PSYCHOLOGICAL DISORDERS

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After reading this chapter, you would be able to:

- understand the basic issues in abnormal behaviour and the criteria used to identify such behaviours,
- appreciate the factors which cause abnormal behaviour,
- explain the different models of abnormal behaviour, and
- describe the major psychological disorders.

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Introduction

You must have come across people who are unhappy, troubled and dissatisfied. Their minds and hearts are filled with sorrow, unrest and tension and they feel that they are unable to move ahead in their lives; they feel life is a painful, uphill struggle, sometimes not worth living. Famous analytical psychologist Carl Jung has quite remarkably said, "How can I be substantial without casting a shadow? I must have a dark side, too, if I am to be whole and by becoming conscious of my shadow, I remember once more that I am a human being like any other". At times, some of you may have felt nervous before an important examination, tense and concerned about your future career or anxious when someone close to you was unwell. All of us face major problems at some point of our lives. However, some people have an extreme reaction to the problems and stresses of life. In this chapter, we will try to understand what goes wrong when people develop psychological problems, what are the causes and factors which lead to abnormal behaviour, and what are the various signs and symptoms associated with different types of psychological disorders?

The study of psychological disorders has intrigued and mystified all cultures for more than 2,500 years. Psychological disorders or mental disorders (as they are commonly referred to), like anything unusual may make us uncomfortable and even a little frightened. Unhappiness, discomfort, anxiety, and unrealised potential are seen all over the world. These failures in living are due mainly to failures in adaptation to life challenges. As you must have studied in the previous chapters, adaptation refers to the person's ability to modify her/his behaviour in response to changing environmental requirements. When the behaviour cannot be modified according to the needs of the situation, it is said to be maladaptive. Abnormal Psychology is the area within psychology that is focused on maladaptive behaviour – its causes, consequences, and treatment.

CONCEPTS OF ABNORMALITY AND PSYCHOLOGICAL DISORDERS

Although many definitions of abnormality have been used over the years, none has won universal acceptance. Still, most definitions have certain common features, often called the 'four Ds': **deviance**, **distress**, **dysfunction** and **danger**. That is, psychological disorders are **deviant** (different, extreme, unusual, even bizarre), **distressing** (unpleasant and upsetting to the person and to others), **dysfunctional** (interfering with the person's ability to carry out daily activities in a constructive way), and possibly **dangerous** (to the person or to others).

This definition is a useful starting point from which we can explore psychological abnormality. Since the word 'abnormal' literally means "away from the normal", it implies deviation from some clearly defined norms or standards. In psychology, we have no 'ideal model' or even 'normal model' of human behaviour to use as a base for comparison. Various approaches have been used in distinguishing between normal and abnormal behaviours. From these approaches, there emerge two basic and conflicting views :

The first approach views abnormal behaviour as a **deviation from social norms**. Many psychologists have stated that 'abnormal' is simply a label that is given to a behaviour which is deviant from social expectations. Abnormal behaviour, thoughts and emotions are those that differ markedly from a society's ideas of proper functioning. Each society has **norms**, which are stated or unstated rules for proper conduct. Behaviours, thoughts and emotions that break societal norms are called abnormal. A society's norms grow from its particular **culture** — its history, values, institutions, habits, skills, technology, and arts. Thus, a society whose culture values competition and assertiveness may accept aggressive behaviour, whereas one that emphasises cooperation and family values (such as in India) may consider aggressive behaviour as unacceptable or even abnormal. A society's values may change over time, causing its views of what is psychologically abnormal to change as well. Serious questions have been raised about this definition. It is based on the assumption that socially accepted behaviour is not abnormal, and that normality is nothing more than conformity to social norms.

The second approach views abnormal behaviour as **maladaptive**. Many psychologists believe that the best criterion for determining the normality of behaviour is not whether society accepts it but whether it fosters the well-being of the individual and eventually of the group to which s/he belongs. **Well-being** is not simply maintenance and survival but also includes growth and fulfilment, i.e. the actualisation of potential, which you must have studied in Maslow's need hierarchy theory. According to this criterion, conforming behaviour can be seen as abnormal if it is maladaptive, i.e. if it interferes with optimal functioning and growth. For example, a student in the class prefers to remain silent even when s/he has questions in her/his mind. Describing behaviour as maladaptive implies that a problem exists; it also suggests that vulnerability in the individual, inability to cope, or exceptional stress in the environment have led to problems in life.

If you talk to people around, you will see that they have vague ideas about psychological disorders that are characterised by superstition, ignorance and fear. Again it is commonly believed that psychological disorder is something to be ashamed of. The **stigma** attached to mental illness means that people are hesitant to consult a doctor or psychologist because they are ashamed of their problems. Actually, psychological disorder which indicates a failure in adaptation should be viewed as any other illness.

Activity 4.1

Talk to three people: one of your friends, a friend of your parents, and your neighbour.

Ask them if they have seen someone who is mentally ill or who has mental problems. Try to understand why they find this behaviour abnormal, what are the signs and symptoms shown by this person, what caused this behaviour and can this person be helped.

Share the information you elicited in class and see if there are some common features, which make us label others as 'abnormal'.

Historical Background

To understand psychological disorders, we would require a brief historical account of how these disorders have been viewed over the ages. When we study the history of abnormal psychology, we find that certain theories have occurred over and over again.

One ancient theory that is still encountered today holds that abnormal behaviour can be explained by the

operation of **supernatural** and **magical forces** such as evil spirits (*bhoot-pret*), or the devil (*shaitan*). **Exorcism**, i.e. removing the evil that resides in the individual through countermagic and prayer, is still commonly used. In many societies, the *shaman*, or medicine man (*ojha*) is a person who is believed to have contact with supernatural forces and is the medium through which spirits communicate with human beings. Through the *shaman*, an afflicted person can learn which spirits are responsible for her/his problems and what needs to be done to appease them.

A recurring theme in the history of abnormal psychology is the belief that individuals behave strangely because their bodies and their brains are not working properly. This is the **biological** or **organic approach**. In the modern era, there is evidence that body and brain processes have been linked to many types of maladaptive behaviour. For certain types of disorders, correcting these defective biological processes results in improved functioning.

Another approach is the **psychological approach**. According to this point of view, psychological problems are caused by inadequacies in the way an individual thinks, feels, or perceives the world.

All three of these perspectives — supernatural, biological or organic, and psychological — have recurred throughout the history of Western civilisation. In the ancient Western world, it was philosopher-physicians of ancient Greece such as Hippocrates, Socrates, and in particular Plato who developed the **organismic approach** and viewed disturbed behaviour as arising out of conflicts between emotion and reason. Galen elaborated on the role of the **four humours** in personal character and temperament. According to him, the material world was made up of four elements, viz. earth, air, fire, and water which combined to form four essential body fluids, viz. blood, black bile, yellow bile, and phlegm. Each of these fluids was seen to be responsible for a different temperament. Imbalances among the humours were believed to cause various disorders. This is similar to the Indian notion of the three *doshas* of *vata, pitta* and *kapha* which were mentioned in the *Atharva Veda* and *Ayurvedic* texts. You have already read about it in Chapter 2.

In the **Middle Ages**, demonology and superstition gained renewed importance in the explanation of abnormal behaviour. Demonology related to a belief that people with mental problems were evil and there are numerous instances of 'witch-hunts' during this period. During the early Middle Ages, the Christian spirit of charity prevailed and St. Augustine wrote extensively about feelings, mental anguish and conflict. This laid the groundwork for modern psychodynamic theories of abnormal behaviour.

The **Renaissance Period** was marked by increased humanism and curiosity about behaviour. Johann Weyer emphasised psychological conflict and disturbed interpersonal relationships as causes of psychological disorders. He also insisted that 'witches' were mentally disturbed and required medical, not theological, treatment.

The seventeenth and eighteenth centuries were known as the **Age of Reason and Enlightenment**, as the scientific method replaced faith and dogma as ways of understanding abnormal behaviour. The growth of a scientific attitude towards psychological disorders in the eighteenth century contributed to the **Reform Movement** and to increased compassion for people who suffered from these disorders. Reforms of asylums were initiated in both Europe and America. One aspect of the reform movement was the new inclination for **deinstitutionalisation** which placed emphasis on providing

community care for recovered mentally ill individuals.

In recent years, there has been a convergence of these approaches, which has resulted in an **interactional**, or **bio-psycho-social approach**. From this perspective, all three factors, i.e. biological, psychological and social play important roles in influencing the expression and outcome of psychological disorders.

Classification of Psychological Disorders

In order to understand psychological disorders, we need to begin by classifying them. A classification of such disorders consists of a list of categories of specific psychological disorders grouped into various classes on the basis of some shared characteristics. Classifications are useful because they enable users like psychologists, psychiatrists and social workers to communicate with each other about the disorder and help in understanding the causes of psychological disorders and the processes involved in their development and maintenance.

The American Psychiatric Association (APA) has published an official manual describing and classifying various kinds of psychological disorders. The current version of it, the **Diagnostic and Statistical Manual of Mental Disorders**, IV Edition *(DSM-IV)*, evaluates the patient on five axes or dimensions rather than just one broad aspect of 'mental disorder'. These dimensions relate to biological, psychological, social and other aspects.

The classification scheme officially used in India and elsewhere is the tenth revision of the **International Classification of Diseases** *(ICD-10)*, which is known as the **ICD-10 Classification of Behavioural and Mental Disorders**. It was prepared by the World Health Organisation (WHO). For each disorder, a description of the main clinical features or symptoms, and of other associated features including diagnostic guidelines is provided in this scheme.

Activity 4.2

Certain behaviours like eating sand would be considered abnormal. But not if it was done after being stranded on a beach in a plane crash.

Listed below are 'abnormal' behaviours followed by situations where the behaviours might be considered normal.

(i) talking to yourself - you are praying.

(ii) standing in the middle of the street waving your arms wildly - you are a traffic policeman.

Think about it and list similar examples.

Factors Underlying Abnormal Behaviour

In order to understand something as complex as abnormal behaviour, psychologists use different approaches. Each approach in use today emphasises a different aspect of human behaviour, and explains and treats abnormality in line with that aspect. These approaches also emphasise the role of different factors such as biological, psychological and interpersonal, and socio-cultural factors. We will examine some of the approaches which are currently being used to explain abnormal behaviour.

Biological factors influence all aspects of our behaviour. A wide range of biological factors such as faulty genes, endocrine imbalances, malnutrition, injuries and other conditions may interfere with normal development and functioning of the human body. These factors may be potential causes of abnormal behaviour. We have already come across the biological model. According to this model, abnormal

behaviour has a biochemical or physiological basis. Biological researchers have found that psychological disorders are often related to problems in the transmission of messages from one neuron to another. You have studied in Class XI, that a tiny space called synapse separates one neuron from the next, and the message must move across that space. When an electrical impulse reaches a neuron's ending, the nerve ending is stimulated to release a chemical, called a **neuro-transmitter**. Studies indicate that abnormal activity by certain neuro-transmitters can lead to specific psychological disorders. Anxiety disorders have been linked to low activity of the neurotransmitter *gamma aminobutyric acid* (GABA), schizophrenia to excess activity of *dopamine,* and depression to low activity of *serotonin*.

Genetic factors have been linked to mood disorders, schizophrenia, mental retardation and other psychological disorders. Researchers have not, however, been able to identify the specific genes that are the culprits. It appears that in most cases, no single gene is responsible for a particular behaviour or a psychological disorder. Infact, many genes combine to help bring about our various behaviours and emotional reactions, both functional and dysfunctional. Although there is sound evidence to believe that genetic/ biochemical factors are involved in mental disorders as diverse as schizophrenia, depression, anxiety, etc. and biology alone cannot account for most mental disorders.

There are several **psychological models** which provide a psychological explanation of mental disorders. These models maintain that psychological and interpersonal factors have a significant role to play in abnormal behaviour. These factors include maternal deprivation (separation from the mother, or lack of warmth and stimulation during early years of life), faulty parent-child relationships (rejection, overprotection, over-permissiveness, faulty discipline, etc.), maladaptive family structures (inadequate or disturbed family), and severe stress.

The psychological models include the psychodynamic, behavioural, cognitive, and humanistic-existential models. The **psychodynamic model** is the oldest and most famous of the modern psychological models. You have already read about this model in Chapter 2 on Self and Personality. Psychodynamic theorists believe that behaviour, whether normal or abnormal, is determined by psychological forces within the person of which s/he is not consciously aware. These internal forces are considered dynamic, i.e. they interact with one another and their interaction gives shape to behaviour, thoughts and emotions. Abnormal symptoms are viewed as the result of conflicts between these forces. This model was first formulated by Freud who believed that three central forces shape personality — instinctual needs, drives and impulses *(id)*, rational thinking *(ego)*, and moral standards *(superego)*. Freud stated that abnormal behaviour is a symbolic expression of unconscious mental conflicts that can be generally traced to early childhood or infancy.

Another model that emphasises the role of psychological factors is the **behavioural model**. This model states that both normal and abnormal behaviours are learned and psychological disorders are the result of learning maladaptive ways of behaving. The model concentrates on behaviours that are learned through conditioning and proposes that what has been learned can be unlearned. Learning can take place by *classical conditioning* (temporal association in which two events repeatedly occur close together in time), *operant conditioning* (behaviour is followed by a reward), and *social learning* (learning by imitating

others' behaviour). These three types of conditioning account for behaviour, whether adaptive or maladaptive.

Psychological factors are also emphasised by the **cognitive model**. This model states that abnormal functioning can result from cognitive problems. People may hold assumptions and attitudes about themselves that are irrational and inaccurate. People may also repeatedly think in illogical ways and make overgeneralisations, that is, they may draw broad, negative conclusions on the basis of a single insignificant event.

Another psychological model is the **humanistic-existential model** which focuses on broader aspects of human existence. Humanists believe that human beings are born with a natural tendency to be friendly, cooperative and constructive, and are driven to self-actualise, i.e. to fulfil this potential for goodness and growth. Existentialists believe that from birth we have total freedom to give meaning to our existence or to avoid that responsibility. Those who shirk from this responsibility would live empty, inauthentic, and dysfunctional lives.

In addition to the biological and psychosocial factors, socio-cultural factors such as war and violence, group prejudice and discrimination, economic and employment problems, and rapid social change, put stress on most of us and can also lead to psychological problems in some individuals. According to the **socio-cultural model**, abnormal behaviour is best understood in light of the social and cultural forces that influence an individual. As behaviour is shaped by societal forces, factors such as family structure and communication, social networks, societal conditions, and societal labels and roles become more important. It has been found that certain family systems are likely to produce abnormal functioning in individual members. Some families have an enmeshed structure in which the members are overinvolved in each other's activities, thoughts, and feelings. Children from this kind of family may have difficulty in becoming independent in life. The broader social networks in which people operate include their social and professional relationships. Studies have shown that people who are isolated and lack social support, i.e. strong and fulfilling interpersonal relationships in their lives are likely to become more depressed and remain depressed longer than those who have good friendships. Socio-cultural theorists also believe that abnormal functioning is influenced by the societal labels and roles assigned to troubled people. When people break the norms of their society, they are called deviant and 'mentally ill'. Such labels tend to stick so that the person may be viewed as 'crazy' and encouraged to act sick. The person gradually learns to accept and play the sick role, and functions in a disturbed manner.

In addition to these models, one of the most widely accepted explanations of abnormal behaviour has been provided by the **diathesis-stress model**. This model states that psychological disorders develop when a diathesis *(biological predisposition to the disorder)* is set off by a stressful situation. This model has three components. The first is the diathesis or the presence of some biological aberration which may be inherited. The second component is that the diathesis may carry a vulnerability to develop a psychological disorder. This means that the person is 'at risk' or 'predisposed' to develop the disorder. The third component is the presence of pathogenic stressors, i.e. factors/stressors that may lead to psychopathology. If such "at risk" persons

are exposed to these stressors, their predisposition may actually evolve into a disorder. This model has been applied to several disorders including anxiety, depression, and schizophrenia.

Major Psychological Disorders

Anxiety Disorders

One day while driving home, Deb felt his heart beating rapidly, he started sweating profusely, and even felt short of breath. He was so scared that he stopped the car and stepped out. In the next few months, these attacks increased and now he was hesitant to drive for fear of being caught in traffic during an attack. Deb started feeling that he had gone crazy and would die. Soon he remained indoors and refused to move out of the house.

We experience anxiety when we are waiting to take an examination, or to visit a dentist, or even to give a solo performance. This is normal and expected and even motivates us to do our task well. On the other hand, high levels of anxiety that are distressing and interfere with effective functioning indicate the presence of an anxiety disorder — the most common category of psychological disorders.

Everyone has worries and fears. The term **anxiety** is usually defined as a diffuse, vague, very unpleasant feeling of fear and apprehension. The anxious individual also shows combinations of the following symptoms: rapid heart rate, shortness of breath, diarrhoea, loss of appetite, fainting, dizziness, sweating, sleeplessness, frequent urination and tremors. There are many types of anxiety disorders (see Table 4.2). They include **generalised anxiety disorder**, which consists of prolonged, vague, unexplained and intense fears that are not attached to any particular object. The symptoms include worry and apprehensive feelings about the future; hypervigilance, which involves constantly scanning the environment for dangers. It is marked by motor tension, as a result of which the person is unable to relax, is restless, and visibly shaky and tense.

Another type of anxiety disorder is **panic disorder**, which consists of recurrent anxiety attacks in which the person experiences intense terror. A panic attack denotes an abrupt surge of intense anxiety rising to a peak when thoughts of a particular stimuli are present. Such thoughts occur in an unpredictable manner. The clinical features include shortness of breath, dizziness, trembling, palpitations, choking, nausea, chest pain or discomfort, fear of going crazy, losing control or dying.

You might have met or heard of someone who was afraid to travel in a lift or climb to the tenth floor of a building, or refused to enter a room if s/he saw a lizard. You may have also felt it yourself or seen a friend unable to speak a word of a well-memorised and rehearsed speech before an audience. These kinds of fears are termed as **phobias**. People who have phobias have irrational fears related to specific objects, people, or situations. Phobias often develop gradually or begin with a generalised anxiety disorder. Phobias can be grouped into three main types, i.e. *specific phobias, social phobias,* and *agoraphobia.*

Specific phobias are the most commonly occurring type of phobia. This group includes irrational fears such as intense fear of a certain type of animal, or of being in an enclosed space. Intense and incapacitating fear and embarrassment when dealing with others characterises **social phobias**. **Agoraphobia** is the term used when people develop a fear of entering unfamiliar situations. Many

agoraphobics are afraid of leaving their home. So their ability to carry out normal life activities is severely limited.

Have you ever noticed someone washing their hands everytime they touch something, or washing even things like coins, or stepping only within the patterns on the floor or road while walking? People affected by **obsessive-compulsive disorder** are unable to control their preoccupation with specific ideas or are unable to prevent themselves from repeatedly carrying out a particular act or series of acts that affect their ability to carry out normal activities. **Obsessive behaviour** is the inability to stop thinking about a particular idea or topic. The person involved, often finds these thoughts to be unpleasant and shameful. **Compulsive behaviour** is the need to perform certain behaviours over and over again. Many compulsions deal with counting, ordering, checking, touching and washing.

Very often people who have been caught in a natural disaster (such as tsunami) or have been victims of bomb blasts by terrorists, or been in a serious accident or in a war-related situation, experience **post-traumatic stress disorder** (PTSD). PTSD symptoms vary widely but may include recurrent dreams, flashbacks, impaired concentration, and emotional numbing.

Activity 4.3

Recall how you felt before your Class X Board examination. How did you feel when the examinations were drawing near (one month before the examinations; one week before the examinations; on the day of the examination, and when you were entering the examination hall)? Also try to recollect what you felt when you were awaiting your results. Write down your experiences in terms of bodily symptoms (e.g. 'butterflies in the stomach', clammy hands, excessive perspiration, etc.) as well as mental experiences (e.g. tension, worry, pressure, etc.). Compare your symptoms with those of your classmates and classify them as Mild, Moderate, or Severe.

Somatoform Disorders

These are conditions in which there are physical symptoms in the absence of a physical disease. In somatoform disorders, the individual has psychological difficulties and complains of physical symptoms, for which there is no biological cause. Somatoform disorders include *pain disorders*, *somatisation disorders*, *conversion disorders*, and *hypochondriasis*.

Table 4.1 : Major Anxiety Disorders and their Symptoms

1. *Generalised Anxiety Disorder* : prolonged, vague, unexplained and intense fears that have no object, accompanied by hypervigilance and motor tension.
2. *Panic Disorder* : frequent anxiety attacks characterised by feelings of intense terror and dread; unpredictable 'panic attacks' along with physiological symptoms like breathlessness, palpitations, trembling, dizziness, and a sense of loosing control or even dying.
3. *Phobias* : irrational fears related to specific objects, interactions with others, and unfamiliar situations.
4. *Obsessive-compulsive Disorder* : being preoccupied with certain thoughts that are viewed by the person to be embarrassing or shameful, and being unable to check the impulse to repeatedly carry out certain acts like checking, washing, counting, etc.
5. *Post-traumatic Stress Disorder (PTSD)* : recurrent dreams, flashbacks, impaired concentration, and emotional numbing followed by a traumatic or stressful event like a natural disaster, serious accident, etc.

Pain disorders involve reports of extreme and incapacitating pain, either without any identifiable biological symptoms or greatly in excess of what might be expected to accompany biological symptoms. How people interpret pain influences their overall adjustment. Some pain sufferers can learn to use active coping, i.e. remaining active and ignoring the pain. Others engage in passive coping, which leads to reduced activity and social withdrawal.

Patients with **somatisation disorders** have multiple and recurrent or chronic bodily complaints. These complaints are likely to be presented in a dramatic and exaggerated way. Common complaints are headaches, fatigue, heart palpitations, fainting spells, vomiting, and allergies. Patients with this disorder believe that they are sick, provide long and detailed histories of their illness, and take large quantities of medicine.

The symptoms of **conversion disorders** are the reported loss of part or all of some basic body functions. Paralysis, blindness, deafness and difficulty in walking are generally among the symptoms reported. These symptoms often occur after a stressful experience and may be quite sudden.

Hypochondriasis is diagnosed if a person has a persistent belief that s/he has a serious illness, despite medical reassurance, lack of physical findings, and failure to develop the disease. Hypochondriacs have an obsessive preoccupation and concern with the condition of their bodily organs, and they continually worry about their health.

Dissociative Disorders

Dissociation can be viewed as severance of the connections between ideas and emotions. Dissociation involves feelings of unreality, estrangement, depersonalisation, and sometimes a loss or shift of identity. Sudden temporary alterations of consciousness that blot out painful experiences are a defining characteristic of **dissociative disorders**. Four conditions are included in this group: *dissociative amnesia, dissociative fugue, dissociative identity disorder*, and *depersonalisation*. Salient features of somatoform and dissociative disorders are given in Box 4.1.

Box 4.1

Salient Features of Somatoform and Dissociative Disorders

Somatoform Disorders	*Dissociative Disorders*
Hypochondriasis : A person interprets insignificant symptoms as signs of a serious illness despite repeated medical evaluation that point to no pathology/disease.	*Dissociative amnesia* : The person is unable to recall important, personal information often related to a stressful and traumatic report. The extent of forgetting is beyond normal.
Somatisation : A person exhibits vague and recurring physical/bodily symptoms such as pain, acidity, etc., without any organic cause.	*Dissociative fugue* : The person suffers from a rare disorder that combines amnesia with travelling away from a stressful environment.
Conversion : The person suffers from a loss or impairment of motor or sensory function (e.g., paralysis, blindness, etc.) that has no physical cause but may be a response to stress and psychological problems.	*Dissociative identity (multiple personality)* : The person exhibits two or more separate and contrasting personalities associated with a history of physical abuse.

Dissociative amnesia is characterised by extensive but selective memory loss that has no known organic cause (e.g., head injury). Some people cannot remember anything about their past. Others can no longer recall specific events, people, places, or objects, while their memory for other events remains intact. This disorder is often associated with an overwhelming stress.

Dissociative fugue has, as its essential feature, an unexpected travel away from home and workplace, the assumption of a new identity, and the inability to recall the previous identity. The fugue usually ends when the person suddenly 'wakes up' with no memory of the events that occurred during the fugue.

Dissociative identity disorder, often referred to as *multiple personality*, is the most dramatic of the dissociative disorders. It is often associated with traumatic experiences in childhood. In this disorder, the person assumes alternate personalities that may or may not be aware of each other.

Depersonalisation involves a dreamlike state in which the person has a sense of being separated both from self and from reality. In depersonalisation, there is a change of self-perception, and the person's sense of reality is temporarily lost or changed.

Mood Disorders

Mood disorders are characterised by disturbances in mood or prolonged emotional state. The most common mood disorder is **depression**, which covers a variety of negative moods and behavioural changes. Depression can refer to a *symptom* or a *disorder*. In day-to-day life, we often use the term depression to refer to normal feelings after a significant loss, such as the break-up of a relationship, or the failure to attain a significant goal. The main types of mood disorders include *depressive, manic* and *bipolar disorders.* **Major depressive disorder** is defined as a period of depressed mood and/or loss of interest or pleasure in most activities, together with other symptoms which may include change in body weight, constant sleep problems, tiredness, inability to think clearly, agitation, greatly slowed behaviour, and thoughts of death and suicide. Other symptoms include excessive guilt or feelings of worthlessness.

Factors Predisposing towards Depression : Genetic make-up, or heredity is an important risk factor for major depression and bipolar disorders. Age is also a risk factor. For instance, women are particularly at risk during young adulthood, while for men the risk is highest in early middle age. Similarly gender also plays a great role in this differential risk addition. For example, women in comparison to men are more likely to report a depressive disorder. Other risk factors are experiencing negative life events and lack of social support.

Another less common mood disorder is **mania**. People suffering from mania become euphoric ('high'), extremely active, excessively talkative, and easily distractible. Manic episodes rarely appear by themselves; they usually alternate with depression. Such a mood disorder, in which both mania and depression are alternately present, is sometimes interrupted by periods of normal mood. This is known as **bipolar mood disorder**. Bipolar mood disorders were earlier referred to as manic-depressive disorders.

Among the mood disorders, the lifetime risk of a suicide attempt is highest in case of bipolar mood disorders. Several risk factors in addition to mental health status of a person predict the likelihood of suicide. These include age, gender, ethnicity, or race and recent occurrence of

serious life events. Teenagers and young adults are as much at high risk for suicide, as those who are over 70 years. Gender is also an influencing factor, i.e. men have a higher rate of contemplated suicide than women. Other factors that affect suicide rates are cultural attitudes toward suicide. In Japan, for instance, suicide is the culturally appropriate way to deal with feeling of shame and disgrace. Negative expectations, hopelessness, setting unrealistically high standards, and being over-critical in self-evaluation are important themes for those who have suicidal preoccupations.

Suicide can be prevented by being alert to some of the symptoms which include :

- changes in eating and sleeping habits
- withdrawal from friends, family and regular activities
- violent actions, rebellious behaviour, running away
- drug and alcohol abuse
- marked personality change
- persistent boredom
- difficulty in concentration
- complaints about physical symptoms, and
- loss of interest in pleasurable activities.

However, seeking timely help from a professional counsellor/psychologist can help to prevent the likelihood of suicide.

Activity 4.4

You may have got some bad news in the family (for example, death of a close relative) or watched your favourite character dying in a film or got less marks than you hoped for or lost your pet. This may have made you sad and depressed and hopeless about the future. Try and recall such incidents in your life. List the situations that led to this reaction. Compare your list and reactions with those of others in class.

Schizophrenic Disorders

Schizophrenia is the descriptive term for a group of psychotic disorders in which personal, social and occupational functioning deteriorate as a result of disturbed thought processes, strange perceptions, unusual emotional states, and motor abnormalities. It is a debilitating disorder. The social and psychological costs of schizophrenia are tremendous, both to patients as well as to their families and society.

Symptoms of Schizophrenia

The symptoms of schizophrenia can be grouped into three categories, viz. **positive symptoms** (i.e. excesses of thought, emotion, and behaviour), **negative symptoms** (i.e. deficits of thought, emotion, and behaviour), and **psychomotor symptoms**.

Positive symptoms are 'pathological excesses' or 'bizarre additions' to a person's behaviour. Delusions, disorganised thinking and speech, heightened perception and hallucinations, and inappropriate affect are the ones most often found in schizophrenia.

Many people with schizophrenia develop **delusions**. A delusion is a false belief that is firmly held on inadequate grounds. It is not affected by rational argument, and has no basis in reality. **Delusions of persecution** are the most common in schizophrenia. People with this delusion believe that they are being plotted against, spied on, slandered, threatened, attacked or deliberately victimised. People with schizophrenia may also experience **delusions of reference** in which they attach special and personal meaning to the actions of others or to objects and events. In **delusions of grandeur**, people believe themselves to be specially empowered persons and in **delusions of control**, they

believe that their feelings, thoughts and actions are controlled by others.

People with schizophrenia may not be able to think logically and may speak in peculiar ways. These **formal thought disorders** can make communication extremely difficult. These include rapidly shifting from one topic to another so that the normal structure of thinking is muddled and becomes illogical (*loosening of associations, derailment*), inventing new words or phrases (*neologisms*), and persistent and inappropriate repetition of the same thoughts (*perseveration*).

Schizophrenics may have **hallucinations**, i.e. perceptions that occur in the absence of external stimuli. **Auditory hallucinations** are most common in schizophrenia. Patients hear sounds or voices that speak words, phrases and sentences directly to the patient (*second-person hallucination*) or talk to one another referring to the patient as s/he (*third-person hallucination*). Hallucinations can also involve the other senses. These include **tactile hallucinations** (i.e. forms of tingling, burning), **somatic hallucinations** (i.e. something happening inside the body such as a snake crawling inside one's stomach), **visual hallucinations** (i.e. vague perceptions of colour or distinct visions of people or objects), **gustatory hallucinations** (i.e. food or drink taste strange), and **olfactory hallucinations** (i.e. smell of poison or smoke).

People with schizophrenia also show **inappropriate affect**, i.e. emotions that are unsuited to the situation.

Negative symptoms are 'pathological deficits' and include poverty of speech, blunted and flat affect, loss of volition, and social withdrawal. People with schizophrenia show **alogia** or poverty of speech, i.e. a reduction in speech and speech content. Many people with schizophrenia show less anger, sadness, joy, and other feelings than most people do. Thus they have **blunted affect**. Some show no emotions at all, a condition known as **flat affect**. Also patients with schizophrenia experience **avolition**, or apathy and an inability to start or complete a course of action. People with this disorder may withdraw socially and become totally focused on their own ideas and fantasies.

People with schizophrenia also show **psychomotor symptoms**. They move less spontaneously or make odd grimaces and gestures. These symptoms may take extreme forms known as **catatonia**. People in a **catatonic stupor** remain motionless and silent for long stretches of time. Some show **catatonic rigidity**, i.e. maintaining a rigid, upright posture for hours. Others exhibit **catatonic posturing**, i.e. assuming awkward, bizarre positions for long periods

Activity 4.5

Can you list some characters in films you have seen or books you have read who suffered from any of the disorders we have studied here like depression or schizophrenia showing some of these delusions?

Can you identify which kind of delusion each of these is?

1. *A person who believes that s/he is going to be the next President of India.*
2. *One who believes that the intelligence agencies/police are conspiring to trap her/him in a spy scandal.*
3. *One who believes that s/he is the incarnation of God and can make things happen.*
4. *One who believes that the tsunami occurred to prevent her/him from enjoying her/his holidays.*
5. *One who believes that her/his actions are controlled by the satellite through a chip implanted in her/his brain by some extraterrestrial beings.*

Box 4.2

Sub-types of Schizophrenia

According to *DSM-IV-TR*, the sub-types of schizophrenia and their characteristics are :

- **Paranoid type** : Preoccupation with delusions or auditory hallucinations; no disorganised speech or behaviour or inappropriate affect.
- **Disorganised type** : Disorganised speech and behaviour; inappropriate or flat affect; no catatonic symptoms.
- **Catatonic type** : Extreme motor immobility; excessive motor inactivity; extreme negativism (i.e. resistance to instructions) or mutism (i.e. refusing to speak).
- **Undifferentiated type** : Does not fit any of the sub-types but meets symptom criteria.
- **Residual type** : Has experienced at least one episode of schizophrenia; no positive symptoms but shows negative symptoms.

of time. Sub-types of schizophrenia and their characteristics are described briefly in Box 4.2.

Behavioural and Developmental Disorders

Apart from those mentioned above, there are certain disorders that are specific to children and if neglected can lead to serious consequences later in life. Children have less self-understanding and they have not yet developed a stable sense of identity nor do they have an adequate frame of reference regarding reality, possibility, and value. As a result, they are unable to cope with stressful events which might be reflected in behavioural and emotional problems. On the other hand, although their inexperience and lack of self-sufficiency make them easily upset by problems that seem minor to an adult, children typically bounce back more quickly.

We will now discuss several disorders of childhood like **Attention-deficit Hyperactivity Disorder (ADHD)**, **Conduct Disorder**, and **Separation Anxiety Disorder**. These disorders, if not attended, can lead to more serious and chronic disorders as the child moves into adulthood.

Classification of children's disorders has followed a different path than that of adult disorders. Achenbach has identified two factors, i.e. *externalisation* and *internalisation*, which include the majority of childhood behaviour problems. The **externalising disorders**, or undercontrolled problems, include behaviours that are disruptive and often aggressive and aversive to others in the child's environment. The **internalising disorders**, or overcontrolled problems, are those conditions where the child experiences depression, anxiety, and discomfort that may not be evident to others.

There are several disorders in which children display disruptive or externalising behaviours. We will now focus on three prominent disorders, viz. *Attention-deficit Hyperactivity Disorder* (ADHD), *Oppositional Defiant Disorder* (ODD), and *Conduct Disorder*.

The two main features of ADHD are **inattention** and **hyperactivity-impulsivity**. Children who are **inattentive** find it difficult to sustain mental effort during work or play. They have a hard time keeping their minds on any one thing or in following instructions. Common complaints are that the child does not listen, cannot concentrate, does not follow instructions, is disorganised, easily distracted, forgetful, does not finish assignments, and is quick to lose interest in boring activities. Children who are **impulsive** seem unable to control their

immediate reactions or to think before they act. They find it difficult to wait or take turns, have difficulty resisting immediate temptations or delaying gratification. Minor mishaps such as knocking things over are common whereas more serious accidents and injuries can also occur. **Hyperactivity** also takes many forms. Children with ADHD are in constant motion. Sitting still through a lesson is impossible for them. The child may fidget, squirm, climb and run around the room aimlessly. Parents and teachers describe them as 'driven by a motor', always on the go, and talk incessantly. Boys are four times more likely to be given this diagnosis than girls.

Children with **Oppositional Defiant Disorder** (ODD) display age-inappropriate amounts of stubbornness, are irritable, defiant, disobedient, and behave in a hostile manner. Unlike ADHD, the rates of ODD in boys and girls are not very different. The terms **Conduct Disorder** and **Antisocial Behaviour** refer to age-inappropriate actions and attitudes that violate family expectations, societal norms, and the personal or property rights of others. The behaviours typical of conduct disorder include aggressive actions that cause or threaten harm to people or animals, non-aggressive conduct that causes property damage, major deceitfulness or theft, and serious rule violations. Children show many different types of aggressive behaviour, such as **verbal aggression** (i.e. name-calling, swearing), **physical aggression** (i.e. hitting, fighting), **hostile aggression** (i.e. directed at inflicting injury to others), and **proactive aggression** (i.e. dominating and bullying others without provocation).

Internalising disorders include **Separation Anxiety Disorder** (SAD) and **Depression**. Separation anxiety disorder is an internalising disorder unique to children. Its most prominent symptom is excessive anxiety or even panic experienced by children at being separated from their parents. Children with SAD may have difficulty being in a room by themselves, going to school alone, are fearful of entering new situations, and cling to and shadow their parents' every move. To avoid separation, children with SAD may fuss, scream, throw severe tantrums, or make suicidal gestures.

The ways in which children express and experience depression are related to their level of physical, emotional, and cognitive development. An infant may show sadness by being passive and unresponsive; a pre-schooler may appear withdrawn and inhibited; a school-age child may be argumentative and combative; and a teenager may express feelings of guilt and hopelessness.

Children may also have more serious disorders called **Pervasive Developmental Disorders**. These disorders are characterised by severe and widespread impairments in social interaction and communication skills, and stereotyped patterns of behaviours, interests and activities. **Autistic disorder** or **autism** is one of the most common of these disorders. Children with autistic disorder have marked difficulties in social interaction and communication, a restricted range of interests, and strong desire for routine. About 70 per cent of children with autism are also mentally retarded.

Children with autism experience profound difficulties in relating to other people. They are unable to initiate social behaviour and seem unresponsive to other people's feelings. They are unable to share experiences or emotions with others. They also show serious abnormalities in communication and language that persist over time. Many autistic children never develop speech and those who do, have repetitive and deviant speech patterns. Children with autism often show narrow

patterns of interests and repetitive behaviours such as lining up objects or stereotyped body movements such as rocking. These motor movements may be self-stimulatory such as hand flapping or self-injurious such as banging their head against the wall.

Another group of disorders which are of special interest to young people are **eating disorders**. These include *anorexia nervosa*, *bulimia nervosa*, and *binge eating*. In **anorexia nervosa**, the individual has a distorted body image that leads her/him to see herself/himself as overweight. Often refusing to eat, exercising compulsively and developing unusual habits such as refusing to eat in front of others, the anorexic may lose large amounts of weight and even starve herself/himself to death. In **bulimia nervosa**, the individual may eat excessive amounts of food, then purge her/his body of food by using medicines such as laxatives or diuretics or by vomiting. The person often feels disgusted and ashamed when s/he binges and is relieved of tension and negative emotions after purging. In **binge eating**, there are frequent episodes of out-of-control eating.

Mental Retardation

You have already read about variations in intelligence in Chapter 1. Mental retardation refers to below average intellectual functioning (with an IQ of approximately 70 or below), and deficits or impairments in adaptive behaviour (i.e. in the areas of communication, self-care, home living, social/interpersonal skills, functional academic skills, work, etc.) which are manifested before the age of 18 years. Table 4.2 describes characteristics of the mentally challenged persons.

Substance-use Disorders

Addictive behaviour, whether it involves excessive intake of high calorie food resulting in extreme obesity or involving the abuse of substances such as alcohol or cocaine, is one of the most severe problems being faced by society today.

Disorders relating to maladaptive behaviours resulting from regular and consistent use of the substance involved are called *substance abuse disorders*. These disorders include problems associated with using and abusing such drugs as alcohol, cocaine and heroin, which alter the way people think, feel and behave. There are two sub-groups of substance-use disorders, i.e. those related to *substance dependence* and those related to *substance abuse*.

In **substance dependence**, there is intense craving for the substance to which the person is addicted, and the person shows tolerance, withdrawal symptoms and compulsive drug-taking. Tolerance means that the person has to use more and more of a substance to get the same effect. Withdrawal refers to physical symptoms that occur when a person stops or cuts down on the use of a psychoactive substance, i.e. a substance that has the ability to change an individual's consciousness, mood and thinking processes.

In **substance abuse**, there are recurrent and significant adverse consequences related to the use of substances. People who regularly ingest drugs damage their family and social relationships, perform poorly at work, and create physical hazards.

We will now focus on the three most common forms of substance abuse, viz. **alcohol abuse and dependence, heroin abuse and dependence**, and **cocaine abuse and dependence**.

Alcohol Abuse and Dependence

People who abuse alcohol drink large amounts regularly and rely on it to help

Table 4.2 : Characteristics of Individuals with Different Levels of Mental Retardation

Area of Functioning	Mild (IQ range = 50–70)	Moderate (IQ range = 35–49)	Severe (IQ range = 20–34) and **Profound** (IQ = below 20)
Self-help Skills	Feeds and dresses self and cares for own toilet needs	Has difficulties and requires training but can learn adequate self-help skills	No skills to partial skills, but some can care for personal needs on limited basis
Speech and Communication	Receptive and expressive language is adequate; understands communication	Receptive and expressive language is adequate; has speech problems	Receptive language is limited; expressive language is poor
Academics	Optimal learning environment; third to sixth grade	Very few academic skills; first or second grade is maximal	No academic skills
Social Skills	Has friends; can learn to adjust quickly	Capable of making friends but has difficulty in many social situations	Not capable of having real friends; no social interactions
Vocational Adjustment	Can hold a job; competitive to semi-competitive; primarily unskilled work	Sheltered work environment; usually needs consistent supervision	Generally no employment; usually needs constant care
Adult Living	Usually marries, has children; needs help during stress	Usually does not marry or have children; dependent	No marriage or children; always dependent on others

them face difficult situations. Eventually the drinking interferes with their social behaviour and ability to think and work. For many people the pattern of alcohol abuse extends to dependence. That is, their bodies build up a tolerance for alcohol and

Box 4.3

Effects of Alcohol : Some Facts

- All alcohol beverages contain ethyl alcohol.
- This chemical is absorbed into the blood and carried into the central nervous system (brain and spinal cord) where it depresses or slows down functioning.
- Ethyl alcohol depresses those areas in the brain that control judgment and inhibition; people become more talkative and friendly, and they feel more confident and happy.
- As alcohol is absorbed, it affects other areas of the brain. For example, drinkers are unable to make sound judgments, speech becomes less careful and less clear, and memory falters; many people become emotional, loud and aggressive.
- Motor difficulties increase. For example, people become unsteady when they walk and clumsy in performing simple activities; vision becomes blurred and they have trouble in hearing; they have difficulty in driving or in solving simple problems.

they need to drink even greater amounts to feel its effects. They also experience withdrawal responses when they stop drinking. Alcoholism destroys millions of families, social relationships and careers. Intoxicated drivers are responsible for many road accidents. It also has serious effects on the children of persons with this disorder. These children have higher rates of psychological problems, particularly anxiety, depression, phobias and substance-related disorders. Excessive drinking can seriously damage physical health. Some of the ill-effects of alcohol on health and psychological functioning are presented in Box 4.3.

Heroin Abuse and Dependence

Heroin intake significantly interferes with social and occupational functioning. Most abusers further develop a dependence on heroin, revolving their lives around the substance, building up a tolerance for it, and experiencing a withdrawal reaction when they stop taking it. The most direct danger of heroin abuse is an overdose, which slows down the respiratory centres in the brain, almost paralysing breathing, and in many cases causing death.

Cocaine Abuse and Dependence

Regular use of cocaine may lead to a pattern of abuse in which the person may be intoxicated throughout the day and function poorly in social relationships and at work. It may also cause problems in short-term memory and attention. Dependence may develop, so that cocaine dominates the person's life, more of the drug is needed to get the desired effects, and stopping it results in feelings of depression, fatigue, sleep problems, irritability and anxiety. Cocaine poses serious dangers. It has dangerous effects on psychological functioning and physical well-being.

Some of the commonly abused substances are given in Box 4.4.

Box 4.4

Commonly Abused Substances (Following the *DSM-IV-TR* Classification)

- **Alcohol**
- **Amphetamines**: dextroamphetamines, metaamphetamines, diet pills
- **Caffeine**: coffee, tea, caffeinated soda, analgesics, chocolate, cocoa
- **Cannabis**: marijuana or '*bhang*', hashish, sensimilla
- **Cocaine**
- **Hallucinogens**: LSD, mescaline
- **Inhalants**: gasoline, glue, paint thinners, spray paints, typewriter correction fluid, sprays
- **Nicotine**: cigarettes, tobacco
- **Opioid**: morphine, heroin, cough syrup, painkillers (analgesics, anaesthetics)
- **Phencyclidine**
- **Sedatives**

Key Terms

Abnormal psychology, Antisocial behaviour, Anxiety, Autism, Deinstitutionalisation, Delusions, Diathesis-stress model, Eating disorders, Genetics, Hallucinations, Hyperactivity, Hypochondriasis, Mental retardation, Mood disorders, Neurotransmitters, Norms, Obsessive-compulsive disorders, Phobias, Schizophrenia, Somatoform disorders, Substance abuses.

Summary

- *Abnormal behaviour is behaviour that is deviant, distressing, dysfunctional, and dangerous. Those behaviours are seen as abnormal which represent a deviation from social norms and which interfere with optimal functioning and growth.*
- *In the history of abnormal behaviour, the three perspectives are, i.e. the supernatural, the biological or organic, and the psychological. In interactional or bio-psycho-social approach, all three factors, viz. biological, psychological and social play important roles in psychological disorders.*
- *Classification of psychological disorders has been done by the WHO (ICD-10) and the American Psychiatric Association (DSM-IV-TR).*
- *A variety of models have been used to explain abnormal behaviour. These are the biological, psychodynamic, behavioural, cognitive, humanistic-existential, diathesis-stress systems, and socio-cultural approaches.*
- *The major psychological disorders include anxiety, somatoform, dissociative, mood, schizophrenic, developmental and behavioural, and substance-use disorders.*

Review Questions

1. Identify the symptoms associated with depression and mania.
2. Describe the characteristics of hyperactive children.
3. What do you understand by substance abuse and dependence?
4. Can a distorted body image lead to eating disorders? Classify the various forms of it.
5. "Physicians make diagnosis looking at a person's physical symptoms". How are psychological disorders diagnosed?
6. Distinguish between obsessions and compulsions.
7. Can a long-standing pattern of deviant behaviour be considered abnormal? Elaborate.
8. While speaking in public the patient changes topics frequently, is this a positive or a negative symptom of schizophrenia? Describe the other symptoms and sub-types of schizophrenia.
9. What do you understand by the term 'dissociation'? Discuss its various forms.
10. What are phobias? If someone had an intense fear of snakes, could this simple phobia be a result of faulty learning? Analyse how this phobia could have developed.
11. Anxiety has been called the "butterflies in the stomach feeling". At what stage does anxiety become a disorder? Discuss its types.

Project Ideas

1. All of us have changes in mood or mood swings all day. Keep a small diary or notebook with you and jot down your emotional experiences over 3–4 days. As you go through the day (for instance, when you wake up, go to school/college, meet your friends, return home), you will observe that there are many highs and lows, ups and downs in your moods. Note down when you felt happy or unhappy, felt joy or sadness, felt anger, irritation and other commonly experienced emotions. Also note down the situations which elicited these various emotions. After collecting this information, you will have a better understanding of your own moods and how they fluctuate through the day.
2. Studies have shown that current standards of physical attractiveness have contributed to eating disorders. Thinness is valued in fashion models, actors, and dancers. To study this, observe the people around you. Select at least 10 people (they may include your family, friends and other acquaintances), and rate them in terms of Large, Average and Thin. Then pick up any fashion or film magazine. Look at the pictures of models, winners of beauty competitions, and film stars. Write a paragraph or two describing the magazine's message to its readers about the normal or acceptable male or female body. Does this view match what you see as normal body types in the general population?
3. Make a list of movies, TV shows, or plays you have seen where a particular psychological disorder has been highlighted. Match the symptoms shown to the ones you have read. Prepare a report.

Weblinks

http://www.mental-health-matters.com/disorders
http://allpsych.com
http://mentalhealth.com

Pedagogical Hints

1. The contents on psychological disorders have to be handled sensitively. After becoming familiar with various kinds of disorders and their symptoms, students may begin to feel and may express that they are suffering from one or more of the given disorders. It is important to explain to the students, not to draw any definite conclusions on the basis of some signs/symptoms experienced.
2. Students need to be made aware that mere knowledge and information about psychological disorders do not provide the necessary skills for either diagnosing or treating psychological disorders.
3. Students should be discouraged from attempting to treat each other, as they are not qualified to do so. Specialised training in clinical psychology/counselling is required to undertake psycho-diagnostic testing.