EDUCATION AND MENTAL HEALTH

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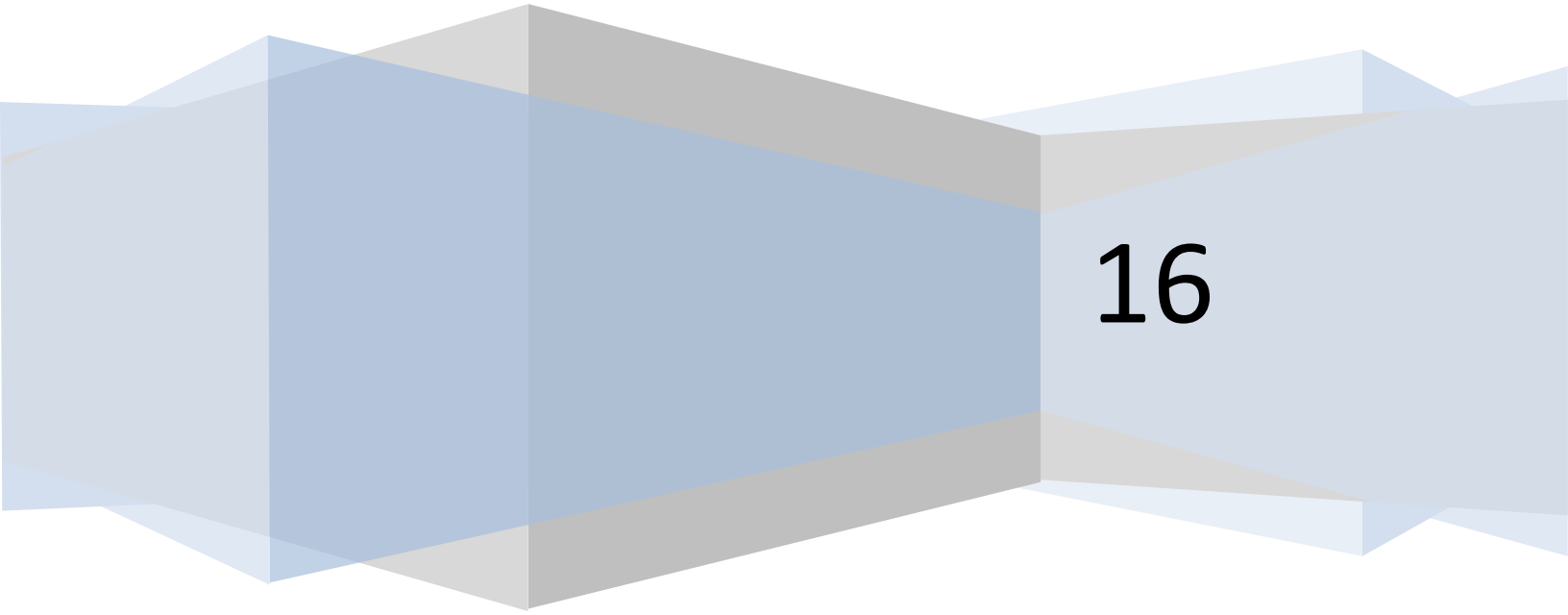
UNIT-III: Mental Illnesses and School Mental health:

Common Psychological disorders related to Anxiety, Mood and Cognition, Psychological disorders in Childhood and Adolescence



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UNIT-III: MENTAL ILLNESSES AND SCHOOL MENTAL HEALTH

3.1 COMMON PSYCHOLOGICAL DISORDERS

3.1.1 ANXIETY DISORDER

Anxiety is heightened fear or tension that causes psychological and physical distress. The American Psychiatric Association recognizes several types of anxiety disorders which can be treated with medications or through counseling. Anxiety is a subjective state of fear, apprehension, or tension. When anxiety occurs without obvious provocation or is excessive however, anxiety may be said to be abnormal or pathological. Normal anxiety is useful because it provides an alerting signal and improves physical and mental performance. Excessive anxiety results deterioration in performance and in emotional and physical discomfort.

There are several forms of pathological anxiety, known collectively as the anxiety disorders. As a group they constitute the fifth most common medical or psychiatric disorder. In the United States 14.6 percent of the population will experience anxiety at some point in their lives. More women suffer from anxiety disorders than do men, by a 2:1 ratio. The anxiety disorders are distinguished from one another by characteristic clusters of symptoms. These disorders include:

- Generalized anxiety disorder(GAD)
- Panic disorder
- Obsessive-compulsive disorder (OCD)
- Phobias
- Adjustment disorder with anxious mood

- Post-traumatic stress disorder (PTSD)

The first three disorders are characterized by anxious feelings that may occur without any obvious provocation, while the latter three are closely associated with anxiety-producing events in a person's life.

- **Generalized Anxiety Disorder (GAD):** GAD is thought to be a biological form of anxiety disorder in which the individual inherits a habitually high level of tension or anxiety that may occur even when no threatening circumstances are present. Generally, these periods of anxiety occur in cycles which may last weeks to years. The prevalence is unknown, but this disorder is not uncommon. The male to female ratio is nearly equal. Benzodiazepine drugs resulting in calming effects on the portion of the brain.
- **Panic Disorder:** is found in 1.5 percent of the United States population, and the female-to-male ratio is 2:1. This disorder usually begins during the young adult years. Panic disorder is characterized by recurrent and unexpected attacks of intense fear or panic. Each discrete episode lasts about five to twenty minutes.

These episodes are intensely frightening to the individual, who is usually convinced he or she is dying. Because people who suffer from panic attacks are often anxious about having another one (so-called secondary anxiety), they may avoid situations in which they fear an attack may occur, in which help would be unavailable, or in which they would be embarrassed if an attack occurred. This avoidance behavior may cause restricted activity and can lead to agoraphobia, the fear of leaving a safe zone in or around the home. Thus, agoraphobia (literally, "fear of the marketplace") is often secondary to panic disorder.

Panic disorder appears to have a biological basis. In those people with panic disorder, panic attacks can often be induced by sodium lactate infusions,

hyperventilation, exercise, or hypocalcemia (low blood calcium). Normal people do not experience panic attacks when these triggers are present. Highly sophisticated scans show abnormal metabolic activity in the right parahippocampal region of the brain of individuals with panic disorder. The parahippocampal region, the area surrounding the hippocampus, is involved in emotions and is connected by fiber tracts to the locus ceruleus, a blue spot in the pons portion of the brain stem that is involved in arousal.

In addition to known biological triggers for panic attacks, emotional or psychological events may also cause an attack. To be diagnosed as having panic disorder, however, a person must experience attacks that arise without any apparent cause.

The secondary anxiety and avoidance behavior often seen in these individuals result in difficulties in normal functioning. There is an increased incidence of suicide attempts in people with panic disorder; up to one in five have reported a suicide attempt at some time. The childhoods of people with panic disorder are characterized by an increased incidence of pathological separation anxiety and/or school phobia.

- **Obsessive-Compulsive Disorder (OCD)**: is an uncommon anxiety disorder with an equal male-to-female ratio. It is characterized by obsessions (intrusive affecting someone or something in an annoying, disturbing and unwanted way , unwelcome thoughts) and compulsions (repetitive, often stereotyped behaviors that are performed to ward off anxiety). The obsessions in OCD are often horrifying to the afflicted person. Common themes concern sex, food, aggression, suicide, bathroom functions, and religion. Compulsive behavior may include checking (such as repeatedly checking to see if the stove is off or the door is locked), cleaning (such as repetitive handwashing or the wearing of gloves to turn a doorknob), or

stereotyped behavior (such as dressing by using an exact series of steps that cannot be altered). Frequently, the compulsive behaviors must be repeated many times.

Sometimes, there is an exact, almost magical number of times the behavior must be done in order to ward off anxiety. Although people with OCD have some conscious control over their compulsions, they are driven to perform them because intense anxiety results if they fail to do so.

The most common psychological theory for OCD was proposed by Sigmund Freud, who believed that OCD symptoms were a defense against unacceptable unconscious wishes. Genetic and brain imaging studies, however, suggest a biological basis for this disorder. Special brain scans have shown increased metabolism in the front portion of the brain in these patients, and it has been theorized that OCD results from an abnormality in a circuit within the brain (the cortical-striatal-thalamic-cortical circuit). Moreover, OCD is associated with a variety of known neurological diseases, including epilepsy, brain trauma, and certain movement disorders.

- **Phobias:** are the most common anxiety disorders. A phobia is an abnormal fear of a particular object or situation. Simple phobias are fears of specific, identifiable triggers such as heights, snakes, flying in an airplane, elevators, or the number thirteen. Social phobia is an exaggerated fear of being in social settings where the phobic person fears he or she will be open to scrutiny by others. This fear may result in phobic avoidance of eating in public, attending church, joining a social club, or participating in other social events. Phobias are more common in men than in women, and they often begin in late childhood or early adolescence.

In classic psychoanalytic theory, phobias were thought to be fears displaced from one object or situation to another. For example, fear of snakes may be a displaced

fear of sex because the snake is a phallic symbol. It was thought that this process of displacement took place unconsciously. Many psychologists now be-lieve that phobias are either exaggerations of normal fears or that they develop accidentally, without any symbolic meaning. For example, fear of elephants may arise if a young boy at a zoo is accidentally separated from his parents. At the same time that he realizes he is alone, he notices the elephants. He may then associate elephants with separation from his parents and fear elephants thereafter.

- **Adjustment disorder with anxious mood:** is an excessive or maladaptive response to a life event in which the individual experiences anxiety. For example, an individual may become so anxious after losing a job that he or she is unable to eat, sleep, or function and begins to entertain the prospect of suicide. While anxiety is to be expected, this person has excessive anxiety (the inability to eat, sleep, or function) and a maladaptive response (the thought of suicide). The exaggerated response may be attributable to the personality traits of the individual. In this example, a dependent person will be more likely to experience an adjustment disorder than a less dependent person.

Adjustment disorders are very common. In addition to adjustment disorders with anxious mood, people may experience adjustment disorders with depressed mood, mixed emotional features, disturbance of conduct, physical complaints, withdrawal, or inhibition in school or at work. These disorders are considered to be primarily psychological.

- **Post-Traumatic Stress Disorder (PTSD)**: is similar to adjustment disorder because it represents a psychological reaction to a significant life event. PTSD only occurs, however, when the precipitating event would be seriously emotionally traumatic to a normal person, such as war, rape, natural disasters such as major

earthquakes, or airplane crashes. In PTSD, the individual suffers from flashbacks to the precipitating event and “relives” the experience. These episodes are not simply vivid remembrances of what happened but a transient sensation of actually being in that circumstance. For example, a Vietnam War veteran may literally jump behind bushes when a car backfires.

People who suffer from PTSD usually are anxious and startle easily. They may be depressed and have disturbed sleep and eating patterns. They often lose normal interest in sex, and nightmares are common. These individuals usually try to avoid situations that remind them of their trauma. Relationships with others are often strained, and the patient is generally pessimistic about the future.

In addition to the anxiety disorders described, abnormal anxiety may be caused by a variety of drugs and medical illnesses. Common drug offenders include caffeine, alcohol, stimulants in cold preparations, nicotine, and many illicit drugs, including cocaine and amphetamines. Medical illnesses that may cause anxiety include thyroid disease, heart failure, cardiac arrhythmias, and schizophrenia

3.1.2 COGNITIVE DISORDERS

Cognitive disorders are on of the category of mental health disorders affect learning, memory, perception, and problem solving, and include amnesia, dementia and delirium. While anxiety disorders, mood disorders and psychotic disorders can also have effect on cognitive and memory functions. The pioneer of the cognitive disorder perspective is Aaron Beck. Another pioneer of cognitive disorder perspective is Albert Ellis. In 1962, Ellis proposed that humans develop irrational beliefs/goals about the world; and therefore, create disorders in cognitive abilities. In 1967, Beck designed what is known as the "cognitive model" for emotional disorders, mainly depression. His model showed that a blending of negative

cognitive functions about the self, the world, and possible selves lead to cognitive mental disorders. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), which describes 250 disorders and their symptoms, cognitive disorders are one of the psychological disorders. The three main areas outlined by the DSM-IV-TR of cognitive disorders are delirium, dementia, and amnesia. There are many sub categories in each of these areas as well

- **DELIRIUM:** Delirium is a state of being unable to think or speak clearly because of mental confusion. DSM-IV includes delirium under cognitive disorders. Delirium is a syndrome, with core features of impairment of consciousness with attentional deficit, other cognitive alterations, and a relatively rapid onset of the disorder with a characteristically fluctuating course. Frequently there are other associated clinical phenomena, which may appear more prominent to the uneducated observer than the core features.

The core features of delirium include altered consciousness, such as decreased level of consciousness; altered attention, which may include diminished ability to focus, sustain, or shift attention; impairment in other realms of cognitive function, which may manifest as disorientation (especially to time and space) and decreased memory; relatively rapid onset (usually hours to days); brief duration (usually days to weeks); and often marked, unpredictable fluctuations in severity and other clinical manifestations during the course of the day, sometimes worse at night (sundowning), which may range from periods of lucidity to quite severe cognitive impairment and disorganization.

Cause: Delirium can be caused by the worsening of previous medical conditions, abuse of medications or drugs, alcohol or drug withdrawals, mental illness, severe pain, immobilization, sleep deprivation and hypnosis.

Treatment: Before delirium treatment, the cause must be established. Medication such as antipsychotics or benzodiazepines can help reduce the symptoms for some cases. For alcohol or malnourished cases, vitamin B supplements are recommended and for extreme cases, life-support can be used.

Haloperidol 0.5 to 1 mg.

- **DEMENTIA:** Dementia (loss of memory) simply means a medical condition that affects especially old people, causing the memory and other mental abilities to gradually become worse, and leading to confused behavior. Dementia is a diminution (reduce) in cognition in the setting of a stable level of consciousness.

Dementia denotes a decrement of two or more intellectual functions, in contrast to focal or specific impairments such as amnestic disorder or aphasia. The persistent and stable nature of the impairment distinguishes dementia from the altered consciousness and fluctuating deficits of delirium. Dementia must also be distinguished from long-standing mental sub-normality, as the former represents an acquired loss of or decline in prior intellectual and functional capacities.

Cause: Dementia can have numerous causes: genetics, brain trauma, stroke, and heart issues. The main causes are diseases such as Alzheimer disease, Parkinson disease, and Huntington disease because they affect or deteriorate brain functions

Diagnosis: The first step in the diagnosis of dementia is to exclude delirium. Delirium can mimic every possible psychiatric disorder and symptom. It is most common in the same populations in which dementia is most common, namely the elderly and the brain-injured. It can be distinguished from dementia by its cardinal feature, disturbance of consciousness. Level of consciousness or arousal must be determined to be stable before a diagnosis of dementia can be made with confidence. FDA approved the cholinesterase inhibitor, donepezil (Aricept), for

symptomatic treatment of mild to moderate cognitive deficits in patients with presumed Alzheimer's disease.

Treatment: For dementia cases, studies suggest that diets with high Omega 3 content, low in saturated fats and sugars, along with regular exercise can increase the level of brain plasticity. Other studies have shown that mental exercise such a newly developed “computerized brain training programs” can also help build and maintain targeted specific areas of the brain. These studies have been very successful for those diagnosed with schizophrenia and can improve fluid intelligence, the ability to adapt and deal with new problems or challenges the first time encountered, and in young people, it can still be effective in later life.

- **AMNESTIC DISORDER:** The essential feature of Amnestic disorders is the acquired impaired ability to learn and recall new information, coupled variably with the inability to recall previously learned knowledge or past events. The impairment must be sufficiently severe to compromise personal, social, or occupational functioning. The diagnosis is not made if the memory impairment exists in the context of reduced ability to maintain and shift attention, as encountered in delirium, or in association with significant functional problems due to the compromise of multiple intellectual abilities, as seen in dementia. Amnestic disorders are secondary syndromes caused by systemic medical or primary cerebral diseases, substance use disorders, or medication adverse effects, as evidenced by findings from clinical history, physical examination, or laboratory examination.

Amnesia patients have trouble retaining long term memories. Difficulty creating recent term loss of memories is called anterograde amnesia and is caused by damage to the hippocampus part of the brain which is a major part of the memory process. Retrograde amnesia is also caused by damage to the hippocampus but the

memories that were encoded or in the process of being encoded in long term memory are erased.

Causes: Amnesia can be caused by concussions, traumatic brain injuries, post-traumatic stress, and alcoholism. Many problems are caused by damage to major memory encoding parts of the brain such as the hippocampus

Treatment: Amnesia is very difficult to treat. If it is caused by an underlying cause such as Alzheimer's disease or infections, the cause may be treated but the amnesia may not be. If caused by dissociative or anxiety disorders, amnesia can be treated by psychotherapy, tranquilizers, and other medications.

A **manic episode** is not a disorder in and of itself, but rather is a part of a type of bipolar disorder. A **manic episode** is characterized by period of at least 1 week where an elevated, expansive or unusually irritable mood, as well as notably persistent goal-directed activity is present

3.1.3 MOOD DISORDERS

Mood is defined as one's general emotional feeling over a period of time. This feeling may vary over this time period, although mood fluctuations are normal for everyone. Mood disorder was called Affective Disorder in the past. The easiest way to understand affect is to look at the individual's facial expressions and reactions and to define them behaviorally. Thus, a mood disorder can be diagnosed when the individual's moods shift more dramatically, more frequently, or last longer. The DSM- IV- TR (APA, 2000) has two classifications of Mood Disorders.

The first subcategory is Depressive Disorders, in which the individual has persistent sadness and finds little or no enjoyment in life and in things that led to enjoyment in the past (this last aspect is known as anhedonia). These individuals also lack energy, in some cases so severe that they find it difficult to leave the

house or to even get out of bed. Depressive Disorders are also known as unipolar depressions, meaning that these types of disorders have no evidence of mania **(**extreme physical and mental state**)** or manic states and only have periods of depression. The opposite of depression is mania, which is characterized by extreme energy, elevated mood, euphoria, irritability, little need for sleep, and flight of ideas. The Bipolar Disorders are the second subtype. These disorders are characterized by mood swings, or shifts, between mania and depression. Bipolar Disorder is commonly known as manic depressive illness or manic depressive psychosis, but these terms are not clinically correct. The latter term may be considered pejorative.

Depressive Disorder

- **Major Depressive Disorder**
- **Dysthymic Disorder**

Bipolar Disorder

- **Bipolar I Disorder,**
- **Bipolar II Disorder, and**
- **Cyclothymic Disorder**

Major Depressive Disorder

Major depressive disorder is characterized by feelings and behaviors that many people experience at times—sadness, guilt, fatigue, loss of appetite—but it is distinguished by their persistence and severity. Major depression may be accompanied by feelings of inadequacy and worthless-ness, weight loss or gain, sleepdisturbances, difficulty concentrating and making decisions, and, in the most se-vere cases, delusions and suicidal impulses.

Dysthymia Disorder

Dysthymia is another chronic mood disorder affecting approximately 2 to 4 percent of the population. Dysthymia is characterized by at least a two-year history of depressed mood and at least two of the following symptoms: poor appetite, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or decision making, or feelings of hopelessness

Bipolar I Disorder

Bipolar I disorder is characterized by one or more manic episodes along with persisting symptoms of depression. A manic episode is defined as a distinct period of abnormally and persistently Many of the psychosocial stressors associated with old age, such as the deaths of loved ones andchronic illnesses, are common causes of clinical depression.(PhotoDisc)Psychology and Mental Health Depression elevated, expansive, or irritable mood. Three of the following symptoms must occur during the period of mood disturbance: inflated self-esteem, decreased need for sleep, unusual talkativeness or pressure to keep talking, racing thoughts, distractibility, excessive goal-oriented activities (especially in work, school, or social areas), and reckless activities with a high potential for negative consequences (such as buying sprees or risky business ventures)

Bipolar II Disorder

Bipolar II disorder is characterized by a history of a major depressive episode and current symptoms of mania

Treatment

There are different types of treatments available for mood disorders, such as therapy and medications. Behaviour therapy, cognitive behaviour therapy and interpersonal therapy have all shown to potentially beneficial in depression. Major depressive disorder medications usually include antidepressants, while bipolar disorder medications can consist of antipsychotics, mood stabilizers and/or lithium

Mood disorder is a group of diagnoses in the DSM-IV-TR

Where a disturbance in the person's mood is hypothesized to be the main underlying feature.

The classification is known as affective disorders in International Classification of Diseases (ICD).

The term “affect” refers to one’s mood or “spirits”. “Affective Disorder” refers to changes in mood that occur during an episode of illness marked by extreme sadness (depression) or excitement (mania) or both. “Mania” describes periods of abnormal elation (a state of extreme happiness or excitement) and increased activity, while “depression” describes an abnormal degree of sadness and melancholy.

English psychiatrist Henry Maudsley proposed an important category of affective disorder.[2] The term was then replaced by mood disorder, as the latter term refers to the underlying or longitudinal emotional state,[3] whereas the former refers to the external expression observed by others.

Mood disorders fall into the basic groups of elevated mood such as mania or hypomania, depressed mood of which the best-known and most researched is major depressive disorder (MDD) (commonly called clinical depression, unipolar depression, or major depression), and moods which cycle between mania and depression known as bipolar disorder (BD) (formerly known as manic depression). There are several sub-types of depressive disorders or psychiatric syndromes featuring less severe symptoms such as dysthymic disorder (similar to but milder than MDD) and cyclothymic disorder (similar to but milder than BD). Mood disorders may also be substance-induced or occur in response to a medical condition.

Major depressive disorder (MDD), commonly called major depression, unipolar depression, or clinical depression, wherein a person has one or more major depressive episodes. After a single episode, Major Depressive Disorder (single episode) would be diagnosed. After more than one episode, the diagnosis becomes Major Depressive Disorder (Recurrent). Depression without periods of mania is sometimes referred to as unipolar depression because the mood remains at the bottom "pole" and does not climb to the higher, manic "pole" as in bipolar disorder

Individuals with a major depressive episode or major depressive disorder are at increased risk for suicide. Seeking help and treatment from a health professional dramatically reduces the individual's risk for suicide. Studies have demonstrated that asking if a depressed friend or family member has thought of committing suicide is an effective way of identifying those at risk, and it does not "plant" the idea or increase an individual's risk for suicide in any way.[6] Epidemiological studies carried out in Europe suggest that, at this moment, roughly 8.5 percent of the world's population are suffering from a depressive disorder. No age group seems to be exempt from depression, and studies have found that depression

appears in infants as young as 6 months old who have been separated from their mothers

Depressive disorder is frequent in primary care and general hospital practice but is often undetected. Unrecognized depressive disorder may slow recovery and worsen prognosis in physical illness, therefore it is important that all doctors be able to recognize the condition, treat the less severe cases, and identify those requiring specialist care.

Mania: When people are in a manic “high,” they may be overactive, overly talkative, have a great deal of energy, and need less sleep than normal.

There are two different types of mood disorders, both of which are cyclical. One is unipolar disorder, in which the cycle is that a person feels normal and then feels depressed. The other type is bipolar disorder, in which the person’s mood cycles from depressed to normal to manic.