



NATIONAL OPEN UNIVERSITY OF NIGERIA

SCHOOL OF EDUCATION

COURSE CODE: EGC 817

COURSE TITLE: ABNORMAL PSYCHOLOGY

COURSE GUIDE

Course Code **EGC 817**

Course Title **ABNORMAL PSYCHOLOGY**

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EGC 817: EGC 817 is a semester, two credit unit course. It is a course for students who offer Masters degree in education guidance and counselling programme however, it is also a suitable course of study for anyone who wants to acquire some knowledge of how to live a normal and stress free life.

The Course

This course is made up of three modules. Each module comprises five units and in all, there are 15 units. As a master Degree student, one of the courses central to your profession is abnormal psychology. This is because at the heart of guidance and counselling is your knowledge of abnormal behaviours in human organisms. Therefore, you need to equip yourself with major facts

and how you can function effectively in this helping profession. You need to study it with all seriousness.

This Course Guide is a window into the course because it tells you briefly what the course is about, what course materials you will be using and how you can work your way through the materials. It suggests some general guidelines for the amount of time you should spend on each study unit of the course in order to complete it successfully. It also gives you some guidance on your tutor marked assignments (TMAs). Detailed information on TMAs is similarly made available. There are regular tutorial classes that are linked to the course. Though tutorial classes are not compulsory, but you are advised to attend these sessions. Happy study.

What you will learn in this Course

This course EGC 817, titled Abnormal Psychology, has been specifically designed to equip you with the knowledge of abnormal behavior in human organisms and to the point that you should be able to discuss confidently on issues concerning human behaviours, especially in educational school environment.

In this regard, the course would highlight the importance of investigations and research in resolving issues and challenges in the study of Psychology through various theories.

- You will learn about the various methods of investigation in abnormal psychology which researchers adopt.
- You will learn about the different topics in abnormal psychology.
- You will learn about the causal factors in abnormal behavior in human organisms.
- More importantly you will be exposed to methods of treating abnormal behaviours.

Course Aims

It is hoped that after your degree, you will rise to certain influential leadership position as a counsellor in the education sector, therefore the major aims of this course are:

- 1) To refresh your memory on the concept of abnormal psychology;
- 2) Deepen your understanding of abnormal psychology;
- 3) Prepare you to be able to discuss coherently on any issues or matter relating to abnormal psychology or its application in school environments or other situations.

Course Objectives

In order to achieve the aims set out above, some carefully stated overall objectives must be considered. In addition, each study unit also has specific objectives. The study unit objectives are always included at the beginning of a study unit; you should read them before you start

working through the study unit. You may want to refer to the objectives as you go through each unit to check on your progress. You should always look at the study unit objectives after completing a study unit. In this way, you can be sure that you have done what was required of you by the study unit. Set out below are also the wider objectives of the course as a whole. By meeting these objectives, you should have achieved the aims of the course. On successful completion of the course, you should be able to:

1. Define the concept of abnormal psychology,
2. Explain the historical perspectives on abnormal psychology,
3. Differentiate between normality and abnormality,
4. Itemise the importance of abnormal psychology,
5. Explain causes of abnormal behaviour in human organisms,
6. Discuss the psychodynamic perspectives on abnormality,
7. Briefly state new psychodynamic perspective,
8. Discuss behavioural perspectives of abnormality,
9. Discuss the cognitive, humanistic, and existential perspectives of abnormality,
10. List the classification of mental disorders.
11. List the major categories of mental disorders
12. Discuss causes, treatments, outcomes, and prevention of abnormalities.

Working through This Course

To complete this course you are required to read the study units carefully and other relevant materials stated in the section on further reading. Each study unit contains Tutor Marked Assignments (TMAs) and at each point in the course you are required to submit assignments for assessment purposes. At the end of the course is a final examination. You will also find listed, all the components of the course, what you have to do and how you should allocate your time to each study unit in order to complete the course successfully and in good time.

Course Materials

Major components of the course are:

- 1) Course Guide
- 2) Study Units
- 3) References
- 4) Presentation Schedule

Study Units

The study units in this course (EGC 817) are as follows:

Module 1.

Unit 1: The Concept of Abnormal Psychology

Unit 2: Historical Perspectives on Abnormal Psychology

Unit 3: The differences between normality and abnormality

Unit 4: The Importance of Abnormal Psychology

Unit 5: Causes of Abnormal Behaviour

Module 2

Unit 1: The Psychodynamic Perspectives on Abnormality

Unit 2: New Psychodynamic Perspective

Unit 3: Behavioural Perspective

Unit 4: Cognitive perspective, Humanistic and Existential Perspective

Unit 5: The Classification of Mental Disorders.

Module 3

Unit 1: Mental retardation

Unit 2: Mood (affective) disorders

Unit 3: Neurotic disorders – somatoform and Dissociative Disorders

Unit 4: Eating and Sleep disorders

Unit 5: Schizophrenia and related psychotic disorders

Presentation Schedule

The presentation schedule included in this course material gives you the important dates of this year for the completion of tutor-marked assignments and for attending tutorials. Remember, you are required to submit all your assignments by the due date. You should guard against falling behind in your work.

Assessment

There are three aspects in the assessment of the course. First is a set of Self – Assessment Exercises (SAEs), second is a set of tutor-marked assignments (TMAs), and third is a written end of semester examination. In tackling the assignments, you are expected to be sincere in attempting the exercises; you are expected to apply the information, knowledge and techniques gathered during the course. The assignments must be submitted to your tutor against formal

deadlines stated in the presentation schedule and the assignment file. The work you submit to your tutor for assessment will make up 40% (post graduate) of your total course mark. At the end of the course, you will need to sit for a final written examination of two hours' duration. This examination will make up the remaining 60% (postgraduate) of your total course mark.

Tutor-Marked Assignments (TMAs)

Assignment questions referred as TMA (Tutor Marked Assignments) for each study units in this course are stated. You will be able to complete your assignments from the information and materials contained in your reading, and study units. However, it is desirable for you to demonstrate that you have read and researched more widely than the required minimum. Using other references will give you a broader viewpoint and may provide a deeper understanding of the subject.

When you have completed each assignment, send it together with a TMA (tutor-marked assignment) form to your tutor. Make sure that each assignment reaches your tutor on or before the deadline given in the presentation schedule and assignment file. If, for any reason, you cannot complete your work on time, contact your tutor before the assignment is due to discuss

the possibility of an extension. Extensions of time will not be granted after the due date unless in exceptional circumstances. You are encouraged to submit all assignments.

Final Examination and Grading

The final examination for this course will be for two hours' duration and it has a value of 60% of the total course grade. The examination will consist of questions, which reflect the type of self-testing, practice exercises and tutor-marked assignments (tutor-attended- to problems) you have previously encountered in this study material.

Use the time between finishing the last study unit and sitting for the examination to revise the entire course. You might find it useful to review your self-tests, tutor-marked assignments and tutor comments on them before the examination. The final examination covers information from all parts of the course.

Course Marking Structure

The following table lays out how the actual course marking is done.

Table I: Course Marking Structure

Stages of Assessment	Percentage of Scores
Assessments	40% (Postgraduate)
Final Examination	60% (Postgraduate)
Total	100% of Course Marks

Course Overview

The next table brings together the study units, the number of weeks you should take to complete them, and the assignments that follow.

Table II: Course Organiser

Unit	Title of work	Weekly Activity	Assessment (end of Unit)
1	Meaning of abnormal psychology	1	Assignment 2
2	Historical perspectives on abnormality.	1	Assignment 3
3	Differences between normality and abnormality.	1	Assignment 3
4	The importance of abnormal	1	Assignment 3

	psychology		
5	Causes of abnormal behaviour	1	Assignment 2
6	Psychosocial view points on abnormal behaviour	1	Assignment 2
7	New psychodynamic perspective on abnormal behaviour	1	Assignment 2
8	Behavioural perspectives on abnormal behaviour	1	Assignment 3
9	Cognitive, humanistic, and existential perspectives on abnormal behaviour	1	Assignment 4
10	Classification of mental disorders	1	Assignment 3
11	Major categories of mental disorders	1	Assignment 3
12	Mood (affective) disorders	1	Assignment 3
13	Somatoform and dissociative disorders	1	Assignment 3
14	Eating disorders: Anorexia and Bulimia	1	Assignment 2
15	schizophrenia	1	Assignment 3
Total no of weeks		15	

How to Get the Most from This Course

In Open and Distance Learning (ODL), the study units replace the University Lecturer. This is one of the great advantages of ODL. You can read and work through specially designed study materials at your own pace, and at a time and place that suit you best. Think of it as reading the lecturer. In the same way that the lecturer might set you some reading to do, the study units tell you when to read your other materials. Just as a lecturer might give you an in-class exercise, your study units provide exercise, for you to do at the appropriate points. Each of the study units follows a common format. The first item is an introduction to the subject matter of the study unit and how a particular study unit is integrated with the other study units and the course as a whole. Next is a set of learning objectives. These objectives let you know what you should be able to do by the time you have completed the study unit. You should use these objectives to guide your study. When you have finished the study unit, you must go back and check whether you have achieved the objectives or not. If you make a habit of doing this, you will significantly improve your chances of passing the course.

The main body of the study unit guides you through the required reading from other sources. This will usually be either from a reading section or some other sources. You will be directed when there is need for it.

Self- Assessment Exercise (SAEs) are stated throughout the study units. Working through these SAEs will help you to achieve the objectives of the study units and prepare you for the assignments and examination.

You should do every SAE as you come to it in the study unit. There will also be numerous examples given in the study units. Work through these when you come to them too.

The following is a practical strategy for working through the course. If you run into any trouble, telephone your tutor immediately. Remember that your tutor's job is to help you. When you need help, don't hesitate to call and ask your tutor to provide necessary guidance. You are encouraged to take note of the following tips:

1. Read this course guide thoroughly.
2. Organise a study schedule. Refer to the course overview for more details. You should note that it is expected of you to devote at least 2 hours per week for studying this course. The number of hours to be devoted for intensive study stated above is outside other need driven academic activities like self help, group discussion and instructional facilitation. Note the time you are expected to spend on each unit and how the assignments relate to the study units. Important information e.g. details of your tutorials, and the date of the first day of the semester is available. You need to gather together all these information in one place, such as in your diary or a wall calendar. Whatever method you choose to use, you should write in your own dates for working on each unit.
3. Once you have created your own study schedule, do everything you can to stick to it. The major reason why students fail is that they get behind with their course work. If you get into difficulties with your schedule, please let your tutor know before it is too late for him to help you.
4. Turn to unit 1, read the introduction and the objectives for the unit.
5. Assemble the study materials. Information about what you need for a unit is given in the table of content at the beginning of each unit. It will be helpful for you to always read both the study unit you are working on and one of the materials for further reading on your desk at the same time.
6. Work through the Unit. The content of the unit itself has been arranged to provide a sequence for you to follow. As you work through the unit, you will be instructed to read sections from other sources. Use the unit to guide your reading.
7. Keep in mind that you will learn a lot by doing all your assignments carefully. They have been designed to help you meet the objectives of the course and, therefore, will help you pass the examination. Submit all assignments not later than the due date.
8. Review the objectives for each study unit to confirm that you have achieved them. If you

feel unsure about any of the objectives, review the study materials or consult your tutor.

9. When you are confident that you have achieved a unit's objectives, you can then start on the next unit. Proceed unit by unit through the course and try to pace your study so that you keep yourself on schedule.
10. When you have submitted an assignment to your tutor for marking, do not wait until you get it back before starting on the next unit. Keep to your schedule. When the assignment is returned, pay particular attention to your tutor's comments, both on the tutor-marked assignment form and also as written on the assignment itself. Consult your tutor as soon as possible if you have any questions or problems.
11. After completing the last unit, review the course and prepare yourself for the final examination. Check that you have achieved the unit objectives (listed at the beginning of each unit) and the course objectives (listed in the course guide).

Tutors and Tutorials

There are 15 hours of tutorials provided in support of this course. You will be notified of the dates, times and location of these tutorials together with the name and phone number of your tutor as soon as you are allocated a tutorial group.

Your tutor will mark and comment on your assignments. He will also keep a close watch on your progress or any difficulties you might encounter and provide assistance to you during the course. You must mail your tutor-marked assignments to your tutor well before the due date (at least two working days are required). They will be marked by your tutor and returned to you as soon as possible. Do not hesitate to contact your tutor by telephone, e-mail, or discussion board if you need help. The following might be circumstances in which you would find help necessary. Contact your tutor if: You do not understand any part of the study units or the assigned readings. You have difficulty with the self – assessment exercises. You have a question or problem with an assignment, with your tutor's comments on an assignment or with the grading of an assignment. You should try your best to attend the tutorials. This is your only chance to have a face-to-face academic contact with your tutor and to ask questions on problems encountered in the course of your study. To gain the maximum benefit from course tutorials, prepare a question list before attending them. You will learn a lot from participating in discussions actively.

Summary

Upon completing this course, you will be required to have acquired basic knowledge on abnormal psychology. You will be able to answer questions like these ones.

- Why is abnormality so difficult to define?
- What characteristics help us recognize abnormality?

- What aspects of Hippocrates' alternative approach to mental disorders were truly revolutionary?
 - What was the role of supernatural beliefs in efforts to understand mental disorders during the Middle Ages?
 - What are the distinction between normality and abnormality?
 - What are the characteristics of abnormality?
 - What are the qualities of individuals with good mental health?
 - What is the relationship between genotypes and phenotypes, and how can genotypes shape and interact with the environment?
 - What is temperament, and why is it important for the origin abnormal behaviour
 - What do we mean by neural plasticity
 - What are the fundamentals Freud's psychoanalytic theories?
 - Explain the concept of anxiety
 - List and describe the different forms of defense mechanisms in line with Freudian theory.
 - Explain the concept of attribution
 - List some dysfunctional assumptions in cognition theory
 - Discuss cognitive therapy as postulated by Aaron beck
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- Give a brief history of classification of mental disorders

- List some of the major categories of mental disorders identified by DSM – IV-TR and ICD - 10
- List some examples of neurotic disorders.

COURSE CODE: EGC 817

COURSE TITLE: ABNORMAL PSYCHOLOGY.

COURSE DEVELOPER: Dr. Okoza J

Module 1

Unit 1: The Concept of Abnormal Psychology

Unit 2: Historical Perspectives on Abnormal Psychology

Unit 3: The differences between normality and abnormality

Unit 4: The Importance of Abnormal Psychology

Unit 5: Causes of Abnormal Behaviour

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UNIT 1: THE CONCEPT OF ABNORMAL PSYCHOLOGY

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Definition of Abnormality

3.2 Abnormality as deviation from the norm

3.3 Abnormality as a discomfort

3.4 Abnormality as mental illness

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

The topics and problems central to abnormal Psychology surround us every day. It should not be a surprise to you that there is still no universal agreement about what we mean by abnormality or disorder. This is not to say we do not have definitions; there are definitions of it. However, every definition provided so far has proved problematic. What is perhaps more important is that even though we lack consensus on a definition, there is still a lot of agreement about which conditions are disorders and which are not. No one element of abnormality is sufficient in and of itself to define or determine abnormality, but the greater the similarity between a given person's behavior and the element of abnormality such as suffering, maladaptiveness, deviancy, violation, social discomfort, irrationality and unpredictability, the more likely it is that the person is abnormal or mentally disordered in some way.

In this unit, you are going to learn about the meaning of abnormal psychology, and the different forms of definitions provided to explain the concept of abnormal behaviour. So be attentive as you learn.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the meaning of abnormal psychology
- Abnormality as a deviation from the norm
- Abnormality as a discomfort

- Abnormality as mental illness

3.0 MAIN CONTENT

3.1 Defining abnormality: Ways of defining abnormality.

The context, or circumstances surrounding behaviour, influenced whether behaviour is viewed as abnormal. We have different perspectives for labeling a behavior as abnormal. These are:

- a. Cultural relativism
- b. Gender relativism
- c. Unusualness
- d. Discomfort
- e. Mental illness
- f. Maladaptiveness

Cultural Relativism

The position of the cultural relativism perspective is that there are no universal standards or rules for labeling a behaviour as abnormal. Instead, behaviours can only be abnormal relative to cultural norms. Thus, cultural relativists believe that there are different definitions of abnormality across different cultures.

Violation of the standards of society. All cultures have rules. Some of these are formalized as laws. Others form the norms and moral standards that we are

taught to follow. When people fail to follow the conventional social and moral rules, we may consider their behavior as abnormal.

3.2 Abnormality as deviation from the norm

The statistical criterion is insufficient because it is essentially neutral; deviation from the norm, however, implies not behaving or feeling as one should. 'Norm' has an 'oughtness' about it: particular behaviours are expected from us at particular times and in particular situations, and if those expectations are not met or are positively transgressed, we and/or our behavior may be judged 'bad' or sick. For example, many people regard homosexuality as abnormal, not because it is statistically less common than heterosexuality, but because the 'normal' or natural form of sexual behaviour in human beings is heterosexuality. From a religious or moral perspective, homosexuality might be judged as bad, wicked and sinful. From a mere biological or scientific perspective, it might be labeled sick, perverse, or deviant.

Deviancy: The word abnormal literally means "away from the normal". But simply considering statistically rare behavior to be abnormal does not provide us with a solution to our problem of defining abnormality. Genius is statistically rare, as is perfect pitch. However, we do not consider people with such uncommon talents to be abnormal in any way. On the other hand, mental retardation (which is also statistically rare and represents a deviation from normal) is considered to reflect abnormality. This tells us that in defining abnormality, we make value judgments.

If something is statistically rare and undesirable (as is mental retardation), we are more likely to consider it abnormal than something that is statistically rare and highly desirable (such as genius) or something that is undesirable but statistically common (such as rudeness, Carson, Butcher, Mineka and Hooley, 2011).

3.3 Discomfort

Proponents of a discomfort criterion for abnormality suggest that behaviours should be considered abnormal only if the individual suffers discomfort as result of the behaviours and wishes to be rid of them. This criterion avoids, to some extent, the problems of using societal norms as the criterion for abnormality. If a person's behaviours violate societal norms but does not cause him or her any discomfort, then behaviours should not be considered abnormal. This view point contributed to a change in how psychologists and psychiatrists viewed one behavior pattern – homosexuality. Gay men and lesbians argued that their sexual orientation is a natural part of themselves and a characteristic that causes them no discomfort and that they do not wish to alter or eliminate. In addition, despite the stress that gay and lesbians endure because of prejudice against them, research showed that homosexuals are no more likely than heterosexuals to experience serious forms of psychological distress (Herek, 1990). Partially because of this arguments, the American Psychiatric Association removed homosexuality from its list of recognized psychological disorders in 1973 (Spitzer, 1981).

Some therapists object to the subjective discomfort criterion, however, because people are not always aware of problems their behaviors create for themselves or for others. For example, some people who have lost touch with reality wander the streets aimlessly, not eating or taking care of themselves, in danger of starvation or exposure to the elements. These people may not be fully aware that they have severe problems and do not seek help. If we require that people acknowledge and seek help for their behaviors before we call those behaviours abnormal, some people who could benefit generally from help might never get it.

Maladaptiveness: maladaptive behavior is often an indicator of abnormality. The consensus among researchers and clinicians is that behaviours and feelings that are maladaptive are those that cause people to suffer distress and prevent them from functioning in daily life. Psychologists have tried to reserve the label maladaptive for behaviour that have one or more of the following characteristics:

1. Behaviours that are physically damaging to the individual, such as when a teenager repeatedly cuts himself during emotional outburst.
2. Behaviours that cause the individual emotional suffering or harm, such as emotional pain people feel when they are depressed.
3. Behavior that severely interfere with the individual's ability to function in daily life, as when a person with extreme phobias become housebound.
4. Behavior that indicate that the individual has lost touch with reality and cannot control his or her behaviours or thoughts, as happens in the disorder called schizophrenia which shall be treated later in this course.

Maladaptive behavior interferes with our wellbeing and with our ability to enjoy our work and our relationship.

3.4 Mental Illness

The fourth way of defining abnormality is as behaviours that result from mental disease or illness. This mental illness criterion implies that there is a clear, identifiable physical process that is deviant from “health” and that leads to specific behaviours or symptoms. However, to date, there is no medical test that identifies this process if it does exist. If we give a person’s symptoms a diagnosis, this is simply a label for that set of symptoms. For example, when we say someone “has” obsessive – compulsive disorder, we can mean only that he or she is exhibiting a set of symptoms, including obsessive thoughts and compulsive behaviours. The term obsessive-compulsive disorder does not refer to an identifiable physical entity that is found in all people who exhibit these symptoms.

4.0 CONCLUSION

In this unit, you have learned about the concept of abnormal psychology and you have now seen that there are different ways to define it. But what is of paramount importance is that whichever perspectives that is followed, abnormal psychology is a branch of psychology that deals with behaviours that interferes normal human functioning in an environment.

5.0 SUMMARY

In this unit, you have learned the following points about abnormal psychology. They include (i) cultural relativism that argues that the norms of the society must be used to determine the normality of a behaviour (2) the discomfort criterion must be considered (3) maladaptives and (4) mental illness must be put into account before a behaviour can be judged to be abnormal or normal.

6.0 TUTOR-MARKED ASSIGNMENT

- Why is abnormality so difficult to define?
- What characteristics help us recognize abnormality?

7.0 REFERENCES/FURTHER READING

Carson, R. C. Butcher, J.N. Mineka, S. & Hooley, J. M. (2011).

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UNIT 2: HISTORICAL PERSPECTIVES ON ABNORMAL PSYCHOLOGY

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- 2.0 Objectives
- 3.0 Main Content
 - 3.1 Historical Perspectives on Abnormality
 - 3.2 Supernatural theories
 - 3.3 Biological theories
 - 3.4 Psychological theories
- 4.0 Conclusion
- 5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Discuss the historical perspectives on abnormality
- Explain supernatural theories on abnormality
- Explain biological theories on abnormality
- Explain the psychological theories on abnormality

3.0 MAIN CONTENT

3.1 Historical Perspectives on Abnormality

Over the years three types of theories have competed for dominance about the causes of mental disorders. These are the biological, the supernatural and psychological or stress-related theories. The biological theories saw mental disorders as similar to physical diseases, caused by the breakdown of one of the systems in the body. The appropriate cure for mental disorders, according to the biological theories, was the restoration of the body to good health. The supernatural theories saw mental disorders as a result of divine intervention, curses, demonic possession, and personal sin. To rid the person of the disorder, religious rituals, exorcisms, confession, and atonement were prescribed. The psychological or stress-related theories saw mental disorders as a result of

traumas, such as bereavement, or chronic stress. According to these theories, rest, relaxation, change of environment, and certain herbal medicines were sometimes helpful to the afflicted person. These different theories determined how people afflicted with disorders were regarded in the society. Let us in some details look at these perspectives.

3.2 Supernatural Theories

The belief that abnormal behavior is caused by supernatural forces could be traced to the ancient Chinese, Egyptians, the Hebrews, all of whom attributed deviance to the work of the devil. One treatment for abnormality in the Stone Age may have been to drill holes in the skulls of people displaying abnormal behaviourism to allow the spirits to escape from a person's body. Archeologists have found skulls dating back to the Stone Age a half-million years ago, in which circular sections of the skulls had been drilled away (Mahar & Mahar, 1985). The tool used for this drilling is called a trephine; thus, the operation was called trephination. Some historians believe that trephination was prescribed for people who were hallucinating – that is, having bizarre and unreal perceptual experiences or who were extremely sad or despondent (Selling, 1940).

In the middle Ages, demonological model of abnormality reigned supreme. Religious dogma held that disturbed people either were possessed involuntarily by the devil or had voluntarily made a pact with the forces of darkness. The killing of witches was justified on theological grounds.

3.3 Biological Theories

About the 5th century B.C., the Greek physician Hippocrates suggested that mental illness are diseases just like physical disorders. He insisted that people with disordered behavior were sick, not possessed by evil spirits. Hippocrates believed that the site of illness was the brain, which he saw as the organ of the mind. Hippocrates, often referred to as the father of medicine, argued that mental disorders are like other diseases of the body. According to Hippocrates, the body is composed of four basic humours: blood, phlegm, yellow bile, and black bile. Let us explain the origin of humour. According to dictionary of psychology, humour is a state of disposition of mind or mood, as in the phrases bad humour or good humour. According to a doctrine propounded by pre-socratic philosophy and widely accepted until the Renaissance, any of the four cardinal bodily fluids, the balance of which was believed to determine a person's temperament or personality: people were thought to be more or less sanguine (optimistic), melancholic (depressive), choleric (short-tempered), or phlegmatic (unemotional) according to the balance in their bodies of blood (sanguis), black-bile (Melaina chole), yellow bile (chole), and phlegm (phlegma). According to Hippocrates, all diseases, including mental disorders, are caused by imbalances in the body's essential humours, typically an excess of one of the humours. Based on careful observation of his many patients, including listening to their dreams, Hippocrates classified mental disorders into epilepsy, mania, melancholia and brain fever. He also recognized hysteria, although he did not view it as a mental disease. Like others, he thought that this was a disorder confined to women and caused by a wandering uterus. (Nolen-Hoeksema, 20004).

By the 1800s, attempts were being made to extend medical diagnoses to mental disorders, which were increasingly being viewed as biological disorders. The biological emphasis was given impetus by the discovery that general paresis, a disorder characterized in its advanced stages by mental deterioration and bizarre behavior, resulted from massive brain deterioration caused by syphilis.

3.4 Psychological Theories

In the early 1900s, Sigmund Freud's theory of psychoanalysis emerged as a new way of viewing deviant behaviour. He was convinced that psychological disorders are caused by unresolved conflicts from childhood that make the person vulnerable to certain kinds of life events.

The situations arouse anxiety, and the person tries to cope with the anxiety by using defense mechanisms such as repression, projection, reaction formation, and displacement. Inappropriate or extreme use of the defense mechanisms results in maladaptive patterns of behaviour. Some disorders, such as obsessions, phobias, and depression that do not involve a loss of contact with reality were called neurosis. Freud thought that in some instances, however, the anxiety caused by these unresolved conflicts may become so great that the person can no longer deal with reality and withdraws from it. These more severe disorders, such as schizophrenia, were called psychosis.

The behaviorual perspective views disordered behaviour not as a reflection of internal psychodynamics and unconscious conflicts, but rather as

learned responses that, like normal behaviours, are learned through classical conditioning, operant conditioning, and modeling. The behavioural perspective has greatly influenced our understanding of how environmental factors help shape abnormal behavior.

Cognitive theorists emphasize the important role played by people's thoughts and perceptions about themselves and the environment. Albert Ellis, Aaron Beck and other cognitive researchers have identified maladaptive and self-defeating thought patterns that are linked to a number of different disorders, such as depression and anxiety. Through this perspective, the key to understanding many maladaptive behaviours' is to isolate the specific thought patterns, beliefs, and attitudes that underlie them.

The humanistic perspective views abnormality as the result of environmental forces that frustrate or prevent people's inherent self-actualisation tendencies and search for meaning in life. Conditions of worth imposed by parents and others can result in the development of a negative self-concept and the need to deny or distort important aspects of experience. If experience, including one's inner feelings, become so incongruous with self-concept that they arouse serious threat, a breakdown or disorganization of the self may occur.

Social theories of mental disorders are concerned with the role of social forces, including interpersonal relationships, family dynamics, and the larger society, in producing psychological symptoms. Inter-personal theories states that mental disorders are the result of long-standing patterns of negative relationships, which have their roots in early experiences with caregivers. Family systems

theories states that families create and maintain mental disorders in individual family members to maintain homeostasis. Social structural theories maintain that societies create mental disorders in individuals by putting them under unbearable stress and by sanctioning abnormal behavior.

Vulnerability –stress model states that each and every one of us has some degree of vulnerability (ranging from low to high) for developing a given psychological disorder. The vulnerability, or predisposition, can have a biological basis, such as our genotype, a brain malfunction, or a hormonal factor. It could also arise from a personality factor, such as low self esteem or extreme pessimism, or from previous environmental factors, such as poverty or a severe trauma or loss earlier in life. Likewise, cultural factors can create vulnerability to certain kinds of disorders.

But vulnerability is only part of the equation. In most instances, a predisposition creates a disorder only when a stressor, some recent or current event that requires a person to cope, combines with a vulnerability to trigger the appearance of the disorder. For example, a person who has a genetic predisposition to depression or who suffered a traumatic loss of parents early in life may be primed to develop a depressive disorder if faced with the stress of another loss later in life. The biological, psychological, and environmental levels of analysis have all contributed to the vulnerability – stress model and to our understanding of behavior disorders and how they develop. Having looked at the historical perspectives of abnormality, it is proper to have some definitions of abnormality.

4.0 CONCLUSION

In this unit, you studied about the historical perspectives of abnormality. You saw how persons suffering from mental disorders were maltreated from the era of Stone Age until medical diagnosis to mental disorders were accepted. It was at this point of scientific investigation into psychological factors in human behaviours that helped to discard the old approach to mental disorders.

5.0 SUMMARY

In this unit, you learned about how abnormal behaviour was believed to be as a result of the work of the devil. Religious dogma held this fact in the Middle ages. The work of the Greek physician Hippocrates helped to throw light on the role of biological factors in mental illnesses. The work of Sigmund Freud opened up the psychological factors on mental disorders. Freud's works laid a solid foundation for the understanding of abnormal psychology.

6.0 TUTOR-MARKED ASSIGNMENT

- What aspects of Hippocrates' alternative approach to mental disorders were truly revolutionary?
- What was the role of supernatural beliefs in efforts to understand mental disorders during the Middle Ages?

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UNIT 3: THE DIFFERENCES BETWEEN NORMALITY AND ABNORMALITY

CONTENTS

- 1.0 Introduction
- 2.0 Objectives
- 3.0 Main Content
 - 3.1 The differences between normality and Abnormality
 - 3.2 Qualities of individuals with good mental health
 - 3.3 The characteristics of abnormality
- 4.0 Conclusion
- 5.0 Summary
- 6.0 Tutor-Marked Assignment
- 7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, we discussed the historical perspectives on abnormality. We learnt about its development from the supernatural theories to social theories of mental disorders. In this Unit, you are going to study the differences between normality and abnormality. This will help you to explain always the meaning of normal behavior and abnormal behavior in the society. But the distinction between normal and abnormal behavior is a complex issue. You need to pay attention to facilitate your comprehension.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the differences between normality and abnormality
- List the qualities of good mental health
- List the characteristics of abnormality

3.0 MAIN CONTENTS

3.1 Differences between normality and abnormality

The problem we face in defining abnormality and normality is that they usually do not have a clear cut dividing line. In defining abnormality we use the word deviance which is primarily a sociological term, implying a violation of rules of behavior. Abnormality also refers to behaviour which is statistically deviant. We also use the mental illness-probably inaccurately, which suggests some type of physical anomaly. These terms are used interchangeably. Thus, while it is always possible to state that abnormality exists, it is extremely difficult to point to

some physical cause, except for those relatively rare cases where a brain disorder has resulted from disease or injury. Put simply, we can usually point to a particular virus as the factor responsible for certain physical illness, identifying the source of behaviour disorders is not simple. They arise from hundreds of variables rather than from one or two.

On the other hand, normality is a concept that is difficult to define, there is a great lack of consensus in the definition of who a normal person is. However, most psychologists agree on some qualities as indicative of good mental health. This is our next focus, and you should pay attention.

3.2 Qualities of individuals with Good Mental Health

A well-adjusted person is supposed to possess the following characteristics:

1. Efficient perception of reality: the normal individual is fairly realistic in this appraisal of his own reactions and abilities of what goes on in the world around him. He evaluates his capabilities in a fairly realistic manner-neither over evaluating his abilities nor shying away from a difficult task because of underestimation of what he can do.
2. Self-knowledge: The well adjusted person has some awareness of his own motives and feelings. The normal person has more awareness than one who is mentally ill. He does not hide important feelings and motives from himself.
3. Ability to exercise voluntary control over behavior: The normal individual feels fairly confident that he can control and direct his own behaviour. He may act on impulse at times but generally he is able to restrain his sexual and aggressive urges (when necessary). He may conform or fail to conform to social norms.

4. **Self-esteem and Acceptance:** The well-adjusted person has some appreciation of his own self-worth and feels accepted by those around him. He is comfortable with other people and is also able to react spontaneously in social situations, at the same time; he does not always feel obliged to subjugate his opinions to those of the group (feeling of worthlessness and alienation).
5. **Ability to form Affectionate Relationship:** The normal individual is able to form close and satisfying relationship with other people. He is sensitive to their needs and feelings and does not make excessive demands for the gratification of his own needs. A mentally ill is self-centered, seeks affection without reciprocity.
6. **Productivity:** A mentally healthy person is able to use his abilities whether meager or simple in productive activities. He has a certain enthusiasm for living and does not have to drive himself to meet the demands of everyday living. A chronic lack of energy and excessive susceptibility to fatigue are common symptoms of psychological tension and unresolved conflict (Osinowo & Imhonde, 2004).

3.3 Characteristics of Abnormality

The concept of abnormality has been looked at from various perspectives. The word abnormal means away from norm. The following are the characteristics of abnormality.

1. **Statistical frequency:** Abnormal behavior is that which is statistically infrequent or deviant from the norm. This definition is based on the statistical frequency. It is imperative to note that most people fall within the average or the middle range; a few are either at the extremes of right or left of bell shaped curve. The problem

with this definition is that a person who is extremely intelligent or extremely well adjusted is classified as abnormal.

2. **Society's Standards:** Generally, society classifies certain behaviours abnormal if they deviate from societal norms. Usually such behavior is also statistically infrequent in the society. The central point here is that an individual's behavior must be evaluated in relation to the standards of his/her social group. A behavior that is deviant from social expectations is considered abnormal. For instance, premarital sex was considered abnormal same twenty years ago. It is normal for American Indian tribes to hear voices or see visions where there is no one talking. Thus, behavior cannot be considered abnormal so long as society accepts it.
3. **Adaptiveness of behavior:** Abnormal behavior is maladaptive because it has adverse effects to the individual and/or society. Thus, the best criterion to determine adaptiveness of behavior is not whether society accepts it but rather whether it fosters the well-being of the individual and consequently the group. In this regard, conforming behavior is abnormal if it is maladaptive. That is if it interferes with optimal functioning, growth and fulfillment. Accordingly, a man who is fearful of crowds that he cannot enter the bus to work/school, a child who has violent aggressive outburst would all be classified as abnormal.
4. **Personal Distress:** Abnormality is seen in terms of individual's subjective feeling rather than behavior.

5. Legal Definition of Abnormality: The legal definition of abnormality declares a person insane on the basis of a person's inability to judge between right or wrong. Insanity is a legal term and not used by psychologists.

In all, none of the above characteristics provides a completely satisfactory description of abnormal behavior. In psychology, all the characteristics (statistical, social, adaptiveness and personal distress) are used in diagnosing psychopathology.

4.0 CONCLUSION

In this unit, you learned about the differences between normality, abnormality, qualities of individuals with good mental health and characteristics of abnormality. As a would-be counselor, such knowledge will serve as veritable instrument for you to function effectively and efficiently in the helping profession.

5.0 SUMMARY

In this unit, you learned that it is a herculean to identify the source of abnormal behaviour unlike physical illness. You also learned about qualities of good mental health to include, efficient perception reality, self-knowledge, ability to exercise voluntary control over behaviour, self-esteem and acceptance, ability to form affectionate relationship and productivity.

Furthermore, you learned that abnormality has the following characteristic – statistical frequency, society's standard, adaptiveness of behaviour, personal distress, and legal connotation.

6.0 TUTOR-MARKED ASSIGNMENT

- What are the distinction between normality and abnormality?
- What are the characteristics of abnormality?
- What are the qualities of individuals with good mental health?

7.0 REFERENCES/FURTHER READING

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UNIT 4: THE SCOPE AND IMPORTANCE OF ABNORMAL PSYCHOLOGY

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 The scope of abnormal psychology

3.2 The importance of abnormal psychology

3.3 Research approaches in abnormal psychology

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit we learnt about the differences between normality and abnormality. We saw that a well-adjusted person is supposed to have efficient perception of reality, self knowledge and self-esteem and acceptance. In the case of abnormality, the person behavior is deviant from the norm, and deviate from the standards of the society.

In this unit, you are going to learn about the importance of abnormality. The reasons why the study of abnormal psychology is important in counselling and the society at large will be discussed.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the scope of abnormal psychology
- Examine the importance of abnormal psychology
- Explain the research approaches in abnormal psychology

3.0 MAIN CONTENTS

3.1 The scope of abnormal psychology

The scope of abnormal psychology may be centred around:

1. The concepts of normality and abnormality. Under this, we can carefully look at behaviours that are considered normal in human organisms and those that

are judged to be abnormal. In fact, this is a complex task to be carried out by psychologists.

2. Causes of abnormal behavior: This scope of abnormal psychology is very important. Here we look at the various causal factors that may be responsible for the different mental disorders found in human organisms. Majorly, we focus discussion on biological, psychosocial, socio-cultural factors as causal agents of abnormality.
3. Symptoms and syndromes of abnormal behavior: This scope of study in abnormal psychology is an imperative. We must be acquainted with the symptoms and syndromes in the different mental disorders to enable us make some diagnosis. A symptom is a physical condition which shows that you have a particular illness. Put simply, symptom is a sign that shows that serious problem exist. Syndromes are a set of physical or mental effects that show that someone has a particular disease.
4. Description of main behavior disorder: Under this scope, the characteristics of all mental disorders are discussed. Every mental disorder has their own peculiar characteristics and knowing them is considered very important for any practitioner in the helping profession.
5. Treatment of behavioural disorders: it is here we discuss the different approaches to the treatment of mental disorders.

Here detailed application of biological method and behavioural approach is highlighted. Under the biological approach different patterns are also learnt. In the behavioural

process, different types ranging from psychodynamic approach to cognitive-behavioural pattern.

3.2 The Importance of Abnormal psychology

1. Abnormal psychology provides us with the knowledge of knowing what normal behavior is and what is abnormal. Behaviourally, the history of patients with phenylketonuria (PKU) may show wide range of abnormalities. These include severe vomiting, smaller than average stature and weight, mild to marked microcephaly, epileptic seizures etc. it only through the study of abnormal psychology that we can know these characteristics of PKU.
2. It is through the study of abnormal psychology that we acquire the knowledge of how biological and genetic factors may create a predisposition toward eating disorders.
3. It is through the knowledge of abnormal psychology that we understand the roles of neurotransmitters in carrying information across the synaptic gap to the next neuron. The neurotransmitters have vital role of play in the behavior of human organisms.
4. The study of abnormal psychology provides us information about the adverse consequences of stress related problems in human life. A careful understanding that stress in its exhaustion stage can kill can only be known in the field o abnormal psychology.

Generally, the study of abnormal psychology is an importance aspect of knowledge that all humans must endeavour to know and internals some of the

essential information in order to live adaptive and acceptable relationships with others in the society.

3.3 Research Approaches in Abnormal Psychology

Researchers of abnormal behaviour face certain special challenges. First, abnormal behaviours and feelings are difficulties to measure objectively because research must rely to a large extent on people's self-reports. Second, people's behaviours and feelings change, often rapidly, complicating assessment. Third, most forms of abnormality probably have multiple causes, and no one study can investigate all possible causes simultaneously. Fourth, ethical concerns limit researchers' abilities to manipulate variables of interest (Nolen-Hoeksema, 2004). You will learn some important research approaches in abnormal psychology with emphasis on scientific method, case studies, correlational studies and experimental studies.

The Scientific Method

Scientific method is a series of steps of obtaining and evaluating information relevant to a problem in a systematic way. In the scientific method, we must state a hypothesis based on a theory. For example, the theory that stress causes depression. A hypothesis is a testable statement of the relationship we expect to see between two or more variables in a study. To generate a testable hypothesis, we need to ask question. How do we prove that stress causes depression? Finding that people who had recently experienced stress are more likely to be depressed than those who had not recently

experienced stress would support the idea. A hypothesis is a statement of what we believe will happen in a study. The primary hypothesis is the one we believe to be true based on a theory. The null hypothesis is the alternative to the primary hypothesis, stating there is no relationship between the independent variable and the dependant variable. The dependent variable is the one we are trying to predict as the outcome in a study. The independent variable is the one that is manipulated in a study to result in the dependent variable. Stress is independent variable and depression is dependent variable. Be attentive as we now focus on case studies.

Case Studies

Case studies have been used for many years as a way of trying to understand the experiences of individuals and to make more general inferences about the sources of psychopathology. Let us go back to the example of stress and depression earlier discussed. If we want to use a case study to test the idea that stress causes depression, we would focus on an individual, interviewing him or her at length, to discover the links between periods of depression and stressful events in his or her life. We might also interview close friends and family to obtain additional information. Based on the information we gathered, we would create a detailed description of the causes of his or her role of stressful events in the episodes.

Case studies are helpful in generating new ideas and in the study of rare problems. Case studies suffer from problems in generalisability and in the

subjectivity of both the person being studied and the person conducting the study (Nolen-Hoeksema, 2004).

Correlational Studies

Correlational studies examine the relationship between two variables without manipulating the variables. A correlation coefficient is usually denoted with the symbol r . A correlation coefficient can fall between -1.00 and $+1.00$. A positively valued correlation coefficient indicates that, as values of the independent variables increase, the values of the dependent correlation increase. For example, a positive correlation between stress and depression would mean that people who report more stressors have higher levels of depression. A negatively valued correlation coefficient indicates that, as values of the independent variable increase, the values of the dependent example, this would mean that people who report more stressors actually have lower levels of depression.

One of the most important things we should take note of in correlations is that they do not tell us anything about causation. That is, even though we may find that an independent and a dependent variables are highly correlated with each other, this does not tell us that the independent variable caused the dependent variable. In other words, even if we found a strong correlation between stress and depression, we should not conclude that stress causes depression. All that a correlation coefficient tells us is that there is a relationship between stress and depression. If we state categorically that stress causes

depression instead of relationship, we commit what is called in research posthoc fallacy.

One of the critical choices in a correlational study is the choice of the sample. A sample is a group of people taken from your population of interest. A sample must be representative. A representative sample is highly similar to the population of interest in terms of sex, ethnicity, age and other essential variables. If a sample is not representative, then the sample is said to have bias. The representativeness of a sample is important to the generalization. You will want to make from your study. If your sample represents only a small or an unusual group of people, then we cannot generalize the results of the study to the larger population. The next focus is an experimental study.

Experimental Studies

The hallmark of experimental studies is control. Here, researchers attempt to control the independent and any potential problem third variables that may arise before they test their hypotheses. We have various types of experimental studies. The first, the human laboratory study, has the goal of including the conditions that we theories will lead to our outcome of interest (for example, increasing stress to cause depression) in people in a controlled setting. The second, the therapy outcome study, also conducted with humans but has the opposite focus of the first types of study. In a therapy outcome study, the researcher wants to reduce the condition leading to the outcome of interest so as to reduce that outcome (for example, decreasing stress to decrease depression).

The third, the animal study attempts to model what happens in humans by manipulating animals in a laboratory. What is important to you in this course is the therapy outcome studies. This alone will be our focus.

Therapy Outcome Studies

For proper understanding, we shall continue with stress and depression example. Therapy outcome studies are appealing because they involve helping people while providing information. The goal of therapy outcome studies is to determine the effectiveness of an experimental therapy over no therapy or as compared with other, often established therapies (Nolen-Hoeksema, 2004; Carson et al., 2004)

Sometimes, people get better simply because of the passage of time. Thus, we need to compare the experiences of people who receive our experimental therapy with those of a control group of people who do not receive the therapy to see if our participants' improvement has anything to do with our therapy. Sometimes, researchers use a simple control group of participants who do not receive the experimental therapy but are tracked for the same period of time as the participants who do receive the therapy. A variation on this simple control group is the **wait list control group**. The participants in this type of group do not receive the therapy when the experimental group does; however they go to a wait list to receive the intervention at a later date when the study is completed. Both groups of participants are assessed at the beginning and end of

the study, but only the experimental group receives the therapy as part of the study.

Another type of control group is the **placebo control group**. This type of group is used most often in studies of the effectiveness of drugs. The participants in this group have the same interactions with experimenters as do the participants in the experimental group, but they take pills that are placebos (inactive substances) rather than the real drug. Usually, both the participants and the experimenters in these studies are unaware what condition the participants are in to prevent demand effects. When this happens, the experiment is known as a **double-blind experiment**.

To ascertain the effectiveness of a particular drug on the treatment of depression during therapy, only the experimental group is given the drug with active ingredients while the control group is given placebos. Therapy outcome studies allow researchers to address a number of methodological and ethical issues. It is difficult to tell which aspect of the therapy led to reduction in the psychopathology (Nolen-Hoeksema, 2004).

4.0 CONCLUSION

In this unit, you learned about the scope, importance of abnormal psychology, you also learned some facts about research approaches in abnormal psychology. This background information is important in that it will guide you to give good assistance to clients during therapy as a professional counseling psychologist.

5.0 SUMMARY

In this unit, you learned the scope of abnormal psychology that covers the concept of normality, causes psychology that covers the concept of normality, causes of abnormal behaviour, symptoms and syndromes, description of main behaviour disorders and treatment of behavioural disorders.

You also learned about the importance of abnormal psychology as it teaches about normal and abnormal behaviours, how biological and genetic factors are implicated in abnormal behaviour and other variables. You also learned the research approaches in abnormal psychology which include the scientific method, case studies, correlational studies and experimental studies. The essence of research is to enable therapists have objective reports about clients' mental disorders.

6.0 TUTOR-MARKED ASSIGNMENT

1. What are the research approaches in abnormal psychology?
2. What is a therapy outcome study?
3. What is placebo control group?

7.0 REFERENCES/FURTHER READING

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UNIT 5: CAUSES OF ABNORMAL BEHAVIOUR

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 causes of abnormal behaviour

3.2 types of causes

3.3 biological causal factors

3.4 Hormonal imbalances

3.5 Genetic vulnerabilities

3.6 Temperament

3.7 Brain dysfunction and neural plasticity

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, we learn about the scope and importance of abnormal psychology. We discovered field of study in abnormal psychology is wide. We also learn about its importance. We realize that it helps us to acquire knowledge on how to live an adaptive and acceptable life in the society.

In this unit, you are going to learn about the causal factors of abnormal behaviours in human organisms. This is an aspect that is considered very important as it will equip us with vital knowledge and it will make us to be careful in the way and manner we live.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the causes of abnormal behavior
- Explain the different causes of abnormal behaviour

- Explain the role of genetic vulnerabilities in abnormal behavior
- Discuss the role of temperament
- Analyse the role of brain dysfunction and plasticity

3.0 MAIN CONTENTS

3.1 Causes of abnormal behavior

3.1 Abnormal Behavior: Types of causes. There are three types, namely:

In spite of one's theoretical perspective, several terms can be used to show the role a factor plays in the etiology, or causal pattern, of abnormal behavior. A necessary cause (e.g., cause X) is a condition that must exist for a disorder (e.g., disorder Y) to occur. A good example is general paresis (Y) a degeneration brain disorder, cannot develop unless a person has previously contracted syphilis (X). 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, Metalsky, & Alloy, 1989). According to this theory, if you are hopeless enough about your future, then you will become depressed.

Lastly, what we study most often in psychopathology research are contributory causes. A contributory cause (e.g., cause X) is one that increase the probability, of a disorder (e.g. disorder (Y) developing but is neither necessary nor sufficient for the disorder to occur. For example, parental rejection could increase the probability that a child will later have difficulty in handling close personal relationship or could increase the probability that being rejected in a relationship in adulthood will precipitate

depression. We can see here that parental rejection is a contributory cause for the person's later difficulties, but it is neither necessary nor sufficient.

Moreover, to distinguish 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 many years later; these would be considered distal 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, may serve as a distal contributory cause predisposing the person to depression or antisocial behaviors in adulthood. By contrast, other causal factors operate shortly before the occurrence of the symptom of a disorder; these would be considered proximal causal factors (Carson, Butcher, Mineka & Hooley, 2011). Sometimes a proximal causal factor may be a condition that proves too much for a person and triggers the onset of a disorder. A loss of job or severe marital difficulties are examples of more proximal causal factors that could lead to depression. In other cases, proximal factors might be involving 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. Another example occurs when a depressed person's behavior alienates friends and family, leading to a greater sense of rejection that reinforces the existing depression (Joiner, 2002). Having looked at types of causes neither let us nor focuses on the actual causes of abnormal behavior.

3.2 BIOLOGICAL CAUSES

The first disorders recognized as having biological or organic components were those associated with gross destruction of brain tissue. These disorders are neurotically diseases- that are; they result from the disruption of brain functioning by physical or biochemical means and often involve psychological or behavioral aberrations. For example, damage to certain areas in brain can cause memory loss, and damage to the left hemisphere that occurs during a stroke can cause dispersion.

Nevertheless, most mental disorders are not caused by neurotically damage per se. For example biochemical imbalances in the brain can lead to mental disorders without causing damage to the brain. Moreover, the bizarre content of delusions and other abnormal mental states like hallucinations can never be caused simply and directly by brain damage. Having said that, let us now focus here on four categories of biological factors that seem particularly relevant to the development of maladaptive behavior.

These are:

1. Neutransmitter and hormonal imbalances in the brain
2. Genetic vulnerabilities
3. Temperament and
4. Brain dysfunction and neural plasticity. It is important to that each of these categories encompasses a number of conditions that influence the quality and functioning of our bodies and our behavior. They are often not independent of

each other, and they often occur in varying combinations in different people. Let us now treat them one by one.

Neurotransmitter and Hormonal Imbalances.

In order for the brain to function normally neurons, or nerve cells, need to be able to communicate effectively one another. The site of the communication between the axon of one neuron and the dendrites and cell body of another neuron is the synapse- a tiny filled space between neurons. These international transmissions are accomplished by neurotransmitters- chemical substances that are released into the synapse by presynaptic neuron when a nerve impulse occurs. There are many different kinds of neurotransmitters; some increase the likelihood that the postsynaptic neuron will “fire” (produce an impulse), and others inhibit the impulse. Whether the neural message is successfully transmitted to the post synaptic neural depends, among other things, on the concentration of certain neurotransmitters within the synapse.

IMBALANCES OF NEUROTRANSMITTERS

One of the basic tenets of biological perspective today is the belief that neurotransmitter imbalances in the brain can result in abnormal behavior and most researchers today agree that this is the only etiology of most disorder. But sometimes psychological stress can bring on neurotransmitter imbalance

Neurons that are sensitive to a particular neurotransmitter tend to cluster together, forming neural paths between different parts of the brain known as chemical circuits. As we will see, different disorders are thought to stem from different patterns of

neurotransmitter imbalances in various brain areas. And different medications used to treat various disorders are often believed to operate by correcting these imbalances.

Although over a hundred neurotransmitters have been discovered to date, four different kinds of neurotransmitter have been most exhaustively studied in relation to psychopathology:

1: nor epinephrine,

2: dopamine,

3: serotonin and

4: gamma amino butyric acid (known as GABA). The first three belong to a class of neurotransmitters called monoamines because each is synthesized from a single amino acid (mono amine means one amine"). Nor epinephrine has been implicated as playing an important role in the emergency reactions our bodies show when we are exposed to an acutely stressful or dangerous situation. Dopamine has been implicated in schizophrenia as well as in addictive disorders. Serotonin has been found to have important effects on the way we think and process information from our environment as well as on behaviors and moods. Not surprisingly, then, it seems to play an important role in emotional disorders such as anxiety and depression as well as in suicide. Lastly, GABA is strongly implicated in reducing anxiety as well as other emotional states characterized by high levels of arousal.

3.3 HORMONAL IMBALANCES

Some forms of psychopathology have also been linked to hormonal imbalances. Hormones are chemical messengers secreted by a set of endocrine glands in our bodies. Each endocrine gland produces and releases its own set of hormones, which travel through our bloodstream and affect various parts of brain and body. Our central nervous system is linked to the endocrine system (in what is known as the neuron endocrine system) by the effects of the hypothalamus on the pituitary gland, which is the master gland of the body, producing a variety of hormones that regulate or control the other endocrine glands.

One particularly important set of interactions occurs in the hypothalamic – pituitary –adrenal – cortical axis. The interaction of this axis involves three processes:

1. Messages in the form of corticotrophin –releasing hormone (CRH) travel from the hypothalamus to the pituitary.
2. In response to CRH, the pituitary releases adrenocorticotrophic hormone (ACTH), which stimulates the cortical part of the adrenal gland (located on top of the kidney) to produce epinephrine (adrenaline) and the stress hormone cortisol. Cortisol mobilizes the body to deal with stress.
3. Cortisol in turn provides negative feedback to the hypothalamus and pituitary to decrease their release of CRH and ACTH, which in turn reduces the release of adrenaline and cortisol. This negative feedback system operates much as a thermostat does to regulate temperature.

We should take note that the malfunctioning of this negative feedback system has been implicated in various forms of psychopathology such as depression and post – traumatic stress disorder. Sex hormones are produced by the gonadal

glands, and imbalance in these (such as the male hormones, the androgens) can also contribute to maladaptive behavior. Moreover, gonadal hormonal influences on the developing nervous system. Also seem to contribute to some of the differences between behavior in men and in women (Collaer & Hines, 1995; Hayward, 2003; Money & Ehrhardt, 1972 as cited in Carson et al., 2011).

3.0 GENETIC VULNERABILITIES.

The biochemical processes we have so far described above are themselves affected by genes. Genes consist of very long molecules of DNA (deoxyribonucleic acid) and are located on chromosomes. Chromosomes are the chain – like structures within a cell nucleus that contain the genes. Genes are the carriers of genetic information that we inherit from our parents and other ancestors. Although neither behavior nor mental disorders are ever determined exclusively by genes, there is substantial evidence that most mental disorders show at least some genetic influence ranging from small to large (Jang, 2005 as cited in Carson, 2011).

Normal human cells have 46 chromosomes containing genetic materials that are encode the hereditary plan that provides the potentialities for development and behavior throughout a life time. The normal inheritance consists of 23 pairs of chromosomes, one of each pair from the mother and one from the father. Twenty – two of these chromosome pairs determine, by the biochemical action, the individual's general anatomical and other physiological characteristics. The

remaining pair, the sex chromosomes, determines the individual's sex. In a female, both of these sex chromosomes – one from each parent – are designated as X chromosomes. In a male, the sex chromosome from the mother is an X, but that from his is a Y chromosome.

Research in developmental genetics has shown that abnormalities in the structure or number of the chromosomes are associated with major defects or disorders. For example, Down's Syndrome is a type of mental retardation (also associated with recognizable facial features such as a flat face and slanted eyes) in which there is a trisomy (a set of three chromosomes instead of two) in chromosome 21. Here the extra chromosome is the primary cause of the disorder. Anomalies may also occur in the sex chromosomes, producing a variety of complications, such as ambiguous sexual characteristics, that may predispose a person to develop abnormal behavior. Fortunately, advances in research have enabled us to detect chromosomal abnormalities, even before birth, thus making it possible to study their effects on future development and behavior.

Although you may hear of scientists having discovered "the gene" for a major disorder, most disorders are not the result of single faulty genes but of combinations of altered genes. Each of these altered genes makes only a small contribution to vulnerability for the disorder. But when a critical number of these altered genes come together, the individual may develop the disorder. This is known as a polygenic process; it takes multiple genetic abnormalities coming together in one individual to create a disorder. Most of the genetic models of the major types of mental disorder are also polygenic. There are a number of physiological disorders,

such as diabetes, coronary heart disease, epilepsy, cleft lip and palate, which are the result of such polygenic processes.

In the field of abnormal psychology, genetic influences rarely express themselves in a simple and straight-forward manner. This is because behavior, unlike some physical characteristics such as eye colour, is not determined exclusively by genetic endowment. It is a product of the organism's interaction with the environment. Put simply, genes can affect behavior only indirectly. Gene "expression" is normally not a simple outcome of the information encoded in DNA but is, rather, the end product of an intricate process that may be influenced by the internal (e.g. intrauterine) and external environment.

The relationship of genotypes to phenotypes

A person's total genetic endowment is referred to as his or her genotype. The observed structural and functional characteristics that result from an interaction of the genotype and the environment are referred to as a person's phenotype. In some cases, the genotypic vulnerability present at birth does not exert its effect on the phenotype until much later in life. In many other cases, the genotype may shape the environmental experiences a child has, thus affecting the phenotype in yet another important way. For example, a child who is genetically predisposed to aggressive behavior may be rejected by his or her peers in early classes because of the aggressive behavior. Such rejection may lead the child to go on to associate with similarly aggressive delinquent peers in later classes, leading to an increased likelihood of developing a full-blown pattern of delinquency in adolescence. When the genotype shapes the environmental experiences

a child has in this way, we refer to this phenomenon as a genotype-environment correlation.

3.5 Temperament

Temperament refers to a child's reactivity and characteristics ways of self-regulation. When we say that babies differ in temperament, we mean that they show differences in their characteristics emotional and arousal responses to various stimuli, and in their tendency to approach, withdraw, or attend to various situations (Rothbart, Derry-berry, & Hershey, 2000 as cited in Carson et al., 2011). Some babies are startled by slight sounds or cry when sunlight hits their faces; others are seemingly insensitive to such stimulation. These behaviours are strongly influenced by genetic factors but prenatal and postnatal environmental factors also play a role in their development (Goldsmith, 2003; Rothbart et al., 2000 as cited in Carson, et al., 2011).

Our temperament is thought to be the basis from which our personality develops. Starting at about 2 to 3 months of age, approximately five dimensions of temperament can be identified: fearfulness, irritability and frustration, positive affect, activity level, and attentional persistence, although some of these emerge later than others. These seems to be related to the three important dimensions of adult personality (1) neurotism or negative emotionality, (2) extraversion or positive emotionality, and (3) constraint (conscientiousness and agreeableness).

We should take not that temperament may also set the stage for the development of various forms of psychopathology later in life. For example, children who are fearful in many situations have been labeled behaviourally inhibited. This trait

has a significant heritable component (Kagan, 2003), and when it is stable, it is a risk factor for the development of anxiety disorders later in childhood and probably in adulthood. Conversely, 2 year old children who are highly uninhibited, showing little fear of anything, may have difficulty learning moral standards for their behavior from parents or society. These group of children have been show at age 13 to exhibit more aggressive and delinquent behavior.

3.6 Brain Dysfunction and Neural Plasticity

Deficiencies of brain structure or function are implicated in many mental disorders. The use of sophisticated new neuro imaging techniques to study the brain function and structure has helped to reveal the cause of mental disorders. There is also issue of neural plasticity. This is the flexibility of the brain in making changes in organization and/or function in response to pre and postnatal experiences, stress, diet, disease, drugs, maturation, etc. existing neural circuits can be modified or new neural circuits can be generated. The effects can either be beneficial or detrimental to the animal or person depending on the circumstances.

4.0 Conclusion

We have learned from this unit that biological or organic components are associated as causal factors of mental disorders. The role of neurotransmitters and hormonal imbalances are also implicated in mental disorders. In addition

temperament and brain dysfunction and neural plasticity are identified as important agents of disorders.

5.0 Summary

In this unit, you learn the following important facts about causes of abnormal behaviours:

1. Necessary sufficient and contributory cause of mental disorders
2. Biological factors responsible for mental disorders
3. The role of neurotransmitters and hormonal imbalances
4. Temperament of the human organisms
5. Brain dysfunction and neural plasticity

6.0 Tutor-Marked Assignment

- What is the relationship between genotypes and phenotypes, and how can genotypes shape and interact with the environment?
- What is temperament, and why is it important for the origin abnormal behavior
- What do we mean by neural plasticity

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MODULE 2

Unit 1: The Psychodynamic Perspectives on Abnormality

Unit 2: New Psychodynamic Perspective

Unit 3: Behavioural Perspective

Unit 4: Cognitive perspective, Humanistic and Existential Perspective

Unit 5: The Classification of Mental Disorders.

UNIT 1: THE PSYCHODYNAMIC PERSPECTIVE ON ABNORMALITY

CONTENTS

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2.0 Objectives

3.0 Main Content

3.1 Psychosocial view points on Abnormal Behaviour

- 3.2 Psychodynamic Perspectives
- 3.3 Fundamentals of Freud's Psychoanalytic Theory
- 3.4 Anxiety, Defense Mechanisms and Unconscious
- 3.5 Psychosexual Stages in Freudian Theory
- 4.0 Conclusion
- 5.0 Summary
- 6.0 Tutor-Marked Assignment
- 7.0 References/Further Reading

1.0 INTRODUCTION

In this unit, you are going to learn about the psychodynamic perspectives on abnormal behavior. Here you gain important knowledge of a psychologist who is regarded as a giant in the field of abnormal psychology. The psychological cannon he fired many years ago are still reverberating in the field of abnormal psychology. His name is Sigmund Freud. Without him the field of abnormal psychology could not have existed. His name will linger in this field.

In this unit, you will learn about his position on abnormality, and the fundamentals of his prominent theory known as psychoanalytic. Furthermore, you will learn about anxiety, defense mechanisms and the unconscious. This unit will be concluded with psychosexual stages in Freudian theory. You must be attentive to learn something here. Even though we shall learn about other

perspectives, this theory is regarded as the solid foundation upon which other theories evolved.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the psychodynamic perspectives of abnormality
- Discuss the fundamentals of Freud's Psychoanalytic theory
- Explain the concept of anxiety, defense mechanism and unconsciousness
- Analyse psychosexual stages in Freudian theory

3.0 MAIN CONTENT

3.1 The Psychosocial view points on Abnormal Behaviour

The psychosocial perspectives attempt to understand humans not just as biological organisms but also as a people with motives, desires, and perceptive. We will examine in some depth five perspectives on human nature and behavior that have been particularly influential. Psychodynamic, behavioural, cognitive, humanistic, and existential perspectives.

3.2 The Psychodynamic Perspectives

Sigmund Freud founded the psycho-analytic school, which emphasized the role of unconscious motives and thoughts, and their dynamic interrelationships in the determination of both normal and abnormal behavior. A key concept here is the unconscious. According to Freud, the conscious part of the mind represents a relatively small area, whereas the unconscious part, like the submerged part of

the iceberg, is the much larger portion. In the depths of the unconscious are the hurtful memories, forbidden desires, and other experiences that have been repressed – that is, pushed out of consciousness. However, unconscious material continues to seek expression and emerges in fantasies, dreams, slips of the tongue, and so forth, as well as when an individual is under hypnosis. Until the unconscious material is brought to awareness and integrated into the conscious part of the mind for example, through psychoanalysis it may lead to irrational and maladaptive behavior. In the next pages, we shall look at a general overview of the principles of classical psychoanalytic theory and the newer psychodynamic perspectives that after Freud's original psychoanalytic theory.

3.3 Fundamental of Freud's Psychoanalytic Theory

The structure of Personality: ID, Ego, and Superego.

Freud theorized that a person's behaviour results from the interaction of three key components of the personality or psyche: the id, ego, and superego. The id is the source of instinctual drive and is the first structure to appear in infancy. These drives are inherited and are considered to be of two opposing types: (1) life instincts, which are constructive drives primarily of a sexual nature and which constitute the libido, the basic emotional and psychic energy of life, and (2) death instincts, which are destructive drives that tend toward aggression, destructive, and eventual death. Freud used the term sexual in a broad sense to refer to almost anything pleasurable, from eating to painting. The id operates on the pleasure principle, engaging in completely selfish and pleasure-oriented

behaviour, concerned only the immediate gratification of instinctual needs without reference to reality or moral considerations. Although the id can generate mental images and wish-fulfilling fantasies, referred to as primary process thinking, it cannot undertake the realistic actions needed to meet instinctual demands.

Consequently, after a few months of life, a second part of the personality, as viewed by Freud, develops the ego. The ego mediates between the demands to the id and the realities of the external world. For example, during toilet training the child learns to control a bodily function to meet parental societal expectations, and it is developing ego that assumes the role of mediating between the physical needs of the body/id and the need to find an appropriate place and time. One of the basic function for the ego is to meet id demands, but in such a way as to ensure the well-being and survival of the individual. This role requires the use of reason and other intellectual resources in dealing with the external world, as well as the exercise of control over id demands. The ego's adaptive measures are referred to secondary process thinking, and the ego operates on the reality principle.

Freud viewed id demands, especially sexual and aggressive strivings, as inherently in conflict with the rules and prohibitions imposed by the society. He postulated that as a child grows and gradually learns the rules of parents and society regarding right and wrong, a third part of the personality gradually emerges from the ego – the superego. The superego is the outgrowth of internalizing the taboos and moral values of society concerning what is right and wrong. It is essentially what we refer to as the conscience. As the superego

develops, it becomes an inner control system that deals with the inhibited desires of the id. Because the ego mediates among the desires of the id, the demands of reality, and the moral constraints of the superego, it is often the executive branch of the personality.

Freud believed that the interplay of id, ego and superego is of crucial significance in determining behaviour. Often inner mental conflicts arise because the three sub-systems are striving for different goals. If unresolved, these intrapsychic conflicts lead to mental disorder.

3.4 Anxiety, Defense Mechanisms and the Unconscious

The concept of anxiety – generalized feelings of fear and apprehension is prominent in the psychoanalytic view point because it is an almost universal symptom of neurotic disorders. Indeed, Freud believes that anxiety played a key causal role in most of the forms of psychopathology. Sometimes the anxiety is overtly experienced, and sometimes it is repressed and then transformed into and manifested in other overt symptoms.

Anxiety is a warning of impending real or imagined dangers as well as a painful experience, and it forces an individual to take corrective action. Often, the ego can cope with the objective world through rational measures. However, neurotic and moral anxiety, because they are unconscious, usually cannot be dealt with through rational measures. In these cases the ego resorts to irrational protective measures that are referred to as ego-defense mechanisms, which shall be described below in a table. These defense mechanisms discharge or

soothe anxiety, but they do so by helping a person push painful ideas out of consciousness. These mechanisms result in a distorted view of reality, although some are more clearly adaptive than others.

Table: Ego-Defence Mechanisms

Name of defence mechanism	Description	Example
Repression	Preventing painful or dangerous thoughts from entering consciousness. The master defence mechanism	A mother's occasional murderous impulse towards her hyperactive 2 year old are denied access to awareness
Displacement	Discharging unacceptable feelings against someone or something other than the true target of these feelings	A woman harassed by her boss at work initiates an argument with her husband at home
Denial	Failing/refusing to acknowledge/perceive some aspect of reality	Refusing to accept that you have a serious illness or your partner is

		going of you
Rationalization	Finding an acceptable excuse (a 'cover story') for some reality quite unacceptable behaviour/situation	Being cruel to be kind: I only did it because I love you
Sublimation	Channeling frustrated sexual energy into substitutive activities	A sexually frustrated artist paints wildly erotic pictures
Reaction formation	Preventing the awareness or expression of unacceptable desires by an exaggerated adoption of seemingly opposite behaviour	A woman who fears her sexual urges becomes a religious zealot
Projection	The ego attributes personal shortcomings, problems, and faults to others	A man who has a strong desire to have an extramarital affair accuses his wife of flirting with other men
Regression	The ego seeks the security of an earlier developmental period in the face of stress	A woman returns home to mother every time she and her husband have a big argument
Fixation	Attaching oneself in an unreasonable or exaggerated way	An unmarried middle aged man still depends

	to some person, or arresting emotional development on a child or adolescent level	on his mother to provide his basic needs
Intellectualization	Adopting a cold, distanced perspective on a matter that actually creates strong, unpleasant feelings	An emergency room physician who is troubled by seeing young people with severe gunshot wounds every night has discussions with colleagues that focus only on the technical aspects of treatment
Identification	Adopting the ideas, values, and tendencies of someone in a superior position in order to elevate self-worth	Prisoners adopt the attitudes of prison officers toward other prisoners.

(Carson et al., 2011; Santrock 2000, Nolen-Hoeksema 2004, & Gross, 2010).

3.5 Psychosexual Stages in Freudian Theory

Freud proposed that, as they develop, children pass through a series of universal psychosexual stages. In each stage, sexual drives are focused on the stimulation of certain body areas, and particular psychological issues can arouse anxiety. The id, ego, and superego must negotiate and develop through these stages

successfully for the child to develop into psychologically healthy adult. The responses of caregivers, usually parents, to the child's attempts to satisfy basic needs and wishes can greatly influence whether a given stage is negotiated successfully. If the parents are not appropriately responsive to the child, helping him or her learn acceptable ways of satisfying and controlling drives and impulses, the child can become fixated at a stage, trapped in the concerns and issues of that stage, trapped in the concerns and issues of that stage, trapped in the concerns and issues of that stage, never successfully moving beyond that stage and through subsequent stages. Let us now discuss the stages briefly.

Oral Stage: 0 – 18th. The oral stage lasts for the first 18 months following birth. In the oral stage, libidinal impulses are best satisfied through stimulation of the mouth area, usually through feeding or sucking. At this stage, the child is entirely dependent on caregivers for gratification, and thus the central issues of this stage are issues of one's dependence and the reliability of others. If the child's caregiver, usually its mother, is not sufficiently available to the child, he or she can develop deep mistrust and fear of abandonment. Children fixated at the oral stage develop an "oral-character" – a personality characterized by excessive dependence on others but mistrust of their love. A number of habits focused on the mouth area, for example, smoking, or excessive drinking and eating are said to reflect on oral character.

Anal stage: 18 months to 3 years. The anal stage lasts from about 18 months to 3 years of age. During this phase, the focus of gratification is the anus. The child becomes very interested in toilet activities, particularly the passing and

retaining of feces. Parents can cause a child to become fixated at this stage by being too harsh or critical during toilet training. People with an “anal personality” are said to be stubborn, over controlling, stingy, and too focused on orderliness and tidiness.

Phallic stage: 3 – 6 years. During the phallic stage, lasting from about ages 3 to 6 years, the focus of pleasure is the genitals. It is during this stage that one of the most important conflicts in sexual development occurs, and it occurs differently for boys and girls. Freud believed that boys and girls. Freud believed that boys become sexually attracted to their mothers and hate their fathers as rivals. Freud labeled this the Oedipus complex, after the character in Greek mythology that unknowingly kills his father and married his mother. Boys fear that their fathers will retaliate against them by castrating them, however. This arouses castration anxiety, which is then the motivation of putting aside their desire for their mothers and aspiring to become like their fathers. The successful resolution of the Oedipus complex helps boys identifying with their fathers value system.

Freud believed that, during the phallic stage, girls recognize that they do not have a penis and are horrified at this discovery. They also recognize that their mothers do not have penis and disdain their mothers and all females for this deficit. Girls develop an attraction for their fathers, in hopes that they will provide the penis they lack. He labeled this the Electra complex, after the character in Greek mythology that conspires to murder her mother to avenge her father's death. Obviously, girls cannot have castration anxiety, because according to

Freud, they feel they have already been castrated. As a result, girls do not have as strong a motivation as boys to develop a superego. Freud argued that females never do develop a superego. Freud argued that females never do develop superego as strong as males' and this leads to a greater reliance on emotion than on reason in the lives of women. Freud also thought that much of women's behaviour is driven by penis envy, the wish to have the male sex organ.

The unsuccessful resolution of the phallic stage can lead to a number of psychological problems in children. If children do not fully identify with their same-sex parent, they may not develop "appropriate" gender roles or a heterosexual orientation. They also may not develop healthy superego and thus be either too self-aggrandizing or too self-deprecating. If children's sexual attraction to their parents is not responded to with gentle but firm discouragement, they may become overly seductive or sexualized and have a number of problems in romantic relationships.

Latency stage: 6 years to puberty. After the turmoil of the phallic stage, children enter the latency stage, during which libidinal drives are quelled somewhat and other attention turns to developing skills and interests and becoming fully socialized into the world in which they live. They play with friends of the same sex and avoid children of the opposite sex – this is when girls hate boys and boys hate girls.

Genital stage: puberty through adulthood. At about the age of 12, children's sexual desires emerge again as they enter puberty, and they enter the

genital stage. If they have successfully resolved the phallic stage, their sexual interests turn to heterosexual relationships. They begin to pursue romantic alliances and learn to negotiate the world of dating and early sexual encounters with members of the opposite sex.

4.0 CONCLUSION

In this unit, you learnt about psychodynamic theory of Sigmund Freud, his psychoanalytic theory and the concept of anxiety, defense mechanisms were discussed and the unit was concluded with psychosexual stages.

5.0 SUMMARY

In this unit, the following issues were discussed and learned

- Psychodynamic perspectives that involve unconscious and conscious parts of the personality
- Psychoanalytic theory that involves the id, ego and superego.
- The different forms of defense mechanisms and anxiety were presented and analysed.

6.0 TUTOR-MARKED ASSIGNMENT

- What are the fundamentals of Freud's psychoanalytic theories?
- Explain the concept of anxiety
- List and describe the different forms of defense mechanisms in line with Freudian theory.

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UNIT 2: NEW PSYCHODYNAMIC PERSPECTIVE

CONTENTS

- 1.0 Introduction
- 2.0 Objectives
- 3.0 Main Content
 - 3.1 Newer psychodynamic perspectives
 - 3.2 object relation theory
 - 3.3 the interpersonal perspective
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 - 3.5 Impact of psychodynamic perspectives
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1.0 INTRODUCTION

In the last unit, you learnt about psychodynamic theory of Sigmund Freud. Issues concerning his psychoanalytic theory were discussed. The concept of anxiety, defense mechanisms and unconsciousness were operationalised. You also learnt about the psychosexual stages in Freud's theory.

In this unit, you will learn about newer psychodynamic perspectives, object-relation theory, the interpersonal perspective, attachment theory and the impact of psychodynamic perspectives.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Discuss newer psychodynamic perspectives
- Explain object relation theory
- Explain the interpersonal perspective
- Discuss attachment theory

3.0 MAIN CONTENT

3.1 Newer Psychodynamic Perspectives

In seeking to understand his patients and develop his theories, Freud and chiefly concerned with the workings of the id, its nature as a source of energy, and the manner in which this id energy could be channeled or transformed. He also focused on the superego but paid relatively little attention to the importance of the ego. Later theorists developed some of Freud's basic ideas in three somewhat different directions. One new direction was that taken by his daughter

Anna Freud (1895 – 1982), who was much more concerned with how the ego performed its central functions as the “executive of personality”. She and some of the other influential second generation of psychodynamic theorists refined and elaborated on the ego defence reactions and put the ego in the foreground, giving it an important organizing role in personality development.

According to this view psychopathology develops when the ego does not function adequately to control or delay impulse gratification or does not make adequate use of defense mechanisms when faced with internal conflicts. This school becomes known as ego psychology. Embarking in a second new direction, other theorists focused the role of an infant’s very early relationships (especially the mother – infant relationship) on the development of his or her personality and self-concept. The third group of influential second generation psychodynamic theorists focused on social determinants of behaviour and on the importance of people’s interpersonal relationships. All three of these new directions omit the traditional (Freudian) psychoanalytic theory’s emphasis on the primary of libidinal energies and intrapsychic conflicts.

3.2 Object-Relations Theory

Object-relations theory was developed by a number of prominent theorists including Melanie Klein, Margaret Mahler, W.R.D. Fairburn, and D. W. Winnicott, starting in the 1930s and 1940s. Although there are many variations on object relations

theory, they share a focus on individuals' interactions with real and imagined other people (external and internal objects) and on the relationship that people experience between their external and internal objects (external and internal objects) and on the relationship that people experience between their external and internal objects (Engler, 2006; Greenberg & Mitchell, 1983 as cited in Carson et al., 2011). An object in this context refers to the symbolic representation of another person in the infant's or child's environment, most often a parent. Though a process of introjections (internal process by which a child incorporates symbolically, through images and memories, important people in his or her life), a child symbolically incorporates into his or her life personality. For example, a child might internalize images of a punishing father, that image then becomes a harsh self-critic influencing how the child behaves. The general notion is that internalized objects could have various conflicting properties – such as exciting or attractive versus hostile, frustrating or rejecting and also that these objects existence, thus giving rise to conflicts. An individual experiencing such splitting among internalized objects is, so to speak, “the servant of many masters” and cannot therefore lead an integrated orderly life.

Several other influential American analysts have become advocates of object relations points of view. Among them is Otto Kernberg noted especially for his studies of both borderline and narcissistic personalities (Kernberg, 1985, 1989, 1998). Kernberg's view is that peoples with borderline personality, whose chief characteristics is instability (especially in personal relationships), are individuals who are unable to achieve a full and stable personal identity (self) because of an inability to integrate and reconcile pathological internalized objects. Because of their inability to structure their internal

world in such a way that the people they know (including themselves) can have a mixture of both good and bad traits, they also perceive the external world in abrupt extremes. For example, a person may be “all good” one moment and “all bad” the next.

3.3 The Interpersonal Perspective

We are social beings, and much of what we are is a product of our relationship with others. It is logical to expect that much of psychopathology reflects this fact – that psychopathology is rooted in the unfortunate tendencies we developed while dealing with our intrapersonal environments. This is the focus of the interpersonal perspective, which began with the defection in 1911 of Alfred Adler (1870 – 1937) from the psychoanalytic viewpoint of his teacher, Freud, and instead emphasizes social and cultural forces, rather than inner instincts as determinant of behaviour. An Adler’s view, people are inherently social beings motivated primarily by the desire to belong to and participate in a group.

Overtime, a number of other psychodynamic theorists also took issue with psychoanalytic theory for its neglect of crucial social factors. Among the best known of these theorists were Erick Fromm (1900 – 1980) and Karen Horney (1883 – 1952). Fromm focused on the orientations, or dispositions (exploitative, for example), that people adopted in their institutions with others. He believed that when these orientations to the social environment were maladaptive, they serve as the bases of much psychopathology. Horney independently developed a similar view and, in particular, rigorously rejected Freud’s demeaning

psychoanalytic view of women (for instance, the idea that women experiences penis envy).

Erik Erikson (1902 – 1994) also extended the interpersonal aspects of psychoanalytic theory. He elaborated and broadened Freud's psychosexual stages into more socially oriented concepts, describing crises or conflict that occurred at eight stages, each of which could be resolved in a healthy or unhealthy way. For example, Erikson believed that during what Freud called the oral "stage", when a child is preoccupied with oral gratification, a child's real development centres on learning either "basic trust" or "basic mistrust" of her or his social world. Learning a certain amount of trust, for instance, is necessary for later competence in many areas of life.

3.4 Attachment theory

Finally, John Bowlby's attachment theory, which can in many ways be seen as having its roots in the interpersonal and object relations perspectives, has become an enormously influential theory in child psychology and child psychiatry, as well as in adult psychopathology. Drawing from Freud and others from these perspectives, Bowlby's theory (1969, 1973, 1980) emphasizes the importance of early experience, especially early experience with attachment relationships as laying the foundation for later functioning throughout childhood, adolescence and adulthood. He stressed the importance of the quality of parental care to the development of secure attachment, but he also saw the infants as playing a more active role in shaping the course of their own development than

had most of the earlier theorists (Carlson & Sroufe, 1995; Sroufe, Carlson, Levy & Egeland, 2003 as cited in Carson et al., 2011).

3.5 Impact of the Psychodynamic Perspectives

Freud's psychoanalytic theory can be seen as the first systematic approach to showing how human psychological processes can result in mental disorders. Much as biological perspective has replaced superstition with organic pathology as the suspected cause of mental disorders for many psychiatrists and psychologists, the psychoanalytic perspective replaced brain pathology with intrapsychic conflict and exaggerated ego defences as the suspected cause at least some mental disorders.

Freud greatly advanced our understanding of both normal and abnormal behaviour. Many of his original concepts have become fundamental to our thinking about human nature and behaviour, and have even had an important influence on the intellectual history of Western civilization. Put simply, the psychological cannon he fired many years ago still reverberating. Two of Freud's contributions stand out as particularly noteworthy:

1. He developed the therapeutic techniques such as free association and dream analysis for becoming acquainted with both the conscious and the unconscious aspects of mental life. The results obtained led Freud to emphasize several points that have been incorporated (in modified forms) into current thinking: (a) the extent to which unconscious motives and defence mechanisms affect behaviour, meaning that the

causes of human behaviour are generally not obvious or available to conscious awareness; (b) the importance of early childhood experiences in the development of both normal and abnormal personality; and (c) the importance of sexual factors in human behaviour and mental disorders.

2. He demonstrated that certain abnormal mental phenomenon occur in the attempt to cope with difficult problems and are simply exaggerations of normal ego-defence mechanisms. This realization that the same psychological principles apply to both normal and abnormal behaviour dissipated much of the mystery and fear surrounding mental disorders.

4.0 CONCLUSION

We have learned about the newer psychodynamic perspectives of abnormality that is different from the position of Sigmund Freud. While Freud's psychodynamic perspectives emphasized the libidinal energies and intrapsychic conflicts, the newer psychodynamic theorists laid emphasis on individual's interactions with real and imagined (external or internal) and the relationship that experience between their external and internal objects. It was concluded that as human beings we need social interaction for healthy living.

5.0 SUMMARY

In this unit we discussed newer psychodynamic perspectives of abnormality. The following facts emerged.

- Object-relation perspectives emphasized the interactions of individuals with his external and internal objects in his environment
- The interpersonal perspective harped on the individuals relationship with people in his environment
- Quality of parental care was highly emphasized in the attachment theory postulated by Bowlby's theory

6.0 TUTOR-MARKED ASSIGNMENT

- Explain object relations theory perspectives about abnormality
- What is attachment and why is it important in the life of children
- Discuss the interpersonal perspective of abnormality

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UNIT 3: BEHAVIOURAL PERSPECTIVE

CONTENTS

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 - 3.3 Operant conditioning
 - 3.4 Modelling and observational learning
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1.0 INTRODUCTION

In the last unit, you learned about newer psychodynamic perspective on abnormality. You saw the clear-cut difference between psychodynamic

perspective and the newer psychodynamic. You also learn about the interpersonal theory, attachment theory and the unit was concluded with impact of psychodynamic perspective.

In this unit, you will learn about the behavioural perspective on abnormality. You will learn more about classical, conditioning theory of Ivan Petrovich Parlov, Operant conditioning of B.F. Skinner a radical behaviourist, Modelling and observational theory of Albert Bandura and the unit will end with the impact of behaviooural perspective.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the behavioural perspective on abnormality
- Discuss classical conditioning theory on abnormality
- Analyse operant conditioning on abnormality
- Explain modeling and observational theory on abnormality
- Explain the impact of behavioural perspective on abnormality

3.0 MAIN CONTENT

3.1 Behavioural Perspectives

The behavioural perspective arose in the early twentieth century in part as a reaction against the unscientific methods of psychoanalysis. Behavioural psychologists believed that the study of subjective experience (e.g. free

association and dream analysis) did not provide acceptable scientific data because such observation was not open to verification by other investigation. In their view, only the study of directly observable behaviour and of the stimuli and reinforcing conditions that control it could serve as a basis for understanding human behaviour, normal and abnormal. The principles of behaviourism, however, focus on how behaviours are learned through experiences in the environment. The two core principles or processes of learning according to behaviourism are classical conditioning and operant conditioning. Later, behaviourists acknowledged that learning can occur through modeling and observational learning. It is now time to discuss the principles of behaviourism, so be attentive.

3.2 Classical Conditioning

Ivan Pavlov, a Russian physiologist, was conducting experiments on the salivary glands of dogs when he made discoveries that would revolutionise psychological theory. Not surprisingly, his dogs would salivate when Pavlov noticed that, after a while, the dogs would begin to salivate when he or an assistant simply walked into the room. This phenomenon gained that name classical conditioning. Pavlov had paired a previously leads to a certain response (the dish of food, which leads to salivating), and eventually the neutral stimulus (Pavlov) was able to elicits that response (salivation). He named the stimulus that naturally produced the desired response the unconditioned stimulus (US), and he named the response created by the unconditioned stimulus the unconditioned response (UR). Thus, in Pavlov's experiments, the dish of food was the US and

salivation in response to this food was the UR. He named the previously neutral stimulus the conditioned stimulus (CS) and the response that it elicited the conditioned response (CR). Thus, Pavlov was the CS, and when the dogs salivated in response to seeing him, thus salivation became the CR. The same general process occurs when a neutral CS is paired with a painful or frightening stimulus such as a mild electric shock or loud noise.

The hallmark of classical conditioning is that a formerly neutral stimulus – the CS – acquires the capacity to elicit biologically adaptive responses through repeated pairing with the UCS. However, we also now know that this process of classical conditioning is not as blind or automatic as was once thought. Rather, it seems that animals (and people) actively acquire information about what CSs allow them to predict, expects, or prepare for an upcoming biological significant event (the UCS). That is, they learn what is called stimulus – stimulus expectancy. Indeed, only CSs that provide reliable and nonredundant information about the occurrence of a UCS acquire the capacity to elicit CRs.

Classical conditioned responses are well maintained over time; that is, they are not simply forgotten (even over many years). However, if a CS is repeatedly presented without the UCS, the conditioned response gradually extinguishes. This gradual process is known as extinction, should not be confused with the idea of unlearning, because we know that the response may return at some future point in time (a phenomenon Pavlov called spontaneous recovery). Below is an illustration of classical conditioning.

Classical conditioning

Before conditioning:

Conditioned stimulus (neutral) CS \longrightarrow Orientation response to light

Unconditioned stimulus (UCS) → Unconditioned response (UCR)
(Painful stimulus) (Pain and fear)

During conditioning

Conditioned stimulus (light) (CS)

+

Unconditioned stimulus (UCS) \longrightarrow conditioned response (fear) (CR)

(Painful stimulus)

Following conditioning:

Conditioned stimulus (alone) (CS) \longrightarrow conditioned response (fear) (CR)

Looking at the illustration given, before conditioning, the CS has no capacity to elicit fear, but after being repeatedly followed by a painful or frightening UCS that elicits pain or distress, the CS gradually acquires the capacity to elicit a fear CR.

Classical conditioning is important in abnormal psychology because many physiological and emotional responses can be conditioned, including those related to fear, anxiety, or sexual arousal and those stimulated by drugs of abuse. Thus, for

example, one can learn a fear of the dark of fear-producing stimuli (such as frightening dreams or fantasies) occur regularly in the dark, or one can acquire a fear of snakes if bitten by a snake.

Classical conditioning can also explain why heroin addicts sometimes have physiological response similar to those they have when they take heroin if they simple see a syringe. They have developed a conditioned physiological response to syringes (which have become a conditioned stimulus) because of the frequent pairing of the syringes with the actual physiological action of the drugs.

3.3. Operant Conditioning

E.L. Thorndike observed that behaviours that are followed by a reward are strengthened, whereas behaviour that is followed by a punishment is weakened. This simple but important observation, which Thorndike labeled the law of effect, led to the development of the principles of operant conditioning – the shaping of behaviour as by providing rewards for desired behaviours and punishments for undesired behaviours. B.F. Skinner is the psychologist most strongly associated with operant conditioning. He showed that a pigeon will learn to press on a bar if pressing it is associated with the delivery of food, and it will learn to avoid pressing another bar if pressing it is associated with electric shock.

In operant conditioning (also called instrumental conditioning), an individual learns how to achieve a desired goal. The goal in question may be to obtain something that is rewarding or to escape from something that is

unpleasant (like the example already given by pigeon). Essential here is the concept of reinforcement, which refers either to the delivery of a reward or pleasant stimulus, or to escape from an aversive stimulus. New responses are learned and tend to recur if they are reinforced. Although it was originally thought that instrumental conditioning consisted of simple strengthening of a stimulus – response connection every time that reinforcement occurred, it is now believed that the animal or person learns a response – outcome expectancy (Domjan, 2005 as cited in Carson et al., 2011). This means that a person learns that a response will lead to a reward outcome. If sufficiently motivated for that outcome (e.g. being hungry), the person will make the response that he has learned produces the outcome (e.g. opening the refrigerator).

Initially a high rate of reinforcement may be necessary to establish an instrumental response, but lesser rates are usually sufficient to maintain it. In fact, an instrumental response appears to be especially persistent when reinforcement is intermittent – when the reinforcing stimulus does not invariably follow the response – as demonstrated in gambling when occasional wins seem to maintain high rates of responding. However, when reinforcement is consistently withheld over time, the conditioned response – whether classical or instrumental – gradually extinguishes.

A special problem arises in extinguishing a response in situations in which a subject has been conditioned to anticipate an aversive event and to make an instrumental response to avoid it. For example, a boy who has nearly drowned in the river Niger may develop a fear of water and a conditioned avoiding response in

which he consistently avoids all large bodies of water. When he sees a pond, lake, or swimming pool, he feels anxious; running away and avoiding contact lessens his anxiety and thus is reinforcing. As a result, his avoidance response is highly resistant to extinction. It also prevents him from having experiences with water that could bring about extinction of his fear. As we shall see in behaviour modification discussions, many of the therapeutic techniques developed by behavioural theorists are designed to extinguish conditioned avoidance responses, which can often interfere greatly with a person's ability to function in everyday life. It is pertinent to look at two common concepts used both classical and operant conditioning, namely, generalization and discrimination.

Generalization and Discrimination

In both classical and operant conditioning, when a response is conditioned to one stimulus or set of stimuli, it can be evoked by other, similar stimuli; this process is called generalization. A person who fears bees, for example, may generalize that fear to all flying insects. A process complementary to generalization is discrimination, which occurs when a person learns to distinguish between similar stimuli and to respond differently to them based on which ones are followed by reinforcement. For example, because yellow orange taste good and green ones do not, condition discrimination will occur if a person has experience with both.

The concepts of generalization and discrimination have many implications for the development of maladaptive behaviour. Although generalization enables us to use past experiences in sizing up new situations, the possibility of making inappropriate

generalizations always exists, as when a troubled adolescent fails to discriminate between friendly and hostile teasing from peers.

3.4 Modelling and Observational Learning

Skinner and other “pure” behaviourists have argued that humans and animals learn behaviour only by directly experiencing the rewards or punishments for these behaviours. In the 1950s, however, psychologist Albert Bandura argued that people can also learn behaviours by watching other people, a view that came to be known as social learning theory.

First, in modeling, people learn new behaviours from imitating the behaviors modeled by important people in their lives, such as their parents. Learning through modeling is more likely to occur when the person modeling the behaviour is seen as an authority figure or is perceived to be like oneself. For example, Bandura (1969) argued that children are most likely to imitate the behaviours modeled by their same sex parent, because this parent is an authority figure and because their same sex parents seem more similar to them than does their opposite-sex parent.

Observational learning takes place when a person observes the rewards and punishments that another person receives for his or her behaviour and then behaves in accord with those rewards and punishments. For example, a child who views his sibling being punished for dropping food on the floor will learn, through observation, the consequences of dropping food on the floor and thus will be less likely to engage in this behaviour herself. Some theorists argue that even extremely negative behaviour, such as teenagers going on armed robbery,

are also due to observational learning. Teenagers see heroes in the media being rewarded for violent behaviour and thus learn that behaviour.

For observational learning, Bandura did a classic series of experiments in the 1960s on how children observationally learned various novel aggressive responses towards a large Bobo doll after they had observed models being reinforced for these responses. Although the children themselves were never directly reinforced for showing these novel aggressive responses, they nonetheless showed them when given the opportunity to interact with the Bobo doll themselves. The possibilities for observational conditioning of both classical and instrumental responses greatly expand our opportunities for learning both adaptive and maladaptive behaviour. It is now time to look at the impact of the behavioural perspective.

3.5 Impact of the Behavioural perspective

By means of relatively few basic concepts, the behavioural perspective attempts to explain the acquisition, modification and extinction of nearly all types of behaviour, maladaptive behaviour is viewed as essentially the result of (i) a failure to learn necessary adaptive behaviour or competencies, such as how to establish satisfying personal relationships, and/or (2) the learning of ineffective or maladaptive response. Maladaptive behaviour is thus the result of learning that has gone awry and is defined in terms of specific, observable, undesirable responses.

For the behaviour therapists, the focus of therapy is on changing specific behaviours and emotional responses – eliminating undesirable reactions and learning

desirable ones. For example, fears and phobias can be successfully treated by prolonged exposure to feared objects or situations, a kind of extinction procedure derived from principles of extinction of classically conditioned responses. Classic work using the principles of operant conditioning also showed that chronically mentally ill people can be retaught basic living skills such as clothing and feeding themselves through the use of token that are earned for appropriate behaviour and that can be changed for desirable rewards (candy, time watching television, passes to go outside, etc).

The behavioural approach is well known for its precision and objectivity, for its wealth of research and for its demonstrated effectiveness in changing specific behaviours. A behaviour therapist specifies what behaviour is to be changed and how it is to be changed. Later, the effectiveness of the therapy can be evaluated objectively by the degree to which the stated goals have been achieved. On the other hand, the behavioural perspective has been criticized for being concerned only with symptoms. However, this criticism is considered unfair to many contemporary behaviour therapists, given that successful symptom – focused treatment often has very positive effects on other aspects of a person's life. Still others have argued that the behavioural approach oversimplifies human behaviour and is unable to explain all of its complexities. Whatever its limitations, the behavioural perspective has had a tremendous impact on contemporary views of human nature, behaviour and psychopathology.

4.0 CONCLUSION

In this unit, you have learnt about behavioural perspective of abnormality. You have acquired knowledge about classical conditioning which means that formerly neutral stimulus (CS) can acquire the capacity to elicit biologically adaptive responses through repeated pairing with the UCS. In operant conditioning an individual learns how to achieve a desired goal. In modeling, people learn new behaviours from imitating the behaviours modeled by important people in their lives. The behavioural approach is well known for its precision and objectivity.

5.0 SUMMARY

In this unit, you have learned the following

- Classical conditioning explain how people developed conditioned response
- The operant condition shows how reinforcement can increase behaviour
- Modeling/observational theory explain how we imitate both real and symbolic models in our lives

6.0 TUTOR-MARKED ASSIGNMENT

- Why is classical conditioning of important in abnormal psychology?
- Differentiate between stimulus generalization and stimulus discrimination
- What is the focus of a behaviour therapist?

7.0 REFERENCES/FURTHER READING

Bandura, A. (1969). Principles of behaviour modification. New York: Holt, Rinehart & Winston.

UNIT 4: COGNITIVE, HUMANISTIC AND EXISTENTIAL PERSPECTIVES

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

3.1 Cognitive theories of abnormality

3.2 Global Assumptions

3.3 Cognitive Therapy

3.4 The impact of the cognitive – behavioural perspective

3.5 The humanistic perspective

3.6 The existential perspective

4.0 Conclusion

5.0 Summary

6.0 Tutor-Marked Assignment

7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learn about behavioural theories of abnormality. The classical conditioning theory, operant conditioning and modeling/observational learning

were analyzed. We concluded the unit with the impact of behavioural perspective.

In this unit, you will learn about cognitive theories of abnormality, global assumption theories, cognitive therapy of Aaron Beck, the humanistic perspective and the existential perspective.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain cognitive theories of abnormality
- Explain global assumptions
- Discuss cognitive therapy
- Explain impact of cognitive-behavioural perspective
- Discuss the humanistic perspective
- State the existential perspective.

3.0 MAIN CONTENTS

3.1 Cognitive Theories of Abnormality

Cognitive theories of abnormality argue that cognition – thoughts or beliefs – shape our behaviours and the emotions we experience. Three types of cognitions that have been the focus of several theories of abnormal behaviour are causal attributions, control beliefs, and dysfunctional assumptions.

When something happens to us, we ask ourselves why that event happened. The answer to this “why” question is our causal attribution for the event. Attribution is simply the process of assigning causes to things that happen. We may attribute behaviour to external events such as rewards or punishment (“He did it for money”), or we may assume that the causes are internal and derive from traits within ourselves or others (“He did it because he is so generous”). Causal attribution help us explain our own or other people’s behaviour and make it possible to predict what we or others are likely to do in the future. A student who fails a test may attribute the failure to a lack of intelligence (a person trait) or to ambiguous test questions or nuclear direction (environmental causes).

Attribution theorists have been interested in whether different forms of psychopathology are associated with distinctive and dysfunctional attributional styles. Attributional style is a characteristics way in which an individual tends to assign causes to bad events or good events. For example, depressed people tend to attribute bad events to internal, stable, and global causes. (“I failed the test because the teacher was in a bad mood and graded it unfairly”). However inaccurate our attributions may be, they become important parts of our view of the world and can have significant effects on our emotional well-being (Mineka et al., 2003). Interestingly, non depressed people tend to have what is called a self-serving bias in which they are more likely to make internal, stable and global attributions for positive rather than negative events.

A control theory focuses on people’s expectancies for their abilities to control important events (Bandura, 1977; Rotter, 1954; Seligman, 1975). When people believe they can control an important event, they will behave in ways to control that event.

When they do not believe they can control an event, they will not attempt to control it or will easily give up when they have difficulty controlling it. Martin Seligman (1975) argued that repeated experiences with uncontrollable events leads a person to develop learned helplessness, the general expectation that future events will be uncontrollable. He described a set of learned helplessness deficits that result from this expectation, including lowered self-esteem, lowered persistence and motivation, and the inability to see opportunities for control when they do arise.

Albert Bandura (1977) argued that a major contributor to people's sense of well-being, motivation and persistence is their sense of self-efficacy. Self-efficacy is a person's belief that he or she can successfully execute the behaviours necessary to control desired outcomes. A good example of high self-efficacy is a man that kept saying, "I think I can, I think I can, I think I can". People with high self-efficacy expectations for a given situation exert more control over that situation, try harder, are more persistent, and are more successful in that situation than are people with low self-efficacy expectations (Bandura, 1989). High self-efficacy expectations also protect a person against negative emotional reactions to a situation. For example, consider the person whose home has been ruined in a flood, like the type we experienced last year 2012 in Nigeria. If that person has high self-efficacy, he will maintain his motivation to rebuild, and will be less likely to become depressed over the loss of his home than if he has a low sense of self-efficacy.

3.2 Global Assumptions

A different set of cognitive theories of psychopathology suggests that we have broad beliefs about how things work, which can be either positive and helpful to us or negative and destructive. These broad beliefs are called global assumptions. Two of the prominent proponents of this view are Albert Ellis and Aaron Beck. They argued that most negative emotions or maladaptive behaviours are the result of one or more of the dysfunctional global assumptions that guide a person's life. Some of the most common dysfunctional assumptions are:

1. I should be loved by everyone for everything I do
2. Things should turn out the way I want them to turn out
3. I should be terribly upset by dangerous situations
4. It is better to avoid problems than face them
5. I need someone stronger and more powerful than me to rely on
6. I should be completely competent, intelligent and achieving in all I do
7. Once something affects my life, it will affect it forever
8. I must have perfect self-control
9. I have no control over my emotions and cannot help feeling certain feelings

People who hold these beliefs will often react to situations with irrational thoughts and behaviours and negative emotions. Aaron Beck developed an effective and widely used therapy for emotional disorders based on this cognitive theory.

3.3 Cognitive Therapy

Beck, who is generally considered the founder of cognitive therapy, has been enormously influential in the development of cognitive – behavioural treatment

approaches to various forms of psychopathology. Following Beck's lead, cognitive-behavioural theorists and clinicians have simply shifted their focus from overt behaviour itself to the underlying cognitions assumed to be producing the maladaptive emotions and behaviour. Fundamental to Beck's perspective is the idea that the way we interpret events and experiences determines our reactions to them. Suppose, for example, that you are sitting in your living room and hear a crash in the adjacent dining room. You may conclude that a thief must have climbed through the window to enter the room. What will your emotional reaction be then? In all likelihood, you would feel frightened. Thus your interpretation of the crash you heard in the next room fundamentally determines your emotional reaction to it. Moreover, certain individuals with prominent danger schemes may be especially prone to making the burglar or thief assumption in this example, leaving them at risk for anxiety and worry.

One central issue for cognitive therapy, then, is how best to alter distorted and maladaptive cognitions, including the underlying maladaptive schemes that led to different disorders and their associated emotions. For example, cognitive-behavioural clinicians are concerned with their client's self-statements- that is, with what their clients say to themselves by interpret what happens in their lives as a negative reflection of their self-worth are likely to feel depressed; people who interpret the sensation that their heart is racing as meaning that they may have heart attack and die are likely to have a panic attack. Cognitive behavioural clinicians use a variety of techniques designed to alter whatever negative cognitive causes the client harbours (Beck, 2005 as cited in Carson, 2011).

3.4 The Impact of the Cognitive Behavioural Perspective

The cognitive behavioural view point has had a powerful impact on contemporary clinical psychology. Many researchers and clinicians have found support for the principles of altering human behaviour through changing the way people think about themselves and others. Many traditional behaviourists, however, have remained skeptical of the cognitive – behavioural viewpoint. Skinner (1970), in his last major address, remained true to behaviourism. He questioned the move away from principles of operant conditioning. He reminded his audience that cognitions are not observable phenomenon and, as such, cannot be relied on as solid empirical data. Although Skinner is gone, this debate will surely continue in some form. However, the criticisms against cognitive behavioural approach seemed to be decreasing over the past 10 to 15 years as more and more evidence accumulate for the efficacy of cognitive – behavioural treatments for various disorders

The Humanistic Perspective

The humanistic perspective views human culture as basically “good” ,Paying less attention to unconscious processes and past causes. It emphasizes present conscious processes and places strong emphasis on people’s inherent capacity for responsible self-direction. Humanistic psychologists think that much of the empirical research designed to investigate causal factors is too simplistic to uncover the complexities of human behaviour. Instead, this perspective is concerned with processes such as love, hope, creativity, values, meaning, personal growth, and self-fulfillment. Although these abstract processes are not readily subject to empirical investigation, certain underlying themes and principles of humanistic psychology can be identified, including the self as a unifying theme and a focus on values and personal growth.

In using the concept of self as a unifying theme, humanistic psychologists emphasize the importance of individuality. Among humanistic psychologists, Carl Rogers (1902 – 1987) developed the most systematic formulation of the self-concept based largely on his pioneering research into the nature of the psychotherapeutic process. Rogers (1951, 1959) stated his views in a series of postulations that may be summarized as follows:

- Each individual exists in a private world of experience of which the I, me, or myself is the centre
- The most basic striving of an individual is toward the maintenance, enhancement and the actualization of the self, and his or her inner tendencies are toward health and wholeness under normal conditions.
- A perceived threat to the self is followed by a defence, including a tightening of perception and behaviour and the introduction of self-defence mechanisms.

Humanistic psychologists emphasize that values and the process of choice are key in guiding our behaviour and achieving meaningful and fulfilling lives. Each of us must develop values and a sense of our own identity based on our experiences, rather than blindly accepting the values of others; otherwise, we deny our own experiences and lose touch with our own feelings. Only in this way can we become self-actualizing, meaning that we are achieving our full potential. According to this view, psychopathology is essentially the blocking or distortion of personal growth and the natural tendency toward physical and mental health.

The Existential Perspective

The existential perspective resembles the humanistic view in its emphasis on the uniqueness of each individual, the quest for values and meaning, and the existence of freedom for self-direction and self-fulfillment. However, it takes a less optimistic view of human beings and places more emphasis on their irrational tendencies and the difficulties inherent in self-fulfillment particularly in a modern, bureaucratic, and dehumanizing mass society. In short, living is much more of a “confrontation” for the existentialist than for the humanists. Existentialists’ thinkers are especially concerned with the inner experiences of an individual in his or her attempts to understand and deal with the inner experiences of an individual in his or her attempts to understand and deal with the deepest human problems.

There are several basic themes of existentialism:

1. Existence and essence: Our existence is a given, but what we make of it – our essence – is up to use. Our essence, is created by our choices, because our choices reflect the values on which we base and order our lives.
2. Meaning and value: The will-to-meaning is a basic human tendency to find satisfying values and guide one’s life by them.
3. Existential anxiety and the encounter with nothingness. Nonbeing, or nothingness, which in its final form is death, is the inescapable fate of all human beings. This awareness of our inevitable death and its implications for our living can lead to existential anxiety, a deep concern over whether we are living meaningful and fulfilling lives.

Thus existential psychologists focus on the importance of establishing values and acquiring a level of spiritual maturity worthy of the freedom and dignity bestowed by one's humanness. Avoiding such central issues creates corrupted, meaningless and wasted lives. Much abnormal behaviour therefore, is seen as the product of a failure to deal constructively with existential despair and frustration.

4.0 CONCLUSION

In this unit, you have learnt about cognitive theories of abnormality. You also learnt about cognitive therapy of Aaron Beck. The humanistic and existential perspectives were also discussed. You have now seen how negative thought affects our well-being as human.

5.0 SUMMARY

In this unit, you have studied the following:

- Cognitive theories of abnormality which states that our thoughts and beliefs shape our behaviour
- That the way we interpret events and experiences determine our reactions to them
- That the central issue in cognitive therapy is how best to alter disturbed and maladaptive behaviours that caused the mental disorders
- That the cognitive behavioural view point is relevant in clinical psychology emphasized the importance of self-concept in human organisms

- The existentialists position is that is given to us and what we make out of it depends on us as living organisms,

6.0 TUTOR-MARKED ASSIGNMENT

- Explain the concept of attribution
- List some dysfunctional assumptions in cognition theory
- Discuss cognitive therapy as postulated by Aaron beck

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UNIT 5: CLASSIFICATION OF MENTAL DISORDERS

CONTENTS

- 1.0 Introduction
- 2.0 Objectives
- 3.0 Main Content
 - 3.1 A brief history of classification of mental disorders
 - 3.2 The Evolution of Diagnostics and Statistical manual of Mental Disorders (DSM)
 - 3.3 Comparism of DSM –IV-TR and ICD-IO
 - 3.4 Major categories of Mental Disorders
- 4.0 Conclusion
- 5.0 Summary
- 6.0 Tutor-Marked Assignment
- 7.0 References/Further Reading

1.0 INTRODUCTION

In the last unit, you learned about cognitive theories of abnormality and that the way we think influence our behaviour. You also learned that the central focus in

cognitive therapy is how best to alter disturbed and maladaptive behaviour. The humanistic and existential views were analyzed

In this unit, you will learn about the classification of mental disorders. You will know about the history of classification and how it started with Kraepelin in 1896. Furthermore, you will learn about the evolution of Diagnostic and Statistical Manual of Mental Disorders (DSM) and the comparison of DSM-IV-TR with ICD-10. ICD means International classification of Diseases.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Give a brief history of classification of mental disorders
- Explain the evolution of DSM
- Compare DSM with ICD-10.

Explain major categories of mental disorders.

3.0 MAIN CONTENTS

3.1 THE CLASSIFICATION OF MENTAL DISORDERS

A brief history of classification

An integral part of the medical model is the classification of mental disorder and the related process of diagnosis. All systems of classification stem from the work of Kraepelin, who published the first recognized textbook of psychiatry in 1883. Kraepelin claimed that certain groups of symptoms occur together sufficiently often for them to be called a 'disease' or syndrome. In other words, there is an underlying physical cause

just as a physical disease may be attributed to a physiological dysfunction. He regarded each mental illness as distinct from all others, with its own origins, symptoms, course and outcome.

Kraepelin (1896) proposed two major groups of serious mental diseases: *dementia praecox* (the original term for schizophrenia), caused by a chemical imbalance, and manic-depressive psychosis (caused by faulty metabolism). His classification helped to establish the organic nature of mental disorders, and formed the basis for the Diagnostic and Statistical Manual of Mental Disorders (DSM), the APA's official classification system, and the International Classification system, and the International Classification of Diseases (ICD) (Mental and behavioural disorder) published by the World Health Organization. At this point, it is important for us to know how the DSM was developed. This will now take us to its evolution.

3.2 THE EVOLUTION OF THE DSM

The DSM is currently in its fourth edition (DSM-IV), with some recent modifications referred to as "DSM-IV-TR", having been made in 2000 TR stands for text revision. This system is the product of a five-decade evolution involving increasing refinement and precision in the identification and description of mental disorders. The first edition of the manual (DSM-I) appeared in 1952 and was largely an outgrowth of attempts to standardize diagnostic practices in use among military personnel in World War II. The 1968 DSM-II reflected additional insights gleaned from a markedly expanded post war research effort in mental health. Over time, practitioners recognized a defect in both

these early efforts: The various types of disorders identified were described in narrative and jargon-laden terms that proved too vague for mental health professional to agree on their meaning. The result was a serious limitation of diagnostic reliability, that is, two professionals examining the same patient might very well come up with completely different impressions of what disorder(s) the patient had.

To cater for this clinical and scientific impasse, the DSM – III of 1980 introduced a radically different approach, one intended to remove, as far as possible, the element of subjective judgment from the diagnostic process. It did so by adopting an “operational” method of defining the various disorders that would officially be recognized. This innovation meant that the DSM system would now specify the exact observation that must be made for a given diagnostic label to be applied. In a typical case, a specific number of signs or symptoms from a designated list must be present before a diagnosis can properly be assigned. The new approach, continued in the DSM – III’s revised version of 1987 (DSM – III – R) and in the 1994 DSM – IV, clearly enhanced diagnostic reliability. It is important for us to know that mental disorders were included in ICD for the first time in 1948 (ICD – 6) and ICD – 10 was published in 1992. The table below is met to show you the major categories of both DSM – IV-TR and ICD-10.

Table: The Major categories of mental disorders as identified by DSM –IV-TR and ICD – 10

S/N	DSM-IV-TR	ICD-10
1	Delirium, dementia, amnesic and other	Organic, including symptomatic,

	cognitive disorders	mental disorders
2	Schizophrenic and other psychotic disorders	Schizophrenia, schizotypal and delusional disorders
3	Substance related disorders	Mental and behavioural disorders due to psychoactive substance use
4	Mood disorders	Mood (affective) disorders
5	Anxiety disorders	Neurotic, stress-related and somatoform disorders
6	Somatoform disorders	
7	Dissociative disorders	
8	Adjustment disorders	
9	Disorders usually first diagnosed in infancy, childhood or adolescence including mental retardation	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
		Disorders of psychological development
		Mental retardation
		Disorders of adult personality and behavior
10	Personality disorders	
11	Sexual and gender identity disorders	
12	Impulse-control disorders not elsewhere	

	classified	
13	Factitious disorders	
14	Sleep disorders	Behavioural syndromes associated with physiological disturbances and physical factors
15	Eating disorders	
16	Other conditions that may be a focus of clinical attention	Unspecified mental disorder.

You have seen the major categories of mental disorder as identified by DSM – IV-TR and ICD – 10. It is important for us now to see their similarities and differences.

3.3 Comparism of DSM – IV-TR and ICD - 10

Broad similarities and differences

From the table we can see how the two systems overlap. Most differences arise because DSM-W-TR uses a larger number of discrete categories to classify disorders that appear under a smaller number of more general categories in ICD – IO.

However, this is also reversed in item 9 from the table. We can see how a general DSM-IV-TR category incorporates three ICD-10 categories. Item 9 in DSM-IV-TR is disorders usually first diagnosed in infancy, childhood or adolescence and this was classified into three as (1) behavioural and emotional disorders with onset usually occurring in childhood and adolescence, (2) disorder of psychological development, and (3) mental retardation in ICD – 10.

Neither system actually uses the term 'mental illness' instead, they use the term mental disorder, which is defined by DSM – IV-TR as:

“a clinical significant behavioural or psychological syndrome or pattern that occur in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual. Neither deviant behavior (e.g. political, religious or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual (APA, 2000).

We have seen the definition of mental disorders by DSM – IV-TR and it is also good for us to see how ICD – 10 also defined it. Mental disorder is used by ICD – 10 as:

To imply the existence of a clinical recognizable set of symptoms or behavior associated in most cases with distress and with interference with personal functions (WHO, 1992)

As we mentioned earlier, both DSM – IV-TR and ICD- 10 use the term mental disorder to avoid the debate of the meaning or value of disease or mental illness. At this point it is vital for us to look at major categories of mental disorders, with examples, based on DSM – IV-TR and ICD – 10.

3.4 Major Categories of Mental Disorder, Based on DSM – IV – TR and ICD – 10

Each major category is stated and the associated disorders listed

1. Organic mental disorders: Delirium, Dementia due to: Alzheimer's disease; Creutzfeldt-Jakob (human version of BSE: 'mad cow disease'); HIV; Huntington chorea; Parkinson's disease. Brain tumours. Brain damage.

2. Schizophrenia and related psychotic disorders: Schizophrenia: paranoid; hebephrenic (disorganized); catatonic; simple; undifferentiated. Schizotypal disorder. Delusional disorder (paranoia). Schizophreniform disorder. Schizoaffective disorder. Brief reactive psychosis
3. Psychoactive substance use disorders: intoxication, harmful use/abuse, dependence, withdrawal state; alcohol; amphetamine, caffeine (and other stimulants); cannabis (cannabinoids); cocaine; hallucinogens; inhalants/volatile solvents; tobacco (nicotine); opioids; sedatives/ hypnotics/ anxiolytics; phencyclidine.
4. Mood (affective) disorders: Depressive disorder (unipolar); manic disorder (bipolar); bipolar 2 disorders; mood disorder with seasonal pattern (seasonal affective disorder/SAD); mood disorder with post-partum onset (post-natal depression); premenstrual disorder; cyclothymic disorder.
5. Neurotic disorders: Anxiety disorder. Phobic anxiety disorders. Obsessive – compulsive disorders. Panic disorders. Dissociative disorders; dissociative amnesia (psychogenic amnesia); dissociative fugue (psychogenic fugue); dissociative identity disorder (multiple – personality disorder); depersonalization, somatoform disorders. Hypochondriasis. Post-traumatic stress disorders.
6. Disorders of infancy, childhood and adolescence: Autistic disorder: Attention-deficit/disruptive behavior disorders; hyperkinetic disorder; conduct disorder. Separation anxiety disorder. Elective mutism. Tic disorders (e.g. Tourette's disorder). Enuresis, Encopresis, Stuttering, Disorders of speech and language. Specific developmental disorders of scholastic skills. Learning disorders.

7. Mental retardation: Mild/Moderate/Sever/profound. Associated with genetic (e.g. chromosome) abnormalities; gross disease of the brain; antenatal damage; prenatal damage; post-natal damage, malnutrition.
8. Personality disorders (disorders of adult personality); antisocial (psychopathic). Paranoid. Schizoid (schizotypal). Anxious/avoidant.dependent. obsessive – compulsive. Emotionally unstable. Histrionic Narcissistic. Pathological gambling. Pyromania, kletemania. Trichotilomania. Factitious disorder.
9. Eating and sleeping disorders. Anorexia nervosa. Bulimia nervosa. Insomnia. Hypersomnia, sleeping walking (sommambulism). Sleep (night) terrors.
10. Sexual and gender identity disorders. Sexual desire disorders. Sexual arousal disorders. Paraphilias: exhibitionism, fetishism, voyeurism; paedophilia; frotteurism; fetishism, voyeurism; paedophilia; frotteurism; tranverstism; sexual sadism; sexual masochism. Transexualis

Do not worry about these different names you have seen. It is important to let you know that in the course of this study you will have a clearer understanding of most of them.

4.0 **CONCLUSION**

You have learned something very important about classification of mental disorders. This knowledge will give an advantage in the understanding of mental disorders as you learn about the different disorders in human organisms.

5.0 **SUMMARY**

In this unit, you learn the following vital points:

- That Kraepelin in 1898 proposed the two major groups of serious mental diseases: Schizophrenia and manic-depressive psychosis
- That the first edition of DSM came out in 1968 and it is currently in its 4th edition.
- We also learn that DSM uses a larger number of discrete categories to classify disorders and ICD – 10 uses smaller number of more general categories
- The major categories of mental disorders were found to include Schizophrenia, mood (affective) disorder, mental retardation, eating and sleeping disorders etc.

6.0 TUTOR-MARKED ASSIGNMENT

- Give a brief history of classification of mental disorders
- List some of the major categories of mental disorders identified by DSM – IV-TR and ICD - 10
- List some examples of neurotic disorders.

7.0 REFERENCES/FURTHER READINGS

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(1987). The Clinical Routes of the Schizophrenia Concept. Cambridge University Press.

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MODULE 3: Major Categories of mental Disorders

Unit 1: Mental retardation

Unit 2: Mood (affective) disorders

Unit 3: Neurotic disorders – somatoform and Dissociative Disorders

Unit 4: Eating and Sleep disorders

Unit 5: Schizophrenia and related psychotic disorders

UNIT 1: MEANING, LEVELS, CAUSES, TREATMENTS, OUTCOMES, AND PREVENTION OF MENTAL RETARDATION.

CONTENTS

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1.0 INTRODUCTION

In the classification of exceptional children, the mentally retarded children belong to the lower end of the scale of intelligence and scholastic aptitude quite opposite and contrary to the gifted and creative who lie at the high end of this scale. As a matter of terminology such children are known by so many names than mentally retarded such as 'feeble minded', 'mentally handicapped', 'mentally deficient', 'mentally subnormal' or 'mentally sub-average', etc. By whatever name we recognize them, it connotes below average mental functioning of a group of children which affects not only their behavior and future development but also creates serious problems for the people responsible for their welfare. As you read this work, pay special attention to it to enhance your comprehension and to display good professionalism in the classroom in handling such children you may come in contact with. We may pose the following questions on this issue of mental retardation. Who are these children? What are the specific characteristics and their requirements? What can be done for them especially in the school environment? Let us start by now look at the meaning of mental retardation.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the meaning of mental retardation
- Identify the levels of mental retardation

- Explain the causes of mental retardation
- List treatment and prevention of mental retardation

3.0 MAIN CONTENT

3.1 Meaning of Mental Retardation

The American Psychiatric Association (2000) in DSM – IV-TR defined mental retardation as “significantly sub-average general intellectual functioning...that is accompanied by significant limitations in adaptive functioning” (p.41) in certain skill areas such as self-care, work, health and safety. For the diagnosis to apply, these problems must have begin before the age of 18. Mental retardation is thus defined in terms of level of performance as well as intelligence. The definition says nothing about causal factors, which may be primarily biological, psychosocial, socio-cultural, or a combination of these. By definition, any functional equivalent of mental retardation that has its onset after age 17 must be considered a dementia rather mental retardation. Pay more attention, you will learn more about it. The distinction is an important one, because the psychological situation of a person who acquires a pronounce impairment of intellectual functioning after attaining maturity is vastly different from that of a person whose intellectual resources were subnormal throughout all or most of his or her development.

Mental retardation occurs among children throughout the world. In its most severe forms, it is a source of great hardship to parents as well as an economic

and social burden on a community. Initial diagnoses of mental retardation occur very frequently at ages 5 to 6 (around the time that schooling begins for most children), peak at age 15, and drop off sharply after that. For the most part, these patterns in age of first diagnosis reflect changes in life demands. During early childhood, individual with only a mild degree of intellectual impairment, who constitute the vast majority of the mentally retarded, often appear to be normal. Their sub-average intellectual functioning becomes apparent only when difficulties in with school work lead to a diagnostic evaluation. When adequate facilities are available for their education, children in this group can usually master essential school skills and achieve a satisfactory level of socially adaptive behavior. Now let us find out the criteria for diagnosing mental retardation in child. Pay more attention this as you learn.

3.2 Criteria for diagnosing mental retardation

The diagnosis of mental retardation requires that a child show both poor intellectual functioning and significant defects in everyday skills. In accordance with DSM-IV-TR (2000) we have the following factors to consider in our diagnosis.

- A. Significantly sub-average intellectual functioning, indicated by an IQ of approximately 70 or below
- B. Significant deficits in at least two of the following areas:
 - i. Communication
 - ii. Self-care
 - iii. Home living

- iv. Social or interpersonal skills
- v. Use of community resources
- vi. Self direction
- vii. Academic skills
- viii. Work
- ix. Leisure
- x. Health
- xi. Personal safety.

C. Onset before age 18

Having seen the criteria for diagnosing mental retardation, we turn to look at the various levels of mental retardation, as defined in DSM – IV – TR (2000) Carpenter, (1997) Gelder, Mayou, Geddes (1999) and ICD – 10 (WHO, 1992).

Table: Different categories of mental retardation

Name	IQ range	Prevalence	Description
Mild	50 – 70	3% (80% of all cases)	Adult can be expected to acquire some independence in most self-care/domestic activities, and earn money from unskilled work. Main difficulties will be in reading, writing, monetary skills, emotional and social in maturity, and inability to adapt readily to social expectations and external stressors.
Moderate	36 – 49	0.3% (12% of	Adults frequently have additional disabilities,

		all cases)	such as epilepsy, and physical and sensory disabilities. Most need supervision with self-care
Severe	20 -25	0.04% (7% of cases)	As above
Profound	Below 20		Adults usually need close supervision and care their whole life. Many can feed themselves with a spoon, most can understand and make simple statements and requests. Most have multiple disabilities.

It is time for us now to describe in greater detail the levels or categories of mental retardation. Be attentive as you learn.

3.3 Levels of Mental Retardation

Mild Mental Retardation: Mildly retarded individuals constitute by far the largest number of those diagnosed as mentally retarded. Within the educational context, people in this group are considered “educable” and their intellectual levels as adults are comparable to those of average 8 to 11 years old children. Children with mild mental retardation can feed and dress themselves with minimal help, may or may not have average motor skills, and can learn to talk and write in simple terms. They can get around their own neighbourhoods well, although they may not be able to venture beyond their neighbourhoods without help. If they are put in special education classes that address their specific deficits, they can achieve a high school education and

become self-sufficient. As adults, they can shop for specific items and cook simple meals for themselves. They may be enjoyed in unskilled or semiskilled jobs. Their scores on IQ tests tend to be between about 50 and 70.

Moderate Mental Retardation

Moderately retarded individuals are likely to fall in the education category of “trainable”, which means that they are presumed able to master certain routine skills such as cooking or minor janitorial work if provided specialized instruction in these activities. In adult life, individuals classified as moderately retarded attain intellectual levels similar to those of average 4 to 7 year old children. Although some can be taught to read and write a little and may manage to achieve a fair command of spoken language, their rate of learning is slow, and their level of conceptualizing is extremely limited. They usually appear clumsy ungainly, and they suffer from bodily deformities retarded people are hostile and aggressive; more typically, they are affable and non-threatening. In general, with early diagnosis, parental help, and adequate opportunities for training, most moderately retarded individuals can achieve partial independence in daily self-care, acceptable behavior, and economic sustenance in a fairly or other sheltered environment. Their scores on IQ tests tend to be between about 35 and 50.

Severe Mental Retardation

Severely retarded individuals are sometimes referred to as “dependent retarded”. In these individuals, motor and speech development are severely retarded, and sensory defects and motor handicaps are common. They can develop limited levels of personal hygiene and self-help skills, which somewhat lessen their dependency, but they are

always dependent on others for care. However, many profit to some extent from training and can perform simple occupational tasks under supervision. Their scores on IQ tests tend to run between 20 and 35.

Profound Mental Retardation

The term “life support retarded” is sometimes used to refer to profoundly retarded individuals. Most of these people are severely deficient in adaptive behavior and unable to master any but the simplest tasks. Useful speech, if it develops at all, is rudimentary. They may achieve vocabularies of 300 to 400 words as adults. Severe physical deformities, central nervous system pathology, and retarded growth are typical; convulsive seizures, mutism, deafness and other physiological anomalies are also common. These individuals must remain in custodial care all their lives. They tend, however, to have poor health and low resistance to disease and thus short life expectancy. Severe and profound cases of mental retardation can usually be readily diagnosed in infancy because of the presence of physical malformations, grossly delayed development (e.g. in taking solid food), and other obvious symptoms of abnormality. These individuals show a marked impairment of overall intellectual functioning. Their scores on IQ tests tend to be below 20. You have learnt the different levels of mental retardation and I am sure you want to know more about it. What may be important to you now is to ascertain the causes of this problem in children. This is now our focus and learns it will interest.

3.4 Causes of Mental Retardation

Experts on mental retardation divide this disorder into two types: organic retardation and cultural familial retardation. In cases of organic retardation, there is evidence of a biological cause for the disorder, and the level of retardation tends to be more severe. In cases cultural familial retardation, there is less evidence for the role of biology and more evidence for the role of environment in the development of the disorder. The severity of the retardation tends to be less severe, and there is a good chance that, with the right intervention, the child will eventually develop normal abilities. Be patient and learn more about this in the next pages.

Biological Causes of Mental Retardation

Some cases of mental retardation occur in association with known organic brain pathology. In these cases, retardation is virtually always at least moderate, and it is often severe. Profound retardation, which fortunately is rare, always includes obvious organic impairment. In this section, we will consider five biological conditions that may lead to mental retardation. They are treated below.

Genetic – Chromosomal Factors

Mental retardation, especially mild retardation, tends to run in families. Poverty and socio-cultural deprivation, however, also tend to run in families, and with early and continued exposure to such conditions, even the inheritance of average intellectual potential may not prevent sub-average intellectual functioning.

Genetic-chromosomal factors play a much clearer role in the etiology of relatively infrequent but more severe types of mental retardation such as Down Syndrome and a heritable condition known as fragile X. The gene responsible for the fragile X syndrome (FMR-1) was identified in 1991. Fragile X syndrome is the second most common cause of mental retardation in males after Down syndrome, is caused when a tip of the X chromosome breaks off. This syndrome is characterized by severe to profound mental retardation, speech defects, and severe deficits in interpersonal interaction. Males with fragile X syndrome have large ears, long faces, and enlarged testes. Two other chromosomal abnormalities that cause mental retardation are trisomy 13 (chromosome 13 is present in triplicate) and trisomy 18 (chromosome 18 is present in triplicate). Both of these disorders lead to severe retardation and shortened life expectancy. The risk of having a child with Down syndrome or any other chromosomal abnormalities increases the older a woman is when she becomes pregnant. This may be because, the older a mother is, and the more likely her chromosomes are to have degenerated or to have been damaged by toxins. In general, mental retardation associated with known genetic-chromosomal defects is moderate to severe.

Infections and toxic agents: mental retardation may be associated with a wide range of conditions due to infections such as viral encephalitis or genital herpes. If a pregnant woman is infected with syphilis or HIV-1 or if she gets German measles, her child may suffer brain damage.

A number of toxic agents such as carbon monoxide and lead may cause brain damage during fetal development or after birth. In rare instances, immunological agents such as antitetanus serum or typhoid vaccine may lead to brain damage. Similarly, if

taken by a pregnant woman, certain drugs, including an excess of alcohol, may lead to congenital malformation. And an overdose of drugs administered to an infant may result in toxicity and cause brain damage. In rare cases, brain damage results from incompatibility in blood types between mother and fetus. Fortunately, early diagnosis and blood transfusions can minimize the effects of such incompatibility (Carson et al., 2011).

Ionizing Radiation: In recent decades, a good deal of scientific attention has been focused on the damaging effects of ionizing radiation on sex cells and other bodily cells and tissues. Radiation may act directly on the fertilized ovum or may produce gene mutations in the sex cells of either or both parents, which may lead to defective offspring. Sources of harmful radiation were once limited primarily to high-energy X rays used in medicine for diagnosis and therapy, but the list has grown to include nuclear weapons testing and leakages at nuclear power plants, among others (Carson et al., 2011). We are still on the causes of mental retardation with discussion based on biological factors. We are now going to look at mental retardation stemming primarily from biological causes which are classified into several recognizable clinical types. These are Down syndrome, phenylketonuria and cranial anomalies. To learn more about this be focused.

Down syndrome

One of the best known causes of mental retardation is down syndrome which is caused when chromosome 21 is present in triplicate rather than in duplicate (for the reason, down syndrome is also referred to as Trisomy 21). From childhood, almost all people

with Down syndrome are mentally retarded, although the level of their retardation varies from mild to profound. Children with Down syndrome have round, flat faces and almond-shaped eyes; small noses; slightly protruding lips and tongues; and short square hand. They tend to be short in stature and somewhat obese. Many of these children have congenital heart defects and gastrointestinal difficulties. As adults, they seem to age more rapidly than normal, and their life expectancy is shorter than average. (Nolen Hoeksema, 2004). The availability of amniocentesis and chorionic villus sampling has made it possible to detect the extra genetic material involved in Down syndrome, which is most often the trisomy of chromosome 21, yielding 47 rather than normal 46 chromosome.

Phenylketonuria

In phenylketonuria (PKU) is carried by a recessive gene and occurs in about 1 in 20,000 births. Children at birth appears normal but lacks a liver enzyme needed to break down phenylalanine, an amino acid found in many foods. The genetic error results in retardation only when significant quantities of phenylalanine are ingested, which is virtually certain to occur if the child's condition remains undiagnosed. If the condition is not detected, the amount of phenylalanine in the blood increases and eventually produces brain damage.

The disorder visually becomes apparent between 6 and 12 months after birth, although such symptoms as vomiting, a peculiar odour, infantile eczema, and seizures may occur during the early weeks of life. Often, the first symptoms noticed are signs of mental retardation, which may be moderate to severe, depending on the degree to

which the disease has progressed. Lack of motor coordination and other neurological problems caused by the brain damage are also common, and often the eyes, skin, and hair of untreated PKU patients are very pale.

The early detection of PKU by examining urine for the presence of phenylpyruvic acid is routine in developed countries, and dietary treatment (such as elimination of p[henylalanine – containing foods) and related procedures can be used to prevent the disorder. With early detection and treatment preferably before an infant is 6 months old – the deterioration process can usually be arrested so that levels of intellectual functioning may range from borderline to normal. A few children suffer mental retardation despite restricted phenylalanine intake and other preventive efforts, however. Dietary restriction in late-diagnosed PKU may improve the clinical picture somewhat, but there is no real substitute for early detection and prompt intervention.

It appears that for a baby to inherit PKU, both parents must carry the recessive gene. Thus, when one child in a family is discovered to have PKU, it is especially critical that other children in the family be screened as well. Also, a pregnant PKU mother whose risk status has been successfully addressed by early dietary intervention may damage her at risk fetus unless she maintains rigorous control of phenylalanine intake. Let us now shift our attention to cranial anomalies.

Cranial Anomalies: Mental retardation is associated with a number of conditions that involve alterations in head size and shape and for which the causal factors have not been definitely established. In the rare condition known as macrocephaly (large headedness), for example, there is an increase in the size and weight of the brain, an

enlargement of the skull, visual impairment, convulsion and other neurological symptoms resulting from the abnormal growth of glial cells that form the supporting structure for brain tissue (Carson, et al, 2011).

Microcephaly: The term microcephaly means “small headedness”. It is associated with a type of mental retardation resulting from impaired development of the brain and a consequent failure of the cranium to attain normal size. The most obvious characteristic of microcephaly is the small head, the circumference of which rarely exceeds 17 inches, compared with the normal size of approximately 22 inches. Microcephalic children are short in stature but having relatively normal musculature and sex organs. Beyond these characteristics, they differ considerably from one another in appearance, although there is a tendency for the skull to be cone-shaped, with a receding chin and forehead. Microcephalic children fall within the moderate, severe, and profound categories of mental retardation, but most show little language development and are extremely limited in mental capacity.

Microcephaly may result from a wide range of factors that impair brain development including intrauterine infections and pelvic irradiation during the mother's early months of pregnancy.

Hydrocephaly – Hydrocephaly is a relatively rare condition in which the accumulation of an abnormal amount of cerebrospinal fluid within the cranium causes damage to the brain tissues and enlargement of the skull. In congenital cases, the head is either already enlarged at birth or begins to enlarge soon thereafter, presumably as a result of a disturbance in the formation, absorption, or circulation of the cerebrospinal fluid. The

disorder can also arise in infancy or early childhood, following the development of a brain tumour, subdural hematoma, meningitis, or other conditions. In these cases, the condition appears to result from a blockage of the cerebrospinal pathways and an accumulation of fluid in certain brain areas.

The clinical picture in hydrocephaly depends on the extent of neural damage, which, in turn, depends on the age at onset and the duration and severity of the disorder. In chronic cases, the chief symptom is the gradual enlargement of the upper part of the head out of proportion to the face and the rest of the body. While the expansion of the skull helps minimize destructive pressure on the brain, serious brain damage occurs nonetheless. This damage leads to intellectual impairment and to such other effects as convulsion and impairment or loss of sight and hearing. The degree of intellectual impairment varies, being severe or profound in advanced cases.

So far we have looked at the biological causes of mental retardation, and we believe that you have gained new knowledge. We now turn to cultural familial factors that cause mental retardation. Be curious more.

Social Contributors to Mental Retardation

Children who have either organic or cultural familial mental retardation are more likely to come from low socio-economic groups. This may be because their parents are also mentally retarded and, thus, have not been able to acquire well-paying jobs. The social disadvantages of being poor may also contribute to lower than average intellectual development. Poor mothers are less likely to receive good prenatal care, increasing the risk of their children being born prematurely. Children living in lower socioeconomic

areas are at increased risk for exposure to lead, because many old, run-down buildings have lead paint, which chips off and is ingested by the children. Poor children are concentrated in the local areas in poorly funded schools, and this is especially true for poor socio-economic ones. Poor children who have lower IQs receive less favourable attention from teachers and fewer learning opportunities. Poor children are less likely to have parents who read to them, who encourage academic success, and who are involved in their schooling. These factors may directly affect a child's intellectual development and may exacerbate the biological conditions that interfere with a child's cognitive development.

Furthermore, in an inadequate socio-cultural environment, the children are deprived of the basic necessities of life for their proper physical, intellectual, emotional and social development. A poverty ridden, deprived, crowded and uncongenial family environment provides sufficient as well as necessary grounds for the germination and perpetuation of mental retardation. The deprived individuals tend to marry spouses like themselves and their poverty compels them to suffer. The severe environmental deprivation in the form of physical, cultural, emotional and intellectual poverty especially during infancy and childhood results in the retardation of the child's intellectual development even when his potential at birth is normal.

Furthermore, environmental hazards that can result in mental retardation include blows to the head, malnutrition, poisoning, birth injury and alcoholism or heavy drinking on the part of the pregnant woman. Fetal alcohol syndrome (FAS) involves a cluster of abnormalities, including mental retardation and facial abnormalities that appear in the

offspring of mothers who drink alcohol heavily during pregnancy. FAS appear in approximately one third of the offspring of pregnant alcoholic women (Santrode, 2004).

You have learnt more things on mental retardation starting from the meaning, levels and its causes. Let us now discuss how this abnormality can be treated and prevented from our families.

3.5 Prevention/Treatments for Mental Retardation

Interventions for mentally retarded children must be comprehensive, intense, and probably long term to show benefits (Singh, Oswald, & Ellis, 1998). Let us now look at some forms of prevention/treatment for mental retardation that may help to correct the disorder. We now present the preventive measures first and foremost.

Prevention of Mental Retardation

Prevention is said to be better than cure is a common aphorism. An attempt should therefore be made to adopt preventive measures for exercising control over the occurrence and development of mental retardation. Some of the measures are discussed below.

Genetic counseling and voluntary birth control

From our discussion on the causes of mental retardation, genetic factors were implicated and played a very significant role. Chromosomal aberrations as well as pairing of defective recessive genes prove detrimental to normal brain development and functioning. Apparently this knowledge may be necessary for caring parents. There are tests to identify parents who may have chromosomal anomalies or defective and inferior

genetic material. Also, there are tests that reveal whether the developing fetus will be a victim of some specific mental retardation. These parents should be informed about the problems to be faced in giving birth to a mentally retarded child.

Proper care of the mother and child

Adequate care of the mother and the new born infant is important for the prevention of mental retardation. It is therefore very necessary to provide rich diet for expectant and nursing mothers. Expectant mothers should avoid the use of alcohol during their gestation period to avoid the danger of fetal alcohol syndrome (FAS). Proper routine health measures should be adopted for the mothers and infants. During labour care should be taken for the prevention of possible physical damage in the form of injuries before birth at the time of birth or immediately after birth.

Provision of normal and stimulating environment after birth

Uncongenial and unfavourable conditions present in one's socio-cultural environment and psychological deprivations especially in early childhood may cause or perpetrate mental retardation. For the prevention of such consequences, there is a great need for educating the parents and other responsible members of society. As much as possible, the children should be provided a normal, stimulating environment for the proper growth and development of their innate potentialities. Illiteracy and poverty of the parents, and poor or defective family environment should rear its head in the satisfaction of children's basic needs. Furthermore, they should not be allowed to develop inferiority feelings, complexes, or frustration on account of their mental disorders.

Self-Assessment Exercise

Provision of public education: The public can be conscientised to adopt preventive measures for controlling mental retardation. For example, this could be done by giving the correct information about the relationship of the mother's age and Down syndrome, and the avoidance of producing children at old age. In a similar vein, retardation caused by toxic agents may be prevented by providing information and education to the public so that they may be saved from their adverse effects (Mangal, 2008).

Treatment for Mental retardation

Whatever preventive measures we may adopt, it is neither possible nor feasible to completely eliminate the possibility of the occurrence of mental retardation. As human, we can neither exercise much control over hereditary influences nor can we avoid accidental hazards, and traumatic experiences. Moreover, we are also handicapped in controlling the unfavourable influences of defective socio-cultural environment and are unable to overcome the deficiency arising from psychological deprivation. Consequently, cases of mental retardation are bound to occur and we have to think out and plan the treatment and remedial measures for the mental retardates.

One fact that has to be noted abinitio while seeking treatment of mental retardation is that there is no cure for mental deficiency. Mental retardates are essentially incurable in the sense that they cannot be given intelligence and made normal. No amount of training or medical care can transform a mental retardate into a normal individual. According to Mangal (2008) the mental subnormal should not be

confused with person who are mentally ill or suffer from mental disease. In this connection, the observation of Wechsler (1979) is worth stating:

Mental deficiency, unlike typhoid fever or paralysis is not a disease. A mentally deficient is not a person who suffers a specific disease process but one who by reasons of intellectual arrest or impairment is unable to cope with his environment to the extent that he needs special case, education institutionalisation.

Having made the above clarifications, we now look at the treatment processes.

Medical Treatment Drug Therapy

Medications are used to reduce seizures, which are common among people with mental retardation; to help control aggressive or self-injurious behavior, and to help improved mood. Neuroleptic medications can reduce aggressive, destructive and antisocial behavior. The potential side effects has made these medications controversial. The atypical antipsychotics, such as risperidone, have been shown to reduce aggressive and self-injurious behavior in adults with mental retardation without inducing serious neurological side effects (Coen, Ohrig, Lott & kerrick, 1998). Antidepressant medications can reduce depressive symptoms, improve sleep patterns, and help control self-injurious behavior in mentally retarded individuals.

Behavioural Strategies

Typically, a child's parents or caregivers are used in treatment and taught new skills for enhancing the child's positive behaviours and reducing negative behaviours. Behavioural strategies are often used to help mentally retarded children and adults to learn new skills. For his purpose, there is a need for proper counseling for parents. Moreover, on account of their emotional involvement the parents do not always realize the shortcomings and deficiency of their children and consequently, they waste a lot of money and time in the hope that some magic cure will be found or the deficiency will automatically disappear with time. Sometimes, they become disturbed by the responsibilities of looking after their mental retarded child. Such disappointed, insecure and guilt-ridden parents begin to demand behavior and intellectual achievement beyond the abilities of the child who is often abused, snubbed and punished for no fault of his. Some parents adopt an over-protective approach in their effort to shield the child from challenging situations and thus make him completely dependent by interfering with the development of whatever abilities or capacities he may possess. It is therefore essential that parents should first realize the truth about their child. They should accept the child's limitations and the mental deficiency in the sense that the child cannot be given more intelligence and made normal.

Secondly, they should be educated to behave normally with their mentally retarded child without being over-protective or rejecting the child.

Thirdly, parents should be given training and education for handling the emotional and social adjustment problems of the retarded children. They should never

compare their achievements and abilities with those of their normal siblings or other children in the home or neighbourhood. It should be seen that the retarded child is not unnecessarily criticized or ridiculed by others.

Fourthly, they should be educated to provide essential training at home to their mentally retarded child. How to train him to manage his affairs independently, how to help the child to develop and seek maximum utilization of his subnormal capacities are some of the areas where useful education and training can be provided by the parents. From our study so far on this mental disorders, it seems education will play a vital role in ameliorating the situation to some reasonable level. We now to turn this aspect.

Provision of Special Education and Training

Typically, educational and training procedures involves mapping out target areas of improvement such as personal grooming, social behavior, basic academic skills, and simple occupational skills. Within each area specific skills are divided into simple components that can be learned and reinforced before more complex behaviours are required. Training that builds on step by step progression can bring retarded individuals repeated experiences of success and lead to substantial progress even by those previously regarded as uneducable.

For mildly retarded youngsters, the question of what schooling is best likely to challenge both parents and teachers. Many such children fare better when they attend regular classes for much of the day. Of course, this type of approach often called mainstreaming or inclusion programming requires careful planning, a high level of teacher skill, and facilitative teacher attitudes (Carson et al, 2011). However, placing

retarded children in a classroom with children of average intelligence can put the retarded children at certain disadvantages. Mentally retarded children may be stigmatized by others and may be provided with education that is above their intellectual capacities.

4.0 CONCLUSION

Mental retardation is a disorders that can adversely interfere with human normal functioning. It is a disorder that has both biological and socio-cultural familial root causes and the intellectual deficiency of the affected children cannot be replaced. Therefore, major stakeholders confronted with this problem needs patience and perseverance to achieve some level of success in assisting the retardates.

5.0 SUMMARY

In this unit, you have learnt the concept of mental retardation as sub-average intelligence below IQ score of 70. You have also learnt the four levels of mental retardation, ranging from mild to profound. We also learnt how a number of biological factors contribute to the development of mental retardation, for example, PKU. Down syndrome and cranial anomalies. We also saw the role of socio-cultural factors in this disorder.

We have seen that intensive and comprehensive educational interventions, administration of drugs can help decrease the level of mental retardation.

6.0 TUTOR-MARKED ASSIGNMENT

1. What is mental retardation?
2. Compare and contrast mild, moderate, severe and profound mental retardation.
3. Describe some of the physical characteristics of children born with Down syndrome. What is its cause?
4. What is the cause of and the preventive treatment for phenylketouria (PKU).

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UNIT 2: MOOD (AFFECTIVE) DISORDERS

CONTENTS

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1.0 INTRODUCTION

In the last unit we studied mental retardation and we are able to know what the mental disorder is all about. We also saw the role of biological factors and socio-cultural problems in mental retardation. We went further to suggest some treatment approaches.

In this unit, you are going to learn something about another disorder called Mood (affective) disorders. You will learn about its meaning, prevalence, types, causal factors and the treatments.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the meaning of mood (affective) disorders
- Mention the prevalence rate of mood disorders
- Discuss the types of mood disorders
- Identify the causal factors of mood disorders
- Discuss the various treatments methods

3.0 MAIN CONTENT

3.1 The Meaning of Mood Disorders

The two key term moods involved in mood disorders are mania, often characterized by intense and unrealistic feelings of excitement and euphoria, and depression, which usually involves feelings of extraordinary sadness and dejection. Some people experience both of these kinds of moods at one time or another, but other people experiences only the depression. These mood states are often conceived to be at opposite ends of a mood continuum, with normal mood in the middle. Although this concept is accurate to a degree, sometimes a patient may have symptoms of mania and depression during the same period. In these mixed episode cases, the person experiences rapidly alternating moods such as sadness, euphoria, and irritability all within the same episode of illness.

As we learn about this orders, we shall discuss first the unipolar disorders, in which the person experiences only depressive episodes, and then we will discuss the bipolar disorders in which the person experience both manic and depressive episodes. This distinction is prominent in DSM-IV-TR, and although the unipolar and bipolar forms of mood disorder may not be wholly separate and distinct, there are notable differences in symptoms, causal factors, and treatments. It is important to note that diagnosing unipolar or bipolar disorder first requires diagnosing what kind of mood episode the person presents with. The most common form of mood episode that people present with is a major depressive episode criteria for major depressive episode, to receive this diagnosis, the person must be markedly depressed (or show a marked loss of interest in pleasurable activities) for most of everyday and for most days for at least 2 weeks. In addition, he or she must show at least three to four other symptoms (for a total of five) that range from cognitive symptoms (such as feelings worthlessness or guilt, and thoughts of suicide), to behavioural symptoms (such as fatigue or physical agitation), to physical symptoms (such as changes in appetite and sleep patterns).

The other primary kind of mood episode is a manic episode, in which the person shows markedly elevated, euphoric, or expansive mood, often interrupted by occasional outburst of intense irritability or even violence – particularly when others refuse to go along with the manic person's wishes and schemes. These extreme moods must persist for at least a week for this diagnosis to be made. In addition, three or more additional symptoms must occur in the same period,

ranging from behavioural symptoms (such as a notable increase in goal-directed activity, often involving loosening of personal and cultural inhibitions as in multiple sexual, political, or religious activities), to mental symptoms where self-esteem become grossly inflated and mental activity may speed up (such as on flight of idea” or “racing thoughts”), to physical symptoms (such as a decreased need for sleep, psychomotor agitation) (Carson et al, 2011). We have now learn about mood disorders, it is now time for us to look at the two types of mood disorders. Our first focus is now unipolar mood disorders.

3.2 Unipolar Mood Disorders

There are two types of unipolar mood disorders, namely Dysthymic disorder and major depressive disorder. We shall examine them separately for the sake of clarity and simplicity.

Dysthymic Disorder

The point at which mood disturbance becomes a diagnosable mood disorder is a matter of clinical judgement and usually concerns the degree of impairment in functioning that the individual experiences. Dysthymic disorder is considered to be of mild to moderate intensity, but its primary hallmark is its chronicity. To qualify for a diagnosis of dysthymic disorder or dysthymia), a person must have a persistently depressed mood most of the day, for more days than not, for at least 2 years (1 year for children and adolescents). In addition, individuals with dysthymic disorder must have at least two or six additional symptoms when depressed. These are:

- a. Depressed mood for most of the day, for more days than not, for at least 2 years (1 year for children or adolescents)
- b. Presence, while depressed, of two (or more) of the following:
 - i. Poor appetite or overeating
 - ii. Insomnia or hypersomnia
 - iii. Low energy or fatigue
 - iv. Low self-esteem
 - v. Poor concentration or difficulty making decisions
 - vi. Feelings of hopelessness
- c. During the 2 year period of the disturbance, the person has never been without symptoms in Criteria A or B for 2 months at a time
- d. No major depressive disorder has been present during the first 2 years of the disturbance
- e. There has never been a manic episode, a mixed episode, or a hypomanic episode, and criteria have never been met for cyclothymic disorder
- f. The symptoms cause clinically significant distress or impairment in functioning

DSM-IV-TR (2000)

It is important to note that periods of mood may occur briefly, but they usually last for only a few days to a few weeks (and for a maximum of 2 months). These intermittently normal moods are one of the most important characteristics distinguishing dysthymic disorder from major depressive disorder. Let us now look at major depressive disorder.

Major Depressive Disorder

The diagnostic criteria for major depressive disorder require that the person exhibit more symptoms than are required for dysthymia and that the symptoms be more persistent (not interwoven with periods of normal mood). To receive a diagnosis of major depressive disorder, a person must be in a major depressive episode (initial, or single or recurrent). An affected person must experience either markedly depressed moods or marked loss of interest in pleasurable activities most of every day, nearly every day, for at least 2 consecutive weeks. In addition to showing one or both of these symptoms, the person must experience at least three or four additional symptoms during the same period. (for a total of at least five symptoms. These symptoms include cognitive symptoms (such as feeling of worthlessness or guilt, and thoughts of suicide), behavioural symptoms (such as fatigue, or physical agitation), and physical symptoms (such as changes in appetite and sleep patterns).

Specifiers for Major Depression or Subtypes

Some individuals who meet the basic criteria for diagnosis of major depression also have additional patterns of symptoms or features that are important to note when making a diagnosis because they have implications for understanding more about the course of the disorder and/or its most effective treatment. These different patterns of symptoms or features are called specifiers. One such specifier is major depressive episode with melancholic features. This designation is applied when, in addition to meeting the criteria for major depression, a patient either has lost interest or pleasure in almost all activities or does not react to usually pleasurable stimuli or desired events. In addition, the patient must experience at least three of the following: (i) early morning awakenings (2) depression being worse in the morning, (3) marked psychomotor

retardation or agitation (4) significant loss of appetite and weight, (5) inappropriate or excessive guilt, and (6) depressed mood that is qualitatively different from sadness experienced during a non melancholic depression.

Psychotic symptoms characterized by loss of contact with reality and delusions (false beliefs) or hallucinations (false sensory perceptions), may sometimes accompany other symptoms of major depression. (We shall treat these terms – delusion and hallucination in details under the disorder called schizophrenia). In such cases the specifier to the diagnosis that is noted is severe major depressive episode with psychotic features. Ordinarily, any delusions or hallucinations present are mood congruent – that is, they seen in some sense “appropriate” to serious depression because the content is negative in tone, such as themes of personal inadequacy, guilt, deserved punishment, death, and disease (Carson et al, 2011).

A third specifier is used when the individual shows “atypical features”. Major depressive episode with a typical feature includes a pattern of symptoms characterized by mood reactivity; that is, the person’s mood brightens in response to potential positive events. In addition, the person must show two or more of the following four symptoms: (i) significant weight gain or increase in appetite (2) hypersomnia (sleeping too much), (3) leaden paralysis (heavy feelings in arms or legs), and (4) a long-standing pattern of being acutely sensitive to interpersonal rejection.

Some unfortunate people experiences both major depression and dysthymic disorder. This has been referred to as double depression. People with double depression are chronically dysthymic, and then occasionally go into episode of major depression. As the major depression passes, however, they return to dysthymia rather

than recover to a normal mood (Nolen –Hoeksema, 2004). We have learnt about unipolar mood disorder, now it a time for us to know the causes of this disorder. Be very attentive about this aspect so that you can learn more.

Causal factors in Unipolar Mood Disorders

In discussing the causal factors, we shall focus on the possible roles of biological, psychosocial and socio-cultural factors in unipolar mood disorders.

3.3 Biological Causal Factors

For a very long time it became obvious that a variety of diseases and drugs can affect mood, leading sometimes to depression and sometimes to elation or even hypomania. We can recall the idea of Hippocrates that was discussed in Module 1. He hypothesized that depression was caused by an excess of “black bile” in the system. Under this biological causal factor, we shall discuss range of factors. We start now with genetic influences.

Genetic Influences: Family studies have shown that the prevalence of mood disorders is approximately three times higher among blood relatives of persons with clinically diagnosed unipolar depression than in the large population.

One specific gene that might be implicated in unipolar mood disorder is the serotonin-transporter gene a gene involved in the transmission and reuptake of serotonin, which is one of the key neurotransmitters of versions or alleles involved – the short allele (s) and the long allele (l), and people have two short alleles (ss), two long alleles (ll), or one of each (sl). Individuals with who possessed the ss allele are twice likely to develop depression following four or more stressful life events as those who

possessed the ll alleles and had four or more stressful events and those with sl alleles are intermediate (Carson et al, 2011).

Neurochemical factors: Early attention in the 1960s and 1970s focused primarily on three neurotransmitter substances of the monoamine class-norepinephrine, dopamine, and serotonin – because researchers observed that antidepressant medications seemed to have the effect of increasing their availability at synaptic junctions. This observation led to the influential monoamine hypothesis that depression was at least sometimes due to an absolute or relative depletion of one or all of these neurotransmitters at important receptor sites in the brain. This depletion could come about through impaired synthesis of these neurotransmitters in the synapse, or through altered functioning of postsynaptic receptors. Collectively, these neurotransmitters are now known to be involved in the regulation of behavioural activity, emotional expression, and vegetative functions, all of which are described in mood disorders (Nolen-Hoeksema, 2004; Carson, et al., 2011).

Abnormalities of Hormonal Regulatory Systems: There has also been a good deal of research on possible hormonal causes or correlates of some forms of mood disorder. The majority of attention has been shifted on the hypothalamic – pituitary – adrenal (HPA) axis, and in particular on the hormone cortisol, which is excreted by the outermost portion of the adrenal glands and is regulated through a complex feedback loop. The human stress response is associated with elevated activity of the HPA axis, which is partly controlled by nor epinephrine and serotonin. The perception of stress or threat can lead to norepinephrine activity in the hypothalamus, causing the release of corticotrophin-releasing hormone (CRH) from the hypothalamus, which in turn triggers

release of adrenocorticotrophic hormone (ACTH) from the pituitary. The ACTH then typically travels through the blood to the adrenal cortex of the adrenal glands, where cortisol is released. Sustained elevations in cortisol can result from increased CRH activation, for example, during sustained stress or threat.

The other endocrine system that has relevance to depression is the hypothalamic – pituitary-thyroid axis. Disturbances to this axis are also linked to mood disorders. For example, people with low thyroid levels (hypothyroidism) often become depressed. In addition, about 20 to 30 percent of depressed patients who have normal thyroid levels nevertheless show dysregulation of this axis (Carson et al, 2011).

Neurophysiological and Neuroanatomical Influences

When we talk of neurophysiological and neuroanatomical influences, our focus is on brain abnormalities. Neuro imaging studies using computerized tomography (CT) scans, positron-emission tomography (PET), and magnetic resonance imaging (MRI) have found consistent abnormalities in at least four areas of the brain in people with mood disorders: the prefrontal cortex, the hippocampus, the anterior cingulate cortex, and the amygdala (Davidson, Pizzagalli, Nitschke, 2002). Both reductions in metabolic activity and a reduction in the volume of gray matter in the prefrontal cortex, particularly on the left side, have been found in people with serious depression. The left prefrontal cortex is more involved in approach-related goals, and in acting in this region is associated with the lack of motivation and goal orientation in depression (Davidson, Pizzagalli, Nitschke & Putnam, 2002).

Abnormalities have also been detected in several other brain areas in depressed patients. One of such area is the anterior cingulate cortex, which shows abnormally low levels of activation in depressed patients. Other research shows that several regions of the prefrontal cortex, including the orbitofrontal cortex show decreased volume in individuals with recurrent depression relative to normal individuals.

Another area involved is the hippocampus. Prolonged depression often leads to decreased hippocampal volume, which could be due to cell atrophy or cell death. Finally, the amygdala tends to show increased activation in individuals with depression, which may be related to their biased attention to negative emotional information. You have learnt about the ways biological factors influence mood disorders; let us now proceed to the second causal factor, which is psychosocial factors.

Psychosocial Causal Factors

The support for important psychological causal factors in most unipolar mood disorders is at least as strong as evidence for biological factors. Stressful events and biological changes influence each other under psychological causal factors. One way in which stressors may act is through their effects on biochemical and hormonal balances and on biological rhythms. Let us now look at the roles of stress in mood disorder.

Stressful Life Events As Causal Factors

Many studies have shown that severely stressful life events often serve as precipitating factors for unipolar depression. Most of the stressful life events involved in precipitating depression involve loss of loved one, serious threat to important close relationships or to one's occupation, or severe economic or serious health problems. For example, separations through death or divorce are strongly associated with depression. Losses that involve an element of humiliation can be especially potent. The stress of care giving to a spouse with a debilitating disease such as Alzheimer's is also known to be associated with the onset of both major depression and generalized anxiety disorder for the caregiver.

Another important distinction has been made between stressful life events that are independent of the person's behaviour and personality (independent life events), such as losing a job because one's company is shutting down or having one's house hit by erosion), and events that may have been at least partly generated by the depressed person's behaviour or personality (dependent life events). For example, depressed people sometimes generate stressful life events because of their poor interpersonal problem solving (such as being unable to resolve conflicts with a spouse), which is often associated with depression. The poor problem solving in turn leads to higher levels of interpersonal stress, which in turn leads to further symptoms of depression. Recent evidence suggests that dependant life events play an even stronger role in the onset of major depression than do independent life events (Carson et al, 2011).

Individual Differences in Response to Stressors: Vulnerability and Invulnerability Factors. Women at genetic risk for depression not only experience more stressful life events (especially dependent life events), but also are more sensitive to them. Women at genetic risk are three times more likely to than those not at genetic risk to respond to severely stressful life events with depression (a good example of a genotype-environment interaction). Conversely, those at low genetic risk for depression are more invulnerable to the effects of major stressors.

In addition to genetic variables, there are a host of other variables that may make some people more vulnerable to developing depression after experiencing one or more stressful life events. Among women who experience severe events, some factors are associated with depression, not having a close relationship with a spouse or lover, not having a job, and having lost a parent by death before the age of 11 years. At this point, let us now turn to another causal factor of unipolar mood disorders.

PSYCHODYNAMIC THEORIES In his classic paper “Mourning and Melancholia” (1917; 1957), Freud noted the important similarity between the symptoms of clinical depression and the symptoms seen in people mourning the loss of a loved one. Freud and colleague, Karl Abraham (1924, 1927), both hypothesized that when a loved one dies, the mourner regresses to the oral stage of development (when the infant cannot distinguish self from others) and introjects or incorporates the lost person, feeling all the same feelings toward the self as toward the lost person. These feelings were thought to include anger and hostility because Freud believed that we unconsciously hold negative feelings toward those we love, in part because of their power over us. This is what led to the psychodynamic idea that depression is anger turned inward. Freud hypothesized

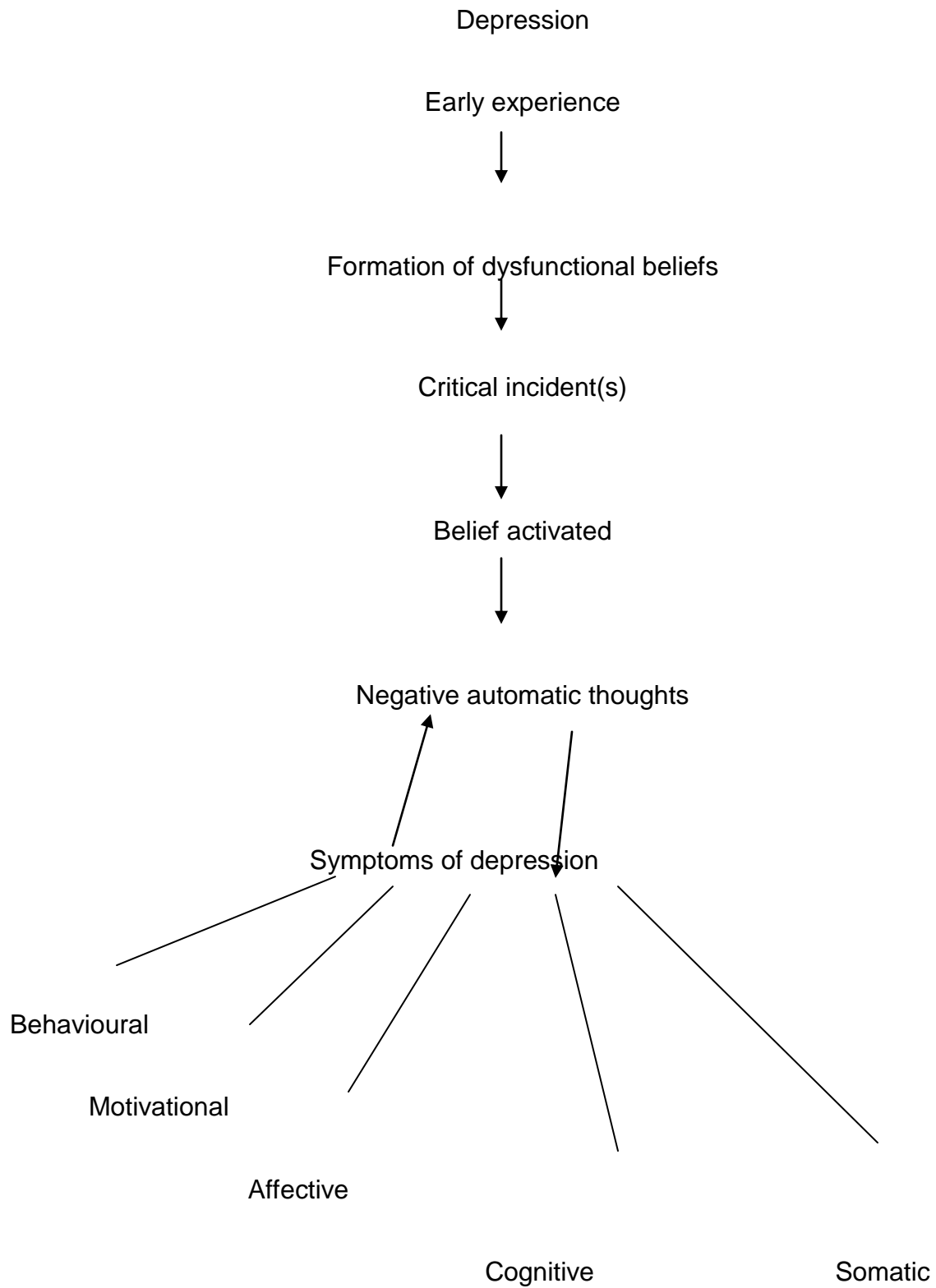
that depression could also occur in response to imagined or symbolic losses. For example, a student who fails in school or who fails at a romantic relationship may experience this symbolically as a loss of his or her parents love.

Freud also hypothesized that someone who has either experienced the loss of a mother or whose parents did not fulfill the infants needs for nurturance and love develops a vulnerability to depression. In either case, the infant will grow up feeling unworthy of love, will have low self-esteem, and will be prone to depression when face with real or symbolic losses.

Behavioural Theories In the 1970s and 1980s, several theorists in the behavioural tradition developed behavioural theories of depression proposing that people become depressed wither when their responses no longer produce positive reinforcement or when their rate of negative reinforcement increases (such as experiencing stressful life events). Such theories are consistent with research showing that depressed persons do indeed receive fewer positive verbal and social reinforcements from their families and friends than do non depressed persons, as well as experience more negative events. Moreover, they have lower activity levels, and their moods seem to vary with both their positive and their negative reinforcement rates. Nevertheless, although such findings are consistent with behavioural theories, they do not show that depression is caused by the factors. Instead, it may be that some of the primary symptoms of depression, such as pessimism and low levels of energy, cause the depressed person to experience these lower rates of reinforcements. For this and other reasons, behavioural theories of the origins of depression are no longer very influential (Carson, etal, 2011).

COGNITIVE THEORY OF DEPRESSION

BECK'S COGNITIVE THEORY Since 1967 one of the most influential theories of depression has been that of Aaron Beck – a psychiatrist who became disenchanted with Psychodynamic theories of depression early in his career and developed his own cognitive theory depression (Beck, 1967) Whereas the most prominent symptoms of depression have generally been considered to be the affective or mood symptoms, Beck hypothesized that h cognitive symptoms of depression of the precedes and cause the affective or mood symptoms, rather than affective or mood symptoms, This is illustrated below for the purpose of understanding this interesting cognitive theory of depression.



Beck's Cognitive Model of Depression

Beck's theory in which negative cognitions are central has become somewhat more elaborate over the years, while still retaining its primary tenets (Becks 1967). Let us carefully learn the processes involved in this theory. First, there are the underlying **depressogenic schemes or dysfunctional beliefs**, which are rigid, extreme, and counterproductive. An example of a dysfunctional belief (that a person is usually not consciously aware of), is, "if everyone does not love me, then my life is worthless." According to cognitive theory, such a belief would predispose the person holding it to develop depression if he or she perceived social rejection. Alternatively, a person with the dysfunctional belief, "If I am not perfectly successful, then I am nobody" would be vulnerable to developing negative thoughts and depress affect if she or he felt like a failure.

These depression-producing beliefs or schemes are thought to develop during childhood and adolescence as a function of one's negative experiences with parents and significant others and they are thought to serve as the underlying diathesis, or vulnerability, to develop depression (Beck, 1967). Although they may lie dormant for years in the absence of significant stressors, when dysfunctional beliefs are activated by current stressors or depressed mood, they tend to fuel the current thinking pattern, creating a pattern of negative automatic thoughts – thoughts that often occur just below the surface of awareness and involve unpleasant pessimistic predictions. These pessimistic predictions tend to center on three themes of what Beck calls the negative cognitive triad: Negative thoughts about the self ("I am ugly", "I am worthless"; "I am a failure"); (2) negative thoughts about one's experiences and the surrounding world ("No one loves me"; "People treat me badly"); and (3) negative thoughts about one's future

("It is hopeless because things will always be this way"). We have learnt very important lessons from unipolar mood disorders. Let us now move to the second type – the bipolar mood disorders.

What is the role of stressful life events in unipolar depression, and what kinds of diatheses have been proposed to interact with them?

Bipolar Disorders

Bipolar disorders are distinguished from unipolar disorders by the presence of manic or hypomanic symptoms. A person who experiences a manic episode has a markedly elevated, euphoric, and expansive mood, often interrupted by occasional outbursts of intense irritability or even violent, particularly when others refuse to go along with the manic person's wishes and schemes. These extreme moods must persist for at least a week for this diagnosis to be made. In addition, three or more additional symptoms must occur in the same time period. There must also be significant impairment of occupational and social functioning, and hospitalization is often necessary during manic episodes.

In milder forms, similar kinds of symptoms can lead to a diagnosis of hypomanic episode in which a person experiences abnormally elevated, expansive, or irritable mood for at least 4 days. In addition, the person must have at least three symptoms similar to those involved in mania but a lesser degree e.g. inflated self-esteem, decreased need for sleep, flights of ideas, pressured speech, etc). although the symptoms listed are the same for manic and hypomanic episodes, there is much less

impairments in social and occupational functioning in hypomania, and hospitalization is not required.

Cyclothymic Disorder

It has long been recognized that some people are subject to cyclical mood changes less severe than the mood swings seen in bipolar disorder. There are the symptoms of the disorder known as cyclothymic disorder. In DSM – IV – TR, cyclothymia is defined as a less serious version of major bipolar disorder, minus certain extreme symptoms and psychotic features, such as delusions, and minus the marked impairment caused by full-blown manic or major depressive episodes.

In the depressed phase of cyclothymic disorder, a person's mood is dejected, and he or she experiences a distinct loss of interest or pleasure in customary activities and pastimes. In addition, the person may show symptoms such as low energy, feelings of inadequacy, social withdrawal and a pessimistic brooding attitude. Essentially, the symptoms are similar to those in someone with dysthymia except without the duration criterion.

Symptoms by hypomanic phase of cyclothymia are essentially the opposite of the symptoms of dysthymia. In this phase of disorder, the person may become especially creative and productive because of increased physical and mental energy. There may be significant periods between episodes in which the person with cyclothymia functions in a relatively adaptive manner. For a diagnosis of cyclothymia, there must be at least a 2 – year span during which there are numerous periods with hypomanic and depressed symptoms (1 years for adolescents and children), and the symptoms must

cause clinically significant distress or impairment in functioning (although not as severe as in bipolar disorder). We have learn something concerning bipolar, hypomnic episode and cyclothymic disorder. Let us go further to look at bipolar disorder I and II.

Bipolar Disorder I and II

Bipolar I disorder is distinguished from major depressive disorder by at least one episode of mania or a mixed episode. A mixed episode is characterized by symptoms of both full-blown manic and major depressive episodes for at least 1 week, whether the symotoms are intermixed or alternate rapidly every few days. The following are the criteria for bipolar I disorder as stated in DSM – IV – TR.

- A. Presence (or history) of one or more Manic or Mixed Episodes (necessary for diagnosis)
- B. Presence (or history) of one or more major depressive episodes (not necessary for the diagnosis)
- C. The mood symptoms in Criteria A or B are not better accounted for by another disorder
- D. The symptoms cause clinically significant disorders or impairment in functioning
- E. Specify if current or most recent episode is:
 - i. Hypomanic
 - ii. Mania
 - iii. Mixed
 - iv. Depressive

DSM – IV –TR also identifies a distinct form of bipolar disorder called Bipolar II Disorder, in which the person does not experience full-blown manic episodes but has experienced clear-cut hypomanic episodes, as well as major depressive episodes as in Bipolar I disorder. Bipolar II disorder is somewhat more common than Bipolar I disorder. Let us now move to consider the causal factors in Bipolar disorder.

- Describe the symptoms and clinical features of cyclothymia and bipolar disorder
- Describe the typical course of Bipolar I and Bipolar II disorders

Causal Factors in Bipolar Disorder

In discussing causal factors in bipolar disorder, we shall focus on biological, psychosocial and socio-cultural factors.

Biological Causal Factors

Genetic Influences: There is a greater genetic contribution to bipolar disorder than to unipolar disorder. A summary of studies using refined diagnostic procedures suggests that about 8 to 9 percent of the first-degree relatives of a person with bipolar illness can be expected to have bipolar disorder relative to 1 percent in the general population. Although family studies cannot by themselves establish a genetic basis for the disorder, results from early twin studies dating back to the 1950s, also point to a genetic basis because the concordance rates for these disorders are much higher for identical than fraternal twins. Efforts to locate the chromosomal site(s) of the implicated gene or genes in this genetic transmission of bipolar disorder suggest that they are polygenic. No consistent support yet exists for any specific mode of genetic transmission of bipolar disorder.

Neurochemical Factors: The early monoamine hypothesis for unipolar disorder was extended to bipolar disorder, the hypothesis being that if depression is caused by deficiencies of norepinephrine and/or serotonin, then perhaps mania is caused by excess of these neurotransmitters. There is some evidence for increased norepinephrine activity during manic episodes and for lowered norepinephrine activity during depressive mood.

Psychosocial Causal factors

Stressful life events: Stressful life events appear to be as important in precipitating bipolar depression as unipolar depression and there is good evidence that stressful life events are often involved in precipitating manic episodes as well.

Psychodynamic Perspective: According to psychodynamic theorists, manic reactions are an extreme defence against or reaction to depression. A contemporary reformulation of the early psychodynamic hypotheses was presented by Neale (1988), who argued that individuals with unstable self-esteem, along with unrealistic standards for what constitutes success, are at work for bipolar disorder. Neale argued that the grandiose ideas that often occur during manic states may serve the purpose of defending against distressing thoughts (Fueled by low self-esteem) by distracting the individual from them.

Socio-cultural Factors

Research on the association of socio-cultural factors with bipolar and unipolar mood disorders is discussed together because of the research conducted in this area has not made clear-cut diagnostic distinctions between the two types of disorders. The prevalence of mood disorders seems to vary considerably among different societies: In some, mania is more frequent, whereas in others, depression is more common. We now conclude the discussion on mood disorders by looking at the methods of treatments.

3.4 Mood Disorders Treatment

There are many forms of treatment now available for mood disorders, particularly depression. Most of these types of treatment have been shown to work for the majority of people. Thus, although there are many pathways into a mood disorder, there are now many pathways, by which people can overcome or control mood disorders as well. We now discuss some of the treatment methods.

Biological Treatments for Mood Disorders

Anti depressant, mood stabilizing, and anti-psychotic drugs are all used in the treatment of unipolar and bipolar disorders. The first category of antidepressant medication was developed in the 1950s; these medications are known as monoamine oxidase inhibitors (MAOIs) because they inhibit the action of monoamine oxidase – the enzyme responsible for the breakdown of norepinephrine and serotonin once released. The MAOIs can be quite effective in treating depression – especially a typical depression – but they can have potentially dangerous, even sometimes fatal, side

effects of certain foods rich in the amino acid tyramine are consumed and so are not used very often today unless other classes of medication have failed.

For most moderately to seriously depressed patients, including these with dysthymia, the drug treatment of choice since the early 1960s until about 1990 was one of the standard antidepressants (called tricyclic antidepressants because of their chemical structure), such as imipramine, which are known to increase neurotransmission of the monoamines (primarily norepinephrine and serotonin). The efficacy of the tricyclics in significantly reducing depressive symptom has been demonstrated in hundreds of studies where the response of depressed patients given these drugs.

Lithium and Other Mood – Stabilizing Drugs

Lithium therapy has now become widely used as a mood stabilizer in the treatment of both depressive and manic episodes of bipolar disorder. The term mood stabilizer is often used to describe lithium and related drugs because they have both antimanic and antidepressant effects that is, they exert mood-stabilizing effects in either direction. Lithium has been more widely studied as a treatment of manic episodes than of depressive episodes, and estimates are that about three-quarters of manic patients show at least partial improvement.

Alternative Biological Treatments

Electroconvulsive therapy: Because antidepressants often take 3 to 4 weeks to produce significant improvement, electroconvulsive therapy (ECT) is often used with severely depressed patients (especially among the elderly) who may present an immediate and

serious suicidal risk, including those with psychotic or melancholic features. It is also used in patients who cannot take antidepressant medications or who are otherwise resistant to medications.

Bright Light Therapy: In the past decade an alternative nonpharmacological biological methods has received increasing attention bright light therapy. Light therapy may help to reduce seasonal affective disorder (SAD) by resetting depressed people's circadian rhythms. Circadian rhythms are natural cycles of biological activities that occur every 24 hours. The production of several hormones and neurotransmitters varies over the course of the day according to circadian rhythms. These rhythms are regulated by internal clocks but can be affected by environmental stimuli, including light. Depressed people sometimes show deregulation of their circadian rhythms. Light therapy may work by resetting circadian rhythms and thereby normalizing the production of hormones and neurotransmitters (Koorengevel, Gordijn, Beersma, Meesters, den Boer, & van der Hoofdakker, 2001).

Another therapy is that light therapy works by decreasing levels of the hormone melatonin, secreted by the pineal gland. Decreasing melatonin, secreted by the pineal gland. Decreasing melatonin levels can increase levels of norepinephrine and serotonin, thereby reducing the symptoms of depression. Finally, studies suggest that exposure to bright lights may increase serotonin levels, thereby decreasing depression (Rosenthal, 1995).

psychotherapy

There are several forms of specialized psychotherapy, developed since the 1970s, that have proved effective in the treatment of unipolar depression, and the magnitude of improvement of the best of these is approximately equivalent to that observed with medications. Considerable evidence also suggests that these some forms of psychotherapy for depression, alone or in combination with drugs, significantly decrease the likelihood of relapse within a 2 year follow up period (Carson et al, 2011). Let us now learn about the different forms of psychotherapy.

Cognitive Behavioural and Behavioural Activation Therapy

One of the two best known psychotherapies for unipolar depression with documented effectiveness is cognitive behavioural therapy (CBT), developed by Beck and colleagues (beck, Weissman, Lester, & Trexlet, 1974). It is a relatively brief form of treatment (usually 10 to 20 sessions) that focuses on here-and now problems rather than on the more remote causal issues that psychodynamic psychotherapy often addresses. For example, cognitive behavioural therapy consists of highly structured, systematic attempts to teach people with unipolar depression to evaluate their beliefs and negative automatic thoughts systematically. They are also taught to identify and correct their biases or distortions in information processing and to depressogenic assumptions. Cognitive therapy relies heavily on an empirical approach in that patients are taught to treat their beliefs as hypotheses that can be tested through the use of behavioural experiments.

A relatively new and promising treatment for unipolar depression is called behavioural activation treatment. This treatment approach focuses intensively on getting patients to become more active and engaged with their environment and with their interpersonal relationships. These techniques include scheduling daily activities and rating pleasure and mastery while engaging in them, exploring alternative behaviours to reach goals, and role playing to address specific deficits. Traditional cognitive therapy attends to these same issues, but to a lesser extent. Behavioural activation treatment, by contrast, does not focus on implementing cognitive changes.

Another variant on cognitive therapy, called mindfulness – based cognitive therapy, has been developed in recent years to be used in people with highly recurrent depression who have been treated with medication in order to prevent further recurrences. The logic of this treatment is based on findings that people with recurrent depression are likely to have negative thinking patterns activated when they are simply in a depressed mood. Perhaps rather than trying to alter the content of their negative thinking as in traditional cognitive therapy, it might be more useful to their thoughts, feelings, and bodily sensations. This group treatment involves training in mindfulness meditation techniques aimed at developing patients' awareness of their unwanted thoughts and feelings and sensations so that they no longer automatically try to avoid them, but rather learn to accept them for what they are simply thoughts occurring in the moment rather than a reflection of reality.

Interpersonal Therapy: The interpersonal therapy (IPT) approach has not yet been subjected to as extensive an evaluation as cognitive behavioural therapy, nor is it as widely available. However, the studies that have been completed strongly support its effectiveness for treating unipolar depression. Indeed, interpersonal therapy seems to be about as effective as medications or cognitive – behavioural treatment. This IPT approach focuses on current relationship issues, trying to help the person understand and change maladaptive interaction patterns. Interpersonal therapy can also be useful in long term follow up for individuals with severe recurrent unipolar depression. Patients who received continued treatment with IPT once a month or who received continued medication were much less likely to have a recurrence than those maintained on a placebo over a 3-year follow-up period (Carson, et al., 2011).

Describe the three major forms of psychotherapy that have been shown to be effective for treating depression.

4.0 CONCLUSION

There are two general categories of mood disorder unipolar depression and bipolar disorder. People with unipolar depression experience only the symptoms of depression (sad mood, loss of interest, disruption in energy, worthlessness and guilt, suicidality). People with bipolar disorder experience both depression and mania (elated or agitated mood, grandiosity, little need for sleep, racing thoughts and speech, increase in goals and dangerous behaviour. As professional teachers and teacher trainees we need good knowledge of this disorders and how the situation can be controlled though biological measures and the use of psychotherapy.

5.0 SUMMARY

In this unit, you have learnt about the meaning of mood disorders, types of mood disorders, causal factors of mood disorders and treatment approaches of mood disorders. We have seen that both biological treatment and psychotherapy are important measures to be adopted to reduce mood disorders in humans.

6.0 TUTOR-MARKED ASSIGNMENT

- Explain the striking differences between unipolar disorder and bipolar disorder
- Explain biological causal factors in bipolar disorder
- With simple illustration, explain Beck's cognitive therapy of depression

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UNIT 3: SOMATOFORM AND DISSOCIATIVE DISORDERS

CONTENTS

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1.0 INTRODUCTION

In the last unit we learnt something on mood (affective) disorders. We discovered that we have two major forms of mood disorders; namely unipolar and bipolar

disorders. We also learnt about the causal factors of the disorder and how the disorders can be treated through biological methods and through psychotherapy.

In this unit, you are going to learn something very interesting on somatoform and dissociative disorders. Here, you will learn something about their meaning, the different types and causal factors of the disorders and we shall also look at the treatment approaches.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the meaning of Somatoform and dissociative disorders
- Explain the different types of Somatoform and dissociative disorder
- Explain the causal factors of both somatoform and dissociative disorders
- Discuss the treatment models of both somatoform and dissociative disorders

3.0 MAIN CONTENT

3.1 The meaning of Somatoform

Soma means “body”, at somatoform disorders involve patterns in which individuals complain of bodily symptoms or defects that suggest the presence of medical problems, but for which no organic basis can be found that satisfactorily explains the symptoms such as paralysis or pain. Such individuals are typically preoccupied with their state of health and with various presumed disorders or diseases of bodily organs. Equally key to these disorders is the fact that the affected patients have no control over their symptoms. They are also not intentionally taking symptoms or attempting to deceive others. For the most part,

they genuinely and sometimes passionately believe something is terribly wrong with their bodies. The prevalence of somatoform disorders appears to vary considerably among differing cultures.

In this unit, we will focus on five distinct somatoform patterns that have been identified:

- (1) Hypochondriasis,
- (2) Somatization disorder
- (3) Pain disorder
- (4) Conversion disorder and
- (5) Body dysmorphic disorder

3.2 Types of Somatoform Disorders

Hypochondriasis

According to DSM-IV-TR, people with hypochondriasis are preoccupied either with fear of contracting a serious disease or with the idea that they actually

Have such a disease even though they do not. Their preoccupations are all based on a misinterpretation of one or more bodily signs or symptoms (e.g. being convinced that their slight cough is a sign of lung cancer). Of course the decision that a hypochondriacal complaint is based on a misinterpretation of bodily signs or symptoms can be made only after a thorough medical evaluation does not find a medical condition that could account for the signs or symptoms. Another defining criterion for

hypochondriasis is that the person is not reassured by the results of a medical evaluation, that is, the fear or idea of having a disease persists despite medical reassurance. Indeed, these individuals are sometimes disappointed when no physical problem is found. Finally, the condition must persist for at least 6 months for the diagnosis to be made, so as to not diagnose relatively transient health concerns.

Not surprising, people with hypochondriasis usually first go to a medical doctor with their physical complaints. Because they are never reassured for long, and are inclined to suspect that their doctor has missed something, they sometimes shop for additional doctors; hoping one might discover what their problem really is. These individuals generally resist the idea that their problem is a psychologist or psychiatrist.

Hypochondriasis may be the most commonly seen somatoform disorder, with a prevalence in general medical practice officially estimated at between 2 and 7 percent (APA, 2000). It occurs about equally often in men and women and can start at almost any age, although early adulthood is the most common age of onset. Once hypochondriasis develops, it tends to be a chronic disorder if left untreated.

MAJOR CHARACTERISTICS: Individuals with hypochondriasis are often anxious and highly preoccupied with bodily functions (e.g. heart beats or bowel movements) or with minor physical abnormalities (e.g. a small sore or an occasional cough) or with vague and ambiguous physical sensations (such as a “tired heart” or “aching veins, APA, 2000). They attribute these symptoms to a suspected disease, and often have intrusive thoughts about it. The diagnoses they make for themselves range from tuberculosis to cancer exotic infections, AIDs, and numerous other diseases.

Although people with hypochondriasis are usually in good physical condition, they are sincere in their conviction that the symptoms they detect represent real illness. They are not malingering-consciously taking symptoms to achieve specific goals such as winning a personal injury lawsuit. Not surprisingly, given their tendency to doubt the soundness of their doctors' conclusions (i.e, that they have no medical problem) and recommendations, the doctor-patient relationships are often marked by conflict and hostility.

THEORETICAL PERSPECTIVES ON CAUSAL FACTORS

Today, cognitive-behavioural views of hypochondriasis are perhaps most widely accepted and have as a central tenet that it is a disorder of cognition and perception. Misinterpretations of bodily sensations are currently a defining feature of the syndrome, but in the cognitive-behavioural view, these misinterpretations also play a causal role if it is believed that an individual's past experiences with illnesses (both themselves and others, and as observed in the mass media) lead to the development of a set of dysfunctional assumptions about symptoms and diseases that may predispose a person to developing hypochondriasis (Carson et al, 2011).

TREATMENT OF HYPOCHONDRIASIS- At least a half dozen studies on cognitive – behavioural treatment of hypochondriasis have found that it can be a very effective treatment for hypochondriasis. The cognitive components of this treatment approach focus on assessing the patient's beliefs about illness and modifying misinterpretations of bodily sensations. The behavioural techniques include having a patient induce innocuous symptoms by intentionally focusing on parts of their body so that they can

learn that selective perception of bodily sensations plays a major role in their symptoms. Sometimes they are also directed to engage in response prevention by not checking their body as they usually do and by stopping their constant seeking for reassurance. The treatment, which is relatively brief (6 – 16 sessions), produced large changes in hypochondriacal symptoms and beliefs, as well as in levels of anxiety and depression.

Somatization Disorder

Somatisation disorder is characterized by many different complaints of physical ailments, over at least several years beginning before age 30, that are not adequately explained by independent findings of physical illness or injury and that lead to medical treatment or to significant life impairment. Not surprising, therefore, somatisation disorder is seen most often among patients in primary medical care settings in cultures all over the world.

In addition to the requirement of multiple physical complaints, DSM-IV-TR (APA, 2000) list four other symptom criteria that must be met at some time during the course of the disorder before a diagnosis of somatization disorder can be made. A diagnostician need not be convinced that these claimed illness actually existed in a patient's background history; the mere reporting of them is sufficient. The four other criteria that must be met are:

1. Four pain symptoms. The patient must report a history of pain experienced with respect to at least four different sites or functions for example, head, abdomen, back, joints or rectum, or during sexual intercourse or urination.

2. Two gastrointestinal symptoms. The patient must report history of at least two symptoms, other than pain, pertaining to the gastrointestinal system-such as nausea, bloating, diarrhea, or vomiting when not pregnant.
3. One sexual symptom: The patient must report at least one reproductive system symptom other than pain for example, sexual indifference or dysfunction, menstrual irregularity, or vomiting throughout pregnancy
4. One pseudoneurological symptom: The patient must report history of at least one symptom, not limited to pain, suggestive of a neurological condition – for example, various symptoms that mimic sensory or motor impairments such as loss of sensation or involuntary muscle contraction in a hand.

If the symptoms of somatisation disorder seem similar to you some ways to those of hypochondriasis, that is because there are indeed significant similarities between the two conditions but there are also enough distinguishing features that they are considered two separate disorders in DSM – IV – TR. For example, although both disorders are characterized by preoccupation with physical symptom, only people with hypochondriasis tend to be convinced that they have an organic disease. Moreover, with hypochondriasis the person usually has only one or a few primary symptoms, but in somatisation disorder, by definition, there are multiple symptoms.

Causal Factors in Somatization Disorder

Despite its significant prevalence in medical settings, it remains quite uncertain about the developmental course and specific etiology of somatisation disorder. There is evidence that it runs in families and that there is a familial linkage between antisocial

personality disorder in men and somatisation disorder in women. That is, one possibility is that some common, underlying predisposition, probably with an at least partly genetic basis leads to antisocial behaviour in men and to somatisation disorder in women.

In addition to a possible genetic predisposition to developing somatisation disorder, other contributory causal factors probably include an interaction of personality, cognitive, and learning variables. People high on neurotism who come from certain kinds of family background may develop a tendency to misinterpret their body sensations as threatening or even disabling. This might be especially likely in families where a child is frequently exposed to models complaining of pain and vicariously learns that complaining about physical symptoms can lead to the garnering of sympathy and attention (social reinforcement) and even avoidance of responsibilities.

Treatment of Somatisation Disorder

Somatization disorder has long been considered to be extremely difficult to treat, but some recent treatment research has begun to suggest that a certain type of medical management and cognitive behavioural treatment may be quite helpful. One moderately effective treatment involves identifying one physician who will integrate the patient's care by seeing the patient at regular visits (i.e. trying to anticipate the appearance of new problems) and by providing physical examinations focused on new complaints (i.e. accepting her or his symptoms as valid). At the same time, however, the physician avoids unnecessary diagnostic testing and makes minimal use of medications or other therapies (Carson et al, 2011).

Pain Disorder

The symptoms of pain disorder resemble the pain symptoms seen in somatisation disorder, but with pain disorder, the other kinds of symptoms of somatisation disorder are not present. Thus pain disorder is characterized by the experience of persistent and severe pain in one or more areas of the body. Although a medical condition may contribute to the pain, psychological factors must be judged to play an important role. In approaching the phenomenon of pain disorder, it is very important to remember that the pain that is experienced is very real and can hurt as much as pain with purely medical causes. It is also important to note that pain is always, in part, a subjective experience that is private and cannot be objectively identified by others.

DSM – IV – TR specified two coded subtypes: (1) pain disorder associated with psychological factors, and (2) pain disorder associated with both psychological factors and a general medical condition. The first subtype applies where psychological factors are judged to play a major role in the onset or maintenance of the pain – that is, where any coexisting medical condition is considered to be of minimal causal significance in the pain complaint. The second subtype applies where the experienced pain is considered to result from both psychological factors and some medical condition that could cause pain. In either case, the pain disorder may be acute (duration of less than 6 months) or chronic (duration of over 6 months).

Treatment of Pain Disorder

Perhaps because it is a less complex and multifaceted disorder than somatisation disorder, pain disorder is usually also easier to treat. Indeed, cognitive

behavioural techniques have been widely used in the treatment of both physical and “psychogenic” pain syndromes. Treatment programmes using these techniques generally include relaxation training, support and validation that pain is real, scheduling of daily activities, cognitive restructuring and reinforcement of “non – pain” behaviours.

Conversion Disorder

Conversion disorder involves a pattern in which symptoms or deficits affecting sensory or voluntary motor functions lead one to think a patient has a medical or neurological condition. However, upon medical examination, it becomes apparent that the pattern of symptoms or deficits cannot be fully explained by any known medical condition. A few typical examples include partial paralysis, blindness, deafness and pseudoseizures. In addition, psychological factors must be judged to play an important role in the symptoms or deficits, because the symptoms usually either start or are exacerbated by preceding emotional or interpersonal conflicts or stressors. Finally, the person must not be intentionally producing or faking the symptoms (APA, 2000).

Early observations dating back to Freud suggested that most people with conversion disorder showed very little of the anxiety and fear that would be expected in a person with a paralysed arm or loss of sight. This seeming lack of concern (known as *La belle indifference* – French for “the beautiful indifference”) in the way the patient describes what is wrong was thought for a long time to be an important diagnostic criterion for conversion disorder.

Conversion disorder is one of the most intriguing and baffling patterns in psychopathology. The term conversion disorder is relatively recent, and historically this

disorder was one of several disorders that were grouped together under the term hysteria.

Freud used the term conversion hysteria for these disorders (which were fairly common in his practice), because he believed that the symptoms were an expression of repressed sexual energy – that is, the unconscious conflict that a person felt about his or her sexual desire was repressed. However, in Freud's view, the anxiety threatens to become conscious, so it is unconsciously converted into a bodily disturbance, thereby allowing the person to avoid having to deal with conflict. For example, a person's guilty feelings about the desire to masturbate might be solved by developing a paralysed hand. This is not done consciously, of course, and the person is not aware of the origin or meaning of the physical symptoms. Freud also thought that the reduction in anxiety and intrapsychic conflicts was the primary gain that maintained the condition, but he noted that patients often had many sources of secondary gain as well, such as receiving sympathy and attention from loved ones (Carson, et al, 2011).

Thus, in contemporary terms, the primary gain for conversion symptoms is continued escape or avoidance of stressful situation. Because this is all unconscious (that is, the person sees no relation between the symptoms and stressful situation), the symptoms go away only if the stressful situation has been removed or resolved. Relatively, the term secondary gain, which originally referred to advantages that the symptom(s) bestow beyond the "primary gain" of neutralizing intrapsychic conflict, has also been retained. Generally, it is used to refer to any "external" circumstance, such as attention from loved ones or financial compensation that would tend to reinforce the maintenance of disability.

Range of Conversion Disorder Symptoms

The range of symptoms for conversion disorder is practically as diverse as for physically based ailments. In describing the clinical picture in conversion disorder, we have four categories of symptoms: (i) sensory, (2) motor (3) seizures and (4) mixed presentation from the first three categories (APA, 2000).

Sensory Symptoms or deficits: Conversion disorder can involve almost any sensory modality, and it can often be diagnosed as a conversion disorder because symptoms in the affected area are inconsistent with how known anatomical sensory pathways operate. Today the sensory symptoms or deficits are most often in the visual system (especially blindness) or in the sensitivity to feeling (especially the anaesthesias). In the anesthesia's, the person loses her or his sense of feeling in a part of the body. One of the most common is glove anesthesia, in which the person cannot feel anything on the hand in the area where gloves are worn, although the loss of sensation usually makes no anatomical sense.

With conversion blindness, the person reports that he or she cannot see and yet can often navigate about a room without bumping into furniture or other objects. With conversion deafness, the person reports not being able to hear and yet orients appropriately upon "hearing" his or her own name. such observations lead to obvious questions: in conversion blindness (and deafness), can affected persons actually not see or hear, or is the sensory information received but screened from consciousness? In general, the evidence supports the idea that the sensory input is registered but that it is somehow screened from explicit conscious recognition.

Motor symptoms or deficits: Motor conversion reactions also cover a wide range of symptoms. For example, conversion paralysis is usually confined to a single limb such as an arm or a leg, and the loss of function is usually selective for certain functions. For example, a person may not be able to write but may be able to use the same muscles for scratching, or a person may not be able to walk most of the time but may be able to walk in an emergency such as a fire where escape is important. The most common speech related conversion disturbance is aphonia, in which a person is able to talk only in a whisper, although he or she can usually cough in a normal manner. Another common motor symptoms is difficulty swallowing or the sensation of a lump in the throat.

Seizures: Conversion seizures, another relatively common form of conversion symptoms, involve pseudoseizures, which resemble epileptic seizures in some ways but can usually be fairly well differentiated via modern medical technology. For example, patients with pseudoseizures do not show any EEG abnormalities and do not show confusion and loss of memory afterward, as patients with conversion seizures often show excessive thrashing about and writing not seen with the true seizures, and they rarely injure themselves in falls or lose control over their bowels or bladder, as patients with true seizures frequently do.

Distinguishing conversion from malingering and from factitious disorder: Sometimes, of course, people do deliberately and consciously feign disability or illness. For these instances, the DSM distinguishes between malingering and factitious disorder on the

basis of the feigning person's apparent goals. The malingering person is intentionally producing or grossly exaggerating physical symptoms and is motivated by external incentives such as avoiding work or military service, obtaining financial compensation or evading criminal prosecution (APA, 2000). In factitious disorder also, the person intentionally produces psychological or physical symptoms (or both), but there are no external incentives. Instead, the personal benefits that playing the "sick role" (even undergoing repeated hospitalizations) may provide, including the attention and concern of family and medical personnel. Frequently these patients surreptitiously alter their own psychology, for example, by taking drugs in order to simulate various real illnesses. Indeed, they may be at risk for serious injury or death and may even need to be committed to an institution for their own protection.

Persons engaged in malingering and those who have factitious disorder are consciously perpetrating fraud by faking the symptoms of diseases are not consciously producing their symptoms, feel themselves to be the "victims of their symptoms" and are very willing to discuss them. When inconsistencies in their behaviours are pointed out, they are usually unperturbed. Any secondary gains they experience are by products of the conversion symptoms themselves and are not involved in motivating the symptoms. By contrast, 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 show to talk about their symptoms, lest the pretense be discovered. Should inconsistencies in their behaviour be pointed out, deliberate deceivers as a rule immediately become more defensive. Thus conversion disorder and deliberate faking of illness are different patterns.

Body dysmorphic Disorder

Body dysmorphic disorder (BDD) is officially classified in DSM – IV – TR (APA, 2000) as a somatoform disorder because it involves preoccupation with certain aspect of the body. People with BDD are obsessed with some perceived or imagined flaw or flaws in their appearance. This preoccupation is so intense that it causes clinically significant distress and/or impairment in social or occupational functioning. Although it is not considered necessary for the diagnosis, most people with BDD have compulsive checking behaviours (such as checking their appearance in the mirror excessively hiding or repairing a perceived flaw). Another very common symptoms is avoidance of usual activities because of fear that other people will see the imaginary defect and be repulsed. In severe cases they may become so isolated that they lock themselves up in their house and never go out even to work.

People with BDD may focus on almost any body part: the skin has blemishes, their breasts are too small, their face is too thin (or too fat) or disfigured by visible blood vessels that others find repulsive and so on. It is very important to remember that these are not the ordinary concerns that most of us have about our appearance; they are far more, extreme, leading in many cases to complete preoccupation and significant emotional pain.

Another common feature of BDD is that people with this condition frequently seek reassurance from friends and family about their defects, but the reassurance almost never provides more than very temporary relief. They also frequently seek reassurance for themselves by checking their appearance in the mirror countless times in a day

(although some avoid mirror completely). They are usually driven by the hope that they will look different, and sometimes they may think their perceived defect does not look as bad as it has at other times).

A biopsychosocial Approach to BDD: The cause of BDD is still in a preliminary stage, but recent research seems to suggest that a biopsychosocial approach offers some reasonable hypothesis. First, it seems likely that there is a partially genetically based personality predisposition that people with BDD may share in common with people who have obsessive – Compulsive Disorder (OCD) and perhaps other anxiety disorders (such as neurotism). Second, BDD seems to be occurring, at least today, in a sociocultural context that places great value on attractiveness and beauty, and people who develop BDD often hold attractiveness as their primary value, meaning that their self-schemes are heavily focused around such ideas as, “if my appearance is defective, then I am worthless”

Treatment of body dysmorphic Disorder: The treatment that are effective for BDD are closely related to those used in the effective treatment of obsessive – compulsive disorder. There is some evidence that antidepressant medications from the selective serotonin reuptake inhibitor category often produce moderate improvement in patient with BDD. In addition, a form of cognitive behavioural treatment emphasizing exposure and response prevention has been shown to produce marked improvement in 50 to 80 percent of treated patients. These treatment approaches focus on getting the patient to identify and change distorted perceptions of his or her body during exposure to anxiety provoking situation.

4.0 CONCLUSION

Various forms of somatoforms and dissociative disorders were discussed in this unit. Hypochondriasis, somatization disorder, pain disorder, and others were seen as disorders that the affected persons have no control over their symptoms and they are also not intentionally faking symptoms to deceive others.

5.0 SUMMARY.

In this unit, you learned about somatoform, hypochondriasis, pain disorder, conversion disorder, body dysmorphic disorder and general sociocultural causal factors. The treatment model recommended for all these disorders is both cognitive and behavioural approach.

6.0 TUTOR-MARKED ASSIGNMENT

- What are the primary characteristics of hypochondriasis and how does the cognitive behavioural view point explain their occurrence?
- What are the symptoms of somatization disorder and pain disorder?

What are the primary symptoms of body dysmorphic disorder?

7.0 REFERENCES/FURTHER READINGS

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UNIT 4: EATING DISORDER: ANOREXIA NERVOSA AND BULIMA

CONTENTS

1.0 Introduction

2.0 Objectives

3.0 Main Content

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3.4 Psychological theories

4.0 Conclusion

5.0 Summary

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1.0 INTRODUCTION

In this unit, you are learning about eating disorders. Eating habits of an average Nigeria educated woman are characterized by dieting. For this reason efforts to restrict the intake of food has become the norm. The psychological meaning of food extends far beyond its nutritive power. It is common for people to devote many hours and much effort to choosing, preparing and serving food. In addition to physical dependent on food, humans have strong emotional association with food. Hungry people feel irritable and unhappy. By contrast a good meal can cause people to feel contented and nurtured. However, the eating disorders we are going to learn about are characterized by gross disturbances in patterns of eating. These are Anorexia Nervosa and Bulimia Nervosa. It is important for you to pay full attention to this interesting and informative knowledge.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the concept of Anorexia and Bulimia as eating disorders
- Examine the various causes of Anorexia and Bulimia
- Discuss the treatment approaches for Anorexia and Bulimia

3.0 MAIN CONTENT

3.1 What is Anorexia Nervosa and Bulimia Nervosa as eating disorders

In learning about these eating disorders, it is pertinent to discuss them one by one. So, let us start with Anorexia Nervosa.

Anorexia Nervosa

Victims of anorexia nervosa, have an intense fear of being fat and severely restrict their food intake to the point of self-starvation. Despite looking emaciated and weighing less than 85 percent of what would be expected of their age, anorexia continue to view themselves as fat. They often crave for food, but have amounts to an eating phobia that can be life threatening. About 90 percent of anorexics are female, mostly adolescents and young adults. Anorexia causes menstruation (Ameonorrhea) to stop; strain the heart produces bone loss, and increases the risk of death.

Some anorexic individuals engaged in various behaviour geared towards weight loss such as abusing laxative and diet pills. Others over eat and then force themselves to purge or rid themselves what they have just eating. The starvation associated with Anorexia nervosa causes a number of physical abnormalities such as menstrual disturbance, dry and cracking skin, gastrointestinal activities and muscular weakness. As self starvation continues, the bodily signs of physical disturbance become more evident. Those who induce vomiting commonly experience the abnormality of the salivary glands, and dental enamel erosion. The extreme result of self starvation is catastrophic and include anaemia, impaired kidney function heart problem and bone deterioration. Death is alarmingly common. In fact among the severe cases that require hospitalization, one out of every 10 dies of starvation, medical complication or

suicide. Karen Carpenter an American musician died as an anorexic Nervosa in 1983.

Bulimia Nervosa

People who suffer from Bulimia Nervosa, are over concerned about becoming fat, but instead of self starvation they binge eat and then purge the food, usually by inducing vomiting or using laxatives. Binge eats means to eat a lot of food in a short time, especially if you have an eating disorder. Bulimics often consume 2,000 to 4,000 calories during binges, and in some cases may consume 20,000 calories per day (Geraciotti, Loosen, Ebert, & Schmidt, 1995). About 90 percent bulimics are female. Those with non purging type, try to compensate for what they eat by fasting or vigorous exercise. In both cases, the individual get caught up in a vicious circle of bingeing by desperate attempts to cleanse themselves of the food gratifying during the eating episode.

Following the purging, hunger will return and once again the circle begins. Many medical implications commonly develop with individuals with Bulimia Nervosa. The most serious of these problems involves life threatening situation associated with purging. For example, the medical impecac Syrup, which is used to induce vomiting in people who has swallowed poisonous substance have severe effects. These effects occur throughout the gastrointestinal, cardiovascular and nervous system. Dental decay that results from recurrent vomiting is common as cavities develop and teeth take on a ragged appearance. Salivary glands become enlarged and skin calluses develop on hands that brush.

You have seen the meaning of these two eating disorders. It is now important for you to know the factors that cause these disorders.

3.2 Causes of Anorexia and Bulimia Nervosa

The question that will be in your mind to ask is, what motivates people to develop such abnormal eating pattern? The answer to this question seems to lie in a combination of environmental, psychological and biological factors. In the next pages you will learn about the roles of these factors.

Environmental Factors

Anorexia and Bulimia are common in industrialized cultures where beauty is equated with “thinness”. Consistent with objectification theory, a study of 16 to 21 year old female college students suggests that a cultural emphasis on viewing one’s body as an object contributes to eating disorder (Noll & Fredrickson, 1998).

For Anorexics, losing weight becomes a battle for success and control: “Me versus food, and I am going to win”. Their perfectionism and need for control may partly stem from their upbringing. Anorexics describe their parents as disapproving and as setting abnormally high achievement standards and they report more stressful events related to their parents than do non anorexics (Waller & Hartley, 1994).

Psychological Factors

A number of socio-cultural and psychological factors have been said to contribute to eating disorders of anorexia and bulimia nervosa. The factors listed below are psychological factors implemented as the cause of eating disorders.

1. Pressure to be thin
2. Cultural norms of attractiveness
3. Food used as a way of coping with negative emotions
4. Over concern with others' opinions
5. Family dynamics characterized by over controlling
6. Parents who do not allow the expression of emotion
7. History of sexual abuse

For the purpose of emphasis, a brief explanation will be made on (i) family influences and (2) childhood sexual abuse.

Family influences: Research revealed that family dysfunction is a factor that contribute to the development of eating disorders. Family behaviour that tent to be noted are such things as rigidity, parental over protectiveness, excessive control, and marital discord between parents (Strober, 1997 as cited in Carson et al, 2011).

Childhood sexual abuse has been implicated in the development of eating disorders. One possibility is that being sexually abused increase the risk of developing other known risk factors for eating disorders such as having a negative body image or high levels of body affect.

Biological Factors

On the biological side, genetic factors may create a predisposition toward eating disorders. Concordance rates for eating disorders are among identical twins than fraternal twins, than second or third degree relatives (Fichtner & Noegel, 1990). Anorexics and Bulimia exhibit abnormal activity of serotonin and other body chemicals that help regulate eating (Walsh & Devlin, 1998).

Stomach acids expelled into the mouth during vomiting causes bulimics to lose taste sensitivity, making the normally unpleasant taste of vomit more tolerable. This help to perpetuate bulimics willingness to keep purging.

3.3 Treatment Approaches for Anorexia & Bulimia Nervosa

Given the multiple perspectives of the causes of eating disorders it follows that effective treatment requires a combination of approaches. Also, treating eating disorders is difficult and may take years, but with professional help about half anorexics and bulimics fully recover. One treatment approach that have proved very useful is the cognitive – behavioural therapy. This is discussed briefly.

Cognitive Behavioural Therapy – cognitive behavioural therapy (CBT), which involves changing behaviour and maladaptive styles of thinking, has proved to be very effective in bulimia. Because anorexia nervosa shares many features with bulimia, CBT is often used with anorexia patients too. The recommended length of treatment is 1 to 2 years. A major focus of the treatment involves modifying distorted beliefs about body weight and food, as well as distorted beliefs the self that may have contributed to the

disorder (e.g. “people will reject me unless I am thin”). A brief discussion on the use of medications is important to conclude these eating disorders.

Medications: It is quite common for patients with bulimia nervosa to be treated with antidepressant medications. Researchers became interested in using these medications to treat bulimic patients after it became clear that many patients with bulimia taking antidepressants do better than patients who are given inert, placebo medications. Perhaps surprisingly, antidepressants seem to decrease the frequency of binges, as well as improving patients’ mood and their preoccupation with shape and weight (Fairburn & Wilson, 2002 as cited in Carson et al., 2011).

4.0 CONCLUSION

In this unit, you learned that both anorexia nervosa and bulimia nervosa are characterized by an intense fear of becoming fat and a drive for thinness. Patients with anorexia nervosa are seriously underweight. This is not true of patients with bulimia nervosa. Eating disorders are more common in women than in men.

5.0 SUMMARY

In this unit, you studied eating disorders classified into two – anorexia nervosa and bulimia nervosa. Both disorders typically begin in adolescence. Genetics factors play a role in eating disorders and neurotransmitter serotonin has been implicated in eating disorders. Socio-cultural and psychological factors are important in the development of eating disorders. The disorders are difficult to treat, but the treatment choice for bulimia nervosa with CBT is also found useful

in treating anorexia nervosa. The use of medications such as antidepressant is also recommended.

6.0 TUTOR-MARKED ASSIGNMENT

- Why do you think cognitive behavioural therapy is so beneficial for patients with eating disorders
- What are the major differences between patients with anorexia nervosa and bulimia nervosa?
- What clinical features do these two forms of eating disorder have in common?

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UNIT 5: SCHIZOPHRENIA

CONTENTS

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- 3.0 Main Content
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1.0 INTRODUCTION

In the last unit, you learned about eating disorders. Anorexia and bulimia nervosa were the only two forms of eating disorders treated. There are many others.

Anorexics engage in food phobia whereas the bulimia binge eat and purge. Both anorexics and bulimics are preoccupied about their body.

In this unit, you will learn about schizophrenia, a mental disorder that cause the personality to lose its unity. You will learn about its meaning, characteristics and symptoms, types, causal factors, and the treatment approach. To benefit from these topics, you need to pay good attention.

2.0 OBJECTIVES

By the end of this unit, you should be able to:

- Explain the concept of schizophrenia and mental disorders
- Discuss the symptoms of schizophrenia
- Ex-plain types of schizophrenia
- Examine the causal factors of schizophrenia
- Analyze the treatment approaches of schizophrenia

3.0 MAIN CONTENT

3.1 What is schizophrenia?

Schizophrenia is a psychotic disorder that involves severe disturbances in thinking, speech, perception, emotion, and behaviour. Dementia praecox was the original term for schizophrenia. The term schizophrenia was introduced by the Swiss Psychiatrists Eugen Bleuler in 1911. Literally, the term means “split mind”.

Blueler intended to suggest that certain psychological functions such as thought, language, and emotion, which are joined together in normal people, are somehow split apart or disconnected in schizophrenia. The term schizophrenia comes from the latin words Schizo, meaning “split”, and phrenia meaning “mind”. The individual’s mind is split from reality, and personality loses its unity (Sartrock, 2000).

Schizophrenia is the same as multiple personality, which sometimes is called a “split personality”, schizophrenia involves the split of an individual’s personality from reality, not the coexistence of several personalities within one individual. A diagnosis of schizophrenia requires evidence that a person misinterpretation reality and exhibits disordered attention, thought or perception. In addition, withdrawal from social interaction is common, communication is strange or inappropriate, personal grooming may be neglected and behaviour may become disorganized (APA, 2000).

3.2 Symptoms of schizophrenia

Individuals with schizophrenia have delusions, or false beliefs. One individual might think he is Jesus Christ, another Nelson Mandela, President Jonathan, for example. The delusions are utterly implausible. One individual might think her thought are being broadcast over the radio, another might think that a double agent is controlling her every move.

Individuals with schizophrenia also might hear (auditory hallucination), see (visual hallucination), smell (olfactory hallucination), feel and taste things that are not there. These hallucinations often take the form of voices. An individual with schizophrenia might be that he hears two people talking about him. Or, on another occasion, he might say, “hear that rumbling”, noise in the pipe. That is one of my men watching out for me.

Often individual with schizophrenia do not make sense of when they talk or write. For example, one individual with schizophrenia might say “Well, Rocky, babe, help is out, happening, but where, when, up, op, side etc. such speech has no meaning. These incoherent loose word associations are called “word salad” or “staccatolike”. In some cases they invent or form new words known as **neologism**.

The motor behaviour of the individual with schizophrenia can be bizarre, sometimes taking the form of an odd appearance, pacing, status like postures, or strange mannerisms. Some individuals with schizophrenia withdraw from their social world. They become so insulated from others they seem totally absorbed in their interior thoughts.

3.3 Types of schizophrenia

Under types of schizophrenia, you will learn about four major types. DSM – IV – TR (2000) differentiates schizophrenia into (1) paranoid (2) disorganized (3) catatonic and (4) undifferentiated.

1. Paranoid schizophrenia: This is a type of schizophrenia characterized by delusions of reference, grandeur and persecution. The delusions usually form a complex, elaborate system based on a complete misinterpretation of actual events. It is not unusual for the individual with paranoid schizophrenia to develop all three delusions in the following order. First, they sense they are special and have been singled out for attention (delusion of reference). Individuals with delusion of reference misinterpret chance events as being directly relevant to their own lives – a thunderstorm for example, might be perceived as a personal message from God. Second, they believe that this special attention is the result of their admirable and special characteristics (delusion of grandeur). Individuals with delusions of grandeur think of themselves as exalted beings – the pope or the president, for example. Third, they think others are so jealous and threatened by these characteristics that they spy and plot against them (delusions of persecution). Individuals with delusions of persecution often feel they are the target of a conspiracy.

2. Disorganized schizophrenia: The central characteristics are confusion and incoherence, together with severe deterioration of adaptive behaviour. Thought disorganization is often so extreme that it is difficult to communicate with them. Their behaviour often appears silly and childlike, and their personal responses are highly inappropriate. These people are usually unable to function on their own.

3. Catatonic schizophrenia: Is a type of schizophrenia characterized by bizarre motor behaviour, which sometimes takes the form of a completely immobile stupor. Even in this stupor, individuals with catatonic schizophrenia are completely conscious of what is happening around them. In a catatonic state, the individual sometimes shows waxy flexibility, for example, if the person's arm is raised and then allowed to fall, the arm stays in the new position.
4. Undifferentiated schizophrenia: This category is for people who exhibit some of the symptoms and thought disorders of the above categories but do not have enough of the specific criteria to be diagnosed in those categories?

In addition, to these formal DSM – IV – TR categories, many mental workers and researchers categorize schizophrenia reactions into two main categories on the basis of two classes of symptoms. Type I schizophrenia is characterized by a predominance of positive symptoms, such as delusions, hallucinations and disordered speech and thinking. These symptoms are called positive because they represent pathological extremes of normal processes. Type II schizophrenia features Negative symptoms – an absence of normal reactions – such as lack of emotional expression, loss of motivation, and an absence of normal speech.

The distinction between positive and negative symptom subtypes seems to be an important one. Researchers have found differences in brain function between schizophrenics having positive symptoms and those with primarily negative symptoms. The subtype also shows differences in life history and prognosis. Negative symptoms are likely to be associated with long history of poor functioning prior to hospitalization and with a poor outcome following treatment. In contrast, positive symptoms especially

those associated with a diagnosis of paranoid schizophrenia are associated with good functioning prior to breakdown and a better prognosis for eventual recovery, particularly if the symptoms came on suddenly and were preceded by a history of relatively good adjustment. Prognosis means a prediction or forecast of the course or outcome of a disorder. The next focus on causal factors in schizophrenia.

3.4 Causal Factors in schizophrenia

Due to the seriousness of the disorder and many years of anguish the incapacitation that its victims are likely to experience, schizophrenia is perhaps the most widely researched of the psychological disorders. There is a growing consensus that schizophrenia results from a biologically vulnerability factor that is set into motion by psychological and environmental events. In the next pages you will learn about biological, psychological and environment factors that brings about the mental disorders of schizophrenia. You must be attentive to learn about this interesting and information loaded topic.

Biological Factors: Biological factors that have been proposed to explain schizophrenia involve heredity and neurobiological factors. One important question to ask is this: if you have a relative with schizophrenia, what are chances that you will develop schizophrenia? It depends on how closely you are related. As genetic similarity increases, so does a person's risk of becoming schizophrenic. An identical twin of an individual with schizophrenia has a 46 percent chance of developing the disorder, a fraternal twin 14 percent, a sibling 10 percent, a nephew or niece 3 percent, and an

unrelated individual in the general population 1 percent (Gottesman & Shields, 1982). Such data strongly suggest that the genetic factors are involved in schizophrenia, although the precise nature of the genetic influence is unknown.

Many neuroscientists believe imbalances in brain chemistry, including deficits in brain metabolism, a malfunctioning dopamine system, and distorted cerebral blood flow, cause schizophrenia. We do know that individuals with schizophrenia produce higher than normal levels of neurotransmitter dopamine. They also have a reduced blood flow in the prefrontal cortex. The dopamine hypothesis states that the symptoms of schizophrenia, particularly positive symptoms, are produced by over activity of the dopamine system in areas of the brain that regulate emotional expression, motivated behaviour and cognitive functioning.

Psychological Factors: Freud and other psychoanalytic thinkers viewed schizophrenia as a retreat from unbearable stress and conflict. For Freud, schizophrenia represented an extreme example of the defense mechanism of regression, in which a person retreats to an earlier and more secure (even infantile) stage of psychosocial development in the face of overwhelming anxiety.

Although contemporary theorists do not propose psychosocial factors as stand alone causes of schizophrenia, stress is the psychosocial factor that is given the most attention in understanding schizophrenia. The diathesis stress view argues that a combination of biogenetic disposition and stress cause schizophrenia (Meehl, 1962). The term diathesis means physical vulnerability or predisposition to a particular

disorder. A defective gene make up might produce schizophrenia only when the individual lives in a stress environment.

Environmental Factors: Stressful life events seem to play an important role in the emergence of schizophrenic behaviour. These events tend to cluster in the two or three weeks preceding the “break” when the acute signs of the disorder appear. A stressful life event seems to interact with biological or personality vulnerability factor. A highly vulnerable person may require little in the way of life stress to reach the breaking point.

Family dynamic is also considered in the development or emergence of schizophrenia. Although researchers have had difficulty pinpointing family factors that contribute to the initial appearance of schizophrenia, one consistent finding is that previously hospitalized schizophrenics are more likely to relapse if they return to a home environment that is high in a factor called expressed emotion. Expressed emotion involves high levels of criticism (“All you do is to sit in front of that TV”), hostility (“We are getting sick and tired of craziness”), and over involvement. (“You are not going out unless I go with you”) (Santrock, 2000). The next focus is in treatment of schizophrenia.

Treatment of schizophrenia

In the treatment of this mental disorder, you will learn about pharmacological approaches and psychosocial approaches. Pay attention to enhance your learning.

Pharmacological Approaches

First – generation Antipsychotics. First generation antipsychotics are medications like chlorpromazine (Thorazine) and haloperidol (Haldol) that were among the first to be used to treat psychotic disorders. Sometimes referred to as neuroleptics (Literally, “seizing the neuron”), these medications revolutionised the treatment of schizophrenia more than 50 years ago and be regarded as one of the major medical advances of the twentieth century (Carson et al., 2011). They are called “first generation antipsychotics” (or “typical psychotics”) to distinguish them from a new class of antipsychotics that have been developed much more recently. These are referred to as “second generation” (or “atypical”) “antipsychotics” (Carson at al, 2011). There is overwhelming evidence that antipsychotic medications help patient. The first generation antipsychotics work because they dopamine antagonists. This means they block the action of dopamine. Recall the biological causal factors of schizophrenia and the role of this neurotransmitter.

Second Generation Antipsychotics. In the 1980s a new class of antipsychotic medications began to appear. The first of these to be used clinically was clozapine (clozaril). The most recent addition is aripiprazole (ability). The reason why these medications are called “second generation antipsychotics” is that they cause for fewer problems than the earlier antipsychotic medication. They are also remarkably effective in alleviating both the positive and the negative symptoms of schizophrenia. You have learnt something about pharmacological methods in treating schizophrenia. The next focus is one psychosocial approaches.

Psychosocial Approaches: Mental health practitioners have been slow to realize the limitations of an entirely pharmacological approach to the treatment of schizophrenia. But the most notable indication of a changing of perspective on the treatment of schizophrenia comes from the American Psychiatric Association (2004) Practice Guideline for the Treatment of Patients with schizophrenia. This document makes recommendations for using medications to manage patients and also highlights the importance of psychosocial interventions. Some of these approaches are briefly described below.

Family Therapy: Evidence from the links between relapse in patients with schizophrenia and high family levels of expressed emotion (EE). You are familiar with this concept. It was discussed under environmental factors as a causal agent in schizophrenia. It is the EE that inspired several investigators to develop family intervention programmes. The idea was to reduce relapse in schizophrenia by changing those aspects of the patient – the relationship that were regarded as central to the EE issue. At a practical level, this generally involves working with patients and their families to educate them about schizophrenia, to help them improve their coping and problem solving skills, and to enhance communication skills, especially the clarity of family communication.

Social Skills Training: Patients with schizophrenia often have very poor interpersonal skills. Their social functioning is also hampered by deficits in their abilities to recognize basic facial emotions such as happiness and anger. The social skills training is designed to help patients acquire the skills they need to function better on a day to day

basis. These skills include employment skills, relationship skills, self care skills, and skills in managing medication or symptoms. Social routines are broken down into smaller, more manageable components. For conversational skills, these element might include learning to make eye contact, speaking at a normal and moderate volume, taking one's turn in a conversation, and so on. Patients learn these skills, get corrective feedback, practice their new skills using role playing, and then use what they have learned in natural settings (Bellack & Muesser, 1993 as cited in Carson et al., 2011).

4.0 Conclusion

In this unit, you learned about schizophrenia and how it affects human personality. It is a problem that cause the patients to display maladaptive behaviours.

5.0 Summary

In this unit, you learned that schizophrenia is a psychotic disorder that interferes with human behaviour. Individuals with schizophrenia experience hlluciantions of different forms. We have different types of schizophrenia – paranoid, disorganized, catatonic and undifferentiated. Causal factors are biological, psychological and environment. Treatment of schizophrenia can be done through pharmacological and psychosocial approaches.

6.0 Tutor-Marked Assignment

- What are the major symptoms of schizophrenia?

- How is hallucination different from a delusion?
- What are the four major subtypes of schizophrenia recognised by the DSM?
- What evidence supports a genetic contribution to schizophrenia?

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