Tutorial letter 501/3/2018

Abnormal Behaviour and Mental Health

PYC3702

Semesters 1 & 2

Department of Psychology

IMPORTANT INFORMATION:

One of three tutorial letters, numbered 501, 502 and 503 for this module code.

These tutorial letters are your study guides for this module code.

BAR CODE

Tutorial Letter 501/2018
(First Study Guide for PYC3702)

Tutorial Letter 501/3/2018

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Introduction

Our blue, green and white planet earth is an incredibly beautiful, diverse spherical space that floats serenely in a universe of moons, planets, stars and galaxies of mysteriously unknown dimensions. Planet earth is surrounded by a unique life giving and life supporting atmospheric space that enables breathing life for an array of abundant, rich and varied soil and rock formations, plant and animal systems, as well as human beings. Life on earth is supported and maintained by the same mechanisms and systems for all living organisms, which are all dependent upon clean sources of air and water. This makes us aware, that everything depends on everything else. Thus, by deciding to neglect, destroy, or eradicate aspects of what constitutes a part of the earth system, we opt to destroy parts of ourselves.

If we want to protect something, we must first be able to appreciate it, and by learning to appreciate something, we need to learn as much as possible about everything. This philosophy is particularly valid in the hybrid knowledge space we call psychology.

The discipline of psychology can be referred to as both a science and an art. These two dimensions i.e. generating knowledge (science) and expressing knowledge (art) mutually interact with each other. This interaction of science and art in psychology forms the basis of the problems we encounter when we engage in psychological research. For example, in order to conceptualise abnormality (objective science) we need to have experienced a world in which normality exists (subjective experience). However, when we experience a world in which abnormality exists (subjective experience) we need to have objective conceptualisations of what constitutes normality (someone else's subjective experience) in order to understand our own experiences of abnormality. When we express our subjective experience in a story (art) we are communicating to the readers what it feels like to have such a normal or abnormal experience (subjective experience). As you can see, it can become quite complicated to think psychologically. It is therefore important to learn as much as possible about the subjective normal and abnormal experiences of others in order to understand our own experiences in the context of our complicated multicultural world of complex family systems, customs, rituals, rites, traditions, parenting practices, languages, personal interests, thought patterns, emotions, interactions and patterns within our social systems, religious thought and practices, political thought, environmental circumstances, and economic conditions. It is equally important to learn as much as possible about our biological reality in the context of the space in which we live on earth, and as organisms that transmute air (gases), water (minerals), plants (minerals and vitamins), and meat (protein and minerals), as well as the scientific understanding of the relevant metabolic and systemic processes in our bodies.

Much of what I have mentioned, you have already touched upon in your other undergraduate courses. Therefore, by studying this module, Abnormal Behaviour and Mental Health, you aim to expand your previous knowledge base by building upon what you have already learnt.

The purpose of this study guide

People have always been fascinated by the strange and unusual. So it is understandable that abnormal behaviour, and more specifically abnormal behaviour that is bizarre or dramatic, has always drawn people's attention. The scientific study of abnormal behaviour, or adult and child pathology, does not cover only the dramatic or bizarre. The field of study of abnormal behaviour is vast and includes the study of psychological problems which vary from minor disorders to disorders which are so intense and serious that individuals suffering from them experience extreme discomfort and impaired functioning. In this module we focus on behaviour that deviates from the normal and also on factors that contribute to the development and maintenance of abnormal behaviour. An important consideration throughout this study of abnormal behaviour is that we can very seldom attribute abnormal behaviour to a single causative factor.

Whereas the emphasis was previously on identifying and explaining abnormal behaviour, the emphasis in our modern society is increasingly on preventing abnormal behaviour and promoting mental health.

Knowledge of abnormal behaviours and their possible etiological factors will enable you to initiate interventions in your community that will improve people's quality of life. In this module we focus on primary and tertiary prevention. When you qualify as a counsellor/psychologist, you will be able to work at the secondary level (that of therapeutic treatment).

You need to remember that the authors of your prescribed book are Americans and wrote the prescribed book for the American market. Although the book does mention the incidence of psychological problems in other countries, it does not specifically refer to the situation in South Africa. We have therefore included material in this study guide (e.g. case studies and study tasks) which we trust you will find helpful in identifying and understanding abnormal behaviour in your community.

The prescribed book for this module is:

Sue, D., Sue, D.W., Sue, D., & Sue, S. (2016). *Understanding abnormal behavior* (11th ed.). UK: Wadsworth, Cengage Learning.

Please note: The textbook by Sue et al. (2013) was published after the DSM-5 was published and therefore please only use this 11th edition (Purple hardcover textbook)

This module is divided into 14 sections which correspond to the relevant chapters in your prescribed book. Additional sections which are not covered in the prescribed book can be found in this study guide, such as prevention, the African perspective, and DSM-5 diagnostic criteria for some disorders. Please note that there are three chapters in the prescribed book which you do not have to study, namely chapter 4 ("Research Methods for Studying Mental Disorders"), chapter 10 ("Eating Disorders") and chapter 17 ("Law and Ethics in Abnormal Psychology").

This study guide will assist you in negotiating your way through the enormously complicated subject matter of identifying, classifying, and describing abnormal behaviour, and it will act as your body of lecturers who speak to you through the written words in this study guide. By means of the written word we will guide you systematically through the content of 14 chapters of your prescribed book, indicating along the way what you are expected to study in order to gain the necessary skills for enabling you to recognise abnormal behaviour and to make informed diagnostic choices. The time we have at our disposal to teach you as many mental disorders as possible, does not allow us to include everything we would like to teach you. We have therefore selected a few disorders from every category that will provide you with a good understanding of a number of disorders people suffer from. These disorders are no more or less important than the ones we did not select. Our choice is simply made on account of the time constraints of this course. We therefore hope that you will fill in the gaps left by this course in your own time.

We have compiled this study guide in such a way that you are able to work from the study guide to the prescribed book. We strongly recommend that you diligently study all the sections in the prescribed book that are pointed out to you as study material.

In some cases we have added additional information in the study guide to clarify aspects that were inadequately dealt with in the prescribed book. We would like you to incorporate this additional material as part of your study plan. As you come across new words in your prescribed book, make sure that you learn to understand and use these new words. For this task you need to consult the glossary at the end of the prescribed book, or a good Dictionary of Psychology. For other general words you do not understand you need to consult a good English dictionary, such as the Oxford English Dictionary (UK) or the Collins English Dictionary (USA).

Outcomes
When you have completed this module, you should:

- understand the complexity of abnormal behaviour and mental health;
- be able to distinguish between normal and abnormal behaviour;
- be able to identify abnormal behaviour in various multicultural contexts. You should become sensitive to the influence of cultural factors on the incidence, manifestation and type of abnormal behaviour in various multicultural contexts;
- be able to classify abnormal behaviour according to the DSM-5 classification system. You should be able to analyse information in a scientific fashion and come to conclusions based on your theoretical knowledge of the DSM-5;
- be able to explain abnormal behaviour according to different perspectives. You should realise that each of the different perspectives on abnormal behaviour has unique possibilities but also limitations. It would be unrealistic to expect a single theory to cover all psychological phenomena or to have satisfactory answers to all psychological problems. Knowledge of the different theoretical explanations of abnormal behaviour provides you with insight into the complex domain of abnormal behaviour;
- be sensitive and be able to show understanding for and empathy with the suffering of people displaying abnormal behaviour;
- have knowledge of professional and other support services in your community to which you can refer people with abnormal behaviour;
- be able to refer people who display abnormal behaviour for professional treatment and support in an effective and appropriate manner;
- be able to promote mental health in your community. You should be sensitive to factors that both threaten and promote mental health. We will expect you to plan and design primary and tertiary prevention programmes for promoting mental health at various levels.

Some of the above outcomes can be achieved by studying the diagnostic criteria of the disorders we require you to study (that includes all the symptoms, the duration and the severity of every disorder), or a description of certain disorders or the complete DSM-5 diagnostic criteria for selected disorders. Due to the scientific nature of this subject matter as well as the combination of biological, psychological, social, and social-cultural factors in interaction with each other, the requirement for specific, detailed knowledge and understanding is very high, in fact much higher than in any other subject you have studied thus far.

Study

In order to achieve the above mentioned outcomes we will provide you with a number of case studies of individuals who were diagnosed with one or more mental disorders. By reading and analysing these case studies, it becomes much easier to identify, classify and understand abnormal behaviour.

Classifying abnormal behaviour

The way in which we classify abnormal behaviour can differ. The ICD-10 is the World Health Organisation's (WHO) International Classification of Diseases which originated in 1850. The latest version of the ICD was introduced in 1994 in all WHO Member States, and constitutes the international standard diagnostic classification for all general epidemiological cases, for the purpose of health management, for clinical use, and for mortality and morbidity statistics (Retrieved from http/www.google.com on 2010/03/28; http//www.who/int/classifications/icd/en/).

The other classification system for classifying abnormal behaviour is the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, which is used in the United States of America and to varying degrees across the world. It provides standard criteria for the classification of mental disorders since its first publication in 1952. The current edition of the DSM-5 (2013) is the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychological Association in 2013.

For the purpose of this module we have chosen the DSM-5 to teach you the criteria for identifying and classifying selected mental disorders. The DSM is considered to be suitable for teaching and researching mental disorders due to its descriptive character. (The ICD on the other hand categorises not only mental disorders but also all the other diseases.) It is therefore the preferred classification system for clinicians, doctors and psychiatrists. The coding system which is used in the DSM-5 is designed to correspond with the codes that are used in the ICD-10. You may however find that the codes may not match at all times, because the two publications are usually not revised synchronously.

We now wish you a safe journey through your study material. Remember to reflect upon and think about what you read and study, maintain your focus consistently on what matters, and ignore what does not matter. Success comes to those who are aware that time is short and detail is essential.

REFERENCES

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

http//www.who/int/classifications/icd/en/

GLOSSARY

Co-morbid/ Comorbidity	refers to more than one disorder or disease in the same individual at the same time.
Disease	a medical syndrome or cluster of physical symptoms, or a physiological disease that manifests in parts of the body
Hybrid	offspring of a mixed union, which in this case refers to psychology as being partially art and partially science
Psychological disorder	a mental abnormality that manifests on the level of thinking, feeling or behaving

The following list is a list of instruction words. If you take note of the instruction word, you will know what is expected of you in each question. You should therefore make sure that you know the meaning of each of the following instruction words:

Name/give	Make a numbered list of names, items or information in a specific category, for example the names of three psychotic disorders. When we ask you to name or give something, no discussion or explanation is required.
Explain	If you are asked to explain something, you should give a reasonably comprehensive answer. You have to make a phenomenon clear by showing how it is caused. You should therefore formulate your explanation as if it is for a reader who knows nothing about this subject, or for someone who is familiar with the technical vocabulary, but who does not understand the point you are trying to make. Concrete examples are very useful here.
Indicate/show	When you are asked to indicate or show something, you have to give proof or evidence to support the issue or point of view. Your answer should include a logical and

	systematic presentation of supporting evidence (proof) and appropriate conclusions.
Characterise	Describe only the most obvious or important characteristic
Compare	Indicate similarities and differences. Students often make the mistake of giving only similarities and disregarding the differences or vice versa.
Contrast	Point out the differences
Distinguish/differentiate	Point out details or characteristics which will help the reader to see the difference between two or more things; in other words compare things by constantly pointing out the differences.
Define	Give the accurate meaning of a concept.
Substantiate	Give evidence and arguments to justify your point of view.
Discuss	Look at an issue from different points of view and give supporting evidence for each point of view. Unless you are asked to do so, it is not necessary to give a synthesis of the different points of view.
Describe	You have to draw a "picture" with words so that the reader can clearly "see" what you are describing. Describing something therefore requires a clear, systematic and logical demonstration of facts.
Report	This instruction is usually given in connection with research. The purpose of the research should be given, the research procedure should be explained and the research results should be given.
Outline/sketch	Give a framework which consists of main ideas (summarised in single words) and supporting information (in concise sentences)
Evaluate	Here you have to make a value judgment using criteria which are provided or which you have to formulate yourself. It is a difficult task in the sense that the reasons for your value judgment have to be stipulated clearly. An evaluation question usually ends with a summary of your conclusions.
Classify	Divide information into categories. Sometimes the categories are given and sometimes not.
Identify	This involves recognising a phenomenon, issue or concept which belongs in a specific class.
Abstract	Find the essence of the topic under discussion and put it in your own words. In this instance never give concrete examples.

Learning Unit 1:

Abnormal Behaviour

Dr Beate von Krosigk

Contents

The study of abnormal behaviour represents the human quest to understand the causes, development, manifestation, and ultimately the alleviation and prevention of disturbances in thinking, feeling and behaving. Our attempts to understand, describe, explain, predict, and control abnormal behaviour are the objectives of the scientific approach/method for investigating abnormal behaviour. This consists of four steps: (a) formulating a research question, (b) expressing the research question in the form of an hypothesis, (c) applying methods of testing the hypothesis, and (d) drawing conclusions about the correctness or falseness of the hypothesis. Depending on the research question, researchers will choose one of the methods below that suits the investigation of their hypothesised problem.

The naturalistic observational method is used when the investigator needs to observe naturally occurring phenomena/behaviour under naturally occurring conditions.

The research method that explores relationships between variables attempts to find one or more possible correlations between the chosen variables. Such correlations cannot be considered as positive proof of cause-effect relationships; they do however have the potential to suggest possible underlying correlations amongst the assumed causes of the observed behaviour and may thus serve to tentatively predict the repetition of such behaviours in the future.

The longitudinal research method is one of the methods that investigate possible correlations over time, by repeatedly observing a sample of subjects at periodic intervals over a very long period of time. In order to reveal cause-effect relationships researchers will choose the experimental method. In this research method, the investigator controls the independent variable under controlled conditions. Experimental investigators need to randomly assign subjects to the treatment and to the control groups in order to eliminate experimenter bias, and to comply with the rules of scientific research. An ethical approach to doing research and an evaluation of internal, external, and construct validity of all experimentation are essential characteristics of value added research methods.

The epidemiological approach examines the rate at which abnormal behaviour occurs in various population groups and in a variety of settings, such as trying to differentiate between contributions from the environment and from heredity in twin study and adoptee study research.

The case-study method's limitations of possible therapist bias and inaccurate and biased case histories in the absence of control groups can be largely overcome by using single-case experimental designs.

Despite the abovementioned precautions, many people still have a lack of understanding and lack knowledge with regard to abnormal behaviour. In order to alleviate this condition, this module ventures into the unknown territories of the body- mind to explore some of the various aspects of abnormal behaviour. The questions that will guide us through the entire module will revolve around the following issues: (a) the need to define abnormal behaviour, (b) the way we establish the causes of abnormal behaviour, and (c) how we can prevent abnormal behaviour. How we determine which research method should be used to study abnormal behaviour will be dealt with in your research module.

In this Learning Unit you will familiarise yourself with the concerns of Abnormal Psychology and how abnormality is determined. You will also learn about the causes/aetiology of abnormal behaviour, and learn the new terminology by either consulting one of the dictionaries, or the glossary at the end of your prescribed book.

1.1 STUDY UNIT: The Concerns of Abnormal Psychology

The Concerns of Abnormal Psychology consider the premises on which our definitions of abnormal behaviour are based by studying the sections "The Concerns of Abnormal Psychology" and "Determining Abnormality".

Activity 1.1
STUDY the section entitled "The Concerns of Abnormal Psychology" on pages 4 to 7 of the prescribed book:

- "Describing Abnormal Behavior"
- "Explaining Abnormal Behavior"
- "Predicting Abnormal Behavior"
- "Modifying Abnormal Behavior"

1.2 STUDY UNIT: Determining Abnormality

How do we recognise abnormal behaviour? Unless we can agree on how to recognise and define abnormal behaviour, we cannot hope to progress much in our study of this subject. Activity 1.2 requires you to explore and critically think about the different aspects that are included in constructing a comprehensive definition of abnormal behaviour. In order to do this you need to study the following sections in your prescribed book in conjunction with the American Psychiatric Association's (2013) DSM-5 definition.

Activity 1.2
STUDY the sections entitled:

- "Views of Abnormality" on pages 8 to 10 in the prescribed book:
  - "Distress"
  - "Deviance"
  - "Personal Dysfunction"
  - "Dangerousnous"
- "Cultural Considerations in Abnormal Behaviour and Sociopolitical Considerations in Abnormality" pages 10-12 of the prescribed book.
- "How C ommon Are Mental Disorders", page 12.

- "Overcoming Social Stigma and Stereotypes", pages 13-15.

Note how different perspectives and vantage points deepen your understanding and knowledge of the multifaceted nature of abnormal behaviour/mental disorders by generating a more comprehensive view of the subject matter.

1.3 STUDY UNIT: The Causes/Aetiology of Abnormal Behaviour

Causes: Early Viewpoints

The need to treat individuals who manifest abnormal behaviour leads to an exploration into the possible causes/beginnings/or the aetiology of abnormal behaviour. The organic or biological perspective tends to view abnormal behaviour as a mental disorder whose origin/cause/beginning/aetiology lies in the organic functioning of the brain, which means that organic malfunction results in psychological/mental/ behavioural malfunction.

The psychological perspective tends to view abnormal behaviour as the result of emotional or cognitive processes as the reason for mental disorders, which means that emotional or cognitive malfunction results in mental/behavioural malfunction.

In the early days of psychology around 1900 AD, either the biological, organic viewpoint or the psychological viewpoint was the preferred choice for explaining the aetiology of abnormal behaviour, although most people combined elements of both.

Activity 1.3

In order to understand the multi-factorial nature of abnormal behaviour/mental disorders you need to STUDY the following sections on pages 20 to 22 in your prescribed book:

- "Causes of Mental Illness: Early Viewpoints" on page 20
- The Biological Viewpoint on page 20
- The Psychological Viewpoint on pages 21 to 22
- "Contemporary Trends in Abnormal Psychology" from page 22 to 30
  - The Influence of Multicultural Psychology
  - Positive Psychology
  - Recovery Movement
  - Changes in the Therapeutic Landscape

Activity 1.4

You are now ready to answer Focus Questions 1, 2, 3, 5, and 8, on page 4 of your prescribed book. Compare your answers with the answers in the Summary on pages 30-31 in your prescribed book.

CONCLUSION

With the increasing research outputs in consciousness and brain research we have developed a more inclusive model of abnormal behaviour which includes biological – organic, biochemical, physiological, genetic aspects in conjunction with psychological – emotional, cognitive, behavioural aspects in the context of social and cultural aspects, which will be the focus of attention in Chapter 2: "Perspectives/Models of Abnormal Behavior".

REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Association.

Learning Unit 2:

Prevention of Abnormal Behaviour

Mrs Banti Mokgatlhe & Ms Christine Laidlaw

Contents

The 11th edition of the prescribed book does not contain this chapter entitled "Psychotherapeutic interventions". It is, however, an important chapter, therefore please ensure that you know the sections on "Community Psychology" and "Prevention of Psychopathology" discussed in the Study Guide. The descriptions of various types of prevention are significant in the study and prevention of abnormal behaviour. The focus in this module is on community psychology, and primary, secondary and tertiary prevention of abnormal behaviour.

Community psychology, as a sub-discipline of Psychology, originated in the United States of America during the Boston Conference of 1965. The field of Clinical Psychology was increasingly being criticised for its availability to selected clients only, and the aim was to develop a conceptual orientation that would allow the professional to intervene in a social system on behalf of individuals requiring assistance. The concern of the early community psychologists was that psychotherapeutic models of helping were irrelevant to the needs of people who had little food and no education, jobs or decent housing. They questioned its selectivity in that it appeared to ignore the more serious and yet socially relevant problems such as substance abuse, crime, violence and women battering.

Most psychologists who adopt the community perspective accept the broader society as it is and assume responsibility for creating or changing existing service organisations and other institutions into more effective agencies for achieving goals and providing more humane, effective care for those in need. They also take responsibility for enhancing human psychological growth and development. This entails intervention to improve the individual’s circumstances, emotional wellbeing and quality of life.

Another major tenet of community psychology is its endeavour to identify and promote the strengths of a community rather than to diagnose problems on the basis of criteria determined by external sources (experts). Community psychology, for example, seeks to support health on the basis of the inherent strengths of the community rather than to prevent illness along the lines advocated by community mental health programmes.

Four theoretical models have been identified in the field of community psychology, namely:

- The mental health model is based on the explicit intention of preventing mental illness and its disruption of usual living patterns.

- The social action model also aims at prevention. It addresses the needs of the poor and attempts to equalise opportunities for upward social mobility.

- The ecological model sees the community as an ecosystem consisting of relationships that operate in an environmental context.

- The organisational model focuses on understanding and preventing mental disorders in organisations. It is seen as a method for facilitating change and development in people.

The area to which community psychology applies is as wide as the interests and concerns of the community itself.

Activity 2.1

Scan-read Learning Unit 2 in this Tutorial Letter 501, in order to familiarise yourself with the contents of this Learning Unit.

2.1 STUDY UNIT: Community Psychology

In this study unit we introduce you to the field of community psychology and, most importantly, the role of community psychologists in the prevention of psychopathology/abnormal behaviour.

Community psychologists instigate community interventions to improve the quality of life of the entire community, whereas clinical psychologists work with individuals or groups to bring about psychological improvement. The community psychologist thus has a preventative orientation in contrast to the clinical psychologist's curative orientation.

Community interventions also tend to be of a more public nature and include the participation of non-professionals, volunteers and self-help support networks. Clinical interventions, in contrast, are essentially more private, are based on interpersonal contact and rarely involve non-professionals. In both instances, the focus is on the enhancement of mental health.

Outcomes

Once you have worked through Study Unit 2.1, you should be able to:

- define community psychology
- describe the role of community psychologists

Study

To be able to do the above you will need to study the overview to this section in this Tutorial Letter 501 as well as study unit 2.1.

2.2 STUDY UNIT: Prevention of Psychopathology

In this study unit we introduce you to different forms of prevention. Preventing psychopathology is one of the most innovative functions of community psychology. Prevention programmes are attempts to maintain health rather than to treat sickness. The main emphasis is on reducing the number of new cases of mental disorders, the duration of disorders among afflicted people, and the disabling effects of disorders. These three areas of prevention have been called primary, secondary, and tertiary prevention.

Primary Prevention

Primary prevention is an effort to lower the incidence of new cases of behavioural disorders by strengthening or adding to resources that promote mental health and by eliminating community characteristics that threaten mental health. As an example of the former, Project Head Start was initiated in 1964, in the United States of America, with the goal of setting up a new and massive preschool program to help neglected or deprived children develop social, emotional, and intellectual skills. Examples of the latter are efforts to eliminate discrimination against members of minority groups to help them fulfil their potential. Both techniques – introducing new resources and eliminating causal factors – can be directed toward specific groups of people or toward the community as a whole.

Munoz and colleagues (Munoz, Glish, Soo-Hoo & Robertson, 1982; Munoz et al., 1995) have been systematically attempting to prevent depression in a community-wide project and in primary care patients. The project was particularly interesting. During a two-week period, nine televised programmes intended to prevent depression were broadcast in San Francisco. Each programme lasted for four minutes and showed viewers some coping skills, such as how to think positively, engage in rewarding activities, and deal with depression. Telephone interviews were conducted with 294 San Francisco residents. Some respondents were interviewed one week before the television segments were shown; others were interviewed one week after; and still others were interviewed both before and after the segments. Information about respondents' depression levels was collected during the interviews. (For those who were interviewed before and after the segments, the depression measure was administered twice). Respondents who were interviewed after the televised segments were also asked to indicate whether they had watched any of the segments. Results indicated that those who saw the segments exhibited a significantly lower level of depression than that found among the non-viewers. The results, however, held only for respondents who had some symptoms of depression to begin with. Watching the television programmes did not change the depression levels of those who initially (before the segments) reported little depression.

The results indicated that a community-wide prevention programme could be beneficial. A large proportion (approximately one-third) of the viewers had some symptoms of depression, and this group showed fewer symptoms after viewing the programs. The long-term effects of the programmes were not assessed.

Another problem in the study was that those who benefited from the programmes had exhibited some initial symptoms. If they were clinically diagnosable as being depressed, the intervention might be considered secondary rather than primary prevention. (Secondary prevention is discussed in the next section.) Nevertheless, the San Francisco study demonstrated the effects of large-scale interventions that may help individuals who already exhibit disorders.

Evidence also exists that early; primary prevention efforts can be successful in reducing the incidence of juvenile delinquency. Zigler, Taussig and Black (1992) noted that few treatment and rehabilitation programmes for children with conduct problems have had much effect. In their review of early intervention programme aimed at children, they found evidence that these programme, intended to promote social and intellectual competence, have had an expected positive effect on preventing conduct problems in children. The investigators speculated that gaining competence may snowball to generate further success in other aspects of life and prevent conduct disorders.

Although interest in primary prevention continues to grow, resistance to prevention is also strong. First, only through prospective and longitudinal research can developmental processes in primary prevention be uncovered (Lorion, 1990). Primary prevention is future-oriented, in that the benefits of the effort are not immediately apparent. Second, primary prevention competes with traditional programme aimed at treating people who already show emotional disturbances. Third, prevention may require social and environmental changes so that stressors can be reduced or resources can be enhanced. Most mental health workers are unable to initiate such changes and many others doubt that people have the ability to modify social structures. Fourth, funding for mental health programmes have traditionally been earmarked for treatment. Prevention efforts constitute a new demand on the funding system. And fifth,

primary prevention requires a great deal of planning, work, and long-term evaluation. This effort alone may discourage many from becoming involved.

Secondary Prevention

Secondary prevention is an attempt to shorten the duration of mental disorders and to reduce their impact. If the presence of a disorder can be detected early and an effective treatment can be found, it is possible to minimise the impact of the disorder or to prevent it from developing into a more serious and debilitating form. For example, classroom teachers can play an important role in secondary prevention by identifying children who are not adjusting to the school environment. Once identified, such children can be helped by teachers, parents, or school counsellors.

In practice, there are a number of problems associated with secondary prevention. First, traditional diagnostic methods are often unreliable and provide little insight into which treatment procedures to use. It has been suggested that more specialised diagnostic techniques be used, perhaps focusing on certain behaviours or on demographic characteristics that may be related to psychopathology. Second, once a disorder is detected, it is often difficult to decide what form of treatment will be most effective with a particular patient. Third, prompt treatment is frequently unavailable because of the shortage of mental health personnel and the inaccessibility of services. Indeed, many mental health facilities have long lists of would-be patients who must wait months before receiving treatment. “Walk-in” clinics, crisis intervention facilities, and emergency telephone lines have been established in an attempt to provide immediate treatment.

Tertiary Prevention

The goal of tertiary prevention is to facilitate the readjustment of the person to community life after hospital treatment for a mental disorder. Tertiary prevention focuses on reversing the effects of institutionalisation and on providing a smooth transition to a productive life in the community. Several programmes have been developed to accomplish this goal. One involves the use of “passes,” whereby hospitalised patients are encouraged to leave the hospital for short periods of time. By spending gradually increasing periods of time in the community (and then returning each time to the hospital), the patients can slowly readjust to life away from the hospital while still benefiting from therapy.

Psychologists can also ease readjustment to the community by educating the public about mental disorders. Public attitudes toward mental patients are often based on fears and stereotypes. Factual information can help modify these attitudes so that patients will be more graciously accepted. This help is especially important for the family, friends, and business associate of patients, who must interact frequently with them. A more difficult problem to deal with is the growing backlash against the discharge of former mental patients into nursing homes or rooming houses in the community. Many community members feel threatened when such patients live in their neighbourhoods. Again, education programmes can help dispel community members’ fears and stereotypes (Sue et al., 2006, pp. 589–592).

Outcomes

Once you have worked through Study Unit 2.2, you should be able to:

- Distinguish between the various types of prevention, namely primary prevention, secondary prevention and tertiary prevention

Study

To be able to do the above you will need to study the introduction to this section in this Tutorial Letter 501 as well as study unit 2.2.

Activity 2.2.

Contact a community worker in your area or community and ask him or her about the role of a community worker in the prevention of psychopathology.

In carrying out this activity you will enhance your understanding about the role of community workers in the prevention of psychopathology in your area.

Additionally, an example of a national advocacy organisation that works towards prevention of mental distress is the South African Depression and Anxiety Group. Explore their nationwide projects on their website www.sadag.org.

Activity 2.3.

The following activity will help you to revise and summarise what you have studied in this Learning Unit:

The learning outcomes of each of the three study units in this chapter were set out clearly in each of the study units. Make sure that you have acquired the necessary knowledge, skills and insights set out in these learning outcomes.

Learning Unit 3: Perspectives/Models of Abnormal Behaviour

Dr Beate von Krosigk

Contents

Introduction

In general, the traditional perspectives/models of abnormal behaviour can be divided into two distinct groups based on the reasoning these perspectives employ for explaining the aetiology of abnormal behaviour. The earlier formulations of the biological, psychoanalytic, psychodynamic, behavioural, cognitive, humanistic, and existential perspectives/models fall within the linear models. These perspectives employ a cause-and-effect reasoning for explaining abnormal behaviour, while the systems perspective (family systems) and ecosystems perspectives/models are circular models, as these perspectives consider circular causality in the aetiology of abnormal behaviour. These latter perspectives are based on the assumption that this circularity can be observed or detected only in the present moment during an actual interaction, while all individuals who are involved in the reciprocal processes of verbal, non-verbal, and behavioural interactions are present.

As scientific research yields more findings that inform the knowledge field of psychology, these perspectives/models are continuously reconsidered, reworked and updated. Because of this, the clear division of these perspectives/models into either linear or circular is becoming increasingly blurry as 'linear' perspectives/models are to varying degrees considering the complexity of different aetiological factors' influence on the development of abnormal behaviour, and how these factors interact to produce the different conditions/disorders we study in psychopathology.

It is therefore very important that you have a clear understanding of the core assumptions of these different perspectives/models and consider how they have evolved to consider multiple avenues of causality since their original formulation.

Although these linear perspectives/models consider the aetiology of abnormal behaviour as more complex than originally formulated, their core assumptions still remain linear, albeit as having a linear causative formulation namely: A leads to Z; A and B leads to Z, or the interaction between A, B and C leads to Z. This differs from a circular causality that can be formulated as: A leads to Z which leads back to A which then leads to Z which leads to A etc.…..(you get the idea!).

Study "Contemporary Trends and Future Directions" in Chapter 2 (pages 68 to 71) and Table 2.3 on page 70 of your prescribed book that highlights the issues discussed above.

As PYC2601 (Personality Theories) is considered a prerequisite for PYC3702 we assume that you have completed your studies of the different personality theories. These theories are the same psychological theories/models or perspectives that we use in Abnormal Behaviour.

In personality theory, the focus in teaching you these perspectives was on how these different theories/model/perspectives describe the development of the personality, whereas the focus in this module, Abnormal Behaviour and Mental Health, is on how these theories explain the development of abnormal behaviour (the aetiology of mental disorders). You will therefore use the same knowledge regarding the different perspectives to explain the aetiology of mental disorders – using the same assumptions, principles, concepts and terminology as in personality theory – as the perspectives are the same and therefore applied in the same way, but for the shift in focus from personality development to development of abnormal behaviour.

You will see that the different mental disorders that you will study in this module have different explanations regarding their aetiology according to these different perspectives. Therefore, for this module (PYC3702) we assume you already know the assumptions, principles, concepts and terminology of these different psychological perspectives and therefore will not examine you on pure theoretical issues regarding these details (unless of course stated otherwise in specific activities, outcomes and study sections in the rest of the study guide).

We will however examine you on the application of these different perspectives towards the explanation of the aetiology of specific mental disorders. Of course, the African perspective, and the Multipath Model are new to this module and therefore we will examine pure knowledge/theoretical aspects as well as more application questions regarding these two perspectives.

Your prescribed book utilises the Multipath Model for the explanation of the development of abnormal behaviour. This model is a meta-model meaning that the model attempts a holistic explanation for the development of abnormal behaviour by incorporating the different aetiological factors into four interrelated and reciprocal dimensions:

- Dimension one: Biological Factors
- Dimension two: Psychological Factors
- Dimension three: Social Factors
- Dimension four: Sociocultural Factors

According to the Multipath Model abnormal behaviour can very seldom be explained in full by one theoretical model. The proponents of the Multipath Model stress the roles and contributions of multiple pathways to and causes of mental disorders. They propose the consideration of combinations of interacting biological, psychological, social and sociocultural factors in explaining abnormal behaviour.

At the beginning of chapter 2 of your prescribed book, you will find 7 “FOCUS QUESTIONS”. After having worked through this chapter, answer these questions, and compare your answers with the answers at the end of the chapter under the heading “SUMMARY”. Should your answers be incomplete refer back to this study guide as well as the prescribed material in chapter 2, and again work through the parts you are required to study.

3.1 STUDY UNIT: Models of Mental Disorders

Begin by reading the case study on Steven V at the beginning of chapter 2 in the prescribed book. While you are doing so become aware of your own underlying presuppositions on which your reasoning is based for understanding Steven V’s abnormal behaviour and family situation. Are you able to identify the perspective(s)/ model(s) you use in order to explain Steven V’s abnormal behaviour?

Write down your observations and retain them for later.

Activity 3.1

You are now ready to STUDY the following sections in your prescribed book:

- "One-Dimensional Models of Mental Disorders", page 34
- "A Multipath Model of Mental Disorders", page 36

As you were studying the abovementioned sections you may have realised that the "One-Dimensional Models of Mental Disorders" refer to the way in which psychologists use a particular personality theory to the exclusion of others in their attempt to explain abnormal behaviour. The "Multipath Model of Mental Disorders" on the other hand integrates different perspectives/models on a number of different dimensions. Explanations from the biological dimension (Bio) can include an array of biological aspects of human functioning, which can be referred to as supportive evidence for the explanation of the presence of abnormal behaviour. These biological aspects include genetic factors, chemical imbalances in the brain, metabolic dysfunction, abnormalities in the neurological structures, and organ malfunction.

Activity 3.2

You can now STUDY the following sections in your prescribed book for a deeper understanding of the four dimensions of the multipath model:

- "Dimension One: Biological Factors", page 40
- "Dimension Two: Psychological Factors", page 50
- "Dimension Three: Social Factors", page 63
- "Dimension Four: Socio-cultural Factors", page 65

Did you recognise that to a large extent, these four dimensions were a revision from your Basic Psychology, Developmental Psychology and Personality Theory modules?

Activity 3.3

Revision

We will now return to your initial reading of Steven V's story, and the observations you made. Has your understanding changed? Do you now see the basis of your reasoning for explaining Steven V's abnormal behaviour, differently?

Are you able to identify the perspective(s)/model(s) you used in order to explain Steven V's abnormal behaviour? And have they changed?

Has your basis for your reasoning changed now that you have gained more knowledge/facts about the different perspectives/models?

Would you use different perspectives/models now than you used before for explaining abnormal behaviour?

We will now return to the beginning of chapter 2 of your prescribed book. Answer the 7 "focus questions" on page 34, and compare your answers with the answers at the end of the chapter under the heading "summary" on page 72. Should your answers be incomplete refer back to this study guide as well as the prescribed material in chapter 2, and again work through the sections you are required to study. Pay particular attention to the aspects you misunderstood, misrepresented, or simply forgot.

Ensure that you know the new terminology as well as all the other words that you do not understand.

CONCLUSION

We have now come to the end of revising Western perspectives/models of abnormal behaviour/mental disorders/psychopathology and will now look at the African perspective of explaining abnormal behaviour.

REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Association.

Learning Unit 4:

Psychopathology from an African Perspective

Mrs Banti Mokgatlhe

Contents

Introduction

The 11th edition of the prescribed book does not contain a chapter entitled "Psychopathology from an African Perspective". It is, however, an important Learning Unit, so please ensure that you know the content below thoroughly.

However a point of caution before reading this Learning Unit; the author acknowledges the fact that most societies have evolved over time. As a result, the general views on Western and African worldviews on most of the issues discussed in this chapter may not be applicable to everyone. So as Africans would say “re inele matsogo metsing”, in other words please accept our apologies if you find any of the material somewhat offensive.

In a multicultural society such as South Africa, the challenge facing many therapists is how to work with people from diverse cultural backgrounds. As most of mainstream psychology is based on Western philosophy and principles, how would you as a Western-trained therapist treat a culturally different client who believes that (a) his or her mental problems are due to spirit possession, (b) only a traditional healer with supernatural powers can deal with the problem, and (c) a cure can be effected via formal ritual and a journey into the spirit world?

Therapists who have little experience of indigenous methods of treatment often have great difficulty in working effectively with clients with an indigenous orientation. It is, therefore, important that therapists and scholars of psychology should be open to alternative worldviews and as such, become culturally sensitive to clients' diverse contexts, develop an understanding of the latter and, as a result, avoid equating differences with deviance.

The debate on the relevance of the psychology practised and taught in South Africa has evolved along with socio-political movements in the country. There is a growing consciousness of the absence of comprehensive theories and treatment models for human problems in a culturally plural society. In this module, we expose you to an African worldview as an alternative approach to psychopathology. A lot still has to be learned about this topic, which has often been overlooked by research in the past.

In this module, we give you a brief and by no means complete picture of some of the important issues in African cultures. For pragmatic reasons we do not cover all African cultures in this module. This does not imply that the cultures not covered are less significant or relevant within the South African context.

In the past, psychology addressed mainly the problems arising from the Western way of life but today there is no conceivable reason to maintain the status quo. There are two views in this debate: those in favour of the status quo and who profess an universalist approach, and those who advocate new theories and the development of treatment models based on cultural relativism. A third view proposes a synthesis of the two. A more detailed discussion of these approaches will follow in Learning Unit 4.

In addition, the fact that western conceptions of normality and abnormality have been exported to Africa to explain the African client has resulted in a lack of development of a theory of abnormal behaviour from a purely African perspective.

Based on the aforementioned, it has become very important to ask the question "what are the main obstacles to developing an African perspective on psychopathology". The posed question is paramount, in that Africanisation of psychology is becoming a prominent topic within academic circles. The call for Africanisation of psychology is based on the argument that an understanding of the complexities of traditional indigenous African epistemologies is necessary for the development of psychological knowledge which is appropriate for Africans (Viljoen,1995; Holdstock,2000; Eagle,2004). The quest for the Africanisation of Psychology can, according to Dawes, (1998, p.7), be ascribed to three factors:

- the fact that psychology "collaborated in the oppression of American blacks and in the African colonial project through the invidious comparison of "primitive" (African) with the "modern" (Western) mind". This applies especially to the development of the "Africentric paradigm" and the Black psychology movement in the USA;

- the fact that psychology in the USA and South Africa "has little relevance to the problems facing the black and the poor". The discipline's response to these population groups were perceived as using models that were deemed unsuitable to the understanding of local conditions of life, with the result that the effectiveness of psychology in resolving the problems of these populations could be questioned; and

- the claim "that psychologies imported to the continent do not accurately portray African life and mentality". Thus questioning the appropriateness and applicability of mainstream theoretical and empirical knowledge for Africa.

Dawes (1998; p.4) and Eagle (2004; p.2) argue that if an African psychology and psychotherapy were to materialise, it should draw from both local (indigenous) and external (westernised) knowledge systems, because these cosmologies exist side by side in contemporary Africa. There is also an argument about Africans being in a transitionary phase in their development that makes it difficult if not impossible to talk about a comprehensive overriding African perspective (Viljoen, 1998).

Viljoen (1998) further argues that Africans are in a transitionary phase in which a shift is taking place from a traditional to a more modern, western oriented way of life. Sogolo (1993) however cautions that the process of change and acculturation that is taking place with regard to these two ways of life does not necessarily imply a development from a lower to a higher level, or that a modern way of life is, by definition, more progressive and qualitatively better than the traditional way of life. As most Africans can find themselves somewhere in between these two ways of life so it would therefore be difficult (reductionist) to situate their functioning within a single way of life.

Peltzer (2005) constructed an African socialisation model based on three different levels of acculturation, namely: ***traditional***, i.e. persons who are slightly affected by modernisation and who function within an established and constant framework of their traditional culture; ***transitional***, i.e. persons living and shuttling between two cultures in the course of their daily lives (e.g. between their work in a town representing a modern lifestyle and values, and the ancestral traditional village where their extended family lives according to traditional norms and values); ***modern***, i.e. individuals who engage fully in the activities of contemporary industrial and post-industrial society with little or no contact with a traditional society. Peltzer warns that these distinctions have not yet been taken into account in most studies of personality in Africa and their disregard may have contributed to error variance and distorted findings.

Nobles (1991) also in the vein accuses psychologists who do not take the traditional perspective into account, of scientific colonialism as laying down western formulations and conceptualisations as standards against which behaviour of all the people of the world should be understood and explained. In his view, too many people look to Africa through a Euro-American lens and do not allow the underlying African life and worldviews to speak for themselves. This then creates problems when psychologists gather data on the behaviour of Africans, using only principles that feature in a western perspective and without insight into African life and worldviews.

Nobles further argues for insight that is uncoupled from Western perspective and generated from a uniquely African perspective, thus pleading for an indigenous psychology. He maintains (1976, pages 171 and 173) that the total effect these different worldviews has on the nature of science has yet to be understood. As long as black researchers ask the same questions and theorise the same theory as their white counterparts, black researchers will continue to be part of a system that perpetuates the misunderstanding of black reality and consequently contributes to our degradation.

Nsamenang (1995, p.785) also pleads for an indigenous understanding of the behaviour of Africans in order to avoid the problem of misunderstanding “African reality” and degradation of the “African”. He notes that African social thought and folk psychology are structured by ethno-theories and epistemologies that differ in remarkable ways from those that drive Western thought and psychology. As a result, when scholars apply Western concepts and categories to African systems, they discover that they do not fit.

Nsamenang (1995) is of the opinion that a lot could be learned from African folklore, idioms, and special use of cues, but a Western-based epistemology and methodology might not be the best way or not be sensitive enough, to extract the essence of African wisdom. Nsamenang maintains that progress in psychology in Africa will only be made with the emergence and development of an indigenous body of psychological knowledge. The indigenous approach in his opinion should not reinvent the wheel by duplicating the existing body of psychological knowledge. He pleads for the contextualisation of the universal body of psychological knowledge within the different cultures. He states that given the peculiar nature of African social thought and modes of survival and life, a contextualist approach to psychological research in African societies is likely to provide data to fill in gaps or complement knowledge of psychological functioning.

(For more details on the references in this section, please contact Mrs. B Mokgatlhe at 012-429 8238 or mokgapb@unisa.ac.za)

Activity 4.1

Scan-read Learning Unit 4 in the Tutorial Letter, in order to familiarise yourself with the contents of this unit.

Activity 4.2

Read a book on traditional healing or attend a cultural event or activity of a culturally different group from your own in your community.

Such an experience could help you to personalise your theoretical understanding through an experiential exercise.

Suggested texts:

Bodibe, R.C. (1992). Traditional healing: An indigenous approach to mental health problems. In J. Uys (ed.), *Psychological counselling in the South African context* (p. 156). Cape Town, South Africa: Pan Books.

Botha, K., & Moletsane, M. (2012). Western and African aetiological models. In Burke, A (2nd ed.), *Abnormal Psychology: A South African perspective* (pp. 72-79). Cape Town, South Africa: Oxford University Press

An understanding and knowledge of the African perspective will enable you to:

- address issues relating to diversity and difference in traditional psychology theories, models and philosophies
- address issues relating to diversity and difference in traditional psychology theories, models and philosophies.
- study psychology from an alternative worldview. Traditional psychology is presented from a limited perspective and this does injustice to one of the greatest attributes of people: the individual and collective diversity in thought, feeling and behaviour. Traditional psychology is not generalisable to people of diverse cultural contexts.
- raise questions about traditional mainstream knowledge in psychology.
- understand and be sensitive to people from diverse cultural backgrounds.
- understand the cultural context and belief systems of African people in order to deliver an effective service as a health care worker.

Societal thinking in South Africa has shifted from the concept of this country as a "melting pot" of different races and cultures to the idea of a conglomeration of many different microcultures. This changing societal emphasis makes the focus on diversity imperative.

4.1 STUDY UNIT: The African Perspective

In defining abnormal behaviour, psychologists usually adopt one of several approaches. The aim of this chapter is to give you an overview of psychopathology from an African perspective. There is no single theory or model to explain the African perspective on psychopathology, as the system is basically intuitive and subjective with differing views as to what constitutes psychopathology from diverse cultural contexts. The pioneering work of Vera Buhrmann (1977, 1979, 1984 & 1987) is a case in point of studies done on pathological behaviour from an indigenous African perspective. The anthropologist Hammond-Tooke's (1975 & 1989) studies of various African tribes also contributed to the awareness that Western diagnostic categories are not applicable to African patients.

Outcomes
Once you have worked through study unit 4.1 you should be able to:

- discuss the development of the African perspective on psychopathology

- define culture
- define ethnocentrism
- define stereotypes

Study
To be able to do the above you have to study the following sections in this Study Guide:

- The introduction to the section on “The African Perspective”
- The section on “Approaches to understanding culture and mental health”
- Universalism
- Relativism
- The section on the “cultural context of Psychopathology”.

Activity 4.3

STUDY the following section in this Tutorial Letter 501:

The concept of psychopathology within the traditional African worldview has evolved through the years to incorporate both traditional African and Western biomedical views. There is sufficient evidence in contemporary society to incorporate both views. This also illustrates the shift that is taking place in the lives of Africans from a traditional to a more modern way of life.

South African psychology has its origins in American and European philosophies, theories, constructs and social systems (Bhana, cited in Mogale, 1999). It’s theories, constructs and methods are therefore based on Western philosophies and values. We can therefore argue that although people from all cultures are more similar than different and in this way identify many psychological constructs and skills applicable in all cultures, it would be invalid to overgeneralise and accept that Western psychology is applicable to Africa in all its aspects.

In order to get a clear understanding of psychopathology within the traditional African perspective, we have to realise that no individual can be understood independently of his or her beliefs, values, traditions, myths, symbols, religion and language. Individuals are carriers of culture, and their behaviour and interaction with others is influenced by the beliefs, customs, thought patterns and symbolism of their community (Schlebusch, Wessels & Rzadkowolsky, 1990, cited in Vilakazi, 1997), and as such, individuals have to be viewed within their cultural context.

All individuals exist in their own cultures with their own cultural back- grounds and thus tend to see things with reference to that background. Culture therefore acts as a filter, not only when we perceive things, but also when we are thinking about and interpreting events.

We may interpret someone’s behaviour from our own cultural background and come to some conclusion about that behaviour based on our own beliefs and theoretical frameworks. Our interpretation may be wrong if the behaviour that we are judging originates from a different cultural orientation than our own. At times, we cannot separate ourselves from our own cultural backgrounds and biases to understand behaviours of others. This type of resistance forms the basis of what is known as ethnocentrism -the viewing and interpretation of the behaviour of others through one’s own cultural glasses (Matsumoto, 1994, p. 6). It is important to be aware of these biases and tendencies in understanding the behaviours of people from different cultural backgrounds.

Ethnocentrism is closely related to another significant concept, namely, stereotypes, which are fixed attitudes, beliefs or opinions about people who belong to cultures other than our own (Matsumoto, 1994, p. 6). Stereotypes may be useful in giving people some kind of basis in judging, evaluating and interacting with people from other cultures, and help us with the process of categorisation, as we constantly have to deal with a large amount of information in our everyday lives. However, stereotypes can become damaging and dangerous when people adhere to them inflexibly and apply the stereotypes to all people of that cultural background, without recognising the possible false bases of the stereotype and individual differences within that culture.

Although not central to this chapter, ethnocentrism and stereotypes are significant concepts to learn about and remember, as it is important to be aware of the potential pitfalls when learning about cultural differences and similarities. We often find that we are different from people of other cultures, either through research or through our everyday experiences and interactions. The discovery of these differences can have severe and serious negative consequences. There is potential for misuse when values such as good/bad, right/ wrong, superior/inferior are attached to others' behaviours if they are different from behaviours in one's own culture.

This was clearly illustrated by research on differences in IQ (intelligence quotient) between different racial groups several years ago. The researcher found racial differences in IQ tests between African-American and European-American participants. This was simply a finding, but some people interpreted this finding as proof ''that European-Americans are genetically or biologically superior to African-Americans. For quite some time, no attention was paid to other interpretations – such as possible cultural biases inherent in the actual tests and testing procedures – because of the frenzy caused by the "genetic" interpretation (Matsumoto, 1994). As it turned out, there was a considerable degree of cultural bias in most of the intelligence tests at that time, and when those cultural biases were controlled, the racial differences were not replicated.

Since psychology involves the study of human behaviour to improve our understanding of people, it is imperative that one of the goals of this endeavour should be to help us in our everyday interactions and dealings with others. As we frequently have contact with people from different cultural backgrounds, we need to learn about the etics (findings that appear to be consistent across different cultures; an etic refers to a universal truth or principle) and emics (refers to findings that appear to differ across cultures; an emic therefore refers to truths that are culture specific) in our truths, that is, in the beliefs we hold about people and the way they are.

Activity 4.4

Imagine you are having a conversation with a person from a different culture from yours. While you are talking to this person, you notice that she does not really make eye contact with you when she speaks. She also does not really look at you when you speak. On a few occasions when her eyes look your way, she quickly averts her gaze if your eyes meet.

Interpret this person's behaviour from your own cultural background and think about this scenario occurring in a job interview, in a teaching or learning situation at school, in business negotiations or even within a therapeutic context. What potential problems and practical implications could arise from the scenario in everyday life?

From your own cultural background, you may have interpreted that she does not feel comfortable about you or your interaction. You may feel put off and reject any attempts at future interaction. But she may come from a culture where gazing directly at someone is discouraged or is even a sign of arrogance. In the South African context, some cultures interpret gazing directly at adults in particular as a sign of disrespect. She may be avoiding eye contact not because of any negative feelings, but as a sign of respect towards you.

4.2 STUDY UNIT: Approaches to Understanding Culture and Mental Health

There are several approaches that are often used to understand the relationship between culture and mental health. For the purposes of this module, however, we look at only two of these approaches.

Outcomes
Once you have worked through study unit 4.2 you should be able to:

- discuss the basic assumptions of the universalist and relativistic approaches to abnormal behaviour
- discuss the relevancy or irrelevancy of the latter approaches to the traditional African worldview
- discuss the advantages and disadvantages of both approaches

Study
To be able to do the above you have to study the following sections in this Tutorial Letter 501:

- The section on “Approaches to understanding culture and mental health”
- Universalism
- Relativism.

Activity 4.5

STUDY the following section in the Tutorial Letter 501:

The universalist approach can be characterised as an “etic” approach that assumes universally-accepted definitions of abnormality and methodology. An etic refers to findings that appear to be consistent across different cultures (a universal truth or principle). The essence of this approach is the assumption of the universal quality of the human psyche and that mental illness is universal. According to this approach, people are alike and therefore require uniform treatment regardless of their racial and cultural backgrounds. The diagnostic criteria and classification system of mental disorders developed in Western psychology and psychiatry is based on this approach.

The concept of an etic is powerful, because of its implication about what we know as truth. If we know something about human behaviour and regard it as a truth, and it is an etic (i.e. universal), then the truth as we know it is truth for all, regardless of culture. If that something that we know about human behaviour and regard as truth is, however, an emic (culture-specific), then what we regard as the truth is not necessarily what someone from another culture regards as truth. In fact, their truth may be quite different! Truth, in this sense, is relative, not absolute.

The value of using this approach for understanding mental illness cross-culturally is that it makes the world knowable to us. It also enables us to make easy comparisons across a range of contexts. A case in point is the international pilot study of Schizophrenia, which explored Schizophrenia in a number of countries across the world. A single diagnostic system and the assumption that the disorder being studied was the same enabled researchers to look at commonalities and differences across cultures.

The major drawback of this approach is that it may detract from our understanding of environmental influences and the unique motivations of individuals, and this would show gross disregard for group, in-group and individual variability. More specifically, the whole issue of labelling of conditions in different contexts and how these conditions are expressed in different cultures may obscure the true nature of universal illnesses.

Labelling can be dangerous because it stigmatises and stereotypes patients whose subsequent actions will be interpreted as part of their "craziness" and who may face discrimination based on their diagnoses. Individuals who have been labelled may also take on the role of a sick or crazy person and hence actually begin to play the part into which they have been cast.

Reliance on the expression of subjective distress, which is also a characteristic of this approach, is problematic in that expressing and describing distress psychologically is not shared by every culture. Cultural groups vary in the degree of distress they report experiencing in association with psychological disorders. Some cultural groups may also have values that prohibit focusing on subjective distress in contrast to Western notions of the importance of self-disclosure.

The general dissatisfaction with the definition of abnormality in the universalist approach led some cross-cultural investigators to argue that we can understand and identify abnormal behaviour only if we take the cultural context into account. This viewpoint suggests that we apply a principle of cultural relativism to abnormality. A woman claiming to be talking to her ancestors, for example, might appear to be disordered if observed on a street corner in a large South African city. Her behaviour could, however, appear to be appropriate and understandable if it is observed in the context of a sangoma ceremony in which she is serving as a healer. The most valuable feature of cultural relativism is its ability to challenge the presumed universality of standards that actually belong to one culture.

This applies equally to conceptions of normality and abnormality. Some behaviour, particularly that associated with psychosis (e.g. delusions and hallucinations), is universally recognised as abnormal (Murphy, 1976). Some researchers (e.g. Kleinman, 1988; Swartz, 1987), however, argue that abnormality and normality are culturally determined concepts. These researchers point to the fact that cultures differ in their beliefs about and attitudes toward abnormal behaviour.

The relativist approach can be characterised as an "emic" approach that assumes culturally relative definitions of abnormality. An emic refers to findings that appear to be different across cultures; an emic, therefore, refers to truths that are culture specific.

A more detailed discussion on common culture-specific syndromes in the South African context follows in study unit 4.6.

The traditional African approach can be adequately explained by the emic approach in that it emphasises differences. It holds, for example, that the behaviour of Africans cannot be adequately explained using psychological and conceptual frameworks that have been developed from the experience of Euro-Americans (Schoeman, 1993, cited in Vilakazi, 1997).

The greatest value of cultural relativism is that in trying to understand illness experiences in different contexts, relativists gain as full a picture as possible of the meaning of the illness to the sufferer, in the context of the sufferer's own family, community and spiritual background.

The drawback of this approach is that it often sees society as being static and cultural groups as maintaining their meaning structures in a stable, uncontaminated way. It ignores the dynamic, changing nature of the social world and the fact that individuals can carry different internalisations of their culture. Although many relativist studies provide rich information on practices and beliefs in local contexts, the scope of these studies tends to be too small to allow broad cross- national comparisons.

In extreme cases, relativists would argue that no comparisons across contexts are possible, as meanings differ in different places. This view could lead to knowledge that is fragmented and difficult to organise. The desire to be as true to context as possible may cause relativists to lose sight of the big picture. Although relativists may argue that Western diagnostic systems are themselves cultural products, and though it may be easy to view the world in terms of these systems, this is not necessarily the best or most useful way of seeing the world. Relativism may in fact offer us a chance to look at universals in a different way. Whether to accept universal or culturally relative definitions of abnormality is an ongoing controversy in the field of cross-cultural psychology.

Activity 4.6

Consider the following scenario:

> A woman is in the midst of a group of people but seems completely unaware of her surroundings. She is talking loudly to no one in particular, often using words and sounds the people around her find unintelligible. When questioned later about her behaviour, she reports that she was possessed by the spirit of an animal and was talking to a man who had recently died.

- Is this woman's behaviour normal?
- Applying the principle of cultural relativism, would you consider the woman's behaviour abnormal or normal?

4.3 STUDY UNIT: The Cultural Context of Psychopathology

In this study unit, we are going to look at the role of culture in the manifestation and development of psychopathology. Every society has its own concept of abnormal behaviour, and what society considers as normal or abnormal is constantly changing. Cultures also differ in both the disorders they identify and the ways in which they diagnose mental illness. Culture can be defined as the sum total of ways of living, including values, beliefs, sense of beauty, language, patterns of thinking, behavioural norms, and styles

of communication that a group of people has developed to assure their survival in a particular environment (Pusch, 1981 in Compton, Helzer, Hai-Gwo, Eng-kung, McEvoy Tiff & Spitnagel, 1991). We are socialised through "cultural conditioning" to adopt our group's ways of thinking and living.

Mental health specialists accordingly have to be sensitive to the cultural context in which they operate. Ignoring the patient's cultural background can only result in misunderstanding and ineffective therapeutic interventions.

Outcomes
Once you have worked through study unit 4.3, you should be able to:

- Discuss the role of culture in psychopathology
- To be able to do so, you have to study the following section in the Study Guide
- The section on the "cultural context of Psychopathology".

Activity 4.7

STUDY the following section in this this Tutorial Letter 501:

Various explanations for the role of culture in psychopathology have been proposed (Wittkower & Prince, 1974, Favazza & Oman, 1980, cited in Vilakazi, 1997):

(1) Psychosocial stressors, as aetiological factors, may be specific to a particular culture. In South African literature, the concept of stress is frequently used to explain the role of culture in psychopathology (see Swartz, 1987). Swartz (1987, p. 15) refers to Jacobs and Hollingshead's view that the wide use of stress as an explanatory construct for abnormal behaviours may be related to the current crisis in South Africa, with widespread repression, violence and social disruption. Such stressors in themselves may not be pathogenic, but become so in relation with other cultural elements and personal vulnerability.

(2) As a result of a combination of particular etiological factors, certain syndromes may occur more frequently in a particular culture than in other cultures.

(3) Some authors (e.g. Schlebusch, Wessels & Rzadkowolsky, 1990, Wittkower & Prince, 1974 in Vilakazi, 1997) postulate that in the case of some mental disorders, the basic structure of the disorders, based on universal psychophysiological reactions is universally the same. The content of the disorders, that is, their symptoms or overt manifestations, is, however, pathoplastically shaped by culture (e.g. cultural beliefs may mould the content of hallucinations and delusions). Ideas that may be delusional in one culture (e.g. sorcery and witchcraft) may be commonly held in another. Auditory or visual hallucinations with a religious content may be a normal part of a religious experience in some cultures.

(4) Culture defines what a community regards as mentally disturbed behaviour. De Vos (1974 in Vilakazi, 1997) states that different communities have different expectations with regard to mentally deranged behaviour. In some cultures, the psychotic individual is expected to be dangerous and excitable. One may suppose that with such expectations there will be a higher incidence of aggressive behaviour in one culture, as compared to another, induced by defensive aggressiveness in dealing with an emotionally or mentally aberrant individual" (De Vos, 1974, p. 552 in Vilakazi, 1997).

(5) Culture shapes attitudes towards the mentally disturbed (Schlebusch, Wessels & Rzakowolsky, 1990 in Vilakazi, 1997).

(6) Culture provides models for interpretation and experience of illness and healing.

(7) Psychopathology differs within as well as across cultures. The prevalence of Schizophrenia and severe depression, for example, varies depending on cultural and demographic factors, although the reasons for this variation are not entirely clear (Compton et al., 1991).

(8) Conceptions of psychopathology also differ within cultures, especially in multicultural societies. Africans who practise traditional religion, for example, believe that spirits can possess an individual and communicate with deceased ancestors. Individuals who report this belief to clinicians unfamiliar with their religious beliefs may be misdiagnosed as psychotic.

(9) Cultural shifts can also lead to prevalent forms of psychopathology. In times of social change, when people do not know what norms to follow and have lost the sense of meaning in life that an intact culture provides, drug abuse, suicide and aggressive behaviour tend to rise dramatically.
(10) Beliefs and perceptions become psychotic only when they are at variance with the prevailing cultural norms.

Activity 4.8

See if you can brainstorm these questions:

(a) Do definitions of normality and abnormality vary across cultures?
(b) Are there universal standards of abnormality?
(c) Do cultures vary in rates of abnormal behaviour?
(d) Is abnormal behaviour expressed in similar ways across cultures?
(e) Can we identify culturally distinct patterns of abnormal behaviour?

The answers to these questions have gained importance over the years as psychologists and mental health professionals have questioned the cultural sensitivity of traditional methods of assessing and treating individuals with psychological disorders. The answers also have implications for how we identify and intervene to change abnormal behaviour.

4.4 STUDY UNIT: The African Worldview versus the Western Worldview

Mental ill health is rampant in Southern Africa and the situation is further complicated by the coexistence of two independent, seemingly antithetical systems of interpreting and treating mental ill health (Stricklin, 1990). The traditional African and Western systems of explaining and treating psychopathology or mental ill health are widely utilised and impact on a large number of people in Africa. Although it is possible that African cultures have studied and treated mental disturbances for longer than people in other parts of the world, (Mutwa, 1946, Friedman, Kaplan & Saddock, 1976, Bryant, 1983 in Stricklin, 1990), the system is still basically an intuitive, religious and mystical system, neither understood nor shared by most of Western psychology – although neither system has remained static over the years. South African patients are often confused about the place and value of the two.

South African black communities often experience an unusual problem during episodes of illness in that they are faced with a choice of whether to consult a Western or traditional health care system or some combination of the two. Urbanisation, industrialisation and other social forces have brought about a more rational and a more individualised lifestyle, which, in many ways, contrasts with the group-oriented, traditional lifestyle of Africa (Vilakazi, 1997). This dramatic change has resulted in an experience of uncertainty, confusion and conflict regarding the choice between Western and traditional approaches to healing.

The problem of choice is often exacerbated by deficiencies in (and the associated inability of) the modern health care system to solve prevalent health problems. People, therefore, often turn to the traditional health care system as an alternative (Staugard, 1990 in Vilakazi, 1997). The Western approach is disease oriented. The patient who adopts this approach is inclined to focus on the symptoms and consequently places less emphasis on social issues; he or she is also more rational and makes decisions on his or her own without needing consensus or support from his or her family members. The traditional approach, by contrast, is socially oriented in its interpretation of health and illness, and requires consensus among all concerned about what constitutes both health and abnormal symptoms and signs (Helms, 1990 in Vilakazi, 1997).

It is important to understand the perspectives of each of these systems in order to see how each views psychopathology. Figure 1, Activity 4.7, outlines the comparative attributes of African and Western healing. We now go on to discuss the African and Western worldviews. Furthermore, traditional beliefs and practices concerning health and illness are still practiced especially in rural areas of South Africa (Louw & Edwards, 1993 cited in Botha & Moletsane (2012). From these traditional beliefs and practices

emanated an African understanding of aetiology. The study conducted by Moletsane (2011) highlights these African etiological explanations.

Outcomes
Once you have worked through study unit 4.4, you should be able to:

- distinguish between the African and Western worldviews
- compare the attributes of the two worldviews

Study
To be able to do the above you have to study the following sections in this Tutorial Letter 501:

- "The African worldview" and "Western worldview".
- Figure 1: "Attributes of African Healing" and "Attributes of Western Healing".

Activity 4.9

STUDY the following section in the Tutorial Letter 501.

African Worldview

A worldview is the way in which individuals perceive their relationship to the world, and interpret and make sense of their reality. The African-centred worldview implies that we look at Africa from the perspective of Africans. Bear in mind that we have read about Africa from a European perspective in the past. The African worldview places a strong emphasis on humanity or Ubuntu, which means that people are people in the presence of other people. People are regarded as the centre of the universe. An example of this focus on people was Dr Nelson Mandela's emphasis on people-centred government.

According to this worldview, all people, animal and plant worlds are filled with spirit. There is, therefore, an interrelationship between the three. Even in death, the spirits of the ancestors are significant. However, the ancestors are not worshipped as is commonly believed; they are honoured. The manner in which people relate to one another and the rituals that surround the slaughtering of animals in appeasing the ancestors are examples of the sense of spirituality that characterises this perspective. People believe in the supernatural and in natural explanations for illness.

Partly because of the presence of a sense of spirituality in the universe, an interconnectedness and holism are assumed. There is a strong belief in the unity of the spirit, mind and matter. The sense of connection is particularly evident in people's relationships with those who are part of the extended family, the clan and the community. Therefore, the individual cannot be viewed in isolation but must be seen as part of his or her system.

Consistent with the sense of connection and an appreciation of the extended family is a strong sense of community. In the African worldview, there is a sense of "I am because we are" and a tendency to feel part of and an obligation to the community. Success is usually in terms of contributing to and being part of the community. In the South African context, members of the white community are more likely to emphasise the importance of the individual. In contrast, black and Indian communities emphasise the importance of belonging to a cultural group, in a way reinforcing the sense and importance of community. Africans are, therefore, collectivistic in their orientation, with the emphasis on collective identity, in-group solidarity and a strong distinction between in-group and out-group.

Closely related to this sense of community is a strong sense of being part of an extended family. The relationship with all members of the family is defined by a set of rituals. The family extends into the clan and each clan has a name that is embraced with pride and honour. Madiba, for example, was Dr Mandela's extended family name. Not having family or being isolated from your family is viewed negatively within this context.

The African view of time extends from the present to the past, with the past extending to the hereafter and the ancestors' having significant influence. Knowledge of the past is important as African people usually know about their forefathers and are familiar with their family trees; they may also feel pity for those who do not know their roots.

It is not unusual for Africans to start talking about various topics by looking at the past. There is an assumption that knowing your past and living in ritualised harmony with the present will ensure peace in the future. Other than that, there is little focus on the future. There is also a significant emphasis on respect for and a veneration of the elderly and the deceased ancestors. Africans believe that the future has no meaning because it has not yet been lived.

In conclusion, we can argue that worldviews do not remain static over time but may change because of various social processes. In South Africa, black people are not always collectivistic in their functioning as we can see by looking at the impact of socioeconomic and political factors on their lives. We cannot overlook the fact that industrialisation, urbanisation, the Western political system, and religion and capitalism have been instrumental in extensively modifying African value systems.

In a related context, it is postulated that affluence leads to a change in the cultural orientation of different societies. This is evident in the South African context where many black people in urban areas appear to have adopted a more Western-oriented outlook and have shed some of their ties with the community; those in the rural areas, in contrast, appear to remain traditionalist and collectivistic in their outlook. The distinction is imperative as we cannot group blacks together as being the same or essentially tribalistic or collectivistic in their orientations.

Black people in the modern context uphold both collectivistic and individualistic values in different contexts. Knowledge of the traditional African worldview, though essential for understanding black South Africans, gives us only a limited perspective on their view of illness. As indicated at the beginning of the chapter, blacks are going through a transitional phase in which they are shifting from a traditional to a more Western way of life.

The attributes of the African worldview on healing are outlined in Figure 1 of Activity 4.10.

Western Worldview

The Western worldview is based on cultural adaptations to living conditions in Western countries.

Central to the Western worldview is a strong focus on individuality. The individual's privacy and self-reliance are emphasised. The individual is expected to be independent, self-sufficient and able to survive on his or her own. There is also the belief that because resources are scarce, people must protect their possessions, and compete for and own resources for personal use.

In this worldview, material objects are highly valued. There is often a sense that what you have is as important if not more important than who you are. Owning possessions is regarded as a significant indication of well-being and success.

In this perspective, everything is usually separated: the various subjects at school, the believers from non-believers, and so on. Distinguishing between the spiritual and the worldly or the mind and the body is common.

Competition is expected and practised everywhere: in relationships with others, with other communities, with other companies, etcetera. Schoolchildren are encouraged to compete on the sports field, for example, the spirit of competition means that winning comes before team spirit and the importance of participating.

The family is defined in a more personal manner. The emphasis is usually on a small family norm, with a family comprising only a mother, father and children. Any deviation from the norm is generally regarded as

abnormal. The legal system is based largely on the notion of a nu-clear family; housing and welfare policies are also based on this notion.

Time is seen as moving from the past to the present with a strong focus on the future. Time is seen as money, that is, a scarce commodity that must be used wisely to prepare and plan for the future. Planning for the future is thus valued and impatience is sometimes expressed when individuals focus on the past. Children and the youth are considered important, because they constitute the future; the elderly are not valued as they are old and are seen as not contributing to the future.

People are usually valued for their role and status in society.

Consistent with a tendency to separate or make distinctions is the strong emphasis on being objective. Being able to distance oneself in a dispassionate manner from a book or a lecture and analyse it critically in an intellectual way is usually valued. The scientist is usually assumed to be analytical and objective, that is, feelings are separated from thought and analysis.

Activity 4.10

The basic attributes of the Western worldviews on healing are outlined in Figure 1. Make sure that you know these opposing views well.

Figure 1

Attributes of African Healing	**Attributes of Western Healing**
(1) Natural and spiritual explanations	(1) Scientific explanations
(2) Supernatural and holistic	(2) Fear of supernatural
(3) De-emphasis of method; values more important	(3) Emphasis on experimentation
(4) Magical	(4) Positivistic
(5) Harmony with nature	(5) Mastery of nature
(6) Harmony with the universe	(6) Mastery of the universe
(7) Oriented to the present	(7) Oriented to the future
(8) Desire to follow traditional ways	(8) Emphasis on "getting ahead"
(9) Veneration of the aged and the ancestors	(9) Disregard for the elderly/ancestors
(10) Individual subservient to the group	(10) Emphasis on "personal success"
(11) Cooperation for the good of all	(11) Competitive – every man for himself
(12) Depreciation of the individual	(12) Aggressive and individualistic
(13) Holistic approach	(13) Analytical approach
(14) Value home and family	(14) Migratory, upward mobility
(15) Intuitive, spiritual	(15) Consciousness and intelligence
(16) Subjective	(16) Objective
(17) Natural and humanistic	(17) Technological and scientific
(18) Intuitively logical	(18) Empirically logical

(Source: Stricklin, 1990, p. 14)

4.5 STUDY UNIT: Traditional African Perspective on Psychopathology

The traditional African perspective takes a holistic view of well-being in that minimal distinction is made between physical and mental functioning. There is a strong belief in the unity of spirit, mind and matter. The interrelatedness of life forms, the environment and the cosmos is taken for granted. This implies that the physical and psychosocial systems in terms of this perspective are interconnected and changes in one system inevitably bring about changes in all others. Traditional African views on illness, mental illness and health in general are, therefore, holistic and cosmological in emphasis. Africans do not

distinguish between the individual and the group, and they recognise that social factors play a major role in the causation, maintenance or cure of abnormality.

The perspective further postulates that the problem resides in relationships with other people and the ancestral spirits. Mental problems are, therefore, the result of failure in human relations in the form of lack of respect for kin or envy and jealousy between people. Behaviours threatening the well-being and equilibrium of the social system such as selfishness, aggressiveness, arrogance and envy are regarded as pathological. As a result, harmony and balance in the family and nature are encouraged.

In terms of this perspective, reality is culture bound and life forms are interrelated with one another and with Mother Nature and the cosmos. The question of "why" rather than "how" misfortunes occur is central to the African perspective. Sorcery or disharmony in the relationship between a person and his or her ancestors is held responsible for many forms of psychopathology.

The perspective relies heavily on supernatural theories of illness. The traditional African system is made up of factors such as belief in the supernatural, appeasement of the ancestors and the extended family system. Traditionally, the origin of sickness (whether psychological or physical illness) is considered to be one or a combination of the following: punishment from the gods for evil done, a curse, witchcraft, an offence against the gods, disruption of harmony in one's earlier life, natural causes, the breaking of taboos or traditional customs, a disruption in social relationships, angry ancestors and possession by evil spirits.

Africans do not generally see illness as located in a single individual. They often grasp the significance of a disease in any individual, more in terms of interpersonal relationships or a possible threat to the group than in personal terms, and treatment often involves the social context as well as the person. Healing within this framework thus involves the entire group and not just the individual.

Spirituality, traditional norms and rituals are the most important aspects of healing. The healing process is set in motion by a trained traditional healer and is indigenous to the culture. The African approach to diagnosis and healing is much more intuitive, experiential and symbolic than the Western approach to diagnosis.

Traditionally, Africans believe that mental disorders occur with a particular intention and that the causes can be identified (Beuster, 1997). Within the African perspective, the disorders are grouped into two categories in line with their perceived causal factors. A distinction is made between Umkhuhlane (refers to disorders caused by natural factors) and Ukufa kwabantu (refers to disorders caused by supernatural factors or the ancestors).

These disorders are "diseases of the African people". In other words, they are diseases and symptoms that are seen to be associated with the African people, and their interpretation is bound up with African views on health and disease. These diseases can best be explained by the animistic theories that ascribe disorders to the dissatisfaction or anger of some personalised supernatural agent such as a spirit, god or ancestor. This is expressed in the saying abaphansi basifulathele or badimo ba re furaletse, which means that the ancestral spirits have withdrawn their protection. Ukuthwasa refers to a "creative illness" following the calling by the ancestral spirits to become a diviner or a religious conversion experience (Murdock et al, 1980, p. 19, cited in Vilakazi, 1997).

Badimo (Sotho) or Amadlozi (Zulu) are the living spirits of the deceased. The ancestors are believed to be benevolent creatures that preserve the honour, traditions and good name of a tribe. They invariably play a significant role in the maintenance of mental health, as they provide protection against evil and destructive forces. Ancestors, according to African beliefs, are "like angels" who serve as intermediaries between the people and their creator (God). The ancestors maintain intimate relationships with their families and their primary concern is the welfare of their descendants (Ngubane, 1977).

The ancestors do punish their kin in situations where they are either disappointed or angered. The disorder or misfortune sent by the ancestors serves as a warning to amend one's behaviour and to follow the culturally prescribed code of conduct. The ancestors also cause mental and physical suffering if

important rituals and customs concerning critical life events are either neglected or incorrectly carried out.

To avoid punishment, extensive birth, initiation, marriage and death rites have to be performed (Beuster, 1997). These rites were prescribed in the distant past of the African people who trust and are grateful to the ancestors. It is believed that if these rites are not performed, the spirits of the ancestors will show their disapproval in no uncertain terms through visitations on their offspring, which may take the form of ill health, misfortune, lack of material resources or even the death of a family member (Gumede, 1990).

The ancestors also make demands on their kin in that they have to be appeased on a regular basis through offerings of animal sacrifices and sorghum beer. They also need to be informed of new developments in the family. If the demands of the ancestors are ignored, protection will be withdrawn and physical or mental disorder can occur. Since the ancestral spirits are believed to play a significant role in the causation of illness, it is also believed that they, and God, have the strength to decide whether or not to cure (Gumede, 1990).

Traditional Africans believe that malicious people like witches and sorcerers can cause mental disorders. These types of disorders can best be explained by magical theories that attribute mental disorders to the covert actions of malice and jealousy of human beings, who cause magical injury through sorcery and witchcraft. Idliso/sejeso refers to poisoning attributed to sorcery.

In the African belief system, religion and magic are inextricably interlinked in determining health (Edwards, 1989 in Vilakazi, 1997). Magic involves the use of witchcraft and sorcery in determining health and illness. Witchcraft (ubuthakathi/boloi) refers to the manipulation and expression of anger or malice by an individual who has evil intentions to destroy. Witchcraft often arises in situations of interpersonal conflict, which could result in someone hiring a sorcerer to harm or kill an enemy. The sorcerer or witch may use several herbal and poisonous substances to prepare the spell by which to harm the victim.

Witches are said to manipulate supernatural creatures, called familiars, to inflict misfortune on their enemies. Sorcerers, by contrast, do not have supernatural powers, but employ magical substances (medicines or poison) to impose mental or physical suffering on others. Any person in the immediate social circle can be a witch, and accusations of witchcraft and sorcery mostly appear in situations where the harmony of the group is threatened. According to traditional African theories of illness, people are vulnerable to witchcraft if they are not immunised and strengthened through rituals. These rituals ensure that the ancestors protect a person against harm or illness (Vilakazi, 1997).

Traditional Africans believe that certain conditions or situations can cause impurity that can lead to illness or mental disorder. Illness in this regard is contracted as a result of exposure to a polluted environment, which does not involve supernatural beings or witchcraft. It is based on the view that the environment is potentially dangerous, and a person falling victim to this danger depends on his or her resistance. Umnyama/ senyama, for example, refers to experiencing illness or adversity because of contact with places or people immediately associated with the major life events such as birth, death, miscarriage, abortion and menstruation. During states of impurity, a person has to go through extensive cleansing rituals.

Africans believe that there is a symbiotic relationship between the individual and his or her environment (Ngubane, 1977). If you should travel to another region without being strengthened beforehand, you could become ill as you have not adapted to the new atmospheric and environmental conditions. If you travel to a strange place, you may cross a dangerous track (umkhondo omubi/mohlala o mobe) which may result in illness if you have not been strengthened or immunised. A related belief is that when moving away, both people and animals leave behind something of themselves and something of the new environment and atmosphere through which they move. What is left behind is a track. The track can be invisible in the form of polluted air (imimoya emibi/moya o mobe) which can be inhaled (Ngubane, 1977). The implication of a polluted environment (omkhondo omubi/sefifi/senyama) is that undesirable air is inhaled or that contamination occurs through touch or stepping over.

Ngubane (1977) describes an example of the ecological interpretation of health in African culture that can clearly be observed at the beginning of life, during pregnancy. An expectant mother is not allowed to walk around contaminated environments that could bring her into contact with death and stress-evoking situations. As soon as the infant is born, both mother and infant must be protected from polluted environments, such as overcrowded places, where the infant can easily be contaminated. This is often done by keeping them indoors for a period of at least a month, although the time spent indoors differs from culture to culture.

These types of disorders refer to illnesses such as influenza that “just happen” and are biomedically treatable. Natural causes are perceived as resulting in “minor” illnesses (e.g. umkhuhlane/mokgotlhane). They are minor in the sense that the illness is interpreted in mundane terms, and can be treated by either ordinary people (e.g. by folk medicine or by buying medicine from a pharmacist or shopkeeper) or by medical practitioners (Vilakazi, 1997). Major illnesses in this regard are perceived as those which can be attributed to supernatural causation.

The above-mentioned categories of disorders form the cornerstone of traditional African cosmological, religious, social and moral worldviews of good and evil, health and sickness. To understand traditional African conceptualisations of mental health, ill- health and misfortunes, we must understand the African cosmos. According to African cosmology, creation comes from God (Mmopi/uMvelingqangi), the creator of all living things visible or invisible (Edwards, 1989 in Vilakazi, 1997). The co-existence between God and humans forms the basis of traditional religion. God is believed to permeate all living things through the ancestors and elders. Within a traditional African context, the traditional healer is believed to have the power to mediate between the ancestors and their families, and the ancestors communicate with their descendants through the healer’s divination.

The traditional healer is often consulted in the event of illness as he or she is trusted as someone with supernatural powers from God and/or the ancestors to solve the problem. Traditional healers are found in almost every cultural group and are given particular names or labels in accordance with the type of treatment method they use. Within the traditional African context, the traditional healer is often consulted due to the belief in the supernatural causation of mental disorders.

Africans traditionally believe that sickness, especially one of an emotional nature, originates as a punishment from the gods for evil done. One can only get rid of the punishment through a traditional sacrifice in consultation with a traditional healer. The traditional healer therefore serves as a mediator between the gods and human beings. He or she is a traditional priest that offers sacrifice to the gods. He or she can look into the future, foresee events and is able to prescribe herbal medicine for the treatment of different kinds of diseases. The traditional beliefs and practices concerning illness and health are still widely followed particularly in rural areas of South Africa.

Outcomes
After you have worked through study unit 4.5 you should be able to:

- discuss the traditional African perspective on psychopathology
- distinguish between disorders resulting from natural factors and disorders resulting from supernatural factors

Study
To be able to do the above, you have to study the section entitled "Traditional African perspective on psychopathology" as described in this study unit.

4.6 STUDY UNIT: Culture-Specific Syndromes

The observation that certain mental disorders are uncommon or occur mainly in specific communities gave rise to the notion of “culture-bound” syndromes. The term is a misnomer. All syndromes occur in a cultural matrix and are thus culturally bound.

The view that some syndromes are culturally influenced and others not is conceptually misleading. These syndromes should rather be called culture specific.

Culture-specific syndromes are forms of abnormal behaviour observed only in certain sociocultural milieus. Findings concerning different rates and courses of disorders across cultures, and of culturally distinct forms of disorders, suggest the importance of culture in shaping the expression of abnormal behaviour. Culture-specific syndromes are also conceived to be a collection of signs, symbols and symptoms (excluding notions of cause) which are restricted to a limited number of cultures, primarily by reason of certain psychological features (Mogale, 1999).

The strongest evidence for applying cultural relativism to abnormality comes from ethnographic reports on culture-bound syndromes. Using primarily emic (culture- specific) approaches involving ethnographic examination of behaviour within a specific cultural context, researchers have identified several apparently unique forms of psychological disorders. Some similarities between symptoms of these culture-specific disorders and those recognised across cultures have been observed. The particular patterning of culture-specific symptoms does however not fit the diagnostic criteria of Western classification schemes (Matsumoto, 1994).

Outcomes
Once you have worked through study unit 4.6, you should be able to:

- define culture-bound syndromes
- describe some of the culture-specific syndromes common in the South African context
- distinguish between ukuthwasa and mafufunyana, and indicate the adaptive and maladaptive aspects of each.

Study
To be able to achieve the above you should study the following sections in this Tutorial Letter 501:

- “Classification of psychopathology in relation to perceived causes”
- “Ukufa kwabantu” (Disorders caused by ancestors)
- “Magical causes”, (Disorders due to sorcery and witchcraft)
- “Pollution” (Disorders due to impurity)
- “Umkhuhlane” (Disorders due to natural causes)
- The introduction to the chapter “culture-specific syndromes”
- The sections on:
    - “Sejeso”
    - “Moriti wa letswele”
    - “Ukuthwasa”
    - “Amafufunyane”
- The case study on Tladi.
- The section on “Feedback: Interpretation from an African Perspective”.

Activity 4.11

STUDY the following section in the Study Guide:

Culture specific syndromes

In South Africa, studies on culture-specific syndromes have identified various of such syndromes.

Sejeso is found among the Sotho-Tswana peoples. It is characterised by the belief that an enemy has poisoned one through food or liquid and is accompanied by intense anxiety. Another disorder is **moriti wa letswele** (literally, shadow of the breast), a characteristically female condition found amongst the Sotho-Tswana speaking people. It is characterised by a psychogenic pain that usually occurs under the left breast.

Then there is the spirit possession of **malombo** among the Venda and **malopo** among the Kgaga and Lobedu (Pedi groups). The illness manifests in the patient complaining of being physically unwell, which is usually ignored by others because the patient is not incapacitated. The illness progresses until the patient falls down and lies flat –in a state of trance. It is at this stage that the diviner tells the family to prepare for the malombo music service, which serves a therapeutic purpose resulting in the curing of the symptoms (Ralushai, 1986 in Mogale, 1999).

Ukuthwasa (among the Nguni) is an illness believed to be sent by the ancestors. The illness is regarded as a positive "calling" by the ancestors to become a traditional healer. This occurs through an experience called thwasa, which some regard as an episode of illness. The thwasa symptoms differ from person to person. Its somatic symptoms could be stomachache, nervousness, backache, pain in the wrists, conversion reactions, prolonged periods of hiccups, flatulence, numbness or pains which restrict movement and performance of usual roles. Behaviourally, the individual tends to withdraw from social life and is mentally confused. Many other symptoms have also been described.

An experienced diviner makes the diagnosis of thwasa, and the candidate (“patient”) enters a period of treatment, which could also be regarded as a training period, with an experienced traditional healer. This lasts until the symptoms have cleared up, after which the patient may either return to his or her former life or, if indicated, continue with further training to eventually become a healer.

Basically, thwasa is treated either by animal sacrifices within the family or training of the individual to be a diviner. Methods of divination vary, and include the use of divining bones (Setswana: ditaola). Divination is a state of altered consciousness during which the diviner is a medium through which the ancestors make their wishes, instructions, indicated treatment etcetera known. Dreams are often used for diagnostic purposes. The traditional viewpoint is that thwasa is not a Western illness and cannot be cured by Western methods of intervention (O’Connel, 1980 in Mogale, 1999). Gillis (1986 in Mogale, 1999) regards thwasa as a pseudopsychotic state, because patients manifest with hallucinations, delusions, seclusiveness and wild running, and it tends to be confused with Schizophrenia. Careful inquiry will, however, reveal the distinct differences between the two.

Buhrmann (1984, pp. 36–37), who mainly worked amongst the Cape Nguni, describes the symptoms of thwasa as follows:

The clinical picture of thwasa resembles an emotional disturbance of greater or lesser degree, which is, r accompanied by physical symptoms. The afflicted usually becomes withdrawn and irritable when spoken to. Sometimes they become very restless, violent, abusive and aggressive. There is a marked tendency to aimless wandering, and they often disappear for days at a time. They neglect their personal hygiene, eat poorly, often look and become physically ill. They hear voices talking to them – “these come from inside me, from the ancestors”. The most significant feature is the excessive dreaming. The dreams are particularly disturbing because they are complex and unclear. Unlike usual dreams, they interfere with sleep.

Another culture-bound syndrome, which is often confused with thwasa, is **amafufunyane** (literally, ‘nerves’) which is described as a form of spirit possession primarily due to witchcraft or sorcery. A mixture of soil and ants from a graveyard are believed to be used by the sorcerer to make a harmful concoction that he or she places in the path of the victim or puts in his or her food. The person so poisoned will become possessed by amafufunyane and will go mad.

Amafufunyane is a mixed syndrome, where a person shows a diversity of syndromes ranging from Psychosis, an Anxiety-based Disorder, Depressive or Bipolar Disorder to Conduct Disorder. The symptoms may include somatoform reactions (abdominal swelling), hysteria, suicidal tendencies, violent outbursts, listlessness, delusions (such as a belief that one has been bewitched), auditory hallucinations (hearing threatening voices of a foreign culture coming from the person’s stomach), fearfulness, disorientation, aggressive and destructive behaviour, tactile hallucinations (strange moving sensations in the stomach) and physical pressure on the head.

Amafufunyane is sometimes referred to as a form of mass hysteria as at times it affects a group of people. The symptoms of amafufunyane vary from person to person, although the central feature lies in the aetiological factors that are often due to forms of witchcraft. Amafufunyane often occurs in situations of social conflict or envy.

Thwasa is considered a healthy calling by the ancestors to become a healer whereas amafufunyane is due to bewitchment or the breaking of customs, which is seen as being related to a negative relationship with the ancestors. According to Buhrmann (1984), bewitchment can be associated with mental illness and is the product of a negative attitude to unconscious material, whereas thwasa involves the acceptance of such material. Therefore, amafufunyane, in contrast to thwasa, is not socially acceptable. The person suffering from amafufunyane shows psychotic symptoms such as hallucinations, delusions of persecution and disorganised speech. The person also shows signs of word salad and speaks in a strange and muffled voice.

Activity 4.12

Read the following Case Study about Tladi carefully and then provide an interpretation and classification of his abnormal behaviour from an African perspective:

Case Study

Tladi, a 40-year-old man, was brought to the local hospital after he was found wandering aimlessly in the streets and talking loudly to no-one in particular. He used words and sounds that people around him could not understand. His speech was fragmented and incoherent. His appearance was unkempt and dirty. He appeared agitated and became violent without provocation. He ran about wildly, assaulting people and breaking things.

Enquiries made by the clinician revealed that his illness had started two years before being admitted to hospital. According to family members, the illness started gradually and the patient deteriorated month after month.

His illness started with symptoms of general listlessness, sleep disturbances and bad dreams, loss of appetite, withdrawal, emotionlessness and unprovoked bouts of anger. He often complained of hearing voices in his stomach, which spoke a different language from his own. The voices told him that his wife did not love him anymore. On one occasion they told him that they had come to kill him as someone else wanted to marry his wife. Whenever he became angry he blamed the voices for causing it. Before the illness started, the patient did not have any physical illness.

He was a hardworking father, married with three children, but his wife left him a year before the illness started. At the time she left him, Tladi was spending a lot of hours at work as he had been promoted and was experiencing a lot of work-related pressure and stress. His wife and their children are now living with her parents. Soon after the illness started Tladi lost his job because of his funny behaviour.

During the clinical interview, the patient reported that he had been bewitched by jealous people in his community who were not happy about his success. He also reported that insects were moving inside his body and that at times he could feel his brain move and heard voices threatening to kill him.

His brothers were of the opinion that his illness was caused by a witch or evil spirit sent by his wife who had left him, or by another person. Tladi grew up as part of a large family in a very poor rural area where violence amongst factions was rife. His father left for the city to work in the mines when Tladi was very young and they hardly ever saw their father while growing up.

On many occasions, Tladi and his siblings were sent to live with his father's parents as there were periods during which his mother was hospitalised for what the local community called "bouts of madness". According to Tladi's brothers, their mother would focus her attention on Tladi when she was ill. She would confuse poor Tladi as she would often behave very inconsistently towards him and

blame him for their father's departure but would then tell Tladi that he was the only child she loved. Tladi's brothers said that they thought she did this because Tladi was the one child that was a lot like their mother, and that they always thought that he would "turn out" to be just like her and now it seemed they were right.

Interpretation from an African perspective

If Tladi were to consult a traditional healer, his illness would be diagnosed as amafufunyane, which is possession by evil spirits caused by witchcraft. The victim is said to be possessed by a horde of spirits of different racial groups. It is believed that a mixture of soil and ants from a graveyard are used to make a concoction which is placed in the path of the victim or put in his or her food. The person so poisoned will become possessed by amafufunyane and will go mad.

In the traditional African context, the term amafufunyane is often used as a way of explaining why a condition has arisen and is, therefore, as much an etiological explanation as it is a diagnostic label. In this regard, the term amafufunyane may not function as a coherent diagnostic label, but as an explanatory term for a range of different symptoms.

Amafufunyane in this context seems to function less as a discrete diagnostic entity than as part of a broad, and occasionally inconsistent, explanatory model. Its function seems to include an aetiological element in providing a meaningful explanation as to why the patient's condition arose, and secondly as a means of avoiding stigma, at least to some extent, and apportioning blame for the condition elsewhere. Thirdly, the condition of amafufunyane is consistent with the broader cultural belief system which provides support for the patient]

Classification of Tladi's abnormal behaviour from an African perspective

As already mentioned in the Tutorial Letter, the causes of psychopathology from an African perspective are classified in relation to perceived causes. This perspective is in contrast to the Western classification system (DSM-5) which puts less emphasis on the causes of abnormal behaviour in their classification system but more emphasis on the presenting symptoms as well as environmental and psychosocial factors.

In Tladi's case his abnormal behaviour can be categorised as falling under a classification category of "Magical causes", (Disorder due to Sorcery and Witchcraft) as he is said to have been bewitched by jealous people within his community. It is also important to indicate the fact that within the traditional African context, there is strong belief that a man who was as successful as Tladi was, is expected to consult a traditional healer to be strengthened with herbal medicine in order to protect himself from malicious people who may bewitch him because of his success.

The Sotho or Setswana "Go itiisa" refers to such a strengthening ritual. Success and prosperity is believed to make one vulnerable to witchcraft.

Activity 4.13

STUDY the following section entitled, "Indigenous theories of health and illness"

Traditional beliefs and practices concerning illness and health are still widely practiced in rural areas in South Africa (Louw & Edwards, 1993, cited in Botha & Moletsane (2012). These beliefs and practices form a coherent system that has maintained individual and social equilibrium for generations. Furthermore, out of these traditional beliefs and practices has come an African understanding of aetiology.

The study conducted by Moletsane (2011) in Burke (2012) highlights these African aetiological explanations (see figure 2 of Activity 4.13)

Figure 2: Indigenous African aetiological explanations

Cause of illness	Explanation
Boloi (Sesotho) or ubuthakathi (IsiZulu): to be bewitched	It can be described as sorcery/witchcraft, or use of supernatural power to harm or kill someone, usually an enemy.
Sefifi/senyama (Sesotho) or isinyama (IsiZulu)	A widow is regarded as contagious as she has "senyama" or "sefifi" which means bad luck due her husband's death. The bad luck can be cured if the widow and the youngest child in the family are cleansed by bathing with a herb concoction as recommended by a traditional healer after the death of her husband. A person who is menstruating or who had sex that day is also regarded as having "sefifi". Such people are not allowed to enter the same room as a new-born baby or a sick person because they might pass their bad luck or illness to the baby or aggravate the condition of the sick person.
Go roula (Sesotho)	A widow has to wear black clothes for 12 months to show that she is mourning for her husband. This only applies to wives, not husbands. If this practice is not properly followed, it can cause illness.
Makgome (Sesotho)	After the death of the husband, a widow is prohibited from having a sexual relationship with anyone. Widows are supposed to abstain from sexual activities for a period of one year. If this practice is ignored, they can cause serious illness to themselves and to anyone who had sexual contact with them.
Go tlola (Sesotho) or Ukudlula in IsiZulu	When a widow fails to abstain from sex during the mourning period, this can cause compulsion neurosis (the uncontrollable impulse to perform stereotyped irrational acts).
Go latlha maseko/setso (Sesotho) or ukulatlha amasikoin isiZulu	This is the failure to perform the traditional practices. For example, due to western influence, people might not believe in African rituals. This might anger the ancestors who will cause ill-health or other types of problems in a person's life.
Ba fase ba re furaletse/ba fase ba re lahlile (Sesotho) or abaphansi ba si fulathele isiZulu	This means that the ancestors have turned their backs against the person. This usually happens when people experience problems either with relationships, work, finance, health, and they think that ancestors are angry with them.
Go thwasa (Sesotho) or Ukuthwasa isiZulu	The calling by the ancestors to become a traditional healer. If ignored, it can cause illness or even death.
Tokolosi (Sesotho) or tokoloshe IsiZulu	Witchcraft through an animal-like witch. The witches can send a "tokolosi" to take part in bewitching another

	person.
Sejeso(Sesotho) or isidliso IsiZulu	Growth or pain in the stomach due to sorcery or witchcraft.
Letswalo (Sesotho) or uvalo (IsiZulu)	Anxiety attributed to witchcraft or sorcery.
Go gatiswa/sefola (Sesotho) or umeqo (IsiZulu)	A disorder attributed to stepping on a concoction of herbs of sorcery. This can cause pain and swollen feet for the person who stepped on the concoction.
Mafofonyane (Sesotho) or Amafufunyane (Isizulu)	Spirit possession as a result of witchcraft or sorcery.
Meila (Sesotho)	Within traditional African perspective members of the community are expected to avoid forbidden or taboo practices or acts or face ancestral wrath which can also result in ill health.

(Source: Adapted from Botha & Moletsane, 2012)

Outcomes
Once you have worked through study unit 4.13, you should be able to:

- To have an understanding of African explanation of aetiology

Study
To be able to do the above you have to study the following sections in this Tutorial Letter 501:

- Indigenous theories of health and illness
- Figure 2: Indigenous African aetiological explanations.

Activity 4.14

You may want to visit the following internet sites for more information on the different issues within the African perspective which would hopefully expand your knowledge in this area.

http://en.wikipedia.org/wiki/Ubuntu_(philosophy)
http://web.africa.ufl.edu/asq/v3/v3i3a1.htm
http://ukpmc.ac.uk/articlerender.cgi?artid=1219894
http://www.springerlink.com/content/v041pj4w7052542l/
http://www3.interscience.wiley.com/journal/118668864/abstract?CRETRY=1&SRETRY=0

CONCLUSION

In this Learning Unit 4, we have seen that traditional definitions of abnormality may be limited, when studying experiences of individuals from other cultures, traditional definitions are not useful in identifying, assessing and treating abnormal behaviour. There is, however, a continuing controversy about whether or not to accept universal or culturally relative definitions of abnormal behaviour. It seems clear that some forms of abnormal behaviour are not universal, but rather unique to certain cultural contexts.

Research also indicates that culturally-sensitive assessment and treatment methods are vital to effectively meet the mental health needs of culturally diverse populations – South Africa as a multicultural society is a case in point.

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Learning Unit 5:

Assessment and Classification of Abnormal Behaviour

Ms Christine Laidlaw & Dr Beate von Krosigk

Contents

Overview

In the mental health field, it is essential to assess and classify individuals who have a mental problem or who ask for assistance with regard to relational and/or behavioural problems as this serves as the first step towards a decision regarding the most appropriate treatment plan for the specific presenting individual. Thus, before a clinician/psychologist attempts to work out a treatment strategy he/she needs to assess and classify abnormal behaviour/mental disorders/ psychopathology. That is if the clinician/psychologist subscribes to the more classical or linear theories of psychology e.g. psychoanalysis, cognitive-behavioural etc. Clinicians that work from a systems- or ecosystemic perspective do not ascribe to assigning abnormal behaviour to a specific identified individual nor do these theorists/therapists consider any classification system leading to a diagnosis of a specific individual as 'pathological' relevant. Please refer to Learning Unit 2 in which you will find more information regarding the family systems theory in psychology.

Familiarise yourself with the most common assessment techniques that psychologists/ clinicians use on a regular basis (pp. 75-89 of the prescribed book) by referring to the sections concerning "Reliability and Validity" and "The Assessment of Abnormal Behavior".

At the time of writing these Tutorial Letters 501, 502 and 503 the DSM-5 criteria has been published and therefore you need to utilise these Tutorial Letters 501, 502 and 503 to guide you through the information in the prescribed book as well as to indicate to you where you need to learn more detailed information based on the DSM-5 manual.

For the purpose of this module we will focus more on the classification and explanation of abnormal behaviour. Studying this module will provide you with knowledge to identify, classify and distinguish abnormal behaviour (pp. 89-100 of the prescribed book) by referring to the sections concerning "Diagnosing Mental Disorders" and "Contemporary Trends and Future Directions".

In the absence of real clients we will make use of case studies throughout your texts to demonstrate the practical identification and classification of abnormal behaviour as well as applying your knowledge regarding the aetiology of the abnormal behaviour. Therefore the use of case studies will assist you in the practical implementation of the knowledge you gain throughout this module.

As a third year student in psychology you are NOT permitted to make diagnoses in the real world – only registered psychologists, psychiatrists and clinicians are permitted to make diagnoses. We merely teach you the diagnostic criteria to enable you to identify abnormal behaviour so you will be more effective in your prevention and referrals of instances of abnormal behaviour to the appropriate mental health care professionals in your community.

The information contained in a case study is fixed. Therefore, we are unable to ask the client additional questions for the purpose of clarifying certain issues. The information the case study provides is all we have to work with. This fact is close to ideal for learning to identify the necessary number of symptoms for recognising a specific disorder as the symptoms are presented in a clear and concise manner. This is seldom the case in a real-world scenario as individuals present with a complex picture of behaviour, that requires extensive knowledge and efficiency in disentangling the different elements of a case before a diagnosis can be attempted.

The DSM-5 and how to classify abnormal behaviour with regard to presenting symptomatology will therefore be the focus of Learning Unit 3: Assessment and Classification of Abnormal Behaviour (Sue, Sue, & Sue, 2016, pp. 89-91).

5.1 STUDY UNIT: Assessment and Classification of Abnormal Behaviour

Activity 5.1

We are now ready to READ the following:

- The entire chapter 3 of your prescribed book
- Background information on the DSM-5 classification system below

Background information on the DSM-5 classification system

Classification is an integral part of understanding abnormal behaviour. It is a means of establishing order for dealing with the nature, causes, and treatment of abnormal behaviour. The purpose of a classification system is to provide distinct categories and indicators for different patterns of behaviour, thought processes and emotional disturbances.

Categories for mental disorders/abnormal behaviour are constantly changing. When social norms change, some behaviour patterns are no longer considered as disorders (e.g. homosexuality was removed from the list of disorders, in 1973, while Acute Stress Disorder was added to the DSM-IV-TR classification system a few years ago).

Early efforts to classify abnormal behaviour originated from the biological/ medical tradition. Emil Kraepelin (1856–1926), was a psychiatrist who believed that psychological disorders were the result of biological and genetic malfunction. He thus initiated the change from classifying according to the traditional view by grouping major symptoms together, to the clinical view by grouping common patterns of symptoms (syndromes) together. This fundamental change from grouping symptoms to grouping patterns of symptoms together had a great influence on the first Diagnostic and Statistical Manual of Mental Disorders (DSM), which was published in1952.

The current version of the DSM, the DSM-5 classification system, published in May 2013, is still based on the medical model/biochemical model/psycho-medical model/psychiatric model. It supports the basic tenets of the medical model, namely, that abnormal behaviour is regarded as similar to a physical illness. According to the DSM-5 classification system, people are regarded as exhibiting abnormal behaviour/psychopathology if they experience emotional distress and/or show significant impairment in functioning, which involves difficulties in meeting daily responsibilities within the family or within society. It also includes behaviour that places people at risk for personal suffering, pain, or death.

Classifying abnormal behaviour/psychopathology according to the DSM-5 classification system involves an assessment of an individual's behaviour in relation to presenting symptoms and related contextual

factors. The DSM-5 is a step towards diagnosing disorders from a dimensional approach in that normal and abnormal behaviour lies more on a continuum rather than in iron-clad categories.

To assist the psychologist to form a clear picture of the person's state of health he/she applies a particular way of thinking about and gathering the information regarding an individual. The psychologist utilises several assessment procedures and collects extensive collateral information in the process of arriving at a diagnosis for the individual's presenting behaviour. We are going to present you with a way of thinking which you need to able to apply when working with the case studies in the chapters and Learning Units that follow.

We will now STUDY the following information with regard to classifying abnormal behaviour comprehensively by utilising the DSM-5 classification system.

To understand what is important and what you are looking for with regard to finding the appropriate disorder(s) in a case study with comprehensive information on an individual, we have compiled a short step-by-step guideline that takes you through the procedure of classifying abnormal behaviour utilising the DSM-5 classification system:

As we read through a case study carefully we are going to go through these step-by-step guidelines of identifying mental disorders by firstly, compiling a differential diagnosis; secondly, eliminating some of these disorders from the list of differential disorders; and then lastly confirming the final diagnosis.

Keep the following list of possible categories of disorders in mind:

Aetiological Medical Conditions (in other words, any medical condition or disease that might be producing the psychological symptoms being manifested)
Personality Disorders
Intellectual Disability (Intellectual Developmental Disorder)
Neurodevelopmental Disorders
Elimination Disorders
Neurocognitive Disorders
Schizophrenia Spectrum and Other Psychotic Disorders
Substance-Related and Addictive Disorders
Bipolar and Related Disorders
Depressive Disorders
Obsessive-Compulsive and Related Disorders
Anxiety Disorders
Trauma- and Stressor-Related Disorders
Dissociative Disorders
Somatic Symptom and Related Disorders
Gender Dysphoria
Sexual Dysfunctions
Paraphilic Disorders
Disruptive, Impulse-Control and Conduct Disorders
Other Conditions That May Be a Focus of Clinical Attention

Step 1: Identify any aetiological medical condition that the individual has that may be causing/contributing to having a mental disorder (e.g. Depressive Disorder due to a cerebrovascular accident).

It is important to first write down any mental disorder caused by a medical condition. The medical condition or physical illness is relevant to understanding and/or managing the individual's mental/clinical disorder. The medical condition needs to be verified by a medical practitioner or specialist.

Step 2: Keeping in mind the age of the person, the Personality Disorders and Intellectual Disability (Mental Retardation in previous DSM editions) need to always be considered because they are long-term disorders which persist for a long time, often from childhood through adulthood. Therefore you need to consider the individual's functioning earlier in his/her life, before the current set of symptoms for which the individual has come to your attention (acute symptoms), developed or became so severe as to come to your attention. This is called the premorbid functioning of the individual. Therefore, since Personality Disorders and Intellectual Disability exhibit chronic long-term symptoms it will become clearer to identify these disorders if some or most of the symptoms are already present premorbidly. Also, the earlier premorbid symptoms of these disorders may be overlooked when the focus is only on the more acute symptoms.

The presence of Personality Disorders or Intellectual Disability usually makes the treatment of other mental disorders more difficult. Personality Disorders and Intellectual Disability are both long-term disorders stemming from childhood or adolescence (their aetiology lies in the past), but they are still present now (at the time of diagnosis). Consider the following:

If the person is 18 years old or older, eliminate the disorders that occur only in childhood and adolescence from the list that you are thinking about, particularly if none of the diagnoses of these childhood disorders has been met before the individual turned 18 years old.

Consider whether the adult in the case study has sufficient features that would meet the criteria for a Personality Disorder. Remember in order for an adult to have a Personality Disorder the features are normally described from their childhood. TIP: When learning about the different personality disorders learn how many criteria are required by each Personality Disorder. Also, remember Personality Disorders are *mostly* only diagnosed in adulthood (from 18 years of age). The DSM-5 does allow Personality Disorders to be diagnosed in middle adolescence if very clear criteria are met for over a year.

A Personality Disorder is a style across contexts which is problematic to others and therefore reported by others. Only occasionally is it experienced as a problem by the afflicted individual him/herself. When a cluster of traits has been identified on account of another person commenting on the individual's past behaviour you need to consider a possible Personality Disorder to classify. When you have identified a Personality Disorder, note how the personality characteristics could influence the remaining symptomatic behaviour in the individual's life.

Step 3: Children: Consider the IQ level of the child which must have been tested by a psychologist in order to be accurate regarding intellectual ability. If a child's IQ falls below 70 and is concurrent with deficiencies in adaptive behaviour, the Intellectual Disability category must be considered. Intellectual Disability occurs before 18 years of age.

Also, if the person is under 18 years old the focus will *likely* be on all categories of disorders excluding generally Personality Disorders.

TIP: Spend extra time thinking about the disorders in the Neurodevelopmental Disorders category, and other disorders diagnosed in childhood or adolescence such as Separation Anxiety Disorder, Selective Mutism, Conduct Disorder etc. as these disorders are often seen in children. Also, always remember to consider the Elimination Disorders category and Gender Dysphoria in Children when the individual is a child.

IMPORTANT: Remember in relation to mental disorders (excluding Personality Disorders) the severity level (such as mild, moderate and severe) and course specifiers should be applied to indicate the individual's current presentation , but only when it is clear that all criteria for a diagnosis of the condition are met (APA, 2013).

Now we can consider the other mental disorders. Thus, to determine your final choice, which involves the diagnosis of a specific disorder, a variety of possible diagnoses must be

considered from different types of disorders that have common or similar symptoms/syndromes to those being manifested by the individual. This process of systematic compiling and then eliminating of possible disorders is called a differential diagnosis. The process of eliminating the disorders that are not relevant to the symptoms picture being exhibited in the case study follows:

Focus on the most prominent symptoms and symptom combinations (syndromes). Take the severity and duration of those symptoms into account and follow a process of elimination by first ruling out the most severe disorders, by looking at the combination of symptoms, severity and duration for each set of disorders of a particular type.

Step 4: The predominant feature of Neurocognitive Disorders is a clinical deficit in cognitive functioning that represents a significant change from a previous level of functioning.

Establish whether any signs of delirium or dementia and memory impairment are present. If the symptoms of a deficit in cognitive functioning and signs of delirium and/or dementia are not present in the case study, and no underlying medical condition or substance use (or both) that can directly account for the cognitive deficits are present the individual cannot be diagnosed as suffering from a Neurocognitive Disorder.

TIP: When learning about Neurocognitive Disorders pay attention particularly to the premorbid functioning of the individual. Neurocognitive Disorders represent an acquired (not developmental) impairment on a previous level of cognitive functioning. Therefore "Neurocognitive Disorders are those in which impaired cognition has not been present since birth or very early life, and thus represents a decline from a previously attained level of functioning." (APA, 2013, p. 591).

Step 5: Look and see if you can identify any symptoms of psychosis which are evident in the Schizophrenia Spectrum and Other Psychotic Disorders category.

The predominant features of Schizophrenia Spectrum and Other Psychotic Disorders are delusions and hallucinations, disorganised speech, and disorganised behaviour. Schizophrenia needs to last for at least six months and it includes at least one month of active phase symptoms. These active phase symptoms include two or more of the following:

- Delusions
- Hallucinations
- Disorganised speech
- Grossly disorganised/catatonic behaviour
- Negative symptoms

The psychotic symptoms should further also not be related to any other mental condition or substance use. If these possible criteria are missing, or if another mental condition or use of a substance could account for the psychotic symptoms, Schizophrenia Spectrum and Other Psychotic Disorders need to be ruled out.

Step 6: Look carefully and see if the individual is using any substances (for example, tobacco, caffeine, drugs and alcohol). Then carefully examine whether their use would amount to displaying the symptoms of one or more of the Substance-Related and Addictive Disorders. If the person is gambling consider Gambling Disorder that falls into the non-substance Addictive Disorder category.

Step 7: Now you are ready to ask yourself the following questions:

- Has there been any change in their level of mood (low or elevated)? If their mood is not euthymic (at a normal level) consider the category of Bipolar and Related Disorders and

the category of Depressive Disorders.

TIP: If the person has ever experienced a full manic or hypomanic episode (abnormally and persistent elevated mood) they will not fall under the category of Depressive Disorders and only the category of Bipolar and Related Disorders must be carefully considered when looking at the mood.

- Is the person displaying the symptoms of an obsession and/or compulsion?

  Obsession: recurrent and persistent thoughts, urges or images that are experienced as intrusive and unwanted by the individual.
  Compulsion: repetitive behaviours or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

  If so, carefully consider all the possible disorders in the Obsessive-Compulsive and Related Disorders category.

TIP: Be careful to differentiate between a delusion and an obsession.

- Is the person experiencing prominent feelings of fear, anxiety or worry? If so, two categories need to be particularly considered namely Anxiety Disorders and Trauma-and Stressor-Related Disorders.

TIP: To identify Trauma- and Stressor-Related Disorders it is important to look for evidence of a traumatic event or stressor that led to the person displaying feelings of fear, anxiety or worry.

- Has the person experienced a trauma (exposure to an actual or threatened death, serious injury, or sexual violence) that is linked to the fact that they are experiencing intrusive symptoms related to the trauma, avoidance behaviour, negative alterations in cognitions and mood, arousal and reactivity etcetera? If so, two categories need to be particularly considered namely Trauma- and Stressor Related Disorders and Dissociative Disorders.

  TIP: Remember Dissociative Disorders cause a disruption of and/or disintegration of consciousness, awareness, memory, identity, emotion, perception, body representation, motor control, and behaviour.

- Is the person experiencing distressing somatic (bodily) symptoms plus abnormal thoughts, feelings and behaviours in response to these symptoms? Consider the category of Somatic Symptom and Related Disorders.

TIP: Be careful to differentiate between an aetiological medical condition, psychosis, malingering and a disorder in the category of Somatic Symptom and Related Disorders.

- Is the person experiencing distress regarding their gender? Consider the category of Gender Dysphoria; or is the person having problems in their sexual functioning? Consider the category of Sexual Dysfunctions. Consider the category of Paraphilic Disorders if the person is experiencing intense sexual urges that are distressing or impair functioning at home or within work contexts.

- Is the person experiencing prominent problems with self-control of emotions and behaviours? Is the person violating the rights of others and/or do their problems with self-control lead to conflict with societal norms or authority figures? If so, consider the category of Disruptive, Impulse-Control and Conduct Disorders.

Note: At third year level you are not expected to identify Feeding and Eating Disorders; Sleep-Wake Disorders; and Medication-Induced Movement Disorders and Other Adverse Effects of Medication of the DSM-5 classification system.

Step 8: Once you have identified the main diagnoses it is important to then see if the individual is experiencing any Other Conditions That May Be a Focus of Clinical Attention such as Relational Problems, Abuse and Neglect, Educational and Occupational Problems, Housing and Economic Problems, Other Problems Related to the Social Environment, Problems Related to Crime or Interaction With the Legal System, Other Health Service Encounters for Counselling and Medical Advice, Problems Related to Other Psychosocial, Personal and Environmental Circumstances, Other Circumstances of Personal History. (This extensive list above provides a holistic and contextual view of an individual's functioning).

Note: An individual can exhibit symptoms that meet the full diagnostic criteria for more than one disorder at the same time. Therefore more than one diagnosis can be made at the same time, which need to be listed by starting with the principal diagnosis. The principal diagnosis is the diagnosis for which the individual was referred to for treatment/assessment or the reason why the individual came for an appointment.

Other Conditions That May Be a Focus of Clinical Attention: is for listing environmental factors and relational problems that may influence the development, maintenance, treatment, or prognosis of mental/disorders including Personality Disorders and Intellectual Disability. Examples of other conditions to be considered, and recorded if relevant include:

- Relational Problems: Problems related to Family Upbringing for example Parent-Child Relational Problem, Sibling Relational Problem, Upbringing Away From Parents, Child Affected by Parent Relationship Distress. Other Problems Related to Primary Support Group for example Relationship Distress with Spouse or Intimate Partner (excluding abuse or sex counselling), Disruption of Family by Separation or Divorce (the divorce must not be finalised), High Expressed Emotion Level within Family, Uncomplicated Bereavement.

- Abuse and Neglect: The DSM-5 specifies whether an initial encounter or a subsequent encounter of abuse or neglect refers and whether abuse is confirmed or suspected. For example Child Maltreatment and Neglect Problems (Child Physical Abuse, Child Sexual Abuse, Child Neglect, Child Psychological Abuse), Adult Maltreatment and Neglect Problems (Spouse or Partner Violence, Physical; Spouse or Partner Violence, Sexual; Spouse or Partner Neglect; Spouse or Partner Abuse, Psychological; Adult Abuse by Nonspouse or Nonpartner.

- Educational and Occupational Problems: Educational Problems (Academic or Educational Problem may include: underachievement, discord with teachers, other staff, other students), Occupational Problems (Problems Related to Current Military Deployment Status, Other Problems Related to Employment may include: unemployment, change in job, stressful work schedule, sexual harassment on the job, discord with boss, supervisor, co-workers, uncongenial or hostile work environment).

- Housing Problems: Homelessness, Inadequate Housing, Discord with Neighbour, Lodger, or Landlord, Problems Related to Living in a Residential Institution.

- Economic Problems: Lack of Adequate Food or Safe Drinking Water, Economic Poverty, Low Income, Insufficient Social Insurance or Welfare Support, Unspecified Housing or Economic Problems.

- Other Problems Related to the Social Environment: Phase of Life Problems (for example entering or leaving school, becoming a parent, retiring), Problems Related to Living Alone (for example loneliness, lack of structure in carrying out activities), Acculturation Difficulty, Social Exclusion or Rejection (for example bullying), Target of (Perceived) Adverse Discrimination or

Persecution, Unspecified Problems Related to the Social Environment.

- Problems Related to Crime or Interaction With the Legal System: Victim of Crime, Conviction in Civil or Criminal Proceedings Without Imprisonment, Imprisonment or Other Incarceration, Problems Related to Release From Prison, Problems Related to Other Legal Circumstances.

- Other Health Service Encounters for Counselling and Medical Advice: Sex Counselling, Other Counselling or Consultation (such as spiritual or religious counselling, dietary counselling, counselling on nicotine use).

- Problems Related to Other Psychosocial, Personal and Environmental Circumstances: Religious or Spiritual Problems (loss or questioning of faith, problems associated with conversion to new faith, questioning of spiritual values), Problems Related to Unwanted Pregnancy, Problems Related to Multiparity, Discord With Social Service Provider, Including Probation Officer, Case Manager, or Social Services Worker, Victim of Terrorism or Torture, Exposure to Disaster, War or Other Hostilities, Other Problems Related to Psychosocial Circumstances, Unspecified Problems Related to Unspecified Psychosocial Circumstances.

- Other Circumstances of Personal History: Other Personal History of Psychological Trauma, Personal History of Self-Harm, Personal History of Military Deployment, Other Personal Risk Factors (Problems Related to Lifestyle: lack of physical exercise, inappropriate diet, high-risk sexual behaviour, and poor sleep hygiene. These are only listed if they do not form part of a criterion of the individual's condition, such as a symptom of the diagnosed mental disorder), Adult Antisocial Behaviour, Child or Adolescent Antisocial Behaviour.

- Problems Related to Access to Medical and Other Health Care: Unavailability or Inaccessibility of Health Care Facilities, Unavailability or Inaccessibility of Other Helping Agencies.

- Nonadherence to Medical Treatment: Nonadherence to Medical Treatment, Overweight or Obesity, Malingering, Wandering Associated With A Mental Disorder, Borderline Intellectual Functioning.

We will now journey through a case study together where we are going to identify the symptoms and features that cause distress to the individual and impair his/her functioning. We are then going to classify the individual's abnormal behaviour according to the DSM-5 classification system.

TIP: Use coloured pens and a ruler to highlight key symptoms or features in the case study.

Activity 5.2.

While you read Elaine's case study below, pretend that you are the psychologist who is actively listening to Elaine's story. Keep in mind that you are actively listening to Elaine's story with the aim of classifying Elaine's abnormal behaviour by utilising the DSM-5 classification system.

Case Study

Elaine is a 25-year old, unmarried computer programmer. She has been working at the same firm for the past seven years. Her employers have great regard for the high-quality work she produces. Elaine has received various good job offers from other firms in the past, but has decided to stay in a familiar work environment. She doubts her ability to cope in a new firm.

From a young age it has been apparent that Elaine, who is a talented young woman, is socially reserved, doubts her own abilities and lives in fear of criticism from others. She experiences any form of criticism, however slight, very negatively and this results in her withdrawing from people for long periods. She does not make friends easily and is always looking for proof of others' acceptance and loyalty. Her colleagues describe her as a sensitive, shy and reserved person who is socially awkward. However, Elaine does have some friends whom she has learnt to trust over the years. She values these friendships highly, yet she hesitates to share her deepest feelings with them. She is petrified that her friends will regard her feelings as stupid or childish. She is also fearful of the day that they may get married and marginalise her. Although she has no male friends, she has indicated to her friends that she often fantasises about a fairy tale wedding and a happy marriage. She avoids all social occasions at work because she does not want to make a fool of herself in front of her colleagues. Although she wants to share in her colleagues' pleasant interactions during breaks, to which she is invited, she mostly spends tea and lunch breaks on her own in her office.

Five months ago, the head of Elaine's section died unexpectedly. Her death was a great loss to Elaine because she was one of the few people with whom Elaine felt comfortable. The management of the firm asked Elaine to take over the head's duties temporarily until a replacement could be appointed. This resulted in intensified stress for Elaine. She is of the opinion that she cannot guide junior staff members and is wary of any confrontation with colleagues.

For the past two months, Elaine has been experiencing serious sleeping problems. She wakes up at three o'clock in the morning and although she feels very tired, she cannot fall asleep again. She stares for hours in the dark, fearing the coming day. By the time she has to get up, she is exhausted and anxious. She has lost interest in her work and other activities. She finds that she has neglected to do simple household chores. Her movements have become lethargic and she experiences problems concentrating. Elaine has lost a lot of weight and has no appetite. Two weeks ago she refused a friend's invitation to dinner, saying that all food tastes like straw to her and that in any event she cannot eat anything because her "intestines are rotten" and cannot digest food. When her shocked friend questioned her more closely, Elaine insisted that her intestines are rotten. Elaine also attributed the serious constipation, which she has experienced during the last two months, to her rotten intestines. She also told her friend that she is convinced that the decay has spread because she is also not menstruating. Elaine's friend convinced her to consult a doctor about her stomach problems and made an appointment for her. Medical tests and examinations were done but no stomach problems could be established. However, Elaine paid no attention to the test results and continues to believe that she is dying a long, drawn-out death.

Elaine is clearly in a deep depression. She obviously enjoys nothing anymore. All her friends' efforts to make her feel better and to cheer her up have come to nothing. She has begun considering suicide as a quick end to all her problems. Elaine has been avoiding all contact with her friends, and for the past four days she has not been to work.

Late one evening a friend, who had been trying for a couple of days to contact Elaine, went to her home. The house was cast in darkness, but the sound of a car idling in the garage caught the friend's attention. With the help of a neighbour, she broke the garage door open. They found a tearful Elaine in her car where she had tried to gas herself. The pipe, which she had connected to the car's exhaust, had a leak and her suicide attempt was unsuccessful. The friend immediately rushed Elaine to hospital. At the hospital she was medically examined and admitted for observation. The next morning she was declared physically fit. At the doctor's and her friend's insistence, Elaine

was transferred to a psychiatric clinic.

During the psychiatric interview the following information about Elaine's history came to light. Elaine was one of twins. When she was 10 years old, both her parents and twin sister were killed in a car accident. Various family members looked after Elaine for a couple of years before she was eventually put in a children's home. After passing matric, she immediately started to work.

Did you consider some of the following differential diagnoses in your elimination process when going through the case study, step-by-step:

- Aetiological i.e. past Medical Condition?

- Schizotypal Personality Disorder: Though Elaine lacks close friends and does show social anxiety, her anxiety in relation to others is not associated with paranoid fears. Furthermore, she does not have ideas of reference, nor a combination of distortions in cognition and perception or magical thinking, suspiciousness/paranoid ideation, constricted affect or eccentric behaviour which are key features of Schizotypal Personality Disorder.

- Schizoid Personality Disorder: People with Schizoid Personality Disorder have a more pervasive detachment and a more limited desire for social intimacy. However, Elaine does, have some friends whom she has learnt to trust over the years and she values these friendships highly. Elaine only avoids people when fearful of being embarrassed, found inadequate or when she anticipates rejection. Additionally, individuals with Schizoid Personality Disorder appear indifferent to the criticism of others whereas Elaine is very sensitive and fearful of the criticism of others.

- Dependent Personality Disorder: Although Elaine has decided to stay in a familiar work environment as she doubts her ability to cope in a new firm due to fears of criticism, she is able to carry out her own work responsibilities. Whereas a person with Dependent Personality Disorder will actively seek out others that will look after them and assume responsibility for them. Individuals with DPD will cling to others for support. Elaine, in contrast, is regarded as shy and reserved and cautious about striking up friendships unless she is certain of being liked.

- Avoidant Personality Disorder: Both Dependent Personality Disorder (DPD) and Avoidant Personality Disorder (APD) are characterised by feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance. However, the primary focus in DPD is being taken care of whereas in APD the focus is avoiding ridicule from others by withdrawing as Elaine does. Individuals with APD want to have relationships with others and feel their loneliness deeply, whereas those with Schizoid Personality Disorder or Schizotypal Personality Disorder may be content with or even prefer their social isolation. Elaine meets the essential features of Avoidant Personality Disorder (four or more criteria need to be met) as she shows a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation over a variety of contexts.

  Duration: Elaine's behaviour has remained relatively stable from childhood into adulthood.

  Intensity: Her behaviour has remained relatively stable over the long-term with a medium intensity of doubt, fear and rejection from childhood into adulthood.

  Pattern of symptoms: From a young age, Elaine has doubted her own abilities. She feared criticism and rejection. She was and still is shy and socially awkward. As an adult she has low self-esteem (she believes she cannot lead junior members of staff, she has refused job offers because she doubts her own abilities). She is still fearful of being criticised and rejected (she avoids confrontation with colleagues, she refrains from sharing her deepest secrets with others for fear of being made a fool of), and she takes criticism negatively. Although she would like to be part of the interactions with her colleagues, she remains alone in her office. She does not

make friends easily. She needs approval from others and then seeks proof of loyalty, because she is afraid of making a fool of herself before others.

- Brief Psychotic Disorder: Elaine does experience a delusion, which is a key symptom of Brief Psychotic Disorder. However, Elaine's mental disorder includes a Major Depressive Disorder and the diagnosis of Brief Psychotic Disorder cannot be made if the psychotic symptoms are better explained by a mood episode (i.e. the psychotic symptoms occur exclusively during a full major depressive, manic or mixed episode). Her delusion of her rotting intestines only occurred during her Major Depressive Episode.

- Delusional Disorder, Somatic type: Elaine does experience a delusion, which is a key symptom of Delusion Disorder. However Elaine's functioning has been impaired beyond merely experiencing a delusion and in addition, her major depressive episode has been longer in duration than the period she has been experiencing the delusion. As such, her delusion has occurred within her Depressive/Bipolar Disorder and therefore Delusional Disorder is ruled out.

- Schizoaffective Disorder: Although Elaine is experiencing mood symptoms and a psychotic symptom (somatic delusion), her delusion has not lasted 2 or more weeks in the absence of her major depressive episode and therefore the diagnosis of Schizoaffective Disorder cannot be made as one criterion is the presence of: Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.

- Bipolar Disorders: Although Elaine is experiencing a major depressive episode, she has never met the criteria for a hypomanic or manic episode in her entire lifetime. Bipolar Disorders are only diagnosed if the individual has had a hypomanic (Bipolar II Disorder) or manic (Bipolar I Disorder) episode(s) before or currently in their lifetime.

- Persistent Depressive Disorder (Dysthymia): In Elaine's case this diagnosis is not made as her depressed mood has not lasted for at least two years.

- Adjustment Disorder: Although Elaine became depressed when her supervisor died, Adjustment Disorder will only be diagnosed when the stress-related disturbance does not meet the criteria for another mental disorder. In Elaine's case she meets the criteria for Major Depressive Disorder.

- Somatic Symptom Disorder: Elaine believes her intestines are rotting which has led her to seek medical attention. Although Somatic Symptom Disorder involves the individual believing that somatic symptoms may reflect serious underlying physical illness, Elaine's focus on her rotting intestines goes beyond the intensity of Somatic Symptom Disorder in that she holds onto this belief by rigidly believing that she is going to die. With a somatic delusion the belief and behaviour are stronger than those found in Somatic Symptom Disorder and also, the wider picture reflects a delusion encased in a severe depressive episode, rather than the individual solely focused on somatic symptoms.

- Major Depressive Disorder: Elaine meets five or more of the following symptoms during the same two-week period and she has had a change from her previous functioning: She has had a depressed mood, been sad and tearful. Elaine has also had an obvious decline in interest in her work and other activities she avoids all contact with her friends. She has been experiencing exhaustion and sleep disturbance, she wakes up at three o'clock and cannot go back to sleep (insomnia). She cannot concentrate. She has had a decrease in appetite, weight loss, constipation, and no menstruation. She has had recurrent thoughts of death, and recurrent suicidal ideation that resulted in a suicide attempt. These symptoms have caused Elaine significant distress and impairment in both her social and occupational functioning. These symptoms are not due to substances or another medical condition. Therefore, she is experiencing a major depressive episode. Specifiers: Elaine has early morning waking (at least

two hours before usual awakening), loss of appetite, psychomotor retardation (slowing down of her ability to carry out tasks that require physical movement and slowing of her thoughts and ability to concentrate), all the above are features of the melancholic features that may accompany a depressed episode. She thus meets the criteria of the specifier 'with melancholic features' as she displays more than three of the melancholic features that are necessary for adding this specifier. In Elaine's case the specifier: 'With mood-congruent psychotic features' is met as Elaine is experiencing a somatic delusion which has a typical depressive theme, in her case that of disease and death.

- Mourning

Note: Although Elaine has experienced the loss of her supervisor, her depressive symptoms do not only revolve around a preoccupation with the loved one. Her depressive symptoms have remained persistent beyond dysphoria in grief or pangs of grief. Therefore, her symptoms go beyond features characteristic of mourning.

With regard to Other Conditions That May Be a Focus of Clinical Attention Elaine currently has problems with regard to:

Other Problems Related to Primary Support Group: she is unmarried and has no family (her parents and twin sister died in a car accident when she was 10 years old).
Problems Related to the Social Environment: Problem Related to Living Alone, Loneliness: she has inadequate social support (her close colleague and direct head/supervisor suddenly died).
Occupational problems: Other Problem Related to Employment: (she was suddenly made acting manager in the absence of her head/supervisor who had suddenly passed away).

Does the following information below agree with what you have identified in the case study?

In Elaine's case, utilising the DSM-5 classification system, the following disorders would be identified and written as follows:

Major Depressive Disorder, single episode with melancholic features, severe with psychotic features (Principal Diagnosis)

Avoidant Personality Disorder

Other Problems Related to Primary Support Group: neither spouse/intimate partner/ family

Problem Related to Living Alone, Loneliness: inadequate social support

Other Problem Related to Employment: suddenly made acting manager due to death of supervisor

Do not worry if you were unable to identify the symptoms, and disorders for diagnosing Elaine's condition. Before you can recognise anything, you need to study and know the clinical picture, the symptoms, the duration, and the intensity for every disorder. Since this is an introductory course to abnormal behaviour, you do not need to study all the disorders found in the DSM-5 classification system. As already mentioned in the "Introduction" (The purpose of Tutorial Letters 501, 502 and 503) we have selected a few disorders from every category for you to study. It is however, of utmost importance that you study the selected disorders as comprehensively as possible (symptoms, features, duration of the disorder and the intensity of symptoms) for they are the tools you will need every time you are asked to identify and classify an individual's behaviour according to the DSM-5 classification system.

Activity 5.3:

You are expected to keep the DSM-5 classification system in mind, while you try to identify and name the relevant disorders for a particular individual found in a case study. Now that you have read Elaine's story once carefully go through the case study again and try to identify the disorder(s) by utilising the recommended step-by-step process with regard to the information you have gained from reading her story.

Remember this framework when identifying disorders in a case study:

Step 1:	Aetiological Medical Conditions
Step 2:	Personality Disorders
Step 3:	Intellectual Disability; Neurodevelopmental Disorders; Elimination Disorders
Step 4:	Neurocognitive Disorders
Step 5:	Schizophrenia Spectrum and Other Psychotic Disorders
Step 6:	Substance-Related and Addictive Disorders
Step 7:	Bipolar and Related Disorders Depressive Disorders, Obsessive-Compulsive and Related Disorders, Anxiety Disorders; Trauma- and Stressor-Related Disorders; Dissociative Disorders, Somatic Symptom and Related Disorders, Gender Dysphoria; Sexual Dysfunctions; Paraphilic Disorders, Disruptive, Impulse-Control and Conduct Disorders
Step 8:	Other Conditions That May Be a Focus of Clinical Attention

These special names (diagnoses) are recognised by the psychologist according to the disorders that are listed under the Diagnostic Categories in the DSM-5. When you know the clinical picture (the pattern of symptoms, the intensity of the symptoms, and the duration of the symptoms) of all the disorders you are required to study you will be able to do this with ease.

Importantly, by following the DSM-5 classification system requires that any aetiological medical condition that leads to a mental disorder must be listed first. After that, the disorder that is the reason for the visit to the psychologist or psychiatrist, (or the disorder that is chiefly responsible for their admission to hospital) is listed next. Remember to write after the diagnosis (Principal Diagnosis) or (Reason for Visit). After writing down the main diagnosis, comorbid diagnoses are then written down:

For example:

Sexual Sadism Disorder (Principal Diagnosis)
Schizoid Personality Disorder
Cannabis Use Disorder, mild

We have now completed our description of the procedure for the classification of abnormal behaviour. If you have not understood everything at the end of this study session, do not panic. As your knowledge of the different disorders increases, so will your ability to classify the disorders according to the DSM-5 classification system.

You will now begin your exciting journey in learning the diagnostic criteria for the selection of mental disorders in this Study Guide (Tutorial Letter 501, Tutorial Letter 502, and Tutorial Letter 503) in conjunction with your prescribed book. Join us, by going through each category of disorders chapter by

chapter towards our objective of learning to identify abnormal behaviour/mental disorders according to the DSM-5 classification system.

GLOSSARY:

clinical picture:	the constellation of visible signs or symptoms associated with a particular disorder, the interpretation of which leads to a specific diagnosis.
co-morbidity:	refers to the presence of more than one diagnosis occurring in an individual at the same time. Comorbidity indicates a mental disorder existing simultaneously but independently with another mental disorder in a patient.
delusion:	a fixed false belief that is resistant to reason or confrontation with actual fact
diagnosis of a mental disorder:	the determination of the nature of a case of a mental disorder or the distinguishing of one mental disorder from another. Or clinical diagnosis: diagnosis based on signs, and symptoms of mental disorders.
differential diagnosis:	the determination of which one of several disorders may be producing the symptoms.
hallucination:	is a perception in the absence of apparent stimulus which has qualities of real perception. Hallucinations are vivid, substantial, and located in external objective space. Hallucinations can occur in any sensory modality for example visual, auditory, olfactory, gustatory, or tactile

REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. Washington, DC: American Psychiatric Association.

Learning Unit 6:

Personality Psychopathology, Disruptive, Impulse-Control, and Conduct Disorders

Mrs Louise Henderson

Contents

Orientation

When studying this chapter it is extremely important to follow the instructions in this tutorial letter as it will guide you through the important information that you either need to add to the information to the prescribed book or will instruct you as to the corrections you need to make to the information in your prescribed book.

At some or other time during your life I am sure that you have described someone or have heard yourself being described as a “perfectionist” or a "cling-on" or been told that you are “paranoid” or “stingy”. Have you ever stopped for a minute to think what you were doing when you described someone in this manner? These are all words or terms that we use to describe other people according to the typical behaviour that they exhibit. What we are in fact doing when we label people in this manner is describing certain aspects of the person’s personality. As individual human beings we all have characteristic ways of responding, thinking and feeling which are relatively consistent over many different contexts. However, at the same time some of these characteristics tend to be more or less pronounced given differing circumstances and contexts. This implies that as human beings we are at the

same time both relatively consistent and predictable but also exhibit a certain degree of flexibility in how we respond, interact, perceive, behave and approach others.

Introduction

In this chapter we will be discussing the problems that arise when an individual's funny quirks or typical way of thinking and behaving go beyond everyday mannerisms and become so problematic as to interfere with their everyday functioning and interaction with others. These personality characteristics then take on a more serious and intense character and we start describing the individual as suffering from a Personality Disorder.

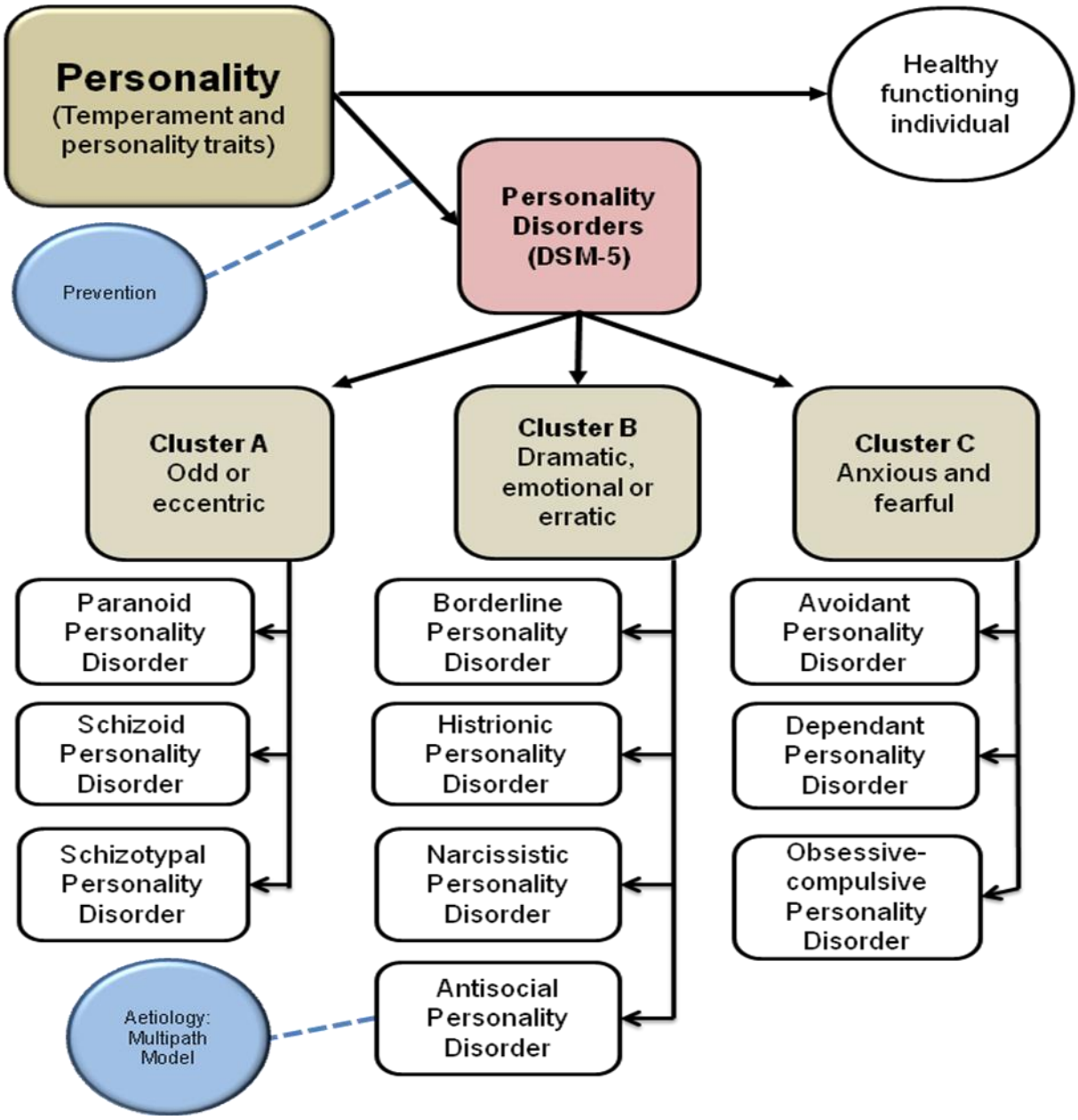
To provide a single definition of personality is difficult as there are as many definitions as there are individuals theorising about and researching the concept of personality. Although these theorists and researchers disagree about a definitive definition of personality they do concur that personality can be understood as the set of relatively stable characteristics or traits that determine what individuals do, how they behave, how they perceive and interact with their social and contextual environment, their thought patterns and cognitive and coping styles etc. In other words those characteristics that make us who we are and cause us to do what we do.

As human beings we are born with a genetically determined set of temperamental traits which, together with amongst others environmental factors, influence how our personality characteristics will emerge and evolve throughout our childhood. By the end of adolescence or early adulthood these characteristics will have become set into established patterns, coping styles and ways of interacting (Butcher, Mineka & Hooley, 2010).

When these characteristics cause an individual to behave, think, perceive etc. in a manner that is not attuned to the demands of the environment and take on an inflexible nature, in other words, cause maladaptive behaviour, and/or lead to longstanding interpersonal difficulties or cause difficulties with regard to their identity or sense of self, we should start to consider the possibility that a Personality Disorder might be present.

In this chapter you will study all the Personality Disorders that are classified according to the DSM-5 classification system and their key features. The Mind map 6.1 below provides an overview of the Personality Disorders. In a later activity you will be asked to study this diagram. You will also study the causal factors in the development of Antisocial Personality Disorder by way of the Multipath Analysis Model (on page 486 in your prescribed book). You will furthermore be challenged to consider how you can become involved in the prevention of Personality Disorders in your community.

Mindmap 6.1 below shows an overview of the information regarding Personality Disorders that you will study in this chapter:



Mindmap 6.1: Personality Disorders

Diagnosing Personality Disorders

Individuals with Personality Disorders therefore possess extreme DSM-5 patterns of responding that are inflexible, longstanding and pervasive over all contexts and situations. The beginning signs of a Personality Disorder can usually be traced back to childhood and symptoms become evident during adolescence and early adulthood and usually continue into late adulthood. In most cases of abnormal personality function, the diagnosis of a Personality Disorder is made after the age of 18 years old.

When considering a diagnosis of a Personality Disorder, the DSM classification system takes into account the individual's ethnic, cultural and social background. According to the DSM-5 (APA, 2013, p. 648), "Personality Disorders should not be confused with problems associated with acculturation

following immigration or with the expression of habits, customs or religious and political values professed by the individual's culture of origin."

Gender also plays an important role when diagnosing Personality Disorders. According to the DSM-5 classification system (APA, 2013, p. 648), certain types of Personality Disorders are more prevalent in specific genders. For example, Antisocial Personality Disorder is diagnosed more frequently in males, whereas Borderline, Histrionic and Dependent Personality Disorders are diagnosed more frequently in females. Although the frequency of diagnosis of the specific Personality Disorders in specific genders most probably do reflect real gender differences in the manifestation of certain personality patterns in the different genders, the DSM-5 also cautions in favour of the awareness of possible influences that social stereotypical gender role expectations might play in clinicians' under- or over-diagnosing of specific Personality Disorders in the different genders.

All human beings exhibit some traits that characterise Personality Disorders to varying degrees at different times. Furthermore, individuals can often exhibit a variety of symptoms, in other words symptoms of different Personality Disorders can co-occur, and it is often difficult to fleece out the different symptoms to make clear cut diagnoses of specific Personality Disorders or to differentiate which of the symptoms can be ascribed to a specific Personality Disorder and which to other mental disorders. It is furthermore very important that clinicians know the diagnostic criteria for the different specific Personality Disorders and that a number of traits of personality be considered in making a diagnosis of a Personality Disorder. A diagnosis of a Personality Disorder cannot be made after considering only a single trait or characteristic. In addition, the personality pattern must represent the individual's current and long-term functioning and only if this pattern is longstanding, persistent and cause marked impairment in social or occupational functioning and/or subjective distress, can a diagnosis of a Personality Disorder be considered.

(Adapted from APA, 2013 and Sue et al., 2010, pp. 203 - 205)

Activity 6.1

Complete the following short questionnaire. It serves as an experiential exercise in providing you with a sense of the nature of the information studied in this chapter. A short discussion follows at the end of the questionnaire. Answer the following questions by ticking the box that applies to you, responding as truthfully as possible. If you have never been in the situation asked about, respond as you think you most likely would react or feel in such a situation.

(1) In general, the prospect of making a mistake angers me.

Completely true	*Mostly true*	*Somewhat true/ somewhat false*	*Mostly false*	*Completely false*

(2) I've been told on a number of occasions that I'm not willing to compromise when confronted with a conflict situation.

Completely true	*Mostly true*	*Somewhat true/ somewhat false*	*Mostly false*	*Completely false*

(3) I am frequently disappointed in my partner/friends/kids/co-workers.

Completely true	*Mostly true*	*Somewhat true/ somewhat false*	*Mostly false*	*Completely false*

(4) I get impatient with people around me – they always mess up in one way or another.

Completely true	*Mostly true*	*Somewhat true/ somewhat false*	*Mostly false*	*Completely false*

(5) It seems that my partner (or friends, if you've never had a partner) always falls short of satisfying me. He or she always misses the little details and nothing is done just right.

Completely true	*Mostly true*	*Somewhat true/ somewhat*	*Mostly false*	*Completely false*

(6) With most tasks, I feel that there is a "right "way and a "wrong" way of doing them and I am not comfortable with alternative ways of getting them done.

Completely true	*Mostly true*	*Somewhat true/ somewhat false*	*Mostly false*	*Completely false*

(7) I have been told by people around me that I focus on the problems in life and if everything is okay, I will always find something that bothers me.

Completely true	*Mostly true*	*Somewhat true/ somewhat false*	*Mostly false*	*Completely false*

(8) I would rather work harder and do things myself then delegate tasks to other people.

Completely true	*Mostly true*	*Somewhat true/ somewhat false*	*Mostly false*	*Completely false*

(9) I expect nothing but the best from myself in whatever I do.

Completely true	*Mostly true*	*Somewhat true/ somewhat false*	*Mostly false*	*Completely false*

(10) Regarding huge moral issues like abortion and the death penalty, how easy is it for you to decide where you stand?

- *Very easy, such issues are black and white for me.*
- *I know where I stand, but there is always a little bit of grey area.*
- *My opinion varies – there is a lot of grey area.*
- *It is impossible for me to find my stance, there are way too many variable.*

These 10 questions attempt to evaluate whether you have tendencies towards perfectionism. Perfectionism is considered a characteristic of personality. All individuals exhibit perfectionistic traits at one time or another and to varying degrees, just as they would any other personality trait. However, when these personality traits are manifested to the extent that they become problematic – causing significant difficulties in occupational and social functioning – we consider the behaviour abnormal.

Because we are discussing personality characteristics/traits, the abnormal behaviour that we are witnessing is described as a Personality Disorder. The choice of what specific Personality Disorder it is depends on the personality trait(s) that is (are) causing the difficulties. The personality trait of perfectionism, for example, is the prominent personality trait that is presented in the extreme in Obsessive-Compulsive Personality Disorder.

Take a minute to think about the following:

How did you experience this questionnaire?

Was it easy to answer the questions or did you have to take some time and somehow try to achieve some degree of objectivity concerning your own behaviour in an attempt to answer the questions accurately?

Often it is much easier to answer questions like the ones above about other people we deal with in our everyday lives. It becomes tricky when we have to start describing our own behaviour. This shows you how little we consciously think about our own day to day behaviour and hopefully makes you somewhat aware of the underlying thoughts, beliefs, habits, values etcetera that motivate your behaviour. This "awareness" is also known as insight and we can, therefore, say that we do not always have insight into our own behaviour or personality. It is only when we make a conscious effort to consider and evaluate our own behaviour that we start fostering some degree of personal insight.

NB: Please take note that it does not mean that you suffer from an Obsessive-Compulsive Personality Disorder if you mostly agreed with the statements made in the 10 questions above. These questions were only evaluating your tendency towards perfectionism. These questions do NOT constitute a valid psychological test of perfectionism and should NOT be regarded as one! If you suspect that you, or someone you know, might be suffering from a Personality Disorder, you should contact a professional psychologist who is registered with the Health Professions Council of South Africa (HPCSA) and who has undergone the necessary training to diagnose and treat Personality Disorders. A list of registered psychologists can be obtained from the Health Professions Council of South Africa (HPCSA) and the Board of Psychology.

Activity 6.2

Scan-read chapter 15 (excluding the section under the heading “Dimensional Personality Assessment and the DSM-5 Alternative Personality Model” on page 494 to table 15.4 on page 499 of the prescribed book

6.1 STUDY UNIT: The Personality Disorders

After scan-reading the chapter you will no doubt have become aware that the Personality Disorders are quite a complex group of disorders. These disorders involve personality traits that are present in most, if not all, healthy functioning individuals and how these traits interact with each one of our unique environments. It involves those aspects that define us as unique individuals and determine how we interact, perceive and understand our world. One can just imagine how difficult it would be to recognise or admit that it is one's own personality, or traits thereof, that are at the root of the problems you are experiencing.

The Personality Disorders involve inflexible and maladaptive patterns of behaviour and inner experience that are pervasive, inflexible and stable over time. These behaviours produce personal and social difficulties, deviate markedly from the expectations of the individual's culture, and lead to distress and marked problems in functioning in society. Diagnosis is difficult because symptoms represent extremes of normal personality traits such as suspiciousness, dependency, sensitivity to rejection or compulsiveness. These disorders, furthermore, often overlap with other disorders and clinicians often do not adhere to diagnostic criteria when diagnosing the Personality Disorders.

The DSM-5 lists 10 Personality Disorders in three clusters. The clusters and Personality Disorders are:

- **Cluster A:** Odd or eccentric behaviour - (Paranoid, Schizoid and Schizotypal Personality Disorders)

- **Cluster B:** Dramatic, emotional or erratic behaviour - (Histrionic, Narcissistic, Antisocial and Borderline Personality Disorders)

- **Cluster C:** Anxious and fearful behaviour - (Avoidant, Dependent and Obsessive-Compulsive Personality Disorders)

Outcomes:
Once you have worked through study unit 6.1, you should be able to:

- define a Personality Disorder
- discuss the general characteristics of Personality Disorders
- discuss the difficulties experienced when trying to diagnose Personality Disorders
- critically discuss the role of factors such as culture, ethnicity, and gender in the aetiology of Personality Disorders

Study:
To be able to do the above you will need to study the introduction to this section in this tutorial letter and the following sections in the prescribed book:

- 'Read' the introduction to this chapter on pages 469 – 471
- Study the section **Introduction** in this Learning Unit in this tutorial letter
- Study the section on **Personality Disorders** in the Orientation to this Learning Unit in this tutorial letter and the sections titled "Personality Psychopathology" on pages 470 – 471 of the prescribed book.
- Study Mind map 6.1 in this tutorial letter.

Activity 6.3

Study the following DSM-5 diagnostic criteria for General Personality Disorder.

DSM-5 diagnostic criteria for General Personality Disorder

A An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
1. Cognition (i.e. ways of perceiving and interpreting self, other people, and events).
2. Affectivity (i.e. the range, intensity, lability, and appropriateness of emotional response).
3. Interpersonal functioning.
4. Impulse control.

B The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

F The enduring pattern is not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication) or another medical condition (e.g. head trauma).

(APA, 2013, pp. 646-649)

To study the different diagnostic criteria for the different Personality Disorders it is helpful to consider that the diagnostic criteria discussed above serve as general diagnostic criteria for all the Personality Disorders. In other words, each of these criteria is relevant to each of the specific Personality Disorders we will be studying throughout this chapter. Consider as example criterion A of the DSM-5 diagnostic criteria. Most of the discussions of the different Personality Disorders refer to this criterion. However, the way the specific general criterion is manifested in each of these different types of Personality Disorders will differ according to the nature of the specific Personality Disorder. Take for example criterion A:

First part of Criterion A:

An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture.

This criterion manifest in the different Personality Disorders in the following manner:

A pervasive pattern of …

Cluster A

- distrust and suspiciousness of others such as that their motives are interpreted as malevolent – **Paranoid Personality Disorder**
- detachment from social relationships and a restricted range of expression of emotions in interpersonal settings – **Schizoid Personality Disorder**
- social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities – **Schizotypal Personality Disorder**

Cluster B

- disregard for and violation of the rights of others – Antisocial Personality Disorder
- instability of interpersonal relationships, self-image, and affect, and marked impulsivity – **Borderline Personality Disorder**
- excessive emotionality and attention seeking – **Histrionic Personality Disorder**
- grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy – **Narcissistic Personality Disorder**

Cluster C

- social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation – **Avoidant Personality Disorder**
- excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation – **Dependant Personality Disorder**
- preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency – **Obsessive-compulsive Personality Disorder**

(Adapted from APA, 2013)

The above is merely an attempt to help you consider that the general criteria for Personality Disorders are relevant to all the different subtypes of Personality Disorders and that you should not consider the diagnostic criteria for the 10 subtypes of Personality Disorders as separate sets of criteria irrelevant to each other. If you keep the above discussion in mind whilst studying the different sets of diagnostic criteria for the 10 subtypes of Personality Disorders in the rest of this chapter, these sets of criteria will most likely be less confusing.

Activity 6.4

What are the main characteristic features of a Personality Disorder?

In your answer to this question, you should indicate your understanding that Personality Disorders are long-standing disorders, develop over a period of time and cause significant social and/or occupational difficulties. Individuals suffering from Personality Disorders have disturbed interpersonal relationships, are rigid in their thinking and behaviour, and seldom have insight into their problem. Note that although symptoms and characteristics of Personality Disorders may be present during childhood and adolescence, a diagnosis of a Personality Disorder is most often made if the individual is at least 18 years old. In rarer cases, the diagnosis of a Personality Disorder can be made in adolescence once all other disorders including Neurodevelopmental and Childhood Disorders that may account for the symptoms being manifested has been considered and eliminated. There are however one exception to this general rule and that is when making a diagnosis of Antisocial Personality Disorder. Antisocial Personality Disorder can only be diagnosed from 18 years of age. This is because another disorder occurring in childhood, namely Conduct Disorder (refer to Study Unit 6.5) has similar characteristic symptoms as Antisocial Personality Disorder which is diagnosed in adulthood. Therefore, if the conduct type symptoms fulfil the diagnostic criteria for Conduct Disorder and the individual is younger than 18 years of age, the diagnosis of Conduct Disorder is made. If the antisocial type symptoms endure after the individual turns 18 years old and the symptoms fulfil the diagnostic criteria for Antisocial Personality Disorder this diagnosis is then made. Once you have studied Study Units 6.3 and 6.5 you will understand the difference between these two different disorders.

Activity 6.5

Study the “Disorders Chart” (Table 15.1) on page 472 of the prescribed book. This table provide you with an overview of all the different subtypes of Personality Disorders. You will be expected to know the key features as well as the DSM-5 diagnostic criteria for all the specific Personality Disorders.

6.2 STUDY UNIT: Cluster A - Disorders characterised by odd or eccentric behaviour

This cluster consists of Paranoid Personality Disorder, Schizoid Personality Disorder and Schizotypal Personality Disorder. They all involve odd or eccentric behaviour. In Paranoid Personality Disorder this odd or eccentric behaviour involves unwarranted distrust and suspiciousness of others. In Schizoid Personality Disorder this involves social isolation, indifference and emotional coldness towards others. In Schizotypal Personality Disorder this involves peculiar thoughts and behaviours.

Outcomes
Once you have worked through study unit 6.2, you should be able to:

- list the specific Personality Disorders classified under cluster A
- define all of these specific Personality Disorders
- discuss the DSM-5 diagnostic criteria for each of these disorders

Study:
To be able to do the above you will need to study the following:

- the introduction to study unit 6.1 in this tutorial letter
- Paranoid Personality Disorder in activity 6.6 and pages 471 to 473 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Paranoid Personality Disorder in Activity 6.6
- Schizoid Personality Disorder on pages 473 to 474 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Schizoid Personality Disorder in Activity 6.8
- Schizotypal Personality Disorder on page 474 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Schizotypal Personality Disorder in Activity 6.9.

Activity 6.6

Paranoid Personality Disorder is characterised by distrust of others. People with this disorder wrongly believe that other people intend to harm them in some way. They are therefore cool towards other people and they interpret innocent actions of others as meant to harm them. They watch other people carefully to be prepared for actions that they could interpret as aimed against them. This attitude often leads to relationship problems.

Complement the information in Table 15.1 in your prescribed book with the more elaborate diagnostic criteria for Paranoid Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Paranoid Personality Disorder.

DSM-5 diagnostic criteria for Paranoid Personality Disorder

A A pervasive distrust and suspiciousness of others such as that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her,
(2) Preoccupation with unjustified doubts about the loyalty or trustworthiness of friends or associates,
(3) Reluctance to confide in others because of unwarranted fear that the information will be used maliciously against them,
(4) Reads hidden, demeaning or threatening meanings into benign remarks or events,
(5) Persistently bears grudges, that is, unforgiving of insults, injuries or slights
(6) Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or counterattack,
(7) Has recurrent suspicions, without justification, regarding the fidelity of spouse or sexual partner.

B Does not occur exclusively during the course of Schizophrenia, a Bipolar Disorder or Depressive Disorder with Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of another medical condition.

Note: If the criteria are met prior to the onset of Schizophrenia, add "premorbid" i.e. "Paranoid Personality Disorder (premorbid)." (APA, 2013, p. 649)

Activity 6.7

Read the following short case study.

(a) Discuss the characteristics typical of someone suffering from a Paranoid Personality Disorder, providing examples from the case study and referring to the DSM-5 diagnostic criteria for Paranoid Personality Disorder provided in activity 6.6.

(b) If you were the psychologist managing Peter's case, would you diagnose Peter's behaviour according to the DSM-5 classification system?

(c) Explain your answer to question (b).

Case study

Peter, an 85-year old retired businessman, was interviewed by a social worker to determine the health-care needs for himself and his bedridden wife. He had no history of treatment for a mental disorder. He appeared to be in good health and mentally alert. Peter and his wife had been married for 60 years, and it appeared that his wife was the only person he had ever really trusted. He had always been suspicious of others. He would not reveal personal information to anyone except his wife, believing that others were out to take advantage of him. He had also refused offers of help from acquaintances because he suspected their motives. When called on the phone he would refuse to give his name until he determined the nature of the caller's business. Peter had always involved himself in "useful work" to occupy his time, even during the 20 years of his retirement. He spends a good deal of time monitoring his investments and has had "run-ins" with his stockbroker when errors on his monthly statement prompted his suspicion that his broker was attempting to cover up fraudulent transactions.

(Adapted from Nevid, Rathus & Greene, 1994)

(a) An individual suffering from a Paranoid Personality Disorder exhibits a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent. These symptoms are long-standing, some symptoms are usually present from adolescence or early adulthood and present in a variety of situations. In Peter's case, he shows distrust and is suspicious of others. His wife is the only person he trusts. He will not reveal personal information to anyone (not even his name on the phone) except to his wife, because he believes that others have malevolent motives towards him. He suspects his stockbroker of fraud in mismanaging his funds and has had a series of run-ins with him. He shows rigidity in his behaviour and thoughts. We can accept that these symptoms are long-standing as Peter has always been distrustful and suspicious of others (except his wife).believing that others were out to take advantage of him. He had also refused offers of help from acquaintances because he suspected their motives. When called on the phone he would refuse to give his name until he determined the nature of the caller's business. Peter had always involved himself in "useful work" to occupy his time, even during the 20 years of his retirement. He spends a good deal of time monitoring his investments and has had "run-ins" with his stockbroker when errors on his monthly statement prompted his suspicion that his broker was attempting to cover up fraudulent transactions (adapted from Nevid, Rathus & Greene, 1994).

(b) A diagnosis of a Paranoid Personality Disorder can be made in Peter's case. He shows a pervasive distrust and suspiciousness of others and misinterprets their motives as malevolent (e.g. his broker and acquaintances that offer their assistance). These symptoms have been present throughout most of Peter's life and presents in a variety of contexts. According to the criteria, Peter's abnormal (paranoid) behaviour must occur in four (or more) situations/contexts. This is true as Peter suspects, without sufficient basis, that others are exploiting, harming, or deceiving him (e.g. his broker). He also shows a preoccupation with unjustified doubts about the loyalty or trustworthiness of friends or associates (declines offers of help, as he is suspicious of their motives). Peter shows reluctance to confide in others because of unwarranted fear that the information will be used maliciously against him (his wife is the only person Peter trusts to an extent). Peter also reads hidden, demeaning or threatening meanings into benign remarks or events such as Peter's accusing his broker of trying to cover up fraudulent transactions after he found errors on his monthly statement. Peter does not suffer from Schizophrenia, a Mood Disorder with Psychotic Features, or another Psychotic Disorder and his symptoms are not due to the direct physiological effects of a general medical condition.

(c) The diagnosis of a Paranoid Personality Disorder will be made according to the DSM-5 classification system. Peter's behaviour is severe enough to cause interpersonal conflict, his problematic personality functioning is longstanding and he manifests more than four symptoms that meet the DSM-5 diagnostic criteria for Paranoid Personality Disorder.

Activity 6.8

Individuals with Schizoid Personality Disorder are typically loners that have no interest in developing social relationships with others. These individuals do not have good friends, are unable to express their feelings, and are seen by others as cold and indifferent. They mostly have solitary interests and occupations and seldom get married. If they are required to interact with others, such as in a work context, their interactions are superficial and limited.

Complement the information in Table 15.1 in your prescribed book with the more elaborate diagnostic criteria for Schizoid Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Schizoid Personality Disorder.

DSM-5 diagnostic criteria for Schizoid Personality Disorder

A Pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) Neither desires nor enjoys close relationships, including being part of a family
(2) Almost always chooses solitary activities
(3) Has little, if any, interest in having sexual experiences with another person
(4) Takes pleasure in few, if any, activities.
(5) Lacks close friends or confidants other than first-degree relatives
(5) Appears indifferent to the praise or criticism of others
(6) Shows emotional coldness, detachment, or flattened affectivity

B Does not occur exclusively during the course of Schizophrenia, a Bipolar Disorder or Depressive Disorder with Psychotic Features, or another Psychotic Disorder, or Autism Spectrum Disorder and is not attributable to the physiological effects of another medical condition.

Note: If the criteria are met prior to the onset of Schizophrenia, add "premorbid" i.e. "Schizoid Personality Disorder (premorbid)."

(APA, 2013, pp. 652-653)

Activity 6.9

As in the case of individuals with Schizoid Personality Disorder, individuals with Schizotypal Personality Disorder are also excessively introverted and show interpersonal deficits. However, in addition to these symptoms they also manifest peculiarities and oddities in speech and behaviour.

Schizotypal Personality Disorder is discussed very briefly in your prescribed book on page 474. Complement this information with the more elaborate diagnostic criteria for Schizotypal Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Schizotypal Personality Disorder.

DSM-5 diagnostic criteria for Schizotypal Personality Disorder

A A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Ideas of reference (excluding delusions of reference)
(2) Odd beliefs or magical thinking that influences behaviour and is inconsistent with subculture norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
(3) Unusual perceptual experiences, including bodily illusions
(4) Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
(5) Suspiciousness or paranoid ideation
(6) Inappropriate or constricted affect
(7) Behaviour or appearance that is odd, eccentric, or peculiar
(8) Lack of close friends or confidants other than first-degree relatives
(9) Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

B	Does not occur exclusively during the course of Schizophrenia, a Bipolar Disorder or Depressive Disorder with Psychotic Features, or another Psychotic Disorder or Autism Spectrum Disorder.

Note: If the criteria are met prior to the onset of Schizophrenia, add "premorbid" i.e. "Schizotypal Personality Disorder (premorbid)."

(APA, 2013, pp. 655-656)

6.3 STUDY UNIT: Cluster B - Disorders characterised by dramatic, emotional or erratic behaviour

This cluster consists of Antisocial Personality Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder and Histrionic Personality Disorder. They all involve odd or eccentric behaviour. In Antisocial Personality Disorder, these behaviours lean toward the erratic behaviour involving aspects such as a failure to conform to social norms, lack of guilt and anxiety and irresponsible behaviours. In Borderline Personality Disorder, this involves more the emotional and erratic behaviours involving intense fluctuations in mood, self-image and interpersonal relationships. In Narcissistic Personality Disorder, these behaviours involve exaggerated self-importance, lack of empathy and exploitative behaviour regarding others. Lastly, in Histrionic Personality Disorder the dramatic and emotional are predominant involving self-dramatization, excessive emotional expressions and attention-seeking behaviours.

Outcomes
Once you have worked through study unit 6.3, you should be able to:

- know which Personality Disorders are classified under cluster B;
- define all of these disorders;
- discuss the DSM-5 diagnostic criteria for each of these disorders;
- explain Antisocial Personality Disorder according to the Multipath Model;
- contribute to a primary prevention programme aimed at preventing the development of Antisocial Personality Disorder in your community.

Study
To be able to do the above you will need to study the introduction to this study unit in this Study Guide as well as the following sections in the prescribed book:

- Antisocial Personality Disorder on pages 475 to 477 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Antisocial Personality Disorder in activity 6.10
- Borderline Personality Disorder on pages 477 to 479 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Borderline Personality Disorder in activity 6.13
- Histrionic Personality Disorder on pages 479 to 481 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Histrionic Personality Disorder in activity 6.14
- Narcissistic Personality Disorder on pages 481 to 482 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Narcissistic Personality Disorder in activity 6.15
- Multipath Model for Antisocial Personality Disorder and Figure 15.1 on pages to 486 of the prescribed book:
  - Biological Dimension
  - Psychological Dimension
  - Social Dimension
  - Sociocultural Dimension.

Activity 6.10

Antisocial Personality Disorder is also known as psychopathy or sociopathy and the general population often calls the individual suffering from this disorder "a psychopath". This disorder and individuals suffering from it have been the topic of many horror films and books.

This disorder is characterised by a pervasive pattern of disregard for and the violation of the rights of others. These symptoms begin in childhood or early adolescence and continue into adulthood. Deceit and manipulation, to gain personal advantage, are core features of this disorder and the individuals fail to conform to social norms with respect to lawful behaviour. They disregard the wishes, rights and feelings of others and repeatedly lie and con others. They act impulsively and fail to consider the consequences of their actions. They show disregard for the safety of themselves or others, and tend to be consistently and extremely irresponsible. They may be indifferent to having hurt, mistreated or stolen from others and may blame their victims for being foolish or helpless or as deserving their fate. They generally fail to compensate or make amends for their behaviour and seem unable to learn from their mistakes.

The DSM-5 diagnostic criteria for Antisocial Personality Disorder are discussed very briefly in your prescribed book. Complement this information with the more elaborate diagnostic criteria for Antisocial Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Antisocial Personality Disorder.

DSM-5 diagnostic criteria for Antisocial Personality Disorder

A There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

(1) Failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
(2) Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
(3) Impulsivity or failure to plan ahead
(4) Irritability and aggressiveness, as indicated by repeated physical fights or assaults
(5) Reckless disregard for the safety of self or others
(6) Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
(7) Lack of remorse, as indicated by being indifferent to or rationalising having hurt, mistreated, or stolen from another

B The individual is at least age 18 years.

C There is evidence of Conduct Disorder with onset before age 15 years.

D The occurrence of antisocial behaviour is not exclusively during the course of Schizophrenia or Bipolar Disorder.

(APA, 2013, p. 659)

Activity 6.11

Read the following case study and

(a) diagnose Pieter's abnormal behaviour according to the DSM-5 classification system.

(b) justify your diagnosis in question (a) by referring to examples from the case study.

(c) explain Pieter's personality functioning according to the Multipath Model.

Case Study

The child's scream sliced through Pieter's nap, waking him abruptly. He looked through the window to see his girlfriend Dina pleading with her three-year-old son to get out of the car and come into the house. "Fine, just sit in the car for all I care," yelled Dina storming into the house.

Seeing Pieter standing in the hall, Dina started to complain about her son who continued to whine in the front seat. Before she could say anything, Dina found herself on the floor, her jaw aching and the taste of blood in her mouth. It took her a second to realise that Pieter had just hit her across the face.

Now he stood over her, berating her as a parent. Stupid bitch. "You can't even take care of your own stupid kid," Pieter shouted. Dina tried to get up but Pieter put his foot on her chest, holding her down. Angry now, Dina dug her nails into Pieter's foot until he yelped in pain and staggered backwards. Dina seized the moment to run for the door. Dina knew she had to get away. Dina knew that Pieter was a maniac when he was like this. She hesitated at the car door fumbling for her keys. Tackled from behind, she slammed into the car. Dina felt her arm snap from the impact. She fell to the ground and closed her eyes as her boyfriend kicked and punched her in a fit of rage. Sometime later, Dina came to, her head, arm and ribs throbbing in pain. "Why am I at the hospital?," she wondered before realising that Pieter, after beating her up, had driven her to the emergency room. "Oh man, here we go again," thought Dina before wincing from a new ache in her hip. As a doctor and a kind nurse Dina had met before tended to her wounds, they asked what had happened. Dina concocted a story about falling from her bicycle. She noticed the subtle glance exchanged between her two caretakers and knew they did not believe her. The doctor suggested that her description of what happened did not match the type of injuries she had and the nurse urged her to tell them what really had happened.

Dina stuck to her story despite the fact that everyone knew that she was lying. It wasn't the first time she had had to endure this type of inquisition and to herself she cursed Pieter for humiliating her like this. After several hours, Dina walked out to the parking lot to look for Pieter. She found him asleep in the car.

Pieter woke up as Dina climbed in the passenger seat. She could tell that he was high on something, probably the dagga he loved to smoke.

"How are you, babe?" asked Pieter concerned. He was always like this after he hit her and Dina knew as he stared at the bright new cast on her arm that several good days would come out of this as he tried to make it up to her.

"I'm OK", she replied. "Where's Max?" she asked, referring to her son. He's at your sister's house," Pieter replied. She will be watching him while we go to Botswana for a couple of days. "I figure you deserve a holiday." It was then that Dina noticed the camping gear in the back seat. She realised once again that Pieter wasn't taking her to Botswana to be nice but was going instead to buy some more drugs. She knew these trips of Pieter's all too well. On several previous occasions Pieter had borrowed his mother's credit card stating that he needed to buy food and clothes but instead withdrew huge amounts from her savings and used the money to travel to Botswana to buy drugs. Dina smiled weakly, closed her eyes and said, "OK, let's go."

Several days and three drug deals later, Dina and Pieter returned to South Africa. Both of them were high on crack cocaine and the minute they walked in the front door Pieter started yelling at Dina about what a lousy mother she was. The conflict escalated until Dina retorted that Pieter's mother was lousy too. The minute the words escaped her mouth, she knew that she had gone too far.

Suddenly, Pieter became eerily calm. He walked back to the kitchen and returned with a knife. Dina's eyes widened in fear and she lunged for the door. Pieter followed her and managed to stab her twice before Dina could free herself and get outside. She was able to drive herself back to the emergency room where she told the nurse that her boyfriend had tried to kill her.

Pieter was arrested later that day and charged with domestic violence, assault, possession of illegal drugs and attempted murder. He was eventually found guilty on all counts. During the sentencing phase of his trial, the court requested that a psychological evaluation be conducted in order to assist the court in determining the appropriate placement and any treatment needed. A psychologist was appointed and Pieter was evaluated over a period of several days. As part of the evaluation, the psychologist asked Pieter a number of questions about his life. Because of the circumstances under which the assessment was done and because of Pieter's tendency to lie, the psychologist also obtained information from police reports, Dina's court testimony, probation reports, school records and interviews with Pieter's mother and other relatives. Pieter was born in Johannesburg. He has an older brother who has a history of offences related to drug abuse. His parents divorced when Pieter was a toddler but not before he had both witnessed and fallen victim to his father's physical abuse. His mother took him and his brother to Durban to get away from the father. After several years, the father found them and kidnapped the two boys from school. The police located him several weeks' later living in a hotel with his two sons. Pieter and his brother were malnourished, dirty and bruised from being beaten.

Pieter and his brother returned to live with their mother. She and her friends drank heavily and abused drugs and it was not long before Pieter began using drugs as well. While still in primary school, he began failing classes, fought frequently with his peers and often was truant. He was expelled from two schools and placed in special classes for the severely emotionally disturbed.

Pieter's mother tried to get help for her son through the school system. She was referred to a counsellor but was inconsistent in keeping appointments. At one point, Pieter was diagnosed with Attention-Deficit Hyperactivity Disorder but his mother refused to let her son take medication. Despite all Pieter's behavioural problems, his mother stood by him, defending him as best she could.

Pieter was first arrested at the age of 12 for shoplifting. His mother convinced the shop owner to drop the charges by paying for the missing items and promising to keep her son out of the store. The shoplifting continued, however, and by the age of 14, Pieter and his friends were breaking into houses in their neighbourhood. When some of his friends got arrested Pieter ran away from home and went back to Johannesburg, supporting himself by stealing and selling drugs. He had long since abandoned school. Following an assault on a shopping mall security guard who caught him stealing, Pieter was placed in a residential facility for juvenile offenders. At the facility, Pieter managed to befriend many of the caretakers and was soon placed in positions of responsibility where he had access to the storerooms.

He started stealing provisions like cigarettes and sweets and sold them to the other boys. When the authorities started noticing that provisions were being stolen Pieter managed to manipulate the situation in such a way that one of the other boys got the blame and was subsequently sent to jail. Pieter remarked smilingly to a fellow student that "that would teach that fool to bad-mouth me".

Pieter was released from the facility on his 18th birthday. He continued to live a transient lifestyle, supporting himself primarily by selling drugs. He spent much of his time in Johannesburg, living with his mother who had since moved back there, and Botswana, transporting drugs between Botswana and South Africa. He had several minor arrests as an adult including driving under the influence, weapon possessions and violation of probation that resulted in several months of prison time.

Although Pieter made good money selling drugs, he could never hang on to it. On several occasions he stole money from his mother and once even manipulated her into signing for a loan to buy a luxury 4x4 truck. He convinced his mother he needed it for his business trips to Botswana but in the end never repaid the loan and so his mother had to use the last of her savings to repay it. After this incident, his mother's house was repossessed, as she had no money left to make the payments. She moved into a small room at the Salvation Army's facility for the aged.

Good looking and charming, Pieter always seemed to be able to find some woman whom he could convince to move in. Although he was often abusive to these women, his generosity, his sense of fun

and adventure and his ability to seduce them with his promises to change and his tales of being victimised himself often won them back. His relationships were short-lived, however, and it was not uncommon for Pieter to be involved with more than one woman at a time. At the time of his arrest for attempted murder, he was 26 years old.

(Adapted from Clipson & Steer, 1998)

(a) Pieter's abnormal behaviour should be diagnosed as:
Cannabis Use Disorder and Cocaine Use Disorder
Antisocial Personality Disorder
Educational problems (low level literacy, never finished schooling, discord with teachers and fellow students)
Partner Violence, Physical and Psychological
Problems related to other Legal Circumstances and Imprisonment (multiple arrests)
Child Physical Abuse, Confirmed.

(b) Pieter abuses marijuana (cannabis) and crack cocaine. Pieter also qualifies for a diagnosis of Antisocial Personality Disorder by displaying at least three of the seven possible symptoms since the age of 15. He is now 26 years old and thus over the minimum age of 18 years at which a diagnosis of a Personality Disorder can be made. He has failed to conform to social norms by repeatedly engaging in illegal activities, selling drugs in particular. He engages in a pattern of consistent deceitfulness, lying in order to meet his needs. He is impulsive, acting without regard for the consequences of his behaviour. He is also prone to aggressiveness and irritability, is quick to anger and resolves most fights with violence. Pieter shows reckless disregard for his own safety as well as that of others (for example, his attack on Dina). He shows consistent irresponsibility by not supporting himself and manipulating others to take care of him. He furthermore shows a lack of remorse for his actions, often making up excuses for his offences.

Educational problems (low literacy level as he never finished schooling, discord with teachers and fellow students)

Partner Violence, Physical and Psychological (Pieter has repeatedly abused Dina both physically – for example assault and injury and psychologically – for example berating her as a parent and calling her derogatory names).

Problems related to other Legal Circumstances and Imprisonment (multiple arrests and imprisonment)

Child Physical Abuse, Confirmed (Pieter was abused by his father who e.g. beat him and caused him to be malnourished)

(c) Important here is to consider all the possible dimensions in Pieter's life and how these dimensions interact and combine to eventually produce the Antisocial Personality Disorder which Pieter manifests. Biological dimensions (such as genetic factors, CNS abnormalities, autonomic nervous system abnormalities), psychological dimensions (such as psychodynamic theory of weakened superego, and cognitive theory of extreme core beliefs), social dimensions (such as parental supervision and involvement, hostile home environment, and role modelling) and sociocultural dimensions (such as gender influences, cultural values), should be considered and how these dimensions play out in Pieter's life. If you are still unsure of the Multipath Model refer to Chapter 2 of your prescribed book where this model is discussed in great detail.

Activity 6.12

According to a research paper published in the British Journal of Psychiatry, early identification and intervention of/with children manifesting conduct problems might be effective in preventing the later development of Antisocial Personality Disorder in many of these children (Hill 2003, pp. 11–14).

Imagine you are the teacher or counsellor at your local school in which there are many conduct problems involving a majority of the learners. The school has been experiencing problems with regard to gangs being formed and gang-related conduct problems. The principal is committed to providing every learner in his school the best possible chance for future life success and approaches you to develop a prevention programme in an attempt to prevent these conduct behaviour problems from becoming a way of life (read Antisocial Personality Disorders from developing) later in the life of these learners.

Primary prevention can be described as "an effort to lower the incidence of new cases of behavioural disorders by strengthening or adding to resources that promote mental health and by eliminating community characteristics that threaten mental health" (Sue et al., 2006, p. 589). With this description of primary prevention in mind, as well as considering the information you have studied in activity 6.10 and 6.11(c) regarding the Multipath Model of Antisocial Personality Disorder, reflect how you would go about developing a primary prevention programme for your school? What other factors (e.g. substance use) would you consider in developing your programme? How would you obtain the "buy in" from the learners for which this programme is being developed? What other resources in your community could you incorporate or approach in becoming involved in your programme?

Activity 6.13

Individuals with Borderline Personality Disorder show a pattern of behaviour characterised by impulsivity and instability in interpersonal relationships, self-image and moods. Interpersonal relationships tend to be intense but stormy and these individuals tend to see others as either "all good" or "all bad". These individuals' impulsivity combined with their mood instability may often lead to erratic self-destructive behaviours such as gambling sprees, reckless driving, suicide attempts and self-mutilation (cutting).

The DSM-5 diagnostic criteria for Borderline Personality Disorder are discussed briefly in your prescribed book. Complement this information with the more elaborate diagnostic criteria for Borderline Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Borderline Personality Disorder.

DSM-5 Diagnostic criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5
(2) A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
(3) Identity disturbance: markedly and persistently unstable self-image or sense of self
(4) Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5)
(5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
(6) Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
(7) Chronic feelings of emptiness
(8) Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
(9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

(APA, 2013, p. 663)

Activity 6.14

Individuals with Histrionic Personality Disorder need to be the centre of attention otherwise they feel unappreciated and they thus manifest behaviour to attract others' attention and interest in them. These behaviours involve dramatic and excessive extroverted behaviour, emotional expressions and often inappropriate sexually seductive behaviour.

The DSM-5 diagnostic criteria for Histrionic Personality Disorder are discussed briefly in your prescribed book. Complement the information in the prescribed book with the more elaborate diagnostic criteria for Histrionic Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Histrionic Personality Disorder.

DSM-5 Diagnostic criteria for Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Is uncomfortable in situations in which he or she is not the centre of attention
(2) Interaction with others is often characterised by inappropriate sexually seductive or provocative behaviour
(3) Displays rapidly shifting and shallow expression of emotions
(4) Consistently uses physical appearance to draw attention to self
(5) Has a style of speech that is excessively impressionistic and lacking in detail
(6) Shows self-dramatization, theatricality, and exaggerated expression of emotion
(7) Is suggestible, (i.e. easily influenced by others or circumstances)
(8) Considers relationships to be more intimate than they actually are.

(APA, 2013, p. 667)

Activity 6.15

Individuals with Narcissistic Personality Disorder exhibit an exaggerated sense of self-importance; have an excessive need to be admired while lacking empathy for the feelings and perspectives of others. These individuals believe they are superior to others and often use self-references and bragging to gain the acclaim they believe they deserve. When others do not provide them with the admiration and validation, they expect they may turn to being hypercritical and even retaliate towards the individuals they believe has slighted them.

The DSM-5 diagnostic criteria for Narcissistic Personality Disorder are discussed briefly in your prescribed book. Complement this information with the more elaborate diagnostic criteria for Narcissistic Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Narcissistic Personality Disorder.

DSM-5 Diagnostic criteria for Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Has a grandiose sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognised as superior without commensurate achievements)
(2) Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
(3) Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
(4) Requires excessive admiration
(5) Has a sense of entitlement, (i.e. unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations)
(6) Is interpersonally exploitative, (i.e. takes advantage of others to achieve his or her own ends)
(7) Lacks empathy: is unwilling to recognise or identify with the feelings and needs of others
(8) Is often envious of others or believes that others are envious of him or her
(9) Shows arrogant, haughty behaviours or attitudes

(APA, 2013, pp. 669-670)

6.4 STUDY UNIT: Cluster C - Disorders characterised by anxious or fearful behaviour

This cluster consists of Avoidant Personality Disorder, Dependent Personality Disorder and Obsessive-compulsive Personality Disorder. They all involve anxious or fearful behaviour. In Avoidant Personality Disorder, these behaviours involve a fear of rejection and humiliation and therefore a reluctance to enter into social relationships. In Dependent Personality Disorder, the individual fears that they will not be able to cope on their own and therefore is completely reliant on others, even if it is to their own detriment. In Obsessive-compulsive Personality Disorder, the fearful or anxious behaviours involve exaggerated aspects of perfectionism, devotion to detail and rigidity.

Outcomes
Once you have worked through study unit 6.4, you should be able to:

- know which Personality Disorders are classified under cluster C;
- define all of these disorders;
- discuss the DSM-5 diagnostic criteria for each of these disorders;
- differentiate between Obsessive-compulsive Personality Disorder and Obsessive-compulsive Disorder;
- distinguish between the different subtypes of Personality Disorders.

Study
To be able to do the above you will need to study the introduction to this study unit in this Study Guide as well as the following sections in the prescribed book:

- Avoidant Personality Disorder on pages 483 to 484 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Avoidant Personality Disorder in activity 6.16
- Dependant Personality Disorder on pages 484 to 485 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Dependant Personality Disorder in activity 6.17
- Obsessive-Compulsive Personality Disorder on pages 485 to 486 and Table 15.1 on page 472 of the prescribed book
- DSM-5 diagnostic criteria for Obsessive-Compulsive Personality Disorder in activity 6.18.

Activity 6.16

Individuals with Avoidant Personality Disorders are socially isolated, introverted, and reluctant to enter into social relationships because of their fear of rejection and criticism. This social isolation and introversion might remind you of individuals with Schizoid Personality Disorder you studied in Study unit 6.2. However, these two disorders are very distinguishable.

Schizoid Personality Disorder falls in Cluster A of the Personality Disorders characterised by odd, eccentric or erratic behaviour. The individual with Schizoid Personality Disorder does not have a need for interpersonal or social relationship so they do not actively seek out these interactions. They prefer their isolated situation and are fine on their own (note the odd and eccentric behaviour). However, Avoidant Personality Disorder falls in Cluster C of the Personality Disorders characterised by anxious and fearful behaviour. Individuals with Avoidant Personality Disorder do have the need for interpersonal and social relationships but avoid these because of their fear of being rejected, criticised or humiliated (note the fearful and anxious behaviour). They therefore experience distress regarding their social isolation.

The DSM-5 diagnostic criteria for Avoidant Personality Disorder are discussed briefly in your prescribed book. Complement this information with the more elaborate diagnostic criteria for Avoidant Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Avoidant Personality Disorder.

DSM-5 Diagnostic criteria for Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
(2) Is unwilling to get involved with people unless certain of being liked
(3) Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
(4) Is preoccupied with being criticised or rejected in social situations
(5) Is inhibited in new interpersonal situations because of feelings of inadequacy
(6) Views self as socially inept, personally unappealing, or inferior to others
(7) Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

(APA, 2013, pp. 672-673)

Activity 6.17

Dependent Personality Disorder is characterised by a pervasive and excessive need to be taken care of and this leads to submissive and clingy behaviour, often to the extent that sufferers endure emotional and physical abuse and subordinate their needs to those of the person on whom they are dependent. The person fears separation that will in effect mean that he or she must function alone and independently. The individual lacks self-confidence and has difficulty making everyday decisions. These individuals perceive themselves as unable to function adequately without the help of others.

The DSM-5 diagnostic criteria for Dependent Personality Disorder are discussed briefly in your prescribed book. Complement this information with the more elaborate diagnostic criteria for Dependent Personality Disorder as proposed by the DSM-5 classification system (APA, 2013). Study the DSM-5 criteria for making a diagnosis of Dependent Personality Disorder.

DSM-5 diagnostic criteria for Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
(2) Needs others to assume responsibility for most major areas of his or her life
(3) Has difficulty expressing disagreement with others because of fear of loss of support or approval. (Note: Do not include realistic fears of retribution).
(4) Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgement or abilities rather than a lack of motivation or energy)
(5) Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
(6) Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
(7) Urgently seeks another relationship as a source of care and support when a close relationship ends
(8) Is unrealistically preoccupied with fears of being left to take care of himself or herself.

(APA, 2013, p. 675)

Activity 6.18

Individuals with Obsessive-Compulsive Personality Disorders have an excessive concern for order and control. They are perfectionistic to the degree that it impacts negatively on their work functioning as they are so preoccupied with order, control, rules and schedules that they become stuck on the details and have a difficult time seeing the larger picture and completing the task. They have difficulty delegating tasks, are stubborn and rigid and are perceived by others as demanding and emotionally cold.

The section in your prescribed book on Obsessive-compulsive Personality Disorder is not comprehensive enough and therefore you should, study the following diagnostic criteria for Obsessive-Compulsive Personality Disorder as suggested by the DSM-5 classification system (APA, 2013).

DSM-5 Diagnostic criteria for Obsessive-Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) Is preoccupied with details, rules, lists, order, organisation, or schedules to the extent that the major point of the activity is lost
(2) Shows perfectionism that interferes with task completion (e.g. is unable to complete a project because his or her own overly strict standards are not met)
(3) Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
(4) Is over overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
(5) Is unable to discard worn-out or worthless objects even when they have no sentimental value
(6) Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
(7) Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes

(8) Shows rigidity and stubbornness.

(APA, 2013, pp. 678-679)

Activity 6.19

What is the difference between Obsessive-Compulsive Personality Disorder (OCPD) and Obsessive-Compulsive Disorder (OCD)?

Note that Obsessive-Compulsive Personality Disorder is a Personality Disorder whereas Obsessive-Compulsive Disorder is a separate diagnosable disorder under the section Obsessive-Compulsive and Related Disorders according to the DSM-5 classification system. If you are unclear regarding OCD refer to chapter 5 of the prescribed book and Learning Unit 7 in the Study Guide. Also, refer to the "Did you know?" table on page 486 of the prescribed book as well as to the discussion regarding the differentiation between these two disorders in the section on Obsessive-Compulsive Personality Disorder on pages 485 to 486.

Activity 6.20

Common to all Personality Disorders is a pattern of disturbed interpersonal relationships.

Discuss how interpersonal relationships might be disturbed in each of the subtypes of Personality Disorders given what you now know about Personality Disorders in general as well as regarding the nature and core features of the different subtypes of Personality Disorders.

The Schizoid Personality Disorder is characterised by an inability to form social relationships and a lack of interest in doing so. Individuals with Schizoid Personality Disorder are unable to express feelings and others see them as cold and distant. These individuals lack social skills and are loners with solitary interests and occupations. In general, this Personality Disorder is characterised by an inability to form attachments to other people. When individuals with Schizoid Personality Disorder are forced to relate to others, such as in work situations, their relationships are superficial and frequently awkward. This reminds us of the Narcissistic Personality Disorder, which also shows only superficial relationships but the dynamics are different. The person with a Schizoid Personality Disorder has superficial relationships, because he or she does not desire close relationships, whereas the individual with Narcissistic Personality Disorder has superficial relationships due to his or her feelings of grandiosity and self-importance. The individual with Schizoid Personality Disorder also tends to comply with the requests or feelings of others in an attempt to avoid extensive involvements and conflicts. This compliance is also found in the Dependent Personality Disorder but it is because of the individual's fear that if he or she were not to comply with others, they would leave him or her.

Individuals with Dependent Personality Disorder show extreme dependence on other people and acute discomfort (panic) at having to be alone. They usually build their lives around other people and subordinate their own needs to keep these people involved with them. They may tolerate emotional and physical abuse in order to avoid being abandoned. They have such low self-confidence that they passively allow other people to take over major decisions in their lives. They function well as long as they are not required to be on their own. These individuals usually appear selfless and understanding since they feel they have no right to express even mild individuality and lack the self-confidence to do so.

Individuals with Avoidant Personality Disorder are hypersensitive to rejection and any sign of social derogation. Common is a lifelong pattern of limited social relationships and reluctance to enter into social interactions. They readily see ridicule and disparagement where none was intended. They are too fearful of criticism and of being rebuffed to seek out other people. Yet they desire affection and are often lonely and bored. Unlike individuals with Schizoid Personality Disorder, they do not enjoy their loneliness. Their inability to relate comfortably to other people causes distress and low self-esteem. They tend to avoid situations in which they might be embarrassed and only enter into social interaction if they are guaranteed unconditional

acceptance. The Avoidant Personality Disorder is distinguished from the Schizoid Personality Disorder by the fact that the person with Avoidant Personality Disorder is described as being hypersensitive, shy and insecure, while the person with a Schizoid Personality Disorder is characterised as being aloof and cold. Whereas the person with a Schizoid Personality Disorder prefers his or her loneliness, the person with an Avoidant Personality Disorder desires affection and does not enjoy his or her loneliness. The difference between the Dependent and Avoidant Personality Disorders is that whereas the former has great difficulty separating in, and from, relationships, and the latter has difficulty initiating them.

Individuals with a Narcissistic Personality Disorder are unable to trust (whereas the person with a Paranoid Personality Disorder mistrusts) and rely on others and therefore develop many shallow relationships in which they expect to be the superior participant. These individuals are preoccupied with receiving attention and recognition from others. Their sense of entitlement is frequently a source of astonishment to others and they behave in stereotypical ways (e.g. bragging) to gain recognition from others to feed their own sense of grandiosity. They seldom permit others to be genuinely close to them or to become dependent on them. These individuals show an impaired capacity for a committed relationship that differs from the inability of the person with Schizoid Personality Disorder in as much as the latter does not necessarily want relationships while the former needs constant recognition and admiration from others. This need for recognition from others also differs from the recognition needed by the person with Dependent Personality Disorder. The person with Narcissistic Personality Disorder needs others to recognise his or her own greatness, whereas the person with Dependent Personality Disorder needs constant recognition from others to ensure him or her of their total commitment. The person with Narcissistic Personality Disorder is unable to take others' perspective and thus only sees things through his or her own eyes. This lack of empathy makes mature relationships difficult if not impossible.

The individual suffering from Paranoid Personality Disorder is suspicious, hypersensitive, rigid, envious and argumentative, which places a lot of strain on interpersonal relationships. The nature of the hypersensitivity of the person with Paranoid Personality Disorder differs from the hypersensitivity of the person with Avoidant Personality Disorder. In the former, the hypersensitivity is due to suspiciousness and the belief that others have evil/damaging intentions whereas the latter's hypersensitivity is due to the fear of being criticised or ridiculed. Individuals with Paranoid Personality Disorder tend to see themselves as blameless, finding the reason for their own mistakes and failures in others. They even go as far as to assign evil motives to others. In their relationships they constantly expect trickery and look for clues to validate their expectations. They are envious of those in high ranks and disdainful of those who seem weak or soft. They may demonstrate restricted affect (being aloof and lacking emotion). This pervasive suspiciousness and mistrust of other people leave individuals with Paranoid Personality Disorder prone to numerous difficulties and hurts in interpersonal relationships.

6.5 STUDY UNIT: Disruptive, Impulse-Control and Conduct Disorders

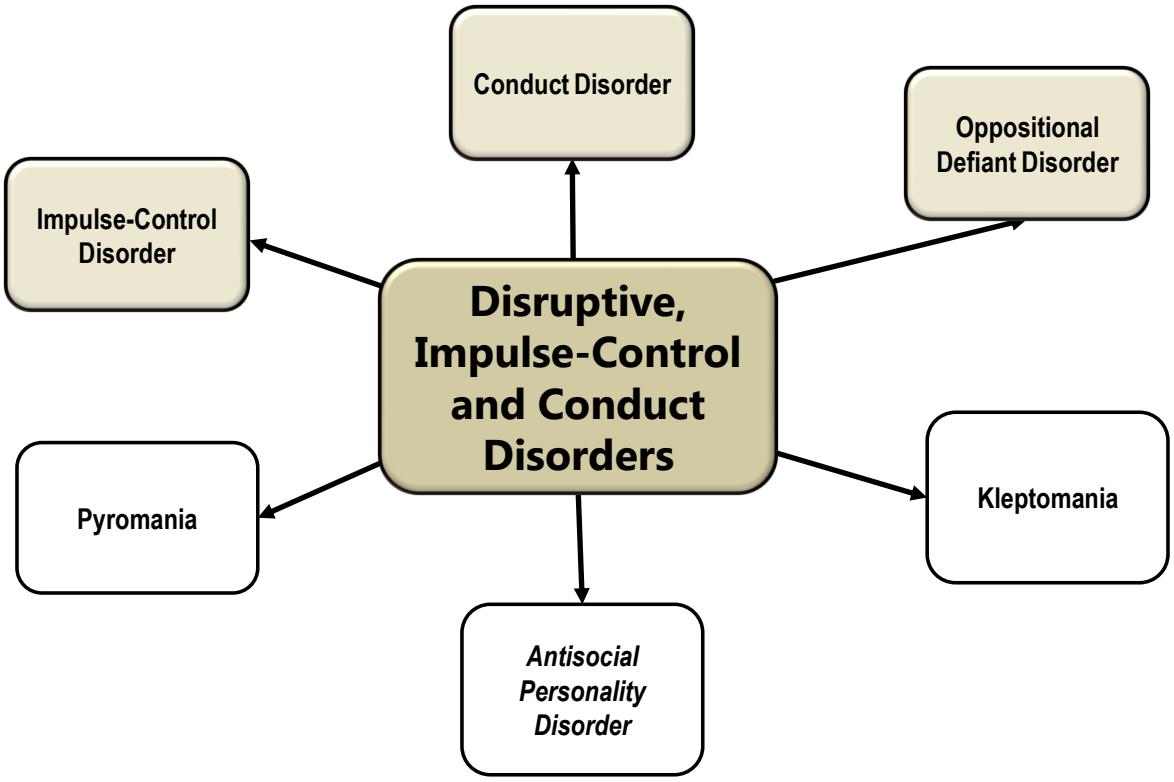
Introduction

The Impulse Control Disorders constitute a separate, independent category of disorders according to the DSM-5 classification system. According to the DSM-5, Impulse Control Disorders fall in the category of "Disruptive, Impulse-Control and Conduct Disorders". These disorders do **not** form part of the Personality Disorders. In your prescribed book, the Impulse Control Disorders are noted in Table 15.2 on page 477 in the same chapter as the Personality Disorders because of the similar characteristic of impulsivity.

Disruptive, Impulse-Control and Conduct Disorders involve problems in the self-control of emotions and behaviours and are manifested in behaviours that violate the rights of others. And or that bring the individual into significant conflict with societal norms or authority figures.

NOTE: Although Antisocial Personality Disorder falls under the Personality Disorders it is also categorised under the Disruptive, Impulse-Control and Conduct Disorders due to the nature of the impulsive, disruptive and antisocial behaviour that is exhibited in this disorder. According to the DSM-5 (APA, 2013, p. 476), Antisocial Personality Disorder is dual coded due to its close connection to the spectrum of "externalising" conduct disorders under Disruptive, Impulse-Control and Conduct Disorders, as well as under Personality Disorders. As Antisocial Personality Disorder was discussed previously in this Learning Opportunity, it will not be repeated here.

Mind map 6.2 below shows an overview of the information regarding Disruptive, Impulse-Control, and Conduct Disorders you will study in this Learning Unit:



Disorders that fall into this DSM-5 diagnostic category include:

- Intermittent Explosive Disorder
- Pyromania
- Kleptomania
- Oppositional Defiant Disorder
- Conduct Disorder
- Antisocial Personality Disorder (Discussed above under Personality Disorders)

Although all these disorders share the same features of problems with self-control of emotions and behaviour, they are different in the emphasis on either the emotional element of the self-control problems or the behavioural component of the self-control problems (Table 6.1).

Table 6.1: Continuum of self-control symptoms

Individuals with Impulse Control Disorders fail to resist an impulse to perform a certain act that could have negative outcomes for themselves and/or others. These individuals experience tension or arousal before the act and feel relieved, excited or gratified once they have committed the act or given in to the impulse or urge. These disorders are characterised primarily by a lack of control and the symptoms are not part of other psychological disorders.

Outcomes
Once you have worked through study unit 6.5, you should be able to:

- define Disruptive, Impulse Control and Conduct Disorders;
- discuss the general characteristics of Disruptive, Impulse-Control and Conduct Disorders;
- know which disorders are classified under Disruptive, Impulse-Control and Conduct Disorders;
- define Intermittent Explosive Disorder, Kleptomania, Pyromania, Oppositional Defiant Disorder, and Conduct Disorder;
- discuss the DSM-5 diagnostic criteria for Intermittent Explosive Disorder;
- describe and discuss Oppositional Defiant Disorder;
- discuss the DSM-5 diagnostic criteria for Oppositional Defiant Disorder;
- describe and discuss Conduct Disorder;
- discuss the DSM-5 diagnostic criteria for Conduct Disorder;
- compare Oppositional Defiant Disorder and Conduct Disorder.

Study
To be able to do the above you will need to study the following sections:

- the introduction to this study unit in this Study Guide
- Table 15.2: Impulse Control Disorders on page 477 of the prescribed book
- the DSM-5 diagnostic criteria for Intermittent-Explosive Disorder in activity 6.22 in this study unit
- Chapter 16: Disorders of Childhood and Adolescence the section under the heading ‘Externalising Disorders among Youth’ and Table 16.3: Disorders Chart – Oppositional Defiant Disorder, Intermittent Explosive Disorder and Conduct Disorder on pages 511 to 516 of the prescribed book:
    - Introduction section under the heading ‘Externalising Disorders among Youth’, pages 511 to 512
    - Oppositional Defiant Disorder on page 512
    - Intermittent Explosive Disorder on pages 512 and 513Conduct Disorder on pages 513 to 514 of the prescribed book
- The DSM-5 diagnostic criteria for Conduct Disorder in activity 6.23 of this Learning Unit
- The DSM-5 diagnostic criteria for Oppositional Defiant Disorder in activity 6.25 of this Learning Unit
- the ‘Etiology of Externalising Disorders’ on pages 514 to 516 of the prescribed book.

Intermittent-Explosive Disorder

Individuals with this disorder have impulsive aggressive outbursts in response to events that do not warrant such an exaggerated anger response. These outbursts have a rapid onset, last for less than 30 minutes; has no prodromal indications and is not premeditated. Individuals with Intermittent Explosive Disorder often have less severe episodes of verbal and/or non-damaging non-destructive or non-injurious physical assault between these extreme intermittent explosive episodes (APA, 2013, p. 467).

Activity 6.21

Road rage, a manifestation of Intermittent Explosive Disorder, has received some media attention over the past few years. Complete the following short questionnaire developed by Dr Leon James at the University of Hawaii, to reflect on your tendency towards experiencing road rage.

Do you experience increased stress?	*YES/NO*
Do you often swear while driving?	*YES/NO*
Are you aggressive while driving?	*YES/NO*
Do you often drive too fast?	*YES/NO*
Do you shout at other drivers?	*YES/NO*
Do you often honk at other drivers?	*YES/NO*
Do you show rude signs at other drivers?	*YES/NO*
Do you often drive too close to the car ahead of you?	*YES/NO*
Do you cut in front of other drivers?	*YES/NO*
Do you often become furious at other drivers?	*YES/NO*
Do you generally feel aggressive?	*YES/NO*
Do you have aggressive fantasies while driving?	*YES/NO*
Do you feel you are competing with the other drivers?	*YES/NO*
Do you feel increasingly rushed?	*YES/NO*
Do you often feel the need to drive recklessly?	*YES/NO*

How did you fare? The good news is that if you answered NO to all the questions you are most likely not a candidate for road rage. The bad news is that the danger signals should start flashing if you answered YES to as few as one of the above questions. According to Dr James, all the questions relate to one another and if you are guilty of one of these behaviours, the chances are good that you are guilty of others as well (Rapport, 5 November 2000).

If you answered YES to one, or the majority of the above questions, it would be wise to take time out and do some well-deserved personal reflection. As individuals interested in the psychological well-being of others, we tend way too easily to neglect our own psychological well-being, which if left ignored can quite readily lead to 'burn out'. Reflect on your life and the many stresses you are experiencing. Now, with the knowledge you have regarding primary prevention; consider what steps you need to take in your own life that will prevent the development of a serious disorder such as Intermittent Explosive Disorder in your future?

If you, or anyone you know need assistance, we strongly advise that you approach a Health Professions Council Registered Psychologist, Counsellor and/or other relevant support services in your community.Additionally, there are many community support organisations that aim at supporting individuals in crisis.

Some of the national organisations are:

Family and Marriage Association of South Africa (FAMSA)

National Office Telephone no:	Tel no: (011) 975 7101
E-mail:	national@famsa.org.za
Webpage:	www.famsa.org.za

Lifeline

SA National Counselling Line:	0861–322–322
National Office:	Tel no: 011–715–2000
Webpage:	www.lifeline.org.za

South African Depression and Anxiety Group

Webpage:	www.sadag.co.za

Childline

SA National Crisis Line:	0800 055 555
Webpage:	www.childline.org.za

People Opposing Women Abuse (POWA)

National Helpline:	083 765 1235
Webpage:	www.powa.co.za

Activity 6.22

The section in your prescribed book on Intermittent Explosive Disorder is not comprehensive enough and therefore you should study the following diagnostic criteria for Intermittent-Explosive Disorder as suggested by the DSM-5 classification system (APA, 2013).

DSM-5 diagnostic criteria for Intermittent Explosive Disorder

A Recurrent behavioural outbursts representing a failure to control aggressive impulses as manifested by either of the following:

1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.
2. Three behavioural outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.

B The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.

C The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation).

D The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.

E Chronological age is at least 6 years (or equivalent developmental level).

F The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, a psychotic disorder, antisocial personality disorder, borderline personality disorder) and are not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects of a substance (e.g., a drug of abuse, a medication). For children ages 6-18 years, aggressive behaviour that occurs as part of an Adjustment Disorder should not be considered for this diagnosis.

Note: This diagnosis can be made in addition to the diagnosis of Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder, or Autism Spectrum Disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in these disorders and warrant independent clinical attention.

(APA, 2013, p. 466)

Conduct Disorder

As previously mentioned Conduct Disorders falls under Disruptive, Impulse-Control and Conduct Disorders in the DSM-5 classification system.

Violence among young people is often linked to Conduct Disorder. The term "Conduct Disorder" encompasses a wide variety of under-controlled behaviour or disinhibited behaviour. A person whose Conduct Disorder pattern persists beyond the age of 18 often engages in physical fights and reckless behaviour, such as driving while intoxicated, speeding or racing cars and financial irresponsibility. Youths with Conduct Disorder lack guilt about their behaviour, which is beyond the mischief and pranks common among children and adolescents. After the age of 18 years, such behaviour is diagnosed as Antisocial Behaviour Disorder.

Although delinquency is not synonymous with having a Conduct Disorder, the two frequently overlap. A delinquent is someone under the age of 18 years who has committed a legal offence, whereas a young person diagnosed with Conduct Disorder has a psychological disorder.

It is important to differentiate between Conduct Disorder and Attention-Deficit/Hyperactivity Disorder (ADHD) (a Neurodevelopmental Disorder that you will study in Chapter 14 of the prescribed book and Learning Unit 16 in Tutorial Letter 503). Although they both involve disruptive behaviour, Conduct Disorder differs a great deal from ADHD. While ADHD children seem literally incapable of controlling their behaviour that do not in itself violate the societal norms and rights of others, children with Conduct Disorders purposefully engage in patterns of antisocial behaviour that violate social norms and the rights of others. Whereas ADHD children throw temper tantrums, children diagnosed with Conduct Disorder are intentionally aggressive and cruel.

Activity 6.23

The section in your prescribed book on Conduct Disorder is not comprehensive enough and therefore you should study the following diagnostic criteria for Conduct Disorder as suggested by the DSM-5 classification system (APA, 2013).

DSM-5 diagnostic criteria for Conduct Disorder

A A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:

Aggression to people and animals

(1) Often bullies, threatens, or intimidates others
(2) Often initiates physical fights
(3) Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
(4) Has been physically cruel to people
(5) Has been physically cruel to animals
(6) Has stolen while confronting a victim (e.g. mugging, purse snatching, extortion, armed robbery)
(7) Has forced someone into sexual activity

Destruction of property

(8) Has deliberately engaged in fire setting with the intention of causing serious damage
(9) Has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

(10) Has broken into someone else's house, building, or car
(11) Often lies to obtain goods or favours or to avoid obligations (i.e., "cons" others)
(12) Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

(13) Often stays out at night despite parental prohibitions, beginning before age 13 years.
(14) Has run away from home overnight at least twice while living in parental or parental surrogate home or once without returning for a lengthy period.
(15) Is often truant from school, beginning before age 13

B The disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning.

C If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Specify type based on age at onset:

Childhood-Onset Type: Onset of at least one criterion characteristic of Conduct Disorder prior to age 10.

Adolescent-Onset Type: Absence of any criteria characteristic of Conduct Disorder prior to age 10.

Unspecified onset: criteria for a diagnosis of Conduct Disorder are met; but there is not enough information available to determine whether the onset of the first symptom was before age 10 years.

Specify if:

With limited prosocial emotions – at least two of the following characteristics persistently over a 12 month period in multiple relationships and settings. Information must be gathered from multiple sources and the characteristics must represent the individual's typical pattern of interpersonal and emotional functioning and not just occasional occurrences in some settings.

Lack of remorse or guilt.
Callous-lack of empathy
Unconcerned about performance
Shallow or deficient affect

Specify current severity:

Mild: Few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others.

Moderate: Number of conduct problems and effect on others intermediate between "mild" and "severe".

Severe: Many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others.

(APA, 2013, pp 469-471)

Activity 6.24

Discuss with a fellow student the role that biological, psychological, social and socio-cultural factors play in the development and maintenance of Conduct Disorders. How will you explain the impact of and the relationship between the different contributing and maintaining factors to your fellow student?

This answer requires an in depth knowledge of the Multipath Model of Conduct Disorders. Refer to the Multipath Model for Conduct Disorders in the prescribed book (pp. 515-516) for an overview on the Multipath Model's conceptualisation of Conduct Disorders in general. In your answer you have to describe the biological, psychological social and socio-cultural contributors to Conduct Disorders as well as the complex reciprocal interaction between these contributing factors.

Oppositional Defiant Disorder

According to the DSM-5 classification system, the core feature of Oppositional Defiant Disorder is a frequent and persistent pattern of angry/irritable mood, argumentative/deviant behaviour and vindictiveness. These symptoms may be confined to only one setting, such as the family home, which results in significant impairment in social functioning. However, the more pervasive the symptoms of this disorder the greater the severity of the disorder. Therefore, the behaviour of the individual should always be assessed across multiple settings and relationships.

Assessing whether an Oppositional Defiant Disorder is present is not an easy task as some of the symptoms of Oppositional Defiant Disorder can manifest to some degree in individuals that do not meet the full criteria for the disorder. Therefore it is important to consider whether the symptoms are indicative of a full-blown Oppositional Defiant Disorder by considering whether at least four symptoms over the previous six months period is presented; whether the persistence and frequency of the symptoms should exceeds what is to be expected for the individual's age, gender and culture; and whether the symptoms form part of a pattern of problematic interactions with others. Furthermore, individuals presenting with symptoms of Oppositional Defiant Disorder often do not consider themselves as angry, oppositional or defiant.

Activity 6.25

The section in your prescribed book on Oppositional Defiant Disorder is not comprehensive enough and therefore you should study the following diagnostic criteria for Oppositional Defiant Disorder as suggested by the DSM-5 classification system (APA, 2013).

DSM-5 diagnostic criteria for Oppositional Defiant Disorder

A A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable mood

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.

Argumentative/Defiant behaviour

4. Often argues with authority figures or, for children and adolescents, with adults.
5. Often actively defies or refuses to comply with requests from authority figures or with rules.
6. Often deliberately annoys others.
7. Often blames others for his or her mistakes or misbehaviour.

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past six months.

Note: The persistence and frequency of these behaviors should be used to distinguish a behaviour that is within normal limits from a behaviour that is symptomatic. For children younger than 5 years, the behaviour should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behaviour should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture.

B	The disturbance in behaviour is associated with the stress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.
C	The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

Specify current severity:

Mild: Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers).
Moderate: Some symptoms are present in at least two settings.
Severe: Some symptoms are present in three or more settings.

(APA, 2013, pp. 462-463)

Activity 6.26

Study the sections titled "Oppositional Defiant Disorder" and "Conduct Disorder" on pages 512 to 514 of the prescribed book. Then read the short case studies of Mark and Ben in these sections. Now compare Oppositional Defiant Disorder and Conduct Disorder by comparing the symptoms these two boys are presenting in the case studies according to what you have studied regarding these two disorders. Given the two case studies indicate the characteristics of externalising disorders and provide examples from both case studies to support these characteristics.

Activity 6.27

Study the aetiology of Externalising Disorders according to the Multipath Model and complete the following task:

Imagine you are a counsellor at a secondary school in the inner city plagued by high levels of youth misconduct. The majority of the learners' households fall into the low socio-economic category. Most households in your schools catchment area are either child-headed households or headed by parents of low educational levels. After a current rise in externalising disruptive behaviours in the school's population, the Department of Education assigns you the task of developing and facilitating a workshop series in which (i) heads of households and/or guardians of the learners in your school are guided, supported and empowered with knowledge and skills to better parent the children in their households, and (ii) the learners are supported towards the improvement of their psychological well-being, and taught skills towards enhancing self-regulative behaviours.

a) Name and define the level of prevention that this workshop series represents.
b) Discuss the information you will present in the session titled: "How to discipline your child" in which you impart parents and guardians with relevant knowledge and skills regarding ways of disciplining their children. You have stated the aim of this specific session as: To prevent disruptive externalising behaviour in children associated with inappropriate parental disciplinary practices.
c) Describe one activity you will use in this workshop series to facilitate the improvement of the levels of personal insight of the parents and guardians regarding their own perceptions of what their definitions of a 'well behaved child' is, and how their children might perceive them as parents (in other words, enabling the parents to 'step into their children's shoes').
d) Provide a synopsis of the characteristics that you would refer to as the ideal representation of a psychologically healthy and self-regulated secondary school learner.

Activity 6.28

The following activities will help you revise and summarise what you have studied in this chapter:

At the beginning of chapter 15 of the prescribed book there are five "Focus Questions" on page 470. Answer questions 1 to 4 of these 5 questions after you have worked through the chapter. Compare your answers to the answers provided at the end of Chapter 15 in the prescribed book under the heading "Summary". If your answers are not complete, consult your study guide and prescribed book again on these questions or contact one of your lecturers. In addition, answer Focus Question 2 on page 504 of Chapter 16 of the prescribed book and compare your answer to the answer provided in the 'Summary' section at the end of the chapter.

The learning outcomes of each of the six study units in this chapter were set out clearly in each of the study units. Make sure that you have acquired the necessary knowledge, skills and insights set out in these learning outcomes.

CONCLUDING COMMENTS

In this Learning Unit, you studied the key features of the Personality Disorders and the Disruptive, Impulse Control and Conduct Disorders in general, and the different subtypes of these two groupings of disorders specifically. This information will allow you to identify and describe the various Personality Disorders and Disruptive, Impulse Control and Conduct Disorders. You should also now be able to compare and distinguish between the different Personality Disorders and the different Disruptive, Impulse Control and Conduct Disorders. You also studied the Multipath Model for Antisocial Personality Disorder and Conduct Disorder in order to explain how these disorders develop. You reflected on a possible primary prevention programme for your local school to curb the future development of Antisocial Personality Disorder in children exhibiting conduct problems and were required to develop a workshop series to educate and support parents and learners in an attempt to curb externalising disruptive behaviour in your schools population. You also reflected on your own psychological well-being and considered the steps you need to take to ensure your own mental health and well-being.

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Learning Unit 7:

Anxiety Disorders, Obsessive-Compulsive and Related Disorders

Mrs Elmarié Visser

Contents

Orientation

As you already know, the classification of abnormal behaviour according to the DSM-5 classification system is based on observable behaviour (symptoms) and not on the presumed aetiology. Obsessive Compulsive Disorder, which was regarded as an Anxiety Disorder in the DSM-IV-TR classification system, has been moved, together with related disorders such as Hoarding Disorder and Body Dysmorphic Disorder, to a new category namely Obsessive-Compulsive and Related Disorders in the DSM-5 classification system. According to the DSM-5 classification system, Anxiety Disorders and Obsessive-Compulsive and Related Disorders are two separate types of disorders, each with its own unique characteristic symptoms. In comparison to the Anxiety Disorders which are primarily characterised by excessive fear and anxiety and related behavioural disturbances, Obsessive-Compulsive and Related Disorders have obsessive thoughts and/or repetitive behaviours as key features. However, keep in mind that there are close relationships between the Anxiety Disorders and some of the Obsessive-Compulsive and Related Disorders. For example, most individuals diagnosed with Obsessive-Compulsive Disorder experience severe anxiety and distress. Barlow and Durand (2015) stated that individuals who require hospitalisation for severe anxiety are likely to have Obsessive-Compulsive Disorder.

Chapter 5, *Anxiety and Obsessive-Compulsive and Related Disorders* in the prescribed book, is divided in two sections on the basis of the distinction the DSM-5 classification system makes between Anxiety and Obsessive-Compulsive and Related Disorders namely:

- Anxiety Disorders; and
- Obsessive-Compulsive and Related Disorders.

Anxiety Disorders

Introduction

Have you ever experienced intense **fear** in the presence of a dangerous or life threatening situation such as being chased by a vicious dog or being the victim in a hijacking incident? What were your reactions in these situations? Did you immediately experience a sense of terror, shortness of breath, an increase in your heart rate, heavy perspiration, light-headedness, a sense of unreality and the urge to flee? Reflecting on these situations and your reactions, you might realise that the threat triggered an alarm reaction which resulted in an appropriate fight (attack) or flight (flee) response. This emotional alarm reaction caused by danger is known as fear. Fear is defined as "... the emotional response to real or perceived imminent threat" by the American Psychiatric Association (2013, p. 189).

In contrast to fear which is triggered by a current, observable and dangerous object or situation, "**anxiety** is the anticipation of future threat" (APA, 2013, p.189). We sometimes feel tense and edgy as if something unpleasant is going to happen. Most of us are for example anxiously awaiting a forthcoming examination or an important job interview. Such a state of apprehension or foreboding also causes unpleasant emotions and cognitions as well as physiological and behavioural symptoms such as intense worry, shortness of breath, increased heart rate and perspiration, light-headedness and the tendency to avoid the situation where unpleasantness or danger might be encountered. As in the case of fear, anxiety also has an adaptive functioning as it prepares us for action. In mild to moderate degrees, anxiety enhances performance (Butcher, Mineka & Hooley, 2010). Anxiety may for example motivate us to study harder for a forthcoming examination or prepare properly for an important interview.

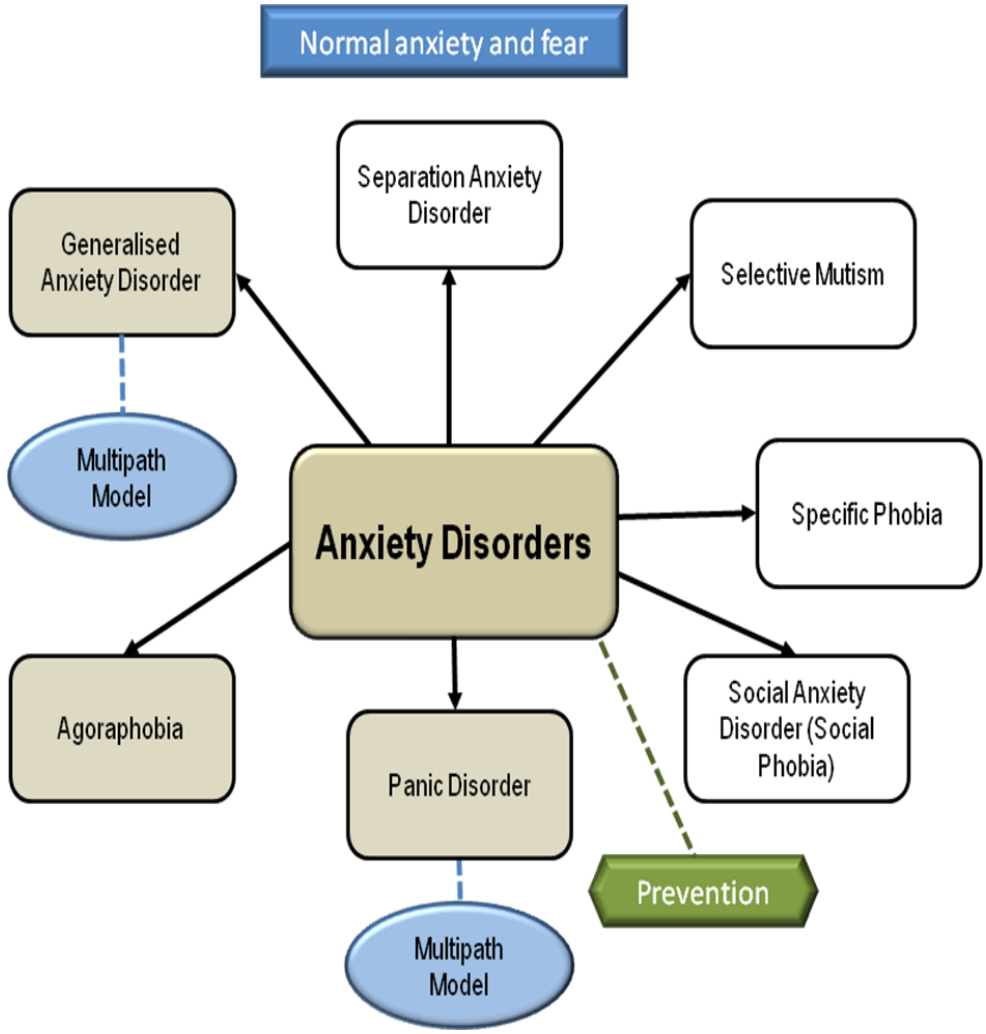
Anxiety and fear are regarded as normal adaptive responses to threats and perceived threats as long as they are mild and realistic reactions given the circumstances and if they do not cause intense discomfort or impairment in our functioning. Unfortunately, some individuals suffer such disabling fear or anxiety that they cannot lead normal lives. Their anxieties and fears are severe, chronic, and interfere with their lives. The amount of anxiety or fear experienced is out of proportion to the harm the threat could cause, their concerns persist when the threat passes and their anxieties and fears result in illogical, maladaptive behavioural patterns. These individuals suffer from Anxiety Disorders as they experience and manifest obvious symptoms of clinically significant fear and/or anxiety.

Pathological anxiety and fear manifest in various ways in different people as seen in the following brief overview. Some individuals experience a general sense of diffuse anxiety and worry about many potentially bad things that may happen (characteristic of a Generalised Anxiety Disorder), other individuals may have a persistent and disproportionate fear of some specific object or situation that presents little or no danger and yet leads to a great deal of avoidance of the feared object or situation (characteristic of a Specific Phobia, Social Anxiety Disorder and Agoraphobia). Some individuals may experience excessive fear or anxiety concerning separation from home or attachment figures (characteristic of Separation Anxiety Disorder) while other individuals may experience recurrent, unexpected urges of intense fear of discomfort which reach a peak within minutes (panic attack) and are persistently worried about having more panic attacks (characteristic of Panic Disorder). Some other individuals may experience such high social anxiety in certain social situations that they become mute in those social situations (characteristic of Selective Mutism). Have you perhaps met an individual who experiences and manifests such extreme anxiety or fears?

The Anxiety Disorders do not involve a loss of contact with reality. People suffering from them are not incoherent or dangerous and they can usually go about most of the day-to-day business of living. Although these people are aware of the illogical and self- defeating nature of some of their behaviours, they seem incapable of controlling them (Sue, Sue & Sue, 2006).

In the first part of this Learning Unit, you are going to study the differences between normal, everyday anxiety and fear and the maladaptive anxiety and fear of the Anxiety Disorders, the DSM-5 diagnostic criteria of three of the seven subtypes of Anxiety disorders namely Panic Disorders, Agoraphobia and Generalised Anxiety Disorders, the main characteristics of four of the seven subtypes of Anxiety Disorders namely Separation Anxiety Disorder, Selective Mutism, Specific Phobia and Social Anxiety Disorder (Social Phobia) as well as the causal factors (aetiology) of Panic Disorders and Generalised Anxiety Disorders according to the Multipath Model. You will also be challenged to become involved in the primary prevention of Anxiety Disorders.

What you are going to study in the first part of this chapter is illustrated visually in the following mind map:



Activity 7.1

Scan-read pages 127 to 152 of chapter 5 in the prescribed book in order to familiarise yourself with the contents of the first section of Learning Unit 7.

Activity 7.2

While working through this Learning Unit, look out for the following **key terms**. Follow the definition suggestions provided in the Study guide as well as Chapter 5 and the Glossary at the back of the prescribed book. Add to the definitions as you encounter more information about these terms. Illustrate the definitions with appropriate examples. Make sure that after you have completed this section of the chapter you know what these terms refer to:

- Anxiety
- Fear
- Anxiety Disorders
- Panic Attack
- Panic Disorder
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Agoraphobia
- Generalised Anxiety Disorder
- Separation Anxiety Disorder
- Selective Mutism.

7.1 STUDY UNIT: Types of Anxiety Disorders

You now know that Anxiety Disorders are rooted in maladaptive anxiety or fear. Anxiety, as described in the Introduction, is a future-oriented mood state in which a person apprehensively anticipates danger or misfortune. This emotional state is characterised by physiological arousal, unpleasant feelings of tension and a sense of apprehension or foreboding. Fear is a present-oriented mood state characterised by an immediate alarm reaction to a dangerous or life-threatening situation. Fear is a basic emotion that involves activation of the "fight or flight" response of the autonomic nervous system.

Anxiety and fear are characterised by a wide range of symptoms that cut across affective, physical, behavioural and cognitive domains:

- *Affective or emotional symptoms* may include a sense of fearfulness and watchfulness and a sense of dread and terror.
- *Cognitive symptoms* range from mild, unrealistic worry to panic. Harm may be anticipated, danger may be exaggerated and severe forms can bring a conviction of impending doom (the end of the world or death). Concentration problems, fears of losing control and dying, a sense of unreality and hyper vigilance may also be experienced.
- *Behavioural symptoms* may include avoidance behaviour, freezing, clinging, dependent and agitated behaviour.
- *Somatic symptoms* are changes in a person's physiological or biological reactions. These symptoms may include increased heart rate and perspiration, elevated blood pressure, tense muscles, goose bumps, shallow breathing, mouth dryness, cold hands and feet, diarrhoea, frequent urination, dilated pupils, light-headedness, faintness and indigestion (Nevid, Rathus & Green, 2008; Nolen-Hoeksema, 2008 and Sue, et al., 2006).

These symptoms manifest in different combinations in different individuals.

In this section of Learning Unit 7, we discuss seven main subtypes of Anxiety Disorders namely Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder (Social Phobia), Panic Disorder, Agoraphobia and Generalised Anxiety Disorder. Although we expect you to know the main characteristics of the seven groups of Anxiety Disorders, in this module we focus on Panic Disorder, Agoraphobia and Generalised Anxiety Disorder.

Outcomes
Once you have worked through study unit 7.1 you should be able to:

- distinguish between normal, everyday anxiety and fear and the maladaptive anxiety and fear of an Anxiety Disorder;
- define Anxiety Disorders in general;
- describe the ways in which the maladaptive anxiety of an Anxiety Disorder manifests; and
- describe the main characteristics of Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder (Social Phobia), Panic Disorder, Agoraphobia and Generalised Anxiety Disorder.

Study
To be able to do the above you will need to study the introduction to the section on Anxiety Disorders, the information provided below on Separation Anxiety Disorder and Selective Mutism in this Study Guide as well as the following sections in the prescribed book:

- The first paragraph, page 128
- Table 5.1: *Anxiety Disorders*, page 134
- Phobias, the paragraph on page 134
- Social Anxiety Disorder, page 135
- Specific Phobias, pages 135 and 136
- Anxiety, Trauma and Stress-Related Disorders in Early Life, pages 505 and 506 (not aetiology treatment and Attachment Disorders).

Activity 7.3

All children are vulnerable to uncertainties, fear and anxieties as part of growing up. Most young children experience separation anxiety to some extent when they are separated from their parents or other important attachment figures. However, most children are able to contain their fears and anxieties and do not experience debilitating distress when separated from their loved ones. In contrast to normal, age-appropriate separation anxiety, children with Separation Anxiety Disorder suffer from persistent, unrealistic fear and anxiety that something will happen to their parents or to themselves that will separate them from their parents They therefore constantly seek their parents' company. Because of their unrealistic fear and anxiety, they often refuse to go to school or go to sleep alone. They often suffer from nightmares with themes of separation and/or physical symptoms such as vomiting, stomachaches or headaches when separated from their parents.

Separation Anxiety Disorder is not limited to the childhood years. Although the symptoms often develop in childhood, they can be expressed throughout adulthood as well (APA, 2013).

The manifestation of Separation Anxiety Disorder varies with age. For example, children may be reluctant to go to school and may not want to be physically separated from their parents, even at home, while adults with Separation Anxiety Disorder typically experience excessive difficulty to cope with changing circumstances such as leaving home and getting married. They typically experience excessive discomfort when they are separated from their loved ones. They often need to check on the whereabouts and wellbeing of their spouses and children (APA, 2013).

Since the prescribed book contains insufficient information on Separation Anxiety Disorder, add the following information and make sure that you know this information.

Separation Anxiety Disorder

The main characteristic of Separation Anxiety Disorder is age-inappropriate and excessive fear or anxiety concerning separation from attachment figures or home.

Individuals with Separation Anxiety Disorder manifest at least three symptoms which could be:

1) recurrent and excessive distress when experiencing or anticipating separation from attachment figures or home,
2) persistent and excessive worry about losing major attachment figures or about an attachment figure being harmed,
3) persistent and excessive worry about experiencing an untoward event (such as being kidnapped or getting lost) that would cause separation from the major attachment figure,
4) persistent reluctance or refusal to leave the attachment figure to go out to school, to work or elsewhere,
5) persistent and excessive fear or reluctance to be alone or without the major attachment figure,
6) reluctance or refusal to go to sleep without the attachment figure being near,
7) persistent nightmares with themes of separation, and
8) recurrent complaints of physical symptoms such as headaches, nausea, stomach aches or vomiting when separation from major attachment figure/s occurs or is anticipated.

The symptoms of anxiety, fear and/or avoidance persist for at least four weeks in children and adolescence and at least six months in adults and cause significant distress and/or impairment in functioning.

(Adapted from APA, 2013)

Activity 7.4

Selective Mutism, which is characterised by a persistent failure to speak in specific situations despite the ability to do so (speak), usually has an onset before the age of five years. This Anxiety Disorder is a relatively rare disorder.

Since the prescribed book contains insufficient information on Selective Mutism, add the following information and make sure that you know this information.

Selective Mutism

The essential feature of Selective Mutism is a consistent failure to speak in specific social situations in which the child is expected to speak (e.g., at school) even though the child has normal language skills and speaks in other situations (e.g., at home). Selective Mutism has a duration of at least one month and has negative consequences on educational or occupational achievement and/or social communication.

(Adapted from APA, 2013)

Activity 7.5

Define Anxiety Disorders.

In your answer to this question, you should indicate that Anxiety Disorders are a group of disorders that are characterised by excessive, maladaptive anxiety reactions or fear. In nearly all cases, the sufferer tries to avoid the anxiety and fear. The anxiety and fear result in abnormal behaviour patterns, reduced social and occupational functioning, and/or distress for the sufferer.

Activity 7.6

Distinguish between normal, everyday anxiety and fear and the maladaptive anxiety and/or fear of an Anxiety Disorder.

In your answer, you should indicate the differences between normal, everyday adaptive anxiety and fear and the maladaptive anxiety and fear of an Anxiety Disorder. The anxiety or fear of an Anxiety Disorder is excessive, unrealistic, and more intense, lasts longer than normal everyday anxiety or fear, and has a negative and limiting effect on the sufferer.

Activity 7.7

Briefly describe the ways in which the maladaptive anxiety of Anxiety Disorders manifests.

In your answer, you have to describe the possible *affective, cognitive, somatic* and *behavioural* manifestations of anxiety.

Activity 7.8

Briefly describe the main characteristics of Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder (Social Phobia), Panic Disorder, Agoraphobia and Generalised Anxiety Disorder.

In your answer to this question, you have to describe the primary characteristics of the seven main subtypes of Anxiety Disorders. Compare your answer with the information contained in Table 5.1: *Anxiety Disorders*, page 134 as well as the information contained in the sections *Phobias* (page 134), *Social Anxiety Disorder (page 135),* Specific Phobias (pages 135 and 136) and *Separation Anxiety Disorder* and *Selective Mutism* (page 506) in the prescribed book as well as with the information provided above (in this Study Guide). If your answer is incomplete, go back to the prescribed book and Study Guide and elaborate on your answer. Make sure that you know this information.

7.2 STUDY UNIT: Agoraphobia and Panic Disorder

Agoraphobia

According to the DSM-5-classification system, Agoraphobia is defined as the fear of being trapped in a situation or place from which escape might be difficult (or possibly embarrassing) or in which help would not be readily available if the individual experiences panic-like symptoms or if a panic attack occurs. The following situations (at least two or more) are feared and avoided: being in a crowd of people or standing in line, using public transportation, or being in open spaces or in enclosed places or being outside of the home alone. The fear or anxiety is out of proportion to the actual danger posed by the feared situations. Some individuals are able to expose themselves, often with the assistance of a companion, to the feared situation but endure these experiences with considerable dread. The fear, anxiety or avoidance is persistent and lasts for six months or more. The fear, anxiety or avoidance of situations causes clinical significant distress or impairment in occupational or social functioning (adapted from APA, 2013).

Panic Disorder

Panic Disorder is characterised by sudden, mostly unexpected episodes of intense fear, horror, acute distress and the presence of various physical symptoms. The person who has a panic attack feels overwhelmed by fear, physical symptoms, and fears that he or she is going to lose control. The panic attacks occur repeatedly and the person lives in fear of the next attack. Periods between panic attacks are usually characterised by free-floating anxiety that is of a far lower intensity than the anxiety experienced during a panic attack.

Two types of panic attacks are described in the DSM-5 classification system:

- **Expected panic attacks** are attacks that have an obvious cue or trigger (e.g., when a person with a specific phobia is confronted with the feared situation or object).

- **Unexpected panic attacks** occur spontaneous without any cues or trigger (e.g., when relaxing) (APA, 2013).

Activity 7.9

The prescribed book contains insufficient information on Panic Attack and Panic Disorder. Add the following information to the information in your prescribed book and make sure that you know this information.

Panic Attack

A panic attack is characterised by a discrete period of intense fear or intense discomfort and is accompanied by at least four or more of the following symptoms:

(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, lightheaded, or faint
(9) chills or heat sensations
(10) paraesthesia's (numbness or tingling sensations)
(11) derealisation (feelings of unreality) or depersonalisation (being detached from oneself)
(12) fear of losing control or "going crazy"
(13) fear of dying.

The panic attack occurs suddenly and reaches a peak within a few minutes. The attack is usually accompanied by a feeling of imminent danger or impending doom and an urge to escape. The person has little control over the attack and often thinks that he or she is dying or going crazy. The attack is also very difficult to hide from bystanders and causes the person great discomfort and embarrassment. A person who has had one panic attack usually fears the next attack.

Panic attack is not a mental disorder and cannot be coded as an independent disorder. Panic attacks occur in the context of any of the Anxiety Disorders as well as other mental disorders.

(Adapted from APA, 2013)

According to the DSM-5 classification system, a **Panic Disorder** is diagnosed when both (1) and (2) in the block below occur.

(1) Recurrent unexpected panic attacks occur.
(2) At least one of the panic attacks has been followed by one month (or more) of one (or more) of the following:
- persistent concern or worry about having additional attacks
- a significant change in behaviour related to the attack
- the disturbance is not attributable to the physiological effects of a substance or another medical condition.
- the disturbance is not better explained by another mental disorder.

(Adapted from APA, 2013)

Outcomes
Once you have worked through study unit 7.2 you should be able to:

- describe the DSM-5 diagnostic criteria for Agoraphobia, panic attack and Panic Disorder;
- identify Panic Disorder and Agoraphobia in a case study; and
- explain the aetiology of Panic Disorder according to the Multipath Model.

Study
To be able to do the above, you should study the introduction to study unit 7.2, the information provided on Agoraphobia, Panic Attack and Panic Disorder (in this Study Guide) as well as the following sections in your prescribed book:

- Agoraphobia, pages 136 and 137
- Panic Disorder, pages 144 and 145
- Etiology of Panic Disorder, pages 145 to 147 (including Figure 5.6 *Multipath Model of Panic Disorder):*
  - Biological Dimension,
  - Psychological Dimension,
  - Social Dimension and
  - Sociocultural Dimension.

Activity 7.10

Describe a panic attack and briefly describe the different types of panic attacks.

The first part of the question requires you to indicate the characteristics of a panic attack. The second part of the question requires you to describe the two types of panic attacks, namely, expected and unexpected panic attacks. Illustrate your answer with appropriate examples. Compare your answer with the corresponding sections in the Study Guide and prescribed book. Add to your answer if it is not complete.

Activity 7.11

In Chapter 3 in this Study Guide, you have learnt the process for classifying abnormal behaviour according to the DSM-5- classification system. Revise that chapter if you are not sure how the classification system works and where to start your search for the appropriate diagnoses as you are now going to apply that knowledge to the following case study.

Carefully read the following case study and try to visualise Ken as a person. List the patterns of symptoms Ken is manifesting as well as the onset, duration and intensity of these symptoms. Remember you first have to compile a differential diagnosis. The process of a differential diagnosis will assist you to distinguish one disorder from another, sometimes a daunting task. (Don't worry too much about the compilation of a differential diagnosis at this stage; the more disorders and conditions you get to know; the easier it will be to compile a differential diagnosis.) Compare Ken's symptoms with the DSM-5 diagnostic criteria of the disorders you are considering and eliminate those disorders and conditions that do not match Ken's symptom patterns.

(a) Classify Ken's abnormal behaviour according to the DSM-5 classification system.

(b) Justify your choice of diagnosis/diagnoses by referring to key features from the case study.

Case study

Ken, a 34-year old man, led a reasonably ordinary life until 18 months ago when his uncle, to whom he was much attached, died suddenly of a heart attack. Ken was very upset about his uncle's death. However, after a few months of mourning, his mood returned to normal. About five months after his uncle's death, Ken suddenly felt a strange, burning sensation in his throat and chest as he was on his way to work one morning. It felt as though he could not breathe. His heart began beating rapidly and he was sweating profusely. Ken was also shivering uncontrollably. His arms and legs felt dead and numb. Ken was convinced that he was having a heart attack and that he would die if he did not get help quickly. He managed to keep control of his car and pulled of the road. A traffic officer called an ambulance and Ken was raced to a nearby hospital. Various medical tests and examinations were done at the hospital. All the results of the tests and examinations were, however, within normal limits and Ken was discharged. By the time he was discharged from hospital, Ken had recovered from all his symptoms. He was able to return to work immediately.

Three weeks later, Ken had a similar attack during a strenuous exercise session. He went to see his doctor. Once again, the doctor could find nothing physically wrong with Ken. Six similar attacks followed in the next two months.

Ken feels very negative about these attacks and for the past six weeks has been living in constant fear that the attacks will recur. He firmly believes that these attacks will result in a heart attack and that he will die. Ken has given up his exercise programme in an effort to avoid further attacks.

(a) Ken's abnormal behaviour should be classified as **Panic Disorder**.

(b) You should have justified the diagnosis as follows:

Ken meets the criteria for a Panic Disorder: In three months, Ken had eight panic attacks during which he felt intense fear and discomfort. During the attacks he experienced various (more than four) somatic and cognitive symptoms, namely pain in the throat and chest, shortness of breath, heart palpitations, excessive sweating, shivering, numbness in his arms and legs and a fear that he was going to die. These panic attacks occurred suddenly and unexpectedly and reached a climax within a short period of time. The attacks were recurrent. The last attack was followed by an on-going fear that the attacks would happen again (fear lasting more than a month). Ken was also worried about the consequences of the attacks. He was afraid that they would lead to a heart attack and that he would die. His behaviour also changed as a result of the attacks. He gave up his exercise programme in an attempt to prevent further attacks.

If your diagnosis differs from the correct diagnosis, refer back to Study Unit 5.1 and Study unit 7.2 in this tutorial letter. Make sure that you know where you went wrong. Contact one of your lecturers if you need assistance.

Activity 7.12

Explain the development and maintenance of Ken's disorder according to the cognitive-behavioural perspective.

Compare your answer with the following answer. Add information from the prescribed book if your answer is incomplete. Also, consult Figure 5.7: *Role of Cognitions in Panic Attacks* in your prescribed book, page 146. You could also make a diagrammatic representation of your answer.

The cognitive-behavioural perspective emphasises that cognitions and conditioning are core elements in the development of Panic Disorder. It has been found that people react differently to physical symptoms and sensations. People with high levels of sensitivity to anxiety also appear to be very aware of their bodies and have an intense fear of and worry about physical sensations. These people tend to misinterpret physical symptoms. They see a rapid heartbeat and shortness

of breath as signs of a heart attack or imminent death. Ken may have high levels of sensitivity to anxiety. The sudden death of his beloved uncle from a heart attack may have frightened Ken into believing that he might have a heart attack that could kill him. Ken might well have become more sensitive to any physical symptom that may point to a heart attack.

Ken immediately incorrectly interpreted the pain in his chest and throat and the shortness of breath as symptoms of a heart attack. This increased his anxiety and tension, which led to more intense physical symptoms. This naturally confirmed his anxiety and fear and gave rise to more catastrophic thoughts. This positive feedback cycle between cognitive and somatic symptoms resulted in a panic attack.

Ken also misinterpreted physical symptoms resulting from a strenuous exercise session as symptoms of a heart attack. This gave rise to greater anxiety and tension and more intense physical symptoms, which ended in a panic attack each time.

The intense fear and discomfort that Ken felt during each panic attack caused him to start fearing recurrences of the attacks. This fear and tension also gave rise to certain physical symptoms of tension that could be incorrectly interpreted as symptoms of a heart attack. Besides the misinterpretations of physical symptoms, a fear of further attacks thus also maintained the recurrent attacks.

7.3 STUDY UNIT: Generalised Anxiety Disorder

The essential feature of Generalised Anxiety Disorders is excessive anxiety and worry about various aspects and activities such as future events, past transgressions, health and finances, job responsibilities, everyday routine activities and possible catastrophic events such as earthquakes and floods. Individuals with Generalised Anxiety Disorder are often described as “worrywarts”. Not only do they worry indiscriminately about everything, their worries are unproductive, they cannot stop worrying and their worries have a negative effect on themselves and on others (Barlow & Durand, 2012).

According to the DSM-5-classification system, Generalised Anxiety Disorder (GAD) is characterised by chronic, at least six months, free-floating anxiety and worry. Individuals suffering from Generalised Anxiety Disorder find it difficult to control their worries. The anxiety and worry are associated with three or more of the following six symptoms:

(1) restlessness or feeling keyed up or on edge
(2) being easily fatigued
(3) difficulty concentrating or going blank
(4) irritability
(5) muscle tension
(6) sleep disturbance.

The anxiety, worry or physical symptoms cause clinical significant distress and/or impairment in social, occupational or other important areas of functioning (APA, 2013).

Outcomes
Once you have worked through study unit 7.3, you should be able to:

- describe the DSM-5 diagnostic criteria for Generalised Anxiety Disorder;
- compare Panic Disorder and Generalised Anxiety Disorder;
- identify Generalised Anxiety Disorder in a case study;
- explain Generalised Anxiety Disorder according to the Multipath Model; and
- contribute to a primary prevention programme aiming to prevent the development of Anxiety Disorders in your community.

Study
To be able to do the above, you need to study the introduction to this study unit in this Study Guide as well as the following sections in the prescribed book:

- Generalized Anxiety Disorder, pages 148 and 149.
- Etiology of Generalized Anxiety Disorder, pages 149 and 150 (including Figure 5.8: *Multipath Model of Generalized Anxiety Disorder*, page 149)
  - Biological Dimension,
  - Psychological Dimension,
  - Social Dimension and
  - Sociocultural Dimension.

Activity 7.13

Compare Panic Disorder with Generalised Anxiety Disorder.

In your answer to this question, you have to indicate the differences and similarities between Panic Disorder and Generalised Anxiety Disorder. Compare your answer with the following example and add to your answer if it is incomplete.

Both Panic Disorder and Generalised Anxiety Disorder are classified by the DSM-5 classification system as Anxiety Disorders.

Anxiety is thus the primary characteristic of both these disorders. Panic Disorder are characterised by recurrent, unexpected panic attacks, which are characterised by high-intensity anxiety and associated physiological and cognitive reactions, such as heart palpitations, sweating, chest pain, chills or hot flushes, fear of losing control or going crazy and/or the fear of dying. Periods between panic attacks are characterised by anxiety of a far lower intensity, which is largely ascribable to the person's fear of another attack, which is mostly unexpected.

Generalised Anxiety Disorder by contrast is characterised by high levels of anxiety (although not of the same high intensity as the anxiety which occurs during a panic attack), which are present for a period of at least six months. Although a person with a Generalised Anxiety Disorder may have a panic attack, chronic worry and anxiety are the primary characteristics of Generalised Anxiety Disorder. The anxiety in the Generalised Anxiety Disorder is also associated with physiological reactions, such as heart palpitations, muscle tension, restlessness, trembling or shaking and nervousness, but they are less serious and last longer than the physiological reactions in Panic Disorder. In contrast to Panic Disorder, where the person fears and tries to avoid a subsequent panic attack, people with a Generalised Anxiety Disorder worry constantly about all kinds of things, no matter how well things are going. The anxiety is not linked to a specific cause and is often described as free-floating anxiety that the person cannot control even if he or she is aware that the anxiety is unfounded or exaggerated.

Activity 7.14

Carefully read the following case study and

(a) Classify Andrea's abnormal behaviour according to the DSM-5 classification system.

(b) Justify your choice of diagnosis/diagnoses

Case study

Andrea is a 39-year old mother of two. She is a B Com graduate and works as a bank manager. Andrea is complaining of serious memory and concentration problems. According to her, she has serious concentration and memory deficits that have resulted in her making a few "financially-disastrous mistakes" at work. She says that she cannot relax outside the office, has a poor self-image and has difficulties making decisions. For the past eight months, Andrea has been having concentration and memory problems and is continuously anxious and worried about one thing or another. According to Andrea, she feels anxious and worried for 75 percent of the time she is awake on an average day. She mentions that she worries a lot about her performance at work, her children's well-being and her relationship with men. Andrea also worries about a variety of smaller things like being on time for her appointments, keeping the house clean and regularly contacting family and friends.

Regarding her children's well-being, she often becomes anxious that her children have been hurt or even killed whilst playing in the neighbourhood if she has not heard from them for a couple of hours.

Andrea has no control over her excessive worry and anxiety. She is also seriously distressed about her constant intense anxiety and worry. "I hate feeling like this the whole day. I just want to feel normal and be in control of what happens in my life!"

In addition to the discomfort which Andrea's symptoms cause her, they also interfere significantly with her life. She spends many additional hours at work and arrives at the office an hour earlier every day so that she can plan her day as carefully as possible. She does this in an effort to reduce the possibility of her making mistakes in her work.

Andrea takes far longer than necessary to finish jobs or make decisions because she questions and worries about the accuracy of every step in the process.

Her symptoms also have a negative influence on her social and family life. According to her, her children often complain that she is tired and irritable and in a bad mood. Andrea mentions that she spends less time with her friends and that the few men who have taken her out, do not contact her again after the first or second date. "They sense that I am not a fun person."

Andrea's worrying and anxiety are also affecting her physically. Andrea complains of muscular tension and she has trouble falling asleep at night. In the morning, she feels tired and not refreshed.

(a) Andrea's abnormal behaviour should be classified as follows: **Generalised Anxiety Disorder**

(b) You should have justified the diagnosis of Generalised Anxiety Disorder as follows:

Andrea meets the criteria for Generalised Anxiety Disorder. The following symptoms have been present for longer than six months:

- Andrea worries for most of the time she is awake each day about nearly everything in her life – her performance at work, her children's well-being and her relationship with men. She also worries about less serious things in her life – being on time for appointments, keeping the house clean and making regular contact with family and friends.
- Andrea has no control over her worrying and anxiety. She feels uncomfortable about her worrying and anxiety.
- Andrea has concentration and memory problems; she has trouble falling asleep and complains about muscular tension. Andrea is always tired and irritable and in a bad mood.
- Andrea's symptoms have a negative effect on her work, social and family life.

If your diagnosis differs from the correct diagnosis, refer back to Study units 5.1 and 7.3 in this tutorial letter. Make sure that you know where you went wrong. Contact one of your lecturers if you need assistance.

Activity 7.15

You and a fellow student are having an argument about the role that biological, psychological, social and sociocultural factors play in the development and maintenance of Generalised Anxiety Disorder.

How will you explain the impact of and the relationship between the different contributing and maintaining factors to your fellow student?

This answer requires an in depth knowledge of the Multipath Model of Generalised Anxiety Disorder. Refer to the Multipath Model for Generalised Anxiety Disorders in the prescribed book for an overview on the Multipath Model's conceptualisation of Generalised Anxiety Disorder.

In your answer, you have to describe the biological, psychological, social and sociocultural contributors to Generalised Anxiety Disorder as well as the complex reciprocal interaction between these contributing factors. Refer to pages 142 and 143 in the prescribed book (pages 142 and 143) for information on the Multipath Model's explanation of Generalised Anxiety Disorder.

Activity 7.16

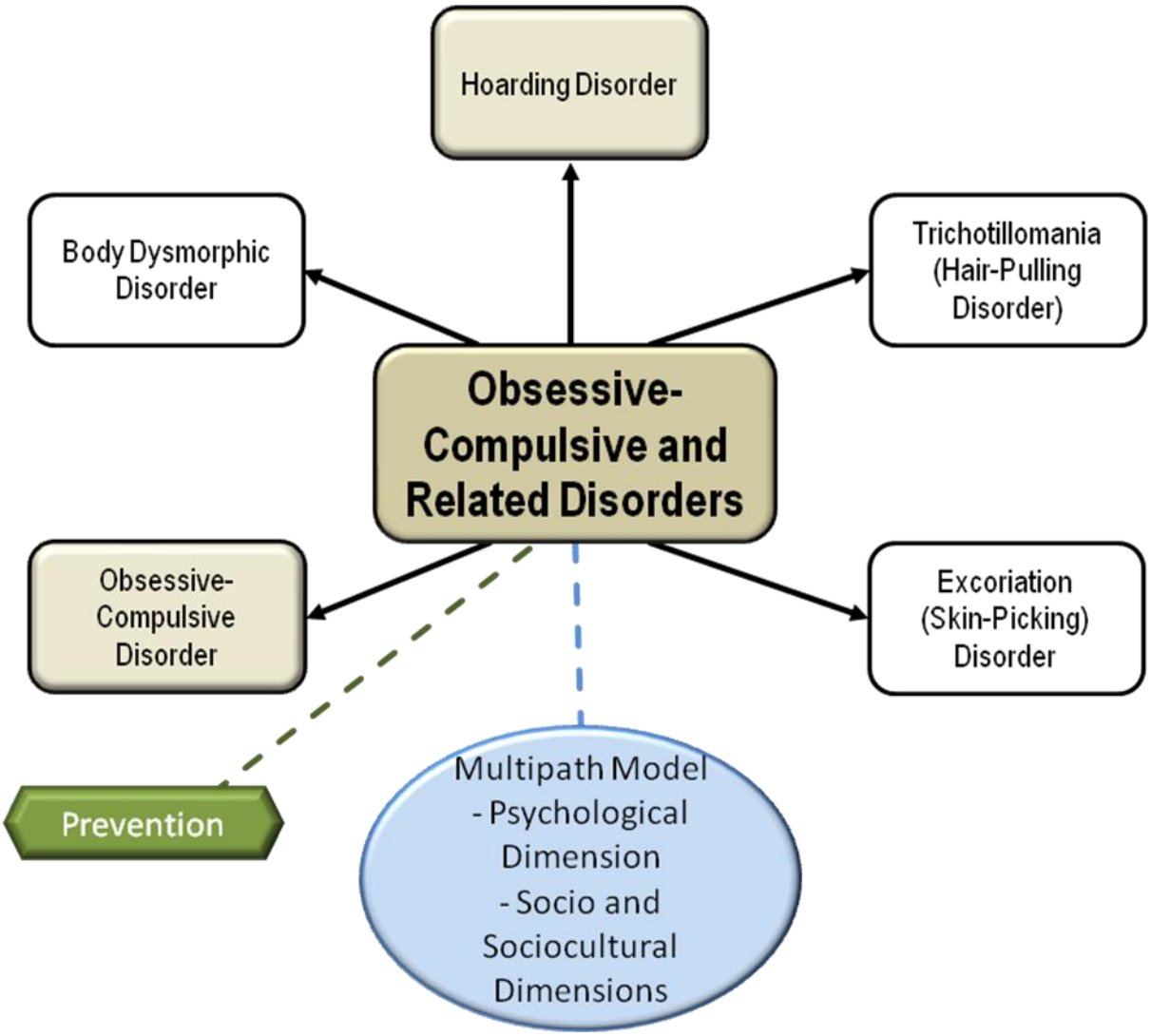
Primary prevention can be described as "an effort to lower the incidence of new cases of behavioural disorders by strengthening or adding to resources that promote mental health and by eliminating community characteristics that threaten mental health" (Sue, et al., 2006, p. 589). With this description of primary prevention in mind, what could you, as a psychology student, do to promote mental health in your community? Would you perhaps consider becoming involved in a programme aimed at strengthening the resources in your community, workplace or family to support those individuals who are vulnerable to develop an Anxiety Disorder? Reflect on how you would implement such a prevention programme.

Obsessive-Compulsive and Related Disorders

Introduction

The category Obsessive-Compulsive and Related Disorders, which is new in the DSM-5 classification system, reflects the increasing evidence that the following five disorders namely, Obsessive-Compulsive Disorder (OCD), Body Dysmorphic Disorder, Hoarding Disorder, Trichotillomania (Hair Pulling) and Excoriation (Skin-Picking) Disorder, share enough similarities (e.g., obsessive preoccupation and/or repetitive behaviours) to group them together in the same disorder cluster. However, each of these five disorders has enough unique distinguishing features to exist as distinct disorders (APA, 2013). Obsessive-Compulsive Disorder is characterised by obsessions (intrusive, repetitive and persistent thoughts, images or urges) and compulsions (repetitive behaviours that the individual feels driven to perform). Body Dysmorphic Disorder is primarily characterised by a preoccupation with perceived defects or flaws in physical appearance while Hoarding Disorder has as its essential feature persistent difficulties discarding or parting with possessions regardless of their value. Other disorders in this category, Trichotillomania and Excoriation Disorder, are primarily characterised by recurrent body-focused repetitive behaviours (e.g. hair pulling and skin picking) and repeated attempts to decrease the behaviours (APA, 2013).

In this section of Learning Unit 7, you are going to study the DSM-5 diagnostic criteria of Obsessive-Compulsive Disorder and Hoarding Disorder, the main characteristics of three of the Obsessive-Compulsive and Related Disorders namely Body Dysmorphic Disorder, Trichotillomania and Excoriation (Skin-Picking) Disorder as well as the causal factors of the Obsessive-Compulsive and Related Disorders according to the Multipath Model.
What you are going to study regarding Obsessive-Compulsive and Related Disorders is illustrated visually in the following mind map:



Activity 7.17

Scan-read pages 151 to 159 of chapter 5 in the prescribed book in order to familiarise yourself with the content of this second part of Learning Unit 7.

Activity 7.18

While working through this section of Learning Unit 7, look out for the following **key terms**. Follow the definition suggestions provided in this Study Guide as well as chapter 5 and the Glossary of the prescribed book. Add to the definitions as you encounter more information about the terms. Illustrate the definitions with appropriate examples. Make sure that after you have completed this chapter you know what these terms refer to:

- Obsessions
- Compulsions
- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Trichotillomania (Hair-Pulling Disorder)
- Excoriation (Skin-Picking) Disorder
- Hoarding Disorder

7.4 STUDY UNIT: Types of Obsessive-Compulsive and Related Disorders and aetiology of Obsessive-Compulsive and Related Disorders

By now you know that Obsessive-Compulsive and Related Disorders involve thoughts and/or actions that are involuntary, intrusive, repetitive and uncontrollable. According to APA (2013), the Obsessive-Compulsive and Related Disorders are associated with reduced quality of life, social and occupational impairment and high levels of distress. The following are examples of the negative consequences of Obsessive-Compulsive and Related Disorders. Individuals with Obsessive-Compulsive Disorder spend a lot of time obsessing and performing compulsions. An obsession about symmetry for example, can prevent the completion of work or school projects because the project is never "right enough". An obsession with gems and dirt and the resulting repetitive hand washing (compulsive behaviour) may for example cause health problems such as skin lesions as well as avoidance of social interactions due to fears of exposure to germs. Nearly all individuals with a Body Dysmorphic Disorder experience impaired psychosocial functioning because of their appearance concerns. These individuals may become housebound because they believe they are ugly, unattractive or deformed. They may also experience impairment in their occupational or academic functioning. The quality of life of individuals with a diagnosis of Hoarding Disorder is often considerably impaired. Hoarding Disorder is associated with occupational impairments, poor physical health and interpersonal conflict. Some individuals with severe Hoarding Disorder may be involved in legal eviction proceedings. Trichotillomania is also associated with distress and social and occupational impairment. Damage to hair growth may be irreversible and individuals who swallow their hair may develop physical problems such as bowel obstruction and perforation. Individuals with Excoriation (Skin-Picking) Disorder also experience distress as well as social and occupational impairment. The majority of individuals with Excoriation (Skin-Picking) Disorder spend at least one hour per day picking, thinking of picking and resisting urges to pick. These individuals also often suffer medical complications and may even require antibiotic treatment for infection and/or surgery (APA, 2013).

Outcomes
Once you have worked through study unit 7.4 you should be able to:

- define obsessions and compulsions;
- describe the DSM-5 diagnostic criteria for Obsessive-Compulsive Disorder;
- describe the DSM-5 diagnostic criteria for Hoarding Disorder;
- describe the main characteristics of Body Dysmorphic Disorder, Trichotillomania and Excoriation (Skin-Picking) Disorder;
- explain Obsessive-Compulsive and Related Disorders according to the Multipath Model (Psychological, Social and Sociocultural Dimensions); and
- Contribute to a primary prevention programme aiming to prevent the development of Obsessive-Compulsive and Related Disorders in your community.

Study
To be able to do the above, you should study the information on Obsessive Compulsive Disorder and Hoarding Disorder provided below as well as the following sections in your prescribed book:

- Table 5.4, *Obsessive-Compulsive Spectrum Disorders*, page 151
- Obsessive-Compulsive Disorder, pages 152 and 153
- Hoarding Disorder, Pages 153 and 154
- Body Dysmorphic Disorder, pages 154 and 155
- Hair-Pulling Disorder (Trichotillomania), pages 155 and 156
- Excoriation (Skin-Picking) Disorder, page 156
- Aetiology of Obsessive-Compulsive and Related Disorders -the Multipath Model, pages 156, 158 and 159, including Figure 5.11 *Multipath model of Obsessive-Compulsive Disorder*, page 157-not the Biological Dimension
  - Psychological Dimension,
  - Social Dimension and

– Sociocultural Dimension.

Activity 7.19

The prescribed book contains insufficient information on Obsessive-Compulsive Disorder and Hoarding Disorder. Add the following information to the information in your prescribed book and make sure that you know this information.

Diagnostic criteria for 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 behaviours (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 behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralise or prevent, or are clearly excessive.
   Note: *Young children may not be able to articulate the aims of these behaviours 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.

Specify if:

With good or fair insight: *The individual recognises 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.*

(Adapted from APA, 2013, p. 237)

Diagnostic criteria for 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.

F The hoarding is not better explained by the symptoms of another mental 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 behaviours (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.*

With poor insight: *The individual is mostly convinced that hoarding-related beliefs and behaviours (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 behaviours (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.*

(Adapted from APA, 2013, p. 247)

Activity 7.20

Describe the characteristic features of Obsessive-Compulsive Disorder.

In your answer to this question, you should indicate a comprehensive understanding of obsessions and compulsions, the functions and effects of obsessions and compulsions as well as the specifiers pertaining to this disorder. Compare your answer with the information in the prescribed book as well as the Study Guide and add to your answer if your answer is not complete.

Activity 7.21

Refer to the following assessment questionnaire (Sue, Sue, Sue & Sue, 2013, p. 147) pertaining to Body Dysmorphic Disorder. Compile similar assessment questionnaires for Trichotillomania, Excoriation (Skin-Picking) Disorder and Hoarding Disorder. Make sure that your questionnaires will elicit all possible relevant information regarding these three disorders according to the DSM-5 classification system.

Assessment For Body Dysmorphic Disorder	
1.	Do you believe that there is a “defect” in any part of your body or appearance?
2.	Do you spend considerable time checking this “defect”?
3.	Do you attempt to hide or cover up this “defect” or remedy it by exercising, dieting, or seeking surgery?
4.	Does this belief cause you significant distress, embarrassment, or torment?
5.	Does this “flaw interfere with your ability to function at school, at social events, or at work?
6.	Do friends or family members tell you that there is nothing wrong or that the defect is minor?

Activity 7.22

Explain the development of Obsessive-Compulsive and Related Disorders according to the Psychological, Social and Sociocultural Dimensions of the Multipath Model.

In your answer you have to describe the psychological, social and sociocultural contributors to Obsessive-Compulsive and Related Disorders as well as the complex reciprocal interaction between these contributing factors. Refer to the relevant pages in the prescribed book for information on the Multipath Model’s explanation of Obsessive-Compulsive and Related Disorders. Compare your answer with the information in the prescribed book. If your answer is incomplete, study the relevant section again and then elaborate on your answer.

Activity 7.23

As mentioned in Activity 7.16, primary prevention can be described as "an effort to lower the incidence of new cases of behavioural disorders by strengthening or adding to resources that promote mental health and by eliminating community characteristics that threaten mental health" (Sue et al., 2006, p. 589). With this description of primary prevention and your knowledge of the aetiology of Obsessive-Compulsive and Related Disorders in mind, what could you, as a psychology student, do to promote mental health in your community? Would you perhaps consider becoming involved in a programme aimed at strengthening the resources in your community, workplace or family to support those individuals who are vulnerable to develop one of the Obsessive-Compulsive and Related Disorders? Reflect on how you would implement such a prevention programme.

Activity 7.24

Anxiety Disorders and Obsessive-Compulsive and Related Disorders are of the most common mental disorders worldwide and affect millions of people worldwide. There is a good chance that sometime you will meet someone with an Anxiety Disorder or one of the Obsessive-Compulsive and Related Disorders. With the knowledge that you gathered from this chapter will you be able to identify an Anxiety Disorder and the Obsessive-Compulsive and Related Disorders? Will you be able to refer a person suffering from an Anxiety Disorder or one of the Obsessive-Compulsive and Related Disorders for professional treatment in an effective and appropriate manner? Are you familiar with the mental health services in your community? Think, for example, of Life Line, Telefriend, Famsa and the South African Depression and Anxiety Support Group (SADAG) that offer crisis resolution services to people with a broad spectrum of problems. Find out what crisis services are available in your area and the nature of services they offer. Would you perhaps consider getting involved in one of these organisations that offer invaluable services to your community?

Activity 7.25

The following activities will help you to revise and summarise what you have studied in this chapter:

(1) At the beginning of chapter 5 of the prescribed book, page 128, there are five ***Focus Questions***. Answer question 2 (not the causal and treatment sections), question 3 (not the treatment section), questions 4 and 5 (not the section pertaining to treatment) after you have worked through chapter 5. Compare your answers to the answers provided at the end of chapter 5 (page163) in the prescribed book under the heading ***Chapter***

Summary. If your answers are not complete, consult your Study Guide and prescribed book on these questions or contact one of your lecturers if you need assistance.

(2) Go back to the sections in the Study Guide referring to the **key terms** and reflect on your understanding of each term. Explain the meaning of these terms to a friend or family member. If you cannot do that, refer back to your prescribed book and Study Guide.

(3) The learning outcomes of each of the four study units in this chapter were set out clearly in each of the study units. Make sure that you have acquired the necessary knowledge, skills and insights from these learning outcomes.

(4) Go to the following internet resources and read on Anxiety Disorders as well as Obsessive-Compulsive and Related Disorders and available support groups regarding prevention.

American Psychiatric Association (http://www.apa.org/pubinfo/panic. html)

South African Depression and Anxiety Group (http://www.sadag. co.za/.)

Anxiety Disorders Association of America (http://www.adaa.org)

CONCLUSION

In the first part of the chapter we have studied the characteristics of seven subtypes of Anxiety Disorders namely Separation Anxiety Disorder, Selective Mutism, Panic Disorder, Generalised Anxiety Disorder, Social Anxiety Disorder (Social Phobia) and Agoraphobia. Knowledge of these disorders should enable you to identify, describe and distinguish between them. We examined the aetiology of Panic Disorders and Generalised Anxiety Disorder from the Multipath Model. In the second part of the chapter we have studied the characteristics of five subtypes of Obsessive-Compulsive and Related Disorders namely Obsessive-Compulsive Disorder, Hoarding Disorder, Trichotillomania, Excoriation (Skin-Picking) Disorder and Body Dysmorphic Disorder. You should be able to identify, describe and distinguish between these disorders. We have also examined the causes of these disorders according to the Multipath Model. You also collected information on crisis centres in your community and you have reflected on possible primary prevention programmes for Anxiety Disorders and Obsessive-Compulsive and Related Disorders.

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