International Journal in Commerce, IT and Social Sciences
Volume 5 Issue 06, June 2018 ISSN: 2394-5702 Impact Factor: 4.218
Journal Homepage: http://ijmr.net.in, Email: irjmss@gmail.com
Double-Blind Peer Reviewed Refereed Open Access International Journal

AN ANALYSES OF SYNDROMALAND SYMPTOMSIN STRUCTURE OF COMMON AND SEVERE PSYCHOPATHOLOGY

Ayaz Uddin Hashmi[1], Dr. Naseem Ahmad[2]
Department of Psychology
[1,2]Shri Venkateshwara University, Gajraula (Uttar Pradesh)

Abstract

The current situation of psychopathology is a science that studies mental disorder, including efforts to understand genetic, biological, psychological and social causes; effective classification schemes (Nosology); Naturally through all stages of development; demonstrations; and treatment. In recent times there have been many new inventions in the field of the diagnosis of mental disorders. DSM is a model of this type, but it is not as effective as necessary. In current research, the psychopathology level study syndrome and symptoms and improve understanding of psychopathology, trying to create a better model to examine and diagnose mental illness. The current study addresses the limits of existing quantitative models to create a broader model of psychopathology that is probably more valid. structural analyses were performed both in syndromic level (which acts as a proxy to diagnose DSM size) as the level of symptoms in a sample of a patient using self-data and interview. A three-factor, containing the dimensions internalization, externalization and psychoticismemerged in both analysis groups.

1. OVERVIEW

While many viewpoints overlap with the noise that needs to be corrected, either through a more complete evaluation, the creation of subtypes or the creation of further disturbances, there is another interpretation of the available data. Instead of being treated as something that should be eliminated, this overlap can best be seen as a sign, even if limited and preliminary, that a common factor (similar to neurosis / negative effect on the spectrum of internalization or disinhibition / impulsivity of externalization spectrum) may be the basis of psychotic disorders, schizotypic personality disorder, dissociative disorders, some sleep disorders and OCD. Previous evidence, which suggests that the rates of concomitance between these disorders are well beyond the product of their base rates in the population, is similar to the evidence of co-occurrence between mood disorders and anxiety that eventually led to the hierarchical models examined above. However, the wide range of comorbidity estimates makes it difficult to draw solid conclusions.

The image is further complicated by the fact that many other studies have discovered that the aforementioned disorders are also comorbid with disturbances of the internalization spectrum. For example, schizophrenia coexists in rates higher than probability not only with obsessive compulsive disorder but also with other anxiety disorders. The review by Braga et al.

(2004) indicates that between 3.3% and 43% of people diagnosed with schizophrenia also meet the criteria for panic disorder and between 8.2% and 36.3% meet the criteria for social phobia. Other reviews have found that between 0.8% and 31% of individuals diagnosed with schizophrenia meet the criteria for GAD and from 0% to 27.5% for agoraphobia (Poko and Castello, 2006). These rates are similar to those reported between schizophrenia and DOC. Similarly, OCD is highly comorbid with mood disorders, as between 25% and 80% of people diagnosed with OCD present the criteria for a depressive disorder.

2. RESEARCH APPROACHES OF COMMON AND SEVERE PSYCHOPATHOLOGY

Participants and Procedures

Psychiatric patients (N = 448, 66% of women, diagnostic rates are presented in Table A1), recruited at the Psychiatric Adult Clinic of the University of Delhi Hospital and the Community Center for Mental Health. Iowa Middle East, participated in the study. Patients were contacted individually and asked if they were interested in participating in a research study. If they were interested, the subjects were scheduled for a period of time to come to the laboratory or, if this was not possible (because they lived many hours apart or because of limited funding during the last weeks of study), they were given a self-assessment package. - Report the measures to be completed at home and return by mail. The majority (N = 352) of the participants came to the laboratory and completed both interview sessions and self-report measurements in small group sessions (381 participants completed at least one session).

Internalization

Inventory of symptoms of depression and anxiety (IDAS, Watson et al., 2007, 2008). IDAS is a 64-item tool derived from analytical factors designed to assess the specific dimensions of symptoms of major depression and related anxiety disorders. Contains 10 scales of specific symptoms: suicide (6 items, eg "I had thought of suicide"), Lasitud (6 items, eg "I felt exhausted"), Insomnia (6 items, for example, "I slept a lot bad "), Loss of appetite (3 items, for example," I didn't want to eat much "), gain of appetite (3 articles, for example" I ate more than usual "), bad mood (5 articles, for example , "I was furious"), Wellness (8 items, eg "I was proud of myself"), Panic (8 items, eg "I was trembling or trembling"), Social Anxiety (5 item; Ex, "I was worried about social embarrassment "and traumatic intrusions (4 items, for example," I had memories of something terrifying happened ").

Interview Measures

Classification version for IDAS doctors (IDAS-CR, Watson et al., 2008). IDASCR is a version of the IDAS interview which consists of a single medical score on each of the 10 specific symptom scales evaluated by IDAS (see above) and Dysphoria by IDAS. Each evaluation is carried out on a 3-point

scale (absent, below the threshold, present). To make these classifications, doctors ask a standard question about the initial probe, as well as several standard follow-up questions for each symptom. Furthermore, clinicians are free to ask further questions to ensure that the person receives an adequate mark in the size. For the classification of IDAS-CR dysphoria, for example, interviewers start with the standard probe question, "Did you feel sad, depressed or depressed during the last two weeks? Questions like" Did you feel inadequate? ";" You had difficulty concentrating? "; and" Were you worried most of the time? "The interviewers also clarified if the reported symptoms were" more days than not "in the last 2 weeks and if (a) had been noticed by others or (b) interfered with the patient's daily activities.

3. RESEARCH METHODOLOGIES

An exhaustive attempt was made to identify all the young people aged between 4 and 18 who lived in MR in different census regions in the Indian states of New Delhi (Einfeld and Tonge, 1996a). These regions were areas of local government, which together represented a cross-section of the Indian community, in particular for the social class, the mixture of ethnic origin and urban / rural distribution, which may be factors associated with psychopathology. The epidemiological cohort was recruited from all health, educational and family agencies that provide services to young people with rare diseases at all levels whose families lived in selected census districts. Children who did not live with their parents but were in institutional care or in small groups were included, provided their parents lived in one of the regions surveyed. These criteria have ensured the inclusion of institutionalized children who tend to have a higher level of behavioral alteration (Einfeld and Tonge, 1992). Registration in regional disability services provided the mechanism for the provision of state-funded services for young people and their families. Given that those with IQ less than 50 (moderate to severe MR) always require a certain type of health, education or social assistance, this longitudinal study has probably achieved a practically complete determination of this population in India (Einfeld et al. Tonge, 1996a).

4. DATA ANALYSIS AND INTERPRETATION

Longitudinal regressions of each of the dependent variables based on the DBC at the age of admission to the ACAD study, aging during the study (both in years), gender (girl = 1, child = 0), MRI level (severe or deep = 1, mild or moderate = 0), if the same respondent has completed the DBC-P or the DBC-A (yes = 1, not = 0), the group (group of syndromes or epidemiological cohort) and the interactions of the group and gender with aging in the study were estimated using Stata version 9 (StataCorp, 2005). Of these independent variables, only aging during the study and interactions with it vary over time. The others are variables "between subjects". The reference group for each syndrome group was the epidemiological cohort, with the exception of those identified with the

syndrome in question. This reference group included those with DS, except for regressions where DS is an independent variable.

In this article, we describe the changes in some parameters of psychopathology during the 11-year period. We have selected some behaviors that are representative of externalization and internalization of interest.

4.1 Externalizing Psychopathology

DBC "disruptive" subscale score

Here, to illustrate the type of analysis performed, we show the results using a figure Fig. 1. In the following results, to save space, we show a figure with Figs means. Figs and describe the significant results of the regression analysis.

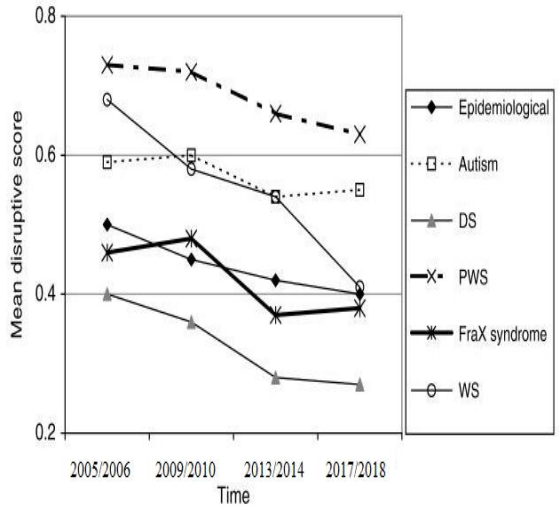

Figure. 1 DBC disruptive scores

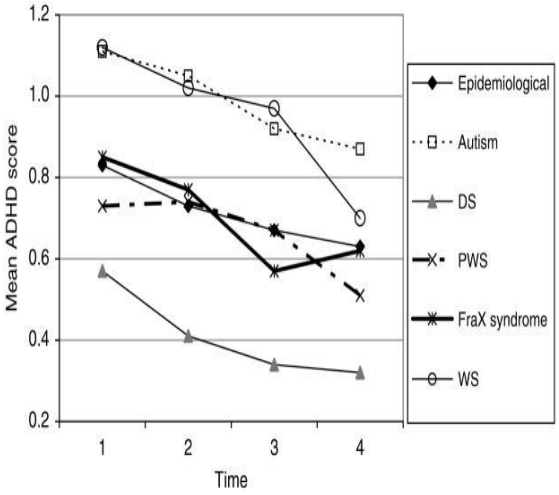

Figure. 2 DBC ADHD scores

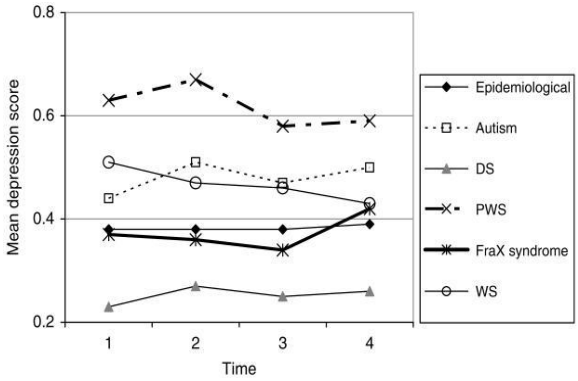

Figure. 3 DBC depression score

4.2 Anxiety

The mean DBC anxiety scores are shown in Fig. 4.

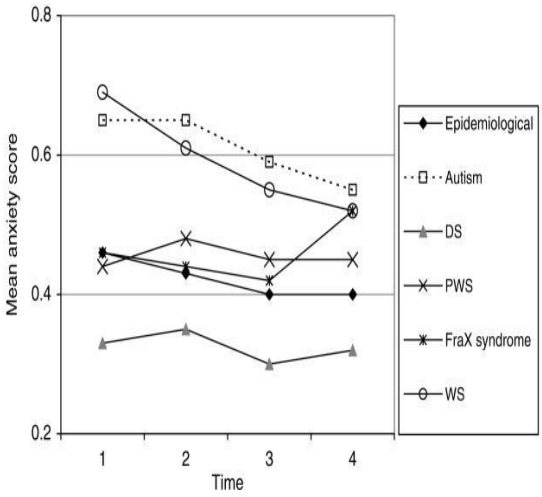

Figure. 4 DBC anxiety score.

4.3 Externalizing Behavior

It was found that destructive behavior decreased slowly with aging. At the public health level, this suggests that during childhood and adolescence, programs must address the disruptive behavior and educational needs of children with MR. For families, it is necessary to increase the availability and establish the effectiveness of different programs of proven efficacy in the treatment of destructive behavior in children and adolescents with MRI.

4.4 Internalizing Behavior

The self-absorption score, which is associated with a lower IQ, decreases. This can represent a developmental phenomenon of greater mental age. The pattern of change in the anxiety subscale is of some interest. The anxiety scores decrease in both sexes with aging, significantly more for children. This is different from the pattern of change observed in children with normal development, in which there is an increase in some anxiety disorders after administration. The reason why this postoperative anxiety increase has not been observed is unknown. On the other hand, depression scores, although higher in girls, do not decrease over time.

4.5 Down Syndrome

As noted elsewhere, participants with DS have less psychopathology throughout the range of symptoms and syndromes.

4.6 Prader-Willi Syndrome

The scores of destructive behavior are higher, especially for "abusive" (offensive, offensive to others), "outbursts of anger" (whims, for example, seals, doors) and "blows" (throwing or breaking objects) for "kicking" (kicking, hitting others). Perhaps this latter behavior requires more physical movement than is easily done for people with PWS. Anxiety is not associated with PWS, but depression is associated.

4.7 Williams Syndrome

WS participants have high initial scores, but fall significantly faster than those in the non-WS epidemiological cohort in most of the outsourcing and internalization dimensions. Previous literature has observed significantly higher anxiety scores in WS compared to other people with MR (Dykens, 2003; Einfeld, Tonge and Florio, 1997), and this is confirmed here. However, we are not aware of the previous observation that this high anxiety decreases significantly faster.

4.8 Fragile X Syndrome

Participants in FraX had lower initial levels of outsourcing behavior, but these were relatively stable. The internalization of behavioral trends showed a mixed pattern. Scores on the "self-absorption" scale tend to persist in FraX syndrome compared to other people whose scores decrease. Scores increase in anxiety but are stable for depression and "self-absorption" scores remain stable.

4.9 Implications for Behavioral Phenotypes

These longitudinal data contribute to an additional dimension when they delineate behavioral phenotypes. The data show that the behavioral characteristics in genetic disorders are not static and, moreover, changes over time are very specific for the disorder in particular. This implies that the effects of genomic lesions on behavioral pathways interact and influence other developmental processes. Therefore, we can anticipate that we will have to describe not only the gene-to-behavioral pathways in a particular syndrome, but the gene-to-behavioral pathways in that syndrome at every stage of life.

5.CONCEPT OF SYNDROMAL STRUCTURE

As indicated above, analyzes of the syndromic level were performed on dimensional representations of DSM syndromes to act as proxies for comorbidity analyzes performed in current DSM diagnoses and to provide information on how the diagnosis could be restructured in future reviews. of the DSM to reflect the comorbidities between these categories These analyzes used composite materials created by self-reports and interview data to evaluate DSM diagnostic constructs.

6. CONCEPT OF SYMPTOM STRUCTURE

As indicated above, analysis of symptom levels were conducted to address heterogeneity problems and potentially to provide an alternative model for DSM-IV that best captures the nature of psychopathology. Although some specific predictions could be made about what might emerge from these symptom-level analyzes (for example, the symptoms of social anxiety and social anhedonia of STPD should coincide with the symptoms of the internalization domain, while the symptoms of the STPD of Unusual beliefs or experiences should coincide with the symptoms of dissociation, in particular depersonalization, a five-factor model that resembles traits of normal personalities with oddities that replace the opening may emerge, not enough is known about All symptom associations included to specify a complete model.In addition, the amount of symptom size included makes it difficult to specify an a priori model that fits the data well.As such, analysis of symptom levels was exploratory in nature. These analyzes were performed on the entire sample of patients due to 1) the greatest number of variables in the analyzes, 2) the above-

mentioned uncertainty of how the symptoms could be correlated (ie the restructuring is more difficult) and 3) the questionable psychometry properties of the STPD subscales. However, these constraints limit the analysis to self-report data. Therefore, the EFAs were performed separately with the interview data to determine whether the same basic pattern would emerge.

6. CONCLUSION

The first series of analyzes was performed at the syndromic level, using dimensional data that evaluated the diagnostic constructs of the DSM. For example, depression has been analyzed as a single dimension (ie, a total score on a depression measure). These analyzes can be considered proxies for the comorbid diagnostic analysis (for example, analyzing depression as a single dimension can be considered a proxy for analyzing MDD as a diagnosis category). Execution of analysis then begins to address some problems with the use of categorical diagnosis DSM, such as base rate problems that have generally led to the exclusion of many DSM diagnoses. Therefore, these analyzes can provide an approximation of what could have been verified if the diagnosis were not excluded due to problems with the base rate. As discussed above, it is likely that these dimensional assessments are more reliable than their dichotomous counterparts and, as such, may provide a more accurate model of psychopathology defined by DSM. The results of these analyzes may also offer further suggestions for reorganizing the current DSM categories in a quantitative hierarchical model in subsequent editions of the DSM (see Watson, 2005). major depressive disorder, panic disorder, social phobia, post-traumatic stress disorder (PTSD), obsessive compulsive disorder, psychotic disorder, dissociative disorder, STPD, antisocial personality disorder, alcohol abuse / dependence and abuse: the following syndromes have been including / drug addiction.

The second set of analyzes was more exploratory (exploratory factorial analysis; EFA) and performed on the size of the symptoms underlying the aforementioned syndromes (eg, analysis of the size of individual symptoms included in depression place of a single dimension of depression) . As such, these analyzes eliminate the problem of the heterogeneity of the disorder and allow a structural "bottom-up" approach. In this approach, the symptoms of mental illness are combined in large dimensions of psychopathology based on their empirical relationships with each other. So the dimensions can be analyzed to determine whether a structure of a higher order than their base. Therefore, this study can be a step towards the construction of a psychopathology model that better represents empirical data and to model more accurately the nature of psychopathology, in other words, a "ship approach" model. Further information on these analyzes is included in the hypothesis and data analysis section.

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