

---

## UNIT 2 CONATIVE DISTURBANCES (INCLUDING BEHAVIOUR)

---

### Structure

- 2.0 Learning Objectives
- 2.1 Introduction
- 2.2 Conative (behavioural) Disturbances in Psychiatric Disorders
- 2.3 Behavioural Disorders in Children
  - 2.3.1 Oppositional Defiant Disorder
  - 2.3.2 Conduct Disorder
  - 2.3.3 Attention Deficit Hyperactivity Disorder
- 2.4 Let Us Sum Up
- 2.5 Answers to Check Your Progress Exercises
- 2.6 Unit End Questions
- 2.7 References and Suggested Readings

---

## 2.0 LEARNING OBJECTIVES

---

After going through this Unit, you will be able to:

- define conation;
- explain the various conative disturbances present in psychiatric disorders; and
- understand behavioural disturbances associated with major disorders in children.

---

## 2.1 INTRODUCTION

---

In the previous unit, you have learnt about the cognitive disturbances in psychiatric disorders. This unit will deal with the conative or behavioural disturbances. Behavioural disturbances form an integral part of almost all psychiatric disorders along with cognitive and affective disturbances. The major difference between most physical disorders and psychiatric disorders is that psychiatric disorders are accompanied by behavioural disturbances which are evident to others. These behavioural disturbances can be due to a variety of reasons which will be dealt with in this chapter. Since behavioural disturbances are evident to others these become the major reason for which patients are brought to treatment or admission to psychiatry ward. In addition, most of the stigma and discrimination associated with psychiatric disorders is the result of these behavioural problems.

### What is Conation?

The Latin “conatus,” from which conation is derived, is defined as “any natural tendency, impulse or directed effort.” Human brain is tripartite or has three elements viz: cognition, affect and conation. Conation is visible and purposeful behaviour arising out of emotions, preferences or beliefs (affective faculties) and learned knowledge and skills (cognitive faculties). Conational actions and reactions are volitional, or purposeful, not a physical, knee-jerk response. When a person is thirsty, sees a glass of water and wants to drink it, he takes a volitional decision to “get conative” – to actually reach down and grab the glass. Conative actions become acts of will when an individual takes self-control over these instinct-driven patterns of behaviour.

Acting, reacting and interacting according to one's conative bent leads to goal-oriented achievement. Conative action differentiates human beings from lower forms of animals. Researchers consider conation the executive function of the brain, with the responsibility for managing the actions stemming from the other faculties, or brain functions. Thus, disturbances in conation are manifested as disturbances in the behaviour or actions that are overtly visible to others. These behavioural disturbances are a part of most of the psychiatric illnesses like depression, mania, schizophrenia, obsessive compulsive disorder and other disorders.

### A Historical and Theoretical Overview

That the mind has three distinct parts is the "Wisdom of the Ages." The Ancient philosophers Plato and Aristotle spoke of the three faculties through which we think, feel and act. In the 18th and 19th centuries, the trilogy of the mind was the accepted classification of mental activities throughout Germany, Scotland, England and America. In the first half of the 20th century, it was American psychologist William McDougall who was its primary proponent. McDougall proposed that all mental activity has three aspects, cognitive, affective and conative; and when we apply one of these three adjectives to any phase of mental process, we mean merely that the aspect named is the most prominent of the three at that moment. Each cycle of activity has this triple aspect; though each tends to pass through these phases in which cognition, affection and conation are in turn most prominent.

#### Check Your Progress 1

**Note:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the three parts of the tripartite brain?

.....  
.....  
.....  
.....

2) What are the functions of the conative faculty in humans?

.....  
.....  
.....  
.....

With this backdrop, we will discuss the various behavioural disturbances in psychiatric disorders and behavioural disturbances in disorders common in children in the subsequent sections of this Unit.

---

## 2.2 CONATIVE (BEHAVIOURAL) DISTURBANCES IN PSYCHIATRIC DISORDERS

---

### a) Irritability, Aggression and hostility

These are the three symptoms or behaviours which are related to each other and can be found to a different extent in almost all the psychiatric illnesses. In its most severe

form, aggression and hostility can be found in psychotic illnesses like schizophrenia, acute and transient psychotic disorders, schizoaffective disorders, delusional disorder, psychotic symptoms associated with substance use, depression and mania. Patients may resort physical aggression in form of aggressive, hostile and violent behaviours like hitting others mainly family members, breaking household objects. Verbal aggression in form of abusive language and threatening language and gestures may be there. It is important to note that in most patients, aggressive and hostile behaviour is usually on provocation but some patients with psychotic disorders can have unprovoked aggression. Unprovoked aggression is seen usually in response to hallucinations when voices tell the patient to perform an action or in response to suspiciousness when patients suspect others of wrongdoing. In its mild form, aggression may manifest in form of irritability in behaviour like not wanting to talk to anyone which is more commonly seen in the depressive disorders and anxiety disorders. These patients are usually very distressed by their symptoms and have lost interest in daily pleasurable activities. Due to this, they become irritable. Irritability usually manifests itself when the significant others related to the patient inform the patient or the examiner that the patient has changed. Many patients themselves feel that they have become irritable and unapproachable. Irritability is one of the main reasons that during the initial stages of the illness, the problem is identified as a behavioural problem and not a disorder. Persons with substance abuse and dependence may become irritable and aggressive when they do not get the substance or when family members refuse to give them the money they need to procure substances. In addition, they may become aggressive and hostile under intoxication of various substances like alcohol, cannabis etc. These behaviours are also present in dementia at different stages and usually increase as the disease progresses.

**Check Your Progress 2**

**Note:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Describe the causes of irritability, aggression and hostility in psychiatric disorders.

.....  
.....  
.....  
.....

2) How does these three symptoms manifest in various psychiatric disorders ?

.....  
.....  
.....  
.....

**b) Parasuicidal Behaviour and Suicidal Behaviour**

Parasuicidal behaviour is an apparent attempt at suicide, commonly called a suicidal gesture, in which the aim is not death. For example, a sublethal drug overdose or wrist slash. Previous parasuicide is a predictor of suicide. Suicidal behaviour is an attempt to end one's life. Suicidal behaviour and parasuicidal behaviour can be a part of the

psychopathology in almost all psychiatric disorders. It is most common in depression. Usually patients having severe depression show this behaviour when they have developed helplessness, hopelessness and worthlessness. They may harm themselves in different ways including hanging, consuming poison, jumping from height, coming in front of a moving vehicle, drowning etc. it is important to note that most patients who commit suicide show some evidence of suicidal behaviour before they actually complete the act like communicating suicidal ideas and plans, threatening to end their lives or non lethal parasuicidal behaviour. Usually a patient having depression is at the maximum risk of committing suicide when they partially improve and gather the energy and motivation to commit the act.

Patients having psychotic illness also have a high chance of committing suicide. There can be various reasons for this. A person having active hallucinatory voices telling him/her to harm himself/herself, may feel compelled to obey to the voices. Person having active psychopathology may be so distressed that he may find suicide as the ultimate and only way of relief. Patients with psychosis who develop insight into their illness and understand that they have this illness may commit suicide. In addition, post psychotic depression is another risk factor for committing suicide.

Suicidal behaviour can also be seen in persons with substance dependence and abuse which may be a result of associated psychiatric illnesses like depression, psychosis etc. Suicidal and parasuicidal behaviour may also be present in different personality disorders, mainly borderline personality disorder characterized by repeated suicidal attempts. In addition, persons having adjustment disorder exhibit various degrees of self injurious behaviours including suicidal attempts and completed suicide. It is not uncommon for a normal student to fail in one exam and then attempt suicide. Persons having unremitting anxiety disorders like OCD, panic and phobias may resort to this behaviour in sheer frustration of their non improving illness and well as associated depression.

**Check Your Progress 3**

**Note:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the different psychiatric disorders that can be associated with self injurious and suicidal behaviour?

.....  
.....  
.....  
.....

2) What is the difference between self injurious and suicidal behaviour?

.....  
.....  
.....  
.....

3) What can be the various methods of committing suicide?  
.....  
.....  
.....  
.....

4) Name the risk factors for suicide in schizophrenia.  
.....  
.....  
.....  
.....

**c) Hallucinatory Behaviour**

Hallucinatory behaviour includes related phenomena like self muttering, self smiling and gesturing. Usually these patients have auditory and visual hallucinations and they exhibit this behaviour while responding to these hallucinations. Patients may respond verbally as well as physically to the hallucinations. It is a prominent feature in most of the psychotic disorders including schizophrenia. Patients may talk to the voices that they hear which manifests in form of muttering, self talk and gesturing. In addition, as explained in the previous section, they may respond verbally by committing or attempting suicide and doing various acts in response to the voices. It is not uncommon to find a patient who attempts suicide or eats inedible things in response to the voices. Many patients would even hit their family members or harm them in other ways in response to the voices telling them to do so. An example would be a patient who refuses to take food from family members or start suspecting the spouse’s character because of the insisting voices. Hallucinatory behaviour can also be present in depression or mania when they are accompanied with psychotic symptoms. In addition, patients with substance use, mainly cannabis and alcohol, can have hallucinatory behaviour. It can also be present in other disorders like dementia, delirium, etc.

**Check Your Progress 4**

*Note:* i) Read the following questions carefully and answer in the space provided below.  
ii) Check your answer with that provided at the end of this unit.

1) Mention the various psychiatric disorders associated with hallucinatory behaviour.  
.....  
.....  
.....  
.....

2) How does hallucinatory behaviour manifests in various psychiatric disorders?  
.....  
.....  
.....  
.....

d) **Social withdrawal and Isolation**

Social withdrawal and isolation are a part of almost all the psychiatric disorders. They may manifest at different stages during the development of a psychiatric illness. In case of psychotic illnesses like schizophrenia, patients may exhibit this behaviour in prodrome when the illness is in initial phase and then in the chronic phase when it is a part of the negative symptoms of psychosis. Some patients can also have social withdrawal in response to positive symptoms like hallucinations and delusions. In patients with depression, social withdrawal and isolation are usually apparent when the illness is moderate to severe. It happens because due to depression, patients have no interest left in any of the pleasurable activities and they are not even interested in talking to anyone. Patients having substance dependence and abuse may isolate themselves from family in fear of getting caught but they usually mix up well with their peer group. Social isolation and withdrawal are also seen in some personality disorders like schizoid and avoidant personality disorders. Persons with obsessive compulsive disorder may become so busy with their illness behaviours that they may isolate themselves. In addition, they may have social withdrawal and isolation because of fear of contamination. Another reason for isolation from others may be the stigma associated with psychiatric disorders.

**Check Your Progress 5**

*Note:* i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Enumerate the reasons of social isolation and withdrawal as seen in various psychiatric disorders.

.....

.....

.....

.....

e) **Obsessive and Compulsive Behaviour**

Patients with obsessive compulsive disorder may have many kinds of compulsive behaviours mainly due to the related obsessions. However, isolated compulsions in absence of obsessions may also be present. Compulsive behaviours are behaviours that are repeated behaviours or rituals that the patient is driven to carry out again and again. Usually they are done to relieve anxiety arising from repeated thought; however the relief lasts for a very short period. Obsessive thoughts keep coming back more strongly and with time even the compulsive behaviours lead to anxiety because they are time consuming, interfere with functioning and socially embarrassing.

Persons with **compulsive behaviours can be grouped into washers, checkers, doubters/ sinners, counters/ arrangers, hoarders.** Washers are afraid of contamination. They usually have cleaning or hand-washing compulsions. Checkers repeatedly check things (oven turned off, door locked, etc.) that they associate with harm or danger. Doubters and sinners are afraid that if everything is not perfect or done just right something terrible will happen or they will be punished. Counters and arrangers are obsessed with order and symmetry. They may have superstitions about certain numbers, colors, or arrangements. Hoarders fear that something bad will happen if they throw anything away. They compulsively hoard things that they do not need or

use. Usually patients with obsessive and compulsive disorder (OCD) have insight and are distressed because of the time they spend on their compulsions as they interfere in their daily activities.

Compulsive behaviours can be of two types, yielding and controlling. Yielding compulsions are actions in accordance with obsessions e.g. washing hands repeatedly when a doubt arises in mind that hands are dirty. Controlling compulsions are performed to nullify the effect of some obsession e.g. when a blasphemous thought comes to mind person touches the door knob to avoid bad effects.

Compulsive behaviours can also be seen in persons having depression and schizophrenia. In schizophrenia, they are seen at different stages like prodrome and also in full blown schizophrenic illness. Some antipsychotics like clozapine and olanzapine can also lead to obsessive compulsive behaviours.

**Check Your Progress 6**

**Note:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Define compulsion.

.....  
.....  
.....  
.....

2) What are the different types of compulsive behaviours seen in OCD?

.....  
.....  
.....  
.....

3) Apart from OCD, what are the other causes of compulsive behaviour?

.....  
.....  
.....  
.....

**f) Catatonic behaviour**

Catatonic symptoms are another kind of motor and behavioural disturbances seen in various psychiatric illnesses. Catatonia is a state of altered body tone. Catatonia is a broad term used to describe a variety of movement disorders. For example, Catatonic Stupor is a state in which patients are immobile, mute, yet conscious. They may exhibit waxy flexibility, so one can move their limbs into postures and the patient will retain these postures, like a wax doll. Other examples of retaining these postures are psychological pillow (the head of the patient hangs in the air if the pillow is suddenly

removed), if the arm is raised high and then the examiner removes his hand, the patient keeps the arm in the air even if it is uncomfortable. Catatonic excitement is uncontrolled and aimless motor activity. Some catatonic symptoms are mitgehen (moving a limb in response to slight pressure on it despite being told to resist the pressure), echopraxia (imitating the movements of another person), automatic obedience (carrying out simple commands in a robot – like fashion), negativism (refusing to cooperate with simple requests for no apparent reason). Catatonia can be seen in schizophrenia (as a subtype called catatonic schizophrenia), depression (when it is severe, called depression with psychotic symptoms), mania and numerous organic insults to the central nervous system.

**Check Your Progress 7**

**Note:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What is catatonia?

.....  
.....  
.....  
.....

2) What are the different disorders related with catatonia?

.....  
.....  
.....  
.....

3) Describe some of the important behavioural symptoms of catatonic syndrome with examples.

.....  
.....  
.....  
.....

**g) Guarded and Evasive Behaviour**

Another common feature seen in psychiatric illnesses is guarded and evasive behaviour. In this the patient resists most of the efforts of the examiner to make a rapport with him. It is very difficult to communicate with patients who have guarded and evasive behaviour. Usually, it is a result of underlying psychotic symptoms like delusions and the patient suspects that even the examiner has some ulterior motives to talk to him. It may also result from hallucinatory voices that tell the patient not to talk to anyone or threaten the patient to hurt him if he indulges in talking.

**h) Bizarre and Odd Behaviour**

Commonly seen in psychotic disorders, bizarre is a term used to describe behaviour

that in implausible and odd behaviour is a term used to describe one or other behaviours that are odd usually not done by others. Patient may be seen wearing one trousers over the others or exhibiting similar kind of behaviour that seems odd to others. It is usually seen in psychotic disorders and OCD. In OCD, the behaviour may seem odd to others like a patient who is compelled to take a few steps backwards after going forward or who has to jump from first to the third tile missing the second one while walking because he believes something wrong will happen otherwise.

**i) Socially Inappropriate Behaviour**

This kind of behaviour is also commonly seen in psychotic illnesses like schizophrenia. Patient shows socially embarrassing behavioural acts like exposing his or her private parts in public, masturbating in public, eve teasing. These behaviours may result in violence towards the patient by people who are not aware that patient has an illness. Many patients of schizophrenia, mania and borderline personality disorder also show sexually promiscuous behaviour leading to undesirable consequences. Many patients would come out of the bathroom naked without caring for the presence of other people in the house. Patients may resort to eating non edible things like raw wheat, rice and even insects and soaps. It can also be seen in dementia.

**j) Reckless Behaviour**

Many patients with mania and hypomania show reckless behaviour that may be dangerous to self and others. They do not realize the consequences of their behaviour. Examples include a patient who drives a vehicle at breakneck speed and tries to jump from the rooftop of a building when challenged by friends to do so.

**k) Behaviour Resulting from Negative Symptoms of Schizophrenia**

The classical negative symptoms of schizophrenia namely avolition, apathy, attentional impairment, alogia and anhedonia lead to behaviour that is unconcerned (patients have no concern for other persons or events that are happening), self neglect (patients do not change clothes or take bath for many days or even weeks, do not brush their teeth, do not take care when they have menstruation, many of them do not wash themselves after passing stools). It is not uncommon to see a patient who has stayed closed in a single room of his or her house for many weeks at a stretch and even passes urine and stools in that room only.

Patients with negative symptoms have usually no energy left in their body to do the activities of daily living and they keep lying at one place for all day. They do not engage in any kind of conversation with family members or others and do not even ask for meals. They do not engage in any kind of employment too. These symptoms are many times mistaken as symptoms of depression but are differentiated from depression on the basis of absence of concern for symptoms, absence of sad mood and absence of distress due to symptoms. There is a complete lack of concern for the symptoms on part of the patient.

**Check Your Progress 8**

**Note:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) In which psychiatric disorder is guarded, evasive, odd, bizarre and socially inappropriate behaviour seen?

2) In which other disorder apart from schizophrenia is odd behaviour seen?

.....  
.....  
.....  
.....

3) Give some examples of socially inappropriate behaviour.

.....  
.....  
.....  
.....

4) Name the major negative symptoms of schizophrenia.

.....  
.....  
.....  
.....

5) How do negative symptoms manifest in terms of behaviour in a patient of schizophrenia?

.....  
.....  
.....  
.....

**l) Other Disorders of Behaviour**

Stereotypy (repeated but non-goal-directed movement such as rocking), mannerisms (normal goal-directed activities that appear to have social significance but are either odd in appearance or out of context, such as repeatedly running one's hand through one's hair or grimacing) Persons having disorganized schizophrenia show silly smile, giggling, talking nonsensically.

In mania, over indulgence in enjoyable behaviours with high risk of a negative outcome (e.g., extravagant shopping, sexual adventures or improbable commercial schemes) is there. In addition, there can be hyperactivity, impulsiveness, over familiarity, a compulsion to speak, reduced sleep requirement, difficulty sustaining attention leading to easy distractibility.

Anxiety disorders can be characterized by a variety of behavioural symptoms namely irritability, poor concentration, always remaining on the edge, restlessness, apprehension, feeling tense and jumpy, tremors and twitches. In phobic anxiety disorders, there is an abnormal, disproportionate fear of an object or situation which leads to anxiety symptoms in form of panic attack.

---

## 2.3 BEHAVIOURAL DISORDERS IN CHILDREN

---

All young children can be naughty, defiant and impulsive from time to time, which is perfectly normal. However, some children have extreme difficulty and challenging behaviours that are outside the norm for their age. The most common disruptive behavioural disorders in children include oppositional defiant disorder, conduct disorder and attention deficit hyperactivity disorder. These three disorders share some common symptoms, so diagnosis can be difficult and time consuming. A child or adolescent may have two disorders at the same time.

### 2.3.1 Oppositional Defiant Disorder (ODD)

It is more common in boys than girls. Some behavioural problems in children with ODD can be: child is easily angered, annoyed or irritated, frequent temper tantrums, argues frequently with adults, particularly the most familiar adults in their lives, such as parents, refuses to obey rules, seems to deliberately try to annoy or irritate others, child can have low self esteem, low frustration threshold. A child with ODD seeks to blame others for any misdeeds or misfortunes.

### 2.3.2 Conduct Disorder

Children with conduct disorder (CD) are often judged as ‘bad kids’ because of their delinquent behaviour and refusal to accept rules. Around five per cent of 10 year olds are thought to have CD, with boys outnumbering girls by four to one. Around one-third of children with CD also have attention deficit hyperactivity disorder (ADHD). Some of the typical behaviours of a child with CD may include frequent refusal to obey parents or other authority figures, repeated truancy, tendency to use drugs, including cigarettes and alcohol, at a very early age, lack of empathy for others, being aggressive to animals and other people or showing sadistic behaviours including bullying and physical or sexual abuse, keenness to start physical fights, using weapons in physical fights, frequent lying, criminal behaviour such as stealing, deliberately lighting fires, breaking into houses and vandalism, and a tendency to run away from home.

### 2.3.3 Attention Deficit Hyperactivity Disorder (ADHD)

The behavioural problems in a child with ADHD may include: **Inattention** – difficulty concentrating, forgetting instructions, moving from one task to another without completing anything. **Impulsivity** – talking over the top of others, having a ‘short fuse’, being accident-prone. **Over activity** – constant restlessness and fidgeting.

#### Check Your Progress 9

**Note:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Which childhood disorders are associated with abnormal behaviour?

.....

.....  
.....  
.....

2) What is ODD? Describe major symptoms of a child with ODD.

.....  
.....  
.....

3) Describe conduct disorder.

.....  
.....  
.....

4) What are the three cardinal symptoms of ADHD?

.....  
.....  
.....

In addition, many psychiatric disorders happening in children can present mainly with behavioural problems. Children with depression often do not present with sadness of mood but present with irritability, social withdrawal, loss of interest in play and other pleasurable activities and disturbances in biological functions.

---

## 2.4 LET US SUM UP

---

Conation is an important aspect of the tripartite brain along with cognition and affect. Conative disturbances manifest as behavioural disturbances in different psychiatric disorders and are one of the major causes of distress, seeking treatment, admission and stigma in psychiatry. Conative disturbances can be seen in adult, childhood as well as elderly patients with different psychiatric disorders. They can be seen in almost all psychiatric disorders including schizophrenia and other psychiatric disorders, affective disorders, anxiety disorders, OCD, personality disorders, substance abuse and dependence, dementia etc. In childhood, the three major disorders associated with behavioural disturbances are ODD, ADHD and conduct disorders.

The various behavioural disturbances seen in psychiatric disorders are irritability, aggression, hostility, self-injurious and suicidal behaviour, hallucinatory behaviour, guarded, evasive, inappropriate, reckless, bizarre, odd, catatonic behaviour. In addition, schizophrenia patients can have behaviour resulting due to negative symptoms which is the major reason for socio-occupational impairment. OCD is characterized mainly by compulsive behaviour.

Thus, behavioural disturbances are at the forefront of the psychopathology of psychiatric disorders and needs to be identified to make a diagnosis and to judge improvement in psychiatric condition with treatment.

---

## 2.5 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

---

### Check Your Progress 1

- 1) Human brain is tripartite or has three elements viz: cognition, affect and conation.
- 2) Its major function is to convert the other faculties like cognition and affect into actions. Conation is visible and purposeful behaviour arising out of emotions, preferences or beliefs (affective faculties) and learned knowledge and skills (cognitive faculties).

### Check Your Progress 2

- 1) These three symptoms or behaviours are related to each other and can be found to a different extent in almost all the psychiatric illnesses. In its most severe form, aggression and hostility can be found in psychotic illnesses like schizophrenia, acute and transient psychotic disorders, schizoaffective disorders, delusional disorder, psychotic symptoms associated with substance use, depression and mania.
  - i) Unprovoked aggression is seen usually in response to hallucinations when voices tell the patient to perform an action. ii) or in response to suspiciousness when patients suspect others of wrongdoing. iii) Persons with substance abuse and dependence may become irritable and aggressive when they do not get the substance. iv) they may become aggressive and hostile under intoxication of various substances like alcohol, cannabis etc. v) These behaviours are also present in dementia at different stages and usually increase as the disease progresses. vi) not wanting to talk to anyone is more commonly seen in the depressive disorders and anxiety disorders.
- 2) Patients may resort to physical aggression in form of aggressive, hostile and violent behaviours like hitting others mainly family members, breaking household objects. Verbal aggression in form of abusive language and threatening language and gestures may be there. Irritability usually manifests itself when the significant others related to the patient inform the patient or the examiner that the patient has changed. Many patients themselves feel that they have become irritable and unapproachable.

### Check Your Progress 3

- 1) Self injurious and suicidal behaviour can be seen in almost all psychiatric disorders like depression, schizophrenia, mania, adjustment disorders, personality disorders, substance dependence and abuse, anxiety disorders including OCD, panic disorder phobias, PTSD etc.
- 2) Parasuicidal behaviour is an apparent attempt at suicide, commonly called a suicidal gesture, in which the aim is not death. For example, a sublethal drug overdose or wrist slashes. Previous parasuicide is a predictor of suicide. Suicidal behaviour is an attempt to end one's life.
- 3) The various methods of committing suicide can be hanging, drowning, jumping from height, shooting oneself with a gun, consuming poison.

- 4) Risk factors for suicide in schizophrenia are: hallucinations, suspiciousness, patients who develop insight into their illness and have a lot of distress, post psychotic depression, substance abuse and dependence.

#### Check Your Progress 4

- 1) The psychiatric disorders associated with hallucinatory behaviour are various psychotic disorders like schizophrenia, acute and transient psychotic disorders, schizoaffective disorder. It can also be seen when affective disorders like mania and depression are associated with psychotic symptoms.
- 2) Hallucinations manifests as behavioural disturbances in form of self smiling, muttering and gesturing. In addition, patients may resort to aggression, violence and suspiciousness to various degrees in response to hallucinations.

#### Check Your Progress 5

- 1) Social withdrawal and isolation are a part of almost all the psychiatric disorders. In case of psychotic illnesses like schizophrenia, patients may exhibit this behaviour in prodrome when the illness is in initial phase and then in the chronic phase when it is a part of the negative symptoms of psychosis. Some patients can also have social withdrawal in response to positive symptoms like hallucinations and delusions.

In patients with depression, social withdrawal and isolation are usually apparent when the illness is moderate to severe. It happens because due to depression, patients have no interest left in any of the pleasurable activities and they are not even interested in talking to anyone.

Patients having substance dependence and abuse may isolate themselves from family in fear of getting caught but they usually mix up well with their peer group. Persons with obsessive compulsive disorder may become so busy with their illness behaviours that they may isolate themselves. In addition, they may have social withdrawal and isolation because of fear of contamination.

Another reason for isolation from others may be the stigma associated with psychiatric disorders.

#### Check Your Progress 6

- 1) Compulsive behaviours are behaviours that are repeated behaviours or rituals that patients are driven to carry out again and again. Usually they are done to relieve anxiety arising from repeated thought.
- 2) Persons with **compulsive behaviours can be grouped into washers, checkers, doubters/ sinners, counters/ arrangers, hoarders**. Washers are afraid of contamination. They usually have cleaning or hand-washing compulsions. Checkers repeatedly check things (oven turned off, door locked, etc.) that they associate with harm or danger. Doubters and sinners are afraid that if everything isn't perfect or done just right something terrible will happen or they will be punished. Counters and arrangers are obsessed with order and symmetry. They may have superstitions about certain numbers, colors, or arrangements. Hoarders fear that something bad will happen if they throw anything away. They compulsively hoard things that they do not need or use. Usually patients with OCD have insight and are distressed because of the time they spend on their compulsions as they interfere in their daily activities.

- 3) Compulsive behaviours can also be seen in persons having depression and schizophrenia. In schizophrenia, they are seen at different stages like prodrome and also in full blown schizophrenic illness. Some antipsychotics like clozapine and olanzapine can also lead to obsessive compulsive behaviours.

### Check Your Progress 7

- 1) Catatonia is a state of altered body tone. Catatonia is a broad term used to describe a variety of movement disorders. For example, Catatonic Stupor is a state in which patients are immobile, mute, yet conscious. Catatonic excitement is uncontrolled and aimless motor activity.
- 2) Catatonia can be seen in schizophrenia (as a subtype called catatonic schizophrenia), depression (when it is severe, called depression with psychotic symptoms), mania and numerous organic insults to the central nervous system.
- 3) They may exhibit waxy flexibility, so one can move their limbs into postures and the patient will retain these postures, like a wax doll. Other examples of retaining these postures are psychological pillow (the head of the patient hangs in the air if the pillow is suddenly removed), if the arm is raised high and then the examiner removes his hand, the patient keeps the arm in the air even if it is uncomfortable. Some catatonic symptoms are mitgehen (moving a limb in response to slight pressure on it despite being told to resist the pressure), echopraxia (imitating the movements of another person), automatic obedience (carrying out simple commands in a robot-like fashion), negativism (refusing to cooperate with simple requests for no apparent reason).

### Check Your Progress 8

- 1) These behaviours are mostly seen in psychotic disorders, most commonly schizophrenia.
- 2) Obsessive compulsive disorder.
- 3) Patients may show socially embarrassing behavioural acts like exposing his or her private parts in public, masturbating in public, eve teasing. Many patients of schizophrenia, mania and borderline personality disorder also show sexually promiscuous behaviour leading to undesirable consequences. Many patients would come out of the bathroom naked without caring for the presence of other people in the house. Patients may resort to eating non edible things like raw wheat, rice and even insects and soaps.
- 4) The classical negative symptoms of schizophrenia are avolition, apathy, attentional impairment, alogia and anhedonia.
- 5) Negative symptoms lead to behaviour that is unconcerned (patients have no concern for other persons or events that are happening), self neglect (patients do not change clothes or take bath for many days or even weeks, do not brush their teeth, do not take care when they have menstruation, many of them do not wash themselves after passing stools). It is not uncommon to see a patient who has stayed closed in a single room of his or her house for many weeks at a stretch and even passes urine and stools in that room only. Patients with negative symptoms have usually no energy left in their body to do the activities of daily living and they keep lying at one place for all day. They do not engage in any kind of conversation with family members or others and do not even ask for meals. They do not engage in any kind of employment too.

## Check Your Progress 9

- 1) Childhood disorders associated with behavioural problems are mainly conduct disorder, ODD and ADHD. In addition, children can have any disorders common with adults like depression, mania and psychosis that can be associated with behavioural problems.
- 2) Children with ODD can be easily angered, annoyed or irritated, show frequent temper tantrums, argues frequently with adults, particularly the most familiar adults in their lives, such as parents, refuses to obey rules, seems to deliberately try to annoy or irritate others, child can have low self esteem, low frustration threshold. A child with ODD seeks to blame others for any misdeeds or misfortunes.
- 3) Conduct disorder: Children with conduct disorder (CD) are often judged as ‘bad kids’ because of their delinquent behaviour and refusal to accept rules. Some of the typical behaviours of a child with CD may include frequent refusal to obey parents or other authority figures, repeated truancy, tendency to use drugs, including cigarettes and alcohol, at a very early age, lack of empathy for others, being aggressive to animals and other people or showing sadistic behaviours including bullying and physical or sexual abuse, keenness to start physical fights, using weapons in physical fights, frequent lying, criminal behaviour such as stealing, deliberately lighting fires, breaking into houses and vandalism, and a tendency to run away from home.
- 4) The three symptoms of Attention Deficit Hyperactivity Disorder (ADHD) may include: **Inattention** – difficulty concentrating, forgetting instructions, moving from one task to another without completing anything. **Impulsivity** – talking over the top of others, having a ‘short fuse’, being accident-prone. **Overactivity** – constant restlessness and fidgeting.

---

## 2.6 UNIT END QUESTIONS

---

- 1) Define conation. What are the reasons of social isolation and withdrawal as observed in various psychiatric disorders.
- 2) Describe catatonic behaviour.
- 3) Discuss the symptoms of behavioural disorders in children.

---

## 2.7 SUGGESTED READINGS AND REFERENCES

---

Gelder, M.G., Andreasen, N.C., Lopez – Iborjr., J.J. & Geddes, J.R. (2009). *New Oxford Textbook of Psychiatry*. 2<sup>nd</sup> ed. New York: Oxford university press.

Kolbe, K. (1990). *The Conative Connection*. Reading, MAL Addison-Wesley Publishing Company.

Sadock, B.J., Sadock, V.A. & Ruiz, P. (2009). *Kaplan and Sadock’s Comprehensive Textbook of Psychiatry*. 9<sup>th</sup> ed. Philadelphia: Lippincott Williams & Wilkins.

Sadock, B.J. & Sadock, V.A. (2003). *Kaplan and Sadock’s Synopsis of Psychiatry*. 9<sup>th</sup> ed. Philadelphia: Lippincott Williams and Wilkins.