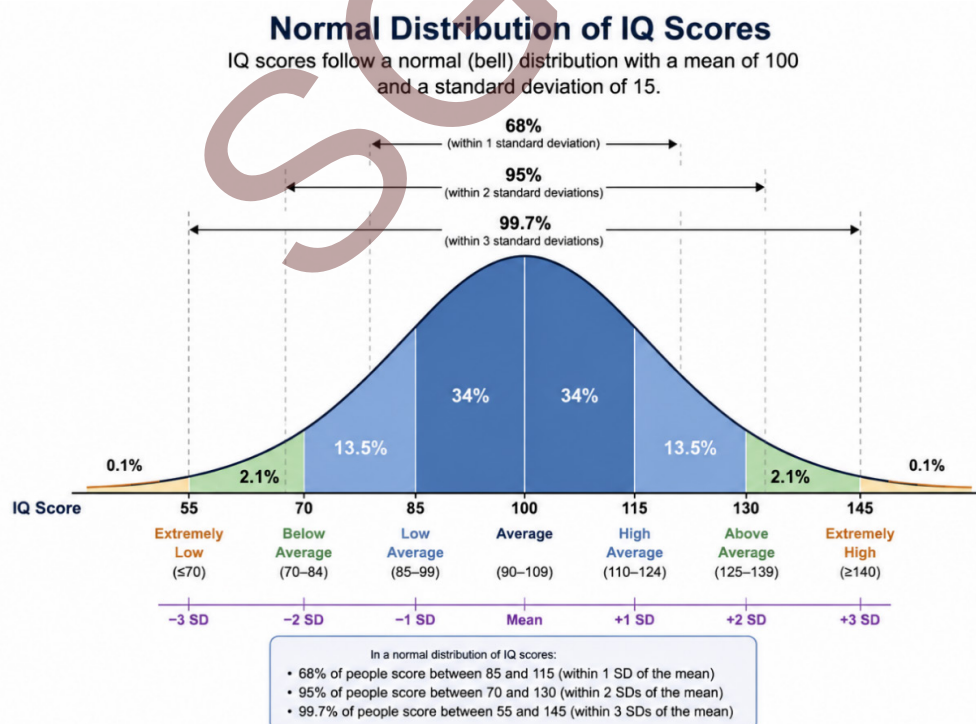


Fig. 1.1.1 Normal Distribution Curve – Intelligence (AI-generated for illustrative purpose)

cultural contexts as a meaningful spiritual experience and a socially accepted form of communication, whereas in many Western clinical frameworks, similar experiences may be classified as hallucinations and viewed as indicators of abnormality.

Such cultural variation highlights the importance of interpreting behaviour and experiences within the cultural context in which they occur, rather than judging them solely by the norms of another culture. A behaviour or experience that is considered unusual or problematic in one cultural context may be meaningful, accepted, or even valued in another. The sociocultural approach therefore emphasises the importance of considering the cultural meaning and context of behaviour when distinguishing between normal and abnormal behaviour.

iii. Functional Approach

The functional approach defines normality in terms of how effectively an individual is able to cope with daily demands and maintain psychological, social, and occupational functioning. Behaviour is considered normal when it supports adjustment to the environment and allows the person to pursue goals, sustain relationships, and manage stress. In contrast, behaviour is viewed as abnormal when it becomes maladaptive, interfering with day-to-day functioning or causing significant distress. Clinical psychology frequently relies on this framework to assess psychological disorders, where impairment in functioning and the presence of significant distress serve as important diagnostic indicators.

However, the absence of any signs of functional impairment does not necessarily indicate psychological well-being. Some individuals may continue to meet their daily responsibilities and function adequately in social, academic, or occupational settings while experiencing substantial psychological distress. Such difficulties may not be

readily apparent to others, highlighting the importance of considering the individual's subjective experience and level of distress alongside observable functioning.

1.1.1.2 Abnormality

Abnormality refers to behaviour or psychological functioning that significantly departs from the established parameters of normality. For example, while feeling sad after a personal setback is considered normal, experiencing persistent loss of interest, withdrawal from all social contact, and inability to carry out basic daily routines over an extended period may indicate abnormal functioning.

A behaviour or psychological state is typically considered abnormal when it meets one or more of the following criteria:

- ◆ **Statistical Deviation:** This is when the behaviour or experience is rare compared to the general population, such as *synesthesia*, where individuals perceive letters or numbers as having specific colours. Although not a disorder, it is uncommon.
- ◆ **Cultural Violation:** When the behaviour breaks accepted social norms or causes discomfort within a cultural context, such as talking loudly to oneself in a public marketplace, which may be interpreted as socially inappropriate or concerning in many settings, depending on cultural expectations.
- ◆ **Maladaptiveness:** When the behaviour interferes with the biological, social, or occupational functioning and reduces the individual's ability to cope effectively, such as persistent compulsive handwashing that leads to skin damage and disrupts daily routines.

However, it should be noted that deviation from normality is not always a mental disorder. As seen in the earlier example of

synesthesia, despite being an abnormal trait, it is not considered abnormal in a clinical sense. Abnormality becomes clinically relevant only when it involves significant distress, dysfunction, or impairment in functioning.

1.1.1.3 Well-Being

Well-being refers to a positive and optimal state of psychological functioning in which an individual is not only free from mental disorder but is also able to cope with normal life stresses, work productively, maintain meaningful relationships, and realise personal potential. Modern psychology emphasises that well-being is not simply the absence of abnormality, but a broader indicator of psychological flourishing.

Though early clinical psychology largely operated on a deficit model, where individuals were considered 'healthy' if they did not meet criteria for a psychiatric diagnosis, contemporary approaches reject this binary distinction between being disordered and healthy. A significant development in this shift was the emergence of positive psychology in the late twentieth century, associated particularly with Martin Seligman and Mihaly Csikszentmihalyi. Positive psychology sought to complement the traditional focus on psychological problems and disorders by systematically examining positive experiences, individual strengths, positive relationships, and the conditions that enable individuals and communities to flourish. This represented an important shift in psychological research and practice from focusing predominantly on what is wrong or impaired to also examining what contributes to well-being and optimal functioning. Well-being consequently came to be understood as a multidimensional and actively maintained state rather than simply the absence of disorder, reflecting a broader academic and sociocultural shift in how mental health is conceptualised.

Following the contemporary framework, well-being is understood through two interrelated dimensions.

1. Hedonic well-being
2. Eudaimonic well-being

Hedonic well-being focuses on the subjective experience of pleasure and life satisfaction. It reflects how a person feels in their day-to-day life, including the presence of positive emotions such as happiness, contentment, comfort, and emotional balance. Eudaimonic well-being, by contrast, focuses on psychological and social functioning. It emphasises autonomy, purpose in life, personal growth, self-acceptance, and the ability to pursue meaningful goals. Unlike hedonic well-being, which centres on 'feeling good,' eudaimonic well-being focuses on 'functioning well.' For example, a person may report high hedonic well-being if they feel generally happy and satisfied with their daily routine, even in the absence of major achievements. However, they may still experience low eudaimonic well-being if they feel their life lacks direction or meaning. Conversely, another individual may experience stress or short-term discomfort while pursuing demanding academic or professional goals, yet still have high eudaimonic well-being due to a strong sense of purpose and personal development.

1.1.1.4 Mental Disorder

A mental disorder is a formal clinical designation. It is fundamentally distinct from transient emotional distress or culturally accepted reactions to life stressors. According to the major contemporary diagnostic framework, the Diagnostic and Statistical Manual of Mental Disorders (DSM), a mental disorder is a syndrome characterised by a clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

Although a disorder diagnosis typically requires the intersection of several dimensions, the following four are commonly used as primary criteria to determine whether an abnormal experience qualifies as a mental disorder.

- i. **Deviance:** The psychological symptoms are markedly different from statistical averages or cultural expectations, such as hearing voices that no one else hears.
- ii. **Distress:** The symptoms cause deep emotional pain, suffering, or anxiety to the individual, or to the individual's immediate social environment, such as a person feeling overwhelming sadness and hopelessness that they cry uncontrollably.
- iii. **Dysfunction:** The condition interferes with the person's ability to perform daily tasks, such as working, studying, or maintaining basic hygiene, struggles or fails to fulfill vital social, domestic, academic, or occupational responsibilities.
- iv. **Danger:** The behaviour presents a risk of physical harm, either directly to the self as self-harm or severe nutritional neglect, or to others.

However, it must be noted that a mental disorder is identified not merely by deviation or distress alone, but by the presence of a clinically significant, persistent disturbance that results in dysfunction and is not an expected or culturally normative response.

1.1.2 Vulnerability, Resilience, and Coping

If mental disorders were simply the inevitable result of facing hardship, conflict, or loss, then pathology would be the standard human condition. However, clinical observation reveals a profound paradox: identical environmental pressures do not produce identical psychological outcomes. One individual may navigate a prolonged period of instability and emerge with their psychological functioning intact, while another may encounter the exact instability and experience a severe cognitive or emotional collapse.

What accounts for this divergence? The answer lies not just in the magnitude of the external stress, but in the internal architecture of the individual encountering it. The onset of a psychological disorder is rarely a sudden,

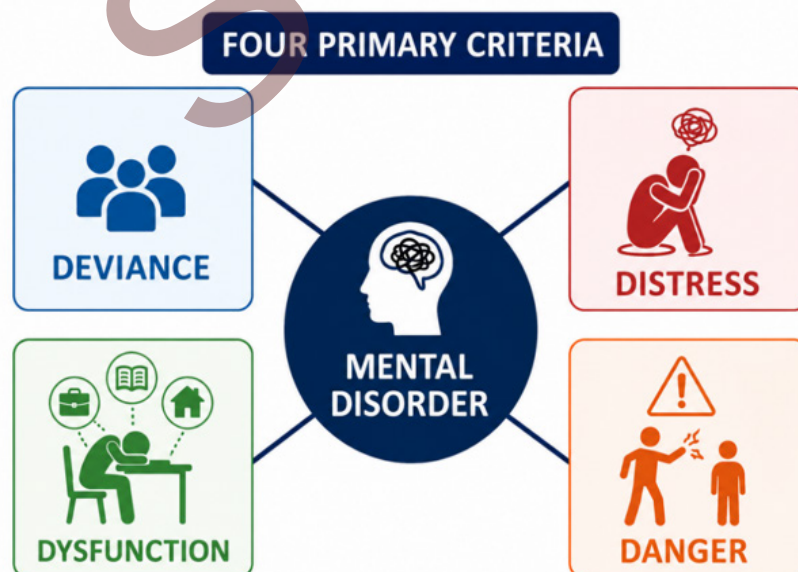


Fig. 1.1.2 The Four Ds of Mental Disorders (AI-Generated)

unprovoked event, and the study of mental disorders, therefore, cannot rely solely on defining symptoms. It must also account for individual differences in how humans process, withstand, and react to adversity and appraise psychological disorders as the outcome of a complex interaction between a person's underlying susceptibilities and their active efforts to manage life's demands. To understand this dynamic, we must explore three interconnected concepts: vulnerability, resilience, and coping.

1.1.2.1 Vulnerability

In everyday language, being 'vulnerable' is often mistakenly equated with emotional weakness. In clinical psychology, however, vulnerability is a neutral, scientific concept used to describe an individual's baseline risk level before a stressful event even occurs.

Thus, vulnerability, which is also often referred to as *diathesis*, can be defined as the underlying biological, psychological, or social predisposition that increases an individual's susceptibility to developing

a mental disorder when exposed to environmental stress. However, it must be recognised that it does not guarantee a disorder. A predisposition becomes a disorder only if sufficient stress triggers it (known as the Diathesis-Stress Model).

Vulnerabilities can be broadly understood across three categories:

- i. **Biological vulnerability**, such as genetic predispositions, neurochemical imbalances, or a family history of psychological disorders
- ii. **Psychological vulnerability**, which includes enduring cognitive patterns, such as interpreting trivial failures as major personal setbacks
- iii. **Social vulnerability** involving environmental and contextual risk factors such as chronic poverty, social isolation, or a weak support network.

1.1.2.2 Resilience

If vulnerability is the predisposition to psychological distress, resilience may be understood as an impenetrable shield

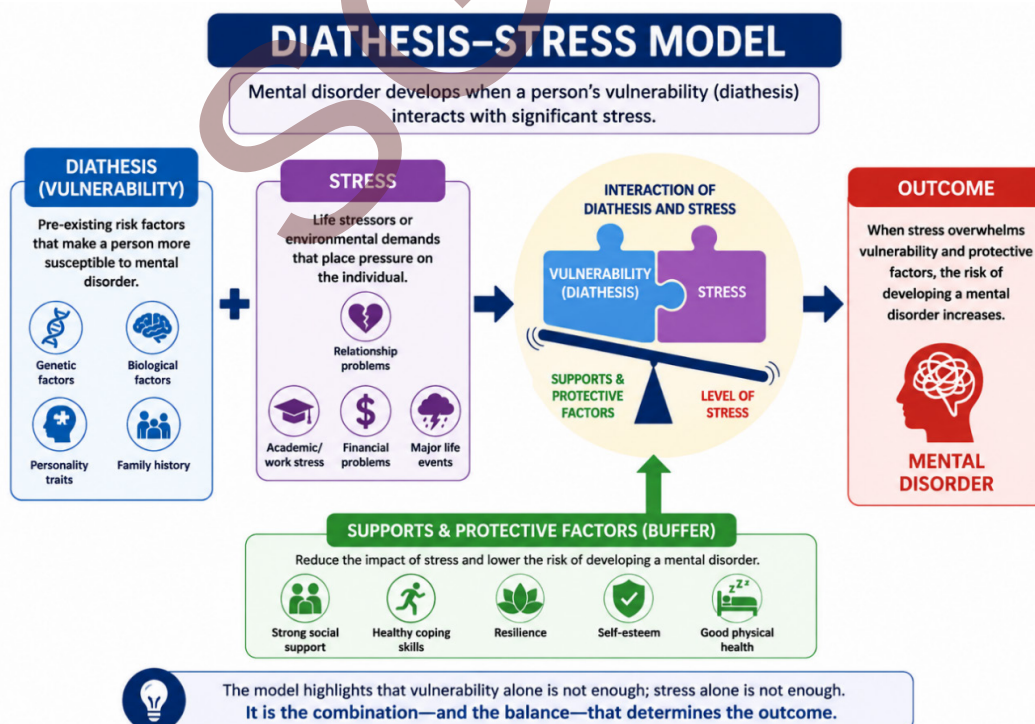


Fig. 1.1.3 Diathesis-Stress Model (AI-Generated)

against it. However, modern psychology defines resilience not as an innate trait of invincibility, but as an active, ongoing process of adaptation. Resilience is defined as the dynamic process of adapting positively and maintaining psychological functioning in the face of significant adversity, trauma, or severe environmental stress.

However, it should not be understood as the absence of distress. Rather, it is the capacity to continue functioning despite the distress. Resilience is largely built through ordinary, everyday processes rather than extraordinary psychological strength, and involves utilising protective factors, such as cognitive flexibility, emotional regulation, and social support. For example, a student having faced the death of a family member may initially experience distress but gradually regain academic and emotional functioning through support systems and adaptive coping, demonstrating resilience.

1.1.2.3 Coping

While vulnerability and resilience reflect an individual's baseline disposition or functional capacity, coping refers to the actual strategies and responses an individual employs in real time when faced with a perceived threat or stressful situation. Thus, coping refers to the conscious and deliberate cognitive and behavioural efforts an individual makes to manage, tolerate, or reduce the internal and external demands of a stressful situation.

Coping strategies may generally be divided into two, depending on what the individual is trying to change.

1. Problem-focused coping

2. Emotion-focused coping

Problem-focused coping targets the external source of stress, where the individual attempts to modify, manage, or eliminate the stressor through direct action, such as solving the problem or changing the situation. It is therefore considered most effective in

situations that are perceived as controllable. For example, an employee struggling with constant distractions in a shared workspace may negotiate quieter working hours, reorganise their schedule to work during less busy periods, or change their seating arrangement to improve concentration.

In contrast, emotion-focused coping targets the individual's internal response to the stressor. Rather than changing the situation or environment, the individual tries to manage emotional distress through cognitive reframing, emotional expression, or support-seeking. It is most effective in situations perceived as less controllable. For example, a person dealing with ongoing uncertainty about a delayed job promotion may focus on managing frustration by adjusting expectations, engaging in relaxation activities, or seeking reassurance from peers while anticipating outcomes beyond their control.

1.1.3 Historical Emergence of the Concept

The concept of mental disorders has not always existed in the way it is understood in contemporary psychology. It has gradually developed over time, shaped by cultural beliefs, religion, philosophy, medicine, and later scientific enquiry. Understanding its historical emergence helps clarify why current definitions are complex and why interpretations of mental disorders continue to evolve.

Historically, the etiology and treatment of abnormal behaviour have been interpreted through three competing frameworks:

- i. **The Supernatural (Demonological) Paradigm** held the belief that abnormal behaviour is caused by external, otherworldly forces such as evil spirits, demons, or divine punishment.
- ii. **The Somatogenic Paradigm** holds that mental illnesses have physical, bodily causes such as brain damage, genetic factors, or chemical imbalances.



iii. **The Psychogenic Paradigm** holds that mental disorders stem from psychological processes such as trauma, environmental stress, or distorted thinking patterns.

While these paradigms represent the major frameworks through which abnormal behaviour has been understood, their prominence has varied across different historical periods. A chronological examination of the evolution of the concept reveals how explanations of mental disorders have shifted over time, reflecting broader changes in cultural beliefs, scientific knowledge, and philosophical thought.

a. Animism and Supernaturalism

Prehistoric conceptualisations of abnormal behaviour were predominantly supernatural. Unusual thoughts, behaviours, or emotional states were rarely separated into a distinct category as a mental disorder. Instead, they were usually explained through spiritual or supernatural frameworks. Distressing experiences such as hearing voices, extreme agitation, withdrawal from social life, or unusual beliefs were often interpreted as possession by spirits, divine punishment, or the influence of supernatural forces. Responses to these conditions were therefore also spiritual, involving rituals, prayers, or exorcisms. Anthropologists have discovered skulls dating back to 6500 BCE that show

trepanation (or trephination), a primitive surgical procedure in which a circular hole was chipped into the cranial vault. While it may have been done to treat head trauma, historical consensus suggests it was also employed to release malevolent spirits presumed to cause aberrant behaviour.

b. The Somatic Shift

A significant shift began in ancient Greek and Roman thought, as thinkers sought to explain human behaviour through natural rather than supernatural causes. Thinkers such as Hippocrates proposed that disturbances in mood and behaviour could be linked to imbalances in bodily fluids, known as humors. He conceptualised the humoral theory, arguing that psychopathology resulted from an imbalance in four vital fluids (blood, yellow bile, black bile, and phlegm). For instance, an excess of black bile was theorised to cause sadness and withdrawal, while an excess of yellow bile was linked to irritability.

Although limited by contemporary scientific knowledge, this marked an important turning point. Psychological disturbances were now considered potentially biological in origin rather than purely spiritual. Later physicians like Galen expanded these ideas and reinforced the view that mental disturbances could be understood through bodily processes.

Table 1.1.1 Paradigms/Frameworks Explaining Abnormal Behaviour

Paradigms	Etiological Premise	Interventions
Supernaturalism	Demonic possession, animistic forces, divine retribution	Exorcism, trepanation, religious rituals
Somatogenesis	Biological pathology, neurological deficits, neurochemical imbalance	Humoral balancing, rest, modern psychopharmacology
Psychogenesis	Maladaptive cognition, unconscious conflict, environmental trauma	Hypnosis, psychoanalysis, cognitive-behavioural therapy

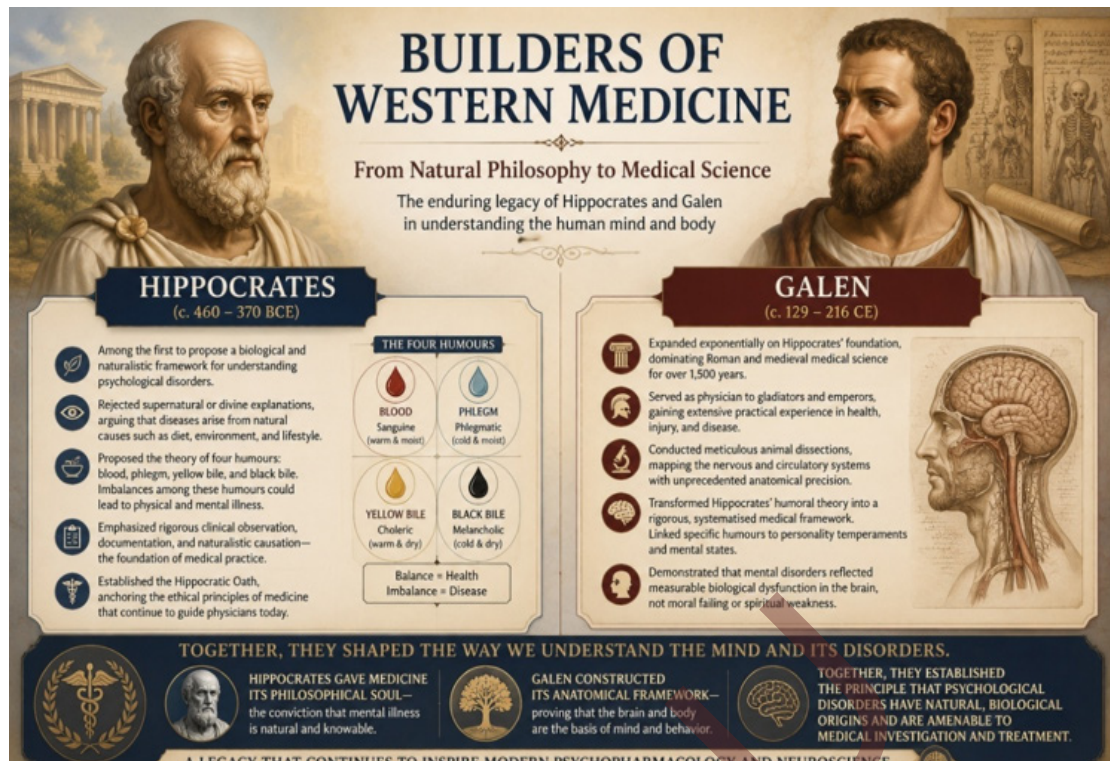


Fig. 1.1.4 Legacy of Hippocrates and Galen (AI-Generated)

c. Middle Ages

Following the collapse of the Roman Empire, scientific enquiry waned in Europe. Conceptualisations of mental illness reverted to demonology and religious mysticism. Mass hysteria phenomena (such as tarantism) were documented, and abnormal behaviour was frequently attributed to witchcraft or demonic pacts. During this era, the first asylums, such as London's Bethlem Royal Hospital, emerged primarily as custodial, rather than therapeutic, institutions.

However, in parts of the Islamic world, scholars preserved and developed earlier Greek medical knowledge. Physicians such as Avicenna described mental disturbances as conditions with physiological and psychological dimensions and recognised the importance of clinical observation. This period, therefore, can be marked by parallel interpretations rather than a single unified understanding.

d. The Asylum Reform and Moral Movement

A major transformation occurred during the Renaissance and early modern period, when institutional care for individuals with severe mental disturbances began to develop in Europe. Unfortunately, early asylums were often custodial rather than therapeutic, focusing more on containment than treatment. However, appalled by the inhumane conditions of custodial asylums, a paradigm shift occurred toward moral treatment. French physician Philippe Pinel advocated unchaining patients, arguing they were afflicted individuals in need of care. Concurrently, William Tuke in England and Dorothea Dix in the United States lobbied for legislative mandates to establish state-funded, therapeutic psychiatric hospitals, transforming the sociopolitical landscape of mental healthcare. This period, thus, also set the stage for the later medicalisation of mental health conditions, as increasing interest emerged in systematic observation and classification of unusual behaviour coupled with the moral movement. And psychiatry began to emerge as a medical discipline focused specifically on mental

disturbances.

e. The Bifurcation: Nosology and Psychoanalysis

Towards the end of the nineteenth century, the field bifurcated into two distinct empirical camps:

- i. **Somatogenic Revival:** The discovery that advanced syphilis caused general paresis (a syndrome involving cognitive decline and paralysis) firmly linked organic disease to psychiatric symptoms. Concurrently, Emil Kraepelin developed the first comprehensive nosology or classification system of psychiatric disorders, differentiating dementia praecox (schizophrenia) from manic-depressive psychosis based on symptom clusters and prognosis. His work laid the foundation for modern diagnostic systems by suggesting that mental disorders could be grouped into distinct types with predictable trajectories.
- ii. **Psychogenic Movement:** Influenced by Franz Mesmer and Jean-Martin Charcot's work on hysteria and

hypnosis, Sigmund Freud articulated the psychoanalytic model. This paradigm shifted focus entirely to psychogenesis, asserting that unconscious conflicts and early psychosexual development were the primary aetiology of neuroses. Behaviourist approaches, in contrast, focused on learned behaviours and environmental conditioning. Together, these perspectives have broadened the understanding of mental disorders by introducing psychological and behavioural or environmental dimensions, alongside biological ones.

f. Psychopharmacology and Deinstitutionalisation

The 1950s is marked by a pivotal development in the field with the synthesis of chlorpromazine (Thorazine), the first antipsychotic medication. Its effectiveness in ameliorating acute psychotic symptoms facilitated deinstitutionalisation, a systemic policy shift that discharged thousands of patients from state psychiatric hospitals back into the community. Consequently, psychiatry and clinical psychology have become increasingly integrated with

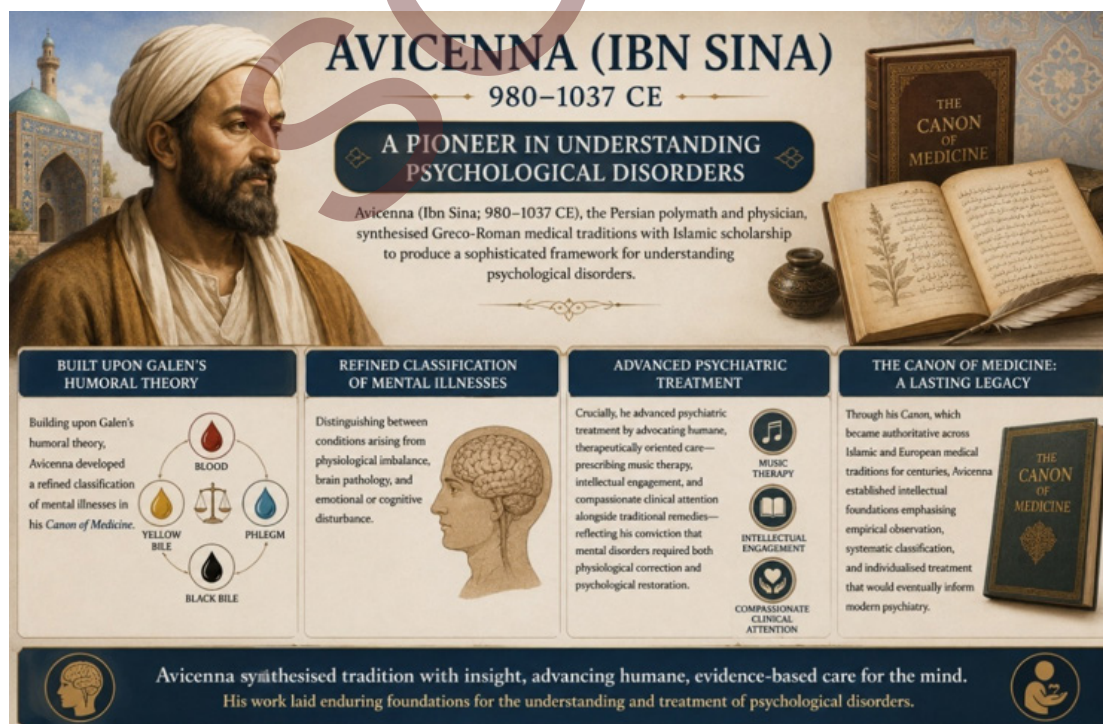


Fig. 1.1.5 Contributions of Avicenna (c. 980-1037 CE) (AI-Generated)



Fig. 1.1.6 Pioneers of Moral Treatment and Mental Health Reform (AI-Generated)

advances in neuroscience, genetics, and pharmacology. Diagnostic manuals such as the DSM and ICD were developed to standardise classification across clinical and research settings. The concept of mental disorder began to be more formally defined as patterns of psychological or behavioural symptoms that cause significant distress, impairment in functioning, or deviate from culturally expected norms.

g. The Contemporary Paradigm: Biopsychosocial Integration

The contemporary discourse largely abandons the rigid dichotomies of the past, such as nature *versus* nurture or somatogenic *versus* psychogenic. Mental disorders are rather understood through the biopsychosocial framework. Proposed by George Engel in 1977, the biopsychosocial model posits that abnormal behaviour is multi-causal. A disorder rarely emerges from a singular biological defect or isolated psychological trauma; rather, it manifests through complex, dynamic interactions among:

- ◆ **Biological factors** such as genetic predispositions, neuroanatomy, and neurochemistry,
- ◆ **Psychological factors** such as maladaptive cognitive schemas, emotional dysregulation, and coping mechanisms; or,
- ◆ **Sociocultural factors** such as systemic inequality, cultural expectations, familial dynamics, and environmental trauma.

This reflects the historical evolution of explanations of mental disorder from relatively single-cause models towards a multidimensional understanding that recognises the interaction of biological, psychological, and sociocultural influences.

The historical development of mental health concepts also demonstrates that the classification and standardisation of mental disorders are not entirely independent of their sociocultural and historical contexts. Diagnostic classifications have changed across editions of the *Diagnostic and*

Statistical Manual of Mental Disorders (DSM) as scientific knowledge, clinical understanding, social attitudes, and cultural perspectives have evolved. For instance, homosexuality was classified as a mental disorder in the earlier editions of the DSM, with the term homosexuality per se removed from DSM II (7th printing, 1973) but replaced by Sexual Orientation Disturbance, with the pathologisation eliminated from the DSM-III-R in 1987, reflecting a significant change in its conceptualisation within psychiatry. Similarly, autism has undergone substantial changes in definition and classification across successive editions, reflecting developments in clinical and scientific understanding.

These developments illustrate that the categories used to define and standardise

mental disorders are historically evolving rather than fixed or universally unchanging. The contemporary understanding of abnormality therefore involves not only recognising multiple influences on the development of mental disorders but also critically examining how psychological distress and disorder have been defined, classified, and understood within particular historical and sociocultural contexts.

1.1.4 Mental Health Laws, Policies, and Regulations in the Indian Context

The understanding and treatment of mental disorders do not depend solely on advances in psychology, psychiatry, or medicine. The rights, care, and protection of individuals

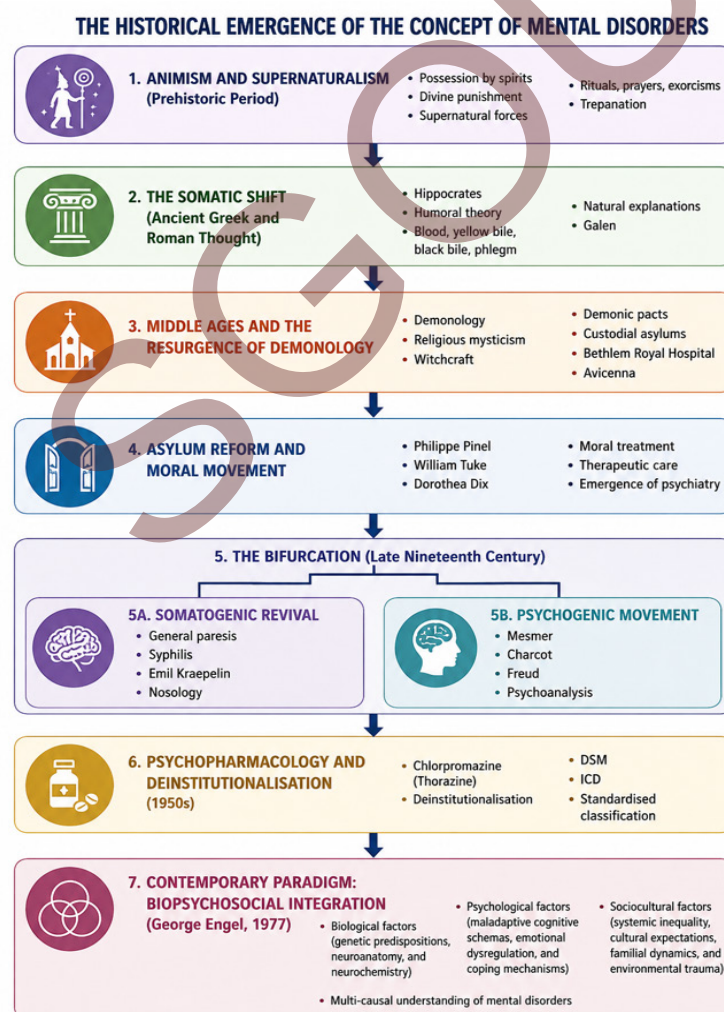


Fig. 1.1.7 Historical Emergence of the Concept of Mental Disorders (AI-Generated)

experiencing mental health difficulties are also shaped by laws, policies, and regulatory frameworks. These frameworks determine how mental health services are organised, who has access to care, how individuals are protected from discrimination, and the standards that mental health professionals and institutions are expected to follow.

In India, the approach to mental health has evolved considerably. Earlier legal provisions focused primarily on the management and institutionalisation of persons with mental illness. However, contemporary mental health legislation increasingly emphasises human rights, dignity, autonomy, access to treatment, and community-based care. This shift reflects broader global developments in mental health policy as well as growing recognition of mental health as an essential component of overall well-being.

1.1.4.1 Early Legislative Approaches

The origins of formal mental health legislation in the Indian subcontinent trace back to the British colonial government in the nineteenth century. During British rule, laws concerning mental illness were largely concerned with the custody and management of individuals who were considered ‘lunatics’ or ‘insane.’ These laws were primarily administrative in nature and reflected the prevailing belief that individuals with severe mental disturbances required supervision and confinement.

- a. The Lunacy Acts of 1858:** Enacted following the transfer of power to the British Crown, the three pieces of legislation known as the lunacy acts were modelled on laws enforced in England at that time. It conflated ‘dangerousness’ with ‘insanity’. The primary legislative intent was not therapy, but social control, focusing on the segregation and detention of individuals in asylums and prisons to mitigate perceived threats to public order.

- b. The Indian Lunacy Act (ILA), 1912:** Modelled on the English Lunacy Act, 1890, this replaced the lunacy acts of 1858. ILA governed the detention of individuals diagnosed as ‘lunatics’, defined then as an idiot or a person of unsound mind, and became the principal legislation governing mental health care during the period. The Act focused mainly on procedures related to institutional admission, detention, guardianship, and management of property. Although it provided a legal framework for mental health institutions, it offered limited protection for the rights and welfare of persons with mental illness. Mental health care was largely institution-based, and individuals had little control over decisions affecting their treatment.

1.1.4.2 Towards a Modern Mental Health Framework

Following India’s independence, growing awareness of mental health needs and human rights concerns led to calls for reform of the prevailing legislation. However, ILA remained in force for four decades while the policy planners focused primarily on upgrading institutional infrastructure and addressing human resource shortages.

- a. National Mental Health Programme, 1982:** A significant milestone towards reform was the launch of the National Mental Health Programme (NMHP) in 1982. The programme sought to make mental healthcare accessible to the broader population by integrating mental health services with the general healthcare system. Its objectives included ensuring the availability of minimum mental healthcare for all, promoting the application of mental health knowledge in general health services, and encouraging community participation in mental health care. The programme marked a shift from institution-centred care towards a



community-oriented approach. It later led to the development of the District Mental Health Programme (DMHP), launched to operationalise the NMHP.

- b. Mental Health Act, 1987:** A significant step in modernising mental health legislation was the enactment of the Mental Health Act, 1987. This Act replaced the Indian Lunacy Act of 1912 and sought to establish a more humane approach to the treatment and care of persons diagnosed with mental disorders. The Act introduced provisions for the regulation of psychiatric hospitals and nursing homes, procedures for admission and discharge, and mechanisms for the management of the private property and affairs of persons unable to do so independently. Though the legislation reflected a growing recognition that individuals with mental illness required treatment and support rather than mere custodial care and was a significant improvement over earlier legislation, it was later criticised for its continued emphasis on institutional care and for providing limited safeguards regarding patient autonomy and rights.

1.1.4.3 Rights-Based Approaches to Mental Health

The twenty-first century witnessed a significant shift in India's approach to mental health, moving from a predominantly medical and institutional model towards a rights-based framework, and influenced by growing awareness of human rights on the global level, international developments in disability law, and recognition of the need to provide accessible, equitable, and community-based mental healthcare.

- a. National Mental Health Policy, 2014:** In addition to legislation, India has developed policy frameworks to guide mental health promotion and service delivery. The National Mental Health Policy, 2014, represents a landmark

policy initiative that aims to improve mental health outcomes across the country. The policy recognises mental health as an integral part of health and well-being and emphasises a life-span approach to mental healthcare. It seeks to reduce stigma and discrimination, improve access to services, promote community participation, and strengthen mental health infrastructure. A key objective of the policy is to ensure equitable access to mental healthcare, particularly for vulnerable and underserved populations. The policy also emphasises prevention, early intervention, rehabilitation, and social inclusion.

- b. Rights of Persons with Disabilities Act, 2016:** Mental health regulation in India is also linked to broader disability rights legislation. The Rights of Persons with Disabilities Act, 2016, recognises mental disorder as one of the specified disabilities and seeks to ensure equality, non-discrimination, and participation in society. The Act provides legal protections in areas such as education, employment, social security, and accessibility, and thus reflects a shift from a purely medical understanding of disability toward a rights-based and inclusion-oriented perspective.

- c. Mental Healthcare Act, 2017:** A major milestone in India's mental health legislation was the enactment of the Mental Healthcare Act (MHCA), 2017. This law represents a rights-based approach to mental health care and aligns with international human rights principles, including those embodied in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) 2006, to which India is a signatory. Following India's ratification of the CRPD, the Parliament enacted the Mental Healthcare Act, 2017, repealing the MHA of 1987. The Act recognises mental healthcare as a legal right and

emphasises dignity, autonomy, and informed decision-making. It seeks to ensure that individuals with mental illness have access to affordable and quality mental health services without discrimination. The Act introduced the concept of *advance directives*, allowing individuals to specify their preferences regarding future mental health treatment should they become unable to make decisions during a period of illness. It also provides for the appointment of a *nominated representative*, who can support decision-making and safeguard the individual's interests.

The legal and policy framework for mental health in India has evolved from a custodial and institution-centred approach

to a rights-based and community-oriented model, and together, these laws and policies seek to promote access to care, protect the rights of individuals with mental illness, and support the development of an inclusive mental healthcare system. Despite significant legislative and policy advances, several challenges remain in the implementation of mental healthcare in India, including shortages of mental health professionals, unequal distribution of services between urban and rural areas, limited mental health infrastructure, and persistent stigma surrounding mental disorders. Addressing these challenges requires continued investment in mental health services, public awareness initiatives, workforce development, and community-based care systems.

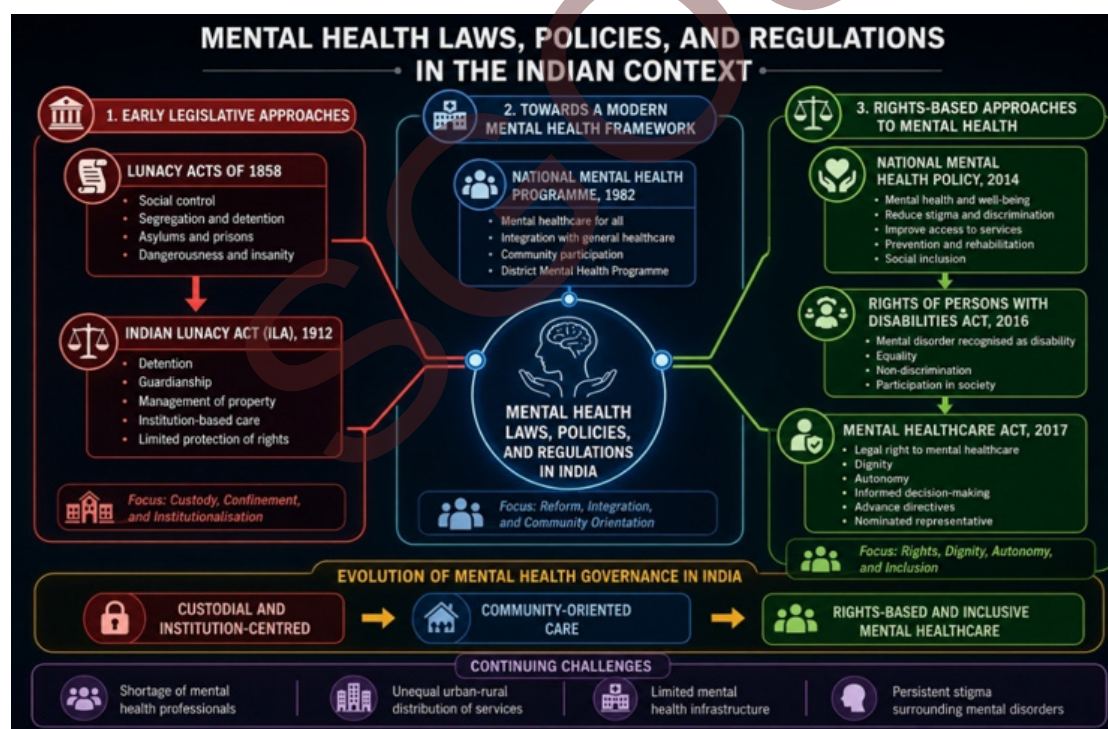


Fig. 1.1.9 Mental Health Laws, Policies, and Regulations in the Indian Context (AI-Generated)

The **National Commission for Allied and Healthcare Professions (NCAHP) Act, 2021**, was enacted to regulate and standardise the education, training, and professional practice of allied and healthcare professionals in India. The Act establishes the National Commission for Allied and Healthcare Professions as the apex regulatory body responsible for maintaining a central register of qualified professionals, setting minimum standards for education and training, and ensuring the recognition of qualifications granted by institutions across India.

Although the Act does not specifically focus on mental health legislation, it is relevant to mental healthcare because it recognises and regulates several allied health professions that contribute to multidisciplinary healthcare services. By institutionalising these standards, the NCAHP Act ensures that professionals providing behavioural health support operate within a regulated, competency-based system, thereby securing the quality of care provided to individuals with mental disorders.

Major Mental Health Institutions in India: A Chronological Overview

The development of mental health care in India can be traced through the establishment and transformation of major mental health institutions. The earliest modern mental asylums were established during the colonial period and initially reflected a largely custodial model of care. Over time, these institutions evolved into centres providing treatment, training, rehabilitation, and research. Some major institutions, arranged in chronological order of establishment, are given below:

Year	Institution	Context of Establishment
1745	Mental Asylum, Bombay	The earliest recorded colonial lunatic asylum in India. It initially served European patients and was part of the colonial institutional system.
1784	Mental Asylum, Calcutta	One of the earliest asylums in eastern India, established during the colonial period.
1794	Mental Asylum, Madras (now Chennai)	Later developed into the Institute of Mental Health, Chennai (popularly known as Kilpauk Mental Hospital); it remains one of India's oldest continuously functioning mental health institutions, and is now the Institute of Mental Health, Chennai.
1847	Lunatic Asylum, Bangalore	Later became the Mysore Government Mental Hospital, and formed one of the institutional predecessors of NIMHANS.
1870	Mental Hospital, Thiruvananthapuram	Established in the erstwhile Travancore State; now the Mental Health Centre, Thiruvananthapuram.
1872	Lunatic Asylum of Calicut	Later developed into the Government Mental Health Centre, Kozhikode (Kuthiravattom) .

1876	Tezpur Lunatic Asylum, Assam	The institution now known as the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health began as the Tezpur Lunatic Asylum in April 1876 under the British Government. It is one of the oldest mental-health institutions in India and has since developed into a tertiary centre for mental-health care, education, and research.
1918	Ranchi European Lunatic Asylum	Later became the Central Institute of Psychiatry (CIP), Ranchi, a major centre for psychiatric care, training, and research.
1954	All India Institute of Mental Health, Bangalore	Established by the Government of India and subsequently amalgamated with the Government Mental Hospital to form NIMHANS in 1974.
1957	Institute of Psychiatry, Goa	Now Institute of Psychiatry and Human Behaviour
1966	Hospital for Mental Diseases (HMD), Shahdara, Delhi	Later became IHBAS
1974	National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore	Established through the amalgamation of the All India Institute of Mental Health and the Government Mental Hospital (Lunatic Asylum, Bangalore), marking an important development in multidisciplinary mental health and neurosciences.
1993	Institute of Human Behaviour and Allied Sciences (IHBAS), Delhi	The former HMD was converted into the Institute of Human Behaviour and Allied Sciences (IHBAS).

Recap

- ◆ Normality involves typical, culturally acceptable patterns of thought and behaviour that enable daily functioning.
- ◆ The statistical approach defines normality based on how frequently a characteristic occurs in a population.
- ◆ The sociocultural approach evaluates normality against the institutionalised expectations of a specific culture.
- ◆ The functional approach links normality to effective coping and adjustment to environmental demands.
- ◆ Abnormality is the significant departure from established parameters of normal functioning.
- ◆ Criteria for abnormality include statistical deviation, cultural violation, and maladaptive behaviour.



- ◆ Well-being is a positive state involving psychological flourishing rather than a passive absence of disorder.
- ◆ Hedonic well-being reflects subjective experiences of pleasure and life satisfaction.
- ◆ Eudaimonic well-being emphasises autonomy, personal growth, and functional purpose.
- ◆ A mental disorder is a clinical syndrome indicating a significant disturbance in psychological functioning.
- ◆ Primary diagnostic criteria for mental disorders include deviance, distress, dysfunction, and danger.
- ◆ Vulnerability, or diathesis, describes an underlying biological, psychological, or social predisposition to mental disorders.
- ◆ Resilience is an active, ongoing process of adapting positively to severe environmental stress.
- ◆ Coping refers to the deliberate efforts an individual makes to manage stressful internal or external demands.
- ◆ Problem-focused coping targets external stressors to modify or eliminate them.
- ◆ Emotion-focused coping manages internal distress when external stressors cannot be changed.
- ◆ Historical explanations for abnormal behaviour fall into supernatural, somatogenic, and psychogenic paradigms.
- ◆ The somatic shift originated with Hippocrates and the humoral theory of vital fluids.
- ◆ The moral movement transformed early custodial asylums into therapeutic psychiatric hospitals.
- ◆ Emil Kraepelin developed the first comprehensive classification system for psychiatric disorders.
- ◆ Sigmund Freud established the psychoanalytic model, focusing entirely on psychogenesis.
- ◆ The contemporary biopsychosocial model posits that abnormal behaviour stems from interacting biological, psychological, and sociocultural factors.
- ◆ The 1858 Lunacy Acts in India prioritised social control over therapeutic care.
- ◆ The Mental Healthcare Act of 2017 established a modern, rights-based approach to mental health care in India.

Objective Questions

1. Which approach defines normality according to the frequency of a characteristic?
2. What specific type of well-being focuses on subjective pleasure and life satisfaction?
3. What specific type of well-being focuses on autonomy, purpose, and personal growth?
4. Name the four criteria used to identify a mental disorder.
5. What diagnostic manual developed by the American Psychiatric Association serves as a major contemporary framework for mental disorders?
6. Which criterion for mental disorders indicates a risk of physical harm?
7. What specific clinical term defines a biological, psychological, or social predisposition to a disorder?
8. Which model states that predispositions become disorders only if triggered by sufficient stress?
9. What type of coping targets the external source of stress directly?
10. What type of coping targets the individual's internal emotional response?
11. Which historical paradigm attributed abnormal behaviour to evil spirits or divine punishment?
12. Which historical paradigm attributes mental illnesses to physical causes like brain damage?
13. Which historical paradigm attributes mental disorders to psychological processes like trauma?
14. Which ancient physician proposed that behavioural disturbances were linked to humours?
15. Who developed the first comprehensive classification system of psychiatric disorders?
16. Which physician articulated the psychoanalytic model of psychogenesis?

17. What systemic policy shift discharged patients from psychiatric hospitals back into the community?
18. What Indian programme was launched in 1982 to integrate mental health services with general healthcare?
19. Which 2014 Indian policy emphasises a lifespan approach to mental healthcare?
20. Which 2017 Indian act introduced the concept of advance directives?

Answers

1. Statistical
2. Hedonic
3. Eudaimonic
4. Deviance, Distress, Dysfunction, Danger
5. DSM
6. Danger
7. Diathesis
8. Diathesis-Stress
9. Problem-focused
10. Emotion-focused
11. Supernatural
12. Somatogenic
13. Psychogenic
14. Hippocrates
15. Emil Kraepelin
16. Sigmund Freud
17. Deinstitutionalisation
18. NMHP
19. National Policy
20. MHCA

Assignments

1. Explain the concepts of normality, abnormality, well-being, and mental disorders, and differentiate between them using relevant psychological criteria.
2. Critically examine why the distinction between normality and abnormality is rarely as clear-cut as it first appears. Use examples to support your answer.
3. Explain the criteria used to determine abnormality. Using the example of synaesthesia, discuss why statistical deviation alone is insufficient to classify a phenomena as a clinical disorder.
4. Discuss the four primary criteria (deviation, distress, dysfunction, danger) used to identify a mental disorder. Why must these criteria intersect rather than operate independently?
5. Trace the historical evolution of explanatory models of mental illness from the demonological paradigm to the biopsychosocial model. What does this trajectory reveal about the nature of scientific understanding of mental disorders?
6. Evaluate the key mental health laws, policies, and regulations in the Indian context and assess their implications for individuals and society.
7. Examine the provisions of the Mental Healthcare Act, 2017 and discuss the extent to which the act reflects a rights-based approach to mental healthcare in India.

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UNIT

Classification and Diagnosis

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ◆ describe the key features and purposes of major classification systems such as DSM (Diagnostic and Statistical Manual of Mental Disorders) and ICD (International Classification of Diseases)
- ◆ compare and contrast the strengths, limitations, and application contexts of DSM and ICD in clinical and research settings
- ◆ discuss the diagnostic assessment techniques, and differentiate between projective and objective diagnostic assessment techniques

Prerequisite

How do we make sense of our physical ailments? A cluster of fever, cough, and fatigue is not left as a vague complaint; it is named influenza or pneumonia with its specific set of criteria, allowing clinicians to communicate, researchers to gather knowledge, and health systems to plan care. Though psychological experiences are far more subjective and varied, the impulse to categorise is the same. How would a clinician know what might help, or how would researchers compare what they learn? Without some form of classification, every account of persistent sadness, intrusive fear, or disrupted thought would remain isolated and private. This need for a shared language is primarily what led to classification systems such as the DSM, developed largely within clinical psychology and psychiatry, and the ICD, designed for global health reporting and policy matters.

Yet, classification alone is not enough. Clinicians must also determine how an individual's experience relates to these categories. Psychological difficulties often reveal themselves gradually through emotions, behaviours, thoughts, and personal narratives, making diagnosis a process of carefully understanding and

interpreting human experience to identify patterns that may require clinical attention. A clinician must therefore listen, observe, assess, and interpret to gradually arrive at an understanding of what a person may be experiencing. But how does one distinguish between a passing emotional struggle and a condition requiring clinical attention? How are deeply personal experiences translated into diagnostic categories that can guide treatment and care? And does a diagnostic category merely describe a pattern that already exists, or does it also organise our perception, shaping what we notice, what we count as relevant, and what we overlook? Let the questions linger as you explore more.

Keywords

Taxonomy, Diagnosis, Clinical Interview, Behavioural Observation, Case History, MMPI, Rorschach Test, TAT

Discussion

1.2.1 Classification Systems

In clinical psychology, classification refers to the systematic process of grouping mental disorders based on shared clinical signs and symptoms, behavioural patterns, and clinical features. Much like a taxonomy in biology or the periodic table in chemistry, a classification system provides psychologists with a standardised, shared language to communicate about psychological distress, guide treatment choices, and conduct scientific research.

Without a reliable classification system, two clinicians might use entirely different terms to describe the same underlying condition, leading to confusion and compromised treatment and care. Classification systems thus serve as an important foundation for the scientific study and clinical management of mental disorders, and the global psychological community currently relies on two major classification systems: the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

a. Diagnostic and Statistical Manual of Mental Disorders (DSM)

The DSM is published by the American Psychiatric Association (APA). It is a specialised manual dedicated exclusively to mental, behavioural, and neurodevelopmental disorders. The DSM provides detailed diagnostic criteria for a wide range of mental disorders and is primarily used by mental health professionals for clinical assessment, diagnosis, research, and training.

First published in 1952, the manual has undergone several major revisions to reflect changing scientific evidence and social values, and advances in psychiatric knowledge and research. The current edition, DSM-5-TR (Text Revision), organises mental disorders into broad categories and provides specific diagnostic criteria that must be met for a diagnosis to be assigned.

A distinguishing feature of the DSM is its emphasis on operational definitions. It uses a categorical and descriptive approach to provide specific, operationalised diagnostic

criteria (a checklist of symptoms, a required duration, and a clause ensuring the symptoms cause significant distress or impairment in daily functioning) without assuming the underlying biological or psychological causes of the disorder.

Thus, rather than relying solely on theoretical explanations, diagnoses are based

on observable symptoms, their duration, severity, and associated impairment, and aim to improve diagnostic consistency across clinicians and settings. While developed in the United States, the DSM has considerable influence on psychological research, clinical training, and professional practice worldwide.

Table 1.2.1 DSM Revisions

Edition	Year	Major Revision/Significance
DSM-I	1952	First edition; organised mental disorders within a predominantly psychoanalytic framework
DSM-II	1968	Revised and expanded diagnostic categories while retaining largely psychodynamic and non-operationalised descriptions
DSM-III	1980	Major shift toward operationalised diagnostic criteria, with explicit symptom-based criteria and a multiaxial system, aimed at improving diagnostic reliability; often characterised as the 'neo-Kraepelinian' turn, marking the move towards a more medical model
DSM-III-R	1987	Revised DSM-III to address inconsistencies and clarify diagnostic criteria; several diagnostic categories and criteria were modified
DSM-IV	1994	Based on an extensive review of research literature; diagnostic categories, criteria, and descriptive text were substantially revised, with disorders added, removed, and reorganised; retained the multiaxial system
DSM-IV-TR	2000	Text revision of DSM-IV, primarily updating descriptive and research information (including prevalence) while retaining the DSM-IV diagnostic classification
DSM-5	2013	Major reorganisation of the classification system; replaced the multiaxial system, reorganised diagnostic chapters along a lifespan/developmental axis, shared features, internalising and externalising dimensions, and introduced or consolidated several disorders into broader spectra, including Autism Spectrum Disorder
DSM-5-TR	2022	Updated diagnostic text and criteria; introduced Prolonged Grief Disorder, and substantially updated cultural, sex- and gender-related, and ethnoracial considerations

Components of the DSM

The DSM does not simply list the names of mental disorders. Each diagnostic entry is organised into several related components, and recognising them is essential to understanding how clinicians describe, distinguish, and communicate psychological disorders. The diagnostic criteria identify the features required for a diagnosis, while the accompanying sections explain how the disorder typically appears, how common it is, how it develops, what factors influence its course, and how it may overlap with other conditions. Reading a DSM entry therefore involves moving from the formal criteria to the broader clinical description and then to the disorder's place within the larger diagnostic picture. The following components follow the general sequence used in DSM-5-TR disorder descriptions.

Diagnostic Criteria

Diagnostic criteria form the core of a DSM entry and identify the symptoms, behaviours, thoughts, emotions, or experiences that must be present for a diagnosis to be considered. Criteria are usually organised into lettered sections, such as Criterion A, Criterion B, and Criterion C. A diagnosis may require a specified number of symptoms from a larger list rather than the presence of every symptom. The criteria may also state how long the symptoms must have been present, how frequently they must occur, or how severe they must be.

Many diagnoses also require clinically significant distress, impairment, or both. Impairment may affect social relationships, education, work, self-care, or other important areas of life. This requirement helps distinguish a mental disorder from an occasional emotional reaction, a personality characteristic, or a behaviour that is unusual but not clinically significant.

The criteria must be considered as a complete set. The presence of one symptom associated with a disorder does not establish that diagnosis. Diagnosis depends on the overall pattern, the duration and severity of the symptoms, their consequences, and the exclusion of better explanations.

Recording Procedures and Codes

Recording procedures describe how to document a diagnosis. When more than one diagnosis is present, the principal diagnosis is generally listed first, followed by additional diagnoses in order of clinical importance. The record may also include severity, remission status, course, or other relevant qualifiers.

Subtypes and Specifiers

Some disorders include subtypes, while others include specifiers. These terms provide additional information about the way a disorder is expressed.

A subtype identifies a particular form of a disorder. A specifier adds clinically relevant detail without creating a separate diagnosis. Specifiers may describe severity; course (episodic or persistent); remission status; age or pattern of onset; the presence of particular symptoms; or a distinctive clinical presentation.

Diagnostic Features

The diagnostic-features section explains how the disorder typically appears in clinical practice. It expands upon the formal criteria by describing characteristic patterns of thought, emotion, behaviour, bodily experience, and interpersonal functioning. The criteria identify what must be present for diagnosis. The diagnostic-features section helps explain what those criteria may look like in an actual scenario.

Associated Features

Associated features are characteristics that commonly occur with a disorder but are not required for the diagnosis. They may include cognitive, interpersonal, physical, behavioural patterns, or common patterns of help-seeking or treatment engagement. Associated features help provide a fuller picture of the disorder. Their presence may support clinical understanding, but they do not confirm a diagnosis. Their absence does not necessarily rule one out.

Prevalence

Prevalence refers to how common a disorder is in a defined population within a specified period. It is usually expressed as a percentage, proportion, or rate. Prevalence differs from incidence. Incidence refers to new cases that develop during a specified period, whereas prevalence includes all existing cases during that period.

Prevalence information helps indicate whether a condition is common or rare and allows comparisons across populations, age groups, cultures, and time periods. However, estimates may differ because of variations in diagnostic criteria, sampling methods, assessment procedures, age ranges, cultural settings, and access to treatment. A prevalence figure is therefore an estimate for a particular population and method, not a fixed universal value.

Development and Course

The development-and-course section describes how a disorder typically begins and changes over time. It may include information about age of onset, developmental differences, duration, recurrence, remission, and whether the disorder is episodic or persistent. These descriptions identify common patterns rather than predicting outcomes in every individual case.

Risk and Prognostic Factors

Risk factors are characteristics or circumstances associated with an increased likelihood of developing a disorder. They may involve biological, psychological, developmental, family, social, or environmental influences. Prognostic factors are characteristics associated with the likely course or outcome after a disorder has developed. They may include symptom severity, duration, age of onset, comorbidity, access to treatment, social support, and response to intervention. Risk factors do not guarantee that a disorder will develop. Similarly, prognostic factors do not determine the outcome. They describe probabilities and patterns observed across groups.

Culture-Related Diagnostic Features

Culture-related information explains how cultural context may influence the expression, interpretation, and reporting of psychological symptoms. A behaviour should not be considered pathological merely because it differs from the expectations of another cultural group. Interpretation requires attention to whether the experience is consistent with the person's cultural context and whether it produces significant distress, impairment, or danger.

Sex- and Gender-Related Features

Some DSM entries describe differences related to sex, gender, symptom expression, risk, prevalence, or course, and help identify possible variations in presentation and support more sensitive assessment.

Diagnostic Markers

Some disorders include information about diagnostic markers. These may involve laboratory findings, physiological indicators, neuroimaging results, genetic findings, or other measurable characteristics associated with the disorder.

A diagnostic marker is not necessarily a diagnostic test. Most mental disorders do not have a single biological test that confirms or excludes the diagnosis. Markers may support assessment or research, but diagnosis generally depends on the overall clinical pattern and the wider assessment.

Association with Suicidal Thoughts or Behaviour

Where relevant, DSM-5-TR entries describe associations between a disorder and suicidal thoughts or behaviour. Some disorders are associated with increased risk of suicidal ideation, suicide attempts, or suicide.

Differential Diagnosis

Differential diagnosis is the process of distinguishing one disorder from other conditions with similar symptoms. Many symptoms are nonspecific. For example, poor concentration may occur in depression, anxiety, ADHD, sleep disorders, substance use, medication effects, or medical conditions. Differential diagnosis therefore requires attention to the complete symptom pattern, history, duration, context, developmental stage, and the course of the disorder.

Comorbidity

Comorbidity refers to the presence of two or more disorders in the same individual, either at the same time or across the lifespan. Comorbidity may increase distress, complicate assessment, affect risk and prognosis, and influence treatment planning. Symptoms of one disorder may also mask or intensify symptoms of another. Comorbidity does not necessarily mean that one disorder caused the other, but it does say that the presence of one diagnosis does not automatically exclude another.

Taken together, these components mean that a DSM diagnosis is more than a label attached to a group of symptoms. The criteria establish the required pattern, while the remaining sections explain how the disorder appears, how common it is, how it develops, what influences its course, what other conditions may resemble it, and what disorders may occur alongside it.

A DSM entry is therefore best read as a connected clinical account rather than as an isolated checklist. The DSM-5-TR provides a structured guide to classification and diagnosis, but its criteria are intended to inform clinical judgment and require appropriate training and experience.

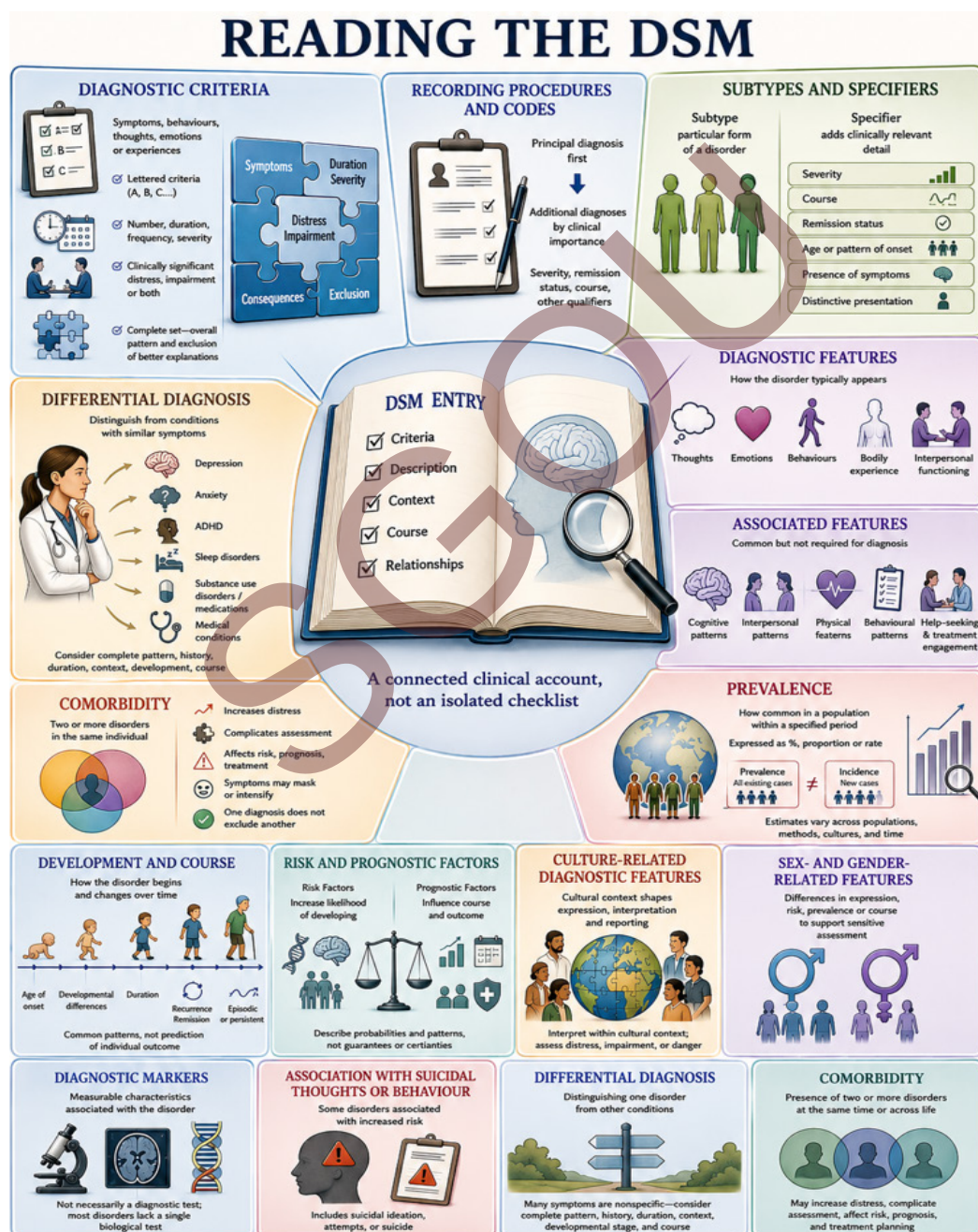


Fig. 1.2.1. Components of the DSM (AI-Generated)

b. International Classification of Diseases (ICD)

The International Classification of Diseases (ICD), developed and maintained by the World Health Organisation, is a comprehensive classification system covering all health conditions, including mental, behavioural, and neurodevelopmental disorders. Unlike the DSM, which focuses exclusively on mental disorders, the ICD serves as a global system for classifying diseases and health-related conditions.

The ICD has a long history dating back to the nineteenth century, and the current version, ICD-11, includes a dedicated chapter on mental, behavioural, and neurodevelopmental disorders. The ICD is designed with a public health focus to help member states track disease prevalence, mortality rates, and health statistics globally. Because it is designed for international application, it seeks to accommodate diverse healthcare systems, cultural contexts, and resource settings and is predominantly used by governments, healthcare systems, hospitals, researchers, and public health agencies across the world.

Compared to the strict, checklist-like criteria of the DSM, the ICD traditionally relies more on clinical descriptions and guidelines, allowing clinicians slightly more flexibility to use professional judgment across diverse cultural settings. Thus, beyond supporting clinical diagnosis, the ICD plays a vital role in health statistics, epidemiological research, insurance systems, and public health planning.

1.2.1.1. Comparative Strengths

Although both systems aim to classify mental disorders, they were developed for somewhat different purposes and therefore possess distinct strengths.

The DSM is generally known for its detailed diagnostic criteria and extensive descriptive information. For instance, in the diagnosis of major depressive disorder, the DSM specifies the number of symptoms required, the minimum duration of symptoms, and the degree of impairment necessary for a diagnosis. This level of specificity can enhance diagnostic reliability and is particularly useful in clinical training and research settings where precise diagnostic definitions are required. Researchers often prefer the DSM because its detailed criteria facilitate consistency across studies.

In contrast, the ICD is designed for global applicability. Its broader scope allows mental disorders to be classified within the larger framework of health conditions. Because it is developed by the World Health Organisation, it serves as the official diagnostic system for many countries and is particularly valuable for international comparisons, public health monitoring, and healthcare administration.

The DSM may therefore be viewed as a highly detailed clinical and research manual, whereas the ICD functions as a comprehensive international classification system applicable across healthcare contexts. Rather than competing systems, they are best understood as complementary tools that serve different but overlapping purposes in the study and management of mental disorders.

Table 1.2.2 Between DSM and ICD

Dimensions of Comparison	DSM	ICD
Published by	American Psychiatric Association (APA)	World Health Organisation (WHO)
Scope of Content	Mental and behavioural disorders alone	All physical and mental diseases/conditions
Diagnostic Style	Highly specific, criteria-driven symptom checklists	Descriptive clinical guidelines with diagnostic thresholds
Cultural Adaptability	Historically criticised for a Euro-American bias, though recent editions include a Cultural Formulation Interview	Intrinsically designed by global committees to ensure cross-cultural applicability

Research Domain Criteria (RDoC)

Research Domain Criteria (RDoC) is a research framework developed by the National Institute of Mental Health, United States, to improve the understanding and classification of mental disorders. Introduced in 2009, RDoC seeks to move beyond traditional diagnostic categories by examining mental disorders through underlying dimensions of functioning, such as cognition, emotion, motivation, social processes, and arousal systems.

The framework integrates findings from genetics, neuroscience, behavioural science, and psychology to study mental health and illness across multiple levels of analysis. Rather than viewing disorders as distinct categories, RDoC conceptualises them as existing along a continuum from normal to abnormal functioning. Its primary goal is to promote research that can lead to more precise diagnoses, improved treatments, and a better understanding of the biological and psychological mechanisms underlying mental disorders.

RDoC RESEARCH DOMAIN CRITERIA

A New Framework for Understanding Mental Health



"RDoC aims to transform the understanding of mental disorders by studying their underlying dimensions of functioning." – National Institute of Mental Health (NIMH)



WHAT IS RDOC?

The Research Domain Criteria (RDoC) is a framework developed by the National Institute of Mental Health (NIMH) to improve the understanding and treatment of mental disorders.

- Introduced in **2009**
- Moves beyond traditional diagnostic categories (e.g., schizophrenia, depression)
- Focuses on dimensions of normal and abnormal functioning across multiple domains



WHY RDOC?



Mental disorders are complex and heterogeneous.



Current diagnostic systems are largely based on observable behaviors, not biology.



RDoC promotes research on underlying biological, psychological, and behavioral mechanisms.



Aims to improve diagnosis, treatment, and prevention through a better understanding of mental health and illness.

THE RDoC FRAMEWORK

RDoC examines functioning across **five broad domains** and **multiple units of analysis**.

DOMAINS (What we study)	NEGATIVE VALENCE SYSTEMS	POSITIVE VALENCE SYSTEMS	COGNITIVE SYSTEMS	SOCIAL PROCESSES	AROUSAL/REGULATORY SYSTEMS
WHAT IT INCLUDES	Responses to potential threat, loss, frustration, and other aversive situations	Approach motivation, reward learning, and positive reinforcement	Attention, perception, memory, language, learning, and cognitive control	Perception and understanding of self and others, affiliation, and social communication	Arousal, regulation of sleep, circadian rhythms, and physiological state
UNITS OF ANALYSIS (Levels at which we study functioning)	GENES	•	•	•	•
	MOLECULES	•	•	•	•
	CELLS	•	•	•	•
	CIRCUITS	•	•	•	•
	PHYSIOLOGY	•	•	•	•
	BEHAVIOR	•	•	•	•
	SELF-REPORTS	•	•	•	•
	PARADIGMS	•	•	•	•

KEY PRINCIPLES OF RDOC



Dimensional: Focuses on continuums of functioning from normal to abnormal.



Transdiagnostic: Cuts across traditional diagnostic boundaries.



Multilevel: Integrates data across genes, biology, behavior, and self-report.



Research Driven: Built on the best available science and continuously evolves.

GOALS OF RDOC



- ✓ Advance research on the mechanisms of mental disorders
- ✓ Develop new measures and tools
- ✓ Inform the development of more precise interventions
- ✓ Improve mental health outcomes for all

RDoC is not a new diagnostic system. It is a research framework to build the foundation for the **future of mental health science**.



By understanding the building blocks of mental function, RDoC paves the way toward better prevention, personalized treatments, and a deeper understanding of the mind.



National Institute of Mental Health

Fig. 1.2.2 Research Domain Criteria (RDoC) (AI-Generated)

1.2.1.2. Application Scenarios

The choice between DSM and ICD often depends on the purpose and the context in which the classification system is being used. Although both provide standardised frameworks for classifying mental disorders, their applications may differ across clinical practice, research, public health, and healthcare administration.

a. Clinical Assessment and Psychological Practice

In clinical assessment and psychological training, practitioners rely on DSM criteria to guide diagnostic decision-making and case formulation, particularly in settings where the DSM is routinely used for detailed psychological assessment. For example, a clinical psychologist conducting a detailed assessment of an individual presenting with symptoms of depression may use DSM diagnostic criteria to determine whether the presentation meets the requirements for a specific depressive disorder. The highly rigid, criteria-based checklists of the DSM ensure diagnostic consistency and inter-rater reliability (the likelihood that two independent researchers will arrive at the same diagnosis for a single participant). The DSM is therefore particularly useful when a clinician requires detailed, specific criteria to guide the diagnostic assessment of an individual.

b. Research Context

In research contexts, both systems may be used depending on the objectives and scope of the research. DSM criteria are often preferred when researchers require detailed and specific diagnostic criteria for participant selection, particularly in studies focusing on particular mental disorders or evaluating psychological interventions. ICD classifications, on the other hand, are particularly useful when the research involves comparisons across countries and healthcare systems because

of their international scope. For example, a study investigating the effectiveness of a new psychological intervention for depression may use established DSM criteria to identify participants who meet specified diagnostic requirements, whereas a multinational study examining the prevalence of mental disorders across countries may use ICD classifications to facilitate international comparison of findings. Thus, the choice between DSM and ICD in research depends largely on whether the study requires detailed diagnostic criteria for participant selection or greater comparability across countries and healthcare settings.

c. Public Health and Healthcare Administration

In public health and healthcare administration, ICD classifications are used more commonly. Because the ICD is the official international standard approved by the World Health Organisation, national governments use it to track health statistics. Governments and health agencies utilise ICD codes to track the prevalence of mental disorders, allocate resources, monitor health trends, and maintain medical records. In India, public healthcare systems, government hospitals, and insurance frameworks rely on ICD codes for official medical records, billing, and health policy planning. For example, a national health survey examining the prevalence of anxiety disorders would typically employ ICD classifications to ensure consistency across healthcare settings. The ICD's clinical descriptions are often easier to apply than the DSM's extensive symptom checklists. While the DSM is highly prominent in academic reading and psychological literature, the ICD is the administrative backbone of global health.

d. Cultural Considerations in Application

Using these classification systems across countries and cultural settings also requires attention to cultural context. Both the DSM



and ICD recognise the importance of the influence of the cultural context in the assessment and classification of mental disorders, although their approaches and applications may differ. Because classification systems have developed within particular historical and cultural contexts, their diagnostic categories and descriptions may not fully capture how psychological distress is expressed, understood, and communicated across cultures. The DSM-5 and DSM-5-TR have incorporated greater attention to cultural variation through cultural formulation guidance and consideration of cultural concepts of distress. The ICD has likewise incorporated cultural considerations into its clinical descriptions and diagnostic guidance. Nevertheless, using either system requires clinicians to consider the individual's cultural background, beliefs, explanatory models, and culturally shaped expressions of distress rather than applying diagnostic criteria without regard to context.

1.2.2 Diagnostic Assessment Techniques

Diagnosis in mental health is not based solely on classification systems such as the DSM or ICD. Rather, it involves a comprehensive clinical investigation. When an individual seeks clinical support, they present a unique collection of subjective symptoms. (such as internal anxiety or low mood) and objective signs. (such as social withdrawal or physiological changes.) The clinician's task is to gather these scattered pieces of information, analyse them systematically, and determine whether they align with the established criteria for a specific mental disorder.

Thus, diagnostic assessment involves a systematic, goal-oriented evaluation of a client's psychological, behavioural, and emotional functioning to formulate a diagnosis, plan appropriate interventions, and guide treatment. Diagnostic assessment

is typically a multi-method process. Rather than relying on a single source of information, mental health professionals combine findings from interviews, observations, psychological tests, and other relevant sources to develop a comprehensive understanding of the individual. The major techniques commonly employed in diagnostic assessment are outlined below:

- i. **Clinical Interview:** This refers to a structured, semi-structured, or unstructured conversation through which the clinician gathers information about the individual's symptoms, personal history, current concerns, and psychosocial functioning. The clinical interview provides valuable insight into the individual's subjective experiences and often forms the foundation of the diagnostic process.
- ii. **Behavioural Observation:** This involves the systematic observation of an individual's behaviour, appearance, emotional expressions, interpersonal interactions, and other relevant characteristics. Observations may be conducted in clinical, educational, or natural settings.
- iii. **Case-History Method:** This involves the collection of background information relating to the individual's developmental history, family circumstances, educational experiences, medical conditions, and significant life events. This information helps place current difficulties within a broader context.
- iv. **Psychological Testing:** This involves employing standardised instruments to assess the psychological state of the client. Psychological tests are among the most commonly used assessment tools and provide objective and systematic information that complements other assessment methods.
- v. **Medical and Neurological Examination:** These include the medical or neurological assessment procedures used to identify

or rule out physical conditions that may contribute to psychological symptoms. Such examinations are particularly important when symptoms may have a biological or neurological basis.

- vi. Collateral Information:** This includes the information obtained from significant others, such as family members, caregivers, teachers, or previous treatment records, and often provides additional perspectives on the individual's functioning and behaviour.

Because no single assessment technique is sufficient on its own, mental health professionals typically rely on a combination of techniques to ensure a reliable and valid assessment.

1.2.2.1 Objective and Projective Tests

Among the various techniques used in diagnostic assessment, psychological testing occupies a unique position as it provides standardised procedures for assessing particular aspects of psychological functioning. The selection and use of psychological tests, however, depend on the purpose of

the assessment, the characteristics of the individual, and the suitability of the test for the population and the context in which it is to be used. Their administration and interpretation therefore follow appropriate ethical standards, including informed consent, confidentiality, and use by appropriately trained professionals.

Psychological tests, however, constitute only one component of the broader diagnostic assessment process. Their findings are therefore understood in relation to information obtained through clinical interviews, behavioural observation, case history, collateral information, and, where indicated, medical or neurological examination. Different tests may provide information about different aspects of psychological functioning and may contribute to diagnostic decision-making, but the result of a single test does not, by itself, constitute a diagnosis. Rather, diagnosis involves the integration and clinical interpretation of information from multiple assessment methods in relation to established diagnostic criteria.

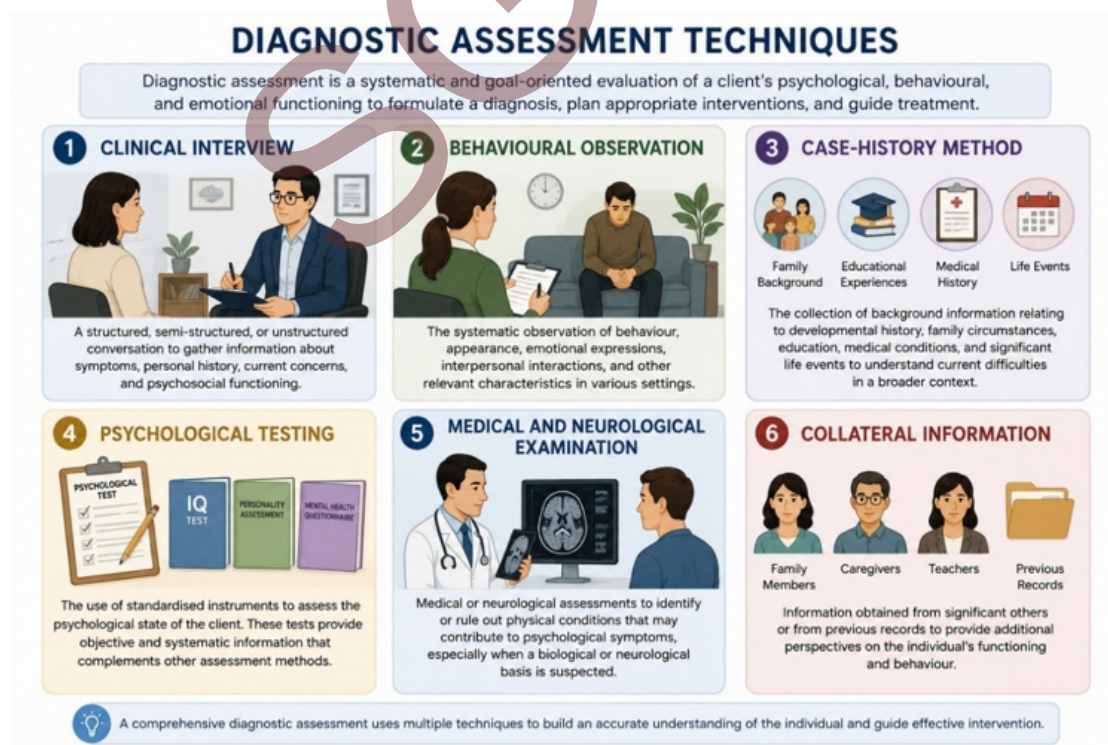


Fig. 1.2.3 Diagnostic Assessment Techniques (AI-Generated)

Within this broader context, psychological tests can be broadly classified into two categories: objective tests and projective tests. These two forms of testing differ primarily in the nature of the tasks presented, the responses elicited, and the ways in which those responses are interpreted.

a. Objective Tests

Objective tests are standardised assessment instruments in which administration, scoring, and interpretation follow clearly defined procedures. Responses are typically structured, and scoring is based on predetermined rules, reducing examiner bias. Most objective tests require individuals to respond to statements, questions, or items made available in a multiple-choice, true or false, or Likert scale format. The responses are then compared with established norms or scoring criteria to generate interpretable results.

A widely known example is the *Minnesota Multiphasic Personality Inventory* (MMPI), which is used to assess personality characteristics through a large number of structured statements to which respondents indicate their level of agreement or disagreement. Similarly, symptom checklists and rating scales used to assess depression, anxiety, or stress are also examples of objective tests because they rely on standardised questions and scoring procedures.

Objective tests offer several advantages, including standardised administration and scoring procedures, high reliability, and the ability to compare an individual's performance with established norms. These characteristics make them particularly useful for diagnosis, screening, and research. However, because responses are restricted to the provided options, objective tests may not fully capture the complexity of an individual's experiences, motivations, or unique personal circumstances. Consequently, they are often used alongside other assessment

methods to provide a more comprehensive understanding of psychological functioning.

b. Projective Tests

Projective tests are assessments that present individuals with ambiguous visual stimuli and ask them to describe what they see or tell a story, aiming to reveal hidden emotions and internal conflicts. These tests have their roots in psychoanalytic theory. The individuals are required to interpret, describe, or construct meaning from the ambiguous stimuli, and the underlying assumption is that when individuals are presented with ambiguous, unstructured stimuli, they will 'project' their unconscious fears, desires, conflicts, and personality dynamics onto the stimulus.

One of the most well-known projective techniques is the *Rorschach Inkblot Test*, in which individuals describe what they perceive in a series of inkblots. Another widely used projective test is the *Thematic Apperception Test* (TAT), where individuals are required to create stories on ambiguous figures. The themes, emotions, and relationships reflected in these stories are examined to understand aspects of personality and motivation.

Projective tests can provide rich qualitative information and may reveal dimensions of experience that are not easily captured through structured questionnaires. However, their interpretation often depends heavily on the examiner's training and expertise. As a result, concerns have been raised regarding their reliability and consistency when compared with objective measures. And, in contemporary practice, objective tests are used more frequently because of their stronger psychometric foundations. Nevertheless, projective techniques continue to be employed in certain clinical settings, particularly as supplementary tools that contribute to a broader understanding of the individual.

Table 1.2.3 Objective Tests

Objective Test/ Instrument	Primary Purpose	Application
Minnesota Multiphasic Personality Inventory (MMPI)	Assessment of personality characteristics and psychopathological symptoms	Used in clinical assessment to evaluate patterns of psychological symptoms and personality functioning, and to inform diagnosis and treatment planning in ambiguous clinical pictures
NEO Personality Inventory (NEO-PI-3)	Assessment of the major dimensions of personality (Five-Factor Model)	Used in clinical settings to obtain a structured profile of personality characteristics that aids case formulation and therapy planning
Beck Depression Inventory (BDI)	Assessment of depressive symptoms	Used to assess the severity of depressive symptoms and to monitor changes over the course of treatment
Beck Anxiety Inventory (BAI)	Assessment of anxiety symptoms	Used to assess the severity of anxiety symptoms in clinical settings and to track response to intervention
Rosenberg Self-Esteem Scale (RSES)	Assessment of self-esteem	Used in clinical practice to assess an individual's overall self-worth as part of case formulation and outcome monitoring



Fig. 1.2.4 Rorschach Inkblot Test Cards

Table 1.2.4 Projective Tests

Projective Test	Description	Application
Rorschach Inkblot Test	Uses a series of inkblot stimuli to elicit responses that are interpreted using a systematic scoring and interpretation framework	May be used as part of a comprehensive assessment to explore aspects of personality functioning, perception, and thought processes when evaluating complex psychological presentations
Thematic Apperception Test (TAT)	Presents ambiguous pictures and asks the individual to construct stories about them	May be used to explore recurring themes in interpersonal relationships, emotional conflicts, needs, and perceptions of significant others when these areas are relevant to the clinical assessment and case formulation
Children's Apperception Test (CAT)	Uses pictures depicting children or animals and asks the child to construct stories about them	May be used with children to explore their perceptions of family relationships, interpersonal experiences, and emotional concerns that may be difficult for them to express directly
House-Tree-Person (HTP)	Involves drawing a house, tree, and person, followed by discussion and interpretation of the drawings	May be used as an exploratory technique with children or adults to generate hypotheses about emotional or interpersonal concerns that can be examined further through interview and other assessment methods

Recap

- ◆ Classification systems systematically group mental disorders based on shared clinical features.
- ◆ A shared classification system ensures clinicians use a standardised language for communication and treatment.
- ◆ Two major diagnostic systems currently in use: DSM and ICD.
- ◆ The DSM is published by the American Psychiatric Association (APA).
- ◆ The DSM focuses exclusively on mental, behavioural, and neurodevelopmental disorders.
- ◆ The DSM utilises operational definitions, providing specific symptom checklists and duration criteria.
- ◆ The DSM emphasises categorical and descriptive approaches over theoretical causes.
- ◆ The ICD is developed and maintained by the World Health Organisation (WHO).
- ◆ The ICD covers all health conditions, including a dedicated chapter for mental disorders.
- ◆ The ICD is designed with a broad public health focus for tracking global disease prevalence.
- ◆ The ICD traditionally relies more on clinical descriptions and guidelines, offering clinicians flexibility.
- ◆ The DSM's detailed criteria enhance diagnostic reliability, making it preferable for research.
- ◆ The ICD's global applicability makes it the official diagnostic system for many countries.
- ◆ The DSM is often used in clinical assessment to guide diagnostic decision-making.
- ◆ The ICD is widely used by governments and health agencies for administration and health statistics.
- ◆ Diagnostic assessment involves a systematic evaluation of an individual's psychological functioning.

- ◆ Assessment is a multi-method process, combining interviews, observations, and testing.
- ◆ A clinical interview gathers subjective information about an individual's symptoms and history.
- ◆ Behavioural observation systematically evaluates an individual's expressions and interactions.
- ◆ Case history places current problems in a developmental context.
- ◆ Medical and neurological exam rules out physical causes.
- ◆ Collateral information comes from family, teachers or records.
- ◆ Objective psychological tests follow standardised administration and clearly defined scoring procedures.
- ◆ The MMPI is a widely known example of an objective personality test.
- ◆ Projective tests present ambiguous stimuli to reveal hidden emotions and conflicts.
- ◆ The Rorschach Inkblot Test and the Thematic Apperception Test (TAT) are classic examples of projective tests.
- ◆ Objective tests offer high reliability, while projective tests often depend heavily on examiner expertise.

Objective Questions

1. What term describes the systematic grouping of mental disorders based on shared features?
2. Which organisation publishes the Diagnostic and Statistical Manual of Mental Disorders?
3. What is the current edition of the DSM?
4. Which classification system is developed by the World Health Organisation?
5. Which classification system covers all global health conditions, not just mental disorders?
6. Which manual is generally preferred by researchers due to its detailed criteria, enhancing consistency?

7. Which system is the official diagnostic standard for many governments and healthcare administrations?
8. What term describes the likelihood that two independent researchers arrive at the exact diagnosis?
9. Which diagnostic system is typically preferred when clinicians face linguistic barriers?
10. What does DSM ensure in research participant selection?
11. What does ICD help track at the population level?
12. What process involves a systematic evaluation of psychological, behavioural, and emotional functioning?
13. What specific assessment technique involves a structured or unstructured conversation?
14. What assessment technique systematically watches an individual's appearance and interpersonal interactions?
15. What assessment method collects developmental history, family circumstances, and medical conditions?
16. What assessment technique uses standardised instruments to evaluate psychological state?
17. What type of assessment identifies physical conditions that may contribute to psychological symptoms?
18. Information obtained from family members or teachers is referred to as what type of information?
19. What category of psychological tests follows standardised administration and predefined scoring rules?
20. Name a widely known objective test used to assess personality characteristics.
21. What category of tests presents individuals with ambiguous visual stimuli?
22. The theoretical roots of projective tests are found in which psychological theory?
23. What well-known projective technique uses inkblots?
24. What well-known projective test requires individuals to create stories about ambiguous figures?
25. Which type of psychological test offers higher reliability and stronger psychometric foundations?

Answers

1. Classification
2. American Psychiatric Association (APA)
3. DSM-5-TR
4. WHO
5. ICD
6. DSM
7. ICD
8. Inter-rater reliability
9. ICD
10. Homogeneity
11. Prevalence
12. Diagnostic assessment
13. Clinical interview
14. Behavioural observation
15. Case-history method
16. Psychological testing
17. Medical/Neurological
18. Collateral
19. Objective
20. MMPI
21. Projective
22. Psychoanalytic
23. Rorschach
24. TAT
25. Objective

Assignments

1. Explain why classification is foundational to clinical psychology. Illustrate what happens to communication, treatment and research without a shared system.
2. Compare DSM and ICD with respect to structure, purpose, and application.
3. Explain the concept of operational definitions as used in the DSM. Why are specific, observable criteria essential for diagnostic consistency and inter-rater reliability? Discuss how operational definitions improve clinical practice and research methodology compared to purely theoretical approaches.
4. Explain why mental health professionals use a multi-method diagnostic assessment approach rather than relying on a single technique. Describe each major assessment method discussed in the unit, and explain how they contribute to a comprehensive diagnostic understanding.
5. In diagnostic assessment, mental health professionals gather both subjective symptoms and objective signs. Define these concepts and explain why both are necessary for accurate diagnosis. What unique information does each provide?
6. Provide a comprehensive comparison of objective and projective psychological tests. Discuss their theoretical foundations, administration, scoring, advantages, and limitations.

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SGOU



BLOCK

Etiology and Theoretical Perspectives



UNIT

Etiology of Mental Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ◆ discuss the concept of etiology of mental disorders in terms of predisposing, precipitating, and perpetuating factors
- ◆ describe the biological perspective on the etiology of mental disorders, focusing on genetic and neurobiological factors
- ◆ explain the psychological perspective on the etiology of mental disorders, with reference to trauma, stress, and personality traits
- ◆ analyse the environmental perspective on the etiology of mental disorders, including childhood experiences, socio-economic status, and cultural influences

Prerequisite

Given are three scenarios. Read them and pause. Note down the explanation that you reach for first.

Scenario I

Two sisters who are raised under the same roof, shaped by years of financial strain and frequent parental conflict. In her late twenties, one sister begins treatment for recurrent depression. The other remembers the same home as difficult, but has not been clinically diagnosed with a disorder.

Now, if it is their early environment that caused the depression, why not both? What would you need to understand beyond the shared history to account for the difference?

Scenario II

Two colleagues, both in their mid-thirties and working at the same company with comparable savings, lost their jobs due to downsizing. In two months, one developed persistent worry, sleeplessness, and panic that started affecting daily functioning. The other grieved, but found freelance work, and gradually returned to previous functioning.

Now, is the job loss sufficient as a cause? What might turn an identical external event into a clinical condition for one and a recoverable setback for the other?

Scenario III

A young adult who had grown up in a supportive and stable environment, with no known history of trauma, major conflict, or significant adversity, experienced their first panic attack during the final year of university, followed by several more over time.

Now, in the apparent absence of a visible hardship or an environmental stressor, is biology alone sufficient to explain the distress? Might there also be unrecognised vulnerabilities, sensitivities to stress, fears carried silently, or inner struggles that remained unnoticed beneath and had never fully surfaced before?

Before we begin the unit, note for yourself:

- i. The first cause you named in each - a present event, a history, or biology.
- ii. The moment you hesitated, because a single cause felt inadequate.
- iii. One real-life example you have seen where the same situation led two people in different directions.

That hesitation is the entry point. The unit will move you from reaching for isolated causes to tracing interactions, where the etiology (the study of the causes and contributing factors responsible for the development of a disorder, disease, or a condition) for mental disorders is never merely an external fact, but a subjective experience filtered through a person's biology, cognition, emotion, and context.

Keywords

Gene-Environment Interaction, Polygenic, Neurotransmitter, Amygdala, Trauma, Attachment, Expressed Emotion (EE), Downward Drift

Discussion

2.1.1. Causes

When we ask why something happened, we often assume that the answer lies in identifying its cause. Yet causes are rarely as straightforward as they appear. A tree does not fall simply because of the storm that finally brought it down. Its fall may also reflect years of gradual weakening, hidden damage within the trunk, or environmental conditions that reduced its ability to withstand stress. The storm is important, but it is only one part of the story.

Understanding the etiology of mental disorders requires a similar perspective. Psychological distress is rarely the result of a single, isolated event. The factors associated with the development of a disorder may not all contribute in the same way or at the same point in time. Some factors increase an individual's vulnerability to psychological difficulties, others contribute to the onset of symptoms, and some contribute to the persistence of the disorder. To understand these different roles, psychologists commonly classify causes into three broad categories: predisposing factors, precipitating factors, and perpetuating factors.

a. Predisposing Factor

A predisposing factor is any condition, trait, or historical event often present from birth or developed early in life that increases an individual's susceptibility to a mental disorder. They are antecedent influences that precede the onset of symptoms and contribute to a heightened state of susceptibility. While these factors do not directly produce psychopathology, they may create a foundation upon which later psychological difficulties become more likely to emerge.

The significance of predisposing factors lies in their ability to shape an individual's capacity to respond to life experiences and environmental demands. Such vulnerabilities may be biological, psychological, or environmental in nature. For instance, genetic predispositions, neurodevelopmental variations, and temperamental characteristics may influence the way an individual experiences and regulates emotions. Or, environmental experiences, particularly those occurring during critical developmental periods, may also contribute to vulnerability by shaping patterns of attachment, self-concept, emotional regulation, and interpersonal functioning.

Importantly, predisposing factors are not equivalent to deterministic causes. The presence of a vulnerability does not guarantee the development of a mental disorder, just as the absence of an identifiable vulnerability does not ensure psychological well-being. Rather, these factors best explain the increased probability that psychological difficulties may arise under particular circumstances. Their influence is therefore probabilistic rather than absolute.

The concept of predisposing factors reflects an important principle in contemporary psychopathology: risk is often cumulative. Multiple vulnerabilities may coexist and interact over time, producing greater susceptibility than any single factor alone. Consequently, psychologists view the development of mental disorders not as the inevitable outcome of one vulnerability, but as the result of complex interactions among biological, psychological, and environmental influences operating across the lifespan. And, therefore, understanding predisposing factors is important not only for explaining

the origins of mental disorders but also for identifying individuals who may be at increased risk.

b. Precipitating Factor

A precipitating factor is an event, circumstance, or experience that contributes to the onset of a mental disorder or triggers the emergence of symptoms. Unlike predisposing factors, which create a state of vulnerability, precipitating factors are more closely associated with the timing of symptom development. They often represent the immediate conditions under which an underlying vulnerability becomes expressed as psychological distress or dysfunction.

Precipitating factors can take many forms and may be biological, psychological, or environmental. Examples include the loss of a significant relationship, academic or occupational stress, exposure to a traumatic event, serious physical illness, major life transitions, or substantial changes in social circumstances. In some instances, precipitating influences may also involve internal psychological experiences, such as persistent negative thinking, unresolved emotional conflicts, or periods of intense stress. Although these events are often identifiable, their impact varies considerably across individuals.

The concept of precipitating factors highlights an important principle in psychopathology: the same event does not affect all individuals in the same way. An experience that triggers significant psychological distress in one person may be experienced as manageable by another. This variation reflects differences in biological characteristics, psychological resources, coping abilities, prior experiences, and available social support. Consequently, precipitating factors are best understood within the broader context of the individual's existing vulnerabilities and strengths.

Importantly, precipitating factors should not be regarded as the sole cause of a mental disorder. Their significance often lies less in the event itself than in the interaction between the event and the individual's predispositions. Thus, contemporary approaches to psychopathology view precipitating factors as catalysts that contribute to the emergence of symptoms rather than as independent causes operating in isolation.

c. Perpetuating Factors

While predisposing factors increase vulnerability and precipitating factors contribute to symptom onset, neither necessarily explains why a disorder continues over time. Many mental disorders persist long after the initial trigger has disappeared. This persistence draws attention to the role of perpetuating factors, the influences that maintain psychological distress, interfere with recovery, or contribute to the continuation of symptoms.

Perpetuating factors may arise from a wide range of biological, psychological, and environmental processes. In some cases, the symptoms of a disorder themselves become part of the problem. For example, persistent anxiety may lead an individual to avoid feared situations, providing temporary relief but preventing opportunities to challenge unrealistic fears. Similarly, depression may result in social withdrawal, reduced activity, and diminished access to positive experiences, all of which can further reinforce depressive symptoms. In this way, patterns that initially develop as responses to distress may gradually become mechanisms that sustain it.

Perpetuating influences are not limited to individual behaviour. Family dynamics, social isolation, ongoing financial difficulties, chronic stress, stigma, or limited access to mental health services may also contribute to the maintenance of psychological disorders. In some instances, the environment may



inadvertently reinforce maladaptive patterns by encouraging dependency, avoidance, or other behaviours that reduce immediate discomfort while prolonging long-term difficulties.

The concept of perpetuating factors highlights the dynamic nature of psychopathology. Mental disorders are not static conditions that emerge from a single cause; rather, they are often

maintained through ongoing interactions between the individual and the environment. Consequently, understanding why a disorder persists is just as important as understanding why it developed in the first place. The identification of perpetuating factors is therefore a central focus of psychological assessment and intervention, as reducing or modifying these influences can play a crucial role in promoting recovery and preventing relapse.

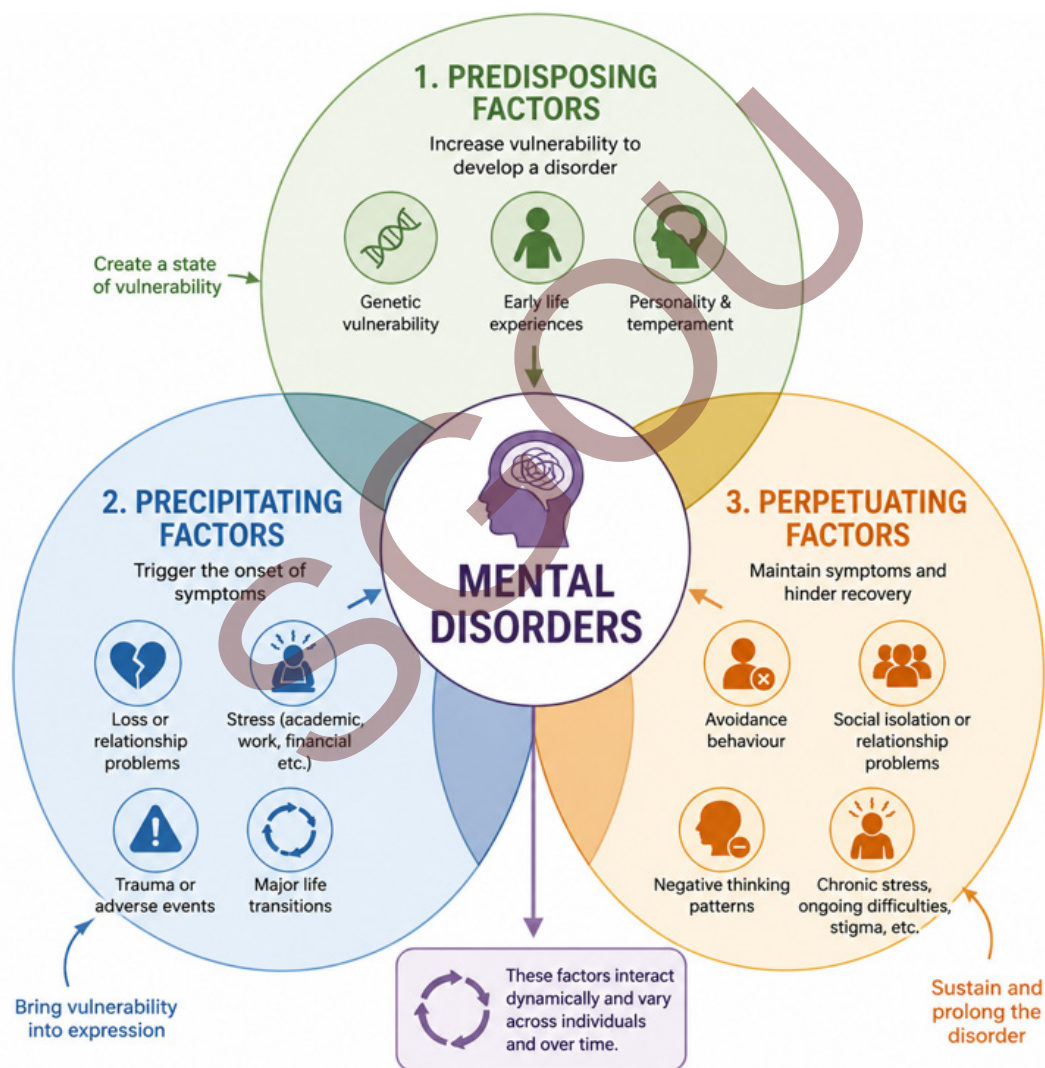


Fig. 2.1.1 Classification of the Causes of Mental Disorders (AI-Generated)

2.1.2. Biological Factors

Why do some individuals appear more vulnerable to certain psychological difficulties than others, even when they are exposed to similar life experiences? Why do mental disorders sometimes cluster within families? And why might two individuals respond differently to the same stressful event despite sharing comparable social and environmental circumstances?

Questions such as these have led psychologists and researchers to examine the role of biological factors in the development of mental disorders. Biological explanations focus on how inherited characteristics, brain structure and function, neurochemical processes, and other physiological mechanisms may influence thoughts, emotions, and behaviour. Rather than viewing mental disorders solely as reactions to life events or environmental conditions, biological perspectives emphasise the role of processes occurring within the body and nervous system.

Contemporary approaches to psychopathology recognise that biological influences rarely operate in isolation. Instead, they interact continuously with psychological experiences and environmental conditions across the lifespan. Nevertheless, an understanding of biological factors remains essential because it provides important insights into why certain individuals may be more susceptible to particular disorders and how disruptions in normal biological functioning can contribute to psychological distress.

Among the many biological influences studied, two areas have received particular attention: *genetics*, which examines inherited vulnerabilities, and *neurobiology*, which explores the role of the brain and nervous system in the development and persistence of mental disorders.

a. Genetics

One of the most extensively studied biological influences on mental disorders is genetics. Genetics refers to the study of heredity and the transmission of characteristics from one generation to the next through genes. Evidence for genetic influences comes from family, twin, and adoption studies. Family studies consistently demonstrate that individuals who have close biological relatives with a mental disorder are at a greater risk of developing the same or a related condition. Twin studies provide further support by comparing the rates at which identical and fraternal twins share particular disorders. Because identical twins share all their genetic material, whereas fraternal twins share only about half, higher rates of similarity among identical twins suggest genetic involvement. Adoption studies also provide valuable evidence by examining individuals raised apart from their biological relatives, allowing researchers to distinguish genetic influences from environmental ones.

Despite substantial evidence for genetic involvement, mental disorders are rarely inherited in a simple or predictable manner. Unlike certain physical conditions that may result from a single gene, most psychological disorders are considered polygenic, meaning that they are influenced by the combined effects of multiple genes. Each gene may contribute only a small amount to overall risk, but together they can increase an individual's vulnerability to developing a disorder.

However, the presence of a genetic predisposition does not guarantee the development of a mental disorder. Genetic influences are best understood as conferring susceptibility rather than determining outcomes. Many individuals who possess a genetic vulnerability never develop a disorder, while others with no known family history may experience



significant psychological difficulties. This observation highlights the importance of gene–environment interaction, a concept referring to the dynamic relationship between genetic predispositions and environmental experiences. Genetic vulnerabilities may increase sensitivity to certain environmental conditions, while environmental factors may influence whether and how genetic potentials are expressed.

Contemporary research, therefore, views genetics as one component of the broader biopsychosocial framework. Rather than acting as an isolated cause, genetic factors interact with neurobiological processes, psychological characteristics, and environmental experiences throughout development. Understanding these interactions has enhanced knowledge of the etiology of mental disorders and contributed to more sophisticated approaches to prevention, assessment, and treatment.

b. Neurobiology

Neurobiology examines how the structure and functioning of the brain and nervous system contribute to mental disorders. The brain regulates thoughts, emotions, perceptions, and behaviour through the activity of interconnected neurons that communicate using chemical messengers known as neurotransmitters. Disruptions in these communication processes have been associated with various forms of psychopathology. For example, alterations in neurotransmitter systems involving serotonin, dopamine, and norepinephrine have been linked to disorders such as depression, anxiety disorders, schizophrenia, and bipolar disorder.

Research has also identified differences in the functioning of specific brain regions among individuals experiencing mental disorders. Areas involved in emotional regulation, memory, decision-making, and stress responses may function differently in certain conditions, contributing to characteristic patterns of thought and behaviour. For instance, in individuals with chronic post-traumatic stress disorder (PTSD), imaging studies often show an overactive amygdala paired with an underactive prefrontal cortex, which is the area responsible for logical reasoning and calming down emotional impulses.

Biological influences on psychological functioning may also arise from structural or neurological conditions that affect the brain. Conditions such as brain tumours, traumatic brain injury, epilepsy, and other neurological disorders may produce changes in cognition, emotion, perception, or behaviour. These conditions demonstrate that psychological and behavioural changes may sometimes be associated with identifiable disturbances in the structure or functioning of the nervous system.

Contemporary perspectives emphasise that neurobiological factors do not operate independently of experience. Brain functioning is shaped by ongoing interactions with environmental influences, life experiences, and psychological processes, highlighting the complex relationship between biology and behaviour.

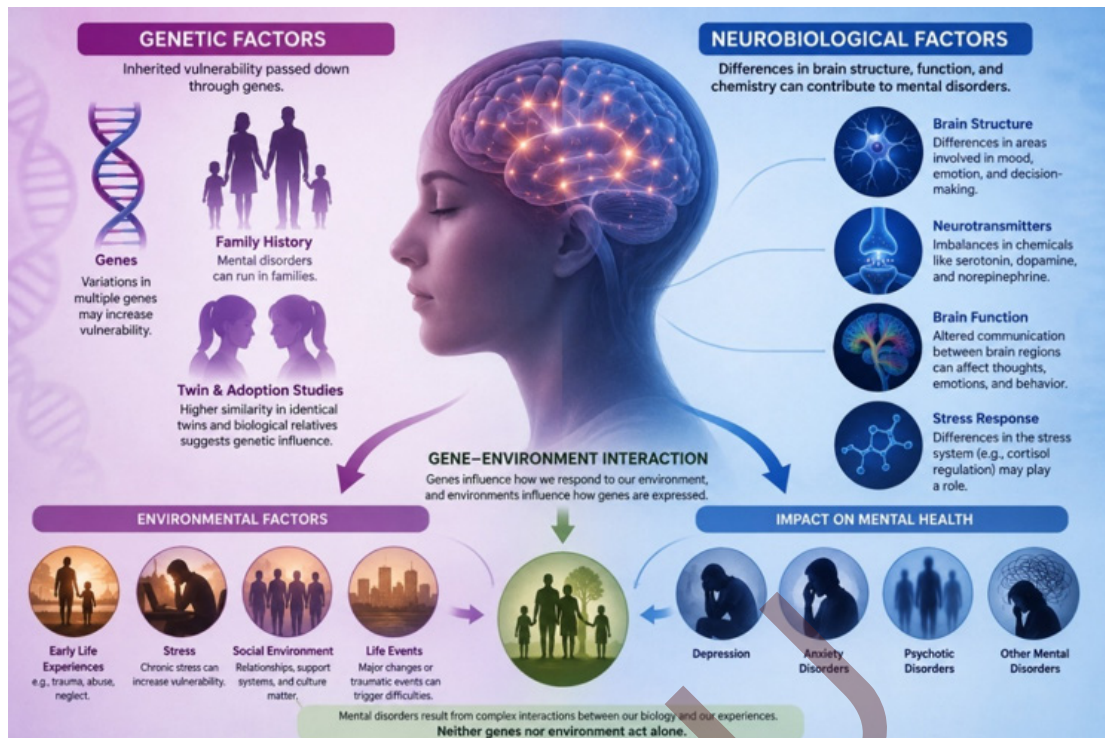


Fig. 2.1.2 Biological Factors and Mental Disorders (AI-Generated)

2.1.3 Psychological Factors

While biological factors help explain an individual's inherited vulnerabilities and neurophysiological functioning, they do not fully account for how people experience, interpret, and respond to the world around them. An individual's psychological functioning is shaped not only by what happens to them, but also by how those experiences are perceived, understood, and integrated into their sense of self. Two individuals may encounter similar circumstances and yet differ considerably in their emotional reactions, coping strategies, and psychological outcomes. Such differences highlight the importance of psychological factors in understanding the etiology of mental disorders.

Psychological factors refer to the internal processes and characteristics that influence thoughts, emotions, and behaviour. They shape how individuals perceive life events, regulate emotional experiences, cope with challenges, and relate to others. Among

the many psychological influences that have been associated with mental health and psychopathology, trauma, stress, and personality traits have received particular attention.

a. Trauma

Trauma refers to experiences that are perceived as intensely threatening, distressing, or overwhelming, that it shatters one's fundamental sense of safety, predictability, and control. Such experiences may include abuse, violence, accidents, natural disasters, severe loss, or exposure to other highly adverse events. Trauma plays a complex role in etiology because it can act as both a predisposing factor and a precipitating one, depending on when it occurs:

- ◆ Acute trauma in adulthood involving a severe event, such as a car accident or a violent assault, often acts as an immediate precipitating trigger for conditions like Post-Traumatic Stress Disorder (PTSD)
- ◆ Childhood trauma, which refers to trauma that occurs early in life (such

as abuse or severe neglect), may become a predisposing factor

While many individuals recover from traumatic experiences over time, trauma can sometimes produce enduring psychological effects that influence emotional regulation, self-perception, interpersonal relationships, and perceptions of safety. Consequently, traumatic experiences are recognised as important risk factors in the development of a range of mental disorders, particularly when they occur during sensitive developmental periods or remain unresolved.

b. Stress

Stress refers to the psychological and physiological responses that arise when individuals perceive that the demands of a situation exceed their ability to cope. Although stress is a normal aspect of life and may, at moderate levels, facilitate adaptation and performance, prolonged or excessive stress can adversely affect mental health. Chronic exposure to stress has been associated with disturbances in emotional functioning, cognitive processes, and physiological regulation, thereby increasing vulnerability to psychological disorders. The impact of stress depends not only on the nature of the stressor but also on the

To explain how stress interacts with vulnerability, clinical psychology relies on the ***Diathesis-Stress Model***. According to this model, mental disorder develops when an underlying diathesis (vulnerability or predisposition) is combined with a sufficient amount of stress.

individual's appraisal of the situation and the available coping resources.

c. Personality Traits

Personality traits are relatively stable patterns of thinking, feeling, and behaving that distinguish one individual from another. These traits influence how people perceive themselves, relate to others, respond to challenges, and regulate their emotions. Although personality traits are not inherently pathological, certain characteristics may increase vulnerability to specific forms of psychological distress. For example, individuals who display high levels of emotional instability, perfectionism, or sensitivity to criticism may be more susceptible to particular mental health difficulties under conditions of stress. Personality traits are therefore considered

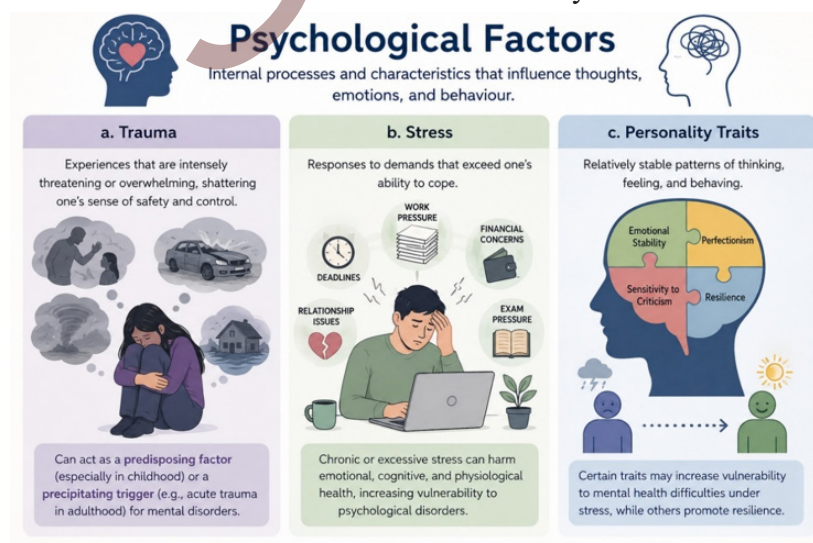


Fig. 2.1.3 Psychological Factors Influencing Mental Health (AI-Generated)

important psychological factors that shape both risk and resilience in relation to mental disorders.

2.1.4 Environmental Factors

When studying mental health, it is typical to focus exclusively on the individual. We examine a person's biological makeup, their genetic history, and their internal thought patterns. However, human beings do not develop in isolation. Long before personal choices begin to shape development, individuals are born into families and live in specific economic conditions, communities, social circumstances, and cultural traditions that influence how they understand themselves and the world around them. These environments provide the contexts in which beliefs form, relationships are established, opportunities are accessed, and challenges are encountered.

Therefore, from an etiological perspective, mental disorders cannot be understood solely by examining biological vulnerabilities or psychological processes within the individual. It is equally important to consider the environments in which development occurs. The quality of early experiences, the social and economic conditions of daily life, and the cultural frameworks that shape values, expectations, and behaviour can all influence psychological well-being. Consequently, environmental factors constitute an important component of contemporary explanations of psychopathology. Among the most widely studied environmental influences are childhood experiences, socio-economic status, and cultural influences.

a. Childhood Experiences

Childhood constitutes a critical period in psychological development, during which individuals acquire patterns of emotional regulation, interpersonal relating, and self-understanding. Consequently, the family environment often serves as the immediate

context within which vulnerabilities or protective factors emerge. When childhood environments are characterised by stability, responsiveness, and emotional support, they can foster resilience and psychological well-being. Conversely, chronic instability, neglect, abuse, or persistent family conflict may increase susceptibility to later psychological difficulties.

The quality and consistency of early caregiving relationships may also influence the development of attachment patterns. Attachment theory, particularly the work of John Bowlby and Mary Ainsworth, proposes that early interactions with caregivers contribute to an individual's expectations about relationships, safety, and the availability of support. Consistent and responsive caregiving is generally associated with secure attachment, whereas inconsistent, unresponsive, or disrupted caregiving may contribute to insecure attachment patterns. Such patterns have been associated with increased vulnerability to anxiety, depression, and interpersonal difficulties later in life.

Researchers have also examined the broader emotional climate of families through the concept of Expressed Emotion (EE). Families characterised by persistent criticism, hostility, or excessive emotional involvement are described as high in expressed emotion. High EE has been associated with poorer outcomes and increased relapse rates among individuals with disorders such as schizophrenia and bipolar disorder, illustrating how family environments may function not only as predisposing factors but also as perpetuating influences.

b. Socio-Economic Status

Socio-economic status (SES) is a multidimensional construct used to quantify an individual's, family's, or group's social and economic position relative to others within a hierarchical social structure. In psychological and sociological research, SES is typically



operationalised and assessed through a combination of three primary intersecting variables, such as educational attainment, income and wealth, and occupational status. A substantial body of research has demonstrated a relationship between socio-economic disadvantage and an increased prevalence of mental health distress. Individuals living in economically disadvantaged circumstances are often exposed to chronic stressors, including financial insecurity, inadequate housing, limited educational opportunities, and reduced access to healthcare and social support.

Two major explanations have been proposed to account for this relationship.

- i. **The Social Causation Hypothesis:** This model argues that the chronic stress of poverty directly contributes to the development of mental disorders. Individuals in low-SES environments face constant external stressors, such as

food insecurity and poor housing, and have fewer resources to cope with them. Over time, this chronic stress depletes psychological resilience, acting as both a predisposing and precipitating factor.

- ii. **The Downward Drift Hypothesis:** This model suggests the reverse sequence. It argues that severe mental disorders may impair an individual's ability to maintain employment, social relationships, and independent functioning, resulting in a decline in socio-economic status over time.

Contemporary perspectives, however, recognise that both processes may operate simultaneously. Socio-economic disadvantage can increase vulnerability to mental disorder, while mental disorder can further intensify economic hardship, creating a self-perpetuating cycle of disadvantage and psychological distress.



Fig. 2.1.4 Environmental Factors and Mental Health (AI-Generated)

Recap

- ◆ Mental disorder etiology is multifactorial and complex, reflecting interactions among biological, psychological, and environmental influences.
- ◆ Causes are classified into three categories: predisposing factors, precipitating factors, and perpetuating factors.
- ◆ Disposing factors are antecedent influences present early in life, creating a heightened susceptibility to disorders.
- ◆ Predisposing factors may be biological, psychological, or environmental in nature, affecting emotional regulation and functioning.
- ◆ Predisposing factors are cumulative and interactive; multiple vulnerabilities together increase susceptibility more than single factors.
- ◆ Precipitating factors are events or experiences contributing to symptom onset, closely associated with the timing of psychological distress.
- ◆ Precipitating factors function as catalysts interacting with predispositions rather than independent causes of mental disorder.
- ◆ Perpetuating factors maintain psychological distress and interfere with recovery even long after initial triggers disappear.
- ◆ Family dynamics, social isolation, stigma, and limited healthcare access function as environmental perpetuating influences.
- ◆ Genetics influences mental disorders through inherited vulnerabilities studied *via* family, twin, and adoption research designs.
- ◆ Most mental disorders are polygenic, involving multiple genes with small cumulative effects rather than single-gene inheritance.
- ◆ Genetic predisposition confers susceptibility rather than determining disorder outcomes; gene-environment interactions are critical.
- ◆ Neurobiology examines brain structure and function; disruptions in neurotransmitter systems (serotonin, dopamine, norepinephrine) affect psychopathology.
- ◆ Brain functioning is shaped by ongoing interactions with experience and environment, not operating independently of psychological processes.
- ◆ Trauma refers to intensely threatening experiences shattering a fundamental sense of safety, predictability, and control.

- ◆ Stress results from perceiving that situational demands exceed coping ability; chronic excessive stress increases vulnerability to disorders.
- ◆ Personality traits are stable patterns influencing self-perception, relationships, and emotion regulation; certain traits increase disorder vulnerability.
- ◆ Attachment theory shows that early caregiver relationship quality shapes expectations about self, others, and relationships throughout life.
- ◆ Expressed Emotion (EE) reflects family emotional climate; high criticism, hostility, or involvement predicts worse outcomes and relapse.
- ◆ The Social Causation Hypothesis argues that the stress of poverty directly contributes to mental disorders.
- ◆ The Downward Drift Hypothesis suggests that severe mental disorders cause a decline in socio-economic status.

Objective Questions

1. What term describes the study of the causes or origins of mental disorders?
2. Which category of factors increases an individual's susceptibility to a mental disorder?
3. Are predisposing factors absolute or probabilistic in their influence?
4. What category of factors triggers the immediate emergence of symptoms?
5. Which factors interfere with recovery and maintain psychological distress over time?
6. What field examines inherited vulnerabilities transmitted from one generation to the next?
7. What type of studies compares individuals raised apart from their biological relatives?
8. What term describes psychological disorders influenced by the combined effects of multiple genes?
9. What concept refers to the dynamic relationship between genetic predispositions and life experiences?

10. What field examines how brain structure and nervous system functioning contribute to disorders?
11. What are the chemical messengers used by neurons to communicate?
12. Imaging studies of PTSD often show an underactive prefrontal cortex and an overactive what?
13. What term describes experiences perceived as intensely threatening that shatter the sense of safety?
14. Does acute trauma in adulthood usually act as a predisposing or precipitating factor?
15. What state arises when perceived situational demands exceed an individual's ability to cope?
16. What term describes relatively stable patterns of thinking, feeling, and behaving?
17. What influential concept describes the quality of the early relationship between a child and primary caregiver?
18. What term describes families characterised by persistent criticism or hostility?
19. High Expressed Emotion is associated with increased relapse rates in bipolar disorder, and what other disorder?
20. What hypothesis argues that the chronic stress of poverty directly contributes to mental disorders?
21. What hypothesis argues that severe mental disorders impair functioning, resulting in a status decline?

Answers

1. Etiology
2. Predisposing
3. Probabilistic
4. Precipitating



5. Perpetuating
6. Genetics
7. Adoption
8. Polygenic
9. Gene-environment
10. Neurobiology
11. Neurotransmitters
12. Amygdala
13. Trauma
14. Precipitating
15. Stress
16. Personality
17. Attachment
18. Expressed Emotion
19. Schizophrenia
20. Social Causation
21. Downward Drift

Assignments

1. Explain why understanding mental disorder etiology requires a multi-factorial approach rather than searching for single causes. Discuss the roles of predisposing, precipitating, and perpetuating factors. How do these three categories interact to explain why the same event triggers disorder in some people but not others?
2. Analyse how symptoms themselves become perpetuating factors. Use anxiety-related avoidance and depression-related social withdrawal to discuss.
3. Explain the concept of gene-environment interaction and its significance within the broader biopsychosocial framework.
4. Compare and contrast trauma as a predisposing factor in childhood versus a precipitating factor in adulthood, with reference to attachment and safety.

5. Examine the influence of childhood family environments on psychological development, specifically referring to attachment theory and Expressed Emotion (EE).
6. Compare and contrast the Social Causation Hypothesis and Downward Drift Hypothesis in explaining the SES-mental health relationship. What evidence supports each model? Why does contemporary psychology recognise that both processes may operate simultaneously? What policy implications follow from this understanding in the Indian context?

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UNIT

Theoretical Perspectives

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ◆ describe major theoretical perspectives on mental disorders
- ◆ explain the key assumptions and concepts underlying each theoretical perspective
- ◆ compare and contrast different theoretical perspectives in terms of their explanations of mental disorders
- ◆ evaluate the strengths and limitations of major theoretical perspectives in understanding mental disorders

Prerequisite

A person has stopped leaving their room for weeks after becoming convinced that ordinary conversations, passing glances, and even small everyday events carry hidden messages directed specifically at harming them. One family member believes the person has become spiritually weak and requires spiritual intervention. A physician suspects changes in brain functioning and recommends medical treatment. A close friend thinks the behaviour began after years of humiliation, loneliness, and emotional neglect. Another person insists that modern society itself, with its pressures, isolation, and constant comparison, is what has broken them down. Faced with the same person and the same behaviour, why do others arrive at such different explanations? Is psychological distress something located within the brain, within the mind, within relationships, or within the social world? And, depending on the explanation we accept, would the response to the person also change?

Now, consider another possibility: what if no single explanation is ever fully sufficient? Human beings are biological organisms, but they are also shaped by thoughts, memories, emotions, relationships, culture, and lived experiences. Can one perspective alone truly capture the complexity of psychological disorders? Or does every explanation illuminate only one part of a much larger reality while leaving other dimensions in shadow? As you begin this unit, reflect on how different ways of understanding mental disorders emerge from different assumptions about the human itself. The questions you ask about the origins of mental disorders may even shape the very way you understand the mental, the person, and the meaning of the disorder.

Keywords

Psychopharmacology, Unconscious Processes, Defence Mechanisms, Conditioning, Cognitive Distortions, Core Schemas, Self-Actualisation, Incongruence, Conditions of Worth

Discussion

Attempts to understand psychological disorders have evolved alongside broader changes in scientific knowledge and cultural beliefs. As understanding of human behaviour expanded, it became increasingly evident that psychological disorders cannot be reduced to a single cause or explained through a single perspective. A complex interplay of biological processes, psychological experiences, interpersonal relationships, and sociocultural contexts shapes human functioning. Consequently, different schools of thought emerged, each emphasising particular aspects of this complexity and offering distinct explanations for the development of psychopathology.

These explanations are organised into theoretical perspectives, which are conceptual frameworks that guide the interpretation of abnormal behaviour. A theoretical perspective not only proposes why psychological disorders develop but also influences how they are assessed, researched, and treated. The assumptions underlying a particular

perspective determine which factors are considered important, which questions are asked, and which forms of intervention are regarded as most effective. And, together, they provide a more comprehensive understanding of psychological disorders than any single explanation could offer in isolation.

2.2.1. Biological Perspective

The biological perspective views psychological disorders not as behavioural deviations or abstract mental states, but as illnesses with underlying genetic, physiological or biochemical causes. Just as a physician would examine the lungs to treat asthma, a biological psychologist looks to the brain, genetics, and bodily systems to understand mental disorders.

Core Assumptions

- ◆ A fundamental assumption of this perspective is that thoughts, emotions, and behaviours originate in the functioning of the brain and nervous system.



Consequently, disruptions in normal biological functioning may contribute to the development of psychological symptoms.

- ◆ Grounded on the evidence from the family, twin, and adoption studies, the biological perspective proposes that genetic predispositions influence an individual's susceptibility to certain mental disorders. Evidence from these studies indicates that disorders such as schizophrenia, bipolar disorder, and major depressive disorder show increased prevalence among biologically related individuals.
- ◆ Alterations in neurotransmitter activity, including abnormalities in their levels, regulation, or receptor functioning, are associated with various psychological disorders. For example, disturbances in serotonin have been linked to depression, while dysregulation of dopamine has been associated with schizophrenia and certain mood disorders.
- ◆ The biological perspective emphasises the role of the brain in regulating emotions, cognition, and behaviour. Research using neuroimaging techniques has identified abnormalities in regions such as the prefrontal cortex, amygdala, and hippocampus in individuals experiencing disorders including depression, anxiety disorders, post-traumatic stress disorder, and schizophrenia.
- ◆ Biological theorists also recognise the influence of hormones, immune functioning, and other physiological systems on psychological well-being. For example, prolonged activation of the body's stress-response system and excessive levels of cortisol have been associated with increased vulnerability to depression and anxiety disorders. Similarly, prenatal influences, inflammation, and physical health conditions were also found to affect psychological functioning.

Strengths

One major strength of the biological perspective is its strong foundation in scientific research and empirical investigation. Advances in fields such as genetics, neuroscience, neurochemistry, and psychopharmacology have significantly enhanced understanding of the biological correlates of psychological disorders and provided objective methods for studying abnormal behaviour. The perspective has also contributed to the development of effective biological treatments, including psychotropic medications and other medical interventions, which have improved the quality of life for many individuals experiencing psychological disorders. Furthermore, by conceptualising mental disorders as conditions influenced by biological processes, the biological perspective has helped reduce the stigma surrounding mental disorders by framing them as medical conditions rather than moral failings, weakness, or lack of willpower.

Limitations

Despite its substantial contributions, the biological perspective has been criticised for placing considerable emphasis on physiological factors while sometimes giving insufficient attention to psychological, social, and cultural influences. Although biological abnormalities are associated with many forms of psychopathology, these factors alone do not fully explain why individuals exposed to similar biological vulnerabilities may experience different outcomes. In addition, establishing causal relationships between biological processes and psychological disorders is often challenging, as biological changes may be both causes and consequences of psychological distress. Critics therefore argue that a purely biological explanation may provide an incomplete understanding of psychopathology and that psychological disorders are more adequately understood through approaches that also consider environmental, cognitive, and sociocultural influences.

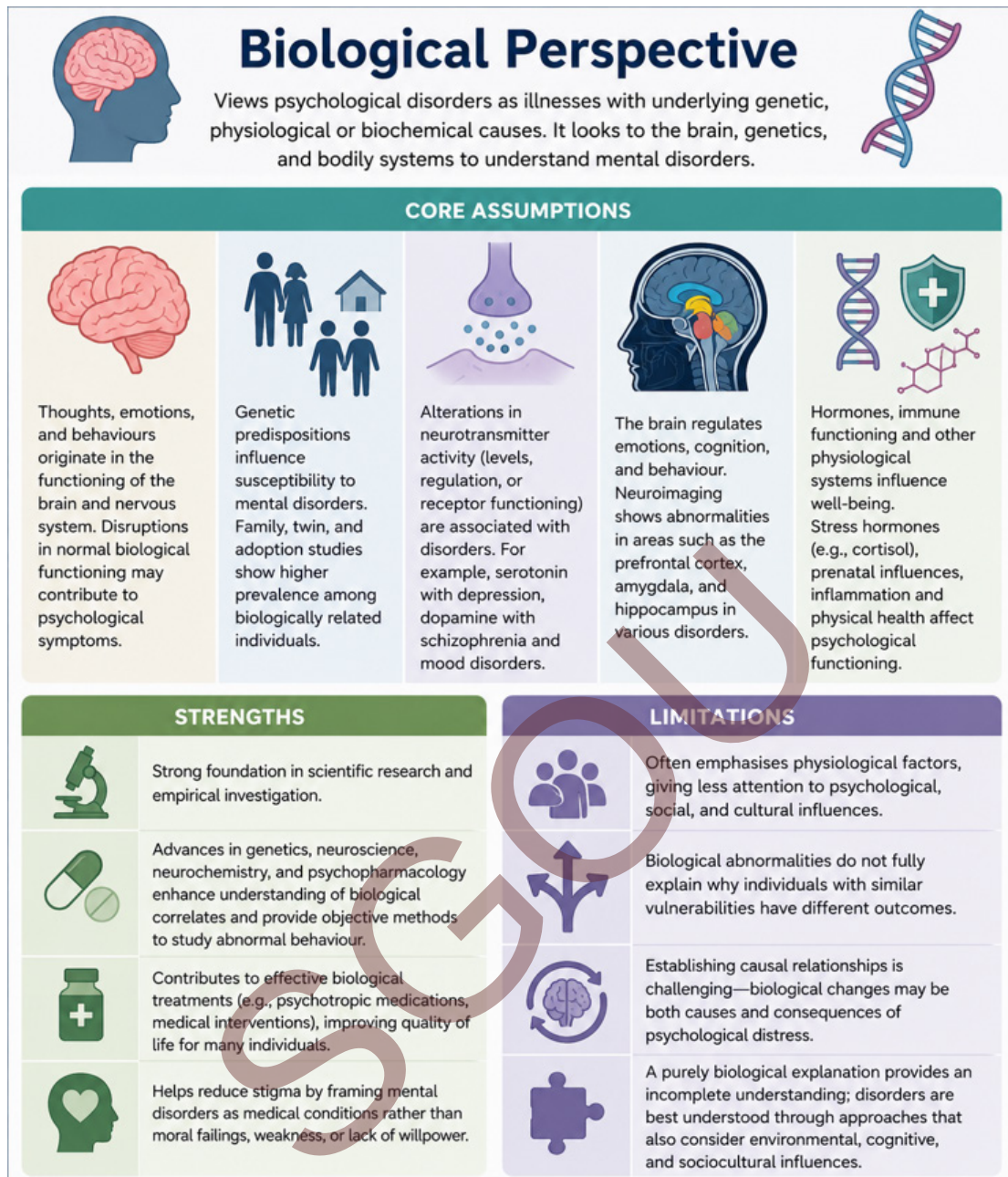


Fig. 2.2.1 Biological Perspective on Mental Disorders (AI-Generated)

2.2.2 Psychodynamic Perspective

The psychodynamic perspective traces its origins to the work of Sigmund Freud and represents one of the earliest systematic attempts to explain psychological disorders. Unlike biological explanations that focus on physiological processes, the psychodynamic perspective emphasises the role of unconscious mental processes, early childhood experiences, and internal

psychological conflicts in shaping behaviour and emotional functioning. According to this perspective, psychological disorders are not the result of current circumstances or conscious incidents alone; rather, they often reflect unresolved conflicts and emotional experiences that operate outside conscious awareness. Although many of Freud's original ideas have been modified and expanded by later theorists, psychodynamic concepts continue to influence contemporary understandings of psychopathology.

Core Assumptions

- ◆ *Human behaviour is influenced by unconscious processes.*

A central assumption of the psychodynamic perspective is that individuals are not fully aware of all the forces that drive their thoughts, emotions, and behaviours. Unconscious wishes, fears, memories, and conflicts may shape behaviour without entering conscious awareness. Consequently, psychological symptoms may be expressions of these underlying unconscious processes.

- ◆ *Early childhood experience shapes personality and psychological development*

Psychodynamic theorists emphasise the lasting influence of childhood experiences on later psychological functioning. Interactions with parents, caregivers, and other significant figures contribute to the development of personality and influence how individuals perceive themselves and relate to others. Difficulties arising during early development may continue to affect emotional well-being throughout life.

- ◆ *Psychological conflict is a part of human functioning*

According to the psychodynamic perspective, behaviour often reflects conflicts between competing psychological forces. Freud proposed that individuals must continually negotiate the demands of instinctual drives, moral standards, and external reality. When such conflicts remain unresolved, they may contribute to psychological distress and maladaptive behaviour.

- ◆ *Defence mechanisms act as psychological safeguards against anxiety*

The psychodynamic perspective assumes that individuals employ defence mechanisms to manage anxiety and protect themselves

from distressing thoughts or feelings. Processes such as repression, denial, projection, rationalisation, and displacement operate largely outside conscious awareness and help reduce emotional discomfort. However, relying too heavily on these mechanisms may interfere with healthy psychological functioning.

Strengths

One major strength of the psychodynamic perspective is its recognition of the complexity of human behaviour and the importance of factors that operate outside conscious awareness. The perspective emphasised the enduring influence of childhood experiences, interpersonal relationships, and emotional conflicts at a time when such factors received little systematic consideration. Many concepts introduced by psychodynamic theorists, including unconscious processes, defence mechanisms, and the significance of early relationships, have had a lasting influence on psychology, psychotherapy, and psychiatry. Furthermore, contemporary research on attachment, emotion regulation, and interpersonal functioning has provided support for several ideas that originated within psychodynamic theory.

Limitations

Despite its historical significance, the psychodynamic perspective has been criticised on several grounds. Many of Freud's original concepts are difficult to test empirically and therefore do not readily lend themselves to scientific verification. Critics have also argued that psychodynamic explanations may place excessive emphasis on childhood experiences and unconscious conflicts while underestimating the influence of current circumstances, learning processes, biological factors, and sociocultural influences. Additionally, some of Freud's early formulations have been challenged for reflecting the social and cultural assumptions of the period in which they

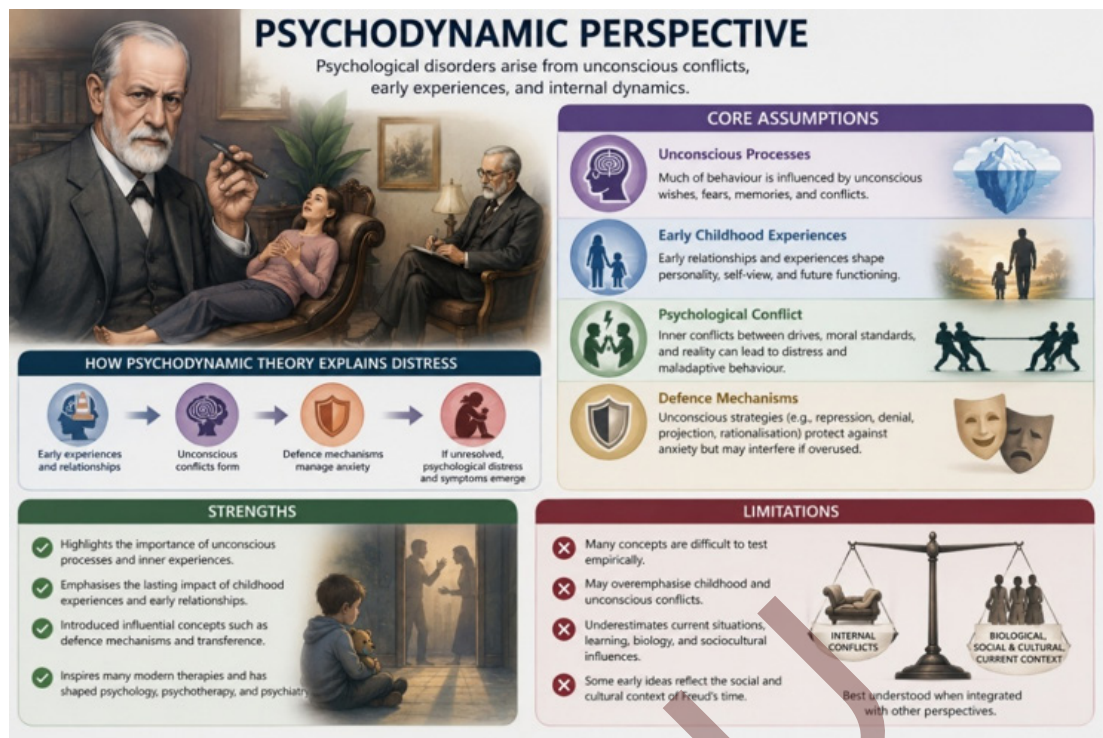


Fig. 2.2.2. Psychodynamic Perspective on Mental Disorders (AI-Generated)

were developed. As a result, although psychodynamic theory remains influential, it is often integrated with other approaches to provide a more comprehensive understanding of psychopathology.

2.2.3. Behavioural Perspective

The behavioural perspective emerged primarily in response to psychoanalytic explanations that relied on unobservable mental processes, such as unconscious motives and conflicts. Influenced by the work of psychologists such as John B. Watson, Ivan Pavlov, and B. F. Skinner, this perspective focuses on observable behaviour and the environmental conditions that shape it. Behavioural theorists argue that behaviour is acquired, maintained, and modified through learning. Consequently, psychological disorders are viewed not as manifestations of underlying unconscious conflicts but as learned patterns of maladaptive behaviour that have been learned through interactions with the environment.

Core Assumptions

◆ *Behaviour is learned*

The behavioural perspective assumes that behaviour is acquired through learning rather than being determined solely by innate factors. Both adaptive and maladaptive behaviours develop as individuals interact with their environment and encounter different learning experiences.

◆ *Environmental factors shape behaviour*

Behaviour is influenced by environmental events and circumstances rather than by unconscious motives or internal psychological forces. According to them, the environment determines which behaviours are acquired, strengthened, maintained, or eliminated over time.

◆ *The same learning principles govern normal and abnormal behaviour*

According to the behavioural perspective, the same learning mechanisms that contribute to adaptive behaviour can also produce

maladaptive patterns associated with psychological disorders.

♦ *Behaviour can be modified through learning*

Because behaviour is learned, maladaptive behaviours can be reduced or replaced through appropriate learning experiences and behavioural interventions. From the behavioural perspective, psychological disorders are maintained because maladaptive behaviours continue to be reinforced over time. Treatment, therefore, focuses on identifying the learning experiences that contribute to problematic behaviour and replacing maladaptive responses with more adaptive ones through behavioural interventions.

Strengths

One of the principal strengths of the behavioural perspective is its emphasis on observable behaviour and scientific investigation. By focusing on measurable actions and environmental influences, behavioural theories have generated a substantial body of empirical research and have contributed to the development of highly

effective therapeutic techniques. Behavioural interventions, including exposure therapy, systematic desensitisation, and behaviour modification programmes, have demonstrated considerable success in the treatment of phobias, anxiety disorders, and other behavioural difficulties.

Limitations

Despite its contributions, the behavioural perspective has been criticised for placing primary emphasis on observable behaviour while providing relatively limited attention to internal mental processes. Critics argue that thoughts, beliefs, emotions, and biological factors often play important roles in the development and maintenance of psychological disorders and cannot be fully understood through learning principles alone. Additionally, some forms of psychopathology, particularly those involving complex cognitive and emotional disturbances, may not be adequately explained solely in terms of conditioning and reinforcement. As a result, contemporary approaches frequently integrate behavioural principles with cognitive, biological, and sociocultural explanations.

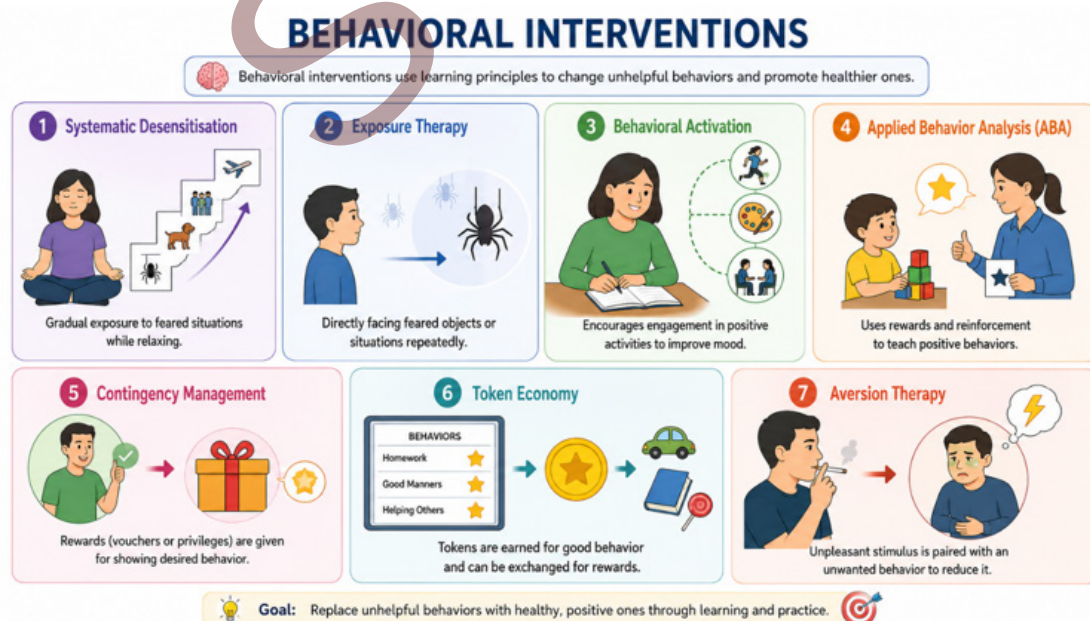


Fig. 2.2.3. Behavioural Interventions (AI-Generated)

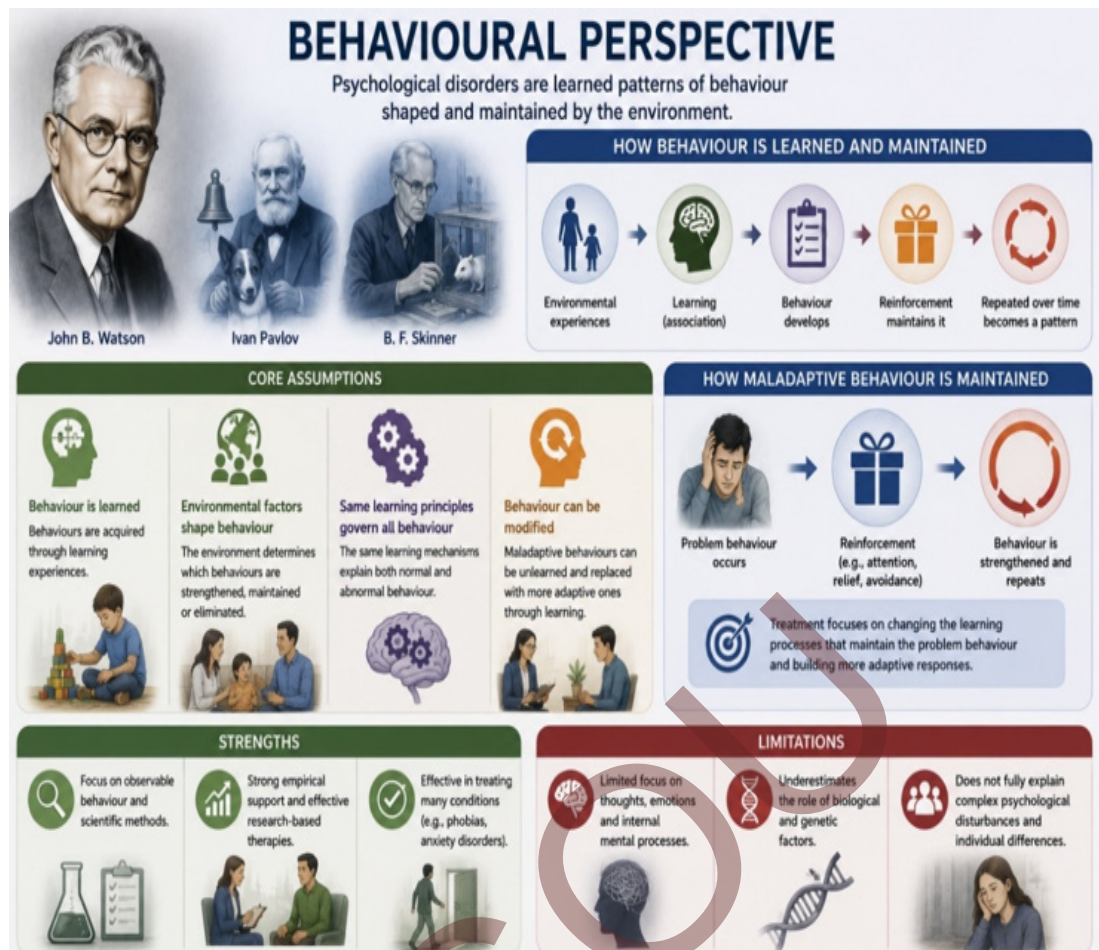


Fig. 2.2.4. Behavioural Perspective on Mental Disorders (AI-Generated)

2.2.4. Cognitive Perspective

The cognitive perspective shifts the focus from unconscious drives or biological structures to internal mental processes. Cognitive theorists argue that individuals, in responding to their environment, actively interpret, evaluate, and assign meaning to their experiences. Consequently, thoughts, beliefs, expectations, and patterns of information processing play a central role in shaping emotions and behaviour. Within psychopathology, the cognitive perspective proposes that psychological disorders are closely linked to maladaptive ways of thinking and interpreting reality. It asserts that psychological disorders result from faulty, irrational, or maladaptive patterns of thinking, perceiving, and interpreting events. According to this model, it is not the event itself that causes psychological

distress, but rather the individual's cognitive interpretation of that event.

Core Assumptions

- ◆ *The interplay of thoughts, feelings, and behaviour*

The foundational framework of the cognitive model relies on a reciprocal cycle among three components: cognition, emotion, and action. This continuous feedback loop maintains maladaptive behaviour. For example, a student who believes that a poor test performance reflects a lack of ability may experience anxiety, avoid future academic challenges, and interpret this avoidance as further evidence of incompetence.

Cognitive distortions

The cognitive perspective proposes that individuals may develop cognitive

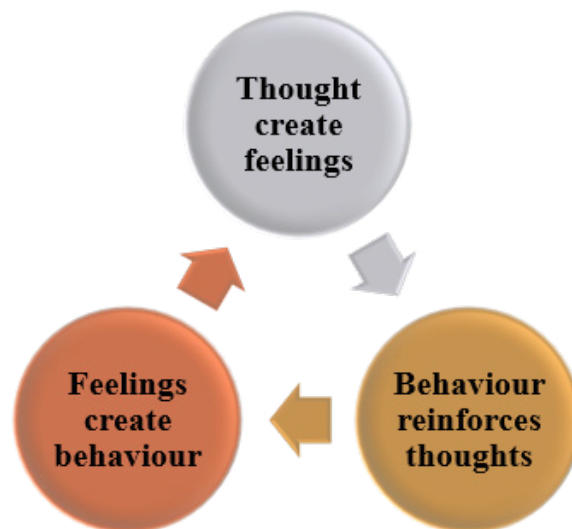


Fig. 2.2.5. Foundational Framework of Cognitive Perspective

distortions, which are habitual, systematic errors in reasoning that lead individuals to inaccurate and often negative conclusions about reality.

♦ *Core schemas*

The cognitive perspective proposes that enduring cognitive schemas guide individuals to organise and interpret information and experiences, and that dysfunctional schemas may contribute to the development and maintenance of psychological disorders.

♦ *Treatment:*

Because psychological distress is maintained by distorted thinking, cognitive

interventions aim to identify, challenge, and modify these maladaptive thoughts. The most prominent intervention is Cognitive Therapy (often combined with behavioural techniques such as Cognitive Behavioural Therapy, or CBT).

Strengths

A major strength of the cognitive perspective is its ability to explain how subjective interpretations shape psychological experiences rather than objective events alone. The perspective has generated extensive empirical research and has contributed significantly to understanding disorders such as depression, anxiety disorders, and stress-related conditions. Its emphasis on

Table 2.2.1 Common cognitive distortions identified by Aaron Beck in individuals experiencing depression and anxiety

Cognitive Distortion	Definition	Example
All-or-Nothing Thinking	Viewing things in black-and-white categories with no middle ground.	<i>If I do not get a perfect score on this assignment, I am a complete failure.</i>
Catastrophising	Anticipating the absolute worst possible outcome, regardless of probability.	<i>I made a mistake during the presentation; I am definitely going to lose my job.</i>
Overgeneralisation	Drawing a sweeping, negative conclusion based on a single isolated event.	<i>They did not reply to my message today; no one ever wants to talk to me.</i>

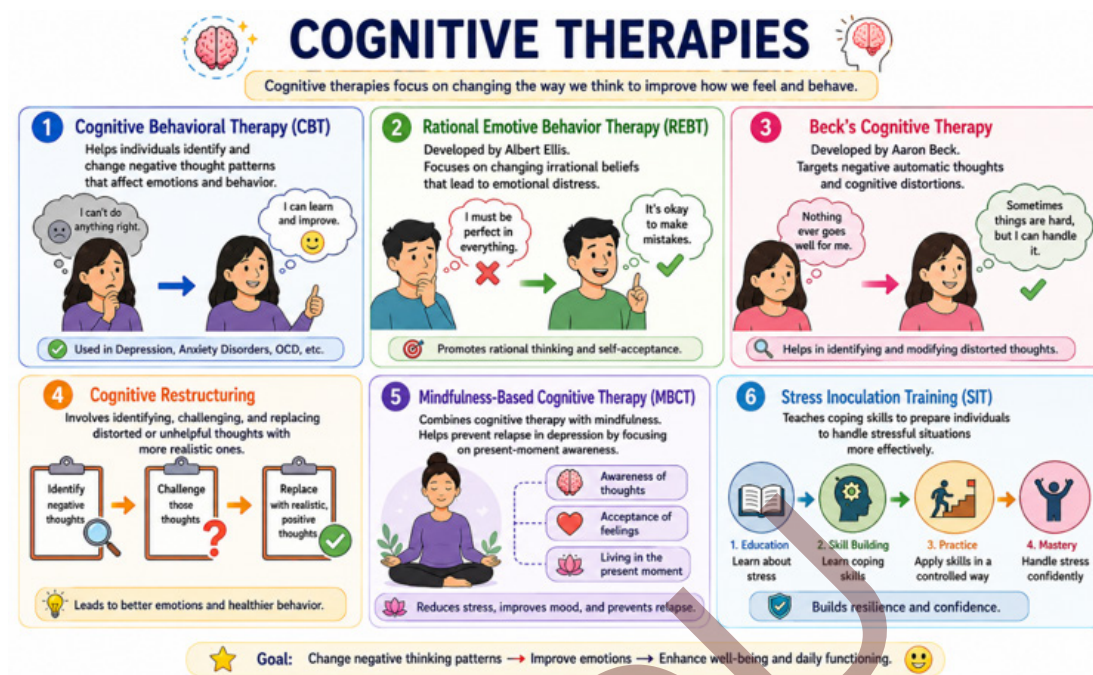


Fig. 2.2.6 Cognitive Therapies (AI-Generated)

identifiable and modifiable thought patterns has also led to the development of highly effective therapeutic approaches, particularly cognitive therapy and cognitive-behavioural therapy (CBT). Furthermore, the cognitive perspective provides a practical framework for understanding the relationship between thoughts, emotions, and behaviour, making it highly applicable in clinical settings.

Limitations

Despite its considerable contributions, the cognitive perspective has been criticised for placing primary emphasis on conscious thought processes while sometimes underestimating the influence of biological

factors, unconscious processes, and broader social contexts. Critics also argue that not all psychological disorders can be adequately explained by maladaptive cognitions alone, particularly conditions involving severe neurobiological disturbances. Additionally, cognitive theories may sometimes overlook the extent to which distorted thinking itself may be a consequence rather than a cause of psychological distress. Consequently, many contemporary approaches integrate cognitive explanations with biological, behavioural, and sociocultural perspectives to achieve a more comprehensive understanding of psychopathology.

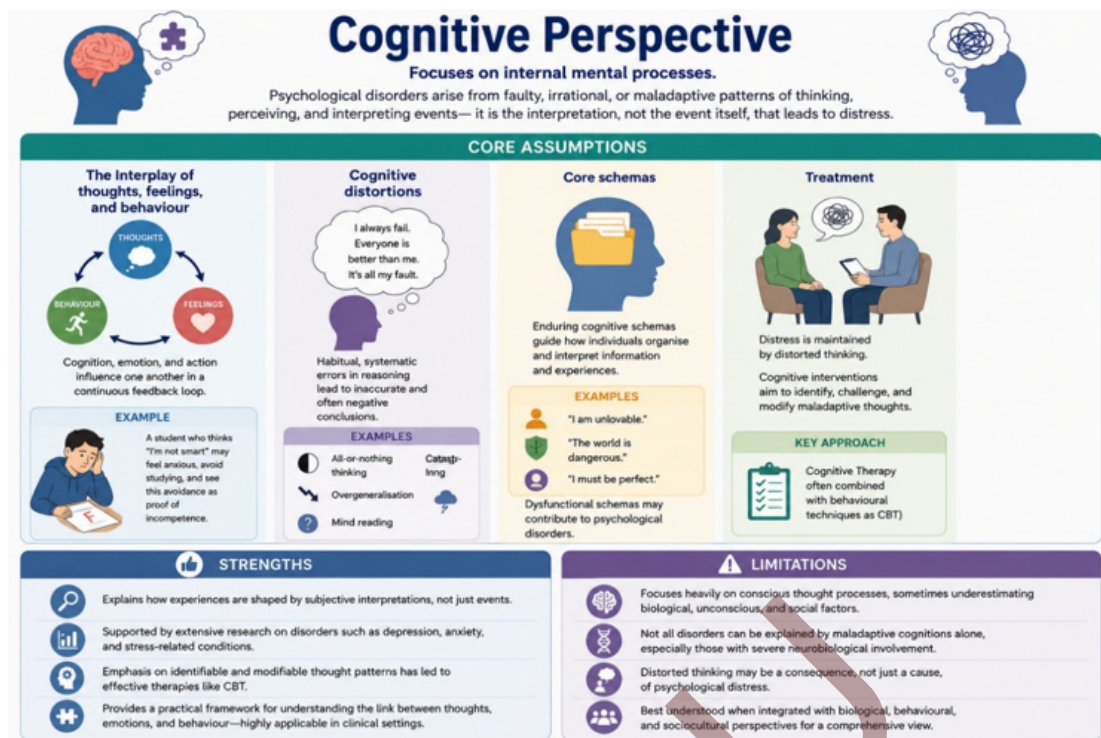


Fig. 2.2.7 Cognitive Perspective on Mental Disorders (AI-Generated)

2.2.5. Humanistic-Existential Perspective

The humanistic-existential perspective emerged as a direct response to the deterministic views of both psychoanalysis and behaviourism. Although humanistic and existential approaches developed from distinct philosophical traditions, they share a common emphasis on human potential, personal responsibility, and the capacity for growth. This framework views human beings as inherently capable of self-awareness, rational thought, and making conscious choices to direct their own lives. Humanistic and existential theorists argued that understanding psychological disorders requires attention to the individual's subjective experience,

personal values, freedom of choice, and search for meaning. From this perspective, psychological disorders are understood not merely as symptoms to be eliminated but as indications that an individual has become disconnected from authentic living, personal meaning, or opportunities for psychological growth.

Core Assumptions

- ♦ *Human beings possess an innate tendency toward growth*

The humanistic-existential perspective assumes that individuals are naturally motivated to develop their potential and move toward psychological growth and fulfilment. Healthy functioning occurs when this tendency is allowed to develop freely.

Although humanism and existentialism are often grouped together due to their shared focus on subjective experience and individual agency, they possess distinct foundational concepts. To explain why psychological distress occurs, this perspective examines the individual's current reality, their pursuit of meaning, and their self-perception.

- ◆ *Subjective experience is central to understanding behaviour*

Individuals respond not simply to objective events but to their personal perceptions and interpretations of those events. Consequently, understanding a person's lived experience is essential for understanding psychological distress.

- ◆ *The search for meaning is a fundamental human motivation*

The perspective assumes that individuals strive to find purpose, meaning, and authenticity in their lives. Difficulties in achieving these goals may contribute to psychological distress and feelings of emptiness or alienation.

- ◆ *Incongruence and conditions of worth*

According to Carl Rogers, a central figure in humanistic psychology, psychological disorders stem from a fundamental mismatch, or incongruence, between the 'real self' (who the person actually is) and the 'ideal self' (who the person they would ideally want to be). This incongruence often develops early in life when acceptance, approval, and affection are given only when an individual behaves in ways that meet others' expectations. Rogers referred to this pattern of conditional acceptance as *conditions of worth*. Over time, the individual suppresses their true desires to meet external expectations, resulting in

severe anxiety and a fragmented sense of identity.

- ◆ *Existential Anxiety and Meaninglessness*

Existential theorists argue that human beings are fundamentally free to make choices, but this freedom carries the heavy burden of responsibility. Existential anxiety is the normal, inherent angst that arises from facing this freedom and the inevitability of death. However, when individuals refuse to take responsibility for their choices or deceive themselves about their freedom (a state referred to as 'bad faith'), they experience deep psychological dysfunction characterised by emptiness, alienation, and a lack of purpose.

Thus, the humanistic-existential perspective explains psychological disorders primarily in terms of obstacles to personal growth, self-understanding, and authentic living. Psychological distress is believed to emerge when individuals become disconnected from their genuine feelings, values, and aspirations, preventing them from realising their full potential.

Humanistic theorists emphasise the concept of self-actualisation, which refers to the realisation of one's potential and capacities. Psychological difficulties may occur when environmental conditions, restrictive social expectations, or negative self-perceptions interfere with an individual's efforts toward

Table 2.2.2 Humanism and Existentialism

Approach	Primary Focus	Cause of Psychological Disorders
Humanistic	The innate drive toward self-actualisation (reaching one's full potential).	Distress occurs when this natural growth is blocked by external expectations or a lack of self-acceptance.
Existential	The challenges of human existence - freedom, responsibility, and death.	Distress results from avoiding the responsibility of making authentic choices, leading to a sense of meaninglessness.

growth and self-development. From this viewpoint, symptoms often reflect unmet psychological needs and obstacles to personal fulfilment.

The existential tradition focuses on the fundamental realities of human existence,

including freedom, responsibility, isolation, uncertainty, and mortality. Existential theorists argue that psychological distress may arise when individuals struggle to confront these realities or avoid making meaningful choices about their lives. Feelings of

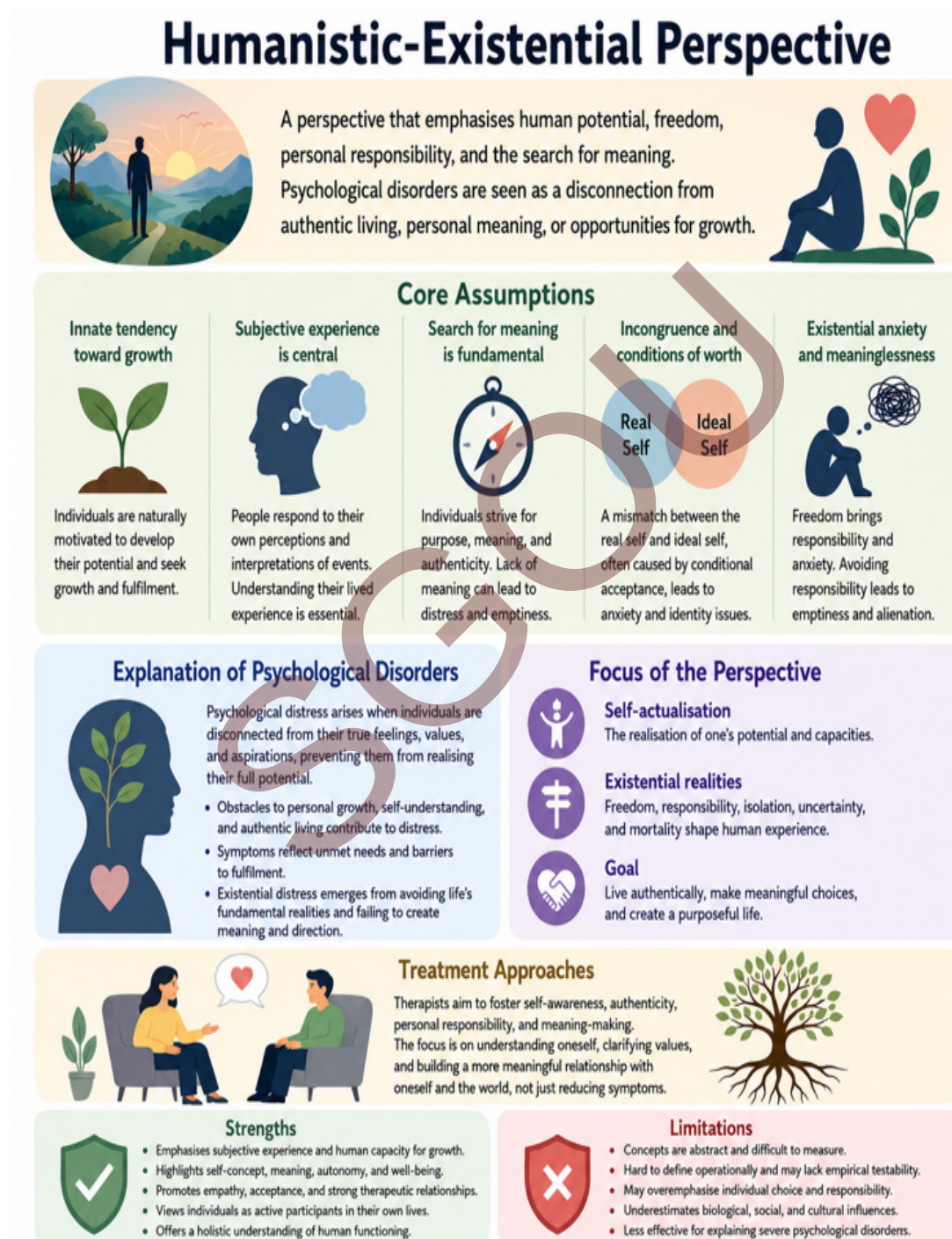


Fig. 2.2.8 Humanistic-Existential Perspectives on Mental Disorders (AI-Generated)

emptiness, lack of purpose, alienation, or existential anxiety may emerge when individuals fail to establish a sense of meaning and direction. Psychological disorders are therefore understood not only as reactions to specific events but also as responses to broader questions concerning identity, purpose, and existence.

Treatment approaches derived from the humanistic-existential perspective seek to foster self-awareness, authenticity, personal responsibility, and meaning-making. Rather than focusing primarily on symptom reduction, therapists aim to help individuals understand themselves more fully, clarify their values, and develop more meaningful ways of relating to themselves and the world.

Strengths

A major strength of the humanistic-existential perspective is its emphasis on the individual's subjective experience and capacity for growth. The perspective broadened the study of psychopathology by highlighting factors such as self-concept, personal meaning, autonomy, and psychological well-being, which earlier approaches often neglected. It also contributed significantly to the development of therapeutic practices that emphasise empathy, acceptance, and the therapeutic relationship. By viewing individuals as active participants in their own lives rather than passive recipients of biological or environmental influences, the perspective offers a more holistic understanding of human functioning.

Limitations

Despite its valuable contributions, the humanistic-existential perspective has been criticised for the abstract and sometimes difficult-to-measure nature of many of its concepts. Ideas such as self-actualisation, authenticity, and meaning are often challenging to define operationally and may not lend themselves easily to empirical testing.

Critics also argue that the perspective may place considerable emphasis on individual choice and personal responsibility while underestimating the influence of biological, social, and cultural factors on psychological functioning. Furthermore, its explanations may be less effective in accounting for severe psychological disorders that involve significant cognitive, behavioural, or neurobiological disturbances.

2.2.6. Socio-cultural Perspective

The socio-cultural perspective emphasises the role of social and cultural factors in shaping human behaviour and psychological functioning. Rather than viewing psychological disorders solely as the result of biological abnormalities or individual psychological processes, this perspective argues that mental health and disorders are influenced by the social environments in which individuals live. Family relationships, social networks, cultural values, socioeconomic conditions, and broader societal structures all contribute to the development, expression, and maintenance of psychological disorders. Consequently, psychological distress is understood not only as an individual experience but also as a phenomenon shaped by social and cultural context.

Core Assumptions

◆ *Social stressors*

Individuals exposed to stressors such as chronic adversity, financial hardship, social exclusion, discrimination, or limited access to opportunities often experience elevated levels of stress that may increase vulnerability to anxiety, depression, substance use disorders, and other forms of psychopathology. Such experiences can undermine coping resources and contribute to long-term psychological difficulties.

◆ *Social roles and labels*

Socio-cultural theorists argue that society dictates the norms for acceptable behaviour. When an individual deviates from these norms, society frequently applies the label of 'abnormal' or 'mentally ill.' Once assigned, this label can become a self-fulfilling prophecy. The individual may internalise the societal expectation and begin to act in accordance with the 'sick role,' while society simultaneously isolates or treats them differently due to the label.

◆ *Family Systems Theory*

Psychological symptoms in one person may also be interpreted as an indicator of dysfunction within the entire family structure. Family relationships provide the primary context for emotional development, socialisation, and interpersonal learning. Persistent family conflict, ineffective communication patterns, neglect, abuse, or other forms of relational dysfunction may contribute to the development and persistence of psychological disorders. Family systems theorists further argue that psychological symptoms may sometimes reflect broader difficulties within the family system rather than problems located entirely within the individual.

◆ *Cultural influence*

Cultural beliefs and values influence how psychological symptoms are interpreted, experienced, and communicated. As a result, psychological disorders may vary in their expression across different cultural contexts.

◆ *Treatment*

Because psychological disorders are viewed as being closely connected to social and cultural environments, interventions informed by the socio-cultural perspective often extend beyond the individual. Treatment may involve family therapy,

community-based interventions, social support programmes, and efforts to address environmental stressors that contribute to psychological distress.

Strengths

A major strength of the socio-cultural perspective is its recognition that psychological disorders do not occur in isolation from the environments in which individuals live. The perspective broadens understanding of psychopathology by highlighting the influence of family dynamics, social relationships, cultural values, and societal conditions on mental health. It has also contributed to greater cultural awareness within psychology and has encouraged clinicians and researchers to consider the impact of social inequality, discrimination, and environmental stressors when examining psychological disorders. By situating psychological distress within a broader social context, the perspective offers a more comprehensive understanding of factors that influence mental health.

Limitations

Despite its valuable contributions, the socio-cultural perspective has been criticised for sometimes placing insufficient emphasis on individual psychological processes and biological influences. Although social and cultural factors clearly affect mental health, they do not fully explain why individuals exposed to similar environments often experience very different psychological outcomes. Critics also argue that social influences can be difficult to measure precisely and that causal relationships between social conditions and psychological disorders are often complex and multifaceted. Consequently, socio-cultural explanations are generally considered most effective when integrated with biological and psychological perspectives.

SOCIO-CULTURAL PERSPECTIVE

Psychological disorders are shaped by social and cultural environments.

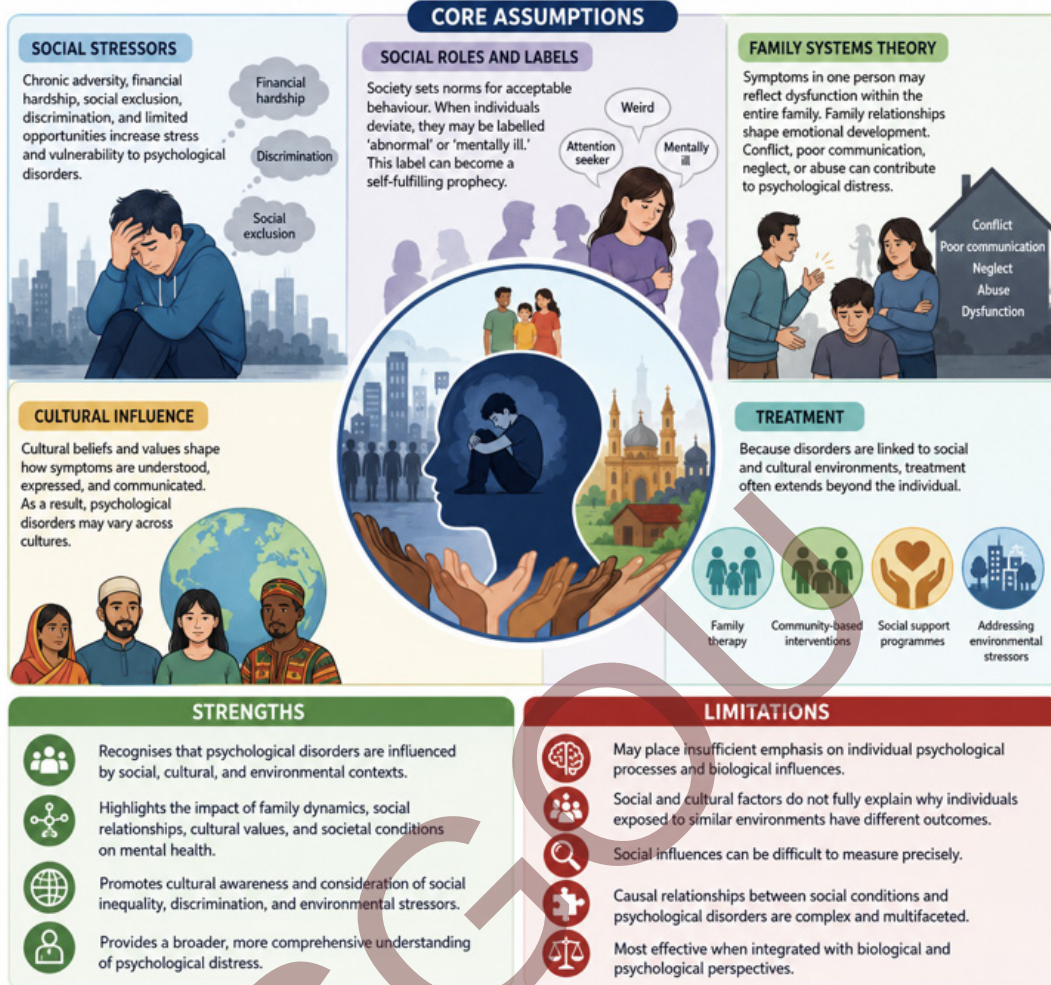


Fig. 2.2.9 Sociocultural Perspective on Mental Disorders (AI-Generated)

Recap

- ◆ Theoretical perspectives provide conceptual frameworks that guide the interpretation, assessment, and treatment of abnormal behaviour.
- ◆ The biological perspective treats psychological disorders as illnesses rooted in genetic, physiological, or biochemical causes.
- ◆ Family, twin, and adoption studies offer substantial evidence that genetic predispositions influence susceptibility to certain mental disorders.
- ◆ Abnormalities in neurotransmitters, such as serotonin and dopamine, are closely linked to depression, schizophrenia, and mood disorders.

- ◆ The psychodynamic perspective focuses on how unconscious mental processes and unresolved internal conflicts shape emotional functioning.
- ◆ Defence mechanisms, such as repression and denial, operate outside conscious awareness to help individuals manage anxiety.
- ◆ The behavioural perspective asserts that both normal and maladaptive behaviours are acquired and modified entirely through learning and environmental interactions.
- ◆ Behavioural treatments aim to identify problematic learning experiences and replace maladaptive responses using targeted behavioural interventions.
- ◆ The cognitive perspective argues that psychological disorders stem from faulty, irrational, or maladaptive patterns of interpreting events.
- ◆ Cognitive distortions are systematic reasoning errors that lead individuals to draw inaccurate, negative conclusions about reality.
- ◆ Dysfunctional core schemas are enduring frameworks that guide information processing and contribute to the maintenance of psychological disorders.
- ◆ The humanistic-existential perspective emphasises an individual's subjective experience, freedom of choice, and inherent capacity for growth.
- ◆ Humanistic theories posit that healthy functioning occurs when a person's innate tendency toward growth and self-actualisation is allowed to develop freely.
- ◆ Psychological distress can stem from incongruence, a fundamental mismatch between the 'real self' and the 'ideal self'.
- ◆ Conditions of worth develop when individuals receive conditional acceptance, forcing them to suppress true desires to meet external expectations.
- ◆ Existential anxiety is the inherent angst that arises from confronting human freedom, responsibility, and mortality.
- ◆ A major limitation of the biological perspective is its potential to overlook environmental and sociocultural influences.
- ◆ The psychodynamic approach is often criticised because many of its core concepts are difficult to verify empirically.
- ◆ Critics of the behavioural perspective argue that it places too much emphasis on observable actions while neglecting internal mental processes.

- ◆ Cognitive theories can sometimes overlook whether distorted thinking is the cause of psychological distress or a consequence of it.
- ◆ The humanistic-existential framework relies on abstract concepts, like authenticity and meaning, which can be challenging to test empirically.

Objective Questions

1. Which perspective views mental disorders as illnesses with underlying genetic or biochemical causes?
2. What specific types of studies are used to support genetic predispositions in the biological perspective?
3. Which perspective emphasises the lasting influence of early childhood experiences and unconscious conflicts?
4. According to psychodynamic theory, what acts as a psychological safeguard against anxiety?
5. Name one specific defence mechanism identified within the psychodynamic perspective.
6. Which perspective emerged in direct response to theories relying on unobservable mental processes?
7. According to behavioural theorists, how is maladaptive behaviour acquired?
8. What specific therapeutic technique is noted for its success in treating phobias under the behavioural perspective?
9. Which perspective proposes that psychological distress is caused by the individual's subjective interpretation of an event?
10. What term describes habitual, systematic errors in reasoning that lead to inaccurate conclusions?
11. What term is used for enduring mental structures that guide how individuals organise and interpret information?
12. What prominent intervention aims to challenge and modify maladaptive thoughts?

13. Which perspective focuses on human potential, personal responsibility, and subjective experience?
14. What humanistic concept refers to the realisation of one's full potential and capacities?
15. According to Carl Rogers, what is the fundamental mismatch between the 'real self' and the 'ideal self' called?
16. What term describes the pattern of conditional acceptance that forces an individual to suppress their true desires?
17. What specific term describes the inherent angst arising from facing fundamental freedom and death?
18. In existential theory, what state occurs when an individual refuses to take responsibility for their choices?
19. Which perspective has been heavily criticised for its concepts being difficult to test empirically?
20. Which theoretical approach relies heavily on psychopharmacology and neuroimaging?
21. Which perspective views symptoms as obstacles to authentic living rather than purely medical issues?

Answers

1. Biological
2. Family/Twin/Adoption
3. Psychodynamic
4. Defence mechanisms
5. Repression (or Denial/Projection/Rationalisation/Displacement)
6. Behavioural
7. Learning
8. Exposure therapy (or Systematic desensitisation)
9. Cognitive

10. Cognitive distortions
11. Core schemas
12. Cognitive Therapy (or CBT)
13. Humanistic-existential
14. Self-actualisation
15. Incongruence
16. Conditions of worth
17. Existential anxiety
18. Bad faith
19. Psychodynamic (or Humanistic-existential)
20. Biological
21. Humanistic-existential

Assignment

1. Explain why the unit argues that psychological disorders cannot be reduced to a single cause. Use the idea of the interplay among biological, psychological and sociocultural contexts to explain.
2. Analyse the psychodynamic perspective's core assumptions about unconscious processes, childhood experiences, and defence mechanisms. Why are these ideas influential yet difficult to test?
3. Compare the behavioural and cognitive perspectives. How does each explain the development of maladaptive behaviour, and how does CBT integrate both?
4. Using phobia as an example, show how behavioural principles explain acquisition and maintenance, and describe how exposure therapy follows from this model.
5. Contrast the humanistic-existential view of freedom and responsibility with the deterministic stance of biological and behavioural models.
6. Make a case for an integrative approach. Show how the strengths of each perspective compensate for the limitations of the others to give a comprehensive understanding of psychopathology.

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BLOCK

Neurodevelopmental and Neurocognitive Disorders



UNIT

Neurodevelopmental Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ♦ differentiate between typical and atypical developmental trajectories across the lifespan
- ♦ define neurodevelopmental disorders according to contemporary diagnostic frameworks
- ♦ discuss the clinical features of Autism Spectrum Disorder, Attention Deficit/Hyperactivity Disorder, and Intellectual Disabilities

Prerequisite

Consider three children who struggle in very different ways in their classroom. One child rarely makes eye contact, becomes distressed when routines change, and seems unable to understand the social rules that others follow effortlessly. Another constantly shifts in their seat, interrupts conversations, forgets instructions, and is often described as ‘careless’ or ‘difficult to control.’ A third child tries sincerely to keep up with lessons and everyday tasks, yet takes much longer than peers to learn, understand, and adapt. Although these children are often judged through labels such as ‘stubborn,’ ‘disinterested,’ ‘immature,’ or even ‘problematic,’ do such descriptions truly explain what they are experiencing? At what point does a difference in development become understood as ‘atypical’? And who determines what counts as ‘typical’ development in the first place?

Now, consider how easily behaviours that appear unusual are misunderstood when viewed only through expectations of performance, discipline, or social conformity. A child who struggles to communicate may be seen as distant. A child unable to sit still may be mistaken for being intentionally disruptive. Another who

learns more slowly may be unfairly judged as lacking effort or motivation. But what if these behaviours are not signs of unwillingness, but reflections of differences in neurodevelopment itself? As you begin this unit, reflect on how human development does not occur in identical ways for everyone, and how understanding neurodevelopmental disorders requires us to look beyond surface behaviour to the complex ways individuals perceive, process, learn from, and respond to the world around them.

Keywords

Milestones, DSM-5-TR, Echolalia, Functional Impairment, Hyperactivity, Impulsivity, Inattention, Adaptive Functioning

Discussion

3.1.1 Typical and Atypical

To understand neurodevelopmental disorders, or mental disorders in general, it is essential to distinguish between typical and atypical development, as these concepts provide an essential framework for understanding developmental differences that emerge early in life and influence various aspects of functioning.

Typical development refers to the pattern of growth and changes that occurs within the expected range for a particular age and developmental stage. It involves the progressive acquisition of physical, cognitive, language, emotional, and social abilities in a generally predictable sequence and broadly consistent with established developmental norms. Typical development does not imply that all individuals develop at the same pace or in the same way. Rather, it acknowledges a range of acceptable variation in developmental progress, with most individuals acquiring key developmental skills within an expected timeframe.

For example, most children learn to walk, develop language, engage in social

interactions, and acquire basic problem-solving skills during predictable periods of development. Although the precise timing of these achievements may vary among individuals, such variations generally remain within the expected range of development and do not significantly impair functioning. Psychologists and medical professionals use these milestones as benchmarks to monitor an individual's developmental progress.

Atypical development, on the other hand, refers to developmental patterns that deviate substantially from what is generally expected for an individual's age and developmental stage. Such deviations may involve delays in achieving developmental milestones, the presence of unusual behaviours, deficits in specific areas of functioning, or developmental trajectories that differ markedly from established norms. Atypical development may affect one or more domains of functioning, including communication, social interaction, learning, attention, emotional regulation, and intellectual abilities.

However, it is important to note that atypical development does not merely



represent individual differences or minor variations in developmental progress. Rather, it involves developmental characteristics that are sufficiently pronounced to interfere with everyday functioning, adaptation, learning, or

social participation. The extent of atypicality may vary considerably, ranging from mild difficulties to more pervasive impairments that require substantial support.

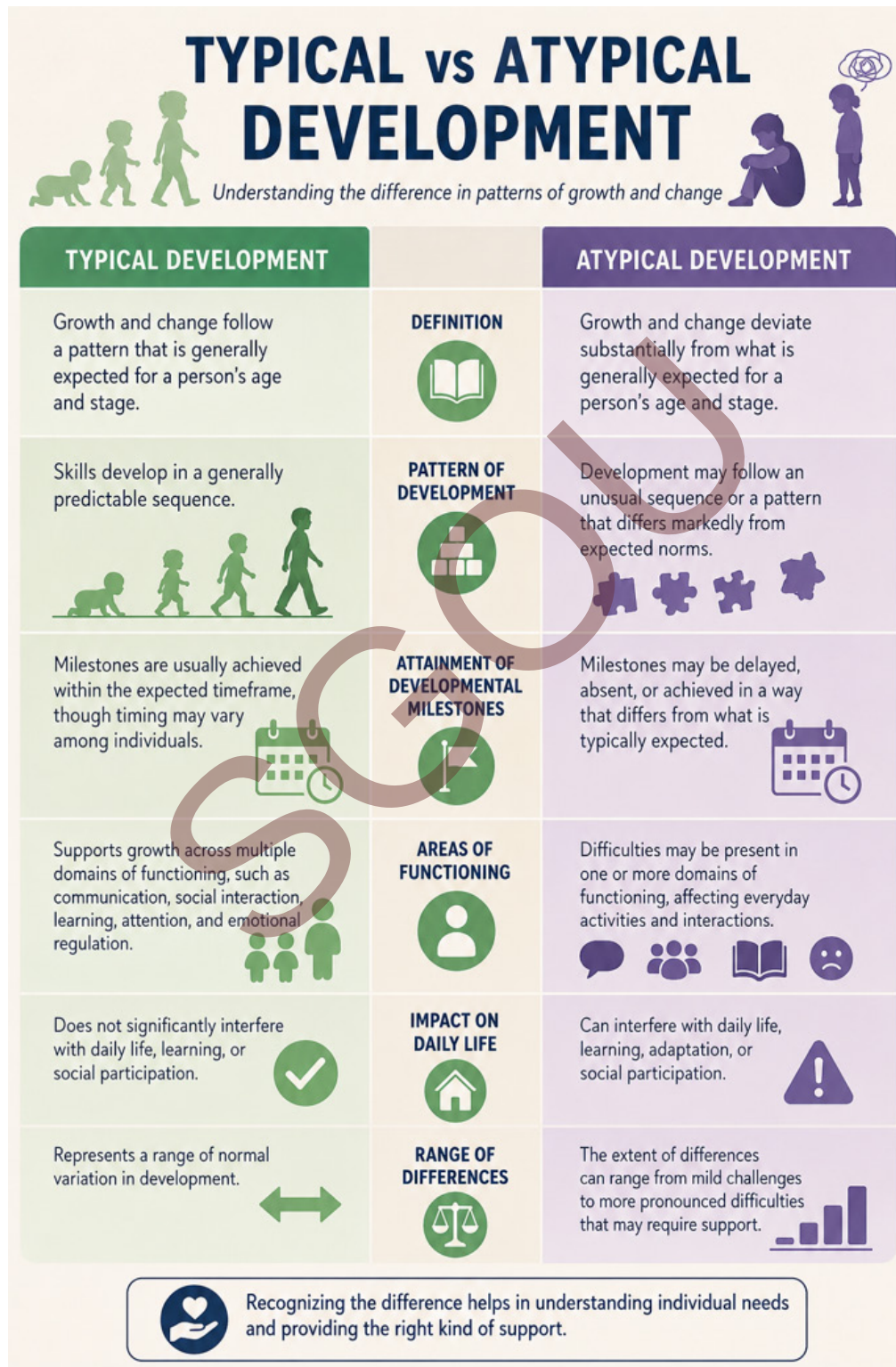


Fig. 3.1.1. Typical *versus* Atypical Development (AI-Generated)

3.1.2. Neurodevelopmental Disorders

Neurodevelopmental disorders are a group of conditions with onset in the developmental period, typically emerging in early childhood before a child enters formal schooling. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM -5-TR), they arise from differences or disruptions in brain development and functioning, leading to difficulties in areas such as learning, attention, communication, social interaction, emotional regulation, and intellectual functioning. These difficulties can affect personal, academic, social, and, later in life, occupational functioning. The severity of impairment varies considerably among individuals, ranging from specific challenges in particular skills to more pervasive difficulties that influence multiple areas of development.

Rather than representing entirely distinct categories, neurodevelopmental disorders are increasingly understood as existing along a continuum of developmental functioning. This means that the symptoms associated with these disorders may vary in intensity and may overlap with typical developmental variations. A diagnosis is made when developmental differences are significant enough to cause functional impairment in everyday life. Neurodevelopmental disorders frequently occur together; for example, individuals with Autism Spectrum Disorder may also have Intellectual Disability, while many children with Attention-Deficit/Hyperactivity Disorder (ADHD) experience co-occurring learning difficulties. Understanding these disorders, therefore, requires recognising both the developmental differences they involve and their impact on an individual's ability to function effectively in daily life.

Neurodevelopmental disorders encompass a diverse range of conditions that affect different aspects of development and

functioning. According to contemporary diagnostic classifications, this category includes disorders characterised by difficulties in intellectual functioning, communication, social interaction, learning, attention, motor coordination, and behavioural regulation. Major neurodevelopmental disorders include Intellectual Disability, Communication Disorders, Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), Specific Learning Disorder, and Motor Disorders. Although these conditions share a developmental origin and often co-occur, each disorder is characterised by a distinct pattern of symptoms and functional impairments.

Among the various neurodevelopmental disorders, Autism Spectrum Disorder (ASD), Attention-Deficit/Hyperactivity disorder (ADHD), and Intellectual Disability are among the most commonly identified and extensively studied. These conditions can significantly influence an individual's cognitive, social, behavioural, and adaptive functioning and often require specialised educational, psychological, and social support. The following sections examine the clinical features of these disorders in greater detail.

3.1.2.1. Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder characterised by persistent difficulties in social communication and social interaction, along with restricted, repetitive patterns of behaviour, interests, or activities. The term spectrum reflects the considerable variation in the nature and severity of symptoms across individuals. While some individuals may require substantial support in daily functioning, others may possess average or above-average intellectual abilities and function relatively independently. Symptoms typically emerge during early childhood, although they may become more apparent as social demands increase with age.



Evolution of Autism Diagnosis

The understanding of autism has changed considerably since it was first described in the clinical literature. These changes have involved not only the terminology and diagnostic criteria used to identify autism, but also broader ideas about what autism is, how it develops, and how autistic people experience the world.

In 1943, Leo Kanner described a group of children who showed distinctive patterns of social interaction, communication, and behaviour, including difficulties in forming ordinary social relationships, unusual responses to aspects of the environment, and a strong preference for sameness. Kanner referred to the condition as *early infantile autism* and considered it distinct from other childhood psychiatric conditions. A year later, Hans Asperger described children who showed difficulties in social interaction and communication alongside restricted interests and distinctive patterns of behaviour, but who often had relatively preserved language and intellectual abilities. Asperger's description later became associated with the term *Asperger syndrome*.

Early clinical descriptions therefore drew attention to considerable variation in how autism could present. Nevertheless, autism was initially conceptualised as a relatively narrow and distinct condition and was subsequently classified within broader categories of childhood disorders, such as childhood schizophrenia. The DSM-II (1968) did not recognise autism as a separate disorder and placed *infantile autism* within the category of childhood schizophrenia. From DSM-III (1980) onward, autism was re-established as a distinct diagnosis and, over successive editions, was further differentiated into several related but separate diagnoses.

The DSM-III (1980) represented an important change by recognising *infantile autism* as a distinct diagnostic category under the newly introduced group of *Pervasive Developmental Disorders*. The DSM-III-R (1987) broadened the criteria and introduced *Autistic Disorder*, while the DSM-IV (1994) and DSM-IV-TR (2000) recognised several related conditions under the broader category of *Pervasive Developmental Disorders*, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

A major shift occurred with the DSM-5 (2013), which brought several previously separate diagnoses together under the single diagnosis of Autism Spectrum Disorder (ASD). The term *spectrum* reflected increasing recognition that autism is not a uniform condition but encompasses substantial variation in communication, social interaction, behaviour, abilities, and support needs. The DSM-5 also introduced levels of support to indicate the degree of assistance an individual may require. The DSM-5-TR (2022) retained this diagnostic framework while making revisions to the text and terminology.

The understanding of autism has also changed beyond diagnostic classification. Earlier clinical descriptions tended to emphasise deficits, abnormalities, and impairment, often viewing autism primarily through the lens of what an individual

could not do or found difficult. Contemporary approaches increasingly recognise that autistic people may have diverse patterns of strengths, abilities, communication, sensory experiences, interests, and ways of relating to others. The emergence of the neurodiversity perspective has further contributed to this shift by emphasising neurological variation as part of human diversity and questioning approaches that define difference exclusively in terms of deficit.

These historical changes are important for understanding the lived experience of autism. A person who would receive a diagnosis of ASD today might not have been identified as autistic under earlier diagnostic systems, particularly if their presentation did not correspond to the narrower descriptions then in use. Changes in diagnostic criteria have therefore influenced not only how clinicians classify autism but also which individuals are recognised as autistic, what kinds of support they can access, and how their experiences are interpreted by families, educators, healthcare professionals, and society.

The clinical presentation of autism spectrum disorder is primarily characterised by difficulties in two broad domains: (a) deficits in social communication and social interaction, and (b) restricted and repetitive patterns of behaviour, interests, or activities.

a. Deficits in Social Communication and Social Interaction

Individuals with ASD often experience challenges in understanding and participating in social interactions. They may have difficulty initiating conversations, responding appropriately in social situations, or maintaining reciprocal communication. Eye contact, facial expressions, gestures, and other forms of nonverbal communication may be reduced or used atypically. Many individuals also find it difficult to understand social cues, interpret the emotions of others, or develop and maintain age-appropriate relationships.

Young children with ASD may show limited interest in social engagement, may not consistently respond to their name, or may have difficulty sharing interests and emotions with others. As they grow older, challenges

in understanding social expectations and navigating interpersonal relationships may become more evident.

b. Restricted and Repetitive Behaviours

A second core feature of ASD is the presence of restricted, repetitive patterns of behaviour, interests, or activities. These may include repetitive motor movements such as hand flapping, rocking, spinning, or repetitive manipulation of objects. Some individuals display repetitive speech patterns, including *echolalia*, which involves repeating words or phrases spoken by others.

Individuals with ASD often exhibit a strong preference for routines and predictability. Changes in daily routines, environments, or expectations may cause significant distress. They may also develop highly focused interests that are unusually intense in comparison with those of their peers.

In addition to the two core domains that define autism spectrum disorder, individuals may display a range of associated characteristics that contribute to the overall clinical presentation.



AUTISM SPECTRUM DISORDER

A	A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive; see text): 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions. 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication. 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.		
B	B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text): 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases). 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day). 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests). 4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).		
C	C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).		
D	D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.		
E	E. These disturbances are not better explained by intellectual developmental disorder (intellectual disability) or global developmental delay. Intellectual developmental disorder and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual developmental disorder, social communication should be below that expected for general developmental level.		
Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.			
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Fig. 3.1.2. Diagnostic Criteria of Autism Spectrum Disorder (DSM-5-TR)

- ◆ **Sensory Differences:** Many individuals with ASD experience atypical responses to sensory stimuli. Some may be highly sensitive to sounds, lights, textures, smells, or physical touch, while others may appear less responsive to sensory input. These sensory differences can influence behaviour, learning, and social participation and are now recognised as an important aspect of the disorder.
- ◆ **Variability in Intellectual and Language Abilities:** Intellectual and language abilities vary considerably among individuals with ASD. Some individuals may have co-occurring intellectual disability and significant language impairments, whereas others may demonstrate average or superior intellectual functioning and well-developed language skills. Despite these differences, difficulties in social communication remain a defining characteristic of the disorder.
- ◆ **Early Onset and Functional Impairment:** Symptoms of ASD typically emerge during the early developmental period, although they may not be fully recognised until social demands exceed an individual's capacities. The symptoms must be sufficiently severe to cause impairment in social, academic, occupational, or other important areas of functioning. The nature and extent of impairment vary widely across individuals, reflecting the spectrum nature of the disorder.

3.1.2.2. Attention Deficit/ Hyperactivity Disorder (ADHD)

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity that significantly interferes with an individual's functioning or development. The symptoms typically emerge during childhood and may persist into adolescence and adulthood, affecting academic performance, social

relationships, occupational functioning, and everyday activities. For a clinical diagnosis, these symptoms must be present before the age of 12 and must occur in two or more settings, such as at home, in school, or during social activities.

The clinical features of ADHD are divided into two primary domains: *inattention* and *hyperactivity and impulsivity*. An individual may exhibit symptoms predominantly from one domain, or a combination of both.

a. Inattention

Inattention refers to persistent difficulties in sustaining focus, organising tasks, and maintaining concentration over time. Individuals with ADHD often find it challenging to attend to details and may make careless mistakes in academic, occupational, or everyday activities. They may have difficulty following instructions, completing tasks, or remaining focused on activities that require sustained mental effort.

Common manifestations of inattention include forgetfulness, distractibility, losing necessary items, difficulty organising tasks, and a tendency to shift attention from one activity to another. Children with ADHD may appear not to listen when spoken to directly, frequently overlook instructions, or struggle to complete schoolwork despite having the necessary abilities.

b. Hyperactivity and Impulsivity

Hyperactivity refers to excessive levels of motor activity that are inappropriate for the individual's age or context. Children with ADHD may frequently fidget, tap their hands or feet, leave their seats when expected to remain seated, run or climb excessively, or appear constantly *on the go*. In adolescents and adults, overt hyperactivity may decrease, often manifesting as feelings of internal restlessness rather than excessive physical movement.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

A	A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2): 1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required. - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate). - Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading). - Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction). - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked). - Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines). - Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers). - Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones). - Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts). - Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments). 2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required. - Often fidgets with or taps hands or feet or squirms in seat. - Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place). - Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.) - Often unable to play or engage in leisure activities quietly. - Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with). - Often talks excessively. - Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation). - Often has difficulty waiting his or her turn (e.g., while waiting in line). - Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).
B	B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C	C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
D	D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E	E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).
Specify whether:	F90.2 Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.
	F90.0 Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.
	F90.1 Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months.
Specify if:	In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.
Specify current severity:	Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.
	Moderate: Symptoms or functional impairment between "mild" and "severe" are present.
	Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

Fig. 3.1.3. Diagnostic Criteria of Attention-Deficit/Hyperactivity Disorder (DSM-5-TR)

Impulsivity involves difficulties in inhibiting immediate responses and considering the consequences of actions. Individuals with ADHD may interrupt conversations, answer questions before they have been completed, have difficulty waiting their turn, or act without adequate forethought. Such behaviours can contribute to interpersonal difficulties and increase the likelihood of accidents or risky decisions.

Although inattention and hyperactivity-impulsivity are discussed separately, they often interact in everyday functioning. Difficulties in sustaining attention may affect learning and task completion, while hyperactive and impulsive behaviours can interfere with social relationships, classroom behaviour, and self-regulation. The relative prominence of these symptoms varies across individuals, giving rise to three specific presentations:

- i. *Combined presentation*: Criteria for both inattention and hyperactivity/impulsivity are met.
- ii. *Predominantly Inattentive Presentation*: Criteria for inattention are met, but criteria for hyperactivity-impulsivity are not.
- iii. *Predominantly Hyperactive-Impulsive Presentation*: Criteria for hyperactivity-impulsivity are met, but criteria for

inattention are not.

3.1.2.3. Intellectual Disability

Intellectual Disability (ID), also referred to as Intellectual Developmental Disorder, is a neurodevelopmental disorder characterised by significant limitations in both intellectual functioning and adaptive functioning. The disorder affects an individual's ability to learn, reason, solve problems, and adapt effectively to the demands of everyday life. These limitations manifest during the developmental period (childhood or adolescence) and affect functioning across educational, social, occupational, and personal domains.

Intellectual disabilities are classified into four levels of severity: mild, moderate, severe, and profound. The severity level is determined by the individual's level of adaptive functioning rather than their test score. This is because adaptive functioning directly dictates the level of support, supervision, and assistance the individual requires to function safely and effectively in daily life. Some individuals require only intermittent assistance in specific situations, while others may need extensive or lifelong support in multiple areas of functioning. The level of support required often depends on the individual and their environment.

Intellectual Disability is not simply a

Table 3.1.1 Severity Levels for Intellectual Developmental Disorder (DSM-5-TR)

Severity	General characteristics
Mild	Difficulties in conceptual, social, and practical functioning, with greater independence possible with appropriate support
Moderate	More substantial limitations in conceptual, social, and practical functioning, with support required for learning and everyday activities
Severe	Significant limitations across domains, with extensive support required for communication, learning, and daily functioning
Profound	Severe limitations in intellectual and adaptive functioning, with extensive support required across most areas of daily life

reflection of poor academic performance or limited educational opportunities. Rather, it involves difficulties in the cognitive processes required for learning and problem-solving, together with challenges in applying these skills to everyday situations. The severity of these limitations varies considerably among individuals, resulting in differing levels of support needs.

a. Deficits in Intellectual Functioning

Intellectual functioning refers to general mental abilities that enable individuals to reason, plan, solve problems, think abstractly, learn from experience, and understand complex ideas. Individuals with Intellectual Disability typically experience difficulties in acquiring and applying knowledge, understanding abstract concepts, and solving novel problems.

These limitations may become apparent in childhood as the individual faces increasing cognitive demands in academic and social environments. Difficulties may be observed in areas such as language development, academic learning, memory, reasoning, and decision-making. As a result, individuals often require additional support to acquire skills that their peers learn more easily.

b. Adaptive Functioning

Adaptive functioning refers to the collection of conceptual, social, and practical skills that individuals use to function effectively in everyday life. These skills enable people to meet developmental expectations and meet the standards of personal independence expected for their age and cultural group.

Adaptive functioning related to ADHD is evaluated across three specific domains:

- ◆ **The Conceptual Domain:** This involves skills related to language, reading, writing, math, reasoning, memory, and practical knowledge. Clinical features include slower language development, limited reading comprehension, and difficulty managing money or understanding time.
- ◆ **The Social Domain:** This involves interpersonal communication, social judgment, empathy, friendship skills, and the ability to perceive the thoughts and feelings of others. Clinical features include difficulties in interpreting social cues, immature social interactions for their age, and a higher risk of being manipulated or gullible.
- ◆ **The Practical Domain:** This involves self-management across life settings, including personal care, job responsibilities, recreation, and organising tasks. Clinical features include requiring guidance or assistance with eating, dressing, bathing, using public transportation, managing a household, or maintaining employment. However, the extent of difficulty in the practical domain varies across individuals and may range from requiring occasional support with complex tasks to needing extensive assistance with basic activities of daily living, depending on the severity levels of Intellectual Developmental Disorder.

In addition to the presence of intellectual and adaptive deficits, the timing of their onset is an important feature in distinguishing Intellectual Disability from other conditions that affect cognitive functioning. The cognitive and adaptive deficits must become apparent during childhood or adolescence. If an individual experiences a loss of cognitive abilities later in life due to a traumatic brain injury or a degenerative disease, it is classified as a neurocognitive disorder rather than an intellectual disability.

INTELLECTUAL DEVELOPMENTAL DISORDER

Intellectual developmental disorder (intellectual disability) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.

The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the developmental period.

Note: The term intellectual developmental disorder is used to clarify its relationship with the WHO ICD-11 classification system, which uses the term Disorders of Intellectual Development.

The equivalent term intellectual disability is placed in parentheses for continued use. The medical and research literature use both terms, while intellectual disability is the term in common use by educational and other professions, advocacy groups, and the lay public.

In the United States, Public Law 111-256 (Rosa's Law) changed all references to "mental retardation" in federal laws to "intellectual disability."

Specify current severity	
F70	Mild
F71	Moderate
F72	Severe
F73	Profound

Fig. 3.1.4. Diagnostic Criteria of Intellectual Developmental Disorder (DSM-5-TR)

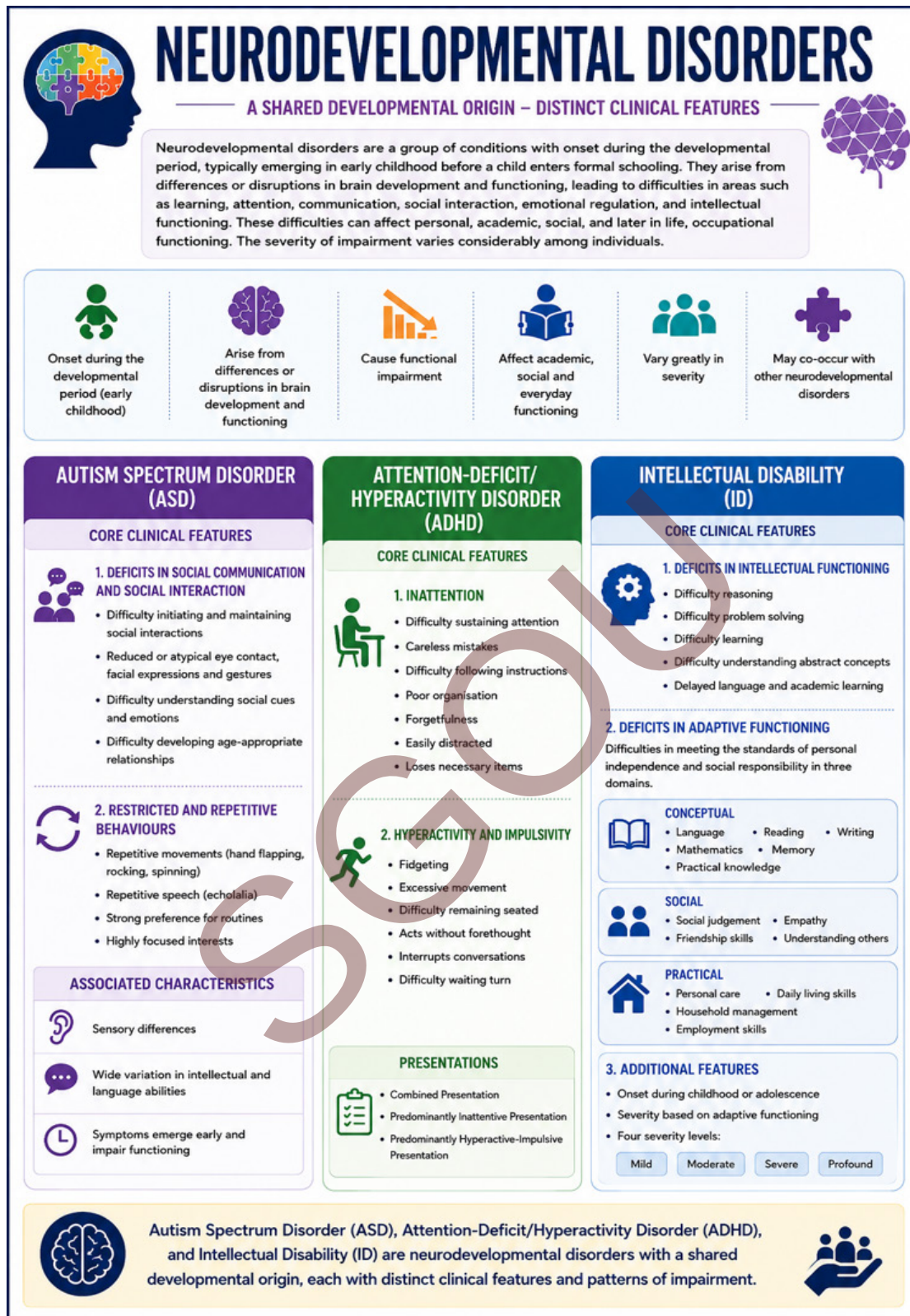


Fig. 3.1.5. Overview of the Clinical Features of Neurodevelopmental Disorders (AI-Generated)

Recap

- ◆ Typical development follows expected developmental milestones.
- ◆ Development occurs within a normal range of variation.
- ◆ Atypical development differs significantly from expected developmental patterns.
- ◆ Atypical development may affect everyday functioning and adaptation.
- ◆ Neurodevelopmental disorders begin during the early developmental period.
- ◆ These disorders result from differences in brain development and functioning.
- ◆ Symptoms usually appear in early childhood.
- ◆ Neurodevelopmental disorders affect learning, communication, attention, and social interaction.
- ◆ Functional impairment is necessary for clinical diagnosis.
- ◆ Different neurodevelopmental disorders may occur together.
- ◆ Autism Spectrum Disorder is characterised by deficits in social communication and interaction.
- ◆ Individuals with ASD often have restricted and repetitive behaviours.
- ◆ Many individuals with ASD experience unusual responses to sensory stimuli.
- ◆ Intellectual and language abilities vary widely among individuals with ASD.
- ◆ ADHD is characterised by persistent inattention and/or hyperactivity-impulsivity.
- ◆ ADHD symptoms should occur in two or more settings.
- ◆ Inattention affects concentration, organisation, and task completion.
- ◆ Hyperactivity involves excessive motor activity and restlessness.
- ◆ Impulsivity results in acting without adequate self-control.
- ◆ ADHD has combined, inattentive, and hyperactive-impulsive presentations.
- ◆ Intellectual Disability involves limitations in intellectual functioning.
- ◆ Intellectual Disability also includes deficits in adaptive functioning.

- ◆ Adaptive functioning includes conceptual, social, and practical skills.
- ◆ Individuals with neurodevelopmental disorders may require different levels of support.
- ◆ Early identification and intervention improve functioning and quality of life.

Objective Questions

1. What is the pattern of growth and change that occurs within the expected range for a particular age called?
2. What term is used for developmental patterns that differ significantly from the expected pattern?
3. During which period do neurodevelopmental disorders usually begin?
4. Which manual classifies neurodevelopmental disorders under mental disorders?
5. What is the essential criterion for diagnosing a neurodevelopmental disorder?
6. What does 'S' stand for in the acronym ASD?
7. Which neurodevelopmental disorder is characterised by persistent deficits in social communication and interaction?
8. What are the two core domains of Autism Spectrum Disorder?
9. What term describes the repetition of words or phrases spoken by others?
10. Which neurodevelopmental disorder is characterised by persistent inattention and/or hyperactivity-impulsivity?
11. Before what age should ADHD symptoms be present for diagnosis?
12. Which ADHD symptom domain involves difficulty sustaining attention and organising tasks?
13. Which ADHD symptom domain includes excessive motor activity?

14. Acting without considering the consequences is an example of what?
15. To diagnose ADHD, symptoms must actively show up in a minimum of how many settings?
16. Name one presentation of ADHD in which only inattention is pre-dominant.
17. Which neurodevelopmental disorder is characterised by significant limitations in intellectual and adaptive functioning?
18. What is the alternative diagnostic term for Intellectual Disability?
19. What type of functioning includes reasoning, problem-solving, and learning?
20. Adaptive functioning is assessed across how many domains?
21. Which domain of adaptive functioning includes language, reading, writing, and reasoning skills?
22. Which adaptive functioning domain involves interpersonal communication and empathy?
23. Which adaptive functioning domain includes personal care and self-management?
24. On what basis is the severity of Intellectual Disability determined?
25. Early identification and appropriate support help improve what for individuals with neurodevelopmental disorders?

Answers

1. Typical development
2. Atypical development
3. Developmental period
4. DSM-5-TR
5. Functional impairment
6. Spectrum
7. Autism Spectrum Disorder



8. Social communication; Repetitive behaviours
9. Echolalia
10. ADHD
11. 12 years
12. Inattention
13. Hyperactivity
14. Impulsivity
15. Two
16. Predominantly Inattentive Presentation
17. Intellectual Disability
18. Intellectual Developmental Disorder
19. Intellectual functioning
20. Three
21. Conceptual domain
22. Social domain
23. Practical domain
24. Adaptive functioning
25. Quality of life

Assignment

1. Explain the exact boundary line that separates a normal, typical variation in development from an atypical developmental pattern. What key criteria must be present for a professional to declare a pattern atypical?
2. It is stated that neurodevelopmental disorders exist along a 'continuum of developmental functioning.' Contrast this modern perspective with the older idea that mental disorders are completely separate, isolated categories. How does a continuum account for symptom overlap?
3. Using the concepts provided in the unit, analyse the clinical and educational challenges that arise when a child experiences co-occurring disorders, such as ASD combined with an Intellectual Disability, or ADHD combined with learning difficulties.

4. Compare and contrast the physical manifestations of hyperactivity and impulsivity in a young child *versus* an adolescent or adult. How and why do these clinical features visually shift as the individual ages?
5. Argue why an Intellectual Disability is not simply a reflection of poor schooling, low motivation, or limited educational opportunities, utilising the discussion provided in the unit.
6. Define adaptive functioning and break down its three specific domains (conceptual, social, and practical). Provide a concrete life skill challenge for each domain that an individual with an Intellectual Disability might encounter.

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UNIT

Neurocognitive Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ◆ define neurocognitive disorders according to contemporary diagnostic frameworks
- ◆ discuss the clinical features associated with Alzheimer's disease, Parkinson's disease, and Major or Mild Neurocognitive Disorder due to Traumatic Brain Injury
- ◆ differentiate major and mild neurocognitive disorders based on severity and functional impairment

Prerequisite

There are illnesses that affect the body by weakening muscles, damaging organs, or limiting movement. But what happens when certain conditions begin to alter memory, attention, language, judgement, or even one's sense of familiarity with the world? Imagine meeting a person who speaks fluently yet forgets the purpose of the conversation halfway through, or someone who recognises a loved one's face but cannot recall their name or relationship. Imagine another person who remains mentally alert but finds their body moving more slowly and with greater rigidity, as though ordinary actions now require negotiation with the body itself. In another case, a person who survived a serious head injury gradually notices changes not only in concentration and memory, but also in emotional control, decision-making, and personality. In such situations, what exactly is changing? In each of these situations, something fundamental appears altered, not merely in the body, but in the person's very experience of thinking, remembering, moving, and relating to the world. But when memory, reasoning, attention, or behaviour begin to change, what exactly is being lost, altered, or disrupted?

Human beings experience the world through cognitive abilities that are so constant in everyday life that they are rarely noticed until they begin to change. Memory allows continuity between past and present; attention enables engagement with the world; language gives form to thought; and judgement guides action and relationships. When these capacities are altered, the effects often extend far beyond the individual symptom itself. Families may feel they are gradually 'losing' someone who is physically still present, while individuals may struggle with frustration, confusion, dependence, or changes in identity and functioning. As you navigate the unit, reflect on how neurocognitive disorders compel us to think not only about disorders of the brain, but also about the fragile relationship between cognition, behaviour, memory, identity, and the experience of being a person.

Keywords

Cognitive Decline, Executive Function, Bradykinesia, Tremors, Disorientation, Substantia Nigra, Dopamine

Discussion

3.2.1 Neurocognitive Disorders

Neurocognitive Disorders are a group of conditions characterised by a decline in cognitive functioning that is acquired rather than developmental. Unlike neurodevelopmental disorders, which are present from early childhood, neurocognitive disorders represent a decline from a previously attained higher level of cognitive performance. The underlying cause of this decline is a known or presumed physiological condition, such as a disease, medical condition, or injury that directly affects brain structure and function.

The cognitive decline can affect one or more cognitive domains, which include:

- ♦ *Attention*: Sustaining focus, dividing attention between tasks, and processing speed.

- ♦ *Executive Function*: Planning, decision-making, working memory, and overriding habits.
- ♦ *Learning and Memory*: Retaining new information and recalling past events.
- ♦ *Language*: Object naming, word-finding, grammar, and receptive comprehension.
- ♦ *Perceptual-Motor*: Visual perception, spatial reasoning, and coordinating movements.
- ♦ *Social Cognition*: Recognising emotions in others and demonstrating appropriate social behaviour.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) distinguishes neurocognitive disorders into two based on the level of severity extent of the cognitive decline and its impact on daily living. Major neurocognitive disorder involves

Table 3.2.1 Major *versus* Mild Neurocognitive Disorders

Feature	Major	Mild
Evidence of cognitive decline	Significant cognitive decline from a previous level of performance in one or more cognitive domains.	Modest cognitive decline from a previous level of performance in one or more cognitive domains.
Impact on Independence	The cognitive deficits interfere significantly with independence in everyday activities. The individual requires assistance with complex tasks (e.g., paying bills, managing medications).	The cognitive deficits do not interfere with independence in everyday activities. The individual can still live independently but may require greater effort or compensatory strategies.
Alternative Explanations	The cognitive deficits do not occur exclusively in the context of delirium and are not better explained by another mental disorder (e.g., major depressive disorder).	The cognitive deficits do not occur exclusively in the context of delirium and are not better explained by another mental disorder.

significant cognitive decline that disrupts an individual's independence in daily activities, whereas mild neurocognitive disorder involves modest cognitive decline in which independence is preserved through extra effort or compensatory strategies.

3.2.1.1 Alzheimer's Disease

Alzheimer's disease is the most common cause of neurocognitive decline in older adults and is characterised by a gradual and progressive deterioration of cognitive functioning. The disorder primarily affects memory in its early stages but eventually impairs multiple cognitive domains, including language, reasoning, judgment, and the ability to carry out everyday activities. Because the condition progresses slowly over time, the initial symptoms may be subtle and are often mistaken for normal age-related forgetfulness. However, unlike ordinary lapses in memory associated with ageing, the cognitive decline observed in Alzheimer's disease is persistent, progressive, and significant enough to interfere with daily functioning.

The disorder is associated with progressive changes in the brain that disrupt communication among nerve cells and ultimately lead to neuronal loss. As these changes accumulate, cognitive abilities gradually deteriorate, resulting in increasing difficulties in personal, social, and occupational functioning. Although Alzheimer's disease most commonly occurs in later adulthood, its effects extend beyond the individual, often creating substantial emotional, social, and caregiving challenges for family members.

The clinical features of Alzheimer's disease emerge gradually and worsen over time. The progression is typically divided into early, middle, and late stages, affecting multiple cognitive and behavioural domains.

a. Memory Impairment

Memory impairment is the most prominent and often the earliest clinical feature of Alzheimer's disease. Individuals typically experience difficulty remembering recently learned information, conversations,



appointments, or events. They may repeatedly ask the same questions, misplace belongings, or forget important details despite repeated reminders. As the disorder progresses, memory difficulties become increasingly severe and may eventually affect long-term memories as well.

b. Difficulties in Learning and Problem-Solving

Individuals with Alzheimer's disease often experience difficulties in acquiring new information and solving everyday problems. Tasks that previously required little effort, such as managing finances, following instructions, making decisions, or planning activities, may become increasingly challenging.

c. Language Deficits

Many individuals develop impairments in language functioning. They may have difficulty finding appropriate words during conversation, following discussions, naming familiar objects, or understanding complex verbal information. As cognitive decline progresses, communication may become increasingly limited, affecting social interactions and relationships.

d. Disorientation and Confusion

Disorientation regarding time, place, and circumstances is another characteristic feature of Alzheimer's disease. Individuals may lose track of dates, seasons, or the passage of time. They may become confused about where they are or how they arrived at a particular location. Such difficulties can increase the risk of wandering and create safety concerns for both the individual and caregivers.

e. Executive Dysfunction

A significant decline occurs in higher-level cognitive processing. This includes

poor planning, difficulty organising daily schedules, impaired judgment (such as dressing inappropriately for the occasion), and difficulty with abstract thinking or financial management.

f. Behavioural and Psychological Changes

In addition to cognitive impairment, many individuals experience behavioural and emotional changes. Common manifestations include irritability, anxiety, depression, apathy, mood fluctuations, suspiciousness, and social withdrawal. Some individuals may become increasingly dependent on others, while others may exhibit agitation or confusion, particularly as the disorder advances.

g. Impairment of Purposeful Movement and Inability to Recognise Objects

Despite having intact motor function, individuals lose the ability to carry out learned, purposeful motor activities. This impairs their ability to perform daily tasks such as buttoning a shirt, using utensils, or tying shoelaces. Also, individuals experience a failure to recognise or identify objects or people, despite having intact sensory functioning. For example, they may look at a clock and not understand what it is, or fail to recognise their own reflection in a mirror.

In short, the clinical features of Alzheimer's disease extend beyond memory impairment to encompass deficits in multiple cognitive domains, behavioural changes, and progressive functional decline. As the disorder advances, these impairments increasingly interfere with independent living and social functioning, highlighting the profound impact of Alzheimer's disease on both affected individuals and their family members and support systems.

ALZHEIMER'S DISEASE

- A.** A. The criteria are met for major or mild neurocognitive disorder.
- B.** B. There is insidious onset and gradual progression of impairment in one or more cognitive domains (for major neurocognitive disorder, at least two domains must be impaired).
- C.** C. Criteria are met for either probable or possible Alzheimer's disease as follows:
For major neurocognitive disorder:
 Probable Alzheimer's disease is diagnosed if either of the following is present; otherwise, possible Alzheimer's disease should be diagnosed.
 1. Evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing.
 2. All three of the following are present:
 a. Clear evidence of decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing).
 b. Steadily progressive, gradual decline in cognition, without extended plateaus.
 c. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).
For mild neurocognitive disorder:
 Probable Alzheimer's disease is diagnosed if there is evidence of a causative Alzheimer's disease genetic mutation from either genetic testing or family history. Possible Alzheimer's disease is diagnosed if there is no evidence of a causative Alzheimer's disease genetic mutation from either genetic testing or family history, and all three of the following are present:
 1. Clear evidence of decline in memory and learning.
 2. Steadily progressive, gradual decline in cognition, without extended plateaus.
 3. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological or systemic disease or condition likely contributing to cognitive decline).
- D.** D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

Coding note (see coding table on pp. 682–683):

For major neurocognitive disorder due to probable or possible Alzheimer's disease, with behavioral disturbance, code first G30.9 Alzheimer's disease, followed by F02.81. For major neurocognitive disorder due to probable or possible Alzheimer's disease, without behavioral disturbance, code first G30.9 Alzheimer's disease, followed by F02.80.

Note: The severity specifiers "mild," "moderate," and "severe" cannot be coded for major neurocognitive disorder but should still be recorded.

For mild neurocognitive disorder due to Alzheimer's disease, code G31.84. (Note: Do not use the additional code for Alzheimer's disease. "With behavioral disturbance" and "without behavioral disturbance" cannot be coded but should still be recorded.)

For major or mild neurocognitive disorder due to Alzheimer's disease: Use additional code(s) to indicate clinically significant psychiatric symptoms due to Alzheimer's disease (e.g., F06.2 psychotic disorder due to Alzheimer's disease, with delusions; F06.32 depressive disorder due to Alzheimer's disease, with major depressive-like episode).

Fig. 3.2.1 Diagnostic Criteria of Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease (DSM-5-TR)

3.2.1.2 Parkinson's Disease

Parkinson's disease is a progressive neurodegenerative disorder that primarily affects movement and motor control. It is now understood that the disorder results from the degeneration of dopamine-producing neurons in a region of the brain known as the *substantia nigra*. As dopamine levels decline, individuals experience characteristic motor symptoms that gradually interfere with everyday functioning. Although Parkinson's disease is primarily recognised as a movement disorder, it may also be accompanied by cognitive, emotional, and behavioural changes, particularly in its later stages, thereby contributing to neurocognitive impairment.

The onset of Parkinson's disease is typically gradual, with symptoms developing slowly over time. The progression and severity of symptoms vary among individuals; however, the disorder generally leads to increasing difficulties in mobility, daily functioning, and cognitive functioning. The clinical features of Parkinson's disease can be broadly

categorised into primary motor symptoms and non-motor symptoms.

a. Primary Motor Symptoms

The clinical presentation of Parkinson's disease typically begins with the observation of the following motor features.

◆ Resting Tremors

One of the most recognisable clinical features of Parkinson's disease is the presence of resting tremors, which occur when a body part is relaxed and not engaged in voluntary movement. Tremors commonly begin in the hands or fingers and are often characterised by a *pill-rolling movement*. They may also affect the arms, legs, jaw, or face. Resting tremors typically diminish during purposeful movement but may become more noticeable during periods of stress or emotional arousal.

◆ Bradykinesia (Slowness of Movement)

Bradykinesia, or the slowing of voluntary movement, is another hallmark feature

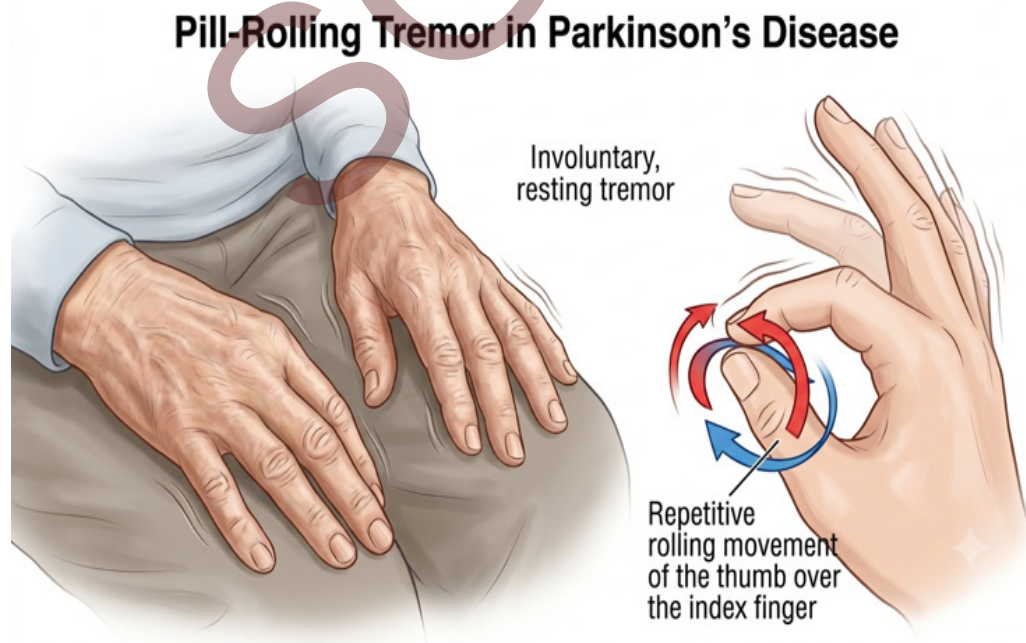


Fig. 3.2.2 Pill-rolling movement (AI-Generated for illustrative purpose)

of Parkinson's disease. Individuals may experience difficulty initiating movements and performing routine activities efficiently. Everyday tasks such as walking, dressing, writing, eating, or rising from a chair may become increasingly slow and effortful.

◆ **Muscular Rigidity**

Muscular rigidity refers to increased muscle stiffness and resistance to passive movement. Individuals may experience persistent muscle tension that restricts flexibility and range of motion. Rigidity can affect various parts of the body and may contribute to discomfort, pain, and difficulties in performing everyday activities. The combination of rigidity and bradykinesia often results in characteristic movement difficulties associated with the disorder.

◆ **Postural Instability and Balance Problems**

As Parkinson's disease advances, many individuals develop impairments in balance and postural control. They may experience difficulty maintaining an upright posture and adjusting their body position in response to environmental demands, increasing the risk of falls and injuries, particularly in the later stages of the disorder.

◆ **Changes in Gait and Facial Expression**

Parkinson's disease frequently alters walking patterns and general movement. Individuals may develop a shuffling gait characterised by short, hesitant steps and reduced arm swing while walking. Turning, stopping, or changing direction may become increasingly difficult. In addition, facial expressions may become reduced, resulting in a mask-like appearance that can make the individual seem emotionally unresponsive despite experiencing normal emotions.

b. Cognitive Impairments

In Parkinson's disease, the cognitive decline typically develops slowly, often after the motor symptoms have been established for several years, and the cognitive profile differs from Alzheimer's disease.

◆ **Executive Dysfunction**

This is frequently the most prominent early cognitive deficit. Individuals struggle with planning, organising, initiating tasks, problem-solving, and shifting their attention between different concepts or activities.

◆ **Slower Cognitive Processing (Bradyphrenia)**

This involves a noticeable delay in thinking, responding to questions, and processing new information, mirroring the slowness seen in their physical movements.

◆ **Memory Deficits**

Unlike the severe amnesia in Alzheimer's disease, where memories fail to form, individuals with Parkinson's disease often experience difficulty with memory retrieval. They struggle to recall information independently, but with cues or hints, they can typically access it.

◆ **Visuospatial Difficulties**

Individuals may experience difficulty accurately perceiving spatial relationships, leading to problems judging distances, recognising objects within complex visual environments, and navigating familiar surroundings.

◆ **Behavioural and Psychiatric Symptoms**

Significant changes in mood and perception often accompany the disorder's progression and can substantially affect the individual's quality of life. Depression

PARKINSON'S DISEASE

- A.** A. The criteria are met for major or mild neurocognitive disorder.
- B.** B. The disturbance occurs in the setting of established Parkinson's disease.
- C.** C. There is insidious onset and gradual progression of impairment.
- D.** D. The neurocognitive disorder is not attributable to another medical condition and is not better explained by another mental disorder.

Major or mild neurocognitive disorder probably due to Parkinson's disease should be diagnosed if 1 and 2 are both met. Major or mild neurocognitive disorder possibly due to Parkinson's disease should be diagnosed if 1 or 2 is met:

1. There is no evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).
2. The Parkinson's disease clearly precedes the onset of the neurocognitive disorder.

Coding note (see coding table on pp. 682–683):

For major neurocognitive disorder probably or possibly due to Parkinson's disease, with behavioral disturbance, code first G20 Parkinson's disease, followed by F02.81.

For major neurocognitive disorder probably or possibly due to Parkinson's disease, without behavioral disturbance, code first G20 Parkinson's disease, followed by F02.80.

Note: The severity specifiers "mild," "moderate," and "severe" cannot be coded for major neurocognitive disorder but should still be recorded.

For mild neurocognitive disorder due to Parkinson's disease, code G31.84. (Note: Do not use the additional code for Parkinson's disease. "With behavioral disturbance" and "without behavioral disturbance" cannot be coded but should still be recorded.)

For major or mild neurocognitive disorder due to Parkinson's disease: Use additional code(s) to indicate clinically significant psychiatric symptoms due to Parkinson's disease (e.g., F06.0 psychotic disorder due to Parkinson's disease, with hallucinations; F06.31 depressive disorder due to Parkinson's disease, with depressive features; F07.0 personality change due to traumatic brain injury, apathetic type).

Fig. 3.2.3 Major or Mild Neurocognitive Disorder Due to Parkinson's Disease (DSM-5-TR)

and anxiety are among the most common mood disturbances and may occur at any stage of the disease, sometimes even preceding the onset of characteristic motor symptoms. Many individuals also experience *apathy*, characterised by a profound lack of motivation, interest, or emotional responsiveness, which is considered a distinct clinical feature separate from depression.

3.2.1.3 Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury

Traumatic Brain Injury (TBI) refers to damage to the brain resulting from an external physical force, such as a blow, jolt, penetrating injury to the head, or rapid acceleration-deceleration of the brain within the skull. Common causes include falls, road traffic accidents, sports-related injuries, assaults, and other incidents involving head trauma. Depending on the severity and location of the injury, traumatic brain injury may produce temporary or long-lasting changes in cognitive, emotional, behavioural, and physical functioning.

When a traumatic brain injury results in a significant decline in cognitive functioning, the condition may be diagnosed as a neurocognitive disorder due to traumatic brain injury. The disorder is classified as major when cognitive deficits substantially interfere with independence in everyday activities such as managing finances, navigating public transportation, or taking medications, and as mild when cognitive difficulties are noticeable but do not significantly impair independent functioning and are sometimes assisted by compensatory strategies. The clinical presentation varies considerably across individuals because the effects depend on the extent and location of brain damage. However, to meet the criteria for a neurocognitive disorder due to TBI, the

cognitive decline must present immediately following the injury or immediately after recovering consciousness, and persist past the acute post-injury period.

The clinical features of a neurocognitive disorder resulting from a TBI vary significantly depending on the location and severity of the brain damage. However, some of the generalised features are detailed below.

a. Impairments in Attention and Concentration

Difficulties in attention and concentration are among the most commonly reported consequences of traumatic brain injury. Individuals may find it difficult to focus on tasks for extended periods, sustain attention in distracting environments, or divide attention between multiple activities, and the processing speed is typically slowed, meaning it requires more time for the individual to understand information and execute a response.

b. Memory Deficits

Many individuals experience impairments in memory following traumatic brain injury. They may have difficulty learning new information, recalling recent events, or retaining information over time. Memory problems may range from mild forgetfulness to more significant impairments that affect daily activities and interpersonal relationships.

c. Executive Functioning Deficits

Traumatic brain injury often affects executive functions, which include planning, organising, problem-solving, decision-making, and self-regulation. Individuals may have difficulty setting goals, managing time effectively, adapting to changing situations, or anticipating the consequences of their actions.

d. Slowed Information Processing

Many individuals experience a slower rate of information processing. Tasks that were previously completed quickly may require considerably more time and effort. Slowed cognitive processing can affect communication, learning, decision-making, and routine activities.

e. Language and Communication Difficulties

Depending on the nature and location of the injury, some individuals may experience difficulties in language and communication. They may struggle to find appropriate words, follow complex conversations, understand detailed information, or express themselves effectively.

f. Emotional and Behavioural Changes

Traumatic brain injury is often associated with significant emotional and behavioural changes. Individuals may become irritable, emotionally unstable, impulsive, anxious, or depressed. Some may experience reduced frustration tolerance, mood swings, or difficulties regulating emotional responses, affecting relationships and social adjustment.

g. Reduced Social Judgment and Self-Awareness

Some individuals experience difficulties in recognising the consequences of their behaviour or understanding social expectations. Reduced insight into one's own difficulties is also common, particularly following injuries affecting the frontal regions of the brain.

h. Physical and Neurological Symptoms

In addition to cognitive impairments, traumatic brain injury may produce physical symptoms such as headaches, dizziness, fatigue, sleep disturbances, balance problems, and sensory changes. Although these symptoms are not cognitive in nature, they often interact with cognitive difficulties and contribute to overall functional impairment.

The diverse consequences of traumatic brain injury underscore the important role of early assessment, rehabilitation, and supportive interventions in promoting recovery and adaptation. Although outcomes vary depending on the severity and location of the injury, timely intervention and ongoing support can significantly improve functional abilities, enhance quality of life, and facilitate successful reintegration into daily activities.

TRAUMATIC BRAIN INJURY

A.

A. The criteria are met for major or mild neurocognitive disorder.

B.

B. There is evidence of a traumatic brain injury—that is, an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull, with one or more of the following:

1. Loss of consciousness.
2. Posttraumatic amnesia.
3. Disorientation and confusion.
4. Neurological signs (e.g., neuroimaging demonstrating injury; visual field cuts; anosmia; hemiparesis; hemisensory loss; cortical blindness; aphasia; apraxia; weakness; loss of balance; other sensory loss that cannot be accounted for by peripheral or other causes).

C.

C. The neurocognitive disorder presents immediately after the occurrence of the traumatic brain injury or immediately after recovery of consciousness and persists past the acute post-injury period.

Coding note (see coding table on pp. 682–683):

For major neurocognitive disorder due to traumatic brain injury, with behavioral disturbance: code first S06.2X9S diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela; followed by F02.81 major neurocognitive disorder due to traumatic brain injury, with behavioral disturbance.

For major neurocognitive disorder due to traumatic brain injury, without behavioral disturbance: code first S06.2X9S diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela; followed by F02.80 major neurocognitive disorder due to traumatic brain injury, without behavioral disturbance.

Note: The severity specifiers “mild,” “moderate,” and “severe” cannot be coded for major neurocognitive disorder but should still be recorded.

For mild neurocognitive disorder due to traumatic brain injury, code G31.84. (Note: Do not use the additional code for traumatic brain injury. “With behavioral disturbance” and “without behavioral disturbance” cannot be coded but should still be recorded.)

For major or mild neurocognitive disorder due to traumatic brain injury: Use additional code(s) to indicate clinically significant psychiatric symptoms due to the traumatic brain injury (e.g., F06.34 bipolar and related disorder due to traumatic brain injury, with mixed features; F07.0 personality change due to traumatic brain injury, apathetic type).

Fig. 3.2.4 Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury (DSM-5-TR)

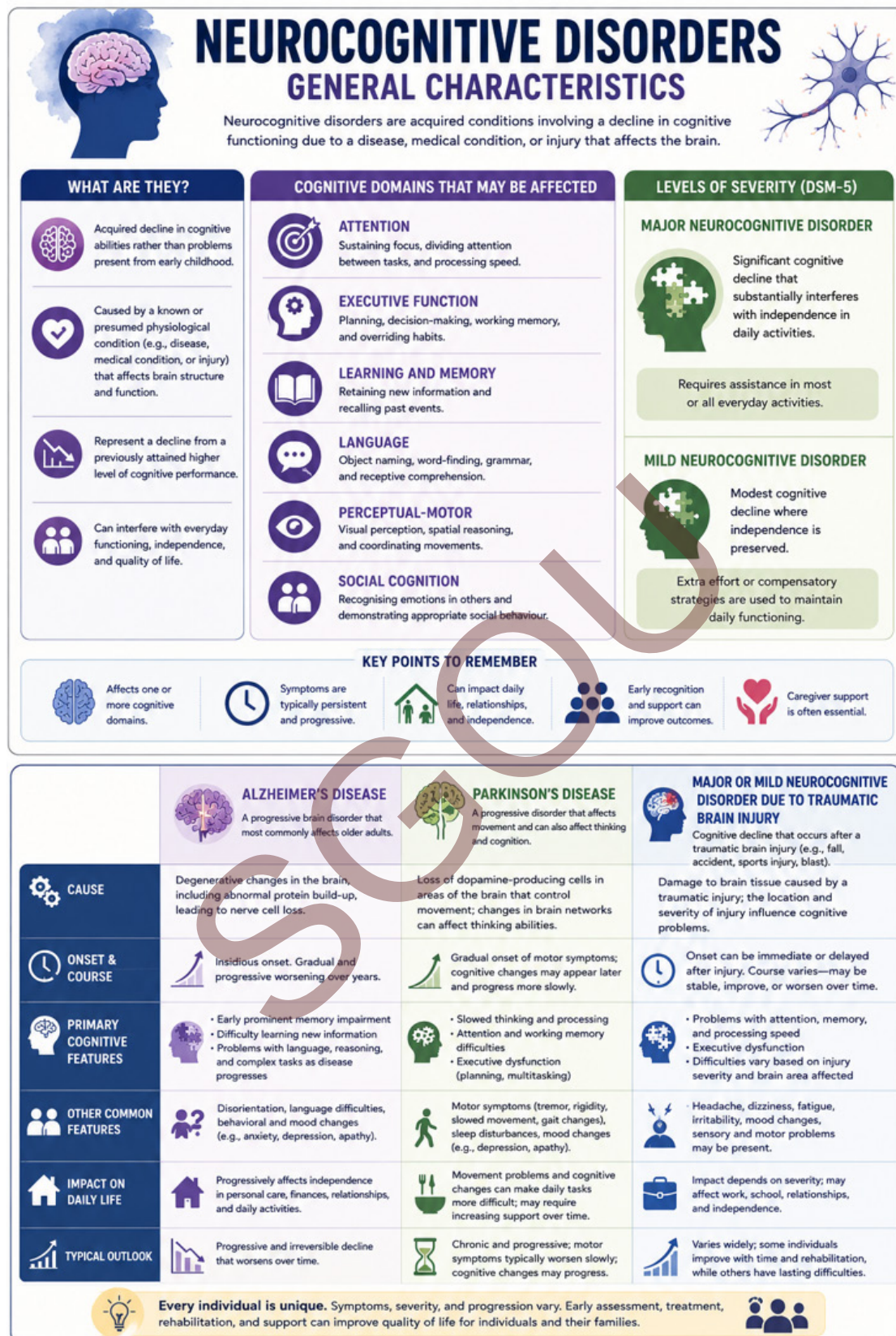


Fig. 3.2.5 Overview of the Clinical Features of the Neurocognitive Disorders Discussed (AI-Generated)

Recap

- ◆ Neurocognitive disorders involve an acquired decline in cognitive functioning.
- ◆ Unlike neurodevelopmental conditions, they are not present from childhood and stem from verified physiological factors.
- ◆ Cognitive decline may affect one or more domains of functioning, such as attention, executive function, learning and memory, language, perceptual-motor functioning and social cognition.
- ◆ DSM classifies neurocognitive disorders into major and mild forms.
- ◆ Major neurocognitive disorder significantly disrupts independence in daily living.
- ◆ Mild neurocognitive disorder involves a modest decline with preserved independence.
- ◆ Alzheimer's disease as the leading cause of progressive neurocognitive decline in ageing populations.
- ◆ Alzheimer's disease usually begins with memory impairment and gradually affects other cognitive functions.
- ◆ Early Alzheimer's symptoms may resemble normal forgetfulness but are progressive and persistent.
- ◆ Memory impairment in Alzheimer's disease often affects recently learned information first.
- ◆ Individuals with Alzheimer's disease may have difficulty learning new information and solving everyday problems.
- ◆ Language deficits in Alzheimer's disease include word-finding difficulty and impaired communication.
- ◆ Disorientation in Alzheimer's disease may involve confusion about time, place, and circumstances.
- ◆ Executive dysfunction in Alzheimer's disease affects planning, judgment, and organisation.
- ◆ Behavioural changes in Alzheimer's disease may include anxiety, apathy, depression, and suspiciousness.
- ◆ Alzheimer's disease may also impair purposeful movement and object recognition.

- ◆ Parkinson's disease is a progressive neurodegenerative disorder mainly affecting movement.
- ◆ It results from degeneration of dopamine-producing neurons in the substantia nigra.
- ◆ Resting tremors are a common motor symptom of Parkinson's disease.
- ◆ Bradykinesia refers to slowness of voluntary movement.
- ◆ Muscular rigidity causes stiffness and resistance to movement.
- ◆ Postural instability increases the risk of falls in Parkinson's disease.
- ◆ Parkinson's disease may produce a shuffling gait and reduced facial expression.
- ◆ Cognitive decline in Parkinson's disease often develops after motor symptoms.
- ◆ Executive dysfunction is a common cognitive feature in Parkinson's disease.
- ◆ Bradyphrenia refers to slowed thinking and mental processing in Parkinson's disease.
- ◆ Memory problems in Parkinson's disease often involve difficulty retrieving information.
- ◆ Visuospatial problems may affect navigation and judging distances.
- ◆ Depression, anxiety, and apathy are common behavioural symptoms in Parkinson's disease.
- ◆ Traumatic Brain Injury results from an external force affecting the brain.
- ◆ Falls, accidents, sports injuries, and assaults are common causes of TBI.
- ◆ Major TBI-related neurocognitive disorder interferes with independence.
- ◆ Mild TBI-related neurocognitive disorder causes noticeable decline without major loss of independence.
- ◆ Attention and concentration problems are common after TBI.
- ◆ Memory deficits after TBI may affect learning and recall.
- ◆ TBI often affects executive functioning, such as planning and self-regulation.
- ◆ Slowed information processing is a frequent consequence of TBI.
- ◆ Some individuals with TBI experience language and communication difficulties.

- ◆ Emotional and behavioural changes after TBI may include irritability, impulsivity, anxiety, and depression.
- ◆ TBI may reduce social judgment and self-awareness.
- ◆ Physical symptoms of TBI may include headaches, dizziness, fatigue, and balance problems.
- ◆ Early assessment, rehabilitation, and support are important in managing neurocognitive disorders.

Objective Questions

1. What is the term for a group of disorders characterised by an acquired decline in cognitive functioning?
2. What is the usual basis of the cognitive decline seen in neurocognitive disorders?
3. Which cognitive domain includes planning, decision-making, and working memory?
4. Which cognitive domain involves recognising emotions and behaving appropriately in social situations?
5. How many levels of severity are used in DSM to classify neurocognitive disorders?
6. If an individual's independent daily functioning is preserved through extra effort, what severity level is diagnosed?
7. Which disease is the most common cause of neurocognitive decline in older adults?
8. What is usually the earliest and most prominent symptom of Alzheimer's disease?
9. Which disorder is marked by persistent and progressive memory decline in older adults?

10. What is the term for confusion about time, place, and circumstances in Alzheimer's disease?
11. What is the term for difficulty in planning, organising, and making judgments in Alzheimer's disease?
12. What is the term for failure to recognise familiar objects despite intact sensory functioning?
13. Which disorder primarily affects movement and motor control due to degeneration of dopamine-producing neurons?
14. In which brain region does neuronal degeneration occur in Parkinson's disease?
15. What is the term for slowness of movement in Parkinson's disease?
16. When are tremors most commonly seen in Parkinson's disease?
17. Structural harm to what broad region of the brain is most tied to lost insight and poor social judgment?
18. What type of walking pattern is commonly seen in Parkinson's disease?
19. What is the term for slowed thinking in Parkinson's disease?
20. What chemical messenger drops off significantly due to cellular degeneration in Parkinson's?
21. What does TBI stand for?
22. Which function is impaired when a person with TBI has difficulty sustaining focus and concentration?
23. Which type of functioning is affected when a person with TBI has difficulty planning, organising, and solving problems?
24. What is an important intervention that helps improve recovery after traumatic brain injury?

Answers

1. Neurocognitive disorder
2. Physiological condition
3. Executive function
4. Social cognition
5. Two
6. Mild NCD
7. Alzheimer's disease
8. Memory impairment
9. Alzheimer's disease
10. Disorientation
11. Executive dysfunction
12. Agnosia
13. Parkinson's disease
14. Substantia nigra
15. Bradykinesia
16. At rest
17. Frontal Region
18. Shuffling gait
19. Bradyphrenia
20. Dopamine
21. Traumatic Brain Injury
22. Attention
23. Executive functioning
24. Rehabilitation

Assignment

1. Contrast the core nature of memory impairments between Alzheimer's disease and Parkinson's disease. Detail the functional differences between a failure to form/retain new data versus an inability to independently retrieve stored data.
2. Explain the motor and cognitive features of Parkinson's disease. Discuss resting tremors, bradykinesia, rigidity, postural instability, executive dysfunction, and slowed cognitive processing.
3. Explain how non-cognitive physical and neurological symptoms of Traumatic Brain Injury (such as chronic headaches, balance problems, dizziness, and sleep disturbances) interact with and worsen a patient's core cognitive deficits like attention and processing speed.
4. Based on the reading of the unit, write an analysis distinguishing the baseline definitions of neurocognitive disorders from neurodevelopmental disorders. Focus on differences in baseline attainment, onset windows, and underlying physiological factors.
5. Why are early assessment, rehabilitation, and supportive interventions important in neurocognitive disorders? Discuss their role in recovery, adaptation, maintenance of independence, and improvement of quality of life.

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BLOCK

Dissociative, Somatic Symptom and Trauma & Stressor Related Disorders



UNIT

Dissociative Disorder and Somatic Symptom and Related Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ◆ differentiate between the clinical presentations of Dissociative Disorders and Somatic Symptom and Related Disorders
- ◆ discuss the clinical features of Dissociative Identity Disorder, Dissociative Amnesia, and Somatic Symptom Disorder
- ◆ explain how Somatic Symptom Disorder shifts the clinical focus from the presence of an unexplainable medical condition to an individual's maladaptive psychological response

Prerequisite

Imagine meeting a person who cannot recall important periods of their life despite having no identifiable brain injury, or someone who speaks and behaves so differently across situations that even close family members feel as though they are encountering different versions of the same person. Imagine another individual who repeatedly experiences severe physical symptoms and distress, moving from one medical consultation to another, even when investigations reveal no sufficient physical explanation for the intensity of the suffering. In each of these situations, the distress is undeniably real, yet its source seems difficult to locate. If the body appears medically healthy, why does the suffering persist? And if memory and identity themselves begin to feel uncertain or fragmented, what happens to a person's sense of self?

We often assume that thoughts, memories, emotions, identity, and bodily experiences exist in a stable and coherent relationship with one another. Yet human experience does not always reveal itself in such direct and traceable ways. There are moments

when emotional conflicts appear to surface through the body, when memories become inaccessible, or when aspects of identity feel strangely disconnected from conscious awareness. Such experiences challenge familiar assumptions about how the mind functions and how suffering reveals itself. Sometimes what cannot be spoken, understood, or consciously processed may emerge in ways that are indirect, fragmented, or deeply embodied. And it is within this complex relationship between memory, identity, and bodily experience that dissociative and somatic symptom disorders are to be understood.

Keywords

Dissociation, Somatic, Fragmentation, Amnesia, Fugue, Depersonalisation, Derealisation, Maladaptive, Chronicity, Agency

Discussion

4.1.1 Definition

Rarely do we stop to reflect on the experiences that give life its sense of continuity and coherence. The experience of being oneself is often taken for granted. The ability to recognise oneself as the same person from one day to the next, to recall personal experiences, to distinguish memories from present events, and to trust the messages communicated by one's body are often assumed to be natural and effortless aspects of everyday life. And these experiences form the foundation of how individuals understand themselves and interact with the world around them. Yet, in some instances, there may be disruptions in how individuals experience themselves, remember personal information, or interpret bodily sensations. Such disturbances can give rise to significant psychological distress and impairment in everyday functioning.

The unit addresses two distinct categories of psychological conditions: Dissociative Disorders and Somatic Symptom and Related Disorders. Although they present differently,

both involve significant disruption in how an individual experiences their mental processes, memory, and physical body, and illustrate the complex interaction between psychological processes and physical functioning. Dissociative disorders involve disruptions in the normal integration of consciousness, memory, identity, emotion, perception, or behaviour. Somatic Symptom and Related Disorders, in contrast, are characterised by distressing physical symptoms accompanied by excessive thoughts, feelings, or behaviours related to those symptoms. Although the manifestations of these disorders differ, both highlight the important role of psychological processes in shaping subjective experiences, symptom presentation, and daily functioning.

Dissociative Disorders are a group of psychological disorders characterised by disruptions or discontinuities in the normal integration of consciousness, memory, identity, emotion, perception, body representation, behaviour, or sense of self. These are characterised by profound, involuntary escapes from reality, and

individuals with these disorders experience a severe disconnection from their core identity, their continuous memories, or their conscious awareness. In clinical psychology, these conditions are generally understood to develop as an involuntary mechanism to cope with severe trauma, particularly prolonged physical or emotional abuse during early developmental stages. The defining feature across all dissociative disorders is a fragmentation of identity or memory that causes significant impairment in an individual's personal, social, or occupational life.

The term *somatic* relates to the physical body. **Somatic Symptom and Related Disorders** are a group of disorders characterised by an intense focus on physical (somatic) symptoms, such as localised pain,

generalised fatigue, or neurological issues, that result in significant psychological distress and the disruption of daily life, accompanied by excessive thoughts, emotions, or behaviours related to those symptoms. The symptoms may or may not be associated with an identifiable medical condition; however, the individual's response to the symptoms is disproportionate and contributes substantially to impairment and distress.

Among the various disorders included within these categories, Dissociative Identity Disorder, Dissociative Amnesia, and Somatic Symptom Disorder are particularly important for understanding how disruptions in identity, memory, and bodily experiences can affect psychological functioning. The following sections examine the clinical features of these disorders in greater detail.

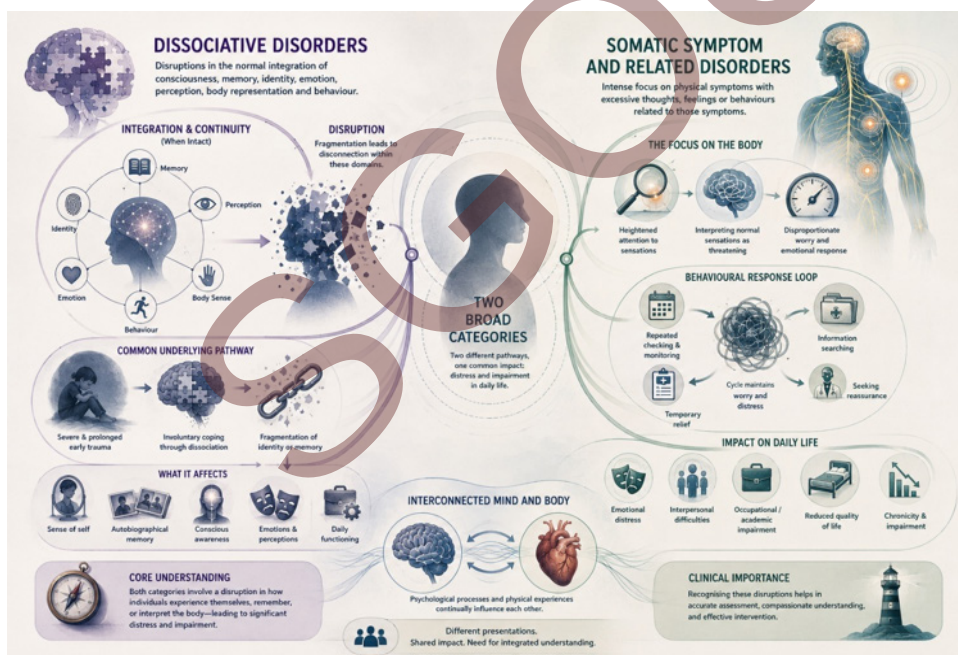


Fig. 4.1.1 Dissociative Disorders and Somatic Symptom and Related Disorders

4.1.1.1 Dissociative Identity Disorder

Dissociative Identity Disorder (DID) is a dissociative disorder characterised by the presence of two or more distinct identity states, or personality states that recurrently take control of an individual's behaviour.

These identity states may differ in their patterns of thinking, feeling, perceiving, and interacting with the environment. As a result, individuals experience a disrupted sense of self, accompanied by significant discontinuities in memory, consciousness, and behaviour.

The disorder is often associated with severe and prolonged traumatic experiences, particularly during childhood. From a psychological perspective, dissociation is understood as a mechanism through which distressing memories, emotions, or experiences become separated from conscious awareness. In Dissociative Identity Disorder, this process becomes so extensive that different aspects of experience may become organised into distinct identity states. The disorder can cause considerable distress and interfere with personal, social, occupational, and interpersonal functioning.

The clinical features of DID are detailed below:

a. Disruption of Identity

The primary feature of DID is a severe disruption of a person's core identity. This disruption involves the existence of distinct identity states, often referred to clinically as *alters*.

- ◆ **Distinct Identity States** : Each identity state has its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and the self. These states may have distinct names, ages, genders, voices, vocabularies, and even physiological characteristics, such as different dominant hands or varying blood pressure readings.
- ◆ **Loss of Agency** : The individual frequently experiences a sudden shift in behavioural control. They may feel as if they are an external observer to their own actions, speech, or thoughts and are completely unable to stop or direct them.
- ◆ **Discontinuities in the Sense of Self** : The shifts between identity states often result in sudden, inexplicable alterations in attitudes, personal

preferences such as food or clothing choices, and deeply held beliefs, leading to a discontinuous sense of self.

b. Recurrent Dissociative Amnesia

Individuals with DID experience significant gaps in their memory that extend far beyond ordinary forgetfulness. These memory gaps present in three main forms:

- ◆ **Gaps in Remote Memory** : An inability to recall significant, well-documented life events from the past, such as childhood experiences, a graduation, getting married, or the birth of a child.
- ◆ **Lapses in Dependable Memory** : Forgetting highly practised skills or well-established knowledge, such as how to drive a car, use a computer, or perform routine occupational tasks.
- ◆ **Discovery of Unexplained Evidence** : The individual may find themselves in a new location without knowing how they arrived. They may also find objects, new clothing, or written documents in their possession that they do not recall acquiring or producing.

c. Depersonalisation and Derealisation

While these can exist as isolated disorders, they are frequently prominent clinical features within the presentation of DID.

- ◆ **Depersonalisation** : This involves feeling detached from one's own body or mental processes. The individual may report feeling like an automaton or that their physical body does not belong to them.
- ◆ **Derealisation** : The sensation that the external world is unreal, dreamlike, or distorted. Familiar

surroundings, objects, or close relatives may suddenly appear strange, artificial, or unfamiliar.

The internal experience of DID is inherently distressing and chaotic. In addition, it is almost always present with severe comorbid psychological symptoms,

including severe clinical depression and pervasive anxiety, non-epileptic seizures or unexplainable somatic symptoms, and self-injurious behaviours and a highly elevated risk of suicidal ideation or attempts, which consistently require specialised clinical intervention.

The Three Faces of Eve

In the early 1950s, psychiatrists Corbett H. Thigpen and Hervey M. Cleckley began treating a young woman from Augusta, Georgia, whom they gave the pseudonym *Eve White* to protect her identity. Their clinical account, first published as a paper in 1954 and later expanded into the book *The Three Faces of Eve* (1957), became one of the most widely cited case studies in the history of dissociative disorders and introduced the condition to a broad public audience for the first time. The individual's real identity, Chris Costner Sizemore, remained concealed for over two decades until she chose to reveal it herself in the 1970s.

At the time of this case, the diagnostic category used was Multiple Personality Disorder (MPD); the term Dissociative Identity Disorder did not exist yet and was only introduced in the DSM-IV in 1994, partly to shift the clinical emphasis away from the idea of literally separate 'personalities' and toward a single individual with fragmented or insufficiently integrated identity states. Sizemore was therefore diagnosed with MPD, not DID, during her lifetime; modern discussions retroactively situate her case within the DID framework because the diagnostic criteria are considered continuous across the name change.

Sizemore initially sought treatment for severe headaches and blackout episodes she could not account for. She reported finding herself in places with no memory of having travelled there, and acquaintances described encounters with her that she had no recollection of. During therapy, Thigpen and Cleckley observed a dramatic shift in her demeanour: a second personality, *Eve Black*, emerged, vivacious, impulsive, and flirtatious, in sharp contrast to the reserved, anxious *Eve White*. *Eve Black* claimed awareness of *Eve White*'s existence and experiences, while *Eve White* remained largely unaware of *Eve Black*'s actions, consistent with the asymmetrical awareness between alters often described in DID.

As treatment progressed, a third personality emerged, whom the psychiatrists called *Jane*, presented as a more integrated, stable identity that appeared to have access to the memories and experiences of both prior personalities.

Thigpen and Cleckley's account ended on a note of cautious therapeutic optimism, and the book (along with the 1957 film adaptation) presented the case as a successful, if partial, resolution. This portrayal contributed significantly to public and professional awareness of dissociative disorders in the mid-20th century.

What makes this case especially significant is that Sizemore later contested the completeness of the original narrative. In her own memoirs – *I'm Eve* (1977) and *A Mind of My Own* (1989) – she disclosed that she had experienced not three, but reportedly around 22 distinct personality states over the course of her life, organised in overlapping groups rather than a single neat progression from two to one. She also stated that the 'successful integration' suggested at the end of Thigpen and Cleckley's account was premature; her dissociative symptoms continued for years afterwards, and she did not consider herself to have achieved lasting integration until later treatment with a different clinician.

However, the case is historically significant as one of the first widely publicised presentations of what was then called multiple personality disorder, now understood under the DSM-5 category of dissociative identity disorder, though, as with many early case studies, questions remain about how much the clinical narrative was shaped by the treatment context and publication process itself.

DISSOCIATIVE IDENTITY DISORDER

- A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.
- B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.
- E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Fig. 4.1.2 Diagnostic Criteria of Dissociative Identity Disorder (DSM-5-TR)

4.1.1.2 Dissociative Amnesia

Memory plays a central role in maintaining a sense of personal identity and continuity across time. Through memory, individuals can recall past experiences, recognise important events in their lives, and maintain a coherent understanding of who they are. Although forgetting is a normal part of human experience, certain forms of memory loss extend beyond ordinary forgetfulness and may significantly disrupt an individual's daily functioning and sense of self. Dissociative Amnesia is one such condition, in which memory disturbances occur without neurological injury or other medical explanations.

Dissociative Amnesia is a dissociative disorder characterised by an inability to recall important autobiographical information,

usually of a traumatic or stressful nature, that cannot be explained by ordinary forgetting. The memory loss is typically too extensive to be accounted for by normal lapses in memory and may interfere with personal, social, or occupational functioning. Unlike amnesia resulting from brain injury or neurological disease, dissociative amnesia is considered to have a psychological origin and is often associated with overwhelming stress, trauma, or emotional conflict.

The clinical features and presentations of dissociative amnesia include:

a. Patterns of Memory Loss

The memory loss in dissociative amnesia can manifest in several distinct patterns, depending on the scope of the information that cannot be retrieved.

- ◆ **Localised Amnesia** : This is the most common form. The individual fails to recall events from a specific, circumscribed period of time, usually the hours or days surrounding a highly traumatic event, such as surviving a severe accident or a natural disaster.
- ◆ **Selective Amnesia** : The individual can recall some of (But not all) the events during a specific period of time. For example, a person may remember certain parts of a traumatic event but have no memory of the most distressing moments within that same timeframe.
- ◆ **Generalised Amnesia** : A rare form involving a complete loss of memory of one's entire life history. Individuals lose awareness of their personal identity, their past experiences, and sometimes well-learned factual knowledge about the world.
- ◆ **Systematised Amnesia** : The individual loses memory for a specific category of information, such as all memories related to a particular person, a specific family member, or a single location. Unlike generalised amnesia, the memory loss is confined to a specific category of information. The person can remember most aspects of their life but cannot recall memories associated with a particular person, event, place, or theme.
- ◆ **Continuous Amnesia** : The individual fails to recall each new event as it occurs, preventing them from forming new memories from a certain point forward. However, it is a rarer, more severe form associated with the disorder.

b. Dissociative Fugue (when present)

A notable clinical feature that can accompany dissociative amnesia is a dissociative fugue. In some cases, Dissociative Amnesia may be accompanied by dissociative fugue, a condition involving sudden, unexpected travel or bewildered wandering and confusion about personal identity or aspects of the past. Individuals in a fugue state may suddenly leave their home or workplace and travel, sometimes adopting a completely new identity, occupation, and lifestyle, without any conscious awareness of their true past.

c. Preservation of Other Cognitive Functions

A crucial clinical feature of dissociative amnesia is the preservation of non-autobiographical cognitive functions. Individuals generally retain their language abilities, intellectual functioning, attention, and the capacity to learn new information. This distinguishes Dissociative Amnesia from memory impairments associated with neurological disorders or neurocognitive conditions. And, even though the individual cannot consciously recall explicit personal memories, their implicit or procedural memory remains completely intact. For instance, an individual with generalised amnesia will still know how to speak their language, read, write, or drive a car.

d. Clinical Distress and Course

- ◆ **Variable Duration**: The amnesic episode may last from a few minutes to several years. Amnesia often resolves suddenly, though it can sometimes leave smaller residual gaps.
- ◆ **Secondary Symptoms** : When the amnesia begins to resolve, or when individuals become aware of

Case 1: The Reverend Ansel Bourne (1887)

Ansel Bourne, a preacher living in Rhode Island, disappeared from his home in January 1887. Two months later, a man calling himself 'A.J. Brown' was found running a small shop in Norristown, Pennsylvania, where he had rented the premises and conducted business for several weeks. *Brown* had no memory of being Bourne and no awareness of his former life. When he abruptly *woke up* as Bourne once again, he had no recollection of the intervening two months, of the journey to Pennsylvania, or of operating the shop.

The case was investigated and documented by the psychologist William James, who arranged for the psychical researcher Richard Hodgson to hypnotise Bourne. Under hypnosis, the 'Brown' identity could reportedly be accessed and gave an account of the period in Pennsylvania, while the waking 'Bourne' identity remained unable to recall it without this intervention.

This case is regarded as the foundational illustration of the fugue presentation: apparently purposeful travel away from one's home or usual place of work, combined with an inability to recall one's past and, in Bourne's case, temporary assumption of a new identity and occupation.

Case 2: Jeff Ingram (2006)

In September 2006, Jeff Ingram was found disoriented and unable to identify himself in Denver, Colorado. He had no memory of his name, his home in Olympia, Washington, or how he had ended up in Colorado. He was eventually identified through media coverage and reunited with his fiancée, though his memory of the preceding period, and initially of much of his prior life, returned only gradually.

Because the case occurred in the era of modern neuroimaging, Ingram underwent brain scans as part of his medical workup. These did not reveal structural damage or other organic findings that would explain his amnesia, supporting a dissociative rather than a neurological explanation.

This case updates the fugue presentation for a contemporary context: it shows the same core features as Bourne's case, unexplained travel and loss of personal identity, but with the added value of demonstrating the exclusionary diagnostic workup (ruling out stroke, traumatic brain injury, seizure disorder, and substance-induced causes) that DSM-5-TR requires before a dissociative etiology can be established.

DISSOCIATIVE AMNESIA

- A.** An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.

Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.

- B.** The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- C.** The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, sequelae of a closed head injury/traumatic brain injury, other neurological condition).

- D.** The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.

Coding note:

The code for dissociative amnesia without dissociative fugue is F44.0.

The code for dissociative amnesia with dissociative fugue is F44.1.

Specify if:

- F44.1** With dissociative fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

Fig. 4.1.3. Diagnostic Criteria of Dissociative Amnesia (DSM-5-TR)

the memory gaps, they frequently experience high levels of distress, confusion, depression, and anxiety.

4.1.1.3 Somatic Symptom Disorder

Individuals experience pain, fatigue, discomfort, or other bodily sensations and may seek medical attention when these symptoms persist or cause concern. In general, these symptoms can be explained by identifiable medical conditions and resolve with appropriate treatment. However, for some individuals, physical symptoms become a source of excessive worry, distress, and preoccupation, significantly affecting their daily lives. In such instances, the individual's thoughts, emotions, and behaviours related to the symptoms may contribute as much to the distress as the symptoms themselves.

Somatic Symptom Disorder (SSD) is characterised by the presence of one or more distressing physical symptoms accompanied by excessive thoughts, feelings, or behaviours related to those symptoms. The symptoms may or may not be associated with a diagnosed medical condition. What distinguishes the disorder is not the absence of a medical explanation but the disproportionate and persistent psychological response to the symptoms. The resulting distress often interferes with personal, social, academic, or occupational functioning.

Somatic Symptom Disorder represents a significant shift in how somatic (physical) conditions are diagnosed in clinical psychology. Previously, diagnoses often relied on the absence of a medical explanation for a physical symptom. Currently, the diagnosis of SSD relies on the presence of a positive psychological response, specifically, the excessive and maladaptive thoughts, feelings, and behaviours that an individual exhibits in relation to their physical symptoms.

The clinical features of Somatic Symptom Disorders include:

a. Presence of Distressing Physical Symptoms

The central feature of Somatic Symptom Disorder is the presence of one or more physical symptoms that are distressing or significantly disrupt daily functioning. Common complaints may include pain, fatigue, gastrointestinal difficulties, dizziness, weakness, or other bodily discomforts. The symptoms may vary in severity and may involve different bodily systems.

b. Excessive Health-Related Thoughts

Individuals with Somatic Symptom Disorder often devote considerable attention to their symptoms and may interpret them as indicators of serious illness. They may repeatedly think about the possible causes or consequences of the symptoms and find it difficult to shift their focus away from health-related concerns. Minor bodily sensations may be perceived as evidence of significant medical problems.

c. Excessive Health-Related Behaviours

Individuals may engage in repeated behaviours aimed at monitoring or addressing their symptoms. These may include frequent medical consultations, repeated requests for diagnostic tests, excessive checking of bodily signs, or constant reassurance-seeking from family members and healthcare providers. In some cases, individuals may spend a substantial amount of time researching illnesses and possible symptoms.

d. Disproportionate Concern Relative to the Symptoms

The symptoms may or may not be associated with a known medical condition. If a diagnosed medical condition is present, the emotional and behavioural response to the symptoms is often excessive when compared with the actual severity of the physical condition. Even when symptoms are relatively mild, the individual may experience

considerable distress and impairment because of the attention and significance attributed to them. However, it is important to understand that the felt physical suffering is entirely authentic, that the individual is not faking or intentionally producing the symptoms.

e. Impairment in Daily Functioning

The preoccupation with physical symptoms may interfere with various areas of life. Individuals may find it difficult to concentrate on work or academic tasks, maintain social relationships, or participate in routine activities. Health concerns may become the dominant focus of daily life, reducing engagement in other meaningful pursuits.

f. Chronicity and Persistence

Somatic Symptom Disorder is often characterised by persistent symptoms and

ongoing concern about health. While any one specific somatic symptom may not be continuously present (for example, a headache may fade while back pain emerges), the overall state of being highly symptomatic and distressed is persistent. As a result, the disorder may become chronic if appropriate intervention is not provided.

Overall, a critical element characterising these disorders is the individual's extreme and disproportionate psychological response to the physical symptoms. The diagnosis depends on the presence of excessive thoughts, feelings, and behaviours related to the physical condition. The clinical focus for these disorders is placed entirely on the individual's severe distress and maladaptive behavioural response to their physical symptoms, rather than simply the presence or absence of a clear medical explanation.

Briquet's Syndrome and Somatic Symptom Disorder

In 1859, French physician Pierre Briquet published a detailed clinical study describing a pattern he observed across more than 400 patients: the presence of multiple, recurrent physical complaints spanning several organ systems, occurring over a long period of time, without an identifiable medical explanation for the full extent of the symptoms. This pattern, later termed 'Briquet's syndrome' in his honour, is widely regarded as the earliest systematic clinical description of what would eventually become a recognised diagnostic category for medically unexplained or excessively distressing somatic complaints.

Briquet's original description went through several stages of diagnostic reformulation over the following century. It directly influenced the development of 'somatisation disorder,' which was formally introduced as a diagnostic category in DSM-III (1980), characterised by a specific threshold of unexplained physical symptoms across multiple body systems. In DSM-5 (2013), this category, along with related diagnoses such as hypochondriasis, was substantially revised and consolidated into the broader diagnosis of somatic symptom disorder, which shifted the diagnostic emphasis away from requiring a strict count of 'medically unexplained' symptoms and toward the presence of excessive thoughts, feelings, or behaviours related to the somatic symptoms themselves, regardless of whether a medical explanation exists.

SOMATIC SYMPTOM DISORDER

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specify if:

With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if:

Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

Fig. 4.1.4 Diagnostic Criteria of Somatic Symptom Disorder (DSM-5-TR)

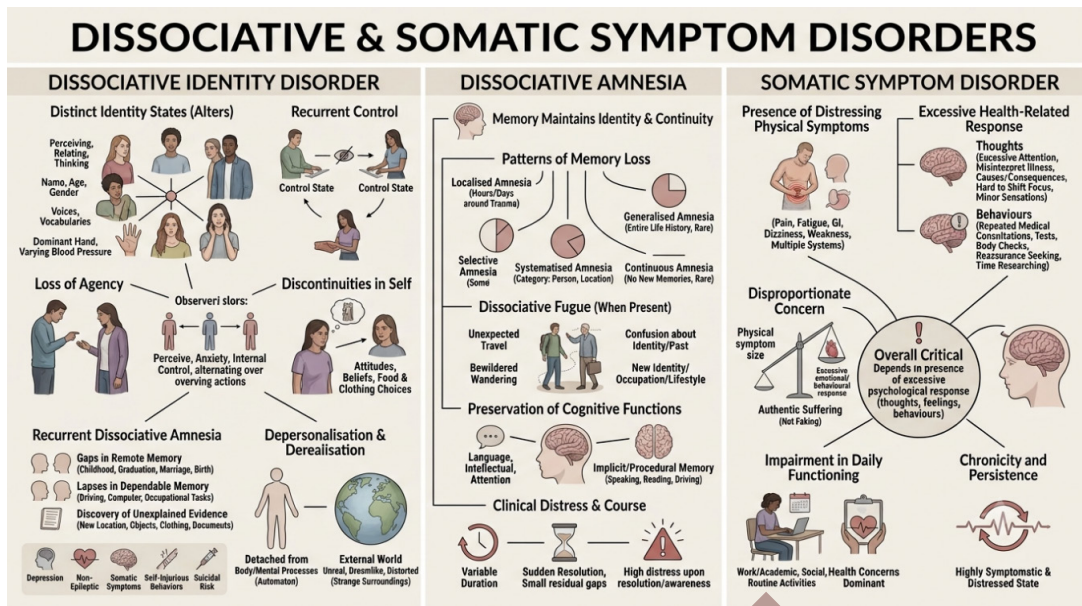


Fig. 4.1.5 Clinical Features of Dissociative Identity Disorder, Dissociative Amnesia, and Somatic Symptom Disorder (AI-Generated)

Recap

- ◆ Dissociative and Somatic Symptom disorders both highlight the interaction of psychology and physical functioning.
- ◆ Dissociative disorders involve disruptions in consciousness, memory, identity, perception, or behaviour.
- ◆ Somatic responses are highly disproportionate, regardless of whether a medical cause is identified.
- ◆ Dissociative Identity Disorder (DID) involves two or more distinct identity states.
- ◆ These identity states may differ in thoughts, feelings, voice, age, gender, or behaviour.
- ◆ Distinct identity states in DID are often referred to as alters.
- ◆ Individuals with DID may have gaps in remote memory about important life events.

- ◆ DID may involve a profound loss of agency, feeling like outside observers of their own bodies.
- ◆ Depersonalisation involves feeling detached from one's own body or mental processes.
- ◆ Derealisation involves feeling that the outside world is unreal, strange, or dreamlike.
- ◆ DID is often accompanied by depression, anxiety, somatic symptoms, self-injury, or suicidal risk.
- ◆ Dissociative Amnesia involves the inability to recall important autobiographical information. The memory loss in dissociative amnesia cannot be explained by ordinary forgetting.
- ◆ Localised amnesia involves forgetting events during a specific period of time.
- ◆ Selective amnesia involves remembering some parts of an event but not others.
- ◆ Generalised amnesia involves loss of memory for one's entire life history.
- ◆ Systematised amnesia affects memory of a particular person, place, or category of information.
- ◆ Continuous amnesia involves failure to remember each new event as it occurs.
- ◆ Dissociative amnesia may sometimes occur with dissociative fugue.
- ◆ Dissociative fugue involves sudden travel or wandering with confusion about identity.
- ◆ A person in fugue may adopt a new identity or lifestyle.
- ◆ In dissociative amnesia, language, attention, and general intellectual functioning are usually preserved.
- ◆ Somatic Symptom Disorder (SSD) features one or more distressing physical symptoms paired with excessive health-related thoughts. The symptoms may or may not have a medical explanation.
- ◆ Diagnosis of SSD relies on a positive psychological response (maladaptive behaviour) rather than medically unexplained symptoms.
- ◆ Common somatic complaints of SSD include localised pain, chronic fatigue, or gastrointestinal issues.

- ◆ The psychological and emotional distress associated with SSD is completely disproportionate to the actual physical severity.
- ◆ The clinical focus in SSD is on excessive thoughts, feelings, and behaviours related to symptoms rather than only on the presence or absence of a medical diagnosis.

Objective Questions

1. What type of disorders involve disruptions in consciousness, memory, identity, perception, or behaviour?
2. What type of disorders are characterised by distressing physical symptoms along with excessive thoughts, feelings, or behaviours about them?
3. Which dissociative disorder is characterised by the presence of two or more distinct identity states?
4. What is the common clinical term used for the distinct identity states in Dissociative Identity Disorder?
5. What is the main disturbance in Dissociative Identity Disorder?
6. What timeline or stage of development is most associated with the trauma that leads to DID?
7. Which dissociative disorder is characterised by an inability to recall important autobiographical information?
8. What is the usual nature of the forgotten material in dissociative amnesia?
9. Which type of amnesia involves an inability to recall events from a specific period of time?
10. Which type of amnesia involves remembering some but not all parts of a traumatic event?
11. Which type of amnesia involves complete loss of memory for one's life history?
12. Which type of amnesia affects memory for a specific person, place, or category of information?

13. Which type of amnesia prevents recall of each new event as it occurs?
14. What is the term for sudden travel or wandering associated with confusion about personal identity?
15. What is the term for feeling detached from one's own body or mental processes?
16. What is the term for the experience in which the external world feels unreal or dreamlike?
17. In Dissociative Identity Disorder, what type of memory problem commonly occurs along with identity disruption?
18. Which disorder is characterised by one or more distressing physical symptoms with excessive psychological response?
19. Which type of memory remains completely intact and unaffected in dissociative amnesia?
20. What does the term somatic refer to?
21. In Somatic Symptom Disorder, what type of behaviour includes repeated medical visits and reassurance seeking?
22. Are the physical symptoms in Somatic Symptom Disorder intentionally produced by the individual?
23. What term describes the long-lasting, ongoing, and persistent nature of Somatic Symptom Disorder?
24. Which disorder may include severe health-related preoccupation even when symptoms are mild?
25. Which cognitive abilities are generally preserved in dissociative amnesia despite autobiographical memory loss?

Answers

1. Dissociative Disorders
2. Somatic Symptom Disorders

3. Dissociative Identity Disorder
4. Alters
5. Identity disruption
6. Childhood
7. Dissociative Amnesia
8. Traumatic memories
9. Localised amnesia
10. Selective amnesia
11. Generalised amnesia
12. Systematised amnesia
13. Continuous amnesia
14. Dissociative fugue
15. Depersonalisation
16. Derealisation
17. Dissociative Amnesia
18. Somatic Symptom Disorder
19. Implicit
20. Physical body
21. Symptom severity
22. No
23. Chronicity
24. Somatic Symptom Disorder
25. Language and attention

Assignments

1. Analyse the paradigm shift in how clinical psychology diagnoses Somatic Symptom Disorder today compared to historical approaches. Focus specifically on the transition from ‘medically unexplainable symptoms’ to ‘positive psychological criteria.’
2. Compare and contrast the nature of memory loss in Dissociative Identity Disorder *versus* Dissociative Amnesia. How do gaps in remote memory, dependable memory, and unexplained evidence differentiate the internal structure of DID from amnesic episodes?
3. Explain the evolutionary or defensive purpose of dissociation during early childhood development. How does an involuntary escape from reality transform into a highly structured fragmentation of identity (alters) in adulthood?
4. Critique the concept of ‘loss of agency’ within Dissociative Identity Disorder. How does an individual experience their own thoughts, actions, and speech when they are acting as an external observer to their physical body?
5. Examine the preservation of implicit memory in a patient diagnosed with Generalised Dissociative Amnesia. How can an individual lose their entire personal history and identity yet retain complex operational skills like reading, writing, and driving?
6. Evaluate the assertion that the physical suffering in Somatic Symptom Disorder is ‘entirely authentic.’ How can a clinician validate an individual’s genuine physical agony while managing behaviours driven by disproportionate psychological responses?

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UNIT

Trauma and Stressor-Related Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ♦ define traumatic and stressor-related disorders according to contemporary diagnostic frameworks.
- ♦ discuss the clinical features of Reactive Attachment Disorder and Post-Traumatic Stress Disorder
- ♦ explain the four distinct symptom clusters that characterise the chronic presentation of Post-Traumatic Stress Disorder

Prerequisite

A child who has rarely experienced consistent care avoids comfort even when distressed, seeming emotionally distant from those around them. Elsewhere, an adult who survived a life-threatening accident continues to react with intense fear months later, startled by ordinary sounds, unable to sleep peacefully, and repeatedly pulled back into memories they cannot fully control. In both situations, the original experience may have passed, yet its effects can persist in thoughts, emotions, relationships, and everyday behaviour. Why do some experiences continue to affect individuals long after the event itself is over? And how can experiences of fear, neglect, or threat begin to shape the way a person relates to safety, trust, and the world around them?

Human beings do not merely experience events; they also carry the emotional meanings attached to those experiences. Moments of overwhelming fear, prolonged neglect, or disrupted care can sometimes leave effects that continue beyond immediate circumstances, influencing emotional responses, relationships, memory,

and behaviour over time. Yet, responses to trauma and stress are rarely identical across individuals. While some gradually regain a sense of safety and stability, others continue to experience distress in ways that deeply affect everyday functioning and relationships. It is within these enduring psychological effects of trauma, threat, and disrupted attachment that trauma- and stressor-related disorders may be understood.

Keywords

Pathogenic, Anhedonia, Dysphoria, Intrusion, Flashbacks, Avoidance, Hypervigilance, Arousal, Reactivity, Neglect

Discussion

4.2.1 Definition

Human development and psychological well-being are profoundly influenced by the experiences individuals encounter throughout life. Supportive relationships, feelings of safety, and stable environments contribute to healthy emotional and social functioning. Most individuals can adapt to everyday challenges and stressors with relative ease; however, some experiences are so adverse, overwhelming, or disruptive that they can have a lasting impact on psychological functioning. Experiences such as neglect, abuse, violence, disasters, accidents, or the loss of significant relationships may challenge an individual's ability to cope and adapt effectively.

The effects of such experiences vary across individuals and developmental stages. In some cases, exposure to adverse circumstances may disrupt the formation of healthy emotional bonds during early childhood. In others, exposure to traumatic events may lead to persistent fear, distress, and difficulties in emotional regulation long after the event has ended. These reactions highlight the important role that life

experiences and environmental stressors play in shaping psychological functioning.

Trauma and stressor-related disorders comprise a group of psychological disorders in which exposure to a traumatic or stressful event is an essential component in the development of symptoms. Unlike many other psychological disorders, these conditions are defined not only by their symptoms but also by their association with identifiable adverse experiences. Some are associated with disruptions in early caregiving relationships, whereas others develop following exposure to traumatic events that threaten an individual's safety or well-being.

To better understand this category, it is necessary to distinguish between the severity and nature of the inciting events, as follows:

- ♦ **Traumatic Events:** These involve exposure to actual or threatened death, serious injury, or sexual violence. This exposure can be direct (experiencing the event oneself), witnessed in person, learned about (if the event occurred to a close family member or friend),

or experienced through repeated occupational exposure to aversive details of a traumatic event (such as first responders).

- ◆ **Stressful Events (Stressors):** These are significant life events that cause severe distress but do not meet the strict medical criteria for a traumatic event. Examples include severe childhood social neglect, parental separation, or chronic environmental instability.

A defining feature of trauma and stressor-related disorders is the high variability in how psychological distress manifests following exposure. While previous clinical classifications grouped many of these conditions primarily under anxiety disorders, it is now established that the clinical presentation extends far beyond fear or anxiety.

Following a traumatic or stressful event, individuals may present with a combination of the following:

- ◆ **Anhedonia and Dysphoria :** A profound loss of the ability to experience pleasure, often accompanied by a generalised state of clinical unease, depression, or dissatisfaction with life.
- ◆ **Externalised Anger and Aggression :** Prominent irritable or aggressive behavioural patterns, often presenting without proportional external provocation.
- ◆ **Dissociative Symptoms :** A disconnection from reality, an altered sense of self, or an inability to recall specific aspects of the distressing event.

Because the clinical response to severe stress is highly variable across different individuals, the Diagnostic and Statistical Manual of Mental Disorders categorises these specific disorders together based on their shared etiology rather than a uniform set of symptoms.

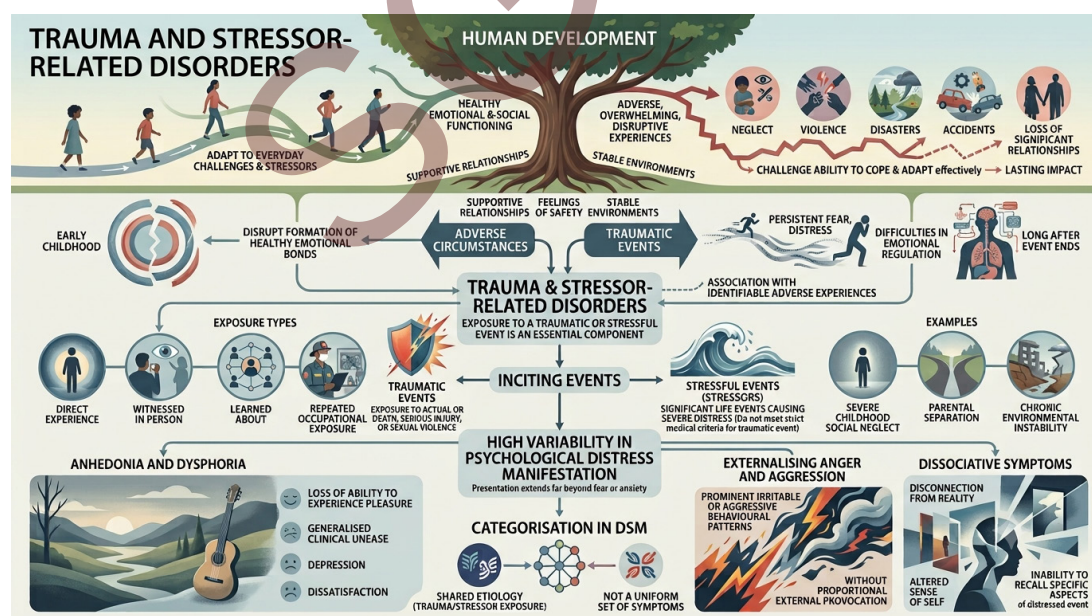


Fig. 4.2.1 Trauma and Stressor-Related Disorders (AI-Generated)

Within the category, Reactive Attachment Disorder and Post-Traumatic Stress Disorder are important examples that illustrate the diverse psychological consequences of adverse life experiences, and the clinical features of these are discussed in detail in the following sections.

4.2.1.1 Reactive Attachment Disorder

The ability to form emotional bonds with significant others is one of the most important developmental achievements of infancy. Infants depend on caregivers not only for physical survival but also for emotional security and social development. Through consistent, responsive, and nurturing interactions, they gradually develop attachment relationships that provide a sense of safety and trust. These early attachments play a crucial role in shaping emotional regulation, social competence, and the ability to form meaningful relationships. However, when they experience severe neglect, deprivation, or repeated disruptions in caregiving, the development of secure attachment may be significantly impaired.

Reactive Attachment Disorder is a trauma and stressor-related disorder that emerges in infancy or early childhood. It is characterised by a markedly disturbed and developmentally inappropriate pattern of attachment behaviours and emotional responsiveness. They exhibit persistent difficulties in seeking, accepting, and responding to care and affection from others. Although the disorder has its onset in early childhood, its effects may have long-term implications for emotional and social functioning.

The clinical features of Reactive Attachment Disorder include:

a. Failure to Seek Comfort When Distressed

One of the most characteristic features of

Reactive Attachment Disorder is a reduced tendency to seek comfort from caregivers during times of distress, fear, or discomfort. Unlike most children, who naturally turn to trusted adults for reassurance and support, children with RAD often appear emotionally self-reliant or withdrawn when upset.

b. Limited Response to Comfort and Affection

Even when caregivers attempt to provide comfort, reassurance, or affection, the child may show little response. The expected emotional connection between caregiver and child may appear weakened or absent, reflecting difficulties forming secure attachment relationships.

c. Emotionally Withdrawn Behaviour

Children with RAD frequently display emotionally withdrawn behaviour in social interactions. They may appear detached, distant, or uninterested in engaging with caregivers and other significant individuals. Their interactions often lack the warmth and reciprocity typically observed in secure attachment relationships.

d. Restricted Positive Affect

Many children with the disorder exhibit limited expressions of positive emotions. Smiling, laughter, affection, enthusiasm, and other positive emotional responses may occur less frequently than expected for their developmental level.

e. Episodes of Unexplained Irritability, Sadness, or Fear

Children with Reactive Attachment Disorder may display recurrent emotional disturbances, including irritability, sadness, fearfulness, or emotional distress that are not readily explained by immediate circumstances. These reactions may occur even during routine interactions with familiar caregivers.



f. Difficulties in Social Relationships

The attachment disturbances associated with RAD often affect broader social functioning. The children may struggle to develop trusting relationships with caregivers, peers, teachers, and other adults. These difficulties can interfere with social adjustment and emotional development.

g. Impairment in Emotional and Social Functioning

The cumulative effects of attachment disturbances can significantly affect emotional regulation, interpersonal relationships, and overall psychosocial functioning. Difficulties in trust, emotional expression, and relationship formation may persist across different social contexts and developmental stages.

REACTIVE ATTACHMENT DISORDER

A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:

1. The child rarely or minimally seeks comfort when distressed.
2. The child rarely or minimally responds to comfort when distressed.

B. A persistent social and emotional disturbance characterized by at least two of the following:

1. Minimal social and emotional responsiveness to others.
2. Limited positive affect.
3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).

E. The criteria are not met for autism spectrum disorder.

F. The disturbance is evident before age 5 years.

G. The child has a developmental age of at least 9 months.

Specify if:

Persistent: The disorder has been present for more than 12 months.

Specify current severity:

Reactive attachment disorder is specified as severe when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Fig. 4.2.2 Diagnostic Criteria of Reactive Attachment Disorder (DSM-5-TR)

A diagnosis of Reactive Attachment Disorder explicitly requires clinical evidence that the child has experienced a pattern of extremes in insufficient care. This history of pathogenic care is the direct cause of the attachment disruptions and includes at least one of the following:

- ◆ *Severe Social Neglect* : The chronic lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
- ◆ *Instability of Caregivers*: Repeated changes in primary caregivers that restrict the child's opportunity to form stable, selective attachments. For example, frequent transitions in the foster care system.
- ◆ *Unusual Rearing Environments*: Growing up in settings that severely limit the opportunity to form selective attachments, such as institutions or orphanages with very high child-to-caregiver ratios.

4.2.1.2 Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is a trauma and stressor-related disorder that may develop following exposure to an actual or threatened traumatic event involving death, serious injury, or sexual violence. Experiences such as natural disasters, serious accidents, physical or sexual assault, war, terrorism, or witnessing death and severe injury can have profound and lasting psychological effects. While many individuals experience acute distress immediately following a trauma, PTSD is diagnosed when this stress reaction fails to resolve and instead develops into a chronic, severely disruptive pattern of symptoms.

The disorder is characterised by persistent psychological distress associated with the traumatic experience, resulting in disturbances in memory, emotion, cognition,

and behaviour. Individuals with PTSD often feel as though the traumatic event continues to intrude into their present lives, affecting their sense of safety, emotional well-being, and daily functioning. For a clinical diagnosis, the symptoms must persist for more than a specified duration following the event and cause significant impairment in social, occupational, or other critical areas of functioning.

The clinical features of PTSD can be categorised into four distinct symptom clusters:

a. Intrusion Symptoms (Re-experiencing)

The individual persistently and involuntarily re-experiences the traumatic event in the present, and includes:

- ◆ **Intrusive Memories and Trauma-Related Nightmares** : Recurrent, involuntary, and highly distressing memories of the trauma, and recurrent distressing dreams in which the content or the emotional affect of the dream is directly related to the traumatic event.
- ◆ **Dissociative Reactions (Flashbacks)** : Episodes in which the individual feels or acts as if the traumatic event is occurring in the present moment. This can range from brief visual intrusions to a complete loss of awareness of current surroundings.
- ◆ **Severe Psychological and Physiological Reactivity** : Experiencing intense psychological distress or marked physical reactions, such as elevated heart rate, sweating, or panic when exposed to internal or external cues that symbolise or resemble an aspect of the trauma.

b. Avoidance Symptoms

The individual engages in persistent



efforts to avoid stimuli associated with the trauma to prevent triggering distress. Clinical features include:

- ◆ **Internal Avoidance** : This includes active efforts to avoid distressing memories, thoughts, or feelings directly associated with the traumatic event.
- ◆ **External Avoidance** : This includes active efforts to avoid external reminders such as specific people, places, conversations, activities, objects, or situations that arouse distressing trauma-related memories.

c. Negative Alterations in Cognition and Mood

The trauma results in a pervasive worsening of the individual's thought patterns and emotional states. Clinical features include:

- ◆ **Dissociative Amnesia** : An inability to recall critical aspects of the traumatic event, which is not due to physical head injury, alcohol, or drugs.
- ◆ **Distorted Beliefs** : Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world, such as beliefs like *I am permanently damaged, the entire world is dangerous, no one can be trusted*, etc.
- ◆ **Distorted Blame** : Persistent, irrational cognitive distortions regarding the cause or consequences of the traumatic event, leading the individual to blame themselves or others inappropriately.
- ◆ **Pervasive Negative Emotional State** : A continuous experience of negative emotions, such as fear, horror, anger, guilt, or profound shame, or a persistent inability

to feel happiness, satisfaction, or loving feelings.

d. Alterations in Arousal and Reactivity

The trauma causes a baseline shift in the individual's physiological arousal, leading to heightened reactivity. Clinical features include:

- ◆ **Irritability and Aggression** : This includes irritable behaviour and angry outbursts, often with little or no provocation, typically expressed as verbal or physical aggression toward people or objects. There could also be engagement in dangerous, self-destructive, or highly impulsive behaviours.
- ◆ **Hypervigilance and Heightened Arousal** : Individuals with PTSD often remain in a state of heightened alertness, constantly and excessively scanning their environment for potential threats. This condition, known as hypervigilance, may be accompanied by exaggerated startle responses, increased sensitivity to unexpected stimuli, and persistent feelings of danger even in safe situations.
- ◆ **Sleep Disturbances** : Sleep-related difficulties are frequently reported in PTSD. Individuals may have trouble falling asleep, staying asleep, or achieving restful sleep, coupled with nightmares, heightened arousal, and persistent anxiety.

Overall, the symptoms of PTSD can significantly interfere with personal, social, academic, and occupational functioning. Difficulties in concentration, emotional regulation, relationships, and coping with everyday demands may affect multiple areas of life and contribute to substantial distress. In some cases, the clinical presentation of PTSD is accompanied by persistent or recurrent dissociative symptoms.

Siegfried Sassoon and W. H. R. Rivers

The case of Siegfried Sassoon provides an important historical example for understanding the development of ideas that later became associated with post-traumatic stress disorder (PTSD). Although PTSD was not formally recognised as a psychiatric diagnosis until 1980, Sassoon's experiences illustrate several psychological responses to combat that are now examined within the study of trauma-related disorders.

Sassoon was a decorated British Army officer and a well-known First World War poet. In July 1917, he issued a public declaration protesting the continuation of the war. He argued that the conflict had become politically driven and was being prolonged unnecessarily. Because Sassoon was a respected officer and public figure, prosecuting him for this declaration would have created considerable political and institutional difficulty. Instead, he was referred to a medical board and sent to Craiglockhart War Hospital in Scotland, where he was classified as suffering from 'shell shock'.

This decision should not be interpreted as meaning that Sassoon's distress was entirely invented or that the diagnosis was used only to protect him from punishment. Sassoon had experienced combat, had been wounded, and was psychologically affected by military service. At the same time, the medical classification served an institutional purpose: it turned a politically challenging act of protest into a medical problem that the military system could treat.

'Shell shock' was the term commonly used during the First World War for a broad range of psychological and physical reactions associated with combat. It was not a standardised diagnosis equivalent to modern PTSD. Depending on the case, it could include anxiety, disturbed sleep, nightmares, intrusive memories, irritability, emotional instability, tremors, paralysis, mutism, sensory disturbances, exhaustion, and difficulties concentrating.

Some of these symptoms resemble those included in current descriptions of PTSD. For example, nightmares and intrusive recollections may be understood as forms of re-experiencing, while sleep disturbance, irritability, and heightened alertness may resemble symptoms of arousal. However, other features of shell shock, such as paralysis, tremors, loss of speech, and certain sensory symptoms, do not correspond directly to PTSD. They may be more appropriately understood through the historical concepts of war neurosis, functional neurological symptoms, hysteria, dissociation, or neurasthenia.

For this reason, Sassoon should not be described as having PTSD in the modern diagnostic sense. PTSD was introduced as an official diagnosis in the American Psychiatric Association's DSM-III in 1980. The case is instead relevant because it shows that severe and persistent psychological reactions to traumatic events were recognised long before the formal diagnostic category existed.

At Craiglockhart, Sassoon was treated by W. H. R. Rivers, a physician, psychiatrist, and anthropologist. Rivers's approach was significant because he did not believe that recovery depended simply on suppressing painful memories or immediately returning the soldier to military duty.

Rivers argued that patients often attempted to repress distressing memories and emotions connected with their wartime experiences. In his view, this process could contribute to anxiety, disturbed sleep, nightmares, and continuing psychological distress. He therefore encouraged patients to discuss their experiences and to understand their emotional responses to combat.

Rivers also treated his patients with a degree of sympathy that contrasted with approaches that interpreted psychological breakdown as weakness, cowardice, or deliberate refusal to fight. By helping patients examine their experiences without treating them as morally defective, he attempted to restore their sense of control and self-respect.

His work can be viewed as an early precursor to trauma-focused therapy because it emphasised the importance of traumatic memory, emotional understanding, and the reduction of avoidance. Nevertheless, the comparison requires qualification. Rivers was not using the modern PTSD diagnosis, and his treatment was not based on contemporary cognitive-behavioural models, standardised exposure protocols, or current evidence-based treatment guidelines. He worked within early twentieth-century theories of repression, memory, and psychological adaptation. His approach is therefore historically related to modern trauma therapy, but it should not be treated as identical to it.

Sassoon eventually returned to active military service. His return does not necessarily demonstrate complete psychological recovery. It reflected a combination of treatment, military expectations, his own sense of duty, and the institutional circumstances of his case. His poems, memoirs, and other writings remain important sources for understanding how combat could affect memory, emotion, identity, and moral judgment.

The case is particularly pertinent in the history of PTSD because it brings together three themes. First, it shows that psychological injury can occur in individuals who are courageous, highly trained, and decorated for military service. Second, it demonstrates that trauma-related symptoms may be shaped by social and institutional pressures, including expectations of masculinity, obedience, and military discipline. Third, it illustrates an early therapeutic emphasis on confronting and understanding traumatic experiences rather than relying only on suppression or rapid return to duty.

The Sassoon–Rivers case should therefore be described as a historical precursor to the study of PTSD, not as a formal case of PTSD. Sassoon’s symptoms and treatment provide evidence that many experiences now discussed in relation to PTSD, such as nightmares, intrusive memories, anxiety, sleep disturbance, and heightened arousal, were present in soldiers long before the diagnosis was created.

And, Rivers’s emphasis on discussing and understanding traumatic memories represented an important early departure from approaches based solely on suppression or rapid return to duty. Although the case predates the formal recognition of PTSD by many decades, it demonstrates that combat-related psychological injury and the therapeutic importance of traumatic memory were being observed and debated long before PTSD entered DSM-III in 1980.

POSTTRAUMATIC STRESS DISORDER IN INDIVIDUALS OLDER THAN 6 YEARS	
A. Traumatic event(s) or exposure 1. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1. Directly experiencing the traumatic event(s) 2. Witnessing, in person, the event(s) as it occurred in others 3. Learning that the traumatic event(s) occurred to a close family member or close friend (in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental) 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or photos, unless this exposure is work related.	D. Negative alteration in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: 1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia) and not to other factors such as head injury, alcohol, or drugs. 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "The one can be trusted," "The world is completely dangerous," "No one seems to care or is permanently aloof"). 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that result in individual blaming himself/herself or others. 4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame). 5. Markedly diminished interest or participation in significant activities. 6. Feelings of detachment or estrangement from others. 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
B. Persistent alteration in arousal (or more) of the following intrusive symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: 1. Recurrent, disturbing, and intrusive memories (recollections) of the traumatic event(s). Note: In children older than 6 years, repetitive play may serve to re-enact themes or aspects of the traumatic event(s) as experienced. 2. Recurrent disturbing dreams in which the content and/or effect of the dream associated with the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content. 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur in contexts, with the usual extreme response being a complete loss of awareness of present surroundings.) Note: In children, trauma specific reenactment may occur in play. 4. Intense or prolonged psychological distress or exposure to external cues that remind or resemble an aspect of the traumatic event(s). 5. Altered physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).	E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: 1. Irritable behavior and angry outbursts (with little or no provocation) (typically expressed as verbal or physical aggression toward people or objects). 2. Hostility or self-destructive behavior. 3. Hypervigilance. 4. Exaggerated startle response. 5. Problems with concentration. 6. Sleep disturbance (e.g., difficulty falling or staying asleep, or restless sleep).
C. Persistent avoidance of stimuli associated with the traumatic event(s) beginning after the traumatic event(s) occurred, as evidenced by one (or both) of the following: 1. Avoidance of or efforts to avoid disturbing memories, thoughts, or feelings about or closely associated with the traumatic event(s). 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse disturbing memories, thoughts, or feelings about or closely associated with the traumatic event(s).	F. Duration of the disturbance (Criteria B, C, D, and E): more than 1 month.
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.
Specify whether: With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the disaster, the individual experiences persistent or recurrent symptoms of either of the following: 1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and in some ways an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality or odd or body or of time moving slowly). 2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition (e.g., complex partial seizures).	
Specify if: With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the event and exposure are of acute symptoms may be immediate).	

Fig. 4.2.3 Diagnostic Criteria of Posttraumatic Stress Disorder in Individuals Older than 6 Years (DSM-5-TR)

POSTTRAUMATIC STRESS DISORDER IN CHILDREN 6 YEARS AND YOUNGER

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.
3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, intrusive, and distressing memories of the traumatic event(s).
Note: In children younger than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur in a continuous, with the most extreme expressions being a complete loss of awareness of personal surroundings.)
Note: In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one (or both) of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia) and not to other factors, such as head injury, alcohol, or drugs.
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "No value seems secure or permanently stable").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead to an individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or excessive sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) more than 1 month.

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

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and in some ways an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality or self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Notes: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Fig. 4.2.4 Diagnostic Criteria of Posttraumatic Stress Disorder in Children 6 Years and Younger (DSM-5-TR)

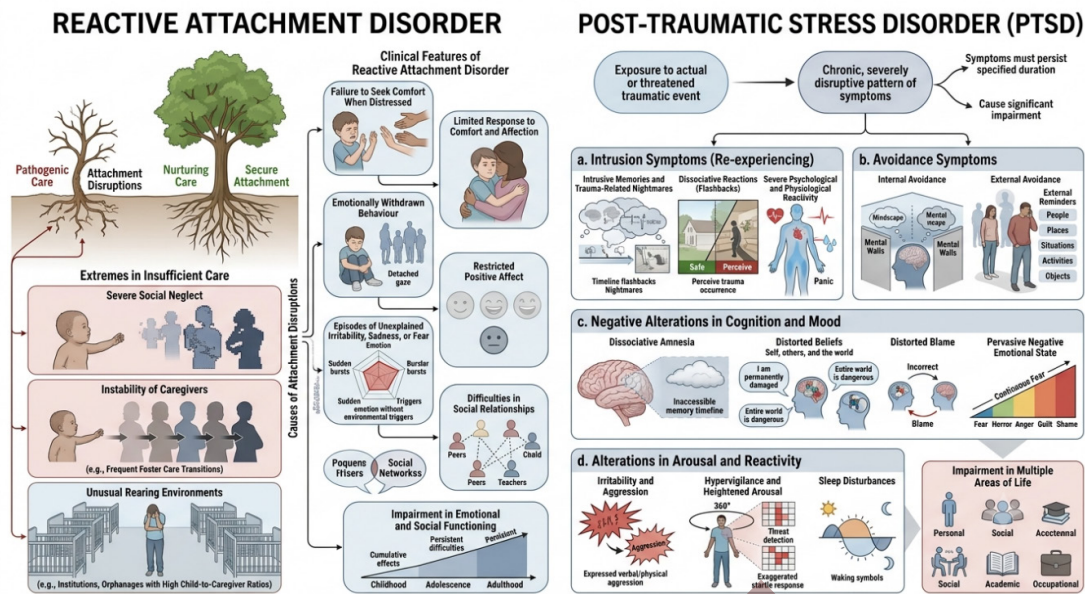


Fig. 4.2.5 Clinical Features of Reactive Attachment Disorder and Post-Traumatic Stress Disorder (AI-Generated)

Recap

- ◆ Trauma and stressor-related disorders require exposure to an identifiable adverse event to diagnose.
- ◆ Traumatic events involve direct, witnessed, or occupational exposure to death, serious injury, or sexual violence.
- ◆ Stressful events cause severe distress but lack actual threats to life, safety, or physical integrity.
- ◆ Psychological distress following trauma is highly variable and extends far beyond basic fear or anxiety.
- ◆ Post-trauma clinical presentation can include anhedonia, dysphoria, externalised aggression, and dissociation.
- ◆ The Diagnostic and Statistical Manual groups these conditions by shared etiology rather than uniform symptoms.
- ◆ Reactive Attachment Disorder is a trauma-related disorder emerging in infancy or early childhood due to extreme care deficits.
- ◆ Children with RAD display a developmentally inappropriate pattern of attachment behaviour and emotional withdrawal, and unexplained episodes of irritability, deep sadness, or fear during routine, safe interactions.

- ◆ Diagnosis of RAD requires historical evidence of extreme, insufficient care, known as pathogenic care.
- ◆ Pathogenic care can manifest as severe social neglect or chronic failure to meet an infant's emotional needs.
- ◆ Instability of caregivers, such as frequent foster care transitions, prevents stable attachment formation.
- ◆ PTSD develops when an acute post-traumatic stress reaction fails to resolve and becomes chronic.
- ◆ The disorder features intrusive thoughts that make individuals feel as if the trauma is ongoing.
- ◆ Symptoms must cause significant operational impairment and persist beyond a specific clinical duration for the diagnosis of PTSD.
- ◆ Intrusion symptoms of PTSD involve involuntary re-experiencing through distressing memories and trauma-themed nightmares.
- ◆ Flashbacks represent dissociative reactions where a person acts as if the trauma is happening in the present.
- ◆ Avoidance symptoms involve persistent, active efforts to bypass any stimuli connected to the trauma.
- ◆ Internal avoidance targets distressing memories, private thoughts, or deep feelings linked to the event.
- ◆ External avoidance targets concrete reminders like specific people, places, conversations, or objects.
- ◆ Trauma-induced dissociative amnesia leaves an individual unable to recall critical elements of the event.

Objective Questions

1. What group of disorders requires exposure to a traumatic or stressful event as an essential part of its development?
2. Trauma and stressor-related disorders are grouped together in clinical manuals based on what shared feature?

3. What term is used for significant life events that cause severe distress but do not meet the criteria for trauma?
4. What is the generalised state of clinical unease, depression, or deep dissatisfaction with life called?
5. Which trauma and stressor-related disorder develops in infancy or early childhood because of severe neglect or insufficient care?
6. What is the main developmental process disturbed in Reactive Attachment Disorder?
7. What clinical phrase describes the extreme history of insufficient care required to diagnose RAD?
8. What is the characteristic pattern of behaviour shown by children with Reactive Attachment Disorder when they are distressed?
9. How do children with Reactive Attachment Disorder usually respond to comfort and affection from caregivers?
10. What type of social-emotional behaviour is commonly seen in children with Reactive Attachment Disorder?
11. What kind of emotional expression is often reduced in children with Reactive Attachment Disorder?
12. What type of early life experience is required for the diagnosis of Reactive Attachment Disorder?
13. Which trauma and stressor-related disorder may develop after exposure to actual or threatened death, serious injury, or sexual violence?
14. What is the term for the repeated involuntary re-experiencing of a traumatic event in PTSD?
15. What are trauma-related episodes called in which a person feels as if the event is happening again?
16. What type of symptoms involve efforts to avoid trauma-related thoughts, feelings, people, or places?
17. What term is used for avoiding distressing memories, thoughts, or feelings related to trauma?
18. What term is used for avoiding external reminders such as places, objects, or conversations related to trauma?

19. What kind of memory disturbance may occur in PTSD when a person cannot recall important aspects of the trauma?
20. What is the term for persistent exaggerated alertness and scanning for danger in PTSD?
21. What type of emotional state in PTSD may include fear, anger, guilt, or shame?
22. What type of behavioural symptom in PTSD may include angry outbursts or aggression with little provocation?
23. What term refers to the inability to feel pleasure or positive emotion after severe stress or trauma?
24. What type of symptom involves disconnection from reality or altered sense of self after trauma?

Answers

1. Trauma and stressor-related disorders
2. Etiology
3. Stressor
4. Dysphoria
5. Reactive Attachment Disorder
6. Attachment
7. Pathogenic Care
8. Failure to seek comfort
9. Limited response
10. Emotional withdrawal
11. Positive affect

12. Insufficient care
13. Post-Traumatic Stress Disorder
14. Intrusion symptoms
15. Flashbacks
16. Avoidance symptoms
17. Internal avoidance
18. External avoidance
19. Dissociative amnesia
20. Hypervigilance
21. Negative emotional state
22. Irritability
23. Anhedonia
24. Dissociative symptom

Assignments

1. Deconstruct the clinical boundaries between a 'traumatic event' and a 'stressful event (stressor)'. Analyse how two individuals might experience similar levels of distress, yet only one meets the strict diagnostic criteria for trauma exposure based on the nature of the event.
2. Discuss the role of adverse life experiences in psychological functioning. Explain how neglect, abuse, violence, disasters, and loss can affect emotional development, attachment, and coping.
3. Explain the concept of pathogenic care as the primary etiological force behind Reactive Attachment Disorder. Detail how institutional rearing environments or caregiver instability disrupt an infant's biological drive to form selective attachments.

4. Discuss the negative alterations in cognition and mood found in PTSD. Explain dissociative amnesia, distorted beliefs, distorted blame, and persistent negative emotional states in relation to trauma.
5. Differentiate between internal avoidance and external avoidance within the context of Post-Traumatic Stress Disorder. Provide examples of how each type of avoidance manifests as a coping mechanism, and explain why avoidance ultimately perpetuates the disorder.
6. Compare and contrast the long-term relational impacts of Reactive Attachment Disorder (developed in infancy) with Post-Traumatic Stress Disorder (developed at any age). How do both conditions fundamentally disrupt an individual's capacity to establish trust and maintain secure interpersonal bonds?

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BLOCK

Anxiety and Obsessive- Compulsive Disorders



UNIT

Anxiety Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ♦ define anxiety disorders according to contemporary diagnostic frameworks
- ♦ discuss the clinical features of Specific Phobia, Panic Disorder, and Generalised Anxiety Disorder
- ♦ differentiate fear, panic, and generalised anxiety across different anxiety disorders

Prerequisite

Everyone experiences moments of apprehension. The uncertainty before a major life decision, entering an unfamiliar place alone, or sensing possible danger may each produce heightened physiological and psychological responses. In many situations, such reactions are natural and even protective, preparing individuals to respond to challenges, uncertainty, or threat. Yet there are times when the anticipation of danger begins to persist beyond the situation itself. A person may avoid travelling long after a frightening experience has passed. Another may live with constant worry despite no immediate crisis. Someone else may suddenly experience overwhelming physical distress and a terrifying sense that something catastrophic is about to happen in completely ordinary situations. At what point do apprehension, worry, and anticipation of threat begin to interfere with functioning?

What makes anxiety particularly difficult to understand is that the danger being anticipated is not always visibly present. The feared event may exist only as a possibility, a memory, an image, or an expectation of what could happen. Yet such possibilities can evoke intensely real psychological and bodily responses. Why are human beings capable of reacting so strongly to threats that are uncertain, distant,

or even imagined? How does anticipation acquire such emotional power? In what ways do past experiences, learned associations, patterns of thinking, and bodily arousal shape the experience of anxiety? And why might attempts to avoid anxiety sometimes strengthen it instead? Further, why do certain forms of anxiety become centred around specific objects, situations, or activities, while others remain more diffuse and persistent? Let these questions linger as you engage with the unit.

Keywords

Disproportionality, Chronicity, Phobia, Restlessness, Hypervigilance, Functional Impairment, Anticipatory Anxiety

Discussion

5.1.1. Definition

Anxiety disorders are a category of psychological disorders characterised by excessive and persistent fear and anxiety, along with related behavioural disturbances. While anxiety is a normal human response to stress, it becomes pathological when it is out of proportion to the actual threat, persists for an extended duration, and significantly impairs an individual's social, occupational, or daily functioning.

To understand anxiety disorders clinically, it is essential to distinguish between two primary emotional responses: fear and an anxiety response. Fear is typically an emotional response to an immediate or perceived imminent threat, whereas anxiety refers to the anticipation of a future threat and is often accompanied by feelings of tension, worry, and heightened vigilance. Individuals with anxiety disorders experience these reactions in ways that are persistent, difficult to control, and disproportionate to the actual level of danger.

Table 5.1.1 Fear *versus* Anxiety

Feature	Fear	Anxiety
Nature of Threat	Emotional response to an imminent, real, or perceived threat currently present in the environment	Emotional response anticipating a future, potential threat
Physiological State	Triggers the 'fight-or-flight' response, characterised by autonomic arousal (e.g., rapid heart rate, immediate surge of adrenaline)	Characterised by muscle tension, a state of chronic vigilance, and preparation for future danger

Behavioural Response

Typically leads to immediate escape, defense, or avoidance behaviours

Leads to cautious, hypervigilant, or avoidant behaviours designed to prevent the anticipated situation

Anxiety disorders are among the most common psychological disorders and can affect individuals across the lifespan. They may influence thoughts, emotions, physical functioning, and behaviour, often leading to avoidance of feared situations and difficulties in personal, social, academic, or occupational functioning. Anxiety disorders share several defining criteria that differentiate them from transient everyday worries:

- ♦ **Disproportionality:** The level of distress or fear experienced by the individual is significantly greater than the actual danger posed by the object or situation.
- ♦ **Chronicity:** The symptoms are not temporary. In clinical diagnostic frameworks, the symptoms must generally persist for a specified duration to ensure transient situational stress is excluded.

- ♦ **Maladaptive Behavioural Coping:** Individuals frequently utilise pervasive avoidance behaviours to manage their anxiety. While avoidance provides short-term emotional relief, it reinforces the anxiety over time and severely limits the individual's daily life.
- ♦ **Functional Impairment:** The anxiety, fear, or avoidance causes clinically significant distress or disrupts critical areas of life, such as academic performance, workplace productivity, or interpersonal relationships.

Among the various anxiety disorders, Specific Phobia, Panic Disorder, and Generalised Anxiety Disorder illustrate different ways in which excessive fear and anxiety may manifest in everyday life, and the unit discusses the clinical features of each in required detail.

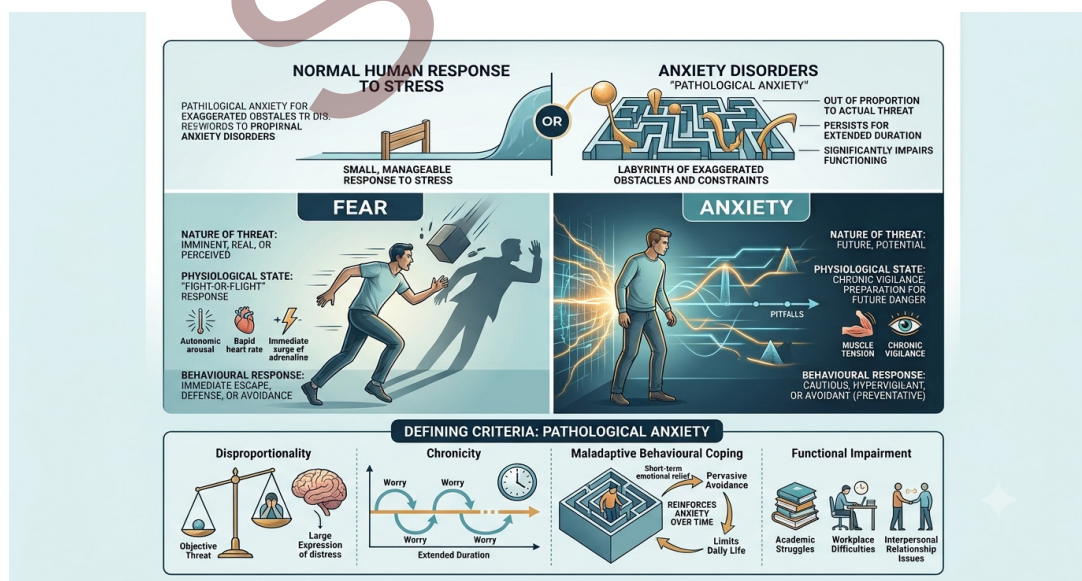


Fig. 5.1.1 Fear versus Anxiety (AI-Generated)

5.1.1.1 Specific Phobia

A specific phobia is an anxiety disorder characterised by a marked, intense, and persistent fear or anxiety concerning a specific object or situation. The fear is disproportionate to the actual threat posed and is often recognised by the individual as

excessive or unreasonable. Exposure to the feared object or situation almost invariably provokes anxiety, leading the individual to avoid it or endure it with considerable distress. As a result, the phobia can interfere with everyday functioning and restrict participation in normal activities.

Table 5.1.2 The Five Primary Subtypes of Specific Phobia

Phobia Subtypes	Clinical Description	Common Examples
Animal	Fear of animals or insects. This is one of the most common subtypes and typically begins in childhood.	Spiders (arachnophobia), dogs (cynophobia), snakes (ophidiophobia)
Natural Environment	Fear of events or objects occurring in nature.	Heights (acrophobia), storms (astraphobia), deep water (aquaphobia)
Blood-Injection-Injury	Fear of seeing blood, receiving injections, or experiencing medical procedures. Note: This subtype often features a unique physiological response where initial heart rate elevation is followed by a sudden drop in blood pressure, frequently resulting in fainting.	Needles (trypanophobia), invasive medical procedures, sight of injury
Situational	Fear of specific situations, environments, or structures.	Flying (aviophobia), elevators, enclosed spaces (claustrophobia)
Other	Phobias that do not fit into the primary categories.	Fear of choking, fear of loud sounds, fear of vomiting (emetophobia)

The clinical features of specific phobia include:

a. Intense and Persistent Fear

The defining feature of Specific Phobia is an excessive and persistent fear of a specific object or situation. Common examples

include fear of animals, heights, blood, injections, storms, enclosed spaces, flying, or particular environmental situations. The fear is typically immediate and disproportionate to the actual level of danger.

b. Immediate Anxiety Response

Exposure to the feared object or situation almost always triggers an immediate anxiety reaction. The individual may experience intense discomfort, nervousness, or panic-like symptoms upon encountering or anticipating the feared stimulus. In children, the anxiety may be expressed through crying, clinging, freezing, or tantrums.

c. Avoidance Behaviour

Individuals with Specific Phobia commonly engage in avoidance behaviours to prevent contact with the feared object or situation. They may alter routines, limit activities, or avoid certain places altogether. Although avoidance reduces anxiety temporarily, it often reinforces and maintains the phobia over time.

d. Recognition of Excessiveness

Many individuals recognise that their fear exceeds the actual danger posed by the object or situation. Despite this awareness, they often find it difficult to control their emotional reactions. The knowledge that the fear is irrational does not necessarily reduce the anxiety experienced.

e. Physical Symptoms of Anxiety

Exposure to the feared stimulus may be accompanied by various physiological symptoms associated with anxiety. These may include rapid heartbeat, sweating, trembling, shortness of breath, dizziness, nausea, or feelings of faintness. The severity of these symptoms varies across individuals and situations.

f. Distress and Functional Impairment

Specific Phobia can interfere with personal, social, academic, or occupational functioning. Individuals may avoid important activities, educational opportunities, travel, medical procedures, or social experiences because of their fear. The resulting restrictions can significantly affect the quality of life.

g. Persistence of Symptoms

The fear associated with Specific Phobia is typically enduring rather than temporary. Symptoms often persist for extended periods and may continue unless appropriate intervention is provided. The persistence of fear distinguishes specific phobias from transient childhood fears or situational anxieties that resolve naturally over time.

Illustrative Cases of Specific Phobia

The following cases illustrate two different historical explanations of specific phobia. The case of Little Hans represents a psychodynamic interpretation, whereas the case of Little Albert represents a learning-based interpretation. Neither case should be treated as a complete modern clinical assessment. Still, both are useful for showing how fear, avoidance, and phobic responses were explained in the development of psychological theory.

Case 1: Little Hans

Little Hans was the pseudonym used by Sigmund Freud for a Viennese boy whose principal phobia developed around horses. The case was published in 1909 as *Analysis of a Phobia in a Five-Year-Old Boy*. Hans became increasingly afraid of horses, particularly the possibility that a horse might bite him. His fear affected his ordinary activities and made him reluctant to leave the house.

Freud did not conduct the child's treatment in the usual direct clinical sense. He saw Hans only once. Most of the case material came from Hans's father, who observed the child, recorded his conversations and behaviour, and communicated with Freud. The father was familiar with psychoanalytic ideas and played an active role in questioning and interpreting his son's experiences. Consequently, the case represents a clinical account mediated through the father rather than a report based on sustained direct observation by Freud.

Freud interpreted Hans's phobia within the framework of the Oedipus complex. He proposed that the boy experienced unconscious affection for his mother, rivalry with his father, and fear of punishment from his father. Freud further linked this conflict with castration anxiety. In this interpretation, the fear of horses functioned as a displacement: an emotionally threatening conflict involving the father was transferred to an external object. This horse could then become the focus of conscious fear.

Freud also gave symbolic interpretations to particular features of the horse. He associated the horse's blinkers with his father's spectacles and the dark markings around the horse's mouth with his father's moustache.

The case has important methodological limitations. The evidence was largely second-hand, the father was involved in gathering and interpreting the material, and Freud's questions and theoretical assumptions may have influenced the account. The case also lacks the standardised assessment, diagnostic procedures, and independent observation expected in contemporary clinical research.

Nevertheless, the case of Little Hans is historically important because it is one of the earliest detailed accounts of childhood phobia. In relation to the clinical features of specific phobia, the case includes several relevant elements: a clearly identifiable feared object, anticipatory anxiety, avoidance of situations in which the object might be encountered, and interference with ordinary functioning. It should therefore be used as an early illustration of a childhood phobic presentation, with Freud's explanation identified specifically as a psychodynamic interpretation.

Case 2: Little Albert

The Little Albert study was conducted by John B. Watson and Rosalie Rayner and published in 1920. The participant, identified in the report as 'Albert B.,' was an infant approximately 11 months old when the conditioning procedures were conducted. He was initially exposed to several objects, including a white rat, a rabbit, a dog, and masks. The researchers reported that these stimuli did not initially produce a clear fear response.

Watson and Rayner then paired the presentation of a white rat with a loud, sudden noise. The noise came from striking a steel bar with a hammer behind the infant. The noise elicited an unconditioned startle and distress response. After repeated pairings, the researchers reported that Albert began to react fearfully to the white rat even when the noise was no longer presented.

The study was interpreted as an early demonstration of classical conditioning of an emotional response. In learning-theory terms, the loud noise functioned as the unconditioned stimulus, the infant's distress response was the unconditioned response, and the previously neutral rat became a conditioned stimulus after being repeatedly paired with the noise. The rat then appeared to elicit a conditioned fear response on its own.

Watson and Rayner also reported generalisation of the response to other stimuli, including a rabbit, a dog, a fur coat, and a mask resembling Santa Claus. This finding illustrated stimulus generalisation: fear acquired in relation to one object may extend to other objects that share similar visual or tactile features. However, the strength and consistency of Albert's reactions varied, and the study's conclusions were based on a single infant and relatively subjective behavioural observations.

The study is relevant to specific phobia because it illustrates several features associated with phobic fear: the acquisition of fear through conditioning, the possibility that fear may be triggered by an otherwise neutral object, and the generalisation of fear to similar stimuli. It does not, however, establish a complete clinical diagnosis of specific phobia. The report did not provide a modern assessment of duration, functional impairment, persistence, or differential diagnosis.

The study also has serious ethical limitations. The researchers deliberately induced distress in an infant, and the published report does not provide reliable evidence that the fear response was systematically removed before the study ended. It thus conflicted with the ethical requirements concerning the minimisation of risk, protection of child participants, informed parental consent, and appropriate follow-up. Later researchers have also debated the identity of Albert and the reliability of some of the original findings.

Under contemporary diagnostic descriptions, specific phobia involves marked fear or anxiety about a particular object or situation, an immediate fear response when the object is encountered or anticipated, active avoidance or endurance with intense anxiety, fear that is disproportionate to the actual danger, persistence typically lasting six months or more, and clinically significant distress or impairment. In children, the response may appear as crying, freezing, tantrums, or clinging.

Neither historical case supplies all the information required for a modern diagnosis. Little Hans is best understood as an early psychodynamic case formulation, while Little Albert is best understood as an early learning experiment rather than a clinical case of established specific phobia. Their significance lies in showing how the same broad clinical phenomenon, intense, object-focused fear, was explained through two influential psychological models: unconscious conflict and conditioned learning.

SPECIFIC PHOBIA

A.	Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood). <i>Note:</i> In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.
B.	The phobic object or situation almost always provokes immediate fear or anxiety.
C.	The phobic object or situation is actively avoided or endured with intense fear or anxiety.
D.	The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
E.	The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
F.	The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
G.	The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).
Specify if	
Code based on the phobic stimulus:	
F40.218	Animal (e.g., spiders, insects, dogs).
F40.228	Natural environment (e.g., heights, storms, water).
F40.23x	Blood-injection-injury (e.g., needles, invasive medical procedures). Coding note: Select specific ICD-10-CM code as follows: F40.230 fear of blood; F40.231 fear of injections and transfusions; F40.232 fear of other medical care; or F40.233 fear of injury.
F40.248	Situational (e.g., airplanes, elevators, enclosed places).
F40.298	Other (e.g., situations that may lead to choking or vomiting; in children, e.g., loud sounds or costumed characters).
Coding note: When more than one phobic stimulus is present, code all ICD-10-CM codes that apply (e.g., for fear of snakes and flying, F40.218 specific phobia, animal, and F40.248 specific phobia, situational).	

Fig. 5.1.2 Diagnostic Criteria of Specific Phobia (DSM-5-TR)

5.1.1.2 Panic Disorder

Panic Disorder is an anxiety disorder characterised by recurrent and unexpected panic attacks accompanied by ongoing concern about additional attacks or their consequences. A panic attack is a sudden surge of intense fear or discomfort that reaches its peak within minutes and is accompanied

by a variety of physical and psychological symptoms. Because the symptoms can be intense and overwhelming, individuals may mistakenly believe they are experiencing a serious medical emergency, such as a heart attack or loss of control. Over time, the fear of experiencing another panic attack may itself become a significant source of distress and impairment.

PANIC DISORDER	
A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur: Note: The abrupt surge can occur from a calm state or an anxious state.	1. Palpitations, pounding heart, or accelerated heart rate. 2. Sweating. 3. Trembling or shaking. 4. Sensations of shortness of breath or smothering. 5. Feelings of choking. 6. Chest pain or discomfort. 7. Nausea or abdominal distress. 8. Feeling dizzy, unsteady, light-headed, or faint. 9. Chills or heat sensations. 10. Paresthesias (numbness or tingling sensations). 11. Derealization (feelings of unreality) or depersonalization (being detached from oneself). 12. Fear of losing control or “going crazy.” 13. Fear of dying.
	Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.
B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:	1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”). 2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).
C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).	
D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).	

Fig. 5.1.3 Diagnostic Criteria of Panic Disorder (DSM-5-TR)

Donald Klein and the Emergence of Panic Disorder as a Distinct Diagnostic Category

Donald F. Klein's work was influential in the development of panic disorder as a distinct diagnostic concept. In the late 1950s and early 1960s, while working at a hospital in New York, Klein observed that some patients who experienced sudden, apparently unexpected panic attacks responded particularly well to the tricyclic antidepressant imipramine. Their acute panic episodes decreased, even when their more persistent anticipatory anxiety or fear of having another attack remained.

Klein published his principal early account in 1964 in an article titled 'Delineation of Two Drug-Responsive Anxiety Syndromes.' He proposed that anxiety disorders could be differentiated partly by their response to medication. In his formulation, patients with spontaneous panic attacks appeared to respond to imipramine, whereas patients with more chronic, generalised anxiety appeared to respond differently and were less specifically affected by imipramine. This approach became known as pharmacological dissection, which involves the use of differential treatment response to investigate whether apparently similar clinical presentations might represent distinct conditions.

At the time, panic attacks and persistent anxiety were often included within the broader diagnostic category of anxiety neurosis. This category combined several forms of anxiety, including sudden attacks of intense fear, chronic anxiety, anticipatory anxiety, and agoraphobic avoidance. Klein's work suggested that this broad category might contain clinically and pharmacologically different syndromes. One presentation was characterised by recurrent, unexpected panic attacks and fear of their recurrence; another involved more continuous, free-floating anxiety and worry.

Klein's interpretation was important, but it should not be comprehended as proving that panic disorder had a single biological cause. His findings suggested a clinically meaningful distinction based on symptom pattern and medication response. Later research also showed that the relationship between panic symptoms, anticipatory anxiety, agoraphobia, and treatment response was more complex than a simple contrast between 'biological panic' and 'psychological generalised anxiety.' Therefore, it is more accurate to say that Klein's work supported the hypothesis of distinct anxiety syndromes rather than conclusively establishing a separate biological disease.

Klein later contributed to the development of DSM-III as a member of the Anxiety and Dissociative Disorders Advisory Committee. His research was an important influence on the revision of anxiety classifications, although the DSM-III distinction resulted from several strands of clinical research, diagnostic debate, and treatment evidence rather than from Klein's work alone.

In DSM-III, published in 1980, panic disorder was formally recognised as a separate diagnostic category. The manual also included agoraphobia with panic attacks as a related diagnosis. Generalised anxiety disorder was defined separately in terms of persistent and diffuse anxiety. Thus, DSM-III did not simply divide anxiety neurosis into panic disorder and generalised anxiety disorder; it reorganised the older category into several related conditions, including panic disorder, agoraphobia, and generalised anxiety disorder.

Klein's observations are especially relevant to the clinical features of panic disorder because they helped draw attention to the difference between: sudden, discrete panic attacks; persistent fear or anxiety between attacks; anticipatory anxiety about having another attack; and avoidance of places or situations where escape might be difficult.

This distinction is clinically important. A person may experience an acute panic attack lasting a relatively short period, yet continue to experience substantial anxiety afterwards because of concern that another attack will occur. In some cases, this fear may lead to avoidance of public transportation, crowded places, open spaces, or situations in which immediate assistance seems unavailable. Such avoidance may develop into agoraphobia.

Klein's contribution was therefore not simply the discovery of a medication that reduced panic attacks. More broadly, his work helped establish the idea that panic attacks could function as a central clinical feature of a distinct anxiety syndrome. It contributed to the transition from the broad and relatively undifferentiated category of anxiety neurosis to a more detailed classification of panic disorder, generalised anxiety disorder, and agoraphobic conditions.

The clinical features of panic disorder are identified through the following components:

experience derealisation (feeling that surroundings are not real) or depersonalisation (feeling detached from their own body).

a. The Panic Attack

A panic attack is the defining feature of the disorder. It is an abrupt surge of intense fear or severe discomfort that reaches a peak within minutes. During this sudden surge, the individual experiences a combination of severe physical and cognitive symptoms.

- ◆ **Physical Symptoms** : These typically include palpitations, a pounding heart, or an accelerated heart rate; excessive sweating; trembling or shaking; sensations of shortness of breath or a feeling of being smothered; chest pain; nausea; and feeling dizzy, light-headed, or faint. The individual may also experience numbness or tingling sensations.
- ◆ **Cognitive Symptoms**: Individuals frequently report a profound fear of losing control or encountering imminent death. They may also

b. Unexpected Nature

A critical diagnostic feature of panic disorder is that at least some of the panic attacks must be *unexpected*. This means there is no obvious external cue or environmental trigger when the attack begins. The panic attack appears to occur completely unprovoked, sometimes even emerging while the individual is in a relaxed state or waking them from sleep (a nocturnal panic attack).

c. Anticipatory Anxiety

Following the initial panic attacks, the individual develops a continuous, persistent worry about when and where the next attack will occur. This state of anticipatory anxiety is a continuous baseline of apprehension that severely degrades the individual's quality of life, even when they are not actively having a panic attack.



d. Maladaptive Behavioural Changes

To manage their anticipatory anxiety, the individual frequently makes significant, maladaptive changes in their daily behaviour. This is primarily a protective effort to avoid situations, physical exertion, or unfamiliar locations where they believe a panic attack might be triggered or where escape or medical help might be unavailable.

- ♦ **Development of Agoraphobia:** If these avoidance behaviours become highly restrictive, the individual may develop a secondary condition known as agoraphobia. This involves an intense fear of

situations such as using public transportation, being in open or enclosed spaces, standing in line, or being outside of the home alone.

In short, Panic Disorder is characterised by recurrent and unexpected panic attacks, persistent worry about future attacks, and behavioural changes aimed at avoiding their occurrence. The disorder illustrates how fear can become self-perpetuating, with anxiety about panic attacks contributing to further distress and impairment. As a result, individuals may experience significant disruptions in their daily functioning, relationships, and overall quality of life.

It is important to distinguish between a panic attack and Panic Disorder. A panic attack refers to a discrete episode of intense fear accompanied by physical and cognitive symptoms. Panic attacks can occur in a variety of psychological disorders and even in individuals without a mental disorder. Panic Disorder, however, involves recurrent unexpected panic attacks together with persistent concern about future attacks and behavioural changes resulting from them.

5.1.1.3 Generalised Anxiety Disorder

Generalised Anxiety Disorder is an anxiety disorder characterised by pervasive, excessive and persistent anxiety and worry about a wide range of everyday events, activities, and routines. The worry is disproportionate to the actual likelihood or impact of the anticipated events and is experienced as difficult to control. Unlike specific phobias, which involve fear of a particular object or situation, or panic disorder, which is characterised by recurrent panic attacks, Generalised Anxiety Disorder involves a pervasive pattern of anxiety that affects numerous aspects of everyday life. Also, unlike a specific phobia or panic disorder, where the fear is connected to a single stimulus or the sudden onset of a panic attack, the anxiety in GAD is diffuse, broad, and constant.

The clinical features of Generalised Anxiety Disorder are identified through the following core domains:

a. Excessive and Uncontrollable Worry

The central cognitive feature of Generalised Anxiety Disorder is *apprehensive expectation*. The individual expects the worst possible outcome in multiple, unrelated areas of life, such as financial security, job performance, the health of family members, or minor daily responsibilities like being late for appointments.

- ♦ **Disproportionate Intensity:** The intensity, duration, and frequency of the worry are vastly disproportionate to the actual likelihood or potential impact of the anticipated event.

- ♦ **Inability to Control:** A defining diagnostic feature is that the individual finds it extremely difficult, if not impossible, to control or stop the worrying thoughts, even when they recognise that the worry is excessive, and the worry frequently interrupts their ability to focus on immediate tasks.

b. Physical and Cognitive Symptoms

The chronic state of mental tension in this disorder manifests physically.

- ♦ **Restlessness:** Feeling consistently restless, on edge, or unable to physically relax.
- ♦ **Fatigue:** Being easily fatigued due to the constant drain of psychological tension.
- ♦ **Concentration Difficulties:** Struggling to maintain focus or experiencing the mind frequently *going blank* because it is overwhelmed by intrusive worries.
- ♦ **Irritability:** A lowered tolerance for frustration and easily triggered agitation.
- ♦ **Muscle Tension:** Chronic, low-grade muscle aches, soreness, or stiffness, particularly in the neck, shoulders, and back.
- ♦ **Sleep Disturbances:** Difficulty falling asleep, often due to a racing mind at night, difficulty staying

asleep, or experiencing restless, unsatisfying sleep.

c. Chronicity

To differentiate generalised anxiety disorder from temporary, situational stress such as anxiety surrounding a major exam or a brief financial crisis, the symptoms must be highly persistent. The excessive anxiety and worry must occur more days than not for a minimum duration of six months.

d. Distinguishing Generalised Anxiety Disorder from Everyday Worry

In clinical practice, it is crucial to distinguish GAD from non-pathological, everyday worrying. The distinction rests on three key differences:

- ♦ **Interference:** Everyday worries can usually be set aside when a more pressing task requires attention. Generalised Anxiety Disorder worries are intrusive and significantly impair daily functioning.
- ♦ **Range:** Everyday worries are typically limited to a few specific, realistic concerns. Generalised Anxiety Disorder encompasses an expansive and constantly shifting list of potential threats.
- ♦ **Physical Symptoms:** Everyday worrying is rarely accompanied by chronic physical symptoms like muscle tension and severe fatigue that are hallmarks of the condition.

GENERALISED ANXIETY DISORDER

- A.** Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B.** The individual finds it difficult to control the worry.
- C.** The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
- Note:** Only one item is required in children.
1. Restlessness or feeling keyed up or on edge.
 2. Being easily fatigued.
 3. Difficulty concentrating or mind going blank.
 4. Irritability.
 5. Muscle tension.
 6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- D.** The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E.** The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- F.** The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder, contamination or other obsessions in obsessive compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Fig. 5.1.4 Diagnostic Criteria of Generalised Anxiety Disorder (DSM-5-TR)

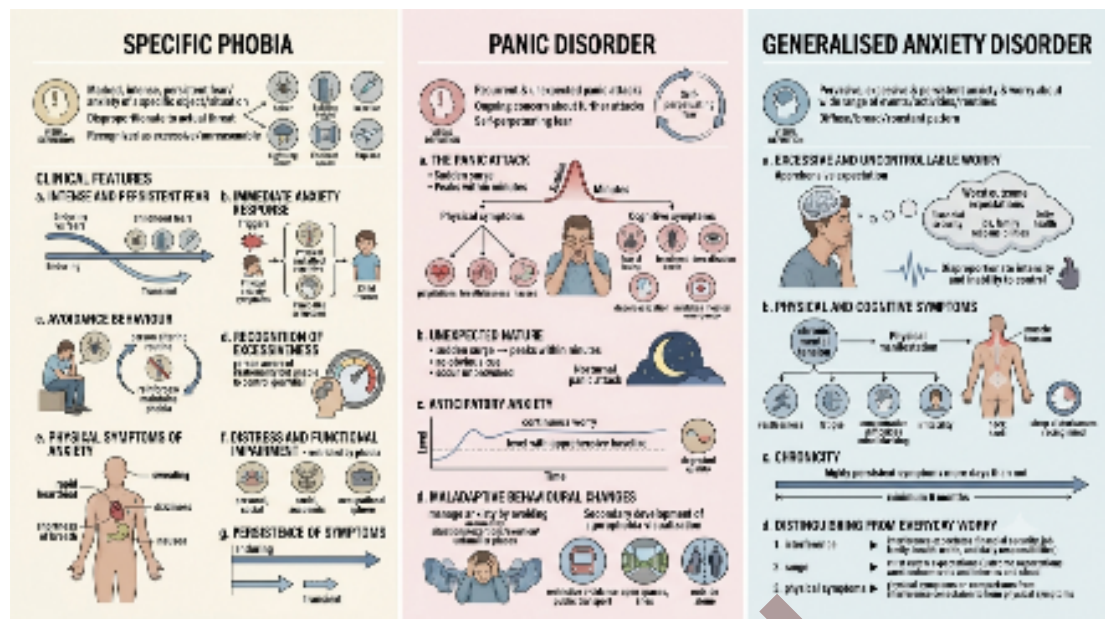


Fig. 5.1.5 Clinical Features of Specific Phobia, Panic Disorder, Generalised Anxiety Disorder (AI-Generated)

Recap

- ◆ Anxiety disorders are characterised by excessive, persistent fear and anxiety alongside behavioural disturbances.
- ◆ Anxiety becomes pathological when it is disproportionate, persistent, and disabling.
- ◆ Fear is an emotional response to an immediate or perceived imminent threat.
- ◆ Anxiety is the apprehension and anticipation of a future, unformed threat.
- ◆ Pathological anxiety is persistent, highly difficult to control, and can impact individuals across the lifespan.
- ◆ Disproportionality means an individual's distress is significantly greater than the actual danger present.
- ◆ Chronicity requires symptoms to persist over an extended duration to rule out transient situational stress.
- ◆ Maladaptive behavioural coping occurs when individuals rely heavily on avoidance to manage their distress.

- ◆ While avoidance yields short-term emotional relief, it reinforces the anxiety loops over time.
- ◆ Functional impairment occurs when fear or avoidance disrupts school, work, or interpersonal relationships.
- ◆ Specific Phobia, Panic Disorder, and Generalised Anxiety Disorder represent distinct structural variations of pathological anxiety.
- ◆ A specific phobia involves a marked, intense, and persistent fear of a distinct object or situation.
- ◆ Common phobic triggers include animals, heights, blood, injections, enclosed spaces, and flying.
- ◆ Exposure to the phobic stimulus almost invariably provokes an immediate, severe anxiety response.
- ◆ Panic Disorder is characterised by recurrent, unexpected panic attacks and ongoing worry about future episodes.
- ◆ A panic attack is an abrupt surge of intense fear or discomfort that reaches its peak within minutes.
- ◆ Somatic components of a panic attack include heart palpitations, chest pain, shortness of breath, and shaking.
- ◆ Cognitive components of a panic attack include an intense fear of losing control or dying.
- ◆ Panic attacks can feature derealisation (unreal surroundings) or depersonalisation (feeling detached from one's body).
- ◆ Anticipatory anxiety is a continuous baseline of worry regarding when and where the next attack will strike.
- ◆ Maladaptive behavioural changes are implemented to avoid situations or physical exertion that might trigger an attack.
- ◆ Severe panic-related avoidance can cause agoraphobia, the intense fear of open, enclosed, or public spaces where escape is difficult.
- ◆ GAD is characterised by pervasive, excessive, and persistent worry about a wide range of everyday events.
- ◆ Unlike phobias or panic, GAD anxiety is diffuse, broad, constant, and not tied to a single stimulus.
- ◆ The primary cognitive feature of GAD is apprehensive expectation, or constantly expecting the worst-case scenario.

- ◆ Somatic features include chronic low-grade muscle tension, stiffness, or soreness in the neck, shoulders, and back.
- ◆ GAD worries span multiple unrelated areas, including finances, job performance, health, and minor daily routines.
- ◆ A key diagnostic boundary of GAD is that the individual finds it nearly impossible to control or stop the worrying thoughts.

Objective Questions

1. What group of disorders is characterised by excessive and persistent fear or anxiety?
2. What term refers to an emotional response to an immediate or imminent threat?
3. What term refers to the anticipation of a future threat?
4. Which anxiety disorder involves intense fear of a specific object or situation?
5. Which clinical criterion describes distress that is significantly greater than the actual danger posed?
6. In Specific Phobia, the fear is usually disproportionate to what?
7. What type of behavioural response is commonly seen in Specific Phobia when the feared stimulus is encountered?
8. What is the immediate emotional reaction often triggered by exposure to a phobic stimulus?
9. Knowing a phobic fear is irrational successfully reduces the physiological anxiety felt. True or false?
10. Which anxiety disorder is characterised by recurrent and unexpected panic attacks?
11. What is a sudden surge of intense fear or discomfort called?
12. Feeling detached from your own physical body or mental processes during panic is called what?

13. Feeling as though your physical surroundings are unreal, artificial, or dreamlike is called what?
14. What specific cognitive feature of GAD involves constantly predicting and expecting the worst possible outcome?
15. What term is used for persistent worry about having another panic attack?
16. What type of behavioural change may develop after repeated panic attacks?
17. What condition may develop when a person begins to avoid situations where escape or help may be difficult during panic-like symptoms?
18. Which anxiety disorder is characterised by excessive and difficult-to-control worry about multiple life areas?
19. Which disorder is centred on broad and persistent worry rather than on a specific feared object or sudden panic attacks?
20. Which anxiety disorder may involve fear of animals, heights, blood, injections, or flying?
21. What kind of symptom includes palpitations, sweating, trembling, or chest discomfort during a panic attack?
22. What kind of symptom in panic attacks includes fear of dying or losing control?
23. In anxiety disorders, what common coping pattern reduces anxiety temporarily but maintains it over time?
24. What important consequence occurs when anxiety significantly affects work, relationships, study, or daily life?

Answers

1. Anxiety disorders
2. Fear
3. Anxiety
4. Specific Phobia
5. Disproportionality

6. Actual danger
7. Avoidance
8. Immediate anxiety
9. False
10. Panic Disorder
11. Panic attack
12. Depersonalisation
13. Derealisation
14. Apprehensive Expectation
15. Anticipatory anxiety
16. Avoidance
17. Agoraphobia
18. Generalised Anxiety Disorder
19. Generalised Anxiety Disorder
20. Specific Phobia
21. Physical symptom
22. Cognitive symptom
23. Avoidance
24. Functional impairment

Assignments

1. Discuss the distinction between fear and anxiety. Explain how their physiological timelines, cognitive focus, and environmental triggers differ, and outline how both transition from normal adaptive evolution into a pathological disorder.
2. Analyse the 'paradox of avoidance' as a maladaptive coping mechanism. Explain the behavioural reinforcement loop in which avoiding a feared stimulus provides immediate relief but ultimately reinforces long-term chronicity and heightens functional impairment.
3. Evaluate the clinical presentation of Specific Phobia. Discuss why an individual's cognitive recognition that their fear is completely irrational or excessive fails to down-regulate the immediate somatic and autonomous panic response upon exposure.
4. Differentiate between Panic Disorder and Generalised Anxiety Disorder (GAD). Compare them on the structural properties of their anxiety, their primary triggers, and their unique cognitive expressions.
5. Discuss how anxiety disorders introduce functional impairment across the lifespan. Using examples from Specific Phobia, Panic Disorder, and GAD, illustrate how pathological fear systematically degrades academic performance, workplace productivity, and interpersonal relationships.

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UNIT

Obsessive-Compulsive and Related Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ♦ define obsessive-compulsive and related disorders according to contemporary diagnostic frameworks
- ♦ discuss the clinical features of Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, and Hoarding Disorder
- ♦ identify the core features that distinguish obsessive-compulsive and related disorders from general anxiety disorders

Prerequisite

Try engaging in the following before you begin the unit. The next time you check something twice, pause for a moment before the second check. Notice what exactly remains unresolved after the first attempt. Is it uncertainty? A lingering sense that something is incomplete? A fear, however small, that something may go wrong if the action is not repeated? Or is the repetition simply habitual, requiring no emotional effort at all?

Now consider a different possibility. Imagine that the feeling does not settle after the second check either. Imagine that reassurance lasts only briefly before the same doubt returns. Imagine that an object becomes difficult to discard, not because it is useful, but because throwing it away produces an unexpected discomfort.

Let us not begin by naming them obsessions or compulsions. Instead, pause at a more pertinent question: at what point do repetitive thoughts, doubts, or behaviours begin to occupy psychological space so persistently that they affect the way individuals experience themselves, their bodies, or their surroundings?

And, sometimes, what appears outwardly ‘normal’ may internally feel impossible to leave unfinished. And perhaps the more difficult question – why is it that a thought or action appears irrational to others, but continues to feel necessary to the person experiencing it?

Keywords

Obsessions, Compulsions, Intrusive Thoughts, Insight, Contamination, Camouflaging, Acquisition, Impairment, Delusional, Avoidance, Disorganisation

Discussion

5.2.1 Definition

Most individuals have, at some point, experienced an unwanted thought that repeatedly enters their mind or felt compelled to check something more than once to ensure that it has been done correctly. Similarly, people may occasionally become preoccupied with aspects of their appearance or find it difficult to discard possessions that hold personal value. In everyday life, such experiences are usually temporary, manageable, and do not interfere significantly with functioning. However, in some cases, intrusive thoughts, repetitive behaviours, or persistent preoccupations become so intense and time-consuming that they cause considerable distress and disrupt functioning.

Obsessive-compulsive and related disorders comprise a group of psychological disorders characterised by recurrent intrusive thoughts, urges, or preoccupations and repetitive behaviours or mental acts that individuals feel driven to perform. Although the specific manifestations vary across disorders, these conditions share common features involving repetitive patterns of thinking and behaviour that are experienced as difficult to control and that significantly

interfere with personal, social, academic, or occupational functioning.

In contemporary diagnostic frameworks, such as the Diagnostic and Statistical Manual of Mental Disorders, these conditions are grouped in a distinct category, separating them from general anxiety disorders due to their specific shared features. According to DSM - 5 - TR, the category includes obsessive compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorder, obsessive-compulsive and related disorder due to another medical condition, other specified obsessive-compulsive and related disorder (e.g., nail biting, lip biting, cheek chewing, obsessional jealousy, olfactory reference disorder [olfactory reference syndrome]), and unspecified obsessive-compulsive and related disorder.

The disorders included within this category, however, differ in their particular focus. Some involve recurrent unwanted thoughts and repetitive rituals, whereas others are characterised by excessive

concerns about perceived flaws in physical appearance or persistent difficulty discarding possessions. Despite these differences, all of these disorders illustrate how repetitive cognitions and behaviours can become a source of significant distress and impairment.

The primary conditions discussed in this unit include Obsessive-Compulsive Disorder, Body Dysmorphic Disorder, and Hoarding Disorder.

5.2.1.1 Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) is the foundational condition within this diagnostic category. Its clinical presentation is defined by the presence of obsessions, compulsions, or a combination of both. These symptoms operate in a cycle: obsessions generate marked anxiety or distress, and compulsions are performed in an attempt to reduce that distress or prevent a feared event. Although compulsive behaviours may temporarily reduce anxiety, they do not address the underlying concern and often reinforce the cycle of obsessions and compulsions. And, to meet the clinical threshold for a diagnosis, these symptoms must be time-consuming or cause clinically significant impairment in social, occupational, or other important areas of functioning.

The two most distinctive clinical features of OCD are,

a. Obsessions

Obsessions are intrusive, unwanted, and recurrent thoughts, urges, or images. Individuals typically attempt to ignore or suppress these obsessions, or to neutralise them with some other thought or action (which often takes the form of a compulsion). The common clinical themes of obsession include,

- ◆ **Contamination:** Persistent fears of exposure to dirt, germs, bodily fluids, or environmental toxins.
- ◆ **Symmetry and Exactness:** An overwhelming need for items to be perfectly aligned, ordered, or symmetrical, often accompanied by a feeling that things are not *just right*.
- ◆ **Harm:** Intrusive thoughts or fears of causing harm to oneself or others, either accidentally or intentionally.
- ◆ **Forbidden or Taboo Thoughts:** Distressing, recurrent thoughts or images of a sexual, religious, or aggressive nature that run contrary to the individual's personal values.

b. Compulsions

Compulsions are repetitive behaviours or mental acts performed in response to obsessions. These behaviours aim to reduce the anxiety triggered by the obsessions. However, the behaviours are not realistically connected to the event they are designed to prevent, or they are clearly excessive. The common clinical manifestations of compulsion include,

- ◆ **Cleaning and Washing:** Excessive or ritualised handwashing, showering, or cleaning of household objects to neutralise contamination fears.
- ◆ **Checking:** Repeatedly verifying that a task has been completed, such as checking that doors are locked, appliances are turned off, or that no harm has occurred.
- ◆ **Repeating and Ordering:** Needing to perform actions a specific number of times, or arranging objects in a precise, mandated order.

- ♦ **Mental Acts:** Performing internal, unobservable rituals, such as counting, praying, or silently repeating specific words to neutralise an intrusive thought.

In addition to these two, the clinical features of OCD also include:

c. Anxiety and Distress

Obsessions typically generate significant anxiety, discomfort, or distress. Compulsions are often performed in an attempt to relieve this anxiety. However, the relief is usually temporary, causing the cycle of obsession and compulsion to recur repeatedly.

d. Awareness of Irrationality

Many individuals with OCD recognise that their obsessions and compulsions are excessive or unreasonable. Despite this awareness, they often feel unable to control their thoughts or resist performing the compulsive behaviours. This insight frequently contributes to feelings of frustration and helplessness.

e. Time-Consuming Nature of Symptoms

Obsessions and compulsions can occupy a substantial portion of an individual's day. Some individuals spend several hours each day engaged in repetitive thoughts or

rituals, leaving less time and energy for other activities and responsibilities.

f. Avoidance Behaviour

To prevent anxiety or reduce exposure to triggers, individuals may avoid situations, objects, or activities associated with their obsessions. For example, a person with contamination fears may avoid public places, while someone with checking compulsions may avoid situations involving responsibility for safety.

g. Impairment in Daily Functioning

The symptoms of OCD can significantly interfere with personal, social, academic, and occupational functioning. Relationships, work performance, and everyday activities may be affected by the time-consuming and distressing nature of the obsessions and compulsions.

h. The Obsession–Compulsion Cycle

A characteristic feature of OCD is the cyclical relationship between obsessions and compulsions. Intrusive thoughts generate anxiety and distress, which in turn motivate the performance of compulsive behaviours. Although these behaviours provide temporary relief, they reinforce the importance of the obsession and increase the likelihood that the cycle will continue.

The Rat Man: Freud's Case of Obsessional Neurosis

Freud's case of the 'Rat Man' is one of the best-known early psychoanalytic accounts of obsessive-compulsive symptoms. The patient was a young Austrian lawyer who consulted Freud in 1907. Freud published the case in 1909 under the title *Notes upon a Case of Obsessional Neurosis*. Freud used a pseudonym to protect the patient's identity.

The patient reported distressing intrusive thoughts, fears, doubts, and compulsive impulses. A central fear involved the possibility that a cruel punishment involving rats might happen to his father and to a woman he loved. These thoughts were experienced as unwanted and frightening rather than as wishes. He also described

compulsive acts, prohibitions, and mental rituals intended to prevent feared harm or reduce his anxiety. The symptoms were intensified after he heard an account of a torture involving rats and became preoccupied with a debt connected with the replacement of his pince-nez, or eyeglasses.

Freud classified the condition as obsessional neurosis, the term used in psychoanalytic literature at the time. The case is historically related to what is now called obsessive-compulsive disorder (OCD), but the two terms should not be treated as identical. Freud's 'obsessional neurosis' referred to a psychoanalytic formulation involving intrusive ideas, compulsive acts, unconscious conflict, and defensive processes.

Freud interpreted the individual's symptoms as expressions of unconscious conflict, particularly conflict between love and hostility, and between aggressive impulses and moral or emotional obligations. He proposed that the obsessional thoughts and rituals functioned as defensive attempts to manage unacceptable thoughts and feelings. In Freud's account, the individual's fear that harm might come to people he loved was connected with ambivalent feelings toward them, especially his father and his future wife. Freud also linked the symptoms to earlier childhood experiences and conflicts.

The case is important for understanding the clinical pattern of obsessive-compulsive symptoms because it contains several features recognisable in contemporary descriptions of OCD: intrusive and unwanted thoughts; fears that harm might occur to oneself or others; excessive doubt and uncertainty; compulsive acts or prohibitions intended to prevent feared consequences; a sense that the thoughts and impulses are unreasonable or distressing; and significant interference with the person's emotional and daily life.

However, the case should not be treated as a modern diagnostic assessment or as proof of Freud's explanation. Freud's conclusions were based on psychoanalytic interviews and interpretation rather than standardised diagnostic instruments. The account also reflects Freud's theoretical assumptions about sexuality, aggression, repression, ambivalence, and unconscious conflict. Later clinicians and historians have therefore continued to debate both the details of the case and the validity of Freud's interpretation.

However, the Rat Man case remains historically significant because it was one of the earliest detailed accounts of severe obsessional symptoms. It helped place intrusive thoughts, compulsive rituals, pathological doubt, and the subjective experience of being compelled within psychiatric and psychological discussion. For a contemporary discussion of OCD, the case is best presented as a historical psychoanalytic case formulation that resembles some features of OCD, rather than as a formally diagnosed case of OCD in the modern sense.

OBSESSIVE -COMPULSIVE DISORDER

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Specify if:

With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

Tic-related: The individual has a current or past history of a tic disorder.

Fig. 5.2.1 Diagnostic Criteria of Obsessive-Compulsive Disorder (DSM-5-TR)

5.2.1.2 Body Dysmorphic Disorder

Body Dysmorphic Disorder (BDD) is an obsessive-compulsive and related disorder characterised by a preoccupation with one or more perceived defects or flaws in physical appearance that are either not observable or appear slight to others. Individuals with the disorder become excessively concerned about these perceived imperfections and often engage in repetitive behaviours or mental acts in response to their appearance-related concerns. The resulting distress can significantly impair personal, social, academic, and occupational functioning.

The distinctive clinical features include:

a. Preoccupation with Perceived Physical Defects

The defining feature of Body Dysmorphic Disorder is an excessive preoccupation with perceived flaws in appearance. The concern may focus on any part of the body, including the skin, hair, nose, teeth, facial features, body shape, or other physical characteristics. Although the perceived defect may appear minor or non-existent to others, the individual experiences it as highly significant.

b. Repetitive Appearance-Related Behaviours

In response to their appearance concerns, individuals with BDD are driven to perform repetitive behaviours or mental acts. These actions are intended to reduce anxiety or conceal the perceived flaw, but they are often difficult to control and consume significant time. The common manifestations include,

- ♦ **Checking** : Repeatedly examining the perceived defect in mirrors or other reflective surfaces.
- ♦ **Grooming and Camouflaging** : Engaging in excessive grooming routines, applying heavy makeup,

or wearing specific clothing to hide the area of concern.

- ♦ **Reassurance Seeking** : Persistently asking others for validation regarding their appearance, which typically provides only temporary relief.
- ♦ **Mental Comparisons** : Constantly and automatically comparing one's appearance to that of other people.

c. Repetitive Mental Acts

Some individuals engage in repetitive mental activities related to their appearance. They may constantly compare themselves with others, mentally review perceived defects, or repeatedly evaluate how they appear to other people. These thoughts can become intrusive and difficult to control.

d. Avoidance of Social Situations

Because of concerns about appearance, individuals may avoid social interactions, public places, photographs, mirrors, or situations where they believe others will notice their perceived flaws. Such avoidance can limit opportunities for education, employment, relationships, and recreational activities.

e. Emotional Distress

The persistent focus on perceived defects is often associated with significant emotional distress. Feelings of anxiety, sadness, frustration, embarrassment, and low self-esteem are common. The distress may become severe enough to interfere with psychological well-being and everyday functioning.

f. Repeated Attempts to Alter Appearance

Some individuals repeatedly seek dermatological, cosmetic, or surgical procedures to correct perceived defects. However, satisfaction with the results is often limited because the underlying preoccupation

remains. Consequently, appearance-related concerns may persist even after treatment or cosmetic intervention.

g. Insight

Similar to Obsessive-Compulsive Disorder, the degree of insight in individuals with BDD varies significantly. An individual may possess good insight, recognising that their appearance concerns are exaggerated. Conversely, they have no insight or have delusional beliefs, maintaining an absolute conviction that their perceived physical defects are exactly as severe as they

believe, regardless of objective evidence to the contrary.

h. Impairment in Daily Functioning

The preoccupation must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The focus of the concern can involve any body area, and it is common for the focus to shift over time. Frequent areas of concern include the skin (e.g., acne or scarring), hair (e.g., thinning), and facial features (e.g., the size or shape of the nose).

Muscle Dysmorphia

This is a specific clinical specifier of BDD occurring almost exclusively in males. It involves a preoccupation with the idea that one's body build is too small or insufficiently muscular, often leading to excessive exercise, dietary restrictions, or the use of anabolic steroids.

Enrico Morselli and the Historical Description of Body Dysmorphic Disorder

A classic historical example relevant to Body Dysmorphic Disorder is the work of the Italian psychiatrist Enrico Morselli. In 1891, Morselli introduced the term *dysmorphophobia* to describe individuals who became intensely preoccupied with an imagined or minor defect in their physical appearance. He noted that these individuals might fear that they were deformed or were becoming deformed, even when no significant abnormality was apparent to others. Their concerns could become persistent and intrusive, producing severe anxiety, shame, and disruption of ordinary activities.

Morselli also described repetitive behaviours associated with these concerns, including examining the appearance in a mirror, touching or measuring the supposedly defective body part, and seeking reassurance. These features resemble behaviours now recognised in Body Dysmorphic Disorder, such as mirror checking, grooming, comparing one's appearance with that of others, reassurance-seeking, and attempts to conceal the perceived defect.

The term *dysmorphophobia* was not identical to the modern diagnosis of Body Dysmorphic Disorder. It belonged to an earlier psychiatric system and emphasised the fear of deformity. Modern BDD is characterised by a persistent preoccupation with

one or more perceived flaws in appearance, accompanied by repetitive behaviours or mental acts and clinically significant distress or impairment. It is currently classified within the obsessive-compulsive and related disorders.

Morselli's account is historically important because it shows that severe appearance-related preoccupation is not exclusively a product of contemporary media or beauty culture. It also demonstrates an early recognition of the distinction between ordinary dissatisfaction with appearance and a pathological preoccupation that dominates attention, produces intense distress, and alters behaviour. For this reason, Morselli's description of dysmorphophobia is often regarded as one of the earliest clinical accounts of what is now called body dysmorphic disorder.

The Wolf Man

A historical case relevant to body dysmorphic disorder is the case of the 'Wolf Man,' the pseudonym Sigmund Freud used for Sergei Pankejeff. Freud's original case history, published in 1918, focused mainly on Pankejeff's childhood neurosis and his well-known dream of wolves. Ruth Mack Brunswick described the appearance-related symptoms more fully several years later, after treating Pankejeff following his earlier analysis with Freud.

Brunswick reported that Pankejeff became intensely preoccupied with the appearance of his nose. He believed that it had been damaged or disfigured and repeatedly examined it in mirrors and shop windows. He carried a pocket mirror, inspected the pores of his nose, and used powder in attempts to manage the perceived defect. His concern occupied so much of his attention that it interfered with his daily life and work.

This presentation resembles several features of Body Dysmorphic Disorder, including preoccupation with a perceived appearance defect, repetitive checking, attempts to conceal or correct the defect, and clinically significant interference. However, the case was not assessed according to modern diagnostic criteria, and Brunswick described it using psychoanalytic terms such as a hypochondriacal fixed idea. The symptoms may also have included obsessive, hypochondriacal, or other disturbances that cannot be distinguished reliably from the available historical account.

The case of Wolf Man should therefore not be understood as a confirmed case of modern body dysmorphic disorder. It is more accurate to describe it as a historical case that resembles BDD and illustrates how an appearance concern can become persistent, repetitive, distressing, and functionally impairing. In combination with Morselli's earlier description of dysmorphophobia, the case helps demonstrate the historical development of ideas that later contributed to the modern concept of body dysmorphic disorder.

BODY DYSMORPHIC DISORDER

- A.** Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
- B.** At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.
- C.** The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D.** The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Specify if:

With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.

Specify if:

Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., “I look ugly” or “I look deformed”).

With good or fair insight: The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks that the body dysmorphic disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that the body dysmorphic disorder beliefs are true.

Fig. 5.2.2 Diagnostic Criteria of Body Dysmorphic Disorder (DSM-5-TR)

5.2.1.3 Hoarding Disorder

Possessions often hold practical, emotional, or sentimental value. Many individuals keep items because they may be useful in the future, remind them of important experiences, or have personal significance. It is also not uncommon for people to accumulate belongings over time and occasionally find it difficult to discard certain objects. However, when the acquisition and retention of possessions become excessive, and the difficulty discarding them begins to interfere with everyday living, the behaviour may reflect a psychological disorder rather than ordinary collecting or sentimental attachment.

Hoarding Disorder is an obsessive-compulsive and related disorder characterised by a persistent difficulty discarding or parting with possessions, regardless of their actual value. Individuals experience a strong perceived need to save items and significant distress at the thought of discarding them. Unlike typical collecting, where items are systematically organised and displayed, hoarding behaviour is characterised by disorganisation and severe spatial congestion. As possessions accumulate, living spaces become increasingly cluttered, often compromising their intended use and creating difficulties in daily functioning.

The clinical features include:

a. Persistent Difficulty Discarding

The defining feature of Hoarding Disorder is a chronic difficulty discarding or giving away possessions. This difficulty occurs regardless of whether the items have practical value. Objects that others may regard as unnecessary or worthless are often retained because the individual perceives them as potentially useful, meaningful, or irreplaceable.

b. Distress Associated with Discarding

Attempts to discard items frequently provoke significant emotional distress. Individuals may experience anxiety, sadness, guilt, or a sense of loss when asked to part with possessions. This emotional reaction contributes to the continued accumulation of belongings.

c. Accumulation of Clutter

The direct result of the inability to discard items is the accumulation of many possessions. This accumulation severely congests and clutters active living areas, such as the kitchen, bedroom, or bathroom, rendering these spaces unusable for their intended purposes.

d. Excessive Acquisition

A common clinical specifier for Hoarding Disorder is '*with excessive acquisition*.' The majority of individuals with this disorder also engage in excessive collection, buying, or gathering of items for which there is no available space. This acquisition process often manifests as:

- ◆ Compulsive buying or shopping
- ◆ Frequently acquiring free items, such as flyers, discarded objects, or promotional materials
- ◆ Continuing to acquire items even when living spaces are already critically compromised

e. Difficulty Organising Possessions

In addition to retaining items, individuals often struggle to organise them effectively. Possessions may accumulate in disorganised piles, making it difficult to locate important items or maintain orderly living environments.

f. Insight

Similar to other disorders in this category, individuals with Hoarding Disorder demonstrate varying levels of insight regarding their condition:

- ◆ **Good or Fair Insight:** The individual recognises that their hoarding-related beliefs and behaviours are problematic.
- ◆ **Poor Insight:** The individual believes their hoarding-related behaviours are not problematic, despite clear evidence to the contrary.

- ◆ **Absent Insight/Delusional Beliefs:**

The individual is completely convinced that their hoarding behaviours and beliefs are entirely rational and necessary, actively resisting any attempts to clear the accumulated items.

g. Impairment in Daily Functioning

The accumulation of clutter can interfere significantly with personal, social, and occupational functioning. Household activities may become difficult to perform, conflicts regarding clutter may strain relationships, and living conditions may become unsafe or unsanitary in severe cases.

It is important to distinguish Hoarding Disorder from ordinary collecting. Collectors typically organise and display their possessions systematically and derive enjoyment from their collections. In contrast, individuals with Hoarding Disorder accumulate items in a disorganised way, experience significant distress related to discarding possessions, and often encounter substantial impairment in daily functioning.

An Early Case of Pathological Accumulation: Hamburger Hoarding

An unusual historical case relevant to the study of hoarding is the 1966 report 'Hamburger Hoarding: A Case of Symbolic Cannibalism Resembling Whitico Psychosis.' The report described a woman with schizophrenia who accumulated raw hamburger meat in a compulsive and highly unusual manner. The authors interpreted the behaviour in relation to her psychotic illness and the symbolic meaning attributed to the meat.

The accumulation occurred in the context of schizophrenia, and the report did not assess the symptoms according to the criteria now used for hoarding disorder, and the case cannot be considered equivalent to the present category of hoarding disorder. In particular, it did not establish the persistent difficulty discarding possessions, the perceived need to save them, distress associated with discarding, or the characteristic cluttering of living areas that define the modern diagnosis.

The case is nevertheless historically significant because it shows that excessive accumulation can occur in different psychiatric conditions and may serve different psychological functions. In some cases, accumulation may be connected with psychosis or unusual beliefs; in others, it may be associated with obsessive-compulsive symptoms, neurocognitive impairment, severe self-neglect, or a distinct hoarding disorder.

Hoarding disorder was recognised as a separate diagnosis in DSM-5 in 2013. Before then, pathological hoarding was often treated as a symptom of obsessive-compulsive disorder or obsessive-compulsive personality disorder. Modern hoarding disorder is characterised by persistent difficulty discarding or parting with possessions, a perceived need to save them, distress associated with discarding, and accumulation that congests living areas and interferes with their intended use.

The historical case therefore illustrates pathological accumulation, but not a confirmed case of hoarding disorder. Its significance lies in showing why clinicians must examine the reasons for saving or accumulating objects, the person's insight, the presence of emotional attachment, the relationship to other psychiatric symptoms, and the effect of the accumulation on daily functioning.

HOARDING DISORDER	
A.	Persistent difficulty discarding or parting with possessions, regardless of their actual value.
B.	This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
C.	The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).
D.	The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).
E.	The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).
F.	The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).
Specify if: With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.	
Specify if: With good or fair insight: The individual recognizes that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic. With poor insight: The individual is mostly convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary. With absent insight/delusional beliefs: The individual is completely convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.	

Fig. 5.2.3. Diagnostic Criteria of Hoarding Disorder (DSM-5-TR)

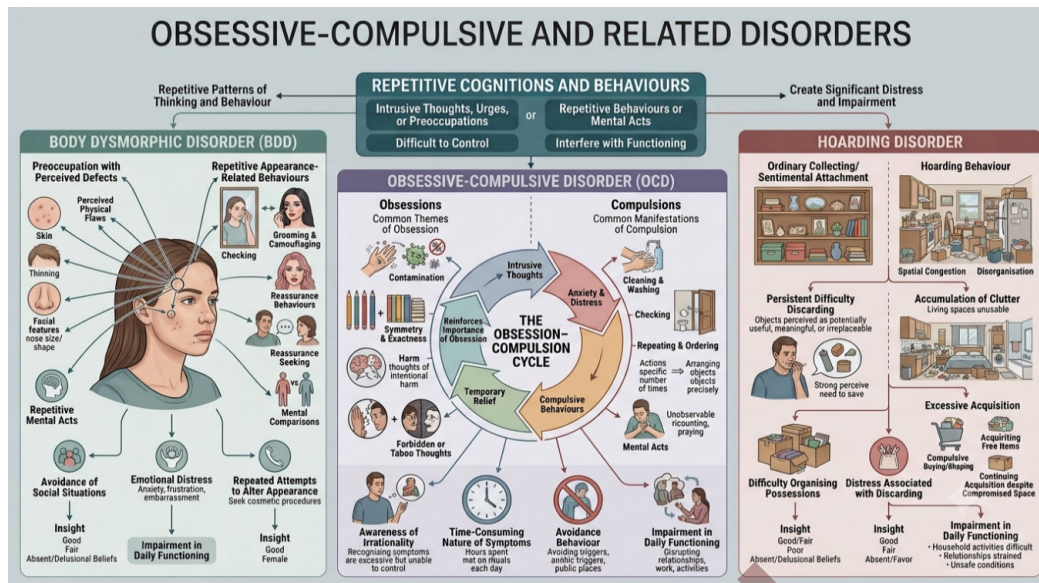


Fig. 5.2.4 Clinical Features of Body Dysmorphic Disorder, Obsessive-Compulsive Disorder, and Hoarding Disorder (AI-Generated)

Recap

- ◆ Obsessive-Compulsive and Related Disorders are grouped into a distinct category separate from general anxiety disorders.
- ◆ Shared features include recurrent intrusive cognitions and repetitive behaviours that are difficult to control.
- ◆ The category includes OCD, BDD, Hoarding Disorder, hair-pulling, skin-picking, and substance-induced variants.
- ◆ OCD serves as the foundational condition defined by a cycle of obsessions and compulsions
- ◆ Obsessions create intense anxiety, while compulsions are performed to temporarily reduce that distress.
- ◆ Compulsions do not address underlying concerns and ultimately reinforce the cycle.
- ◆ Common obsession themes include contamination, symmetry, harm, and forbidden thoughts.
- ◆ Common compulsion manifestations include washing, checking, repeating, ordering, and silent mental acts.

- ◆ Body Dysmorphic Disorder (BDD) involves preoccupation with perceived defects in physical appearance. The perceived defect may be minor or not visible to others.
- ◆ Repetitive behaviours involved in BDD include excessive mirror checking, skin grooming, camouflaging, and reassurance seeking.
- ◆ Repetitive mental acts involved in BDD include constantly comparing one's physical appearance to other people.
- ◆ Hoarding Disorder is defined by persistent difficulty discarding or parting with possessions, regardless of actual value.
- ◆ Attempting to discard items provokes severe emotional distress, anxiety, guilt, or a sense of loss.
- ◆ Accumulated items severely clutter active living spaces like kitchens, bedrooms, and bathrooms.
- ◆ The disorder frequently includes a specifier for excessive acquisition through compulsive buying or gathering free items.
- ◆ Unlike collectors, individuals with Hoarding Disorder struggle to organise their possessions systematically.

Objective Questions

1. What group of disorders is characterised by recurrent intrusive thoughts, urges, or preoccupations along with repetitive behaviours or mental acts?
2. In contemporary diagnostic frameworks, obsessive-compulsive disorders are separated from which general class of disorders?
3. Which disorder is defined by the presence of obsessions, compulsions, or both?
4. What term is used for intrusive, unwanted, and recurrent thoughts, urges, or images in OCD?
5. What term is used for repetitive behaviours or mental acts performed to reduce anxiety in OCD?
6. What common obsession theme in OCD involves fear of germs, dirt, or bodily fluids?

7. What obsession theme in OCD involves a need for perfect alignment, order, or exactness?
8. What type of OCD symptom includes repeated handwashing, showering, or cleaning?
9. What type of compulsion involves repeatedly verifying locks, appliances, or safety?
10. What type of compulsion includes counting, praying, or silently repeating words?
11. What is the cyclical relationship between intrusive thoughts and rituals in OCD called?
12. What type of behaviour may individuals with OCD use to reduce exposure to triggers?
13. Which disorder is characterised by preoccupation with one or more perceived defects in appearance?
14. What common behaviour in BDD involves repeatedly looking at the perceived flaw in reflective surfaces?
15. What behaviour in BDD involves excessive grooming, makeup, or clothing to hide a perceived defect?
16. What type of behaviour in BDD involves repeatedly asking others for validation about appearance?
17. What type of repetitive mental activity in BDD involves comparing one's appearance with that of others?
18. What clinical term describes an individual's level of awareness regarding the reality or irrationality of their disorder?
19. Which disorder is characterised by persistent difficulty discarding possessions regardless of their actual value?
20. What specifier is commonly used when Hoarding Disorder includes excessive collecting, buying, or gathering of items?
21. What difficulty, besides discarding, is commonly seen in Hoarding Disorder with respect to possessions?
22. What common consequence is seen across OCD, BDD, and Hoarding Disorder when symptoms interfere with work, relationships, or daily life?

23. How do clinical manifestations of these disorders differ from normal everyday intrusive thoughts or attachments?

Answers

1. Obsessive-Compulsive disorders
2. Anxiety Disorders
3. Obsessive-Compulsive Disorder
4. Obsessions
5. Compulsions
6. Contamination
7. Symmetry
8. Cleaning
9. Checking
10. Mental acts
11. Obsession-compulsion cycle
12. Avoidance
13. Body Dysmorphic Disorder
14. Mirror checking
15. Camouflaging
16. Reassurance seeking
17. Mental comparison
18. Insight
19. Hoarding Disorder

- 20. Excessive acquisition
- 21. Organisation difficulty
- 22. Functional impairment
- 23. Functional impairment

Assignment

1. Explain the self-reinforcing mechanism of the obsession-compulsion cycle. How does short-term anxiety relief directly contribute to the long-term maintenance of the disorder?
2. How do obsessions and compulsions differ from one another in OCD? Discuss their characteristics with suitable examples, such as contamination fears, checking, symmetry, and mental rituals.
3. Analyse the role of 'insight' across OCD, BDD, and Hoarding Disorder. How does an individual's transition from 'good insight' to 'absent/delusional insight' alter the complexity of their clinical presentation?
4. Compare and contrast the repetitive physical actions seen in OCD (e.g., cleaning, ordering) with the repetitive appearance-related behaviours seen in BDD (e.g., checking, camouflaging).
5. Based on the discussion provided in the unit, defend the clinical decision to separate Obsessive-Compulsive and Related Disorders into their own distinct category rather than leaving them classified as general anxiety disorders.
6. Explain the meaning and clinical features of Hoarding Disorder. Discuss persistent difficulty discarding, distress associated with discarding, clutter, excessive acquisition, and difficulty organising possessions.

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BLOCK

Feeding and Eating Disorders and Elimination Disorders



UNIT

Feeding and Eating Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ◆ define feeding and eating disorders according to contemporary diagnostic frameworks
- ◆ explain the major diagnostic types of feeding and eating disorders
- ◆ discuss the clinical features of feeding and eating disorders

Prerequisite

Eating feels so biologically natural that it becomes difficult to imagine it as a site of profound psychological conflict. If a software program suddenly starts deleting its own core operating code, we would recognise it as a critical system failure. Yet when a human being persistently resists hunger, fears nourishment, or engages in patterns of eating that visibly harm the body, these experiences are often dismissed as trivial.

Before we examine the clinical features of feeding and eating disorders, consider one paradox of human behaviour. Imagine two individuals enduring prolonged emotional distress: persistent pressure to perform, feelings of inadequacy, instability in relationships, and a growing sense that important aspects of life remain beyond personal control. Over time, one begins responding by rigidly restricting food intake. Calorie counting, controlling portions, and enduring hunger gradually come to provide a sense of order, certainty, and mastery otherwise absent from life. The second one responds differently. Eating begins to function as a temporary relief from emotional distress, loneliness, or overwhelm, only to be followed by guilt, shame, and repeated attempts to compensate for the episode afterwards.

In both cases, food is no longer nourishment alone. It has become a way of negotiating distress, control, comfort, or emotional survival itself. Why does something as biologically fundamental as eating gradually become intertwined with control, comfort, guilt, fear, or self-worth? And, when the fundamental drive for self-preservation itself becomes a means of negotiating psychological survival, where do we draw the line between a typical behaviour and pathology?

Keywords

Pica, Binge-Eating, ARFID, Regurgitation, Body Image, Anorexia, Bulimia, Purging, Binge Eating, Rumination Disorder, Nutritional Deficiency

Discussion

6.1.1 Definition

Feeding and Eating Disorders represent a distinct category of psychological disorders characterised by persistent disturbances in eating-related behaviours that result in altered consumption or absorption of food and significantly impair physical health or psychosocial functioning. These disorders involve more than occasional changes in appetite or eating habits; they reflect enduring patterns of behaviour that can interfere with normal growth, development, health, and quality of life. Feeding and Eating Disorders may occur across different stages of life and vary in their presentation. Some disorders are characterised primarily by severe restriction of food intake, whereas others involve recurrent episodes of excessive eating or compensatory behaviours intended to prevent weight gain.

A critical aspect of Feeding and Eating Disorders is their direct physiological impact. Because these behavioural disturbances directly interfere with nutritional intake and metabolic processes, they often lead to severe physiological complications. Consequently, assessing and managing these disorders requires considering both their

physical consequences and the psychological factors that contribute to their development and maintenance.

6.1.2 Types

The diagnostic category of feeding and eating disorders encompasses a range of conditions that differ in their symptoms, patterns of eating behaviour, and associated concerns. While they share the core feature of disrupted eating behaviours, they differ in their specific clinical presentations and the nature of the behavioural disturbance. The primary types recognised in the DSM-5-TR include:

a. Pica

Pica is characterised by persistent consumption of non-nutritive and non-food substances over a period of at least one month, in a manner that is developmentally inappropriate and not part of a culturally supported or socially normative practice. Common non-food substances consumed include paper, soap, soil, chalk, or ice.

b. Rumination Disorder

Rumination Disorder involves the repeated



regurgitation of food after eating for a period of at least one month. Regurgitated food may be re-chewed, re-swallowed, or spit out. This behaviour is not attributable to an associated gastrointestinal or other medical condition. The behaviour occurs repeatedly and cannot be fully explained by a medical condition.

c. Avoidant/Restrictive Food Intake Disorder

Avoidant/Restrictive Food Intake Disorder is an eating or feeding disorder manifested by a persistent failure to meet appropriate nutritional or energy needs. Individuals with this disorder may show a lack of interest in eating, avoid foods based on the sensory characteristics, or restrict intake due to concerns about aversive consequences of eating, such as choking or vomiting. Unlike Anorexia Nervosa (discussed next), the restriction is not motivated by concerns about body weight or body shape.

d. Anorexia Nervosa

Anorexia Nervosa is characterised by a restriction of food intake relative to physiological requirements, leading to a significantly low body weight. The disorder is accompanied by an intense fear of gaining

weight or becoming fat, as well as a marked disturbance in the way individuals perceive or experience their body weight and shape. Individuals often have a distorted perception of their body weight or shape and may continue restrictive behaviours despite serious health consequences.

e. Bulimia Nervosa

Bulimia Nervosa involves recurrent episodes of binge eating, during which individuals consume unusually large amounts of food accompanied by a sense of lack of control. These episodes are followed by compensatory behaviours, such as self-induced vomiting, misuse of laxatives, fasting, or excessive exercise, intended to prevent weight gain.

f. Binge Eating Disorder

Binge-Eating Disorder is characterised by recurrent episodes of excessive food consumption accompanied by a feeling of loss of control. Unlike Bulimia Nervosa, these episodes are not regularly followed by compensatory behaviours. As a result, the disorder is often associated with significant distress and may contribute to obesity and related health problems.

Table 6.1.1 Types of Feeding and Eating Disorders

Diagnostic Type	Primary Behavioural Disturbance	Core Psychological Mechanism	Body Image Focus
Pica	Consuming non-nutritive, non-food materials (chalk, paper, soil).	Developmental/ Inappropriate urges.	No
Rumination Disorder	Repeated, unforced regurgitation and re-chewing of food	Habitual, non-gastric physical pattern	No

ARFID	Severe restriction based on food sensory traits or fear of choking	Sensory sensitivity or fear of aversive consequences	No
Anorexia Nervosa	Extreme restriction of food intake leading to significantly low weight	Intense fear of gaining weight and getting fat	Yes (Highly Distorted)
Bulimia Nervosa	Cycles of out-of-control binge eating followed by purging/fasting	Desire to counteract calories and prevent weight gain	Yes (Central to self-worth)
Binge Eating Disorder	Recurrent episodes of eating unusually large amounts of food	Felt loss of control and deep emotional distress	No (Not required for diagnosis)

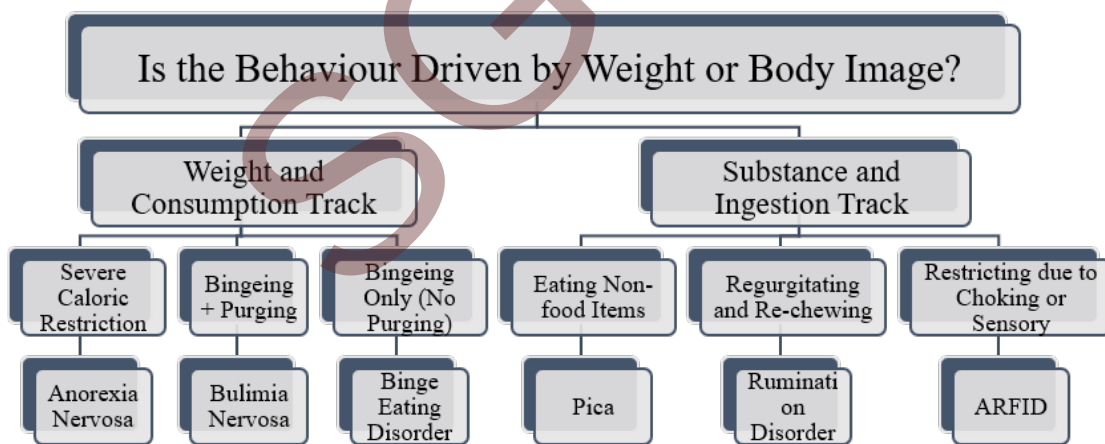


Fig. 6.1.1 Diagnostic Types of Feeding and Eating Disorders

PICA	
A.	Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
B.	The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
C.	The eating behavior is not part of a culturally supported or socially normative practice.
D.	If the eating behavior occurs in the context of another mental disorder (e.g., intellectual developmental disorder [intellectual disability], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.
Coding note: The ICD-10-CM codes for pica are F98.3 in children and F50.89 in adults.	
Specify if: In remission: After full criteria for pica were previously met, the criteria have not been met for a sustained period of time.	

Fig. 6.1.2 Diagnostic Criteria of Pica (DSM-5-TR)

RUMINATION DISORDER	
A.	Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
B.	The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis).
C.	The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.
D.	If the symptoms occur in the context of another mental disorder (e.g., intellectual developmental disorder [intellectual disability] or another neurodevelopmental F98.21 disorder), they are sufficiently severe to warrant additional clinical attention.
Coding note: The ICD-10-CM codes for rumination disorder are F98.21 in children and F50.89 in adults.	
Specify if: In remission: After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time.	

Fig. 6.1.3 Diagnostic Criteria of Rumination Disorder (DSM-5-TR)

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) associated with one (or more) of the following:

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
2. Significant nutritional deficiency.
3. Dependence on enteral feeding or oral nutritional supplements.
4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Specify if:

In remission: After full criteria for avoidant/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.

Fig. 6.1.4 Diagnostic Criteria of Avoidant/Restrictive Food Intake Disorder (DSM-5-TR)

ANOREXIA NERVOSA

- A.** Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- B.** Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- C.** Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Coding note: The ICD-10-CM code depends on the subtype (see below).

Specify whether:

F50.01 Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge-eating or purging behavior (i.e., self induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

F50.02 Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge-eating or purging behavior (i.e., self induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

- **Mild:** BMI ≥ 17 kg/m².
- **Moderate:** BMI 16–16.99 kg/m².
- **Severe:** BMI 15–15.99 kg/m².
- **Extreme:** BMI < 15 kg/m².

Fig. 6.1.5 Diagnostic Criteria of Anorexia Nervosa (DSM-5-TR)

BULIMIA NERVOSA	
A.	Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances. 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
B.	Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
C.	The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
D.	Self-evaluation is unduly influenced by body shape and weight.
E.	The disturbance does not occur exclusively during episodes of anorexia nervosa.
Specify if: In partial remission: After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time. In full remission: After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.	
Specify current severity: The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability. Mild: An average of 1–3 episodes of inappropriate compensatory behaviors per week. Moderate: An average of 4–7 episodes of inappropriate compensatory behaviors per week. Severe: An average of 8–13 episodes of inappropriate compensatory behaviors per week. Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors per week.	

Fig. 6.1.6 Diagnostic Criteria of Bulimia Nervosa (DSM-5-TR)

BINGE-EATING DISORDER	
A.	Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances. 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
B.	The binge-eating episodes are associated with three (or more) of the following: 1. Eating much more rapidly than normal. 2. Eating until feeling uncomfortably full. 3. Eating large amounts of food when not feeling physically hungry. 4. Eating alone because of feeling embarrassed by how much one is eating. 5. Feeling disgusted with oneself, depressed, or very guilty afterward.
C.	Marked distress regarding binge eating is present.
D.	The binge eating occurs, on average, at least once a week for 3 months.
E.	The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.
Specify if: In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time. In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.	
Specify current severity: The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability. Mild: 1–3 binge-eating episodes per week. Moderate: 4–7 binge-eating episodes per week. Severe: 8–13 binge-eating episodes per week. Extreme: 14 or more binge-eating episodes per week.	

Fig. 6.1.7 Diagnostic Criteria of Binge-Eating Disorder (DSM -5 - TR)

6.1.3 Clinical Features of Feeding and Eating Disorders

Although Feeding and Eating Disorders differ in their specific manifestations, many share common psychological, behavioural, and physical characteristics. Understanding their clinical features helps in recognising how disturbances in eating behaviour can affect both physical health and psychological well-being.

a. Disturbances in Eating Behaviour

The most distinguishing feature of Feeding and Eating Disorders is the presence of abnormal patterns of eating. These may include severe restriction of food intake, recurrent episodes of excessive eating, consumption of non-food substances, regurgitation of food, or highly selective eating habits. Such behaviours often persist despite their negative consequences and may become difficult for the individual to control.

However, the nature of the disturbance varies across disorders. Individuals with Anorexia Nervosa typically engage in severe restriction of food intake in an effort to lose weight or prevent weight gain. In Bulimia Nervosa and Binge-Eating Disorder, disturbances involve recurrent episodes of excessive food consumption. However, only Bulimia Nervosa is characterised by compensatory behaviours such as self-induced vomiting or excessive exercise. In contrast, individuals with Avoidant/Restrictive Food Intake Disorder avoid or restrict food intake because of a lack of interest in eating, sensory sensitivities, or fear of adverse consequences, rather than concerns about body weight. Pica involves the consumption of non-food substances, whereas Rumination Disorder is characterised by the repeated regurgitation of food after eating.

b. Preoccupation with Food, Eating, Body Weight, or Body Shape

Many individuals with eating disorders become excessively concerned with food, eating habits, body weight, or physical appearance. Thoughts about food consumption, dieting, weight control, or body image may occupy a substantial portion of their attention and influence daily decision-making. In some disorders, concerns about body weight and shape become central to an individual's self-evaluation and self-esteem. For example, such concerns are particularly prominent in Anorexia Nervosa and Bulimia Nervosa, where body weight and shape often play a central role in self-evaluation. Individuals with Binge-Eating Disorder may also experience concerns about weight and body image, although these are generally less central to the diagnosis. In contrast, Avoidant/Restrictive Food Intake Disorder, Pica, and Rumination Disorder are not primarily driven by body-image concerns.

c. Distorted Body Image

Individuals with disorders such as Anorexia Nervosa and Bulimia Nervosa may experience disturbances in the way they perceive their bodies. They may view themselves as overweight despite being underweight or place undue importance on body size and shape when evaluating their self-worth. These distortions can contribute to unhealthy eating behaviours and resistance to treatment.

d. Consequences on Physical Health

Feeding and eating disorders can produce significant physical complications. Depending on the disorder, individuals may experience weight loss, malnutrition, nutritional deficiencies, fatigue, weakness, gastrointestinal problems, dehydration,

hormonal disturbances, or other medical complications. In severe cases, the disorders can become life-threatening and require immediate medical intervention.

Anorexia Nervosa is often associated with severe weight loss, malnutrition, and nutritional deficiencies. Individuals with Bulimia Nervosa may experience electrolyte imbalances, dental erosion, and gastrointestinal complications due to recurrent purging behaviours. Binge-Eating Disorder may contribute to obesity and related health conditions. In Avoidant/Restrictive Food Intake Disorder, restricted dietary intake may cause nutritional deficiencies and impaired growth, whereas Pica can lead to poisoning, infections, or intestinal complications depending on the substances consumed. Rumination Disorder may lead to weight loss, malnutrition, and dental problems when persistent.

e. Emotional Distress

Many individuals experience considerable emotional difficulties, including anxiety, depression, guilt, shame, irritability, and low self-esteem. Eating-related behaviours may serve as attempts to cope with emotional distress, but they often contribute to further psychological difficulties over time. For example, individuals with Anorexia Nervosa often experience anxiety related to food consumption, weight gain, and body image, along with low self-esteem and feelings of inadequacy, whereas those with Bulimia Nervosa frequently report guilt, shame, and self-criticism following binge-eating episodes and compensatory behaviours.

f. Impaired Social Functioning

The symptoms of Feeding and Eating Disorders frequently interfere with social relationships and participation in everyday activities. Individuals may avoid social situations involving food, withdraw from

family and friends, or experience conflict with others regarding their eating habits, leading to isolation and reduced quality of life. For example, individuals with Anorexia Nervosa or Bulimia Nervosa may avoid meals with others because of concerns about food intake, body image, or fear of being observed while eating. Those with Binge-Eating Disorder may withdraw from social situations because of embarrassment or shame regarding their eating behaviour. Individuals with Avoidant/Restrictive Food Intake Disorder often experience difficulties in social situations involving unfamiliar foods, while those with Pica or Rumination Disorder may encounter stigma, misunderstanding, or social rejection because of their unusual eating behaviours. As a result, many individuals experience social isolation and reduced quality of life.

g. Cognitive Difficulties and Poor Concentration

Malnutrition, persistent preoccupation with food, and emotional distress may affect concentration, memory, and decision-making abilities. Individuals may find it difficult to focus on academic, occupational, or everyday tasks because of concerns related to eating, weight, or physical appearance. Such difficulties are particularly evident in Anorexia Nervosa, where prolonged nutritional deprivation may impair cognitive functioning. Individuals with Bulimia Nervosa and Binge-Eating Disorder may find that intrusive thoughts about food, eating, or body weight interfere with attention and concentration. In Avoidant/Restrictive Food Intake Disorder, nutritional deficiencies may similarly affect cognitive performance, particularly in children and adolescents.

h. Ritualistic or Compensatory Behaviours

Some feeding and eating disorders are associated with repetitive behaviours

intended to control food intake or body weight. These may include strict dieting, excessive exercise, self-induced vomiting, misuse of laxatives, repeated calorie counting, or rigid eating routines. These behaviours often become habitual and help maintain the disorder. For example, individuals with Avoidant/Restrictive Food Intake Disorder may develop highly restricted eating routines based on sensory preferences or fears related to eating, and those with Bulimia Nervosa engage in self-induced vomiting, fasting, excessive exercise, or misuse of laxatives. In contrast, compensatory weight-control behaviours are generally absent in Binge-Eating Disorder, Pica, and Rumination Disorder.

i. Impairment in Daily Functioning

The combined effects of physical symptoms, emotional distress, and preoccupation with eating-related concerns can significantly disrupt academic, occupational, social, and personal functioning. Everyday responsibilities may become increasingly difficult to manage as the disorder progresses. For example, in the case of Anorexia Nervosa, severe weight loss and malnutrition may impair academic, occupational, and social participation. And individuals with Bulimia Nervosa and Binge-Eating Disorder may experience difficulties arising from emotional distress, preoccupation with eating, and associated health problems.

Classic Cases in the History of Eating Disorders

The history of eating disorders includes several important clinical descriptions that preceded modern diagnostic classifications. One of the best-known is the case of ‘Ellen West’, a pseudonym used by the Swiss psychiatrist Ludwig Binswanger. Ellen West had a long history of depression, severe preoccupation with food and weight, restrictive eating, and episodes of overeating followed by compensatory behaviours. Binswanger interpreted her condition through existential analysis and diagnosed her with schizophrenia, but later writers have viewed the case as more consistent with Anorexia Nervosa involving binge-purge features. Because the original account does not contain all the information required for a modern diagnosis, it is more accurate to say that the case resembles anorexia nervosa with binge-purge symptoms rather than to assign a definitive retrospective diagnosis.

The emergence of Bulimia Nervosa as a distinct diagnostic concept is more directly associated with the British psychiatrist Gerald Russell. In 1979, Russell described an *ominous variant of anorexia nervosa* involving recurrent episodes of overeating, an intense fear of gaining weight, and compensatory behaviours such as self-induced vomiting or laxative misuse. Many of the patients he described were not markedly underweight, which demonstrated that serious eating pathology could exist without the low body weight traditionally associated with anorexia nervosa. His work helped establish bulimia nervosa as a distinct clinical syndrome.

The historical development of Binge-Eating Disorder is associated with Albert Stunkard’s descriptions of recurrent episodes of consuming unusually large amounts of food, often accompanied by stress, shame, and self-condemnation. Unlike Bulimia Nervosa, these episodes were not necessarily followed by regular compensatory vomiting, fasting, or excessive exercise. Binge-Eating Disorder was formally recognised as a separate eating disorder only later, in DSM-5 in 2013.

These historical accounts illustrate that eating disorders cannot be defined by body weight alone. Restriction, binge eating, purging, intense fear of weight gain, overvaluation of body shape, and loss of control may occur in different combinations. Modern diagnosis therefore depends on the overall pattern of symptoms, the person's relationship with food and body image, compensatory behaviours, duration, distress, impairment, and physical consequences.

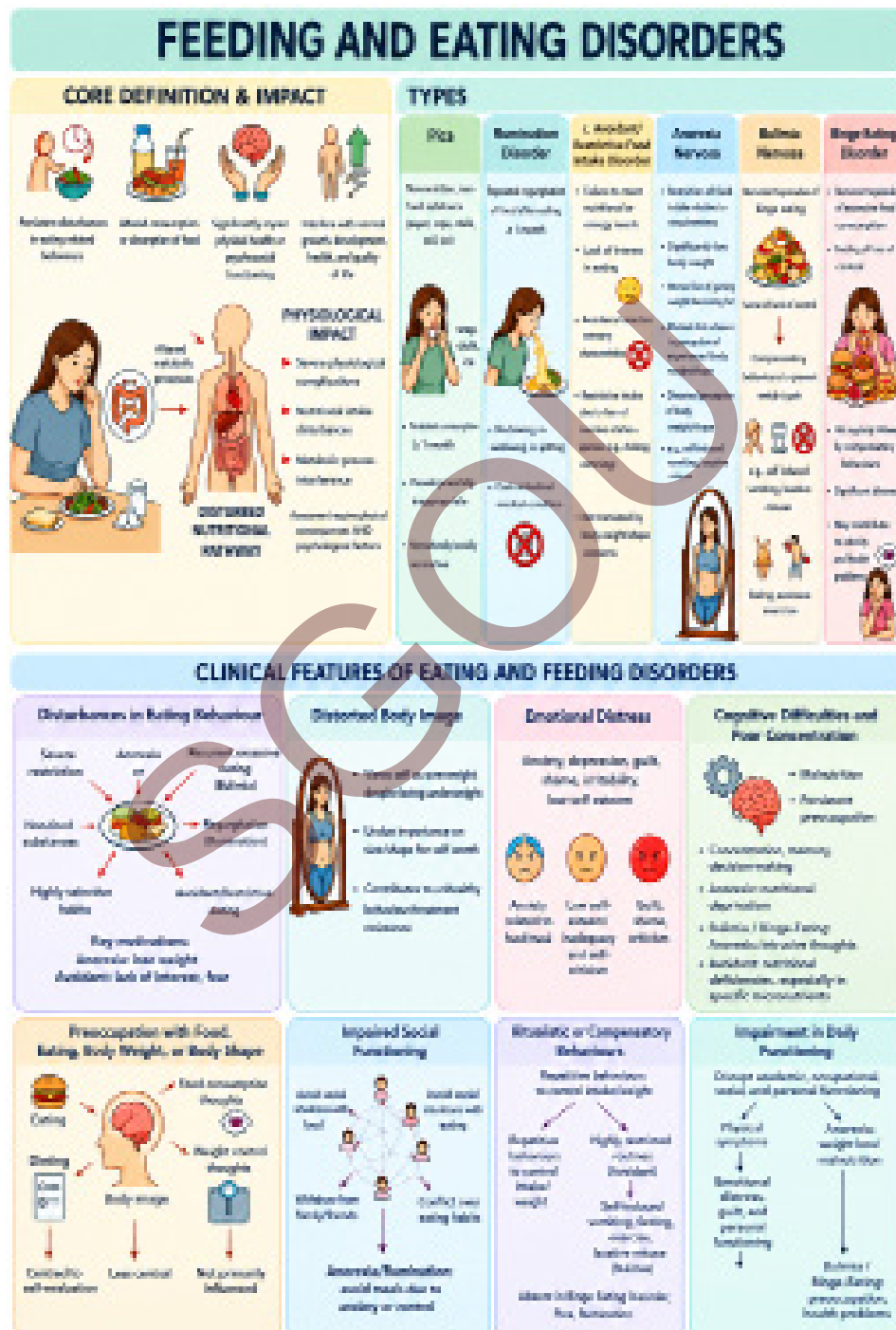


Fig. 6.1.8 Feeding and Eating Disorders at a Glance (AI-Generated)

Recap

- ◆ Feeding and Eating Disorders involve persistent disturbances in eating-related behaviour.
- ◆ These disturbances alter food intake, absorption, or nutritional functioning, and can impair both physical health and psychosocial functioning.
- ◆ Some Feeding and Eating Disorders involve severe food restriction, and others involve recurrent binge eating or compensatory behaviours.
- ◆ A key feature of these disorders is their direct effect on physical health.
- ◆ Pica involves persistent eating of non-food, non-nutritive substances.
- ◆ Rumination Disorder involves repeated regurgitation of food after eating. The regurgitated food may be rechewed, re-swallowed, or spit out.
- ◆ Avoidant/Restrictive Food Intake Disorder (ARFID) involves failure to meet nutritional or energy needs.
- ◆ Individuals with ARFID may avoid food due to sensory sensitivity, low interest in eating, or fear of choking/vomiting, and is not driven by concerns about body weight or body shape.
- ◆ Anorexia Nervosa involves restriction of food intake due to an intense fear of gaining weight, leading to significantly low body weight.
- ◆ Bulimia Nervosa involves recurrent binge-eating episodes with loss of control, and compensatory behaviours to prevent weight gain.
- ◆ Common compensatory behaviours include self-induced vomiting, laxative misuse, fasting, or excessive exercise.
- ◆ Binge-Eating Disorder involves recurrent binge eating with a sense of loss of control.
- ◆ Unlike bulimia nervosa, Binge-Eating Disorder does not involve regular compensatory behaviours.
- ◆ Feeding and Eating Disorders share disturbances in eating behaviour as a central feature, and can cause serious physical complications, such as malnutrition, dehydration, fatigue, weakness, and nutritional deficiencies.
- ◆ Disturbances may include food restriction, excessive eating, regurgitation, selective eating, or eating non-food substances.

- ◆ Body image concerns are especially prominent in Anorexia Nervosa and Bulimia Nervosa.
- ◆ Distorted body image is a common feature in Anorexia Nervosa and sometimes Bulimia Nervosa.
- ◆ Feeding and Eating Disorders often affect emotional well-being, social life, and everyday functioning.
- ◆ Early identification is important because these disorders can become chronic and medically dangerous.
- ◆ The cumulative toll of these physical and mental symptoms causes severe distress, eroding academic, work, and personal life.

Objective Questions

1. What group of disorders is characterised by persistent disturbances in eating or feeding behaviour?
2. Which feeding disorder involves the repeated eating of non-food, non-nutritive substances?
3. Which disorder involves repeated regurgitation of food after eating?
4. Which disorder is characterised by restricted food intake without body-image disturbance?
5. Which eating disorder is characterised by significantly low body weight and intense fear of gaining weight?
6. Which eating disorder involves recurrent binge eating followed by compensatory behaviours?
7. Which eating disorder involves recurrent binge eating without regular compensatory behaviours?
8. In Pica, the substances consumed are typically what kind of substances?
9. What does ARFID stand for?
10. In ARFID, food restriction is not primarily driven by concerns about what two things?

11. What kind of fear may lead a person with ARFID to avoid eating after a distressing experience?
12. In Anorexia Nervosa, what is the central behavioural feature related to food intake?
13. What intense fear is commonly present in Anorexia Nervosa despite low body weight?
14. True or False: Occasional, temporary changes in appetite are classified as feeding and eating disorders.
15. What disturbance in self-perception is commonly seen in Anorexia Nervosa?
16. What is the term for eating an unusually large amount of food with a sense of loss of control?
17. Name the common chemical consequence on teeth when an individual purges *via* vomiting over a long period.
18. In Bulimia Nervosa, what type of behaviours are used to prevent weight gain after binge eating?
19. What is self-induced vomiting an example of in Bulimia Nervosa?
20. Which disorder may involve misuse of laxatives, fasting, or excessive exercise after binge eating?
21. In Binge-Eating Disorder, what is absent that distinguishes it from Bulimia Nervosa?
22. What term refers to repeated eating episodes accompanied by a sense of loss of control?
23. What important area of self-evaluation is often disturbed in Anorexia Nervosa and Bulimia Nervosa?
24. What major outcome occurs when feeding and eating disorders significantly affect health, work, study, or social life?

Answers

1. Feeding and Eating Disorders
2. Pica
3. Rumination Disorder
4. ARFID
5. Anorexia Nervosa
6. Bulimia Nervosa
7. Binge-Eating Disorder
8. Non-food substances
9. Avoidant/Restrictive Food Intake Disorder
10. Body weight and shape
11. Choking fear
12. Food restriction
13. Weight gain
14. False
15. Body-image disturbance
16. Binge eating
17. Dental Erosion
18. Compensatory behaviours
19. Purging
20. Bulimia Nervosa
21. Compensatory behaviours
22. Binge eating

23. Body image

24. Functional impairment

Assignment

1. Describe the clinical features of Pica and Rumination Disorder. Explain how these disorders differ from ordinary eating habits and discuss the possible risks associated with each.
2. Discuss why a purely medical approach that only restores weight or nutrition is insufficient for long-term recovery in Anorexia Nervosa. Address the roles of body image distortion and emotional distress in your analysis.
3. What is Avoidant/Restrictive Food Intake Disorder (ARFID)? Discuss its clinical features and explain how it differs from anorexia nervosa and other eating disorders.
4. Differentiate Bulimia Nervosa and Binge-Eating Disorder. Compare them with respect to binge eating, loss of control, compensatory behaviours, body image concerns, and clinical consequences.
5. Compare Pica, Rumination Disorder, ARFID, Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder in terms of their central symptoms, eating patterns, and impact on health and functioning.
6. Explain the role of body image and weight-related concerns in Feeding and Eating Disorders. Discuss why such concerns are central in Anorexia Nervosa and Bulimia Nervosa but not in ARFID, Pica, or Rumination Disorder.
7. 'Feeding and Eating Disorders involve more than abnormal eating habits; they are serious psychological conditions with medical consequences.' Critically discuss this statement with reference to the disorders included in the unit.

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UNIT

Elimination Disorders

Learning Outcomes

Upon completion of the unit, the learner will be able to:

- ♦ define elimination disorders according to contemporary diagnostic frameworks
- ♦ differentiate between the distinct types and clinical subtypes of Enuresis and Encopresis
- ♦ discuss the clinical features of Elimination Disorders

Prerequisite

Few bodily functions are learned with as much monitoring and regulation during childhood as the control of elimination. What begins as a developmental process quickly becomes tied to ideas of cleanliness, maturity, self-control, privacy, and social acceptance. A child who successfully learns bladder and bowel control is rarely noticed for it; it is treated as an ordinary milestone of growing up. Yet when difficulties such as frequent urination or defecation in inappropriate situations continue beyond what is sanctioned, the experience often becomes surrounded by embarrassment, punishment, secrecy, ridicule, or anxiety, even though the behaviour itself involves one of the most basic physiological functions of the human body.

Although such experiences are most often associated with childhood, the distress attached to them may extend far beyond the physical act itself. Now consider what these experiences may feel like from the perspective of the child rather than the observer. What happens when a behaviour associated with shame

or humiliation continues despite repeated efforts to control it? How might fear of ridicule, anxiety about accidents, family responses, or the anticipation of social embarrassment begin to shape a child's emotional world, self-esteem, relationships, or everyday functioning? Sometimes, the distress attached to elimination difficulties may extend far beyond the behaviour itself, gradually becoming intertwined with the child's developing sense of competence, safety, and acceptance. And, as you move through the unit, reflect on how experiences involving elimination may come to carry meanings and emotional consequences far beyond the bodily function itself.

Keywords

Enuresis, Encopresis, Continence, Nocturnal, Overflow Incontinence, Intentional Elimination, Developmental Age, Bladder Control, Bowel Control, Emotional Distress

Discussion

6.2.1 Definition

Elimination Disorders are a group of disorders characterised by the recurrent and inappropriate elimination of urine or faeces into clothing, bedclothes, or other unsuitable places. These disorders are typically diagnosed during childhood or adolescence, when an individual fails to achieve age-appropriate bladder or bowel control after the period when such control is developmentally expected. Although elimination disorders are most commonly identified during childhood, their consequences often extend beyond physical functioning and may affect self-esteem, peer relationships, and overall psychological well-being.

The core defining features of these disorders include:

- ◆ **Developmental inappropriateness :** The behaviour is diagnosed only when the child has reached a chronological or developmental age where continence is expected (typically 4 to 5 years of age).

- ◆ **Absence of Organic Pathology:**

The symptoms must not be entirely attributable to a direct physiological effect of a substance, such as a diuretic or laxative or a general medical condition, such as spina bifida, diabetes, or a gastrointestinal disorder.

- ◆ **Pattern of Occurrence:** The elimination must occur regularly over a specified timeframe, causing significant distress or impairment in social, academic, or other vital areas of functioning.

While the behaviour is frequently involuntary, it can occasionally be intentional. For example, a child who has already achieved full physiological bladder or bowel control may engage in intentional elimination as a non-verbal expression of psychological distress, anger, or defiance. This category primarily distinguishes between the inappropriate passage of urine and the inappropriate passage of faeces, which are classified as separate clinical entities within contemporary diagnostic frameworks.

6.2.2 Types

Elimination disorders are classified according to whether the difficulty involves the inappropriate elimination of urine or faeces. Both conditions share the requirement that the behaviour occurs at a developmental age where continence is expected and is not due to a medical condition or the physiological effects of a substance; they differ in their symptoms, developmental patterns, and associated challenges.

The two principal types of elimination disorders are: Enuresis and Encopresis.

a. Enuresis

Enuresis is characterised by the repeated voiding of urine into inappropriate places, most commonly bedding or clothing. The behaviour may occur intentionally or unintentionally, although most cases involve involuntary urination. To meet the threshold for a formal diagnosis, the behaviour must occur repeatedly (typically at least twice a week for at least three consecutive months) or cause clinically significant distress or impairment. The chronological or developmental age of the individual must be at least 5 years.

Enuresis is often classified into different forms based on the timing and developmental history of the symptoms:

- ◆ **Nocturnal Enuresis:** In this type, urination occurs during sleep and represents the most common form of enuresis.
- ◆ **Diurnal Enuresis:** In this type, urination occurs during waking hours.
- ◆ **Nocturnal and Diurnal Enuresis:** In this type, urination occurs both during sleep and while awake.

Enuresis may also be classified according to whether bladder control was previously established, into:

- ◆ **Primary Enuresis:** The child has never achieved a prolonged period of bladder control.
- ◆ **Secondary Enuresis:** The condition develops after a period during which bladder control had already been established.

b. Encopresis

Encopresis refers to the repeated passage of faeces into clothing or other inappropriate places after the age at which bowel control is expected. Similar to enuresis, the behaviour may be involuntary or intentional, and can create significant distress for both the child and family members. For a diagnosis, at least one such event occurs each month for at least three months, and the individual's chronological age (or, equivalent developmental level) must be at least 4 years.

Encopresis is categorised into two clinical specifiers, which are crucial for determining the appropriate intervention strategy:

- ◆ **Encopresis With Constipation and Overflow Incontinence:** This is the most common form. It is characterised by a history of severe constipation. The impaction or accumulation of a large mass of stool causes the colon to stretch, reducing sensory feedback. Consequently, liquid or semi-solid faeces leak around the hard impaction involuntarily.
- ◆ **Encopresis Without Constipation and Overflow Incontinence:** In this presentation, there is no evidence of constipation on physical examination or history. The faeces are typically of normal form and

consistency. Soiling in this subtype is more likely to be intermittent and, as discussed in the previous section,

is more frequently associated with intentional behaviour or comorbid behavioural disorders.

ENURESIS	
A.	Repeated voiding of urine into bed or clothes, whether involuntary or intentional.
B.	The behavior is clinically significant as manifested by either a frequency of at least twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
C.	Chronological age is at least 5 years (or equivalent developmental level).
D.	The behavior is not attributable to the physiological effects of a substance (e.g., a diuretic, an antipsychotic medication) or another medical condition (e.g., diabetes, spina bifida, a seizure disorder).
Specify whether: Nocturnal only: Passage of urine only during nighttime sleep. Diurnal only: Passage of urine during waking hours. Nocturnal and diurnal: A combination of the two subtypes above.	

Fig. 6.2.1 Diagnostic Criteria of Enuresis (DSM-5-TR)

ENCOPRESIS

- A. Repeated passage of feces into inappropriate places (e.g., clothing, floor), whether involuntary or intentional.
- B. At least one such event occurs each month for at least 3 months.
- C. Chronological age is at least 4 years (or equivalent developmental level).
- D. The behavior is not attributable to the physiological effects of a substance (e.g., laxatives) or another medical condition except through a mechanism involving constipation.

Specify whether:

- **With constipation and overflow incontinence:**
There is evidence of constipation on physical examination or by history.
- **Without constipation and overflow incontinence:**
There is no evidence of constipation on physical examination or by history.

Fig. 6.2.2 Diagnostic Criteria of Encopresis (DSM-5-TR)

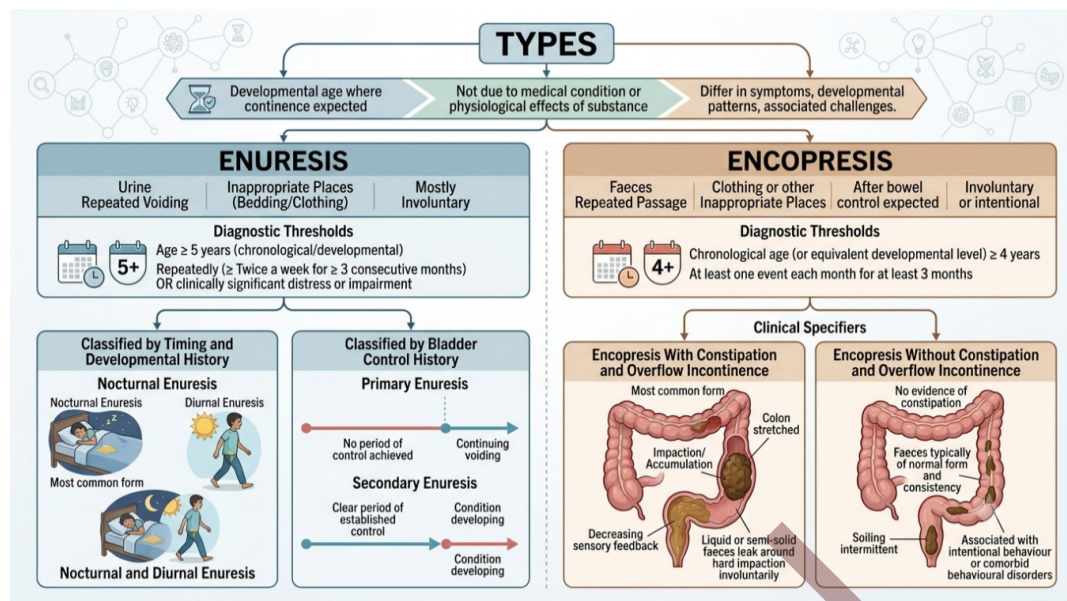


Fig. 6.2.3 Types of Elimination Disorders

6.2.3 Clinical Features of Elimination Disorders

Although Enuresis and Encopresis differ in whether they involve difficulties with urinary or bowel control, both disorders share several clinical features related to elimination behaviour, emotional well-being, social functioning, and developmental adjustment. At the same time, certain features are more characteristic of one disorder than the other. Examining these clinical features clarifies how persistent elimination difficulties affect children's functioning and well-being.

a. Repeated and Inappropriate Elimination

The defining feature of Elimination Disorders is the repeated passage of urine or faeces into inappropriate places after the age at which control is developmentally expected. In Enuresis, this involves repeated urination into bedclothes, clothing, or other unsuitable locations. The episodes may occur during sleep, during waking hours, or in both situations. In Encopresis, the inappropriate elimination involves the passage of faeces into clothing or other unsuitable places.

The behaviour may occur intentionally or unintentionally, although involuntary episodes are more common.

b. Developmentally Inappropriate Elimination Behaviour

A diagnosis of an Elimination Disorder is made only when the behaviour occurs beyond the age at which bladder or bowel control is typically expected. Occasional incidents are common during toilet training and early childhood; however, in elimination disorders, the difficulties persist beyond the expected developmental period. This distinguishes pathological elimination problems from normal developmental variations.

c. Lack of Control Over Elimination

Many children with Elimination Disorders experience difficulty exercising voluntary control over urination or defecation. In primary enuresis, the child may never have achieved sustained bladder control, whereas in secondary enuresis, urinary accidents emerge after a period of successful control. In encopresis, particularly when associated with chronic constipation, repeated stool retention

may eventually result in involuntary leakage of faeces. As a result, many elimination episodes occur despite the child's efforts to remain continent.

d. Persistence of Symptoms

The symptoms of elimination disorders are not isolated incidents but occur repeatedly over time. It is the persistence of urinary or faecal accidents that distinguishes Elimination Disorders from occasional incidents that are common during childhood development. The duration and frequency of symptoms are important considerations in clinical assessment and diagnosis.

e. Emotional Distress and Embarrassment

Elimination Disorders often give rise to feelings of embarrassment, shame, frustration, and low self-esteem. Children with Enuresis may feel distressed about

bedwetting, especially when sleepovers, school trips, or overnight activities are involved. Similarly, children with Encopresis may also experience similar humiliation or anxiety, and repeated incidents can negatively affect a child's self-confidence and emotional well-being.

f. Social and Interpersonal Difficulties

The symptoms of Elimination Disorders may interfere with social interactions and peer relationships. Children with Enuresis may avoid overnight stays, camps, or other activities that increase the likelihood of their condition being discovered. Children with Encopresis may withdraw from social situations because of fear of embarrassment or negative reactions from others. Consequently, both disorders can contribute to social isolation and reduced participation in age-appropriate activities.

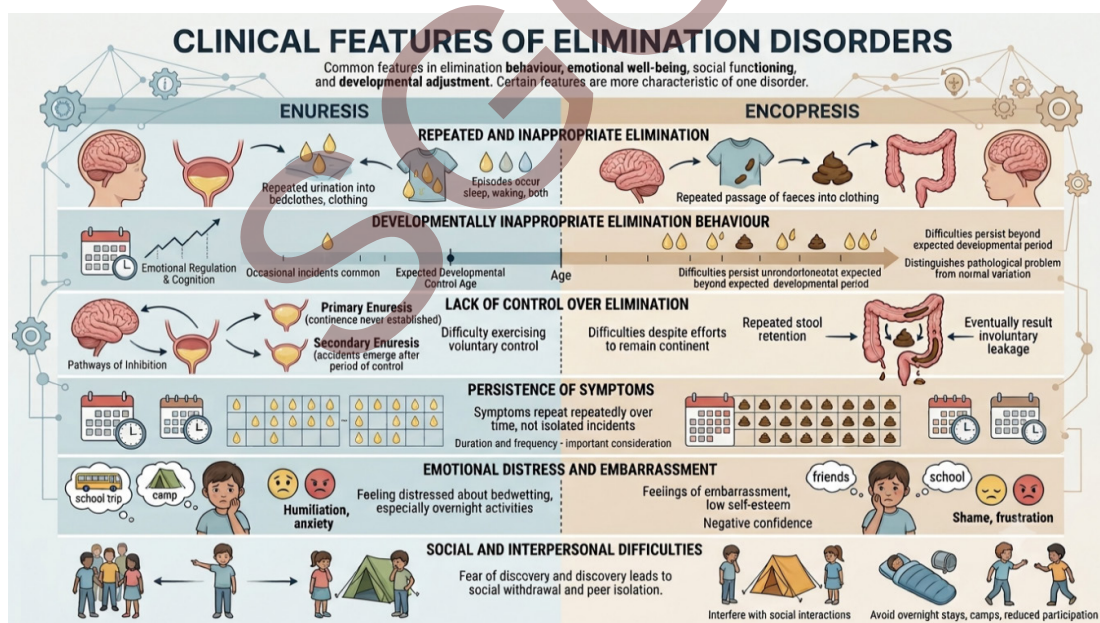


Fig. 6.2.4 Clinical Features of Elimination Disorders

Recap

- ◆ Elimination Disorders involve repeated and inappropriate passage of urine or faeces.
- ◆ Elimination may occur in clothing, bedclothes, or other unsuitable places.
- ◆ These disorders are usually diagnosed in childhood or adolescence.
- ◆ Diagnosis is made only when bladder or bowel control is developmentally expected.
- ◆ Elimination Disorders are not diagnosed when symptoms are fully explained by a medical condition or substance use.
- ◆ The behaviour must occur repeatedly over a period of time.
- ◆ Symptoms must cause distress or impairment in functioning.
- ◆ Elimination may be involuntary in most cases, though in some cases, elimination may be intentional. Intentional elimination may reflect distress, anger, or defiance.
- ◆ Elimination Disorders are mainly classified into Enuresis and Encopresis.
- ◆ Enuresis involves repeated voiding of urine into inappropriate places.
- ◆ Nocturnal enuresis occurs during sleep.
- ◆ Diurnal enuresis occurs during waking hours.
- ◆ Nocturnal and diurnal enuresis occur both during sleep and wakefulness.
- ◆ Primary enuresis means the child has never achieved sustained bladder control.
- ◆ Secondary enuresis develops after bladder control had previously been established.
- ◆ Encopresis involves repeated passage of faeces into inappropriate places.
- ◆ One major type of encopresis occurs with constipation and overflow incontinence.
- ◆ Encopresis without constipation and overflow incontinence occurs without evidence of constipation.
- ◆ A core clinical feature of Elimination Disorders is repeated inappropriate elimination.
- ◆ Lack of voluntary control is common in Elimination Disorders.

- ◆ Persistence of symptoms over time is important for diagnosis.
- ◆ Emotional well-being may be negatively affected by persistent symptoms.
- ◆ Social isolation may develop when children fear negative reactions from others.
- ◆ Elimination Disorders can affect emotional, social, and developmental adjustment.

Objective Questions

1. What group of disorders is characterised by repeated inappropriate elimination of urine or faeces?
2. At what general stage of life are elimination disorders most commonly diagnosed?
3. What developmental concept is central to the diagnosis of Elimination Disorders?
4. What is the term for repeated voiding of urine into bedclothes, clothing, or other inappropriate places?
5. What is the term for repeated passage of faeces into clothing or other inappropriate places?
6. What is the usual minimum developmental age required for a diagnosis of Enuresis?
7. What is the usual minimum developmental age required for a diagnosis of encopresis?
8. What type of Enuresis occurs during sleep?
9. What type of Enuresis occurs during waking hours?
10. What type of Enuresis occurs both during sleep and during waking hours?
11. What term is used when a child has never achieved a prolonged period of bladder control?

12. What term is used when Enuresis begins after bladder control has already been established?
13. Which type of Encopresis is most commonly associated with severe constipation?
14. What is the term for leakage of liquid or semi-solid stool around impacted faeces?
15. In Encopresis without Constipation, what is usually absent on physical examination or history?
16. For a formal Enuresis diagnosis, how many times a week must the symptom typically occur?
17. For how many consecutive months must Enuresis symptoms be present to meet diagnostic criteria?
18. How frequently must an Encopresis event occur to qualify for a diagnosis?
19. For how many consecutive months must Encopresis symptoms persist to meet diagnostic criteria?
20. What is the defining behavioural feature shared by both Enuresis and encopresis?
21. What type of control is often impaired in Elimination Disorders?
22. What term refers to the repeated continuation of symptoms over time in Elimination Disorders?
23. What type of functioning may be affected when children avoid peers or social situations because of elimination problems?
24. What kind of cause must be ruled out before diagnosing an Elimination Disorder?
25. What broader area of mental well-being can be affected by persistent Elimination Disorders?
26. Do isolated, occasional urinary accidents qualify as an elimination disorder?

Answers

1. Elimination Disorders
2. Childhood
3. Continence
4. Enuresis
5. Encopresis
6. Five years
7. Four years
8. Nocturnal enuresis
9. Diurnal enuresis
10. Nocturnal and diurnal enuresis
11. Primary enuresis
12. Secondary enuresis
13. Encopresis with constipation
14. Overflow incontinence
15. Constipation
16. Twice
17. Three months
18. Once monthly
19. Three months
20. Inappropriate elimination
21. Voluntary control

22. Persistence of symptoms
23. Social functioning
24. Organic pathology
25. Psychological well-being
26. No

Assignment

1. Discuss the core defining features required to diagnose a child with an Elimination Disorder, emphasising why developmental age and the absence of organic pathology are critical criteria.
2. Compare and contrast primary and secondary enuresis. How might the developmental history and potential psychological triggers differ between a child presenting with the primary *versus* the secondary form?
3. Explain the physiological mechanism behind 'Encopresis with Constipation and Overflow Incontinence.' Why does severe stool retention ultimately result in involuntary leakage?
4. Analyse the differences between intentional and involuntary elimination. How should a clinician interpret intentional Encopresis without constipation in the context of a child's psychological distress or defiance?
5. Evaluate the deep psychological and emotional consequences of Elimination Disorders on a school-aged child.

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MODEL QUESTION PAPER SETS



QP CODE:

Reg. No :

Name :

FIFTH SEMESTER BA PSYCHOLOGY EXAMINATION

DISCIPLINE CORE COURSE

B23PY05DC (CBCS - UG) Understanding Psychological Disorders I

2024-25 Admission Onwards

Model Question Paper- Set - I

Time: 3 Hours

Max Marks: 70

Section A

Objective Type Questions

Answer any ten questions. Each carries one mark (10x1=10 marks)

1. What term refers to the quality of the early relationship between a child and the primary caregiver?
2. What is the term for the repeated regurgitation of food after eating?
3. Which cognitive domain involves planning, decision-making, and working memory?
4. What is the term used for a persistent difficulty in discarding possessions, regardless of their practical value?
5. What term describes the psychological and physiological response that arises when perceived situational demands exceed an individual's ability to cope?
6. Which experience involves feeling detached from one's own body or mental processes?
7. What is the term for the inability to experience pleasure following severe stress or trauma?
8. What term describes habitual, systematic errors in reasoning that lead to inaccurate conclusions?
9. What is the term for persistent consumption of non-nutritive, non-food substances?
10. What type of neurocognitive disorder involves modest cognitive decline while independence in everyday activities is preserved?



11. What term describes the pattern of conditional acceptance that may cause individuals to suppress their true desires?
12. What is the term for repeated urination into bedclothes, clothing, or other inappropriate places?
13. Which hypothesis proposes that chronic poverty-related stress contributes directly to the development of mental disorders?
14. What term describes the experience in which the outside world feels unreal, strange, or dreamlike?
15. What term refers to the realisation of one's potential and capacities in the humanistic perspective?

Section B

Very Short Answers

Answer any ten. Each question carries two marks.

(10X2=20)

16. What is meant by eudaimonic well-being?
17. Name the three presentations of ADHD.
18. State the meaning of vulnerability or diathesis in clinical psychology.
19. What is adaptive functioning in Intellectual Disability?
20. What is gene-environment interaction?
21. Differentiate statistical normality from functional normality.
22. What is meant by a perpetuating factor?
23. What is Pica?
24. Differentiate primary and secondary enuresis.
25. What is anticipatory anxiety in Panic Disorder?
26. Name the two broad types of coping.
27. What is Dissociative Amnesia?
28. What is nocturnal enuresis?
29. Differentiate depersonalisation from derealisation.
30. What is meant by atypical development?.

Section C

Short Answers

Answer any five. Each question carries four marks.

(5X4=20)

31. Discuss the four primary dimensions commonly considered in identifying a mental disorder.
32. Differentiate Specific Phobia, Panic Disorder and Generalised Anxiety Disorder on the basis of the nature of anxiety.
33. Discuss in detail the two core clinical domains of Autism Spectrum Disorder and illustrate the types of difficulties included in each.
34. Explain how the statistical, sociocultural, and functional approaches provide different bases for understanding normality.
35. Discuss the developmental and diagnostic features that distinguish Enuresis from ordinary childhood accidents.
36. Explain the clinical features of Anorexia Nervosa and the importance of body-image disturbance.
37. Explain the obsession–compulsion cycle in OCD and why compulsions may maintain the cycle.
38. Describe how predisposing, precipitating and perpetuating factors differ in their roles in the development and maintenance of mental disorders.
39. Differentiate Bulimia Nervosa and Binge-Eating Disorder with reference to binge eating and compensatory behaviours.
40. Explain the major patterns of memory loss described in Dissociative Amnesia.

Section D

Essay/Long Answers

Answer any two. Each question carries ten marks.

(2X10=20)

41. Critically examine the major theoretical perspectives on psychological disorders. Compare the biological, psychodynamic, behavioural, cognitive, humanistic-existential and socio-cultural perspectives, and show why an integrative understanding is valuable.



42. Discuss the major clinical features of Dissociative Identity Disorder, Dissociative Amnesia and Somatic Symptom Disorder. Highlight the ways in which disruptions of identity, memory and bodily experience affect functioning.
43. Analyse the nature of anxiety disorders with reference to Specific Phobia, Panic Disorder and Generalised Anxiety Disorder. Explain how avoidance, persistence and functional impairment contribute to the maintenance of pathological anxiety.
44. Discuss neurodevelopmental disorders with reference to the distinction between typical and atypical development, the nature of neurodevelopmental disorders, and the clinical features of Autism Spectrum Disorder, ADHD and Intellectual Disability.

SGOU



QP CODE:

Reg. No :

Name :

FIFTH SEMESTER BA PSYCHOLOGY EXAMINATION

DISCIPLINE CORE COURSE

B23PY05DC (CBCS - UG) Understanding Psychological Disorders I

2024-25 Admission Onwards

Model Question Paper- Set - 2

Time: 3 Hours

Max Marks: 70

Section A

Objective Type Questions

Answer any ten questions. Each carries one mark (10x1=10 marks)

1. Which factor contributes to the onset of psychological symptoms?
2. Which disorder is characterised by a preoccupation with perceived defects or flaws in physical appearance?
3. What term describes developmental patterns that deviate substantially from what is expected for an individual's age and developmental stage?
4. What is the term for a sudden travel or wandering accompanied by confusion about identity?
5. Which disorder is characterised by excessive and persistent worry about a wide range of everyday events?
6. What is the term for a decline in cognitive functioning that is acquired rather than developmental?
7. What is the term for a state in which an individual refuses to take responsibility for their choices according to the existentialist perspective?
8. What is the term for the repeated passage of faeces into clothing or other inappropriate places?
9. Which type of behaviour in OCD involves repeatedly verifying that a task has been completed?

10. What term describes the exaggerated alertness and continuous scanning for danger that may occur in PTSD?
11. Which hypothesis proposes that severe mental disorders may lead to a decline in socio-economic status?
12. What is the term for a psychological disorder involving persistent disturbances in eating-related behaviour that impair physical health or psychosocial functioning?
13. What term describes distressing physical symptoms accompanied by excessive thoughts, feelings, or behaviours related to those symptoms?
14. What is the term for the persistent expectation of the worst-case scenario characteristic of Generalised Anxiety Disorder?
15. Which type of memory remains preserved in dissociative amnesia despite autobiographical memory loss?

Section B

Very Short Answers

Answer any ten. Each question carries two marks.

(10X2=20)

16. What is the defining behavioural feature of Hoarding Disorder?
17. What is ARFID and how does its restriction differ from that in Anorexia Nervosa?
18. What is meant by the functional approach to normality?
19. What is dissociative fugue?
20. What is a perpetuating factor?
21. What is meant by selective amnesia?
22. What is bradyphrenia?
23. What is a panic attack?
24. What are the three domains of adaptive functioning?
25. Name the three broad types of vulnerability discussed under the diathesis concept.
26. What does *polygenic* mean in the context of mental disorders?

27. What is meant by conditions of worth in Carl Rogers' theory?
28. What is meant by neurocognitive decline being acquired rather than developmental?
29. Why is statistical deviation alone insufficient to classify a behaviour as a clinical disorder?
30. What is Rumination Disorder?

Section C

Short Answers

Answer any five. Each question carries four marks.

(5X4=20)

31. Describe the four symptom clusters of Post-Traumatic Stress Disorder.
32. Explain the role of childhood experiences, attachment and Expressed Emotion in the development or maintenance of psychological difficulties.
33. Discuss the clinical features of Reactive Attachment Disorder and the role of pathogenic care in its development.
34. Compare Pica and Rumination Disorder with reference to their characteristic eating behaviours and possible effects on health.
35. Explain the distinction between major and mild neurocognitive disorder and relate it to independence in daily functioning.
36. Compare the behavioural and cognitive perspectives in explaining maladaptive behaviour and psychological distress.
37. Explain how avoidance produces short-term relief but contributes to the persistence of anxiety.
38. Discuss the defining features of Encopresis, including the two principal clinical presentations.
39. Explain how well-being differs from the mere absence of mental disorder, with reference to hedonic and eudaimonic well-being.
40. Give an account of the defining features of Anorexia Nervosa and the role of body-image disturbance.

Section D

Essay/Long Answers

Answer any two. Each question carries ten marks.

(2X10=20)

41. Discuss the nature and clinical features of Dissociative Disorders and Trauma and Stressor-Related Disorders, with particular reference to Dissociative Amnesia, Reactive Attachment Disorder and Post-Traumatic Stress Disorder.
42. Compare Obsessive-Compulsive Disorder, Body Dysmorphic Disorder and Hoarding Disorder. Explain their characteristic repetitive or preoccupational patterns and their effects on daily functioning.
43. Discuss neurocognitive disorders with reference to their acquired nature and the clinical features of Alzheimer's disease, Parkinson's disease and Neurocognitive Disorder due to Traumatic Brain Injury.
44. Explain the concepts of normality, abnormality and well-being, and discuss why cultural context and functional impairment are important when distinguishing normal from abnormal behaviour.

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