Tutorial letter 502/3/2016

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 502/3/2016

(Second Study Guide for PYC3702)

Contents

Tutorial Letter 503/3/2016
(Third Study Guide for PYC3702)

Contents

Tutorial Letter 501/3/2016
(First Study Guide for PYC3702)

Contents

Learning Unit 8:

Somatic Symptom and Related Disorders, Dissociative Disorders

Mrs Elmarié Visser & Ms Christine Laidlaw

Contents

Orientation

As explained in Tutorial letter 501/2016, the classification of abnormal behaviour according to the DSM-5 classification system is based on observable behaviour (symptoms) and not on the presumed aetiology. The DSM-5 classification system distinguishes between Somatic Symptom and Related Disorders and Dissociative Disorders on the basis of clearly observable behaviour. "Dissociative Disorders are characterised by a disruption and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013, p. 291). Somatic Symptom and Related Disorders, by contrast, are characterised by "the prominence of somatic symptoms associated with significant distress and impairment" (APA, 2013, p. 309).

According to the DSM-5 classification system, Dissociative Disorders and Somatic Symptom and Related Disorders are, therefore, two separate types of disorders, each with its own characteristic symptoms. Chapter 7 in the prescribed book*, Somatic Symptom and Dissociative Disorders,* is divided into two parts on the basis of the distinction which the DSM-5 classification system makes between Dissociative Disorders and Somatic Symptom and Related Disorders, namely:

- Somatic Symptom and Related Disorders; and
- Dissociative Disorders

Somatic Symptom and Related Disorders

Introduction

Somatic Symptom Disorder and other disorders with prominent somatic symptoms constitute a category in DSM-5 called Somatic Symptom and Related Disorders. This category includes the disorders of Somatic Symptom Disorder, Illness Anxiety Disorder, Conversion Disorder (Functional Neurological Symptom Disorder), Psychological Factors Affecting Other Medical Conditions, Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another, Other Specified Somatic Symptom and Related Disorder, and Unspecified Somatic Symptom and Related Disorder. All of the disorders in this category share a common feature: the prominence of somatic symptoms associated with significant distress and impairment. This is in contrast to Malingering, in which the symptoms are manifested with a deliberate purpose in mind for external incentives.

Individuals with disorders with prominent somatic symptoms are commonly encountered in primary care and other medical settings but are less commonly encountered in psychiatric and other mental health settings. After all, Katon, Sullivan and Walker (2001) found that in primary care, physical complaints are frequently accompanied by psychological disorders and may constitute the primary, or even the only reason for the appointment with a physician.

When a diagnosis from the category of Somatic Symptom and Related Disorders is made, cultural factors have to be taken into account. Cultural factors can influence the frequency, expression and interpretation of somatic complaints. What might be regarded as symptoms of a disorder in one culture may be considered acceptable religious and healing rituals in another culture. When somatic symptom complaints occur, it is important to determine whether these symptoms can be fully explained in a specific social context and whether the symptoms result in obvious distress and impaired functioning (APA, 2013, p. 313).

Somatic Symptom Disorder (SSD)

Somatic Symptom Disorder (SSD) is characterised by somatic symptoms that are either very distressing or result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings and behaviours regarding those symptoms. To be diagnosed with SSD, the individual must be persistently symptomatic (typically at least for six months).

The SSD criteria do not require a specific number of complaints from four symptom groups, as previously required for Somatisation Disorder in the DSM-IV-TR. The DSM-5 criteria for SSD however does require somatic symptoms that must be significantly distressing or disruptive to daily life and must be accompanied by excessive thoughts, feelings, or behaviours.

Another key change in the DSM-5 criteria is that while medically unexplained symptoms were a key feature for many of the disorders in DSM-IV, a SSD diagnosis in the DSM-5 does not require that the somatic symptoms are medically unexplained. In other words, symptoms may or may not be associated with another medical condition. The DSM-5 cautions that it is not appropriate to diagnose individuals with a mental disorder solely because a medical cause cannot be demonstrated. Furthermore, whether or not the somatic symptoms are medically explained, the individual would still have to meet the rest of the criteria in order to receive a diagnosis of SSD.

The DSM-5 criteria emphasises the degree to which a patient's thoughts, feelings and behaviours about their somatic symptoms are disproportionate or excessive. The DSM-5 notes that some patients with physical conditions such as heart disease or cancer will indeed experience disproportionate and excessive thoughts, feelings, and behaviours related to their illness, and that these individuals may qualify for a diagnosis of SSD. This in turn may enable them to access treatment for these symptoms. In this sense, SSD is like depression; it can occur in the context of a serious medical illness. Importantly, many people who have SSD have another medical diagnosis which requires medical assistance.

Remember to differentiate Somatic Symptom Disorder from: Other medical conditions, Panic Disorder, Generalised Anxiety Disorder, Depressive Disorder, Illness Anxiety Disorder, Conversion Disorder, Delusional Disorder, Body Dysmorphic Disorder and Obsessive-compulsive Disorder.

Illness Anxiety Disorder

Within Illness Anxiety Disorder, illness and somatic concerns becomes a central feature of the individual's identity and self-image, a frequent topic of conversation and a characteristic response to stressful events. Individuals repeatedly examine themselves, do excessive information-gathering on suspected illnesses and continuously seek reassurance and soothing from others. Some individuals avoid situations that they feel may compromise their health status. Individuals may consult multiple physicians for the same problem and are not satisfied with the results despite extensive medical visits.

Remember to differentiate Illness Anxiety Disorder from: Other Medical Conditions, Adjustment Disorders, Somatic Symptom Disorder, Anxiety Disorders, Obsessive-compulsive and Related Disorders, Major Depressive Disorder and Psychotic disorders.

Conversion Disorder (Functional Neurological Symptom Disorder)

In Conversion Disorder (Functional Neurological Symptom Disorder), the essential feature is neurological symptoms that are incompatible with neurological disorders after thorough neurological assessments. Research indicates that Conversion Disorder is two to three times more common in females.

Remember to differentiate Conversion Disorder from: Neurological Diseases, Somatic Symptom Disorder, Factitious Disorder Imposed on Self, Malingering, Dissociative Disorders, Body Dysmorphic Disorder, Depressive Disorders and Panic Disorder.

Factitious Disorder Imposed on Self and Factitious Disorder Imposed on Another

The essential feature of Factious Disorders is the intentional falsification of medical or psychological signs and symptoms in oneself, or others that are associated with the identified deception, in the absence of obvious external rewards. Factitious Disorder Imposed on Self embodies persistent problems in connection with perception and identity of an individual. The reason Factitious Disorders are placed in the category of Somatic Symptom and Related Disorders is that research has found that individuals present to professionals with somatic symptoms and medical disease conviction.

Importantly, in relation to Factitious Disorder Imposed on Another, when an individual falsifies illness in another vulnerable other this diagnosis is made in relation to the perpetrator not the victim. The victim may be given a diagnosis of abuse within the category of Other Conditions That May Be a Focus of Clinical Attention.

Remember to differentiate Factitious Disorder from: Somatic Symptom Disorder, Malingering, Conversion Disorder, Borderline Personality Disorder, and a medical condition or mental disorder not associated with intentional symptom falsification.

In study units 8.1 and 8.2, you are going to study the DSM-5 diagnostic criteria of Illness Anxiety Disorder, and Conversion Disorder (Functional Neurological Symptom Disorder), the main characteristics of Somatic Symptom Disorder, Factitious Disorders and Psychological Factors Affecting Other Medical Conditions as well as the aetiology of Somatic Symptom and Related Disorders according to the psychodynamic viewpoint and the Multipath Model. You will also be introduced to Malingering which resembles Somatic Symptom and Related Disorders closely. Remember in the DSM-5, Malingering falls under the category of Other Conditions That May Be a Focus of Clinical Attention: Non-adherence to Medical Treatment.

Psychological Factors Affecting Other Medical Conditions

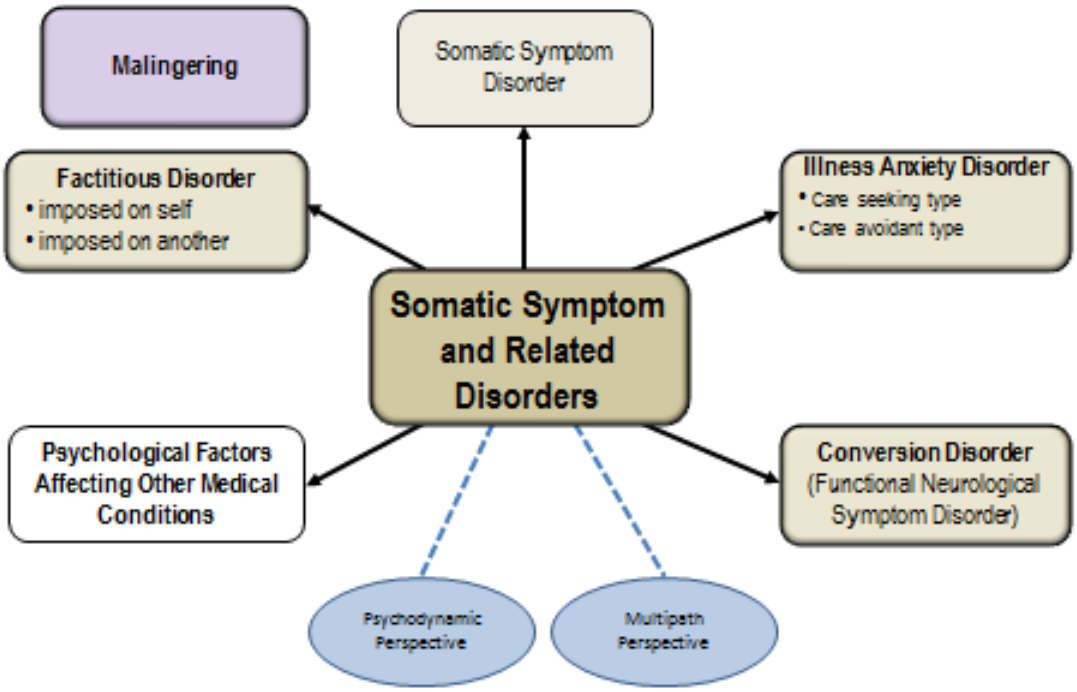
The essential feature of Psychological Factors Affecting Other Medical Conditions is the presence of one or more specific psychological or behavioural factor(s) that adversely affect(s) a general medical condition. There are several different ways in which these factors may adversely affect the general medical condition. The factors may influence the course of the general medical condition (which can be inferred by a close temporal association between the factors and the development or exacerbation of or delayed recovery from

the medical condition). The factors may also interfere with treatment of the general medical condition. The psychological factors may constitute an additional health risk for the individual (e.g. continued overeating in an individual with weight-related diabetes). They may precipitate or exacerbate symptoms of a general medical condition by eliciting stress-related physiological responses (e.g. causing chest pain in individuals with coronary artery disease). Thus, before a diagnosis of Psychological Factors Affecting Other Medical Conditions can be made a specific set of criteria have to be met.

The psychological or behavioural factors that influence medical conditions include mental disorders, as well as psychological symptoms or personality traits that do not meet the full criteria for a specific mental disorder, maladaptive health behaviours, or physiological responses to environmental or social stressors. Psychological or behavioural factors play a potential role in the presentation or treatment of almost every medical condition. Psychological Factors Affecting Other Medical Conditions should therefore be reserved for those situations in which the psychological factors have a clinically significant effect on the course or outcome of the medical condition, or place the individual at a significantly higher risk for an adverse outcome. There must be reasonable evidence to suggest an association between the psychological factors and the medical condition, although it may often not be possible to demonstrate direct causality or the mechanisms underlying this relationship. Psychological and behavioural factors may also affect the course of almost every major category of disease, including cardiovascular conditions, dermatological conditions, endocrinological conditions, gastrointestinal conditions, neo-plastic conditions, neurological conditions, pulmonary conditions, renal conditions and rheumatologic conditions. It is important for professionals to differentiate when writing diagnoses between Etiological Medical Conditions (general medical conditions) and a diagnosis of Psychological Factors Affecting Other Medical Conditions. Psychological Factors Affecting Other Medical Conditions includes the following conditions: Coronary Heart Disease, Migraine, Tension, and Cluster Headaches, Asthma, as well as Stress and the Immune System.

(Adapted from APA, 2013, p. 309-327).

What you are going to study in this Learning Unit is illustrated visually in the following mind map:



Activity 8.1

Scan-read the section on Somatic Symptom and Related Disorders in chapter 7 of the prescribed book (pages 197 to 212 and 224 to 225) as well as the section on Psychological Factors Affecting Medical Conditions in chapter 6 of the prescribed book (pages 178 to 192) and familiarise yourself with the content of these sections.

Activity 8.2

While working through study unit 8.1, look out for the following **Key Terms**. Follow the definition suggestions provided in this chapter and the Glossary of the prescribed book. Add to the definitions as you encounter more information about the terms. Illustrate the definitions with examples. Make sure that after you have completed this study unit you know what these terms refer to:

- Somatic Symptom Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Illness Anxiety Disorder
- Factitious Disorder Imposed on Self
- Factitious Disorder Imposed on Another
- Malingering
- Psychological Factors Affecting Medical Conditions

8.1 STUDY UNIT: Types of Somatic Symptom and Related Disorders

The prescribed book (chapter 7) discusses the following:
Somatic Symptom Disorder.
Conversion Disorder (Functional Neurological Symptom Disorder),
Factitious Disorder Imposed on Self/ Factitious Disorder Imposed on Another
Illness Anxiety Disorder and
Psychological Factors Affecting Medical Conditions (chapter 6).

Consult pages 197 to 212 and pages 178 to 186 in the prescribed book. You must **know** the main characteristics of these disorders and the concept of Malingering (which will be discussed in Activity 8.4). In this module, we study the diagnostic criteria of Illness Anxiety Disorder and Conversion Disorder (Functional Neurological Symptom Disorder) in depth.

Outcomes

Once you have worked through study unit 8.1, you should be able to:

- define Somatic Symptom and Related Disorders
- distinguish between Somatic Symptom and Related Disorders and Malingering
- describe the main characteristics of Somatic Symptom Disorder, Psychological Factors Affecting Medical Conditions and Factitious Disorders
- describe Conversion Disorder (Functional Neurological Symptom Disorder) and Illness Anxiety Disorder and also the DSM-5 criteria for both these disorders.

Study

To be able to do the above, you should study the DSM-5 criteria for Illness Anxiety Disorder, Conversion Disorder (Functional Neurological Symptom Disorder) and Malingering in this Tutorial Letter 502 and the following sections in the prescribed book:

- Somatic Symptom and Related Disorders, page 198;
- Table 7.1 Somatic Symptom and Related Disorders, page 198;
- Somatic Symptom Disorder, pages 199 to 201;
- Illness Anxiety Disorder, pages 201 to 202;
- Conversion Disorder (Functional Neurological Symptom Disorder), pages 202 to 203;
- Factitious Disorder and Factitious Disorder Imposed on Another, pages 203 to 205 and
- Psychological Factors Affecting Medical Conditions, page 179.

Activity 8.3

Add to the information in the prescribed book on Conversion Disorder (Functional Neurological Symptom Disorder) and Illness Anxiety Disorder Make sure that you **know** these criteria well.

DSM-5 diagnostic criteria for Conversion Disorder (Functional Neurological Symptom Disorder)

A One or more symptoms or deficits altered voluntary motor or sensory function.

B Clinical findings provide evidence of incompatibility between the symptom and recognised neurological or medical conditions.

C The symptom or deficit is not better explained by another medical or mental disorder.

D The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Specify symptom type:

With weakness or paralysis
With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)
With swallowing symptoms, or globus (a sensation of a lump in the throat)
With speech symptoms (e.g., dysphonia (reduced speech volume), slurred speech)
With attacks or seizures (non-epileptic/ psychogenic)
With anaesthesia or sensory loss
With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)
With mixed symptoms
Specify if: Acute episode: Symptoms present for less than 6 months. Persistent: Symptoms occurring for 6 months. Specify if: With psychological stressor (*specify stressor*) Without psychological stressor

(Adapted from APA, 2013, p. 318-319.

DSM-5 diagnostic criteria for Illness Anxiety Disorder

A Preoccupation with having, or acquiring a serious illness.

B Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.

C There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.

D The person performs excessive health related behaviours (e.g., repeatedly check his or her body for illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments or hospitals).

E Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.

F The illness-related preoccupation is not better explained another mental disorder such as Somatic Symptom Disorder, Panic Disorder, Generalised Anxiety Disorder, Body Dysmorphic Disorder, Obsessive-Compulsive Disorder, or Delusional Disorder, somatic type.

Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is

frequently used.
Care-avoidant type: Medical care is rarely used.

(APA, 2013, p. 315).

Activity 8.4

Please STUDY the following definition of Malingering (APA, 2013, pp. 726-727):

In the DSM-5, Malingering is found in the category of Other Conditions that May Be a Focus of Clinical Attention: Non-adherence to Medical Treatment. The essential feature of Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives such as avoiding military duty, avoiding work or obtaining financial compensation, evading criminal prosecution, or obtaining drugs.

Malingering differs from Factitious Disorder, in that Malingering involves an external incentive (e.g., money) whereas there is no external incentive in Factitious Disorders. Factitious Disorders involve the individual adopting the sick role or presenting a vulnerable other that is to adopt the sick role. Somatic Symptom Disorder, Illness Anxiety Disorder and Conversion Disorder are differentiated from Malingering as they do not involve the *intentional* production of symptoms.

Activity 8.5

Provide a comprehensive definition of Somatic Symptom and Related Disorders.

Compare your answer with the definition of Somatic Symptom and Related Disorders provided in the Introduction to this Learning unit and the prescribed book, page 198. Add to your answer if it is not complete.

Activity 8.6

Distinguish between Conversion Disorder, Factitious Disorder Imposed on Self, and Malingering.

In your answer you should have pointed out the following differences between Conversion Disorder, Factitious Disorder and Malingering:

Conversion Disorder	Factitious Disorder	Malingering
Characterised by motor, sensory or seizure-like symptoms incongruent with any recognised neurological or medical disorder. Individuals are not consciously faking symptoms; the person believes there is a genuine physical problem. Often related to traumas or even mild stressors.	Characterised by physical or psychological signs or symptoms which are deliberately displayed to be able to adopt a sick role. External motives for the behaviour (e.g. economic gain or avoiding legal liability) are absent.	Characterised by deliberate or false or severely exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work or financial compensation.

Activity 8.7

Carefully read the following case study and then do the following:

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

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

Case study

Kate, a 30-year-old woman, has been referred by her doctor for psychological evaluation and treatment. Three weeks ago Kate inexplicably became as blind as a bat. She has had numerous neurological and medical examinations and tests to try to find the cause of her sudden blindness, but no general medical condition could be found to which her blindness could be ascribed. Kate was declared physically healthy.

During a couple of interviews with a psychologist, the following information came to light: Kate married Charles, a much older and dynamic man, at a relatively young age. She has always been very dependent on his advice and guidance. She has always allowed him to make all the important decisions about their life, even if she does not always agree with them. Kate very seldom leaves the house alone to go shopping, for example, or to visit friends. Charles nearly always accompanies her. At present Kate has no friends or outside interests. Her life has always revolved around her husband and her two young children. Four years ago Charles decided to improve his professional qualifications and registered for full-time postgraduate studies at a tertiary institution. Although Kate was very anxious and unsure of herself, she entered the job market and supported the family while Charles was studying. Kate found it very difficult to leave her two young children in someone else's care while she was working, but she felt it was her duty to support Charles. She was also very proud of his academic achievements.

When Charles finished his studies, he got a very good position with a large salary. Kate resigned from her job at Charles's insistence and went back to looking after her home and children full time. Kate has noticed that Charles pays far less attention to her and the children and that he has started getting home very late. Although it makes her anxious, she has put Charles's lack of involvement down to his long working hours and tension at work.

About a month ago Kate accompanied Charles to a social function at work. After Charles had fetched drinks for them, he simply disappeared. Kate began to feel anxious and tense and went to look for Charles. She found him in their car, in a tender embrace with a beautiful young woman. She was stunned and totally shocked at what she saw and fled from the parking area without them seeing her. Charles joined her again later and revealed nothing about his relationship with the other woman. Kate did not know how to deal with the situation and decided to rather say nothing about her "discovery". She was very hurt and tried to get closer to Charles in many different ways. Unlike previously, however, it seemed that Charles did not even notice her efforts.

One morning when Kate woke up she found that she could not see. She was distressed that she would not be able to look after her home and children. Charles took leave from work and took her from specialist to specialist to help her regain her sight.

From Kate's history it became evident that she is the younger of two children. As a child she was very dependent on her parents' guidance and had little self-confidence. When she was 12 years old, her mother was paralysed in a car accident. Her mother was stuck in a wheelchair for four years until she suddenly died of a stroke. Kate had great difficulty coming to terms with her mother's ill-health and battled to accept that her mother could no longer take care of her, but in fact needed caring for herself. Kate married Charles shortly after her twentieth birthday.

(a) Kate's abnormal behaviour should be classified as follows:

Conversion Disorder (Functional Neurological Symptom Disorder) with sensory loss

Dependent Personality Disorder

Relationship Distress with Spouse
Unspecified Problem Related to Social Environment (Lack of friends or other sources of support.)
Other Problem Related to Employment: Unemployment

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

Kate meets the criteria for **Conversion Disorder (Functional Neurological Symptom Disorder) with sensory loss.** She manifests physical symptoms which suggest a medical condition and which impair physical functioning. Thorough examinations by various specialists did not, however, indicate any medical condition which is responsible for the symptoms of complete blindness. The context in which the symptoms have occurred suggest the presence and role of psychological factors in the development of the symptoms. The symptoms can be associated with her husband's unfaithfulness to her and lack of involvement. There is no evidence that Kate is deliberately or consciously producing her blindness. The possibility of Malingering and Factitious Disorder is, therefore, eliminated. The symptoms of blindness are causing Kate distress and impairing her functioning.

Consult Learning Unit 6, for more information on Dependent Personality Disorder. The diagnosis of **Dependent Personality Disorder** was made for the following reasons in Kate's case: Even as a child and adolescent, Kate showed signs of inordinate dependence and lack of self-confidence. She was married at a young age. As an adult she relied on her husband's guidance and support and she allowed him to make decisions even if she did not always agree with them. She feels uncomfortable and anxious when her husband is not close by and involved. Her husband's lack of involvement and unfaithfulness led her to try to get closer to him. She did not, however, confront him about his unfaithfulness. She also found it difficult accessing the job market and obviously does not have much self-confidence.

Other Conditions That May Be a Focus of Clinical Attention which may influence the diagnosis, treatment and prognosis of Kate's abnormal behaviour are listed as follows:

Relationship Distress with Spouse
Unspecified Problem Related to Social Environment (Kate does not really have friends or other sources of support.)
Other Problem Related to Employment-unemployment (Kate, once again, does not have the security of a career should her husband leave her.)

If your diagnoses differ from the correct diagnoses, refer back to tutorial letter 501/3/2016, Study unit 5 (Assessment and Classification of Abnormal Behaviour) and Study Unit 8.1 in this tutorial letter. Make sure you know where you went wrong. Contact one of your lecturers if you need assistance.

Activity 8.8

Read the following case study carefully and then do the following:

(a) Classify Kim's abnormal behaviour on the five axes of the DSM-5 classification system.

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

Case study

Kim is a 28-year-old married woman. She describes her childhood as very unhappy. She was the younger of two children. Her mother suffered chronic migraine attacks and was often not able to care for the children. Kim's father, a very busy businessman, often had to look after his wife and children when his wife was in bed during one of her migraine attacks. Kim describes him as emotionally cold and aloof. She felt neglected and her self-image was very poor. Kim's mother died when she was 11 years old. Kim became very dependent on her eldest sister and was emotionally shattered when her sister married, left home and relocated overseas with her new family.

Kim married at the age of 19 and looked forward to starting a new life. She dedicated herself to her husband and lost touch with her friends. She preferred her husband to make all the important decisions and, to avoid conflict, she always agreed with him. Without her husband's support and reassurance she felt lost. During the third year of their marriage Kim found out that her husband was having an extramarital affair. She was deeply hurt but was not able to leave him. Although her husband broke off his relationship with the other woman, Kim found it difficult to stop thinking about

the relationship.

A year after Kim found out about her husband's extramarital affair, she went to see her doctor, complaining about anxiety and tension. It soon became clear that Kim was worried mainly about her health. Every time she had slight physical symptoms such as being out of breath or a headache, she became extremely worried that she had a serious disease. To Kim, a headache is a sign of a possible brain tumour. She interprets shortness of breath as an imminent heart attack, and other physical sensations she soon exaggerates as possibly being cancer.

The media seem to be the main source of Kim's anxiety and fear. Each time an article appears on or a programme features a disease, Kim gets carried away by the facts of the disease and then for days looks out for the symptoms in herself.

Kim's husband is very concerned about her complaints. When her complaints first began, they spent a good deal of time and money on doctors' visits. Each doctor told Kim exactly the same thing: "There is nothing wrong with you -you are quite healthy." Eventually she stopped the visits because her husband could no longer afford the high medical bills. Kim's fears could not be resolved and her life is filled with unhappiness.

(Adapted from: Barlow & Durand, 1995).

(a) You should have diagnosed Kim's abnormal behaviour as follows:

Illness Anxiety Disorder, care-seeking type

Dependent Personality Disorder

Relationship Distress with Spouse (husband's infidelity in the past).

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

Kim meets the criteria for **Illness Anxiety Disorder**. For more than six months she has been preoccupied with fears that she may have some deadly disease, based among other things on her misinterpretation of bodily sensations or symptoms. Her preoccupation persists despite seeking out repeated medical examinations and assurances that she is physically completely healthy. The preoccupation clearly causes Kim distress and she spends a huge amount of time seeking out answers and medical care. She also shows lack of insight into her condition. After all this time she has still not realised that her fears of a possible disease are excessive.

Consult Learning Unit 6, for more information on the different types of personality disorders. The diagnosis of Dependent Personality Disorder was made for the following reasons in Kim's case: Even as a child Kim showed signs of dependence. She was emotionally dependent on her sister and was devastated when her sister left home. She is clearly very dependent on her husband's support and guidance. She allows him to make all the decisions and in order to avoid conflict, she always agrees with him. When she found out about his unfaithfulness, she felt deeply hurt but she could not leave him. Kim is clearly emotionally dependent on her husband and cannot function independently.

Other Conditions That May Be a Focus of Clinical Attention, which may influence the diagnosis, treatment and prognosis of Kim's other diagnoses, are:

Relationship Distress with Spouse (Although, Kim's husband was unfaithful to her years ago and ended the extramarital affair, the memories still have an adverse effect on Kim.)

If your diagnoses differ from the correct diagnoses, refer back to Tutorial letter 501/3/2016, Study unit 5 (Assessment and Classification of Abnormal Behaviour) and Study Unit 8.1 in this tutorial letter. Make sure you know where you went wrong. Contact one of your lecturers if you need assistance regarding the diagnosis of Kim's abnormal behaviour.

8.2 STUDY UNIT: The aetiology of Somatic Symptom and Related Disorders

Most theoretical perspectives focus on what they see as the primary cause of Somatic Symptom and Related Disorders. The psychodynamic perspective focuses on the repression of conflicts in particular and their conversion into physical symptoms. The behavioural perspective emphasises the role of reinforcement in the Somatic Symptom and Related Disorders. The biological perspective focuses on innate factors which produce a greater sensitivity to pain and bodily functions. The sociocultural perspective focuses on the social limitations which are placed on women and which may result in Somatic Symptom and Related Disorders. In contrast to these perspectives, which focus on linear causative factors, the multipath model emphasises the interaction between various factors in causing and maintaining Somatic Symptom and Related Disorders.

In this study unit we focus on the explanation of Somatic Symptom and Related Disorders according to the psychodynamic perspective and the multipath model.

Outcomes
Once you have worked through study unit 8.2, you should be able to:

- explain Somatic Symptom and Related Disorders according to the psychodynamic perspective
- explain Somatic Symptom and Related Disorders according to the multipath model
- contrast the psychodynamic perspective and multipath model's explanations of Somatic Symptom and Related Disorders.

Study
To be able to do the above, you should study the following section in the prescribed book:

- "Etiology of Somatic Symptom and Related Disorders", pages 205 to 209.

Activity 8.9

Read the case study about Kate again (Activity 8.7) and explain the Conversion Disorder Kate is suffering from according to the psychodynamic perspective.

In your answer to this question you should have pointed out that the psychodynamic perspective views the physical symptoms of Somatic Symptom and Related Disorders as a defence against the awareness of unconscious conflicts and anxiety. According to Freud, symptoms of Conversion Disorder (Functional Neurological Symptom Disorder) are caused by the repression of some or other conflict. To protect the person against extreme anxiety, the conflict is converted into physical symptoms. Because of Kate's history, her husband's unfaithfulness and lack of involvement were traumatic for her. Not only is she very dependent on him and afraid that he may leave, but she may also well have aggressive feelings towards him because of his unfaithfulness. To protect Kate from extreme anxiety, the conflict is converted into physical symptoms in the form of blindness. The focus is now no longer on her anxiety and emotional conflicts, but on observable physical symptoms of the body.

According to the psychodynamic perspective, the development of somatic symptoms has both primary and secondary gains for Kate. The symptoms are also maintained by these two forms of gain. The symptoms of blindness provide a primary gain in the sense that Kate is protected against the anxiety associated with the conflict (the need for protection against the anxiety leads to the physical symptoms). The focus is now on the physical symptoms and not on the underlying conflict. There is a secondary gain in the satisfaction of Kate's dependency needs. Kate's blindness forces her husband to pay her more attention and to take care of her, and in this way her dependency needs are fulfilled.

Add to your answer if necessary. Consult your prescribed book (page 207) again if necessary.

Activity 8.10

Critically contrast the psychodynamic perspective's explanation of Somatic Symptom and Related Disorders with the multipath model's explanation of Somatic Symptom and Related Disorders.

This question requires a sound knowledge of both the multipath model and the psychodynamic perspective of Somatic Symptom and Related Disorders. You also have to point out the differences regarding the two models' explanations of Somatic Symptom and Related Disorders. The psychodynamic perspective is an one-dimensional model that only focuses on the individual's intrapsychic processes that contribute to development and maintenance of Somatic Symptom and Related Disorders. Elaborate on these intrapsychic processes. Also give your opinion on the implications of explaining Somatic Symptom and Related Disorders by only focusing on intrapsychic factors.

The multipath model on the other hand is a multi-dimensional model that acknowledges the complex and reciprocal interaction of multiple factors in the development and maintenance of Somatic Symptom and Related Disorders. These factors include biological, psychological, social and sociocultural factors (refer to pages 205 to 209 of the prescribed book). This holistic model thus encompasses the contributing intrapsychic factors described by the psychodynamic perspective as well as other individual factors such as a low pain threshold, a high sensitivity to body sensations, catastrophic thoughts as well as social factors such as parental modelling and reinforcement, social isolation and social restrictions placed on women. Elaborate on these contributing factors and the reciprocal interaction between them and give your opinion on the advantages and disadvantages of this meta-model.

Dissociative Disorders

Introduction

As explained in the Orientation to Learning Unit 8, the characteristic feature of Dissociative Disorder is a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behaviour, functions which are usually integrated. The symptoms of Dissociative Disorders cause the person distress and/or impairment in functioning (APA, 2013). Before explaining the various Dissociative Disorders, it is important to make sure that you have a thorough grasp of the concept *dissociation*. Consider the following three scenarios:

On his way to court to defend a high profile client, Bongani, a young advocate, was stopped by a traffic officer and requested to present his driver's licence. For a few seconds Bongani could not remember where his driver's licence was, nor could he recall his full name and ID number.

As Maria was parking her car in front of the venue where she had to write her final examination paper, she suddenly realised that she had no recollection of her trip to the examination venue, including the obvious landmarks she had passed along her way.

As Ben entered the board room where he had to present his proposal regarding a new product to the board members of his company, he for a few seconds experienced the feeling that he was dreaming. Everything and everybody in the room including himself, felt strange and unreal.

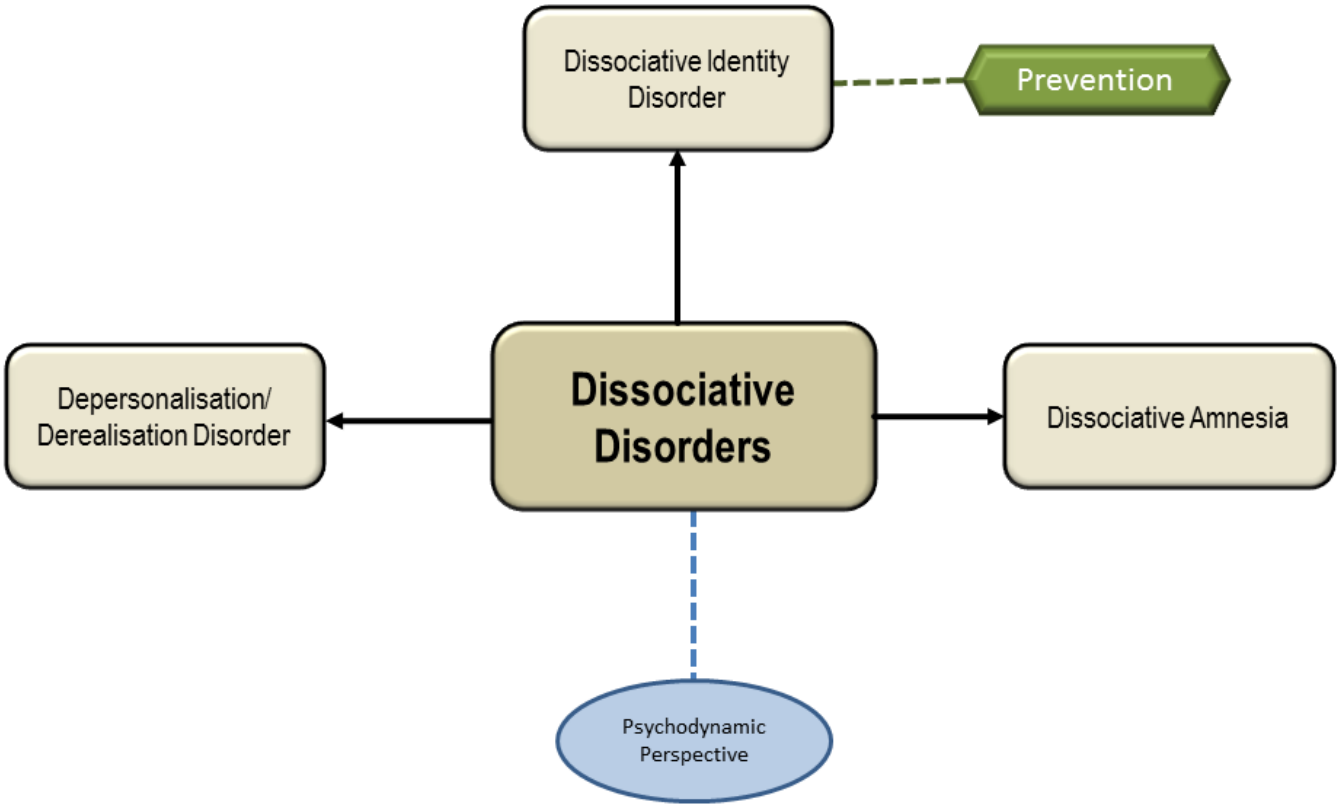
We are sure that you can relate to Bongani, Maria and Ben's experiences, which are quite normal given their momentary, insignificant consequences. Most of us occasionally experience non-pathological, slight alterations or detachments in memory, consciousness or identity, especially when we are under stress or tired. These experiences are known as *dissociation* or *dissociation experiences*. Unfortunately, for a few people these experiences are so intense, extreme and chronic that they lose their memory to such an extent that their functioning is impaired, or they lose their identity entirely and assume a new one or they lose their sense of reality and are unable to function (Barlow & Durand, 2009). In these cases of *pathological dissociation* a diagnosis of Dissociative Disorder is justified.

Dissociative symptoms are often found in the aftermath of trauma. Both Acute Stress Disorder and Posttraumatic Stress Disorder (which will be studied in Learning Unit 9), often contain dissociative symptoms such as amnesia, numbing, flashbacks and derealisation/depersonalisation (APA, 2013).

A cross-cultural perspective is extremely important in evaluating Dissociative Disorders, because dissociative conditions are common and accepted expressions of cultural activities or religious experiences in many societies. Refer to page 210 in the prescribed book, the section on *Culture and Somatic Symptom and Dissociative Disorders* for examples of culture bound conditions. According to the DSM-5 classification system, dissociation should not be considered inherently pathological. Dissociation often does not lead to significant distress, impaired functioning or help-seeking behaviour. However, when culturally-defined syndromes which are characterised by dissociation cause distress and impaired functioning, these syndromes are considered manifestations of pathology (APA, 2013).

8.3 STUDY UNIT: Types of Dissociative Disorders

In study units 8.3 and 8.4 you are going to study the DSM-5 diagnostic criteria of Dissociative Amnesia (with or without dissociative fugue) and Dissociative Identity Disorder, the five types of dissociative amnesia, and the main characteristics of Depersonalisation/Derealisation Disorder as well as the aetiology of Dissociative Disorders according to the psychodynamic perspective. What you are going to study in these two study units is illustrated visually in the following mind map:



Activity 8.11

Scan-read the section on Dissociative Disorders in chapter 7 of the prescribed book (pages 212 to 222) and familiarise yourself with the content of this section.

Activity 8.12

While working through study unit 8.3, look out for the following **Key terms** and follow the definition suggestions provided in Chapter 7 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 study unit, you know what these terms refer to:

- Dissociative Disorder
- Dissociative Amnesia
- False memory
- Localised amnesia
- Selective amnesia
- Generalised amnesia
- Systematised amnesia
- Continuous amnesia
- Dissociative fugue
- Depersonalisation/Derealisation Disorder
- Dissociative Identity Disorder (Multiple-Personality Disorder).

Outcomes

Once you have worked through Study Unit 8.3, you should be able to:

- define Dissociative Disorders
- describe the DSM-5 criteria for Dissociative Amnesia (with or without dissociative fugue) and Dissociative Identity Disorder
- describe the different types of dissociative amnesia and distinguish between these types of amnesia
- describe the main characteristics of Depersonalisation/Derealisation Disorder.

Study

To be able to do the above, you need to study the DSM-5 definition of Dissociative Disorder provided in the Orientation to Learning Unit 8 and the DSM-5 diagnostic criteria for Dissociative Amnesia and Dissociative Identity Disorder in this tutorial letter as well as the following sections in the prescribed book:

- Dissociative Disorders, page 212;
- Dissociative Amnesia and Dissociative Fugue, pages 212 to 215;
- Table 7.6: Disorders Chart: Dissociative Disorders, page 213;
- Depersonalization/Derealization Disorder, pages 215 and 216 and
- Dissociative Identity Disorder, pages 216 to 218.

Activity 8.13

The prescribed book contains insufficient information on Dissociative Amnesia and Dissociative Identity Disorder. Add the following information to the information in your prescribed book and make sure that you **know** these criteria.

DSM-5 Diagnostic criteria for Dissociative Amnesia

A An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.
Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalised amnesia for identity and life history.

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

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

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

Specify if:

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

(APA, 2013, p. 298).

DSM-5 Diagnostic criteria for Dissociative Identity Disorder

A Disruption of identity characterised by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behaviour, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B Recurrent gaps in the recall of everyday events, important personal information, and/ or traumatic events that are inconsistent with ordinary forgetting.

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

D The disturbance is not a normal part of a broadly accepted cultural or religious practice.
Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E The symptoms are not attributable to the physiological effects of a substance (e.g. blackouts or chaotic behaviour during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

(APA 2013, p. 292).

Activity 8.14

Define Dissociative Disorder.

In your answer you should have indicated that the characteristic feature of Dissociative Disorder is a disruption of and/or discontinuity in the normal integration of consciousness, memory, emotions identity, perception, body representation, motor control, or behaviour. The symptoms of Dissociative Disorder cause distress and/or impaired functioning. Dissociative Disorder can be ascribed to psychological factors.

Activity 8.15

Name three types of Dissociative Disorders and give the main characteristics of each type.

Compare your answer with the information provided in *Table 7.6 Dissociative Disorders* (page 213 of the prescribed book). If your answer is not complete, consult the relevant study material and add to your answer.

Activity 8.16

Distinguish between dissociative amnesia, permanent amnesia due to neurobiological damage or toxicity (characteristic of Mild or Major Neurocognitive Disorder) and normal age-related changes in memory.

It is very important that you are able to distinguish between dissociative amnesia on the one hand and permanent amnesia due to neurobiological damage or toxicity on the other hand. Dissociative amnesia is the result of psychological factors and is always potentially reversible because the memory has been successfully stored, whereas the amnesia in the Mild or Major Neurocognitive Disorders are the direct physiological consequence of a specific medical condition or substance which prevent memory storage or retrieval. We should also make a clear distinction between dissociative amnesia and the age-related cognitive decline and non-pathological forms of amnesia which are found in everyday forgetfulness. Read the following sections in chapter 13 in your prescribed book: *Types of Neurocognitive Disorders,* pages 402 to 406, *Table 13.1, Neurocognitive Disorders, page 403*, *Table 13.3 Normal aging or Neurocognitive Disorder?*, page 404, and make sure that you know what the distinctions are between Dissociative Amnesia and these other types of disorders which also have amnesia as a distinctive symptom. Also, make sure that you are able to describe the differences between dissociative amnesia and normal age-related changes in memory.

Activity 8.17

Compare the different types of dissociative amnesia.

In your answer you should have pointed out the similarities and differences between localised, selective and systematised amnesia. You should have indicated that all three types of amnesia are characteristic of Dissociative Amnesia, and that all three types involve primary memory that is lost. The five types differ, however with regard to the degree and type of memory loss. You should have pointed out these differences very clearly. Compare your answer with the corresponding section in the prescribed book. If your answer is not complete, study that section again and add to your answer.

Activity 8.18

Carefully read Irene's story and do the following:

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

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

Remember you first have to compile a differential diagnosis when you are required to classify abnormal behaviour according to the DSM-5 classification system. Although you are only familiar with a few disorders at this stage, you are already able to consider several possibilities such as Dissociative Amnesia, Dissociative Identity Disorder, Depersonalisation/Derealisation Disorder, Generalised Anxiety Disorder, and Panic Disorder in Irene's case.

Case study

Irene, is a 37-year-old post office worker and the mother of two young daughters. Her supervisors have referred her to the company's psychologist because they believe her inconsistent behaviour is affecting the entire office's morale. Irene's moods and behaviour apparently fluctuate so drastically that her co-workers have begun to feel uncomfortable, because they never know how she is going to react. One moment she is the "asthmatic" who is allergic to smoke, who is passive and depressive and suffering from all kinds of guilt feelings. Then, as soon as her supervisors reprimand her about being behind with her work, she runs crying out of the office and returns minutes later, laughing and cursing with a cigarette in her mouth and insisting that everyone call her Sabine. On various occasions when her supervisors have questioned her about her inconsistent behaviour, she denies any knowledge of it and says that they do not understand how she feels.

During the first interview, Irene was very downhearted, and the psychologist had to encourage her to cooperate and tell her life story. She could remember nothing about her childhood, but said that she has been depressed and anxious most of her adult life.

She also mentioned that she is very worried about her inability to remember various incidents to which her colleagues have referred. She said that she has realised that these breakdowns in her memory have become more serious since her father moved in with her and her two young daughters. (Her mother died a year ago, and her father insisted that he move in with her because she is divorced and he is getting older and needs her to look after him.)

When the psychologist asked Irene about her relationship with her father, she was insistent that the psychologist should believe that she loves her father. However, when the psychologist pressed her for more information, Irene immediately became quiet and withdrawn. When she spoke again, she asked the psychologist for a cigarette and when he answered that he does not allow smoking in his office, she began to swear at him. Her whole attitude changed. She crossed her legs in a seductive way and undid the top buttons of her blouse, commenting how hot it was. When the psychologist addressed her as Irene, she burst out laughing, saying that "that scaredy cat has gone" and that it was now Sabine to whom he was talking; if he had anything to say, he must say it to Sabine. In answer to a question about her father, she asked the psychologist what he wanted to know about the "animal" who was supposed to be her father. Sabine recounted how Irene had been sexually molested by her father for the greater part of her life, and that her "pathetic excuse for a mother" did nothing to stop it, because she lived in fear of her husband who regularly beat her. Sabine also said that she was there to protect "the scaredy cat" (Irene) and Essie against their father and that she would not hesitate to kill him if he did anything to her daughters.

In subsequent interviews, Sabine introduced the psychologist to Essie, the frightened and anxious little girl. Little Essie cannot yet read or write but she loves drawing (only with black and red wax crayons), which is difficult for her because she has one crippled hand which she cannot use at all. At the mention of her father's name, Essie crept crying into the corner of the room. It came out that Sabine has not allowed Irene and Essie to know about each other. Sabine said that initially Irene was in charge of their life for the most part, but that since Irene's father moved in with them, she is no longer capable of looking after them.

The psychologist also found that Essie was the one who remembered and who constantly relived the abuse, without being aware of the fact that she was already an adult woman. Irene, on the other hand, was the one who married and had two children, while Sabine was there to protect them all.

(a) Irene's abnormal behaviour should be classified as follow:

- Dissociative Identity Disorder
- Personal history (past history) of sexual abuse in childhood.
- Other Problems Related to Employment.

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

Dissociative Identity Disorder: Irene meets the criteria for Dissociative Identity Disorder. She has three distinct identities, Irene, Sabine and Essie, who alternately take control of Irene's behaviour. Each of these identities has a separate name, self-image, behaviour pattern and history. Irene displays (in interaction with her supervisors) definite gaps in memory in respect of personal information. She is not aware of her inconsistent behaviour. Only the Sabine personality is aware of the other two identities. The different personalities occur in different circumstances. The symptoms cause impairment in social and occupational functioning.

Personal history of sexual abuse in childhood: Irene was sexually molested by her father. These negative experiences during her childhood are quite possibly the reason for the dissociation of integrated functions. At present Irene's father is living with her and her young daughters. The family situation appears to be tense and there is the fear that the father might also molest Irene's daughters.

Other Problems Related to Employment: There is friction between Irene and her colleagues and supervisors, which leads to increased tension.

If your diagnoses differ from the correct diagnoses, refer back to Tutorial letter 501/3/2016, Study unit 5 (Assessment and Classification of Abnormal Behaviour) and Study Unit 8.3 in this tutorial letter. Make sure that you know where you went wrong. Contact one of your lecturers if you need assistance.

STUDY UNIT 8.4: The aetiology of Dissociative Disorders

Introduction

The Dissociative Disorders are a complex and fascinating group of disorders which we have not yet really understood or explained properly. Various perspectives have tried to explain the cause and maintenance of Dissociative Disorders. It appears from various research findings that trauma during childhood plays a prominent role in the development of Dissociative Disorders and particularly Dissociative Identity Disorder. These findings support the belief that Dissociative Identity Disorder develops as an attempt to deal with abuse. The construction of alternate personalities can be seen as a way in which traumatised children learn to distance themselves psychologically from severe abuse" (Nevid et al, 1997, p 245). Psychological theories can help us to understand how traumatic experiences are converted into Dissociative Disorders.

The Multipath dimensions that contribute to Dissociative Disorders are discussed in your prescribed book. For the purposes of this module, you should be able to explain Dissociative Disorders from the point of view of the psychodynamic perspective.

Outcomes

Once you have worked through Study Unit 8.4, you should be able to:

- discuss Dissociative Disorder according to the psychodynamic perspective and
- contribute to a primary prevention programme in your community aimed at preventing Dissociative Identity Disorder.

Study
To be able to do the above, you need to study the following sections in the prescribed book:

- Pages 219 to 221, *Psychological Dimension* including Figure 7.5: *The Posttraumatic Model of Dissociative Identity Disorder,* page 221.

Activity 8.19

Explain Dissociative Identity Disorder according to the psychodynamic perspective.

In answering this question, you should have pointed out that Dissociative Disorders are the result of the individual's extreme use of repression to banish the anxiety arising from unpleasant or traumatic events from consciousness. This process is the result of conflict in the personality structure, that is, conflict between the impulses of the id and the demands of the superego, which results in severe anxiety. If total repression of these impulses is not possible (as a result of the power of these impulses and/or the weakness of the ego), dissociation or separation of certain mental processes may occur. The dissociation process is taken to extremes in Dissociative Identity Disorder. The separation of mental processes is so extreme that independent identities, each with a unique memory and behavioural style, are formed. As mentioned, conflict in the personality structure is responsible for this process. If opposing personality components (arising from the id and the superego) are equal in strength, the ego (which is too weak) is not able to control all the irreconcilable elements. A compromise is then reached in which all the different opposing parts of the personality are alternately expressed and suppressed. Since these parts are so incompatible and irreconcilable, they cannot possibly all be expressed at the same time.

The personality which is most appropriate for the situation in which the individual finds himself or herself is allowed to express itself while the others are suppressed. These personalities exist independently and are not usually aware of one another. Intense anxiety and disorganisation would arise if these personalities expressed themselves simultaneously.

According to the psychodynamic perspective, the split in the personality occurs as a result of earlier traumatic experiences and the person's/child's inability to escape these experiences. One or more of the personalities takes on the psychological pain of these traumatic events and thus protect the other personalities against the pain. This enables the person to survive despite extreme trauma and psychological pain.

Not all individuals who have traumatic experiences during their childhood develop Dissociative Identity Disorder. It appears that the person who develops Dissociative Identity Disorder must, in addition to experiencing the trauma, have the ability to dissociate or separate certain memories and mental processes. When people who are able to dissociate are exposed to overwhelming stress, they block out the experience and develop separate identity systems if they have no sources of support. These people then develop Dissociative Identity Disorder

If your answer is not complete, go back to your prescribed book and expand on your answer where necessary.

Activity 8.20

Now that you are familiar with the psychodynamic explanation of Dissociative Identity Disorder, critically evaluate this explanation of Dissociative Identity Disorder. Do you identify with this explanation of Dissociative Identity Disorder? Motivate your answer.

Activity 8.21

Almost every person suffering from Dissociative Identity Disorder (DID) reports being physically and/or sexually abused as a child. The abuse in DID is most often carried out by parents or family members and is chronic over an extended period of childhood. These victims of childhood trauma also report an absence of support systems and an inability to escape the horrible, unbearable abuse. Child abuse is also associated with many other severe mental disorders such as Major Depressive Disorder and Posttraumatic Stress Disorder.

Explore what programmes and support services regarding the mental and physical safety and wellbeing of children and families are available in your community. Consider how you, as a third year Psychology student, could contribute to these worthwhile programmes and support structures. Contact one of the organisations such as Teddy Bear Clinic (JHB), Childcare South Africa, Lifeline, Telefriend, Childline or Famsa that offer educational programmes to children, families and communities as well as support to victims of child abuse. Consider becoming involved in the promotion of mental health and the wellbeing of children and families in your community.

Activity 8.22

The following activities will help you to revise and summarise what you have studied in study units 8.3 and 8.4:

1. In the beginning of Chapter 7 of the prescribed book, page 198, there are two Focus Questions. Answer the second question (not the treatment section) after you have worked through study units 8.3 and 8.4. Compare your answers to the answers provided at the end of Chapter 7, page 226, in the prescribed book under the heading *Chapter Summary*. If your answers are not complete, consult your this tutorial letter and prescribed book again.
2. Go back to the beginning of study unit 8.3 in this tutorial letter to *Key Terms* and reflect on your understanding of each term. Explain the meaning and use of these terms to a fellow student. If you battle to do so, refer back to your prescribed book and study units 8.3 and 8.4.
3. The learning outcomes of study units 8.3 and 8.4 were set out clearly. Make sure that you have acquired the necessary knowledge, skills and insights set out in these outcomes.
4. Go to the following internet resources and expand your knowledge on Dissociative Disorders and available support groups regarding prevention:

Information about Dissociative Disorder:

@ health
http://www.athealth.com/consumer/disorders/Dissociative.htm/

Mental Help Net
http://www.mentalhelp.net/poc/center-index.php?id=41

National Alliance on Mental Illness
http://www.nami.org/Content/ContentGroup/Helpline1/ Dissociative_Disorders.htm

Mayo Clinic
http://www.mayoclinic.com/health/dissociative-disorders/ DS00574

Merck
http://www.merck.com/mmpe/sec15/Ch197/Ch197a.html

Mental Health
http://www.mentalhealth.about.com/od/problems/Mental_ Illness_Mental_Disorders.htm

Information on support groups:

SAPS Family Violence, Child Protection and Sexual Offences Unit (FCS)
http://www.saps.gov.za/org_profiles_/core_function_components/fcs/policing.htm

Family and Marriage Association of South Africa (FAMSA)
http://www.famsa.org.za/

Childline
http://www.childlinesa.org.za
http://www.childline.org.za (Provincial contact information)

Telefriend
http://www.telefriend.org.za/

CONCLUSION

In study units 8.1 and 8.2, we studied Somatic Symptom and Related Disorders. We looked at the main characteristics of Somatic Symptom Disorder and Factitious Disorders, and discussed Conversion Disorder and Illness Anxiety Disorder in more detail. We explained Somatic Symptom and Related Disorders according to the psychodynamic perspective and the multipath model. We also explained the importance of being able to identify Malingering. You should therefore be able to identify and explain the Somatic Symptom and Related Disorders.

In study units 8.3 and 8.4, we studied the main characteristics of Dissociative Amnesia (with and without dissociative fugue), Dissociative Identity Disorder and Depersonalisation/Derealisation Disorder. We studied Dissociative Amnesia and Dissociative Identity Disorder in greater depth. Knowledge of these disorders should enable you to identify and describe these disorders yourself. We also explained Dissociative Identity Disorder from the point of view of the psychodynamic perspective. You also explained the mental health support structures and organisations in your community, especially those that focus on the prevention and treatment of child abuse and family pathology.

REFERENCES

American Psychiatric Association. (2000). Diagnostic *and statistical manual of mental disorders* (4th ed. Text Revision). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Barlow, D.H., & Durand, V.M. (1995). *Abnormal psychology*. Pacific Grove: Brooks Cole.

Barlow, D.H., & Durand, V.M. (2009). *Abnormal psychology: An integrative approach* (5th ed.). Belmont, CA: Wadsworth Cengage Learning.

Katon W., Sullivan, M., & Walker, E. (2001). Medical symptoms without identified pathology: relationship to psychiatric disorders, childhood and adult trauma, and personality traits. *Annual Internal Medicine*, *134*(9 Pt 2), 917-925.

Nevid, J.S., Rathus, S.A., & Green, B. (1997). *Abnormal psychology in a changing world* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Learning Unit 9:

Trauma- and Stressor-Related Disorders

Dr Beate von Krosigk & Mrs Elmarié Visser

Contents

Overview

The mutual interaction between the body and the mind is complex. You will notice when you read chapter 6 in the prescribed book that the authors reflect this complexity in the way they use the information we have at our disposal.

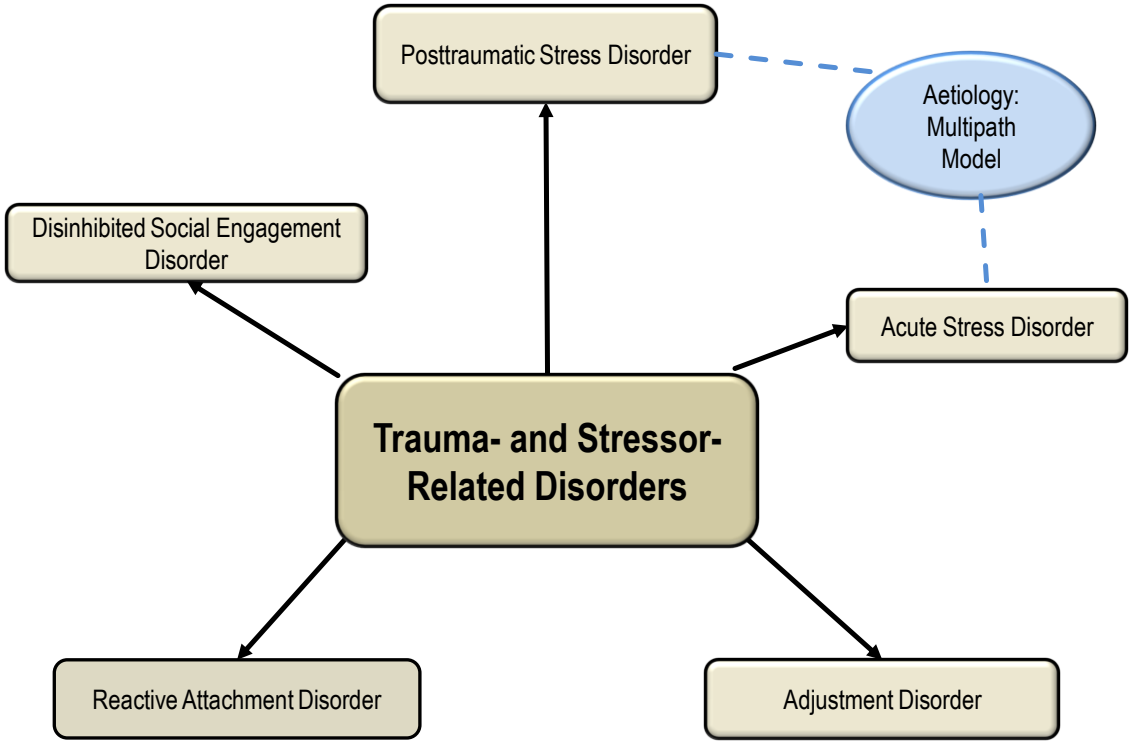
The relationship between illness and stress is embedded in complex mutual interactions between biological, psychological, social, and socio-cultural factors, and although stressor-related effects have always been present, there was no stressor-related category name in the DSM until now. In the past, Acute and Posttraumatic Stress Disorders were categorised as Anxiety Disorders in the DSM-IV-TR until the end of 2012.

Since the inception of the DSM-5 in May 2013, a new DSM-5 category, Trauma- and Stressor-Related Disorders, has become the officially recognized diagnostic category for the following two childhood disorders - Reactive Attachment Disorder and Disinhibited Social Engagement Disorder - and three childhood/ adulthood disorders - Acute Stress Disorder, Posttraumatic Stress Disorder and Adjustment Disorders - which are all depicted in the mind map below.

Possible reasons for this shift could be that individuals who have been identified with one of the Trauma- and Stressor-Related Disorders, have experienced or been exposed to a traumatic or stressful event. The presence of psychological distress which usually follows the exposure to such a traumatic or stressful event typically manifests as symptoms of anhedonia (loss of experiencing pleasure), dysphoria (a state of feeling sad, unwell or unhappy), externalising angry and aggressive symptoms, or dissociative symptoms, in addition to the typical presence of anxiety- and fear-based symptoms. This combination of anxiety, dissociative, depressive, aggressive, angry, and fear based symptoms has therefore baffled clinicians for many years, and stress and trauma related disorders were thus relegated to a wide spectrum of different

DSM categories. This heterogeneous group of symptoms has also been recognised in the Adjustment Disorders, Reactive Attachment Disorder and Disinhibited Social Engagement Disorder.

In the case of Reactive Attachment Disorder and Disinhibited Social Engagement Disorder, social neglect was found to be the common etiological foundation for traumatic experiences in children below the age of five. Social neglect of children can lead to either internalising, depressive, withdrawn behaviour, as depicted in Reactive Attachment Disorder, or Disinhibiting and Externalising behaviour, as depicted in Disinhibited Social Engagement Disorder (refer to pages 506-507).



Note: The DSM-IV-TR category “Psychological Factors Affecting Medical Conditions: Psychophysiological Disorders” on pages 178-194 in Sue et al. (2013) appeared in earlier versions of the DSM. However, in the DSM-5 (2013), this category has changed to the following: “Somatic Symptom and Related Disorders: Psychological Factors Affecting Other Medical Conditions”. This DSM-5 category now falls under the umbrella of the “Somatic Symptom and Related Disorders” which is studied in Learning Unit 8: Somatic Symptom and Dissociative Disorders.

9.1 STUDY UNIT: Acute and Posttraumatic Stress Disorders

We are now going to begin by reading the introduction to chapter 6 (page 165-166) and the section "Acute and Posttraumatic Stress Disorders" on pages 168–176 in the prescribed book.

Since Acute and Posttraumatic Stress Disorders are not described comprehensively in your prescribed book, the diagnostic criteria according to the DSM-5 are presented below. You are required to study the DSM-5 criteria for both Acute and Posttraumatic Stress Disorder in order to be able to identify the symptoms/syndromes in case studies and in people who have experienced traumatic events.

Outcomes
Once you have worked through study unit 9.1, you should be able to do the following:

- name the five types of Trauma and Stressor Related Disorders
- distinguish between stressor and stress

- describe the DSM-5 criteria for Acute Stress Disorder
- describe the DSM-5 criteria for Posttraumatic Stress Disorder
- identify individuals who are suffering from Acute Stress Disorder and from Posttraumatic Stress Disorder

Study

To be able to do the above you will need to study the mind map at the beginning of this chapter, the DSM-5 diagnostic criteria for Acute Stress Disorder and for Posttraumatic Stress Disorder in Activity 9.1 in this Tutorial Letter, and the difference between stress and stressors – pages 165-166 in the prescribed book.

Activity 9.1

STUDY the DSM-5 diagnostic criteria for Acute Stress Disorder and for Posttraumatic Stress Disorder

DSM-5 diagnostic criteria for Acute Stress Disorder

A Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing in person the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms

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

Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms

6. An altered sense of reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the traumatic event(s) typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, or restless sleep).
11. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance.
13. Problems with concentration.
14. Exaggerated startle response.

C Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

Note: Symptoms typically begin immediately after the trauma, but persistence for at least three days and up to a month is needed to meet disorder criteria.

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

E The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

(APA, 2013, pp. 280-281).

DSM-5 diagnostic criteria for Posttraumatic Stress Disorder

Note: The following criteria apply to adults, adolescents, and children older than 6 years.

A Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing in person the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

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

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic events.
   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme

expression being a complete loss of awareness of present surroundings.)
Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

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

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

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

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

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

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

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

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

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

Specify whether:

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

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

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

Specify if:

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

(APA, 2013, pp. 271-272).

Activity 9.2

In order to check whether you have understood and learnt the DSM-5 diagnostic criteria for Acute and Posttraumatic Stress Disorder, you can do the following tasks by carefully reading the case study below:

Case study

Thandi, a 28-year-old single parent, has been referred by her employer for psychological evaluation. Thandi, who has always been a reliable and conscientious worker, began to stay away from work without any reason and the standard of her work had deteriorated. Nine months ago while waiting for a taxi, Thandi and her eldest child, a 10-year-old daughter, were abducted by a gang of men and taken to a deserted, open field. Both Thandi and her daughter were brutally assaulted, raped repeatedly and threatened with death. On Thandi's instructions her daughter tried to run away, but she was caught by the men and stabbed repeatedly in the throat with a knife. After hours of torture, the abductors tied Thandi and her daughter up, set the grass around them on fire and drove off. Thandi was left to listen helplessly to her daughter dying. Passers-by who saw the smoke and heard Thandi's cries for help took her and her daughter to a nearby hospital. Shortly after their admission to hospital, Thandi's daughter passed away.

The police launched a large-scale manhunt for the perpetrators but they were not arrested. Thandi felt very guilty that she had lived while her daughter had died; she believed that she had failed to protect her daughter.

Four months ago, Thandi started having recurrent nightmares about the traumatic event. She also started to have flashbacks during the day that were so vivid that she felt as though she were reliving the trauma. In her dreams and in the flashbacks, she could see and smell her daughter's blood spurting from her throat, and could hear her daughter's terrified screams and death rattle, and the rapists' jeers.

Thandi also started to fear the dark and the gruesome nightmares. The smell of a veld fire made her very nauseous and anxious. She refused to travel by taxi, because the taxi reminded her of her trauma. This meant that she had to get up very early in the morning in order to catch a train to her workplace. Thandi appeared to be emotionally blunted and she began to neglect her younger son. She mentioned to the psychologist that she felt very distant from people. She also did not enjoy having lunch with her colleagues anymore. She lost interest in all social activities.

Thandi had trouble concentrating on her work; she was exhausted. She experienced serious sleeping problems and was irritable with everyone and everything around her. She had a heightened startle reaction and sporadic temper outbursts.

Thandi was clearly experiencing a lot of tension. She felt very guilty about her daughter's death, especially because she could do nothing to save her. She blamed herself for being so helpless and

powerless during the traumatic experience. It was clear that the traumatic event filled Thandi with horror.

Inquiries about her past brought the following information to light: Thandi was an illegitimate child who grew up with her grandmother in a rural area. From a young age she was sexually molested by an uncle. When as a teenager she told her grandmother about the molestation, her grandmother did not believe her and threw her out of the house. Thandi experienced this rejection as very traumatic, because she was emotionally dependent on her grandmother. Thandi was forced to move to the city to try to find work.

In the city she got involved in a relationship with a much older man, on whom she became emotionally dependent. They had a very close relationship. Two children were born from this relationship. A year ago Thandi's partner was killed in a taxi accident. Thandi was initially devastated by her partner's death. She battled to cope financially on her own. She was, however, determined to ensure a good future for her children. Thandi's life revolved around her children and her job for the past year. Apart from her colleagues, she has no other close friends.

Activity 9.3

Now that you have read the case study above, do the following:

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

(b) Justify your choice of diagnosis/diagnoses.

When you have completed both questions, you can compare your answers with the feedback on Activity 9.3 below.

Feedback on Activity 9.3

(a) Posttraumatic Stress Disorder (Principal Diagnosis)
Other Problems Related to Primary Support Group:
(Death of her daughter and partner, and Thandi is a single parent.)
Other Problems Related to the Social Environment:
Unspecified Problem Related to Social Environment (Thandi does not have adequate social support.)
Economic problems:
Unspecified Housing or Economic Problem (Since her partner's death, Thandi has battled to cope financially.)
Problems Related to Crime or Interaction With the Legal System:
Victim of Crime (Exposure to severe trauma, victim of torture, police have not arrested the perpetrators.)

(b) **Principal diagnosis:** Posttraumatic Stress Disorder,

Thandi meets the criteria for Posttraumatic Stress Disorder, for the following reasons:

Thandi had a very traumatic experience during which she was threatened with death and was severely assaulted sexually and physically by a gang of men. She was also a helpless onlooker as her daughter was raped and stabbed several times with a knife. As she lay tied up and helpless, the men set the veld around her on fire. Thandi's daughter died after the traumatic event. During the trauma Thandi felt helpless. She could not save herself and her child. She was filled with horror at the rape and assault.

Thandi persistently re-experiences the trauma in dreams, flashbacks and associations. Thandi experiences intense physiological discomfort (she feels nauseous) and psychological discomfort (she is very anxious) when she is exposed to situations that remind her of the traumatic incident.

She does everything in her power to avoid being reminded of the trauma. She will, for example, no longer take a taxi because she associates the trauma with a taxi.

She no longer takes proper care of her son and has started to neglect her work. Her responsiveness has decreased markedly. She feels isolated from people and avoids people. She is emotionally blunted.

Thandi exhibits persistent symptoms of heightened arousal: she has trouble sleeping; she is irritable, has outbursts of anger, experiences difficulty concentrating and displays a heightened startle response.

The disorder has lasted longer than a month (four months).

The disorder has resulted in clinically significant discomfort and impairment of occupational, social and general functioning.

The disorder is not attributable to the physiological effects of a substance or another medical condition.

9.2 STUDY UNIT: Aetiology of Acute and Posttraumatic Stress Disorders

Outcomes

Once you have worked through study unit 9.2, you should be able to:

- Identify and describe the factors that may contribute to the development of Acute Stress Disorder and Posttraumatic Stress Disorder.

Study

To be able to do the above you will need to study the sections from pages 171-176 in your prescribed book and do activity 9.4 in this Tutorial Letter 502.

Activity 9.4

Study the sections from page 171-176 in your prescribed book and do the following:

Posttraumatic Stress Disorder can seldom be attributed to a single causative factor. Identify the factors that may have contributed to the development of Posttraumatic Stress Disorder in Thandi's case and indicate the role of these factors in the development of her disorder.

Feedback on Activity 9.4

The experience and interpretation of the traumatic event play the most important role in the aetiology of a Posttraumatic Stress Disorder. The more serious and the more personal the stressor is, the greater its impact. Thandi was undoubtedly subject to an extremely severe trauma which closely affected her and her young child, whom she loved very much. Thandi experienced the stressor as overwhelming. She was not only raped, assaulted and threatened with death, but also had to watch her child being raped, assaulted and stabbed with a knife. Her child's injuries led to her death. Thandi also feels extremely guilty because she lived but could not protect and save her child. Thandi's trauma can be described as catastrophic and had a very negative impact on her.

We can also identify various predisposing factors in Thandi which made her more vulnerable to Posttraumatic Stress Disorder. Thandi had an unhappy childhood; she was molested as a child and rejected by her primary caregiver as an adolescent. She seems to be emotionally dependent on others and perhaps does not have adequate independent coping mechanisms. Thandi does not have friends and we can surmise that she is reasonably withdrawn and inhibited. Shortly before the trauma, Thandi lost her partner, which made her very sad. While she was still trying to work through one loss, she suffered a second loss. Thandi also has financial problems. An accumulation of stressors can have a very negative impact on a person. It appears from the case study that Thandi feels that she has lost control of her life.

In the presence of extremely severe stressors and numerous predisposing factors, Thandi also had no effective support systems to support her during the crisis. Support systems serve as buffers between stressors and predisposing factors. The lack of support systems not only contributed to the development of the disorder, but also reduced the likelihood of a good prognosis of the disorder.
If you were not able to identify all the factors which contributed to Thandi's development of Posttraumatic Stress Disorder, you should go back to the prescribed book and familiarise yourself with the possible causative factors of Posttraumatic Stress Disorder.

Activity 9.5

Violence is commonplace in South Africa. South Africa is also often hit by various natural disasters. Therefore, there is a good chance that sometime you will meet someone with an Acute Stress Disorder or Posttraumatic Stress Disorder.

Read the following portions of reports which have appeared in South African newspapers:

"It was not, in fact, a search for bodies, but for body parts. I thought that someone was burning tar. I was outside the house when the explosion happened. There was an incredible bang and I thought something had exploded in my lounge. For about 30 seconds you could've heard a pin drop."

"It is a miracle that he lived after being shot in the face three times at close range, but for this brave young traffic officer it is still a battle even after two years to go on with as normal a life as possible."

"A group of masked men stormed and began stoning a hamburger outlet belonging to the American firm McDonalds yesterday afternoon shortly after about a thousand Muslims signed an undertaking in the Greenpoint stadium to go and "help their brothers in Palestine". Cars which were parked outside the outlet were also damaged."

"The word "suffer" has taken on new meaning in the life of a man from Witpoortjie on the West Rand. He was attacked and robbed twice on the same night and then dropped at home without clothes by the police."

Find other reports in the media about traumatic events. Identify factors which could possibly contribute to Acute and Posttraumatic Stress Disorders. Also read follow-up reports on the victims and take note of how they deal with the traumatic events. How would you deal with similar traumas?

Crisis services are available in most centres. Think, for example, of Lifeline, Telefriend, Famsa and the Depression and Anxiety Support Group which offer crisis resolution services to people with a broad spectrum of problems. Find out what crisis services are available in your area and what sort of services they offer. Would you perhaps consider getting involved in one of these organisations which offer invaluable services to the community?

9.3 STUDY UNIT: Adjustment Disorders

Adjustment Disorders are an important aspect of the Trauma-and Stress-Related Disorders, and since they are not extensively included in the 11^{h} edition of your prescribed book (refer to pages 166-167), we have provided you with this section that you are required to study well.

According to the DSM-5 Adjustment Disorders can accompany any medical disorder and most mental disorders. Adjustment Disorders can be diagnosed in addition to another mental disorder only if the latter does not explain the particular symptoms that occur in reaction to the stressor (APA, 2013, p. 289). They are also associated with an increased risk of suicide attempts and have a high rate of completed suicides.

The subjective distress or impairment in functioning associated with Adjustment Disorders are characterised by behavioural and emotional symptoms, such as decreased performance at work or school or temporary changes in social relationships (APA, 2013, p. 288), due to one or more stressors of any severity.

Adjustment Disorders can be distinguished from Acute Stress Disorder and Posttraumatic Stress Disorders by taking the timing and symptom profile into consideration. Adjustment Disorders can, for example, be diagnosed immediately and persist for up to six months after exposure to the stressor, while Acute Stress Disorder can only be diagnosed between three days and one month after exposure to the stressor in conjunction with the required symptom profile, and Posttraumatic Stress Disorder can only be diagnosed between one and six months after exposure to the stressor in conjunction with the required symptom profile for the disorder.

The following stressors could give rise to Adjustment Disorders in some individuals:

- Interpersonal problems (on-going interpersonal problems, termination of a deep friendship, marital problems and/or betrayal by a business partner)
- Recurrent stressors (seasonal business crises, educational examination crises)
- Continuous stressors (persistent painful illness with increasing disability, living in a crime ridden neighbourhood)
- Stressors due to developmental events (going to school, leaving the parental home, getting married, having a baby, becoming a parent, getting divorced, re-entering the parental home, failing to attain occupational or personal goals, retrenchment, retirement)
- Stressors related to the death of a loved one (when cultural, religious, or age appropriate norms are taken into consideration; the death of a loved one can lead to Adjustment Disorders, when the intensity and quality or persistence of grief symptoms exceed the expected norm)
- Another category*, Persistent Complex Bereavement Disorder* has specifically been created for grief- and bereavement-related symptoms.

An Adjustment Disorder should also be diagnosed when the individual has not been exposed to a traumatic event but displays the symptom profile of either Acute Stress Disorder or Posttraumatic Stress Disorder. (Adapted from APA, 2013)

Outcome
Once you have worked through study unit 9.3, you should be able to:

- Describe the characteristics of Adjustment Disorders
- Describe the types of stressors that can lead to Adjustment Disorders.

Study
To be able to do the above you will need to study the introduction to study unit 9.3 and do activity 9.6 in this tutorial letter 502.

Activity 9.6

Study the DSM-5 diagnostic criteria for Adjustment Disorders.

DSM-5 diagnostic criteria for Adjustment Disorders	
A	The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
B	The symptoms or behaviours are clinically significant, as evidenced by one or both of the following:
1.	Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptoms of severity and presentation.
2.	Significant impairment in social, occupational, or other important areas of functioning.
C	The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a pre-existing mental disorder.
D	The symptoms do not represent normal bereavement.

E Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Specify whether:
With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.

With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant.

With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant.

With disturbance of conduct: Disturbance of conduct is predominant.

With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.

Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

(APA, 2013, pp. 286-287).

Diagnosing a person with Adjustment Disorder

When the severity of the stressor is of any severity or type other than what is required for Criterion A for Acute Stress Disorder, a diagnosis of Adjustment Disorder can be made. A diagnosis of Adjustment Disorders is also made when the response to a Criterion A stressor (e.g. spouse leaving, being fired) evokes the symptom pattern (syndrome) of Acute Stress Disorder without meeting criterion A of Acute Stress Disorder (or any other specific mental disorder) such as exposure to actual or threatened death, serious injury, or sexual violence. For example, severe stress reactions to life-threatening illnesses that may include some Acute Stress Disorder symptoms may be more appropriately described as an Adjustment Disorder. Some forms of Acute Stress responses such as anger, guilt, and depression do not form a part of the Acute Stress Disorder syndrome and are better described as an Adjustment Disorder. Depressive or anger responses in an Adjustment Disorder may involve rumination about the traumatic event, but they do not include involuntary and intrusive distressing memories as in Acute Stress Disorder.

Activity 9.7

Distinguish between Posttraumatic Stress Disorder and Adjustment Disorder with regard to stressor and symptoms.

9.4 STUDY UNIT: Reactive Attachment Disorder

Introduction

In this study unit, we will look at Reactive Attachment Disorder of infancy or early childhood, which is an internalising disorder that centres on the trauma small children experience as a result of having been socially neglected. Social neglect, or the absence of care giving in children under the age of five, is a diagnostic requirement of Reactive Attachment Disorder. It is characterised by a pattern of disturbed and developmentally inappropriate attachment behaviours, in which a child rarely or minimally turns to an attachment figure for comfort, support, protection, and nurturance. Children with Reactive Attachment Disorder have the capacity to form selective attachments, but they are unable to do so because of limited opportunities during their early developmental years due to neglect. They thus fail to demonstrate behavioural manifestations of selective attachments toward primary caregivers. This is evidenced during times of distress, when they demonstrate no consistent effort to obtain comfort, support, nurturance, or protection from caregivers, and only respond minimally when they are comforted. The disorder is thus associated with the absence of comfort seeking behaviours and the absence of a positive response when being comforted. In addition, such children's emotion regulation capacity is compromised, since they are

unable to display positive emotions, and often display negative emotions such as fear, sadness, and irritability.

A diagnosis of Reactive Attachment Disorder should not be made for children under the age of nine months, or in those who are developmentally unable to make selective attachments (APA, 2013). Remember that these two attachment disorders Reactive Attachment Disorder and Disinhibited Social Engagement Disorder that begin in childhood are part of the Trauma and Stressor related disorders according to the DSM-5 classification system.

Outcome

Once you have worked through study unit 9.4: Reactive Attachment Disorder you should be able to do the following:

- Identify Reactive Attachment Disorder
- Describe the DSM-5 criteria for Reactive Attachment Disorder

Study

Study the Attachment Disorders on pages 506-507 in the prescribed book and the DSM-5 diagnostic criteria for Reactive Attachment Disorder in activity 9.7.

Activity 9.7

The 11th edition of the prescribed book contains a short section on Reactive Attachment Disorder on pages 506-507. Please read through these pages and study the introduction to this Study Unit, as well as the DSM-5 diagnostic criteria for Reactive Attachment Disorder below.

STUDY the DSM-5 diagnostic criteria as provided below:

DSM-5 diagnostic criteria for Reactive Attachment Disorder

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

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

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

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

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

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

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

E The criteria are not met for Autism Spectrum Disorder.

F The disturbance is evident before age 5 years.

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

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

Specify current severity:
Reactive Attachment Disorder is specified as **severe** when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

(APA, 2013, pp. 265-266).

9.5 STUDY UNIT: Disinhibited Social Engagement Disorder

Introduction

Disinhibited Social Engagement Disorder is characterised by a pattern of behaviour that involves culturally inappropriate, overly familiar behaviour with relative strangers. This type of familiarity with strangers violates the social boundaries of the culture. Diagnosing a child with Disinhibited Social Engagement Disorder can only occur when the child is developmentally mature enough for being able to form selective attachments. It thus needs to be at least nine months old before a diagnosis of Disinhibited Social Engagement Disorder can be made.

Social neglect with its accompanying developmental delays is the common aetiological denominator of both Disinhibited Social Engagement Disorder and Reactive Attachment Disorder. Disinhibited Social Engagement Disorder may therefore co-occur with cognitive and language delays, stereotypes, and other signs of severe neglect such as malnutrition or being poorly cared for. Even when these signs of neglect are no longer present, signs of the disorder may still persist. Children who present with no current signs of neglect can still present with symptoms of Disinhibited Social Engagement Disorder, and the condition can also exist without overtly disordered attachment behaviour. In order to develop Disinhibited Social Engagement Disorder, the neglect should have occurred in the first few months of the baby's life, even before it can be diagnosed. If the neglect began and occurred after the age of 2 the development of the disorder and its manifestation could not be associated with the neglect.

Outcome

Once you have worked through study unit 9.5: Disinhibited Social Engagement Disorder you should be able to do the following:

- Identify Disinhibited Social Engagement Disorder
- Describe the DSM-5 criteria for Disinhibited Social Engagement Disorder

Study

Study the Attachment Disorders on pages 506-507 in the prescribed book and the DSM-5 diagnostic criteria for Disinhibited Social Engagement Disorder in activity 9.8.

Activity 9.8

STUDY the DSM-5 diagnostic criteria as provided below:

DSM-5 diagnostic criteria for Disinhibited Social Engagement Disorder

A A pattern of behaviour in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:

1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
2. Overly familiar verbal or physical behaviour (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B The behaviours in Criterion A are not limited to impulsivity (as in Attention-Deficit/Hyperactivity Disorder) but include socially disinhibited behaviour.

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

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

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

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

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

Specify current severity:
Disinhibited Social Engagement disorder is specified as **severe** when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

(APA, 2013, pp. 268-269).

Activity 9.9

Compare Reactive Attachment Disorder and Disinhibited Social Engagement Disorder.

CONCLUSION

You are now well prepared to identify individuals who are suffering from Trauma- and Stress-Related Disorders. You are also in a better position to refer victims of crime to trained counsellors or psychologists who are equipped to assist victims of trauma effectively.

Revision Activity

1. Define the following terms: Stress
   Stressor
   Acute Stress Disorder
   Posttraumatic Stress Disorder

Reactive Attachment Disorder
Disinhibited Social Engagement Disorder

2. Answer Focus Questions 1 and 2 on page 166 in your prescribed book.

(Now check your definitions by comparing them to those found in a Dictionary of Psychology or by referring to the Glossary at the back of your prescribed book, and compare your answers to Focus Questions 1 and 2 with the Summary on page 195).

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: Fifth Edition* (DSM-5). Arlington VA: American Psychiatric Association.

Burke, A. (Ed.) (2012). *Abnormal psychology: A South African perspective (2nd ed.).* Cape Town, South Africa: Oxford University Press.

Learning Unit 10

Substance-Related and Addictive Disorders

Mrs Bantobetse (Banti) Mokgatlhe & Mrs Louise Henderson

Contents

Orientation

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, commonly referred to as DSM-5 is the latest version of the American Psychiatric Association's gold standard text on the names, symptoms, and diagnostic features of every recognized mental illness, including addictions. The DSM-5 which has replaced the DSM-IV-TR, recognises Substance-Related disorders as resulting from the excessive use of ten separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens (phencyclidine or similarly acting arylcyclohexylamines), other hallucinogens such as LSD, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants (including amphetamine-type substances, cocaine, and other stimulants), tobacco, and other or unknown substances (APA, 2013, p. 481). Therefore, while some major groupings of psychoactive substances are specifically identified, use of other or unknown substances can also form the basis of a Substance-Related or Addictive Disorder.

The DSM-5 explains that activation of the brain's reward system is central to problems arising from drug use - the rewarding feeling that people experience as a result of taking drugs may be so profound that they neglect other normal activities in favour of taking the drug. While the pharmacological mechanisms, for each class of drug is different, the activation of the reward system is similar across substances in producing feelings of pleasure or euphoria, which is often referred to as a "high" (APA, 2013, p. 481).

In addition to Substance-Related Disorders, the DSM-5 in this section further includes Gambling Disorder under the heading 'Non-Substance-Related Disorders'. The inclusion of this disorder in this section of the

DSM-5 is based on the idea that gambling behaviours activates reward systems similar to those activated by substances of abuse and produce behavioural symptoms that appear comparable to those produced by the Substance Use disorders. However, other behavioural patterns such as internet gaming, have also been described although research on these and other behavioural syndromes is less clear.

The DSM-5 also recognises that people are not all automatically or equally vulnerable to developing Substance-Related Disorders, and that some individuals have lower levels of self-control, which may be brain-based, which predispose them to developing problems if exposed to drugs (APA, 2013, p. 481).

Chapter 11 Substance-Use Disorders in the prescribed book, has been renamed Substance-Related and Addictive Disorders in the DSM-5 classification system. The DSM-5 distinguishes between two groups of

Substance-Related Disorders:

- Substance Use Disorders
- Substance-Induced Disorders.

The essential feature of Substance Use Disorders is a cluster of cognitive, behavioural, and physiological symptoms which point to the continued use of the substance despite significant substance-related problems (APA, 2013, p. 483). Substance-Induced Disorders namely Intoxication, Withdrawal, and Substance-Induced Mental Disorders, are specific groupings of the signs and symptoms manifested by the individual due to the recent use (Intoxication,) or cessation or decreased use (Withdrawal) of a substance. Substance/Medication-Induced Mental Disorders are potentially severe, usually temporary, but sometimes persisting central nervous system syndromes that develop in the context of the effects of substances of abuse or medications or toxins and include Substance-Induced Psychosis, Substance-Induced Bipolar and Related Disorders, Substance-Induced Depressive Disorders, Substance-Induced Anxiety Disorders, Substance-Induced Obsessive-compulsive and Related Disorders, Substance-Induced Sleep Disorders, Substance-Induced Sexual Dysfunctions, Substance-Induced Delirium and Substance-Induced Neurocognitive Disorders.

The DSM-5 allows clinicians to specify how severe the Substance Use Disorder is, depending on how many symptoms are identified:

- Mild - Two or three symptoms
- Moderate - four or five symptoms
- Severe - six or more symptoms

Clinicians can also add specifiers such as:

- “in early remission” - defined as at least 3 but less than 12 months without Substance Use Disorder criteria (except craving),
- “in sustained remission” - defined as at least 12 months without criteria (except craving)
- “in a controlled environment” - is used if the individual is both in remission and in an environment where access to the substance is restricted (e.g locked hospital units or substance-free jail)
- “on maintenance therapy” - (applies to individuals who are taking long-term maintenance medication, such as nicotine replacement medication) and no criteria for the substance use disorder have been met for this class of medication.”

Introduction

Substance-Related Disorders and Addictive Disorders

This Learning Unit looks at the most common substances of abuse prevalent in our society. After you have studied this Learning Unit you will be able to understand the phenomenon of Substance-Related Disorders and also be able to differentiate between two categories of Substance Related Disorders, i.e. Substance Use Disorders and Substance-Induced Disorders. Furthermore you will be able to differentiate between various substances as far as their effect on behaviour and thought processes of the individual is concerned.

Most of us who have been exposed to someone with a substance-related problem have asked ourselves why the person would engage in such behaviour and whether his or her behaviour actually constitutes a problem

or not. We can really only address these concerns if we have a fundamental understanding of the biochemical effects of the substances involved and if we are skilled in being able to identify and classify substance use in abnormal behaviour. The three study units in this chapter will introduce you to these issues.

Throughout the ages and in all cultures, a variety of substances have been consumed. The ingestion of various substances, whether through swallowing, inhaling or injection, for recreational, spiritual, emotional or other purposes continues to uniquely characterise various cultures. While the spectrum of available chemical substances has increased, and indeed become more complex, society's response to the excessive use of such substances has not changed. The use and reliance on substances are consistently sanctioned across most cultures. In South Africa, the use of certain substances such as cocaine, LSD, marijuana, alcohol and nicotine is circumscribed by law. While some of these substances are illegal, others are defined in terms of an age restriction or levels of acceptable consumption.

The reasons for societal sanctioning of substance use are varied. The physiological consequences for the individual often translate into diminished productivity, public health sector costs, disruption of family life and other undesirable effects. The primary concern to psychologists studying Substance-Related Disorders is the point at which an individual's consumption of a particular substance crosses the line between moderation and overuse of substances. For both curative and preventative purposes, psychologists seek to classify the person's substance-related behaviour and try to understand the causes of such behaviours.

In the DSM-5, the major change with Substance-Related Disorders is the removal of the distinction between “abuse” and “dependence.” The DSM-IV-TR diagnoses of Substance Abuse and Substance Dependence have been replaced with a single diagnosis, Substance Use Disorder. However, Substance Intoxication and Withdrawal remain (as was the case in the DSM-IV), with only updated definitions. The DSM-5 therefore does not include the diagnoses of Substance Abuse and Substance Dependence as used in the DSM-IV-TR. Rather, the criteria are provided for Substance Use Disorder, accompanied by criteria for Intoxication, Withdrawal, Substance-Induced Disorders, and Unspecified Substance-Related Disorders.

According to the DSM-5 classification system, the criteria for **Intoxication** includes the presence of clinically significant problematic behavioural or psychological changes (e.g., mood lability, impaired judgement, impaired social or occupational functioning etc) that develop during, or shortly after substance ingestion. The criteria for **Withdrawal** in terms of the DSM-5 includes the presence of a characteristic withdrawal syndrome (characterised by e.g. insomnia, increased hand tremor, vomiting, anxiety, autonomic hyperactivity etc) that develops within several hours to a few days after the cessation of or reduction in heavy and prolonged use of a substance.

The criteria for hallucinogen use disorder are the same as for other disorders, with the exception of withdrawal as a recognisable symptom or consequence of Hallucinogen use. This is based on the fact that hallucinogen withdrawal syndrome has not been consistently documented in humans, and as such the diagnosis of hallucinogen withdrawal syndrome is not included in the DSM-5.

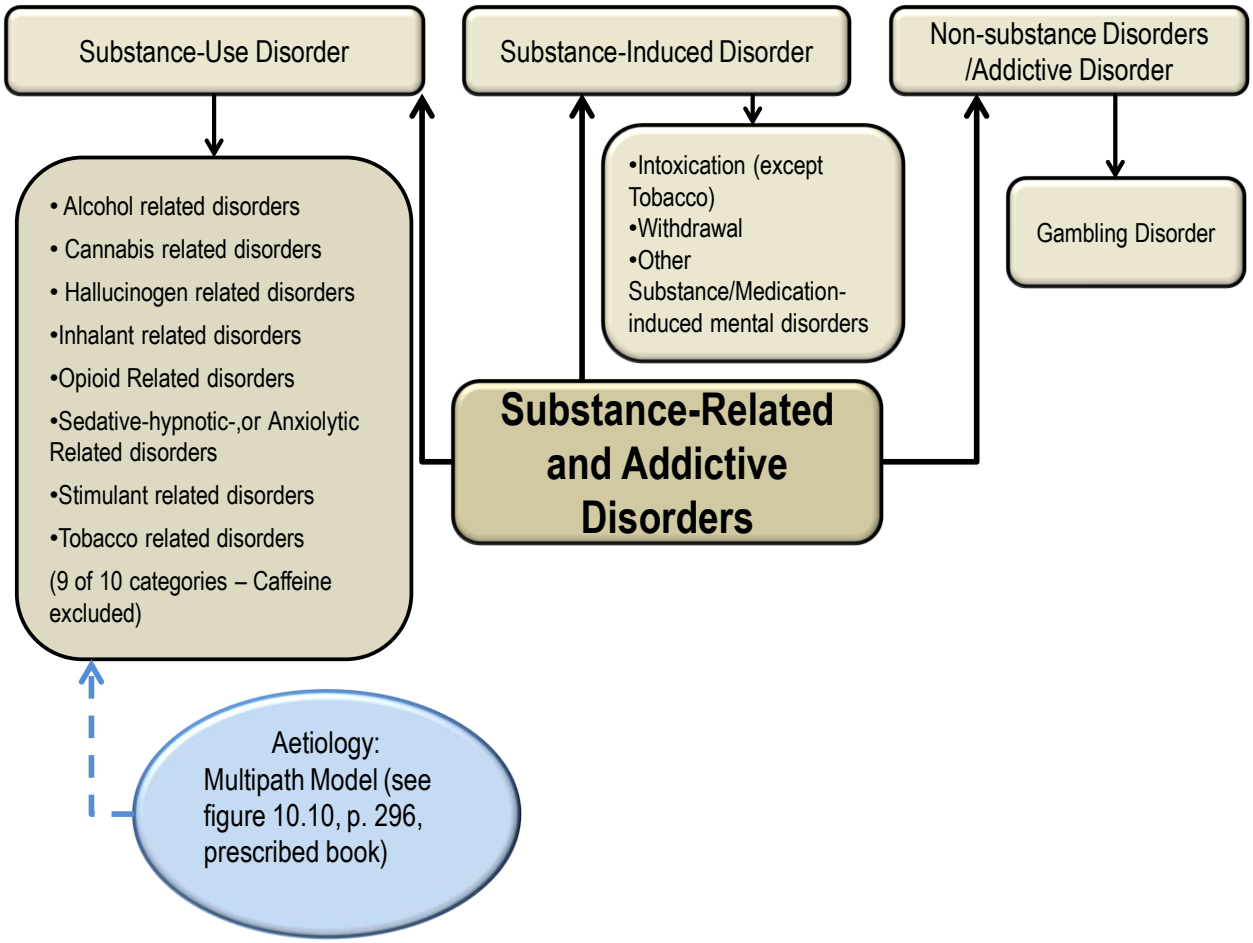
Furthermore, the chapter has also been expanded to include a non-substance-related addictive disorder, which is regarded as behavioural addiction “gambling disorder” as additional category. According to the APA, this change “reflects the increasing and consistent evidence that some behaviours, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.” (2013, p. 481).

During the past few years, South Africa has seen a marked growth in the gambling industry due to changes in the country's gambling laws, the reintegration of the former “homelands" and revision of the country's borders and the introduction of a national lottery. A far greater number of people now have opportunities to gamble because of the accessibility to these facilities and the many attractions associated with them. These factors together with the current poor economic conditions in our country have no doubt made gambling a more attractive activity which promises very lucrative results. It therefore seems justified to make the statement that more individuals might well be developing gambling behaviours. However, it is not always easy to differentiate between “normal” gambling behaviour and “abnormal” gambling behaviour. Adding the varied religious opinions into the equation complicates the issue even more.

In this Learning Unit, we are also going to discuss Gambling Disorder. According to the DSM-5 this condition shares some similarities with “Pathological Gambling” as defined by the DSM-IV-TR classification system.

The key characteristic of Gambling Disorder is persistent and recurrent maladaptive gambling behaviour that disrupts personal, family or occupational areas of the individual's life. The individual may be preoccupied with gambling, shaping his or her thinking and behaviour around themes associated with gambling. These individuals also often manifest many irrational beliefs or superstitions concerning gambling, for example “recipes" for winning, and often deny the “pathological" nature of their gambling behaviour.

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



Activity 10.1

Scan-read chapter 11 in your prescribed book (pages 327 to 360), in order to familiarise yourself with the contents of this chapter.

Activity 10.2

While working through this chapter, look out for the following key terms. You may add as many as you like as you go through the chapter. Follow the definition suggestions provided in chapter 11 and the glossary in the prescribed book. Add to the definitions as you encounter more information about the terms. Illustrate your understanding of the definitions with appropriate examples. Ensure that after you have completed this chapter you know what these terms refer to:

- Substance Use Disorder
- Substance-Induced Disorder
- Intoxication
- Delirium tremens
- Psychoactive substances
- Withdrawal
- Tolerance
- Stimulants
- Opioids

- Hallucinogens
- Depressant
- Sedatives/hypnotics and Anxiolytics
- Inhalants

The above-mentioned terms describe variations in substance use patterns**.** Please refer to pages 328- 342 of your prescribed book to find the relevant definitions of the concepts. Make sure that you can make a clear distinction between the various concepts. In the DSM-5 the term "addiction" has been replaced with the more neutral term Substance-Use Disorder which indicates the wider range of this disorder Polysubstance abuse (as referred to in the prescribed book on pages 343-344), is a term often used when multiple different substances are used, however it is not a diagnostic category in the DSM-5. Therefore in the case of use of or intoxication or withdrawal from the use of multiple substances, each substance should be recorded separately.

10.1 STUDY UNIT: Criteria of Substance-Related and Addictive Disorders

Substance Use Disorder in the DSM-5 combines the DSM-IV-TR categories of Substance Abuse and Substance Dependence into a single disorder (Substance Use Disorder) measured on a continuum from mild to severe. Each specific substance with the (exception of caffeine, which cannot be diagnosed as a Substance Use Disorder) is diagnosed separately specifying the substance of use (e.g., Alcohol Use Disorder, Cocaine Use Disorder, etc).

Outcomes
Once you have worked through study unit 10.1 you should be able to:

- Identify symptoms of Substance Use Disorders and Substance-Induced Disorders
- Distinguish between Substance Use Disorders and Substance-Induced Disorders.
- Identify the specific subtype of Substance-Related Disorders
- Describe the DSM-5 diagnostic criteria for:
    - Alcohol Use Disorder
    - Alcohol Intoxication
    - Alcohol Withdrawal
    - Cannabis Intoxication
    - Cannabis Withdrawal
- Describe the common features of Substance/Medication-Induced Mental Disorders.

Study
To be able to do the above you will have to:

- study the introduction to this Learning Unit,
- the DSM-5 criteria for Alcohol Use Disorder in activity 10.3 in this study guide,
- page 329 of the prescribed book
- the DSM-5 criteria for:
    - Alcohol Intoxication
    - Alcohol Withdrawal
    - Cannabis Intoxication
    - Cannabis Withdrawal
    - common features of Substance/Medication-Induced Mental Disorders in activity 10.4 of this tutorial letter.

Whereas a diagnosis of Substance Abuse (according to the DSM-IV-TR) previously required the presence of only one out of four possible symptoms in the absence of dependence symptoms for the same substance, Mild Substance Use Disorder in DSM-5 requires two or three symptoms from a list of 11 (as indicted in the orientation section). Drug craving has also been added to the DSM-5 while problems with law enforcement, has been eliminated because of cultural considerations that make the criteria difficult to apply globally.
The diagnosis of dependence was also removed in the DSM-5 as it created much confusion as most people link dependence with "addiction" when in fact dependence can be a body's normal response to a substance.

Activity 10.3

The prescribed book does not contain information on the DSM-5 criteria for Alcohol Use Disorder. Add the following information to the information in your prescribed book and make sure you study this information.

DSM-5 Diagnostic criteria for Alcohol Use Disorder

A A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from the effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
    a) a need for markedly increased amounts of alcohol to achieve intoxication or desired effect
    b) markedly diminished effect with continued use of the same amount of alcohol
11. Withdrawal, as manifested by either of the following:
    a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for alcohol Withdrawal from the specific substances pp. 499-500, APA,2013)
    b) Alcohol (or a closely related) substance such as a benzodiazepine is taken to relieve or avoid withdrawal symptoms

Specify if:
In early remission: Full criteria were previously met, none of the criteria have been met for at least three months but less than 12 months, (excluding criterion regarding craving to use alcohol)
In sustained remission: Full criteria were previously met, none of the criteria have been met for at least 12 months or longer, (excluding criterion regarding craving to use alcohol)

Specify if:
In a controlled environment: if individual in an environment where access to alcohol is restricted.
Severity specifiers:
Mild: 2-3 symptoms
Moderate: 4-5 symptoms
Severe: 6 or more symptoms

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 4 or 5 is present)
Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 4 nor 5 is present).

(Adapted from, APA 2013, p. 490-491).

Activity 10.4

The prescribed book does not contain sufficient information on the DSM-5 criteria for Substance-Induced Disorders. In this Learning Unit we will study the DSM-5 diagnostic criteria of Alcohol and Cannabis Intoxication and Withdrawal, and the generic diagnostic criteria for Substance/Medication-Induced Mental Disorder, as examples of Substance-Induced Disorders. Therefore add the following

information regarding Intoxication, Withdrawal, and Substance/Medication-Induced Mental Disorder to the information in your prescribed book and make sure you study this information.

DSM-5 Diagnostic criteria for Alcohol Intoxication

A Recent ingestion of alcohol.

B Clinically significant problematic behavioural or psychological changes (e.g. inappropriate sexual or aggressive behaviour, mood lability, impaired judgement) that developed during, or shortly after, alcohol ingestion.

C One (or more) of the following signs and symptoms developing during, or shortly after, alcohol use:

1. Slurred speech.
2. Incoordination.
3. Unsteady gait.
4. Nystagmus.
5. Impairment in attention or memory.
6. Stupor or coma.

D The signs and symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

(APA, 2013, p. 497).

DSM-5 Diagnostic criteria for Alcohol Withdrawal

A Cessation of (or reduction in) alcohol use that has been heavy and prolonged.

B Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use described in criterion A:

1. Autonomic hyperactivity (e.g. sweating or pulse rate greater than 100 bpm).
2. Increased tremor.
3. Insomnia.
4. Nausea or vomiting.
5. Transient visual, tactile, or auditory hallucinations or illusions.
6. Psychomotor agitation.
7. Anxiety.
8. Generalised tonic-clonic seizures.

C The signs and symptoms in criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

(APA, 2013, pp. 499-500).

DSM-5 Diagnostic criteria for Cannabis Intoxication

A Recent use of cannabis.

B Clinically significant problematic behavioural or psychological changes (e.g. impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgement, social withdrawal) that developed during, or shortly after, cannabis use.

C Two (or more) of the following signs and symptoms developing within 2 hours of cannabis use:

1. Conjuntival injection.
2. Increased appetite.
3. Dry mouth.
4. Tachycardia.

D The signs and symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

(APA, 2013, p. 516).

DSM-5 Diagnostic criteria for Cannabis Withdrawal

A Cessation of cannabis use that has been heavy and prolonged (i.e. usually daily or almost daily use over a period of at least a few months).

B Three (or more) of the following signs and symptoms develop within approximately 1 week after criterion A:

1. Irritability, anger, or aggression.
2. Nervousness or anxiety.
3. Sleep difficulty (e.g. insomnia, disturbing dreams).
4. Decreased appetite or weight loss.
5. Restlessness.
6. Depressed mood.
7. At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache.

C The signs and symptoms in criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

(APA, 2013, pp. 517-518).

DSM-5 Common features for Substance/Medication-Induced Mental Disorder

A The disorder represents a clinically significant symptomatic presentation of a relevant mental disorder.

B There is evidence from history, physical examination, or laboratory findings of both of the following:

1. The disorder developed during or within 1 month of a substance intoxication or withdrawal or taking medication; and
2. The involved substance/medication is capable of producing the mental disorder.

C The disorder is not better explained by an independent mental disorder (i.e., one that is not substance- or medication-included). Such evidence of an independent mental disorder could include the following:

1. The disorder preceded the onset of intoxication or withdrawal or exposure to the medication.
2. The full mental disorder persisted for a substantial period of time (e.g., at least 1 month after the cessation of acute withdrawal or severe intoxication or taking the medication. This criterion does not apply to substance-included neurocognitive disorders or hallucinogen persisting perception disorder, which persist beyond the cessation of acute intoxication or withdrawal.

D The disorder does not occur exclusively during the course of a delirium.

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

(APA, 2013, pp. 487-488).

Activity 10.5

Study the DSM-5 diagnostic criteria for a type of Substance Use Disorder (Alcohol Use Disorder) and then answer the following:

Read the case study about Jim presented in the introduction of Chapter 11, pages 331 in your prescribed book. Then provide a diagnosis of Jim's behaviour according to the DSM-5 classification system and justify your choice of diagnosis/diagnoses by referring to key features from the case study. To assist you at arriving at a final diagnosis you may start with identifying and listing Jim's symptoms as well as indicating the onset, duration and intensity of these symptoms. Compare your list of Jim's symptoms with the DSM-5 diagnostic criteria of the disorders you are considering and eliminate those disorders and conditions that do not match Jim's symptom patterns.

In your response to this activity, Jim's behaviour can be classified according to the DSM-5 diagnostic criteria as a Substance-Related Disorder and the diagnosis will be *Alcohol Use Disorder*. Jim's pattern of consumption clearly meets the duration requirement of a 12 month period. He meets definite signs of tolerance, and he meets criteria 6, 8, 9, 10 cited in the criteria box above, thus exceeding required number of two criteria. Please note that we do not have any clear information in the case study about the presence of withdrawal or attempted terminations of consumption.

Jim also receives a diagnosis under Occupation Problems, namely *Other Problem Related to Employment*, as he had recently lost his job due to his drinking behaviour.

Activity 10.6

Distinguish between Substance Use Disorders and Substance-Induced Mental Disorders.

In your answer to this question, you should indicate that Substance Use Disorders refer to a problematic pattern of recurrent use of a variety of substances, extending over a period of 12 months which results in notable impairment or distress and continues despite social, occupational, psychological, or physical problems.

Substance-Induced Mental Disorders reflect the fact that the symptoms of many clinical disorders can also be caused by the use of substances. Some of the Sexual Dysfunctions discussed in chapter 14 of the prescribed book, for example, comprise symptoms that may have been caused by substance abuse. The classification of such disorders on the DSM-5 classification system thus requires that the

possibility that the relevant symptoms might be substance-induced to be ruled out first. Furthermore, certain Neurocognitive Disorders (refer to chapter 13 of the prescribed book) can be as a result of substance use.

10.2 STUDY UNIT: Criteria for Addictive Disorders

The inclusion of **Gambling Disorder** in the category of Substance-Related and Addictive Disorders is new to the DSM-5 classification system. Previously, in the DSM-IV-TR, Pathological Gambling was included into the section on Impulse Control Disorders. This change in the DSM-5 reflects the latest research findings that alludes to the fact that Gambling Disorder is similar to Substance-Related and Addictive Disorders in clinical expression, brain origin, co-morbidity, physiology, and treatment

Outcomes
Once you have worked through study unit 10.2 you should be able to:

- Identify symptoms of Gambling Disorder
- Specify the intensity of a Gambling Disorder
- Describe the DSM-5 diagnostic criteria for Gambling Disorder

Study

- **To be able to do the above you will need to study the introduction to the section on Substance-Related and Addictive Disorders in this Tutorial Letter 502 and the DSM-5 diagnostic criteria for Gambling Disorder in activity 10.7 in this Tutorial Letter 502.**

Activity 10.7

Make sure you know the DSM-5 criteria for Gambling Disorder, below.:

DSM-5 Diagnostic criteria for Gambling Disorder

A Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning next venture, thinking of ways to get money with which to gamble).
5. Often gambles when feeling distress (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even (“chasing” one’s losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

B The gambling behavior is not better explained by a manic episode.

Specify current severity:
Mild: 4–5 criteria met.
Moderate: 6–7 criteria met.
Severe: 8–9 criteria met.

Adapted from APA (2013, pp. 585-589).

10.3 STUDY UNIT: A selection of substances

It is certainly beyond the scope of this study unit to study all the common substances associated with Substance-Related Disorders. However, it is imperative that we gain at least a rudimentary understanding of the workings of a number of common substances. This study unit introduces you to a selection of such substances, namely, alcohol, cannabis, cocaine and LSD.

Outcomes

Once you have worked through study unit 10.3 you should be able to:

- distinguish between the selected substances and describe their short term effects and addictive potential.
- classify most of known substances (as depressants, sedatives, stimulants or hallucinogens)

Study

To be able to do the above you will need to study the following sections in the prescribed book:

- table 11.2, on page 330 indicates the differences between alcohol, cannabis, cocaine and caffeine in terms of their category, short term effects and addictive potential.
- the sections on “Depressants”, “Stimulants”, Dissociative Anaesthetics”, “Substances with Mixed Chemical Properties” and “Hallucinogens”, pages 331-341

Activity 10.8

Add the following information to that of the prescribed book and make sure that you know this information.

Drug Abuse within the South African context

The incidence of drug abuse is increasing worldwide every year. As South Africa continues to strengthen its ties with foreign countries, more and more drugs are coming into the country. Many of the drugs are smuggled into the country from these countries. The drug trade is now a multi-million rand industry and it is becoming easier and easier to buy illegal drugs with many suppliers on the streets.

It is also an issue of serious concern that people become dependent on (addicted to) drugs at a very young age. What is even more worrying is the fact that most addicts engage in ant-social acts such as stealing, or becoming prostitutes to get money to buy drugs. There are many myths about substance abuse that necessitates greater education and awareness, especially amongst the most vulnerable, the youth. Many young people initially start to experiment with substances such as cigarettes, alcohol, and marijuana as they deem these substances as low risk. However, additionally to the health risks, these substances also entail additional risks as the mortality and morbidity rates are further increased due to impaired driving, unsafe sexual practices and aggression which are related to the abuse of these substances.

The substances discussed in this section are considered illegal with the exception of solvents in terms of the South African drugs and drug trafficking Act, Act 140/92. The most common street drugs are classified according to the effect on the brain. The 3 main classes are uppers (stimulants), downers (depressants) and hallucinogens (result in hallucinations). Uppers include cocaine, ecstasy, tik, crystal meth or methamphetamine and amphetamines. These substances stimulate the brain and increase heart rate. Typical signs of stimulants are high energy levels, insomnia, irritability, increased excitability, hyperactivity, abrupt mood changes, and nervousness. The downers on the other hand suppress or delay certain brain functions. Depending on which part of the brain is suppressed, they are divided into two sub-groups:- either narcotic or tranquilising substances such as heroin or mandrax.

Figure 10.2: The most common drugs of abuse in South Africa, their street names, their effects and risks

Heroin, "H", "Smack" , "horse", "brown sugar" Like cocaine it creates euphoria but once the ''high'' is over, depression sets in. All negative feelings of guilt, tension and anxiety disappear after use. It is extremely dangerous because it quickly becomes addictive. At higher doses the slowed breathing is more pronounced and can lead to death if respiration is completely depressed. A major problem with heroin use is the way it is used especially if injected. Sharing injecting needles increases the HIV and Hepatitis B and C infections. Long-term use causes liver damage, seizures, coma and death.	**Marijuana, "dagga", "patje", "joint", "zol", "skyf", "dope", 'ganja', ''hashish'** Dagga from cannabis plant is grown in South Africa. It produces a feeling of relaxation while high doses can produce mild hallucinations. Most users claim the drug increases their creative thinking. Prolonged uses can lead to problems with both learning and memory. It increases the risk for heart attack and chronic bronchitis (Zinkler, 2006). In men and women it can lead to infertility. Lung cancer is a real risk amongst users.
Cocaine, "coke/snow", "harlie", "blow" It is a popular party or entertainment drug. It is a powerful, addictive stimulant that directly affect the brain.Users take it to give them a feeling of confidence and euphoria. Once over the ''high'' the user can sink into depression, which is why they become addicted to it. Long term-use, results in heart and lung disease and brain damage. It is a very expensive drug and many of its users turn to crime to pay for their addiction.	**Solvents: "glue", "benzene", "nail polish remover" and "spray paint"** These are commonly abused substances, amongst street kids. They are legal and easy to obtain. The children put the substance on a piece of cloth to get a ''high''. They feel dizzy and drowsy after sniffing. They cannot concentrate and can even stay away from school. Many start shoplifting or become prostitutes to buy more solvents. The long-term effects are weight loss, memory impairment, bone marrow damage and brain damage.
Mandrax, "buttons", "mandies", "whites" Mandrax is known as Methaqualone depresses the central nervous system depressant and is classified as a sedative-hypnotic drug. They are sold as tablets. Users of mandrax often crush the tablets, mix powder with dagga and smoke it. It gives a feeling of relaxation and euphoria for a few hours. Then they feel weak and sometimes have stomach pains and vomit. Compared to the drugs it is relatively cheap, but addicts need more and more drugs to get high and often move onto cocaine. Long-term effects include epilepsy, serious emotional problems, insomnia, toxic psychosis etc.	**Ecstasy, "the love drug", "tc", "e"** It is popular at rave parties and night clubs. Small children are often tricked into taking them because they look like sweets with pictures on them. It gives users lots of energy to dance all night. It also produces mild euphoria and hallucinations when taken in high doses. Some people react so badly to the chemicals in the tablets that they become dehydrated, fall into a coma and die. The long term effects include; brain damage, kidney failure, psychosis and convulsions.
Methamphetamine, "Tik", "speed", "Tuk-tuk". Tik is a South African nickname for a drug methamphetamine. Commonly used at the Cape Flats in the Western Cape. Tik is a crystal that is prepared from a light bulb heated from below to produce fumes that can be inhaled. Tik produce feelings of confidence, power and heightened sexual levels, the feeling of being on top of the world, especially if that world is ordinarily dominated by gangsterism, unemployment and poverty. Long-term use results in memory loss, weight loss, dental and skin problems and stroke.	**"Nyaope", "Kataza", "wunga ~~Ungah~~" or Pinch"," Sugars''** It is street drug that is allegedly said to have come to widespread use in South Africa since 2010. It mostly found in the impoverished townships of the country. It's a potent cocktail of dagga, heroin or mandrax and is the latest drug of choice for thousands of South African teenagers. It is also sometimes mixed with rat poison to enhance its effect. Elosine Auckamp (Sanca's Thusong treatment centre, in Eersterus, Pretoria), said more than 10 teenagers

	from the area seek treatment at the centre for nyaope addiction every month. Users initially feel euphoric, and a general sense of relaxation, but the effects soon wear off and another hit is required. Withdrawal from nyaope includes painful stomach and muscle cramps. Long-term effects include pulmonary complications, liver or kidney damage, lung complications, etc.

Activity 10.9

- Discuss the information on different drugs mentioned in activity 10.7
- Why are young people using drugs?
- The health and social effects of drugs.
- What kinds of drugs are available in your area?
- Which drug rehabilitation centres are available in your area?

10.4 STUDY UNIT: Aetiology of Substance-Related Disorders

This study unit explores a number of theoretical models and their application to Substance-Related Disorders. There is a complex variety of theoretical explanations for substance-related abnormal behaviour from various perspectives.

Outcomes:
Once you have worked through study unit 10.4, you should:

- understand and be able to discuss the Multipath Model's explanation of the development of Substance-Related disorders.
- understand and be able to apply the biological, psychodynamic and behavioural approaches to the development of Substance-Related Disorders.

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

- Aetiology of Substance-Related Disorders pages 334-350,
- Biological dimension, pages 349-351,
- Psychological dimension ,pages 345-346,
- Social dimension, pages, 346-347
- Socio-cultural dimension, pages 347-348
- The section provided below.
-

Add the following to the information regarding the aetiology of Substance-Related Disorders. Make sure that you know this information.

Both the acquisition and maintenance of drinking behaviour is influenced by a complex interaction of psychological and physical factors. Many theories have been proposed to explain this complexity. The following are some of the major perspectives which provide explanations on the development and maintenance of **Substance Use Disorders**:

1. Psychodynamic explanations, emphasises the role of childhood traumas (e.g. overprotective mother, maternal neglect, or frustration of dependency needs) during the oral stage of development , which result in of painful conflicts involving dependency needs (Kansas,1988). During stress or encounters with situations reminiscent of the original conflicts, symptoms such as anxiety, depression, and hostility began to occur. Alcohol is seen as (1) releasing inhibitions and allowing the repressed conflicts to be expressed or (2) enabling people to obtain oral gratification and to satisfy oral dependency needs.

2. Behavioural explanations are based on two assumptions (1) alcohol temporarily reduces anxiety and tension and (2) drinking behaviour is learned.

3. Cognitive explanations, emphasises the expectancy effect which indicates that those who expect to gain pleasure from drinking alcohol are most likely to drink it. This cognitive expectation may play an important role both in initiating and maintaining drinking behaviour.

Activity 10.10

Carefully read the following case study and:

(a) Classify Agnes's abnormal behaviour according to the DSM-5 classification system
(b) Briefly justify your choice of diagnosis/diagnoses by citing key symptoms in the case study.
(c) Explain the development and maintenance of Agnes's disorder according to the behavioural model.

Case Study

Agnes, a married woman aged 42, was admitted to a psychiatric clinic after being arrested for drunken driving and referred for treatment. On admission to the clinic, Agnes appeared very anxious, tense and tired. She tried to conceal her shaking hands by clenching them tightly in her lap. During the interview with the psychologist she had difficulty remaining in her chair, and from time to time she got up and walked around the room for no apparent reason. Agnes was clearly very embarrassed about her condition, and begged the psychologist to help her. She also tried to get the psychologist to promise that her husband would not be informed about her admission to the clinic.

During the interview with the psychologist, the following information came out: Agnes's parents both died in a car accident when she was only 18 months old. After their death she lived for a few years with her paternal grandmother, who was very old, until she also died. Agnes said that her grandmother had never wanted to care for her, but had felt it was her duty to do so. Agnes described her grandmother as a cold, distant woman who never stopped criticising her. After her grandmother's death, Agnes had to move in with an unmarried aunt who was a successful businesswoman. Like her grandmother, her aunt was doing no more than her duty by caring for Agnes, and she could not endure the fact that Agnes was, as she perceived it, ''spineless and with no opinions of her own and no strength of character''. Even as a teenager, Agnes found it hard to make decisions for herself, and never rebelled against authority or rules. Friends often abused her, as she could never say 'no' to people and always helped the others with their homework. In matric she suffered a sports injury and met a doctor, John Brown, who treated her with sympathy and consideration. She fell madly in love with the much older man, and married him shortly after passing matric.

Agnes worked as her husband's receptionist, never objected to working long hours. He was obviously the centre of her existence. Although she wanted to have children, she accepted John's decision not have children without protesting. She left all the important decisions to him. John preferred to organise their lives, although he did sometimes get irritated when she asked for his advice and opinions regarding even the simplest of tasks. Although John had a short temper and often hit her when she was annoyed and frustrated, Agnes never stood up to him, she always accepted his requests for forgiveness after he assaulted her, and forgave him every time. Clearly, Agnes was terrified that she might lose John if she stood up to him.

About two years ago, Agnes found out that John was having an affair with a beautiful young medical representative. Although she was crushed by his unfaithfulness, she did not confront him about it. She just did more and more favours for him, serving him to such an extent that he sometimes got annoyed and pushed her out of the room, locking the door.

Agnes could not handle this clear rejection from John. Six months after she had found out about John's extramarital affair, she turned to drink in an attempt to dull the mental anguish she was experiencing. At first she would have a couple of quick drinks after work while she was cooking, then she started slipping out at lunch time to stock up on drinks and to have a couple more. In a matter of months she had to greatly increase the amount of alcohol she drank to get the same effect. She realised that she had a problem, especially since she developed chronic gastritis which was diagnosed by a reluctant John. Agnes made repeated efforts to stop drinking. Two days without alcohol, however, led to her developing serious symptoms similar to those she showed on admission to the clinic, which meant that she increased her consumption of alcohol in order to get rid of the symptoms. John was becoming more and more critical of her and enjoyed pointing out the growing number of mistakes she was making at the consulting room. He often scolded and humiliated her in

front of the patients and repeatedly threatened to fire her. Agnes feared being fired. Agnes had nobody to turn to as she had no relatives or close friends.

The day of Agnes' arrest for drunken driving, she had heard John making a date with his girlfriend to meet at an exclusive restaurant later that day. Agnes had a few drinks and followed him. In clear sight of everyone in the restaurant Agnes, slurring her words begged John not to leave her. She was obviously drunk and was making a spectacle of herself. John icily informed her that their marriage was over, and requested the security guards to remove her. Back in her car, Agnes took the bottle of alcohol which she kept in the glove compartment and drank until she almost drained it. In her shocked and drunken state she sped erratically through the streets until the traffic police forced her off the road and arrested her. Without her knowledge they contacted John but he refused to fetch her or help her in any way. He confirmed that their marriage has come to an end

(a) Agnes' abnormal behaviour should be classified as:
- Alcohol Withdrawal
- Alcohol Use Disorder, severe
- Dependent Personality Disorder
- Other Problems Related to primary support group:
  - Disruption of Family by Separation or Divorce - Relationship with husband causing Agnes distress due to the extramarital affair John is having and his intended divorce from her.
- Psychological abuse by partner:
  - John often scolds and humiliates Agnes in front of patients and repeatedly threatens to fire her.
- Physical abuse by partner - John had a short temper and often assaulted Agnes.
- Problems related to other legal circumstances:
  - Agnes came to the clinic after being arrested for drunk driving.

(b) You should have justified the diagnoses as follows:
- Agnes clearly meets the criteria for Alcohol-Induced Disorder – Withdrawal as well as Alcohol Use Disorder.
- Alcohol Use Disorder:
  - Agnes' pattern of alcohol consumption clearly meets the duration requirement of a 12-month period (she has been abusing alcohol for the past 18 months).
  - She shows more than *six* symptoms of Alcohol Use Disorder and therefore the severity of her condition is *severe*.
  - Agnes' maladaptive pattern of alcohol use leads to clinically significant occupational and social impairment and distress;
  - she spends a great deal of time obtaining alcohol;
  - Agnes is unable to cut down on the use of alcohol despite its harmful physical (chronic gastritis) effect on her.
  - her use of alcohol causes significant interpersonal conflict;
  - and it affects her job performance;
  - She has made unsuccessful efforts to stop drinking;
  - her use of alcohol caused her to be a danger driving under the influence;
  - and led to her arrest;
  - She shows definite signs of tolerance (she had to greatly increase the amount of alcohol to get the same effect).
- Alcohol Withdrawal:
  - She manifests with physical and emotional symptoms such as anxiety, tension, insomnia, shaking and restlessness after ceasing intake of alcohol. She also needs alcohol to relieve these withdrawal symptoms.
- Dependent Personality Disorder:
  - Agnes clearly fulfils the diagnostic characteristics of Dependent Personality Disorder – refer to Learning Unit 6 in tutorial letter 501 for more information regarding this diagnosis.
- Agnes also meets the criteria for "Other Conditions That May Be The Focus Of The Clinical Attention", more specifically "Other Problems Related To Primary Support Group" as evidenced by Agnes' relationship distress with her spouse (husband deciding to ending their marriage); and both Psychological and Physical Abuse by her Partner (husband).

(c) The behavioural model states that all behaviour, both normal and abnormal, are acquired through learning. This learning can take place in different ways, for example by observational learning, classical conditioning and operant conditioning. In the case of Alcohol Use Disorder the behavioural model's explanation relies mainly on two assumptions namely, the fact that alcohol temporarily numbs the psyche of the individual reducing anxiety and tension(thus negative reinforcement)- the tension reduction model, and drinking behaviour is learned (strongly influenced by learned expectations)- expectancy model. The behavioural model further states that individual characteristics, coping behaviour and cognitive factors should also be considered when explaining the learning of drinking behaviours.

In Agnes' case she started drinking alcohol in an attempt to relieve the unhappiness and "mental anguish" she was experiencing after she found out that her husband was having an affair and the rejection that she felt after all the extra effort that she has put in to win John back has had no effect. Initially the effects of the alcohol reduced the emotional distress Agnes felt which in turn served as a negative reinforcement to her drinking of alcohol. Agnes did not only drink to numb her emotional distress, but drank alcohol to relieve the physical symptoms she was experiencing when she tried not to drink (the reduction of the negative symptoms serving as negative reinforcement).

The confrontational scene she played out at the restaurant could be considered as support of the avoidance-approach conflict and the role this plays in alcohol abuse. Theorists propose that alcohol reduces anxiety caused by this conflict by decreasing avoidance behaviour and increasing approach behaviour. This can clearly be seen in Agnes' drunken approach of John begging him to take her back in front of the entire restaurant clientele where she, based on information derived from the case study that she is normally far too anxious to approach John with her needs/wants if she were sober.

Activity 10.11

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

1. At the beginning of chapter 11 of the prescribed book, page 328, there are five **Focus Questions**. Answer questions 1, 2 and 3 (not treatment sections). Compare your answers to the answers provided at the end of chapter (pages 359-360) in the prescribed book under the heading **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 in your own words. 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 Substance-related and Addictive Disorders and available support groups regarding prevention. SANCA's information and Resource Centre: http://wn.apc.org/sanca,The MRC's Mental Health & Substance Abuse prevention resources: http://www.mrc.ac.za/urban/hotlinks.htm,
5. There is ample material dealing with primary prevention, that has been developed over the years in South Africa (posters, booklets, videos, etc) relating to "I'm addicted to life programme", Soul City SABC programme, TADA/POPPETS programme, etc. Materials have also been produced by Pick 'n Pay, the Department of Health and Welfare, DrugWise, etc.
6. For more information and assistance with Substance-Related problems, contact:
    - Alcoholics Anonymous: 011 452 9907 or visit www.aanonymous.org.za
    - Drive Alive: 011 788 9789
    - Phoenix House: 011 726 4210
    - SANCA National: 011 781 6410
    - Houghton House: 011 728 0850

CONCLUSION

This Learning Unit introduced you to some of the most important concerns regarding Substance-Related and Addictive Disorders. Various aspects of the classification of these disorders, selected substances and the aetiology of Substance-Related and Addictive Disorders were also addressed.

Substance-Related and Addictive Disorders are a growing concern worldwide. It is a sad reality of our times that the availability of drugs has increased through organised crime, and that exposure to drug use has become a common occurrence in the lives of even younger people. As mental health practitioners we have an obligation to extend our knowledge of Substance-Related and Addictive Disorders beyond the scope of this chapter.

REFERENCES

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

Barlow, D.H., & Durand, V.M., (2012). *Abnormal psychology: An integrative approach*. Wordswoth, CA: Cengage learning.

Butcher, J.N., Mineka, S., & Hooley, J.M. (2010). *Abnormal psychology* (14th ed.). Boston, MA: Allyn & Bacon.

Nevid, J.S., Spencer, A.R., & Greene, B. (2008). *Abnormal psychology in a changing world.* (7th ed.). London, England: Pearson.

Nolen-Hoeksema, S. (2008). *Abnormal psychology: Media and research update* (4th ed.). New York, NY: McGraw-Hill.

Learning Unit 11

Sexual Dysfunctions, Gender Dysphoria and Paraphilic Disorders

Mrs Bantobetse (Banti) Mokgatlhe, Ms Christine Laidlaw & Mrs Elmarié Visser

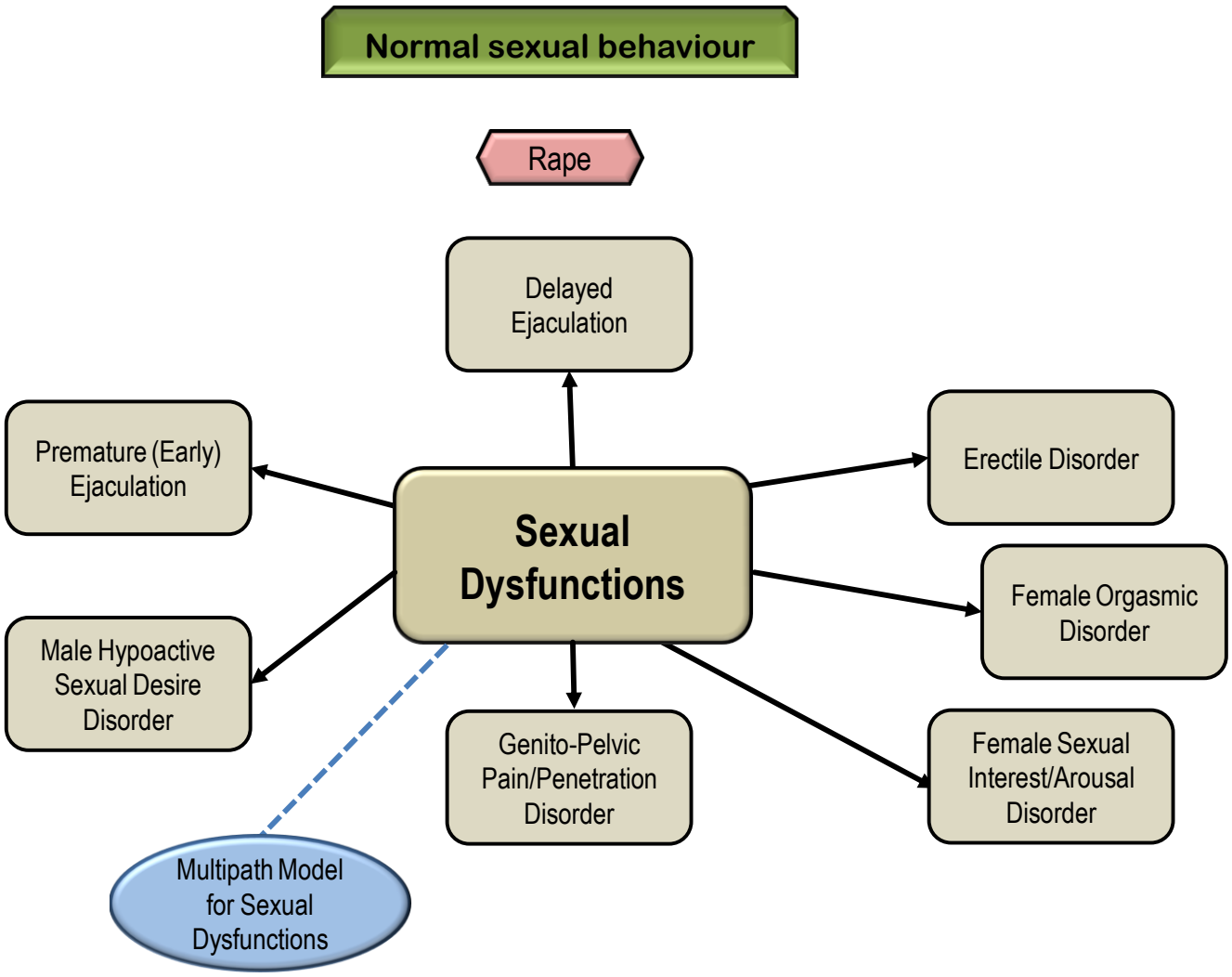
Contents

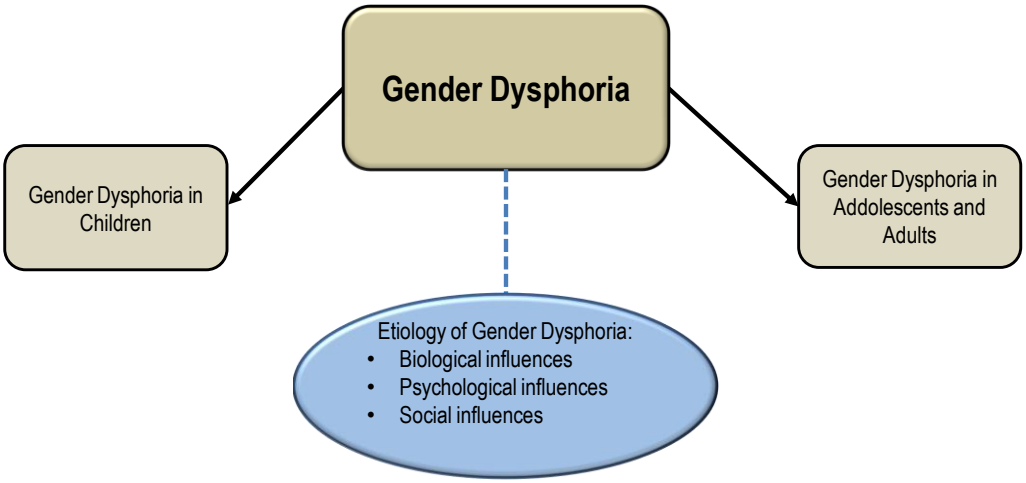
Orientation

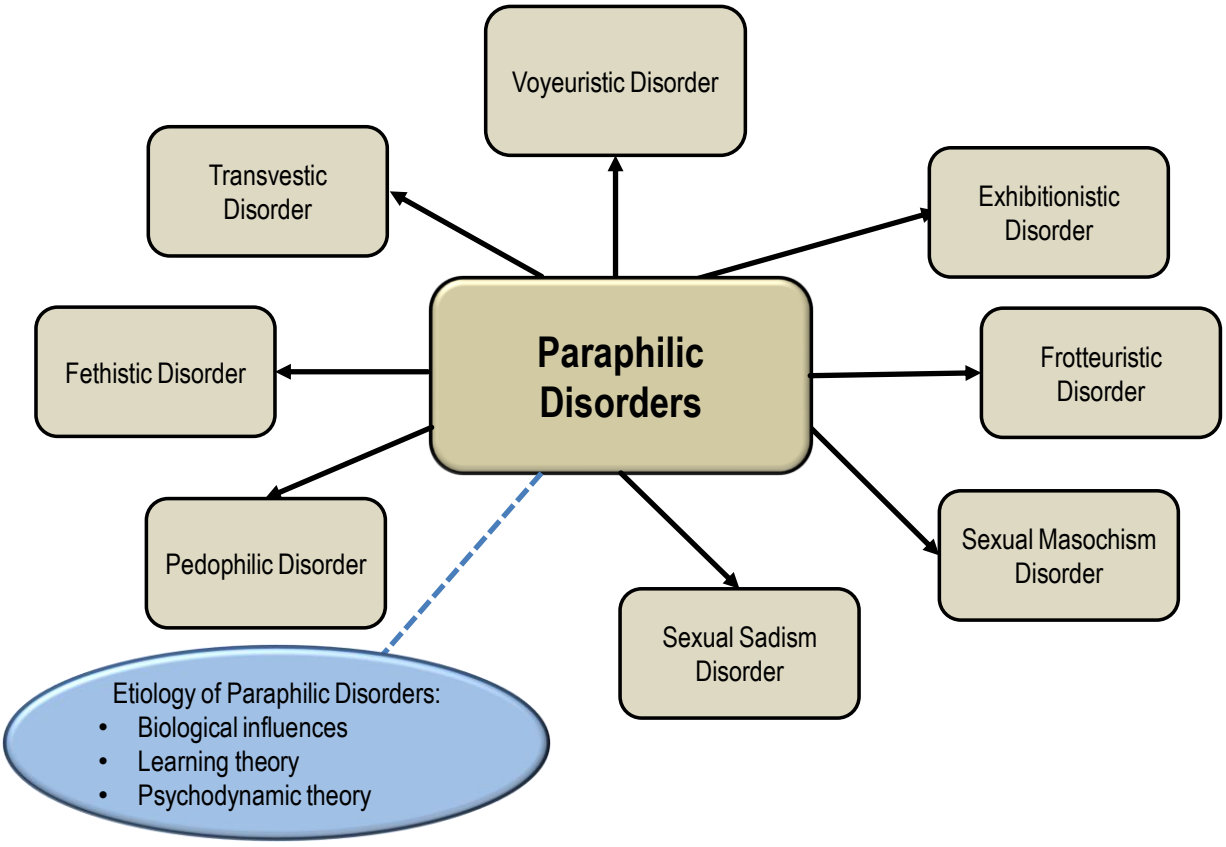
In this Learning unit, we are going to focus on normal sexual behaviour, selected Sexual Dysfunctions, Gender Dysphoria and Paraphilic Disorders in terms of the DSM-5 classification system. The focus will be also on sexual aggression, given the widespread prevalence of the latter in South African society. The DSM-IV-TR, category of “Sexual and Gender Identity Disorders” has been renamed “Sexual Dysfunctions” and Gender Identity Disorder is now in a separate category termed “Gender Dysphoria”, in the DSM-5. Paraphilic Disorders have been moved from within the category of “Sexual and Gender Identity Disorders” in the DSM-IV-TR to its own separate section in the DSM-5.

Human sexuality is a complex, diverse phenomenon. The various cultural and normative aspects associated with it make it extremely difficult to effectively classify sexual behaviour as either normal or abnormal. What is considered acceptable in one cultural context is not necessarily acceptable in another culture. Even within a particular culture, we find variations and often conflicting views on the acceptability of certain sexual behaviours because these views are influenced by demographic variables such as gender and age. To make matters even more complex, sexual attitudes, values and behaviours change over time. Nevertheless, because sexuality is such a central aspect of our lives, many behavioural, relational and emotional problems are associated with it, and effective classification of abnormal sexual conduct is, therefore, imperative. Considerations such as the self-defeating nature of certain sexual behaviours, current values and norms, the risk such behaviours hold for others and their impact on general functioning form the basis for the classification of abnormal sexual conduct.

Look at the following visual schemes (mind maps) of information regarding: normal sexual behaviour, Sexual Dysfunctions, Gender Dysphoria, Paraphilic Disorders and sexual aggression (rape) that you will study in this Learning unit.




Gender Dysphoria
Gender Dysphoria in Children
Gender Dysphoria in Addolescents and Adults
Etiology of Gender Dysphoria:
• Biological influences
• Psychological influences
• Social influences


Voyeuristic Disorder
Transvestic Disorder
Exhibitionistic Disorder
Fethistic Disorder
Paraphilic Disorders
Frotteuristic Disorder
Pedophilic Disorder
Sexual Masochism Disorder
Sexual Sadism Disorder
Etiology of Paraphilic Disorders:
• Biological influences
• Learning theory
• Psychodynamic theory

Activity 11.1

Scan-read chapter 14 in the prescribed book, in order to familiarise yourself with the contents of this Learning Unit.

Activity 11.2

While working through this Learning unit, look out for the following **Key terms**. You may if you like add more key terms as you go through the chapter. Follow the definition suggestions in chapter 14 and the **Glossary** in the prescribed book. Add to the definitions as you encounter more information about the terms. Illustrate your understanding of the definitions with appropriate examples. Ensure that after you have completed this chapter you know what these terms refer to:

- Sexual Dysfunctions
- Delayed Ejaculation
- Erectile Disorder
- Female Orgasmic Disorder
- Female Sexual Interest/Arousal Disorder
- Genito-Pelvic Pain/Penetration Disorder
- Male Hypoactive Sexual Desire Disorder
- Premature (Early) Ejaculation
- Gender Dysphoria
- Paraphilic Disorders
- Voyeuristic Disorder
- Exhibitionistic Disorder
- Frotteuristic Disorder
- Sexual Masochism Disorder
- Sexual Sadism Disorder
- Pedophilic Disorder
- Fethistic Disorder
- Transvestic Disorder
- Rape

The above-mentioned terms describe variations in sexual patterns. Please refer to pages 437-442 of your prescribed book to find the relevant definitions of the concepts. Make sure that you can make clear distinctions between these various concepts.

11.1 STUDY UNIT: Sexual Dysfunction

Introduction

In this study unit we introduce you to Sexual Dysfunctions characterised by clinically significant disturbance in a person's ability to respond sexually (aroused) or to experience sexual pleasure (achieve orgasm). An individual may have several Sexual Dysfunctions at the same time and in such cases, all the dysfunctions should be diagnosed. In the DSM-5, gender-specific Sexual Dysfunctions have been added, and, for females, Sexual Desire and Arousal Disorders have been combined into one disorder: Female Sexual Interest/Arousal Disorder. All of the DSM-5 Sexual Dysfunctions (except Substance-/Medication-Induced Sexual Dysfunction) now require a minimum duration of approximately 6 months to distinguish transient (temporary) sexual difficulties from more persistent sexual dysfunction.

Genito-pelvic Pain/Penetration Disorder is new in DSM-5 and represents a merging of the DSM-IV-TR categories of Vaginismus and Dyspareunia, which were highly comorbid and difficult to distinguish. In the DSM-5, the diagnosis of Sexual Aversion Disorder has been moved to Other Specified Sexual Dysfunction due to rare use.

According to the DSM-5 classification system, for a majority of people with Sexual Dysfunctions, the time of onset may indicate different aetiologies and interventions. ***Lifelong*** refers to a sexual problem that has been

present from first sexual experiences, and ***acquired*** applies to sexual difficulties that develop after a period of a relatively normal sexual function. ***Generalised*** refers to sexual difficulties that are not limited to certain types of stimulation, situations, or partners, and ***situational*** refers to sexual difficulties that only occur with certain types of stimulation, situations, or partners. The focus in this study unit will only be on a selected number of these dysfunctions, because of their prevalence and the significance of psychological factors in their aetiologies (APA, 2013).

The stages of sexuality (desire, arousal, and orgasm are each associated with specific dysfunction). Given the multitude of physiological, biochemical and psychological factors interacting in the human sexual response cycle, it is no wonder that Sexual Dysfunctions are varied and common. Generally, Sexual Dysfunctions are considered to be caused by a combination of physiological and psychological reasons.

Outcomes
Once you have worked through study unit 11.1, you should be able to:

- identify and describe the various Sexual Dysfunctions discussed in the prescribed book
- distinguish between the various Sexual Dysfunctions

Study
To be able to do the above, you should study the introduction to study unit 11.1and the Table on Sexual Dysfunctions in Activity 11.3 in this Study Guide as well as the following sections in the prescribed book:

- The introduction to the chapter, pages 433-442
- What is “normal sexual behaviour”?, pages 433-436
- The sexual response cycle, pages 436-437
- Sexual Interest/Arousal Disorders, pages 438-439
- Erectile Disorder, pages 439-440Orgasmic Disorders, 440-441
- Genital-Pelvic Pain/Penetration Disorder, page 441-442
- Aetiology of Sexual Dysfunctions, pages 442-446

Activity 11.3

Make sure that you **study** this table.

Sexual Dysfunction	Symptoms	Age of Onset and Prevalence	Course
Delayed Ejaculation	Marked delay in ejaculation or marked infrequency or absence of ejaculation during partnered sexual activity over at least six months.	Lifelong delayed ejaculation begins with early sexual experiences and can continue throughout life.	The prevalence remains relatively constant until age 50 years, where incidence increases significantly. Men in their 80s report twice as much difficulty ejaculating as men younger than 59 years.
Erectile Disorder	Repeated failure to obtain or maintain erections during partnered sexual activities and occurs in the majority of sexual occasions over at least six months.	Problems with erection particularly occur after age 50 years.	
Female Orgasmic Disorder	Marked delay, marked infrequency of, or absence of orgasm or markedly reduced	A woman’s first experience of orgasm can occur any time from	Women’s rates of orgasm consistency are higher during masturbation than

	intensity of orgasmic sensations in 75-100% of sexual activity encounters for at least six months. Diagnosis not made if severe relationship distress, intimate violence or significant contextual stressors are present or effects of medication/substances or another medical condition.	prepubertal period well into adulthood. Female orgasmic problems reportedly are 10-42% present in females. Approximately 10% of females do not experience orgasm throughout their lifetime.	during sexual activity with a partner.
Female Sexual Interest/ Arousal Disorder	Lack of or significantly reduced sexual interest/ arousal by at least three of the following: Absent or reduced interest in sexual activity, Absent or reduced sexual thoughts or fantasies, No or reduced initiation of sexual activity and unreceptive to partner's attempt to initiate, Absent or reduced sexual excitement or pleasure during sexual activity in most encounters, Absent or reduced sexual interest/arousal in response to any erotic cues, or Absent/reduced genital or non-genital sensations during sex in most encounters. Additionally, lack of interest for at least six months; not due to severe relationship distress, or severe stressors, or a nonsexual mental disorder, effects of medication/substances or another medical condition. The woman is distressed about the symptoms.	Prevalence unknown. Some older women report less distress about low sexual desire. Sexual desire may decrease with age.	For lifelong subtype, low sexual desire stems from first sexual experience. Normative changes in sexual desire occur across the lifespan. Women in longer-duration relationships report engaging in sex despite low desire at the outset of a sexual encounter compared with women in shorter-duration relationships. Vaginal dryness in older women is related to age and menopausal status.
Genito-Pelvic Pain/Penetration Disorder	Involves four symptom dimensions: difficulty having intercourse, genitor-pelvic pain, fear of pain or vaginal penetration, tension of the pelvic floor muscles. Significant distress in any of the dimensions is diagnosable.	Prevalence unknown. In North America, 15% of women report pain during sex. Genito-Pelvic Pain complaints peak during early adulthood and in peri- and postmenopausal phase and possibly in postpartum period. Women are primarily.premenopausal when presenting with difficulties having	Unclear course. To determine subtype check occurrence of pain-free or fear/tension-free sex. Most have physical causes and can be treated.

		intercourse.	
Male Hypoactive Sexual Desire Disorder	Persistently or recurrently deficient or absent sexual thoughts, fantasies or desire for sexual activity for approximately six months causing significant distress and not due to severe relationship distress or other severe stressors, a nonsexual mental disorder, medication/ substance or another medical condition	Prevalence varies according to country of origin and assessment method. Approximately, 6% of younger men (ages 18-24) and 41% of older men (ages 66-74) have sexual desire problems. However persistent lack of interest in sex lasting more than six months affects only 1,8% of men (ages 16-44)	Normative age-related decline in sexual desire. Erotic visual cues are more potent in younger men.
Premature (Early) Ejaculation	Ejaculation with minimal sexual stimulation before, during, or shortly after penetration	Premature ejaculation is defined as occurring within 1 minute of vaginal penetration, thus only 1-3% of men have the diagnosis. Despite 20-30% of men internationally presenting with premature ejaculation problems	For lifelong subtype, premature ejaculation stems from first sexual experience. Often related to performance anxiety. Some men experience problems in initial sexual encounters but gain ejaculatory control over time. For Acquired subtype, premature ejaculation usually occurs during or after a man is in his forties

(Adapted from APA, 2013).

Activity 11.4

Define sexual dysfunction.

In your answer to this question, you should indicate that a Sexual Dysfunction is defined as any recurrent and persistent disruption of the normal human sexual response cycle. Classification according to the DSM-5 system requires that frequency, subjective distress, chronicity and impact on general function also be considered in the diagnosis.

For additional interest on Sexual Dysfunctions you may want to go to the sitehttp://www.safersex.co.za

Activity 11.5

Distinguish between Delayed Ejaculation, Erectile Disorder, and Premature Ejaculation in men. In answering this question, please refer to the table in Activity 11.3.

Activity 11.6

Explain the aetiology of Sexual Dysfunctions according to the Multipath Model.

11.2 STUDY UNIT: Gender Dysphoria

Introduction

With the new edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-5) Gender Identity Disorder receives a new name, "**Gender Dysphoria**". Although historically confused with homosexuality, Gender Dysphoria constitutes a separate diagnostic category in the DSM-5. Both Gender Identity Disorder and Gender Dysphoria describe a condition in which someone is intensely uncomfortable with their anatomical sex and his or her self-identity as male or female and strongly identifies with, and wants to be, the opposite gender. Some of these people may live as their desired gender or even seek gender reassignment surgery to alter their gender. The DSM-IV-TR emphasised the identity issue e.g. the incongruity between someone's birth gender assigned when they were an infant and the gender with which the individual identifies. While this incongruity is still crucial for Gender Dysphoria, the DSM-5 emphasises the importance of the distress experienced about the incongruity of the diagnosis.

This shift in emphasis reflects the recognition that the disagreement between the birth sex and the gender identity is not necessarily pathological if it does not cause the individual distress. According to Rosenberg (2009) many transgender people (those who identify with a gender different from the one they were assigned at birth/infancy, are not distressed by their cross-gender identification and as a result should not be diagnosed Gender Dysphoria.) The DSM-5 further separates the diagnosis of Gender Dysphoria for children from that adolescents and adults.

Gender dysphoria is manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender.

A post transition specifier is important because many individuals, after transition, no longer meet the criteria for Gender Dysphoria; however, they continue to undergo various treatments to facilitate life in the desired gender. Become familiar with the following terms below:

- Gender Identity: An individual's internal sense of being male, female, or something else. Since gender identity is internal and a psychological construct, one's gender identity is not necessarily visible to others.
- Gender Expression: How a person represents or expresses one's gender identity to others, often through behaviour, clothing, hairstyles, voice or body characteristics.
- Transsexual: A term for people whose gender identity is different from their assigned sex at birth. Often transsexual people alter or wish to alter their bodies through hormones or surgery in order to make it match their gender identity.
- Cross-dresser: A term for people who dress in clothing traditionally or stereotypically worn by the other sex, but who generally have no intent to live full-time as the other gender.

This study unit focuses on the classification and aetiology of Gender Dysphoria.

Outcomes

Once you have worked through study unit 11.2, you should be able to:

- Identify Gender Dysphoria in Children as well as Adolescents and Adults
- discuss various perspectives on the aetiology of Gender Dysphoria

Study

- **To be able to do the above, you should study the introduction to study unit 11.2 and the diagnostic criteria of Gender Dysphoria in Activity 11.7 in this Study Guide as well as the following sections in the prescribed book:**

- Gender Dysphoria, page 449-450
- Aetiology of Gender Dysphoria, page 450-451

Activity 11.7

Study the DSM-5 diagnostic criteria for Gender Dysphoria in Children and Adolescents/Adults provided below.

DSM-5 diagnostic criteria for Gender Dysphoria in Children

A A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least six of the following indicators (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls, a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender

B The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning

Specify if: With a disorder of sex development.

DSM-5 diagnostic criteria for Gender Dysphoria in Adolescents and Adults

A A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following indicators:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

Specify if: With a disorder of sex development
Specify if: Posttransition

(APA, 2013, p. 452-453).

Activity 11.8

Distinguish between Gender Identity Disorder and homosexuality

It is important to note that homosexuality is not a classifiable disorder according to the DSM-5 classification system. Whereas homosexuality involves an individual's sexual orientation reflecting a sexual preference for same-sex partners, Gender Dysphoria, as defined above, represents a distinct psychological disorder. In answering the question, you should briefly define both concepts and point out the essential difference between them.

Activity 11.9

Familiarise yourself with the Psychological Society of South Africa's Position Statement on Sexual and Gender Diversity at www.psyssa.co.za and the South African Society of Psychiatrist's Position Statement on Homosexuality at http://www.sasop.co.za/C_DC_PState_009.asp.

Activity 11.10

Summarise the essential characteristics of the biological, psychodynamic and behavioural perspectives on the aetiology of Gender Dysphoria.

In answering this question please note that the relevant perspectives are discussed in the prescribed book under the heading "Etiology of Gender Dysphoria', page 450. We advise you to list the essential characteristics of each perspective. Note that you are not required to compare these perspectives.

Activity 11.11

For additional interest you may want to watch the film '*Boys Don't Cry*' (1999) which explores Gender Dysphoria. Or go to The World Professional Association for Transgender Health (WPATH), http://www.wpath.org for transgender health resource information.

11.3 STUDY UNIT: Paraphilic Disorders

Introduction

With the introduction of the DSM-5, paraphilias where renamed **Paraphilic Disorders** based on the fact that a paraphilia in and of itself may not cause personal distress or harm to others. Most people with atypical sexual interests do not have mental disorders. To be diagnosed with Paraphilic Disorder, the DSM-5 requires that a person with such a disorder has to experience personal distress about their interest, not merely distress because of society's disapproval; or have a sexual desire or behaviours involving unwilling persons or persons unable to give legal consent. This was done, with the revision in the names of most of the disorders in order to differentiate between the behaviour itself and the disorder stemming from that behaviour (e.g., Sexual Masochism in DSM-IV-TR is renamed **Sexual Masochism Disorder** in the DSM-5). This subtle but significant difference prevents us from inappropriately labelling any person who engages in consensual atypical sexual behaviour with a mental disorder. With this revision, the DSM-5, clearly distinguishes between atypical sexual interest and mental disorders involving these desires or behaviours.

As such, in the DSM-5, there is a distinction between paraphilias and Paraphilic Disorders. A Paraphilic Disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a Paraphilic Disorder, and a paraphilia by itself does not automatically justify or require clinical intervention. In the diagnostic criteria for each of the Paraphilic Disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (distress, impairment, or harm - or risk of harm - to others). Individuals who meet both Criterion A and Criterion B are diagnosed as having a Paraphilic Disorder. A diagnosis would not be given to individuals whose symptoms meet Criterion A but not Criterion B - that is, to those individuals who have a paraphilia but not a Paraphilic Disorder.

This study unit on Paraphilic Disorders, includes eight conditions: Exhibitionistic Disorder, Fetishistic Disorder, Frotteuristic Disorder, Pedophilic Disorder, Sexual Masochism Disorder, Sexual Sadism Disorder, Transvestic Disorder, and Voyeuristic Disorder.

Fantasies play a central role in human sexuality and are considered vital for a normal sexual response cycle.

While most people have fantasies that facilitate a normal sex life, some people come to rely on specific and singular fantasies and urges in what can be described as an abnormal and limited sexual response. The Paraphilic Disorders involve such fantasies and urges. When someone acts upon, or is severely distressed by, sexual fantasies and urges involving non-human objects, non-consenting persons or suffering and humiliation, he or she is probably suffering from one of the Paraphilic Disorders, especially when such fantasies and urges have been present for more than six months. Clearly, whether the content and nature of fantasies are normal or not remains a matter for debate, and therefore the classification of Paraphilic Disorders is a contentious issue in psychopathology. In this study unit, we focus on the Paraphilic Disorders as in general and on Pedophilic Disorder specifically because of its prevalence in South African society.

Outcomes
Once you have worked through study unit 11.3, you should be able to:

- describe the different Paraphilic Disorders
- correctly distinguish between the various Paraphilic Disorders
- discuss the aetiology of the Paraphilic Disorders with reference to the psychodynamic and behavioural perspectives
- critically discuss aspects of Pedophilic Disorder

Study
To be able to do the above, you should study the introduction to study unit 11.3 and the DSM-5 diagnostic criteria for Pedophilic Disorder in Activity 11.15 in this Study Guide as well as the following sections in the prescribed book:

- The introduction to Paraphilic Disorders, pages 452-454;
- Paraphilic Disorders Involving Nonhuman Objects, pages 454-455;
- Paraphilic Disorders Involving Non-consenting Persons, pages 455-458;
- Paraphilic Disorders Involving Pain or Humiliation, pages 458-459;
- Table 14.6, Paraphilic Disorders, page 453;
- Aetiology and Treatment of Paraphilic Disorders, pages 459-460;

Please note that the Paraphilic Disorders have been categorised under three types (involving non-human objects, non-consenting persons, or pain and humiliation). You should be able to distinguish between these types and provide examples of all three.

Activity 11.12

Distinguish between the following Paraphilic Disorders on the basis of main characteristics, age of onset, prevalence and course:

- Fetishistic Disorder
- Transvestic Disorder
- Sexual Masochism Disorder
- Voyeuristic Disorder
- Frotteuristic Disorder
- Pedophilic Disorder
- Exhibitionistic Disorder
- Sexual Sadism Disorder

A diagrammatic comparison of the Paraphilic Disorders is presented in the prescribed book Table 14.6 p. 453, which should serve as a basis for your answer.

Activity 11.13

Define Pedophilic Disorder.

Pedophilic Disorder involves obtaining erotic gratification through urges for, acts of or fantasies about sexual contact with a prepubescent child. The sexual practices of Paedophilic Disorder are considered illegal and criminal within South Africa's legal system (Bowman, 2005).

Activity 11.14

Critically discuss the diagnostic criteria for the diagnosis of Paedophilic Disorder according to the DSM-5 classification system.

See the following table indicating the (summarised) diagnostic criteria for Paedophilic Disorder. Note that the question requires you to critically discuss these criteria. You therefore have to consider them, and perhaps even discuss them with someone else, in order to formulate your own critical views in this regard. For instance, do you agree with all of the criteria? What is your personal view on the age of consent and the required five years' age difference between perpetrator and victim?

Activity 11.15

Study the DSM-5 diagnostic criteria for Pedophilic Disorder provided below:

DSM-5 diagnostic criteria for Paedophilic Disorder

A Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviours involving sexual activity with a prepubescent child or children (generally 13 years or younger).

B The fantasies, sexual urge, or behaviours cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C The person is at least 16 years of age and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify whether:
Exclusive type (attracted only to children)
Non-exclusive type

Specify if:
Sexually attracted to males
Sexually attracted to females
Sexually attracted to both

Specify if:
Limited to incest

(Adapted from APA, 2013, p. 697-698).

Activity 11.16

Briefly discuss the physical and psychological symptoms displayed by child victims of sexual abuse. While each child victim's response to sexual abuse is unique, there are certain reactions that are known to be fairly common in such cases. These reactions, or symptoms, can be summarised as follows:

Physical symptoms displayed by child victims of sexual abuse	Psychological symptoms displayed by child victims of sexual abuse
Disturbance of appetite, variations in weight, headaches, urinary tract infections.	Sleep disturbances, nightmares, diminished school performance, concentration difficulties, disciplinary/behavioural problems, sexualised behaviour (inappropriate sexual play), symptoms of Posttraumatic Stress Disorder (including flashbacks, avoidance and hyperalertness), and sometimes Elimination disorders.

Activity 11.17

Briefly discuss the research findings regarding the psychological profiles of child molesters.
Most of the research findings regarding the psychological profiles of people with Pedophilic Disorders are discussed in the section on Pedophilic Disorders, under the heading “Paraphilic Disorders", in your prescribed book on pages 452-460. We advise you to summarise these findings.

Activity 11.18

Critically discuss and compare the psychodynamic and behavioural perspectives regarding the aetiology of the Paraphilic Disorders on pages 459-460 in your prescribed book.

Both these perspectives are discussed in the section entitled “Etiology and Treatment of Paraphilic Disorders" in the prescribed book. Note again that you are not required to study the discussions on the treatment of the Paraphilic Disorders. Formulate your own opinion on the two perspectives, and indicate the differences and similarities between them.

Activity 11.19

Sexual abuse of children is a disconcerting, widely prevalent phenomenon in South Africa. You may be aware of children who are at risk of being sexually abused. For your personal development, you should visit an organisation that renders services to victims of sexual abuse. These may include social welfare organisations, medical clinics or the SAPS Child Protection Unit closest to your home. These professionals have a wealth of information regarding sexual abuse that you may benefit from. For the enrichment of your studies, however, you should enquire about their observations regarding the following:

- the symptoms presented by the child sexual abuse victims in their caseload
- the psychological profiles of child molesters that they have encountered in their work

These enquiries should enable you to review your answers to questions mentioned above, and to perhaps add new information to your current answers.

11.4 STUDY UNIT: Sexual aggression (rape)

Introduction

The violation of a person's privacy is considered unacceptable across various cultures. Such violation is at its most destructive when it involves sexual pressure or sexual coercion. Sadly, such behaviour is commonplace in South African society. Concerns about sexual harassment, rape and incest are increasingly being expressed in the media. This study unit focuses on rape as an example of sexual coercion. Note that rape, or being a rapist, is not a classifiable disorder according to the DSM-5 classification system, largely because of the varied motivational factors associated with rape. The psychological profiles of various types of rapists have, however, been extensively researched.

Outcomes
Once you have worked through study unit 11.4, you should be able to:

- define rape
- distinguish between the different types of rapists
- discuss the effects of rape
- discuss the aetiology of rape

Study
To be able to do the above, you should study the introduction to study unit 11.3 in this Study Guide as well as the following sections in the prescribed book:

- Sections on “Rape and Effects of Rape”, pages 460-462;
- Table 14.7 “The Facts about Rape”, page 461;
- “Etiology of rape, pages” 462-465;

Activity 11.20

Critically discuss the definition of rape provided in the prescribed book.

The relevant definition is provided in the section entitled “Rape”, page 460. The definition of rape is a contentious issue. Consider the matter of which actions (coercion, threat, touching, date rape, penetration, etc.) and participants (same sex, opposite sexes, etc.) should be included in a definition that meets your own criteria for a sound definition.

Activity 11.21

Discuss the true facts about the act of rape.

Compare your answer with the ten relevant facts listed in the table 14.7, page 461 of your prescribed book.

Activity 11.22

Discuss the cluster of emotional responses to rape known as “rape trauma syndrome”.

The relevant information is provided under the sub-heading “Effects of Rape”, page 462. Note that two phases have been identified in rape trauma syndrome, and that the symptoms show considerable consistency with Posttraumatic Stress Disorder.

Activity 11.23

With regard to the aetiology of rape, discuss the three motivational types of rapists mentioned in the prescribed book.

See the section under the subheading entitled “Etiology of Rape”, page 462. Ensure that you are able to define and distinguish the three motivational types accurately. Also note that the research on this typology of rapists tends to support the notion that rape has more to do with aggression and violence than with sex. Sex is considered the means by which the rapist acts out the primary motivations of aggression and violence.

Activity 11.24

Discuss Baron, Strauss and Jaffee's cultural spillover theory of the aetiology of rape, and provide your personal, substantiated opinion on whether this theory can be applied to explain the relatively high incidence of rape in South Africa.

See the section under the subheading entitled “Etiology of Rape", page 463. Ensure that you understand the essential premise of the theory (the incidence of rape is higher in cultures or environments that encourage violence), and that you can apply their determinants of support for violence to the South African context.

Activity 11.25

Contact the Rape Crisis Centre nearest to where you live and ask them for more information on rape in your community. You could also ask them for guidelines on how to appropriately assist someone who has been raped, should the occasion arise. The people providing services at rape crisis centres can provide you with practical insights that should enable you to compare the local reality with what you have learned in this study unit.

Activity 11.26

Go to Learning Unit 9 and read the case study of Thandi again, reflecting on Post-traumatic Stress Disorder now in light of the information you have learnt about sexual aggression, specifically rape.

Activity 11.27

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

1. At the beginning of chapter 14 of the prescribed book, page 434, there are five **"Focus Questions"**. Answer all the questions but leave out questions about treatment after you have worked through chapter. Compare your answers to the answers provided at the end of chapter 14(page 467) in the prescribed book under the heading **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 K**ey terms** and reflect on your understanding of each term. Explain the meaning of these terms to a friend or family member in your own words. 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 more on Sexual Dysfunctions and Gender Dysphoria as well as useful resources that can be accessed for support:

http://www.psychnet.uk.com/dsm5/Gender Dysphoria.htm

www.dsm5.org

CONCLUSION

This Learning Unit introduced you to some of the most important concerns regarding Sexual Dysfunctions, Gender Dysphoria as well as Paraphilic Disorders. Various aspects of the classification of these disorders and their aetiology were also addressed. Sexual aggression and rape were also covered.

Sexual abuse is a growing world-wide. It is a sad reality of our times that many children are victims of sexual abuse and the perpetrators are mostly people known to the child. As citizens educated in mental health we have an obligation to extend our knowledge about Sexual Dysfunctions, Gender Dysphoria as well as Paraphilic Disorders beyond the scope of this Learning Unit and play a significant role in the prevention of child sexual abuse.

REFERENCES

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

Barlow, D.H., & Durand, V.M. (2012). *Abnormal psychology: An integrative approach*. Wadswoth, CA: Cengage Learning.

Bowman, B. (2005). Children, pathology and politics: *Genealogical perspectives on the construction of the paedophile in South Africa*. Unpublished doctoral dissertation, University of Witwatersrand. Johannesburg, South Africa.

Butcher, J.N., Mineka, S., &Hooley, J.M. (2010). *Abnormal psychology* (14th ed.). Boston, MA: Allyn & Bacon.

Nevid, J.S., Spencer, A.R., & Greene, B. (2008). *Abnormal psychology in a changing world* (7th. ed.). London, England: Pearson.

Nolen-Hoeksema, S. (2008). *Abnormal psychology: Media and research update* (4thed.). New York, NY: McGraw-Hill.

Learning Unit 12:

Depressive Disorders
Bipolar and Related Disorders

Mrs Elmarié Visser

Contents

Orientation

Most mentally healthy people have mood swings from day to day and from situation to situation which are appropriate and acceptable in the context in which they are experienced and expressed. We feel happy and excited when we succeed and are victorious. Failure and disappointment, on the other hand, can lead to feelings of heartache and dejection. These diverse emotions are appropriate, acceptable reactions to things that happen from day to day and change without adversely affecting our general functioning. In contrast to this, there is the mood of a person suffering from a Depressive Disorder or a Bipolar Disorder - extreme, persistent and pervading every facet of the person's life. The person's general functioning is adversely affected and/or the person suffers significant distress.

Bipolar and Related Disorders and Depressive Disorders are often called mood disorders because they primarily involve disturbances in emotions. The abnormal mood, whether deeply unhappy, sad or irritable (characteristic of Depressive Disorder) or heightened and euphoric (characteristic of Bipolar and Related Disorders), is the main characteristic of these disorders. Depression is an emotional state which is

characterised by intense feelings of sadness, worthlessness and uselessness. Intense irritability during a depressive episode is also common. Mania, by contrast, is an emotional state which is characterised by intense and unrealistic feelings of elation and happiness or excitability and hyperactivity. Hypomania is a milder form of mania. Both the Bipolar and the Depressive Disorders are, however, more than just emotional disorders. These disorders are characterised by four sets of symptoms, namely, emotional, cognitive, physiological and behavioural symptoms, and manifest differently in different people. One person suffering from a Major Depressive Disorder will, for example, display severe symptoms of depression and sorrow. This person will also display a reduced ability to concentrate, will suffer severe weight loss, insomnia, feelings of worthlessness and thoughts of suicide. He or she will experience significant psychological discomfort. Another individual suffering from the same disorder will, for example, display as the more prominent symptoms a lack of interest in life, deep unhappiness and will not enjoy things previously enjoyed. He or she will sleep excessively, but will remain tired and have little energy; he or she will also have lost a lot of weight and will be constipated. The person's movements will be slow and the facial expressions mask-like. He or she will also be unable to make decisions and will display impaired general functioning.

The DSM-5 classification system distinguishes between Bipolar and Related Disorders, and Depressive Disorders. These two types of disorders, each with its own characteristic symptoms, are divided into two parts in Learning Unit 12 namely:

- Depressive Disorders and
- Bipolar and Related Disorders

Depressive Disorders

Introduction

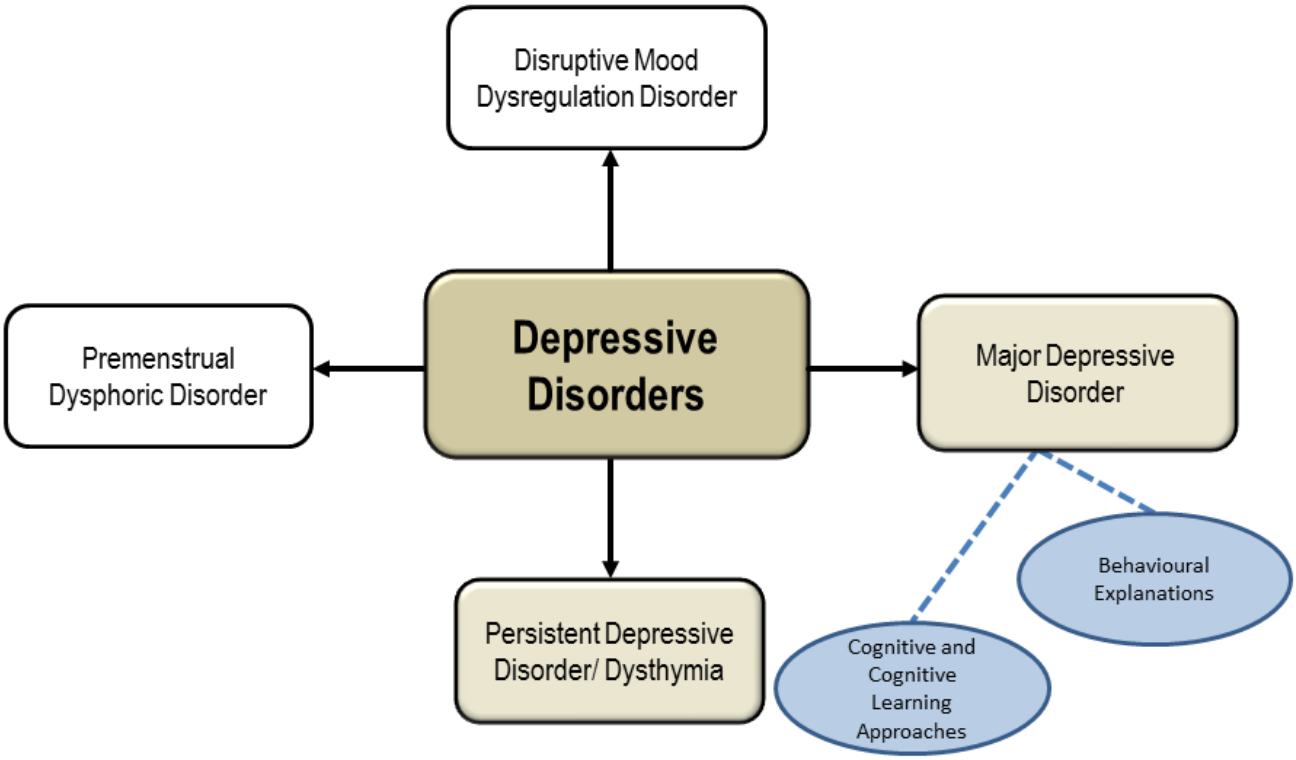
Depressive Disorders are also sometimes referred to as unipolar disorders. "The common feature of all Depressive Disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (APA, 2013, p.155). Depressive Disorders have no presence or history of mania or hypomania episodes.

The DSM-5 classification system distinguishes between eight types of Depressive Disorders namely: Disruptive Mood Dysregulation Disorder, Major Depressive Disorder, Persistent Depressive Disorder (Dysthymia), Premenstrual Dysphoric Disorder, Substance/Medication Induced Depressive Disorder, Depressive Disorder Due to Another Medical Condition and Other Specified/Unspecified Depressive Disorders. Refer to Tables 8.2 (page 235) and Table 16.2 (page 511) in the prescribed book for a concise description of Major Depressive Disorder, Persistent Depressive Disorder (Dysthymia), Disruptive Mood Dysregulation Disorder and Premenstrual Dysphoric Disorder.

The Depressive Disorders are common in the general population and are often described as *the disease of our time*. Researchers have done thousands of studies in an attempt to understand Depressive Disorders better. The different perspectives, including the psychodynamic, behavioural, cognitive, family systems and biological perspective, all have explanations for the causes of Depressive Disorders. A better understanding of the Depressive Disorders not only helps professionals to treat them with greater success, but also makes it possible for them to introduce effective preventative measures.

In study units 12.1, 12.2 and 12.3, we discuss the characteristics of depression, the DSM-5 diagnostic criteria for Major Depressive Disorder and Persistent Depressive Disorder (Dysthymia), the main characteristics of Disruptive Mood Dysregulation Disorder and Premenstrual Dysphoric Disorder and the possible causes of the Depressive Disorders according to the behavioural, cognitive and cognitive-behavioural perspectives. You will also be challenged to become involved in the primary and tertiary prevention of Depressive Disorders.

What you are going to study in the next three study units is illustrated visually in the following mind map:



Activity 12.1

Scan-read chapter 8, pages 229 to 249 in the prescribed book and familiarise yourself with the contents of the section on Depressive Disorders before you go on to the next activity.

Activity 12.2

While working through study units 12.1, 12.2 and 12.3, look out for the following **Key terms**. Follow the definition suggestions provided in Chapter 8 and the Glossary of the prescribed book as well as information provided in this tutorial letter. 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 these three study units you know what these terms refer to:

- apathy
- anhedonia
- lethargy
- self-denigration
- catatonia
- melancholia
- psychotic symptoms
- mood-congruent/mood-incongruent psychotic features
- rumination
- mood disorder
- insomnia
- mania
- Depressive Disorder
- Unipolar Disorder
- Major Depressive Disorder

- Persistent Depressive Disorder (Dysthymia)
- Disruptive Mood Dysregulation Disorder
- Premenstrual Dysphoric Disorder

12.1 STUDY UNIT: Depressive Disorders - the symptoms of depression

Introduction

After you have read the *Orientation* above, it should be clear to you that we can make a distinction between normal feelings of downheartedness and a Depressive Disorder. Depression has certain essential characteristics. Besides the extreme emotions which are the primary characteristic of depression, Depressive Disorders are also characterised by certain cognitive, physiological and behavioural symptoms. These symptoms occur in varying degrees and in different combinations in different people. An in-depth knowledge of all these different symptoms enables the professional to identify the presence of a Depressive Disorder and treat it accordingly.

Outcomes

Once you have worked through study unit 12.1, you should be able to:

- define Depressive Disorder
- distinguish between normal feelings of sadness and irritation and Depressive Disorder
- describe the most common symptoms of depression

Study

To be able to do the above, you will need to study the introduction to study unit 12.1 in this tutorial letter as well as the following sections in the prescribed book:

- Depressive and Bipolar Disorders, page 229;
- Symptoms Associated with Depressive and Bipolar Disorders, page 230;
- Symptoms of Depression, pages 230 to 232; and
- Table 8.1: Symptoms of Depression and Hypomania/Mania (focus on symptoms of Depression), page 231.

Activity 12.3

- Describe the general symptoms of depression under the following headings: *Emotional, Cognitive, Behavioural* and *Physiological Symptoms in Depression*.

- Compare your answer with the subsections headed *Affective Symptoms in Depression, Cognitive Symptoms in Depression, Behavioral Symptoms in Depression* and *Physiological Symptoms in Depression*, pages 231 to 232 and *Table 8.1*: *Symptoms of Depression and Hypomania/Mania (Depression)*, page 231 in the prescribed book. Add to your answer if it is not complete.

Activity 12.4

Read the following case study about Amanda (Sue, Sue & Sue, p. 213, 2013) and identify the depressive symptoms which Amanda displayed.

Case study

Amanda is a forty-year old homemaker with three children. Her husband, Jim, is sales manager for a motor car dealer. The family does well financially and lives comfortably. For years, family life was stable, cohesive, and loving. However, Jim began to notice that his wife was becoming increasingly unhappy, frequently saying that her life lacked purpose. Jim tried to reassure her and suggested that she find some hobbies or socialise with their neighbours. However, Amanda became progressively more absorbed in her belief that her life was meaningless.

After a while, Amanda no longer bothered to cook, clean or take care of the children. At first Jim

thought that her "bad mood" would pass, but as her lethargy deepened, he became increasingly worried. Amanda told him that she was incredibly tired, that household chores took too much energy, and that she no longer had strong feelings for anything. She often asked to be left alone. Amanda felt guilty about her inability to take care of the children, but everything was simply too overwhelming. Sometimes she cried uncontrollably for hours. Nothing Jim said could improve her spirits or stop her crying. Amanda finally agreed to seek help and is currently receiving medication and psychotherapy for her depression.

Adapted from Foundations of Abnormal Behavior, 10th edition, 2013.

Were you able to identify the following depressive symptoms in Amanda's case?

- She became more and more unhappy and depressive.
- Nothing could improve her depressed mood. All John's attempts to make her feel better were unsuccessful.
- She saw her life as meaningless and lacking purpose. Life was no longer important to her.
- She no longer had any interest in taking care of her home and children.
- She was tired and did not have the energy or motivation to do her daily chores. This condition, which is characterised by a lack of motivation and low activity levels, can be described as lethargy.
- She became apathetic (emotionally indifferent) and withdrew socially.
- She cried uncontrollably and inconsolably.
- Her symptoms lasted a considerable period of time and her impaired functioning was clearly observable.
- Clear psychological discomfort. (Amanda's condition indicates that she needs professional help.)

12.2 STUDY UNIT: Classification of Depressive Disorders

Introduction

As you know by now, the DSM-5 classification system divides the Depressive Disorders into several main categories or subtypes. In this study unit we are going to study the DSM-5 diagnostic criteria for Major Depressive Disorder and Persistent Depressive Disorder (Dysthymia) and the characteristics of both Disruptive Mood Dysregulation Disorder and Premenstrual Dysphoric Disorder.

Outcomes

Once you have worked through study unit 12.2, you should be able to:

- describe the DSM-5 criteria for Major Depressive Disorder and Persistent Depressive Disorder (Dysthymia);
- compare Major Depressive Disorder and Persistent Depressive Disorder (Dysthymia);
- distinguish between grief and Major Depressive Disorder;
- describe the characteristics of both Disruptive Mood Dysregulation Disorder and Premenstrual Dysphoric Disorder;
- identify and classify the Depressive Disorder a person is suffering from according to the DSM-5 classification system; and
- identify and apply the specifiers for Depressive Disorders.

Study

To be able to do the above, you should study the DSM-5 criteria for Persistent Depressive Disorder (Dysthymia), as well as the specifiers for Depressive Disorders in this tutorial letter and the following sections in the prescribed book:

- Evaluating Mood Symptoms (depression), pages 233 and 234;
- Depressive Disorders, page 234
- Diagnosis and Classification of Depressive Disorders, page 234;

- Major Depressive Disorder, pages 234 and 235;
- Table 8.2: Depressive Disorders, page 235;
- Specifiers for Depressive Disorders (first two paragraphs), page 235;
- Persistent Depressive Disorder (Dysthymia), page 236;
- Premenstrual Dysphoric Disorder, pages 236 and 237;
  Depressive Reactions to Grief, page 237 (not the section on Persistent complex bereavement disorder);
- Disruptive Mood Dysregulation Disorder, pages 509 and 510 and
- Table 16.2 Disruptive Mood Dysregulation Disorder and Pediatric Bipolar Disorder, page 511 (only the section on Disruptive Mood Dysregulation Disorder).

Activity 12.5

Refer to the prescribed book, page 234, Depressive Disorders and add the following:
Disruptive Mood Dysregulation Disorder is also a subtype of Depressive Disorders.

Refer to the prescribed book, page 235, Table 8.3 DSM-5 Criteria for Major Depressive Episode and add the following:
There has never been a manic episode or a hypomanic episode.
This criteria also applies to Major Depressive Disorder.

Activity 12.6

The DSM-5 criteria for Persistent Depressive Disorder (Dysthymia) are given only very briefly in the prescribed book. Complement this information with the more elaborate diagnostic criteria contained in the DSM-5 classification system (APA, 2013). Make sure you **know** these criteria well.

DSM-5 Diagnostic Criteria for Persistent Depressive Disorder (Dysthymia)

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

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

1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness

C During the 2-year period of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D Criteria for a Major Depressive Disorder may be continuously present for 2 years.

E There has never been a manic episode or a hypomanic episode, and criteria have never been met for Cyclothymic Disorder.

F The disturbance is not better explained by a persistent Schizoaffective Disorder, Schizophrenia, Delusional Disorder, or other Specified or Unspecified Schizophrenia Spectrum and other Psychotic Disorders.

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

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

(APA, 2013, p. 168).

Activity 12.7

It is not always easy to distinguish between the normal response to a significant loss (grief) and a Major Depressive Disorder. For example, people who are mourning the death of a loved one often show the same symptoms as those of Major Depressive Disorder. Mourning the death of a loved one is a normal reaction and it has a specific function. But if the bereavement starts to show signs of pathology, professional help should be sought and the presence of a Major Depressive Disorder in addition to the normal response to a significant loss should be considered.

Add the following information regarding grief (normal reaction to a significant loss) and make sure that you are able to distinguish between grief and Major Depressive Disorder.

Distinction between grief and Major Depressive Disorder

- In grief the predominant affect is feelings of emptiness and loss, while in Major Depressive Disorder it is persistent depressed mood and the inability to anticipate happiness or pleasure.
- The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of Major Depressive Disorder is more persistent and not tied to specific thoughts or preoccupations.
- The pain of grief may be accompanied by positive emotions and humour that are uncharacteristic of the pervasive unhappiness and misery characteristic of Major Depressive Disorder.
- The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in Major Depressive Disorder.
- In grief, self-esteem is generally preserved, whereas in Major Depressive Disorder feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved).
- If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about *joining* the deceased, whereas in Major Depressive Disorder such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

(APA, 2013, p. 161).

Activity 12.8

We use *specifiers* to provide increased specificity regarding the diagnosis of certain mental disorders such as Depressive Disorders and Bipolar and Related Disorders. A clear description of symptom patterns, the duration of these symptom patterns as well as the severity of the symptoms, convey information that is relevant to the planning of effective treatment. For example, a diagnosis of Major Depressive Disorder with the appropriate specifiers (e.g., single or recurrent episode; mild, moderate or severe; with or without psychotic features, followed by other appropriate specifiers such as with melancholia or catatonia, provide detailed information regarding a specific diagnosis which enhances effective management of the disorder. Two of the specifiers for Depressive Disorder and two of the specifiers for Bipolar and Related Disorders are discussed in the prescribed book, pages 236 and 258 to 259. Add the following information regarding the specifiers for Depressive Disorders and Bipolar and Related Disorders and make sure that you are able to **identify** and **apply** these specifies.

Current severity

"Severity is based on the number of criterion symptoms, the severity of those symptoms, and the degree of functional disability.

Mild: Few if any**,** symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social and occupational functioning.

Moderate: The number of symptoms, intensity of symptoms, and/or functional impairment is between those specified for “mild” and “severe”.

Severe: The number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning” (APA, 2013, p.188).

With psychotic features
With mood-congruent psychotic features: (Depressive Disorders) the content of all delusions and hallucinations is consistent with the typical **depressive** themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment**/** (Bipolar and Related Disorders) during manic episodes, the content of all delusions and hallucinations is consistent with the typical **manic** themes of grandiosity, invulnerability, etc., but may also include themes of suspiciousness or paranoia, especially with regards to other’s doubts about the individual’s capacities, accomplishments, and so forth.

With mood-incongruent psychotic features: (Major Depressive Disorder) the content of all delusions or hallucinations does not involve the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment, or the content is a mixture of mood-incongruent and mood-congruent themes/(Bipolar I Disorder) the content of delusions and hallucinations is inconsistent with the episode polarity themes as described above, or the content is a mixture of mood-incongruent and mood-congruent themes (APA, 2013, pp.152 & 186).

With catatonia
The catatonia specifier can apply to any episode of mania or depression if catatonic features are present during most of the episode (APA, 2013, pp. 152 &.186). Refer to Learning Unit 14, Schizophrenia Spectrum and Other Psychotic Disorders in Tutorial letter 503 and chapter 12 of your prescribed book for a description of catatonia.

With melancholic features
One of the following is present during the most severe period of the current episode: (1) lack of pleasure, in all or almost all, activities. (2) Lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens).

Three (or more) of the following: (1) A distinct quality of depressed mood characterised by profound despondency, despair, and/or moroseness or so-called empty mood. (2) Depression that is regularly worse in the morning. (3) Early-morning awakening (i.e. at least 2 hours before usually awakening). (4) Marked psychomotor agitation or retardation. (5) Significant anorexia or weight loss. (6) Excessive or inappropriate guilt (APA, 2013, pp. 151 &.185).

With peripartum onset
This specifier can be applied to the current or most recent mood episode such as major depressive episode in Major Depressive Disorder or manic, hypomanic or major depressive episode in Bipolar I disorder if onset of mood symptoms occurs during pregnancy or in the four weeks following delivery (adapted from APA, 2013).

Activity 12.9

The following short questionnaire, which appeared in an article by Brody in the New York Times (1992, p. C12), was compiled to help people determine for themselves whether they are suffering from severe depression.

The idea is not to diagnose yourself, but to make you more aware of problems which you might like to discuss with a professional.

Are you depressed?			
		Yes	**No**
1.	I feel downhearted, dejected and sad.		
2.	I no longer enjoy the things I used to enjoy.		
3.	I think others would be better off if I were dead.		
4.	I think that I am no longer of any use to anyone and that no-one needs me.		
5.	I have noticed that I have lost weight.		
6.	I find it difficult to sleep at night.		
7.	I am restless and cannot sit still.		
8.	My mind is not as clear as it used to be.		
9.	I get tired for no reason.		
10.	I have no hope for the future.		

Add up your answers: If you agreed with five or more of the statements, including either item 1 or item 2, and these complaints have been present for two weeks or longer, professional help is strongly recommended. If you answered "Yes" to statement 3, please get professional help urgently. Contact the toll-free suicide hotline in South Africa at 0800–567–567 or SADAG at 0800–205026 and speak to a trained counsellor who will assist you.

You could put Brody's questionnaire to good use if you suspect that a family member or friend of yours is depressive and want to determine whether to refer the person for professional help. When you ask a person who is depressed these questions, bear in mind that a person suffering from depression is often not motivated to answer questions and also does not have the energy to elaborate on his or her answers. Depressed persons often have poor concentration and they might battle to focus their attention on the questions. People suffering from depression are often vague and/or embarrassed about their negative emotions, behaviour and thoughts. They are also often irritated and agitated and might resist answering personal questions. It is, therefore, advisable to get collateral information on the person. Observe the person carefully. Are the person's movements and speech slow, and does the person look depressed, tired and sad? Can the person concentrate on questions? What other questions would you ask the person besides those in the questionnaire? Remember that the duration of the depressive episode and the effect of the disorder on social and occupational functioning are important determinants in identifying a Mood Disorder.

If your friend or family member is suffering from a Depressive Disorder, you can ask his or her general practitioner for a referral to a psychologist or psychiatrist.

Activity 12.10

Refer to Learning Unit 5, activity 5.2, in tutorial letter 501/2016. Read Elaine's case study again without looking at the differential and final diagnoses. With the knowledge you have acquired regarding Depressive Disorders and Personality Disorders, (a) classify Elaine's abnormal behaviour according to the DSM-5 classification system and (b) compare your diagnoses with the diagnoses provided (Tutorial Letter 501/2016). If your answer is incomplete, go back to the relevant sections in tutorial letters 501 and 502 and your prescribed book and make sure that you understand where you went wrong. Contact one of your lecturers if you need assistance.

Activity 12.11

Explain why a diagnosis of Major Depressive Disorder is made in Elaine's case and why her behaviour cannot be seen as bereavement only.

Although Elaine went through a period of mourning after the death of her section head with whom she had had a very good relationship, a diagnosis of Major Depressive Disorder is made in addition to grief for the following reasons:

- Elaine manifests persistent severe depressed mood with mood-congruent psychotic features.
- Her depressed mood is not tied to specific thoughts or preoccupations regarding her loss.
- She clearly does not experience or anticipate any happiness and pleasure.
- She sees herself as worthless, unable to cope and with no hope for the future.
- Her thoughts about death as a way out of her problems resulted in a serious suicide attempt.
- Elaine's symptoms are not characteristic of normal bereavement. Her functioning is clearly diminished and she experiences severe distress. She meets the criteria for Major Depressive Disorder and she urgently needs professional help.

Activity 12.12

Explain why a diagnosis of Persistent Depressive Disorder (Dysthymia) was not made in Elaine's case.

Persistent Depressive Disorder (Dysthymia) is a chronic disorder which lasts for at least two years. We can therefore describe Persistent Depressive Disorder (Dysthymia) as a chronic Depressive Disorder. If a Major Depressive Episode persists for two years, a diagnosis of *Persistent Depressive Disorder with persistent major depressive episode* is made. Elaine's symptoms did not last longer than a few months and a diagnosis of Persistent Depressive Disorder (Dysthymia) can therefore not be made in Elaine's case.

Activity 12.13

Describe (a) the characteristics of Disruptive Mood Dysregulation Disorder and (b) Premenstrual Dysphoric Disorder.

Compare your answers with the information provided in the prescribed book, pages 509 to 510, page 511 (Table 16.2 Disruptive Mood Dysregulation Disorder and Pediatric Bipolar Disorder, section regarding Mood Dysregulation Disorder) as well as pages 235 (Table 8.2 Depressive Disorders, section regarding Premenstrual Dysphoric Disorder) and 236 to 237 in your prescribed book. If your answers are not complete, study these sections again.

Activity 12.14

Provide a concise description of the following specifiers for Depressive Disorders:

(a) mild, moderate, severe
(b) single episode
(c) recurrent
(d) with mood-congruent psychotic features
(e) with mood-incongruent psychotic features
(f) with melancholia
(g) with postpartum onset
(h) with catatonia
(i) with anxious distress and
(j) with a seasonal pattern.

Compare your descriptions of these specifiers for Depressive Disorders with the information provided in this tutorial letter, Activity 12.8 as well as with the relevant information in your prescribed book, page 236.

12.3 STUDY UNIT: The aetiology of Depressive Disorders

Introduction

There have been many efforts over the centuries to understand the causes of Depressive Disorders and to find a treatment for them. Despite all the research that has been done in this field, we cannot yet say with certainty what the cause or causes of depression are and how we should treat Depressive Disorders. The different perspectives offer different explanations for the causation of Depressive Disorders and each advocates a certain type of treatment. Each of the different perspectives focuses on only one or some aspects of the Depressive Disorders and thus offers only partial explanations for depression.

The psychodynamic perspective emphasises unconscious conflicts associated with loss and anger, whereas the behavioural perspective focuses on reduced reinforcement during a loss. The cognitive perspective focuses on the individual experiencing a depressive mood's cognitive distortions and low self-esteem. According to the biological perspective, a deficit of two neurotransmitters, norepinephrine and serotonin, may lead to depression. According to the genetic view, an innate predisposition to biochemical abnormalities is the cause of Depressive Disorders. The family systems perspective focuses on important relationship patterns in which Depressive Disorders occur. The emphasis in this perspective is not on the causes of the Depressive Disorder, but rather on understanding relationship patterns which give rise to the abnormal behaviour and the function of the abnormal behaviour within a particular family system.

The role of stressors as a precipitating factor in the development and maintenance of Depressive Disorders has been widely researched and is generally recognised. According to the diathesis-stress model, some people are vulnerable to developing a Depressive Disorder in the presence of stress. At present it is generally recognised that the interaction between the biological, psychological and social dimensions have to be taken into account in explaining Depressive Disorders.

Outcomes

Once you have worked through study unit 12.3, you should be able to:

- explain Depressive Disorders according to the Behavioural Perspective, the Cognitive and the Cognitive-Learning Approaches;
- describe the relationship between stress and depression.

Study

To be able to do the above, you should study the following sections in the prescribed book:

- Behavioral Explanations, pages 241to 242;
- Cognitive Explanations, pages 242 and 243;
- Learned Helplessness and Attributional Style, pages 243 to 245 and
- Social Dimension, page 245.

Activity 12.15

Explain Elaine's Depressive Disorder according to the Behavioural perspective. Please refer to Elaine's case study in Learning Unit 5, activity 5.2 in Tutorial letter 501/2016.

Compare your answer with the following answer. If your answer is not complete, study the behaviour perspective pertaining to depression in the prescribed book again (pages 241 to 242) and supplement your answer where necessary.

According to the behavioural explanation of depression, depression is the result of low levels of positive reinforcers. According to Lewinsohn and other prominent researchers, there are three sets of variables which enhance or hinder a person's access to positive reinforcers:

1. The number of events and activities that are potentially reinforcing to the person. It appears from the case study that Elaine does not have many positive reinforces in her life. Her personality style does not elicit much positive reinforcement. She does not make friends easily and does not join in

group activities. She also avoids conversing with others at her workplace. Because of her hypersensitivity to and fear of criticism, she is socially withdrawn, which lowers her chances to receive positive attention. She also does not have close family members to give her positive reinforcements.

2. The availability of reinforcements in the environment: The one clear source of reinforcement in Elaine's life appears to be her employers' regard for the high quality work she produces. Currently she is at risk of losing their regard. She is experiencing such high levels of stress that she will probably not perform according to her usual high standard. Elaine also lost her section head, a source of positive reinforcement. Because of her personality style, the chances are good that Elaine will not turn to her friends for support and comfort during her stressful times.

3. A person's behaviour and social skills: It appears that throughout her life Elaine has not had good social skills to elicit positive reinforcement from her environment. In seeking reassurance of acceptance, she may have offended potential friends and pushed them away. She also withdraws from people for long periods when she experiences any form of criticism from them. She avoids group occupational activities for fear of rejection. When Elaine became depressed, she withdrew from her small group of friends and thus lost all possible reinforcement. She also lost interest in her work and began to neglect her work by not going to work and in this way lost another possible source of reinforcement. By drawing into a world of depression, Elaine lost all possible social and occupational reinforcement.

   It is thus clear that in Elaine's case, low levels of positive reinforcement are present on all three these levels. According to Lewinsohn, these low levels of reinforcement lead to depression.

   The behavioural perspective also recognises the role of stress in the development of depression. Elaine took the loss of her section head and friend very badly. The impact of this stressor was increased by the management of her firm's decision to place Elaine in a managerial position. Elaine was not able to reverse these stressors. Loss of control over her life and events may have made Elaine more self-critical. An awareness of her own shortcomings may also have further diminished her self-confidence and functioning. The resultant depressive mood further affected her ability to function effectively and made her more vulnerable to a serious Depressive Disorder.

Activity 12.16

Explain Elaine's Major Depressive Disorder according to the cognitive-learning approach. Please refer to Elaine's case study in Learning Unit 5, activity 5.2 in tutorial letter 501/2016.

Compare your answer with the following answer. If your answer is not complete, go back to the cognitive-learning explanation of Depressive Disorders in your prescribed book (pages 242 to 245) and supplement your answer where necessary.

According to the cognitive-learning perspective, feelings of helplessness are at the core of a Depressive Disorder. Seligman's learned helplessness theory of depression combines concepts of the behavioural and cognitive perspectives and proposes that people develop a Depressive Disorder when they believe that they no longer have control over the outcome of things that happen in their lives and that they themselves are responsible for their helplessness. In Seligman's view, all symptoms of depression derive from this perception of helplessness and self-blame.

We are not given much information on what Elaine is thinking, but using the information in the case study, we can guess that Elaine feels that she has lost control over her life. She experienced security in her work place until the death of her section head. She clearly had no option than to take over the head's duties although she dreaded the managerial position with its duties and responsibilities.

From the case study it also appears that Elaine lacks self-confidence, feels inadequate and has low self-esteem. We can guess that Elaine's view of the world is sombre and that she feels helpless and powerless.

The basic assumption of the cognitive-learning approach is that both thoughts about, and feelings of helplessness are acquired or learnt. According to this approach, individuals who have suffered a loss early on and who have a pessimistic attribution style (constructing loss as internal, global and stable), are vulnerable to developing depression. As a child Elaine suffered various painful losses. She lost her parents and her twin sister at a young age. Various family members looked after Elaine. She probably experienced several losses as she was moved between family members. She eventually lost her family when she was put in a children's home. She had no control over her situation. She might well have developed the implicit conviction that an outcome is independent of reaction. These recurrent experiences of lack of control and powerlessness may have interfered with her motivation to try to control the outcome and any opportunity to learn that reaction controls outcome. They also made her anxious for as long as she was unsure about the uncontrollability of the outcome. From the case study it appears that Elaine may believe that at present she has no control over her situation. It may seem to her that nothing that she does will change her circumstances. Responding is therefore useless. Elaine displays an obvious lack of the necessary self-confidence and motivation to stand up to and control challenges and stressors. Elaine may also attribute her lack of control to herself and her shortcomings (her self-esteem is very low).

According to the revised cognitive-learning perspective, people who feel that things that happen to them are beyond their control, ask themselves why this is the case. If they ascribe their lack of control to an internal cause ("It is my fault") which is simultaneously global ("I have no skills; I am a failure") and stable ("I always fail"), they feel helpless about preventing future negative outcomes and feel robbed of any hope that something positive will happen. Because a sustained feeling of helplessness often results in a Depressive Disorder, there is a possibility that these people will develop such a disorder.

People with a depressive attribution style - a tendency to attribute negative outcomes to personal, global and stable faults or characteristics - are very likely to become depressive when they experience negative events (stressors). It is not clear from the case study what Elaine's attribution style is. However, given Elaine's background history, we could guess that she has a pessimistic attribution style which makes her more vulnerable to developing a Depressive Disorder as a result of something negative happening to her. If she ascribes her loss of control over an important source of stability and satisfaction (her position at her workplace) to internal causes which are simultaneously global and stable (e.g. "It's my fault, I've got no skills or positive characteristics. Nobody likes and respects me. I will not be able to succeed as a manager. The junior staff members will not accept me as their manager"), and she has reason to expect future losses of control and as a result will have persistent feelings of helplessness and hopelessness. Elaine is, therefore, vulnerable to developing a Depressive Disorder according to the cognitive-learning approach.

Research findings indicate that a feeling of hopelessness is the most accurate predictor of a suicide attempt. Elaine's feelings of helplessness and hopelessness-her pessimistic conviction that her current circumstances, problems and negative mood will not change, give rise to intense suffering. Elaine saw suicide as the only effective solution to her problems.

Activity 12.17

Stress and the lack of support systems seem to play a major role in the onset and maintenance of depression. Describe the role of stress and social resources in the development and maintenance of Elaine's severe depression.

Activity 12.18

Now that you are familiar with the relationship between stress and depression, consider how you as a psychology student and member of your community, could contribute to the primary prevention of depression in your community. Would you perhaps consider becoming involved in a programme aimed at the development of effective coping skills and stress management? Consider how social support structures could be employed as buffers between stress and the development of depression. Consider how programmes like these could be implemented in your community.

Activity 12.19

Consider the following description of tertiary prevention before doing the activity: "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" (Sue, Sue & Sue, 2006, p 591).

Elaine was admitted to a psychiatric hospital to be treated for the Major Depressive Disorder from which she was suffering. Suppose you, as a mental health worker, were asked to draw up a tertiary prevention plan for Elaine to be implemented as soon as she is discharged from hospital. Briefly explain

(a) what your prevention plan for Elaine would entail and

(b) how you would implement your plan.

Bipolar and Related Disorders

Introduction

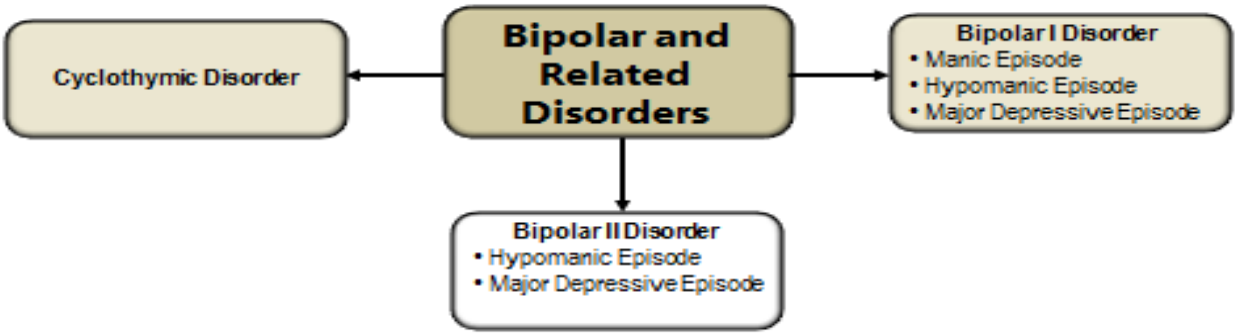
In study unit 12.1 you studied depression and its characteristics in depth. Depression and mania can be described as the opposite ends of a mood continuum on which normal mood is at the centre. The focus in study units 12.4 and 12.5 is on Bipolar and Related Disorders which have both mood types as the central feature. The term *bipolar* refers to the sufferers experiencing both the mood types, depression and mania/hypomania, usually in an alternating pattern. Bipolar Disorders in which only mania is present are very rare. Manic episodes are usually followed by depressive episodes. Bipolar and related Disorders are thus characterised by the presence or history of at least one manic or hypomanic episode alternated with depressive episodes.

The DSM-5 classification system distinguishes between seven subtypes of Bipolar and Related Disorders namely: Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, Substance/Medication-Induced Bipolar and Related Disorder, Bipolar and Related Disorder Due to Another Medical Condition, Other Specified Bipolar and Related Disorder and Unspecified Bipolar and Related Disorder. The distinction which is made between Bipolar I Disorder, Bipolar II Disorder and Cyclothymic Disorder is illustrated in your prescribed book, *Table 8.7 Bipolar Disorders*, page 256.

In contrast to the Depressive Disorders, which have been widely researched, we know relatively little about the aetiology of Bipolar Disorders. Most of the psychological perspectives have not yet succeeded in explaining the aetiology of Bipolar Disorders. The biological perspective has, however, thrown some light on the possible causes of Bipolar Disorders.

In study units 12.4 and 12.5, we discuss the characteristics of mania and hypomania, the DSM-5 diagnostic criteria for Bipolar I Disorder and Cyclothymic Disorder and the main characteristics of Bipolar II Disorders.

What you are going to study in the next two study units is illustrated visually in the following mind map:



Activity 12.20

Scan-read chapter 8, pages 230 and 231; pages 232 and 233 and pages 255 to 261 in the prescribed book and familiarise yourself with the content of the section on Bipolar and Related Disorders before you go on to the next activity.

Activity 12.21

While working through study units 12.4 and 12.5, look out for the following **Key terms.** Follow the definition suggestions provided in Chapter 8 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 these three study units you know what these terms refer to:

- Bipolar Disorder
- mania
- hypomania
- grandiosity
- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder

12.4 STUDY UNIT: Bipolar and Related Disorders - symptoms of mania and hypomania

Introduction

After you have read the *Orientation* to Learning Unit 12, it should be clear to you that we can make a distinction between a normal elevated mood state and a Bipolar Disorder. Mania and hypomania, a milder form of mania, have certain essential characteristics. Besides the extreme emotions which are the primary characteristic of mania and hypomania, manic and hypomanic episodes are also characterised by certain cognitive, physiological and behavioural symptoms. These symptoms occur in varying degrees and in different combinations in different people. An in-depth knowledge of all these different symptoms enables the professional to identify the presence of a Bipolar and Related Disorder and treat it accordingly.

Outcomes
Once you have worked through study unit 12.4 you should be able to:

- define Bipolar and Related Disorder
- distinguish between normal feelings of elation and Bipolar and Related Disorder
- describe the most common symptoms of mania and hypomania
- distinguish between mania and hypomania
- distinguish between depression and mania

Study
To be able to do the above you will need to study the introduction to study unit 12.4 in this tutorial letter, as well as the following sections in the prescribed book:

- Symptoms associated with Depressive and Bipolar Disorders (focus on the Bipolar and Related Disorders), pages 230;
- Table 8.1: Symptoms of Depression and Hypomania/Mania, (focus on Hypomania/Mania), page 231;
- Symptoms of Hypomania or Mania, pages 232 and 233;
  Evaluating Mood Symptoms, pages 233 and 234 (focus on information pertaining to hypomania and mania); and
- Diagnosis and Classification of Bipolar Disorders, pages 255 and 256 including Table 8.6 DSM-5 Criteria for a Hypomanic or Manic Episode, page 255.

Activity 12.22

Define Bipolar and Related Disorder

In your answer you should have indicated that the characteristic feature of Bipolar and Related Disorder is the presence or history of a manic or hypomanic episode, preceded or followed by major depressive episodes or depressive symptoms. The elevated, expansive or irritable mood which is characteristic of mania and hypomania is accompanied by somatic, cognitive and behavioural changes that have a negative impact on the individual's capacity to function. The symptoms also cause clinical significant distress.

Activity 12.23

Describe the general symptoms of mania, using the following headings: *Emotional Symptoms, Cognitive Symptoms, Behavioural Symptoms* and *Physiological Symptoms*.

Compare your answer with the subsections headed *Emotional Symptoms of Hypomania or Mania, Cognitive Symptoms of Hypomania or Mania, Behavioral Symptoms of Hypomania or Mania* and *Physiological Symptoms of Hypomania or Mania*, pages 232 to 233 and *Table 8.1: Symptoms of Depression and Hypomania/Mania*, page 231 in the prescribed book. Add to your answer if it is not complete.

Activity 12.24

Distinguish between mania and hypomania.

In your answer, you should have pointed out the following: Although manic and hypomanic episodes have the same essential characteristics, a hypomanic episode is less serious than a manic episode and does not impair social and occupational functioning as severely. In hypomania, there are no psychotic symptoms (delusions and hallucinations) and the person is not really a danger to himself or herself or other people. Hospitalisation is also not necessary. In contrast to hypomania, a manic episode is a serious mood disturbance which leads to severe impairment of social and occupational functioning. During a manic episode, the person often displays psychotic symptoms and can be a danger to him- or herself and others, and often has to be hospitalised. Mania and hypomania, therefore, differ chiefly in intensity and effect (APA, 2013).

Activity 12.25

Read the following case study about Alan (Sue et al., pp. 215-216, 2013) and list the manic symptoms which Alan displays.

Case study

Upon returning to work after a short vacation, Alan, a twenty-six-year old computer programmer, seemed unusually happy, talkative, and energetic; he bragged that he was getting by on only a few hours of sleep by eating sugar. He brought several huge cakes to work and insisted that co-workers eat some of each cake. Initially, everyone was surprised and amused by his antics. However, amusement was soon replaced with irritation when Alan's continual talking and interruptions to share new ideas interfered with their work.

One morning, Alan jumped onto a desk, making obscene remarks and yelling, "Listen! We aren't working on the most important aspects of our data! Erase, re-program, you know what I mean. We've got to examine the total picture based on the input!" Alan's speech was so rapid and disjointed that it was difficult to understand him. Alan then grabbed a chair and began to smash computers. After several co-workers grabbed him, Alan continued to shout and struggle. Police officers were summoned; they handcuffed Alan to restrain his movements. Within hours, he was taken to a psychiatric ward for observation.

Adapted from Sue et al. (2013). *Foundations of abnormal behavior*, 10th edition.

Were you able to identify the following manic symptoms in Alan's case?

- A definite period (the past two weeks) of abnormal and sustained elevated mood and endless energy.
- His behaviour is uninhibited, domineering, impulsive, offensive and not goal-directed. He is overactive. Frustration makes him behave aggressively.
- He shows signs of exaggerated optimism without any basis, excessive self-confidence and delusions of grandeur.
- Alan is more talkative and louder than usual. His speech is rapid and flustered. His thoughts seem to run away with him before he can articulate them (pressure of thoughts). He also displays flight of ideas. His speech is disjointed and it is difficult to follow him. His attention shifts rapidly from one topic to another (he talks about work, utters profanities and makes obscene comments about the secretaries).
- The manic symptoms clearly detract from Alan's social and occupational functioning.
- Alan has to be hospitalised because he is a danger to himself and others.

Activity 12.26

Distinguish between depression and mania in terms of the emotional, cognitive, physiological and behavioural symptoms.

This question requires you to point out the differences between depression and mania with respect to the emotional, cognitive, physiological and behavioural symptoms. Compare your answer with Table 8.1 entitled *Symptoms of Depression and Hypomania/Mania*, page 231 in the prescribed book. Add to your answer if it is not complete and ensure that you can clearly differentiate between depression and mania.

Activity 12.27

Bearing in mind the case studies of Amanda (Activity 12.4) and Alan, distinguish between a Depressive Disorder and a Bipolar Disorder on the one hand and normal feelings of dejection and elation on the other hand.

We can distinguish between a Depressive Disorder and Bipolar Disorder and normal feelings of dejection and elation on the basis of intensity, duration and effect. The symptoms of both Depressive Disorders and Bipolar and Related Disorders are far more intense and last longer than normal feelings

of dejection and elation. The symptoms of Depressive Disorder and Bipolar Disorder invade all facets of a person's life and negatively affect the person's general functioning. The symptoms of the Depressive Disorder and the Bipolar and Related Disorders involve far more than a normal, acceptable reaction to an event or situation and often result in severe discomfort for the person.

From the case studies, it is clear that both Amanda and Alan displayed symptoms which are far more intense than normal feelings of dejection or elation. Their symptoms were not short-lived and also lasted for a certain time, and they adversely affected all facets of their lives. Both Alan and Amanda's social and occupational functioning was impaired and they both experienced discomfort. Both Amanda and Alan required professional help and were a danger to themselves. There was a real danger that Amanda might attempt suicide because life had lost all meaning for her. Alan, with his impulsive, uninhibited and aggressive behaviour, was a danger to others but also needed to be protected from himself and his impulsive behaviour.

12.5 STUDY UNIT: Classification of Bipolar and Related Disorders

Introduction

As you know by now, the DSM-5 classification system divides the Bipolar and Related Disorder into several main categories or subtypes. In this study unit we are going to study the DSM-5 diagnostic criteria for Bipolar I Disorder and Cyclothymic Disorder and the characteristics of Bipolar II Disorder.

Outcomes

Once you have worked through study unit 12.5, you should be able to:

- describe the DSM-5 criteria for Bipolar I disorder and Cyclothymic Disorder
- describe the characteristics of Bipolar II Disorder
- compare Bipolar I Disorder, Bipolar II Disorder and Cyclothymic Disorder
- identify and classify the Bipolar Disorder a person is suffering from according to the DSM-5 classification system;
- identify and apply the specifiers for Bipolar and Related Disorders.

Study

To be able to do the above, you should study the DSM-5 criteria for Bipolar I Disorder and Cyclothymic Disorder as well as the specifiers for Depressive and Bipolar and Related Disorders in this tutorial letter and the following sections in the prescribed book:

- Bipolar Disorders, page 255;
- Diagnosis and Classification of Bipolar Disorders, pages 255 to 256;
- Table 8.7 Bipolar Disorders, page 256;
- Bipolar I Disorder, page 257;
- Bipolar II Disorder, pages 257 and 258;
- Cyclothymic Disorder, page 258 and
- Features and Conditions Associated with Bipolar Disorder, pages 258 and 259.

Activity 12.28

The description of Bipolar I Disorder and Cyclothymic Disorder is given only very briefly in the prescribed book (pages 257 and 258). Complement this information with the more elaborate diagnostic criteria contained in the DSM-5 classification system (APA, 2013). Make sure you **know** the criteria for these two disorders well.

DSM-5 Diagnostic Criteria for Bipolar I Disorder

For a diagnosis of Bipolar I Disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

Manic Episode:

A A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalisation is necessary).

B During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behaviour:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only three hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features.

D The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

Hypomanic Episode:

A A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day.

B During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behaviour, and have been present to a significant degree:

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only three hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D The disturbance in mood and the change in functioning are observable by others.

E The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalisation. If there are psychotic features, the episode is, by definition, manic.

F The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Major Depressive Episode:

Refer to page 235 in the prescribed book for the DSM-5 criteria for Major Depressive Episode.

(APA, 2013, pp. 123-125).

DSM-5 Diagnostic Criteria for Cyclothymic Disorder

A For at least two years (at least one year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet the criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet the criteria for a major depressive episode.

B During the above two year period (one year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than two months at a time.

C Criteria for a major depressive, manic, or hypomanic episode have never been met.

D The symptoms in Criterion A are not better explained by Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Other Specified or Unspecified Schizophrenia Spectrum and Other Psychotic Disorder.

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

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

(APA, 2013, pp. 139-140).

Activity 12.29

In recording **Bipolar I Disorder**, terms should be listed in the following order:

Bipolar I Disorder, type of current or most recent episode (e.g., most recent episode manic or hypomanic or depressed) and its status with respect to current severity (mild, moderate or severe), presence of psychotic features, followed by any other relevant specifiers (e.g., melancholic features, catatonia, with peripartum onset, rapid cycling). Refer to activity 12.8 in this tutorial letter and the section on specifiers, pages 236 and 258 to 259 in the prescribed book, and make sure that you are able to apply these specifiers correctly.

Activity 12.30

Outline the primary distinguishing features of Bipolar I Disorder, Bipolar II Disorder and Cyclothymic Disorder.

Make sure that you know what a manic episode, a hypomanic episode, a major depressive episode and Cyclothymic Disorder involve. Your answer should include the following primary distinguishing features:

Bipolar Disorders	Primary distinguishing features
Bipolar I Disorder	The presence or a history of a manic episode. The manic episode may have been preceded by, and may be followed by hypomanic or major depressive episodes.
Bipolar II Disorder	Major depressive episode/s which alternate with hypomanic episode/s. No history of manic episodes.
Cyclothymic Disorder	The presence of various periods of hypomanic symptoms and various periods of depressive symptoms (which do not meet the criteria for manic, hypomanic or major depressive episodes) for a period of at least two years.

Activity 12.31

Read the following case study carefully and then do the following:

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

(b) Substantiate your choice of diagnosis/diagnoses.

Case study

It is 03:00 in the morning, the fourth night that Steve, a second-year student, has not slept. He is writing pages and pages in a notebook at a terrific rate. At first he was capturing his thoughts on a word processor, but because his thoughts come flooding in so rapidly and he is so anxious to get them all down on paper and his hands cannot keep up, he grabbed a pen and notebook. As he paces up and down writing hurriedly in his notebook, he curses his hands which still cannot keep up with his thoughts. Suddenly he has a brilliant idea: He can phone his sister, who is a secretary, to come and type for him as he dictates his thoughts to her.

Despite the time of night, he is determined to phone his sister immediately. Steve is quite sure that she will come and help him straightaway, and that she will be delighted to share in his fame when his book is published. Steve is convinced that his book will be a bestseller and that he will soon be internationally famous. He jumps into his car and goes racing up and down the streets looking for a telephone.

When his sister answers the telephone, she is immediately on her guard when she hears it is Steve. She has been worried about him for a while now. When she saw him two months ago, Steve showed no interest in his studies, which he was previously enjoying. He was having trouble keeping up with the course. He complained that he could not concentrate, he had lost a lot of weight and he looked tired and weary, he was clearly depressive and mentioned to her that he felt worthless and could no longer see any sense or meaning in life. Now Steve's sister is most surprised to hear an extremely keyed-up Steve's voice on the phone. He babbles away about the bestseller that he is busy writing, and asks her to come over urgently to help him with it. When she refuses to come, Steve gets very angry and swears at her about being jealous of him. She promises, however, to come over the next day.

Steve storms away angrily from the phone. When he reaches his car, he suddenly remembers about the two strange girls whom he took home to his flat earlier in the evening after meeting them at a club. He had sexual intercourse with both girls various times before starting to work on his book. He races home at a dangerous speed and is ready for more sexual activities. His book is clean forgotten.

The next morning Steve's sister persuades him to go to the medical clinic on campus. Although she is surprised at Steve's energy, she is very concerned about him because his appearance is dishevelled and he looks like a total stranger. It comes out that he has not been attending classes for a week, although the exams are not far off.

At the clinic, Steve entertains the staff with his jokes and clever comments, and he obviously enjoys all the attention he gets. He talks without stopping. He jumps from topic to topic, and it is extremely difficult to follow what he is saying. He does not answer any questions properly, because the smallest movement or sound distracts him. When the doctor on duty asks Steve to sit still and answer his questions, Steve gets furious. He begins swearing at the doctor, knocking office furniture about. Two security guards subdue him with difficulty. The doctor then arranges for Steve to be admitted to a psychiatric clinic.

(Adapted from: Case Studies in Abnormal Psychology, 1998).

(a) Steve's abnormal behaviour should be classified as:

Bipolar I Disorder, manic episode, severe without psychotic features (principle diagnosis).
Educational problems.

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

Steve meets the criteria for a severe Bipolar I Disorder without psychotic symptoms. At present Steve is displaying symptoms of a *manic episode*. It appears that he has been displaying these symptoms for the past week and his condition requires hospitalisation. The Bipolar I Disorder has clearly impaired his social and occupational (academic) functioning. Steve has the following symptoms: his mood is persistently elevated and irritable, he has an inflated self-esteem and grandiose plans (writing a bestseller and becoming internationally famous), he is much more talkative than usual, pressure of thoughts and flight of ideas are present, he is distractible, his activity levels have risen (working without stopping on his book), he shows psychomotor agitation and is restless (paces up and down), his judgement is impaired and he is involved in pleasurable activities which may have negative consequences (sexual intercourse with two strange women, reckless driving).

The specifier *severe without psychotic symptoms* indicates, on the one hand, Steve's need for almost constant supervision to protect him from himself and to protect others from him and, on the other hand, the seriousness of his symptoms and his impaired functioning. There are, however, no psychotic symptoms. Take care not to confuse his grandiose feelings and his inflated self-esteem with a delusion.

Earlier, Steve also displayed symptoms of a Major Depressive episode which adversely affected his general functioning and caused him distress. He displayed the following symptoms: depressive mood, loss of interest in activities which he previously enjoyed, difficulty concentrating, weight loss, tiredness and weariness, a feeling of worthlessness and an inability to find sense and meaning in life.

Educational problems (problems coping with the demands of his academic course).

(It should be borne in mind that there are possibly other social and environmental stressors present and that collateral information about Steve should be obtained. The case study focuses mainly on the symptoms of Steve's abnormal behaviour.)

If your diagnoses differ from the correct diagnoses, refer to Learning Unit 5 in tutorial letter 501/2014 and study units 12.4 and 12.5 in this tutorial letter. Make sure that you know where you went wrong. Contact one of your lecturers if you need assistance.

Activity 12.32

Explain why a diagnosis of Bipolar I Disorder is made in Steve's case rather than a diagnosis of Bipolar II Disorder or Cyclothymic Disorder.

To be able to answer this question, you need a thorough knowledge of the differences and similarities between Bipolar I, Bipolar II and Cyclothymic Disorder. Because Steve displays symptoms of a Bipolar Disorder, you should have considered all three disorders when analysing Steve's case study and compiling a differential diagnosis. The duration and intensity of Steve's symptoms meet the criteria for a Bipolar I Disorder, most recent episode manic.

Bipolar II Disorder is eliminated for the following reason: Although Steve has a history of a Major Depressive episode, a diagnosis of Bipolar II Disorder cannot be made because the manic symptoms which Steve is displaying meet the criteria for a manic episode. These symptoms are far more severe than the symptoms that occur during a hypomanic episode which are characteristic of Bipolar II Disorder.

Cyclothymic Disorder is eliminated for two reasons: Steve is displaying symptoms which meet the full criteria for both a manic and a Major Depressive episode. His symptoms are, therefore, far more serious than the characteristic symptoms of a Cyclothymic Disorder. Steve's disorder is also not chronic as is the case in Cyclothymic Disorder. Steve has only been displaying symptoms of a Bipolar Disorder for the past few months.

Activity 12.33

The following activities will help you to revise and summarise what you have studied in Learning Unit 12:

1. At the beginning of Chapter 8, page 230 of the prescribed book, there are three *Focus Questions*. Answer questions 1, 2 (not the section on treatment) and 3 (not the sections on aetiology and treatment) after you have worked through this Learning Unit. Compare your answers to the answers provided at the end of Chapter 8 in the prescribed book under the heading *Chapter Summary*, page 295. If your answers are not complete, consult Tutorial letter 502/2016, and chapter 8 in your prescribed book again on these questions.
2. Go back to the **Key terms** (Depressive Disorders and Bipolar and Related Disorder) in this tutorial letter and reflect on your understanding of each term. Explain the meaning of these terms to a fellow student in your own words. If you battle to do so, refer back to your prescribed book and study guide.
3. The learning outcomes of the five study units in this Learning Unit were set out clearly in each study unit. Make sure that you have acquired the necessary knowledge, skills and insights set out in these learning outcomes.
4. Go to the following internet resources and read on Depressive Disorder, Bipolar and Related Disorder and available support groups regarding prevention:

   http://www.sadag.co.za
   http://www.bipolar.co.za
   http://www.webmd.com/depression/

CONCLUSION

In Learning Unit 12 we have studied the characteristics of five of the Depressive Disorders and three of the Bipolar and Related Disorders. The knowledge you have gained should enable you to identify and describe these disorders, and to distinguish between these disorders and disorders/conditions which are closely related to them. We have explained Depressive Disorders according to the behavioural, cognitive and cognitive-learning perspectives. We have also explored the relationship between stress and Depressive Disorders. What you have learnt should enable you to draw up a prevention plan for use in preventing and treating depression.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text revision). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Brody, J.E. (1992, September 30). *Myriad masks hide an epidemic of depression.* New York Times, C. 12.

Clipson, C.R., & Stear, J.M. (1998). *Case studies in abnormal psychology*. New York, NY: Houghton Mifflin.

Sue, D., Sue, D.W., & Sue, S. (2006). *Understanding abnormal behaviour* (8th ed.). Boston, MA: Houghton Mifflin.

Sue, S., Sue, D.W., & Sue, D. (2013). *Foundations of abnormal behaviour* (10th ed.). Boston, MA: Houghton Mifflin.

Learning Unit 13:

Suicide

Mrs Elmarié Visser

Contents

Orientation

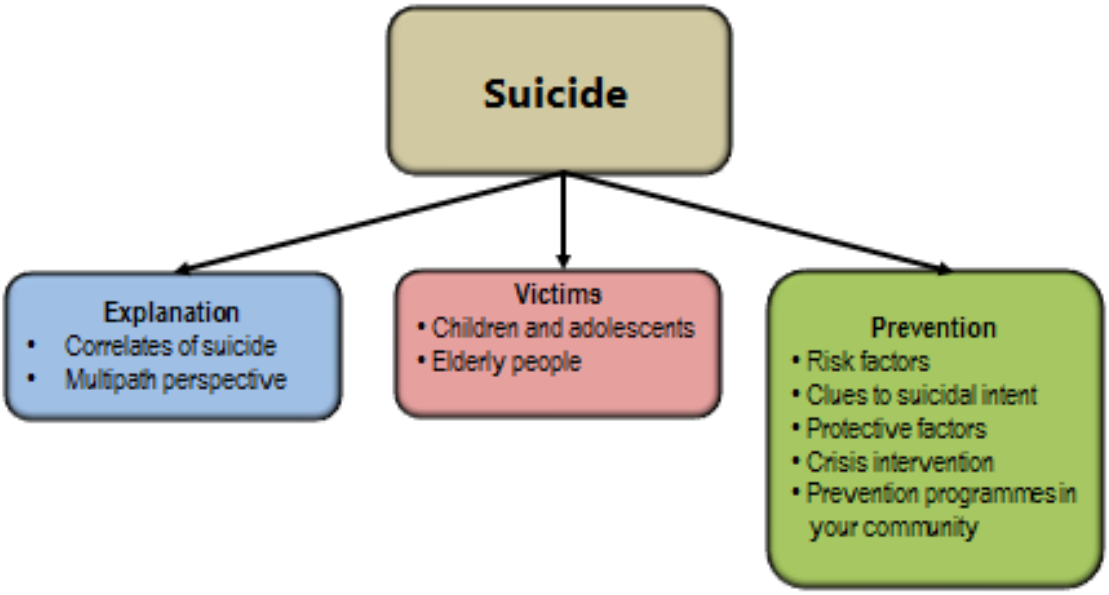
Suicide is a major problem in South Africa. It is estimated that a South African commits suicide every hour with 20 more attempting to take their lives daily. According to Caruso of the Suicide Organisation, suicide is on the rise in South Africa and children as young as 10 are dying by suicide. Have you ever wondered about the reasons why a person, especially a young person, runs out of reasons to live? Have you perhaps ever had thoughts of suicide yourself, or do you know someone in your community who has committed suicide or tried to commit suicide? Should we not ask ourselves what we can do to reduce the risk of suicide in our community and save the lives of human beings?

Suicide - taking one's own life - is not classified as a mental disorder according to the DSM-5 classification system. However, suicide is so common and so tragic that it requires the attention of all mental health professionals. One problem in the study of suicide is that it has no obvious aetiology. Suicide is a complex act with many facets. It is an act that arises from the specific and idiosyncratic circumstances of the person's life, and because all people's lives and circumstances are different, the reasons for suicide differ considerably. No theory has yet succeeded in explaining suicide completely. In this chapter, we study general trends. Please remember, though, that trends cannot always be applied to all situations.

Suicide is an irreversible act. The treatment of suicide is, therefore, at the level of early identification and prevention.

In Learning Unit 13 we discuss the correlates of suicide and focus on the multipath perspective of suicide. We discuss two groups of people who are especially victimised by suicide, the young and the elderly. We also discuss the prevention of suicide. Risk and protective factors in suicide and clues to suicidal intent are explored. You will also be challenged to become involved in the prevention of suicide in your community.

What you are going to study in Learning Unit 13 is illustrated visually in the following mind map:



Activity 13.1

Scan-read chapter 9 in the prescribed book and familiarise yourself with the contents of this chapter before you go on to the first study unit.

Activity 13.2

While working through this Learning Unit, look out for the following **Key terms**. Follow the definition suggestions provided in Chapter 9 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 Learning Unit that you know what these terms refer to:

- Suicide
- Suicide ideation
- Psychological autopsy
- Alcohol-induced myopia
- Copycat suicide
- Suicide lethality

13.1 STUDY UNIT: Correlates of suicide

Introduction

The study of suicide is based primarily on two research strategies: retrospective analysis (psychological autopsy) and the study of people who have survived suicide attempts. Although these research strategies have limitations, we still use them in an attempt to understand suicide better. The primary purpose of these studies is to isolate the events and circumstances that lead to suicide and to identify the characteristics of potential suicide victims. Information about these factors helps mental healthcare workers to prevent suicide and to prevent people from making subsequent suicide attempts.

In this study unit, we study factors which correlate with suicide. Although these factors do not fully explain suicide, research studies have shown that they often precede suicide. Among the most common precipitating factors which lead to suicide are stress, feelings of hopelessness, depression, alcohol consumption, various other mental disorders, imitation of suicide and change in economic status.

Not all individuals, to whom these factors apply, commit suicide. In trying to explain why some people are more vulnerable than others to committing suicide, various theorists offer more comprehensive explanations for suicide. The sociocultural, psychodynamic and biological perspectives each have a separate explanation for suicide. Although all three of these perspectives have made valuable contributions to understanding suicide, none of them has succeeded in investigating and explaining all facets of suicide. The multipath perspective of suicide offers an integrated and multidimensional explanation of suicide.

Outcomes
Once you have worked through study unit 13.1 you should be able to:

- describe the correlates of suicide
- explain suicide according to the multipath perspective.

Study
To be able to do the above you should study the following sections in the prescribed book:

- "'Suicide' and 'Suicide ideation'" in the introduction to chapter 9, pages 267 and 268;
- "Facts about Suicide", pages 268-270;
- "Effects of Suicide on Friends and Family", pages 270-273;
- "A Multipath Perspective of Suicide", pages 280-286.

Activity 13.3
Describe the factors that are highly correlated with suicide.

Activity 13.4
Describe the relationship between depression and suicide.

In answering this question, you should have:

- defined depression and suicide
- discussed the high correlation between depression and suicide
- pointed out that the correlation between depression and suicide is high, but also very complex (not all people suffering from depression commit suicide and not all people who attempt/commit suicide are/were depressed)
- pointed out that people often commit suicide as they come out of the deepest phase of depression
- explained that feelings of hopelessness are a better warning sign of suicide than depression

If your answer is not complete, consult the prescribed book (pages 282 and 283) again and add to your answer.

Activity 13.5
Describe the relationship between alcohol consumption/Alcohol Intoxication and suicide.

In answering this question, you should have:
- defined suicide and alcohol intoxication (Refer to Learning Unit 10, Activity 10.4 for more information on Alcohol Intoxication)
- pointed out that there is a high correlation between alcohol consumption/intoxication and suicide
- discussed the function and the effect of alcohol consumption/intoxication in suicide: People who are having serious problems and whose state of mind is negative often use alcohol in an effort to feel better or to give them the courage to commit suicide. Alcohol has a disinhibiting effect and relieves the fear of death of a person who is planning to commit suicide. It is therefore easier for the person

to proceed to the act of suicide. Alcohol also impairs a person's judgment and problem-solving skills and makes the person more vulnerable to committing suicide.

- explained the relationship between suicide and alcohol-induced myopia: It has been found that people who commit suicide are more rigid in their thinking, less flexible in their problem solving and more inclined to dichotomous thinking. Alcohol causes cognitive and perceptual processes to decline. The myopic effect of alcohol therefore impairs these people's already deficient judgment and problem-solving skills and increases the likelihood of their committing suicide when they experience psychological conflict and need.

If your answer is not complete, consult the prescribed book (page 260) again and add to your answer.

Activity 13.6

Explain suicide according to the multipath perspective.

In answering this question, you should have discussed the biological, psychological, social and sociocultural factors that are correlated with suicide. You should also have pointed out the complex relationship and interaction between these four dimensions. It should be clear that suicide is not simply one of cause and effect but an interaction among biological, psychological, social and sociocultural factors.

Activity 13.7

Read the case studies of Carl Johnson (page 267) and Tammy Jimenez (page 283) in the prescribed book.

Take note of the different reasons and combinations of reasons for suicide in each of these case studies.

Activity 13.8

In Learning Unit 5, Activity 5.2, pages 58 to 62, in Tutorial Letter 501/2016, we discussed a case study, one about Elaine. Elaine made a serious suicide attempt and obviously expected to die. Read this case study again. Bearing in mind what you now know about the possible causative factors of suicide, identify and briefly discuss the factors which gave rise to Elaine's suicide attempt.

In your answer you should have identified and discussed the following factors:

- Major Depressive Disorder, which is a serious Depressive Disorder, was diagnosed in Elaine's case. Elaine displays symptoms of loss of enjoyment, exhaustion and grief. Elaine also displays clear signs of mood changes and severe psychological pain and distress which she can no longer endure.
- Elaine has feelings of hopelessness - a pessimistic outlook that her circumstances, negative mood and problems will not change. Elaine (who shows inadequate personality characteristics - Avoidant Personality Disorder) has lost perspective and sees suicide as the only effective solution to her problems.
- Elaine has experienced severe psychosocial and environmental stressors.
  Explain how these stressors, for example, the serious losses Elaine suffered, acted as precipitating factors in her suicide attempt.
- Elaine does not have an extensive social support network or close ties with her community. Social isolation and a lack of social support during times of stress increase the risk of suicide. Elaine avoids her sources of support, her friends. Elaine also lost her source of support at work after her supervisor died.

13.2 STUDY UNIT: The victims of suicide

Introduction

People of all age groups commit suicide. The incidence of suicide differs however; from age group to age group that is, for example, suicide is higher among the elderly than among younger people. In study unit 13.1 we discussed the factors and situations which correlate with suicide. Although these factors and situations relate to all age groups, each group also has unique problems and demands which play an important part in the incidence of suicide in that specific group. Knowledge of these factors will help the mental health worker to understand suicide better and to act preventatively.

In this study unit, we discuss three age groups in which the incidence of suicide is high. These three age groups are: children, adolescents and the elderly. The emphasis in this study unit is on the characteristics of the people in these three age groups who are vulnerable to committing suicide and on the factors and situations which correlate with suicide in each age group.

Outcomes

Once you have worked through study unit 13.2, you should be able to describe the:

- characteristics of people who commit suicide in childhood, adolescence and old age
- factors and situations which show a high correlation with suicide in childhood, adolescence and old age.

Study

To be able to do the above, you should study the following sections in the prescribed book:

- "Suicide and Specific Populations", pages 273-279.

Activity 13.9

Describe (a) the characteristics of children, adolescents and elderly people who are vulnerable to committing suicide, and (b) the factors and situations which show a high correlation with suicide during childhood, adolescence and old age.

Compare your answers to (a) and (b) with the corresponding sections in the prescribed book. Add to your answer if it is not complete.

13.3 STUDY UNIT: Preventing Suicide

Introduction

Suicide is an irreversible deed. Preventing this tragic and fatal deed depends to a large extent on early identification and timeous, successful intervention before the deed is committed. According to Sue, Sue and Sue (2003), the successful prevention of suicide entails a three-step process:

1. Collecting knowledge about and identifying the risk factors and warning signs of suicide.
2. Evaluating the probability (high, moderate or low) of whether the person will act on his or her suicide wish.
3. Implementing appropriate actions.

The implementation of intervention strategies includes crisis intervention, psychotherapy and hospitalisation.

Suicide not only ends a valuable life, but also has far-reaching consequences for the victim's family, extended family, friends and community. Various bodies and organisations offer valuable suicide prevention services in the form of crisis intervention and counselling. Telefriend's phone-in service, Lifeline's 24-hour crisis phone-in service, the Depression and Anxiety Support Group's crisis intervention service and support groups (SADAG), Befrienders South Africa and Famsa's crisis intervention and counselling services, are examples of suicide

prevention services which are available countrywide to potential suicide victims and their family members. Diagnostically, suicide is still a criterion of Major Depressive Disorder. However suicidality can occur in conjunction with other abnormal behaviour. The DSM-5 research teams are still deciding how to reflect suicidality and suicidal gestures more broadly. Currently, Non-Suicidal Self-Injury (NSSI) is only a proposed diagnosis which is still being researched (Sue et al, 2016, p. 507-508) together with a proposed diagnosis of Suicidal Behaviour. Remember that a Personal History of Self-Harm is diagnosable according to the DSM-5 in the category of *Other Conditions That May Be a Focus of Clinical Attention.*

Outcomes
Once you have worked through study unit 13.3 you should:

- have a thorough knowledge of the risk factors associated with suicide
- be able to identify the risk factors and warning signs of suicide
- be able to determine the probability of a person's carrying out his or her suicide wish
- be familiar with the prevention of suicide and the suicide prevention programmes in your community to which you can refer people who are contemplating suicide.

Study
To be able to do the above, you should study the following sections in the prescribed book:

- "Preventing suicide", pages 286-292;
- Table 9.2: "Risk and protective factors", page 287;
- Figure 9.4: "The process of preventing suicide", page 288.

Activity 13.10

Sandra, a 14-year-old girl, mentions that she would rather die than keep living. Draw up a list of various factors which would indicate to you whether or not she will commit suicide.

In answering this question, you should have considered the following possible risk factors:

The fact that Sandra is an adolescent girl puts her in a high risk group for committing suicide. The incidence of suicide among adolescent girls is high. Sandra has already expressed a suicide wish. This increases the possibility that she may commit suicide. The possibility would be further increased if she is preoccupied with death. If Sandra already has a detailed suicide plan; a suicide weapon; has previously attempted suicide; and has begun getting her affairs in order by giving away her possessions, the chances of her committing suicide are increased. If Sandra shows symptoms of depression and feelings of hopelessness, aggression and/or hostility; has been exposed to someone else's suicide which she might try to imitate; uses alcohol or other substances; has recently suffered a serious loss or other trauma; her family is unstable and/or is severely stressed economically and/or suffering from medical and psychiatric diseases; her parents abuse alcohol or other substances, are not available to support her and/or are poor role models as regards coping with stress, the possibility that Sandra will commit suicide is high.

The number, intensity and combination of these factors will determine how strong the possibility is that Sandra will commit suicide. If there are many risk factors present and her suicide plan is carefully worked out and fatal, Sandra is in serious danger of committing suicide.

If only a few risk factors are present and Sandra has only suicidal thoughts but no specific suicide plan, the possibility that Sandra will commit suicide is reduced.

If you did not consider all these factors, consult your prescribed book again and add the missing factors to your list.

Activity 13.11

Differentiate between high, moderate and low suicide risk factors and mention the preventative measures associated with each of the three categories.

Compare your answer with the information contained in Figure 9.4 : *The Process of Preventing Suicide,* page 288 in your prescribed book. Add to your answer if necessary.

Activity 13.12

With the high incidence of suicide in South Africa, the chances are good that you will one day have to deal with a suicide threat. How are you going to handle it? Crisis intervention services which include suicide prevention services are offered in most centres across the country. Draw up a list of the services which are offered in your community. Approach one of these crisis intervention services (e.g. Lifeline, Telefriend, Famsa, the Depression and Anxiety Support Group or Befrienders South Africa, or call the toll-free suicide hotline in South Africa at 0800-567-567 and find out the following:

- what type of services are offered
- how suicide threats are handled
- who offers the services
- what type of training is given to the people who provide the services

Would you perhaps consider being trained as a volunteer worker who could provide a valuable service in the community? Find out more about this from one of the organisations we have mentioned.

Activity 13.13

The following activities will help you to revise and summarise what you have studied in Learning Unit 13:

1. At the beginning of chapter 9, page 250 of the prescribed book, there are 5 *Focus Questions*. Answer questions 1, 2, 3 and 4 after you have worked through this chapter. Compare your answers to the answers provided at the end of chapter 9 in the prescribed book under the heading *Summary*, pages 273 and 274. If your answers are not complete, consult your prescribed book again on these questions.

2. Go back to the beginning of this Learning Unit in this tutorial letter to the **Key terms** and reflect on your understanding of each term. Explain the meaning of these terms to a fellow student in your own words. If you battle to do so, refer back to your prescribed book and Learning Unit 13 in this tutorial letter.

3. The learning outcomes of each of the three study units in this Learning Unit 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 suicide and available support groups regarding prevention:

   http://lifeline.org.za
   http://www.sadag.co.za
   http://www.metanaia.org/suicide/
   http://befrienders.org/helplines/helpline.asp?C2-South+Africa

CONCLUSION

Suicide is among the top 10 causes of death in Western society. Although there are differences of opinion about suicide rates in Africa, the incidence of suicide in South Africa is unquestionably high. In Learning Unit 13, we have discussed the factors that are positively associated with suicide. Although we have identified general predisposing and precipitating factors, we also have to take the uniqueness of each person and his or her circumstances into account. The complexities of South African society, for example, differ from those of American and European society and factors associated with our rapid socio-political changes, unemployment; inadequate educational and health facilities, growing urbanisation and Westernisation, poverty, or housing shortages, play different roles in individual suicide cases.

Suicide is an irreversible act. The only successful way to deal with suicide is to prevent it. By applying crisis intervention strategies, we can evaluate suicidal intentions and prevent people from implementing their suicide plans. Various organisations and bodies offer suicide prevention services.

REFERENCE

Sue, D, Sue, D.W., & Sue, S. (2003). *Understanding abnormal behavior.* (7th ed.). Boston, MA: Houghton Mifflin.