BLOCK 3
DISORDERS OF PERSONALITY, PARAPHILIC AND SUBSTANCE-RELATED DISORDERS

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UNIT 8 PERSONALITY DISORDERS-CLUSTER A*

Structure

Learning Objectives

After reading this Unit, you will be able to:

- Explain the characteristics and classification of personality disorders;
- Examine the difficulties in diagnosing and difficulties in studying the causes personality disorder;
- Identify the clinical causes, and treatment of paranoid personality disorder;
- Describe the causal factors and treatment of schizoid personality disorder; and
- Explain the causal factors and treatment of schizotypal personality disorder.

8.0 INTRODUCTION

So far, you have learnt the defining criteria of psychological disorders according to DSM-5 classification. Moving further, you learnt about the clinical aspects of anxiety disorders, psychotic disorders, somatic symptoms disorder, mood disorders and eating disorders. There causal factors and treatment methods were also discussed. It must be clear by now, that the mentioned disorders are not a part of an individual's basic personality structure. This means that after treatment, the person can return to her/his day-today functioning. On the other hand, personality disorders are different. Personality disorders are related to one's

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personality structure. 'Personality disorder' is the 'normal' way of functioning by the person. Personality disorders are classified into Cluster A, B, and C. In this Unit, you will learn about Cluster A personality disorders, that includes paranoid personality disorder, schizoid personality disorder and schizotypal disorder. Their causal factors and treatment will also be discussed. Cluster B and C personality disorders will be explained in the subsequent Unit.

8.1 DEFINING PERSONALITY DISORDERS

Personality of an individual can be understood as a set of unique traits and behaviors that describe and characterise the individual. These typical traits, coping styles and behaviors usually emerge during childhood and then become established patterns by early adulthood. These characteristics or blend of characteristics make a person unique (Weinberg & Gould, 1999). The continuity, constancy, consistency and stability of these traits and dispositions over time define personality development (Larsen & Buss, 2008). It has also been agreed upon that the five trait dimensions: neuroticism, extraversion/introversion, agreeableness/antagonism, openness to experiences and conscientiousness (John & Naumann, 2008; McCrae & Costa, 2008) can be used to define personality.

The personality disorders are a heterogeneous group of disorders. They are usually characterised by problems in forming a stable positive sense of self and sustaining close and constructive relationships. According to DSM-5, a person is to be diagnosed with personality disorder if there is significant impairment in self (identity or self-direction) and interpersonal (intimacy or empathy) functioning. The person's enduring pattern of behavior must not be flexible and should be pervasive, stable and longer in duration that deviates from the individual's cultural expectations. It should cause clinically significant distress or impairment in functioning in various areas of life and should be manifested in at least two of the areas: cognition (ways of perceiving self, others and events), affectivity (range, intensity and appropriateness of emotional response), interpersonal functioning or impulse control.

It has been understood and agreed upon that people with personality disorders cause difficulty in their own lives as well as that of the others. Others usually find their behavior confusing, unpredictable, vexing and also unacceptable at times. The pattern that they have developed over time color their perception totally thus determining their reactions to newer events and situations in the same light, repeating their maladaptive patterns over and over again.

The category of personality disorders encompasses a broad range of behavioral problems which may differ in their form and severity. DSM-5 categorizes them into three clusters on the basis of important similarities amongst the disorders.

Cluster A: It includes paranoid, schizoid and schizotypal personality disorders. These disorders involve thinking and behavior which appears unusual, odd and eccentric to other people and may often lead to various social problems. It may range from distrust to suspiciousness and even social detachment.

Cluster B: It includes histrionic, narcissistic, borderline and antisocial personality disorder.These disorders involve tendency of the individual (diagnosed with it) to be dramatic, erratic, unpredictable and also emotional.

Cluster C: It includes obsessive compulsive, avoidant, and dependent personality disorders. These disorders involve tendencies to be anxious and fearful.

Often people are diagnosed with more than one personality disorders and as per research, disorders in the same cluster tend to co-occur (Lenzenweger, Lane, Loranger, and Kessler, 2007). Personality disorders first appeared in DSM III on Axis II in 1980. Axis II, since then (till DSM-IV-TR) has been used to assess disorders (personality disorder and intellectual disabilities) that are usually long-standing or life-long problems that first arise or encountered in childhood and are different from Axis I difficulties (the standard psychiatric syndromes which were coded on Axis I). But people can have disorders of Axis I which are symptomatic of Axis II disorders. For example, a person may have depression (Axis I) which could be a result of dependent personality disorder. The use of clusters has been a part of personality disorder since then and has also been questioned a lot for its validity. Due to various overlaps across categories and clusters (Krueger & Eaton, 2010; Sheets & Craighead, 2007) it was proposed to remove the cluster organization from DSM-5. But, they have been used as an organizing rubric providing a lot of convenience in understanding them and thus has been discussed as clusters here despite the fact that axial system has been abandoned by DSM-5. So, now, personality disorders are included with rest of the disorders.

The epidemiological studies to understand the prevalence of personality disorders have been very few especially in comparison to other disorders but whatever few exist have differing conclusions (Lenzenweger, 2008). Prevalence for one or more personality disorders have ranged from 4.4 to 14.8 percent (Grant, Stinson, Dawson, Chou, and Ruan, 2005; Paris, 2010). The difference and discrepancy could be due to problems in diagnostic criteria and its clarity.

Box 8.1: Difficulties in Diagnosing Personality Disorder

- Diagnostic criteria for personality disorders is neither sharply nor clearly defined as they are for other diagnostic categories. A lot of judgment is required on the part of the clinician as the criteria for personality disorders is defined mainly by inferred traits (Samuel and Widiger, 2008) or consistent patterns of behavior rather than objective behavioral standards.
- Some of the personality diagnoses are not very common in the community setting or even most clinical settings, they are found in less than even 2 percent of the patients (Zimmerman, Rothschild, & Chelminski, 2005).
- Many people who may seem to have some personality related issue may not fit any of the personality disorder categorization or diagnosis in particular, thus, the dimensional approach is the best suited here.
- Research suggests that people diagnosed with personality disorders at one point in time when interviewed after 2 years qualified for another diagnosis, though they may have some of the symptoms of the previous diagnosis (McGlashan, Grilo, Sanislow, Ralevski, et al., 2005).
- Diagnosis made on the basis of structured interviews or self-report inventories have been found to be low on reliability and validity (Trull & Durrett, 2005). A unified dimensional classification has been emerging and attempt has been made to integrate various existing approaches in

order to make the diagnosis more reliable and accurate (Krueger, Eaton, Clark, 2011). The most influential of them being the five factor model based on five basic personality traits. Within the dimensional approach, an attempt was made to recast the personality traits to correspond to the pathological extremes: negative affectivity (neuroticism), detachment (extreme introversion), antagonism (very low agreeableness), disinhibition (very low conscientiousness). Psychoticism was not found to be the pathological extreme of openness rather it reflected traits similar to psychotic disorders (schizotypy) (Watson, Clark & Chmelewski, 2008).

Box 8.2: Difficulties in Studying the Causes of Personality Disorder

- Personality disorders did not receive any formal attention till they were added in DSM III in 1980. Thus, the work itself began later in comparison to other disorders.
- A major issue is that a high level of comorbidity is found among them. Zimmerman and his colleagues (2005) reported that almost 45 percent of the 900 patients (their sample) qualified for at least one personality disorder and out of these (45 percent), almost 60 percent qualified for more than one and 25 percent qualified for two or more personality disorders based on the given clinical criteria. Due to the high levels of comorbidity it gets difficult to conclude which causal factors are associated with which particular personality disorder.
- Researchers were found to have more faith in the prospective studies (people are observed before a disorder occurs and are followed to see who develops what problem and what could be the possible reasons behind it). However, a vast majority of research is conducted on people who already have the disorder, so understanding is based on either the retrospective recalls or current observation of biological, emotional, cognitive and interpersonal functioning. Thus, the conclusions could be very preliminary and tentative.
- Infants' temperament may predispose them to development of a particular trait and thus a disorder in consequence (Paris, 2012). It lays foundation for development of personality as an adult but other factors may also be responsible for it. For most disorders, it has been found that "the genetic contribution is mediated by genetic contribution to primary trait dimension most implicated in each disorder rather than to the disorders themselves" (Livesley, 2005; Kendler et al. 2008 as cited in Butcher, Hooley, Mineka, 2013). Researches are being attempted to understand the psychobiological layer of the traits mainly seen to be involved in personality disorders (Depue, 2009; Paris, 2005, 2007; Roussos & Siever, 2012).
- With the ultimate goals of reaching an enriched biopsychosocial understanding, apart from these biological causes, psychoanalytic, learning based models, cognitive patterns, attachment styles, social patterns, cultural values etc. have also contributed to the understanding.

Check You Progress 1

1) Define personality disorders.

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2) List the clusters of personality disorders.

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3) Name the personality disorders included in Cluster A.

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8.2 CLUSTER A PERSONALITY DISORDERS

The main symptoms of Cluster A are social awkwardness and social withdrawal, dominated by distorted thinking patterns. It is also known as the odd, eccentric cluster. People falling in this cluster may display unusual behavior, for instance, suspiciousness and distrust as well. In cluster A, we will discuss, Paranoid, Schizoid and Schizotypal personality disorders here.

8.3 PARANOID PERSONALITY DISORDER

Being wary of people, questioning their motives is not very uncommon and can also be adaptive. But, being too distrustful and questioning anyone and everyone each moment can impact relationships. It can interfere working with others or in groups, with making friends and many other aspects of life which involve interaction with people on a daily basis. They usually assume that people out there (in the world) are to harm or trick them and thus they do not confide in them. The defining feature of this disorder is the persistent unjustified distrust (Edens, Marcus, & Morey, 2009). People with paranoid personality disorder usually get suspicious even in the situations where most people would find their suspicions to be unfounded. They may interpret the events unrelated to them or remotely related to them as personal attacks on them (Bernstein & Useda, 2007). This makes their interpersonal relationships very difficult and strained as this distrust often extends even to the close family members. They see themselves as completely blameless, instead they put the blame on other people guilty even for their own mistakes and failures. Thus, they may always look "on guard" and expect trickery from others which forces them to look for cues to validate their false expectations.

They are usually argumentative, may complain or may remain quiet but are commonly seen to bear grudges, refuse to forgive insults (that they may have perceived) and may also get violent (Bernstein & Useda, 2007; Edens et al.,

2009; Falkum et al., 2009). They are in touch with reality, although may experience certain transient psychotic symptoms during stress. Also, they are more likely and liable for schizophrenia (Lenzenweger, 2009).

Box 8.3: DSM-5 Criteria for Paranoid Personality Disorder (APA, 2013)

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

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

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

   Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," i.e., "paranoid personality disorder (premorbid)."

8.3.1 Causal Factors

The evidence of biological contribution to paranoid personality disorder is very limited. Arguments have been made about the partial genetic transmission linking it to schizophrenia but there are no conclusive or consistent researches pointing at the same (Kendler, Czajkowski, Tambs, Torgersen, Aggen, Neale, & Reichborn 2006). Researches have also suggested that this disorder is slightly more common amongst the relatives of people with schizophrenia (Tienari et al. 2003), although the associations are not very strong.It may also occur through the heritability of high levels of neuroticism or even antagonism (traits in paranoid personality disorder) (Hopwood & Thomas, 2012; Kendler et al., 2006).

As far as psychological contributions are concerned, retrospective researches suggest that mistreatment or/and traumatic childhood could play a role in development of paranoid personality (Natsuaki, Cicchetti & Rogosch, 2009). Parental neglect, abuse and exposure to violence could also be responsible.

Freeman and colleagues (1990) discussed some basic faulty and maladaptive assumptions these people may have about others, "People are malevolent and deceptive," "They'll attack you if they get the chance". Some researchers have pointed that these assumptions are build due to their early upbringing as they are asked to be careful, vigilant and on their toes all the time (Carroll, 2009).

Certain cultural factors have also found to be playing role in paranoid personality disorder. Groups of people, such as refugees, prisoners, older adults are considered to be susceptible to this disorder due to their unique experiences (Rogler, 2007). Cognitive factors may also interact with cultural factors, for instance a refugee with language barrier who is looked at differently by others may always be suspicious and wary of people around them.

8.3.2 Treatment

One of the major impediments in their treatment is their distrustful relationship due to which they are unlikely to develop a warm, trusting and meaningful relationship with their therapist (Skodol & Gunderson, 2008). If they go and seek treatment it is usually due to some other problem they might be facing like depression or some sort of anxiety. It is rarely due to their personality issues that they would seek treatment themselves. Cognitive therapy is widely used to challenge and counter their faulty thinking patterns with an emphasis on changing the belief that most people cannot be trusted and most people are there to harm them (Skodol & Gunderson, 2008). Still, there are no confirmed demonstrations that any form of treatment could significantly improve the lives of people with paranoid personality disorder.

8.4 SCHIZOID PERSONALITY DISORDER

The term schizoid was used by Bleuler (1924) in order to describe people who had a tendency to turn away from the outside world. People with schizoid personality disorder demonstrate a pervasive pattern of social detachment and an extremely restricted range of emotional expression and thus remain socially isolated. They do not usually seek out for relationships on their own, and are most often cold, aloof, and indifferent to people around them.

People with schizoid personality disorder are not interested in maintaining close relationships with others, neither romantic nor sexual relationships. Thus, they appear to be cold, distanced and detached people who are neither affected by praise nor by criticism. Homelessness also appears to be common in these people (Rouff, 2000). The social deficiencies found in people with schizoid personality disorder are more extreme as compared to individuals having paranoid personality disorder. "They consider themselves to be observers rather than participants in the word around them." (Freeman, Pretzer, Fleming, & Simon, 1990, p.125). They appear to be socially inept and superficial due to their indifference towards social cues and nuance and are often classified as loners and introverts. Here, it is very important to mention and emphasize that all loners or introverts are not people with schizoid personality (Bernstein et al., 2009). As they are not emotionally reactive, they rarely experience strong emotions (positive or negative), rather they show apathetic mood.

On the five factor model, they show high levels of introversion (being low on warmth, positive emotions and gregariousness), low levels of openness to feelings (Widiger, Trull et al., 2002) and are also found to be low achievement striving as well (Hopwood & Thomas, 2012). Like the other two disorders of Cluster A, the thought process of individuals with paranoid personality disorder is not that unusual (Cloninger & Svakic, 2009).

Table 8.1: Grouping Schema for Cluster A Disorders

Psychotic like symptoms		
Cluster A Personality Disorder	**Positive** (example: ideas of reference, magical thinking, perceptual distortion)	**Negative** (example: Poor rapport, social isolation and constricted affect)
Paranoid	Yes	Yes
Schizoid	No	Yes
Schizotypal	Yes	No

Source: Adapted from Siever, L.J. (1992). Schizophrenia spectrum personality disorder. As cited in Barlow, D. H., & Durand, V.M. (2012). *Abnormal Psychology: An integrative approach.* (6th ed.)

8.4.1 Causal Factors

Extensive research is yet to be conducted to understand the genetic, biological and/or psychosocial causal factors to schizoid personality disorder (Phillips, Yen & Gunderson, 2003). Some theorists and researchers are of an opinion that the disruption in sociability could be due to some sort of impairment in the affiliative system (Depue & Lenzenweger, 2005). Childhood shyness may also act as a predispositional factor to schizoid personality disorder later as an adult. Childhood abuse and neglect have also been reported in the retrospective studies among the individuals with this disorder (Johnson, Bromley, & McGeoch, 2005). Some researchers have also indicated that parents of children with autism are likely to have this disorder (Constantino et al., 2009). There is a possibility and a particular biological dysfunction may play a role in both autism and schizoid personality disorder and that gets combined with some early difficulties like aspects of interpersonal relationships which impact the social interaction of the individual.

Cognitive theorists have suggested that the maladaptive schemas of these individuals lead them to be self-sufficient loners and look at others as intrusive people. Their core dysfunctional belief might be, "I am basically alone" (Beck et al., 1990, p. 51). The reasons behind development of such defeating and faulty schemas are not yet fully researched upon.

Box 8.4: DSM 5 Criteria for Schizoid Personality Disorder (APA, 2013)

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

   1) Neither desires nor enjoys close relationships, including being part of a family.

2) Almost always chooses solitary activities.

3) Has little, if any, interest in having sexual experiences with another person.

4) Takes pleasure in few, if any, activities.

5) Lacks close friends or confidants other than first-degree relatives.

6) Appears indifferent to the praise or criticism of others.

7) Shows emotional coldness, detachment, or flattened affectivity.

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," i.e., "schizoid personality disorder (premorbid)."

8.4.2 Treatment

Usually people with schizoid personality disorder rarely come for treatment unless it is a response to some crisis such as losing a job or some other extreme issue (Kelly et al., 2007). Therapy usually starts with making them understand value in social relationships and may also be taught about empathy and understanding others (Skodol & Gunderon, 2008). Thus, they may receive training in social skills development. They are taught to identify a social network-a person or those who would be supportive to them (Bender, 2005).

Check Your Progress 2

1) According to DSM-5, list the criteria for schizoid personality disorder.

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2) Briefly explain the psychological causes of paranoid personality disorder.

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8.5 SCHIZOTYPAL PERSONALITY DISORDER

Schizotypal personality disorder is characterized by excessive introversion, along with social and interpersonal difficulties. They tend to have perceptual and cognitive distortions, suspicious (Cloninger & Svakic, 2009) and odd behavior (Kwapil & Barrantes-Vidal, 2012). Their contact with reality is usually intact but under extreme stress they may also experience certain transient psychotic symptoms (APA, 2013).

Schizotypal personality disorder is on a continuum with schizophrenia, but here there is absence of certain symptoms such as hallucinations and delusions. They often come as bizarre to others due to their odd ways of dressing, relating to others and the way they think and behave. They may have ideas of reference and yet may be able to acknowledge the unlikeliness of it. People with schizophrenia too have ideas reference but they can not test reality unlike individuals with schizotypal personality disorder. They may believe in magical thinking or believe that they have magical powers like being a clairvoyant. They may even report unusual perceptual experiences but do not have extreme perceptual distortions like people with schizophrenia. Schizotypal personality disorder has been understood as an attenuated form of schizophrenia (Lenzenwerger, 2010). Bizarreness and oddities in thinking, speech and other behaviors are the characteristic features of schizotypal personality disorder (McGlashan et al., 2005).

Some aspects of scizotypy such as introversion and neuroticism can be explained through the five factor model of personality, however the aspects related to cognitive and perceptual distortions can not be explained through the model (Watson, Clark, Chmielewski, 2008); especially, unusual beliefs and experiences, eccentricity and cognitive and perceptual dysregulation (Krueger, Eaton, Derringer, Markson, Watson, & Skodol, 2011). It is important for mental health professionals to practice caution especially when dealing with certain cultural practices which may differ from their own and thus may look distorted or may look like an odd behavior before giving a final diagnosis.

Box 8.3: DSM- 5 Criteria for Schizotypal Personality Disorder (APA, 2013)

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

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

B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.

Note: If criteria are met prior to the onset of schizophrenia, add "premorbid," e.g., "schizotypal personality disorder (premorbid)."

8.5.1 Causal Factors

A review of studies has suggested that the prevalence of schizotypal personality disorder in the general population is about 2 to 3 percent (Raine, 2006) with a moderate heritability (Kwapil & Barrantes-Vidal, 2012). A genetic relationship of schizotypal personality disorder has long been suspected with schizophrenia. It has been found that it is a part of the spectrum of liability for schizophrenia that occurs in first degree relatives of people having schizophrenia (Kwapil & Barrantes-Vidal, 2012; Raine, 2006). Teenagers with schizotypal personality disorder are at high risk of developing schizophrenia and/or schizophrenia-spectrum disorders. The biological association between the two disorders has been understood by various studies and researches. Both have been found to have a deficit in the ability to visually track a moving target (Coccaro, 2001); deficits in ability to sustain attention (Raine, 2006); deficits in working memory (Farmer, O'Donnell, Niznikiewicz, Voglmaier, McCarley, & Shenton, 2000) and language abnormalities which could be related to abnormalities in their auditory processing (Dickey, Morocz, Niznikiewicz, Voglmaier, Tone, Khan et al. 2008).

Another aspect to that has been proposed is that there is a second subtype which is not genetically linked to schizophrenia and is characterized by cognitive and perceptual deficits. It might be linked to history of early childhood trauma and abuse (Raine, 2006). Low family socioeconomic background and exposure to stressful events could also be the contributors (Tessner, Mittal, & Walker, 2011).

8.5.2 Treatment

It has been estimated that almost 30-50 percent of the people with schizotypal personality also meet the diagnostic criteria for major depression. Thus, their treatment also involves the ones given to people with major depression. The interest is slowly increasing in looking for treatment methods and strategies for schizotypal personality gradually as it is also viewed as a precursor to schizophrenia. Some studies have used antipsychotic medication, community treatment and social skills training as a combination to treat people with this disorder. And, it has been found that using this approach has either reduced the symptoms or has delayed the onset of later schizophrenia (Nordentoft et al., 2006).

Check Your Progress 3

1) List the main characteristics of schizotypal personality disorder.

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2) Suggest treatment options for schizotypal personality disorder.

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8.6 SUMMARY

Now that we have come to the end of this unit, let us list all the major points that we have already learnt.

- Personality disorders indicate an inflexible and distorted behavioral pattern resulting in maladaptive ways of perceiving, thinking and relating to others and their environment.
- DSM has categorized personality disorders into three clusters and the validity of this categorization has been questioned. DSM-5 has not used this categorization but this has been used due to commonalities shared by disorders categorized under each cluster.
- Cluster A includes Paranoid, Schizoid, and Schizotypal personality disorders. The characteristic features of this disorder are eccentricities or oddities. Genetic and biological causes are implicated in Schizotypal personality disorder, but the research around causes of paranoid and schizoid disorders is relatively less.
- Cluster B includes histrionic, narcissistic, antisocial and borderline personality disorders. People falling in this cluster are found to be emotional, erratic and dramatic. Research in the area of histrionic and narcissistic personality is very scant but certain biological and psychosocial factors have been researched upon to understand the causality of borderline and antisocial personalities.
- Cluster C comprises of avoidant, dependent and obsessive-compulsive personality disorders. This cluster characterises fearfulness, tension, shyness and anxiety-based symptoms. Inhibited temperament may increase the risk for avoidant personality and those high on traits such as neuroticism and agreeableness may increase risk for dependent personality disorder especially when faced with authoritarian and overprotective parenting styles.

8.7 KEYWORDS

Personality: A set of unique traits and behaviors that describe and characterise the individual.

Personality disorder Any significant impairment in self (identity or self-direction) and interpersonal (intimacy or empathy) functioning.

Cluster A: Disorders involve thinking and behavior which appears unusual, odd and eccentric to other people and may often lead to various social problems. It may range from distrust to suspiciousness and even social detachment.

Cluster B: Disorders involve tendency of the individual (diagnosed with it) to be dramatic, erratic, unpredictable and also emotional.

Cluster C: Disorders involve tendencies to be anxious and fearful.

8.8 REVIEW QUESTIONS

1) Groups of people, such as refugees, prisoners, older adults are considered to be susceptible to _____ disorder.
2) Cluster A personality disorders include _____.
3) _____is characterised by excessive introversion, along with social and interpersonal difficulties.
4) Personality disorders first appeared in DSM III on _____ in 1980.
5) A genetic relationship of schizotypal personality disorder has long been suspected with. _____.
6) Define personality disorders. What are the general DSM criteria for diagnosing personality disorder?
7) Mention the difficulties in diagnosing personality disorder.
8) What are the issues in understanding the causes of personality disorder?
9) Mention the characteristics of the three clusters of the personality disorders.
10) Differentiate amongst the disorders of Cluster A.
11) Elucidate the treatment measures of paranoid personality disorder.

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8.10 WEB RESOURCES

- For personality disorders, watch 'Personality Disorder in DSM-5' by Andrew Skodol (Karolinska Institute)

  https: //www.youtube.com/watch?v=4mgifm3ftl8.

Answer Fill in the Blanks (1-5).

1) paranoid personality disorder
2) paranoid, schizoid and schizotypal personality disorders
3) Schizotypal personality disorder
4) Axis II
5) schizophrenia.

UNIT 9 PERSONALITY DISORDERS: CLUSTER B AND CLUSTER C*

Structure

Learning Objectives

After reading this Unit, you will be able to:

- Explain the characteristics of Cluster B;
- Identify the characteristics of Cluster C personality disorders;
- Discuss the clinical causes, and treatment of histrionic, narcissistic, antisocial and borderline personality disorders; and

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- Describe the clinical features, causal factors and treatment of avoidant, dependent and obsessive-compulsive personality disorders.

9.0 INTRODUCTION

Personality disorders are related to one's personality structure and is the 'normal' way of functioning by the person. Personality disorders are classified into Cluster A, Cluster B, and Cluster C. In the previous Unit, you learnt about Cluster A personality disorders, that included paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder. Their causal factors and treatment were also be discussed. In this Unit, the clinical features, causal factors and treatment of Cluster B and Cluster C personality disorders will be explained.

9.1 CLUSTER B PERSONALITY DISORDERS

The prevailing symptoms of Cluster B are being dramatic, erratic or emotional. We will discuss histrionic, narcissistic, antisocial and borderline personality disorders in this section.

9.1.1 Histrionic Personality Disorder

Histrionic personality disorder is characterised by exaggerated expression of emotions such as hugging someone fiercely they have just met or crying uncontrollably during a sad movie (Skodol & Gunderson, 2008). Another characteristic feature of this disorder is excessive attention-seeking behavior. Their lively, charming, dramatic and extraverted behavior usually makes them center of attention and they may feel unappreciated if they are not being attended to by people. But, soon people around them get tired of this level of attention they seek for constantly which usually results in unstable and unsatisfying relationships. Their appearance and behavior are usually found to be very dramatic, theatrical and at times sexually provocative as well (Freeman, Freeman & Rosenfield, 2005). They also tend to be vain, uncomfortable and self-centered when not in limelight and very much concerned about their looks. They can also be impulsive and can have difficulty in delaying gratification. Speech is often very vague, lacking details and also impressionistic with a major concern of approval from others. Their cognitive style could be characterized by a tendency to view situations in an absolutistic manner (black and white) (Beck, Freeman, & Davis, 2007).

The prevalence of histrionic personality disorder in the general population has been estimated to be around 2 to 3 percent (Blashfield, Reynolds, & Stennett, 2012) and some studies also suggest of its prevalence more in women as compared to men (Lynam & Widiger, 2007). The reasons provided behind this gender difference has been very controversial as it is suggested that the criteria for histrionic personality disorder encompasses maladaptive variants of female-related traits mainly such as seductiveness, vanity, overdramatization and too much concern with one's physical appearance (Widiger & Bornstein, 2001). However, there are certain characteristic traits of this disorder which are more commonly found in men such as excitement seeking behavior or low consciousness. Some recent researches have pointed towards the influence of some form of bias on the basis of gender in the diagnosis of histrionic personality disorder (Lynam & Widiger, 2007).

Box 9.1: DSM 5 Criteria for Histrionic Personality Disorder (APA, 2013)

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

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

9.1.1.1 Causal Factors

Despite its long history, very little research has been conducted to understand the causality behind histrionic personality disorder. It could be perhaps due to the difficulty faced by the researchers in differentiating it from other personality disorders (Bornstein & Malka, 2009). Some researchers have also pointed towards its diagnosis as invalid and referring it as being "dead" (Blashfield et al., 2012). Thus, it was recommended to be removed from DSM-5.

One hypothesis points out a genetic link with antisocial personality disorder. Lilienfield and colleagues (1986), found that almost two-thirds of people with histrionic personality also met the criteria for antisocial personality disorder. Thus, the idea has been proposed that there might be some common underlying predisposition between the two or they may be the sex-typed alternative expressions of the same condition- expressed as predominantly histrionic personality in women and antisocial personality in men (Cale & Lilienfield, 2002a, 2002b). However, this idea still remains controversial and requires much research further.

Histrionic personality disorder may also be characterized by extreme versions of two common personality traits- extraversion and, to a lesser extent, neuroticism (these two have partial genetic basis) (Widiger & Bornstein, 2001). People with high levels of extraversion of patients with histrionic personality are found to be high on gregariousness, openness to fantasies and excitement seeking. Their high levels of neuroticism may be involved in depression and self-consciousness aspects. Maladaptive schemas especially about the need for attention and to validate their self-worth might also be responsible for the disorder. Their core dysfunctional beliefs may include, "If I can't entertain people, they'll abandon me." (Beck et al., 1990, p.50).

9.1.1.2 Treatment

Therapists have tried to deal with the attention seeking behavior of the people with histrionic personality. For instance, in one of the researches, using a behavioral paradigm the researchers rewarded the appropriate behavior and interaction of people with traits like histrionic personality and were fined for their attention seeking behavior. They found significant improvement after an 18-month follow-up (Kass et al., 1972). As they usually manipulate people through their charm or emotional tactics, a large part of the therapy goes in focusing at their interpersonal relationships (Beck et al., 2007). They are also taught more appropriate and acceptable ways to negotiate in order to get their demands fulfilled.

9.1.2 Narcissistic Personality Disorder

According to Greek mythology, there was a young hunter Narcissus who remained aloof and arrogant, holding many women in disdain who happened to fall for him. To punish Narcissus for his arrogance, the goddess of revenge, Nemesis, put a spell on him due to which when he next noticed his reflection in a pool of water, he was enamored by it; love overtook him. He became entirely absorbed by his beautiful image without realizing that it was actually himself. Psychoanalysts have used the term narcissist to describe those individuals who give a lot of importance to themselves and are preoccupied with receiving attention from others most of the times (Cloninger & Svakic, 2009).

Narcissistic personality disorder is characterized by exaggerated sense of self importance that the individual gives to one's self. Another important feature is preoccupation with seeking attention, admiration and lack of empathy (Ronningstam, 2005, 2009, 2012). It can be of two types: *grandiose* and *vulnerable*. The defining features of the grandiose type of narcissism are aggression, dominance and grandiosity. Thus, they are known to overestimate their abilities and underestimate that of the others. They have a high sense of entitlement and believe that they deserve it all. They brag a lot about themselves and use constant self-references, in order to get recognition which, they usually claim for. They easily take offense and rarely forgive others (Exline, Baumesiter, Bushman, Campbell, & Finkel, 2004). Vulnerable narcissists have a fragile sense of self-esteem and they use arrogance and disdain to mask their shame and hypersensitivity towards criticism and rejection from outside (Cain, Pincus & Ansell 2008). They usually avoid relationships and intimacy due to their fear of rejection and criticism. They might look completely absorbed with their achievements and its fantasies but they do experience and nurse profound shame about their ambitions. Both the types seem to be associated with high levels of antagonism/ low agreeableness (low modesty, arrogance, superiority, feelings of grandiosity), low altruism, and tough mindedness (lack of empathy). In the case of grandiose narcissist, it is the close relatives and family who are more distressed about their behavior rather than the individual (narcissist) herself/himself. Vulnerable narcissists usually have a high level of negative affectivity (Miller, Widiger, & Campbell, 2010). Wink (1991) tried understanding how the spouses of people narcissism described them and came to the conclusion that they are "bossy, intolerant, cruel, argumentative, dishonest, opportunist, conceited, arrogant, and demanding" and those with high grandiosity were also additionally described as being "aggressive, outspoken, hard-headed, assertive and

determined", whereas patients high on vulnerability were "worrying, emotional, defensive, anxious, bitter, tense and also complaining" (p. 595).

Another important aspect of individuals with narcissism is their inability to take other person's perspective and if they do not receive validation as they wanted or desired, they may turn out to be retaliatory (Rasmussen, 2005). This disorder may be seen more in men as compared to women (Golomb, Abraham, & Rosenbaum, 1995). It is a relatively rare disorder especially in comparison to other personality disorders with an estimated occurrence of 1 percent in the population.

Box 9.2: DSM 5 criteria for Narcissistic Personality Disorder (APA, 2013)

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

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

9.1.2.1 Causal factors

There is a wealth of theories about narcissistic personality disorder but little empirical research in comparison. Kohut (1978) believed that it arises mainly from the failure of parenting wherein parents fail to model empathy in the early developmental stages of the child. Thus, the child (and later as an adult) gets tangled in the endless search for this ideal person who would meet the unfulfilled empathic needs.

It has also been found that grandiose narcissism is not generally associated with childhood abuse, neglect or poor parenting but perhaps with parental overvaluation. On the other hand, vulnerable narcissism is associated with

emotions, physical and perhaps sexual abuse and intrusive, controlling or cold parenting styles (Miller, 2011; Miller & Campbell, 2008). Lasch (1978) suggested that increasing prevalence of narcissism is a consequence of large-scale social changes with emphasis on characteristics like individualism, competitiveness, hedonism and ambition (Huang et al., 2009).

9.1.2.2 Treatment

For people with narcissistic personality disorder, both the number of studies carried out and the success report gathered is limited (Cloninger & Svakic, 2009). Here, the main focus of the therapy is grandiosity. After which attention is also paid to hypersensitivity to evaluation and lack of empathy for others (Beck et al., 2007). Relaxation techniques are used for such individuals which can be helpful for them in accepting and handling the criticism.

Check Your Progress 1

Fill in the blanks

1) _____ is characterised by extreme versions of two common personality traits- extraversion and, to a lesser extent, neuroticism.

2) _____is characterised by exaggerated sense of self and the importance that the individual gives to one's self.

3) Grandiose narcissism is not generally associated with _____.

4) The main focus of the therapy is _____ for the treatment of narcissistic personality disorder.

5) One hypothesis points out a genetic link between _____with antisocial personality disorder.

9.1.3 Antisocial Personality Disorder

People with antisocial personality disorder (ASPD) are found to be the most puzzling and intriguing of the individuals that the clinicians would see in their practicing career. They are characterised by their tendency to persistently disregard and violate social norms and rights of others with a combination of deceit, aggression and antisocial behavior and activities. They lack ethical or moral development and have no remorse or loyalty towards anyone.

Robert Hare is considered to be the pioneer in studying people with this disorder and describes them as, "social predators who charm, manipulate, and ruthlessly plow their way through life, leaving a broad trail of broken hearts, shattered expectations, and empty wallets. Completely lacking in conscience and empathy, they selfishly take what they want and do as they please, violating social norms and expectations without the slightest sense of guilt or regret" (Hare, 1993, p. xi). They tend to be impulsive, deceitful and irresponsible as well (De Brito & Hodgins, 2009). Lying and cheating is their second nature making it difficult for them to distinguish between truth and lies to reach their goals. Almost 60 percent of the people with antisocial personality disorder are found to have substance abuse as well (Taylor & Lang, 2006). Cleckley (1941/1982) identifies a constellation of 16 characteristics to define "psychopathic personality". Hare and colleagues build on it to develop a 20-item checklist that serves as a major

assessment tool. Six of which are included in his Revised Psychopathy Checklist (PCL-R): 1. Glibness/superficial charm, 2. Grandiose self-worth, 3. Need for stimulation, 4. Pathological lying, 5. Conning/manipulation, and 6. Lack of remorse (Neumann, Hare, & Newman, 2007, p. 103).

There are two dimensions of psychopathy- a) affective and interpersonal core, b) behavioral dimension. The affective and interpersonal core consists of traits such as lack of remorse, callousness, glibness, lack of empathy, charm etc. while the behavioral dimension focuses mainly on the behavior including impulsivity, socially deviant lifestyle, poor and irresponsible behavior, parasitic lifestyle etc. DSM mainly focused on the observable behaviors as opposed to personality traits so that the clinicians could reliably agree on the diagnosis. The basic logic behind this is that it is difficult to assess someone for a trait of manipulation but comparatively easier to see if the individual is engaged in certain behavior such as repeated fighting or stealing. Some of the characteristics of antisocial personality disorder are described in Box 9.3.

Box 9.3: Some Characteristic Features of People with Antisocial Personality Disorder

Inadequate conscience development

- Can understand ethical values only at a verbal level.
- Intellectual development is normal but conscience development is stunted (Fowles & Dind, 2005).
- Affective and interpersonal dimension is positively related to verbal intelligence but antisocial dimension is negatively related to intelligence.
- May "act out" tensions and then worry them.

Irresponsibility and Impulsive behavior

- Total disregard for needs, rights and well-being of others.
- High on thrill seeking, deviant and unconventional behavior.
- Rarely forego immediate pleasure for some future gain.
- Occurrence of alcohol, or any other substance dependence and abuse.
- Elevated rates of suicide attempts

Rejection of authority

- Do not follow social norms and rules.
- Difficulty with educational and law enforcement authorities.
- Behave as if immune to the consequences of their action.

Ability to impress and exploit others

- Very charming, win friends easily (Patrick, 2005).
- Good sense of humor and optimistic outlook.
- Frequent liar, may seem sorry when caught in the act but are not so.
- Good insight into other people's needs and weakness.
- Find excuses readily for their conduct, usually projecting blame on others.

Inability to maintain good relationships

- Ability to win liking of others initially but rarely keep close friends and relationships.
- Irresponsible, cynical, unsympathetic, egocentric, ungrateful and remorseless.
- Cannot understand love.
- Violence towards family members is common.
- Manipulative and exploitative in their sexual relations.
- Considered as a menace for family and society.

Results from long term follow-up researches show that many adults with psychopathy or antisocial personality disorder had conduct disorder as children (Robins, 1978; Salekin, 2006). It has been found that the chances of having adult antisocial personality disorder increase if the child has had a history of both conduct disorder and attention deficit/hyperactivity disorder (Moffit, Caspi, Rutter, & Silva, 2001). A major difference between the two is that lack of remorse is there in antisocial personality disorder but not in the criteria for conduct disorder.

Box 9.4: DSM 5 Criteria for Antisocial Personality Disorder (APA, 2013)

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
   1) Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
   2) Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3) Impulsivity or failure to plan ahead.
   4) Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
   5) Reckless disregard for safety of self or others.
   6) Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
   7) Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

9.1.3.1 Causal Factors

In a classic study done by Crowe (1974), children of criminal mothers who were later adopted by other families were compared with adopted children of normal

mothers. These children were separated from their mothers very early thus ensuring that environmental factors from biological parents had lesser or no impact. It was found that adopted children of criminal mothers had significantly higher rates of conviction than the others. Another important finding presented was that the children of criminal mothers who had spent more time in the orphanages later became criminals than either the adopted children of normal mothers or adopted children of criminal mothers (who did not spend much time in the orphanages). Thus, pointing towards interaction between genetics and environment. Genetic factors may play an important role in the presence of certain environmental cues and influences and vice versa. This has further been researched upon and validated (Thomas, 2009; Ferguson, 2010).

Early theoretical work in this area has suggested two major hypotheses- under-arousal and fearlessness. According to the **under-arousal hypothesis**, people with antisocial personality have abnormally low levels of cortical arousal (Sylvers et al., 2009). It could also be the primary cause of their risk taking and further anti-social behavior; in order to boost their low levels of arousal they may seek stimulation. Raine and colleagues (1990) found that future criminals (assessed when 15year-old due to their antisocial behaviors) had lower skin conductance and heart rate during rest periods and also slow brain wave activity which was indicative of low arousal. On the other hand, the **fearlessness hypothesis** says that, the psychopaths have a higher threshold for experiencing fear than most of the other people (Lykken, 1982).

According to Jeffrey Gray (1987) there are three major brain systems that influence our learning and emotional behavior: the behavioral inhibition system (BIS), the reward system and the fight/flight system. BIS and the reward system have been used to explain the behavior of people with psychopathy. BIS is located in the septohippocampal system involving both serotonergic and noradrenergic neurotransmitter systems. It plays a role in our ability to stop or slow down in the wake of impending punishment or novel situation. The reward system is responsible for our behavior when we are approached with positive reward-associated with hope and relief. Malfunctioning of these two systems is very much evident in the case of psychopaths. It has been hypothesized that the imbalance between these two systems may make fear and anxiety as produced by BIS less apparent and positive affect associated with reward system more prominent (Levenston, Patrick, Bradley, & Lang, 2000). Thus, psychopaths do not become anxious while committing the acts that are considered antisocial.

As a result of several studies, the researchers hypothesized that as soon as a psychopath sets his eyes on a reward goal, they do not deter (unlike non-psychopaths) despite the signs that the goal could be no longer available or achievable (Dvorak-Bertscha, Curtin, Rubinstein, & Newman, 2009). This could be due to their reckless, daring and thrill-seeking behavior. An interesting research also suggested that the aggression in children with antisocial personality may also escalate due to their interaction with their parents (Granic & Patterson, 2006). It was also found that in order to restore peace in the house and perhaps also in the relationship many times parents give in to the demands of the child eventually promoting their behavior of fighting and not giving up at any cost. If this "coercive family process" gets combined with factors such as less parental involvement, poor or less effective child monitoring activities it may help in maintaining the aggressive behavior (Chronis et al., 2007). Some evidence from adoption studies have also suggested that shared environmental factors could have a very important role in the etiology of antisocial personality disorder.

9.1.3.2 Treatment

One of the major issues in treating ASPD is that they are capable of manipulating even their therapists, thus, there are very few documented successful treatment cases of ASPD. Mostly, therapists agree with detaining or imprisoning them for their antisocial acts so that any future such acts can be avoided. Precaution is something that has been mainly encouraged here so that the high-risk children can be identified and treatment can be attempted on them before they enter adulthood. One of the common strategies used is to train parents of these children by teaching them how to identify these behavioral problems and using a reward-based system to encourage prosocial behavior. However, family dysfunction, poor socioeconomic status or even high conduct related issues with the child may risk the treatment or may result in dropout form the treatment (Kaminski, Valle, Filene, & Boyle, 2008). Drugs such as lithium and anticonvulsants that are used to treat bipolar disorder have been found to be successful to some extent in dealing with aggressive/impulsive behavior but the evidence is not solid to make concrete conclusions (Markovitz, 2001). Cognitive behavioral therapy mainly targets: social perspective taking, helping them in increasing self-control, increasing victim-awareness, teaching anger management skills, changing antisocial attitudes and even curing their drug addiction. It is important to note here that when dealing with ASPD, therapists are actually dealing with the complete lifestyle of an individual rather than a few subsets of behavior (Hare et al., 2012). It has also been found that their behavior can be managed when they are in the prison or the facilities where treatment is being administered but does not generalize once these people go back to the real outside world (Harris & Rice, 2006).

9.1.4 Borderline Personality Disorder

The term borderline was originally used to refer to the people who had a condition which could be termed as being between neurotic and psychotic -"borderline". However, later this explanation was termed as schizotypal personality disorder which is biologically also related to schizophrenia. The current diagnosis of borderline personality disorder (BPD) is not biologically linked to schizophrenia.

The characteristic pattern of people with BPD is impulsivity and instability in self-image, moods and even in relationships. This affective instability is usually manifested by extreme and intense responses to any of the environmental triggers without thinking about any sort of long-term consequences. They can also go through rapid shifts in emotions from one to another (Paris, 2007). Their sense of self has been described as fragmented. They have highly unstable relationships perhaps due to their unstable self-image and affective instability usually ending in disappointment and anger. Though, it also important to note here that their fear of abandonment is also very strong and thus they try to avoid it as much as possible (Livesley, 2008). These people are also prone to get into self-destructive and erratic behavior. Suicide attempts can also be a part of the clinical picture, it could be manipulative and some may also end up completing the act. Self-injury or self- mutilation id a common feature amongst people with BPD but again it has to be understood with caution that everyone or anyone engaging in any kind of self-harm do not have BPD, such a behavior could be performed to relieve oneself of anxiety or as a result of dysphoria.

With these behavioral and affective symptoms, there are cognitive symptoms as well in the patients with BPD. There can be very short periods when they may have psychotic-like symptoms such as losing contact with reality, delusional experiences or even hallucinations (Paris, 2007). This particular personality disorder leads to significant social, occupational and academic functioning and is also seen to commonly co-occur with mood disorders, anxiety disorders, eating disorders and substance-use as well.

Box 9.5: DSM-5 Criteria for Borderline Personality Disorder (APA, 2013)

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

1) Frantic efforts to avoid real or imagined abandonment.

   (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)

2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3) Identity disturbance: markedly and persistently unstable self-image or sense of self.

4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).

   (Note: Do not include suicidal or self-mutilating behavior)

5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7) Chronic feelings of emptiness.

8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

9.1.4.1 Causal Factors

It has been found that genetic factors may play an important role in development of BPD. One of the major aspects supporting this view is that both affective instability and impulsivity that are prominent manifestations of people with BPD are partially heritable (Hooley et al., 2012). The genes involved in regulation of the neurotransmitter dopamine may also have a role to play in BPD (Hooley et al., 2012) along with lower serotonin levels. The low serotonin level might be a reason why they are not able to stop their impulsive behaviors. Structural brain abnormalities studies show that patients with BPD may have reductions in the

volume of hippocampus and amygdala perhaps thus showing more aggression and impulsivity.

Some of the retrospective psychosocial studies have pointed towards the role of childhood trauma, adversity and maltreatment (Bandelow et al., 2005). Paris (1999, 2007) had offered a diathesis-stress theory to understand the probably causality of BPD- people with high levels of impulsivity and affective instability may have a diathesis which may lead to the development of BPD but in the presence of certain triggers and risk factors such as trauma, parental neglect, failure, or some kind of loss. In the presence of such nonspecific factors an individual who is already affectively unstable may become labile or dysphoric, coupled with impulsivity, they may also act out on it to cope up with their negative affect. Weakening of the family structures may be a major reason of increasing prevalence of BPD in today's times.

9.1.4.2 Treatment

It has been found that people with BPD seek for treatment much more than ASPDs or other disorders. Anticonvulsants and antipsychotics are usually found to be effective in treating the core symptoms of BPD. However, the efforts become slightly complicated due to their drug abuse or suicide attempts. Marsha Linehan has developed an approach called as Dialectical Behavior Therapy (DBT) which has been found to be quite successful in these cases (Linehan et al., 2006). In this treatment priority is given to the suicidal behavior then the ones that interfere with the therapy and its continuation followed by the behaviors which may interfere with the quality of life of the individual. Patients are taught to regulate their emotions and handling problems on an everyday basis. They are also given treatment similar to those of patients with PTSD as that they can dowse off the fear associated with traumatic events. Then they are made to trust their own responses more than depending on other people for constant validation by helping them in visualizing themselves where they are not reacting to the criticisms negatively. DBT has been found to be an effective therapy which is impactful in helping people with BPD (Stanley et al., 2007).

Check Your Progress 2

Fill in the blanks

1) Tendency to persistently disregard and violate social norms is characteristic of _____.

2) _____ says that the psychopaths have a higher threshold for experiencing fear than most of the other people.

3) Identifying behavioral problems and using a reward-based system to encourage prosocial behavior is treatment method adopted for _____.

4) The characteristic pattern of people with bipolar personality disorder is _____.

5) Anticonvulsants and antipsychotics are usually found to be effective in treating the core symptoms of _____.

9.2 CLUSTER C PERSONALITY DISORDERS

Cluster C personality disorders comprises of three personality disorders-avoidant, dependent and obsessive-compulsive. The common characteristics are anxiety and fearfulness. To help understand the mentioned disorders, let us look at the clinical features, causal factors and treatment of each disorder.

9.2.1 Avoidant Personality Disorder

Extreme social inhibition and introversion are characteristic patterns of avoidant personality disorder. Due to this they have a pattern of limited social relationships and are reluctant in social interactions. They do not seek out for other people as they are scared of being criticized for rebuffed by them. However, this does not mean that they do not desire affection; they often feel lonely and bored. Millon & Martinez (1995) believed that it is important to distinguish between individuals who are asocial as they are apathetic, have flat affect, indifferent towards criticism and not interested in interpersonal relationships (diagnosis comparable to schizoid personality disorder) and those who are asocial because they fear rejection and thus are interpersonally anxious. The latter category is the one that fits the diagnosis of avoidant personality disorder (Millon & Martinez, 1995). Unlike people with schizoid personality disorder, they do not enjoy their aloofness. Due to their inability to relate to others they may have low self-esteem and may even be associated with depression (Sanislow et al., 2012).

Researchers have concluded that people with avoidant personality disorder show generalized shyness or nervousness and may also avoid novel situations and even emotions (this can also include avoiding positive emotions). They may also exhibit their inability in experiencing pleasure (Taylor et al., 2004). Another tricky distinction is between social phobia and avoidant personality disorder. Some investigators have concluded that avoidant personality could be simply a more severe manifestation of generalized social phobia (Carter & Wu, 2010).

Box 9.6: DSM-5 Criteria for Avoidant Personality Disorder (APA, 2013)

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

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

9.2.1.1 Causal Factors

Avoidant Personality disorder may have its roots in an innate "inhibited" temperament due to which the newly born, infant and child may feel timid or even inhibited in a new or an ambiguous situation. Some of the studies also show that genetic vulnerability for avoidant personality disorder can also been seen in people with social phobia if not fully then at least partially (Reichborn-Kjennerud et al., 2007). Fear of rejection and negative evaluation has also been found to be moderately heritable along with traits such as introversion and neuroticism and all these are prominent in people with avoidant personality disorder. There is also a possibility that these biologically based inhibited temperaments may actually serve as a diathesis and when one faces experiences such as emotional abuse or rejection (as a child), it may eventually lead to avoidant personality disorder.

9.2.1.2 Treatment

The problems experienced by people with avoidant personality are similar to those with social phobias and that is why a similar set of techniques is used for both. Behavioral intervention techniques for social skill management and anxiety are very helpful here as well (Borge et al., 2010). It is important to note that the therapeutic alliance is an important predictor in avoidant personality disorder for the success of treatment (Strauss et al., 2006).

9.2.2 Dependent Personality Disorder

Dependent personality disorder is characterised by an individual's extreme need to be taken care of, thus, pointing towards her/his submissive and also clingy behavior. They may show fear of being separated from others just being alone as they find themselves inept or incompetent. They may not get angry with others, or find fault in others due to their fear of being separated from others or losing their support. This is indicative of the fact that such people may remain in physically or psychologically abusive relationships. Thus, they usually carve their lives around other people giving lesser importance to their own needs and not having confidence in themselves they take decisions with the help of others. In terms of the five-factor model, dependent personality disorder is associated with prevalence of neuroticism and agreeableness (Lowe et al., 2009).

The prevalence of dependent personality disorder has been seen in women more than men. This not just due to the gender bias in the diagnosis but mainly because of the higher prevalence of traits such as neuroticism and agreeableness in women which are also characteristic features of dependent personality disorder (Lynam & Widiger, 2007). Some of the features of dependent personality disorder also overlap with that of histrionic, borderline and avoidant personality and a clear understanding of the three necessary is to make a diagnosis. The difference between avoidant and dependent personality has already been highlighted above. Similarly, both borderline and dependent personalities fear abandonment by people around them but their reactions to it can be different, for instance, people with borderline personality may react with feelings of emptiness and rage whereas people with dependent personality may initially become submissive and then may seek for new relationships.

Box 9.7: DSM 5 Criteria for Dependent Personality Disorder (APA, 2013)

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

1) Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2) Needs others to assume responsibility for most major areas of his or her life.
3) Has difficulty expressing disagreement with others because of fear of loss of support or approval.

   (Note: Do not include realistic fears of retribution.)
4) Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5) Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6) Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7) Urgently seeks another relationship as a source of care and support when a close relationship ends.
8) Is unrealistically preoccupied with fears of being left to take care of himself or herself.

9.2.2.1 Causes Factors

Genetic influence has been found to be modest in the case of dependent personality disorder (Bornstein, 2011, 2012). Traits such as neuroticism and agreeableness (prominent in dependent personality disorder) have a genetic component to it. There is also a possibility that at least partial predisposition to dependence and anxiousness may make them prone to negative impact of authoritarian and overprotective parenting, thus, reinforcing their dependent behavior.

As described by cognitive researchers, people with dependent personality disorder, the underlying schemas about themselves might be maladaptive and thus they may have a core belief about them being weak, incompetent and requiring others for their survival (Ramussen, 2005). This has also been supported by recent researches (Arntz et al., 2011).

9.2.2.2 Treatment

Majority of the treatment literature in this case is descriptive. They look like ideal patients because of their attentiveness towards the therapist and eagerness to share their problems but they are eventually found to be compliant to everything the therapist says. Their submissiveness becomes a major hindrance in the therapy (Borge et al., 2010). Their core belief about themselves being weak and dependent on others is challenged using cognitive behavior therapy (Beck et al., 2007) and the urge to be confident, independent and take decisions on their own is instilled in them.

9.2.3 Obsessive-Compulsive Personality Disorder

People with obsessive-compulsive personality disorder (OCPD) show an excessive concern with maintaining order and control. They exhibit perfectionist tendencies by paying attention to rules, orders and schedules. Their perfectionism can be dysfunctional to the extent that they may never finish their projects as they are too preoccupied with trivial details and thus, utilize their time poorly (Yovel et al., 2005). They might be too devoted to work to the extent that they may have difficulty in doing anything for leisure and entertainment. Others may view them as rigid or cold as they usually don't delegate tasks to others.

It is important to note that unlike people with Obsessive-Compulsive Disorder (OCD) they do not have obsessions or follow compulsive rituals. Instead people with OCPD have lifestyle characteristics of high neuroticism, inflexibility, high conscientiousness and also perfectionism. It has also been found that only about 20 percent of the people with OCD have a comorbid diagnosis of OCPD (Albert et al., 2004). In fact, people with OCD are more likely to be diagnosed with either avoidant or dependent personality disorder (Wu et al., 2006).

Box 9.8: DSM-5 Criteria for Obsessive-Compulsive Personality Disorder (APA, 2013)

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

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

9.2.3.1 Causal Factors

As per the biological dimensional approach of Cloninger (1987), there are three personality dimensions that have been discussed- novelty seeking, harm avoidance and reward dependence. People with OCPD are seen to have lower levels of

novelty seeking and reward dependence but a higher level of harm avoidance. Some research has also confirmed that OCPD traits show a modest genetic influence (Calvo et al., 2009). Personality trait-based theories have discussed that people with OCPD are high on conscientiousness (Samuel & Widiger, 2011). This could also be a reason for their perfectionist tendencies, highly controlling behavior or extreme devotion towards work.

9.2.3.2 Treatment

Therapy usually focuses on their need for keeping everything in control and order. They are helped by teaching them relaxation and distraction techniques to keep the compulsive thoughts away. Cognitive Behaviour Therapy has been found to be effective with patients of OCPD (Svartberg et al., 2004).

9.3 SOCIOCULTURAL CAUSES OF PERSONALITY DISORDERS

According to some of the researches, there is less variation in personality disorders across cultures than within cultures. This could be due to the fact that all the cultures share the basic five personality traits (Allik, 2005). Paris (2001) noted that certain personality disorders have increased in the American society in past few years, this could be due to the changing cultural priorities with time. For instance, narcissistic personality disorder has been found to be more prevalent in western societies and a probable reason for it could be the emphasis on personal success and ambition (Widiger & Bornstein, 2001). It has also been suggested that as emotional dysregulation and impulsive behavior has increased over the years (especially since World War II), it may have some association with the increased prevalence of borderline and ASPDs over a period of time for the same time frame. It may have its connections with breakdown of traditional family systems and various other social structures (Paris, 2001). Thorough research in this area is required before making any further claims.

Check Your Progress 3

Fill in the blanks

1) _____ and _____are characteristic patterns of avoidant personality disorder.

2) _____ exhibit perfectionist tendencies by paying attention to rules, orders and schedules.

3) Genetic influence has been found to be modest in the case of _____.

4) _____therapy has been found to be effective with patients of OCPD.

5) Avoidant Personality Disorder may have its roots in an _____ temperament.

9.4 SUMMARY

Now that we have come to the end of this unit, let us list all the major points that we have learnt.

- Personality disorders indicate an inflexible and distorted behavioral pattern resulting in maladaptive ways of perceiving, thinking and relating to others and their environment.
- DSM has categorized personality disorders into three clusters and the validity of this categorization has been questioned. DSM-5 has not used this categorization but this has been used due to commonalities shared by disorders categorized under each cluster.
- Cluster B includes histrionic, narcissistic, antisocial and borderline personality disorders. People falling in this cluster are found to be emotional, erratic and dramatic.
- Research in the area of histrionic and narcissistic personality is very scant but certain biological and psychosocial factors have been researched upon to understand the causality of borderline and antisocial personalities.
- Cluster C comprises of avoidant, dependent and obsessive-compulsive personality disorders. This cluster characterises fearfulness, tension, shyness and anxiety-based symptoms.
- Inhibited temperament may increase the risk for avoidant personality and those high on traits such as neuroticism and agreeableness may increase risk for dependent personality disorder especially when faced with authoritarian and overprotective parenting styles.
- Behavioural interventions and Cognitive Behaviour therapy are found to helpfull to treat personailty disorder.

9.5 KEY WORDS

Cluster B Personality Disorders: The prevailing symptoms of this cluster are being dramatic, erratic or emotional. It includes histrionic, narcissistic, antisocial and borderline personality disorders.

Cluster C Personality Disorders: Characterises fearfulness, tension, shyness and anxiety-based symptoms. It includes avoidant, dependent and obsessive-compulsive personality disorders.

Histrionic Personality Disorder: Characteristic features are excessive attention-seeking, lively, charming, dramatic and extraverted behavior.

Narcissistic Personality Disorder: Characterised by exaggerated sense of self-importance that the individual gives to one's self, seeking attention, admiration and lack of empathy.

Antisocial Personality Disorder: Characterised by the tendency to persistently disregard and violate social norms and rights of others with a combination of deceit, aggression and antisocial behavior and activities.

Borderline Personality Disorder: Characteristic pattern is impulsivity and instability in self-image, moods and even in relationships.

Avoidant Personality Disorder: Characterised by extreme social inhibition and introversion.

Dependent personality disorder: Characterised by an individual's extreme need to be taken care of, pointing towards her/his submissive and clingy behavior.

Obsessive-compulsive Personality Disorder: Excessive concern with maintaining order and control, exhibit perfectionist tendencies by paying attention to rules, orders and schedules are the main charecteristies.

9.6 REVIEW QUESTIONS

1) Elucidate the clinical features of borderline personality disorder.
2) List the criteria for dependent personality disorder, according to DSM-5.
3) What are the main characteristics of Cluster C personality disorders?
4) Discuss some of the causes of avoidant personality disorder?
5) What are the sociocultural causes of personality disorders?

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9.18 WEB RESOURCES

- Case of David Berkowitz (Psychopathy and ASPD)

  http://maamodt.asp.radford.edu/Psyc%20405/serial%20killers/Berkowitz,%20David.pdf

- Portrayal of Borderline Personality Disorder (BPD) in the movie;

  Girl, Interrupted (1999) directed by James Mangold (Starring, Winona Ryder, Angelina Jolie, Clea DuVall, Brittany Murphy, Whoopi Goldberg, Elisabeth Moss, and Vanessa Redgrave).

Answers to Check Your Progress

Check Your Progress 1

1) Histrionic personality disorder
2) Narcissistic personality disorder
3) Parental overevaluation
4) Grandiosity
5) Histrionic personality disorder.

Check Your Progress 2

1) Antisocial personality disorder
2) Fearlessness hypothesis
3) Antisocial personality disorder
4) Impulsivity and instability in self-image, moods and even in relationships
5) Borderline personality disorder.

Check Your Progress 3

1) Extreme social inhibition; and introversion
2) Obsessive-compulsive personality disorder
3) Dependent personality disorder
4) Cognitive Behaviour
5) Innate “inhibited”.

UNIT 10 PARAPHILIC DISORDERS AND SEXUAL DYSFUNCTIONS*

Structure

Learning Objectives

After reading this Unit, you will be able to:

- Make an attempt to define boundaries between normality and psychopathology in understanding sexuality;

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- Describe the influence of culture and gender on sexual norms;
- Explain sexual response cycle of men and women;
- Explain sexual dysfunctions and paraphilias; and
- Develop an understanding of the treatment approaches of sexual disorders and dysfunctions.

10.0 INTRODUCTION

Humans have sexual preferences and fantasies which may be surprising for others and even for oneself at times. Sexuality is considered to be one of the most private aspects of life which may contribute to love, happiness and pleasure. Sex is an important concern for various people, but many have difficulty talking about it openly as sex is considered as a taboo in various societies and cultures. Sex has also been a focus of curiosity to us. Depictions of sexual behavior can be seen in cave drawings (prehistoric times), the classical Indian text on human sexuality *Kamasutra,* Leonardo Da Vinci's anatomical illustrations of intercourse and then in current times various pornographic sites on internet are also used to abate the curiosity. In this Unit, we explain normal sexuality, sexual response cycle, and gender differences in sexuality. The DSM-5 criteria for paraphilic disorders, gender dysphoria, and sexual diffunctions are discussed.The treatment options for the disorders are also indicated.

10.1 WHAT IS NORMAL SEXUALITY?

Various magazines report sensational information on sexual practices in the form of surveys they conduct, such as, men can reach orgasm 15 or more times in a day (a rather rare ability in reality) or how women fantasize about being raped (they may have fantasies of submission but these are not about being actually raped) (Critelli & Bivona, 2008). Two of the major shortcomings of these surveys are: first, in a way they claim to divulge the sexual norms but are actually distorting the truth. Second, these so-called facts are not based on any scientific methodology or research and thus are not reliable. They sell magazines but perpetuate myths in the society as well.

Box 10.1: Some important terms to remember:

Sex: Quality of being male or female.

Sexual intercourse: Insertion of penis when erect in vagina. Other forms include anal sex (penetration of the anus by the penis), oral sex (penetration of the mouth by the penis or oral penetration of the female genitalia) and fingering (sexual penetration by the fingers).

Sexuality: Encompasses sex, gender identities, roles, sexual orientation, pleasure, intimacy and reproduction.

Sexual health: "The integration of somatic, emotional, intellectual & social aspects of sexual being in ways that are positively enriching and enhance personality, communication and love" (WHO, 2002).

Sexual rights: Rights free of coercion, discrimination and violence.

Sexual norm: It could be a personal or social norm. Culture having a norm regarding sexuality and defining it on the basis of age, consanguinity, race.

Definition of normal or desirable human sexual behavior may vary with time and place. For instance, Von Krafft-Ebing (1902) claimed that early masturbation would damage the sexual organs and would lead to the exhaustion of a finite reservoir of sexual energy. Victorian view was that too much sexual activity and sexual appetite was dangerous and thus had to be restrained using various ways. Current views seem to be very tolerant of a variety of sexual expressions. It is only when these fantasies begin to affect other people and harm them, they begin to qualify as abnormal. If the sexual fulfillment becomes difficult or socially unacceptable then that would be considered as abnormal. Three kinds of sexual behavior meet this definition; first, gender identity disorder, psychological dissatisfaction with the biological sex of himself/herself. This disorder may not be specifically sexual in nature, rather a disturbance in the person's identity as either a male or female (the traditional binary distinction). Second, difficulties in functioning adequately while having sex are categorized under various sexual dysfunctions. And, third, is a category named paraphilias, a term for sexual deviation. It includes deviances in which sexual arousal occurs in the context of inappropriate objects or individual. But, before understanding these disorders, it is important to revisit the question – what qualifies as normal sexual behavior?

One way to understand normality has been to understand the norm or what is prevalent in the society, although it may not be necessarily the most correct or accurate way to go about it. In a survey conducted by Billy, Tanfer, Grady and Klepinger (1993), 3,321 males were interviewed (in the age bracket of 20-39 in United States). All participants in the study were sexually experienced, at least in the vaginal intercourse. Three-fourth participants in the study were engaged in oral sex, but only one-fifth had ever participated in anal sex. Another finding of the research was that almost 23.3 percent of the sample had sex with twenty or more partners which is considered as the high-risk behavior. More than 70 percent were found to have only one sexual partner during the previous year. One of the surprising findings from this research was that majority of the men had engaged only in heterosexual behavior and only 2.3 percent had engaged in both homosexual as well as heterosexual behavior, whereas only 1.1 percent had engaged in homosexual behavior exclusively.

10.2 SEXUAL RESPONSE CYCLE

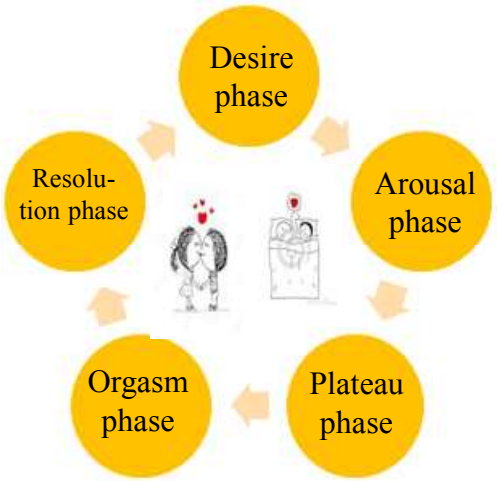

Fig. 10.2: The human sexual response (Based on Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. Boston: Little, Brown. And Kaplan, H. S. (1979). Disorders of sexual desire, New York, NY: Brunner)

Many researchers have tried understanding the sexual response cycle, but the Kinsey group (in 1940s) made a breakthrough attempt by interviewing people about their sexuality (Kinsey, Pomeroy, & Martin, 1948). Masters and Johnson went a step ahead by collecting laboratory data in order to study physiology and psychology of sexual behavior. They have contributed two major books to the field- *Human Sexual Responses* (1966) and *Human Sexual Inadequacy* (1970).

Phases in human sexual response cycle:

1) **Desire phase:** sexual urges occur as a response to the sexual cues or fantasies.

2) **Arousal phase:** this stage is like the preparation for main event and involves foreplay as well. An increase in muscular tension, breathing and heart rate can be noticed. In males, penile tumescence (increased flow of blood into penis) and erection can be observed. In females, vasocongestion (blood pools in the pelvic region) can be observed leading to vaginal lubrication and breast tumescence (erect nipples).

3) **Plateau phase:** in this stage, the changes noticed in the arousal phase are intensified. Genitalia may become highly sensitive (may be painful to touch). Muscle spasm can be noticed in the feet, hands and face.

4) **Orgasm phase:** this is the climax of the sexual response cycle that involves involuntary muscle contraction. There is rapid intake of oxygen followed by sudden, forceful release of sexual tension. In males, there is feeling of inevitability of ejaculation followed by ejaculation of semen and in females, rhythmic contractions in vagina occurs.

5) **Resolution phase:** this stage is marked by decrease in arousal followed by orgasm (especially in males). It is marked by a general sense of well-being, enhanced intimacy and fatigue. With further sexual stimulation,females are capable of returning to orgasm phase (multiple orgasms in females) but males need more time to recover after the orgasm and this period is known as the refractory period which may last from several minutes to hours.

10.3 GENDER DIFFERENCES IN SEXUALITY

Across researches, it has been found that males engage more in sexual thoughts-sex, masturbation and behavior than females (Andersen, Cyranowski & Aarestad, 2000). There can be exceptions to this but these are the averages. Males are also found to be desiring more sexual partners in comparison to females (Baumeister, Catanese, & Vohs, 2001; Herbenick, Reece, Schick, et al. 2010)

A common finding among various sexual surveys is that men reported to masturbate (self-stimulation to orgasm) more than women (Oliver & Hyde, 1993; Peplau, 2003; Petersen & Hyde, 2010). Masturbation has not found to be in correlation with later sexual functioning, the frequency of intercourse or any sexual adjustment. Why women masturbate lesser has always been an intriguing question to the sex researchers. Although men have more permissive attitude towards pre-marital sex, the gap between men and women is growing smaller with time (Peplau, 2003). One of the traditional views is that women have been taught to relate sex with romance and emotional intimacy, whereas for men it has been more of physical satisfaction and gratification. The reasons could also be anatomical in nature- erectile response in men and the relative ease in providing

stimulation, masturbation is more convenient (anatomically) for men as compared to women.

Other gender differences are reflected in the acts of casual sex and attitudes towards it. One of the terms used for casual sex among college going students is "hook up", which is physically intimate behavior outside of a committed relationship (Owen, Rhoades, Stanley & Fincham, 2010). Studies reported that casual sex is often initiated by alcohol and women seemed less likely to view it as a positive experience than men. Another interesting area of study in this regard is the sexual self-schemas and core beliefs of self-consciousness where gender differences seem to exist.

Box 10.2: Socio-cultural influences on sexual practices

The expression and acceptance of sex and sexual practices has varied considerably across times and cultures. For instance, almost all cultures have taboos against sex between close relatives. Views about acceptable sexual behavior has changed over a period of time. Nudity and sexuality has always been correlated. But, with time and culture, the idea of lack of clothing has changed. In this context, it is very difficult to categorize one kind of behavior as 'normal' and other one as 'abnormal'. The following section will discuss how with time and culture, sexual behavior and the opinion of it being "acceptable" or "non- acceptable" may change dramatically.

Initially (around 1750s) Swiss physician Tissot proposed a **degeneracy theory** stating that semen is necessary for both physical and sexual potency and also for development of masculine secondary sexual characteristics (Money, 1985). Basing his observations on eunuchs and castrated animals, he asserted that masturbation and patronizing prostitutes are two very harmful practices which leads to the wastage of vital fluid-semen. Thus, to avoid wastage of semen, married people should engage in sex and that too only for the purpose of procreation.

Similarly, abstinence theory was advocated in America by the Reverend Sylvester Graham (Money, 1985) in 1830s. His emphasis was on healthy food, physical fitness and sexual abstinence. During those times the so- called treatments prescribed for masturbation were sewing of foreskin with silver wire or circumcision without any anesthesia (for boys) and burning clitoris with carbolic acid (for girls). The idea was that the consumption of meat would increase sexual urges and desires, thus, people were asked to eat healthy and bland food. From there came, Kellogg's cornflakes, pitched almost as "anti-masturbatory" food (Money, 1986; p. 186).

It was only in 1972. The American Medical Association declared that, "Masturbation is a normal part of adolescent sexual development & requires no medical management" (p.40).

In another part of the world, Sambia tribe of Papua New Guinea, a form of homosexuality is practiced in the context of initiation rituals for males. Two main beliefs of the society being- semen conservation and female pollution (Herdt, 2000; Herdt and Stoller, 1990). The society emphasized on the importance of semen for physical growth, strength and spirituality. They also believed that it takes many inseminations to impregnate a woman and a lot of semen (quantity of semen) is used in the process which body cannot

easily replenish and thus body has to conserve semen. They also considered female body to be unhealthy due to the menstrual fluids it contains. In order to maintain adequate amounts of semen in the body, young men practice semen exchange with each other, thus, learning fellatio (oral sex) to ingest semen. Its only after they reach puberty that they could take penetration roles, inseminating other younger boys. This whole process is to assure that men fulfill their masculine identity and move towards becoming a "full man". Until teenage, any sort of heterosexual contact is prohibited but later, in adolescence they are expected to marry and begin a life of exclusive heterosexual activity.

In India, till September 2018, the Section 377 of Indian Penal Code was a law under which homosexual activities were criminalized considering them as 'against the nature of law'. Thus, it can be said that the ideas around sex and sexuality are also constructed as per the socio-cultural practices and contexts.

Check Your Progress 1

1) How do you explain normal sexuality?

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2) Think of some examples of gender differences in sexuality from your own observation and experience.

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10.4 PARAPHILIC DISORDER

Paraphilias are recurrent, intense sexually arousing fantasies, urges and behavior that involve (a) non-human objects (shoes, hair, etc), (b) suffering or humiliation of oneself or partner (c) children or other non-consenting people. It is to be diagnosed if the condition lasts at least for 6 months. Here, there is deviation (para) in something that the individual is attracted to (philia).

Diagnosing paraphilias have always remained challenging due to a few reasons; with some paraphilias, the individual (having the paraphilia) does not experience distress in himself/herself. For instance, a pedophile who has assaulted and molested child does not feel guilty about it. However, it has been considered as a mental disorder due to its impact on others (especially the child). Another important aspect here is the fact that there are some categories of paraphilias which are also compatible with psychological health and happiness and may neither have signs of distress and may also involve two consenting adults.For instance, someone with a foot fetish may find a partner comfortable with this sexual interest and may readily indulge in it, while, some others may experience shame and guilt in expressing such a desire. Thus, paraphilias are unusual sexual

interests, not causing harm to the individual or others. It is only if they cause harm, they are considered as paraphilic disorders (Blanchard, 2010).

With time, some of these behaviors are also becoming more common, raging a debate if it is appropriate to diagnose some of these behaviors as paraphilic disorders. Fetishistic disorder, sexual sadism and transvestic disorders have not been included in the classification system of the Swedish National Board of Health and Welfare (Langstrom, 2010), stating reasons that people practice variants of sexual behavior safely and with consenting adult partners thus, not to be diagnosed. Paraphilias have a compulsive quality to themselves and as per research some individuals require orgasmic release as often as 5 to 10 times a day (Garcia & Thibaut, 2010).

10.4.1 Fetishistic Disorder

The Fetishistic disorder is marked by recurrent, intense sexually arousing fantasies, urges and behaviors that involve the use of some inanimate object or part of the body to obtain sexual gratification. Clothing (especially undergarments), leather (garter belts etc.) and articles related to feet (women's shoes, stockings) are considered to be common fetishes. Apart from this, some people focus on certain non-sexual parts of the body such as, nails, feet, hands, hair etc. for arousal.

According to DSM-5, it is characterized as a condition with persistent use of or dependence on non-living objects or specific focus on a body part (non-genital) for sexual arousal. In the earlier versions of DSM, arousal revolving around non-genital body parts was called as partialism. DSM- 5 included partialism into fetishistic disorder.

Majority of the reported cases of fetishism are of males, female fetishists are extremely rare (Mason, 1997). Some continue their fetish by themselves in secrecy by kissing, smelling, sucking, fondling or just gazing at the object of interest while masturbating. Others ask their partners to put on the fetish as a stimulant for intercourse. The attraction for a fetishist may seem involuntary and irresistible-compulsive in nature. The disorder may begin in adolescence, although it may acquire its special significance even earlier than this, that is, during childhood. In order to obtain the required object of arousal, some men may even commit theft, burglary or assault. It has been seen that that articles that are most commonly stolen by them are women's undergarments.

One common hypothesis regarding causality of fetishism focuses on classical conditioning and social learning theories (Hoffman, 2012). For example, female undergarment is closely linked to the act of sex and the female body thus becoming an object of arousal. The person with fetishistic disorder feel compulsively attracted towards the object of interest, the attraction is experienced as involuntary and irresistible. The degree of erotic focus is what distinguishes fetishistic disorder from an ordinary attraction.

10.4.2 Voyeuristic Disorder

According to DSM-5, Voyeuristic disorder involves a recurrent and intense desire to obtain sexual arousal and gratification by watching others in a state of undress (especially women) or couples engaging in sexual activity. Such individuals

usually masturbate during their peeping activity and achieve orgasm either while watching the activity or wile remembering the peeping activity. They are commonly called as 'Peeping Tom' (mostly men). For some men with this disorder, voyeurism is the only sexual activity they indulge in; for others, it might be a preferred one but not absolutely necessary for sexual arousal (Kaplan & Kreuger, 1997).

A true voyeur is not excited by watching a woman who is undressing for his benefit. It is the element of risk that is important for the voyeur, and the anticipation of the reaction of woman once she would get to know about him watching her. People with this disorder are mostly charged with loitering than with peeping (Kaplan & Kreuger, 1997).

Watching the body of an attractive woman is a sexually stimulating activity in itself, especially for heterosexual men. The mystery and secrecy around the idea of sex and sexuality tend to increase curiosity to know more about it. Also, if a young man curious to know more about sexual activities feels shy or incompetent in any way, he may accept voyeurism as a substitute to fulfill his sexual needs rather than approaching a female. This may help avoiding rejection thus maintaining the self- esteem and self-status of an individual. Voyeurism commonly occurs with other paraphilias such as exhibitionism (Langstrom & Seto, 2006).

Box 10.3: Case Study: A Peeping Tom

A young, married man lived in an attic apartment with his wife. The wife went out to work in order to enable her husband to attend his school and run the household. She would usually come home late at night tired and irritable and often in no mood for indulging in sexual activity. They also mentioned that "the damned springs in the bed would squeak" perhaps further dampening her spirits. In order "to obtain some sexual gratification", he would try to look through his binoculars at the room next door and would see the young couple there engaged in erotic activities occasionally. As this would stimulate him highly, he continued with this activity. During his second endeavor, he was reported to the police. This offender was found to be immature for his age, moralistic in his attitude towards masturbation and sex, and prone to engage in rich but immature sexual fantasies.

10.4.3 Exhibitionistic Disorder

It is a recurrent and intense urge, fantasy or behavior to obtain sexual gratification by exposing one's genitals to others (usually unwilling strangers) without their consent and in inappropriate circumstances. Very much like voyeuristic disorder, there is rarely an attempt to have an actual contact with the stranger. In some cases, the exposure of genitals is also accompanied by suggestive, vulgar gestures or even masturbation. The exposure may take place in any secluded location or sometimes even in certain public spaces.

It has been understood that the element of shock is highly arousing to these individuals. In many instances, the exposure is repeated under constant sort of conditions. For instance, the offender may exhibit himself at the same place or at the same time of the day every time. For male offenders, in most cases the victim is usually a young or middle aged woman who is unknown (stranger) to the offender. Children and adolescents could also be a target of the offenders.

Exhibitionism is commonly seen to co-occur with voyeurism, sadomasochistic interest and cross-dressing (Langstrom, 2010). It is mainly the intrusive aspect of the whole act, along with the violation of norms related to modesty, respect and privacy of an individual about "private parts", due to which exhibitionism has been considered as a criminal offense.

The urge of the exhibitionist to expose is overpowering and uncontrollable and is perhaps triggered by anxiety, restlessness and sexual arousal. It is perhaps due to the compulsive nature of the urge that the act is repeated, in many cases at the same place and even at the same time of the day. After the act, they may regret and repent it, but in the tension of the moment they may not even care for the legal obstructions.

10.4.4 Sexual Sadism and Masochism Disorders

Both sadism and masochism are about wither inflicting pain (sadism) on others or suffering pain themselves (masochism) (Hucker, 2008). The term sadism is derived from **Marquis de Sade's** name (1740-1814) who would meet out cruelty for sexual purposes. As per DSM-5, a person is to be diagnosed with sadism if he expresses intense sexually arousing urges and behaviors that involve meting out physical and/or psychological pain on another individual. Another closely related pattern to this is "bondage and discipline" (B & D), that may involve tying up a person, hitting, spanking etc. for sexual pleasures. A number of sexually sadistic acts also occur in a consensual sexual relationship without any evident harm to the partners involved. Thus, it becomes all the more important to distinguish transient or occasional sadomasochistic behaviors from sadism or masochism as a paraphilia.

A very small section of males with sexual sadism also enjoy inflicting pain and humiliation acts that are non-consensual and could also be fatal (Krueger, 2010). A sadist may slash a woman's wrist, spank her, tie her up using a harness, and stick her up with a needle to experience orgasm. The act may vary in intensity from one sadist to another, from fantasy to severe disfigurement, damage and even murder in some cases. The diagnosis also includes an important aspect where the victim is to be non-consenting or the one with experience of marked distress and difficulties. In certain cases, sadists are found to mentally replay their torture and harm inflicted on others later while masturbating to attain orgasm. One promising and very important modification that is being worked on is a dimensional approach that could differentiate sexual sadists who are dangerous (like some of the serial killers involved in sadomasochistic tendencies) from those who are not (Krueger, 2010).

The term masochism has been derived from the Austrian novelist, **Leopold V. Sacher-Masoch** (1836-1895). His fictional characters would often indulge in sexual pleasure of pain. According to DSM-5, to be diagnosed with sexual masochism disorder, the person must have experienced recurrent and intense sexually arousing fantasies or behaviors that would involve acts of being beaten, bound or humiliated. However, some forms of masochism can be further worrisome- such as autoerotic asphyxia, that involves self-strangulation. The loss of oxygen to the brain could be resulting on sexual pleasure and orgasm. In some cases, something or the other may go wrong which would result in the individual harming himself by accidentally hanging himself. It may look absurd and even ironic that inflicting or receiving pain could be sexually arousing, but it

is not uncommon. Some of these behaviors are also usually mild and harmless (Krueger, 2010).

10.4.5 Pedophilic Disorder

Pedophilia is also called as pedohebephilllic disorder wherein, *pedes* is Greek for "child", *hebe* is "pubescence" and *phillia* means "attraction". Thus, it is diagnosed when adults are said to derive sexual pleasure (recurrent, intense and distressing desire and urge) through sexual contact with prepubertal children. DSM-5 requires the offender to be at least 18 years old and at least 5 years older than the child. Most people with the said disorder report to use child pornography to sexually gratify themselves (Riegel 2004) and thus it has been added in the DSM criteria. Action is not considered necessary for the diagnosis. A person with this disorder is sometimes content with just stroking the child's hair, but may also be found to be fondling with the child's genitalia or encouraging the child to manipulate his/her genitalia. Penetration although can cause injury but is not the goal, it could be a by- product of the activity. If not found by adults or protested by the child, such acts may continue for months or even years. Thus, it is considered to be the most tragic sexual deviance (Blanchard, 2010).

Almost all the individuals with pedophilia are males, and about 2/3rd of their victims are young girls, between the ages of 8 and 11 (Cohen &Galynker, 2002). Pedophilia is usually first recognized in the adolescence and then may persist for a lifetime. These child molesters are usually found to engage in various cognitive distortions which are self- justifying in nature, such as, the child will benefit from the sexual contact and that the child often initiates such contact (Marziano et al. 2006). Some pedophiles have been found to idealize innocence, unconditional love and simplicity- the core aspects of childhood (Cohen & Galynker, 2002). It has also been discovered the majority of the offenders have themselves been abused as a child (Lee et al. 2002).

Box 10.4

The World Health Organization has defined main types of child abuse as physical abuse, sexual abuse, emotional abuse, and neglect. Child sexual abuse (CSA) has increased over the years not only in India but the world over. The spaces like home, schools, hotel, and other public places, have witnessed CSA. The experience has a traumatic effect resulting in changes in the brain, physical and psychological problems like depression, posttraumatic disorder, suicide and such other disorders. The Government of India passed The Protection of Children from Sexual Offences Act (POCSO) in 2012 to effectively address the menace of CSA. POCSO Act was modified in 2019 to include death penaltyforaggravated sexual assault, strict punishment to those engaging in crimes against children, levying fines and imprisonment to curb child pornography. To facilitate direct reporting of CSA and timely disposal of cases, the Ministry of Women & Child Development launched POCSO e-box.

10.4.6 Incest

Incest refers to sexual intimacy and relations between close relatives, between whom marriage is forbidden as per the societal norms. These are culturally prohibited sexual relations between brother and sister or a parent and child. One of the most pathological ones being the relationship between father and daughter. Incest is considered as a taboo in almost all the societies with Egyptian pharaohs being an exception, who would marry their sisters to save royal blood from "contamination". According to present scientific knowledge, incest may have a

legitimate reason behind it. The offspring from a father-daughter or brother-sister pair will have a greater possibility of inheriting a recessive gene from each parent, which might be a carrier of some disease or disorder. Thus, avoiding mating between close relatives to evade some mental and physical illnesses. As per the evidence, families with cases of incest are usually extremely male dominated and patriarchal and the parents are also usually more neglectful and emotionally distant (Madonna, Van Scoyk & Jones, 1991).

Box 10.5: Case Study: Incest

In 2007, the case of an Austrian incest perpetrator Josef Fritzl shook the entire world. He had kidnapped his daughter Elisabeth when the girl was 18 and had imprisoned her in a soundproof compartment that he had built in the basement of his house. The girl was forced to write a note stating that she had joined a cult and was thus leaving the family. During her long imprisonment, she was repeatedly forced by her father to indulge in sexual activity. She bore seven of his children, one of whom died in infancy. Three children were reared by the family upstairs and other three lived with her in the basement. Owing to one of the child's illness, she went to the hospital and there the staff found Fritzls' story to be suspicious finally leading to investigation and ending Elisabeth's ordeal (Dahlkamp et al. 2008).

Check Your Progress 2

1) How difficult it is to diagnose paraphilias?

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2) Differentiate between voyeuristic and fetishistic disorders.

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3) List the important features of paedophilic disorder.

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10.5 ETIOLOGY OF THE PARAPHILIAS

Most people do not want to talk about their paraphilias and thus it leaves very few opportunities with the researchers to understand their causes. Most of the studies rely on very small and non-representative samples (Kafka, 2010) due to which making conclusions with certainty is always questionable.

10.5.1 Neurobiological Factors

As majority of people with paraphilias are men, there has been a major assumption that androgens (male hormones like testosterone) may have a role to play. Androgens are important in regulating sexual desires and it has been found that

sexual desire is uncharacteristically higher in people with paraphillias(Kafka, 1997). But, men with paraphilias do not have higher levels of androgens in their bodies (Thibaut, De La Barra, Gordon,Cosyns & Bradford, 2010). Thus, there are inconclusive results in the area.

Psychopathologists are also showing interest in the phenomenon of weak inhibitory control in these paraphilic disorders. This may be indicative of a weak biologically based Behavioral Inhibition System (BIS) in brain (Ward & Beech, 2008) which might be responsible for repressing the serotonergic functioning.

10.5.2 Psychological Factors

While understanding the plausible psychological theories of paraphilias a number of risk factors have been seen to play a role-conditioning experiences, sexual abuse, cognition, distortion and past relationships. Disordered relationships during childhood or adolescence may also play a role in development of healthy sexual relationships in future (Ward & Beech, 2008). Many pedophiles have reported of being abused as a child, which is a strong predictor of later sexual abuse by the victim, that is, victim turns the perpetrator (Fagan, Wise, Schmidt & Berlin, 2002). But in many cases, these first time or early instances do not reflect their sexual patterns, thus, leaving gap in the literature.

Some behaviorists argue that classical conditioning may also be a reason for paraphilias. By chance an unusual or inappropriate stimulus got associated with sexual arousal (Kinsey, Pomeroy & Martin, 1948). For example, a young man may masturbate to images of women dressed a certain way and repetition of the same over a period of time may make that 'certain way' sexually arousing for the individual. Similar hypotheses have been made for pedophebephilic, exhibionistic, voyeuristic and other paraphilias. There is support to this theorization (Rachman, 1996), yet there are researches that do not support most of the components of classical conditioning (O'Donohue & Plaud, 1994). It is also important to mention here that before a sadist or a pedophile acts on their behavior, they already may have fantasized about it many times about it while masturbating and gaining pleasure. Thus, sexual arousal or orgasm already gets reinforced through association with a specific stimulus.

Some paraphilias are also considered as an outcome of inadequate social skills. Evidence suggests that men with pedohebephilia often have poor social skills (Dreznick, 2003). Another question is that do these people have conventional sexual relationships or these paraphilias act as substitutes. There are evidence to both the sides.

Cognition and the distortions also have a role to play in understanding paraphilias. It has been found that men engaging in paraphilias with non-consenting women often have a hostile attitude towards women. For instance, a voyeur may believe that a woman who is at a place where she can be easily watched over while undressing, in reality wanted someone to look at her (Kaplan & Kreuger, 1997). Some researchers have also pointed at the role of alcohol and negative affect especially as a trigger to pedohebephilic, exhibitionst or voyeurist incidents. Table 10.1 highlights some of the cognitive distortions of people with various paraphilias and rape.

Table 10.1: Examples of Cognitive Distortions in Sexual Paraphilias and Rape

Category	Pedohebephelllic disorder	Exhibitionistic disorder	Rape
Misattributing blame	"She started it by being cuddly."	"The way she was dresses, she was actually asking for it."	"She was saying no, but her body was saying otherwise"
Denying sexual intent	"I was just teaching her about sex…. Its good it came from her father"	"I was just looking for a place to pee."	"She deserved it, I was trying to teach her a lesson."
Justifying the cause	"If I wasn't molested as a child, I'd never have done this."	"If I only knew how to get a date, I wouldn't have to expose."	"I she would have given me what I wanted, I wouldn't be forced to rape her."
Deflecting censure	"This happened years ago. Let's just forget about it."	"It's not that I have raped anyone."	"I only did it once."

Source: Maletzky (2002)

10.6 TREATMENT OF PARAPHILIAS

Most of the behaviors involved in paraphilias is considered to be illegal. Thus, someone diagnosed with it is usually imprisoned and then treatment is given to them. How to enhance motivation to change the behavior?

Usually people with paraphilias deny having a problem and state that they can control their behavior on their own without any professional assistance. A lot of times the blame is shifted on the victims. Following tips can be followed to enhance their motivation to change (Miller & Rollnick, 1991)

1) It is important to feel empathetic towards the reluctance of the offender to admit his/her state and seek treatment.
2) Point out how treatment could be of possible help to him/her and its positive consequences.
3) Highlight the negative consequences of refusing the treatment- both legal and personal.
4) Make him/her understand that how psychophysiological assessments will make the sexual tendencies and proclivities very clear.

Behavior therapy is mainly directed at altering the associations from arousing to neutral. **Covert sensitization** is used for it, where short-term pleasure usually overweighs long-term harm because of the strong immediate reinforcement and gratification it is providing. So, the patients are asked to associate sexually arousing images (in imagination) with reasons as to why they are harmful.

Cognitive procedures are also used to counter distorted views (mentioned in Table 11.1) and modify them. Therapists also use social skill training and sexual impulse training to modify these thinking patterns (Maletzky, 2002). Empathy based training modules are also designed to help the sexual offenders.

A popular drug used to treat people with paraphilias is an androgen named *cyproterone acetate* (Seto, 2009). This is like "chemical castration" wherein the drug reduces or eliminates the sexual desire by decreasing testosterone levels in the body. Another one that is used is, medroxyprogesterone (Fagan et al., 2002). These drugs are effective only when taken regularly.

Box 10.6: DSM Criteria for Paraphilic Disorder (APA, 2013)

Fetishistic Disorder

A. Over a period of at least 6 months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on nongenital body part(s), as manifested by fantasies, urges, or behaviors.

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

C. The fetish objects are not limited to articles of clothing used in cross-dressing (as in transvestic disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator).

Transvestic Disorder

A. Over a period of at least 6 months, recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviors.

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

Voyeuristic Disorder

A. Over a period of at least 6 months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, as manifested by fantasies, urges, or behaviors.

B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The individual experiencing the arousal and/or acting on the urges is at least 18 years of age.

Exhibitionistic Disorder

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors.

B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Sexual Sadism Disorder

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors.

B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Sexual Masochism Disorder

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors.

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

Pedophilic Disorder

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

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

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

Check Your Progress 3

1) What are the psychological causes of paraphilias?

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2) In what ways does behaviour therapy treat paraphilias?

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10.7 GENDER DYSPHORIA

The essence of masculinity and femininity is a deep-seated personal sense and has been termed as gender identity which is different from gender roles. Gender roles are about the masculinity and femininity of overt behavior. Although gender identity has a strong correlation with the biological sex, but the correlation is not perfect. Some people feel as if they are trapped in a body of wrong sex, that is, their physical gender is not consistent with their sense of identity.

As per DSM-5, Gender Identity Disorder is termed as Gender Dysphoria. It is the discomfort one has with one's sex-based physical characteristics or with one's societally assigned gender. The change has been made to make the diagnosis more descriptive and theoretically as neutral as possible. So, people who were diagnosed with gender identity disorder (GID) earlier will certainly experience gender dysphoria. It has been taken into consideration that the degree of dysphoria may vary or fluctuate over a period of time within the same individual (Cohen-Kettenis & Pfafflin, 2010). Gender dysphoria can be diagnosed either during adolescence or adulthood or even at the childhood stage.

10.7.1 Gender Dysphoria in Childhood

Boys who have gender dysphoria usually show a marked preoccupation with the activities which are typically and traditionally defined as feminine (Zucker & Bradley, 1995). They prefer to dress like girls and enjoy activities and games like playing with dolls or playing house. While playing house, they most often become a mother. They usually avoid rough play behavior and express their desire to be a girl. They may like watching shows with their favorite woman character. They are often laughed upon called as "sissies" by their friends.

Girls with gender dysphoria usually recoil or become hesitant at their parents' attempt to dress them up in traditional feminine clothes. They prefer short hair and fantasize typically powerful heroes like ironman, superman etc. They show lesser interest in playing with dolls and rather are interested in other sports. They look like what we call as 'tomboys' but differ from them due to their desire to be a boy or grow up as a man. They are often misidentified by strangers as boys. Usually girls with gender dysphoria are treated better in comparison to boys with gender dysphoria (Cohen-Kettenis et al. 2003).

It is interesting to note that most common adult outcome of boys with gender dysphoria is homosexuality rather than transsexualism (opting for surgeries for sex change) (Zucker, 2005). Researchers over the years have argued that such children should not be considered "disordered" as they might be unhappy due to the societal pressure and bias of negative attitude towards cross-gender behavior. But some others have concluded it to be due to the discrepancy between their biological sex and psychological gender and are called as with mental disorder (Zucker, 2005). Also, they are laughed upon and mistreated by their peers, have tensed relationships with their parents leading to their distress eventually. It is again important to note here that some cultures (like Samoa) do not show stigma towards gender non-conforming children (Vasey & Bartlett, 2007).

10.7.2 Treatment

For children and adolescents with gender dysphoria the attempt is to mainly deal with child's unhappiness with the biological sex and to ease the relationship with the parents (Zucker et al. 2008). They may also have mood and anxiety related issues that may need therapeutic attention. To treat gender dysphoria, psychodynamic perspective has been found to be helpful herein the inner conflicts are examined, understood and resolved. Two important facts to note about gender dysphoria are: first, for most children with gender dysphoria, the problem remits during childhood only (Wallien & Cohen-Kettenis, 2008). Second, children who remain with dysphoria till their adolescence may remain so even in their adulthood and may opt for sex reassignment surgeries.

Box 10.7: DSM Criteria for Gender Dysphoria (APA, 2013)

Gender Dysphoria in Children

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

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

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

Gender Dysphoria in Adolescents and Adults

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

1) A marked incongruence between one's experienced/ expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2) A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3) A strong desire for the primary and/or secondary sex characteristics of the other gender.

4) A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5) A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6) A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

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

10.8 TRANSSEXUALISM

Adults with gender dysphoria may have a desire to change their sex permanently and transit to the gender with which they identify, it is called as transsexualism. This is usually done by seeking medical assistance (Cohen-Kettenis & Pfafflin, 2010). It is perhaps a rare disorder as some of the past European researches have suggested that about 1 in 30,000 males and 1 in 100,000 females seek this sex reassignment surgery. But some recent studies have suggested that approximately 1 in 12,000 men in Western countries opt for it (Lawrence, 2007).

It is important to note that many transsexuals had gender dysphoria as children but most children who have gender dysphoria do not opt for sex reassignment surgeries. Most of the female-to-male transsexuals recall being 'tomboyish' as children and most of them are sexually attracted to women. But, in the case of male-to-female transsexuals there can be two kinds-*homosexual* and *autogynephilic transsexuals* (Bailey, 2003). Homosexual transsexuals are very much like gay men with same sex orientation. So, they are attracted to males, which is their biological sex before the surgery. But, because they identify themselves as women, they often define their sexual orientation as heterosexual. For autogynephillic transsexuals, they are attracted to thoughts, images or fantasies of themselves as women (Blanchard, 1991, 1993).

Attempts have been made to understand transsexualism. One of the hypotheses in this regard says that there could be some prenatal hormonal influences due to which children with gender identity disorder may later become transsexuals (Meyer-Bahlburg, 2010). There is also a possibility that some families are more in support of their boys' 'defeminization' as compared to others. It is also important to highlight that they are different from people with transvestic fetishism as their purpose of cross dressing is not sexual arousal or gratification. Here, the goal is to live life in a manner that is consistent with that of the gender they prefer to be. They must also be distinguished from intersex individuals as they are not born

with ambiguous genitalia or associated with any hormonal or physical abnormalities.

10.8.1 Treatment

It has been agreed upon that usually psychotherapy is not very effective with adolescents or adults with gender dysphoria (Cohen-Kettenis, Dillen & Gooren, 2000; Zucker & Bradley, 1995). However, surgical sex reassignment has been found to be effective. Biological men are given estrogen for breast development, skin softening etc. and biological women are given testosterone to increase facial and bodily hair, deepen the voice and cease menstruation. Living with hormonal therapy serves as a trial period for them before undergoing surgery. Only a small section of female-to-male transsexuals seek an artificial penis as the surgery is quite expensive and also not very well developed. Another important point to consider here is that the artificial penis is not capable of erection and thus they must always rely on artificial ways to have intercourse. Thus, many also function sexually without penis.

Check Your Progress 4

1) What does 'gender dysphoria' mean?

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2) Is there any relationship between transsexualism and gender dysphoria?

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10.9 SEXUAL DYSFUNCTIONS

Sexual dysfunction refers to impairment in the desire or ability to achieve sexual pleasure and gratification. It can mainly be divided in 3 categories (as proposed by DSM-5): those involving sexual desire and arousal; orgasmic disorders and sexual pain disorders. Separate diagnostic criteria have been provided for both men and women. Sexual dysfunction may occur in both homosexual and heterosexual couples. It can be due to psychological or interpersonal reasons or may have physical factors involved behind it. It is also important to note that they might be a secondary consequence to certain medications people may be taking (Baron-Kuhn & Segraves, 2007). For sexual dysfunctions to be diagnosed it is important that the dysfunction should be persistent and recurrent and should result in marked clinical distress with functioning.

Table 10.2: List of Different Sexual Dysfunctions according to DSM-5

In Men	In Women
Delayed ejaculation disorder	Female orgasmic disorder
Erectile disorder	Female sexual interest/arousal disorder
Early ejaculation disorder	Genito-Pelvic pain/penetration disorder
Male hypoactive sexual desire disorder	
In both Men/Women: Substance/medication-induced sexual dysfunction	

10.9.1 Male Hypoactive Sexual Desire Disorder

A person diagnosed with hypoactive sexual desire disorder has little or no interest in any sexual activity and has been distressed due to low levels of sexual thoughts and desires for at least 6 months. (Wincze, Bach, & Barlow, 2008; Wincze, 2009). There are other ways to gauge it-if the frequency of sexual activity is less than twice a month for a married couple, or if they do not think about sex at all. There are men who may have sex twice a week but just to keep their marriage safe and in reality, do not think about sex at all.

It is important to understand the possible factors that may be behind it before the diagnosis is given- it could be due to some problems emanating from partners, due to some cultural beliefs or even personal vulnerabilities or a medical condition. Many experts have a belief that it is usually acquired or situational rather than lifelong.

Treatment: It has been found that psychological factors are perhaps more closely linked to low sexual desire in men in comparison to hormonal factors. Thus, psychological treatment and therapies are more effective. For men with low testosterone levels, testosterone injections are used (Brotto, 2010). But still more research is required to understand the probable treatment procedures of this disorder.

10.9.2 Erectile Disorder

Erectile disorder is a sexual arousal disorder. Here, the issue is not sexual desire. Individuals with arousal disorder may have sexual urges and a strong desire to have sex but the problem is in becoming physically aroused. A male with an inability to achieve or maintain erection sufficient enough for sexual intercourse is diagnosed with the erectile disorder (Wincze, 2009). It is diagnosed only when the difficulty has a psychogenic origin for a combination of psychogenic and medical factors are involved.

Masters and Johnson (1975) hypothesized that anxiety about sexual performance can lead to erectile dysfunction. Later, Barlow and colleagues (1983, 1996) have questioned the role of anxiety as anxiety can also enhance sexual performance. Barlow (2002) highlighted that the cognitive distractions associated with anxiety in dysfunctional men may interfere with sexual arousal. They may also get distracted by negative thoughts about their performance during a previous sexual encounter. Thus, their distraction and preoccupation with negative thoughts than anxiety has a role to play here in inhibiting their sexual arousal (Wincze et al.,

2008) and further feeding on the self-defeating thoughts due to the inability to achieve erection. For majority of men who take antidepressant medicines (SSRIs), erectile dysfunction could be a side effect (Rosen & Martin, 2003). Increase in age can also lead to erectile difficulties (Lindau, Schumm, Laumann, Levinson, O'Muircheartaign& Waite, 2007). Most of the cases of erectile dysfunction in older men can be due to vascular diseases due to which the ability of the penis to hold blood decreases to maintain an erection. Thus, hardening of the arteries, high blood pressure, and other diseases such as diabetes that cause vascular problems often account for erectile disorder. Smoking, obesity, and alcohol abuse are associated lifestyle factors, and lifestyle changes can improve erectile function (Gupta et al., 2011).

Treatment: A number of medical treatment techniques are employed in this case, especially when cognitive behavioral techniques fail. These treatment techniques include: (1) medicines to promote erection (Viagra, Levitra, Cialis); (2) injections of smooth-muscle-relaxing drugs onto erection chambers; (3) a vacuum pump (Duterte, Seagraves & Althof, 2007). In cases of nerve damage and thus inability to achieve erection, penile implants are used. These are the devices made of silicone rubber which can be inflated to provide erection on demand. The commercial success of drugs like Viagra and Cialis is indicative of the prevalence of sexual dysfunction in men and also the high importance people give to sexual performance. Studies also reveal that of these medicines are used in conjunction with cognitive-behavioral therapy, their effects can be enhanced (Meston & Rellini, 2008).

10.9.3 Early Ejaculation Disorder

"Premature ejaculation" of DSM-IV-TR is called as early ejaculation disorder in DSM-5. Ejaculation may occur before, on, or very shortly after penetration, much before the man wants it to. Studies have revealed that the average duration of time to ejaculate with this disorder is almost 15 seconds. Very importantly, the major consequence of this disorder is failure of the partner to achieve sexual satisfaction and also embarrassment for the early ejaculating man. Due to early ejaculation both the sexual and interpersonal relationship of the individual with their partner gets impacted negatively (Graziottin & Althof, 2011). As per DSM-5, a number of factors might impact the time of ejaculation but the key element to diagnosis is if the ejaculation occurs before, on, or just after penetration and that too before the man wants it then the individual may be diagnosed with early ejaculation disorder. This is because, in sexually normal men, the ejaculatory impulse is under voluntary control, at least to some extent. They can forestall ejaculation from penetration to almost 10 minutes. Men with early ejaculation are unable to do so effectively. There can be a variety of factors working behind it such as higher anxiety levels, high penile sensitivity or high levels of arousal to sexual stimuli. Yet, the explanation remains insufficient to understand the reasons behind early ejaculation.

Treatment: Behavioral therapy has been used a lot to deal with the issue of early ejaculation, especially the technique of 'pause-and-squeeze' as developed by Masters and Johnson (1970). But, some recent studies have reported lower success rate of the technique (Duterte et al. 2007). It has been found that the antidepressants such as Paroxetine, Sertraline, Fluoxetine and Dapoxetine are helpful in prolonging ejaculation as it blocks the serotonin reuptake (Jannini & Porst, 2011).

10.9.4 Delayed Ejaculation Disorder

It refers to the inability to ejaculate during intercourse in men. Men with total inability to ejaculate are rare and about 85 percent of men who have delayed ejaculation disorder can achieve orgasm by getting stimulation in other ways, mainly during solitary masturbation (Wincze et al., 2008). In some other cases, men can ejaculate in front of the partner but only through manual or oral stimulation. Delayed ejaculation can also be due to physical issues such as multiple sclerosis or use of some antidepressants.

Treatment: Couple therapy in which man tries to achieve orgasms through intercourse with a partner has found to be effective. It is important to reduce the performance anxiety about achieving the orgasm versus sexual gratification and intimacy (Meston & Rellini, 2008). This is also done using behavioral therapy and cognitive behavioral therapy approaches.

10.9.5 Female Sexual Interest/Arousal Disorder

As per the research, women who have low sexual desire also have lower levels of arousal during sexual activity and thus, for women, DSM- 5 has combined the category of interest and arousal in the disorder Female Sexual Interest/Arousal Disorder. Psychological factors have an important role to play in reduced sex drive (Meston & Bradford, 2007). There is one slight issue with the diagnosis of this disorder. People usually come to get themselves treated on the behest of their partners and also due to readily available public knowledge on their own owing to their understanding of frequency of sexual contact. It is important to know that frequency of sexual contact vary widely among normal individuals, therefore, it becomes difficult to decide what is "not enough" and would require clinical intervention. DSM-5 leaves this judgment to the clinician on the basis of patient's age, and life context. If a person has depression or had it in the past, that could also contribute to sexual desire disorder (Meston & Bradford, 2007). Testosterone may also have a role to play in diminishing sexual desire but testosterone replacement therapy is beneficial (both in men and women) only in the cases of people with very low testosterone (Meston & Rellini, 2008).Daily hassles, worries, poor relationship and lesser satisfaction, conflicts and disagreements, weak or reducing emotional bonding may also contribute to sexual desire disorder (Meston & Rellini, 2008).

Until recently, female sexual desire and the disorders related to it was not given a lot of importance. This could have been due to sweeping mindset and a myth that women do not care much about sex. But recently, some findings have suggested that a linear progression from desire to arousal and finally orgasm, as originally posited, might not be there always in the case of women (Meston & Bradford, 2007). For many women sexual desire is experienced only after sexual stimuli has led to subjective sexual arousal (Basson, 2003; Meston & Bradford, 2007). For some sexual activity may act as a motivator to enhance emotional intimacy or self-image as an attractive woman (Basson, 2003, 2005).

Major manifestation of sexual arousal disorder is failure to achieve the swelling and lubrication of the vulva and vaginal tissues making sexual intercourse difficult and uncomfortable. The cause is not being researched upon very well but it could range from sexual traumatization at an early stage to the twisted and tabooed views of the society about "sex". It could also be due to disinterest in the current

partner. Biological factors behind it could be the usage of SSRI medicines or some sort of medical illness (Diabetes, some injury etc.), and reduced levels of estrogen especially during menopause.

Treatment: No effective aphrodisiacs exist as such to help in enhancing sexual desire. As mentioned earlier, injecting testosterone works with men and women who have very low testosterone levels. Some studies (such as Segraves et al. 2004) have highlighted that continuous use of Bupropion (antidepressant), may improve sexual arousal and orgasm frequency in women with hypoactive sexual desire disorder. Very much like other sexual dysfunctions, patients are taught some sensate focus exercises involving couples to learn to focus on pleasurable sensations by touching without making intercourse or achieving orgasm as a major goal.

10.9.6 Genito-Pelvic Pain/Penetration Disorder

DSM-IV-TR had mentioned two sexual pain disorders: *vaginismus* and *dyspareunia* which have been combined in DSM-5 because of lack of scientific report to support distinct categories (Binik, 2010). Vaginismus was understood to be an involuntary spasm of the muscles near the vaginal entrance, thus preventing penetration and sexual intercourse. But these vaginal spasms could not be reliably diagnosed and women who were diagnosed with vaginismus basically complained of pain during penetration and anxiety before and during sexual intercourse (Reissing et al. 2003). Confusion over difference between the two is over the fact that the hallmark symptom of vaginismus does not occur clearly whereas the chief symptom of dyspareunia (genital pain associated with sexual intercourse encounters) is common in women with vaginismus as well. Thus, in DSM-5 both have been combined together. Studies have revealed that genito-pelvic pain disorder has more of a biological basis than psychological. It could occur due to infections or inflammation of vagina, vaginal atrophy that may occur with age, scars and bruises from vaginal tearing or lack of sexual arousal.

Some researchers have argued against categorizing sexual pain disorders as sexual disorders (Binik, 2005; Binik et al., 2007) as the pain caused here is qualitatively similar to the pain in other areas of the body and even the cause of pain is similar to other pain disorders. Thus, they have argued to categories these as pain disorders.

Treatment: Cognitive-behavioral interventions including education about sexuality, cognitive restructuring, progressive muscular relaxation and vaginal dilation exercises have been found to be effective in sexual pain disorders (Bergeron, Biniketal., 2001). Some medical treatments such as surgical removal of the vulvar vestibule has been found to be successful.

10.9.7 Female Orgasmic Disorder

Female orgasmic disorder can be diagnosed in women who have no issues pertaining to sexual arousal or otherwise enjoying sexual activity but show recurrent delay or absence of orgasm after the excitement phase (as per DSM-5). They would also be distressed by this. Achieving orgasm through clitoral stimulation during sexual intercourse is such a common occurrence and thus is

not regarded as a dysfunction (Meston & Bradford, 2007). However,there is a small percentage of women who can achieve orgasm only through direct mechanical stimulation of clitoris, oral stimulation or through electric vibrators. And, there are some who are unable to achieve orgasm under any sort of stimulation, called as *lifelong orgasmic dysfunction*. The diagnosis of orgasmic dysfunction in women has always been complicated due to the subjective quality of orgasm, as it varies from one woman to another or within the same woman from time to time (Graham, 2010). There can be various contributory factors towards female orgasmic disorder such as feeling fearful about the sexual relationship, feeling of inadequacy, anxiety and tension. Some women also tend to experience sexual guilt (common in religious women if not experiencing orgasm). Some other try to pretend having an orgasm or fake orgasms, this may leave them irritated and frustrated with themselves and eventually their partners as well. Yet, researchers have not been able to identify the cause with certainty. Possible biological factors responsible here could be intake of SSRIs. Some recent evidences have suggested that the genital anatomy of women and the differences in it (from one to another) may allow some to achieve orgasm more easily than others (Wallen & Lloyd, 2011).

Treatment: There has always been questions if treatment should be sought for orgasmic disorder (especially in women) and clinicians have come to agree that the decision should be best left to women themselves about it. But, in cases with lifelong orgasmic disorder it is best to seek treatment. Cognitive behavioral treatment involves education about anatomy, sexuality and masturbation exercises. Gradually the partner is involved in helping to attain orgasm (Meston &Rellini, 2008). It' is important to note here that situational anorgasmia may have psychological and relationship related issues involved and are more difficult to treat (Althof & Schreiner-Engel, 2000).

Box 10.8: DSM Criteria for Different Sexual Dysfunctions in Men and Women (APA, 2013)

Men

Delayed Ejaculation

A. Either of the following symptoms must be experienced on almost all or all occasions (approximately 75–100 percent) of partnered sexual activity (in identified situational contexts or, if generalized, in all contexts), and without the individual desiring delay:

   1) Marked delay in ejaculation.

   2) Marked infrequency or absence of ejaculation

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/ medication or another medical condition.

Erectile Disorder

A. At least one of the three following symptoms must be experienced on almost all or all (approximately 75–100 percent) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
   1) Marked difficulty in obtaining an erection during sexual activity.
   2) Marked difficulty in maintaining an erection until the completion of sexual activity.
   3) Marked decrease in erectile rigidity.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/ medication or another medical condition.

Premature (early) Ejaculation

A. A persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it.

   Note**:** Although the diagnosis of premature (early) ejaculation may be applied to individuals engaged in nonvaginal sexual activities, specific duration criteria have not been established for these activities.

B. The symptom in Criterion A must have been present for at least 6 months and must be experienced on almost all or all (approximately 75–100 percent) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts).

C. The symptom in Criterion A causes clinically significant distress in the individual.

Male Hypoactive Sexual Desire Disorder

A. Persistently or recurrently deficient (or absent) sexual/ erotic thoughts or fantasies and desire for sexual activity. The judgment of deficiency is made by the clinician, taking into account factors that affect sexual functioning, such as age and general and sociocultural contexts of the individual's life.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual. D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to these effects of a substance/medication or another medical condition.

Women

Female Orgasmic Disorder

A. Presence of either of the following symptoms and experienced on almost all or all (approximately 75–100 percent) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):

   1) Marked delay in, marked infrequency of, or absence of orgasm.

   2) Markedly reduced intensity of orgasmic sensations.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress (e.g., partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Female Sexual Interest/Arousal Disorder

A. Lack of, or significantly reduced, sexual interest/arousal, as manifested by at least three of the following:

   1) Absent/reduced interest in sexual activity.

   2) Absent/reduced sexual/erotic thoughts or fantasies.

   3) No/reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate.

   4) Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75–100 percent) sexual encounters (in identified situational contexts or, if generalized, in all contexts).

Check Your Progress 5

1) List the sexual dysfunctions in men and women.

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2) Define sexual dysfunction.

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10.10 SUMMARY

Now that we have come to the end of this unit, let us list all the major points that we have learnt.

- Sexuality is considered to be one of the most private aspects of life which may contribute to love, happiness and pleasure. Sex is considered as a taboo in various societies and cultures and in many societies, it is talked openly.
- The human sexual cycles consist of desire phase, arousal phase, plateau phase, orgasm phase and resolution phase.
- Researches have concluded gender differences in sexuality behaviour. The experience and acceptance of sex and sexual practice has also varied across times and cultures.
- Paraphilias are recurrent, intense sexually arousing fantasies, urges and behavior that involve non-human objects (shoes, hair, etc.); suffering or humiliation of oneself or partner; children or other non-consenting people. It is to be diagnosed if the condition lasts at least for 6 months.
- The paraphilic disorders are fetishistic disorder, transvestic disorder, voyeuristic Disorder, exhibitionistic disorder, sexual sadism disorder, sexual masochism disorder, and pedophilic disorder.
- Neurobiological and psychological factors play an important role in the etiology of paraphilias.
- According to DSM-5, Gender Identity Disorder is the discomfort one has with one's sex-based physical characteristics or with one's societally assigned gender.
- The common sexual dysfunctions in men are delayed ejaculation, erectile dysfunction, and early ejaculation. In females, the sexual dysfunctions are female orgasmic disorder, female sexual interest/arousal disorder, and genito-pelvic pain/penetration disorder.
- Psychological and medical treatment options are available for sexual dysfuctions.

10.11 KEYWORDS

Incest: Refers to sexual intimacy and relations between close relatives, between whom marriage is forbidden as per the societal norms.

Paraphilias: Recurrent, intense sexually arousing fantasies, urges and behavior that involve (a) non-human objects (shoes, hair, etc), (b) suffering or humiliation of oneself or partner (c) children or other non-consenting people.

Fetishistic disorder: Characterised as a condition with persistent use of or dependence on non-living objects or specific focus on a body part (non-genital) for sexual arousal.

Exhibitionistic disorder: Characterised by recurrent and intense urge, fantasy or behavior to obtain sexual gratification by exposing one's genitals to others (usually unwilling strangers) without their consent and in inappropriate circumstances.

Sexual dysfunction: Impairment in the desire or ability to achieve sexual pleasure and gratification. It can mainly be divided in 3 categories: those involving sexual desire and arousal; orgasmic disorders and sexual pain disorders.

Transexualism: When adults with gender dysphoria may have a desire to change their sex permanently and transit to the gender with which they identify.

10.12 REVIEW QUESTIONS

1) Discuss the causal factors in the etiology of paraphilias.
2) Elucidate the role of socio-cultural factors in development of gender differences in sexuality.
3) Describe the paraphilic disorders as listed in DSM-5.
4) Explain the development of gender identity disorder in children.
5) What are the main criteria for sexual dysfunctions in men and women? Discuss the treatment approaches.

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10.14 WEB RESOURCES

- Understanding Paraphillic Disorders and Treatment of sexual offenders
  https:/www.youtube.com/match?v=-z-29ihOj8&=17s
- Sexual offending: Measuring and understanding paedophilic sexual interest by Dr. Carolite O. Ciardha
  http://www.youtube.com/watch? v=GVIyah XoOg

UNIT 11 SUBSTANCE-RELATED DISORDERS AND BEHAVIORAL ADDICTIONS*

Structure

Learning Objectives

After reading this Unit, you will be able to:

- Differentiate between substance use, abuse, and dependency;
- Explain the harmful physical and psychological effects of alcohol and drug use;
- Describe the etiology of substance use disorders;

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- Elucidate treatment and prevention of substance use disorders; and
- Explain the nature of gambling disorder.

11.0 INTRODUCTION

Use of different substances to achieve desired psychological effects are common for all individuals. For example, many of us use substances that are addictive to wake up (tea/coffee), to feel energetic (soft drinks and energy drinks), stay attentive (cigarettes), to relax (alcohol), or to reduce pain (pain killer medicines). However, some individuals become 'addicted' to certain substances i.e. they develop a pathological need for the substance leading to distress and dysfunction to the entire family. Substance-related addictions like alcohol and drug dependencies are serious global concerns for scientists as well as the public. Substance-related disorder is a mental illness in which an individual faces stigma as well as apathy from the public who consider such individuals to be a nuisance to the society. A number of crimes including sexual assault, rape, and murders are linked to substance use and abuse. Studies report that addictions are maladaptive patters of adjustment to stressful situations. However, this does not remove personal responsibility from the etiology of substance-related disorders. Personality traits and individual lifestyles contribute to the development of substance dependencies. Alcohol and drug use and abuse common across all socio-economic strata and age groups, are responsible for immense human suffering and tragic waste of thousands of lives every year. It is one of the most common and difficult to treat problems faced by the society today. In this Unit, we will focus on the substance use disorders, alcohol use disorder, and drug use disorders. There causes and treatment will be also be discussed. Gambling disorder, which has been included in DSM-5 for the first time, will also be explained.

11.1 IMPORTANT TERMS RELATED TO SUBSTANCE-RELATED DISORDERS

DSM-5's chapter on addictions was changed from "Substance-Related Disorders" to "Substance-Related and Addictive Disorders" to reflect changes in our understanding of the concept of 'addictions'. DSM-5 asserts that 'addiction' should be enlarged to include not just psychoactive substances, but also types of behavior such as gambling that shows similarity in experiences and biology of those addicted to substances like alcohol, nicotine, heroin, cocaine etc.

The following terms are important to understand substance-related disorders.

Psychoactive substances*:* Psychoactive substances are those that affect the mental functioning of an individual by affecting one's central nervous system (CNS). Psychoactive substances are classified as *sedatives* (alcohol and barbiturates), *stimulants* (caffeine, cocaine and amphetamines), *opiates* (opium, morphine, codeine, and heroin), *hallucinogens* (cannabis, like marijuana and hashish, LSD, PCP etc.), and *tranquilizers* (valium and xanax). Some of these substances are not even considered as substance of use and abuse by the public (e.g. caffeine) and some may even be culturally sanctioned, such as the consumption of *'bhang'* (a preparation of cannabis) on festivals like Holi in India. Adults can purchase some substances from shops near their homes like alcohol and nicotine legally, other substances can only be purchased through a medical

prescription (pain medications like morphine and anxiety medications like, valium).Still others, such as heroin, Ecstasy, and methamphetamine, are illegal.

Substance Use*:* Refers to ingestion of psychoactive substance in moderate amount that does not significantly interfere with social, educational or occupational functioning. For instance, use of alcohol is normal in many family gatherings in certain cultures. Similarly, everyone is familiar with the use of caffeine in daily consumptions of tea and/or coffee.

Substance intoxication*:* Intoxication refers to the body's reaction to the ingested psychoactive substance. It involves changes in psychological states (e.g. impaired judgment and mood changes) and physical abilities (problems in waking and talking). Intoxication is the physiological reaction to the ingested substance-drunkenness or getting high. Intoxication or physiological effect of a substance depends on the type of substance uses, amount taken, and individual differences in biological reaction.

Substance Abuse*:* Refers to maladaptive drug use i.e. repeated and excessive use of substances to the point that recurring problems are evident. For instance, if a person likes to binge drinks and ends up in regular fights with people around him/her. Others will perceive such an individual as obnoxious and people will eventually stop calling him/her for a get together. Substance abuse involves use of a substance to the point that it affects one's academic, personal, interpersonal, social, and occupational functioning and/or subjects to self or others to physical danger.

Substance Dependency/Addiction*:* Refers to more severe forms of substance-use disorders characterized by tolerance and withdrawal symptoms that greatly affect many areas of their lives and causes a significant amount of distress. First, tolerance is the physiological dependency wherein an individual's body requires increasingly greater amounts of the drug to experience the same effect. Same amount of drug before does not give same effect. Second, withdrawal is the experience of unpleasant effects when the substance in no longer ingested. Withdrawal symptoms range from headaches in the absence of tea/coffee to alcohol withdrawal delirium that can cause hallucinations. It is important to note that, not all drugs show tolerance and severe withdrawal for example in case of marijuana or LSD, drug dependence is understood better in terms of drug-seeking behavior. The drug-seeking behaviour reflects the desperate need to ingest more of the substance to feel good/relaxed (standing in the cold to smoke or stealing money to buy drugs) and relapse (after a period of abstinence).Thus, even though one may not show tolerance and severe withdrawal symptoms for marijuana/ LSD, they may show drug-seeking behaviour. This is called, psychological dependence.

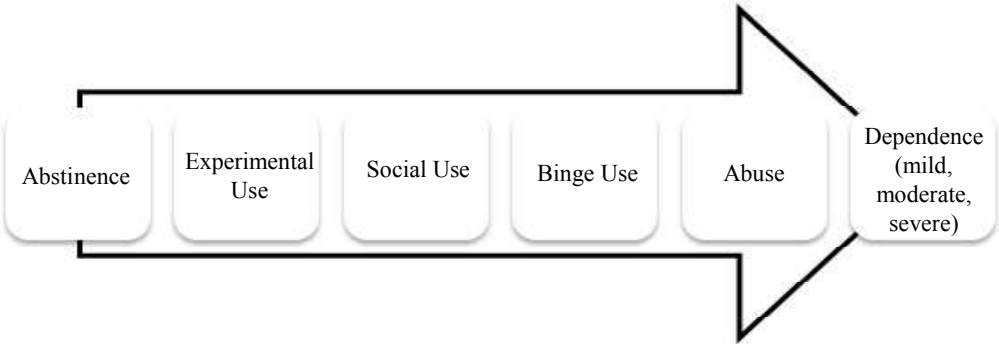

Fig. 11.1: Dimensional approach to the use and abuse of substances

Box 11.1: Some clarifications about Substance Use, Abuse and Dependency

Can you use substances and not abuse them?

Yes, some people may use substances like caffeine, nicotine, alcohol, marijuana occasionally without abusing them.

Can you abuse substances and not become addicted to them?

Yes, a person may hurt self or be nuisance for others under the influence of alcohol but may not be addicted to it.

Can you become dependent on a substance and not abuse them?

Yes, people may need to be prescribed addictive drugs by doctors for medical treatments, and may show symptoms tolerance and withdrawal. For instance, cancer patients may be dependent on morphine, but they are not abusing it.

If substance use and dependency are different, why do countries prohibit use of substances?

It is difficult to predict ahead of time about an individual, who is likely to lose control and become addicted to drugs and who is not. Thus, many countries and cultures emphasize on total abstinence of drug use.

Check Your Progress 1

1) What are psychoactive substances?

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2) Are all cases of substance abuse also cases of substance dependency?

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11.2 SUBSTANCE USE DISORDERS

A major change from DSM-IV to DSM-5 is the removal of the two categories of substance related disorders: substance abuse and dependency and their combination into a single substance use disorder. This is because researchers found that reliability of substance abuse category was poor and substance abuse and dependency often co-occur. Substance use disorder involves ingestion of psychoactive substances in excessive quantity, there may be a need to cut down on the usage but the person finds it difficult to do so. The individual ends up spending a lot of time in trying to procure, use, or recover from the substance, and is likely to give up on important social, occupational, or recreational activities because of substance use. The substance use affects the individual's functioning at home and work, and negatively impacts important relationships. The individual may continue to use the substance in spite of the danger it poses to him/her and leads to physical or psychological problems. Finally, the use of the substance

may lead to development of tolerance and withdrawal symptoms. An important addition to the diagnostic criteria in DSM-5 is the dimensional classification according to severity of symptoms. Presence of two to three symptoms is classified as mild, four to five symptoms classified as moderate, and six or more symptoms being classified as severe substance use disorder. DSM-5 has grouped substance-use related disorders in following general categories: **depressants, stimulants, opiates, hallucinogens, and other drugs of abuse; and gambling disorder under non-substance related disorder** (See Fig.11.2)**.**

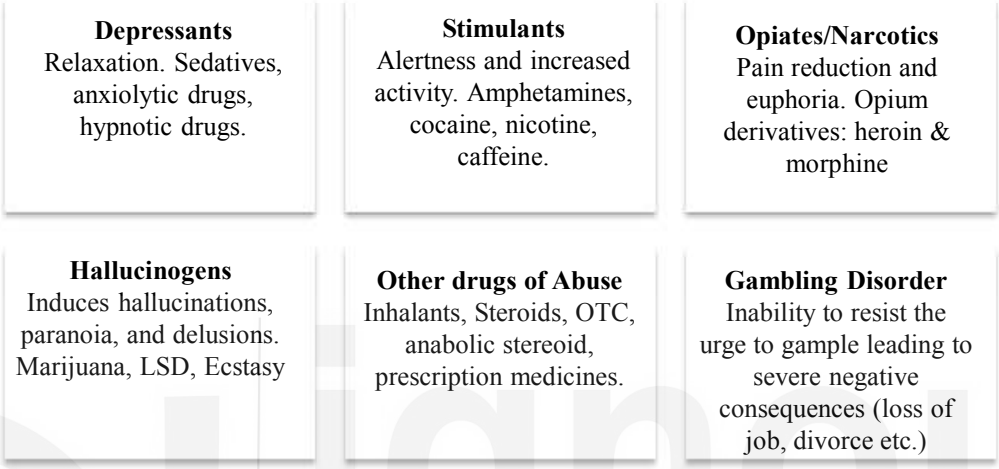

Fig. 11.2: Classification of Substance and Behavioral Addictions

Box 11.2: Case Study: Substance Use Disorder

Afsana, an 18-year-old girl was a student at a private university in Delhi who enjoyed partying more than most of her friends. While most of her friends thought of college as an opportunity to make a career and life, Afsana entered college with the intention of socializing and having as much fun as possible. She was academically, a high achiever who scored 97 percent in class 12th CBSE and was easily able to get into one of the best colleges. In college she found herself overwhelmed by professors demands for extensive written projects, reading assignments, and oral presentations. She also went through dissolution of a romantic relationship with someone she had known since school. She would often feel low and upset. Afsana was somewhat impulsive, extroverted and gregarious. She blended easily into parties, made friends, and found sexual partners with ease. During these parties, she would drink alcohol excessively and would often drive back to her home in early morning hours after the party got over. She occasionally smoked marijuana.Using these substances eased her concern about demands of college and satisfied her personal need for attention and companionship. Her college attendance was very poor and unfortunately, she failed all but one paper in her first semester.The next semester, Afsana vowed to work hard in college, this strategy worked for the first 2 weeks. She soon became bored and started attending parties where she could drink alcohol again. Over a period of time, she realized she needed to drink more alcohol to experience the same 'high' that she used to earlier. Soon, she began to experiment with new and different drugs such as methamphetamine and LSD. She realized that she almost ran out of money from buying alcohol and drugs. She stopped attending classes and spent much of her time watching TV, sleeping and surfing the internet She even started drinking at her rented

accommodation (PG). It was common to find her passed out at parties after which her friends would get her back to the PG, but recently she had started passing out in her PG. The local guardians informed her parents who immediately took her to a rehabilitation facility. At the rehabilitation centre, Afsana underwent a painful process of drug withdrawal and even more painful process of admitting to her parents about what happened to her in the past one year.

Box 11.3: DSM-5 Criteria for Substance Use Disorder (APA, 2013)

A mild substance use disorder is diagnosed if three of the following criteria are met. People meeting four or five criteria are classified as having moderate substance use disorder, and severe substance use disorder is diagnosed in cases where 6 or more of the criteria are met.

1) Taking the substance in larger amounts or for longer than you are meant to.
2) Wanting to cut down or stop using the substance but not managing to.
3) Spending a lot of time getting, using, or recovering from use of the substance.
4) Cravings and urges to use the substance.
5) Not managing to do what you should at work, home, or school because of substance use.
6) Continuing to use, even when it causes problems in relationships.
7) Giving up important social, occupational, or recreational activities because of substance use.
8) Using substances again and again, even when it puts you in danger.
9) Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10) Needing more of the substance to get the effect you want (tolerance).
11) Development of withdrawal symptoms, which can be relieved by taking more of the substance.

11.3 STATISTICS

India is growing at an incredible pace; it's culture, social values, demographics, and economy is rapidly changing and all this has impact on its people. According to WHO, 30 percent of Indian population consumes alcohol regularly and 11percent are moderate to heavy users. According to the Organisation for Economic Co-operation and Development (OECD) 2015 report, during 1992-2012, the per capita consumption of alcohol in India has increased by whopping 55 percent, the third highest increase in the world. In a meta-analysis study by Reddy and Chandrashekhar (1998) prevalence rate of alcohol and drug use was found to 6.9/1000. Cannabis, heroin, opium, and hashish are most commonly used drugs in India (Sharma, Arora, Singh, Singh & Kaur 2017). Some evidence suggests that there in an increase in use of illicit drugs. According to WHO, approximately 28 million people worldwide incur significant health risks by using various psychoactive substances other than alcohol and tobacco. According to a UN report, 1 million heroin addicts are registered in India and unofficially there

maybe, about 5 million. It has been estimated that in India, by the time most boys reach 9th grade, about 50 percent of them would have tried at least one of the substances of abuse nature. This number may be a modest estimate of the actual prevalence rate since many drug abusers may not seek help. Drug use may occur at any age, but is most common during adolescence and young adulthood.

Recent epidemiological research has suggested that the traditional gap between men and women has narrowed when it comes to the development of substance use disorders. Co-morbidity with other mental disorders is common, about 37 percent of people with alcohol use disorder have comorbid mental condition (Lapham et al., 2001). Given that alcohol is a depressant, depression ranks high among the mental disorders often comorbid with alcoholism, many alcoholics commit suicide. People who abuse alcohol, pose danger for themselves and others. Over half of deaths and injuries caused by automobile accidents are related to alcohol use and is frequently associated with violent and non-violent crimes relative to other drugs like marijuana.

Check Your Progress 2

1) What are some of the important changes in DSM-5 in the category of substance use and related disorders compared with DSM IV TR?

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2) What are some of the general categories of substances of abuse listed by DSM-5?

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11.4 ALCOHOL USE AND DEPENDENCE DISORDER

The World Health Organization (1992) defines alcohol dependence syndrome as;

> **"a state, psychic and usually also physical, resulting from taking alcohol, characterized by behavioral and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence; tolerance may or may not be present"**

As can be seen in the case study (Box 11.2) in response to the overwhelming demands of the college life,Afsana began to drink excessive alcohol at parties in which alcohol was easily available. She stopped attending college and even failed her first semester exams. She put herself in hazardous situations as she would

often pass out at these parties or would drive back to her PG drunk. She would often run out of money as she spent all her money on buying alcohol. In spite of making attempts to give up on alcohol, Afsana was unable to stay away from drinking alcohol for more than 2 weeks after leaving. She developed tolerance since she needed to drink more alcohol to experience the same 'high' that she used to earlier.

11.4.1 Effect on the Brain

Although alcohol is a depressant, its initial effect is that of a stimulant because the inhibitory centers of the brain are initially slowed down. There is a general experience of wellbeing when inhibitions are reduced, and people become more outgoing. At higher levels,it depresses brain functioning by inhibiting the brain's excitatory neurotransmitter i.e. glutamate. Higher order cognitive functions like judgment, rational thinking, self-control, inhibition etc. are diminished. For example, a drinker may indulge in sexual uninhibited behavior, which is otherwise inhibited. They may misjudge their ability to drive a car.Perceptions of cold, pain and other discomfort are dulled. Alcohol generates general feelings of warmth, well-being, and expansiveness,resultantly the individual begins to show affection towards his family and friends. Individual experiences lack of motor coordination, slurring of speech, vision impairment, and the thought processes are confused.When alcohol blood concentrations reach 0.5 per cent, the person passes out. Alcohol concentration greater than 0.55 per cent is usually lethal. Effects of alcohol depends on (a) amount of food in stomach, (b) duration of drinking (c) physical condition (d) metabolizing rate of alcohol, for instance women have lower than men.In excessive and frequent abuser, brain is accumulates diffuse organic damage even when no extreme organic damage symptoms are present.

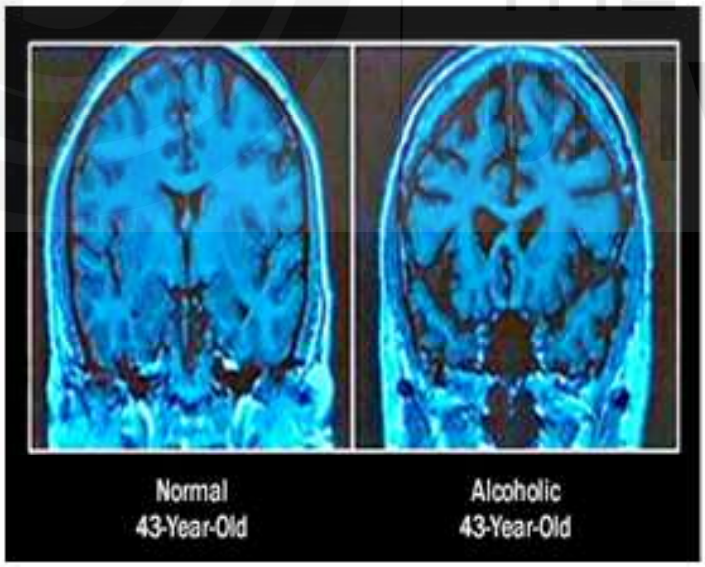

Fig. 11.3: Brain scan image of a person with alcohol use disorder relative to a typical control

Source: https://www.webmd.com/mental-health/addiction/ss/slideshow-alcohol-body-effects.

11.4.2 Physiological Effects

Alcohol affects various parts of the body. It goes to the stomach and then to the small intestine where it is absorbed in blood stream. Circulatory system distributes it throughout the body. Finally, as it goes into the liver it is metabolized and

broken down. Metabolization of alcohol uses a lot of water that may cause dehydration, headache, dry mouth, and tiredness, which is experienced as a 'hangover'. Large amounts of alcohol may overwork and damage the liver (causing cirrhosis). Approximately, 15-30 percent heavy drinkers develop cirrhosis of liver. Alcohol is high calorie drug, but contains 'empty calories' which means that alcoholic beverages have no nutritional value. This is why many heavy and long time drinkers suffer from malnutrition. In longer term, chronic abuse of alcohol impairs the body's ability to absorb nutrients, so it becomes difficult to overcome the problem and having vitamin pills also cannot make up the nutritional deficiency.Gastrointestinal problems are also common in people with alcohol use disorder. Overall, alcohol reduces the life span of an individual by 12 years than the average person.

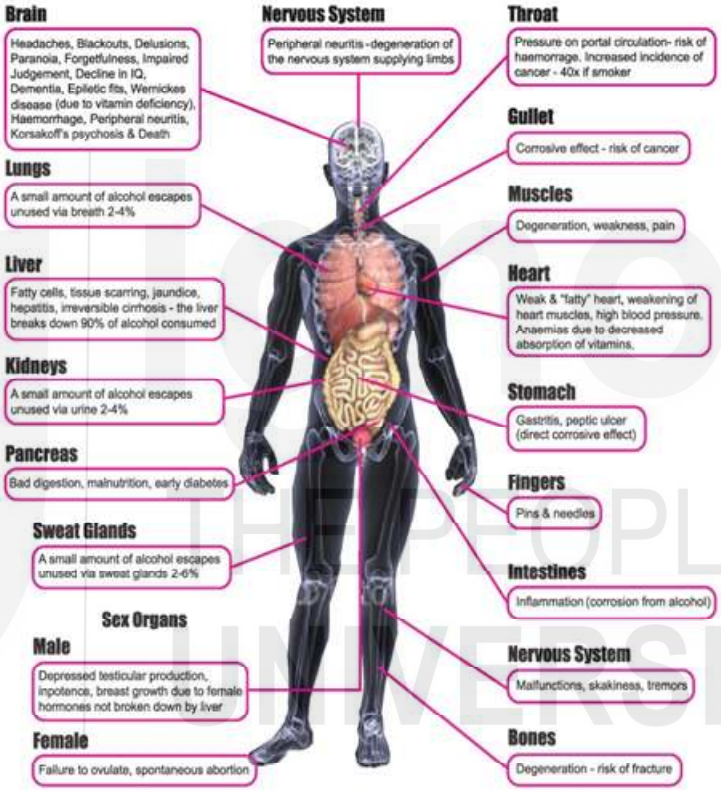

Fig. 11.4: Effect of alcohol on the body

Source: https://ragingalcoholic.com/alcohol-abuse-effects/

11.4.3 Psychosocial Effects

In addition to physiological effects, a chronic and heavy drinker of alcohol usually suffers from oversensitivity, depression, and chronic fatigue. For many people, alcohol may be used as an emotional coping strategy by dealing with stressors of life temporarily as it leads to feelings of well-being and self-worth. However, excessive and frequent use of alcohol may lead to impaired judgment, poor reasoning, and deterioration of personality. People who have been using alcohol for a long time tend to become irresponsible, their personal appearance and hygiene may be affected, and they tend to become neglectful of spouse and family. Alcohol also makes people vulnerable to many injuries and perpetrator intimate partner violence. Loss of employment and relationship is a common repercussion of chronic alcoholism. According to a study by WHO, alcoholism in India is one of the major causes of poverty in India.

11.4.4 Psychoses Associated with Severe Alcohol Abuse

Excessive and long-term use of alcohol can result in severe mental health problems. People may experience acute psychotic episodes characterised by temporary loss of contact with reality, confusion, excitement, and delirium. In people who drink excessive alcohol for a long time, a reaction called alcohol withdrawal delirium can be seen if the person enters a state of withdrawal. In alcohol withdrawal delirium, the person experiences disorientation to time, place, vivid hallucinations (animals like snake, lizards, roaches), extreme suggestibility, fear, hand tremors, fever, rapid heartbeat etc. It may last for 3-6 days, and the person is badly scared. It may also cause death because of convulsions and heart failure. Another alcohol related psychosis in long older alcoholics who have been drinking for a long time is the Alcohol Amnestic Disorder (formerly known as *Korsakoff's syndrome*). In this condition the individual has memory defects along with falsified memories. The person appears delusional, delirious, and disoriented. She/he is unable to recognize objects and people they have just seen so they confabulate to fill in the memory gaps. The symptoms of alcohol amnestic disorder are now linked to vitamin B (thiamine) deficiency and other dietary inadequacies. However, diet rich in vitamins and minerals generally has not being found to restore the patient to normal physical and mental health. Research suggests personality deterioration along with some memory impairments remain.

Check Your Progress 2

1) Why do long-term abusers of alcohol also usually suffer from malnutrition?

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2) What is Alcohol Amnestic Disorder?

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11.5 DRUG USE AND DEPENDENCE DISORDER

Apart from alcohol, the psychoactive drugs most commonly associated with abuse and dependence include (1) narcotics, such as opiates or opioids, including opium and heroin; (2) sedatives, such as barbiturates; (3) stimulants, such as cocaine and amphetamines; (4) hallucinogens, such as LSD; (5) and other miscellaneous drugs like inhalants, Steroids, OTC, prescription medicines etc. As discussed previously, most of these substances are illegal or need medical prescription for their use. However, DSM-5 has also classified dependency on other substances like caffeine and nicotine that can be easily bought by adults. Psychoactive substances differ in two regards, (1) dependence potential (loss of control over drug use or the compulsive seeking and taking of drugs) (2) lethal dose ratio (the dose at which given percentage of subjects will die). Heroin is the drug with highest dependence potential followed by morphine, nicotine, and cocaine.

Marijuana, caffeine, and ketamine have moderate dependence potential. Finally, hallucinogens like LSD and Psilocybin have low dependence potential. In spite of these differences, significant use and abuse of all these substances can have many negative consequences for an individual and the family members and has been classified as substance use disorder in DSM-5.

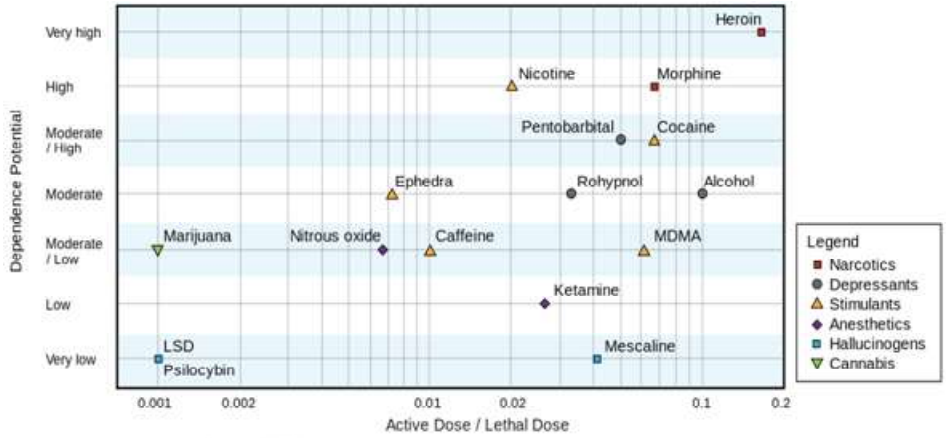

Fig. 11.5: Lethal ratio and dependence potential of various psychoactive drugs.

Source: Gable, R. S. (2006). Acute toxicity of drugs versus regulatory status. In J.M. Fish (Ed.),Drugs and Society: U.S. Public Policy, pp.149-162, Lanham, MD: Rowman & Littlefield Publishers.

11.5.1 Opium and its Derivatives (Narcotics)

Opiate refers to the natural chemicals in the opium poppy that relieves pain and induces sleep. Morphine, heroin, codeine are three powerful class of opiates that are abused. They are commonly introduced into the body by smoking, snorting, eating, or through hypodermic needles. Heroin usage leads to an initial euphoric spasm (rush) lasting 60 seconds which many addicts compare to sexual orgasm. It is typically followed by a lethargic state in which bodily needs (food and sex) are reduced; pleasant feelings of euphoria and relaxation tend to dominate. This state lasts for about 4-5 hours, which leads to a negative phase where addicts experience an intense craving for the drug. Since the dependence potential of heroin is very high, physiological dependency usually develops over continual use for 30 days. Users get withdrawal symptoms experienced as physical illness approximately 8 hours of last usage as physical illness. Opiate withdrawal is an extremely painful experience for some people with symptoms including runny nose, tearing eyes, perspiration, restlessness, and an intensified desire for the drug. As time passes, the symptom become more severe; person experiences chilliness that alternates with vomiting, diarrhea, flushing and excessive sweating, abdominal cramps, pains in the back, and insomnia. Occasionally symptoms include delirium, hallucination and manic activities. These symptoms usually disappear on 7th-8th day. After this, the individual's former tolerance for drug is reduced as a result there is a risk that taking the former large dosage might result in overdose. Heroin addicts experience ill health and general personality deterioration that may not result directly from pharmacological effects of the drug, but are products of financial strain, lack of proper diet, loss of social position and self-respect as an addict becomes more and more desperate to procure the required daily dosage. People often resort to lying, stealing, and/or prostitution to support the habit. Additionally, many addicts are increasingly vulnerable to illnesses like HIV-AIDS, and hepatitis because of the use of unsterile needles.

Pregnant women who abuse heroin during pregnancy increase the chances of premature birth, low birth weight or miscarriage.

11.5.2 Depressants

Apart from alcohol, class of depressants includes sedatives (calming), hypnotic (sleep-inducing), and anxiolytic (anxiety reducing) drugs. Barbiturates are a powerful class of sedatives that act somewhat like alcohol by slowing down the action of the central nervous system. Physicians use them to calm patients down and in stronger doses they are able to produce sleep instantly. Overdose of barbiturates especially along with other depressants like alcohol is lethal because they result in paralysis of brain's respiratory centers. Other effects include poor decision-making and problem solving, sluggishness, slow speech, and sudden mood shifts. Physiological and psychological dependence is common in middle-aged and older people who often rely on them as "sleeping pills".They are referred to as 'silent abusers' because they take the drug in privacy of their homes and ordinarily do not become public nuisance.

11.5.3 Stimulants

In contrast to depressants, stimulants like cocaine, amphetamines, caffeine, and nicotine increase the activity of central nervous system. Like opium, cocaine is a plant extract, and can be ingested by sniffing, swallowing, or injecting. However, unlike the opiates, cocaine stimulates the brain. Cocaine is costly and is generally used by upper class and affluent members of the society. Like the opiates, it leads to a euphoric state of 4-6 hours duration during which user experiences a state of enthusiasm, confidence and contentment. Initially it was believed that tolerance to cocaine does not increase with increase use, however this view has now changed. When cocaine, is chronically abused, withdrawal symptoms such as frightening hallucinations similar to those in acute schizophrenia may develop in addition depression like symptoms. Cocaine use is linked to unemployment, psychological, and legal problems.

Another class of stimulants is the amphetamines also known as 'wonder pills' that helps people to stay alert and awake and function temporarily at a level beyond normal. It is one of the most illicitty consumed drug. A popular amphetamine is the Methamphetamine. During World War II, soldiers used to take amphetamines to remain active and keep fatigue at bay. In typical population, students and athletes striving to improve their performances use amphetamines. The study by Berro et al., (2017), concluded that tolerance develops quickly in just 6 days. Common reactions include high BP, enlarged pupils, unclear or rapid speech, profuse sweating, tremors, excitability, loss of appetite, confusion, and sleeplessness. Since they tend to reduce appetite, they are also popular with people trying to lose weight. Users may abuse amphetamines to maintain intense euphoric activity for a few days without sleeping or eating after which exhausted or depressed they sleep or crash for several days. Then the cycle starts again. Amphetamines are not energy pills. They push users towards greater expenditures of their own resources-often to the point of near fatal exhaustion.Today, they are occasionally used for medical purpose, for weight reduction, narcolepsy, and hyperactivity in children on whom they have a calming effect. Excessive use of amphetamines can cause psychosis, suicide, homicide, assault are also associated with amphetamine abuse.

Caffeine and nicotine are two most common psychoactive substances used. Caffeine elevates mood and decreases fatigue. In larger doses, caffeine can make one feel jittery and lead to insomnia. It is called the gentle stimulant because it is thought to be least harmful of all addictive drugs and is found in tea, coffee, and many cola drinks and cocoa products. Withdrawal symptoms include unpleasant mood, drowsiness, and headaches.

Nicotine is a poisnous alkaloid in tobacco and found in cigarettes, chewing tobacco, cigar, clove cigarettes, *bidis* and *hookah*. In small doses, it stimulates the central nervous system that can reduce stress and improve mood. However, nicotine use is related to high blood pressure, increase drisk of heart attack and cancer. It produces high physiological and psychological dependence. For instance, smokers try to maintain nicotine at a steady level in bloodstream otherwise they are bound to experience withdrawal symptoms including depressed mood, insomnia, anxiety, difficulty concentrating, restlessness, and increased appetite and weight gain. Relapse rates are high in nicotine dependency. Morissette et al., 2007 conclude that nicotine use is highly prevalent among those with anxiety disorders.

11.5.4 Hallucinogens

Also called *psychedelics*, hallucinogens are unlike opiates, stimulants, and depressants that affect people by either making them feel 'up' or 'down'. Hallucinogens essentially change the way individuals perceive the world. Psychedelics do not "create" sensory images but distort sight, sound, feelings, taste, and even smell. A popular hallucinogen is Lysergic Acid Diethylamide (LSD). The street name of LSD is acid; it is an odorless, colorless, and tasteless drug that was first chemically synthesized in Hoffman in 1938. It was thought to be useful to study hallucinogenic states and remained in laboratory until 1960s, when it was first produced for recreational use. After ingesting LSD, a person typically goes through eight hours of changes in sensory perception, mood swings, and feelings of depersonalization and detachment. For some people this experience can be extremely frightening and unpleasant. Tolerance to LSD develops quickly however, sensitivity returns after a week of abstinence. For most hallucinations, no withdrawal symptoms are reported.

Marijuana is another hallucinogen that was extensively used in US in 1960s and early 1970s. It is the name given to dried parts of cannabis or hemp plant that grows in the wild and is also called 'weed'. Another drug called hashish is a stronger drug which is derived from resin of the plant. Under the influence of marijuana, otherwise-normal experiences seem extremely funny, or the person may enter a dream like state in which time seems to stand still. A person's sense of time is stretched or distorted so that an event that lasts only a few seconds may seem to cover a much larger span or vice versa. Users often report heightened sensory experiences, like vivid colours or greater appreciation of music. Feelings of well-being in small doses can transform into feelings of anxiety and paranoia, a into paranoia when larger doses are taken.There is a strong relationship between daily marijuana use and psychotic symptoms.

Long-term usage of marijuana is related to cognitive impairments, relationships with significant others, and employment are also affected.Continued use produces a lax lifestyle, lethargy and passivity.

11.5.5 Other Drugs of Abuse

Young males (13-15 years) from economically disadvantaged families are likely to abuse inhalants like spray paint, hair spray, paint thinner, gasoline, nitrous oxide (laughing gas), nail polish remover, whitener, and felt-tipped marker. The intoxication of inhalants resembles that of alcohol intoxication. Frequent usage builds up tolerance and withdrawal involve sleep disturbances, tremors, irritability, and nausea. Stereoids are derived from hormone testosterone and have medical usage but sportspersons, bodybuilders, and models often use them to enhance performance and body size.Regular use of inhalants, steroids, and painkillers damage the body and are related to mood disturbances.

Check Your Progress 3

1) What is the dependence potential of a drug?

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2) A drug like marijuana does not have a high dependence potential but is still classified under drug use disorder. Why?

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11.6 CAUSAL FACTORS OF SUBSTANCE USE DISORDERS

Development of addiction to any substance is a complex process involving the following elements: (1) addictive property of the substance (2) constitutional vulnerability (diathesis), (3) environmental reinforcement and pressures (stressors).

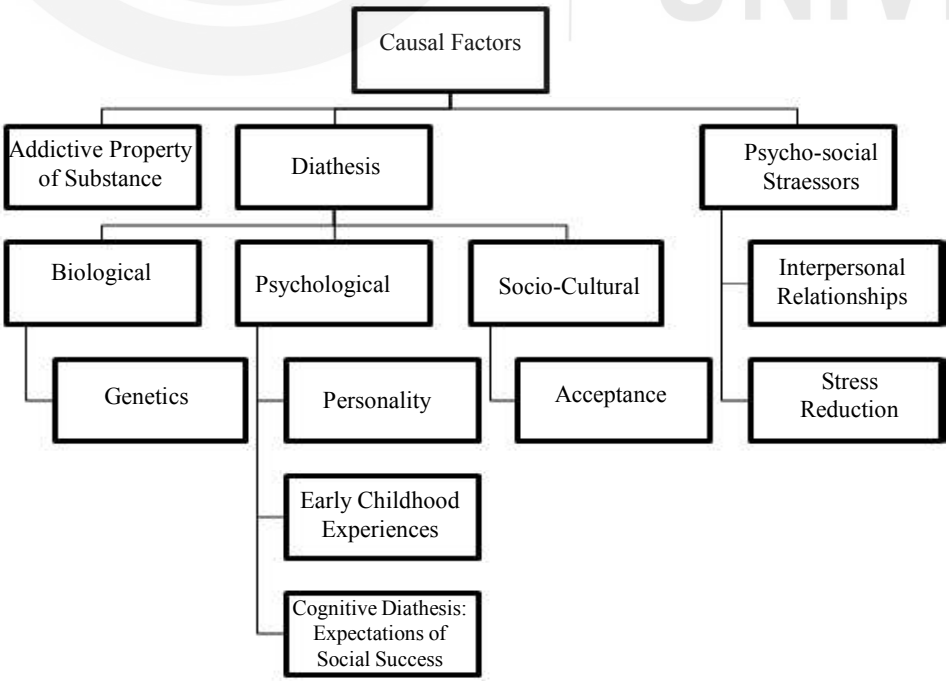

Fig. 11.6: Causal factors underlying substance use disorder

11.6.1 Addictive Property of Substance

All drugs including alcohol play a role in addiction through activation of the 'pleasure pathway' or the **Mesocorticolimbic Dopamine Pathway (MCLP)**. The MCLP also called the reward pathway is related to functions like control of emotions, memory, and gratification. All substances including alcohol produce euphoria by stimulating this area in the brain thereby reinforcing the use of the substance by making consumption of the substancepleasurable/rewarding. Continued exposure to the brain leads to neurochemical changes, which result in withdrawal symptoms that can be avoided by ingesting the substance. Thus, taking drugs and alcohol is pleasurable and is positively reinforced. Once the individual addicted to the substance, the pleasure reduces but the withdrawal symptoms increase, which can be excruciating, people take drugs/alcohol to avoid them. Some drugs have more intense withdrawal symptoms (e.g. heroin) than others (e.g. marijuana).

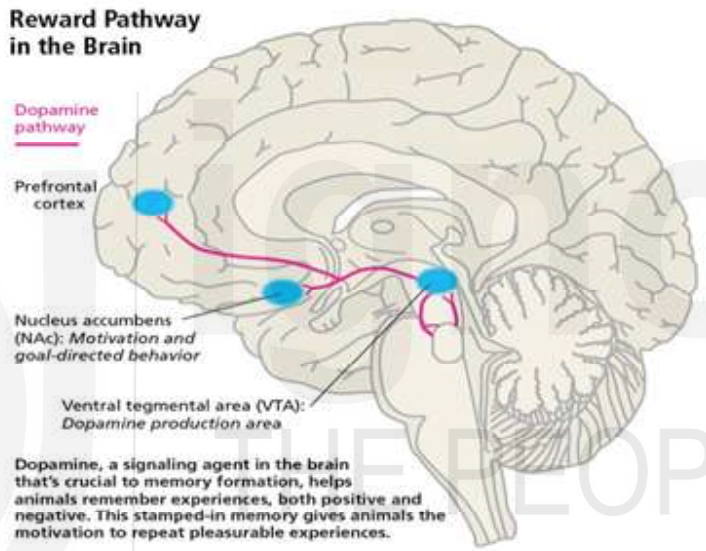

Fig. 11.7: Pleasure/reward pathway in the brain (Mesocorticolimbic Dopamine pathway; MCLP)

Source: http://discovermagazine.com/2015/may/17-resetting-the-addictive-brain

11.6.2 Diathesis for Substance Use Disorder

Biological Diathesis*:* Genetics plays an important role in developing vulnerability to the addictive power of the many drugs. Family studies have provided strong evidence for genetic inheritance of alcohol use disorder, in males almost 30 percent of alcoholics had at least one parent with alcohol problems (Cotton,1979) and 40 percent had both-parents with alcohol dependency (Cloninger and Colleagues .1986). Greater concordance for monozygotic twins has been found for nicotine, marijuana and drug abuse in general. Molecular genetics study found that a gene related to dopamine release and reuptake is related to being nicotine addiction. It is important to note that being born to an alcoholic parent and not necessarily being raised by one increases the risk of a person becoming alcoholic. Children of alcoholic parents adopted by nonalcoholic parents were nearly twice as likely to have alcohol problems.

Psychological Diathesis: In general, high levels of negative emotionality and low constraint, high risk-taking and impulsivity are common psychological traits

predictive of future use and abuse of drugs and alcohol abuse. Genetic sensitivity to alcohol use disorders may be related to heritability of these personality traits. Other psychological characteristics of potential alcohol abusers has been including: emotional immaturity, expecting a lot form the world, needing a lot of praise or reassurance, strong negative reactions to failures, low frustration tolerance, feelings of inadequacy, impulsivity and aggression. Antecedant personality variables predicted the age of onset of drinking alcohol like lower lever of behavioural control and resiliency (Wong et al., 2006) rebelliousness and sensation seaking (Sargent et al., 2006) and greater generalized anxiety (Kaplow et al., 2001).

Early childhood experiences with lack of stable family relationships and parental guidance can lead to development of psychological vulnerability for substance use and abuse in general in future. Research has examined the role of the following six factors that have been significantly associated with development of alcoholism later in life: presence of alcoholic father, lack of "attachment" to father, acute marital conflict between parents, lax parental supervision and inconsistent discipline, frequent moving during family's early years, and lack of family cohesiveness. Abuse of substances early in child's life by a parent in life is also strongly associated with substance abuse by their children later in life. The parent in such a situation is seen as a negative role model. Further, the child may see parent's use of alcohol as validation of the act. Moreover, there is a strong association of experiences of stress in such families along with lack of proper guidance by the parents. Early childhood experience of abuse especially sexual abuse in women is also linked to abuse of substance abuse later in life.

Cognitive diathesis*:* Some adolescents have grown up with the belief that alcohol/ drug use will lower stress and anxiety, increase sexual desire and pleasure, and enhance popularity and acceptance by peers. For instance, in a study, participants who believed they were consuming alcohol but were actually given alcohol-free drink subsequently became more aggressive. According to some psychologists, there is a reciprocal-influence of this cognitive belief; adolescents begin drinking as a result of expectations that using alcohol is related to social success. By contrast, expectations of harm are related to lower likelihood of substance use behaviour. Adolescents who perceived great risk with drug use were less likely to use the drug than those who perceived little or moderate risk rate. Finally, greater the expectations perceived prevalence ("everyone does it"), greater the use. Since these expectations play a major role initiation and maintenance of substance usebehavior in teenagers, it is important for interventions to focus on altering these social expectations before substance use begins.

Socio-cultural Diathesis: In many cultures especially in advanced countries, alcohol use is common as it acts as a 'social lubricant' and tension reducer that enhances social events. Socio-cultural acceptance towards alcohol use may be related to high rate of alcohol abuse and dependence in some cultures. In such cultures, alcohol is readily available. For instance, in wine-drinking societies, wine is present in many settings including college canteens and cafeterias. By contrast, negative cultural attitudes in certain cultures for instance, in Islamic countries, maybe related to low rates of alcohol dependency. In India there are 'dry states' i.e. alcohol is not distributed or sold and doing so is illegal. However, in India there is high cultural acceptance of use of weed. Consuming *Bhaang* (cannabis leaves) on the festival Holi is widely popular and even legal. Marijuana use is also common in Shiva worshipers. Overall, many religious sanctions and

social customs can become a social diathesis making an individual vulnerable to consumption of alcohol as a coping strategy to everyday stressors in life. The effect of exposure to positive media portrayal of alcohol has been linked to increased social acceptance of alcohol consumption. Although in India, advertisements of alcoholic drinks have been banned, yet, movies, TV shows, and popular songs display consumption of alcohol as a 'cool' activity.

Fig. 11.8: Positive media portrayal of alcohol use

Source: www.youtube.com

11.6.3 Psychosocial Stressors

According to diathesis-stress model, having biological and psychological disposition and socio-cultural acceptance is not enough to develop alcohol-use disorder. A person must be (a) exposed to the substance, (b) living in an environment that promotes alcohol use, and (c) experience of stressors and pressures in life. For example (Box 11.2), Afsana had gone through a major change in her life, moving from school to college in which she found herself to be overwhelmed by professors' demands for extensive written projects, reading assignments, and oral presentations. She had also simultaneously experienced the painful experience of dissolution of a romantic relationship with someone who she had known since school. So all these stressors influenced the risk of substance use (alcohol in this case).

Interpersonal Relationships: Psychiatric, marital, and legal problems in family are related to drug abuse and lack of emotion support from parents is linked to increased use of alcohol, cigarettes, marijuana etc. Excessive drinking for instance often begins during crisis periods in marital or other intimate personal relationships. Marital partners may behave towards each other in ways that promote or enable a spouse's excessive drinking. Conversely, excessive use of alcohol may lead to marital disputes and even domestic violence. The stresses of family crisis can further lead to an increased substance abuse issues.

Role of Stress Reduction*:* Mood alteration is one of the primary purposes of abuse of psychoactive drugs. People continue to use drugs to escape from unpleasantness in their lives, escape from physical pain (opiates), escape from stress (nicotine), and escape panic/anxiety (benzodiazepine). For instance, it has been reported that about 42 percent American Soldiers in Vietnam War became addicted to heroin (Robbins, Davis and Nurco, 1974). Substance abuse is high amongst victims of child sexual abuse and in case of individuals facing acculturation difficulties like migrant labours and those living in slum areas. It is also high in children of parents with substance abuse, who may abuse substances to get away from the stressors at home. A typical person who abuses a drug maybe undergoing excessive stressors in life or may have low tolerance to tensions and stresses that may initiate alcohol or drug consumption to relieve the stress. This can become reinforcing and may lead to increased use and abuse of alcohol. This model has been criticized as it underestimates the role of motivation in alcohol addiction processes. If we were to solely use the tension-reduction causal model, we would expect alcoholism to be more common than it is. Also, it does not explain why some excessive drinkers are able to maintain control in society and others are not. Some scientists place higher value on the importance of individual motivation on development of alcohol dependency; a person consciously or unconsciously decides to consume alcohol.Those who are not motivated are able to find more constructive ways of reducing stress.

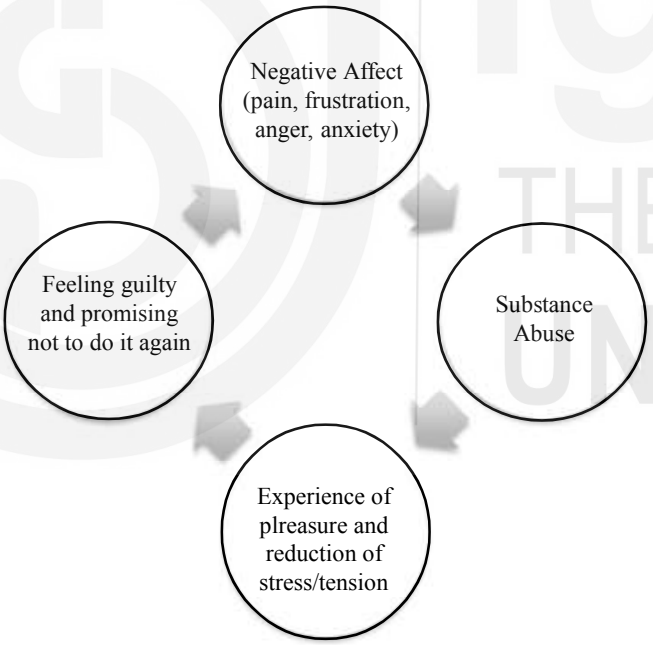

Fig. 11.9: Stress reduction and reinforcement cycle

Check Your Progress 4

1) What are the different factors responsible for psychological diathesis for substance dependency?

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2) How do psychosocial stressors contribute to addiction process?

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3) Does media play a role in the etiology of substance dependency?

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11.7 TREATMENT OF SUBSTANCE USE DISORDER

Etiology of substance use disorders involves a combination of biological, psychological and socio-cultural factors. Moreover, fewer than 25 percent of people who have significant problems with substance use seek treatment for the problems, making treatment of alcohol and drug use a challenging task for individuals and medical professionals. Treatment involves multiple components; typically, the first step is to help someone overcome the painful withdrawal process with the ultimate goal being abstinence. In use of certain substances (like caffeine), the goal is to limit the use of the substance to a definite amount (e.g. 2 cups).

11.7.1 Biological Treatment

Use of medications is extremely important in the withdrawal processes of certain substances. In case of abuse of certain drugs like heroin and alcohol, medications like sedatives are prescribed to deal with the disturbing symptoms of withdrawal in presence of a medical professional. Moreover, in certain cases medications are important to minimize the effect of dangerous withdrawal symptoms like seizures and heart attack. Biological treatments are also aimed to substitute the pleasurable experience of alcohol with negative experiences or find other substances that provide the similar positive experiences without the addictive qualities. In case of psychoactive drugs like opiates, antagonist drug like *naltrexone,* is given to the addict that blocks and cancels out the effect of opiates and also produces immediate withdrawal symptoms that are extremely unpleasant. In case of alcohol antagonist, *Acamprosate* is used that decreases the cravings in people dependent on alcohol. It has been found that using antagonist drugs are useful in combination of other therapeutic efforts. Aversive treatment involves associating the substance of abuse with a drug like *Antabuse,* that produces feelings of nausea and vomiting. In case of nicotine abuse, silver nitrate laced gums are given that produce a bad taste. This is a successful approach only when clients are extremely motivated to continue taking them outside of supervision of a doctor. An alternative approach to associating aversive experiences with substance use is to find substitute drugs that produce similar positive experiences of the abused substance. For instance, heroin addicts are given the alternative *methadone* which has the pain-reducing qualities of heroin, but may not always make the individual addicted to it, especially when it is used in combination with counseling. In case of nicotine addiction, nicotine patches, gum, inhaler, or nasal spray may be used; they lack the carcinogenic elements of cigarette smoke. Over a period of time, individuals are able to taper their usage to minimal and

finally give up on nicotine. In few cases however, individuals may become addicted to the substitute substance, like nicotine patch in case of nicotine dependency.

11.7.2 Psychosocial Treatment

Biological treatment of substance abuse in isolation is not very effective treatment of substance use disorders; most individuals also need counseling support and therapy. A number of programs and models have been developed. First, inpatient facilities are designed to help the individual successfully go through the withdrawal process along with support of mental health professionals who provide them with counseling so that they can successfully go back to their family and work life. However, in most countries including India, inpatient facilities are extremely expensive and may be unavailable and inaccessible to many sections of the population. Outpatient care is relatively cheaper than inpatient care can also provide effective treatment for substance use intervention. Under its National Drug De-addiction Programme, the Government of India has funded about 483 detoxification and 90 counselling centers across the country to treat people with substance use disorders. About 45 percent of people seeking treatment in these centers are for alcohol dependence disorder (Prasad, 2009). However, many of these centers are finding it hard to function in recent times because of lack of funding.

Alcoholics Anonymous (AA) is a global support group of people who identify as 'alcoholics' and want to help themselves. The organization is designed to be independent from the medical community and is self-supporting group of anonymous individuals who see alcoholism as a disease and want to empower individuals to abstain from itsuse. The anonymous aspect of AA meetings helps individual seek help without experiencing stigma and judgments from others around them. AA proves to be effective of highly motivated individuals. AA is also present in India along with many similar support groups that provide individuals with social and emotional support for de-addiction processes. Such support groups have also been formed for other substances like Cocaine Anonymous and Narcotics Anonymous.

While Alcoholics Anonymous aims for total abstinence, certain programs have been developed that emphasize on controlled usage instead of total abstinence because they feel that complete abstinence may be an unrealistic goal for many addicts. The goal of these controversial programs is to enable social usage of substances like alcohol replacing it with substance use. Over the years, some researchers especially in United Kingdom have used programs focused on controlled usage, whereas in other countries like United States, abstinence-based programs are used.

In general, most programs involve some form of *aversive therapy* where the substance of abuse is associated with aversive stimuli like a painful shock when drinking a glass of alcohol. The goal is to replace positive associations that an individual have of the substance with negative associations. Another behavioural strategy, that is contingency management. It involves identification of behaviours that are then reinforced through tokens or other kinds of rewards. For instance, in one study, cocaine negative urine sample was rewarded with cash vouchers.

Community based approaches in the recent times have helped us understand why individual based approaches may not be effective for everyone. In a

community-based approach, substances abusers are helped to identify a spouse, friend, or relative to be part of relationship therapy that may help them improve relationships with important others. Abusers are also made to identify social situations that might influence them to abuse, such as friends and certain social situations like parties and get-togethers, where the substance will be commonly used and abused by others. Clients are given assistance with employment, education, and finances to help reduce their stress and improve their overall functioning in life. Finally, new recreational activities are discussed and encouraged to replace substances that would previously help them 'feel good' or 'de-stress.'

Most psychosocial programs towards the end, focus on relapse prevention, or help prepare individuals to 'stay clean' on their road to recovery. For instance, Cognitive-Behavioural Therapy helps remove the ambivalence about drug use by making patients examine the positive beliefs they may hold regarding substance use and abuse for example, "drugs make me look cool" and confront the negative consequences of its use, "every time I start doing drugs, my grades fall." Identification of 'high risk' situations (e.g. "extra money in my pocket", "fight with friends/parents", "break up with boyfriend/girlfriend" etc.) and strategies are developed in advance to deal with these situations along with craving that an individual may feel. Incidents of relapse are dealt as incidents that can occur instead of a globalized sense of failure that may inevitably lead to more substance use.

11.7.3 Prevention Programs

Mental health professionals have focused on developing programs that not only help in treatment of substance abusers, but also programs that can prevent future possible use and abuse of substance in high risk populations like teenagers and young adults. In general, these programs have focused on peer-pressure resistance training, correction of beliefs and expectations that make them prone to abuse substances, inoculation against mass media messages, and peer leadership. Individuals are taught enhancement of self-esteem, social skills, and resistance training (just say no). The results are mixed, while self-esteem enhancement has been shown to be not very effective, resistance and social skill training proves to be effective in case of girls. It is important to understand, since etiology of dependency of any substance involves an interaction of biopsychosocial factors, an effective program needs to implement and effect change at multiple levels involving several stake holders including the individual, family, neighborhood, peers, schools, colleges, media, government, private and non-governmental organizations.

Check Your Progress 4

1) How does substitution of a drug with another drug help in treatment of the drug use?

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2) What is aversive therapy?

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3) How are substance use prevention programs different from the treatment programs?

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11.8 GAMBLING DISORDER

Gambling has a long history, for instance, dice related games were part of many civilizations.Yudhishthira in the epic *Mahabharata* lost his all his wealth, his entire kingdom, his brother and even his wife in a rigged game of dice. Some countries have legalized gambling whereas in other countries gambling is banned. Gambling disorder (also known as pathological gambling) involves continuous or periodic loss of control over gambling, a preoccupation with gambling and with obtaining money for gambling in spite of adverse consequences. In DSM IV TR, pathological gambling was classified as an impulse control disorder. In DSM-5, gambling disorder has been classified as an addiction. Although gambling disorder does not involve chemically addictive substance, still DSM-5 has classified it as a behavioural addiction because like substance related addictions, behavioural addictions also involve short-term gains despite long-term disruption. Gamblers also experience cravings similar to substance abusers. Additionally, researchers have found that there is a high comorbidity between substance dependency, personality disorders and alcohol dependency.

Gambling takes many forms, casino gambling, bets on horse racing or sports like cricket betting. It also involves games like Internet games, number games, lottery etc. In either case, pathological gambling significantly affects an individual's social, psychological, familial, and economic well-being. Pathological gamblers may use all heir savings, neglect their family's needs, borrow money from friends and relatives, or resort to illegal means to obtaining money for gambling.

Box 11.4: DSM-5 Criteria for Gambling Disorder(APA, 2013)

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

1) Needs to gamble with increasing amounts of money in order to achieve the desired excitement.

2) Is restless or irritable when attempting to cut down or stop gambling.

3) Has made repeated unsuccessful efforts to control, cut back, or stop gambling.

4) Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).

5) Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).

6) After losing money gambling, often returns another day to get even ("chasing" one's losses).

7) Lies to conceal the extent of involvement with gambling.

8) Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.

9) Relies on others to provide money to relieve desperate financial situations caused by gambling.

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

Causal Factors: Pathological gambling is a learned behavior that is highly resistant to extinction. Many people who go on to gamble pathologically usually experience winning a substantial sum of money the first time they gambled (beginner's luck). This is variable-ratio schedule of reinforcement given by Skinner, where the individual learns to give high and steady rates of response expecting that she/he would be rewarded and makes it extremely difficult for an individual to give up.

Pathological gamblers have been found to share personality traits. Typically, they are rebellious, immature, thrill-seeking, superstitious, anti-social compulsive and impulsive. Impulse-driven behavior such as pathological gambling is associated with brain mechanisms involved in motivation, reward, and decision-making. Further, neurodevelopmental events during adolescence affecting these brain areas.

Treatment: Treatment of gambling disorder is similar to other addictive disorders and equally difficult. Pathological gamblers exhibit a denial of their problem, impulsivity and resolute optimism ("I will win enough to cover all my losses"). Cognitive-Behavour Therapy (CBT) has been popularly used with varied success rates. CBT involves setting financial limits, planning alternative activities, preventing relapse, and imaginal desensitization. A study found that CBT improved its efficiency when it was combined with meetings at Gambler's Anonymous (organization similar to Alcoholics Anonymous). Additionally, positive outcomes in treatment are also found when family relationship concerns are addressed as part of the treatment. Many people with gambling disorder are resistant to treatment; more effective programs must addresses concerns related to prevention of gambling behaviours.

11.9 SUMMARY

Now that we have come to the end of this unit, let us list all the major points that we have already learnt.

- Substance dependency or addiction refers to more severe forms of substance-use disorders characterised by tolerance and withdrawal symptoms that greatly affect many areas of one's lives and causes a significant amount of distress.

- Alcohol negatively affects various parts of the body. In excessive and frequent alcohol abuser, brain accumulates diffuse organic damage even when no extreme organic damage symptoms are present.

- Development of substance dependency is a complex process involving the addictive property of the substance, constitutional vulnerability(diathesis), and environmental reinforcement and pressures (stressors).

- Use of medications is extremely important in the withdrawal processes of certain substances. Biological treatments are also aimed to substitute the pleasurable experience of alcohol with negative experiences or find other substances that provide the similar positive experiences without the addictive qualities.

- Biological treatment of substance abuse in isolation is not very effective treatment of substance use disorders; most individuals also need counseling support and therapy.

- Substance abuse prevention programs work towards preventing future possible use and abuse of substance in high-risk populations like teenagers and young adults.

- Gambling disorder (pathological gambling) involves continuous or periodic loss of control over gambling, a preoccupation with gambling and with obtaining money for gambling in spite of adverse consequences.

11.10 KEYWORDS

Substance Use: Ingestion of psychoactive substance in moderate amount that does not significantly interfere with social, educational or occupational functioning.

Substance Abuse: Refers to maladaptive drug use i.e. repeated and excessive use of substances to the point that recurring problems are evident.

Substance Dependency: Addiction is characterised by tolerance and withdrawal symptoms that greatly affect many areas of their lives and causes a significant amount of distress.

Tolerance: Physiological dependency wherein an individual's body requires increasingly greater amounts of the drug to experience the same effect.

Withdrawal: Experience of unpleasant effects when the substance in no longer ingested.

Korsakoff's Syndrome: Also known as Alcohol Amnestic Disorder, an alcohol related psychosis in long older alcoholics who have been drinking for a long time is the individual usually has memory defects along with falsified memories. The person appears delusional, delirious, and disoriented.

Dependence Potential: Capacity of a substance to cause loss of control over its use or compulsive seeking and taking of the substance.

Pleasure Pathway: The activation of the pleasure pathway or the Mesocorticolimbic Dopamine Pathway in the brainis implicated in substance dependency as it is related to functions like control of emotions, memory, and gratification.

Aversive Therapy. Associating negative experiences with ingestion of a substance to treat substance dependency.

11.11 REVIEW QUESTIONS

1) When an individual requires more than previously used amount to experience the same effect:
   a) Withdrawal
   b) Substance Abuse
   c) Tolerance
   d) Substance Use
2) Alcohol concentration greater than _____ percent in blood is usually lethal.
3) Long-term alcohol use can cause damage to the liver. This condition is called:
   a) Korsakoff's Syndrome
   b) Cirrhosis
   c) Alcohol withdrawal delirium
   d) Malnutrition
4) _____ are psychoactive substance that alter the way people perceive the world.
   a) Depressants
   b) Analgesics
   c) Stimulants
   d) Hallucinogens
5) Aversive treatment involves associating the substance of abuse with another drug like _____that produces feelings of nausea and vomiting
6) Pathological gambling is a learned behavior related to _____schedule of reinforcement given by Skinner.
   a) Variable-ratio
   b) Fixed-ratio
   c) Fixed-interval
   d) Variable-interval
7) Describe various psychoactive drugs associated with substance use disorders.
8) Elucidate the causes of substance use disorders.
9) Explain the psychosocial treatment of substance use disorders.

10) Discuss the causes and treatment of gambling disorder.

11.12 REFERENCES AND FURTHER READING

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11.14 WEB RESOURCES

- More information for Alcoholics Anonymous in India;
  http://www.aagsoindia.org/
- Documentary of drug abuse in Punjab, India;
  https://www.youtube.com/watch?v=13ICgM2zYRQ
- Magnitude of Substance Use in India 2019;
  http://socialjustice.nic.in/writereaddata/UploadFile/Magnitude_Substance_Use_India_REPORT.pdf

***Answers to Fill in the Blanks* (1-5):**

(1) Tolerance, (2) 0.55 percent, (3) Cirrhosis, (4) Hallucinogens, (5) Antabuse, (6) Variable-ratio

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