



Block**3****CLINICAL MANIFESTATIONS, COURSE AND
OUTCOME OF MENTAL DISORDERS**

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BLOCK 3 CLINICAL MANIFESTATIONS, COURSE AND OUTCOME OF MENTAL DISORDERS

Introduction

In Block 3, **Clinical Manifestations, Course and Outcome of Mental Studies**, we will explore the various dimensions of psychiatric disorders. This Block is intended to provide a comprehensive understanding of clinical manifestations and outcome of psychiatric disorders.

Unit 1, Cognitive Disturbances, discusses the characteristics of normal thinking and components of normal thought and it delves on the various disorders of thought.

Unit 2, Conative Disturbances, brings out the various conative (behavioural) disturbances in psychiatric disorders like, catatonic behaviour, irritability, aggression and hostility, socially inappropriate behaviour and so forth. It also focusses on disorders of children with behavioural disturbances.

Unit 3, Affective Disturbances lays stress on the importance of emotions, mood and affect. It discusses the various types of disturbances occurring in emotions, mood and affect.

Unit 4, Course and Outcome of Mental Disorders, describes the course and outcome of important mental disorders. It also explores the relevant factors that may affect the course and outcome of important mental disorders.

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UNIT 1 COGNITIVE DISTURBANCES

Structure

- 1.0 Learning Objectives
- 1.1 Introduction
- 1.2 Normal Thought Process-Definition, Characteristics and Components
- 1.3 Disorders of Thought
 - 1.3.1 Disorders of Form of Thinking
 - 1.3.2 Disorders of Stream of Thinking
 - 1.3.3 Disorders of Content of Thinking
 - 1.3.4 Disorders of Possession of Thinking
- 1.4 Let Us Sum Up
- 1.5 Answers to Check Your Progress Exercises
- 1.6 Unit End Questions
- 1.7 Suggested Readings and References

1.0 LEARNING OBJECTIVES

After reading this Unit, you should be able to:

- define normal thinking;
- describe the characteristics of normal thinking;
- name the components of normal thought;
- describe various types of disorder of each component of thought; and
- explain various First Rank Symptoms (FRS).

1.1 INTRODUCTION

The term “cognition” refers to a higher faculty for the processing of information, applying knowledge and changing preferences. This term is used in different disciplines (such as philosophy, psychology) with different meanings. For the purpose of this Unit, we would restrict ourselves to the process of thinking.

1.2 NORMAL THOUGHT PROCESS

- **Definition of thinking**

Thinking refers to the ideational components of mental activity, processes used to imagine choices, evaluate, plan, judge, choose between choices, and will. Normal thinking is characterized goal – directed flow of ideas, symbols and associations initiated by a task and leads to a logical conclusion.

Most of the thinking involves complex rules of syntax, grammar and pragmatics (social use of language) but for the sake of understanding we would first simplify the characteristics of normal thinking process as suggested by Schneider.

● **Characteristics of normal thought**

Schneider suggested that there are three features of healthy thinking, which are as follows:

- a) **Constancy:** Completed thought persists until and unless it is replaced by another consciously desired thought.
- b) **Organization:** The contents of the thought are related to each other and do not blend with each other but are arranged in an organized manner and sequence.
- c) **Continuity:** Sudden ideas, related thoughts or observations which appear during formulation of a particular thought, are not allowed to intrude but are arranged in order in the whole content of conscious.

Disturbance in any of these of characteristics leads to disorders of form and stream of thought process.

● **Components of normal thought**

Thought process expressed either in written or spoken form can be divided for the sake of understanding into four main components:

- a) **Form:** It is the syntactical and grammatical structure, i.e. how the thoughts are formed and connected to each other.
- b) **Stream:** It concerns with the flow of ideas.
- c) **Content:** Content is what the thoughts/ideas are about i.e. what is being conveyed.
- d) **Possession:** Normally, we all experience our thoughts to be our own and well in our control. Though, this sense of personal possession is never on forefront of our mind.

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) Define the term 'cognition'.

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2) Name three characteristics of normal thought process.

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1.3 DISORDERS OF THINKING

The division of thought process into various components is arbitrary and overlapping and so is the division of their disorders.

1.3.1 Disorders of the Form of Thinking

The disorders of form of thinking are collectively known as formal thought disorders and historically included various term such as derailment, incoherence, knights move, word salad and so on. But most of these terms were used interchangeably and had no definite meaning. Defining various disorders of thinking operatively is one of major contributions of Nancy Andreason in the area of phenomenology.

To elicit formal thought disorder, patients should be allowed to talk freely and spontaneously.

- **Incoherence (word salad):** Represents a disturbance of syntax so that the sentences lack cohesiveness and are grammatically incorrect leading to a meaningless whole.
- **Derailment (loosening of associations):** It is slow and progressive digression from the original topic. The topics are not related to each other. However, the chunks of speech covering various topics are syntactically correct and are meaningful.

For example, a person is asked about his family. He starts with the number of family members and who they are but moves onto the description of city he studies in, to the weather and then to the automobiles and so on giving some details for each topic before moving on to next topic.

- **Tangentiality:** The reply to a question starts with an irrelevant answer which may or may not be related to the question and the patient touches the right or relevant reply somewhere and then again moves on to something unrelated. This is akin to a tangent falling onto the circumference of a circle.
- **Neologism:** It is the invention of new words or giving a new meaning to the old words.
- **Perseveration:** It is the repetition of the same word or idea in response to the different questions.
- **Poverty of content of speech (empty speech):** It is the speech that gives no or little information though the amount of speech is normal. The speech may contain repetitions, vagueness and concrete material.

1.3.2 Disorders of Stream of Thinking Include

- **Flight of ideas** is characterized by the following:
 - 1) An accelerated flow of thoughts associated with
 - Pressure of speech,
 - Ideas shift from one topic to another. The direction of flow and shift is usually decided by rhyming, puns and clang associations and,
 - 2) One is able to trace back the sequence of flow.

- **Circumstantiality:** Patient takes too long to reach the goal. He gives too many unnecessary details to describe but never loses the track and reaches the endpoint eventually.
- **Poverty of speech (laconic speech):** The amount of spontaneous speech is reduced remarkably and one finds oneself repeating the question or encouraging the patient too often to give the answer.

1.3.3 Disorders of Content of Thinking

Includes delusions, overvalued ideas and various other ideations such as ideas of hopelessness, helplessness, worthlessness and suicidal ideas.

Delusions are false, firm beliefs which cannot be corrected by any amount of reasoning and cannot be explained by the patient's socio-cultural background. Another important component of the definition is their morbid origin i.e. how a delusion is formed or in simple terms, how a patient reaches to the conclusion which forms the basis and content of his belief system. E.g. In real life also many husbands are unfaithful but to say that the wife has delusion of infidelity one must ascertain how she knows about the husband not being chaste. Patients usually collect evidence from unrelated behaviours e.g. the way her husband is talking, walking, dressing or the perfume she can smell on his shirt.

The absurdity and implausibility of a delusion makes it a bizarre delusion. The delusions may be systematized (i.e. themes have internal coherence and connectedness) and elaborate or non-systematized and different delusions can contradict each other.

Depending upon the theme delusions can be of various types – delusions of persecution, reference, grandeur, infidelity, guilt, poverty, nihilism, and somatic.

Patient's other preoccupations, concerns and phobias are also described under the content of thought. For example, ideas of hopelessness, ideas of helplessness, ideas of worthlessness, suicidal ideas, and guilt feelings.

1.3.4 Disorders of Possession of Thinking

Normally, we are in control of our thoughts, feelings and acts. Though, this is never on the forefront of our mind but we recognize that our thoughts, feelings and actions to be our own and not alien or foreign. But this sense of control is lost in many disorders.

Obsessions are repetitive, insistent and persistent ideas, impulses or images that invade the mind against one's will. Obsessions are recognized as one's own but are considered senseless and absurd, yet the effort to control them leads to anxiety. By contrast, delusions are held with conviction and considered right and true by the patient.

First-rank symptoms are group of symptoms representing ego boundary disturbances and usually an external agency is blamed. These include:

- 1) *Thought insertion* wherein patient experiences thoughts being inserted in to his mind and thoughts are recognized as not being his own.
- 2) *Thought withdrawal* wherein the thoughts are being taken away by some external agency.
- 3) *Thought broadcast:* Thoughts leave the boundary of one's mind and become accessible to others without patient telling these to others.
- 4) *Thought echo:* One's own thoughts are heard aloud.

- 5) *Voices arguing*: This is a form of third person auditory hallucinations where voices discuss the patient in third person.
- 6) A voice giving *running commentary* on whatever patient is doing.
- 7) *Made affect*: The emotions are recognized as alien, imposed on the patient e.g. a patient admitted that the tears were rolling down but she did not feel sad inside and felt that this was forced onto her.
- 8) *Made act*: The action carried out by the patient is not considered as his/her own.
- 9) *Made impulse*: A sudden urge to do something takes over the patient. The patient recognizes the action involved in fulfilling the urge as his own but not the impulse. e.g. a patient suddenly got up and smashed his wrist watch. He described the act as his own but that the urge was imposed upon him.
- 10) *Somatic passivity*: The patient is a passive recipient of bodily sensations caused by an external agency.

These symptoms are at times collectively known as delusions of control.

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) Name various formal thought disorders.

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2) Define delusion.

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3) Describe circumstantiality.

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4) Define obsession.

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5) Describe thought insertion.
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1.4 LET US SUM UP

The term “cognition” refers to a higher faculty for the processing of information, applying knowledge and changing preferences. Normal thinking is characterized goal-directed flow of ideas, symbols and associations initiated by a task and leads to a logical conclusion. Schneider suggested that there are three features of healthy thinking, i.e. constancy, organization and continuity. Disorders of form of thinking are collectively known as formal thought disorders and include derailment, incoherence, tangentiality, neologism, poverty of content of speech and perseveration. Disorders of stream include flight of ideas, circumstantiality, and poverty of speech. Disorders of content include delusions, overvalued ideas and various other ideations such as ideas of hopelessness, helplessness, worthlessness and suicidal ideas. Delusion is defined as false, firm belief which cannot be corrected by any amount of reasoning and cannot be explained by the patient’s socio-cultural background. It is morbid in origin. Depending upon the theme, delusions can be of various types – delusions of persecution, reference, grandeur, infidelity, guilt, poverty, nihilism, and somatic. Disorders of possession of thought include obsessions and various first rank symptoms. Obsessions are defined as repetitive, insistent and persistent ideas, impulses or images that invade the mind against one’s will. They are recognized as one’s own but are considered senseless and absurd, yet the effort to control them leads to anxiety. First-rank symptoms are group of symptoms representing ego boundary disturbances and usually an external agency is blamed.

1.5 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress 1

- 1) It refers to a faculty for the processing of information, applying knowledge and changing preferences.
- 2) Constancy: means that a completed thought persists until and unless it is replaced by another consciously desired thought.
 - a) Organization: means that the contexts of the thought are related to other do not blend with each other but are arranged in an organized manner and sequence.
 - b) Continuity: means that sudden ideas, related thoughts or observations which appear during to formulating of particular thought, are not allowed to intrude but are arranged in order in the whole content of conscious. Disturbance in any of these of characteristics leads to disorders of form and stream of thought process.

Check Your Progress 2

- 1) The disorders of form of thinking are collectively known as formal thought disorders and historically included various term such as derailment, incoherence, knights move, word salad and so on. Derailment, incoherence, tangentiality, neologism, poverty of content of speech and perseveration are various disorders of form of thought.
- 2) Delusion is a false, firm belief which cannot be corrected by any amount of reasoning and cannot be explained by the patient's socio-cultural background and is morbid in origin.
- 3) Patient takes too long to reach the goal. He gives too many unnecessary details to describe but never loses the track and reaches the endpoint eventually.
- 4) Obsessions are repetitive, insistent and persistent ideas, impulses or images that invade the mind against one's will. Obsessions are recognized as one's own but are considered senseless and absurd, yet the effort to control them leads to anxiety.
- 5) It is a first rank symptom wherein where in patient experiences thoughts being inserted in to his mind and thoughts are recognized as not being his own.

1.6 UNIT END QUESTIONS

- 1) Classify the disorders of thought process.
- 2) How would you differentiate between a delusion and an obsession?
- 3) List various First-rank Symptoms (FRS) and describe the "made phenomena" in detail.

1.7 FURTHER READINGS AND REFERENCES

Andreason, NC. (1979). *Thought Language and Communication Disorder. Archives of General Psychiatry* 36, 1315-30.

Fish, F. (1985). *Clinical Psychopathology*. Bristol: John Wright.

Mellor, CS. (1970). *First-rank Symptoms of Schizophrenia. British Journal of Psychiatry* 117, 15-23.

Sethi, S. (2008). *Textbook of Psychiatry*. Elsevier, India.

Sims, A. (2003). *Symptoms in the Mind-An Introduction to Descriptive Psychopathology*. Saunders, Elsevier.

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?

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

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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.

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

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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?

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

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3) What can be the various methods of committing suicide?
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4) Name the risk factors for suicide in schizophrenia.
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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.
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2) How does hallucinatory behaviour manifests in various psychiatric disorders?
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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.

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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.

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

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

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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?

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2) What are the different disorders related with catatonia?

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

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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?

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2) In which other disorder apart from schizophrenia is odd behaviour seen?
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3) Give some examples of socially inappropriate behaviour.
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4) Name the major negative symptoms of schizophrenia.
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5) How do negative symptoms manifest in terms of behaviour in a patient of schizophrenia?
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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?

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

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3) Describe conduct disorder.

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4) What are the three cardinal symptoms of ADHD?

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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*. 2nd 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*. 9th ed. Philadelphia: Lippincott Williams & Wilkins.

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

UNIT 3 AFFECTIVE DISTURBANCES

Structure

- 3.0 Learning Objectives
- 3.1 Introduction
- 3.2 Types of Disturbances in Mood and Affect
- 3.3 Quality of Mood and Affect
- 3.4 Disturbances in the Range of Mood and Affect
- 3.5 Disturbances in the Reactivity and Intensity of Mood and Affect
- 3.6 Disturbances in Intensity of Mood and Affect
- 3.7 Let Us Sum Up
- 3.8 Answers to Check Your Progress Exercises
- 3.9 Unit End Questions
- 3.10 Suggested Readings and References

3.0 LEARNING OBJECTIVES

After studying this Unit, you will be able to know:

- differences between emotions, mood and affect;
- types of disturbances in emotions, mood and affect;
- disturbances in quality of mood;
- disturbances in the range of emotions;
- disturbances in reactivity of mood and its intensity; and
- disturbances in the appropriateness of mood and affect.

3.1 INTRODUCTION

Cognition, conation and emotions are three important functions of mind. In the previous two Units, we have discussed about the disturbances of cognition and conation. In this Unit, focus is on affective disturbances (disturbances of emotions, mood and affect). Before going into further details, it is important to understand the concept of emotions, mood and affect.

In simple words, emotion refers to a feeling state involving thoughts, physiological changes, and an outward expression or behaviour. **Fish** defines emotion as a stirred up state caused by physiological changes occurring in response to an event, which tends to maintain or abolish the causative event. According to the famous **James Lange** theory of emotions, emotions are the result of self-awareness of the physical and bodily changes in presence of a stimulus. However, in a contrasting view taken by **Cannon and Bard**, emotions is considered having a temporal primacy and the visceral and behavioural changes follow the emotion, e.g. one feels afraid on seeing a lion and then the sympathetic and behavioural changes follow. There is also a two factor theory of emotion, which explains emotions to be a result of two factors: physiological arousal and cognition.

Thus, emotion could be taken as a complex state, which has cognitive, behavioural and physiological components.

Literature describes six basic emotions, which are expressed on face. These include anger, disgust, fear, happiness, sadness and surprise. Though these emotions are universal, there are cultural variations in their expression. For example, there may be customary rules in a culture, that determine who can show which emotion to whom and when, or which events are likely to produce a particular emotion.

A feeling is a positive or negative reaction to some experience or an event, and is the subjective experience of emotion. It could be marked but is often transitory. In simple English, the word feeling also refers to an active experience of somatic sensation, like touch or pain, and also the passive subjective experience of emotion.

The terms mood and affect are frequently used in psychiatry in describing the symptomatology of various psychiatric illnesses. In simple English, affect is a broad term, which may cover mood, feeling, attitude, preferences and evaluations. However, in psychiatry, its use is restricted to describing the emotional state, which may be judged by external reactions like laughter, crying, anger or fear. Affect refers to a person's present emotional responsiveness or emotional state as on now. It is a short lived emotional state, which is dynamic and keeps on changing depending on the situation, thought process and the external environment. On the contrast, mood is a pervasive and sustained emotion, which colours the person's perception of the world. Descriptions of mood and affect may be sad, anxious, angry, happy, calm, irritable, etc.

It is possible to objectively know the emotional state and infer about the mood and affect of a person by observation of non-verbal cues like facial expression especially the eyes, gesture, posture, tone of voice, and general appearance. However, this assessment may also be influenced by the emotional state of the examiner.

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) Define emotion, mood and affect.

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2) What is feeling?

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3) What are different emotions?

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3.2 TYPES OF DISTURBANCES IN MOOD AND AFFECT

Disturbances in emotion can occur in terms of quality of mood or affect or in terms of emotional reactivity, intensity (depth) and range of emotional reactions.

Quality or type of mood or affect refers to the kind of emotional state (mood or affect) of a person. This would include normal emotions like happiness, sadness, irritability, anger etc. Abnormal emotional disturbances in quality or type of emotion would include depressed affect or mood, euphoria, elation, ecstasy, etc.

Emotional reactivity refers to the fluctuations in mood that occur in response to changes in environment or external situations. This includes emotional reactions to various emotion laden stimuli. Inappropriate and labile affect and la belle indifference are the disturbances of the reactivity of affect.

Depth refers to ability to convey an emotion or create an impact of the emotional state. Intensity and depth of emotion convey the same meaning.

Range of emotions refers to the various emotions, a person is able to display during an interview session. Range may be restricted as happens in schizophrenia.

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 different areas in which disturbances of emotions manifest.

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3.3 QUALITY OF MOOD AND AFFECT

Normal emotions of sadness, happiness, irritability, anger may get exacerbated in different psychiatric illnesses especially the mood disorders, anxiety disorders and certain other illnesses. Elation and depression, seen in mania and depressive disorders, can be understood to be a qualitative and pathological exaggeration of the cheerfulness and unhappiness. This section discusses various abnormal mood states, the disturbance in the quality of mood and affect.

Euphoria is an exaggerated feeling of wellbeing a state of excessive unreasonable cheerfulness, which cannot be explained by the real life circumstances. Euphoria is seen in mania, and also in organic states, especially those associated with frontal lobe impairment.

Elation refers to a mood state consisting of feelings of joy, euphoria, triumph, and optimism and intense self satisfaction. A related term is **elevated mood**, which refers to an air of confidence and enjoyment, a mood which is more cheerful than normal, but is not pathological. **Expansive mood** is characterized by expression of feelings without

restraint, frequently with an overestimation of reality. Like euphoria elation and expansiveness are also seen in mania and organic brain illness.

Ecstasy is a calm exalted state of feeling of happiness. It is different from the morbid cheerful mood or elation. Ecstasy may occur in mental illnesses or in abnormality of personality. Ecstatic mood has also been described in patients with exalted delusion in schizophrenia. It can also be seen in healthy populations at times of profound religious experience or occasions of deep emotions like after childbirth.

Depression is a feeling of dejection which colours all thought and activity. It could be a normal reactive unhappiness or morbid unpleasant mood, which is present all the time for a number of days, indicating a depressive disorder. Patients may complain of feeling low, sad, dejected, and gloomy. Pervasive and persistent depressed mood is a characteristic of depressive illness. Depressive mood can also be presenting symptoms in a range of psychiatric illnesses like obsessive compulsive disorder, schizophrenia and panic disorder where it is secondary to the primary psychopathology.

Anxiety is an unpleasant emotion characterized by apprehension in anticipation of a danger (external or internal), accompanied by a feeling of impending doom. It has also been described as fear of unknown. Patient may complain of feeling stressed and tense. Sometimes, autonomic symptoms of anxiety like palpitations, sweating, difficulty breathing may be accompanying. Anxiety is the presenting symptom in anxiety disorders, but can be one of the symptoms in most of psychiatric illnesses.

Irritability is a mood state of abnormal or excessive excitability with easily triggered anger, annoyance and impatience. Irritability may be seen in depression, dysthymia, mania, mixed affective illness and schizophrenia and many of the personality disorders.

Perplexity is a bewildered or puzzled state of mind, that may be seen in anxiety, delirium and emerging schizophrenia.

Morbid surprise may be seen in latah, a culture bound syndrome, seen in Malaysia, in which there occurs an exaggerated startle response, accompanied by multiple echo phenomena like echolalia, echopraxia and echomimia.

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) How do euphoria, elation and ecstasy differ from each other?

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2) How would you define irritability? What are the illnesses, in which irritable mood is seen?

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3) What is perplexity?

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3.4 DISTURBANCES IN THE RANGE OF MOOD AND AFFECT

A normal person shows a range of emotions in response to various situations. These emotions would include happiness, sadness, anger, surprise, fear and disgust. This range may get restricted in illnesses like schizophrenia.

Restricted or constricted affect refers to reduction in the range of emotions displayed by a person. It is a characteristic of schizophrenia and is a milder form of inadequacy of affect.

Blunted affect is a disturbance of affect, characterized by severe reduction in the range of emotions and is manifested as lack of emotional sensitivity. The person may appear socially awkward. Blunting of affect is a feature of schizophrenia.

Flat affect or flattening of affect refers to a limitation of the usual range of emotional expression expressed usually by facial and bodily gestures. The person does not show much affect in any direction, though whatever is expressed, is appropriate in that direction. Flattening of affect is seen in schizophrenia.

Blunting and flattening of affect are sometimes used interchangeably in literature to refer to an unchanging facial expression, decreased spontaneous movements, poverty of expressive gesture, , poor eye contact, affective unresponsivity and lack of vocal inflection. Thus it is not a single feature, but a composite of a number of observable characteristics.

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) What are different disturbances in the range of emotions?

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2) How does constricted affect differ from blunted and flat affect.?

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3.5 DISTURBANCES IN THE REACTIVITY AND INTENSITY OF MOOD AND AFFECT

This refers to abnormalities in emotional reactivity to various external situations or environmental changes. Disturbances in reactivity include inappropriate affect, incongruous affect, lability, apathy, la belle indifference.

Inappropriate affect refers to the affective expression which is out of harmony with the idea, thought, speech or the environmental situation. For example, a patient may react to sad news with laughter or describe a happy memory with a sad face. Inappropriate affect is a feature of schizophrenia.

Labile affect is characterized by rapid and abrupt changes in the affective expression, unrelated to external stimuli. Lability involves both an intensification of emotions and instability in persistence of the emotional state, associated with dramatic changes from one extreme to other. Thus the emotional reaction is inappropriate in the context. Lability is seen in mania and organic psychiatric disorders.

Incongruous affect refers to misdirection of emotions; an indifferent event may produce a severe emotional outburst, while an event that may objectively appear to be emotionally charged, but does not lead to any emotional response. For example, a person may start crying loudly over a loss of a ten rupees note, but may not show any emotional reaction, while giving details of his mother's death. Incongruous affect is seen in schizophrenia.

La belle indifference is an inappropriate attitude of calmness or lack of concern about one's disability or illness. La belle indifference is a result of dissociation of affect and has been classically described as a feature of conversion disorder, where a patient does not show any significant emotional response to the disability with which she is presenting.

Apathy is different from the dissociation of affect. Apathy refers to emotional indifference, often with a sense of futility. It may manifest as a lack of motivation. Apathy may be seen in schizophrenia, chronic cannabis abuse, socially deprived situations like, in prisons.

3.6 DISTURBANCES IN INTENSITY OF MOOD AND AFFECT

There can be a loss of feeling especially in patients with depression. The patient describes it as subjective experience of loss of feelings that were formerly present. On an objective assessment, one may not find any abnormality. The loss of feeling may refer to all emotions like sadness, joy, anger, fear, etc. A mother may say that she does not get any feeling while hugging her children. Patients presenting with depersonalization or derealisation may also give similar complaints.

Anhedonia refers to loss of capacity to experience pleasure. This is a result of diminution of the emotions. There is a complete loss of ability to enjoy anything in life or get satisfaction from the everyday events or objects. Anhedonia has been typically described

in depression. It is also one of the negative symptoms described in schizophrenia, where it manifests mainly in the social context, with inability to experience pleasure in social relationships.

Euphoria, elation, depressed mood and ecstasy are also disturbances in the intensity of emotional expression with the respective emotions are being expressed intensely.

Similarly intensification of anger, fear and surprise can be seen. The fear as seen in phobias is a disturbance of intensity of emotions. The morbid surprise as described in a previous section in this chapter is also a disturbance of intensity of emotions.

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) What is inappropriate affect? In which illnesses it is seen?

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2) How do apathy and anhedonia differ from each other?

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3) Describe disturbances in intensity of emotions.

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3.7 LET US SUM UP

Emotion refers to a feeling state involving thoughts, physiological changes, and an outward expression or behaviour. Different emotions include anger, disgust, fear, happiness, sadness and surprise. Mood is an emotional state which lasts for some time, and colours the subjective experiences. Affect refers to the emotional state at a particular moment of time. Disturbances in emotion can occur in terms of quality of mood or affect or in terms of emotional reactivity, intensity (depth) and range of emotional reactions. Euphoria and elation are seen in mania. Blunting of affect and inappropriate affect are characteristic of schizophrenia.

3.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress 1

- 1) Emotion refers to a feeling state involving thoughts, physiological changes, and an outward expression or behaviour. Affect refers to a person's present emotional responsiveness or emotional state as on now. Mood is a pervasive and sustained emotion, which colours the person's perception of the world.
- 2) A feeling is a positive or negative reaction to some experience or an event, and is the subjective experience of emotion. It is often transitory.
- 3) There are six basic emotions, which are expressed on face. These include anger, disgust, fear, happiness, sadness and surprise. These emotions are universal, but there is cultural variations in their expression.

Check Your Progress 2

- 1) Disturbances in emotion can occur in terms of quality of mood or affect or in terms of emotional reactivity, intensity (depth) and range of emotional reactions.

Check Your Progress 3

- 1) Euphoria is an exaggerated feeling of wellbeing a state of excessive unreasonable cheerfulness, which cannot be explained by the real life circumstances. Elation refers to a mood state consisting of feelings of joy, euphoria, triumph, and optimism and intense self-satisfaction. Ecstasy is a calm exalted state of feeling of happiness.
- 2) Irritability is a mood state of abnormal or excessive excitability with easily triggered anger, annoyance and impatience. It may be seen in depression, dysthymia, mania, mixed affective illness and schizophrenia and personality disorders.
- 3) Perplexity is a bewildered or puzzled state of mind, that may be observed in anxiety, delirium and emerging schizophrenia.

Check Your Progress 4

- 1) Different disturbances in the range of emotions would include happiness, sadness, anger, surprise, fear and disgust. This range may get restricted in illnesses like schizophrenia.
- 2) Constricted affect refers to reduction in the range of emotions displayed by a person. While as, blunted affect is a disturbance of affect, characterized by severe reduction in the range of emotions and is manifested as lack of emotional sensitivity. The person may appear socially awkward.

Check Your Progress 5

- 1) Inappropriate affect refers to the affective expression which is out of harmony with the idea, thought, speech or the environmental situation. Inappropriate affect can be seen in schizophrenia.
- 2) Apathy refers to emotional indifference, often with a sense of futility. It may manifest as a lack of motivation. While as, anhedonia refers to loss of capacity to experience pleasure. There is a complete loss of ability to enjoy anything in life or get satisfaction from the everyday events or objects.

- 3) The disturbances can be a loss of feeling especially in patients with depression. The loss of feeling may refer to all emotions like sadness, joy, anger, fear, etc. Patients presenting with depersonalization or derealisation may also give similar complaints.

3.9 UNIT END QUESTIONS

- 1) Describe various disturbances of affect seen in schizophrenia
- 2) Describe the affective disturbances seen in mania
- 3) Write a short note on the concept of emotions.

3.10 SUGGESTED READINGS AND REFERENCES

- Casey P, Kelly B (2007). *Fish's Clinical Psychopathology*. 3rd edition. Gaskell: London.
- Oyebode F (2009) *Sims' Symptoms of Mind*. 4th edition. Saunders Elsevier: Edinburgh.
- Sadock BJ, Sadock VA (2007): *Kaplan & Sadock's Synopsis of Psychiatry: Behavioural Sciences/Clinical Psychiatry*, 10th Edition. Lippincott Williams & Wilkins.



UNIT 4 COURSE AND OUTCOME OF MENTAL DISORDERS

Structure

- 4.0 Introduction
- 4.1 Descriptors of Course and Outcome
- 4.2 Course of important Psychiatric Disorders
 - 4.2.1 Psychotic Disorders
 - 4.2.2 Mood Disorders
 - 4.2.3 Anxiety Disorders
 - 4.2.4 Substance Use Disorders
- 4.3 Let Us Sum Up
- 4.4 Glossary
- 4.5 Answers to Check Your Progress Exercises
- 4.6 Unit End Questions
- 4.7 Suggested Readings and References

4.0 INTRODUCTION

Having learnt the classification, epidemiology and clinical features of mental disorders in the previous Units, we shall proceed further to discuss the course and outcome of mental disorders. Before proceeding further, it is important to remember a few essential points regarding the course and outcome of mental disorders:

- i) Mental disorder is a broad rubric, which consists of many individual disorders, each having a different course and outcome. The presence of one psychiatric disorder may alter the course and outcome of other co-morbid disorders.
- ii) The course and outcome discussed in this chapter for individual disorders is the general tendency commonly seen in people with these problems. The course may vary among different people.
- iii) For an individual patient suffering from a particular disorder, the course may be affected by various factors like age at onset, comorbidity pattern etc. (which will be discussed subsequently). Even if we know all the associated factors, it may not be possible to *accurately* predict the likely course and outcome for a particular patient.
- iv) Treatment of these conditions has a significant positive impact on the course and outcome. Hence, the course of both treated and untreated mental disorders are discussed.

Why study course and outcome?

How does studying the course and outcome of mental disorders help us in managing the patients?

- On communicating the diagnosis, patients and their family members often want to know more about their illness. This is usually about the likely outcome of illness,

how much improvement can be expected and regarding the likelihood of having a recurrence of the illness again. Knowing the course and outcome helps us to *educate* the patient and family members on these aspects.

- Knowing the natural course of illness helps because, it helps us to differentiate whether the decrease in symptoms observed is due to natural course of the illness or the treatment given.
- It helps us to estimate which stage of the illness the patient is currently in. Different stages of illness need different treatments. For example, in the acute stage, *treatment* has to be given more aggressively for control of symptoms. While in the later stages, treatment should be geared towards prevention of recurrences and rehabilitation.

With this background we would discuss the course and outcome of important mental disorders in the subsequent sections.

Learning Objectives

After reading this Unit, you will be able to:

- define various terms used to describe the course and outcome of mental disorders;
- describe the course and outcome of important mental disorders; and
- ascertain the relevant factors that may affect the course and outcome of important mental disorders.

4.1 DESCRIPTORS OF COURSE AND OUTCOME

In this Unit, we would be defining the commonly used terms that are used to describe the course and outcome of mental disorders. Since most mental disorders are chronic conditions, similar terms are used to describe the course and outcome of these conditions. As you know, *course of illness* refers to the usual trajectory the disease follows from the moment of exposure to *causal agents* until recovery or death. In mental disorders, where the cause of illness is not known exactly, course is described from the onset of first symptom. The description of course of the disease, which is not manipulated in anyway like treatment etc. is known as *natural history of the disease*. The word *Prognosis* is used to denote the prediction of the probable course and outcome of a disease. As discussed previously, prognosis can be calculated accurately for large populations as a whole, but it is impossible to predict *accurately* how a particular patient's prognosis is likely to be for any disease. But knowledge of the general course and outcome an illness and also the factors affecting course and outcome will give an idea on the likely prognosis of a patient.

Different aspects like how the illness begins, how the illness progresses over time and likely outcome of the illness should be described separately to get a better picture of the overall course of the illness. The terms used to describe each of these aspects are discussed separately.

Terms related to onset of illness

Onset of illness refers to how the symptoms of the disease begin to appear in a patient. Onset is defined as the time span from the beginning of the first symptom to the time of developing a full blown diagnosable psychiatric syndrome.

- 1) Abrupt: The onset is described as abrupt when it occurs within 48 hours

- 2) Acute: It is called acute when it occurs within more than 48 hours but less than two weeks
- 3) Insidious: When the onset of illness is subtle, and the symptoms develop so gradually that it is difficult to ascertain when the onset exactly occurred, it is known as insidious onset

Terms related to progression of illness:

The course of a chronic illness is described as either continuous or episodic.

- 1) **Continuous course:** An illness is considered to be continuous when the symptoms of the illness never disappear completely throughout the course of the illness. It is further divided into
 - a) Waxing and waning course: When the symptoms of the illness increases or decreases, showing a fluctuating level of symptoms, but never reaches the symptom free level.
 - b) Progressive course: When the symptoms of the illness steadily worsen over time, the illness is called a progressive illness.
 - c) Static course: The course is said to be static, when the symptoms have progressed to an extent, and do not show any further deterioration or improvement.

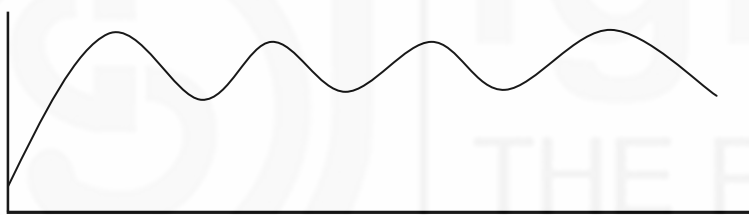


Fig. 1: Waxing and waning course

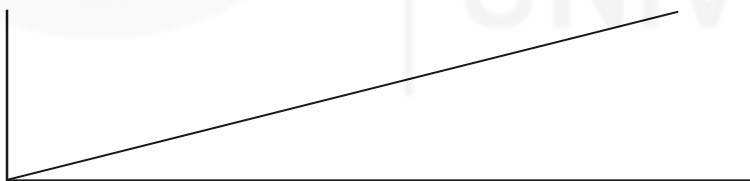


Fig. 2: Progressive course

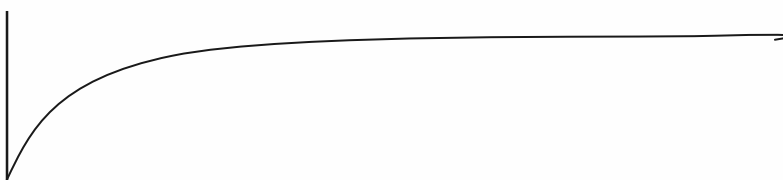


Fig. 3: Static course

- 2) **Episodic Course:** The course of the illness is said to be episodic, if the symptoms disappear completely for varied periods of time, only to reappear again. The period of illness when the symptoms are present i.e. the period between the onset of symptoms to complete disappearance of symptoms is known as an *episode of*

illness. The intervening symptom-free period is known as periods of *remission*. These are illustrated graphically in figure 4.

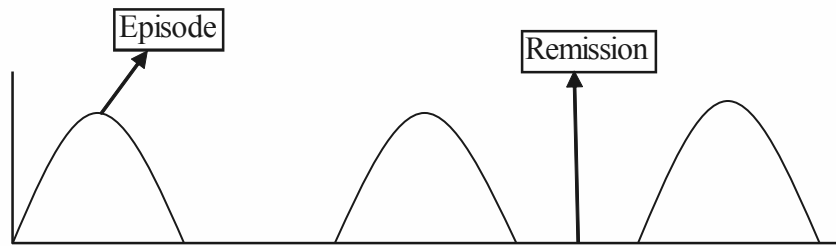


Fig. 4: Episodic course

There are a few other terms used in the description of course of an episodic illness:

- a) **Remission:** This refers to the period in which the symptoms disappear completely.
- b) **Recovery:** When remission is sustained for prolonged periods, i.e. at least 6 months duration, it is known as recovery.
- c) **Relapse:** If the symptoms restart again during periods of remission, it is known as a relapse of symptoms and these symptoms are considered to be of the same episode.
- d) **Recurrence:** When the symptoms restart after recovery i.e. 6 months of sustained remission, it is known as recurrence of a new episode.

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) How does the study of course and outcome of an illness help us in managing a patient?

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2) What is the difference between acute and insidious onset of illness?

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3) What is the difference between remission and recovery?

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4.2 COURSE OF IMPORTANT PSYCHIATRIC DISORDERS

With this background, we shall now proceed to discuss the course of some important psychiatric disorders. The disorders discussed below are those that are seen commonly in clinical scenario. Those who are interested in the course of other disorders, can refer to the references given in the *further reading* section.

4.2.1 Psychotic Disorders

1) Schizophrenia

As you would have read in the previous Units, schizophrenia is a serious mental illness characterized by three categories of problems, namely positive symptoms, negative symptoms and cognitive impairment. The positive symptoms include delusions, hallucination, formal thought disorder etc. and the negative symptoms include anhedonia, apathy, alogia, avolition and asociality. Different patients have different degrees of these symptoms. Each of these categories follows a different course during the illness. The positive psychotic symptoms usually begin in late adolescence and improve rapidly with treatment. The negative symptoms and cognitive impairment may begin earlier. They are more persistent and resistant to treatment.

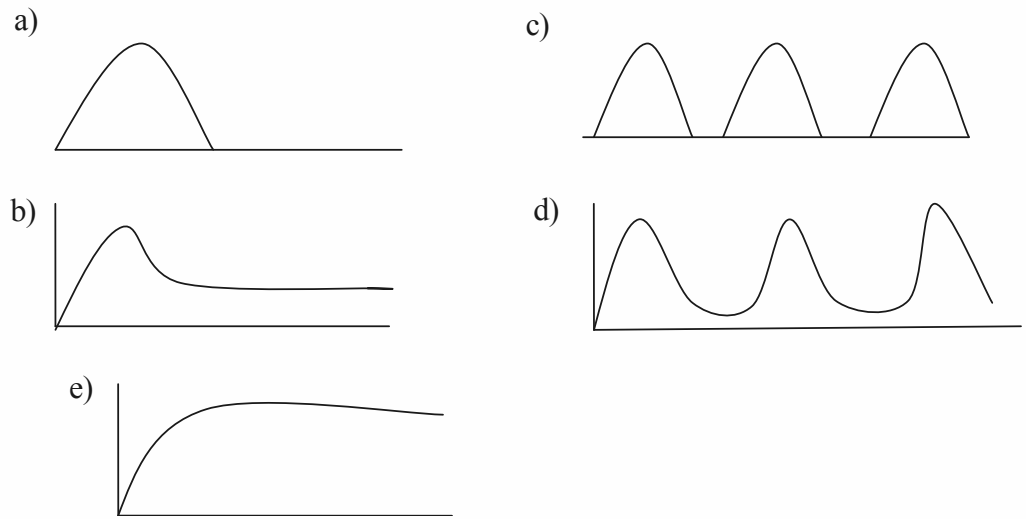
The widely held belief is that schizophrenia being a serious mental illness has a very poor prognosis and has low chance of recovery. But most of the recent research evidence has given contrary evidence suggesting that schizophrenia has a highly variable course and outcome. Further, the recent developments in treatment methods have greatly improved the prognosis of patients suffering from schizophrenia. This would be clearer as we discuss further

- i) **Onset:** As discussed earlier, there is marked variation in the course and outcome of schizophrenia, including the onset of illness. In a majority of patients, the symptoms of schizophrenia start developing in the late adolescence, with most of the patients developing the disease by 30 years of age. It has also been observed that female patients have a slightly later age of onset compared to males. Some female patients develop the illness in their middle age i.e. around menopause.

The illness can be either acute or insidious in onset. In some patients the illness shows a more insidious onset, and starts with negative symptoms like asociality along with vague fearfulness and other behavioural disturbances like agitation, irritability; which slowly progresses to develop clear-cut positive psychotic symptoms like delusions and hallucinations. In other patients the illness starts more acutely starting with positive symptoms like delusions and hallucinations. As will be discussed later, the latter group has a better prognosis compared to the former.

- ii) **Course:** The course of schizophrenia is highly variable. Five patterns of course have been described for schizophrenia namely,
- single psychotic episode followed by complete remission;
 - single psychotic episode followed by incomplete remission;
 - two or more psychotic episodes, with complete remissions between episodes;
 - two or more psychotic episodes, with incomplete remissions between episodes;
 - continuous (unremitting) psychotic illness.

These are illustrated in the figures below:



The course of the illness for an individual patient may follow any of the above described courses. The course of the illness has been markedly altered in recent years due to treatment with antipsychotic patients. Most of the patients show at least some degree of improvement with antipsychotic treatment.

- iii) **Outcome:** Although the outcome of schizophrenic illness is also variable, most of the patients attain at least some degree of symptomatic improvement with antipsychotic medications. The positive psychotic symptoms show better response to antipsychotic medications compared to negative symptoms and cognitive impairment. Despite symptomatic improvement, patients may not be able to reach their previous occupational and social functional status due to the persistence of negative symptoms and cognitive impairment. Hence many patients may need other forms of help like rehabilitation to help them attain their previous socio-occupational functional status.

There is a sizable minority (around 10 to 20%) of patients who develop complete remission of symptoms and regain complete functional status after they develop an episode of schizophrenia. There are other patients who may have longstanding minimal symptoms. They may be able to function adequately, with minimal symptoms and continuous antipsychotic treatment. Taken together, around 30 to 40% of patients have a good prognosis i.e. they are able to lead at least a somewhat normal life. There are some patients who have continuous deteriorating illness who belong to the poor prognosis group. Around 20-35% of patients show such an illness, but as mentioned previously they show at least some degree of improvement (both symptomatically and functionally) with treatment. The remaining patients remain in the intermediate-prognosis group, with moderate improvement and moderate level of functional status. One interesting aspect of the prognosis of schizophrenia is that many patients with schizophrenia in developing countries including India, show a good prognosis compared to those of the developed countries. This has been attributed to the good family support in developing countries which has shown to foster improvement.

The attainment of good functional status in a patient with schizophrenia with continuing psychotic symptoms is excellently demonstrated in the 2001 Hollywood movie “A Beautiful Mind”!

- iv) **Mortality:** Another aspect of schizophrenia outcome that deserves attention is the mortality. It has been seen that people suffering from schizophrenia live on an average 12 to 15 years lesser than the general population. One important cause of premature death in schizophrenia is suicide. People with schizophrenia are 10 to 20 times more likely than the general population to commit suicide. Schizophrenic patients may have suicidal thoughts when they are acutely ill i.e. when they are suffering from florid positive psychotic symptoms like delusions and hallucinations. Some patients also get distressed and attempt suicide immediately after they improve from a psychotic episode, when they come to terms with how the illness has affected their lives. Hence patients with schizophrenia should be actively monitored throughout the course of their illness for the presence of suicidal thoughts and plans.

But the major cause of death in people with schizophrenia is due to physical conditions like heart diseases. The prevalence of physical illness and early death due to physical illness is found to be elevated in people with schizophrenia when compared to the general population. Risk factors for cardiovascular mortality like poor diet, inadequate exercise, sedentary lifestyle, obesity and smoking is higher in people with schizophrenia. Some newer antipsychotic medicines also increase the risk for diabetes and high cholesterol levels, further increasing the risk factor for cardiovascular diseases. Due to the presence of negative symptoms like amotivation, apathy and asociality, people with schizophrenia do not seek treatment even when they have symptoms of medical illness. Further, they are ostracized in the society and their medical needs are not given priority. Hence in people with schizophrenia, it is important to actively monitor for medical illness and relevant risk factors to prevent premature mortality.

- v) **Factors affecting course and outcome of schizophrenia:** The course and outcome of schizophrenia have been found to be affected by various factors, which are given in table 1. The knowledge of these factors can give an idea of how the likely prognosis may be, but we may not be able to accurately predict the course for a particular patient. Not all of these factors can be modified with intervention (e.g. Gender). But other factors (like delay in starting treatment) can be modified through education and community intervention.

Table 1: Factors that affect the course and outcome of schizophrenia

Good prognostic factors	Bad prognostic factors
Good premorbid social and work histories	Poor premorbid social, and work histories
Female gender	Male gender
Late age of onset	Early age of onset
Acute onset	Insidious onset
Stressful events preceding onset	No obvious stressful events
Predominantly positive symptoms	Predominantly negative symptoms
Good social support	Poor social support
Married	Single, divorced, widowed
Early initiation of treatment	Delay in initiation of treatment

2) Acute and transient psychotic disorders

This group of psychotic disorder is by definition characterized by acute or abrupt onset of symptoms and rapid remission of symptoms within 1-3 months. The disorder has an onset characteristically in young adults aged between 20 and 30 years, more commonly seen in females. After remission, which usually occurs within days or weeks, the patients

do not have any residual symptoms unlike schizophrenia. Many patients experience recurrence of such episodes, which too recover completely. Some of these patients have been shown to be re-diagnosed as either schizophrenia or mood disorder in follow-up. In the acute phase, many disorders present with agitation and excitement, which may be misdiagnosed as acute and transient psychotic disorder. By and large this disorder is a good prognosis condition, with most patients achieving full functional recovery in long term.

3) Persistent delusional disorder

This is a relatively uncommon condition characterized by the presence of a single or a set of related delusions, in the absence of other psychotic or mood symptoms. This disorder usually starts in the 30s with an insidious onset. But some people develop this disorder even at a later age. It usually remains stable and does not progress, unlike schizophrenia. In many patients, the delusion affect only those aspects of life related to the delusion. For example, in a person with a delusion that his wife is not faithful to him, his family life will be affected to a great extent. But he may be functioning normally in his occupational life and other aspects. The presence of a precipitating factor before the onset of illness and persecutory delusions are good prognostic factors. The presence of comorbid disorders like depression is a poor prognostic sign. The major difficulty in these patients is that they do not come for treatment despite years of illness, due to the well preserved functioning in at least certain aspects of life and poor insight into the illness.

4) Schizoaffective disorder

Schizoaffective disorder is characterized by both mood (depressive or manic) and psychotic symptoms in the same episode of illness. The disorder usually runs an episodic course and the prognosis is intermediate i.e. better than schizophrenia and worse than mood disorders. It depends on which group of symptoms predominates.

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) What are the various patterns of course described in schizophrenia?

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2) Enumerate the factors that indicate a good prognosis in schizophrenia.

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4.2.2 Mood Disorders

1) Depressive disorder

- i) **Onset:** Depressive disorder can occur at any age from childhood to old age. It usually starts in middle age, more commonly in 30s. The onset of depressive disorder is usually gradual or insidious. Depression occurring as a part of depressive disorder has more of a gradual onset compared to those that occur in bipolar disorder. But patients who develop a depressive disorder after a stressful life event can have an acute onset of depressive disorder. The initial episodes are usually precipitated by stressful life events, but later episodes start occurring without any obvious precipitating event.
- ii) **Course:** Depressive disorder characteristically runs an episodic course, with complete remission of symptoms in between the episodes. Variations do occur. For example, around 10 to 15% of patients just have a single episode of illness with no further episodes. Another 10% of patients also have chronic stable course of depressive disorder. But majority of the patients have an episodic course, each untreated episode lasting 6 to 13 months. The treated episode usually lasts for an average of 3 months, depending on when the treatment was initiated. As the course of the disorder progresses, patients tend to have more frequent episodes that last longer. Studies have shown that patients develop an average of 5-6 episodes, when followed up for a period of 20 years. One particular type of depressive disorder known as seasonal affective disorder follows a particular pattern of illness characterized by recurrence of episodes in a particular season of the year, usually in winter.
- iii) **Outcome:** Although recurrent depressive disorder improves with treatment, it runs a chronic episodic course. But the incidence of further episodes is decreased in people taking prophylactic antidepressant medicines. Recently, it has been seen that many patients may have some minor symptoms in-between the episodes, and the presence of such symptoms, increases the chance of further episodes. Further, stopping of treatment before complete remission of symptoms could lead to heightened chance of recurrence. It is recommended that people having recurrent episodes of depression should take antidepressants for longer periods to prevent further development of episodes.
- iv) **Mortality:** Mortality seems to be higher in people with depressive disorder when compared to the general population. Suicide is an important cause of increased mortality in this population. More than half of people who commit or attempt suicide suffer from depressive disorder. Severity of depression, past history of suicidal attempts, comorbid personality disorders, anxiety and substance use increase the risk of suicide in these patients. Other causes of mortality like accidents and physical illness have also seen to be increased in patients with depressive disorder. This occurs due to factors like altered physiological status in people suffering from depressive disorders, substance use and unhealthy eating habits.
- v) **Factors affecting course and outcome:** Certain factors predict the course and outcome of depressive disorders. For example, presence of comorbid substance use disorder, ongoing stress and personality disorder is associated with worse outcome of depressive disorders. Onset of depression at old age is associated with longer duration of illness, although the severity may be less severe. The presence of multiple previous episodes of depression, longer episodes in past and persistence of residual symptoms predict a poorer outcome of the current episode of illness.

2) **Bipolar affective disorder**

- i) **Onset:** Bipolar disorder has an earlier age of onset compared to unipolar depressive disorder with an onset usually around 20 years of age. Male patients have a slightly earlier age of onset compared to female patients. People with a variant of bipolar disorder known as bipolar disorder-II (who do not develop severe manic episodes and present only with depressive episodes and hypomanic episodes) have a slightly later age of onset compared to bipolar-I disorder. The illness usually starts with a depressive episode in most patients. Onset of symptoms appears to be more acute in bipolar disorder compared to depressive disorder.
- ii) **Course:** The illness characteristically runs an episodic course with almost complete remission of symptoms in between the episodes. A minority of patients (around 10%) do not develop further episodes after their first manic episode. Around 10-20% of patients develop only recurrent manic episodes with no depressive episodes. But majority of patients have recurrent episodes, which are either of manic or depressive in nature. Each manic episode lasts for an average duration of around 4 to 6 months. Depressive episodes are also more acute in onset and shorter in duration in bipolar disorders compared to unipolar depression. The recurrences tend to occur more frequently as the illness progresses and the periods of remission decreases and stabilize after a certain time period. On an average, patients develop one episode every 2-3 years. But this estimate is just an average and the frequency of episodes varies greatly among different individuals. During the course of their illness, some people suffer from very frequent episodes i.e. four or more episodes in a year. This phase is known as *rapid cycling* bipolar affective disorder and is usually difficult to treat.
- iii) **Outcome:** The outcome of bipolar disorder is worse than unipolar depression, characterized by more frequent recurrences. Some patients have some minor symptoms in-between the episodes, and the presence of such symptoms, increases the chance of further episodes. The recurrence of manic symptoms greatly affects the occupational status of the patients due to their impaired judgment during the episodes leading to occupational errors. Further, the stigma associated with the presence of a mental illness and breaks in the occupational career also contribute to their decreased functional status. The severity of the episodes and the risk of recurrences can be greatly controlled by treatment with continuous treatment with medications.
- iv) **Mortality:** The risk of mortality in bipolar disorder is higher than that in the general population. Suicide risk is found to be high in this population. Other medical causes of mortality like heart diseases and stroke are also found to be higher in bipolar patients. Treatment with lithium has shown to decrease suicide in patients with bipolar disorder.
- v) **Factors affecting course and outcome:** Poor premorbid occupational status, alcohol dependence, psychotic symptoms, inter-episode depressive features and male gender are associated with a poor prognosis. Short duration of manic episodes, advanced age of onset, few suicidal thoughts, and few coexisting psychiatric or medical problems predict a better outcome. Long term regular treatment also improves the outcome of patients with bipolar affective disorder.

3) **Dysthymia**

Dysthymia is characterized by low grade depressive symptoms which are present for long periods. This disorder has an early age of onset. Around 50% of patients have an

onset before the age of 25 years. Onset is usually insidious. The disorder tends to run a chronic course and usually patients seek treatment after a decade of illness. The prognosis improves with treatment. Some patients may develop either a depressive disorder or bipolar disorder over long term.

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 is the usual age of onset of depressive disorder and bipolar affective disorder?

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2) What is rapid cycling bipolar disorder?

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4.2.3 Anxiety Disorders

Anxiety disorders are the most common psychiatric disorders seen in the community. They usually share the common features of early age of onset and a chronic waxing and waning course. Individual anxiety disorders have different age of onset and course. For example the peak age of onset common anxiety disorders are as follows: Specific phobias in middle childhood; social phobia in middle adolescence; panic disorder in late adolescence; generalised anxiety disorder in young adulthood; and Obsessive compulsive disorder in early adulthood. Earlier anxiety disorders were considered to be relatively mild conditions. But recent research findings show that they are associated with significant disability and functional impairment. Many of these patients may not seek treatment due to poor awareness of the availability of treatment options for these conditions. The course of some anxiety disorders are discussed briefly.

Generalised anxiety disorder starts at an early age, at around 20 years of age and tends to run a chronic course with fluctuating severity and symptom patterns. Periods of sustained remission are rare without treatment. Patients usually have other comorbidities like depression and other anxiety disorders. Early age of onset, untreated status and presence of comorbidities is associated with poor outcome.

Panic disorder usually has its onset in late adolescence, but can occur at any age. People with panic disorder may develop fear of going to crowded places and travelling secondary to fear of having another panic attack. This latter condition known as *agoraphobia* increases the disability associated with panic disorder. Other psychiatric disorders like depression, substance use may also coexist. They are also prone to have increased risk of suicide. This disorder tends to run a chronic course, but it may remit completely in some people. Most of the patients have good response to treatment, which has to be continued for adequately long duration to prevent recurrence of attacks.

Social phobia begins in middle adolescence and runs a chronic course. It causes marked impairment in academic and occupational functioning. It may persist into adulthood if not treated adequately. Specific phobia has an earlier age of onset and it too persists into adulthood. Specific phobia causes dysfunction only in circumstance the person has to face the feared stimuli.

Obsessive compulsive disorder (OCD) usually starts by around 20 years of age, but for some people it may also have its onset in early childhood. The disorder can have an acute or insidious onset. Usually people suffering from this disorder delay seeking treatment due to unawareness and shame about the symptoms. OCD usually runs a chronic course with fluctuating level of symptoms. Some people may show improvement in symptoms and may remit completely without any treatment. But a majority of patients need long term treatment to improve their condition. Comorbidities including both psychiatric and physical illnesses, are commonly seen in patients suffering from obsessive compulsive disorder.

4.2.4 Substance Use Disorders

People with substance use disorders like alcohol dependence, nicotine dependence (e.g. cigarette smoking) etc. show a characteristic pattern of substance use behaviour which leads to significant dysfunction and health risks. This pattern generally follows a similar course, irrespective of the substances used. The use of such substances usually has an onset in adolescence period. People usually start by using commonly and legally available substances like cigarette and alcohol. Some people who are predisposed to develop substance use disorders, continue using these substances in a more regular basis and in a few years become dependent (or addicted) to these substances. They are not able to quit them even though they experience harmful effects due to these substances. After a few years they develop significant health problems due to these substances and also other financial and social problems. Some people also start using illegal substances like cannabis and heroin and they become dependent on these substances on due course.

At the peak of their dependence some people may succumb to death due to physical complications of these substances or overdose. Some people develop depression and suicidal ideations and they may die of suicide. They may also meet with accidents under intoxication. Significant familial problems like separation, divorce, disowning by family members may occur. At this stage many of them may be willing to quit the substances, but they may not be able to do so. Substance dependence is a chronic disorder which follows a waxing and waning course. By employing various methods, some people quit substances but they may relapse in future following a stressful event, craving or pressure from peers. Adequate treatment may help these patients in decreasing the physical and social complications as well as decreasing the relapses and helping to maintain abstinence.

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) What is the usual age of onset of various anxiety disorders?

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2) What are the common causes of premature death in substance use disorders?

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3) How do mental disorders predispose to physical illness?

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4.3 LET US SUM UP

From the above discussion, you would have understood that mental disorders include a broad rubric, containing various individual disorders, each having a different course and prognosis. Many mental disorders are chronic illnesses, which have an onset in early age. Nevertheless they may begin at any age and their course is variable. The course is often characterized by either remission-relapses or by fluctuations in the level of symptoms. They cause significant impairment in the patient's lives. Some patients have a good prognosis and remit completely with treatment. There are some disorders like acute and transient psychotic disorders which are short lasting and have a good prognosis.

Mental disorders may sometimes be comorbid with each other. Such comorbidity worsens the prognosis of either disorder. Due to unhealthy lifestyle and decreased access to treatment, people with mental disorders are more prone to develop physical illness. Mental disorders may also lead to death due to suicide, accidents or increased risk of physical illness. There are various factors which affect the course and prognosis of mental disorders. Some of them like early initiation of treatment, continuous treatment and social support are modifiable. These factors have to be targeted with interventions like screening for mental disorders, early initiation of treatment, education of the family members and the general population to improve the prognosis of mental disorders.

4.4 GLOSSARY

- 1) **Course:** Course of an illness refers to the usual trajectory the disease follows from the moment of exposure to *causal agents* until recovery or death
- 2) **Prognosis:** Prognosis refers to the prediction of the probable course and outcome of a disease.
- 3) **Onset:** The time from the beginning of the first symptom to a full blown diagnosable psychiatric syndrome.

- a) **Abrupt:** The onset is described as abrupt when it occurs within 48 hours
 - b) **Acute:** It is called acute when it occurs within more than 48 hours but less than two weeks
 - c) **Insidious:** When the onset of illness is subtle, that it is imperceptible when the onset exactly occurred, it is known as insidious onset
- 4) **Continuous course:** An illness is considered to be continuous when the symptoms of the illness never disappear completely throughout the course of the illness. It is of three types
- a) **Waxing and waning:** When the symptoms of the illness increases or decreases, showing a fluctuating level of symptoms, but never reaches the baseline i.e. symptom free level.
 - b) **Progressive:** When the symptoms of the illness steadily worsen over time, the illness is called a progressive illness.
 - c) **Static:** The course is said to be static, when the symptoms have progressed to an extent, and do not show any further deterioration or improvement
- 5) **Episodic Course:** The course of the illness is said to be episodic, if the symptoms disappear completely for varied periods of time, only to reappear again.
- 6) **Remission:** This refers to the period in which the symptoms disappear completely
- 7) **Recovery:** When remission is sustained for prolonged periods, i.e. at least 6 months duration, it is known as recovery
- 8) **Relapse:** If the symptoms restart again during periods of remission, it is known as a relapse of symptoms and these symptoms are considered to be of the same episode.
- 9) **Recurrence:** When the symptoms restart after recovery i.e. 6 months of sustained remission, it is known as Recurrence of a new episode.
- 10) **Mortality:** Deaths occurring in patients suffering from a disorder.

4.5 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress 1

- 1) How does the study of course and outcome of an illness help us in managing a patient?
Studying the course and outcome helps us to:
 - 1) educate the patient and family members on what to expect when one is suffering from a particular disorder
 - 2) know how much the treatment given has helped the patient
 - 3) adjust treatment according to the stage of illness
- 2) The onset is described acute when it occurs within more than 48 hours but less than two weeks. When the onset of illness is subtle, and the symptoms develop so gradually that it is difficult to ascertain when the onset exactly occurred, it is known as insidious onset

- 3) Remission refers to the period in which the symptoms disappear completely. When remission is sustained for prolonged periods, i.e. at least 6 months duration, it is known as recovery.

Check Your Progress 2

- 1) Five patterns of course have been described for schizophrenia namely,
 - a) single psychotic episode followed by complete remission;
 - b) single psychotic episode followed by incomplete remission;
 - c) two or more psychotic episodes, with complete remissions between episodes;
 - d) two or more psychotic episodes, with incomplete remissions between episodes;
 - e) continuous (unremitting) psychotic illness.
- 2) Refer to Table 1.

Check Your Progress 3

- 1) Both disorders can occur at any age. Bipolar affective disorder starts at the age of around 20. Depressive disorder starts at a later age at around 30 years of age.
- 2) Rapid cycling bipolar disorder is characterised by frequent occurrences of manic or depressive episodes i.e. 4 or more episodes within a year.

Check Your Progress 4

- 1) Specific phobias in middle childhood; social phobia in middle adolescence; panic disorder in late adolescence; generalised anxiety disorder in young adulthood; and Obsessive compulsive disorder in early adulthood.
- 2) Premature death can occur in substance use disorder due to
 - 1) Physical complications of the substances
 - 2) Suicide
 - 3) Accident
 - 4) Overdose of the substances taken.
- 3) Mental disorders can predispose to physical illness due to:
 - 1) Sedentary lifestyle
 - 2) Poor eating habits
 - 3) Substance use
 - 4) Side-effects of treatment

4.6 UNIT END QUESTIONS

- 1) What are the different types of course of chronic mental disorders?
- 2) Describe the course and outcome of schizophrenia.
- 3) How does the course of depressive disorder differ from that of bipolar affective disorder?
- 4) Discuss the course and outcome of various anxiety disorders.
- 5) What are the various factors associated with mortality in mental disorders?

4.7 SUGGESTED READINGS AND REFERENCES

Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR (2000). 4th ed., text revision. Washington, DC: American Psychiatric Association.

Frank E., Prien R.F., Jarrett R.B., Conceptualization and rationale for consensus definitions of terms in major depressive disorder. Remission, recovery, relapse, and recurrence. *Arch Gen Psychiatry*. 1991;48:851-855.

Gelder M.G., López-Ibor J.J. & Andreasen N. (2009). *New Oxford Textbook of Psychiatry*, 2nd ed. Oxford: Oxford University Press.

Rihmer Z. (2007). Suicide risk in mood disorders. *Current Opinion in Psychiatry* 20:17–22.

Riso L.P., Thase M.E., Howland R.H., A prospective test of criteria for response, remission, relapse, recovery, and recurrence in depressed patients treated with cognitive behaviour therapy. *Journal of Affective Disorders*. 1997;43:131-142.

Sadock B.J., Sadock V.A. & Ruiz P. (2009). *Kaplan & Saddock's Comprehensive Textbook of Psychiatry*. 9th ed. Philadelphia: Lippincot Wiliams & Wilkins.

Sadock B.J. & Sadock V.A. (2007). *Kaplan & Saddock's Synopsis of Psychiatry*. Behavioural Sciences/Clinical Psychiatry, 10th ed. . Philadelphia: Lippincot Wiliams & Wilkins.

Saha S., Chant D. & McGrath J (2007). A systematic review of mortality in schizophrenia: Is the differential mortality gap worsening over time? *Arch Gen Psychiatry*. 2007;64(10):1123-1131.

Stein D.J., Hollander E. & Rothbaum B.O. (2009). *Textbook of Anxiety Disorders*, 2nd ed. Washington, DC: American Psychiatric Association.

Van Os J. & Kapur S. (2009). Schizophrenia. *Lancet* 2009; 374: 635–45.

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MENTAL DISORDERS

BLOCK 1 CLASSIFICATION OF MENTAL DISORDERS

- Unit 1 : Classification of Mental Disorders: Need, Historical Perspective and the Modern System of Classification
- Unit 2 : Schizophrenia and Other Psychotic Disorders
- Unit 3 : Mood Disorders
- Unit 4 : Neurotic Group of Disorders
- Unit 5 : Other Disorders which do not Fall in Above Categories of Psychiatric Disorders

BLOCK 2 EPIDEMIOLOGY AND PREVALENCE OF MENTAL DISORDERS

- Unit 1 : Epidemiology: General Concepts, Epidemiological Methods, Epidemiology of Mental Disorders – International
- Unit 2 : Epidemiology of Mental Disorders in India
- Unit 3 : Global Burden of Mental Illness
- Unit 4 : Impact of Mental Disorders on Society

BLOCK 3 CLINICAL MANIFESTATIONS, COURSE AND OUTCOME OF MENTAL DISORDERS

- Unit 1 : Cognitive Disturbances
- Unit 2 : Conative Disturbances
- Unit 3 : Affective Disturbances
- Unit 4 : Course and Outcome of Mental Disorders

BLOCK 4 IDENTIFICATION AND ASSESSMENT OF MENTAL DISORDERS

- Unit 1 : Techniques of Interviewing and Case History Taking
- Unit 2 : Steps in Mental Health Assessment
- Unit 3 : Psychological Assessment
- Unit 4 : Role of Physical Investigation and Assessment in Mental Disorders

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