1

UNDERSTANDING ABNORMAL BEHAVIOR : CLINICAL ASSESSMENT AND DIAGNOSIS - I

Unit Structure

1.0 OBJECTIVES

After reading this unit you will be able to:

- Understand what is meant by abnormality and the difficulties in defining it.
- Discuss the factors involved in the development of abnormality.
- Describe the development and use of the Diagnostic and Statistical Manual of Mental Disorders.

1.1 INTRODUCTION

Efforts to understand, explain and control problematic behaviors can be traced back to several years. Abnormal Psychology is the systematic study of abnormal behavior. It is a branch of psychology that is concerned with the etiology, symptomatology, and the process of mental illnesses. In this chapter we will examine what is meant by deviant or 'abnormal' behavior?

After defining abnormality, we will discuss the challenges involved in characterizing abnormal behavior as well as the causes of abnormality. Following this we will discuss the Diagnostic and Statistical Manual of Mental Disorders and related topics.

The concept of psychological assessment, behavioral assessment, multicultural assessment, environmental assessment and physiological assessment would be discussed with relevant examples.

1.2 WHAT IS ABNORMAL BEHAVIOUR?

Let's consider the following case.

Does anything about Raju seem strange to you? How would you feel if you were to see someone like Raju walking in your neighborhood? You could be surprised or scared or may even laugh? You may think there is something abnormal about this person. On what basis is Raju judged to be abnormal? Is it because the way he is talking is odd? Or since he is making high claims? Or because one cannot anticipate how he may behave after a while?

Anything that deviates from the normal or differs from the usual or typical is called abnormal. However, there can be exceptions and certain very unusual behaviors may also be considered normal in the given cultural/social context. E.g. a gifted child. So, on what we should decide what is normal and what is abnormal?

To answer the above question, there are certain criteria that help us define abnormality and also distinguish between what is normal and abnormal.

1.2.1 Defining Abnormality

The current diagnostic procedures used in the mental health community rely on four important ways in which abnormality can be defined.

Impairment: According to this criterion, maladaptive behaviors that prevent an individual from functioning well in his/her daily life can be considered abnormal. Impairment refers to a reduction in a person's ability to function at an optimal or average level. For example, when a woman consumes psychoactive substances (drugs), her cognitive and perceptual abilities get impaired, and she would be at risk if she drives in this state. In the case mentioned earlier, Raju spent all his savings to buy an expensive

camera thinking that he could set up a studio. This can be thought of as his impaired judgment.

In certain situations, the person may report feeling great and describe oneself in positive terms but those around may suggest that s/he is functioning inadequately in her/his personal or work life. E.g. an individual experiencing manic symptoms of Bipolar disorder.

Distress: This criterion suggests that a particular behavior should be considered as abnormal if the individual suffers discomfort because of that behavior and wish to get rid of them.

The experience of distress - emotional or physical pain - is common in life. However, in case of mental disorders the intensity of pain is so high that it interferes with the person's daily living. For example, a victim of an extremely traumatic event may experience unrelenting pain or emotional turmoil and may not be able to cope in daily life.

Risk to Self or Other People: When an individual's actions pose a threat to one's own life or to the life of others, the behavior is considered to be abnormal. A severely depressed individual is at risk for committing suicide and therefore the condition is referred to as abnormal. Similarly, a person suffering from Schizophrenia is out of touch with reality and may put oneself and/ or others at risk. In some situations, a person's thoughts and behaviors threaten the physical or psychological wellbeing of others and are therefore, considered abnormal such as the act of abusing children or exploiting others.

Socially and Culturally Unacceptable Behaviour: Behaviours that are not in line with the social or cultural norms are considered abnormal. Certain behaviours may be acceptable in some cultures but considered odd in certain others. For e.g., In India, the phenomenon of being possessed by God is a common practice during Navratri or other festivals, but the same behaviour would be considered abnormal in most of the other countries. Thus, the social context needs to be taken into account while judging behaviour as normal or abnormal.

1.2.2 Challenges Involved in Characterizing Abnormal Behaviour

Although there are clear criteria for defining abnormality, diagnosing abnormal conditions is not as straightforward as it may seem. In 1973, David Rosenhan conducted a classic study that threw light on the difficulties involved in this process - 8 sane individuals were able to trick the staff of 12 psychiatric hospitals across the United States. Each of them was gainfully employed and presented oneself at these hospital reporting hearing voices such as "Empty", "Hollow," and "Thud." These kind of psychotic symptoms were chosen because they had never been reported in the history of psychiatric literature.

Except their names and employment, none of their other details were changed and thus their history and present behaviour (except for the symptoms) could not be considered abnormal in any way. Interestingly, all

the hospitals admitted these pseudopatients and although they stopped producing the symptoms immediately following the admission, none of the staff members noticed it. On the contrary, their ordinary actions were taken as additional evidence of their abnormality.

What was most striking was the inhuman approach of the staff - the pseudopatients felt as if nobody from the staff was concerned about their needs. Also, the staff didn't believe them when they tried to convince them that they were actually normal. The pseudopatients were released in 7 to 52 days and at the time of discharge, each of them had received a diagnosis of 'schizophrenia in remission', which meant that their symptoms were not present, at least during that time.

Rosenhan (1973) concluded that what prevented the hospital staff from detecting the pseudopatient's normality is the general bias to call a healthy person sick. Since this study involved deception of the mental health professionals, it was criticized for an ethical reason. Questions pertaining to why a control group was not used for comparison were raised. It was also said that since the symptoms reported (hallucinations) were of a serious nature, most clinicians would have done what the hospital staff did.

Scribner (2001) found that Rosenhan's controversial study had led to an extreme change in the mental health field where now patients with diagnosable psychotic symptoms had difficulty receiving mental health services. He reported 7 cases with documented history of chronic Schizophrenia, 6 of which were not treated even while they were in the active phase of symptoms.

Lauren Slater (2004) attempted to replicate Rosenhan's study.

She went to several clinicians complaining hearing "thud" and no other symptom. She was denied admission everywhere and at the most, diagnosed with depression with psychotic symptoms, was prescribed some medication and sent away. She also reported that as opposed to the pseudopatient's experience in the Rosenhan study, she was treated very kindly by every mental health staff.

Thus, in spite of the criticisms, Rosenhan's study proved to be crucial in pointing out that the attitudes towards diagnosing and admitting individuals with psychological difficulties need to change.

1.2.3 What causes Abnormality?

There are various assumptions about the causes of abnormality. One being the biological approach which considers the abnormal behaviours to be caused by a biological factor such as genetic vulnerability to a disorder inherited from a parent, imbalance in neurotransmitters, brain injury, toxic substances etc. The psychological approach considers the abnormal behaviours to be caused by the early childhood experiences, traumatic experiences, maladaptive thought process, low self-concept etc. The social perspective considers the abnormal behaviours to be caused by the

disturbed interpersonal relationships, discrimination, or the negative social environment in which an individual lives.

There is long going debate whether abnormality is caused due to biological or environmental factor? This is referred to as the nature-nurture question wherein some consider the abnormality to be caused by something in the nature i.e. biological or due to nurture i.e. environmental factor. E.g. when a professional singer's child also becomes a professional singer. So, was the singing ability passed genetically through birth or was it because of having father who is a professional singer and so the behavior learned through observation, countless hours of repetition and practice.

So, now the forth approach is considered to be more acceptable. Social scientists are of the view that there is an interaction between biological, psychological and social factors. This approach is termed as '**biopsychosocial**'. On the similar line, the **diathesis-stress model** suggests that an individual is genetically predisposed (diathesis) i.e. they carry some genetic risk to a particular disorder to a particular disorder or have acquire vulnerability early in life due to some formative events such as birth complications, head injury, traumas, or malfunctioning or harsh family. This vulnerability placed them at higher risk of developing that disorder as they grow when they experience any kind of traumatic or stressful situation or trigger. The can be due to psychological factors like a faulty personality trait, irrational thought process, low self-esteem or due to social factors like a history of abuse or poor interpersonal relations.

The full-blown disorder can develop only when the vulnerability combines with the stress. Also, a feedback loop tends to develop, such that, changes in one system lead to changes in the second and then the changes in the second system bring about changes in the first. For example, an increase in a certain neurotransmitter (biological factor) may make an individual angry and irritable (psychological factor). This may cause the person to react angrily towards his friends, who may begin avoiding him (social factor) due to this behaviour. The rejection from friends (social factor) may make the person even more agitated, which may cause further changes in the neurotransmitters (biological factor).

Although the theoretical approaches are discussed in detail in topic 2, let's have a brief look at the biopsychosocial factors involved in the development of abnormality.

Biological causes:

- In understanding what causes abnormality from the biological perspective, mental health professionals focus on the processes in a person's body, such as genetic inheritance, altering function of nervous system or physical disturbances.
- Many disorders run in the family. For example, the chances of the son or daughter developing schizophrenia are greater if either of their

parents is suffering from it as compared to children of parents who do not have the disorder.

- Other factors such as medical conditions (thyroid), brain damage (head trauma), exposure to certain environmental stimuli (toxic substances, allergens), ingestion of certain medicines, illicit drugs, etc., can cause disturbances in the physical functioning that cause emotional or behavioural disturbances.

Psychological causes:

- Traumatic life experiences that have an impact on the individual's thoughts, feelings, behavior or personality constitute the psychological factors in the development of abnormality. For example, an irrational fear of the marketplace may be caused due to a childhood experience of having been lost in the market.
- Early interpersonal relationships may lead to distortions in perception and faulty thought processes. For example, a boy who is very upset because his girlfriend didn't call back may realize that his reaction stems from his history of being disappointed by his unreliable parents and having internalized the idea that important people tend to disappoint.
- Unrealistic expectations, learned helplessness, focusing on the negative, blaming, dichotomous thinking (seeing things as black or white), catastrophizing (exaggerating) etc., can trigger psychological difficulties.
- Low self-esteem, poor judgment, pessimistic thought process, low self-confidence makes a person more vulnerable to the psychological difficulties

Sociocultural causes:

- The term sociocultural refers to the sources of social influence in one's life. The most immediate or inner circle that has an impact on a person comprises of the family members and friends. A troubled relationships can make one feel depressed. Similarly, a failed lover may become suicidal.
- The next circle involves extended family, neighbours with whom there is less interaction. Nonetheless their behaviours, standards, attitudes, and expectations do influence individuals.
- The next circle involves teachers, school, college, institution, workplace. What an individual learns from each of these places or the experiences that they get plays an important role in shaping ones thought and behavior.
- The society plays a decisive role in most people's lives. Political turmoil, even at the local level can leave one feeling anxious or fearful. Discrimination based on gender, caste, sexual orientation, disability

can have an impact on individuals. As seen earlier, social and cultural norms determine what would be called abnormal, to a large extent.

1.3 THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

- Mental health professionals refer to the Diagnostic and Statistical Manual of Mental Disorders (DSM) for standard terms and definitions of various forms of abnormality. It is a classification system that includes descriptions of all psychological disorders, which are also known as mental disorders.

- The DSM, published by the American Psychiatric Association (APA), is periodically revised to incorporate the latest information related to psychological disorders. The DSM was first published in 1952 and since then has gone through several changes with its latest version being DSM-IV-TR (text revision).

- To develop revised editions of the DSM, task forces are appointed which comprise of clinicians and researchers with expertise in specific disorders. Based on their research and case studies analysis, a list of several disorders ranging from mild adjustment problems to severe disorders has been listed.

- The DSM ensures standardized interpretation of the diagnostic labels and provides a common language and format for communication between clinicians and researchers.

Its multiaxial format (explained later in the chapter) also allows thorough evaluation of cases with attention to the mental disorders, general medical conditions, psychosocial problems, and the level of functioning, which might get ignored if the focus were on evaluating only the presenting complaints.

- The recent editions of the DSM follow an a theoretical approach, that is, they try to present psychological disorders in a manner that reflects observable phenomena rather than what caused it. For example, anxiety disorders are described in terms of the associated psychological and physical symptoms associated with no reference to what caused these symptoms.

- The DSM classification system also helps in treatment planning. For example, a clinician would choose very different treatment plans for individuals with anxiety disorders as compared to those with psychotic illnesses. Also, every DSM-IV diagnosis has specific numerical code, which helps individuals acquire health insurance to manage the treatment cost.

- The authors of the DSM have tried to develop a reliable and scientifically and clinically sound system such that anyone showing a specific set of symptoms receives the same diagnosis across clinicians, irrespective of their theoretical orientation.

- Emphasis has also been on the ensuring its validity i.e. the extent to which the diagnostic criteria measure a specific disorder and how well the disorders can be distinguished from each other. For this, the experts have been required to consider the base rate of a disorder - that is, the frequency with which a disorder is found among the general population. Low base rate means fewer cases and therefore establishing the reliability of the disorder becomes difficult.

1.3.1 How the DSM Developed

The DSM was the first official classification system that was developed exclusively for diagnosing mental disorders. Let's look at the history of the DSM - the initial editions of this manual were not as precise and reliable as the recent ones.

- The DSM-I, the first edition published in 1952, followed a theoretical approach where mental disorders were seen as a result of an individual's 'emotional reactions' or their 'emotional problems'.
- The DSM-II which was published in 1968, tried to introduce explicit definitions and diagnostic terms that would reduce reliance on theoretical assumptions. However, the criteria to describe different was not precisely explained and was mostly based on the concepts of psychoanalytic theory.
- In 1974, the APA appointed a task force i.e. a team of scholars and practitioners to develop a manual that would be based on observable phenomena and acceptable to clinicians irrespective of their theoretical orientation. This led to the DSM-III, published in 1980.
- Although the DSM-III was a refined edition, it had instances in which the diagnostic criteria were not entirely clear. Due to this, the DSM-III-R was published in 1987 as an interim manual till a more complete edition was developed.
- Around the same time, the APA once again set up a task force that worked towards improving the reliability and validity of the diagnoses, in stages. In stage 1, its members reviewed the relevant research published which was then carefully analyzed in stage 2. The next stage involved field trials in which several thousand individuals with diagnosed psychological disorders were interviewed. Consistency in diagnosis was assessed by having pairs of clinicians independently rate clients through videotaped interviews. To establish the validity of the diagnosis, clinicians evaluated individuals diagnosed with specific psychological disorders, with the number and nature of symptoms needed to diagnose specific conditions. These field trials helped to empirically decide the specific kind and number of symptoms that would make a diagnostic criteria. For example, to diagnose Major Depressive Disorder, a person has to have atleast five out of the nine listed symptoms which include lack of interest, sad mood, disturbed sleep, disturbed appetite, feelings of worthlessness, etc.

- Thus, the DSM-IV was published in 1994. A major feature of this version was that it included 'the symptoms cause clinically significant distress or impairment in social, occupational or other areas of functioning' as one criterion for almost half of all the disorders.

- The DSM-IV with updated information, known as DSM-IV-TR (text revised) was published by 2013.

- And, then the latest been DSM-V was published in 2013. A lot of changes have been made from DSM-IV-TR to DSM 5. One of the key changes is the elimination of multi-axial system. Then, the task forces of DSM 5 also considered getting away with the categorical model to represent different disorders and adopt the dimensional model. But they end up not doing so. However, Section 3 of DSM 5 provides clinician the description of different disorder based on dimensional model.

- The current organization of DSM 5 begins with neurodevelopmental disorders, then next category is of "internalizing" disorders (wherein anxiety, depressive, and somatic symptoms are more prominent) and lastly "externalizing" disorders (wherein impulsive, disruptive conduct and substance use symptoms are more prominent).

1.3.2 Controversial Issues Pertaining to the DSM

- For many years, critics of the DSM have argued that it tends to unfairly label people and is not a very reliable and valid tool. It is also suggested that politics and culture have influenced the definitions of disorders from time to time. For example, homosexuality was included as a diagnostic category in the DSM-II and was removed following protests from gay activists at the APA annual conferences from 1970 to 1973.

- Also, pressure from the Vietnam War veterans forced the authors of DSM-III to recognize that a group of symptoms experienced by survivors of traumatic events represented a disorder and thus post-traumatic stress disorder was introduced. This demonstrates the biased processes involved in defining mental disorders.

- In addition to this, the DSM classification system is criticized for being prejudiced against women, in that women are more likely to be diagnosed with personality or mood disorders because feminine personality characteristics are perceived as being pathological. As a result of this, the authors of the DSM-IV have been particularly careful about basing their decisions on fair interpretation of the research data (Kirk & Kutchins, 1992; Kutchins & Kirk, 1997).

1.3.3 Definition of Mental Disorder

The concept of mental disorders is fundamental to the processes of diagnoses and treatment. The authors of the DSM define a mental disorder as "a clinically significant behavioral or psychological syndrome or

pattern that occurs in an individual that is associated with present distress (e.g., painful symptom) or disability (i.e., impairment in one or more areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom and it is not typical or culturally expected."

Let's understand this definition.

- **A mental disorder is clinically significant** - this implies that the symptoms have to be present for a specified period of time and should have a major effect on the person's life. Thus, an occasional low mood or strange behaviour or a sense of instability are common experiences and do not represent a mental disorder. In order to be considered it as significant it need to be persistent and severe in nature.

- **A mental disorder is behavioral or psychological syndrome or pattern** - a syndrome is a collection of defined symptoms. A behavioural or psychological syndrome indicates a set of observable actions and the thoughts and feelings reported by the individual. Accordingly a random thought or behaviour does not constitute a mental disorder. A person has to experience a wide range of defined thoughts, feelings and behaviours in order to be called as having a psychological disorder.

- Further, it is **associated with present distress, disability, impairment or serious risk**. This means that the syndrome sufficiently interferes with the individual's everyday functioning. For example, a woman who compulsively washes hands may be very disturbed by her actions and may not be able to overcome the behaviour. Her productivity at work and social life may also be severely affected by this.

  In certain mental disorders the person may not experience any distress but there may be a serious risk to life. For example, a person in a hyperexcited state of mania, having a good time, may believe he can fly and is thus at risk.

- Finally, **the disorder is not a culturally expected or sanctioned pattern**. For example, a woman feeling sad, having difficulty eating, sleeping, concentrating, etc., for few days, following the death of her husband, will not be called as suffering from Major Depressive Disorder because it is an expected reaction to this event.

1.3.4 Assumptions of the DSM-IV-TR

The DSM is based on some assumptions:

1. **Medical Model**: The DSM follows a medical model which means that every physical and psychological disorder is regarded as a disease. In this sense the DSM is similar to the ICD, the International Classification of Diseases (ICD), developed by the World Health Organisation, and ensures uniformity in the usage of medical terms.

According to this view, schizophrenia is a *disease* and the individual suffering from it is referred to as *patient*. The use of the term *mental disorder* is also in line with this view. Although the term mental disorder implies a distinction between 'mental' disorders and 'physical' disorders, it is important to recognize that there aren't any fundamental differences between mental disorders and general medical conditions. Mental disorders tend to involve biological factors and similarly physical disorders have psychological components.

2. A theoretical Orientation: The authors of the DSM have tried to develop a descriptive rather than explanatory classification system, that is, a psychological disorder is presented as an observable phenomenon rather than in terms of what caused it.

The DSM is neutral with respect to the theories of causality. For example, the DSM-IV-TR classifies social phobia as an anxiety disorder in which the person has persistent fear of social or performance situations, without any reference to whether the anxiety is caused due to a childhood trauma or an unconscious conflict or any other factor.

The early editions of the DSM were based on the psychoanalytical tradition in which mental disorders were seen as 'neurosis' or an 'emotional reaction' to one's problems and were thought to be a result of unconscious conflicts. The term neurosis is not a part of the DSM anymore but is still commonly used to describe symptoms that are distressing and do not have a physiological basis. The term is also used to refer to excessive anxiety or worry and to distinguish the condition from psychosis.

Psychosis involves the presence of hallucinations (false perceptions) and delusions (false beliefs). It is a condition in which the person is not in touch with reality and shows grossly disturbed and bizarre behaviour. Psychosis is not a diagnostic category but used as a descriptive term in the DSM-IV-TR.

3. Categorical Approach: The DSM-IV-TR classifies the disorders into separate categories. For instance, conditions which involve excessive anxiety or worry are categorized as anxiety disorders, those which affect the mood are referred to as mood disorders.

Although systematic, this approach has a limitation - psychological disorders cannot be very neatly separated from one another. For example, it is difficult to distinguish between sad mood and clinical depression (severe enough to receive a diagnosis of depression). Also, some cases involve a mixed presentation such a person experiencing anxiety and sad mood or mood symptoms with psychosis.

There are two issues related to the categorical approach. One is comorbidity, that is, conditions in which a person has two or more disorders that co-exist. For instance, negative emotional states are common in anxiety disorders, mood disorders and some personality disorders. The second is that of boundaries - some disorders have

overlapping symptoms, such as conduct disorder, oppositional defiant disorder and attention- deficit/hyperactivity disorder (Widiger & Samuel, 2005).

Due to this, a dimensional approach is being considered. That is, instead of fitting an individual's symptoms into some category s/he would receive a numerical rating on his symptoms indicating the severity of each. The dimensional model is thought to give a better picture of the individual's condition. And, the task force of DSM 5 is hoping to develop the next edition using dimensional model.

4. Multiaxial system: This system involves assessing five areas of an individual's functioning so that the treatment can be planned accordingly and the course of the disorder can be predicted. The DSM comprises of five axes:

Axis I: Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention

This axis is used for listing the various forms of abnormality, that is, the clinical syndromes or disorders with the exception of the Personality Disorders and Intellectual Disability, such as Schizophrenia, the different types of Anxiety disorders, such as social phobia, specific phobia, generalized anxiety disorder etc., the Obsessive and compulsive related disorders like obsessive compulsive disorders, hoarding disorder, body dysmorphic disorder, etc., Mood disorders such as major depressive disorder, bipolar disorder, etc., Adjustment disorders, Cognitive disorders like delirium, dementia, amnestic disorder, etc. If an individual has more than one Axis I disorder, all should be reported with the primary reason for the visit being listed first.

Axis II: Personality Disorders and Mental Retardation

All the Personality Disorders like Paranoid personality disorder, Schizoid personality disorder, Schizotypal personality disorder, Antisocial personality disorder, Narcissistic personality disorder, etc., and Intellectual Disability are reported on Axis II. Maladaptive personality features or excessive use of defense mechanisms can also be mentioned here. This axis ensures that the unhealthy personality characteristics and mental retardation will be taken into account while attending to the primary complaint.

Axis III: General Medical Conditions

This axis is for reporting the general medical conditions that are important in understanding an individual's mental disorder. General medical conditions may be related to the mental disorders in several ways. In some cases they may play a role in the development of an Axis I disorder, for example, Hypothyroidism may lead to depressive symptoms in some or an individual may develop an Adjustment disorder as a reaction to the diagnosis of Brain tumor. In certain cases medical conditions may influence the treatment of the Axis I disorder, for instance, a person's

heart disease may influence the clinician's choice of medicines for this patient's depression.

Axis IV: Psychosocial and Environmental Problems

The psychosocial and environmental problems that influence the diagnosis, treatment and prognosis (future course) of mental disorders listed on Axis I and/or II are reported on this axis. This includes a negative life event, interpersonal stresses, lack of social support, etc. These problems may influence the development or treatment of mental disorders or may develop as a result of the Axis I/II condition.

Axis V: Global Assessment of Functioning

This axis is for reporting the clinician's judgement of the individual's overall functioning, which is useful in treatment planning or predicting its outcome. The Global Assessment of Functioning (GAF) scale is used by clinician to rate the individual's psychological, social and occupational functioning. For example, score of 100 means superior functioning with no symptoms while a score of 50 indicates serious symptoms.

91-100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
81-90	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
71-80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
61-70	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupational, or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
41-50	Severe symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).

31-40	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
21-30	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).
11-20	Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
1-10	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.0 Inadequate information.

1.4 CLASSIFYING ABNORMAL BEHAVIOR

- Most sciences rely on classification (e.g., the periodic table in chemistry and the classification of living organisms into kingdoms, phyla, classes, and so on in biology).
- At the most fundamental level, classification systems provide us with a nomenclature (a naming system) and enable us to structure information in a more helpful manner.
- Organizing information within a classification system also allows us to study the different disorders that we classify and therefore to learn more about not only what causes them but also how they might best be treated.
- A final effect of classification system usage is somewhat more mundane.
- The classification of mental disorders has social and political implications (see Blashfield & Livesley, 1999; Kirk & Kutchins, 1992). Simply put, defining the domain of what is considered to be pathological establishes the range of problems that the mental health profession can address. As a consequence, on a purely pragmatic level, it furthermore delineates which types of psychological difficulties warrant insurance reimbursement and the extent of such reimbursement.

1.5 HISTORICAL VIEW OF ABNORMAL BEHAVIOR

The historical view of abnormal behavior has come a long way considering the reason behind the abnormal behavior to be attributed to supernatural forces or evil forces to the knowledge based on scientific study. The course of this evolution has at times been matter of efforts of many prominent experts and researchers.

Demonology, Gods and Magic

- As mentioned earlier, one of the earliest explanations to the abnormal behavior was attributed to God or evil spirits.
- References to abnormal behavior in early writings show that the Chinese, Egyptians, Hebrews, and Greeks often attributed such behavior to a demon or god who had taken possession of a person.
- Whether the "possession" was assumed to involve good spirits or evil spirits usually depended on the affected individual's symptoms. If a person's speech or behavior appeared to have a religious or mystical significance, it was usually thought that he or she was possessed by a good spirit or god. Such people were often treated with considerable awe and respect, for people believed they had supernatural powers.
- Most possessions, however, were considered to be the work of an angry god or an evil spirit, particularly when a person became excited or overactive and engaged in behavior contrary to religious teachings.
- Apparently they were punished and punishment involve withdrawal from God's protection and abandonment of the person to the forces of evil.
- In such cases, every effort was made to rid the person of the evil spirit. The primary type of treatment for demonic possession was **exorcism**, which is a physically and mentally painful form of torture carried out by a shaman, priest,or medicine man.
- Archaeological evidence also showed the use of the procedure called as **trephining** on the people showing abnormal behavior. The trephining is a process wherein a hole is drill on the skull of an individual with the believe that the hole will pave way to remove the evil spirit out of the body.

Hipoocrates' Early Medical Concepts

- The Greek physician Hippocrates (460–377 b.c.), often referred to as the father of modern medicine, received his training and made substantial contributions to the field.
- Hippocrates denied that deities and demons intervened in the development of illnesses and instead insisted that mental disorders, like other diseases, had natural causes and appropriate treatments.

- He believed that the brain was the central organ of intellectual activity and that mental disorders were due to brain pathology. He also emphasized the importance of heredity and predisposition and pointed out that injuries to the head could cause sensory and motor disorders.
- Hippocrates classified all mental disorders into three general categories—mania, melancholia, and phrenitis (brain fever)— and gave detailed clinical descriptions of the specific disorders included in each category.
- He relied heavily on clinical observation, and his descriptions, which were based on daily clinical records of his patients, were surprisingly thorough.
- However, Hippocrates had little knowledge of physiology. He believed that hysteria (the appearance of physical illness in the absence of organic pathology) was restricted to women and was caused by the uterus wandering to various parts of the body, pining for children. For this "disease," Hippocrates recommended marriage as the best remedy

Early Philosophical Conceptions of Consciousness

Plato:-

- The Greek philosopher Plato (429–347 b.c.) studied mentally disturbed individuals who had committed criminal acts and how to deal with them.
- He wrote that such persons were, in some "obvious" sense, not responsible for their acts and should not receive punishment in the same way as normal persons. He also made provision for mental cases to be cared for in the community (Plato, n.d.).
- Plato viewed psychological phenomena as responses of the whole organism, reflecting its internal state and natural appetites. Plato emphasized the importance of individual differences in intellectual and other abilities and took into account sociocultural influences in shaping thinking and behavior.
- His ideas regarding treatment included a provision for "hospital" care for individuals who developed beliefs that ran counter to those of the broader social order. There they would be engaged periodically in conversations comparable to psychotherapy to promote the health of their souls (Milns, 1986). Despite these modern ideas, however, Plato shared the belief that mental disorders were in part divinely caused.

Aristotle

- The celebrated Greek philosopher Aristotle (384–322 B. C.), who was a pupil of Plato, wrote extensively on mental disorders. Among his most lasting contributions to psychology are his descriptions of consciousness.

- He held the view that "thinking" as directed would eliminate pain and help to attain pleasure.
- On the question of whether mental disorders could be caused by psychological factors such as frustration and conflict, Aristotle discussed the possibility and rejected it; his lead on this issue was widely followed.
- Aristotle generally subscribed to the Hippocratic theory of disturbances in the bile. For example, he thought that very hot bile generated amorous desires, verbal fluency, and suicidal impulses.

Later Greek and Roman Thought

- Hippocrates' work was continued by some of the later Greek and Roman physicians.
- One of the most influential Greek physicians was Galen (a.d. 130–200), who practiced in Rome. He made a number of original contributions concerning the anatomy of the nervous system. (These findings were based on dissections of animals; human autopsies were still not allowed.)
- Galen also took a scientific approach to the field, dividing the causes of psychological disorders into physical and mental categories. Among the causes he named were injuries to the head, excessive use of alcohol, shock, fear, adolescence, menstrual changes, economic reversals, and disappointment in love.
- Roman medicine reflected the characteristic pragmatism of the Roman people. Roman physicians wanted to make their patients comfortable and thus used pleasant physical therapies such as warm baths and massage.
- However, they also followed the principle of contrariis contrarius ("opposite by opposite")—for example, having their patients drink chilled wine while they were in a warm tub.

Early Views of Mental Disorders in China

- China was one of the earliest developed civilizations in which medicine and attention to mental disorders were introduced (Soong, 2006).
- However, at this early date, Chinese medicine was based on a belief in natural rather than supernatural causes for illnesses. For example, according to them, the human body, like the cosmos, is divided into positive and negative forces that both complement and contradict each other. If the two forces are balanced, the result is physical and mental health; if they are not, illness results. Thus, treatments focused on restoring balance.

- Chinese medicine reached a relatively sophisticated level during the second century, and Chung Ching, who has been called the Hippocrates of China, wrote two well-known medical works around a.d. 200. Like Hippocrates, he based his views of physical and mental disorders on clinical observations, and he implicated organ pathologies as primary causes. However, he also believed that stressful psychological conditions could cause organ pathologies, and his treatments, like those of Hippocrates, utilized both drugs and the regaining of emotional balance through appropriate activities.

Views of Abnormality During the Middle Ages

- During the Middle Ages (about a.d. 500 to a.d. 1500), the more scientific aspects of Greek medicine survived in the Islamic countries of the Middle East.

- The first mental hospital was established in Baghdad in A.D. 792. It was soon followed by others in Damascus and Aleppo (Polvan, 1969). In these hospitals, mentally disturbed individuals received humane treatment.

Humanitarian Approaches

- During the latter part of the Middle Ages and the early Renaissance, the superstitious beliefs that had hindered the understanding and therapeutic treatment of mental disorders began to be challenged. Scientific questioning reemerged and a movement emphasizing the importance of specifically human interests and concerns began—a movement (still with us today) that can be referred to as humanitarian approach.

- Paracelsus (1490–1541), a Swiss physician, was an early critic of superstitious beliefs about possession. He insisted that the dancing mania was not a possession but a form of disease, and that it should be treated as such. Although Paracelsus rejected demonology, his view of abnormal behavior was colored by his belief in astral influences (lunatic is derived from the Latin word luna, or "moon"). He was convinced that the moon exerted a supernatural influence over the brain—an idea, incidentally, that persists among some people today.

- Johann Weyer (1515–1588), a German physician and writer was so deeply disturbed by the imprisonment, torture, and burning of people accused of witchcraft that he made a careful study of the entire problem.

- About 1583 he published a book, On the Deceits of the Demons, that contains a step-by-step negation of the Malleus Maleficarum, a witch-hunting handbook published in 1486 for use in recognizing and dealing with those suspected of being witches. In his book, Weyer argued that a considerable number, if not all, of those imprisoned, tortured, and burned for witchcraft were really sick in mind or body and that, consequently, great wrongs were being committed against

innocent people. Weyer's work enjoyed the approval of a few outstanding physicians and theologians of his time.

- Weyer was one of the first physicians to specialize in mental disorders, and the founder of modern psychopathology. Unfortunately, however, he was too far ahead of his time. He was scorned by his peers and his works were banned by the Church and remained so until the twentieth century.

- From the sixteenth century on, special institutions called asylums—sanctuaries or places of refuge meant solely for the care of the mentally ill—grew in number. The early asylums were begun as a way of removing from society troublesome individuals who could not care for themselves. Although most early asylums, often referred to as "madhouses," were not pleasant places or "hospitals" but primarily residences or storage places for the insane. The unfortunate residents lived and died amid conditions of incredible filth and cruelty.

- Later because of the efforts of some prominent professionals, the situation started changing. In the United States, the Pennsylvania Hospital in Philadelphia, completed under the guidance of Benjamin Franklin in 1756, provided some cells or wards for mental patients. The Public Hospital in Williamsburg, Virginia, constructed in 1773, was the first hospital in the United States devoted exclusively to mental patients. However, there too, the treatment techniques were aggressive, aimed at restoring a "physical balance in the body and brain." They included powerful drugs, water treatments, bleeding and blistering, electric shocks, and physical restraints. For example, a violent patient might be plunged into ice water or a listless patient into hot water.

- By the late eighteenth century, most mental hospitals in Europe and America needed reform. The humanitarian treatment of patients received great impetus from the work of Philippe Pinel (1745–1826) in France. In this capacity, he received the grudging permission of the Revolutionary Commune to remove the chains from some of the inmates as an experiment to test his views that mental patients should be treated with kindness and consideration—as sick people, not as vicious beasts or criminals. Had his experiment proved a failure, Pinel might have lost his head, but fortunately it was a great success. Chains were removed; sunny rooms were provided; patients were permitted to exercise on the hospital grounds; and kindness was extended to these poor beings. The effect was almost miraculous. The previous noise, filth, and abuse were replaced by order and peace.

- At about the same time that of Pinel, an English Quaker named William Tuke (1732–1822) established the York Retreat, a pleasant country house where mental patients lived, worked, and rested in a kindly, religious atmosphere (Narby, 1982). The Quakers believed in treating all people, even the insane, with kindness and acceptance.

- Benjamin Rush (1745–1813), the founder of American psychiatry and also one of the signers of the Declaration of Independence was associated with the Pennsylvania Hospital in 1783, Rush encouraged more humane treatment of the mentally ill; wrote the first systematic treatise on psychiatry in America, Medical Inquiries and Observations upon Diseases of the Mind (1812); and was the first American to organize a course in psychiatry (see Gentile & Miller, 2009).

- But even his principal remedies were bloodletting and purgatives. In addition, he invented and used a device called "the tranquilizing chair," intended to reduce blood flow to the brain by binding the patient's head and limbs.

- Despite these limitations, we can consider Rush an important transitional figure between the old era and the new.

- During the early part of this period of humanitarian reform, the use of **moral management**—a wide-ranging method of treatment that focused on a patient's social, individual, and occupational needs—became relatively widespread. This approach, which stemmed largely from the work of Pinel and Tuke, began in Europe during the late eighteenth century and in America during the early nineteenth century.

- Despite its reported effectiveness in many cases, moral management was nearly abandoned by the latter part of the nineteenth century. The reasons were many and varied. Among the more obvious ones were overcrowding, lack of sufficient staff and limited hospital facilities. Two other reasons are, in retrospect, truly ironic. One was the rise of the **mental hygiene movement**, which advocated a method of treatment that focused almost exclusively on the physical well-being of hospitalized mental patients. Although the patients' comfort levels improved under the mental hygienists, the patients received no help for their mental problems and thus were subtly condemned to helplessness and dependency. Secondly, advances in biomedical science also contributed to the demise of moral management and the rise of the mental hygiene movement.

- Benjamin Franklin's work with electricity was among the earliest efforts to explore electric shock to treat mental illness, an insight he gained accidentally. His proposals for using electricity to treat melancholia (depression) grew out of his observations that a severe shock he had experienced altered his memories.

- Dorothea Dix (1802–1887) became an important driving force in humane treatment for psychiatric patients. In 1841, she began to teach in a women's prison. Through this contact she became acquainted with the deplorable conditions in jails, almshouses, and asylums. As a result of what she had seen, Dix carried on a zealous campaign between 1841 and 1881 that aroused people and legislatures to do something about the inhuman treatment accorded the mentally ill. Through her efforts, the mental hygiene movement grew in America.

- Millions of dollars were raised to build suitable hospitals, and 20 states responded directly to her appeals. She also directed the opening of two large institutions in Canada and completely reformed the asylum system in Scotland and several other countries. She is credited with establishing 32 mental hospitals.

- Later critics have claimed that establishing hospitals for the mentally ill and increasing the number of people in them spawned overcrowded facilities and custodial care (Bockhoven, 1972; Dain, 1964). However, her advocacy of the humane treatment of the mentally ill stood in stark contrast to the cruel treatment common at the time.

Nineteenth-Century Views of the Causes and Treatment of Mental Disorders

- In the early part of the nineteenth century, mental hospitals were controlled essentially by laypersons because of the prominence of moral management in the treatment.

- Effective treatments for mental disorders were unavailable, the only measures being such procedures as drugging, bleeding, and purging, which produced few objective results.

- However, during the latter part of the century, professionals gained control of the insane asylums and incorporated the traditional moral management therapy into their other rudimentary physical medical procedures.

Changing Attitudes Toward Mental Health in the Early Twentieth Century

- By the end of the nineteenth century, mental patients admitted to mental hospital or asylum lived under relatively harsh conditions despite of moral management. Little was done by the resident psychiatrists to educate the public or reduce the general fear and horror of insanity. A principal reason for this silence, of course, was that early psychiatrists had little actual information to impart and in some cases employed procedures that were damaging to patients.

- Gradually, however, important strides were made toward changing the general public's attitude toward mental patients.

- The twentieth century began with a continued period of growth in asylums for the mentally ill; however, the fate of mental patients during that century was neither uniform nor entirely positive. The movement to change the mental hospital environment was also enhanced significantly by scientific advances in the last half of the twentieth century, particularly the development of effective medications for many disorders—for example, the use of lithium in the treatment of manic depressive disorders (Cade, 1949) and the introduction of phenothiazines for the treatment of schizophrenia.

- During the latter decades of the twentieth century, our society had seemingly reversed its position with respect to the means of providing humane care for the mentally ill in the hospital environment. Vigorous efforts were made to close down mental hospitals and return psychiatrically disturbed people to the community. This movement, referred to as **deinstitutionalization**, although motivated by benevolent goals, has also created great difficulties for many psychologically disturbed persons and for many communities as well.

- The original impetus behind the deinstitutionalization policy was that it was considered more humane and cost effective. There was great hope that new medications would promote a healthy readjustment and enable former patients to live more productive lives outside the hospital.

- However, deinstitutionalization movement failed. The problems caused by deinstitutionalization appear to be due, in no small part, to the failure of society to develop ways to fill the gaps in mental health services in the community (Grob, 1994).

- By the end of the twentieth century, inpatient mental hospitals had been substantially replaced by community-based care, day treatment hospitals, and outreach.

1.5.1 The Emergence of Contemporary Views of Abnormal Behavior

While the mental hygiene movement was gaining ground in the United States during the latter years of the nineteenth century, great technological discoveries occurred which led to the scientific, or experimentally oriented, view of abnormal behavior and the application of scientific knowledge to the treatment of disturbed individuals. The four major themes in abnormal psychology that spanned the nineteenth and twentieth centuries and generated powerful influences on our contemporary perspectives in abnormal behavior are (1) biological discoveries, (2) the development of a classification system for mental disorders, (3) the emergence of psychological causation views, and (4) experimental psychological research developments.

1. **Biological Discoveries:**

Advances in the study of biological and anatomical factors as underlying both physical and mental disorders developed in this period. A major biomedical breakthrough, for example, came with the discovery of the organic factors underlying general paresis—syphilis of the brain. One of the most serious mental illnesses of the day, general paresis produced paralysis and insanity and typically caused death within 2 to 5 years as a result of brain deterioration. The discovery of a cure for general paresis began in 1825, when the French physician A. L. J. Bayle differentiated general paresis as a specific type of mental disorder.

The field of abnormal psychology had come a long way—from superstitious beliefs to scientific proof of how brain pathology can cause a specific disorder. This breakthrough raised great hopes in the medical community that organic bases would be found for many other mental disorders—perhaps for all of them.

With the emergence of modern experimental science in the early part of the eighteenth century, knowledge of anatomy, physiology, neurology, chemistry, and general medicine increased rapidly. Scientists began to focus on diseased body organs as the cause of physical ailments. It was the next logical step for these researchers to assume that mental disorder was an illness based on the pathology of an organ—in this case, the brain.

The first systematic presentation of this viewpoint, however, was made by the German psychiatrist Wilhelm Griesinger (1817–1868). In his textbook The Pathology and Therapy of Psychic Disorders, published in 1845, Griesinger insisted that all mental disorders could be explained in terms of brain pathology.

In the 1920s through the 1940s, an American psychiatrist, Walter Freeman, followed the strategies developed by Italian psychiatrist Egas Moniz to treat severe mental disorders using surgical procedures called lobotomies. These surgical efforts to treat mental disorder were considered to be ineffective and inappropriate by many in the profession at the time and were eventually discredited, although lobotomy is still used in some rare cases.

2. Development of a Classification System

The most important contributions of Emil Kraepelin was his system of classification of mental disorders, which became the forerunner of today's DSM classification. Kraepelin noted that certain symptom patterns occurred together regularly enough to be regarded as specific types of mental disease. He then proceeded to describe and clarify these types of mental disorders, working out a scheme of classification that is the basis of our present system. Kraepelin saw each type of mental disorder as distinct from the others and thought that the course of each was as predetermined and predictable.

3. **Development of the Psychological Basis of Mental Disorder**

Despite the emphasis on biological research, understanding of the psychological factors in mental disorders was progressing as well. The first major steps were taken by Sigmund Freud (1856–1939), the most frequently cited psychological theorist of the twentieth century (Street, 1994). During five decades of observation, treatment, and writing, Freud developed a comprehensive theory of psychopathology that emphasized the inner dynamics of unconscious motives (often referred to as psychodynamics) that are at the heart of the psychoanalytic perspective. The methods he used to study and treat patients came to be called psychoanalysis.

The Evolution of the Psychological Research Tradition: Experimental Psychology

The origins of much of the scientific thinking in contemporary psychology lie in early rigorous efforts to study psychological processes objectively, as demonstrated by Wilhelm Wundt (1832–1920) and William James (1842–1910).

- **The Early Psychology Laboratories**

In 1879, Wilhelm Wundt established the first experimental psychology laboratory at the University of Leipzig. While studying the psychological factors involved in memory and sensation, Wundt and his colleagues devised many basic experimental methods and strategies. Wundt directly influenced early contributors to the empirical study of abnormal behavior; they followed his experimental methodology and applied some of his research strategies to study clinical problems.

By the first decade of the twentieth century, psychological laboratories and clinics were burgeoning, and a great deal of research was being generated (Goodwin, 2011). This period saw the origin of many scientific journals for the propagation of research and theoretical discoveries, and as the years have passed, the number of journals has grown. The American Psychological Association now publishes 54 scientific journals, many of which focus on research into abnormal behavior and personality functioning

- **The Behavioral Perspective**

Although psychoanalysis dominated the field of abnormal psychology at the end of the nineteenth century and in the early twentieth century, another school—behaviorism—emerged out of experimental psychology to challenge its supremacy.

Behavioral psychologists believed that only the study of directly observable behavior—and the stimuli and reinforcing conditions that "control" it—could serve as a basis for formulating scientific principles of human behavior. The behavioral perspective is organized around a central theme: the role of learning in human behavior.

Although this perspective was initially developed through research in the laboratory rather than through clinical practice with disturbed individuals, its implications for explaining and treating maladaptive behavior soon became evident.

Classical Conditioning:

- A form of learning in which a neutral stimulus is paired repeatedly with an unconditioned stimulus that naturally elicits an unconditioned behavior. After repeated pairings, the neutral stimulus becomes a conditioned stimulus that elicits a conditioned response.

- This work began with the discovery of the conditioned reflex by Russian physiologist Ivan Pavlov (1849–1936). Around the twentieth century, Pavlov demonstrated that dogs would gradually begin to salivate in response to a nonfood stimulus such as a bell after the stimulus had been regularly accompanied by food.

- Pavlov's discoveries in classical conditioning excited a young American psychologist, John B. Watson (1878–1958), who was searching for objective ways to study human behavior. Watson thus changed the focus of psychology to the study of overt behavior rather than the study of theoretical mentalistic constructs, an approach he called behaviorism.

Operant Conditioning

- E. L. Thorndike (1874–1949) and subsequently B. F. Skinner (1904–1990) were exploring a different kind of conditioning, one in which the consequences of behavior influence behavior.

- Behavior that operates on the environment may be instrumental in producing certain outcomes, and those outcomes, in turn, determine the likelihood that the behavior will be repeated on similar occasions.

- For example, Thorndike studied how cats could learn a particular response, such as pulling a chain, if that response was followed by food reinforcement. This type of learning came to be called **instrumental conditioning** and was later renamed operant conditioning by Skinner. Both terms are still used today.

1.6 SUMMARY

In this unit we had defined abnormality and discussed the four important ways in which abnormality can be defined. Changes involved in characterizing abnormal behaviour were also discussed. Following this we had discussed the various causes of abnormality. The concept of Diagnostic and Statistical Manual of Mental Disorders was also discussed along with various controversial issues pertaining to the DSM.

1.7 QUESTIONS

1. Discuss the various ways in which abnormality can be defined.

2. Discuss the Diagnostic and Statistical Manual of Mental Disorders.

3. Write short notes on –

a. Definition of Mental Disorder

b. Assumptions of DSM-IV-TR

c. Five Axis of DSM

1. Write a note on the Classification of abnormal behavior
2. Write a detail note on Humanitarian Approaches
3. Write a detail note on the Emergence of Contemporary views of Abnormal Behavior

1.7 REFERENCES

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2

UNDERSTANDING ABNORMAL BEHAVIOR : CLINICAL ASSESSMENT AND DIAGNOSIS II

Unit Structure

2.0 OBJECTIVES

After reading this unit you will be able to:

- Explain how Psychological Assessment is carried out with the help of Clinical interviews and Mental Status Examination.
- Understand Behavioural, Multicultural, Environmental and Physiological assessment.

2.1 THE BASIC ELEMENTS IN ASSESSMENT

2.1.1 Psychosocial Assessment

Psychological assessment refers to gathering and integration of psychological data for the purpose of a psychological evaluation through the use of tests, interview, observation, etc. This kind of an assessment is carried out in order to arrive at a diagnosis for an individual with a mental disorder, to determine the individual's intellectual capacity, to predict how suitable a person is for a job and to assess if a person is competent to stand trial.

There are various techniques used in assessment. For e.g. clinical interview, mental status examination, behavioral assessment, multicultural assessment, neuropsychological assessment etc. Out of these many we will be discussing the following two - the clinical interview and the mental status examination.

1. Clinical Interview

This is the most common method used to assess the client, his presenting problem, and history and future goals. The interview involves asking questions in a face-to-face interaction. The clinician may audiotape or videotape the details or note them down during or after the interview with the due consent from the client. There are two kinds of clinical interviews:

Unstructured Interview:

- In this type of an interview, the client is asked open-ended questions related to his or her presenting problem, the family background and life history.
- The term 'unstructured' is used to indicate that the interviewer is free to ask questions in any order and frames them in a manner that he prefers. The client's response to the previous question and nonverbal cues such eye-contact, posture, tone of voice, etc., guide the interviewer in this process.
- The interviewer's approach is influenced by the purpose of the interview. A clinician who wants to arrive at a diagnosis would ask questions related to the client's symptoms, such as changes in mood, sleep pattern, disturbance in appetite, nature of thoughts, etc., their onset, duration and progress, medical or psychiatric history if any, etc.
- Some clients seek help for personal issues such as disturbed relationships and may not have a diagnosable psychological disorder. In such cases the interviewer would try to enquire about the reasons for the client's distress.
- A significant part of an unstructured interview is history taking, which involves asking questions related to personal history such as major life events since childhood, academic interest and performance, number of friends and leisure activities, work life, marriage, habits, etc., and family history such as numbers of family members, close relatives and relationships with them, atmosphere at home, history of illnesses in the family, etc.
- This gives the clinician a picture of the client's world and may also help draw connections between the client's current problem and a traumatic event in early life.

Structured and Semistructured Interviews:

- The structured interview gives less freedom to the clinician as it involves asking a set of predetermined questions in a fixed order. The semistructured interview also has a standardised set of questions but the interviewer can ask follow up questions to clarify the client's responses, if needed.
- The advantage of structured and semistructured interviews is that they help make accurate diagnosis. Some of these are designed to cover a

wide range of psychological disorders while others are meant to diagnose specific conditions such as a Schizophrenia or Mood or Anxiety disorder. Secondly, one gets lots of information of the client in short period of the time. Thirdly, can be very well used by the practitioner who is new in the field and serve helpful to come down to appropriate diagnosis.

- The Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) is a commonly used structured interview while the Structured Clinical Interview for DSM-IV-TR Axis I disorders (SCID-I) and the Structured Clinical Interview for DSM-IV Personality disorders (SCID-II) are examples of semistructured interviews (despite the word structured).

- The World Health Organisation (WHO) and the U.S. Alcohol, Drug and Mental Health Administration (ADAMHA) have developed the Composite International Diagnostic Interview (CIDI), which is an assessment tool that has been translated in many languages and can be used with people from different cultures.

2. Mental Status Examination

The mental status means what and how the client thinks, speaks and behaves. The mental status examination or the MSE is used to assess the client's thoughts, feelings and behaviour and identify symptoms. The MSE report is based on the client's responses and the clinician's objective observations of the client's appearance, speech and behaviour. One of the examples of a structured MSE is the mini-mental status examination (MMSE) which is very useful in assessing patients with cognitive disorders such as dementia. Following are the components of the MSE:

1) Appearance and Behaviour: The clinician carefully looks for any peculiarities in the client's appearance and overall behaviour as this can give an insight into her/her mental state. Anxious patients tend to fidget or pace around while some others tend to move about in a sluggish manner. Clinicians asses client's motor behaviour, that is, the movements. Eg. **hyperactivity** which refers to increased physical activity and quick movements or **psychomotor agitation** which is characterized by agitation and excessive motor and cognitive activity. Some patients show **psychomotor retardation**, that is, visible slowing of thoughts, speech and movements. Strange mannerisms, stereotyped movements and vocal or motor tics (involuntary muscular movements) are seen in some others.

In extreme cases, motor abnormalities may manifest as **catatonia** which is seen in psychotic patients. Some of these patients constantly maintain an immobile position (catalepsy) or assume bizarre postures or can be moulded into a position that is then maintained (waxy flexibility).

Some may experience **Compulsion** which is a form of motor disturbance in which there is an uncontrollable impulse to perform an act repeatedly. For example, counting the fingers or scratching one's nose before

answering every question, chanting a particular mantra every few minutes, etc.

2) Orientation: This refers to one's awareness of time, place and person. In some disorders, the patient's sense of themselves and the surrounding is disturbed. Assessing orientation is very important in diagnosing cognitive disorders such as Delirium, Dementia, Amnesia and also psychotic disorders like Schizophrenia.

3) Content of Thought: Disturbances in the thought process occurs in various forms. Some patients may have an **obsession**, which means an intrusive, repetitive, thought, image or impulse which causes distress. For example, thoughts of being unclean or contaminated, that is often accompanied by the compulsion of washing hands.

Another form of disturbance in thought content is **delusions**. These are unshakable, false beliefs which cannot be corrected through logical reasoning. For example, a man may believe that he is a messenger of God who has been sent on Earth for a special mission. Delusions can be of different types:

- **Grandeur**: A person's exaggerated conception of one's importance, power, beauty or identity. Above is the example of Grandeur type of delusion.
- **Control**: False thinking that a person's will, thoughts or feelings are being controlled by external forces. One form of this delusion is ***thought broadcasting*** in which the person believes that his/her thoughts can be heard by others as if they were being broadcast over the air. Likewise, ***thought insertion*** is a delusional belief that others are implanting thoughts in a person's mind.
- **Reference**: False belief that other's actions refer to oneself or that others are talking about him/her. E.g. when someone watches a web series and believes that the conversation between the two protagonist is meant specifically for them.
- **Persecution**: False belief that the person him/herself or a loved one is being harassed, cheated or mistreated by someone. E.g, **My colleague break into my cabin at night and steal my important files.**
- **Self-blame**: False feeling of regret or guilt in which the person holds him/her responsible for some wrongdoing. E.g., a person might think that he/she is responsible for the covid pandemic.
- **Somatic**: False belief involving body functions such the belief that the brain is rotting or melting.
- **Infidelity**: False belief associated with pathological jealousy about a person's lover being unfaithful.

There are **overvalued ideas** which refer to unusual thoughts of a bizarre nature but they are not as rigid as delusions. For example, a man who believes that his credit card number should end with the digit 6 and refuses to accept a new credit card with a different last number. **Magical thinking** involves seeing a connection between two events which would seem unrelated to most people. For example, a woman may believe that every time she buys things from a particular shop her husband loses a contract. Overvalued ideas and magical thinking do not indicate that the person has a mental disorder but suggests some psychological decline. Violent thoughts such suicidal ideas or thoughts of harming or killing another person also need to be assessed.

4) Thinking Style and Language: An individual's style of thinking is manifested through his or her speech. For example, speaking to person with Schizophrenia or other forms of psychosis can be difficult because their language may be illogical. Examples of thought disorder:

- **Incoherence**: The speech is not clear and understandable. For example, "the ice-cream threw the poodle that is not here."
- **Loosening of associations**: Ideas expressed are unrelated. For example, "Suma is nice person but there is lot of poverty in the world and I am going to cut my hair tomorrow."
- **Illogical thinking**: Thoughts that has wrong conclusions. For example, a person who likes milk thinks she must be a cat.
- **Neologisms**: New words created, often by combining syllables of other words. For example, "I saw some "snarks" today that were "boredomly bad."
- **Blocking**: Sudden interruption in the train of thought before the idea is finished.
- **Circumstantiality**: Indirect speech that is delayed in reaching the point by bringing in lot of irrelevant details.
- **Tangentiality**: Going off on a different point without coming to the original idea.
- **Clanging**: Association of words similar in sound but not in meaning. For example, "That is Ross, there is so much moss, the coin will toss."
- **Confabulation**: Making up ideas to fill in gaps in memory. This is not an attempt to lie but to give the most possible answer. For example, when one is not very sure if he has had breakfast and is asked what he had eaten, he may give an elaborate account of a typical breakfast.
- **Echolalia**: Pathological repeating of words or phrases of one person by another.
- **Flight of ideas**: Rapid, continuous shifting from one idea to another in which ideas tend to be connected.

- **Pressure of speech**: Rapid speech as if the person feels forced to speak continuously.
- **Perseveration**: Continuing with a response to a previous question or stimulus after a new question or stimulus is presented.

5) Affect and Mood: Emotion is a complex feeling state with somatic, cognitive and behavioural components. **Affect** refers to an observed expression of emotion. While assessing the affect, the clinician checks if it is **appropriate** (condition in which emotional tone is in harmony with the accompanying idea) or **inappropriate** (disharmony between the feeling tone and the thought or idea accompanying it).

The **intensity of affect,** that is, its strength is also noted. The affect is described as **blunted affect** when there is a severe reduction in the intensity of externalized feeling tone and as **flat affect** when signs of affective expression are absent or nearly absent, the face is immobile and voice is monotonous. On the other hand, **exaggerated** or **heightened** or overdramatic **affect** is reported when the emotional expression is very strong. The range of affect in terms of the variety of emotional expressions noted is also taken into account.

Mood is a pervasive and sustained state of emotion that one feels inside. Mood may be described as **dysphoric** (unpleasant feelings such as sadness or irritability), **euphoric** (very cheerful with feelings of grandeur), **euthymic** (normal range of mood; absence of depressed or elevated mood), angry, anxious, etc.

6) Perceptual Experiences: Some psychological disorders are characterized by disturbances in perception. The clinician enquires about these by asking whether the patient hears voices or sees things that others are unaware of. Hallucinations are false sensory perceptions in the absence of real external stimuli. These are different from illusions in which there is distortion of a real stimulus such misperceiving a rope as a snake. Hallucinations can involve any of the five senses:

- **Auditory hallucinations** are the most common and involve hearing sounds or voices (usually insulting comments such as "you are dumb") or conversations. **Command hallucinations** are those in which one hears instruction to act in a certain way.
- **Visual hallucinations** involve seeing images of objects or persons. For example, a person may claim to see God or one's spouse who has passed away.
- **Olfactory hallucinations** are uncommon and refer to false perception of smells such as unpleasant odours.
- **Gustatory hallucinations** are false perceptions of taste usually unpleasant in nature.
- **Somatic hallucinations** involve false sensations pertaining to the body, usually tactile such as crawling sensation on or under the skin.

7) Sense of Self: Some psychological disorders affect the person's identity or the sense of 'who am I.' **Depersonalisation** is a phenomenon in which the person feels he is unreal, strange or unfamiliar with himself. For example, one may feel that his mind and body are not connected. One may also experience **identity confusion** which involve a lack of clear sense of who one is, what one's role is, etc.

8) Motivation: In some psychological disorders, the patients lose interest in all activities to the extent that even ordinary tasks such as having a bath or dressing may seem difficult. Some may not be willing to put in any effort to change and might find their familiar state of distress better than the uncertainty of facing new challenges.

9) Cognitive Functioning: During the MSE, the clinician attempts to judge the client's general intellectual capacity from the answers given by the client, on questions related to attention and concentration, memory, ability to think in an abstract manner, etc. For instance, in case a client's memory is severely impaired, the clinician might suspect a neurological condition such Alzheimer's disease. Here, the clinician doesn't administer an IQ test but rather gets a general idea about the client's cognitive abilities.

10) Insight and Judgement: The clinician is also interested in seeing whether the client understands one's own difficulties. Insight refers to a person's ability to understand the true cause and meaning of a situation. For example, a person who has paranoid delusions may be very defensive and unable to see things objectively, showing poor insight.

Judgment is the ability to assess a situation correctly and to act appropriately in the situation. Clients who are severely impaired may not be in a position to make correct decisions and this may result in harm to self or others. Thus, checking the client's judgment gives the clinician an idea of protective measures that may have to be initiated.

3. Behavioural Assessment

Behavioural assessment involves systematic recording of an individual's behaviour in order to identify problem behaviours, the factors that help maintain these behaviours and decide techniques to modify the undesirable behaviours. Clinicians use various methods such as behavioral interviews, observational methods - naturalistic observation/ controlled observation, self-monitoring, role-playing, inventories, checklists, etc., of which behavioural self- report and observation are most common.

Behavioural Self-Report:

- This is a method in which the client provides information about how frequently certain behaviours occur, either through an interview or by monitoring oneself and filling up checklists or inventories developed for this purpose.

- The advantage of self-report is that it helps obtain critical information about the client's behaviours which others would not have access to.
- Behavioural interviews involve a detailed enquiry into what happens before, during and after the behaviour in question. In understanding the 'before' factors, the clinician may ask questions such as when and where does the behaviour occur, does the behaviour occur in presence of any particular person or stimulus, etc.
- Particulars of the 'during' phase may be found out with the help of questions such as how many times and for how long does the problem behaviour occur, what happens first, what follows that, etc.
- The client is also asked about the consequence of the behaviour in terms of what effect does it have or how does it benefit him or her. For example, in case of a client who wants to give up smoking, the clinician may be interested in knowing how frequently the person smokes in a day, any specific time and place at which he smokes, does he smoke in the company of certain people, what triggers the smoking behaviour, what the client thinks and feels after smoking, etc.
- Thus, the extensive information obtained helps set realistic goals and devise strategies to change the undesirable behaviour.
- Another behavioural self-report technique is self-monitoring, which involves keeping a record of the frequency of the problem behaviour such as, number of cigarettes or calories consumed, number of times the client bit her nails or had unwanted thoughts or got angry.
- The client is trained to note the time, place and relevant information pertaining to the target behaviour. Self-monitoring is a very useful technique because it may lead to important insights, for example, a woman may realise that she tends to eat more while watching the television or when she is distracted.
- Behavioural checklists or inventories help to find whether certain events or experiences have occurred. For example, the Conners Ratings Scales-Revised uses self and observer ratings to assess attention deficit hyperactivity disorder and determine the number and nature of undesirable behaviours present. Checklists and inventories are quite commonly used in the clinical set up because they are easy to use and economical.

Behavioural Observation:

- In this method, the clinician observes and records the frequency of the behaviour in question, including any other relevant situational variables. For example, a nurse may be asked to observe the number of times a patient washes her hands and also her reactions when she is prevented from doing that. Or a trained observer may record the number of times a child leaves his place or speaks out of turn.

- In observing the clients, the clinician first selects the problem behavior or the target behavior on the basis of an interview, direct observation or using behavioural checklists or inventories. The problem behaviour is then broken down into behavioural terms, that is, it is defined. For example, temper tantrum would be defined in terms of crying and shouting.

- Selecting vague target behaviours is inappropriate in behavioural observation because it makes measurement difficult. For example, violent behaviour cannot be measured unless specified as breaking things around or whichever is the behaviour exhibited.

- It is best to observe the target behaviour in the natural setting and this kind of behavioural observation is known as in vivo observation. In assessing a child with attention deficit hyperactivity disorder, a clinician is likely to get an accurate picture of the child's problem behaviours if he is observed in the classroom or at home rather than in the lab or clinic.

- While using this method the clinician has to be careful about the client's reactivity - the knowledge of being observed can influence the target behaviours. In order to avoid these problems, the client may be observed through a one-way mirror. In some situations, others may be included and the client's interaction with them may be observed with focus on the target behaviours.

4. Multicultural Assessment

In the process of assessment, the clinician needs to be sensitive to the cultural, racial and ethnic background of the client. There is a growing emphasis on developing culture fair tests and being careful while administering and interpreting psychological tests as the background from which the client comes can seriously influence the test performance. For example, while assessing a client whose mother-tongue is not English, the clinician needs to ensure that the instructions are followed and that the client's scores are interpreted on the basis of norms developed for that specific group. Also, certain phrases or behaviours may have multiple meanings and are likely to be misunderstood by the clients. Thus, the clinicians are required to have to sufficient knowledge of the client's cultural background and critically evaluate the tests to see if they are designed for use with the specific group to which the client belongs.

5. Environmental Assessment

As seen earlier, the environment that surrounds a person has a tremendous impact on his/her life. Psychologist Rudolf Moos has developed Environmental **assessment scales** in which individuals provide ratings on aspects of the environment that are thought to influence behaviour. This includes the various circles of social influence in one's life such as the family, the neighbourhood, the school and the society at large. For example, in the Family Environment Scale is used to assess aspects of the client's family such as the nature of relationships between the family

members. Nature of relations, such as cohesiveness and identification with family members, expression of emotions, etc; the activities that the family engages such as what do the members do for recreation or how are responsibilities shared, attitudes / beliefs of the family members, etc.

Another example is the Global Family Environment Scale, a cross-cultural tool that measures factors such as the extent to which the family provides good physical and emotional care, secure attachments, consistency and discipline.

These scales can be used to assess the home environment of children/adolescents with behavioural disorders, excessive anxiety, etc., and thus help clinicians get insight into the family dynamics of the client and understand its impact on the client's condition.

6. Neuropsychological Assessment

- Neuropsychological assessment involves assessing brain functioning from how an individual performs on certain psychological tests.
- Two best known test batteries that are used for neuropsychological evaluation are the Halstead-Reitan Battery and the Luria-Nebraska Neuropsychological Battery.
- The Halstead-Reitan is used to differentiate between the brain damaged individuals and the neurologically intact and comprises of subtests such as category test, tactual performance test, rhythm test, speech-sounds perception test, time sense test, aphasia screening test, finger-oscillation test, etc. This may often be combined with the MMPI-2 to get a measure of the individual's personality and the WAIS-III to assess cognitive functioning.
- The Luria-Nebraska test assesses a wide range of cognitive functions such as memory; motor functions; rhythm; tactile, auditory and visual functions; receptive and expressive speech; writing; spelling; reading and arithmetic.
- This test is extremely sensitive for identifying specific types of problems such as dyslexia and dyscalculia rather giving global impressions of brain dysfunction. Also as compared to the Halstead-Reitan battery, this test is administered faster and is more standardised.
- The Neuropsychological Assessment Battery (NAB) is another instrument that can be administered within 4 hours and includes modules on attention, language, memory, spatial functions, executive functions, etc.

The reliability and validity of neuropsychological tests may be affected by mood states (anxiety and depression), motivation and also effects of medication

2.1.2 Physiological Assessment

As discussed earlier that biological factor plays an important role in various psychological disorder. It is important to understand the biological basis of behaviour. Due to this physiological assessment becomes a part of the evaluative process.

Psycho-physiological Assessment

- Psycho-physiological assessment involves the use of instrumentation to monitor psycho-0physiological processes, based on the idea that psychological experiences are associated with definite physiological components such as changes in heart functioning, muscles, skin, brain, etc.
- The **electroencephalogram (ECG)** is used to monitor whether the heart is functioning normally. A measure of the blood pressure gives an estimate of any excessive or damaging pressure of the blood against the walls of the blood vessels. This helps to assess the risk for developing any stress-related heart conditions.
- The **electromyography (EMG)** is an instrument which is used to measure muscle tensing/contraction associated with stress and to rule out conditions such as headaches.
- Individuals tend to sweat excessively when they are tensed - this leads to changes in the electrical properties of the skin and can be measured with the help of the **galvanic skin response (GSR).**

Brain Imaging Techniques

Various techniques that construct pictures of the structure and function of the brain have been developed since the 1970s:

The Electroencephalogram (EEG):

- The EEG measures the electrical activity in the brain that indicates one's level of arousal, that is, whether one is alert, resting, sleeping or dreaming.
- The procedure involves attaching the electrodes onto the scalp with an electricity-conducting gel. The machine picks up the brain activity and a device called the galvanometer, which has an ink pen attached to it, writes continuously creating wave-like patterns on moving paper strip.
- The EEG shows a distinct pattern of brain waves depending on the mental activity one engages in. Thus, the EEG recording helps in assessing conditions such as epilepsy in which convulsions are caused by disturbed neural activity, sleep disorders, brain tumors, etc.
- An abnormality in the EEG patterns is used as a basis for further investigations. In recent years computerised interpretations of the EEG have made objective evaluation possible. The computer can convert specific EEG patterns into colour-coded plots.

- For example, low amplitude areas are shown in black or blue while high amplitude areas are highlighted in yellow and red. These colourful images help understand the patterns of electrical activity throughout the surface of the brain and are useful for diagnosis.

Computerized Axial Tomography (CAT CT scans):

- This is a technique in which one lies down with the head in a large X-ray tube. Highly focused beam of X-rays is then passed through the brain from many different angles. Differing densities of the different brain regions result in different deflections (bending) of the X-rays.

- The deflection is greater in case of dense tissue such as bones and it is least in case of fluid. The X-ray detectors gather the readings taken from multiple angles and a computerised program constructs an image of the brain in the form of slices (tomo means 'slice' in Greek).

- This method helps obtain a cross sectional slice of the brain from a specific angle or level. For example, CT scans can provide images such as the fluid filled ventricles in the brain, showing differences in the brains of people with and without Schizophrenia.

Magnetic Resonance Imaging (MRI):

- This technique uses magnetic fields and radio waves to produce high quality two or three dimensional images, based in the water content of the different tissues. The person undergoing an MRI lies inside a tunnel-like structure that surrounds the person with a strong magnetic field.

- The activity of the electromagnetic energy from several angles, through a computer program is converted into a high resolution image of the scanned region. The MRI images are quite detailed and can detect tiny changes of structures within the body.

- Using the MRI, trauma to the brain can be seen as bleeding or swelling. Sometimes tumors that go undetected in CT scans can be seen in MRI. It is also used in identifying brain dysfunction in specific disorders.

- For example, one study compared the MRIs of women with Major Depressive Disorder (MDD) and controls on a task in which they had to learn objects paired with faces displaying six emotions. It was seen that women with MDD had difficulty learning the pairs and also showed larger amygdala (part of the limbic system that is involved in emotional responsiveness). However, when both the above factors were taken together, only women with MDD and larger amygdala were found to do poorly on the learning task. This suggests that the memory deficit may have resulted from changes in the brain triggered by MDD (Weniger, Lange & Irle, 2006).

Functional Magnetic Resonance Imaging (fMRI):

- This is a new technique and a specialized MRI which relies on the idea that when an area of the brain becomes active due to mental processing, the blood flow to that region increases.
- This scan is called 'functional' MRI because it shows the brain as it is functioning while performing a mental task and is therefore very useful in psychological assessment.
- The fMRI produces images of the active brain regions when one processes information. This is done by showing regions with increased activity in different colours reflecting high and low levels of blood flow. The advantage of this technique is that it shows the brain in action rather than just its physical structures.

Positron Emission Tomography (PET), Singe Photon Emission Computed Tomography (SPECT):

- This is another brain imaging technique that involves injecting a radioactively labelled compound into the person's veins which binds itself to the oxygen in the blood.
- This compound travels to the brain through the blood and emits positively charged electrons (positrons), which are detected by the scanner. A computer program then converts this into images showing the structure and function of organs and tissue.
- Bright colours like red indicate greater activity in the brain while colours likes blue-green-violet suggest lower activity. Thus, any kind of mental activity will result in lighting up a region of the brain.

2.3 SUMMARY

In this unit the concept of psychological assessment was discussed. The important instruments of psychological assessment, i.e., clinical interview as well as mental status examination were discussed. Various types of assessment such as multicultural assessment, environmental assessment, physiological assessment were also discussed.

2.4 QUESTIONS

1. Explain Clinical Interview and its types.
2. Write a detailed note on Mental Status Examination.
3. Write short notes on the following.

a. Behavioural Assessment
b. Multicultural Assessment
c. Environmental Assessment
d. Neuropsychological Assessment

4. Discuss the different types of Physiological Assessment.

2.5 REFERENCES

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3

CAUSAL FACTORS AND VIEWPOINTS - I

Unit Structure

3.0 OBJECTIVES

After reading this topic you will be able to:

- Explain how theoretical orientation of the clinicians and researchers determines the way they perceive abnormal behaviour.
- Critically evaluate the biological, psychodynamic, humanistic, sociocultural, behavioural and cognitively based perspectives of Abnormal Psychology.
- Understand the integrative biopsychosocial approach to the theories and treatment of psychological disorders.

3.1 INTRODUCTION

Many different theoretical perspectives have been developed to conceptualize and explain the various causes of abnormal behavior. In this unit we will discuss the most prominent theoretical perspectives. The chapter begins with the discussion on the purpose of theoretical perspectives. Then we will discuss Biological perspectives include the nervous system and its role in the development of abnormal behavior. Under this we will discuss the role of genetics, models of genetic transmission and the treatments based on biological perspectives such as Psychosurgery, Electroconvulsive therapy, TMS, DBS, Medication, etc. All these, including evaluation of biological perspective, would be discussed.

Then we will study different psychological perspective such as important concepts of psychodynamic perspectives, post Freudian theories and evaluation the psychodynamic perspective. After that we will study humanistic perspective which was developed in 1950s out of works of Carl Rogers, Abraham Maslow and others. Person centered and self-actualization theories as well as treatment based on it would be examined and evaluated. Then behavioral and cognitively based perspectives are discussed. An important theoretical view point expressed in writings of Ivan P. Pavlov in his classical conditioning, B.F. Skinner in his operant conditioning, etc is discussed. Social learning and social cognition developed late in 1960s and grew out of behavioral perspective. It was developed by Albert Bandura. Cognitive based theory developed out of the work of Aaron Beck and Albert Ellis. Treatment approaches based on cognitive perspective include conditioning techniques, contingency management techniques, modeling and self-efficacy training and cognitive therapies are discussed.

After psychological theory we will study Socio-cultural factors that are important to understand and assess abnormal behaviour. Among the socio-cultural perspectives, family perspective on psychopathology would be discussed. Similarly, Social discrimination and Social influences and historical events would be studied. Treatment based on socio-cultural perspective such as family therapy, group therapy, multicultural approach, milieu therapy would also be briefly discussed. Following this socio-cultural perspective will be evaluated.

Towards the end of this unit we will discuss the biopsychological perspective on theories and treatment.

3.2 THE PURPOSE OF THEORETICAL PERSPECTIVES IN ABNORMAL PSYCHOLOGY

This chapter focuses on what causes abnormality. There are different schools of thought that vary in their beliefs and assumptions about what leads to abnormal behaviours and how they can be treated. The theoretical orientation of the clinicians and researchers determine how they perceive abnormal behaviour. In practice, most experienced clinicians follow an eclectic approach, that is, they put together concepts and techniques from several theoretical perspectives.

Following are some of the most prominent theories that are important to know while trying to understand various mental disorders.

3.3 CAUSES AND RISK FACTORS:

Central to the field of abnormal psychology are questions about what causes people to experience mental distress and to behave maladaptively. If one knew the causes for given disorders, one might be able to prevent conditions that lead to them and perhaps reverse those that maintain them.

Necessary, Sufficient, and Contributory Causes

- A **necessary cause** (e.g.**,** cause X) is a condition that must exist for a disorder (e.g., disorder Y) to occur. For example, general paresis (Y)—a degenerative brain disorder—cannot develop unless a person has previously contracted syphilis (X). Or more generally, if Y occurs, then X must have preceded it. To date, most mental disorders have not been found to have necessary causes, although there continues to be a search for such causes.

- A **sufficient cause** (e.g., cause X) of a disorder is a condition that guarantees the occurrence of a disorder (e.g., disorder Y). For example, one current theory hypothesizes that hopelessness (X) is a sufficient cause of depression (Y) (Abramson et al., 1995; Abramson et al., 1989). Or, more generally, if X occurs, then Y will also occur. However, a sufficient cause may not be a necessary cause; there are other causes of depression as well.

- A **contributory cause** (e.g., cause X) is one that increases the probability of a disorder (e.g., disorder Y) developing but is neither necessary nor sufficient for the disorder to occur. Or, more generally, if X occurs, then the probability of Y occurring increases. For example, parental rejection could increase the probability that a child will later have difficulty in handling close personal relationships. We say here that parental rejection is a contributory cause for the person's later difficulties, but it is neither necessary nor sufficient (Abramson et al., 1989, 1995).

- In addition to distinguishing among necessary, sufficient, and contributory causes of abnormal behavior, we must also consider the time frame under which the different causes operate. Some causal factors occurring relatively early in life may not show their effects for many years; these would be considered **distal causal factors** that may contribute to a predisposition to develop a disorder. For example, loss of a parent early in life, or having abusive or neglectful parents as a child or adolescent, may serve as a distal contributory cause predisposing a person to depression or antisocial behaviors later in life.

- By contrast, other causal factors operate shortly before the occurrence of the symptoms of a disorder; these would be considered **proximal causal factors**. A severe difficulties with a school friend or a marital partner are examples of more proximal causal factors that could lead to depression.

- In other cases, proximal factors might involve biological changes such as damage to certain parts of the left hemisphere of the brain, which can lead to depression.

- A **reinforcing contributory cause** is a condition that tends to maintain maladaptive behavior that is already occurring. An example is the extra attention, sympathy, and relief from unwanted

responsibility that may come when a person is ill; these pleasant experiences may unintentionally discourage recovery.

- For many forms of psychopathology, we do not yet have a clear understanding of whether there are necessary or sufficient causes, although answering this question remains the goal of much current research. We do, however, have a good understanding of many of the contributory causes for most forms of psychopathology. Some of the distal contributory causes set up vulnerability during childhood to some disorder later in life. Other more proximal contributory causes appear to bring on a disorder directly, and still others may contribute to maintenance of a disorder. This complex causal picture is further complicated by the fact that what may be a proximal cause for a problem at one stage in life may also serve as a distal contributory cause that sets up a predisposition for another disorder later in life. For example, the death of a parent can be a proximal cause of a child's subsequent grief reaction, which might last a few months or a year; however, the parent's death may also serve as a distal contributory factor that increases the probability that when the child grows up he or she will become depressed in response to certain stressors

Feedback and Bidirectionality in Abnormal Behavior

- Traditionally, the task of determining cause-and-effect relationships has focused on isolating the condition X (cause) that can be demonstrated to lead to condition Y (effect). For example, when the alcohol content of the blood reaches a certain level, alcoholic intoxication occurs.

- When more than one causal factor is involved, as is often the case, the **term causal pattern** is used. Here, conditions A, B, C, and so on lead to condition Y. In either case, this concept of cause follows a simple linear model in which a given variable or set of variables leads to a result either immediately or later.

- In the behavioral sciences, however, not only do we usually deal with a multitude of interacting causes but we also often have difficulty distinguishing between what is cause and what is effect because effects can serve as feedback that can in turn influence the causes. In other words, the effects of feedback and the existence of mutual, two-way (bidirectional) influences must be taken into account. Consider the following example, which illustrates that our concepts of causal relationships must take into account the complex factors of bidirectionality of feedback

- **Perceived Hostility** A boy with a history of disturbed interactions with his parents routinely misinterprets the intentions of his peers as being hostile. He develops defensive strategies to counteract the supposed hostility of those around him such as rejecting the efforts of others to be friendly, which he misinterprets as patronizing. Confronted by the boy's prickly behavior, those around him become defensive, hostile, and rejecting, thus confirming and strengthening the

boy's distorted expectations. In this manner, each opportunity for new experience and new learning is in fact subverted and becomes yet another encounter with a social environment that seems perversely and persistently hostile—exactly in line with the boy's expectations

Diathesis-Stress Models

- A predisposition toward developing a disorder is termed a diathesis.
- It can derive from biological, psychological, or sociocultural causal factors.
- Many mental disorders are believed to develop when some kind of stressor operates on a person who has a diathesis or vulnerability for that disorder.
- The diathesis or vulnerability results from one or more relatively distal necessary or contributory causes, but is generally not sufficient to cause the disorder. Instead, there generally must be a more proximal undesirable event or situation (the stressor), which may also be contributory or necessary but is generally not sufficient by itself to cause the disorder except in someone with the diathesis.
- Researchers have proposed several different ways that a diathesis and stress may combine to produce a disorder (Ingram & Luxton, 2005; Monroe & Simons, 1991).
- In what is called the **additive model**, individuals who have a high level of a diathesis may need only a small amount of stress before a disorder develops, but those who have a very low level of a diathesis may need to experience a large amount of stress for a disorder to develop. In other words, the diathesis and the stress sum together, and when one is high the other can be low, and vice versa; thus, a person with no diathesis or a very low level of diathesis could still develop a disorder when faced with truly severe stress.
- In what is called an **interactive model**, some amount of diathesis must be present before stress will have any effect. Thus, in the interactive model, someone with no diathesis will never develop the disorder, no matter how much stress he or she experiences, whereas someone with the diathesis will show increasing likelihood of developing the disorder with increasing levels of stress.
- More complex models are also possible because diatheses often exist on a continuum, ranging from zero to high levels.
- Since the late 1980s, attention has been focused on the concept of **protective factors**, which are influences that modify a person's response to environmental stressors, making it less likely that the person will experience the adverse consequences of the stressors (Cicchetti & Garmezy, 1993; Masten et al., 2004; Rutter, 2006a, 2011).

- One important protective factor in childhood is having a **family environment** in which at least one parent is warm and supportive, allowing the development of a good attachment relationship between the child and parent that can protect against the harmful effects of an abusive parent (Masten & Coatsworth, 1998).

- Ordinarily, protective factors operate only to help resist against the effects of a risk factor rather than to provide any benefits to people without risk factors (Rutter, 2006a).

- Protective factors are not necessarily positive experiences. Indeed, sometimes exposure to stressful experiences that are dealt with successfully can promote a sense of self-confidence or self-esteem and thereby serve as a protective factor; thus some stressors paradoxically promote coping. This "steeling" or "inoculation" effect is more likely to occur with moderate stressors than with mild or extreme stressors (Barlow, 2002; Hetherington, 1991; Rutter, 1987).

- And some protective factors have nothing to do with experiences at all but are simply some quality or attribute of a person. For example, some protective attributes include an easygoing temperament, high self-esteem, high intelligence, and school achievement, all of which can help protect against a variety of stressors (Masten, 2001; Rutter, 1987; Sapienza & Masten, 2011).

- Protective factors most often, but not always, lead to **resilience**—the ability to adapt successfully to even very difficult circumstances. An example is the child who perseveres and does well in school despite his or her parent's drug addiction or physical abuse (Garmezy, 1993; Luthar, 2003; Sapienza & Masten, 2011). More generally, the term resilience has been used to describe the phenomenon that "some individuals have a relatively good outcome despite suffering risk experiences that would be expected to bring about serious sequelae" (Rutter, 2007, p. 205).

3.4 VIEWPOINTS FOR UNDERSTANDING THE CAUSES OF ABNORMAL BEHAVIOUR: BIOLOGICAL VIEWPOINT:

The biological perspective focuses on how certain abnormalities in the activities of the brain and the nervous system affect behavioural, cognitive and emotional functioning of an individual.

The Nervous System and Behaviour

The nervous system is a complex structure that regulates our thoughts, behaviours and emotions. The central nervous system's function is to transmit messages from different parts of the body to the higher decision making centre and then send their messages back to body. These messages are relayed by the neurons, which are specialized cells for receiving, moving and processing information.

Neurons, Synapses and Neurotransmitters:

- There are over 100 billion neurons in the human body which carry messages between the brain and the body. These neurons form an interconnected pathway and pass the messages through neural transmission and synaptic transmission.
- In neural transmission the information within the neuron moves in the form of an electrochemical impulse and is called an action potential, while synaptic transmission is the process by which information is transmitted from one neuron to another neuron.
- Neurons are arranged in the form of chains but they do not touch each other. The space between the axon of one neuron and the dendrite of another is a gap called the synapse.
- When the neuron is stimulated, the resting potential changes and activates an action potential which travels along the axon to its tip, that is, the synaptic knobs which have tiny vessels called synaptic vesicles that contain neurotransmitters.
- Neurotransmitters are chemical substances which carry information across the synapse and can have two effects on the receiving neuron - inhibitory (turn off) or excitatory (turn on).
- If the effect is excitatory in nature then there is a change in the resting potential of the receiving neuron and the process of neural transmission occurs in this neuron. On the other hand, if the effect of the neurotransmitter is inhibitory, no action potential is generated in the receiving neuron and the message is not transmitted.
- For some neurotransmitters there is a reuptake – the neurotransmitters are reabsorbed by the synaptic terminals from which they were released. Reuptake prevents the action of the neurotransmitter and the further production of the chemical.
- Whether a neuron will generate an action potential and pass the message to other neurons in its pathway depends on the balance between the excitatory and inhibitory synapses. Thus, the neuron integrates all the signals it receives and responds to the stronger signal.
- Scientists have found several types of neurotransmitters which operate in the brain and carry out different functions. So, any imbalance in the level of these neurotransmitter has a tendency to develop various symptoms of mental disorders. Synaptic transmission in the brain can be altered through the use of drugs that increase or decrease the effectiveness of the neurotransmitter.
- Serotonin plays a crucial role in the regulation of mood, appetite and sleep. Low levels of serotonin are associated with depression. Antidepressants work by inhibiting the reuptake of serotonin that increases the amount of serotonin in the brain.

- Norepinephrine is an excitatory neurotransmitter and influences mood states. It is a stress hormones and prepares the body during the fight and flight response. Drugs like cocaine/amphetamines have their psychological effects by prolonging the action of norepinephrine and slowing its reuptake. Its insufficiency causes depression.

- Dopamine when released in the brain produces intense feelings of pleasure. An excess of dopamine is thought to cause Schizophrenia while its deficit leads to Parkinson's disease.

- Gamma-aminobutyric acid (GABA) is a major inhibitory neurotransmitter. It slowdowns the functioning of the other neurotransmitter. Antianxiety drugs work by activating the action of GABA, which slows down the nervous system.

- Acetylcholine (ACh) usually has an excitatory effect, is present mainly in the hippocampus and plays an important role in the formation of new memories. Less amount of ACh caused by the degeneration of the neurons that produce it is associated with Alzheimer's disease.

- Glutamate is primarily the excitatory neurotransmitter which plays a very important role in normal brain functioning. It sends signals to the cells in the central nervous system.

Genetic Influences on Behaviour

Genetics or heredity is biologically what one gets from one's parents.

Basic concepts in Genetics

- The basic unit of genetics is the genome which is the complete set of instructions for the development of every cell in the body. The human genome is present in the nucleus of the trillions of cells in one's body and consists of long molecules of deoxyribonucleic acid (DNA). Phenotype refers to the expression of the genes as a result of their interaction with the environment.

- Strands of the DNA have the information needed by the cells to produce the protein which the primary component of all organisms. An important function of the DNA is to replicate itself before cell division begins so that every new cell has a copy of the instructions required for manufacturing the protein.

- There are 32000 thousand genes in the human body, which are functional units of the DNA and carry the precise instructions for manufacturing a specific protein. Genes are microscopic bags of chemicals found on the chromosomes.

- Human beings have 23 pairs of chromosomes, one in each set from each of the parents. Of the 23 single chromosomes in each cell, 22 are called autosomes and carry non-sex-related information. The 23rd one is the X or Y sex chromosome. In normal females the combination of chromosomes is XX while it is XY in normal males.

- The arrangement of genes on the chromosomes has no logical reason - a gene that determines the eye colour may be next to the gene that influences the height.

- Genes go through mutations, that is, alterations or changes caused from incorrect copying of instructions during cell replication and this may be inherited or acquired. Inherited mutations are caused due to mutations in the DNA of the reproductive cells (sperm and ovum) - when these mutated cells get passed to the child, the mutations would be found in all the cells in the child's body. Acquired mutations are changes in the DNA that occur throughout one's life due to sunlight or carcinogens. Inherited mutations play a role in diseases such as cystic fibrosis and sickle anemia and may predispose a person to cancer, mental illnesses, etc. However, our cells have the ability to repair many of these mutations. If the cells fail to do so, the mutations are passed to the future copies of the affected cell.

Models of Genetic Transmission

- The chromosomes operate in pairs and each set has the same genes on it but in different combinations called alleles. Alleles refer to whether the combination of genes is dominant or recessive. The hair colour, texture, eye colour, etc., are decided by the combination of alleles inherited by the individual. A dominant allele always shows its effect irrespective of what the other allele in the pair is whereas a recessive allele expresses its effect only if it paired with another allele of its own kind.

- Genetic disorders have a dominant-recessive pattern of transmission. In dominant pattern of disease inheritance, if the person has a normal allele and a disease allele, he is likely to develop the disease because the disease allele is dominant. Since, this person carries a normal and a disease allele, his/her child has a 50 percent chance of inheriting the disease allele and thus a 50 percent chance of having the disease.

- In recessive pattern of disease inheritance where both parents carry one normal allele (N) and one disease allele (D), neither of them have the disease but both are carriers of it. The combination of alleles that they are likely to pass on to their children are NN, ND, DN or DD. Thus, their children has $1/4^{th}$ chances of being normal (NN), $1/4^{th}$ chances of developed the disease (DD) and $2/4^{th}$ chances of being carriers of the disease (ND, DN).

- Disease inheritance sometimes is much complex and cannot be explained through the dominant-recessive pattern of transmission. In such cases the pattern is likely to be polygenic, that is, multiple genes may play a role in the expression of a characteristic. Diabetes, coronary heart disease, epilepsy, etc., are a result of such polygenic processes.

- It is suggested that genetic factors are involved in the manifestation of several traits such as subjective wellbeing, political views, job satisfaction, religiosity etc. (Plomin & Caspi, 1999).

Genes, Environment and Psychological Disorders

- Researchers believe that an important aspect of genetic transmission is that what are inherited are only the predisposition and not the inevitability of the disorder. It is the mutual influences of nature (biology) and the nurture (environment) on each other that determine most psychological disorders.

For instance, the trait of extraversion is thought to be partially inherited (Loehlin, McCrae, Costa & John, 1998).

A child born with extraversion genes may generate positive reactions in people in her environment, which further strengthen this personality trait. It is also suggested that people tend to select environments that are consistent with their inherited interests and capabilities and these environments in turn facilitate the expression of these characteristics.

- The diathesis-stress model suggests that a person must carry some risk to the disorder in order to develop it. This vulnerability can be biological - inheriting disordered genes, it may be psychological - a faulty personality trait, or social - a history of abuse or poor interpersonal relations. In addition to this, for the disorder to develop, one must experience some kind of stress or trigger. This stress could be biological - an accident or illness that changes the neurotransmitter balance, psychological - perceived loss of control, or social - a traumatic event. The full- blown disorder can develop only when the vulnerability combines with the stress.

A large study which demonstrates the diathesis-stress model involved biological parents with and without psychiatric disorders and their children. They were interviewed and ratings were obtained to determine the child's chances of developing psychiatric disorders (Johnson et al., 2001). A significant factor here was the presence of maladaptive parental behaviour. It was found that children who developed psychiatric disorders tended to come from homes with maladaptive parental behaviours, irrespective of whether their parents had psychiatric disorders or not. Similarly, children of parents who had psychiatric disorders were found to develop the disorders only when there was a history of disturbed parental behaviour. Thus, the diathesis of parental psychiatric disorders produced a full blown illness only when combined with the stress of living with parents having maladaptive behaviours.

Thus, a genome may not always express itself in the phenotype. A phenomenon called incomplete penetrance occurs when the genotype that predisposes a person to a disorder doesn't get manifested.

- According to the multifactorial polygenic threshold several genes of varying influence are involved in the transmission of a disorder or

characteristic. The specific combination of inherited genes decides whether the vulnerability or risk is high, low or moderate. The symptoms of the disorder are thought to develop when the combined effect of genetic and environmental factors exceeds a certain threshold (Moldin & Gottesman, 1997). This model is more popular than the single-gene explanations of genetic transmission.

Treatment

Biological therapies work on reducing symptoms of a disorder by focusing on the physiological abnormalities.

Psychosurgery: This is a surgical intervention on the brain and typically involves cutting off the frontal lobe from the rest of the brain. This technique was developed by Egas Moniz to treat people with severe psychosis in 1935 and won the Nobel Prize in 1949 for the same. The negative effects of this technique included loss of motivation and emotional dullness. Psychosurgery is not used anymore but yet recommended by some to manage some forms of obsessive compulsive disorder (Woerdeman et al., 2006).

Electroconvulsive Therapy (ECT): The ECT was developed by Ugo Cerletti in 1937 as a treatment for psychosis based on his observation that dogs that underwent convulsions induced through electric shocks appeared much calmer later.

The procedure for ECT involves giving the patients anesthesia so that they aren't conscious and muscle relaxants so that their muscle don't jerk violently. Metal electrodes are then taped to the head and a current of 70-130 volts is passed through one or both sides of the brain for about half a second. As a result the patient goes into a convulsion which lasts for about few seconds.

ECTs seemed to be effective in dealing with many types of severe psychological disorders, especially those who are showing resistance to medication. Example, ECT are often given to depressive patients who haven't responded to medication. However, how exactly the technique helps is not clearly known.

ECTs are controversial for several reasons. First, there were reports about it being inappropriately used to punish patients who seemed out of control. Second, ECT can result in memory loss and difficulties in learning new material. Third, though it is very effective in relieving depression, the relapse rate is 85 percent. And finally, the idea of passing electric current through a person's body is very frightening and seems like a very primitive form of treatment.

Transcranial Magnetic Stimulation (TMS): This method involves placing an electromagnet on the scalp and passing electric current through the cortex to increase or decrease the excitability of neurons in a given region. The effect is not restricted only to the cortex but spreads to the subcortical areas of the brain. It is suggested that TMS is likely to replace

ECT as a treatment for depression (Couturier, 2005) and is quite effective when given in combination with medication (Rumi et al., 2005).

Deep Brain Stimulation (DBS): In DBS an electrical conductor is planted in the brain, which provides continuous low electrical stimulation to a small area of the brain. The procedure involves inserting a thin insulated wire in the brain and connecting it through an extension of the insulated wire passed under the skin of the head, neck and shoulder to a neurostimulator (battery) which is placed under the skin near the collar bone. The DBS was developed with the aim of increasing activity in certain brain regions, for instance, the basal ganglia which is less active in patients with Parkinson's disease. The technique is also being considered for treating obsessive compulsive disorder and depression.

Medication: This is the most commonly used form of biological treatment. Medications work by altering the activity and amount of neurotransmitters.

- Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine and setraline, block the reuptake of serotonin thus increasing the amount of this neurotransmitter in the synapse. SSRIs are effective in treating several disorders such as depression, obsessive compulsive disorder, eating disorders, borderline personality disorder, etc.
- Tricyclic Antidepressants such as clomipramine and desipramine, work by blocking the reuptake of norepinephrine and serotonin and are used in treating depression and obsessive compulsive disorder.
- Benzodiazepines like clonazepam and diazepam are antianxiety drugs which increase the activity of GABA and thus inhibit the brain regions that produce anxiety and panic.
- Atypical Antipsychotics such as clozapine and olanzapine block the serotonin and dopamine receptors in the limbic system and are effective in treating Schizophrenia and Alzheimer's disease.
- Mood stabilisers such as lithium and valproate work by decreasing levels of catecholamines and increasing release of GABA to manage Mania and Bipolar disorder.
- Neuroleptics like chlorpromazine and haloperidol are antipsychotic medicines that block the dopamine receptors and are effective in treating Schizophrenia and Alzheimer's disease.

Biofeedback: Biofeedback involves the use of instrumentation to monitor psychophysiological processes, combined with behavioural principles to bring these functions under voluntary control. The technique is based on the idea that autonomic functions such as heart rate, blood pressure, galvanic skin response, etc., can be voluntarily altered through the use of reinforcement. It is suggested that some physiological symptoms are caused due misinterpretation of bodily cues (Miller & Dworkin, 1977). In biofeedback, patients are taught to identify their bodily sensations through

sophisticated instruments and then are encouraged to change these functions by providing a reward. For instance, one may learn to recognise muscle tension followed by techniques to relax them. When the person is able to reduce muscle tension through relaxation then some lights or music is put on which acts as reinforcement. This is often combined with shaping in such a way that the initial goals are within the person's reach and then are gradually made difficult.

Evaluation of the Biological Perspective

- It is important to understand the biological basis of behaviour as all psychological problems are manifested in the body. Also there is a reciprocal relationship between biological and psychological factors explained as the concept of feedback loop in the earlier chapter. For instance, exam anxiety raises the heart beat, sweating, etc. and these bodily sensations interfere with the ability to concentrate. The thought that one is not able to focus makes one even more anxious which further leads to physical changes.
- In the development of some psychological disorders such as Schizophrenia and Depression, biological factors like genetic involvement play a crucial role and accordingly biological therapy, that is, medication becomes the primary treatment.
- Researchers have also found that the experience of traumatic events or chronic stress affects the brain's structure and functions. It is suggested that with each traumatic incident the neurotransmitter systems become more easily dysregulated - the first episode may take a strong stressor to cause the dysregulation but later mild stressors can also initiate the dysregulation.
- Finally, the biological perspective helps understand genetic contributions to psychological disorders and traits, and the patterns of genetic transmission. The advancements in genetic technology provide improved solutions for genetically based disorders.

3.5 SUMMARY

In this unit we have discussed the various theoretical perspectives. In this we had discussed the biological perspective and concepts related to it such as neurons, synapse, neurotransmitters, basic concepts of genetics, models of genetic transmission, etc. Treatment based on biological perspectives were also discussed.

3.6 QUESTIONS

1. Write short notes on the following.

a. Necessary, Sufficient, and Contributory Causes

b. Feedback and Bidirectionality in Abnormal Behavior

c. Diathesis-Stress Models

2. Discuss the biological treatment approaches.

3.7 REFERENCES

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4

CAUSAL FACTORS AND VIEWPOINTS - II

Unit Structure

4.0 OBJECTIVES:

After reading this topic you will be able to:

- Explain how theoretical orientation of the clinicians and researchers determines the way they perceive abnormal behaviour.
- Critically evaluate the biological, psychodynamic, humanistic, sociocultural, behavioural and cognitively based perspectives of Abnormal Psychology.
- Understand the integrative biopsychosocial approach to the theories and treatment of psychological disorders.

4.1 INTRODUCTION

Under this we will discuss different psychological perspective such as important concepts of psychodynamic perspectives, post Freudian theories and evaluation the psychodynamic perspective. After that we will study humanistic perspective which was developed in 1950s out of works of Carl Rogers, Abraham Maslow and others. Person centered and self-actualization theories as well as treatment based on it would be examined and evaluated. Then behavioral and cognitively based perspectives are discussed. An important theoretical view point expressed in writings of Ivan P. Pavlov in his classical conditioning, B.F. Skinner in his operant conditioning, etc is discussed. Social learning and social cognition

developed late in 1960s and grew out of behavioral perspective. It was developed by Albert Bandura. Cognitive based theory developed out of the work of Aaron Beck and Albert Ellis. Treatment approaches based on cognitive perspective include conditioning techniques, contingency management techniques, modeling and self-efficacy training and cognitive therapies are discussed.

After psychological theory we will study Socio-cultural factors that are important to understand and assess abnormal behaviour. Among the socio-cultural perspectives, family perspective on psychopathology would be discussed. Similarly, Social discrimination and Social influences and historical events would be studied. Treatment based on socio-cultural perspective such as family therapy, group therapy, multicultural approach, milieu therapy would also be briefly discussed. Following this socio-cultural perspective will be evaluated.

Towards the end of this unit we will discuss the biopsychological perspective on theories and treatment.

4.2 PSYCHODYNAMIC PERSPECTIVE

The psychodynamic view emphasizes on the idea that behaviour is primarily influenced by unconscious factors. The term 'psychoanalytical' is used to refer to Freud's ideas while the term 'psychodynamic' covers a broader perspective that focuses on unconscious processes as well as various other factors that are thought to influence behaviour.

Freud's Psychoanalytic theory

- Freud was a neurologist from Vienna who became interested in unconscious processes while working with Jean Charcot. Freud's theory was controversial because he wrote extensively about the role of sexual instincts during a period when sex was not discussed openly.
- He was of the opinion that early childhood experiences are the most influential in determining one's personality. He believed that events that occur in childhood deeply impact the unconscious mind and these experiences continue to influence an individual in his adulthood.
- This idea was based on Freud's analysis of his own dreams, thoughts and early childhood memories. He also realized that by recollecting the memory of his traumatic train ride at the age of 4, he was relieved from some very disturbing symptoms.
- Being a medical student he was convinced that disorders of the mind could be studied scientifically and that they are caused by physiological processes.

Structure of Personality: Id, Ego and Superego

According to Freud, the psyche or the mind comprises of three structures - the id, ego and the superego and used the term *psychodynamics* to explain

that our behaviour is the result of a complex interaction between these structures.

Id: The id is the most primitive part of the unconscious mind and contains sexual and aggressive instincts. It is based on the 'pleasure principle' and needs immediate satisfaction of its desires.

- Id works on the 'pleasure principle' An unfulfilled desire or impulse creates tension and only when it is satisfied that one experiences pleasure. The id tries to achieve pleasure from the actual gratification of needs as well as wishful thinking.

- Freud uses the term primary process thinking to indicate id's attempts to satisfy needs by forming wish-fulfilling mental images of the desired objects. In other words, primary process thinking satisfies motives in imagination rather than reality. Fantasizing about your enemy, being beaten up or having your favourite desert is an instance of primary process thinking.

Ego: This part of the personality has conscious awareness and enables the individual to perceive, use judgment, memory and make decisions necessary to adapt to the environment.

- It also helps to transform the wishes and fantasies of the id into reality. It works on the 'reality principle' which makes the individual face the constraints and difficulties of the external world.

- The ego engages in secondary process thinking, a more logical and rational way of solving problems. For example, suppose a man has an argument with his wife and as a result gets delayed and misses his bus. In this case primary process thinking would probably make him curse wife whereas secondary process thinking would help him look for a solution such as finding an alternate way of reaching his destination.

- According to Freud, the ego doesn't have a motivating force and draws its energy from id's energy that is the libido. He also believed that although the ego reflects conscious awareness, one is unaware of certain aspects of the ego. This includes, memories of events in which one has been self-centered or cruel or aggressive or behaved in sexually unacceptable ways.

Superego: This refers to one's conscience and is the part of the psyche that guides the ego's efforts of gratifying the impulses and desires of the id.

- The superego represents the do's and don'ts of the society that one has internalized. It focuses on what is right and what is wrong. An individual's whose superego is very high seems to be very moralist and righteous. And an individual's whose superego is very low seems to be very anti-social and irresponsible

- So, Freud was of the opinion that if it weren't for the superego, man would have tried to seek inappropriate and unacceptable forms of pleasure such as rape, murder, etc.
- Ego acts as a mediator between Id and Superego. As mentioned earlier, Ego tries to satisfy Id but consider the judgment of Superego and finding a mid-way between the two. Eg. Meena is in attending a class and craves for food (Id), but she knows that it is wrong to eat food during class and she needs to concentrate on what the teacher is teaching (superego). So, to pacify her craving she tells herself that she will have a lunch immediate after the lecture and now she needs to concentrate in the class (ego).

Defense Mechanisms: Defenses are strategies to protect oneself from unpleasant and disturbing emotions. They are used to protect one's ego. For example, if one is feeling guilty about getting poor marks in the exam, blaming the teacher for being partial may make him feel better. Defense mechanism can be healthy if used in moderation. The problem arises when they are used rigidly and in excess, so much so that it can give rise to psychological disorders.

Adaptive Defenses: These are healthy ways of coping with stress. Some of the healthy and adaptive defenses include the following.

a. Humor: Focusing on the funny/lighter aspects of a situation. **Example:** Mohan joked about how he slipped and fell down during the conference.

b. Self-assertion: Dealing with distress by expressing one's thoughts, feelings directly. **Example:** Asha told her husband that she was let down when he cancelled their dinner plan at the last moment.

c.) Suppression: A conscious attempt to avoid unpleasant or disturbing thoughts or ideas. **Example:** Sheena decided to avoid thinking about her recent break up so that she could concentrate on her studies.

d.) Sublimation: Channelizing one's energies in socially desirable ways. **Example:** Betrayed in love, Mona decided to do her PhD on the dynamics of romantic relationships.

Mental Inhibition: These are unconscious strategies to keep unwanted thoughts, feelings, memories, desires, out of conscious awareness.

a.) Displacement: Transferring an unpleasant emotion onto a non-threatening stimulus. **Example:** Being scolded by her mom, Rita slaps her doll.

b. Dissociation: Withdrawing or distancing oneself from the unpleasant memories, aspects of self or the environment. **Example:** While being shouted at by the teacher, Gopal withdrew into his fantasy world thinking about his favourite dinner being cooked at home.

c.) Intellectualisation: Excessive emphasis on external reality or irrelevant details to avoid expression or experience of emotion. **Example:** Sumit who is getting divorced talks excessively about the validity of marriage as a social institution.

d.) Reaction formation: Changing an unacceptable feeling or desire into the opposite. **Example:** Roma who feels jealous of her younger brother showers him with lot of gifts.

e.) Repression: An unconscious attempt to push disturbing thoughts or ideas out of awareness. **Example:** As an individual has a phobia of injection missed his appointment for vaccination. Or a child suffers abuse by parent, represses the memories and becomes completely unaware of them as he grow but has difficulty in forming relationship.

Minor Image-Distorting Defenses: These are tactics in which an individual derives his self-esteem by altering or misrepresenting the image of self, the body or others.

a. Devaluation: Dealing with distress by assigning negative characteristics to oneself or others. **Example:** Roshan feels that she doesn't get good marks because of low intelligence and lack of proper guidance.

b. Idealisation: Seeing others in unrealistically positive light. **Example:** Sita ignores her husband's dominance by thinking that he is a man of high self-belief.

c. Omnipotence: Dealing with stress by thinking that one is superior to others. **Example**: Prakash behaves arrogantly with others especially during exams.

Major Image-Distorting Defenses:

a. Denial: Refusing to accept disturbing aspects of reality. An unconscious attempt to ignore the reality of the situation or not able to acknowledge the reality or consequences of the reality. **Example:** Reema refused to acknowledge the news of her brother's accidental death.

b. Splitting: Disintegrating the positives and negatives feelings or aspects of self and others. Seeing things as all or none. **Example:** Mr. Ramesh was Sneha's favourite uncle whom she idealized. But ever since he spoke against her, she began viewing him as mean and evil.

c. Disavowal: Here, the individual disclaims responsibility in an attempt to keep unpleasant thoughts, feelings, desires, and impulses out of conscious awareness

d. Projection: Seeing one's own unacceptable characteristics or thoughts, feelings, impulses as someone else's. **Example:** Satish is attracted to other women and accuses his wife for being interested in other men.

c.) Rationalisation: Giving logical but false explanations to cover up one's real thoughts/ideas. **Example:** Rekha who's upset because her friend didn't invite her to a party said that she wasn't interested in it in the first place.

Defenses Involving Action: These are strategies in which an individual deals with the stress by acting or withdrawing from it.

a. Acting out: Dealing with distress with actions instead of thoughts or feelings. **Example:** Children throw temper tantrums when they are annoyed.

b. Passive aggression: Expressing anger, disappointment or opposition indirectly. **Example:** Nita stops talking to her husband when she is angry about something he has done.

c.) Regression: Dealing with distress by reverting to an earlier age level. Generally an individual behave childlike during difficult time. **Example:** Tushar began thumb sucking after the birth of his younger sibling.

Defenses Involving Breaks with Reality: These are coping techniques that involve the use of bizarre thoughts or behaviour.

a. Delusional Projection: Delusionally seeing one's own unacceptable characteristics or thoughts, feelings, impulses as someone else's. **Example:** Karan who's attracted to other women thinks that his wife is interested in other men and is convinced that she is having an affair with someone.

b. Psychotic distortion: Dealing with distress by delusional misrepresentation of reality. **Example:** Geeta developed the belief that she is an adopted child because her father scolded her for overspending.

Psychosexual Development: Freud's theory of personality is a developmental theory. He believed that our personality is formed as we pass through a series of stages from infancy to adulthood and that the events which occur during these stages are especially significant. He put forth the idea that every stage is characterized by a body part that is found pleasurable (erogenous zone) and how the child learns to satisfy the sexual desire associated with each stage is crucial in determining the personality.

Freud developed this theory on the basis of the reports of his own patients. He was convinced that their problems were caused by repressed sexual desires of early life. He spoke of two forms of disturbances, **regression**, in which a person reverts back to a previous level, and **fixation**, in which the person remains, stuck or fixed at a particular psychosexual stage.

1.) Oral stage: In this stage which lasts from birth to 18 months, the mouth and the lips are the primary source of pleasure for the infant. This stage is divided into the oral-passive or receptive phase in which the child

gains pleasure from nursing or eating, and the oral-aggressive phase in which the child enjoys chewing, spitting and tries to bite anything that is around. In Freud's view, regression or fixation at the oral passive phase would result in an adult who depends excessively on oral gratification such as overeating, cigarette smoking, etc. Those who are regressed or fixated at the oral-aggressive phase tend to be unfriendly and critical of others.

2.) Anal stage: In this stage the toddler (18 months to 3 years) derives pleasure from holding on to and expelling feces. Fixation at this stage may result in an anal retentive personality, that is, an adult who is a control freak and obsessed about hoarding things. On the other hand, fixation at this stage may also result in an anal expulsive character, that is, an adult who is sloppy, disorganised and uncontrolled.

3.) Phallic stage: According to Freud, the child faces a significant crisis in this stage of development (3 to 5 years) in which the erogenous zone is the genitals. Here, the child develops sexual attraction towards the opposite sex parent (Freud referred to this as the Oedipus complex in boys and Electra complex in girls, based on Greek mythology).

Oedipus complex is wherein the young boy wishes to unconsciously kill his father and sexually possess the mother. However, he fears that the father will punish him by cutting off his genitals (castration anxiety) for having sexual feelings for the mother. This crisis is resolved when the child represses his feelings for his mother and identifies with the father.

Electra complex is wherein the girl discovers that she doesn't possess a penis and comes to blame her mother for the same. She also hopes to share her father's penis and becomes sexually and emotionally attracted towards him. This crisis gets resolved when the girl identifies with the mother and incorporates her values.

Thus, in this stage the children's superego begins to develop and prepares them for dealing with unacceptable sexual urges. Freud believed that neurosis results from an inability to resolve the Oedipus/Electra complex.

4.) Latency stage: This is the phase (5 to 12 years) in which the sexual energies take a backstage. During this phase, children channelize their energies into school work and play. They interact and imitate parents and others of the same sex.

5.) Genital stage: In this stage (12 onwards), there is renewed interest in deriving sexual pleasure through the genitals. Masturbation begins and since parents are ruled out as sex objects through the resolution of the phallic stage, one starts looking out for opposite sex partners. Any unresolved issues from the earlier stages interfere with one's ability to successfully pass through this stage.

Post-Freudian Psychodynamic Views: The post-Freudian theorists believed in the unconscious aspects of personality but criticized Freud for overemphasizing on sexual and aggressive instincts. They considered

socio-cultural influences such as interpersonal and social needs to also play an important role in shaping one's personality.

- Carl Jung (1875-1961) felt that Freud took a one-sided view of the human condition. Jung believed that although the unconscious mind contained selfish and hostile forces, it also contained positive, even spiritual motives. He put forth the concept of 'archetypes', that is, certain images which are commonly held by all human beings. For example, the good or evil, self, hero, etc. Jung believed that characters like superman are popular because they evoke the hero archetype.

His original and lasting contribution is the idea of introversion extroversion. He modified Freud's view of the unconscious and said that we have a personal unconscious that consists of our unknown impulses, desires, thoughts, etc., and a collective unconscious, whose contents are the same for all humans.

He also said that healthy personality development involves harmony between the conscious and unconscious elements of the personality and imbalance between these results in psychological disorders.

- Alfred Adler (1870-1937) and Karen Horney (1885-1952) have both focused on the ego and self-concept. They put forth the idea that we all wish to see ourselves in positive light and use defenses in order to maintain this positive image.

They asserted that neurosis develops in people who see themselves as inferior and these feelings emerge in childhood. Adler believed that as children we are small and dependent on adults for protection, due to which we begin life with feelings of inferiority. Healthy personality development depends on outgrowing the inferiority of childhood and seeing ourselves as competent adults.

Karen Horney believed that conflicts don't develop as a result of inborn motives but because of inadequate child-rearing experiences. If a child feels loved and secure no conflict will develop and positive aspects of personality will dominate.

Both of them also emphasised on the role of social and interpersonal factors in shaping the personality and believed that close relationships are very satisfying in themselves and are not sought to fulfill sexual or aggressive desires.

- Erik Erikson (1902-1994) formulated a theory of human development that covers the entire life span. He described eight stages of the life cycle. At each stage individuals face some crisis that increases their vulnerability. When they successfully master a particular stage, they gain strength and move on to the next stage.

Stage	Approximate age	Positive Outcomes	Negative Outcomes
1.Trust versus mistrust	Birth – 1.5 years.	Feelings of trust from others' support.	Fear and concern regarding others.
2. Autonomy versus shame and doubt	1.5 – 3 years.	Self-sufficiency if exploration is encouraged.	Doubts about self; lack of independence.
3.Initiative versus guilt	3 – 6 years.	Discovery of ways to initiate action.	Guilt from actions and thoughts.
4.Industry versus inferiority	6 – 12 years.	Development of sense of competence.	Feelings of inferiority; little sense of mastery.
5.Identity versus identity confusion	Adolescence	Awareness of uniqueness of self; knowledge of roles.	Inability to identify appropriate roles in life.
6.Intimacy versus isolation	Early adulthood	Development of loving, sexual relationships and close friendships.	Fear of relationships with others.
7.Generativity versus stagnation	Middle adulthood	Sense of contribution to continuity of life.	Trivialisation of one's activities.
8.Ego-integrity versus despair	Late adulthood	Sense of unity in life's accomplishments.	Regret over lost opportunities.

- Object relations theorists such as Melanie Klein (1882-1960), Margaret Mahler (1897-1985), D.W.Winnicott (1896-1971) and Heinz Kohut (1913-1981) suggested that we create images or representations of ourselves and others, on the basis of our early relationships, and these are carried throughout adulthood and influence subsequent relationships. They suggested that self concept develops in 4 stages:

i. **Undifferentiated stage**: In this stage there is no sense of self

ii. **Symbiosis:** Here, the newborn doesn't distinguish between self and others but has images of good self / bad self and good others/bad others. In this stage, the child perceives things as all good or all bad.

iii. **Separation-individuation:** In this stage, the child begins to distinguish between self and others but the images of good me-bad me and good other-bad other are not integrated. For example, a child who is annoyed with a parent, sees only the bad image of the parent and says 'I hate you' with all his heart.

iv. **Integration stage:** By this stage the child understands complex representations that include both good and bad aspects of self and others. For example, the child who is annoyed with a parent now might say 'I am mad at you but I still love you.

- Mary Salter Ainsworth (1913-1999) and others developed characterizations of infants depending on the way they relate to the caregiver. They described four attachment styles:

a.) Fearful, in which the child desires emotional closeness but is uncomfortable becoming close due to lack of trust or the fear of getting hurt.

b.) Preoccupied, in which the child wants to be emotionally close and uncomfortable without close relationships. The child is dependent and believes that others don't value him as much as he does.

c.) Dismissing, in which the child is self-sufficient and prefers not be emotionally close to anyone or have others depend on him.

d.) Secure, in which the child is comfortable depending on others and letting others depend on him. The child also doesn't worry about being left alone or rejected.

Treatment

- According to Freud, the goal of psychoanalytical treatment is to become consciously aware of the repressed material. This is achieved through techniques like **free association**, in which the client is encouraged to feel free and speak about anything that comes to his mind, and **dream analysis**, in which the client relates details of a dream and freely associates them while the psychoanalyst gives meaning to the dreams on the basis of its content and the associations.

- The essence of psychoanalysis is the systematic **analysis of transference** and **resistance**. Transference is the process in which, while interacting with the therapist, the client relives conflictual relationships shared with one's parents and transfers them onto the therapist. Often clients resist or hold back in therapy which blocks the process. Dealing with unconscious fears and conflicts is painful and as a result the client might forget (unconsciously block) important information, may not be able to freely associate, postpone appointments or discontinue therapy altogether.

- The therapist uses **interpretation**, a technique in which client's resistance is analyzed and then he or she is helped to work through the

conflictual issues by resolving them in a healthy manner as compared to what had occurred in the childhood.

- The post-Freudian therapists developed new theories of personality and methods of treatment but the reliance on Freudian concepts to explore the unconscious continued.

Evaluation of Psychodynamic Theories

- Freud is credited for developing the first extensive theory of psychology and an organized approach to therapy. Although the role of instincts and the unconscious continues to be debated on, the idea that early childhood is crucial in shaping one's personality and that the therapist plays a significant role in facilitating the process of change, are popular among clinicians irrespective of their theoretical orientation.

- There is lot of evidence in support of the idea of the importance of early life and that attachment styles are related to psychological disorders. For example, one study found that adolescents with an insecure attachment style are more likely to develop anxiety disorders as compared to those with a secure attachment style (Warren et al., 1997). Another study found that those with an insecure style receive higher scores on depression and experience depressive symptoms. It is suggested these individuals selectively focus on the negative information and hold themselves responsible for the negative events (Shaver, Schachner, & Mkulincer, 2005; Reis & Grenyer, 2004).

One study also showed that infant attachment style can predict relationship with one's romantic partner - those with a secure attachment style comfortably relate to others and enjoy close relationships and interdependence; ambivalent or preoccupied individuals want and seek emotionally close relationships but worry that others won't value them as much; those with fearful style experience conflicts because they feel others will reject or be disloyal to them; while those with a dismissive style are self-sufficient and not very interested in close relationships.

- Freud's theory did change the conceptualisation of psychological disorders, but a major criticism in this regard is that Freudian concepts such as the unconscious material, repression, dreams, etc., cannot be empirically tested. However, the concept of unconscious does find wide acceptance in other areas of Psychology, for example, implicit memory, where the person may not remember details of an event but the performance clearly seems to be influenced by it is an instance of an unconscious process.

- Interestingly certain aspects of Freud's theory cannot be adequately tested and challenged. For example, if one refutes the idea that the defense mechanisms are used to protect oneself from anxiety aroused by unconscious sexual impulses, Freud would suggest that it is one's anxiety about coming to terms with this fact that prevents him acknowledging it.

Feminist have criticised Freud for being biased against women and emphasising on male development. Karen Horney rejected his concept of penis envy as the central factor that determines their personality. She suggested that women don't envy the penis or masculinity per se but the power and privileges they enjoy in society.

- Traditional psychoanalysis is criticised for being lengthy. However, there are newer brief forms of therapy that use transference-based interpretations and focus on the current problems of the client. Brief psychodynamic therapy (BPT), developed by McCullough and associates (2003) is based on the idea that the client's problem stems from the excessive use of dysfunctional defense mechanisms. BPT involves increasing the clients' awareness of their defenses and encouraging them to drop the defenses and experience the unpleasant emotions. The therapists then help the clients come to terms with these distressing thoughts and impulses and develop healthy ways of expressing them. Finally, the clients, especially those with personality disorders are helped to build a positive self image and rewarding relationships with others.

4.3 HUMANISTIC PERSPECTIVE

The humanistic perspective emerged as the 'third force' in psychology to emphasize on the 'human' behind the cognitions, behaviours and feelings, which seemed to be largely ignored by psychoanalysis and behaviourism. According to this psychological view, human beings possess an innate tendency to improve and to determine their lives by the decisions they make.

Existential views have also influenced the humanistic perspective. Existentialists believe that human beings try to seek the meaning of their existence and those who appreciate each moment and live as fully as possible in each moment are mentally healthy. The important founders of humanistic psychology include Carl Rogers and Abraham Maslow.

Person-Centered Theory

- The person-centered or client-centered theory has been developed by Carl Rogers, who considered every human being as unique. He believed that individuals naturally move towards self-actualisation, that is, fulfillment of their potential for love, creativity and meaning. The term 'client-centered' suggests the idea that the focus is on the client and not on the therapist or therapeutic techniques.

- The concepts of 'self' and 'self-concept', one's subjective perception of who one is and what one is like are central to Rogers's theory. He said there is the self – the person one thinks he is and the ideal self - the person one wishes to be. For example, I am an average student (self) but I would like to get a distinction in my exams (ideal self).

- According to Rogers, a person is said to be fully functional or well-adjusted when there is a match between the real and ideal self and

between one's self-image and his experiences. The term 'fully' implies that the individual is utilising his psychological resources effectively. Thus, a psychological disorder results from an inability to use one's full potential that leads to an inconsistency between how one perceives oneself and reality.

- Due to stress from parents and the society, individuals develop rigid, distorted perspectives of self and lose touch with their values and needs. Consider the case of Sohan, who believes he is unpopular when in fact most of his classmates are fond of him. This creates a mismatch between reality and Sohan's perception of it. Others may try to interact with him but his ignorance would cause him to avoid them. According to Rogers, this leads to emotional distress, unhealthy behaviours and in extreme cases, psychosis.

- Rogers viewed a fully functioning individual as steadily moving towards his own growth. He also suggested that psychological problems result in children who have critical and harsh parents. Messages such as 'you are a good boy only if you listen to me' create 'conditions of worth' which make the child insecure and anxious that he might do something that would disappoint his parents. Conditional love on part of the parents is responsible for the child's low self-esteem and the difficulties that follow.

Self-Actualisation Theory

- Abraham Maslow, best known for his hierarchy of needs suggested that the source of motivation is certain needs. He proposed five types of needs - at the base of the hierarchy are the basic biological needs for hunger, thirst, etc., followed by the safety needs, the need for belongingness, esteem needs and at the top of the hierarchy is the need for self-actualisation.

- Maslow defined self-actualisation as the inner directed drive in human beings to reach their highest potential. He described self-actualised people as those who are more concerned about the welfare of others than themselves, they usually work for some cause or task than for fame or money, they enjoy the company of their friends but are not dependent on their approval, they have an accurate view of life and are yet positive about life etc.

- Maslow was of the opinion that there are very few self- actualising individuals in this world and that many are partially actualised who get to experience self-actualisation in what he referred to as the 'peak experience' - intensely moving experiences in which one is completely immersed and feels a sense of unity with the world.

- He also said that behaviour is dominated and determined by needs that are unfulfilled. When an individual attempts to satisfy his needs he does it very systematically by beginning with the most basic needs and then gradually working up the hierarchy.

- Both Maslow and Rogers were of the view that psychological disorders are caused by a movement away from the ideal state and had similar ideas about the conditions that hinder self- actualisation.

Treatment

- Rogers firmly believed that the focus on therapy should be the client and his needs. The clinician's role is to help the client realise that he is innately good and enhance his understanding of himself.

- To deal with the difficulties caused by the conditions of worth, Rogers suggested that the therapist provides the client with what he called as the core conditions necessary for therapeutic change - positive regards, empathy and genuineness. He believed it is important for the therapist to have unconditional positive regard for the client, that is, a non-judgmental acceptance of what the client thinks, feels and says. He defined empathy as the therapist's ability to enter the client's phenomenal world - to experience the client's world as if it were your own without ever losing the 'as if' quality. The term genuineness refers to being honest and suggests that the therapist behaves in ways that are congruent with his self- concept and thus consistent across time.

- Therapists following the Rogerian approach use the techniques of reflection and clarification. Reflection involves rephrasing and mirroring back what the client has just said. For example, a client might say, "I feel terrible about having fought with mom." The therapist's reflection of this statement could be, "So you feel very bad when you have a fight with your mom." Clarification involves throwing light on or making clear a vague statement made by the client about how he feels. For example, if the client says, "I am mad at my friend for not returning my call", to which the therapist might say, "And may be slightly hurt as well."

- Rogers also said that the therapist needs to avoid making suggestions to the client as this lowers the dignity of the client and his capacity to be self-directing.

- Maslow did not put forth a model of therapy to treat psychological disorders but rather provided theoretical guidelines for the most favourable form of human development.

- In recent times, theorists have come up with techniques like motivational interviewing (MI) which involves using the core therapeutic conditions suggested by Rogers in an attempt to encourage changes from within and make the client independent.

Evaluation of Humanistic Theories

- One criticism against the humanistic theories is that its concepts cannot be scientifically tested. There has been some research on the

effectiveness of this approach but the measurement was based on self-report techniques rather than objective evaluation.

- The humanistic theories are not very useful in explaining psychological disorders. Nonetheless, Maslow's principles are very popular and widely used in industry to enhance employee motivation.

4.4 BEHAVIOURAL AND COGNITIVELY BASED PERSPECTIVES

According to the behavioural and cognitively based perspectives, abnormality results from faulty ways of thinking which are learned, and lead to maladaptive behaviours.

Classical Conditioning

Classical conditioning is a type of learning which was studied experimentally by Ivan Pavlov. It refers to the formation of an association between a conditioned stimulus and response through repeated presentation of the conditioned stimulus with the unconditioned stimulus that originally produced the response.

For example: Sharda feels sad every time she sees the sari gifted by her husband, who passed away recently. Here, sari is initially a neutral stimulus because it doesn't evoke any response by itself. But after becoming associated with her husband (a naturally evoking stimulus) seeing the sari (now, a conditioned stimulus) evokes the emotion of sadness (conditioned response) .

Some crucial elements in classical conditioning:

- The stimulus which naturally evokes a reflex-like response is called the unconditioned stimulus.
- The reflex-like response produced by the unconditioned stimulus is called the unconditioned response.
- The stimulus which is neutral in the beginning and begins evoking a response after being paired with unconditioned stimulus is called the conditioned stimulus.
- The response produced by the conditioned stimulus after pairing it with the unconditioned stimulus is called the conditioned response.
- In stimulus generalisation, an individual responds in the same way to different stimuli that have common properties.
- In stimulus discrimination, an organism learns to differentiate among different stimuli and restricts its responding to one stimulus rather than the other.
- The gradual reduction in the frequency of the conditioned response and its eventual disappearance is called extinction.

- Spontaneous recovery refers to the reappearance of a previously extinguished response after sometime has gone without exposure to the conditioned stimulus.

John Watson (1878-1958) demonstrated how conditioned fear developed through an experiment conducted on an 11 month old infant 'Little Albert'. In the experiment, Albert was playing with white rats when Watson with his associate exposed him to a loud noise. Following this incident Albert developed a fear for rats. This process is called aversive conditioning in which an aversive/painful stimulus (noise) becomes associated with a neutral stimulus (rats). Through stimulus generalisation, Albert began fearing other white objects too. Although experiments of this sort are not conducted anymore due to ethical restrictions, Watson's work helped explain the development of phobias (irrational fears).

Counterconditioning, a process of eliminating the classically conditioned response by pairing the conditioned stimulus with an unconditioned stimulus to elicit a response that is stronger than the conditioned response and that cannot occur at the same time as the conditioned response, is used to treat phobias.

Operant Conditioning

- Operant or Instrumental conditioning is a type of learning in which a voluntary response is strengthened or weakened depending on its positive or negative consequences. Skinner, the father of operant conditioning, was influenced by Thorndike's law of effect which states that responses that satisfy some motive are repeated.

- Operant conditioning is based on the concept of reinforcement, a process by which a stimulus increases the probability that an earlier behaviour will be repeated. Reinforcers are of several kinds: a primary reinforcer satisfies some biological need and work naturally without any prior experience. For example, food and water are primary reinforcers.

- A secondary reinforcer is a stimulus that becomes reinforcing because of its association with a primary reinforcer. Money is a secondary reinforcer because it helps obtain primary reinforcers. Attention, recognition and praise are secondary reinforcers and often play a role in the maintenance of psychological symptoms. For example, the aches and pains reported individuals with somatoform disorders are often reinforced due to the attention they get from family members.

- Reinforcement can be positive or negative. In positive reinforcement, behaviour is repeating because of the reward that follows. In negative reinforcement, the behaviour is repeated because it removes something unpleasant from the environment.

- Negative reinforcement is often confused with punishment. In negative reinforcement the frequency of the behaviour increases whereas

punishment involves an unpleasant or painful stimulus that decreases the probability that an earlier behaviour will be repeated.

- For example, a mischievous child may be told that he wont be allowed to go out to play in the evening if he misbehaves. This is an instance of negative reinforcement because withdrawing the pleasant stimulus (play) would encourage the child to behave (increase in frequency). On the other hand, beating the child for misbehaving is an instance of punishment because that is expected to reduce his disobedience (decrease in frequency).

- Shaping is a technique based on the principles of reinforcement in which every step towards the desired goal is reinforced. For example, while teaching a child to write alphabets, they are first encouraged to draw a standing line, a sleeping line, then a slanting line and then finally an A.

This is a very commonly used behavioural technique. For example, a shy person who has difficulty communicating may be encouraged to look at others and smile, then the next step would involve greeting them, still later speaking one line, then holding a conversation for two minutes and so on.

Social Learning and Social Cognition

- The social learning view is given by Albert Bandura who argued that people also learn by observing the behaviour of other people. Modeling is the process in which people acquire new behaviours by imitating the behaviour of important people in their lives.

- Social learning theorists study the influence of modeling and one's relationships with others on the development of psychological disorders. They are also interested in social cognition, that is, the manner in which we interpret, analyse, remember and use information about the social world.

- Bandura said that observational learning (vicarious reinforcement) takes place when a person observes the rewards and punishments that another person receives for his behaviours and behaves accordingly.

- He also put forth the concept of self-efficacy, that is, the belief that one can successfully execute behaviours necessary to control desired outcome ('I think I can'). Self-efficacy is found to be related to motivation, self-esteem, interpersonal relationships, health behaviours, addictions, etc. (Bandura et al., 2004).

Cognitively Based Theory

- The cognitively based theories believe that cognitions, that is, thoughts or beliefs, shape behaviours. Aaron Beck and Albert Ellis are two well-known cognitive theorists who have contributed to the understanding of several psychological disorders, especially depression.

- Beck spoke about automatic thoughts - ideas that are so deep- rooted that the individual is often not aware of them, which come to mind spontaneously and cannot be neglected. For example, if one slips and fall one might think "how stupid am I," "others must be thinking I am so dumb," etc. These automatic thoughts are usually of a self-defeating nature and are followed by the experience of negative emotions.

- Automatic thoughts arise from faulty attitudes. These attitudes make a person interpret situations in a biased manner as shown below:

Dysfunctional Attitude

I need to at my best at all times.

↓

Experience

I happen to slip and fall.

↓

Automatic Thought

I am so dumb / People must be thinking I'm stupid.

↓

Negative Emotion

I feel useless and angry.

- Albert Ellis gave the A-B-C model which suggests that how one feels is determined by the way one thinks about the events in his life. A refers to the 'activating event', B to the 'beliefs' and C is the 'consequences'. According to him, irrational beliefs, that is, unrealistic and exaggerated views about self and the world are the cause of several psychological disorders. Conforming rigidly to these irrational beliefs using 'should/must/ought' makes one feel miserable and results in emotional disturbances.

- David Barlow gave a model that explains the impact of a combination of physiological, cognitive and behavioural factors on the development of anxiety disorders. For example, a panic attack may be triggered when a person who hyperventilates (physiological factor) after climbing up stairs, misinterprets (cognitive factor) the physiological signs as an indication of an impending heart attack and forms associations between some stimuli and the experience of panic, consequently avoiding that situation (behavioural factor).

Treatment

The behavioural and cognitively based approach asserts that abnormality results from faulty thought processes which are learned and can be unlearned.

Conditioning Techniques

- Using principles of classical conditioning and operant conditioning such as positive and negative reinforcement, counterconditioning, aversive conditioning, extinction, etc behaviour therapists help client change faulty behavioural patterns and substitute them with healthy behaviours.

- Joseph Wolpe used counterconditioning to treat phobias or irrational fears. For example, he taught cats who were classically conditioned to experience anxiety in a room in which they were administered shocks, to associate the room with eating, which reduced their anxiety.

- Counterconditioning is effective when the new stimulus used is able to evoke a response that is stronger and cannot exist at the same time as the conditioned response. For example, to help little Albert get rid of his fear of white rats, one needs to pair white rats with a stimulus such as chocolates or his favourite toy. Fear (evoked by the rats) and joy (evoked by the chocolate/toy) being contradictory states cannot co-exist and repeated pairing of this nature would gradually help to reduce his fear.

- Another form of counterconditioning is systematic desensitisation in which the therapist attempts to reduce the client's anxiety by combining relaxation techniques and progressive or graded exposure to the phobic stimulus. For example, to treat a client with dog phobia, the therapist may gradually expose him to the concept of dog in a hierarchical order. The first step would involve helping the client enter a relaxed state following which the therapist would speak about the feared stimulus (the dog), the next step would involve watching pictures of a dog, next watching a live dog outside from the window and so on till the client is comfortable with the idea of being close to a dog without anxiety.

- Also often used is the technique of flooding, which is the opposite of systematic desensitisation and involves intensely exposing the client to the feared object. For example, instead of gradually desensitising a person who has bat phobia he may be exposed to a bunch of bats in entirety.

- Wolpe developed one more form of counterconditioning - assertiveness training, which involves expressing oneself and satisfying one's own needs and feeling good about it without hurting others in the process. In this technique, the aim is to learn to communicate the desired emotion (anger) effectively so that the opposing emotion (anxiety) gets weakened. As a result the client is able to express one's needs and deal with the challenging situation effectively.

Contingency Management Techniques

- These set of techniques are based on the idea that any behaviour that is followed by a positive consequence (reward) is repeated and undesirable behaviours can be unlearned by taking away the rewards. Accordingly, contingency management involves helping a client connect the outcome of the behaviour with the behaviour itself. This technique is effective in reducing disruptive behaviours such as temper tantrums, in disciplining children, developing good habits, reducing smoking, weight management, etc.

- Token economy is a form of contingency management in which clients earn tokens or points showing desirable behaviour which can be later exchanged for some concrete reward. For example: In 1970s, at a mental health centre in Illinois, researchers designed an environment for Schizophrenia inpatients that encouraged appropriate socialisation, participation in group activities, self-care such as bed-making, and discouraging violent behaviours. They then set up a token economy in which patient could earn small luxuries such as buy cigarettes with the tokens earned for keeping the room clean or be fined (lose tokens) for behaving inappropriately. This technique can also be used to mange behavioural disorders in children.

Modeling and Self-Efficacy Training

- Bandura believed in observational learning (vicarious reinforcement) and used this understanding in treating phobias by showing clients video-tapes or real-life model. For example, a boy who has developed the fear of white rats may be shown a video in which a boy is enjoying playing with a rat. This helps the boys to understand that rats need not be dangerous and dealing with them can be fun.

- Another form of this technique is participant modeling, in which the therapist first demonstrates the desired behaviour to the client and then helps him do the same. For instance, in the earlier example, the therapist might first play with the rat and then support the client in doing so.

- Bandura is also credited for his theory of self-efficacy. According to this theory, people's beliefs about their capacities are better predictors of their accomplishments than their actual skills. He said that fears develop because the person believes that he doesn't have the resources needed to deal with the phobic stimulus and thus by improving self-efficacy, the fear can be eliminated. Bandura describes four ways of improving self- efficacy:

1.) Performance attainment: The best way to enhance self- efficacy is to successfully carry out the desired task.

2.) Vicarious experience: By observing someone similar overcome a problem, one is likely to believe or have greater confidence that one can also overcome a similar problem.

3.) Verbal persuasion: Encouragement by saying 'you can do it' can increase confidence and reassure a person of his capabilities.

4.) Physiological state: one is not likely to feel confident about doing well when one is sweating excessively. By learning to relax and consciously changing the physiological arousal one can reduce stress and improve self-efficacy.

Thus, self-efficacy training can be useful in overcoming problems such as smoking, obesity, undesirable health habits, etc.

Cognitive Therapies

- According to the cognitive and cognitive-behavioural therapies, the way we think determines the way we feel. Based on this principle is the technique of cognitive restructuring in which the therapist helps the client change the way he thinks about himself, others and the future. The therapist does this by encouraging the client to identify maladaptive attitudes and irrational beliefs, challenge them and replace them with ideas that can be checked in real life.

- Panic control therapy (PCT) is a form of cognitive-behavioural therapy that is used to treat panic disorder which is a type of anxiety disorder in which the person experiences recurrent and unexpected panic attacks. PCT combines cognitive restructuring, exposing the client to the bodily sensations associated with panic attacks and breathing retraining. Here, the client is taught to identify how faulty cognitive judgments are contributing to the experience of anxiety, examine their reactions and change them with appropriate breathing techniques and recognise places, persons and behaviours that make them feel safe.

- Acceptance and Commitment Therapy (ACT) is also a cognitively based form of therapy in which the client is encouraged to acknowledge and accept all the distressing thoughts, feelings and behaviours and thereby gain a sense of control that helps them in their commitment to overcome them.

Evaluation of Behavioural and Cognitively Based Perspective

- The cognitive - behavioural perspective is credited for its simple approach that emphasises on the use of objective/empirical procedures.

- According to the humanists, the behavioural perspective limits the scope of Psychology because it doesn't take into account the active choices that individuals make (free will) in dealing with the environment.

- The Psychoanalysts have criticised the behaviourists for ignoring the fascinating unconscious influences on behaviour.

- However, the cognitive theories acknowledge that thought processes need to be studied and that implicit ideas about the self do influence behaviours.

- Behavioural and cognitive theories have a wide application and are useful in explaining and treating a variety of disorders including anxiety disorders, mood disorders, eating disorders, sexual dysfunctions, etc.

4.5 SOCIOCULTURAL PERSPECTIVE

This perspective focuses on how social and cultural agents or external factors such as other people, social institutions and events in the social context, influence the individual. The term sociocultural refers to all the circles of social influence that surround the individual that is the family, neighbourhood and society.

Family Perspective of Psychopathology

According to the family perspective, psychopathology or dysfunction in an individual reflects psychopathology or dysfunction in the family members. There are four approaches under this perspective:

1.) Intergenerational, given by Murray Bowen, suggests that how parents interact with their children is influenced by how they were treated as children.

2.) Salvador Minuchin gave the Structural approach which puts forth the idea that in normal families every individual has specific functions and the relationship boundaries are fixed and that troubles occur if family members are too close or too distant.

3.) In the Strategic approach, proposed by Jay Haley, the therapist influences the client with direct instructions about how to resolve issues within the family, especially power relationships.

4.) In the Experiential approach, Carl Whitaker suggests that the family dysfunctions are caused by obstacles in one's personal development. Virginia Satir's sculpting techniques involves making clients role-play difficulties in interaction. John Gottman found that characteristics such as contempt, criticism, defensiveness and stonewalling are related to difficulties in a marriage.

Family theorists have provided insights that help explain and treat psychological disorders. For example, Eating disorders may be found in families with disturbed relationships and starving oneself is seen as an adolescent's attempt to demonstrate one's control over one's body and life.

Social Discrimination

- Sociocultural theorists suggest that discrimination on the grounds of gender, race, religion, social class, age, sexual orientation, etc., can also cause psychological disorders.

- Due to stressors such as poverty, unemployment, lack of education, nutrition, access to health care systems, etc., many psychological

difficulties are commonly found among those from the lower socio-economic strata.

- In addition to this, the rates of crime and substance abuse are high and poor physical and mental health often results in premature death (Khaw et al., 2008). Age and gender bias can cause tremendous frustration and emotional difficulties giving rise to psychological symptoms, especially since these characteristics are fixed.

Social Influences and Historical Events

- Theodore Millon (1988), a personality psychologist suggested that changing societal values has led to a rise in psychological disorders in the West. Social instability makes children perceive the world as threatening and unpredictable and thus increase the risk of developing disorders later in life.

- The rates of mental disorders are higher in societies that go through significant social change. Reorganisation in the society, such as industrialisation, changing people's roles and relationships to the society from a worker to an unemployed person or in a situation like India-Pakistan partition, from a majority culture to a minority or multicultural society.

- Traumatic events of historical or political significance or natural disasters such as the earthquakes, floods, famines also adversely affect mental health. American psychologists, studying the effects of war have found that it negatively affects psychological functioning. Also, the possibility of developing serious anxiety disorders is greater among those who have been disturbed by terrorist attacks, harassment, imprisonment or experienced war.

Treatment

Therapists play a significant role in helping individuals cope with the stresses within the family, immediate environment or the society at large, especially since the world cannot be changed.

Family Therapy

- Family therapy focuses on helping the family members relate to each other and communicate in healthy ways. The therapist often spends time talking to every family member so as to build rapport, especially with those who seem to resist therapy.

- To improve communication, the therapist may initiate a conversation, observe the dynamics of their relationship and then guide the two members as they proceed. Sometimes these sessions are videotaped or held in rooms with one-way mirrors.

- Family therapy is different from individual psychotherapy, that is, here the therapist works on disturbed relationship patterns in the family as a whole rather than the individual issues of family members.

- Also, family therapists believe that harmonious relationships among family members are more beneficial to treatment than the client-therapist relationship.
- Various techniques are used by family therapists, for example, an intergenerational therapist may use a genogram, which is a diagrammatic representation of all relatives in the recent past. This information gives the therapist an idea of the nature of relationships shared by the family members, which is then used to bring about desirable changes.

Strategic family therapists work on finding solutions to issues within the family by making the members role-play conflicting views; while an experiential family therapist focuses on helping the family members develop a better understanding of their relationships.

Group Therapy

- In this method people having similar problems share their experiences with each other. Irvin Yalom (1995) suggested that this technique is effective for various reasons - it relieves the individuals and gives them hope as they realise that their problems are not exceptional; they receive useful information and suggestions from others who share how they dealt with their issues and the feeling of being of help to someone makes them feel better about themselves.
- The evidence for the effectiveness of group therapy comes from Alcoholics Anonymous, in which individuals with alcohol-related problems and their families share their stories and the techniques they successfully used to stay away from it.
- Group therapy also helps individuals with pedophilias, who have sexually abused children, to drop their defenses by providing a very supportive environment to share their concerns (Berlin, 1998).
- Studies have shown that group therapy is effective for individuals with depression, especially when combined with individual therapy or medication (Kasters et al., 2006).

Multicultural Approach

- The therapists need to be sensitive to the cultural background of the clients. When dealing with clients from different backgrounds, treatment should incorporate three components: awareness, knowledge and skills.
- Awareness refers to the idea that the therapist needs to be familiar with how the cultural context influences the client's experience or the way he relates to others.
- Knowledge relates to taking the responsibility of finding out about the client's cultural background and its effect on assessment, diagnosis and treatment.

- Skills refer to expertise in the specific therapy techniques that would work with the clients of a particular culture.

Milieu Therapy

- The term milieu implies the surrounding or the environment. This form of therapy involves scientific structuring of the environment by the staff - therapist, nurse or the paramedical professional, and clients as a team, to enhance the client's functioning.
- It focuses on improving social interaction, the physical structure of the setting and scheduling activities such as group therapy session, occupational therapy, physiotherapy, etc.
- The goal of milieu therapy is to provide a supportive environment that encourages socially desirable behaviour and to keep as many links as possible to the client's life, beyond the family.

Evaluation of Sociocultural Perspective

- Clinicians acknowledge the role of the environment in causing or maintaining psychological symptoms, with the understanding that not much can be changed in the surrounding. For example, discrimination has adverse effects on one's mental health but putting a stop to it is difficult. Similarly, the client's family may have a clear role in his psychological problems but the family members may be uncooperative or unavailable.
- Though group therapy can be very effective, several clients are shy or ashamed of sharing their concerns in front of others who are seen as strangers. These issues can be dealt with in individual therapy by focusing on how the cultural background of the client influences the way he relates to others.
- In certain cases biological theories provide better explanations of disorders than the sociocultutral ones. For example, Schizophrenia cannot be accounted for by dysfunctional family patterns. However, disturbed communication within the family is known to increase the severity of Schizophrenia or cause relapse.
- Thus, though the sociocultural perspective throws light on the psychological disorders, they are better explained when the biological and psychological perspectives are combined with it.

4.6 BIOPSYCHOSOCIAL PERSPECTIVE ON THEORIES AND TREATMENT: AN INTEGRATIVE APPROACH

There are five major schools of thought discussed in this chapter. In actual practice, most clinicians prefer an eclectic approach that integrates concepts and multiple perspectives.

There are three ways in which clinicians combine the different therapeutic models (Goldfried & Norcross, 1995): technical eclecticism, theoretical integration and the common factors approach. Those who follow technical eclecticism acknowledge that particular techniques across theoretical perspectives are effective in treating a particular problem, irrespective of their own theoretical orientation. For example, a psychoanalyst may value the use of graded exposure in treating a patient with phobia.

Theoretical integration comprises of developing one's own theory about the patient's presenting problem by incorporating principles from different theoretical models. For instance, a therapist may believe that maladaptive family system and faulty cognitions have contributed to the client's condition and accordingly develop an intervention plan by combining these two approaches.

The common factors approach involves using the core principles shared by the different theoretical models and those which have been proven to effective in clinical practice such as the counselor-client relationship (O'Leary & Murphy, 2006). Some clinicians follow a mixed model of integration which combines aspects of all the three integrative approaches.

In understanding the psychological disorders in the following chapters it is important to take into account the various biological, psychological and social factors that may contribute to its development and treatment.

4.7 SUMMARY

In this unit we have discussed the various theoretical perspectives. The first perspective was the psychodynamic perspective developed by Sigmund Freud. We discussed the structure of personality and the concept of defense mechanism. We also discussed the psychosexual stages of development. Post Freudian Psychodynamic writers were also discussed. Psychodynamic theory was evaluated. The next perspective that we discussed was the Humanistic perspective. The person- centered theory as well as self-actualisation theory was discussed.

Sociocultural perspective was the next perspective which we discussed. We discussed the family perspective of psychopathology, social discrimination and related concepts. Family therapy, group theory, milieu therapy was also discussed.

Behavioural and cognitive based perspective is one of the most dominant current perspectives. The behavioural perspective includes classical conditioning, operant conditioning as well as social learning. Cognitive based theories as well as treatment based on cognitive and behavioural approaches were also discussed. These treatment approaches include conditioning techniques, contingency management techniques, modeling and self-efficacy training, etc.

Towards the end of the unit we had discussed the concept of biopsychosocial perspective.

4.8 QUESTIONS

1. Discuss the concepts of Id, Ego and Superego as given by Sigmund Freud.
2. Discuss the various Adaptive Defenses.
3. Explain the psychosexual stages of development as outlined by Sigmund Freud.
4. Write notes on the following

a. Person centered theory

b. Self actualisation theory

5. Discuss the sociocultural perspective in detail.
6. Discuss the behavioural and cognitive perspective.
7. Write short notes on the following.

a. Conditioning Techniques

b. Contingency Management Techniques

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5

PANIC, ANXIETY, OBSESSIONS AND THEIR DISORDERS - I

Unit Structure

5.0 OBJECTIVES:

After reading this unit you will get to know

- About symptoms, causes and treatments of OCD and PTSD.
- What is the bio-psychosocial perspective of anxiety disorders.

5.1 OBSESSIVE COMPULSIVE DISORDER (OCD) :

OCD is a type of anxiety disorder but differs from other anxiety disorders. The person shows either obsessions and/or compulsion, which are excessive and unreasonable.

Obsessions

They are recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause anxiety or distress.

Compulsions

They are repetitive behaviours (such as hand washing, checking, etc.) or mental acts (such as praying, repeating words, etc.) that the person feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

People with obsessive compulsive disorder experience anxiety when they have an obsessions and when they cannot carry out their compulsions. They try to ignore or suppress their obsessive thoughts. For them these thoughts are so disturbing that they try to neutralize it by engaging in

some other thoughts or some compulsive behavior. For e.g. hand washing. Some without any obsessive thought tend to engage in the ritualistic, compulsive behavior. E.g. counting 10 after every 20 steps of walking. An individual suffering from OCD experiences significant distress and impairment in their personal, social and occupational functioning.

Common obsessions one focuses on are contamination, checking, need to put things in order etc. Common compulsion are repetitive behavior, putting things inn order, cleaning, checking etc.

BIOLOGICAL PERSPECTIVE –

Biological theories: Biological theories of OCD speculate that areas of the brain involved a in the execution of primitive patterns of behaviour, such as washing rituals, may be impaired in people with OCD. Researchers have found abnormalities in the basal ganglia area of the brain which plays an important role in motor movements. They also found abnormal functioning of prefrontal cortex which plays an important role iin inhibiting unwanted thoughts, images or urges.

Biological treatment: The drugs that regulates serotonin have proven helpful in treating OCD. The most effective drug therapies for OCD are the antidepressant known as selective – serotonin reuptake inhibitors (SSRI). In an extreme cases wherein drugs are not proving effective enough to deal with the symptoms of OCD then patients is treated with psychiatric surgery.

PSYCHOLOGICAL PERSPECTIVE –

Psychodynamic theories: Psychodynamic theory of OCD suggest that the obsessions and compulsions symbolizes unconscious conflict or impulses. According to psychodynamic theorist, fixation in anal stage of psychosexual development is associated with OCD.

Psychodyanamic treatment: The therapy for OCD involves uncovering these unconscious thoughts.

Cognitive behavioral theories suggest that people with OCD are chronically distressed, think in rigid and moralistic ways, judge negative thoughts as more acceptable than other people do, and feel more responsible for their thoughts and behaviours. This makes them unable to turn off the negative, intrusive thoughts that most people have occasionally. Compulsive behaviours develop through operant conditioning, people are reinforced for compulsive behaviours by the fact that they reduce anxiety.

Cognitive Behavioural Therapy (CBT): CBT have also proven helpful for OCD. These therapies expose OCD client to the content of their obsessions while preventing compulsive behaviour, the anxiety over the obsessions and the compulsions to do the behaviours are extinguished.

Unfortunately neither the drug therapies nor the cognitive. behavioural therapies tend to eliminate the obsessions and compulsions completely. The relapse rate with the drug therapies is high once the drugs are discontinued. Cognitive behavioural therapies help prevent relapse.

5.2 POSTTRAUMATIC STRESS DISORDER (PTSD):

PTSD is an anxiety disorder which occurs after a person experiences a severe trauma. It is a set of symptoms including hyper vigilance, re-experiencing of the trauma, emotional numbing experienced by trauma survivors.

People who experience severe and long lasting traumas, who have lower levels of social support, who experience socially stigmatizing traumas, who were already depressed or anxious before the trauma, or who have maladaptive coping styles may be at increased risk for PTSD.

When the distress persists for few days to a month after the traumatic event then the diagnosis of Acute stress disorder is assigned to that individual. However, when the symptom persists beyond one month then the diagnosis of PTSD is given.

The three main categories of symptoms of PTSD are –

1. **Re – experiencing of the traumatic event –**

Frequent nightmares, flashbacks of the event, other stimulus remind the event, etc.

2. **Emotional numbing and detachment -**

Avoidance of anything which reminds of the event, restricted emotional responses, no reaction to any kind of emotional provocation, sometimes unable to remember certain aspects of the event, etc.

3. **Hyper vigilance and chronic arousal -**

Constantly alertness for the traumatic event, panic and flight, chronically over aroused, easily startled, quick to anger, etc.

Four types of events are seen to result in PTSD –

1. **Natural disasters –** Floods, earthquakes, fires, tornadoes, etc.
2. **Abuse –** Physical abuse like beating, sexual abuse like rape, emotional abuse like critical parents, etc.
3. **Combat and War related traumas -** War prisoners witnessing deaths, war zone stress etc.
4. **Common traumatic events -** Accidents, sudden death of loved ones, drowning, heart break, etc.

BIOLOGICAL PERSPECTIVE

Biological Theories – Researchers have found that lower level of the hormone cortisol can result in PTSD, as it prolongs the activity of the sympathetic nervous system. PTSD people show increased blood flow in the amygdala area of the brain.

Twin and family studies shows that PTSD can be inherited, it runs in the family

Biological Treatment – Serotonin reuptake inhibitors (SSRI) and Benzodiazepines are helpful in treating PTSD symptoms.

PSYCHOLOGICAL PERSPECTIVE

Psychological Perspective - Human beings live with many assumptions about themselves and others, this keeps the person's faith and trust intact. But an individual may experience PTSD if these assumptions get shattered because of any kind of trauma.

People already suffering from depression and anxiety are more vulnerable to develop PTSD.

The onset of PTSD also depends on the person's coping styles and adjustments. People using self-destructive styles such as taking alcohol, drugs, isolation are more vulnerable to PTSD.

Cognitive Treatment - Systematic desensitization helps the patient to identify the stimulus and rank the fear ascendingly. Positive imagery training helps the victims of rape to recover from PTSD. Stress management methods helps to develop skills to overcome stressful issues.

SOCIOCULTURAL PERSPECTIVE

Sociocultural Theories - People with strong social and supportive social group are less likely to develop PTSD after a trauma.

Sociocultural Treatment- Community level interventions helps the people with PTSD caused by natural disasters, etc.

Check Your Progress –

1. What are the causes of PTSD?
2. What are the treatments of PTSD?

5.3 BIOPSYCHOSOCIAL PERSPECTIVE OF ANXIETY DISORDERS:

Biology is clearly involved in the experience of anxiety disorders. Evolution has prepared our bodies to respond to threatening situations with physiological changes that make it easier for a person to flee or fight an attacker. In few persons this reaction leads to chronic arousal, to over

actively or poorly regulated arousal. These people are more prone to severe anxiety reactions to threatening stimuli and to the anxiety disorders.

Social perspective focus on differences between groups in the rates and expression of anxiety disorders. Women have higher rates of almost all the anxiety disorders than do men. Women may have more genetic vulnerability to anxiety disorders because of changes in their hormonal levels.

Culture may differ in their expression of this disorder. Psychological perspective focus on the upbringing of an individual e.g., specific traumatic experiences that some have suffered.

5.4 SUMMARY:

PTSD focuses on avoiding thoughts or images of past traumatic experiences.

OCD disorder focuses on repulsive intrusive thoughts and the use of ritualistic behaviours.

5.5 QUESTIONS :

1. Define Obsessive Compulsive Disorder. Discuss its theories and treatment.
2. Define Post Traumatic Disorders and discuss its causes and treatment.
3. Write a note on Biopsychosocial perspective of Anxiety Disorders.

5.6 REFERENCES

Abnormal psychology by David H. Barlow & V. Mark Durand, 1995, 2005, New Delhi.

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6

PANIC, ANXIETY, OBSESSIONS AND THEIR DISORDERS - II

Unit Structure

6.0 OBJECTIVES:

After reading this unit you will get to know

- About the nature of anxiety disorder.
- About the causes and treatments of panic disorder and phobias.
- About symptoms, causes and treatments of GAD.

6.1 INTRODUCTION:

Anxiety is a body's natural response to stress. It is an emotion wherein, while facing any stressful situation, an individual experiences fear, worry and apprehension. In case of anxiety disorder, these feelings of fear, worry and apprehension are extreme and are out of proportion.

Anxiety disorder is characterized as a feeling of worry or fear that is so strong that it interferes with the normal functioning of an individual and causes distress and impairment. Many a time an individual experience somatic symptoms. For e.g., heart palpitation, sweating, muscle tension etc. when a person is in stress.

There is no single cause of excessive emotional reactions such as anxiety or panic. It seems that there is strong evidence of anxiety to be genetic in nature. Though a very well and empirically sound explanation is also provided by Behaviorists theorist and Cognitive behavior theorist and the treatment proposed by these approaches were found to be very effective in dealing with the disorder. Different anxiety disorders such as GAD, OCD, PTSD, Phobias, etc., can be treated by different approaches such as biological, psychological, cognitive therapies, counseling, etc.

The Fear and Anxiety Response Patterns

- There has never been complete agreement about how distinct the two emotions of fear and anxiety are from each other. Historically, the most common way of distinguishing between the fear and anxiety response patterns has been whether there is a clear and obvious source of danger that would be regarded as real by most people. When the source of danger is obvious, the experienced emotion has been called fear (e.g., "I'm afraid of snakes"). With anxiety, however, we frequently cannot specify clearly what the danger is (e.g., "I'm anxious about my parents' health")
- In recent years, however, many prominent researchers have proposed a more fundamental distinction between the fear and anxiety response patterns (e.g., Barlow, 1988, 2002; Bouton, 2005; Grillon, 2008; McNaughton, 2008). According to these theorists, fear is a basic emotion (shared by many animals) that involves activation of the "fight-or-flight" response of the autonomic nervous system. Its adaptive value as a primitive alarm response to imminent danger is that it allows us to escape.
- Anxiety response pattern, in contrast, is a complex blend of unpleasant emotions and cognitions that is both more oriented to the future and much more diffuse than fear (Barlow, 1988, 2002). But like fear, it has not only cognitive/subjective components but also physiological and behavioral components.
- At the cognitive/subjective level, anxiety involves negative mood, worry about possible future threats or danger, self-preoccupation, and a sense of being unable to predict the future threat or to control it if it occurs.
- At a physiological level, anxiety often creates a state of tension and chronic overarousal, which may reflect risk assessment and readiness for dealing with danger should it occur ("Something awful may happen, and I had better be ready for it if it does"). Although there is no activation of the fight-or-flight response as there is with fear, anxiety does prepare or prime a person for the fight-or-flight response should the anticipated danger occur.
- At a behavioral level, anxiety may create a strong tendency to avoid situations where danger might be encountered, but there is not the immediate behavioral urge to flee with anxiety as there is with fear (Barlow, 1988, 2002).
- The adaptive value of anxiety may be that it helps us plan and prepare for possible threat. In mild to moderate degrees, anxiety enhances learning and performance. For example, a mild amount of anxiety about how you are going to do on your next exam, or in your next tennis match, can be helpful.
- But anxiety is maladaptive when it becomes chronic and severe, as we see in people diagnosed with anxiety disorders. Although there are many threatening situations that provoke fear or anxiety unconditionally, many of our sources of fear and anxiety are learned.

6.2 ANXIETY DISORDERS:

Most of the people tend to have some childhood fears or adulthood fears which are mild, short-term, or reasonable. However, the fears experienced by people with anxiety disorder are so severe and chronic that it interferes with their functioning and negatively affects their quality of lives. As mentioned earlier, their fears are out of proportion to dangers that they truly face. The emotion response could be related to real fearful stimuli or perceived threat. Once an individual experiences the anxiety, it tends to feed on itself so that it might not stop even if the particular life stressor has long since passed.

Four types of symptoms determine the presence of anxiety-

1. ***Somatic symptoms*** – muscle tension, heart palpitation, stomach pain etc.
2. ***Emotional symptoms*** – restlessness, fearfulness, irritability and constant watchfulness.
3. ***Cognitive symptoms*** – problems in taking decisions and concentration, fear of dying, losing control, etc.
4. ***Behavioural symptoms*** – escapism in behaviour, aggressiveness, avoidance, etc.

There are different types of disorders where the main cause is anxiety and panic. Anxieties are consciously expressed or take some maladaptive forms like phobia, GAD, PTSD, etc.

6.3 PANIC DISORDER AND PHOBIAS

Symptoms of Panic Attacks

Panic disorder is a disorder wherein an individual experiences panic attack on recurrent basis or there is constant worry of experiencing another panic attack for least a month. Panic attacks, are short but intense periods in which individual experiences intense fear and physical symptoms such as heart palpitations, trembling, a feeling of choking, dizziness, intense dread, losing ones control, going crazy, or even dying. In order to diagnosis a person with panic disorder he/she must experience a panic attack more than once. They tend to engage in maladaptive behavior such as avoiding the place where they had the first panic attack.

Panic attacks may occur in the absence of any environmental triggers. For some people panic attacks are situationally predisposed. The person is more likely to have them in certain situation but does not always have them when in those situations. In all cases, however, the panic attack is a terrifying experience, causing a person intense fear or discomfort.

Some people with panic disorder have many attacks in a short period of time. Less frequently, people who have panic disorder often fear that they have life – threatening illnesses. E.g., thyroid disorders, or with a cardiac disorder called mitral value prelate. Between 1.5 and 4 percent of

people will develop panic disorder at some time in their lives. Most people who develop panic disorder usually do so sometime between late adolescence and their mid thirties. Many people with panic disorder also suffer from chronic generalised anxiety, depression, and alcohol abuse.

Biological Perspective

According to biological theory, an individual with panic disorder have over reactive autonomic nervous systems, which put them into a full flight-or-fight suspense with little provocation. This may be the result of imbalances in norepinephrine or serotonin or due to hypersensitivity to feelings of suffocation. There are also some evidence that panic disorder may be transmitted genetically.

Antidepressants and benzodiazepines have been effective in reducing panic attack and agoraphobic behaviour, but people tend to relapse into these disorders when they discontinue these drugs.

Psychological Perspective

Psychological theories suggest that people who suffer from panic disorder pay very close attention to their bodily sensations, misinterpret bodily sensations in a negative way, and engage in snowballing, catastrophic thinking. This thinking then increases physiological activation, and a full panic attack starts.

Cognitive–behavioural therapy (CBT) seems to be an effective treatment to deal with panic disorders. Clients are taught relaxation exercises and then they learn to identify and challenge their catastrophic styles of thinking, often while having panic attacks induced in the therapy sessions.

6.4 PHOBIAS

Agoraphobia :-

The term agoraphobia is from the Greek word meaning “fear of the market place”. However, the agoraphobia as a disorder is just not limited to market place but it is a condition in which an individual has a fear of any place that they think they might have trouble escaping or getting help in an emergency. E.g., fear of not receiving any help if they experience a panic attack, when they are watching movie in the threatre. Here, the basic fear is not of the place (stimuli) but of not able to receive any help. Which make this different from all other type of phobias. People with agoraphobia fear of not receiving any help if needed in crowded places, bustling places, such as the market place or the shopping mall. They also fear enclosed space, such as buses, subways, or elevators. Finally, they fear wide open spaces, such as open fields, particularly if they are alone. This fear is so much in some individuals are they refrain from leaving their home.

According to DSM 5, the symptom must persist over the period and should be seen in an individual for at least 6 months. In most cases,

agoraphobia begins within one year after a person begins experiencing frequent anxiety symptoms.

In DSM-IV-TR, agoraphobia was not considered as a separate diagnosis from panic disorder. So, people used to get the diagnosis of panic disorder with or without agoraphia. But in DSM 5, based on considerable body of research and ICD system, agoraphobia is consider as a separate diagnosis in DSM 5.

Agoraphobia strikes people in their youth. In one large study, more than 70 percent of the people who developed agoraphobia did so before the age of 25, and 50 percent developed the disorder before the age of 15 (Bourden et al. 1988).

Phobias

Specific Phobias:-

Phobias are intense and extreme fear of a particular object or situation. When people with these phobias encounter their feared objects or situation, their anxiety is immediate and intense, and some may even have full blown panic attacks. They go to any length to avoid encountering the fearful object or situation. And most importantly they experience significant distress and impairment.

Most phobias develop during childhood. Adults with phobias recognize that their anxieties are illogical and unreasonable but they can't control their anxiety, however children may not have this insight. Although as many as 4 in 10 people seem to have specific phobia some point in the lifetime, making it one of the most common disorders.

Specific phobias fall into one of four categories, (APA, 2000) animal type, natural environment type, situational type, and blood – injection – injury type.

a. **Animals type phobias** is having extreme fear of a specific animal or insets, such as dogs, cats, snakes, or spiders. A snake phobia appears to be the most common type of animal phobia in the United States.

b. **Natural environment type phobia** are intense fear of a specific events or situations in the natural environment, such as storms, heights, fire or water.

c. **Situational type phobias** usually involve fear of public transportation, tunnels, bridges, elevators, flying, and driving. Claustrophobia, or fear of enclosed spaces, is common situational phobia. People with situational phobias believe they might have panic attacks in their phobic situations.

d. **Blood-injection-injury type phobias**, was first recognized in DSM IV. People with this type of phobia, fear seeing blood or an injury, receiving an injection, or experiencing any other medical procedure.

e. **Miscellaneous type phobia** include the objects or situations, an individual is intensely anxious of, which cannot be categorized in any of the above four category.

Social Phobia

People with social phobia has an extreme fear of the social situation wherein they think others will scrutinized them. They are intensely afraid of getting embarrassed in front of other people. Social phobia creates severe disruption in a person's daily life. People with social phobia may avoid eating or drinking in public. They fear that they might embarrassed themselves with the noise while they eat or drop food, or otherwise embarrass themselves. They may avoid writing in public, including signing their names, for fear that others see their hands tremble.

People with social phobia tend to fall into three groups (Eng et al 2000). Some people with social phobia fear only public speaking. Others have moderate anxiety about a variety of social situations. Finally, who have severe fear of many social situations, from speaking in public to just having a conversation with another person, are said to have a generalised type of social phobia.

Social phobia is relatively common, with about 8 percent of the U.S. adult population qualifying for the diagnosis in a 12 month period and one in eight people experiencing the disorder at some time in their lines (Kessley et. al., 1998, Schnier el. al, 1992) Women are somewhat more likely than men to develop this disorder.

Once it develops, social phobia tends to be a chronic problem if untreated. Most people with a social phobia do not seek treatment for their symptoms.

6.5 GENERALISED ANXIETY DISORDER (GAD)

People with GAD worry about many things in their lives. E.g., worry about their performance on the job, about how their relationships are going, and about their own health. The focus of their worries is not limited to one issue or a particular situation or object but they tend to worry about many different things. Their concern may shift frequently. Their worry is accompanied by many of the physiological symptoms of anxiety, including muscle tension, sleep disturbances, and a chronic sense of restlessness.

GAD is a relatively common type of anxiety disorder, with about 4 percent of the U.S. population experiencing it in any six- month period. The majority of people with GAD also develop another anxiety disorder, such as phobias or panic disorder and many experience depression as well.

Theories of Generalised Anxiety Disorder

1. Psychodynamic Theories :-

Freud (1917) developed the first psychological theory of generalised anxiety. He distinguished among three kinds of anxiety : realistic, neurotic, and moral. Realistic anxiety occurs when we face a real danger or threat, such as an oncoming tornado. Neurotic anxiety occurs when we are repeatedly prevented from expressing our id impulses, it causes anxiety. Moral anxiety occurs when we have been punished for expressing our id impulses, and we come to associate those impulses with punishment, causing anxiety. Generalised anxiety occurs when our defense mechanisms can no longer contain either the id impulses or the neurotic or moral anxiety that arises from these impulses.

More recent psychodynamic theories attribute generalised anxiety disorder to poor upbringing, which results in fragile and conflicted images of the self and others. Children whose parents were not sufficiently warm and nurturing, and many have been overly strict or critical, may develop images of the self as vulnerable and images of others as hostile. As adults, their lives are filled with frantic attempts to overcome or hide their vulnerability, but stressors often overwhelm their coping capacities, causing frequent bouts of anxiety.

2. Humanistic and Existential Theories :-

Carl Roger's humanistic explanation of generalised anxiety suggests that children who do not receive unconditional positive regard from significant others become overly critical of themselves and develop conditions of worth, harsh self-standards they feel they must meet in order to be acceptable. Throughout their lives, these people, then, strive to meet these conditions of worth by denying their true selves and remaining constantly vigilant for the approval of others. They typically fail to meet their self-standards, causing them to feel chronically anxious or depressed.

Existential theorists attribute generalised anxiety disorder to existential anxiety, a universal human fear of the limits and responsibilities of one's existence. Existential anxiety arises when we face the finality of death, the fact that we may unintentionally hurt someone, or the prospect that our lives have has no meaning. We can avoid existential anxiety by accepting our limits and striving to make our lives meaningful, or we can try to silence that anxiety by avoiding responsibility or by conforming to other's rules. Failing to confront life's existential issues only leaves the anxiety in place, however, and leads us to "inauthentic lives".

3. Cognitive Theories :-

Cognitive theories of GAD suggest that the cognitions of people with GAD are focused on threat, at both the conscious and non conscious levels. At the conscious level, people with GAD have a number of maladaptive assumptions that set them up for anxiety, such as "I must be loved or approved of by everyone," "It's always best to expect the worst, "People with GAD believe that worrying can prevent bad events from happening. These beliefs are often superstitions, but people with GAD also believe that worrying motivates them and facilitates their problem solving, yet people with GAD seldom get around to problem solving.

Indeed, they actively avoid visual images of what they worry about, perhaps as a way of avoiding the negative emotion associated with those images.

Their maladaptive assumptions lead people with GAD to responds to situations with automatic thoughts, which directly stir up anxiety, cause them to be hyper vigilant, and lead them to overreact to situations.

Check Your Progress:-

1. What do you mean by GAD?

2. Discuss the different theories of GAD?

6.6 SUMMARY

Anxiety disorders are complex and most common form of mental disorder. Anxiety is a future oriented state where a person focuses on the possibility of experiencing danger. Panic and anxiety create different anxiety disorders.

In phobia, the person avoids situations that produce severe anxiety or panic disorders. Specific genetic vulnerability seems to put person at risk for anxiety disorder. Psychological and social causes can result in anxiety disorders. Psychological, social and biological treatments helps a patient with anxiety disorder.

6.7 QUESTIONS

1. Define Anxiety and Panic Disorders and discuss their symptoms.

2. Write notes on the following.

a. Agoraphobia

b. Specific Phobia

c. Social Phobia

3. What is Generalised Anxiety Disorder. Discuss the various theories of Genderdised Anxiety Disorder.

6.8 REFERENCES

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7

SOMATIC SYMPTOMS AND DISSOCIATIVE DISORDERS - I

Unit Structure

7.0 OBJECTIVES

After studying this unit you should be able to:

- Understand the concept of Dissociative Disorders
- Know the details about various types of Dissociative Disorder
- Know the biopsychsocial perspective of various Somatoform Disorder, Psychological Factors Affecting Medical Conditions and Dissociative Disorders.

7.1 INTRODUCTION

Dissociative disorders are an extreme form of psychological disturbance involving anxiety and conflict in which part of an individual's personality actually separates from the rest of his or her conscious functioning. One type of dissociative disorder is the Dissociative Identity Disorder. Characteristics of Dissociative Identity Disorder as well as its theories and treatment would be discussed in brief. Some other dissociative disorders that we would discuss in brief include Dissociateive Amnesia

and its variants, Dissociative Fugue, Depersonalisation Disorder. Theories and treatment of these various dissociative disorders will be discussed. Towards the end of the unit we will discuss the biopsychsocial perspective of various Somatoform Disorder, Psychological Factors Affecting Medical Conditions and Dissociative Disorders.

7.2 DISSOCIATIVE DISORDERS

Dissociative disorders are one of the disorders that have received considerable media attention. Dr. Sigmund Freud and Morton Prince carried out some pioneering studies on this disorder. The dissociative disorder refers to a group of related disorders in which there is certain altered states of consciousness. The dissociative disorder are described as sudden temporary alterations in the normally integrative functioning of consciousness, identity or motor behavior. Dissociative disorders are characterised by alterations in perceptions: a sense of detachment from one's self from the world or from memories.

Dissociative disorders are an extreme form of psychological disturbance involving anxiety and conflict in which part of an individual's personality actually separates from the rest of his or her conscious functioning. An individual with dissociative disorder experiences a temporary alteration in consciousness involving a loss of personal identity, decreased awareness of immediate surroundings and odd bodily movements. Once the dissociation has occurred, the content of the dissociated part becomes inaccessible to the rest of the client's conscious mind.

Some of the most common types of dissociative disorders include: Depersonalization Disorder, Dissociative Amnesia, Dissociative Fugue, Dissociative Indentity Disorder, etc. We would discuss the different variants of dissociative disorders.

7.2.1 Depersonalization Disorder:

It is a dissociative disorder, usually occurring in adolescence, in which individuals lose their sense of self and feel unreal or displaced to a different location. Depersonalization involves a sense of thing or experiences as being "unreal" and a feeling of estrangement from oneself or one's surrounding, both feelings have an unpleasant quality and are experienced as a distinct change from one's usual mode of functioning. In this disorder an individual feels that he is out of his body and the body is distorted. Sometimes, people also report that they were dead and floating above the body.

Individuals with this disorder feel that they are, all of a sudden, different. For example, that their bodies have drastically changed and hence, become very much different. Individuals with this disorder have an out-of-body experience in which they feel that they are, for time, floating above their physical bodies and observing what is going on below. The phenomenon of depersonalization includes alterations of mind-body perception, ranging from detachment from one's experiences to the feeling that one has stepped out of one's body.

Depersonalization experiences also occur in normal people when they are placed under great stress or when they use mind-altering drugs, such as marijuana or LSD. In depersonalization disorder, however, distortions of mind-body perceptions happen repeatedly without provocation by drugs. Periods of extreme stress, such as the time immediately following an accident can also precipitate an episode of Depersonalization in a vulnerable individual.

This disorder is often precipitated by acute stress resulting from an infectious illness, an accident, or some other traumatic event. Individuals who experience depersonalized state are usually able to function entirely normally between episodes. Depersonalization is a psychological mechanism whereby one "dissociates" from reality. Depersonalization is often a part of a serious set of conditions where reality experience and even one's identity seem to disintegrate.

This disorder is episodic by nature and lasts for few minutes or hours. This is the most frequent disorder of dissociative type, so it is thought that it must be mildest form of dissociation and must be more easily curable. It is assumed that depersonalization must be an attempt to escape from a stressful situation. However, the data about the disorder is not very clear.

Most experts agree that dissociative disorders are the end product of intensely traumatic experiences during childhood, especially those involving abuse or other forms of emotional maltreatment. Other forms of traumatic experiences, which can be transient or long lasting may also lead to dissociative disorders. Current views with regard to causation of dissociative disorder is largely based on psychological perspectives. Our knowledge of biological factors involved in causation of these conditions is highly limited.

7.2.2. Dissociative Amnesia:

Dissociative Amnesic was earlier called as psychogenic amnesia. In this disorder an individual is unable to remember important personal details and experiences usually associated with traumatic or very stressful events. This memory loss is not attributable to brain dysfunction, brain disorder or drugs. In this disorder an individual forgets his personal information in totality or is unable to remember some specific personal details.

Dissociative Amnesia is common during the time of war or similar stressful events. It should be remembered that in most cases of Dissociative Amnesia, the forgetting is very selective for traumatic events or memories rather than generalized. Dissociative Amnesia is found to be common during war. There are four forms of dissociative amnesia, each associated with the nature of a person's memory loss. The four forms of dissociative amnesia are as follows:

i. **Generalized Amnesia*:*** In this type of amnesia an individual is unable to remember personal information, including one's identity. The duration of this disorder may range from being a life long or may last for about 6 months or a year.

ii. **Localized or Selective Amnesia*:*** In this type of amnesia there is a failure to recall specific events. These specific events, which are difficult to remember, are related to specific period of time. This amnesia is more common as compared to generalized amnesia.

iii. **Selective Amnesia:** The individual fails to recall some, but not all details of events that have occurred during a given period of time. For example, the survivor of fire may remember the ambulance ride to the hospital, but not having been rescued from the burning house.

iv. **Continuous Amnesia*:*** It involves a failure to recall events from a particular date up to and including the present time. For example a soldier may remember his childhood and youth until the time he entered the armed services, but he may have forgotten everything that took place after his first tour of combat duty.

Dissociative Amnesia is very difficult for clinicians to diagnose, because there are so many possible causes of memory loss. Amnesia can also result from physical dysfunction due to brain injury, epilepsy, substance abuse, etc. Some individuals also fake symptoms of dissociative amnesia to gain certain benefits or advantages. For example, a man who has committed a serious crime may claim that he remembers nothing of the incident or even who is.

7.2.3. Dissociative Fugue:

It was formerly called as psychogenic fugue. The term Fugue means flight and this disorder is very much similar to dissociative amnesia. In this disorder, an individual take off from one place and move to another place without their conscious awareness and may be further confused, on gaining awareness, as to how they arrived at this new place. In this disorder a person is completely forgets their own identity or is confused about personal identity suddenly and unexpectedly travels to another place.

People in a fugue state are unable to recall their history or identity and a few may even assume a new identity. A fugue is rare and usually passes quickly. The disorder is more likely to occur at certain times, such as during a war or following a natural disaster. Personal crises or extreme stress, such as financial problems the desire to escape punishment or the experience of a trauma can also precipitate fugue states. Some other important features of this disorder are as follows:

- This disorder usually occurs in adulthood and never before adolescence. It rarely occurs after the person has crossed the age of 50.
- Dissociative Fugue is such a rare disorder that virtually no controlled
- Fugue state end rather abruptly and the individual returns home recalling most if not all of what happened. In this disorder, the disintegrated experience is more than memory loss, involving

atleast some disintegration of identity if not the complete adaptation of a new role.

- One type of distinct dissociative disorder not found among western cultures is "Amok", which is very similar to the term "running amok". In this state an individual is in a trance like state and often brutally assaults and sometimes kills persons or animals and acquires a mysterious source of energy, runs or flees for a long time, etc. This disorder is most common among males

- A still another type of dissociative disorder found among the native people of Aartic which is similar to "Amok" is called "Pivloktoq" and the same disorder amongst the Navajo tribe is called "Frenzy Witchcraft".

Generally individuals who experience dissociative amnesia or a fugue state usually get better on his or her own and remember what they have forgotten. The therapy focuses on recalling what happened during the amnesia or fugue states, often with help of friends or family who know what happened, so patients can confront the information and integrate it into their conscious experience.

7.2.4 Dissociative Identity Disorder (DID):

It is the most interesting and dramatic of all the dissociative disorder and was earlier called as multiple personality disorder. In Dissociative Identity Disorder, a person develops more than one self or personality. These personalities are referred to as alerts, in contrast to the core personality, the host.

In this disorder, more than 1 personality or fragments of personality coexist within one body and mind. In some cases the identities are complete, each with its own behavior, tone of voice and physical gestures. In other cases, only a few characteristics are distinct, because the identities are only partially independent.

The disorder was made famous in novels and movies, such as "Sybil" and "The Three Faces of Eve". In Dissociative Indentity Disorder, each alter is understood to be a consistent and enduring pattern of perceiving, relating to and thinking about the environment and the self.

Characteristics of Dissociative Identity Disorder:

The major characteristics of this disorder are as follows:

i. Amnesia is the most important characteristic feature of this disorder. In amnesia, an individual have gaps in their memory about some aspects of their personal history.

ii. The identity of this disorder is fragmented.

iii. Many personalities live inside one body. These can be anywhere from 3 to 4 to more than 20.

iv. Certain important aspects of person's identity are dissociated.

A person who comes for treatment with a DID is called as a host personality. The host personality tends to hold many different identities together. The transition from one personality to another is called as a "switch". During a switch, physical transformation may occur. Posture, facial expressions, pattern of facial wrinkling and even physical disabilities may occur. One of the most important debatable issue is whether the DID can be faked or whether it is real. Some important points with respect to this disorder are as follows:

- Individuals with DID are very suggestible and the alternative personalities that these individuals manifest are actually created as a reaction to leading questions suggested by therapists

during psychotherapy or in a state of hypnosis. Generally it is found that the core personality is submissive and passive. And the alter personality gets developed as a reaction to the alter personality.

- Objective tests suggest that many people with fragmented identities are not consciously and voluntarily simulating
- The prevalence rate of this disorder has been found to be between 3% to 6 %.
- DID is more common among females. The ratio of females to males is as

- The onset of this disorder is always in childhood, often as young as 4 years of age, although it is usually identified approximately at the age of 7 years.

- It has also been noted that there is a high degree of comorbidity of DID with other disorders. It has also been found that large percentage of DID patients may have substance abuse, depression, somatisation disorder, borderline personality disorder, panic attacks and eating disorders.

- DID is often misdiagnosed as a psychotic disorder.

- DID occur in a variety of cultures across the world.

- Some investigators have studied the ability of individuals to fake dissociative experiences. According to them, it is possible to stimulate dissociative disorder. Various experiments conducted by Spanos et al (1994) have suggested that the symptoms of DID could be faked. They found that in one experiment 80 percent of the individuals could successfully fake an alternative personality.

Richard Kluft (2005) has done considerable research in this area. Putnam et al (1986) have noted that, in the 50 years prior to 1970s, only a handful of cases had been reported, but since 1970s, the number of reports increased astronomically, in to thousands. In fact, more cases of this

disorder were reported during one 05 – year period in the 1980s than had been documented in the preceding two centuries.

Causes of Dissociative Identity Disorder (DID): Some important causes of DID are as follows:

i. **Childhood Traumatic Events:** Many surveys have reported that DID is a result of traumatic life events. Putnam et al (1986) examined 100 cases and found that 97 % of the patients had experienced significant trauma, usually sexual or physical abuse and 68 % had reported incest. Similarly, Ross et al (1990) had reported that, of the 97 % of the cases, 95 percent reported physical or sexual abuse. Often the abuse is bizarre and sadistic. Traumatised individuals fail to develop an integrated and continuous sense of self

ii. **Lack of Social Support:** It has also been found that a lack of social support during or after the abuse also seems implicated. A recent study of 428 adolescent twins has demonstrated that in 33% to 50% of the cases dissociative disorder could be attributed to chaotic, nonsupportive family environment.

iii. **Sociocognitive Model of DID:** This model was presented by Lilienfeld et al (1999). According to this model, clients enact the roles that they feel (consciously or unconsciously) are demanded by the situation. Social attention to the condition of DID, along with unintentional prompting by therapist, can lead to the development of this disorder in vulnerable individuals. According to Sociocognitive Model, these individuals may in fact have suffered abuse as children, but many other factors, socially determined, operate to create the dissociative symptoms in adulthood

iv. **Biological Contributions:** Some researchers have implicated biological contributions in the development of DID. It has been reported that individuals with certain neurological disorders, particularly seizure disorders, experience many dissociative symptoms. Devinsky et al (1989) reported that approximately 6 % of the patients with temporal lobe epilepsy reported "out of body" experiences. Similarly, another groups of researchers (Schenk and Bear, 1981) have found that about 50 % of the patients with temporal lobe epilepsy displayed some kinds of dissociative symptoms.

Treatment of Dissociative Disorder: Some important points with respect to the treatment of this disorder are as follows:

i. The treatment of DID is much more difficult as compared to other dissociative disorders. Not much controlled research has been done on the effects of treatment, though there are many documented successes of attempts to reintegrate identities through long-term psychotherapy.

ii. The strategies that therapist use today in treating DID are based on accumulated clinical wisdom as well as procedures that have been successful with posttraumatic stress disorder.

iii. The major goal in treating DID is to identify cues or triggers that provoke memories of trauma and/or dissociation and to neutralize them. Most important in the treatment process is that the patient is taught to confront and relieve the early trauma and gain control over the horrible events, at least as they recur in the patient's mind

iv. In the treatment of DID hypnosis is often used to gain access to unconscious memories and bring various alters into awareness.

v. Treatment of dissociative disorders involves helping the patient re-experience the traumatic events in a controlled therapeutic manner in order to develop better coping skills. In the case of dissociative identity disorder, therapy is often long term, and may include antidepressant drugs. Particularly essential with this disorder is a sense of trust between therapist and patient.

vi. Sopme clinicians have used cognitive-behavioural techniques in the treatment of DID instead of or in addition to hypnotherapy in an effort to change the client's dysfunctional; attitudes. These attitudes arise from the client's history of abuse and includes the following core beliefs:

- That it is wrong to show anger or defiance
- That one cannot handle painful memories
- That one unconsciously hates the parents or experiences conflicting attitudes towards one or both the parents
- That one must be punished
- That one cannot be trusted, etc.

According to Ross (1997) these core beliefs needs to be changed. Kluft (1989) has used cognitive-behavioural techniques to bolster an individual's sense of self-efficacy through a process called temporizing, in which the client controls the way that the alters make their appearance. This may be accomplished through hypnosis in an effort to help the client develop coping skills that can be used when dealing with stress.

1. Dissociative Identity Disorder and the Legal System: Forensic psychologists and other legal experts have been concerned with the legal aspects of DID. Legal Defendants have used this diagnostic category as a defense for their offences. Forensic psychologists and other members of the judicial system are faced with the difficult task of differentiating a true dissociative disorder from instances of malingering. Kenneth Bianchi, a serial murdrer also known as the Hillside Strangler, faked multiple personality disorder defense. Individuals who seek to explain their crimes as products of alter personalities typically invoke an insanity defense or claim that they are not competent to stand trial (Slovenko, 1993). Accused undertake the defense that they have committed the crime under the control of an alter personality. They may further claim that the offense was committed in a state of dissociation and that they have no recall of what happened. Steinberg et al (2001) developed criteria for assessing the validity of dissociative symptoms within the context of clinical and

forensic evaluations. They recommended the use of Structued Clinical Intervies for DSM IV Dissociative Disorders – Revised (SCID – D – R).

7.3 SOMATOFORM DISORDERS, PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITIONS AND DISSOCIATIVE DISORDERS: THE BIOPSYCHOSOCIAL PERSPECTIVE

Historically these disorders were regarded as neurosis rather than psychosis. People with these disorders have experienced conflict or trauma during their lives and circumstances have created strong emotional reactions that they could not integrate in to their memory, personality and self-concept. The symptoms seen in somatisation disorder and dissociative states represent not a loss of contact with reality but a translation of various emotions in to terms that are less painful to acknowledge than is the original conflict or trauma.

Stressful events in many individuals trigger maladaptive responses in physical functioning, ranging from variety of physical conditions to sleep dysfunctions and various somatic complaints which are often vague. Currently the most prevalent view is that stress related factors and not repressed sexuality is central to understanding somatoform disorders. Besides stress, learning seems to play a strong role, especially in cases where individuals have developed secondary gains from their symptoms.

With regard to dissociative disorders, researchers believe that, actual, rather than imagined trauma is the source of such symptoms as amnesia, fugue and multiple identities.

Cognitive behavioural therapists have also offered their perspective on this group of disorders. According to them low feelings of self-efficacy, lack of assertiveness and faulty ideas about the self can all be contributing factors to somatoform and dissociative disorders. For example believing that one must be sick to be worthy of attention is a dysfunctional attitude that underlie the development of somatoform disorders. Similarly faulty beliefs about the self and the role of the self in past experiences of trauma seem to be important cognitive factors that may contribute to an individual's vulnerability to developing these maladaptive thoughts or susceptibility to trauma.

7.4 SUMMARY

In this unit we have discussed the concept of Dissociative disorders. We have attempted to understand as to how these group of disorders are an extreme form of psychological disturbance involving anxiety and conflict in which part of an individual's personality actually separates from the rest of his or her conscious functioning. One type of dissociative that we discussed in detail was the Dissociative Identity Disorder (DID). The various characteristics of Dissociative Identity Disorders as well as its theories and treatment were discussed.

Many different types of dissociative disorders that we would discuss in brief include Dissociateive Amnesia and its variants, Dissociative Fugue, Depersonalisation Disorder. Theories and treatment of these various dissociative disorders were also briefly discussed. Towards the end of the unit we have discussed the biopsychsocial perspective of various Somatoform Disorder, Psychological Factors Affecting Medical Conditions and Dissociative Disorders.

7.5 QUESTIONS

Q1. What are Dissociative disorders? Discuss Dissociative Indentity Disorder (DID), its Characteristics, Causes and treatment.

Q2. Write a note on Dissociative Identity Disorder and the Legal System.

Q3. Discuss Dissociative Amnesia, Dissociative Fugue and Depersonalization Disorder.

Q4. Write a note on The Biopsychosocial Perspective of Somatoform Disorders, Psychological Factors Affecting Medical Conditions and Dissociative Disorders.

7.6 REFERENCE

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8

SOMATIC SYMPTOMS AND DISSOCIATIVE DISORDERS - II

Unit Structure

8.0 OBJECTIVES

After studying this unit, you should:

- Know the concept of somatoform disorders.
- Understand conversion disorder.
- Comprehend somatization disorder and related conditions.
- Know body dysmorphic disorder and hypochondriasis.
- Understand conditions related to somatoform disorders.
- Know theories and treatment of somatoform disorders.
- Understand Psychological Factors Affecting Medical Conditions and associated topics such as coping, stress and the immune system, etc.

8.1 INTRODUCTION

In this unit we will discuss the concept of somatoform disorders. The concept of conversion disorder, somatisation disorder and related conditions, dysmorphic disorder as well as hypocondriasis will also be discussed. Following this we will discuss the various conditions related to somatoform disorders, such as malingering, factitious disorder and Munchausen's syndrome. Theories and treatment of somatoform disorder would also be discussed.

Many medical conditions are influenced by psychological factors. DSM IV TR category of psychological factors affecting medical conditions

includes situations in which psychological or behavioural factors have an adverse effect on a medical conditions. Theories and treatment of these conditions would also be discussed.

8.2 SOMATIC SYMPTOMS AND RELATED DISORDERS

Somatoform disorders are those disorders in which an individual complains of bodily symptoms but for which there is no clear-cut identifiable physical cause. Somatoform disorders include a variety of conditions in which conflict becomes translated in to physical problems or complaints that cause distress or impairment in a person's life. Psychologists have known Somatoform disorders since a long time. The term "soma" refers to body and somatoform disorders are those bodily disorders for which there is no biological basis for physical complaints and the cause is largely a result of psychological factors. Somatoform disorders can be defined as an anxiety based pattern in which an individual complains of bodily symptoms that suggest the presence of a physical problem, but for which no organic basis can be found. Health professionals find it difficult distinguishing between a physical cause and a psychological cause when it comes to understanding bodily symptoms.

DSM-IV has identified many different forms of somatoform disorders. These include: Conversion disorder, Somatisation disorder and related conditions, Body dysmorphic disorder, Hypochondriasis, etc.

1. Hypochondriasis (Illness Anxiety Disorder): An individual who is suffering from hypochondriasis believe or fear that they have a serious illness, when in fact they are merely experiencing normal bodily reations. It is one type of somatoform disorder, which is characterized by multiple complaints about possible physical illness where no evidence for such illness can be found. DSM 5 has relabel this diagnosis as 'Illness Anxiety Disorder'

In hypochondriasis, anxiety is a result because an individual misinterprets the bodily symptoms as indicative of illness or disease. For e.g., if a person is having a headache then he might think that he is having brain tumor. They have an unrealistic interpretation of relatively common physical complaint. Their complaints are not restricted to any logical symptoms. They have trouble in giving precise description of their symptoms.

They read a lot on medical topics and feel certain that they are suffering from every new disease they read or hear about. They believe that they are seriously ill and cannot recover. Besides, they also keep themselves well informed about the latest medical treatments by reading popular newspaper and magazines.

These patients are so preoccupied with their health, that many of them keep detailed information about diet, functioning of body, etc. Since the preliminary symptoms of this disorder are generally of health concerns, an

individual with this disorder is likely to visit a family physician. As their symptoms have no physical causes, no treatment is possible. Inspite of best efforts by the doctors to convince the individual that nothing is medically wrong with him and the disorder is more psychological in nature; the patient is not able to understand this. Hence, they keep on changing their physician until the physician treats the disease, which does not exist at all. The problem of hypochondriasis come to the attention of mental health experts only when all relevant medical conditions concerned with the presenting physical complaints are ruled out.

Hypocondriasis differs from somatisation disorder on the following grounds.

a. It occurs after the age of 30 years.

b. The abnormal concerns of hypocondriacal individuals are vague, general, and do not focus on particular set of symptoms.

c. Hypocondriacal persons have a belief that they have a serious illness, which is unique.

Research studies indicate that hypochondriasis shares many features with anxiety disorders, particularly panic disorders. These two disorders are frequently comorbid i.e. individuals with a hypochondriacal disorder have an additional diagnosis of anxiety disorder.

Patients having hypochondriasis are distinguished from those having illness Phobia. Illness Phobia is future oriented, i.e. individuals who fear developing a disease is said to have illness Phobia. On the other hand hypochondriasis is a current anxiety about a presumed illness. In other words, individuals who mistakenly believe they currently have a disease are diagnosed as having hypochondriasis.

The prevalence of hypochondriasis in general population is not well known. It is estimated that anywhere between 1% to 14% of the medical patients has hypochondriasis. The sex ratio of this disorder is 50-50. Once it was believed that hypochondriasis was most common among elderly population. However, this is not so. It is estimated that hypochondriasis can develop at any time of life, with peak age period found in adolescence, middle age (40s and 50s) and ages 60 years.

Hypochandriasis is a culture specific disorder. Its manifestation is considerably influenced by sociocultural factors. Two important culture specific syndromes are as follows:

a. Koro

b. Dhat

Koro: This syndrome is generally found among Chinese males, though it is also found among western women to a lesser extent. In this syndrome there is a belief accompanied by severe anxiety and sometimes panic that genitals are retracting into the abdomen. Koro occurs in Chinese males

because of the central importance given to sexual functioning among Chinese males. In this syndrome an individual feels guilty about excessive masturbation, unsatisfactory intercourse or promiscuity. These events generally predispose men to focus their attention on their sexual organs, which generally increases anxiety and arousal leading to hypochondrical symptoms.

Dhat: This is another culture specific syndrome, most common among Indians. It is an anxious concern about loosing one's semen. The loss of semen is associated with a vague mix of physical symptoms including dizziness, weakness and fatigue that are not so specific as in Koro.

The various somatic symptoms present in hypochondriasis poses diagnostic problem for a clinician and hence the clinician must remember the following points:

a. First, the clinician must be accurately aware of the specific culture or subculture of a patient in order to understand the cultural manifestation of this disorder.

b. A clinician must rule out the physical cause of somatic complaints before referring the patient to a mental health professional.

c. The mental health professional must determine the nature of somatic complaints in order to know whether they are associated with a somatoform or are a part of other psychopathological syndrome such as panic attack.

Causes of Hypochondriasis: Some important causes of hypochondriasis are as follows:

- **Disorder of Cognition and Perception:** Hypochondriasis is a disorder of cognition and perception with strong emotional contributions. Individuals with hypochondriasis pay undue attention to physical sensations that are common to all normal individuals. They quickly focus their attention on these sensations. The very fact of focusing attention of their self increases their arousal and makes physical sensations seem more intense than they actually are. For e.g. a minor headache may be interpreted as a sign of brain tumor.

- **Increased Perceptual Sensitivity:** Experiments using the stroop test has revealed that individuals having hypochondriasis show enhanced perceptual sensitivity to illness cues. They also tend to interpret ambiguous stimuli as threatening.

- **Integrated Approach:** It should be remembered that no single biological or psychological cause can be implicated in this disorder. Researchers have pointed out that the fundamental causes of hypochondriasis are similar to those implicated in the anxiety disorder.

According to Cote et al (1996) three important factors related to the etiology process of this disorder are as follows:

i. Hypochondriasis seems to develop in the context of stressful life events. Such events often involve death or illness.

ii. People who develop hypochondriasis tend to have had a disproportionate incidence of disease in their family when they were children.

iii. Important interpersonal and social influence also plays an important role in the development of hypochondriasis. For

e.g. some people who come from families where illness is a major issue seem to have learned that an ill person is often paid increased attention. Hence, they develop illness.

Treatment: Some important points related to treatment of this disorder are as follows:

i. Our knowledge about the treatment of this disorder is limited. Scientifically controlled studies are very rare.

ii. Treatment of this disorder consists of identifying and challenging illness related misinterpretation of physical sensations and on showing the patient how to create "symptoms" by focusing attention on certain body areas.

iii. Psychoanalysis has been found to be less effective with this type of diorder. Ladee (1966) found that only four out of the 23 patients with this type of treatment improved.

iv. Kellner (1992) found that reassurance seems to be effective in some cases, especially when it is given by a medically trained person such as a family physician.

v. Participation in support groups (i.e. group therapy or counselling) can also be of considerable benefit for such patients.

2. **Somatisation Disorder and Related Conditions:** Somatisation disorder involves the expression of psychological issues through bodily problems that cannot be explained by any known medical condition or as being due to the effects of a substance. They tend to complain of having some or other physical problems like weakness, double vision, or headache, allergies, nausea, stomach problem, and menstrual and sexual difficulties.

The difference between somatization disorder and conversion disorder is that somatisation disorder involves various physical symptoms whereas in conversion disorder an individual complaints of voluntary motor or sensory deficits that suggest a neurologic or medical condition. In conversion disorders an individual reports multiple and recurrent bodily

symptoms rather than a single physical complaint. Such people experience pain and sickness in exaggerated manner.

This condition generally, which is relatively rare, first appears before the age of 30 years and leads to problems in the areas of social, occupational and interpersonal functioning. Individuals suffering from this disorder generally tend to be from lower socioeconomic classes.

This disorder was earlier called as Briquet's Syndrome, after the famous French physician, Pierre Briquet who in 1859 described patients who has multiple somatic complaints for which he could not find any medical cause. Somatisation disorder was known as Briquet's syndrome for more than 100 years and was called as somatisation disorder for the first time only in 1980s in the DSM- III. In this disorder there are repeated and multiple vague somatic complaints for which there is no physiological cause. This is a very rare disorder and occurs on a continuum.

The prevalence shows that majority of the individuals with somatisation disorder tend to be women, unmarried and from lower socioeconomic groups. In addition to a variety of somatic complaints, individuals may also have psychological complaints, usually anxiety or mood disorders.

Biological Theory- According to biological theorist, genetic factors plays an important role in somatization disorder. Early studies of possible genetic contributions have had shown mixed results. For e.g. Torgerson (1986) found no increased prevalence of somatisation disorder in monozygotic pairs. However, most recent studies have found that this disorder run in families and may have a heritable basis. It has also been observed that Somatisation Disorder is strongly linked in family and genetic studies to Antisocial Personality Disorder.

Jeffrey Gray and his associates (1985) have implicated neurophysiological factors in the development of somatisation disorder. A variety of neurophysiological evidence suggests a dysfunction in the brain circuit in somatisation disorder.

Psychological Theory – According to behavioral theory, somatisation disorder is a learned disorder. Individuals learn from significant others, and through role modeling, significant somatic symptoms that are characteristic of these disorders.

Sociocultual Theory - According to Widom (1984) and Colninger (1987) in the occurrence of somatisation disorder, social and cultural factors too play an important role. Gender roles encourage development of somatisation disorder in women in many cultures.

Treatment: Treatment of somatisation disorder is exceedingly difficult and there are no treatments with proven effectiveness that seem to cure the syndrome. Barlow et al (1992) have pointed out that somatisation disorder can be better managed by providing patients with the following:

- Providing reassurance.
- Reducing stress.
- Reducing the frequency of help-seeking behavior.

People with somatisation disorder do not voluntarily seek psychotherapy. They seek psychotherapy only on the insistence from their physician. The prognosis of this disorder is generally poor.

3. Pain Disorder: It is one variant of somatisation disorder in which instead of the multiple somatic complaints, individual demonstrates only one symptom, i.e. pain. The pain causes intense personal distress or impairment. The client is not faking pain. But the pain pertaining any of the bodily area do not have any medical base to it. In some cases of pain disorder there may be a diagnosable medical condition but the reported experience of pain is more than what can be normally seen. In such cases, there may have been a clear physical reason for pain at least initially, but psychological factors play a role in maintaining it.

An important feature of pain disorder is that the pain is real and it hurts regardless of the cause. Since it is a new and a separate category more research on it is needed to increase our understanding of this disorder.

People with pain disorder are likely to become dependent on substances, either illicit drugs or prescription medications, in their effort to alleviate their discomfort.

4. **Conversion Disorder:** Conversion disorder involves a translation of unacceptable drives or troubling conflicts in to bodily motor or sensory symptoms that suggest neurological or other kinds of medical conditions. According to Barlow and Durand (2000), conversion disorder can be defined as physical malfunctionng such as blindness or paralysis suggesting neurological impairment but with no organic pathology to account for it.

The essential feature of this disorder is an involuntary loss or alteration of a bodily function due to psychological conflict or need, causing the individual to feel seriously distressed or to be impaired in social, occupational or other important areas of life. It should be remembered that the person is not intentionally producing the symptoms. Clinicians cannot establish a medical basis for the symptoms and it appears that the person is converting the psychological conflict or need in to a physical problem.

This disorder was earlier called as hysteria and it involves a neurotic pattern in which symptoms of some physical malfunctioning or loss of control appear without any underlying organic pathology. In 1850s a French physician Paul Briquet systematically described and categorized various symptoms of hysteria based on his review of about 400 patients. Jean Martin Charcot used the technique of hypnosis to show that psychological factors played a role in the physical symptoms of hysteria. Pierre Janet and Hyppolyte Marie Bernheim did considerable work on

hysteria and enhanced the understanding about it. Sigmund Freud developed a radically different theory of hysteria. He called it as hysterical neurosis.

The symptoms of conversion disorder are multiple. All these symptoms of conversion disorder can be grouped into three broad categories. These are as follows:

A. ***Sensory Symptoms:*** Some of the sensory symptoms involved in conversion disorder are as follows:

- Anesthesia: loss of sensitivity.
- Analgesia: loss of sensitivity to pain.
- Hypesthesia: partial loss of sensitivity.
- Hyperaesthesia: excessive sensitivity.

Ironside and Bachelor (1945) found the following sensory symptoms among conversion disorders. These are blurred vision, photophobia, double vision, night blindness, jumping of print during attempts to read, etc. These researchers also found that the symptoms of each airman (whom they studied) were closely related to his performance duties. Night fliers were more subject to night blindness, while day fliers more often developed failing day vision.

B. ***Motor Symptoms:*** Some common motor symptoms seen in conversion disorder are as follows:

i. Paralysis: Such a behavior is usually confined to only one arm or leg and the loss of function is usually selective for e.g. writer's cramp, ticks (localized muscular twitches).

ii. Contractors: Such a behavior involves flexing a finger and toes or rigidity of the larger joints such as elbows and knees. Paralysis and contractors frequently lead to walking disturbances.

iii. Aphonia: is a most common speech disturbance. In this disorder an individual is able to talk only in whispers and mutism.

iv. Convulsion: This is an occasional motor symptom. However, people with hysterical convulsion show features or the usual characteristics of true epileptics.

C. ***Visceral Symptoms:*** Visceral conversion reactions also cover a wide range of symptoms, including headaches "lump in the throat" (formerly known as globus hystericus) and choking sensations, coughing spells, difficulty in breathing, cold and clammy extremities, bleaching, nausea, vomiting, and so on. Occasionally, persistent hiccoughing or sneezing occurs.

Accurate diagnosis of conversion disorder is a difficult task because conversion disorder can stimulate every known disease. Conversion disorder can be distinguished from organic disorder on the basis of the following points.

1. **La Belle Indifference:** This means that those who have conversion disorder are unconcerned about the long-range effects of their disabilities. Individuals with organic disorder are very much concerned about the long-range effect of their symptoms.

2. **Selective nature of the dysfunctioning:** Individuals who have conversion disorder are highly selective with respect to symptom pathology. For example, in conversion blindness, an individual does not usually bump into people or objects; "paralyzed", muscles can be used for some activities but not others; and controlled contractors usually disappear during sleep.

3. **Under hypnosis or narcosis:** The interesting fact that under hypnosis or narcosis (a sleep like state induced by drugs) the symptoms can usually be removed, shifted, or reinduced by the suggestion of the therapist. Similarly, if the individual is suddenly awakened from a sound sleep, he or she may be tricked into using a "paralyzed" limb.

In the development of a conversion disorder, the following chain of events typically occurs:

a. A desire to escape from some unpleasant situation.

b. A feeling or a wish to be sick in order to avoid the situation (this wish, however is suppressed as unfeasible or unworthy); and under additional or continued stress.

c. The appearance of the symptoms of some physical ailment. The individual sees no relation between the symptoms and the stress situation. The particular symptoms that occur are usually those of a previous illness or are copied from other sources, such as symptoms observed among relatives, seen on television, or read about in magazines.

Conversion disorders seem to stem from feelings of guilt and the necessity for self-punishment. Those who suffer from conversion disorder also suffer from a dissociative disorder. It is difficult to diagnose conversion disorder. Individuals suspected of conversion disorder must be given a thorough neurological examination in addition to follow up to determine whether a client's symptoms represent an underlying medical condition.

Conversion disorders were once relatively common in civilian and especially in military life. In World War I, conversion disorders were the most frequently diagnosed psychiatric syndrome among soldiers. It was also relatively common during World War II. Conversion disorders typically occurred under highly stressful combat conditions and involved

men who would ordinarily be considered stable. These disorders are common among soldiers exposed to combat.

Statistical details reveal that conversion disorder may occur in conjunction with other disorder particularly Somatization disorder.

Conversion disorder is a rare phenomenon affecting about 1 to 3 % of those referred for mental health care. The disorder often runs in families. It generally appears between the ages of 10 and 35 Years and is more frequently observed among women and in people with less education.

5. **Body Dysmorphic Disorder:** This is an imaginative disorder. This disorder is also called as "imagined ugliness" (Phillips, 1991). It is a somatoform disorder in which there is an excessive preoccupation with some imagined defect in appearance by some one who actually looks reasonably normal.

Individuals having this disorder have distorted negative concerns about their own body or some part of their body. They are preoccupied, almost to the point of being delusional, with the idea that a part of their body is ugly or defective. They are so preoccupied with this thought that experience intense distress and impairment in their personal, work and social life. They may be abnormally worried about the texture of their skin, too little facial hair, or they feel that there is deformity in the shape of their nose, mouth, jaw or eyebrow. Individuals with this disorder become fixated on mirrors. They often view themselves in a mirror to check as if any change is taking place in them. These individual may approach doctor for having corrective surgery and may undergo multiple cosmetic surgery. Preliminary research suggests that as many as 2% of all the patients who request plastic surgery may have this disorder. It has also been noted that surgery on people with Body Dysmorphic Disorder seldom produced the desired results and these people return for additional surgery on the same defect, or concentrate on some new defect. Recent research (1993) has revealed that preoccupation with imagined ugliness actually increased in people who had plastic surgery, dental procedures or special skin treatments for their perceived problems.

They may have "ideas of reference", i.e. when a two people are engrossed in their own conversation, a person with body dysmorphic disorder may think that they are gossiping or laughing about the defect. In a very severe case, individuals might have suicidal ideation as well as suicidal attempt and even actual suicide.

The prevalence of this disorder is hard to estimate since by its very nature it tends to be kept a secret. This disorder is more commonly found among females; however, in Japan more males experience this disorder. This disorder occurs in adolescence and peaks at the age of 18 or 19 years.

Causes: The etiology of this disorder is not well known. There is no data available to indicate whether this disorder run in families or whether there is biological or psychological predisposition to this disorder.

The pattern of comorbidity with other disorders does give us some indication about the etiology of this disorder. This disorder co- occurs with hypochondriasis, however it does not co-occur with other somatoform disorders, nor does it occur in family members of patients with other disorders. A disorder that has been frequently found to co-occur with Body Dysmorphic Disorder is the Obsessive Compulsive Disorder.

Body Dysmorphic Disorder has considerable degree of similarity with Obsessive Compulsive Disorder. Some important points are as follows:

i. Individuals with Body Dysmorphic Disorder often complain of persistent, intrusive and horrible thoughts about their appearances, and they engage in such compulsive behaviours as repeatedly looking in mirrors to check their physical features.

ii. Body Dysmorphic Disorder and Obsessive Compulsive Disorder also have approximately the same age of onset and run the same course.

iii. The treatment of these two disorders is also the same. Medically the drug that block the reuptake of serotonin, such as Clomipramine (Anafranil) and fluoxetine (Prozac) are useful in both these disorders. Similarly, exposure and response prevention, the type of cognitive behavior therapy that is effective with Obsessive Compulsive Disorder, has also been successful with Body Dysmorphic Disorder.

Treatment: Biological treatment includes use of SSRI to reduce the symptoms associated with depression and anxiety due to body dysmorphic disorder and other symptoms of BDD like distress, bodily preoccupation and compulsion.

Psychological treatment of this disorder consists of bringing about a cognitive change in the individual. CBT is used to challenge their irrational thought process about their body and making them understand that appearance is just one aspect of their total identity.

6. **Conditions Related to Somatoform Disorders:** Some important conditions related to somatoform disorders that we will discuss in this section are as follows:

i. **Malingering *(Faking)*:** It involves deliberately feigning the symptoms of physical illness or psychological disorder for an ulterior motive. A person may feign physical problem to either obtain financial gain, avoid punishment or to fulfill some other motive.

It is difficult to distinguish between malingering and any other type of somatoform disorders. In the former the person is consciously aware that he is faking a disorder, whereas, in conversion disorder the individual is not aware, it occurs unconsciously. Three important points that can help one to distinguish between other type of somatoform disorder and malingering are as follows:

- An individual with somatoform disorder is indifferent to the symptoms as compared to other disorders, i.e., they show "la belle indifference".
- Somatoform disorders are often precipitated by marked stress.
- Individuals with any type of somatoform disorders can usually function normally and that they seem to be really unaware either of this ability or of sensory input.

Psychologists have developed psychological instruments to determine whether a patient is malingering or not. One type of scale is the validity scales found in the MMPI or EPQ. Another instrument is the Validity Indicator Profile (Frederick, 1998) which consists of verbal and nonverbal tasks designed to determine whether a subject is responding legitimately or is trying to look impaired.

ii. **Factitious Disorder:** Factitious disorder falls between malingering and somatoform disorders. It refers deliberately faking to non-existent physical or psychological disorder for no apparent gain except possibly sympathy and attention. People fake symptoms or disorders, not for the purpose of any particular gain but because of an inner need top maintain a sick role. The symptoms may be either physical or psychological or they may be a combination of both. These individuals relish the notion of being ill and may go to great lengths either to appear ill or to make themselves ill

Munchausen's Syndrome: It is a type of factitious disorder (also known as factitious disorder imposed on self), named after Baron von Munchausen, a retired German cavalry officer known for his tall tales. Munchausen's Syndrome involves chronic cases in which the individual's whole life revolves with the pursuit of medical care. Munchausen syndrome is a type of factitious disorder, or mental illness, in which a person repeatedly acts as if he or she has a physical or mental disorder when, in truth, he or she has caused the symptoms. They are even willing to undergo painful or risky tests and operations in order to get the sympathy and special attention given to people who are truly ill. Munchausen syndrome is a mental illness associated with severe emotional difficulties.

Persons with Munchausen syndrome intentionally cause signs and symptoms of an illness or injury by inflicting medical harm to their body, often to the point of having to be hospitalized. Like some will secretively injure themselves to cause signs like blood in the urine or cyanosis of a limb. These persons are sometimes eager to undergo invasive medical interventions. They are also known to move from doctor to doctor, hospital to hospital, or town to town to find a new audience once they have exhausted the workup and treatment options available in a given medical setting. Persons with Munchausen syndrome may also make false claims about their accomplishments, credentials, relations to famous persons, etc.

Munchausen by proxy syndrome: A related condition, called Munchausen by proxy syndrome (factitious disorder imposed on another), refers to a caregiver who fakes symptoms by causing injury to someone else, often a child, and then wants to be with that person in a hospital or similar medical setting.

The exact cause of Munchausen syndrome is not known, but researchers believe both biological and psychological factors play a role in the development of this syndrome. Some theories suggest that a history of abuse or neglect as a child, or a history of frequent illnesses requiring hospitalization, might be factors associated with the development of this syndrome. Researchers also are studying the possible link with personality disorders, which are common in individuals with Munchausen syndrome.

Distinguishing Somatization, Pain, and Conversion Disorders from Malingering and Factitious Disorder

Earlier we mentioned that the DSM distinguishes between malingering and factitious disorder on the basis of the feigning person's apparent goals. It is sometimes possible to distinguish between a conversion (or other somatic symptom) disorder and malingering, or factitiously "sick-role-playing," with a fair degree of confidence, but in other cases it is more difficult to make the correct diagnosis. Persons engaged in malingering (for which there are no formal diagnostic criteria) and those who have factitious disorder are consciously perpetrating frauds by faking the symptoms of diseases or disabilities, and this fact is often reflected in their demeanor. In contrast, individuals with conversion disorders (as well as with other somatic symptom disorders) are not consciously producing their symptoms, feel themselves to be the "victims of their symptoms," and are very willing to discuss them, often in excruciating detail (Maldonado & Spiegel, 2001, p. 109). When inconsistencies in their behaviors are pointed out, they are usually unperturbed. Any secondary gains they experience are byproducts of the conversion symptoms themselves and are not involved in motivating the symptoms. On the other hand, persons who are feigning symptoms are inclined to be defensive, evasive, and suspicious when asked about them; they are usually reluctant to be examined and slow to talk about their symptoms lest the pretense be discovered. Should inconsistencies in their behaviors be pointed out, deliberate deceivers as a rule immediately become more defensive. Thus conversion disorder and deliberate faking of illness are considered distinct patterns.

7. **Theories and Treatment of Somatoform Disorder:** Causes and treatment of each of the somatoform disorder has been discussed above. However it is important to understand as to what motivates people to appear sick. Psychologists explain motives with the help of primary gain and secondary gain. Primary gain is avoidance of burdensome responsibilities because one is "disabled". Secondary gain is the sympathy and attention the sick person receives from other people.

Somatoform disorders can best be explained as interplay of biological factors, learning experiences, emotional factors and faulty cognitions. According to this integrative approach, childhood events set the stage for the later development of symptoms.

Most contemporary approaches to treating somatoform disorders involve exploring a person's need to play the sick role, evaluating the contribution of stress in the person's life and providing clients with cognitive behavioural techniques to control their symptoms. Medication can also be used in certain cases. For some patients with somatisation disorder, antidepressant medications can serve an important role in treatment.

8.3 PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITIONS

Bodily conditions can be adversely affected by psychological factors. For example, intense emotional stress can increase one's vulnerability to getting sick and can seem to slow down recovery from an ailment.

Psychological factors can influence physical health either indirectly, by changing behaviors that affect your health, such as eating, sleeping and socializing, or directly, by producing changes in your hormones and/or heart rate. Additionally, the mind can interact with the benefits of a medicine, reducing the effectiveness of a certain drug or worsening the negative symptoms associated with certain medical conditions. Therefore, you should monitor your thoughts towards your health and psychological well-being when coping with any medical condition.

The diagnosis of "Psychological Factors Affecting Medical Conditions", is given to those individuals who suffer from a recognized medical condition that is adversely affected by emotional factors that influence the course of the medical condition or interfere with treatment, create additional health risk or aggravate its symptoms. Emotional and psychological factors can aggravate any physical problem.

8.3.1 Theories and Treatment of Psychological Factors Affecting Medical Conditions:

Researchers who study the mind body relationship attempt to determine why some people develop physiological or medical problems, when their lives become busy, complicated or filled with pleasant events. Some important factors worth noting are as follows:

1. **Stress:** Stress refers to unpleasant emotional reaction a person has when he or she perceives an event as threatening. The emotional reaction to stress may include heightened physiological arousal due to increased reactivity of the sympathetic nervous system. The term stressor is used to refer to any event that leads to stress. Holmes and Rahe (1967) developed the Social Readjustment Rating Scale to assess life stress in terms of life change units. They identified individuals who are prone to stress and likely to develop physical problems and illnesses as a result of constant exposure to stress. In recent years cognitive model of stress has been put

forward which emphasizes the fact that it is not the event itself but the ways in which it is interpreted that determines its impact.

2. **Coping:** Another important factor that is related to Psychological Factors Affecting Medical Conditions is coping mechanisms that is used by an individual. Coping can be defined as active efforts to master, reduce or tolerate the demands created by stress. Coping is the process of managing taxing circumstance, expending effort to solve personal and interpersonal problems, and seeking to master, minimize, reduce, or tolerate stress. Coping can be defined as facing and finding effective means of overcoming problems and difficulties.

Coping consists of efforts, both action- oriented and intrapsychic, to manage (i.e. master, tolerate, reduce, minimize) environmental and internal demands and conflicts among them". Coping strategies are also defined as actions that people take to master, tolerate, reduce or minimize the effects of stressors and they can include both behavioural and psychological strategies. Coping efforts can be either adaptive or effective (healthy) or unadaptive and ineffective (unhealthy). Effective methods of coping with stress help to remove the source of stress or control our reactions to it. Ineffective coping techniques are those techniques that can come in the way of our adaptation or that can create more problems for us in the long run.

There are two types of coping:

Problem Focused Coping: It is a type of coping that is basically concerned with alleviating the problem, trying to change the situation so that the problem is eliminated or to avoid the occurrence of the same or similar problem in the future. Problem focused coping is concerned with direct efforts to deal with, understand and overcome current causes of stress. Problem focused coping is generally superior in reducing the adverse effects of stress.

Emotion Focused Coping: It is a form of coping an individual makes attempt to manage and deal with negative emotions and feelings that may develop due to the stressful situation. Emotion focused coping also involves learning to handle one's emotions in an appropriate manner so that we can face and adjust to situations where we find the problem to be uncontrollable. Emotion focused coping centers around efforts to reduce or manage the emotional distress resulting from stress and often involves strategies such as refusing to recognize painful realities concluding oneself that things could be worse, masking the stress with alcohol or other drugs.

3. Stress and the Immune System: Immune system is an important system of our body that consists of cells, organs and chemicals in the body that responds to attacks on the body from diseases and injuries. Immune system protects us from onslaught. Immune system is the body's means of identifying and eliminating any foreign materials (e.g. bacteria, parasites or even transplanted organs, etc.,) that enter our body.

A new subject which studies how stress influences an individual's body immune system is called as ***Psychoneuroimmunology.*** It is more specifically defined as the study of the effects of psychological factors such as stress, emotions, thoughts and behaviour on the immune system. The field of *psychoneuroimmunology* focuses on the relationship between psychological influences (such as stress), the nervous system, and the immune system.

Stress appears to depress immune function in two main ways. First, when people experience stress, they more often engage in behaviors that have adverse effects on their health: cigarette smoking, using more alcohol or drugs, sleeping less, exercising less, and eating poorly. In addition, stress may alter the immune system directly through hormonal changes. Research indicates that glucocorticoids—hormones that are secreted by the adrenal glands during the stress response—actively suppress the body's immune system.

Two important points with respect to immune system and stress that are worth noting:

- Stress triggers the same response in the immune system that infection triggers.
- Positive effects of stress on the immune system only seem to work when the stress is not continuous and a chronic condition. Prolonged stress has detrimental effect on our immune system functioning.

A large number of research studies have revealed that stress considerably influences the immune system's abilities to defend the body. A large number of studies, both laboratory as well as field, have been carried out to demonstrate how immune system functioning is influenced by stress and related variables.

4. **Emotional Expression*:*** When emotional expression is inhibited, health problems arise. Research studies have demonstrated that expressing emotions is beneficial to one's physical health and mental well-being. Inability to express one's emotions appropriately– either emotional outburst or its suppression is unhealthy and can lead to wide variety of problems – both physical as well as psychological. Research studies by James Pennebaker (1997) have observed that actively confronting emotions that arise from an upsetting or a traumatic event can have long-term health benefits. For example writing about a distressing experience facilitates coping and contributes to physical health.

5. Personality Style*:* One's personality style is also closely associated with development of physical and mental health problems. One type of personality style that has been extensively studied is the "Type A" personality pattern. Type A people who are impatient, irritable, and aggressive and are always in a pressure to get something done is more prone to develop cardiovascular disorders such as heart attacks. Type

A individuals react explosively to stressful situations. The sympathetic system of Type A individual is always alert and at its peak. Type A individuals with high levels of hostility, commonly engage in unhealthy behaviours, such as smoking and consuming large amounts of alcohol.

A new personality type that has been identified by some researchers (Sher, 2005, Pedersen and Denollet, 2003) is the "Type D" (Distressed) personality. These individual are at increased risk for heart disease due to their tendency to experience negative emotions while inhibiting the expression of these emotions when they are in social situations. These individual also have a reduced quality of life and they benefit less from medical treatment.

Sociocultural factors: Sociocultural factors play an important role in causing and aggravating stress-related disorders. Living in a harsh social environment threatens a person's safety, interferes with the establishment of social relationships and involves a high level of conflict, abuse and violence. Chronic exposure to stressful environment can lead to higher cortisol levels resulting in disturbances in the immune system.

Treatment: Treatment of problems associated with the condition called "Psychological factors affecting medical conditions" requires a multidimensional approach. Medical treatment alone is insufficient. People must be taught to change their lifestyle, develop certain behaviours and changes in attitude that can go a long way in altering their lifestyle and consequently gain control over their health and problems. One interdisciplinary approach that has been developed is called as ***behavioural medicine***, which makes use of behavioural techniques and learning approaches. In this approach they are taught to learn about unhealthy bodily processes and to take action to avoid or modify circumstances in which they are likely to become sick. Individuals learn to monitor early signs of mounting tension and to initiate steps to avert the further development of pain.

8.4 SUMMARY

In this unit we have discussed the concept of somatoform disorders and the various types of somatoform disorders which include conversion disorder, Somatisation disorder and related conditions, Pain disorder, Body dysmorphic disorder and Hypochondriasis. Clinical symptoms, causes and treatment of each of these disorders were briefly explained.

Three conditions related to Somatoform Disorders were discussed in brief. These include: Malingering *(Faking)*, Factitious Disorder and Munchausen's Syndrome. Theories and Treatment of somatoform disorders were also discussed in brief.

Psychological Factors Affecting Medical Conditions as well as its theories and treatment were discussed.

8.5 QUESTIONS

Q1. What are somatoform disorders.

Q2. Write short notes on the following:

a. Conversion disorder

b. Somatisation Disorder and Related Conditions

c. Pain Disorder Body Dysmorphic Disorder:

d. Hypochondriasis:

e. Conditions Related to Somatoform Disorders

f. Distinguishing Somatic Disorders from Malingering and Factitious Disorder

g. Theories and Treatment of Somatoform Disorder

Q3. Discuss the Theories and Treatment of Psychological Factors Affecting Medical Conditions:

8.6 REFERENCES

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