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LESSON 1
ABNORMAL PSYCHOLOGY

According to William James (1842-1910)" To study the abnormal is the best way of understanding the normal".

What is Psychology?

Psychology is the science of behavior it deals with prediction and control of behavior. Psychologists use the methods of science to investigate and study all kinds of behavior and mental processes say for example the activity of single nerve cell to social conflicts that take place in complex societies or say from the development of language in childhood to the major adjustments required in old age.

Why study Psychology?
- Know thy self
- To have a clear understanding of your own behavior, personality, attitudes, emotions, cognitions and many more things about yourself and others.

What is Abnormal Psychology?

It is a branch or field of Psychology which relates to mental disorders or psychopathology. It involves studying patterns of thinking and behaving that are maladaptive, disruptive .These disruptive patterns of thinking and behaving ultimately effects the individual relationship with others.

You may have heard about a number of mental disorders in television talk shows or in dramas or in the movies. Most of us are even familiar with the names of these mental disorders, such as Depression, Anxiety disorder, Eating disorder, Schizophrenia, Post traumatic stress disorder, Obsessive Compulsive disorder and many more.

Abnormal Psychology studies:
- The symptoms (what the disorders look like?), about
- The etiology (what causes these disorders),
- The assessment (how we can measure the disorders)
- The diagnosis (how we can classify the disorders)
- The prognosis (the possible outcome of the disorder)
- The treatment (how we intervene)
- Social implications (the effects that disorders have on the individual, their family and on the society in particular).

Example

A SIXTEEN YEAR OLD GIRL in her biology class saw the dissection of a frog, about half way she left the room but she was bothered by images of the dissection. She began to avoid situations where she might see blood or injury .she found it difficult to look at raw meat or band aid. She could not stand the sight of blood. She fainted in her class frequently and she could not stand the people talking about blood, surgery or injury.

Symptoms sight of blood, injury or band aid or raw meat created fear.
Etiology saw a dissection of frog
Assessment impaired functioning, and DSM-IV-TR
Diagnosis blood injury Phobia
Prognosis good
Treatment phobia treatment by Systematic Desensitization
Social implications can not study in class; enter professions like medicine or nursing.

Psychology is the scientific study of behavior where as Abnormal Psychology is the application of psychological science to the study of mental disorders.
PSYCHOSIS is a general term that refers to several types of severe mental disorder in which the person is considered to be out of contact with reality.

Neurosis is a term no more used now we use the term **Anxiety disorders** it refers to mild types of mental disorder in which the person has contact with reality but its one area of his life which is problematic.

Recognizing the presence of a disorder
- All mental disorders are typically defined by a set of characteristic features; one symptom by itself is seldom sufficient to make a diagnosis.
- A group of symptoms that appear together and are assumed to represent a specific type of disorder is referred to as a syndrome.
- The significance of any specific feature depends on whether the person also exhibits additional behaviors that are characteristic of a particular disorder.
- The duration of a person's symptoms is also important.
- Mental disorders are defined in terms of persistent maladaptive behaviors.

Impairment is the ability to perform social and occupational roles is another consideration in identifying the presence of a mental disorder.
One of the most difficult issues in the field of abnormal psychology centers on the processes by which mental disorders are identified.
Psychologists and other mental health professionals do not at present have laboratory tests that can be used to confirm definitively the presence of psychopathology because the processes that are responsible for mental disorders have not yet been fully discovered.

Clinical psychologists depend on their observations of the person's behavior and descriptions of personal experience.
Insanity is a legal term that refers to judgments about whether a person should be held responsible for criminal behavior if he or she is also mentally disturbed.
Nervous breakdown is an old fashioned term that indicates, in very general terms, that a person has developed some sort of incapacitating but otherwise unspecified type of mental disorder.
This expression does not convey any specific information about the nature of the person's problems.
Crazy is a term that does not convey specific information and carries with it many unfortunate, unfounded, and negative implications.
Mental health professionals refer to psychopathological conditions as mental disorders or abnormal behaviors.
Lunatic, insane, mad and nuts are terms referring to bizarre set of behaviors.

Example A
I felt the need to clean my room at home every Sunday and I would spend some four to five hours at it. I would take every book out of the bookcase, dust it and put it back. At that time I loved doing that .Then I did not want to do it, but I could not stop and it made me think for the time that I might be nuts. (Case A, diagnosed with obsessive compulsive disorder, citation from Summers, 1996)

Example B
Whenever I get depressed it's because I have lost a sense of myself. I cannot find reasons to like myself. I think I am ugly, I think no one likes me and I have become short tempered. Nobody wants to be around me. I am left alone. Being alone confirms that I am ugly and not worth being with. I think I am responsible for everything that goes wrong. (Case B, diagnosed with depression, citation from Thorne, 1993)

Example C
Voices, like roar of a crowd. I felt like Jesus (Christ), I was being crucified. It was dark. I just continued to huddle under the blanket, feeling weak, and defenseless in a cruel world, I could no longer understand (Case C, Diagnosed with Schizophrenia, citation from Emmons & et.al, 1997)

The three examples cited are about exceptional, the unusual, the different, and the abnormal people.

Have you ever given a thought why we are fascinated by the disturbed people?

Do we see something of ourselves in them?

Do we at various moments think feel and act like the way disturbed people do most of the time?

Most of the people get anxious, depressed, suspicious, socially withdrawn or anti social, just less intensely and briefly, so its no wonder that while studying about the psychological disorders may at times evokes a strange sense of self recognition and an understanding of our own personality dynamics.

According to William James (1842-1910)" To study the abnormal is the best way of understanding the normal".

Another important reason for our curiosity about the disturbed people is that many of us have felt either personally or through friends or family members, the suffering and pain associated with the presence of a psychological disorder.

Myths and Misunderstandings of Abnormality/Mental Illness/Psychological Disorders
Following are the misconceptions and misunderstandings about the Psychological Disorders

No	Behavior Perception
1	A person who has been mentally ill can never be normal.
2	Even if some mentally ill persons return to normal, most do not and people remain crazy
3	People with Psychological problems are unpredictable.
4	Mentally ill persons are dangerous and they could become aggressive at any time
5	Mentally ill people are misfits.

All the five myths are related to abnormal behavior or mental illness are not based on any empirical evidence.

Team approach in psychology
Psychiatrist is an MBBS, with an internship in psychiatric disorders. He prescribes drugs, psychosurgery and procedures like Electroconvulsive therapy. He identifies biological causes of disorder.

Clinical Psychologist has a master degree in psychology, a diploma in clinical psychology or a PhD degree in psychology. He identifies psychological, emotional, and behavioral causes of abnormal behavior.
Sociologist has a master degree in sociology. He identifies the sociological causes of abnormal behavior.
A team approach is needed in abnormal psychology.

WHAT IS ABNORMAL BEHAVIOR

Difficulty in defining Abnormality
In this era of rapid technological advancement, you might think there would be some objective test like a blood test or a like a brain scan that could determine whether an individual is normal or abnormal?

There is no such test available; however psychologists rely on signs, symptoms, and subjective criteria for deciding when the observed symptoms (signs) constitute abnormality. Four criteria for defining abnormality have been proposed. They are often called the four D's, Deviance, Distress, Dysfunction and Danger.

Deviant behavior means different extreme unusual and bizarre
Distress refers to unpleasant or upsetting behavior of an individual
Dysfunctional or disruptive in a way that possibly can became dangerous as well
Danger of hurting one self and others

1. **Deviance**
    a. Deviance from the Cultural Norms
    b. Deviance from the Statistical Norms

 a. Deviance from Cultural Norms
Every culture has certain standards, norms and yardsticks for acceptable behaviors and behavior that deviates or differs markedly from those norms is considered abnormal. The followers of Cultural Criteria perspective argue that we should respect each culture's definition of abnormality for the members of that culture. By doing so we do not impose one culture's standards for behavior on another. The concept of abnormality changes over time, within the same society. Forty years ago, most Americans would have considered men wearing earrings as abnormal but today it's considered as differences in lifestyle rather than as signs of abnormality differ from one society to another and over time within the same society.

b. Deviance from Statistical Norms
The word abnormal means away from the normal or away from the norm. Many characteristics such as height, weight and intelligence cover a range of values, when measured over an entire population. Most people for example fall within the middle range of height and few are abnormally tall or short. Abnormal behavior is statistically infrequent or deviant from the norm. A person who is extremely intelligent or happy would be classified as abnormal while defining Abnormal Behavior we must consider more than the statistical frequency.

2. **Dysfunction**
Abnormal behavior tends to interfere with daily functioning. It so upsets, distracts or confuses its victims that they cannot care for themselves properly.

Example
 An individual quits his job, leaves his family and prepares to withdraw from the productive and meaningful life in order to live in an empty isolated distant apartment where he feels comfortable and satisfied. So this dysfunctional behavior indicates psychological abnormality.
A behavior is abnormal if its maladaptive that is if it has adverse effects on the individual or on Society. A man who is fearful of crowds that he cannot board in the bus to work.

3. **Distress**
The individuals' subjective feelings of pain, anxiety, depression, agitation, disturbance in sleep, loss of appetite, numerous aches and pains. Most people who are diagnosed with a mental disorder feel entirely miserable while they may appear normal to the observer.

4. Danger

Psychological dysfunctioning is behavior that becomes dangerous to oneself or others. A pattern of functioning that is marked by carelessness, poor judgment, hostility or misinterpretations can jeopardize one's own wellbeing and that of many other people as well. A person may seem to be endangering himself by being least bothered about his diet and health and for others by his collection of arms and guns.

None of these four criteria provide a satisfactory description of abnormal behavior, in most cases; all four criteria are used in diagnosing abnormality. All mental health professionals and public judge abnormality by practical consideration of

What is Abnormal Behavior?

By what criteria do we distinguish abnormal behavior from normal behavior?

    a.   The content of the behavior (what a person does?) The content of behavior that causes discomfort, appears weird, and is inefficient.

    b.   The context of the behavior (where and when the person does it?) Does the individual display the behavior in public or privately.

With regard to content, behavior is likely to be judged abnormal by society if it causes
    i.   Discomfort
    ii.   Appears bizarre or weird
    iii.   Is dysfunctional (distracts, upsets)

People will tolerate a considerable amount of discomfort even bizarreness in themselves and others if the behavior is not so frequent or disruptive that it interferes with the demands of everyday life e.g. a successful businessman was found to have lined all his clothes with newspapers to protect himself against harmful radiation from alien's spaceship. Every one of his office thought that this was bizarre behavior.--

The second criteria used in the practical approach is context where and when the behavior occurs. How would you feel if you were asked to enter a room and stare everybody who was attending a party or to tell jokes at a funeral? You would hesitate. It is because you recognize that these actions would be in appropriate to the situation and your behavior will be labeled as abnormal. According to the second criteria of context of behavior (where and when the behavior takes place) --

What is Normality?

Normality is even more difficult to define as compared to Abnormality

What is Normality?
Normality refers to adjustment.
The traits or characteristics of well adjusted individuals or mentally healthy individuals or psychologically well adjusted individual is reflected by the followings:

    1.   Appropriate perception of reality. Normal individuals are realistic in appraising their reactions, capabilities, and in interpreting in what is going on in the world around them. They do not misinterpret what others say or so they do not overate or underestimate their abilities. They do not avoid difficult tasks.
    2.   Ability to exercise voluntary control over behavior. Normal individuals feel confident about their ability to control their behavior.
    3.   They rarely act impulsively and refrain from aggressive behavior.
    4.   Self Esteem and Acceptance: Normal people have appreciation of their own worth and they feel accepted by those around them. Feelings of worthlessness, alienation and lack of acceptance are prevalent among abnormal.

5. Ability to form affectionate relationships. Normal individual are able to form close and satisfying relationships with other people. They are sensitive to the feelings of others and do not make excessive demands on others. Abnormal individuals are extremely self centered; they seek affection but are unable to reciprocate.
6. Productivity: Well adjusted people are able to channel their abilities into productive activity. They do not suffer from lack of energy and they do experience excessive fatigue.

Defining Psychological Disorders
Psychological Disorder is a psychological dysfunction with in an individual that is associated with distress or impairment in functioning and a response that is not typical or culturally expected.

Psychological dysfunction refers to a breakdown in cognitive, emotional, or behavioral functioning of the individual. A schizophrenic individual exhibits breakdown of cognitive (thinking), emotional (feeling) or behavioral (action) functions.

The disorder or behavior must be associated with distress and impairment. It is quite normal to be distressed or upset, if someone close to you dies. This distress and impairment makes you unable to function socially i.e. that is an individual attempts to avoids friends, relatives and even work colleagues.

The criterion, that the response be a typical or not culturally expected. At times, something is considered abnormal because it occurs infrequently it deviates from the average say when someone is extremely short or tall or eccentric. So we can conclude that behavioral, emotional or cognitive dysfunction that is unexpected in a culture and associated with personal distress or impairment in functioning is abnormal (Jerome Wakefield. 1992, 1997).

SO LET US SEE HOW MENTAL HEALTH PROFESSIONALS STUDY ABNORMALITY
There are two guidelines for defining abnormality used by mental health professionals.

Guidelines for defining Abnormality

Impaired Functioning

Diagnostic and Statistical Manual (DSM-IV-TR)
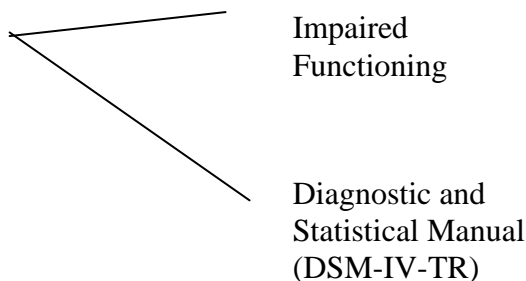
1. Impaired Functioning
A judgment about a behavior or an experience which causes impaired functioning i.e. difficulty in performing appropriate and expected roles. Judgment about the impairment can be made in reference to the person's context, the back ground of behavior, the person's age, and gender, historical, social and cultural background of the behavior.

2. **The Diagnostic and Statistical Manual DSM-IV-TR**
Another judgment about determining abnormality is whether a person's behavior fit expert professional rules for specific diagnosis. These rules are stated in the diagnostic and statistical manual, 4th Edition, revision called DSM-IV-TR. This system is used around the world for classifying psychological disorders and problems. The world health organization (WHO) publishes another manual used worldwide, the international classification of diseases (ICD) which is similar in many respects to the DSM-IV-TR Manual. DSM IV-TR has five diagnostic axes

Let us study the examples using these two guidelines

Example H
H was a conscientious and reliable secretary in a business office. She was cheerful and easygoing. Now she has missed many days of work and has to force herself to go to the office. At home she prefers to be alone away from her husband and children. She has nightmares and wakes up screaming at night. A year ago she was working late in her office; a stranger entered the building, found H alone, and robbed her at gunpoint. H was traumatized by the event and for days H could not go to work at her office.

The case H clearly has impaired functioning and with the help of DSM –IV-TR she is diagnosed as suffering from Post Traumatic Stress Disorder PTSD.
Neurosis is a term no more used now we use the term **Anxiety disorders** it refers to mild types of mental disorder in which the person has contact with reality but its one area of his life which is problematic.

PSYCHOSIS is a general term that refers to several types of severe mental disorder in which the person is considered to be out of contact with reality.

What is meant by Psychopathology?
The term Psychopathology is the scientific study of Psychological disorders. There are three major categories of concepts that make up the study and discussion of Psychological disorder.

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                                        ┌──────────────────────────┐
                                    ──► │   Clinical Description    │
                                        └──────────────────────────┘
┌──────────────────────────┐
│  Study of Psychological  │           ┌──────────────────────────┐
│         disorder         │ ─────────►│   Causation Etiology      │
└──────────────────────────┘           └──────────────────────────┘

                                        ┌──────────────────────────┐
                                    ──► │      Treatment and        │
                                        │        Outcome            │
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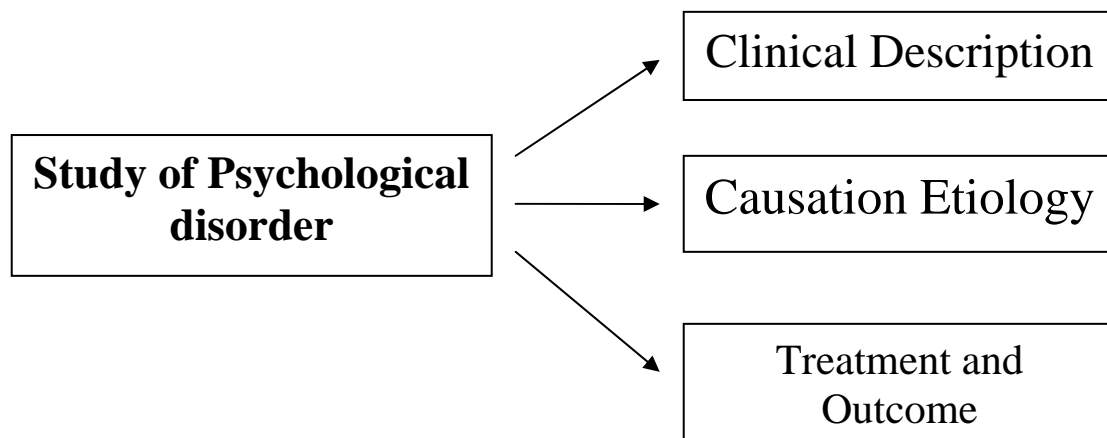
The Clinical description represents the unique combination of behaviors, thoughts and feelings that make a specific disorder. The word clinical refers to types of problems or disorders that you find in a clinic or hospital and especially with activities connected with assessment and treatment.

The clinical description of a disorder is further elaborated by the concepts of
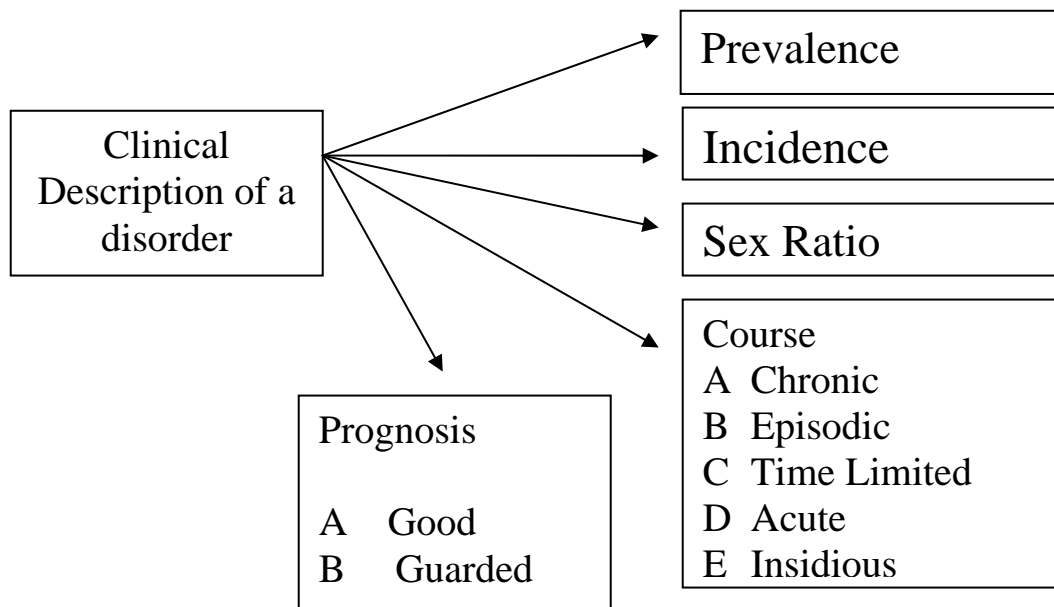
Prevalence refers to how many people in the population as a whole have the disorder? The figure or number of cases is called the prevalence of the disorder.

Incidence means how many new cases occur during a given period of time, say in a year?

Sex Ratio means what percentage of males and females have the disorder? And the typical age of onset which often differs from one disorder to another.

Course refers to somewhat individual pattern that most disorders follow or take. Schizophrenia (a Psychotic disorder) follows a chronic course which tends to last a longtime, sometimes a whole lifetime.

Episodic Course

Mood disorders (say depression) follow an episodic course in which an individual is likely to recover within a few months and a reoccurrence of the disorder at a later time. Time limited course means that the disorder will improve without treatment in short period of time.

Some disorders have sudden acute onset while some disorders develop generally over an extended period of time having an insidious onset.

Prognosis refers to chances of improvement of the disorder, so when we say that "prognosis" is "good", it means that the individual will improve (more chances of improvement),while the statement that "prognosis" is "guarded" means that the probable outcome does not looks good (less chances of improvement)
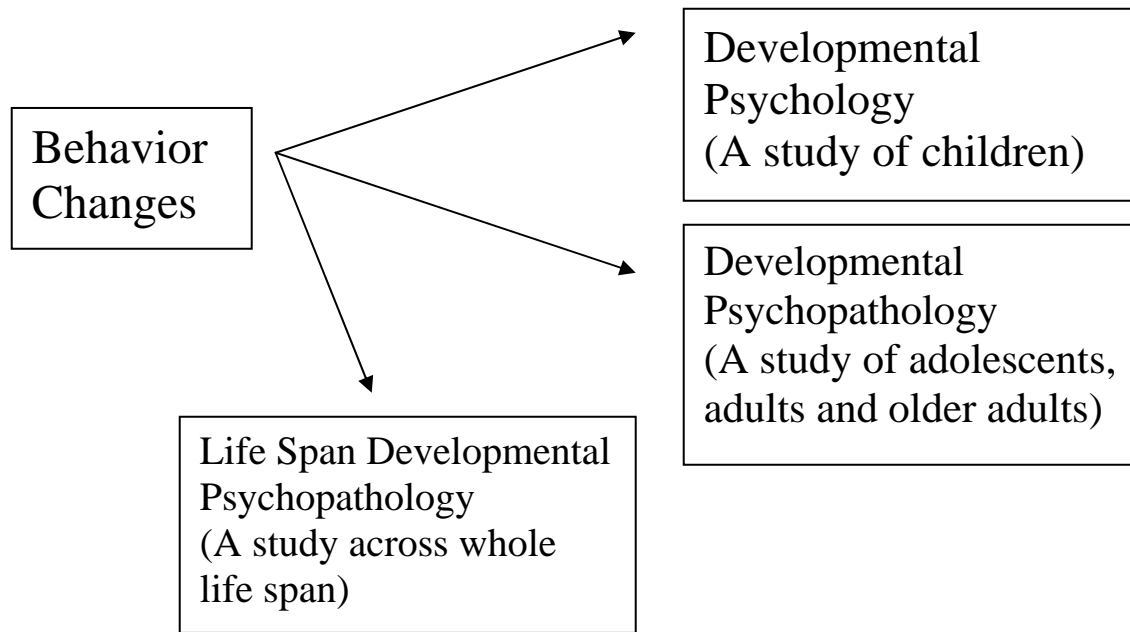
The study of changes in behavior overtime refers to science developmental psychology while the study of changes in abnormal behavior forms the discipline of developmental psychopathology (A relatively new and challenging field)

The study of behavior across the entire age span is referred as Life Span Developmental Psychopathology.
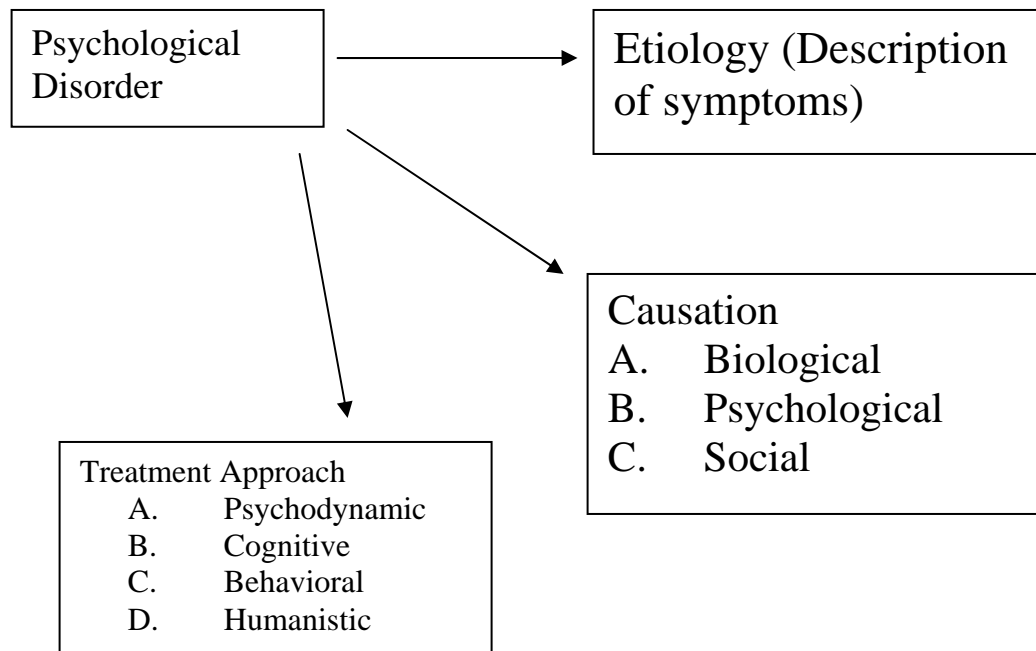
The Etiology or study of origins has to do why a disorder begins (what causes it) and it includes the biological, psychological and social dimensions.
Treatment /Intervention/Therapy can be during a medication or psychosocial treatment such as Psychodynamic, cognitive, behavior or humanistic therapy. The triad approach of Etiology, the causation, and the treatment of disorder is currently used.

LESSON 3
PSYCHOPATHOLOGY IN HISTORICAL CONTEXT I

Throughout history, many societies have held quite different views of the problems that we consider to be mental disorders. The search for explanations of the causes of abnormal behavior dates to ancient times, as do conflicting opinions about the etiology of mental disorders. Ancient records attribute abnormal behavior to the disfavor of the gods or the mischief of demons.

Models for Studying Psychopathology

1. Supernatural Model
2. Biological Model
3. The Psychological Model

What purpose do these Models serve?
These Models try to explain the cause of individual Abnormal Behavior. Each model represents its own individual interpretation of psychopathology and recommends its individual treatment procedures. So all the models try to answer the question that

Following are the Models of Studying Psychopathology

1. The Supernatural Model
This Model attributes Abnormal Behavioral to magic, evil spirits, demons, moon and the stars. This model includes

     a- Witchcraft and Demonology
     b -Moon and Stars
     c- Mass Hysteria

a- Witchcraft and Demonology
The individuals suffering from mental disorders are possessed and controlled by magic, evil spirits and demons etc.
The Treatments included punishments like chaining them or keeping them in cages or horrible ritual of boring a hole in the skull.
These victims after going through an unfair trial were condemned as witches or demons were burned alive or hanged. Witchcraft trials reached their peak in the sixteenth and seventeenth century. In 1692, in a small town of Salem, Massachusetts a group of 19 women and men were hanged as witches.

b- Moon and stars
The Latin word for moon is Luna, this inspired people to use the word lunatic for abnormal people, but now this word , is not used any more. According to this notion the movements of the full moon and the stars have an effect on behavior of people. This view is reflected by followers of astrology who think that their behavior as well as major events in their lives can be predicted by the position of the planets.

c- Mass Hysteria
It is a phenomenon in which the experience of an emotion seems to spread to those in the surroundings around. If an individual is frightened and sad this feeling and experience spreads to near by people and soon this feeling further escalates, develops into a panic and the whole community is affected. For example the 8th October 2005 Earthquake experience affected the whole Pakistani nation and the whole nation was traumatized.
The Supernatural model is still popular and used in undeveloped cultures where poverty is high and literacy rate is low and mental health professionals are not permitted to play their role. People still look towards magic and rituals performed by peers and fakirs for the solutions of mental disorders.

2-Biological model
This model attributes mental disorders to disease and biochemical imbalances in the body.

Greek Contribution
- Hippocrates (450-377 B.C.)
- Galen (129-198A.D.)

Nineteenth Century
- J.P. Grey -1854
- E. Kraeplin -1913

Twentieth Century
- Insulin shock therapy
- Electroconvulsive therapy

The Greek contribution
The Greek physician Hippocrates ridiculed demonological accounts of illness and insanity. Instead, Hippocrates hypothesized that abnormal behavior, like other forms of disease, had natural causes. Health depended on maintaining a natural balance within the body, specifically a balance of four body fluids (which were also known as the four humors): blood, phlegm, black bile, and yellow bile.
Hippocrates argued that various types of disorder or psychopathology, resulted from either an excess or a deficiency of one of these four fluids.
The Hippocratic perspective dominated medical thought in Western countries until the middle of the nineteenth century.
People trained in the Hippocratic tradition viewed "disease" as a unitary concept.
In other words, physicians did not distinguish between mental disorders and other types of illness. All problems were considered to be the result of an imbalance of body fluids, and treatment procedures were designed in an attempt to restore the ideal balance.

Four fluid theory
Galen a Roman physician adopted Hippocratic theory and advocated that the four fluids relate to the Greek environmental concepts such as heat (blood) ,dryness (black bile), moisture (yellow bile) and cold (phlegm).
Each fluid was related to one quality. Excess of one or more fluids were treated by regulating the environment to increase or decrease heat, dryness, moisture and cold depending on the deficiency of the fluid.
Example
King Charles the sixth, when he got sick he was treated according to the following concept of Galen. He was moved to less stressful countryside environment to restore the balance of his body fluids .Rest, good diet and exercise were recommended.

Techniques of Treatment
1-**Bloodletting**, a technique where a measured amount of blood was removed by leeches to minimize aggressive tendencies. Induced vomiting was used to reduce Depression .The diagnosed person was forced to eat tobacco and half boiled cabbage for vomiting.
2-**Syphilis**
A sexually transmitted disease caused by a bacterial micro-organism entering the brain.
The person having syphilis developed behavior patterns and cognitions of a psychotic disorder i.e. Schizophrenia and paralysis. The symptoms of Schizophrenia include
Hallucination (apperception), delusion (false belief) of grandeur, persecution and reference and bizarre behaviors as well.

Nineteenth Century
J.P.Grey theorized that mental disorder (insanity) was always due to physical causes and emphasis should be on rest and diet, proper room temperature and ventilation.
He even invented the rotary fan and used it State Hospital in New York.

Emil Kraepelin
Contributed in the area of diagnosis and classification of Psychological Disorders
Each psychological disorder has a different age of onset and time course to follow, along with a different cluster of presenting symptoms. His descriptions of Schizophrenia are still useful. Schizophrenia is a psychotic disorder. It has 11 subtypes where reality contact is severed (lost), delusions (false beliefs) and hallucinations (apperception).

Twentieth Century

Insulin shock therapy
In 1927 Manfred Sakel, a Viennese physician ,began using higher and higher dosages of Insulin, the patients had convulsions and went into a state of coma but surprisingly these patients recovered so physicians started to use it frequently. The method was abandoned because it was dangerous, caused coma and even death.
Joseph Meduna, in 1920 observed that Schizophrenia was rarely found in epileptics (which later did not prove to be true) and his followers concluded that induced brain seizures might cure Schizophrenia.

Electroconvulsive Therapy (ECT) was used extensively and frequently by doctors but was a controversial method some doctors even used it to penalize the difficult unmanageable patients. It is effective with suicidal patients.

Moral Therapy
It advocated humane and responsible care of the institutionalized patients and encouraged and reinforced social interaction with them. Mental Hygiene Movement started with the concept of Moral Therapy
Pioneers in the Mental Reforms
P.Pinel (1745-1826)
William Tuke (1732-1822)
Benjamin Rush (1745-1813)
Dorothea Dix (1802- 1887)
All these individuals were the pioneers in the Mental Hygiene Movement which led to Asylum Reforms in Europe and America.

In nutshell we can say
- The Biological Model had a scientific approach.
- Focus on medical procedures of treatment, drugs and medicines.
- Insulin Shock Therapy and Electroconvulsive Therapy are physically dangerous as well as harmful. It is ethically wrong to use these methods with humans.
- Plato and Aristotle both emphasized on the importance of social environment and early learning on later psychopathology. They wrote about the importance of dreams fantasies and cognitions in studying behavior.
- Moral Therapy the term moral means emotional or psychological rather than a code of conduct.

The Creation of the Asylum
In Europe during the Middle Ages, "lunatics" and "idiots," as the mentally ill and mentally retarded were commonly called, aroused little interest and were given marginal care. Disturbed behavior was considered to be the responsibility of the family rather than the community or the state. In the 1600s and 1700s, "insane asylums" were established.

Early asylums were little more than human warehouses, but as the nineteenth century began, the moral treatment movement led to improved conditions in at least some mental hospitals. Founded on a basic respect for human dignity and the belief that humanistic care would help to relieve mental illness, moral treatment reform efforts were instituted by leading mental health professionals of the day.

Contribution by Dorthea Dix
In the middle of the 1800s, Dorthea Dix argued that treating the mentally ill in hospitals was to be more humane and more economical than caring for them haphazardly in their communities. She urged that special facilities be provided to house mental patients.
The creation of large institutions for the treatment of mental patients led to the development of a new profession—**Psychiatry.**

By the middle of the 1800s, superintendents of asylums for the insane were almost always physicians who were experienced in taking care of people with severe mental disorders.
The Association of Medical Superintendents of American Institutions for the Insane (AMSAII), which later became the American Psychiatric Association (APA), in 1844.

Worcester Lunatic Hospital: A Model Institution
In 1833, the state of Massachusetts opened a publicly supported asylum for lunatics, a term used at that time to describe people with mental disorders, in Worcester.
Samuel Woodward, the asylum's first superintendent, also became the first president of the AMSAII.
Woodward claimed that mental disorders could be cured just like other types of diseases.
Treatment at the Worcester Lunatic Hospital included a blend of physical and moral procedures.

3. Psychological Model consists of following
a. Psychoanalysis
b. Humanistic
c. Behavioristic

Psychoanalysis
 Psychoanalysis was pioneered by Sigmund Freud (1856-1939). He learned the art of Hypnosis from France. He experimented with somewhat different procedures of Hypnosis. He used Hypnosis in a innovative way. He encouraged his patients to talk freely about their problems, conflicts and fears .He discovered the unconscious mind and its influence in psychopathology by using the techniques of Free Association, Dream Analysis and Freudian Slips.

Structure of the mind: According to Freud the mind consists of

                              Id
Mind--------------ego
                        Superego

Id – which operates on pleasure principle, it is childish and immature. Libido provides energy to Id, Ego and Superego. Ego operates on Reality Principle and it is the master control .It works on logic and reason The Superego it operates on the moral principle and it is the conscience of the Psyche. The Ego mediates and resolves conflict between Id and Superego.

Defense Mechanism or Coping Styles
The Ego battles with Id and Superego to resolve conflicts, at times the resulting anxiety is so overwhelming that the Ego has to adopt unconscious protective processes called Ego Defense Mechanisms or Coping Styles. They have following characteristics in common

1. Operate at unconscious level.

2. Distort reality.
3. Protect the Ego.
4. All normal and abnormal individuals both use it in their daily life.

Some important ego defense mechanisms are following

1-Denial, 2- Displacement, 3- Projection, 4- Reaction formation,5- Repression,
6-Rationalization, 7- Sublimation

Psychosexual Theory of Development
Freud proposed a theory of development. This is known as the psychosexual theory of development. The main emphasis in this theory is on the physical and psychological development.

Psychosexual theory of ------------ development	1- Oral stage -birth to 18 months
	2- Anal stage-18 months to 3 years
	3- Phallic stage -3 to 6 years
	4- Latency stage
	5-Genital stage-6 to 12 years

The stages of development represent patterns of gratifying our basic the needs, those needs which are not gratified appear as fixations or psychopathologies at later adulthood. Oral stage fixations include nail biting, chewing pencils. Freud is the first personality theorist to discuss the developmental perspective in the study of abnormal behavior.

Psychoanalytic Therapy
 It focuses on unconscious processes, conflicts and past experiences.

The techniques include
- Free Association
- Dream Analysis
- Freudian Slips
- Transference
- Analysis of humor

PSYCHOPATHOLOGY IN HISTORICAL CONTEXT II

1. Psychological Model

It is a long leap from
   a. Witch craft and Demonological concepts
   b. From notorious biological methods (Insulin shock therapy, Lobotomy, Electroconvulsive therapy) of 1920's and 1930's.

Plato listed two causes of mental disorders (a). Social and cultural influence's in one's life. (b). learning that took place in the environment.
Moral therapy a treatment approach of the 18th century, the term Moral really meant emotional or psychological rather than code of conduct. Moral therapy proposed humane treatment and responsible care of institutionalized psychologically disturbed individuals.

Moral therapy also advocated providing opportunities for appropriate social and interpersonal contact.
Mental Hygiene Movement with heroic efforts of Dorthea Dix improved and reformed the asylums and inspired the construction of new institutions in America and in other countries as well.

The Psychological tradition was dormant/dead for some time but in 20th century is reemerged in form of several schools of thought.

   a. Freudian psychoanalytic model
   b. Jungian analytical psychology model
   c. Adlerian Individual psychology model
   d. Humanistic model
   e. Behavioral model
   f. Cognitive model

Psychoanalytic or Psychoanalysis or psychodynamic approach pioneered by Sigmund Freud (1856-1939) emphasized on internal mental processes and childhood experiences. The core elements of this approach include.
   i. Analysis of mental structures in conflict.
   ii. Levels of consciousness
   iii. Defense mechanisms
   iv. Psychosexual stages of development.

$$Id \rightarrow \text{Pleasure Principle}$$

Mental Structures $\longrightarrow$ Ego $\rightarrow$ Reality Principle

$$\text{Super Ego} \rightarrow \text{Moral Principle}$$
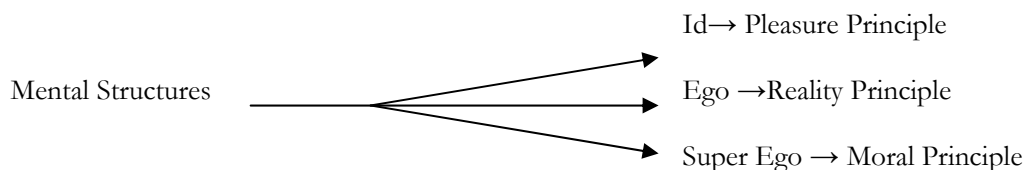
The human psyche consists of **id, ego** and **super ego**, the thoughts attitudes and behaviors of three are in state of conflict called intra-psychic conflict.

Id is the unorganized reservoir of wishes or passions related to our sexual and aggressive drives, it strives for immediate gratification that bypasses demands of reality, order logic and reason. The Id is like a child when it wants something it wants it there and then without regard for consequences, so Id operates on pleasure principle.

This refers to Greek concept of hedonism meaning pleasure. The energy within the Id is labeled as the libido. The Id has its own characteristic way of processing information, cognitive style referred as primary process. The thinking patterns of Id are illogical, irrational, emotional immature and purely selfish.

Ego – the selfish and dangerous drives of id do not go unchecked ego ensures that we must find ways to meet our basic needs with out offending everyone around us. The ego operates according to the reality principle and the cognitive operations of the ego are characterized by logic, reason and are referred as the secondary process.

The ego is the master control, it tries to resolve conflicts between the demands of Id with in the permitted boundaries of super ego.

The ego has the role to mediate conflict between the Id and super ego according to realities of the world. If it mediates successfully, we see an intelligent, creative individual who is well adjusted while if ego is unsuccessful either Id or super ego will be strong.

If Id is strong, we see an antisocial criminal and if super ego is strong we see a pure, rigid, nonflexible individual. Super ego is the storehouse of moral and ethical standards taught by parents, teachers and culture (it also refers to the conscience of the psyche). It operates according to the moral Principle when we do something wrong, when ethical, moral standards are violated than super ego generates guilt.

Example
You go to a garden where you see red roses you face intra-psychic conflict

| Id→	Ego↔	Super Ego
I want red rose and I want it now.	I can afford to buy red roses from flower shop	Stealing is bad. The sign says don't pluck flowers.

Example
You go to a store you see a lovely jacket but the price is high but no one is looking you face intra-psychic conflict:
Example

Id→	Ego↔	Super Ego
I want the jacket and I want it now.	I have to be realistic I cannot afford the jacket.	Stealing is bad.

Levels of Consciousness:

Consciousness

Preconscious/
Sub conscious
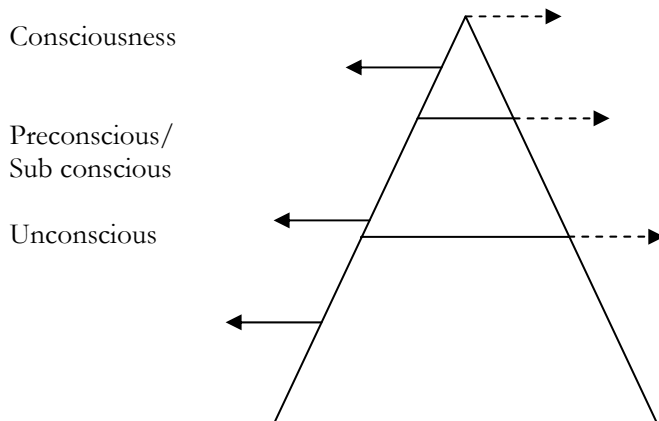
Unconscious

According to this triangle, the top smallest part is the conscious experience the middle small layer is subconscious and the largest portion is unconscious.

According to Freud that part of the mind about which we are aware is consciousness but it is a small part of mental life. You are listening to me it is your conscious mental activity. The preconscious comprises of thoughts or activities that are easily made conscious by an effort to remember or say, you have the present lecture's handout in front of you and you are conscious that you are writing on it. The largest segment is the unconscious not easily reachable yet it gives rise on to important needs and influences our behavior.

Example

All your nightmares, phobias, fears influence you and you can not get rid of them because they lie in unconscious. Freud suggested techniques of reaching the unconscious

Means of Tapping Unconscious

- Free Association
- Dream Analysis
- Transference
- Analysis of humor
- Analysis of Freudian Slips
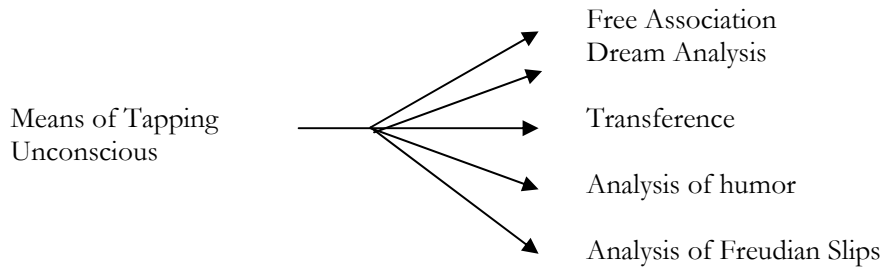
Example

You stand near a river, the top water is the conscious part, fill out some muddy water in container, it is the sub-conscious and when you dug the river bed and find something buried in it well that is the unconscious part.

Defense Mechanism

The ego fights a battle to stay on top of id and super ego. The conflicts between id and super ego produce anxiety that is a threat to ego. The threat or anxiety experienced by ego is a signal that alerts the ego to use unconscious protective processes that keep primitive emotions associated with conflicts in check. These protective processes are defense mechanisms or coping styles.

Id
↓

Coping styles   Ego
                         ↑
                         Super ego
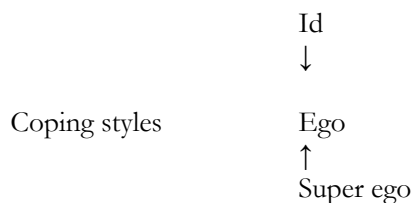
Defense Mechanisms
  a.   Denial
  b.   Displacement
  c.   Projection
  d.   Rationalization
  e.   Reaction formation
  f.   Repression, sublimation

| TABLE 2–1	Some Freudian Defense Mechanisms
Denial	Insistence that an experience, memory, or need did not occur or does not exist. For example, you completely block a painful experience from your memory.
Displacement	Feelings or actions are transferred from one person or object to another that is less threatening. For example, you kick your dog when you are upset with your boss.
Projection	Attributing one's own feelings or thoughts to other people. For example, a husband argues that his wife is angry at him when, in fact, he is angry at her.
Rationalization	Intellectually justifying a feeling or event. For example, after not getting the offer, you decide that a job you applied for was not the one you really wanted.
Reaction formation	Converting a painful or unacceptable feeling into its opposite. For example, you "hate" a former lover, but underneath it all you still really love that person.
Repression	Suppressing threatening material from consciousness but without denial. For example, you "forget" about an embarrassing experience.
Sublimation	Diverting id impulses into constructive and acceptable outlets. For example, you study hard to get good grades rather than giving in to desires for immediate pleasure.
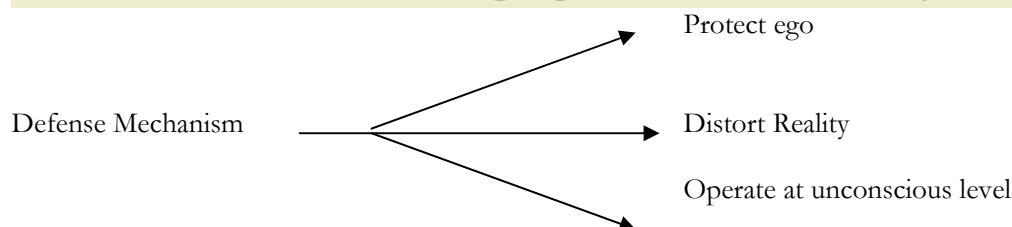
Humour and sublimation are defense mechanisms that correlate with psychological health

Who uses these defense mechanisms?
Normal and abnormal?
Both?

Psychosexual stages of development
Freud theorized that during childhood we pass through a number of psycho sexual stages of development.
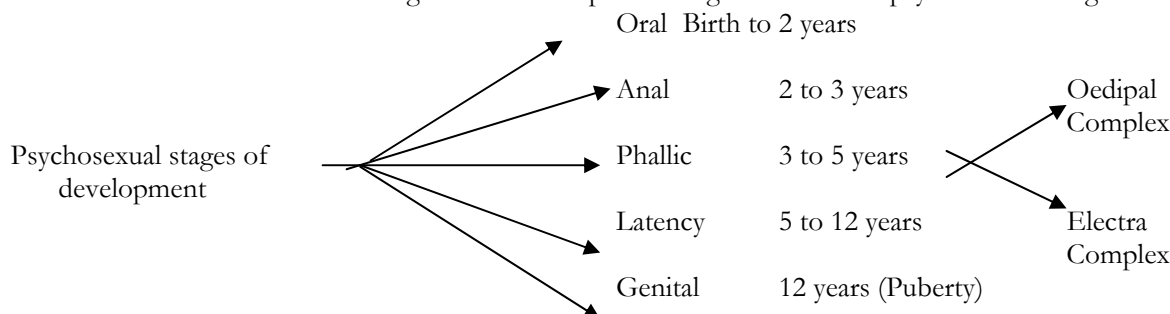
Each stage of development represent a specific period of development where our basic needs arise and an under or over gratification of the needs at any stage leaves a strong impression on the individual in form of a fixation or psychopathology reflected throughout his adult life.

In the oral stage the major source of pleasure is the mouth where the infant sucks, bites, through mouth, any fixation at this stage appears in form of nail biting , chewing pencils, paper etc. smoking cigarettes. In the Anal stage, which extends from one to three years toilet training begins. Any conflict or fixation at this stage appears in form of a person who is very neat, clean and strict in following rules/norms.

Phallic stage begins at the three years and goes up to five years, boys have oedipal complex a wish to have sexual attachment with their mother while girls shift away from mother and get closer to father an experience labeled as Electra complex.

Latency stage is where interest in sexual drive is less but it is the Genital stage where interest in opposite gender develops tendency to impress the opposite gender is more. One is more preoccupied to make a good impression on opposite gender through one's looks, dress and conversation. Often you see a young growing up standing in front of the mirror and either trying to focus how to look even better etc. Each stage of development is important for moral healthy adjustment any fixation at any stage may result in form psychopathology or an immediate behavior.

Neo-Freudians
Carl Jung (1875-1961)
Alfred Adler (1870-1937)
Karen Horney (1885-1952)

Carl Jung and Alfred Adler were followers of Freud but they drifted away from him and disagreed on the concept of sexuality. Jung conceived humans as having a collective unconscious or archetypes i.e. a collection (store) of primitive ideas, images that are inherited and shared across the human race. So collective unconscious is wisdom accumulated by society and culture and passed down from generation to generation. Alder advocated that humans are social beings motivated by social needs than by sexual needs.

Karen Horney believed that environmental factors and childhood relationships are the most important factor in secure psychological adjustment.

Techniques of Psychoanalysis
Psychoanalysis is a therapeutic process which reveals unconscious mental process and conflicts through catharsis and insight.

Free association the patient is asked to lie on a couch and the therapist sits behind the client, then the patient is asked to give a running account of his thought pattern uninterrupted without social censoring it. This technique brings to the conscious level emotionally loaded material that at times can be painful, threatening to be discussed at conscious level.

Dream analysis refers to the process in which the contents of the dream usually the id impulses (wishes) related to the unconscious conflicts. The therapist interprets the contents of dreams and relates them to various unconscious wishes.

Example
Suppose you go to the bazaar and you want to buy a very expensive pair of shoes, costing a fortune. Your mother refuses to buy and says that you are out of your mind. So at night, you dream that you are owner of that shoe shop so your id desire has been fulfilled in a dream.

The relationship between the patient and the therapist /clinician/psychoanalyst/counselor is very important.

Patient   →   therapist
Relationship
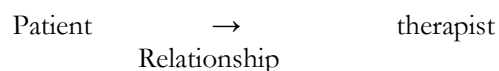
The patient may relate with therapist positively as with an important person in his life like parents, teachers, and friends. We label it as positive transference phenomenon.

The patient may relate negatively with the therapist with anger resentment or dislike. We say negative transference has occurred. The patient may at times like the therapist while at times resent him so an ambivalent transference takes place. The therapist (is human) he also at times project his feelings, emotion usually positive ones towards the patient this is counter transference. This should not happen.

| Therapist | ← | Client | Ambivalent positive negative |
| Therapist | → | Client | Counter transference |

Freudian slips means you wanted to say something but you said something wrong or embarrassing say Freud went to USA to deliver lectures on psychoanalysis and a professor introduced him as Dr. Fraud, though he apologized but that is a Freudian slip.

Humor is an essential part of psyche. What sort of humor do you read and enjoy? For Freud humor is mostly related to death and sex two unknown areas of your life about which you are not sure

PSYCHOPATHOLOGY IN HISTORICAL CONTEXT III

PSYCHOLOGICAL MODEL

Humanistic Model
Humanistic view puts the emphasis on the positive aspects of life, free choices and personal growth experiences. Abnormality results from refusal to accept personal responsibility for one's own actions and thoughts. So human behavior is caused by the choices we make voluntarily. The Humanistics assume that human nature is inherently good and they blame abnormal / aggressive behavior caused by the society but not by the individual.

Abraham Maslow (1908-1970) postulated a hierarchy of needs beginning with physiological needs at the bottom and self actualization at the top. An individual must meet the basic needs before trying to meet the higher needs.

Self Actualization

Self Esteem

Love and Belongingness

Safety Needs

Psychological Needs
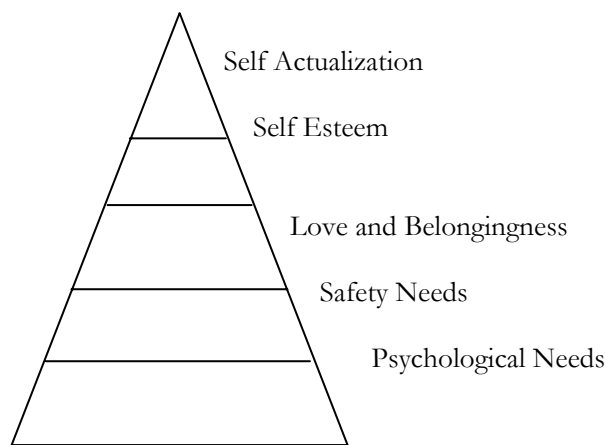
Maslow's Hierarchy of needs

The triangle or pyramid has a broad base and narrow top, so majority of individuals are involved at fulfilling basic needs and only few reach the top i.e. self actualization means that we can reach our highest potential in all areas of functioning if we had freedom to grow. Majority of the people are involved in fulfilling the needs at the lower level and it is very few who reach the top e.g. Quaid-e-Azam, Dr Abdul Salam.

Carl Rogers (1902-1987) originated the client centered therapy, later known as person centered approach. The therapist takes a passive position and provides the client and environment to develop insight about the self consists of all the perceptions, ideas and values that characterize "I" "Me" i.e. what I am and what I can do.

The main constructs of the theory are unconditional positive regard and empathy. Unconditional positive regard being given the sense that they are valued by parents and others even when they are less than ideal or perfect.

Empathy is understanding the of client's world from client's frame of reference or putting, yourself in the client's shoe and trying to understand his problem how he perceives it.

Behavioral Model / Cognitive-Behavioral / social learning model
Behavioral model emphasizes that behavior patterns (both normal and abnormal) are learned from the environment. The three forms of learning associated with psychological disorders are

1.   Classical Conditioning
2.   Operant Conditioning
3.   Observational learning/Modeling.

Classical Conditioning
It is a basic form of learning, discovered by a Russian physiologist Ivan Pavlov (1849-1936). Pavlov and associates were investigating salivation process in dogs. They gave meat powder and the dog salivate it.

The Classical Conditioning process involves following terms

UCS →Unconditioned stimulus
UCR →Unconditioned response
CS →   Conditioned stimulus
CR →   Conditioned response

The dogs salivated as the researchers were about to provide meat power, soon after the dogs salivated at the sight of the researchers and also to the sound of their footsteps

Meat powder → salivation
UCS   **UCR**

Sight of researchers   →   Salivation
Footsteps of researcher

CS   **CR**
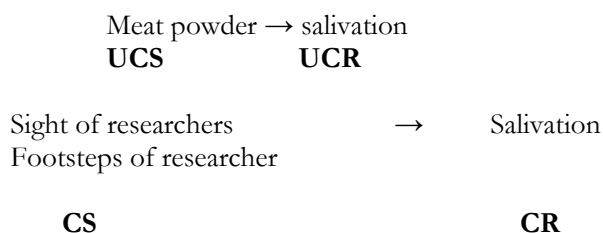
Now learning comes in form of any association with any person or object. This is unconditioned stimulus. In this case sight of the researchers or the footsteps of the researchers acquires the power to elicit the same response so now footsteps or sight of researchers is the conditioned stimulus leading to conditioned response.

Extinction
CS →   ~~CR~~
Now conditioned stimulus does lead to conditioned response. This is extinction. That is the footsteps of the researchers or their sight did not lead to salivation. In another classic study by Watson (1878-1958) an 11 months old boy Little Albert – acquired a conditioned fear. Albert was introduced to a white rat, he showed no fear to it. When Albert tried to reach the white rat, a loud noise was produced which startled little Albert. This process was repeated for a number of trials, so little Albert learnt to be afraid of white rat or through classical conditioning; Little Albert acquired the fear or Phobia of white rat.

White rate   +   loud noise →   Fear
NS   Paired   UCS   UCR

The neutral stimulus was white rat paired with unconditioned stimulus loud noise leading to fear response in little Albert. After a number of trials, the neutral stimulus took the status of conditioned stimulus and evoked the conditioned response that is fear.
White rat   →   Fear
CS   CR
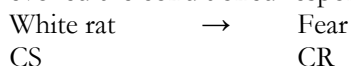
Stimulus Generalization
Little Albert became afraid of all white furry animals, toys, so this is called stimulus generalization i.e. the response generalizes to all similar objects. Watson's Student Mary Cover Jones (1896-1987) thought that if fear could be learned or acquired or classically conditioned perhaps it could be un-learned/extinction can take place. She worked with a boy Peter, who was three years old, who were already afraid of white rabbits.

Jones decided to bring white rabbit in to the room where peter was playing for a short time each day. She also arranged for other children whom she knew did not fear rabbits. Jones noted that gradually Peter's fear decreased and diminished and soon Peter was touching and playing with rabbits.

Extinction is when the bond between conditioned stimulus with conditioned response is weaken or broken.

CS → ~~CR~~

In this case white rabbit does not elicit fear response. So the bond between the CS and CR is broken. Parents in our culture create a lot of fear in children, when little children are crying. Parents often say, a jin will come out of the dark and get you. So our parents condition children to be phobic of dark.

Operant Conditioning
The term operant conditioning was coined by Skinner (1904-1990) behavior operates on the environment and changes in some way. The reinforcement or reward affects the behavior.
When responses lead to satisfying consequences, the responses are strengthen and likely to occur in future.

1. When positive consequences follow a behavior, the behavior is rewarded and more likely to occur in future. Maladaptive and desirable behavior alike can be acquired through their consequences. When a child screams in the store for a toy, she gets her way because the parents want her to be quiet. The child learns that screaming produces rewards.

2. When an unwanted behavior leads to negative outcome, the likely hood that the unwanted behavior will occur in future is reduced. When an alcohol addict is given some irritating agent in his drink which causes vomiting and swatting, he learns to give up drinking alcohol or when misbehaving student is corrected in front of the class, the probability of misbehavior to reoccur in future is reduced. Punishment can have desirable outcomes but harsh and cruel and consistent punishments are detrimental.

Shaping, a process of reinforcing successive approximations to a final behavior take an example of a mentally retarded child. How he has to learn to fill water in his glass and the whole task is broken down in to small steps, such as
1. Holding the glass.
2. Filling it with water from the jug.
3. Sufficient level of the water in the glass.
4. Putting the jug back on the table.
5. Taking the glass to the level of the mouth.
6. Taking a sip of water without spilling it.
7. As the learner masters each steps of the whole task is reinforced and the whole shaping process may take a week for the mentally retarded child.

Observational Learning or Modeling
Stanford university professor, Albert Bandura, pioneered the analysis of observational learning or modeling which is process of learning behavior by observing others. It is learning through imitation. Aggressive behavior can be learned by observing others. Adult models punched and abused "a bobo doll" while children watched and were later permitted to play with the same doll and children imitated aggressive behaviors as observed.
Social learning theory by Bandura purposes, that behavior is the product of both external stimulus events and internal cognitive process.

Cognitive model
Cognitive model is concerned with human cognition how human beings perceive recognize, attend, reason and judge. This model includes:

1. Rational Emotive Behavior Therapy. (REBT) (Albert Ellis) 1962
2. Cognitive Theory Of Depression (Aaron Beck - 1967)

1. **Rational Emotive Behavior Therapy. (REBT) (Albert Ellis) 1962**

According to Albert Ellis, maladaptive behavior results when people operate on misguided and inaccurate assumptions. Ellis catalogued 11 irrational believes responsible for maladaptive behavior. The ABC of rational emotive behavior therapy is where:

A – Activating event
B – Belief System
C – Emotional behavioral consequences.

A   →   **C**
Activating   Emotional Behavioral
Event   consequences

A   →   B   →   C
         Activating events
         Filter through one's
         Belief system

A   →   B   →   C
         Irrational beliefs

Activating event A can cause unwanted emotional and behavioral consequences when filter through beliefs that are irrational.

2. Cognitive Theory of Depression.
For Beck, depressed people possess a negative cognitive triad.

About themselves
Deprived, defeated diseased.
the world which is
 full of road blocks

Future which is devoid of hope

Depressed individual
and negative cognitions
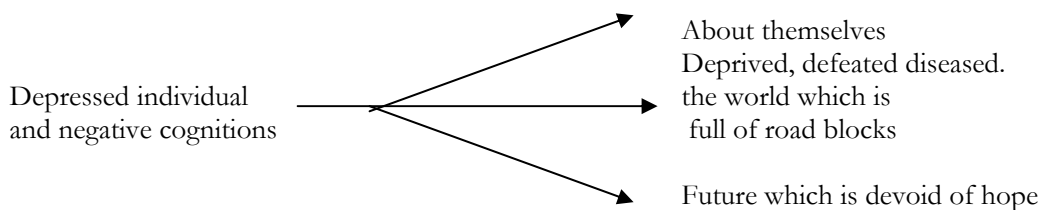
Beck says depressed individual see themselves as defeated, deprived and diseased and their world as full of road blocks and their future without hope.

Summary
The models discussed were
1. Supernatural Model
2. Biological Model
3. Psychological Model
4. Humanistic Model
5. Behavioral Model
6. Cognitive Model
7. Cognitive theory of depression.

In today's world psychologists study abnormal behavior not with reference to one single model rather they adopt the integrative approach which respond to all aspects of abnormal behavior.

LESSON 6

RESEARCH METHODS

What is research?
Research is a process of constant exploration and discovery. It is a systematic process of collecting and analyzing information (data), in order to increase our understanding of the phenomenon with which we are concerned or interested.

Research is characterized by following attributes
1. It is based on work of others
2. It is replicable
3. It is generalized to other settings
4. It is based on theory
5. It is doable
6. It generates new questions
7. It is incremental
8. The ultimate aim is the betterment of society

Research is fact finding exercise
There are many research methods like Observation, interview, surveys, experiments etc. Research is about establishing a hypothesis and Abnormal Psychology focuses on hypotheses which explain the nature, causes, and treatment of a disorder.

Types of Research Being Used In Abnormal Psychology

Following types of research are used in Abnormal psychology

- **Individual case study** is used to study one or more individual in depth.
- **Research by correlation**; tell whether a relationship exists between two variables. Epidemiological research is a type of correlation research that reveals the incidence, prevalence and consequences of a disorder.
- **Research by experiment** can follow two designs group or single. In both designs, a variable or variables are manipulated and their effects are observed in order to determine the nature of casual relationship.
- **Genetic research** includes Family Studies, Adoption Studies, Twin Studies, Genetic Linkage Analysis and Association Studies.

- Research examines psychopathology across time include **Cross Sectional** and **Longitudinal designs**.

The popular books, television programs about detectives, private investigators, mysteries, murders and robberies always interest you, catch your attention because they force you to think and act logically. They focus on facts. Science and scientists aim to discover facts or laws that operate in their disciplines.

Psychologists are scientists who are interested in facts about human behavior. Questions like, why we should study research methods? Students often argue that why they should study research methods

Eight reasons, why you should study research methods:

1. To understand psychology better.
2. To keep up with recent discoveries by reading research.
3. To evaluate research claims.
4. To protect yourself from quack and frauds.
5. To be a better thinker.

6.   To be scientifically literate, better educated citizen and consumer.
7.   To improve your market ability in information age.
8.   To do your own research.

1. To Understand Psychology better
The question, why you should study research method has a classic answer for the classic question i.e. that is to understand psychology and specially abnormal psychology, the science of the study of mental disorders in a better way. To study abnormal psychology without knowing the research methods would be like buying a car without a knowing about its made and its engine or buying a house without seeing its location and structure. Psychology's value in the world often comes not from its facts but from its methods of study i.e. the most wonderful and useful thing that psychology can offer is not a prepackaged answer to the problem (related to human behavior) based on facts but rather its method of getting answers to the problems. So these methods of getting answers to the problems of behavior are the research methods of study.

2. To Read Research
When research gets answers to the problems that interest you and then you must read and interpret scientific research reports.
i.   What is the latest treatment for depression?
ii.   What are the causes of shyness?
iii.   How the work place stress can be reduced?
If you want to be up to date,
(a) Then read research
(b) Know research terminology
(c) Understand logic of research.
(d) Consult the original source.
(e) Draw your own conclusions.
Reading about research teaches you though in a vague sense how to do research. If your knowledge is up to date, with each year, you would be providing most up-to date information to your students and to your clients and you would be given treatments to your clients that work.

Would you be pleased to go to a teacher or to a clinician whose knowledge and skills were say some ten years out of date? Think about it.
Would you really go? No.

3. To Evaluate Research
If you understand research, you will be able to critically evaluate it. These days, knowledge is available through libraries, newspapers, through television and through internet. To judge as to how much importance to be given to a particular research study is very difficult. Evaluating a research is a useful skill, which can only develop when you read good quality research and quantity of research.

4. To Protect Yourself from Quacks and Frauds
These days you observe experts who are free to go on television talk shows and on internet and some times they provide dangerous tips on how to loose weight, quit smoking, solve relationship problems related to parent child, husband wife and brother and sister and employee employer etc. I do not mean that all experts are giving bad advice but it is really very hard to differentiate between what is a good piece of suggestion and what is not?

Today science, non-science and pseudo-science exist side by side in form of books, on television talk shows and on internet. We live in the age of information or tell me is it that we live in the age of misinformation? Without training in research, it is hard to distinguish, which information is useful and which is harmful.

5. To Be a Better Thinker
Scientific approach makes you a better thinker, improves your thinking skills and it makes you learn to solve problems and make decisions, judge and interpret information, so it raises your practical intelligence. This

practical intelligence is necessary for understanding real life situations. Learning about research methodology is actually learning about understanding real life situations and problems.

So actually, you learn to separate facts from fictions, science from non-science.

6. To be scientifically literate
People should profit from experience, science and technology. It is science and technology which shapes and moulds our experiences and behavior. But in reality majority of the people, they do not believe in science. They believe in palmistry, astrology, handwriting analysis, foot reflexology and numerology. Be a firm believer of science and objective factual information.

7. **To increase marketability**
With research knowledge and information, you make yourself a potential candidate for job market. If you have technical information, ability to evaluate and create information and analytical ability and an ability and skill to turn data in useful market information then this skill will be helpful in business, law, medicine and of course in psychology.

8. To do your own research
It is not surprising that Charles Darwin enjoyed exploring about the mysteries of the nature and John Watson enjoyed experimenting with animal and human subjects while exploring about the mysteries of human behavior, so you begin to understand what Carl Rogers meant when he said, "We need to sharpen our vision of what is possible and (continue) pursuit of significant new knowledge."

When psychologists frequently come across questions like what criteria should be used to identify psychological disorder? What factors caused mental disorders? How does an individual biological or cognitive or social influence contribute to his problems? To answer questions like these and others, psychologists frequently conduct research based on scientific methods.

What is science?
Science is the observation, identification, description, experimental investigation and theoretical explanation of natural phenomenon. These methods of science i.e. observation, identification, description, experimental investigation and theoretical explanation are based on Empiricism i.e. we can know about the world through careful observation or more precisely through naturalistic observation and controlled observation.
 Naturalistic observation is watching animals or humans in their normal environment. It gives a realistic picture of behavior. Participant observation is naturalistic observation in which the observer becomes a participant in the group being observed (to reduce observer effect).
 Laboratory observation or controlled observation is watching animals or humans in a laboratory setting. The advantage is in controlling the environment and making use of specialized equipment.
Observation assists an individual in identifying and asking research questions i.e. hypothesis.

Hypothesis
Hypothesis is a logical and testable question and opinion, opened for verification through experiment or test.

 Hypotheses formulation and its sources
  1.   From observation
  2.   From previous research finding
  3.   From personal experience
  4.   Other sources as well

The basic steps involved in the scientific inquiry

S.   Specifying the problem.
C.   Collecting information.

I.   Identifying possible causes.
E.   Examining options.
N.   Narrowing the options by narrowing the experimentation.
C.   Comparing data.
E.   Extending, revising and testing.

The basic steps in scientific inquiry aim for precision and replication. Scientists and psychologists spell out specify the procedures and methods so that others can replicate and reproduce their findings and ambiguity should not be there.

Ambiguity can be reduced by operational definitions, which define a concept by other operations (steps used in measuring it). Aggression is a concept so what does researcher means by it? Beating the enemy or injuring the enemy.

There is no psychology without scientific inquiry because without science, psychology has few facts and would be little batter than palmistry, astrology, graphology or any pseudo science. So science has helped:
1.   Psychologists to get rid of superstitions
2.   Develop understanding how to help people.
3.   Scientific inquiry is actually research process, which is a logical, rational proven way of obtaining information related to human behavior.

Basic components of a research

1	Hypothesis	An educated guess or statement to be supported by data.
2	Research Design	The plan for testing the hypothesis. The sample or subjects to be used. The instrument and tool to be utilized.
3	Dependent Variable	An aspect of phenomenon that is measured, expected to change or influenced by the independent variable.
4	Independent variable	The aspect that is manipulated or that thought to influence the change in the dependent variable.
5	Internal Validity	The extend to which results of the study can be attributed to the independent variable.
6	External Validity	The extend to which results of the study can be generalized or applied outside this study.

RESEARCH DESIGNS

Variable is a noun not an adjective it represents a class of outcomes and it can take more than one value. Hair color is a variable red, black, white, grey etc.

Types of Variables
Dependent variable (outcome, result, effect, and criterion) is a variable that indicates that whether the manipulation of the independent variable had an effect.

Independent variable (treatment, factor, and predictor) is a variable that is manipulated to examine its impact on a dependent variable.

Confounding variable (extraneous, threatening) is a variable that is related to independent or dependent but not an intended part of study.
Example: vitamin A influences vision of subjects.
Vitamin A   independent variable
Vision   dependent variable
Food   confounding variable
Rich in Vitamin A
Hypothesis
Hypothesis is an educated guess, a research idea:
Hypothesis tells us how two or more variables are related to each other. Research process begins by generating hypothesis.

Hypothesis Generation
    a. By observation – Keen observation
    b. By studying previous researches.
    c. By refuting an old existing theory related to a phenomenon or develops your own theory.

Characteristics of hypotheses
    a. Make it testable.
    b. Make it supportable.
    c. Be sure to have a rational- how theory can help.
    d. Demonstrate its relevance –how it can solve a practical problem.

When you decide how you want to test your hypothesis you have a research design / plan
    a. What will be your sample? How the sample will be selected? What will be the sample size?
    b. Instruments / tools / questionnaires to be used
    c. Statistical tests to apply
Research design includes aspects that you want to measure in the people (you are studying that is dependent variable) and its influence on people's behavior (i.e. independent variable).
Example
Vitamin A influences (or effects) the eye sight of subject.
Vitamin A is independent variable.
Eye Sight is dependent variable.

Research Design
Two groups with equal number of subjects which are equally matched on all characteristics are randomly selected.
One is experimental group

The other is control group

The only difference between experimented and the control group is that of treatment. The experimental group is exposed or given vitamin A, while the control group does not get any Vitamin A. so if the eye sight or vision of the experimental group improves or is better than control group then it is attributed to what? It is because of Vitamin A.

Internal validity is the extent to which a researcher can be confident that the independent variable is influencing or is causing the dependent variable.

Confounding variables or extraneous
It is any factor occurring in a study that makes the results uninterruptible that pollute or contaminate the results. If the experimental group was eating diet rich in Vitamin A, or a lot of carrots, that improved their vision ---. So all these are confounding variables for our research because then independent variable will not be responsible for bringing changes in dependent variable i.e. The Vitamin A dosage administered to the experimental group subjects in laboratory will not be the only aspect which will change or influence the vision or eye sight of the subjects.

Dependent variable / Independent variable
Variables are factors that are connected together in form of hypothesis. The first variable is dependent variable. Dependent variables are factors or aspects of the study that are influenced by independent variable and they are expected to change. Independent variable is that aspect that is being manipulated or controlled and thought to change the dependent variable. In the above mentioned study, Vitamin A is the independent variable which is varied or given to experimental group but not to the control group. While dependent variable is eye sight of the subject. So it is Vitamin A which is the independent variable responsible for bringing change in the dependent variable i.e. eye sight of the subject.

Internal Validity / External Validity
Internal validity is the extent to which results can be attributed to independent variable. A study that is not open to alternative explanations of the results is set to be internally valid and it is free of confounding factors or variables. A confounding factor is that, which might have affected the dependent or independent variable. When a confounding variable is present, the researcher or the investigator cannot know, whether it is the independent variable or any other confounding variable responsible for the results.

External Validity of a study
In internal validity of the study, we focus only on the results of the study that can be attributed to the independent variable. While in external validity we want the results to apply to people / samples other than the subjects of the study or we want to generalize the results to the other settings. That is, if one group of subjects suffers from depression due to death of a loved one, we want the same results to be applied to other samples of the population as well. So internal validity and external validity are working in opposition to one another.

Statistical Significance / Clinical Significance
Statistics is part of psychology, in psychological results; statistical significance means that the probability of obtaining the observed effects by chance is small. But it is important to understand the difference between statistical and clinical significance.
Example: Consider a group of adults, who are mentally retarded and they are involved in self injurious behavior of hitting or slapping themselves. Suppose we are to try a new drug treatment for the self injurious behavior of adults with mental retardation. We examined one group that receive medication and a second group that received a placebo (an empty sugar coated pill). To learn whether the new drug diminished or decreased self injury, we use a rating scale to assess how frequently subjects hit themselves. At the beginning of the study, all the subjects hit themselves an average of ten times per day. At the end of the study, we found through the scores on the rating scale that the group on the medication received lower scores or hit themselves less number of times then the untreated group. So we can conclude that the results are

statistically significant. Statistical significance depends on size of the effect, when you look at the people who were rated as improved. You find that they still hit themselves about six times per day. Although the frequency is lower. But some of the subjects hit themselves in such a manner that they produce serious cuts and bruises. This may suggest that your statistically significant results may not be clinically significant i.e. important to the people who hurt themselves. The effect size that is the actual statistical impact on treated and un-treated persons in a research can be known by looking at the results of the group as a whole. The behavioral scientist Wolf (1978) advocated the assessment technique labeled as social validity this technique involves obtaining information from the person being treated as well as by significant others about the importance of changes that have occurred. In the example, we might ask the employer, the family members, friends and others. If they think that the medication has truly reduced the self injurious behavior in the mentally retarded adults. If the effect of the treatment is large enough to impress those who are directly involved, the treatment effect is clinically significant. So statistical technique measures the effect size and the subjective clinical significance measures the social impact on individual or people around him.

The Average Client
Very often we look at results from studies and make generalizations about the group and we ignore individual differences. The tendency to see all participants as one homogeneous group is labeled as the patient uniformity myth. Comparing groups according to their mean scores (Group A improved by 50% over group B). This hides important differences in individual reactions to our interventions and treatments. The patient uniformity myth leads researchers to make inaccurate generalization about disorders and their treatment.
 It would not be surprising if a researcher studying the example of the treatment of self injurious behavior concluded that a drug was a good treatment. Although some participants did improve with treatment while others actually got worse. These fine differences would be averaged out in the analysis of the group as a whole, the person whose head hitting increased with the new drug, it would make a little difference that this client and its effect on him will be averaged out. While majority of the people of the same age, gender, cognitive ability and history of treatment improved, so practitioners who deal with all types of disorders would consider, that all treatments on a homogeneous group will be the same. The whole sample is treated as an averaged client.

Studying individual case
The science of abnormal psychology began with careful descriptions of symptoms and arrangement of these symptoms in to categories.

Descriptive Studies or descriptive approaches are procedures used to summarize an organized sample of data. They include
1- Observation
2- Case study which focuses on single individual and
3- Survey, which seek to describe a population.

1- Observation includes -----------naturalistic observation
                              controlled observation
Naturalistic observation is watching animals and humans behave in their natural environment. It gives a realistic picture of the behavior.
In Participant Observation the observer becomes a participant in the group being observed (to reduce observer effect).
Observer effect is tendency of animals and humans to behave differently from normal behavior pattern when they know that they are being observed.
Controlled or laboratory observation is watching animals or humans behavior in laboratory. The advantage of this observation is that the experimenter has complete control over the situation and specialized equipment can be used.

2-Case Study

Case study examines and describes in depth an individual's current feeling, thoughts and behaviors. It investigates intensively one or more individuals, who display the behavior patterns. The case study method relies on a clinician's observations of differences between one person and group with a disorder, people with other disorders and people with no psychological disorders. The clinician usually collects as much information as possible, to obtain a detailed description of the person. Historically, interviewing the person under study yielded a great deal of information on personal, medical, family background, education, health and work history, as well as the person's own opinion about the nature and causes of the problems being studied. Case studies are important in the history of abnormal psychology.

 It was S. Freud and E. Kraepelin who used clinical case study. Freud's case studies provided valuable descriptions of his theory of the development of mental disorders.

 Kraepelin's observations of the case studies helped him to construct the first system for the classification of abnormal behavior.

 Wolpe's book psychotherapy by reciprocal inhibition, is based on his treatment procedure called systematic desensitization, which he applied on some 200 cases, as our knowledge has increased, we rely less on case study method.

The case study method is valuable in examining rare disorders. Say when a disorder occurs at a very low frequency, such as 1 case in 10,000, data on such large number of cases is next to impossible. So we depend on single case.

Mental disorder called Multiple Personality, a rare type of disorder where within one person would reside two or more then two opposing personalities, a disorder which receives much attention on the media in films and TV is a target case for single case analysis. All of you have read the famous fictional characters of Dr. Jekyll and Mr. Hyde (first one a noble character and Mr. Hyde an evil character). Dr. Jekyll a noble and handsome doctor who had his private laboratory where he use to go at night and prepare a secret drink, after taking that drink he would become very ugly and notorious. Then he would go out and kill and rob innocent people. In the morning he would be noble and kind again.

The famous case of Eve White, a young woman showed Multiple Personality disorder, under stress Eve White would suffer from a black out period where she would dress like her twin sister Eve Black, talk like her, would be assertive like her and would not listen to her mother. Hypnosis and long term psychotherapy gave Eve White the personality of Jane who was sober and assertive. Rare cases like this one in real life are few.

Drawbacks of case study methods:
      i.   Case study lacks internal validity (methodological control)
      ii.   Case study lacks external validity (representative ness)

Advantages of case study:
      The case study method is a valuable source for:
      i.   Examining rare disorders
      ii.   Evaluating and assessing innovative treatment or interventions.

3-Surveys
Surveys provide information about the nature and scope of mental health problems across large population and regions often leading clues to the causes of disorder. Surveys are an important tool in epidemiological research which is the study of the incidence and prevalence of disorders in a specific or specified population.

Incidence refers to the number of new cases of disorder during the specified period of time or incidence refers the estimated number of new cases during a specific period of time.

Example
Suppose we would like to know the incidence of new cases of college freshmen using drug like Cocaine is increasing. So prevalence means the overall frequency of the disorder in a specific population.

So the epidemiological data help us to identify the causes of disorder, as in the case of cholera which broke out in London during the last century. No one knew that how the disease was spreading. But as the data on incidence and locations of cases were gathered and examined, researcher noticed a pattern and made a hypothesis, correctly, that the source was contaminated water.

In the year 1980, NIMH survey of nearly twenty thousand institutionalized and community residents revealed that 1 in every 3 US adults had experienced a psychological disorder and that 1 in every 5 was currently experiencing a disorder. The incident of serious psychological disorder is doubly high among those below the poverty line (Center for Diseases Control) like so many other correlations, the poverty causes a disorder, raises a chicken and egg question. Does poverty cause disorder? Or disorder cause poverty? It's both. In schizophrenia a psychotic disorder in which persons looses contact with reality, understandably leads to poverty. Poverty can also precipitate disorders, especially depression in women and substance abuse in men.

In case of AIDS virus, epidemiological researchers track the incidence of this disease among several population (among gay men, among drug users, among spouses and children of infected individuals), researchers have found how the aids virus is passed from person to person like other types of other co-relational research, epidemiological research cannot tell us what cause a particular phenomenon but the knowledge the prevalence and course of disorder tells us and provide understanding in the right direction.

A major concern for survey is external validity if a survey is based on the responses of women from the posh section of the society, then the results cannot be generalized to the entire population of the city, because the participants are not representative of the whole population. To ensure representative ness of the sample, we use random sampling, regardless of the size of the sample, every member of the population has an equal chance of being included or another method would be to seek participants, who match on the predetermined picture of the demographic characteristics of the population.

Limitation of Survey method
One obstacle is that not all subjects who agree to participate provide accurate information. Participants may intentionally distort their answers for a multitude of reason. For example, persons ask about the mental health of their family members may paint a very bright picture than actually does not exist. A second obstacle is that the wording of survey questions can influence the answer and detract from the internal validity of the survey.

Research by Co-relation
When two variables relate to each other, a statistical relationship between the two variables is called a co-relation.
Example 1
People with depression are more likely to have negative attributions?
One variable is depression and the other one is negative attribution. In order to explore the relationship between the two, a test or experiment is to be designed to explore it.
Example 2
Exposure of violent films on television is responsible for children's higher level of aggression.
One variable is exposure to television and the other is high level of aggression. Two things are occurring together. Do not imply that one cause the other i.e. variable X
Causes variable Y cannot be incurred from Co-relation.
In another example allergies and depression may be related. Research reveals a surprisingly high co-relation between allergic reactions and depressive symptoms. But what causes what. Does depression make you have allergies?
Does X causes Y or is it that presence of allergies cause people to become more depressed that is Y causes X?
Or is it that a third variable Z, some common underline biological factor which make people become allergic and depressed. Is it that Z causes X and Y?
Kinds of Co-relation
There are two types of co-relation, Positive co-relation and negative co-relation. Increase in one variable is associated with increase in same strength and quantity in the other variable, it is called positive correlation. Decrease in one variable is related with decrease in same strength and quantity of the other is also labeled as positive co-relation. Perfect positive co-relation is +1.00. Negative Correlation is when increase in one

variable leads to decrease in another variable. It is negative correlation. Perfect negative correlation is -1.00. The correlation coefficient is represented by small r. so correlation allows us to see whether a relationship exists between two variables but it does not conclude either variable cause the other. So it means X is related with Y but we do not know whether X causes Y?

Or Y causes X? Or a third variable Z causes variable X and Y?

Epidemiological Research

Epidemiology is the study of the incidence, distributions and consequences of a particular problem or set of problems in one or more population. One strategy is to determine the incidence of disorder, the estimated number of new cases, during a specific period of time.

A related strategy is involved determining prevalence, the number of people with a disorder at any one time. Epidemiologists study the incidence and prevalence of disorders among different groups of people. The epidemiology research aims to determine the medical problems and psychological problems. In 1900, a number of Americans displayed symptoms of strange mental disorder. Its symptoms were similar to organic psychosis, which is caused by taking drugs or great quantities of alcohol. Most of the victims were poor and they were African Americans. Using the method of epidemiological research Gold Berger found correlations between the diet and the disorder, and he identified the cause of disorder as a deficiency of the Vitamin B, their diet was improved and the symptoms were eliminated. A long term wide spread benefit of Gold Berger findings was introduction of Vitamin enriched bread in the 1940.

In 1980, Mount St. Helens volcano erupted, creating extensive property damage and loss of life. When subjects of a comparable (control) community that was similar in demographics but had not experienced a similar traumatic event, the researchers found a significant high number of psychological disorders in the people who live near Mount St. Helens. This is a co-relational study. There is a relationship between stress and psychological problems.

EXPERIMENTAL REASEARCH DESIGNS

An experiment involves manipulation of an independent variable and the observation of its effects. We manipulate an independent variable to answer the question of causality. If we observe a correlation between social supports and psychological disorders, which are two variables, we can change the extent of social supports and see its effect on prevalence of psychological disorders. So, we are carrying out an experiment or a test. What will this experiment tell us about the relationship between these two variables? If we increase social supports and find no change in the frequency of psychological disorders, it can mean that lack of social support does not cause psychological problems. If we find that psychological disorders decrease or diminish with increase social supports, we can be sure that non-support does contribute to them.

Experiment
Experiment is a deliberate manipulation of a variable to see if corresponding changes in behavior result, allowing the determination of cause-and-effect relationships.
Independent variable (IV) is variable in an experiment that is manipulated by the experimenter. Dependent variable (DV) is variable in an experiment that represents the measurable response or behavior of the subjects in the experiment.
An experiment is a research procedure in which a situation or a behavior or both are manipulated and the effect of the manipulation is observed. Most of us perform experiments throughout our lives without knowing that we are actually behaving in a scientific manner of conducting an experiment. (Manipulation is introducing and withdrawing a variable that would not have occurred naturally).

Research by Experiment
An experiment involves manipulation of an independent variable and the observation of its effects. We manipulate an independent variable to answer the question of causality.
If we observe a correlation between social supports and psychological disorders, which are two variables, we can change the extent of social supports (independent variable) and see its effect on prevalence of psychological disorders (dependent variable).
So, we are carrying out an experiment or a test. What will this experiment tell us about the relationship between these two variables? If we increase social supports there is decrease in prevalence of psychological disorders (negative correlation) or decrease in social supports increase in prevalence of psychological disorders(negative correlation). Take another example exposure to violent television develops aggression in children

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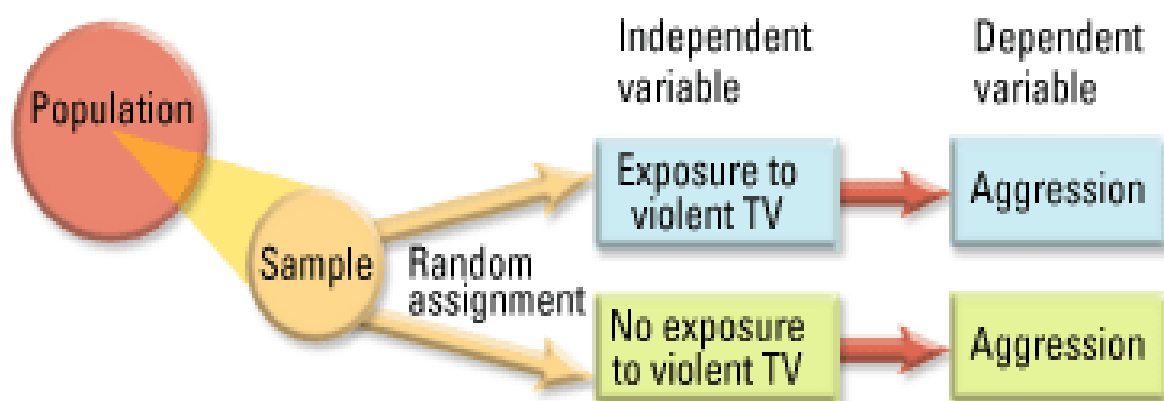
Following are the Experimental Designs to be studied
    1-   Group Experimental Designs
    2-   Single Experimental Designs

Group Experimental Designs
In group experimental designs, an independent variable is changed to see how the behavior of the people in the group is affected.
Example:
Suppose we design a treatment to help reduce insomnia in older adults, (Mellinger, Balter, 1985).
The experimenters treated twenty individuals and followed them for ten years to see whether their sleep patterns improved. So the treatment is independent variable and the sleep pattern is dependent variable.
 The researchers found that the adults, who were treated for sleep problems still sleep less than eight hours per night. Is the treatment a failure? May be not. The question that cannot be answered is what would have happened to group members if they had not been treated. May be their sleep patterns would have been worst. We do not know. We cannot go back in time.
The goal of every experiment is to isolate and identify the true or primary cause from host of other possible causes. The major obstacle to isolating the true cause is the confounding variables. We can control the confounding variable effect by using following methods.

Control Groups
One answer to this problem is that we can use control groups. In the same experiment on study of sleep a control group consists of people who are similar to experimental group in every way except that they are not exposed to the independent variable. This group of people can be assessed ten years later and their sleep patterns can be observed over time. The researchers may observe that control group people sleep few hours less as they get older as compared to experimental group. The control allows the researchers to see that the treatment did help the experimental group subjects.
Control group subjects match with experimental group in age, gender, socio-economic background and problems they are reporting. The only difference between both the groups is of treatment variable (independent variable).
    •   Experimental group are subjects in an experiment who are subjected to the independent variable.
    •   Control group are subjects in an experiment who are not subjected to the independent variable and who may receive a placebo treatment.

Placebo Control Groups
People in the experimental group often expect to get better. So when behavior changes, as a result of people's expectations rather than due to independent variable we label the phenomenon as placebo affect.
The word placebo means "I Shall Please" in other words placebo means inactive medications such as sugar coated empty pills. The placebo is given to the members of control group to make them believe that they are getting treatment. (Parloff, 1986).
A placebo control in a medication study can be carried out because people in the control group receive something that "looks like" medicine that the experimental group is getting. If the therapists want their clients to expect improvement, this placebo affect helps strengthen the treatment.
    •   <u>Placebo effect</u> is the phenomenon in which the expectations of the participants in a study can influence their behavior.
    •   <u>Experimenter effect</u> is the tendency of the experimenter's expectations for a study to unintentionally influence the results of the study.

Single Blind Control Group Technique
Single blind control group technique is a kind of placebo control group procedure where the participants in the study (are) blind or un-aware of what group they are in or what treatment they are given. This type of control eliminates participant's bias which may affect the results.

Double Blind Control Group Technique

In this technique, which is a type of placebo control group where the participants in the study (are) blind or unaware of what group they are in or what treatment they are given and so are the researchers or therapists who are providing the treatment or manipulating the independent variable. This type of control eliminates the participant's bias and the researcher's bias as well. So when both the researchers and participants blinds, there is less chance that bias will affect the results.

Triple Blind Control Technique

In a triple blind control technique study, suppose we want to study the effects of a target drug with placebo were being compared the patients, the administrators and the judges on the administrators, were unaware of the fact which patients belonged to the control group and which patients belonged to the experimental group .

Comparative Treatment Research

In this type of design, the researcher gives different treatments to two or more comparable groups of people with the same disorder and then measure how the independent variable helped the people, who received it. This is called comparative treatment research.

In the example of the study on sleep with older adults, two groups of older people can be selected. One group given medication for insomnia and the other group given cognitive behavioral therapy and the results are compared. In every treatment, the **process** and **outcome** are two important issues to be studied.

Process focuses on the mechanism and outcome on the result.

There is an old joke that someone went to a physician for common cold problem. The physician prescribed the new drug and said it's a miracle drug and the cold will be gone in seven to eight days. As we all know, that cold typically improves in seven to ten days. So seven to ten days is the process of testing the miracle drug and cure of the cold is the result.

Outcomes can be positive or negative. In a research by Francis and Hart, (1992) who worked with depressed in patient in hospital setting and they used the strategy that the activity level of the depressed should be increased. Francis and Hart noted improvement and decrease in their depression levels of patients whose activity level was increased but this improvement disappeared outside the hospital environment. If you look at their outcomes in the hospital, you see improvement, if you follow them home after being discharged from the hospital; the treatment was not affective at all.

Randomization

When researcher assigned participants to a condition in an experiment purely by chance i.e. by flipping a coin or using a table random numbers, they employ randomization to assign subjects to experimental and control groups or to matched groups.

One can use the technique of randomization to assign subjects to experimental or control groups, to be sure that all the characteristics of the population are fully represented in the two groups.

In all experiments of psychology random sampling procedures are used to form the experimental and control groups.

Matching

Matching is an attempt to ensure that the participants in all conditions are comparable. First by defining the important ways that people could differ from one another and then placing an equal number of persons of each type in each group.

Example

 If we are studying depression among both the genders then we would assign people of both genders and almost same characteristics of both the genders in the two groups.

Counter Balancing

When ever different aspects of an experiment are sequentially presented to participants, it is important to consider the order of presentation because the sequence of events could influence the dependent variable and it needs to be controlled. One way to control unwanted sequence of events is by counter balancing.
Example
When we use medication and supportive therapy with depression patients then be sure that sequence of experiment first demands medication and then supportive therapy.

Quasi- Experimental Design
 In this design the researchers do not assign subjects to control or experimental groups rather they make use of groups which already exists in world.
Suppose we want to study the relationship between child abuse and depression among children so we select children with history of abuse.

Natural experiments
In this type of experiment it is nature rather then experimenter who manipulates the independent variable and the experimenter studies its effects. This design is used in studying the psychological effects of unpredictable events such as earthquakes, plane crashes and fires.
On 8th October 2005 earthquake hit Pakistan and it caused huge loss to life and property.
It leads to the development of Post Traumatic Stress Disorder (PTSD) in surviving women, men and children.
A Fokker flight in July 2006 from Lahore to Multan crashed killing all on board created fear in all people traveling in Fokker flights.

Analogue experiments
Researchers demand subjects in laboratory to behave in ways they believe, to be analogous to real life abnormal behavior.
Example
        M. Seligman has worked on a pattern of behavior he calls it learned helplessness that he believes it to be analogue to human depression. He exposed humans to unpleasant and unavoidable stimuli (such as noise, failures on cognitive tasks). The subjects displayed sadness, passivity, pessimistic, behavior pattern similar to learned helplessness.
The limitation of this design is that laboratory phenomenon is superficially similar to depression.

Single Case Experimental Designs
Skinner gave us the concept of single case experimental design. This method involves the systematic study of one individual under a variety of experimental conditions. The experimenter manipulates the independent variable in ways that reduce the likely hood of confounding the explanations. Skinner thought, it was better to know a lot about the behavior of one individual then to make only a few observations of a large group and then average the response.
Psychopathology is involved with the suffering of specific people and its methodology has greatly helped in understanding factors involved in individual psychopathology.
Following are the single case experimental designs.

1.   **Repeated Measurements**.
         One of the most important strategies, used in single case experimental design is Repeated Measurement in which a behavior is measured several times instead of only once before you change the independent variable. The researcher takes the same measurement over and over to learn how variable the behavior is (how much it changes day to day) and whether it shows any obvious trend (is it getting better or worst?)
         Example:
         A young woman labeled 'A' comes into her office complaining about anxiety. Anxiety is a feeling of being restless, uncomfortable and uneasy. When she is asked to rate her feelings of anxiety on a rating scale of 0 to 10. she gives her anxiety a score of 9 whereas 10 is the worst. After several weeks of treatment, client A rates her anxiety at 6. Can we say that the treatment

has reduced her anxiety? Not necessary. Using the repeated measurement techniques, we can measure client A's anxiety each day during the week before her visit to the office and observe that the ratings differ greatly. On a good day she rated her anxiety 5 and on a bad she rated her anxiety at 8. Repeated measurement techniques helps to identify how a person is doing before and after treatment. We can conclude that client A had good and bad days both before and after treatment and doesn't seem to have change much. There are important parts of repeated measurements:

      i.   The degree of behavior change with different interventions.
      ii.   The degree of behavior change over time.
      iii.   The trend and direction of behavior change.

2. **Withdrawal Designs.** The withdrawal design or the reversal design assesses the effects of an intervention on problem behavior, the problem behavior changes systematically with the provision and removal of treatment. So 'A' refers to the baseline conditions and 'B' to the treatment. In this design, the baseline and the treatment conditions are alternated. A simple withdrawal design has three parts.

      i.   A person's condition is evaluated before the treatment to establish a baseline 'A'.
      ii.   Then comes the independent variable 'B'
      iii.   And last the treatment is withdrawn (return to the baseline).

Example:

In case of client A having anxiety problem, first we measure the client A's anxiety level before the treatment to establish a baseline, then in the second step, we give the independent variable (treatment) and in the third step, treatment is withdrawn and client A returns to step one i.e. baseline level. Some psychologists support the use of withdrawal designs because it means drug holiday i.e. a period of time when medication is withdrawn for two reasons:

      i.   All medications have negative side effects and therefore, unnecessary medication should be avoided.
      ii.   Whether change in behavior is due to the treatment effect or not.

3.   Multiple Baseline

Another single case experimental design, strategy is multiple base line designs. Unlike the reversal design, the multiple baseline design doesn't require removing treatment. In a multiple base line design, two or more baselines of different durations are recorded simultaneously and the intervention is applied for one baseline at a time.

The multiple baselines can be different behaviors by a single person (anxiety and depression), the same behavior by different persons or (depression among two persons) or one behavior (depression) in different situations. The logic this design is that if the treatment is responsible for changes, then these changes will be evident on the baselines that are treated and not evident on the untreated baselines.

Example:

A researcher wants to know whether a treatment is effective for child behaviors such as crying and fighting with siblings so crying is one baseline where as fighting is another baseline. Treatment could first focus on crying and then on fighting with siblings. This is multiple baseline across behaviors.

The researcher can start treatment at different times across different settings.

The young woman, who was experiencing anxiety at office, could get treatment at office and when this treatment is effective at office, same intervention could be used at home. This is multiple baseline across settings.

Shortcomings of single subject designs

Single subject designs has disadvantage such as:

      i.   Their results cannot be generalized.

Research by experiment takes into account:

      i.   The concept of experiment.
      ii.   Independent variable, dependent variable and the confounding variable.

iii.   It studies group experimental designs (Placebo control groups, single blind control group,
         double blind control group, comparative treatment group)
iv.   Single case experimental design (Reversal Design, multiple baseline design).
v.   In both these designs, a variable or variables is manipulated and the effects are observed in
         order to determine the nature of a casual relationship.

GENETICS

Genetics means what we inherit from our parents. I got my mother's eyes, I got hair like my father, and I am stubborn like my father. This suggests how we look, feel and behave is predetermined by our genetic make up. The field of **behavior genetics** deals with phenomenon how genetic information in form of chromosomes from both father and mother is transmitted to children.

Chromosomes contain genes; the **gene**s transmit a biochemical code which is responsible for determining the structure and activity of the body's protein. At the biochemical level, the genetic code leads to physiological and physical differences. These differences include like height, weight, color of hair and color of eyes, which are the result of number of different genes. Genetic research is growing rapidly because people are interested to know the gender of their unborn child and the intelligence level of their children.

Table – 1
Terms used in genetic research

Term	Definition
Genotype	The genetic characteristics a person inherits e.g. someone may inherit a genetic pre-disposition for a disorder but the genotype may or may not result in the disorder.
Phenotype	A person observed behavior and trait patterns. A disorder may be inherited but it is the phenotype expression of the genotype that is seen.
Dominant Gene	A gene whose heredity characteristics prevail in the offspring.
Recessive Gene	A gene whose heredity characteristics are seen only when paired with another identical gene.
Single dominant gene	A single gene whose expression prevails in the offspring (for example, colorblindness).
Multiple genes	Several genes whose expression prevails in the offspring (for example, height)
DNA fragment	A portion of a gene; DNA stands for deoxyribonucleic acid, the principal component of genes.

Some important terms used in behavior genetics are following
Phenotype refers to observable characteristics or behavior of the individual whereas **genotyp**e refers to unique genetic make up of individual.
Dominant gene is one which is expressed in offspring. If the offspring has dark black hair then dominant genes for hair color is black.
Recessive gene is one which is expressed when paired with an identical one.
Single dominant gene is one which is expressed as a rare types of disorder such colorblindness.
Multiple genes refer to trait that is expressed in the offspring due to a number of genes such as height.
DNA stands for **deoxyribonucleic acid**, the principal component of genes.
Example
A person with Down syndrome typically has mental retardation, a variety of other physical characteristics such as slanted eyes and thick tongue. These characteristics are the phenotype. The genotype is the extra

21st chromosome that causes Down syndrome. We have following traditional research strategies which scientists use as they study interaction between environment and genetics.

Table – 2
Methods, Goals and Limitations of Genetics Research

Method	Question to be answered	Limitations
Family Study	Does the disorder runs in families?	Cannot separate genetic and environmental effects
High Risk Study	What factor influence development of the disorder?	Cannot separate genetic and environmental effects, although it can characterize the impact of specific effects; results generalizable only to similar high-risk populations.
Twin Study	Is the disorder inherited?	Rare examples; environmental\ factors uncontrolled
Adoption Study	Can we separate genetic and environmental contributions?	Difficult to get accurate information on biological parents or to control confounding factors.
Pedigree Analysis	What is the nature of inheritance?	Requires large inbred families with the disorder
Linkage Analysis	Where is the gene located	Best with disorders controlled by a single dominant gene.

Family Studies (whether a disorder runs in family?)
These studies verify whether the frequency or prevalence of a particular disorder is higher among the family members, then in the general population.
1- The investigator first identifies a patient's with a particular disorder and a comparison group without the disorder.
2-The next step is to obtain information about each close relative of the participants both with and without the disorder – either by directly interviewing them or, if that is not possible, by asking each participant or someone else in the family about the relatives.
 3-Finally, the researcher compares the rates of the disorder to see if these rates are higher among the relatives of patients with the disorder than in the control group representing the general population.
 In family studies, scientists examine a behavioral pattern in the context of family.
If there is a genetic influence, the trait should occur in the first degree relatives (parents, siblings and offspring) then in the second degree or distant relatives. The presence of a trait in distant relatives in terms should be somewhat greater then in the population as a whole.

Example
William Grove at University of the Minnesota, who used the family study method to study schizophrenia. He administered structured **interviews, questionnaires** and **task**s to **seventeen** schizophrenic patients, **sixty** one first degree relatives and **eighteen** normal control subjects. The result showed that schizophrenic and their relatives scored significantly more in the abnormal direction, then the normal control subjects.
High Risk Method
This is a type of family study in which the child of a parent with an identified disorder is studied. In other words by comparing development and eventual outcome of a child of a disordered parent with a child of normal parents, the researchers hopes to learn about the child at risk for developing a disorder. These studies have shown that a child of a depressed mother is more likely then a child of a non-depressive mother
    i.   to be depressed
    ii.   to experience conflict with mother.

Adoption Studies

How we can separate the influence of environment from genetic influences in families? One way is through adoption studies. Scientists identify adoptee, which has a particular pattern or psychological disorder and they attempt to locate first degree relatives who were raised in different family setups.

Example:

Suppose a young man has a disorder and he discovers that his brother was adopted as baby and brought up in a different home. They study whether siblings brought up in different families display the disorder to the same extent as the original subject. If brothers are raised in different families have the disorders more frequently then would be expected by chance. Then we can conclude that genetic inheritance is a contributor.

In adoption study, **cross fostering** is a type where researcher study, children of normal biological parents or disordered parents.

Another type of adoption studies is the family study of **adoptee,** where children adopted by people are studied.

Twin Studies

If we want to study genes closely, we should study the development of identical twins (monozygotic twins).

The twins who do not look alike but have identical genes are called fraternal twins (dizygotic twins). In twin studies, researchers want to know whether identical twins have the same traits or different.

Plomin in 1990, points out correlation for height in identical twins as 0.90 and in fraternal as 0.45. These findings show height is 90 percent heritable trait.

Michael Lyons and his colleagues in 1995 conducted a study on anti-social behavior among the members of Vietnam era twin registry. All the subjects were twins. The researchers concluded that family environment was a strong influence in inheriting anti-social trait in another words, after the individual grew up and left his family early environmental influences mattered less and less and it was genes only.

Genetic linkage and association studies

The results of series of family, twins and adoption studies suggest that a particular disorder has a genetic component but to locate that defected gene or genes is difficult. To locate a defected gene, there are two methods Genetic Linkage and Association Studies.

The basic principle of genetic linkage analysis is simple. When a family disorder is studied, other inherited characteristics are also measured at the same time. These other characteristics are called genetic markers.

The genes for a disorder and the genetic marker lays close together on the same chromosome e.g. in studying bipolar affective disorder, researchers found two genetic markers on chromosome 11, suggesting that a gene for bipolar affective disorder might be on chromosome 11. This is genetic linkage study.

The second strategy for locating specific genes is called association studies. It also uses genetic markers. In association studies, researchers compare people with and people without the disorder. If certain genetic markers occur more often people with the disorder, it is assumed that the genetic markers are close to the genes involved with the disorder. Association studies are better able to identify genes that may only weekly be associated with a disorder.

To Study Behavior across Time

When we want to know whether a behavior pattern changes or remains the same over time, we use cross sectional designs or longitudinal designs. Researcher wants to inquire

What course does a disorder follow?

What role genetics play in this disorder?

Are the affects of the treatment meaningful?

so we want to inquire about the study of psychopathology across time.

Longitudinal designs (same people followed across time)

One way to examine what course a disorder follows is through longitudinal designs. In longitudinal study we study changes in behavior over time by repeatedly measuring the same subjects or participants at selected intervals of time.

This allows the researcher to assess individual behavior change.

Example

We may study depression in women earthquake survivors in the year 2006 then in the year 2007.

 M. Seligman (1992) conducted a longitudinal study on depression among children.

The sample was 508 third grade children who were interviewed every 6 month over a period of 5- year. The depression symptoms included sadness, trouble in the patterns of sleeping and eating.

The longitudinal research is costly and time consuming.

Cross Sectional Studies (people of different ages viewed at the same time)

In cross sectional studies, we examine the same behavioral characteristics in different individuals at different ages at the same time e.g. we might study the symptoms of a disorder assessed at one particular time in children, adolescents and adults.

EXAMPLE

We study depression symptoms among women earthquake survivors who are 30years, 50years and 60years in the year 2006.

Sequential Design

The combination of longitudinal and cross sectional designs in a strategy is called Sequential Design.

Julia Wallace and Micheal O'Hara (1992) used both, longitudinal and cross sectional design explored whether depression among 65 year olds and above, change over time.

The cross sectional design included interviewing the different age ranges like 65-69, 70-74, 75-79, 80-84, 85-89,and 90- above. The longitudinal design included interviewing the subjects 3 and 6 years later. Both parts of the sequential design produced the same findings that is depression seem to increase as we grow old but social support can prevent it.

Follow up studies

In follow up studies, we identify patients at a particular point, such as when they are first diagnosed and study these people again at a later time (in future).

Follow back studies

Follow back studies where earlier records at school or treatment agencies are examined.

High risks studies

Where researchers look at children, exposed to conditions that are thought to contribute to disorder such as a child living with a depressed mother, or children living in poverty or children in war zone areas,

 in both of these types of studies, cross sectional and longitudinal, we study psychopathology across time.

Studying Behavior across Cultures

We study people from different cultures but unfortunately most research literature is available about western culture only. In Malaysia, researchers have described a disorder, they called Gila which has some features of schizophrenia but it differs from it in important ways.

The independent variable is the effect of culture on behavior so we can say that the difference between looking at culture as a treatment and our typical design is important. People in different cultures see the same behaviors very differently and researchers have trouble in comparing the incidents and the prevalence rates.

Example

Depression is one disorder seen differently in different cultures.

The Power of a Program of Research

When we examine different research methods independently, it is important to understand that we are asking a type of question or we are conducting research using a strategy or a method. So actually we are asking or inquiring about the power of the program of research.

 It was Patterson and his colleagues at university of Oregon studied the aggressive behavior of children. They wanted to know why children are aggressive.

 Patterson also looked at prevalence of aggressiveness of children and the prevalence rate was 25%. In other words some levels of aggression appear to be normal. But when that normal level of aggression exceedes, it become pathological.

 Patterson also conducted experimental studies in which, he observed how a five year old boy reacted to his mother's attempt to change his problem behavior. The boy's mother restrained the child but did not talk to him during this time. Later, in the experimental condition, the mother talked to the son in a positive way when he complained. It was found that the boy was more likely to complain about being restrained then when he was talked with. Patterson concluded that the role of mother is influential in modifying son's behavior. As this example indicates, research is conducted in stages or phases and a complete picture of any behavior can be seen only after looking at it from many different perspectives.

Replication
The real strength of a research program lies in its ability to replicate its findings in different ways to built confidence in the results. If you look back at the research strategies we have described, you will find that replication is one of the most important aspects of each research method. The more time a researcher repeats a process (about the behavior he is studying or changes he is expecting). The more sure he is about what cause the changes.

RESEARCH ETHICS

It refers to norms, standard, methods of conducting research. Why we should observe these ethics?
Let us go through some research examples

1-Watson and Rayner in 1920
In this study an 11 month old boy, Albert was introduced to white rat and he was reported to show no fear. Just as he reached out to touch the rat a loud noise was created which startled little Albert and on repeated trials, Albert learned to fear white furry objects.

2-Latane and Darley (1976)
In this study a child was asked to guard the experimenter's pet hamster, which was then removed secretly from the cage through a hole in the floor when the boy was not looking. This was a source of mental stress for the boy.

3-Researchers and clinicians frequently use experimental and control groups in experiments where the experimental group gets the treatment while the control group gets placebo (sugar coated pills). This placebo looks like treatment but actually it is deception.

4-After World War – II, the Nazis forced the prisoners of war to go through some painful and uncomfortable "medical experiments."

5-Milgram's Experiment on Obedience and Conformity
The debate on ethical principles in psychological research began with the classic experiment by Milgram in which volunteers were introduced to a participant; this participant was actually an experimental confederate. The volunteers became the teacher and they were asked to administer electric shocks to the participant for each mistake he made. The electric shocks ranged from 15 volts to 450 volts which was labeled as danger: severe shock". A tape recording of screams and refusals of the confederate also deceived the volunteers. The volunteers were pressurized to continue the experiment. The volunteer continued to administer the electric shocks up to 450 volts.

This study opened the debate that the normal people are capable of behaving like a sadistic and cruel or evil individual.

To control these unethical practices in research the British Psychological Society (BPS) and the American Psychological Association (APA) provides Ethical Principles for Conducting Research with Human Participants (1992). The principles guide researcher the areas like risk, consent, deception, debriefing, and withdrawal from investigation, confidentiality, protection of participants, observational research, giving of advice to participants, and monitoring of colleagues in profession.

- Ethics committees consists of groups of psychologists or other professionals who look over each proposed research study and judge it according to its safety and consideration for the participants in the study.
- Common ethical guidelines:
    1. Rights and well-being of participants must be weighed against the study's value to science.
    2. Participants must be allowed to make an informed decision about participation.
    3. Deception must be justified.
    4. Participants may withdraw from the study at any time.
    5. Participants must be protected from risks or told explicitly of risks.
    6. Investigator must debrief participants, telling the true nature of the study and expectations of results.
    7. Data must remain confidential.

Scientists and researchers raise many ethical questions related to a research project. Ethical issues are concerned with federal and state laws as well.

The American Psychological Association (APA) has formulated an ethics code regarding conduction of research, therapy, teaching and serving as administrators.

Following ethical standards are spelled out before researchers begin a psychological research.

Approval for the research project
1-Psychologists plan and conduct a research according to federal and state law and regulations as well as abiding by professional standards, governing the conduct of research related to human participants and animal subjects.

2-Psychologists get permission and approval from institutions and organizations, they are part of and they are conducting research for. So, they seek permission from their institutional research boards and other higher research boards governing them.

3-Psychologists design to conduct research in a scientific manner so that ethical acceptability under the ethics code is provided through institutional review boards, animal care and use societies or committees, peer consultations and other proper mechanisms. Psychologists take appropriate protections for the rights and welfare of human participants and other persons affected by research.

Nearly every college and university has an independent committee or a board which reviews every research project involving humans or animals as subjects, spells out the expenditure on the research and the benefit it will provide to the society. Thus every individual, who wants to do research, should inquire from the proper authority, about the appropriate procedure for institutional review.

Following ethical issues are important when we use humans as subjects.

i. Risk
Risk is involved related with physical, psychological or social injury that may be caused to subjects. So a risk- benefit ratio should be purposed for each research project which is just like calculating a profit –loss index of the research project. Whether research participants are at risk or not, is an important question. Life is a risky affair. When we go to school, cross a street, all activities have an element of risk. To say that human participants in psychological research are at risk of physical, psychological and social risk of hurting themselves. So then it means that assessing risk benefit ratio is important. Risk is physical harm or possibility of physical injury. The researcher should protect participants from physical injury, bodily harm, emotional and mental stress arising out of deception as well. Minimal risk means that the possibility and magnitude of harm or discomfort in the research are not great or not more than the one encountered in the daily life during the performance of routine physical or psychological tests.
Example – 1:
     The example discuss in the beginning of eleven months old Albert.
Example – 2:
       Milgram's Study on obedience

ii. Consent
Researchers seek the willingness or consent of their students, patient, clients and other members of the community who are taking part in a scientific investigation. So informed consent of participants is either taken verbally or in writing in form of a contract that clearly spells out each and every detail of the investigation. In other words lying, cheating or fraudulent behavior on part of participant is violation of the consent contract. Inform consent means, that psychologist has informed the participant about the nature of the research, the methodology of the research, the consequences or results of declining to participate or to withdraw from the research at any stage.
Example:

In every research it is very essential that the consent should be taken from the participants.

iii. Deception
Deception means to hide, to withhold information or misinformation to participants about an aspect of a research. Psychologists use deceptive techniques to study different phenomenon but they never deceive their research participants about significant aspects about the research. They have to provide logic and rationale why they are using deception.
Example:
Milgram in 1977, has suggested that deception or masking or technical illusion would be more appropriate.

Example:
The study carried on by Griffin (1959) who made a systematic observation of white people's attitude towards negros. He painted himself black sat in a bus and observed white people's attitude towards him, this practice continued for a month. He wrote down all these perceptions in his book 'Black like me'. This book is a precursor of the civil rights movement in USA.

iv. Privacy
Privacy refers to the rights of the individual to decide, how information about him is to be communicated to others i.e. whenever possible, the information about participants will be kept confidential. Privacy is keeping a piece of information about their client confidential.
Example:
The information related to the fact that even if a prime minister of a country is being treated for a psychological disorder, this information is sacred and it should be kept confidential.

v. Debriefing
Debriefing is an opportunity for participants to know about a research. Debriefing is necessary to remove any harmful effects or misconceptions about participation as well as an opportunity to explain to participants about the need for deception. So debriefing educates the participants about the research, it rationale, its method, its results and why the real purpose of the experiment was hidden from the participant. So debriefing is good for both the participant and the researcher.
Example:
Take the example of a little boy who was guarding the experimenter's pet hamster.
 Example 2:
Debriefing was essential in case of Milgram's study.
Example 3:
In control group experiments, very often placebos are used. Which are fake medicines so debriefing again is essential?

vi   Non Participation in research
The investigator should give the participant full information of the experiment, the level of discomfort involved. The participant has the right to withdraw at any point of the experiment and they will not be punished or his grade will not be affected.

Vii   Power of the investigator
The practice of getting students, prisoners and psychiatric patients as participants for the stressful experiments where rewards such good grades, pack of cigarettes and release from hospital routine activity are promised. If the student refuses to participate, his grade may be effected, or he will be asked to study another extra credit course, prisoners privileges will be withdrawn and psychiatric patients will be asked to do more to please the clinician.
Human participants should be informed in 7 ways.
1. What procedure will be used in experiment?
2. All potential risks should be identified.
3. Any benefits be identified.
4. Participation and performance should be kept confidential.

5. Compensation in case of harm.
6. Questions related to experiments who will answer.
7. No penalty if subjects refuse to participate or leave it in the experiment in the middle.

Plagiarism

Psychologists do not present portions or elements of another persons work or data as their own, even if the other person's work or data source is missing so it means that the publication credit be given to the real author. Don't present portion or elements of another person's work as your own or avoid giving the impression that another person's work is yours. Ignorance is not a legitimate excuse. If you do not know that it's a crime even then there is not excuse for it.

Research on animal subjects is justified by the need to gain knowledge without putting humans to jeapody.

- Animal research – answers questions we could never do with human research.
- Focus is on avoiding exposing them to *unnecessary* pain or suffering.
- Animals are used in approximately 7% of psychological studies.

These rabbits are part of a drug-testing study. Their bodies are enclosed in the metal cases to prevent movement during the test. What steps might the researchers be using to treat the animals ethically?

Care and use of animals as subjects in research
1. People who conduct research with animals should treat animals humanely.
2. Appropriate consideration to be given to comfort, health, and humane treatment of laboratory animals with which research is conducted.
3. Researchers should make efforts to minimize the discomfort and pain of animal subjects. The cage in which the animal is to be kept must be clean, proper light, temperature and fresh supply of food and water be made available.
4. A procedure subjecting animals to pain, stress, discomfort is used only when no other alternative procedure is available.
5. Surgical procedures are performed under appropriate anesthesia.
6. When it's necessary that animal life be terminated it is to be done rapidly with minimum pain and in accordance with accepted procedure.

Let us learn about **Ethics of doing research in abnormal psychology**.

1-The clinician's decision to delay treatment, the people who need it is frequently questioned. Treatment is also with held when placebo control group are used in group experimental design.

2-Another important question relates to inform consent. Participants are told that they may or they may not receive a treatment. True inform consent is rare, in other words, only volunteers who are willing to participate in a study, their inform consent is seek.
 The concept of informed consent is derived from World War II where prisoners of war were forced into medical experiments.

3- APA wants that adults and children both should be protected from physical and psychological harm.
Informed consent of children of age 7 and older is taken from their caregivers.

The society for research in child development 1990 has endorsed guidelines for research with children be provided to their caregivers and guardians.
The APA ethical principles for conducting research is an extremely comprehensive document towards overall guidance towards respect for people's rights and dignity, concern for others welfare and social responsibility.
 The new millennium looks forward to researchers to give up their unprofessional and unethical attitude towards research.

CAUSES OF ABNORMAL BEHAVIOR

Many questions related to the etiology or causes of abnormal behavior come to one's mind. Such as
What causes depression?
Is it due to biochemical imbalance in the brain?
Is it caused by faulty thinking?
Are there any particular characteristics or lifestyles common among the depressed people?

The cause of abnormal behavior remains a mystery. So let us explore the mystery of the causal factors underlying abnormal behavior. The major models of studying abnormal behavior or psychopathology include

      i.   Biomedical Model
      ii.   Psychoanalytical Model
      iii.   Humanistic Model
      iv.   Behavioral Model
      v.   Cognitive Model

A model is a general orientation to the field of abnormal psychology. Every model has its own assumptions about human behavior and its own set of hypothesis, how a mental disorder develops and each model prescribes its own set of treatment.
The major models have their own individual interpretation of the etiological factors of abnormality.
 No single model can explain behavior in a satisfactory manner. Therefore, psychologists today focus on eclecticism, or they use the integrated approach in talking about etiology of a mental disorder.

Multidimensional Integrative Approach
Let us take an example of a sixteen year old girl who suffered from blood-injury-injection phobia.
 We would like to study the issue of **causation**.
 In this case, there are **biological** dimensions, there are **psychological** dimensions, **Emotional**, **social** and **interpersonal** influences as well.
---So let us see this example: A young sixteen year old girl was referred for anxiety disorder, after repeated episodes of fainting. In her biology class the teacher showed a film of dissection of frog, about half way in the film she felt lightheaded and left the class. Then she began to avoid looking at injured people, visiting sick at hospital, she could not stand the sight of raw meat or band aids used in covering wounds.--

Biological Dimensions
The biological dimensions include causal factors from the field of genetics and neuroscience that is the girl has a genetic predisposition to be phobic. So there is a biological dysfunction to be afraid of blood injury injection. Psychological dimensions include causal factors from behavioral and cognitive processes, including learning from environment, social learning and even un-conscious processes. The behavioral responses will include tendency to escape and avoid situations where there would be blood or injury or injection (hospitals or any road side accident). Emotional influences include increased fear and anxiety, where as interpersonal influences which includes friends and family would always rush to help the victim whenever she faints at the sight of blood. Finally, developmental influences would include that a young sixteen old girl is passing through a difficult stage of development, she is in her teenage years where any unfortunate phobic reaction may make her more ill at a later stage. n this example we have gone through the biological influences, the behavioral influences, the emotional influences, social influence and developmental influences. So we have adopted a multidimensional integrative approach to study blood injury infection phobia.

Influences	Reactions
Biological	Biological factors include genes and neuroscience. Increased heartbeat, pulse rate, breathing, etc.
Behavioral	Avoidance to see blood or injury or injection, fainting spell.
Emotional / Cognitive	Increased fear and anxiety
Social	Disruptions at school and home, friends and family run to help her, doctors say nothing is physically wrong.
Developmental	An important developmental stage of sixteen year old teenage girl.

The Bio-Psycho-Social Model studies how biological (evolution, individual genes, brain structure and chemistry), Psychological (stress, trauma, learned helplessness, mood related perceptions and memories) and social (roles, expectations, definition of normality and disorder) factors interact to produce specific psychological disorders. The Multi-Dimensional Integrative Approach and Bio-Psycho-Social Approach are the same.

Let us take another example:

On 8th October 2005, the northern areas of Pakistan experienced the worst earthquake in the history of the country. Killing billions making a huge population homeless and without any social support. This traumatic experience created earthquake phobia in every citizen of the country. You can apply this chart to any one earthquake victim from your country.

1-Genetic contributions to psychopathology

What causes you to look like one or both of your parents or grand parents? The answer is Genetics or inheritance.

- **Genes** are microscopic units of DNA that carry information about heredity. Genes are located on **chromosomes, threadlike** microscopic structures found in the nucleus of cells.
- **Behavior genetics** is a much broader approach that studies genetic influences on the development of normal and abnormal behavior. A **genotype** is an individual's actual genetic structure. It is impossible to observe much of an individual's genotype directly. Instead, what we observe is the **phenotype,** the expression of a given genotype. It usually is impossible to infer a precise genotype from a given phenotype, because phenotypes, but not genotypes, are influenced by the environment.
- Dominant/recessive inheritance causes some rare forms of mental retardation, but most mental disorders are not caused by a single gene—Instead, they are **polygenic,** that is, they are caused by more than one gene.
- Behavior genetic research is powerful, but unfortunately; people often misinterpret it. One serious misinterpretation is that a psychological disorder is inevitable, even predestined, if it has a genetic component. Nature and nurture are not separate influences on behavior. Nature and nurture always work together.

Huntington a disease of the brain, it is due to genes that cause deterioration in a specific area of the brain and causes changes in personality, such as cognitive functioning and motor behavior such as un controllable shaking and jerkiness through out the body.

 Another disease due to genetic influence is called Phenyketonuria caused at birth, it is caused by the inability of the body to break down phenyl-alanine, a chemical compound found in many foods.

In a normal human cell 46 chromosomes are arranged in 23 pairs. In each pair, one chromosome comes from father and one from mother. The first 22 pairs of chromosomes are programmed for the development of body and brain and the last pair determines the individual sex. Most of our behavior, personality and intelligence (IQ) is determined by many genes, each contributing only a tiny portion.

- Behavior geneticists have developed important methods for studying broad, **genetic contributions** to behavior, including family studies, twin studies, and adoption studies.
- Family studies ask whether diseases "run in families." where as the Twin studies say that siblings, DZ twins share an average of 50 percent of their genes, whereas MZ twins share 100 percent of their genes.
- The key comparison involves determining the **concordance rate** of the two sets of twins; specifically whether MZ twins are more alike than DZ twins are alike.
- A twin pair is concordant when both twins either have the same disorder or are free from the disorder, for example, both suffer from schizophrenia.
- The twin pair is discordant when one twin has the disorder but the other does not, for example, one twin has schizophrenia but the co-twin does not.
- Remember that (1) most emotional problems, like most normal behaviors, appear to be polygenic; (2) behavior genetic findings fail to specify the mechanism of genetic influence.

2-Gene and Environment interaction
Eric Kendel explored gene and environment interaction and their relationship to psychological disorder. We will discuss two models 1-the Diathesis-Stress Model and 2-the Reciprocal Gene Environment Model.

Diathesis-Stress Model
In the diathesis-stress model individuals inherit characteristics traits from multiple genes and they have tendencies to express certain traits and behaviors which may then be activated under conditions of stress i.e. each inherited tendency is a diathesis which means a condition that makes one vulnerable to developing a disorder. So when, a stressor comes along the disorder develops. In our example of a sixteen year old girl suffering form blood injury injection phobia, we can say according to this model that she had vulnerability or inherited tendency so when she saw the dissection of the frog that acted as a stressor and led to the expression of disorder. So in this model of gene environment interaction, genetic predisposition was there and environmental stress provided the opportunity for the disorder to be expressed.

The Reciprocal Gene Environment Model
There is now substantial evidence that people with genetic vulnerability to develop a certain disorder also have a personality trait for developing a certain disorder such as in case of blood injury injection phobia, the genetic predisposition, vulnerability and personality traits. All combined in the reciprocal gene environment model. This model applies to the development of the depression in people.
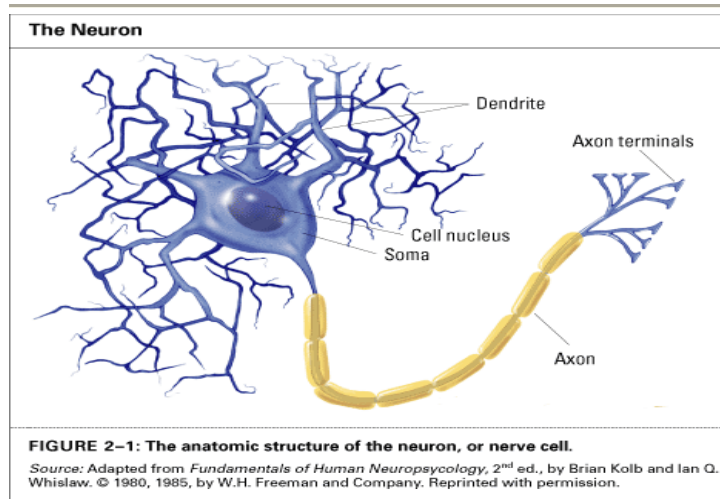
3-Neuroscience and its contribution to psychopathology
- The field of **anatomy** is concerned with the study of biological structures, and the field of **physiology** investigates biological functions.
- **Neuroanatomy** and **neurophysiology** are subspecialties within these broader fields that focus specifically on brain structures and brain functions.
- The study of neuroanatomy and neurophysiology is the domain of an exciting, multidisciplinary field of research called **neuroscience**.

The Neuron
Billions of tiny nerve cells—**neurons**—form the basic building blocks of the brain.
- Each neuron has four major anatomic components: the soma, or cell body, the dendrites, the axon, and the axon terminal. The *soma*—the cell body and largest part of the neuron—is where most of the neuron's metabolism and maintenance are controlled and performed.
- The *dendrites* branch out from the soma; they serve the primary function of receiving messages from other cells.
- The *axon* is the trunk of the neuron.
- Messages are transmitted down the axon toward other cells with which a given neuron communicates.

The Neuron

Dendrite

Axon terminals

Cell nucleus

Soma

Axon

FIGURE 2–1: The anatomic structure of the neuron, or nerve cell.
Source: Adapted from *Fundamentals of Human Neuropsycology*, 2nd ed., by Brian Kolb and Ian Q. Whislaw. © 1980, 1985, by W.H. Freeman and Company. Reprinted with permission.

The *axon terminal* is the end of the axon, where messages are sent out to other neurons.
- Within each neuron, information is transmitted as a change in electrical potential that moves from the dendrites and cell body, along the axon, toward the axon terminal.
- The axon terminal is separated from other cells by a **synapse,** a small gap filled with fluid.
- Unlike the electrical communication within a neuron, information is transmitted chemically across a synapse to other neurons. The axon terminal contains *vesicles* containing chemical substances called **neurotransmitters,** which are released into the synapse and are received at the **receptors** on the dendrites or soma of another neuron. The process of **reuptake,** or reabsorption, captures some neurotransmitters in the synapse and returns the chemical substances to the axon terminal.
- *Neuromodulators* are chemicals that may be released from neurons or from endocrine glands.

Neuromodulators can influence communication among many neurons by affecting the functioning of neurotransmitters.

The central nervous system consists of the brain and the spinal cord. The brain uses an average of 140 billion nerve cells called neurons to transmit information throughout the nervous system. A typical neuron contains a central cell body with two kinds of branches; one kind of branch is called Dendrite having receptor cells. The other kind of branch called axon that transmits nerve messages to other neuron. So the brain and neurons are just like a powerful computer and the computer is programmed to control thinking and actions of each and every organ of the body.

- Nerve cells or neurons are not actually connected. There is a small space through which a nerve impulse or message or nerve current must pass to get to the next neuron. This space between the axon of one neuron and the Dendrite of another neuron is called the synaptic cleft. The chemical that is released from the axon of one nerve cell and transmit the impulse to the receptor of another cell is called the neurotransmitter (Specialized Chemical that defuses across the synaptic gap and stimulates the next neuron).

Neurotransmitters and Psychopathology Scientists have found that disruptions in the functioning of various neurotransmitters are present among some people with mental disorders.

- An oversupply of certain neurotransmitters is found in some mental disorders, an undersupply in other cases, and disturbances in reuptake in other psychological problems.
- Abnormalities in the dopamine system in the brain may be involved in schizophrenia.
- Other evidence links the availability of various neurotransmitters with depression, hyperactivity, posttraumatic stress disorder, and many other psychological problems.
- The identification of biochemical differences definitely does not mean that these problems are caused by "a chemical imbalance in the brain," even though many people mistakenly leap to this conclusion.

The list of neurotransmitters includes Acetylcholine, Nor epinephrine (Noradrenaline) Serotonin, Dopamine, Glutamate and Gamma Amino Butyric Acid (GABA). Neurotransmitters are chemicals that act

on behavior. Increasing or decreasing the flow of neurotransmitters is important. Research on neurotransmitters tells us that the production of neurotransmitters in different parts of the brain effect behavior and mood.

THE STRUCTURE OF BRAIN

Neuro-anatomists divide the brain into three subdivisions: the hindbrain, the midbrain, and the forebrain.

Basic bodily functions are regulated by the structures of the **hindbrain**, which include the medulla, pons, and cerebellum. The **medulla** controls various bodily functions involved in sustaining life, including heart rate, blood pressure, and respiration. The **pons** serves various functions in regulating stages of sleep. The **cerebellum** serves as a control center in helping to coordinate physical movements.

The **midbrain** also is involved in the control of some motor activities, especially those related to fighting and sex.

The **forebrain** evolved more recently than the hindbrain and midbrain and, therefore, forebrain is the site of most sensory, emotional, and cognitive processes. These higher mental processes of the forebrain are linked with the midbrain and hindbrain by the **limbic system.**

The limbic system is made up of a variety of different brain structures that are central to the regulation of emotion and basic learning processes.
Two of the most important components of the limbic system are the thalamus and the hypothalamus.
The **thalamus** is involved in receiving and integrating sensory information from both the sense organs and higher brain structures. The **hypothalamus** controls basic biological urges, such as eating, drinking, and sexual activity.

Most of the forebrain is composed of the two **cerebral hemispheres.** In general, the *left cerebral hemisphere* is involved in language and related functions, and the *right cerebral hemisphere* is involved in spatial organization and analysis. The two cerebral hemispheres are connected by the **corpus callosum**, which is involved in coordinating the different functions that are performed by the left and the right hemispheres of the brain.
The **cerebral cortex** is the uneven surface area of the brain that lies just underneath the skull. It is the site of the control and integration of sophisticated memory, sensory, and motor functions. The cerebral cortex is divided into four lobes.

The **frontal lobe** is involved in controlling a number of complex functions, including reasoning, planning, emotion, speech, and movement. The **parietal lobe** receives and integrates sensory information and also plays a role in spatial reasoning. The **temporal lobe** processes sound and smell, regulates emotions, and is involved in some aspects of learning, memory, and language. The **occipital lobe** receives and interprets visual information.

The brain has three sections, the fore brain, the mid brain and the hind brain. It is in the fore brain that there are two cerebral hemispheres and the thalamus and the hypothalamus. The thalamus relays information between CNS and the Cerebral Cortex. The hypothalamus regulates hunger, thirst, temperature. Below the fore brain is the mid brain. The mid brain coordinates communication between forebrain and hindbrain. The hind brain has structures like the Pons, Medulla, Reticular Activating System and it is connected to spinal cord. The Pons control sleep, dream and the wake state of an individual, Medulla control breathing and heartbeat. The reticular activating system screens the incoming information.

Peripheral Nervous System

> The **peripheral nervous system** includes all connections that stem from the central nervous system and innervate the body's muscles, sensory systems, and organs.

The peripheral nervous system itself has two subdivisions

1. **The voluntary (intentional) somatic nervous system** governs muscular control.
2. **The involuntary, autonomic nervous system** regulates the functions of various body organs, such as the heart and stomach. The somatic nervous system controls intentional or voluntary actions.

The autonomic nervous system is responsible for psycho-physiological reactions are responses that occur with little or no conscious control. The autonomic nervous system can be subdivided into two branches, the sympathetic and parasympathetic nervous systems. Psycho-physiological over-arousal and under-arousal both may contribute to abnormal behavior. For example, over-activity of the autonomic nervous system (a pounding heart and sweaty hands) has been linked with excessive anxiety. In contrast, chronic autonomic under-arousal may explain some of the indifference to social rules and the failure to learn from punishment found in antisocial personality disorder.

The autonomic nervous system consists of **sympathetic** and **para-sympathetic** components.

The sympathetic component is active during time of intense arousal i.e. emergency whereas the **parasympathetic** component is associated with rest or normal level functioning. Whenever an emergency situation arises, the sympathetic component is activated and all are bodily indicators such as heartbeat, pulse rate, body temperature, breathing rate is increased from the normal level to meat the emergency situation such as (fight or flight). After some time when the fight and flight situation is over, the body must return to its normal level of functioning so that all our internal organs should not be tired and wired out.

Psychosocial influences on brain structures and functions
Psychosocial influences on brain can be studied by the case of a man who had been successful as an accountant, husband and father. He had a brain surgery for a brain tumor after his surgery, he returned to work but he failed in his job, separated from his family and got involved in lengthy and un-controllable compulsive rituals. Most of his time was consumed washing, dressing and rearranging his room. So he was suffering from OCD (Obsessive Compulsive Disorder) for this case, the lesion in the brain while operating his brain, tumor might be responsible for his OCD.

A boy's mother was killed in an accident shortly after his birth. His legal father married another woman when the boy was three years old. The boy's step mother began a course of physical and psychological abuse that will make you shiver. For years, the boy was locked in a closet. He was deprived of food and water. His brother and sister would sneak food to him. He was even beaten by a broom stick. This extreme abuse retarded the child's intellectual, emotional and social growth.

A number of similar cases have been reported. Children after getting out of these constraints conditions are admitted in the psychiatric hospital resume their normal growth.

David Spiegel a psychiatrist at Stanford University in 1986, study 86 women with advance breast cancer. This breast cancer was expected to kill them within two year's time. The prognosis was very poor. These women were provided group psychotherapy to relieve their anxiety, depression and pain. All patient had routine medical care for their cancer, in addition 50 patient of the 86 met with their therapist for psychotherapy once a week in small groups. Dr. Spiegel's therapy did magic, the group receiving therapy lived twice as long on average as the control group. These findings do not say that psychosocial interventions cure advanced cancer, but they certainly point to one thing that psychological factors affect physical processes involved in life threatening diseases. There is a good evidence that reducing stress and giving patient's better cooping procedures and a sense of control seems to boost immune system functioning.

William Greenough and his colleagues in 1990 studied that the nervous system of the rats raised in enriched highly stimulated environment developed differently from those rats that were couch potatoes. The active rats had many more connections between nerve cells in the Cerebellum and grew many more dendrites. Through this experiment, the scientists learn that our nervous system is constantly changing as a result of learning and experience even in old age and some of these changes are permanent.

The biomedical model takes in to account the concept of disease, the ties between brain and psychopathology, the link between biological and environmental stress.

Psychoanalytic Model

This model studies psychopathology with reference to unconscious, childhood experiences and intra-psychic conflict.

Psychoanalysis was pioneered by Sigmund Freud (1856-1939). He learned the art of Hypnosis in France. He experimented with somewhat different procedures of Hypnosis. He used Hypnosis in an innovative way. He encouraged his patients to talk freely about their problems, conflicts and fears .He discovered the unconscious mind and its influence in psychopathology by using the techniques of Free Association, Dream Analysis and Freudian Slips.

Structure of the mind: According to Freud the mind consists of Id – which operates on pleasure principle, it is childish and immature. Libido provides energy to Id, Ego and Superego. Ego operates on Reality Principle and it is the master control .It works on logic and reason .The Superego it operates on the moral principle and it is the conscience of the Psyche. The Ego mediates and resolves conflict between Id and Superego.

Defense Mechanism or Coping Styles

The Ego battles with Id and Superego to resolve conflicts, at times the resulting anxiety is so overwhelming that the Ego has to adopt unconscious protective processes called Ego Defense Mechanisms or Coping Styles. They have following characteristics in common

- a. Operate at unconscious level.
- b. Distort reality.
- c. Protect the Ego.
- d. All normal and abnormal individuals both use these in their daily life.

Some important ego defense mechanisms are following

1-Denial 2- Displacement, 3- Projection, 4- Reaction formation, 5- Repression, 6-Rationalization, 7- Sublimation.

Psychosexual Theory of Development

Freud proposed a theory of development. This is known as the psychosexual theory of development. The main emphasis in this theory is on the physical and psychological development.

Psychosexual theory of development

1. Oral stage -birth to18 months
2. Anal stage-18 months to 3 years
3. Phallic stage -3 to 6 years
4. Latency stage
5. Genital stage-6 to 12 years

The stages of development represent patterns of gratifying our basic the needs, those needs which are not gratified appear as fixations or psychopathologies at later adulthood

Oral stage fixations include fingernail biting, chewing pencils.

Freud is the first personality theorist to discuss the developmental perspective in the study of abnormal behavior.

Psychoanalytic- Therapy It focuses on unconscious processes, conflicts and past experiences.

CAUSES OF PSYCHOPATHOLOGY

Throughout history, the search for explanations of the causes of abnormal behavior dates to ancient times, the ancient records attribute abnormal behavior to the disfavor of the gods or the mischief of demons.

Models for Studying Psychopathology

- Biomedical Model
- Psychoanalytical Model
- Humanistic model
- Behavioral model
- Cognitive Model

These Models try to explain the cause of individual Abnormal Behavior. Each model represents its own individual interpretation of psychopathology and recommends its individual treatment procedures. So all the models try to answer the question that
- Why it is that someone is acting so strange?
- What is the cause of abnormal behavior?

Biological model and Psychoanalytic Model
The biological model seems to answer this question with reference to the concepts of genetics and neuroscience. The psychoanalytic model focuses on unconscious, childhood and psychosexual development.
These models have been fully covered in lecture no 11 and12

Humanistic Model
Abraham Maslow (1908-1970)
He presented a need theory, in form of a hierarchy. In order to understand his theory, imagine a triangle which has a broad base and a narrow top. The basic survival needs are at the base of the triangle where as the need of self esteem, love and self actualization can only be satisfied when needs at the lower level have been satisfied.

Hierarchy of Needs
1. Self Actualization.
2. Self Esteem
3. Love and belongingness
4. Safety
5. Physiological

Empathy and Unconditional Positive Regard are the central concepts of Roger's approach.

Empathy refers to understand the client's problem from client's perspective.
Example
Parents and teachers try hard to understand the problems of their children and students by using their children's and student's frame of reference.

Unconditional positive regard is to give respect and dignity to every individual because he is a human being not because of some reason that he is rich, educated, handsome etc
Example
The sweeper, who cleans your home daily, should get unconditional positive regard from you simply because he is a human being and not because that he works at your home.

Behavioral Model
This model emphasizes the overt (observable) behavior of the person and the environmental influences on it.

Pavlov and Classical Conditioning
It is a type of learning, where a neutral stimulus is paired with an unconditional stimulus, acquires the status of conditioned stimulus and leads to the desired response.
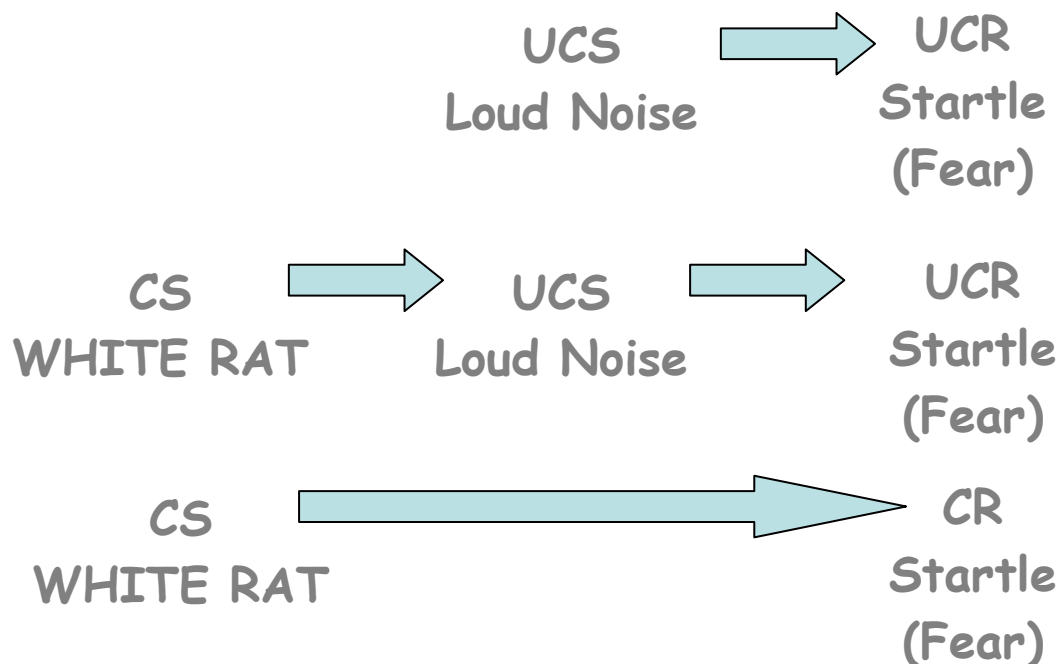
- Unconditioned stimulus (UCS) is a naturally occurring stimulus that leads to a response. Unconditioned means "unlearned" or "naturally occurring."
- Unconditioned response (UCR) is a response to a naturally occurring or unconditioned stimulus.

Example:
A dangerous situation produces fear in a person without any prior learning or conditioning .The dangerous situation is the unconditioned stimulus (UCS) and the fear reaction is the unconditioned response (UCR) They occurs naturally. A neutral stimulus does not produce a response but when neutral stimulus is repeatedly paired with dangerous situation it becomes conditioned stimulus (CS) capable of producing the fear response.

Conditioned stimulus (CS): stimulus that becomes able to produce a learned response by being paired with the original unconditioned stimulus.

- <u>Conditioned</u> means "learned."

- A neutral stimulus can become a conditioned stimulus when paired with an unconditioned stimulus.--

- <u>Conditioned response (CR)</u> - learned response to a conditioned stimulus.

UCS
Loud Noise ⟹ UCR
Startle
(Fear)

CS
WHITE RAT ⟹ UCS
Loud Noise ⟹ UCR
Startle
(Fear)

CS
WHITE RAT ⟹ CR
Startle
(Fear)

Watson worked on an 11 month old, little Albert to acquire the phobia of white fury objects. Albert was not afraid of white rat and he use to play with white rat. The loud noise was UCS which lead to UCR of being startle (fear), now loud noise was paired with white rat, on repeated trials the pairing of UCS(loud noise) with CS(white rat)   lead to new type of learning called conditioning . Now CS (white rat) led to CR (startle or fear)

Example
When some mothers in our culture, create phobia of darkness in children, by saying that 'a jinn will come out from the darkness and eat them.'

Operant Conditioning
It was pioneered by B.F. Skinner. Operant Conditioning is concerned with the consequences of behavior i.e. the probability whether a response will increase or decrease with reinforcement.
A result card with good grades is rewarded, so the probability of this response of working hard for a result card with good grades will increase.

- **Operant conditioning** is the learning of behavior through the effects of pleasant and unpleasant consequences to responses.
- **Thorndike's Law of Effect** - law stating that if a response is followed by a pleasurable consequence, it will tend to be repeated, and if followed by an unpleasant consequence, it will tend not to be repeated.
- Behaviorist wants to study only observable, measurable behavior.
- **Reinforcement** - any event or stimulus that when following a response, increases the probability that the response will occur again.
- **Positive reinforcement** - the reinforcement of a response by the addition or experiencing of a pleasurable stimulus.
- **Negative reinforcement** - the reinforcement of a response by the removal, escape from, or avoidance of an unpleasant stimulus.
- **Punishment** - any event or object that, when following a response, makes that response less likely to happen again.

Observational Learning or Modeling
Stanford university professor, Albert Bandura, pioneered the analysis of observational learning or modeling which is process of learning behavior by observing others. It is learning through imitation.
Example
Aggressive behavior can be learned by observing others. Adult models punched and abused "a bobo doll" while children watched and were later permitted to play with the same doll and children imitated aggressive behaviors as observed.
Social learning theory by Bandura purposes, that behavior is the product of both external stimulus events and internal cognitive process.

Cultural, Social and Interpersonal Factors
In various cultures around the world, people suffer from fear or phobia reactions. The cultural factors influence the form and contents of psychopathology. Many disorders differ within a single culture and within the same country. Fear and phobias are universal occurring across all cultures. For example: Children living in war zones areas of the world are constantly under the fear of potentially life threatening events.

Social Effect
A large number of research studies have shown that greater the number of frequency of social relationships, the longer the individual is likely to live. A study was done on healthy volunteers. The authors measured the participation of subjects in social relationships and its relation with other factors such as poor sleep quality and increased likely hood to catch cold. The surprising results were that greater the number of social types lesser the chance of catching the cold. This shows social interpersonal factors influence psychological and neurobiological (immune system). Schizophrenia and major depression occur in all cultures but they look different from one culture to another because, the individual symptoms are strongly influenced by social and interpersonal context. Depression in the western culture is exhibited with a feeling of guilt and inadequacy, whereas in developing countries depression is reflected in physical symptoms such as fatigue, illness, aches and pains in different parts of the body.

Social Stigma
Psychological disorders continue to carry stigma in our society. We in a developing society still perceive schizophrenia, depression, cancer as disorders about which you have to be hush up or to be secretive about it. What will people think about it? How 'I' and 'my family' will live with this stigma?

Interpersonal Psychotherapy (IPT)
This therapy focuses on interpersonal relationships and interpersonal experiences. In IPT, the patient and the therapist identify life stresses that lead to psychological disorder and interpersonal problems in the individual. The important interpersonal issues relate with marital conflict, acquiring a new job, that is job change or change in relationships. This is a brief therapy, like cognitive behavioral therapy and ten to fifteen sessions are effective for problems such as depression.

Gender roles have strong effect on psychopathology. The likely hood of insect phobia or small animal phobia is more prevalent to be among females as compare to 90% of the people with this phobia. Bulimia Nervosa an eating disorder occurs almost entirely in young females. Almost all cultures emphasize on girls to lean and thin. So girls are under the pressure to eat less and appear lean. **Emotions** Charles Darwin some 134 years ago in 1872, suggested that fear emotion is programmed in all animal and humans i.e. if you are caught in a road accident, or you are swimming in a river to save your life, well you are going through fight or flight response where you mobilize all your energy to escape the danger (flight) or to withstands it (fight). Walter Cannon (1929) gave the concept of physiology of fear. In fear, your cardiovascular system is activated, blood vessels constrict, excess of blood is redirected to muscles and always available to vital organs. You have seen people in emergency to become white with fear, trembling with fear, hairs standings on their ends, breathing becomes faster, heartbeat increases, increased amount of glucose is released into the blood stream, pupils of eyes dilate, the mouth becomes dry, sweat breaks out on the forehead. These are all indicators or physiological responses of an individual going through an emotional state. The anxiety disorders and mood disorders are called emotional disorders.

Richard Lazarus (1968, 1991) who proposed that **change in an individual's environment**, is **perceived as potential change in the person.** The type of appraisal or perception you make determines the emotion you are experiencing.
For example: If you see somebody holding a gun in a dark alley, you will perceive this situation as dangerous and experience fear. But if you perceive that the person who is standing is insane and is holding a toy gun, you will not be afraid and scared, so cognition and emotion interact and form the basis of emotion of fear.

Cognitive model
Cognitive model is concerned with human cognition that how human beings perceive recognize, attend, reason and judge. This model includes:

3.   Rational emotive behavior therapy. (Albert Ellis) 1962.
4.   Cognitive theory of depression (Aaron Beck - 1967).

1.   Rational emotive behavior therapy. (Albert Ellis) 1962.
According to Albert Ellis, maladaptive behavior results when people operate on misguided and inaccurate assumptions. Ellis catalogued 11 irrational believes responsible for maladaptive behavior. The ABC of rational emotive behavior therapy is where: A – Activating event,   B – Belief System and C – Emotional behavioral consequences.   Activating event A can cause unwanted emotional and behavioral consequences when filter through beliefs that are irrational.

2. Cognitive Theory of Depression.
For Beck, depressed people possess a negative cognitive triad.
Beck says depressed individual see themselves as defeated, deprived and diseased and their world as full of road blocks and their future without hope.

In today's world psychologists study abnormal behavior not with reference to one single model rather they adopt the integrative approach which respond to all aspects of abnormal behavior.

CAUSES OF ABNORMAL BEHAVIOR
ETIOLOGICAL FACTORS OF ABNORMALITY

We have talked about the different models of Psychology; each model represents its own unique interpretation of the etiology and treatment of abnormal behavior. After studying each model we extracted (located) some important factors underlying abnormality. From the study of biomedical model we have located the biological factors of abnormality similarly, after going through the Psychoanalytic model, Humanistic Model, Behavioral model and Cognitive model we extracted the psychological factors, emotional and social factors. All these factors, they combine together in Bio-Psycho-Social approach or multidimensional integrative approach. The biological factors focus on genetics, the interaction of genes and environment. This model also focuses on neuron, brain and spinal cord.

1-Biological Factors
a- Genes and its interaction with environment
- b-The study of neuro-anatomy and neurophysiology is the study n**euroscience. The Neuron** Billions of tiny nerve cells—**neurons**—form the basic building blocks of the brain. Each neuron has four major anatomic components: the soma, or cell body, the dendrites, the axon, and the axon terminal.
- The *dendrites* branch out from the soma; they serve the primary function of receiving messages from other cells. The *axon* is the trunk of the neuron. Messages are transmitted down the axon toward other cells with which a given neuron communicates.
- Scientists have found that disruptions in the functioning of various neurotransmitters are present among some people with mental disorders.
- An oversupply of certain neurotransmitters is found in some mental disorders, an undersupply in other cases, and disturbances in reuptake in other psychological problems. Abnormalities in the dopamine system in the brain may be involved in schizophrenia.
- Other evidence links the availability of various neurotransmitters with depression, hyperactivity, posttraumatic stress disorder, and many other psychological problems.
  c- Major Brain Structures
- Neuro-anatomists divide the brain into three subdivisions: the hindbrain, the midbrain, and the forebrain.
- Basic bodily functions are regulated by the structures of the **hindbrain**, which include the medulla, pons, and cerebellum.
- The **medulla** controls various bodily functions involved in sustaining life, including heart rate, blood pressure, and respiration.
- The **pons** serves various functions in regulating stages of sleep.
- The **cerebellum** serves as a control center in helping to coordinate physical movements.
- The **midbrain** also is involved in the control of some motor activities, especially those related to fighting and sex.
- The **forebrain** evolved more recently than the hindbrain and midbrain and, therefore, is the site of most sensory, emotional, and cognitive processes. These higher mental processes of the forebrain are linked with the midbrain and hindbrain by the **limbic system.**
- The limbic system is made up of a variety of different brain structures that are central to the regulation of emotion and basic learning processes.
- d- Spinal cord is along bundle of neurons that carries messages to and from the body to the brain that is responsible for a very fast, life saving reflexes.

2-PSYCHOLOGICAL FACTORS

- **Human Nature and Temperament**
- The writings of British psychiatrist John Bowlby greatly influenced psychologists' views about the human need to form close relationships. The heart of Bowlby's theory was the observation that children form **attachments** early in life—special and selective bonds with their caregivers.
- Bowlby based his approach, known as *attachment theory,* on findings based on the study of animal behavior.
- Research on the effects of *insecure* or *anxious attachments*—uncertain parent child relationships are a product of inconsistent and unresponsive parenting during the first year of life—is of particular relevance to the development of abnormal behavior.
- The development of attachments, or more generally of *affiliation* with other members of the same species, is one of the two broad categories of social behaviors studied by psychologists.
- One of the most important areas of research on individual differences in personality is the study of **temperament,** characteristic styles of relating to the world.
- Individual differences in temperament may play a role in a number of psychological disorders, especially personality disorders and child behavior problems.
- **Emotions,** internal feeling states, are essential to human experience and to our understanding of mental disorders.

Learning and Cognition

Emotions, motivations, and temperamental styles can be modified, at least to some degree, by learning.

- Cognitive theories like Albert Ellis's REBT and Beck's Depression theory suggests that distorted perceptions of reality cause people to become depressed.
- A successful treatment based on this theory encourages depressed people to be more scientific and realistic in evaluating conclusions about themselves.

The Sense of Self

Maslow's theory of needs in which self actualization is given importance. **Self-esteem***,* valuing one's abilities, is another important and much discussed aspect of our sense of self. Evidence indicates that high self-esteem is more of a product of success; similarly low self-esteem may result from psychological problems.

Life Span Developments

Life span developmental psychopathologists want to understand how different periods of development influence, how stress and other factors have an impact on mental disorders. Eric Erickson (1982) suggested that we go through eight major crises during our life and each crisis is influenced by biological maturation, social factors and the developmental stages we are passing through. Erickson believe, "we grow and change even beyond 65." During older adulthood, we look back and view our lives as rewarding or as disappointing. Erickson's developmental theory is more comprehensive and advanced as compared to Sigmund Freud's.

Theory	Developmental Stages	Period of Growth
Freud's Psychosexual theory	Five	1st year to 12 years
Erick Erickson's developmental theory	Eight	1st year to 65 years and beyond

Equifinality

Equifinality is a construct which we frequently use in developmental psychopathology to indicate that we must consider a number of paths to a given disorder e.g. if we like to study schizophrenia, we can study it its delusional symptoms, or its difficulty in focusing attention or the state of delirium of the schizophrenics. Researchers are exploring the different pathways to a single disorder.

- **Development**, or how people grow and change, is of basic importance to normal and abnormal psychology.
- A key developmental concept is that psychological growth can be characterized by various **developmental stages**—periods of time marked by age and/or social tasks during which children or adults face common social and emotional challenges.
- Two prominent theories that divided development into stages are Freud's theory of **psychosexual** development and Erickson's theory of **psychosocial** development.

Relationships and Psychopathology
- Much evidence links abnormal behavior with distressed or conflicted relationships, still it often is impossible to determine if troubled relationships actually cause abnormal behavior.
- Example when an individual enjoys a large number of social relationships
- The findings of this large body of research indicate that marital status (separation, divorce, second marriage) and psychological problems clearly are *correlated*.

Gender and Gender Roles
- Gender and **gender roles,** expectations regarding the appropriate behavior of males or females, can dramatically affect social relationships and social interaction.
- Gender roles may influence the development, expression, or consequences of psychopathology.--

Prejudice and Poverty
- An increased risk for psychological disorders is associated with prejudice and poverty, the conditions of poverty effect a large number of people in many ways.

Societal Values
- Broad social values also may influence the nature and development of abnormal behavior.
- The broad practices, beliefs, and values of our society play a role in defining abnormal behavior and in shaping the scientific enterprise that attempts to uncover the roots of psychopathology.

SYSTEM THEORY
- **Systems theory** is an approach to integrating evidence on different contributions to abnormal behavior.
- You can think of systems theory as similar to the bio-psychosocial model or the multidimensional integrative approach but systems theory also embraces several key concepts that deserve some elaboration.

Holism
- A central principle of systems theory is **holism**, the idea that the whole is more than the sum of its parts. A human being is more than the sum of a nervous system, an organ system, a circulatory system, and so on.
- We can appreciate the principle of holism if we contrast it with its scientific counterpoint, reductionism.
- **Reductionism** attempts to understand problems by focusing on smaller and smaller units, viewing the smallest possible unit as the true or ultimate cause.
- One approach is not right, while the others are wrong. The lenses are just different, and each has value for different purposes.
- **Causality** The cause of any one case of abnormal behavior occasionally can be located in one area of biological, psychological, or social functioning.
- More commonly, however, understanding the causes of psychological problems involves a multitude of causal influences, not in one single area of biological or psychological or social.
- The cause of any one case of abnormal behavior occasionally can be located in one area of biological, psychological, or social functioning.

Developmental Psychopathology

- **Developmental psychopathology** is a new approach to abnormal psychology that emphasizes the importance of *developmental norms* which include *a*ge-graded averages—to determine what constitutes abnormal behavior.

CLASSIFICATION AND ASSESSMENT

Assessment is the process of gathering information from a new patient. It is the systematic collection and analysis of information about a person's characteristics and behaviors.

A **classification system** consists of a list of various types of problems and their associated symptoms.
In Diagnosis we identify or recognize a disorder on the basis of its **characteristic symptoms**.

A **classification system** is used to subdivide or organize a set of objects. Classification system can be based on various principles, and its value will depend primarily on the purpose for which they were developed. Different classification systems are not necessarily right or wrong; they are simply more or less useful.
Clinical assessment and diagnosis are centered to the study of the psychopathology. Clinical assessment refers to systematic evaluation and measurement and psychological, biological and social factors in an individual presenting with a possible psychological disorder. Diagnosis is the process of determining whether the particular problem that the individual has needs all the criteria as given in DSM-IV-R in the classification of disorders.

Example A
Suppose your class fellow experiences sensations that make her believe she is having a heart attack. Difficulty in breathing, rapid heart beat and burden on her chest. She is taken to the emergency of a hospital and she is told that the problem is psychological and physically she is al right.

Example B
Your aunt is depressed, she has lost her husband. She does not eat, does not sleep, and does not go to her work. You are worried. You want her to return to normal.

Example C
A teacher observes that one of her students is disruptive, unpopular with the class. What should be done and how the problem should be treated.

When we frequently come across medical problems, psychological problems, social problems or a combination of either of the two, we frequently ask **how can we decide**? **How can we be sure**, **what treatment is needed?** How can we differentiate between **different types** of **psychological disorders?**
In the mental health field, we describe, classify, explain, select, predict, plan and evaluate to do all these tasks; we need procedures and methods to measure and define psychological disorders.

Tools for Assessment
Assessment is the systematic collection and analysis of information about a person's characteristics and behaviors. There are several assessment procedures, such as:
1. Interviews
2. Questionnaires
3. Psychological tests
4. Rating Scales
5. Observation
6. Behavior samples

Each assessment procedure is to judge according to the following criteria which includes

1. Reliability
2. Validity
3. Standardization
4. Utility

1. Reliability

Reliability refers to consistency or repeatability of the results. Reliability is computed by several statistical procedures. Reliability is expressed as a matter of degree. Usually, on a continuum of 0 to 1 where one means perfect reliability, this is a rare thing. There are three types of reliability.

    a.   Test Retest
    b.   Internal consistency
    c.   Inter rater reliability

Test retest: is the consistency of a test results over time. The same test questionnaire or an interview should yield the same results, when used on the same person twice (tested on two different occasions). This type of reliability is important when compulsive behavior is being measured or anxiety is being measured.

Split Half (Internal consistency) A type of reliability is internal consistency or correspondence (correlation) between test items. A questionnaire intended to measure potential for child abuse so we focus on the concept of child abuse, now every item of the questionnaire should relate and measure the concept of child abuse. If all the items on the questionnaire contribute to identify this concept then individual item-item correlation will be high and individual item to total item score will be high.

Inter rater reliability A type, of reliability is Inter rater reliability or consistency among scorers or observers. Independent judges, who are observing a person's behavior, come to the same conclusion. This kind of reliability evaluates the agreement between two raters administering the same interview, rating the same video of a person's behavior or observing a person's behavior in a particular setting. High inter rater reliability increases the confidence that the procedure is measuring, what it is suppose to measure. It is clear that an instrument measuring a behavior should be high in reliability if we want to draw conclusions from it. For example: an intelligence test demonstrates low test retest reliability. It clearly shows that it is not measuring intelligence.

        While two observers, observe the same child in the classroom and agree in their ratings that his intelligence should be high.

2. Validity

Validity is a method, which means does the test measure, what it has been designed to measure i.e. an intelligence should measure intelligence, a personality test should measure personality then it is a valid measure and it will give valid and accurate results. Suppose that a bag of sugar when put on the scale should read its weight, every time the same bag of sugar is put on the scale should give the same reading. Then the weighing scale is valid.

Kinds of Validity:

    a.   Face validity
    b.   Criterion (Predictive validity and Concurrent validity)
    c.   Content validity
    d.   Construct validity

Face validity does not by itself establish the test's trust worthiness. It simply conveys that the test and its items should appear making sense to the test taker. This is not validity in the real sense. It's simply means that a test on depression should include questions about how often a depressed individual cry or weeps. So face validity is the apparent sense the test makes to the person who is taking it.

Predictive validity is a test ability to predict a person's future characteristics or behavior. We could establish predictive validity by administering a test to a group of school students and predict their performance for the future senior school i.e. predictive validity makes prediction about the individual's future behavior based on his present behavior. When we ask questions like, Is an individual likely to become anxious or depress in future? We are dealing with the concept of predictive validity.

Concurrent Validity: A test designed to measure student's present or current anxiety state e.g. should produce anxiety scores that agree with school counseling records and parent's reports.

Content validity: A test that displays high content validity reflects that it measures all important aspects of the behavior, skill or quality that it is measuring. All achievements test and intelligence test and all teacher made classroom test should have high content validity. All entrance exams and admission tests should have high content validity (THEY SHOULD BE CONTENT BASED).

Construct validity: Construct validity measures what they are intended to measure and not something else. Do achievement tests measure ability in a given subject area or do they measure something else? Some students do very well on an achievement test and others do very poorly on multiple choice tests. Before any test can be useful, it must meet the requirements of standardization and utility criteria as well.

3. Standardization

Standardization is process by which a certain set of standards or norms is determined for a technique in order to make its use consistent across different measurements, e.g. the assessment might be given to a large number of people who differ on important factors, such as age, race, gender, socio economic status and diagnosis, where scores would then be used as a standard or norm for comparison purposes, e.g. if you are a Pakistani, 19 years old male from a middle class background on your score on a psychological test should be compared to the scores others like you.

4. Utility

A final criterion for deciding that an assessment procedure is worth employing is its utility or usefulness. To be useful, the assessment procedure should be valid, reliable, standardized and useful.

DIAGNOSING PSYCHOLOGICAL DISORDERS

The term classification refers to any effort to construct groups or categories and to assign objects or people to these categories or groups on the basis of their attributes, characteristics or relations. Methods of classification include:

1.   Classical categorical system
2.   Dimensional system
3.   Prototypical approach

In order to classify the psychological disorders we need a classification system. The term classification refers to process to construct categories and to assign people to these categories on the basis of their attributes or relations. Classification in scientific context refers to taxonomy. It also refers to nomenclature, which describes the names and labels that may make up a particular disorder such as schizophrenia or depression. Classification is at the heart of every science. If we can not label and order objects or experiences or behaviors scientists could not communicate with one another and our knowledge will not advance. Therefore, we develop a system with which we could define or classify behavior. Abnormal psychology is based on the assumption that a behavior is part of one category or disorder and not of another one.

Psychologists use three approaches or strategies to classify disorders:

1.   The categorical approach
2.   Dimensional approach
3.   Prototypical approach

The categorical approach
It was Kraepelin, the first psychiatrist to classify psychological disorders from a biological or medical point of view. For Kraepelin in term of physical disorders, we have one set of causative factors which do not overlap with other disorders. We have one defining criteria, which every body in the category or in the group should meet.
      Example   Schizophrenia

Dimensional Approach
A second strategy is a dimensional approach, in which we note the variety of cognitions, moods, and behaviors with which the patient presents and quantify them on a scale. For example, on a scale of 1 to 10, a patient might be rated as severely anxious (10), moderately depressed (5), and mildly manic (2) to create a profile of emotional functioning (10, 5, 2). Although dimensional approaches have been applied to psychopathology, they are relatively unsatisfactory.

Prototypical approach
A third approach, for organizing and classifying behavioral disorders which is an alternative to the first two. It is called a prototypical approach. It identifies some essential characteristics of a disorder and it also allows for certain non-essential variations that do not necessarily change the classification. With this approach classifying the disorder by different possible features or properties any candidate must meet (but not all) of them to fall in that category. In depression, there are five important symptoms such as:

1.   Depressed mood all of the day
2.   Weight loss
3.   Insomnia
4.   Fatigue
5.   Feeling of worthlessness

For a person might have three or four of the characteristics of the depression but not all five of them. Yet we still diagnose the person as depressed.

Categories versus Dimensions
- After a category has been defined, an object is either a member of the category or it is not. A **categorical approach to classification** assumes that distinctions among members of different categories are qualitative.
- In other words, the differences reflect a difference in kind (quality) rather than a difference in amount (quantity).
- An alternative, scientists often employ a **dimensional approach to classification**—that is, one that describes the objects of classification in terms of continuous dimensions.
- Rather than assuming that an object either has or does not have a particular property, it may be useful to focus on a specific characteristic and determine *how much* of that characteristic the object exhibits.

From Description to Theory
- Mental disorders are currently classified on the basis of their descriptive features or symptoms.
- We need a classification system for abnormal behavior for two primary reasons.
- First, a classification system is useful to clinicians, who must match their clients' problems with the form of intervention that is most likely to be effective.
- Second, a classification system must be used in the search for new knowledge.

Brief History of Classifying Abnormal Behavior

Brief Historical Perspective
- Currently, two diagnostic systems for mental disorders are widely recognized.
- 1--One—the *Diagnostic and Statistical Manual* (DSM)—is published by the American Psychiatric Association.
- 2--The other—the *International Classification of Diseases* (ICD)—is published by the World Health Organization.
- During the 1950s and 1960s, psychiatric classification systems were widely criticized. One major criticism focused on the lack of consistency in diagnostic decisions.
- Renewed interest in the value of psychiatric classification grew steadily during the 1970s, culminating in the publication of the third edition of the DSM in 1980.This version of the manual represented a dramatic departure from previous systems.

The DSM-IV-TR System
- More than 200 specific diagnostic categories are described in DSM-IV-TR. These are arranged under 18 primary headings.
- The manual lists specific criteria for each diagnostic category.
- The DSM-IV-TR employs a multiaxial classification system*; that is, the person is rated on five separate axes.
- Each axis is concerned with a different domain of information.
- Two are concerned with diagnostic categories and the other three provide for the collection of additional relevant data.

TABLE 4-2	Major Domains of Information in DSM-IV-TR
Axis I	**Clinical Disorders and Other Conditions That May Be a Focus of Attention** (includes all mental disorders in the manual except those listed on Axis II).
Axis II	**Personality Disorders and Mental Retardation** (includes all personality disorders and/or mental retardation. Clinician can also list maladaptive *personality features*, characteristic defense mechanisms, or coping styles).
Axis III	**General Medical Conditions** (includes medical problems that can cause symptoms of an Axis I or Axis II disorder or act as a psychological stressor).
Axis IV	**Psychosocial and Environmental Problems** (includes life events from the past year that may have an impact on diagnosis or treatment, such as divorce or unemployment).
Axis V	**Global Assessment of Functioning** (describes the person's level of psychological, social, and occupational functioning on a single scale from 1 to 100).

DSM is not a perfect document but this imperfect document gives valuable information. Each axis of DSM provides an important piece of information related to a person's behavior. Each axis is like a piece of a puzzle and when all the pieces or axes are put at the right places we get a complete picture.

EVALUATING SYSTEMS

Reliability
- Reliability refers to the consistency of measurements, including diagnostic decisions.
- One important form of reliability, known as inter-rater reliability, refers to agreement among clinicians.

Validity
- Validity refers to the meaning or importance of a measurement—in this case, a diagnostic decision.
- Validity is, in a sense, an index of the success that has been achieved in understanding the nature of a disorder.
- Etiological validity is concerned with factors that contribute to the onset of the disorder.
- Concurrent validity is concerned with the present time and with correlations between the disorder and other symptoms, circumstances, and test procedures.
- Predictive validi**ty** is concerned with the future and with the stability of the problem over time.
- Each time the DSM-IV-TR is revised, new categories are added and old categories are dropped, presumably because they are not sufficiently useful.

Problems and Limitations of the DSM-IV-TR System
DSM-IV-TR does not classify clinical problems into syndromes in the simplest and most beneficial way.
- One of the important issues involves **comorbidity,** which is defined as the simultaneous appearance of two or more disorders in the same person.
- Co morbidity rates are very high for mental disorders as they are defined in the DSM system.

Basic Issues in Assessment

Purposes of Clinical Assessment
- **Psychological assessment** is the process of collecting and interpreting information that will be used to understand another person.
- Three primary goals guide most assessment procedures: making predictions, planning treatments, and evaluating treatments.
- Different assessment procedures are likely to be employed for different purposes.

Assumptions about Consistency of Behavior
- Psychologists must be concerned about the consistency of behavior across time and situations.
- They want to know if they can **generalize** about the person's behavior in the natural environment on the basis of the samples of behavior that are obtained in their assessment.
- Psychologists typically seek out more than one source of information when conducting a formal assessment.(observation, interview, and psychological tests)
- Because we are trying to compose a broad, integrated picture of the person's adjustment, we must collect information from several sources and then attempt to integrate these data.
- One way of evaluating the possible meaning or importance of this information is to consider the consistency across sources.

Evaluating the Usefulness of Assessment Procedures
- In the case of assessment procedures, reliability can refer to various types of consistency.
- For example, the consistency of measurements over time is known as **test–retest reliability.**
- The internal consistency of items within a test is known as **split-half reliability.**
- The validity of an assessment procedure refers to its meaning or importance.
- Is the person's score on this test or procedure actually a reflection of the trait or ability that the test was designed to measure?

- And does the score tell us anything useful about the person's behavior in other situations?
- In general, the more consistent the information provided by different assessment procedures, the more valid each procedure is considered to be. Interviews, observational procedures, and personality tests must be carefully evaluated.
- The most useful assessment procedures are likely to vary from one problem to the next.
- Assessment procedures that are useful in evaluating the effectiveness of a drug treatment program for hospitalized depressed patients may be quite different from those used to predict the need for medication among hyperactive schoolchildren.

Interviews
- The clinical interview is the most commonly used procedure in psychological assessment.
- Most of the categories that are defined in DSM-IV-TR are based on information that can be collected in an interview.
- Interviews provide an opportunity to ask people for their own descriptions of their problems.
- Interviews also allow clinicians to observe important features of a person's appearance and nonverbal behavior.

Structured Interviews
- Assessment interviews vary with regard to the amount of structure that is imposed by the clinician.
- Some are relatively open-ended, or nondirective.
- **Structured interviews**, in which the clinician must ask each patient a specific list of detailed questions, are frequently employed for collecting information that will be used to make diagnostic decisions and to rate the extent to which a person is impaired by psychopathology.
- Structured interviews list a series of specific questions that lead to a detailed description of the person's behavior and experiences.
- Structured interview schedules provide a systematic framework for the collection of important diagnostic information, but they don't eliminate the need for an experienced clinician

The Mental Status Examination
The mental status examination involves systematic observation of an individual's behavior. This type of observation occurs when one individual interacts with another. Mental status examination can be structured and detailed. It covers five categories:

1. **Appearance and behavior**
   This includes individual's dress, appearance, posture and facial expression e.g. an individual can be slow, lazy and lethargic. Another individual can be active and agile.
2. **Thought Process**
   Clinicians listen to patient's talk and they get a good idea of the patient thought process. Is his talk reality oriented, each idea connected with one another or is it full of fantasy, delusions hallucinations or is it disjointed speech with no association of ideas e.g. schizophrenia.
3. **Mood and affect**
   A mental health clinician focuses on mood which is the feeling state of the individual and affect reflects the emotion. Is the client and his talk depressed or in a hopeless fashion or is it in optimistic fashion.
   Example: is the individual laughing or crying, happy or sad, full of expressions or flat without expression.
4. **Intellectual Function**
   This estimates the intelligence of the individual. Is the individual of average intelligence, above average intelligence or below average intelligence?
5. **Perception of person, place and time.**
   This refers to, does the individual know, who he is, where he is and what date and what time is it?

The mental status examination tells us how people think, feel and behave and how these actions might contribute to explain their problems. So actually, we are doing behavioral assessment of people. This behavioral assessment is done by using direct observation of an individual's thought, feelings and behavior in situations or context where the individual is having problems.

Advantages of the Clinical Interview as an Assessment Tool
1. The interviewer can control the interaction and can probe further when necessary. By observing the patient's nonverbal behavior, the interviewer can try to detect areas of resistance. In that sense, the validity of the information may be enhanced.
2. An interview can provide a lot of information in a short period of time.

Limitations of the Clinical Interview as an Assessment Tool
1. Some patients may be unable or unwilling to provide a rational account of their problems.
2. People may be reluctant to admit experiences that are embarrassing or frightening.
3. Subjective factors play an important role in the interpretation of information provided in an interview.

Observational Procedures
- Observational skills play an important part in most assessment procedures.
- Sometimes the things that we observe confirm the person's self-report, and at other times the person's overt behavior appears to be at odds with what he or she says.
- Observational procedures may be either informal or formal.
- Informal observations are primarily qualitative.
- The clinician observes the person's behavior and the environment in which it occurs without attempting to record the frequency or intensity of specific responses.
- Although observations are often conducted in the natural environment, there are times when it is useful to observe the person's behavior in a situation that the psychologist can arrange and control.

Rating Scales
- A **rating scale** is a procedure in which the observer is asked to make judgments that place the person somewhere along a dimension.
- Ratings can also be made on the basis of information collected during an interview.
- Rating scales provide abstract descriptions of a person's behavior rather than a specific record of exactly what the person has done.
  These are assessment tools, which are used before the treatment to assess changes in patient's behavior after the treatment. Brief psychiatric rating scales are usually used and completed by hospital staff to assess an individual on different constructs related with physical or psychological illness.

Behavioral Coding Systems
- Rather than making judgments about where the person falls on a particular dimension, **behavioral coding systems** focus on the frequency of specific behavioral events.
- Some adult clients are able to make records and keep track of their own behavior—a procedure known as **self-monitoring.**

Advantages of Observational Methods
- Rating scales are primarily useful as an overall index of symptom severity or functional impairment.
- Behavioral coding systems provide detailed information about the person's behavior in a particular situation.

Limitations of Observational Methods

Observational procedures can be time-consuming and therefore expensive. Observers can make errors. People may alter their behavior, either intentionally or unintentionally, when they know that they are being observed—a phenomenon known as **reactivity.**

- Observational measures tell us only about the particular situation that was selected to be observed.
- There are some aspects of psychopathology that cannot be observed by anyone other than the person who has the problem.

ASSESSMENT of PERSONALITY I

Personality Inventories
Personality inventories present an elaborate picture of an individual's overall personality including the traits, the characteristics, the tendency and the styles that are thought to underlie behavior.

The questions in personality inventories are presented in form of statements. These statements are the items of personality test. Many personality inventories are available such as MMPI Minnesota Multiphasic Personality Inventory. This test was develop in 1940 and published in 1943. It is based on empirical approach i.e. the collection and evaluation of data. The individual is presented with statements and the answers have options like true, false and cannot say. Some of the statements from MMPI are following:

- I cry easily
- I am happy most of the time.
- I believe, I am being followed

MMPI consisted of 550 items. MMPI consists of ten clinical scales, meaning that it diagnosis people on ten clinical disorders. It has got four validity scales, which include:

1. Lie scale
2. The F Scale, Infrequency scale
3. K scale, The Defensiveness Scale
4. The Can not say scale

- They consist of a series of straightforward statements; the person being tested is typically required to indicate whether each statement is true or false in relation to an individual.
- Some personality inventories are designed to identify personality traits in a normal population, and others focus more specifically on psychological problems.
- The most extensively used personality Inventory is the Minnesota Multiphasic Personality Inventory (MMPI). The inventory was revised several years ago, and it is currently known as the MMPI-2.
- The MMPI-2 is based on 567 statements that cover topics ranging from physical complaints and psychological states to occupational preferences and social attitudes. Scoring of the MMPI-2 is objective.
- After the responses to all questions are totaled, the person receives a numerical score on each of 10 clinical scales as well as on four validities.

The MMPI not only diagnoses a person on ten clinical scales it also detects sources of invalidities like lying, carelessness, defensiveness on part of respondent. It attempts to present all information in form of a profile of scores. This profile of scores across all ten clinical scales and four validity scales is presented as deviations from general population norms. The normal scale score is a T-score of 50 any score above 50 is a sign of pathology.

TABLE 4–7	Clinical Scales for the MMPI	
Scale Number	**Scale Name**	**Interpretation of High Scores**
1	Hypochondriasis	Excessive bodily concern; somatic symptoms
2	Depression	Depressed; pessimistic; irritable; demanding
3	Hysteria	Physical symptoms of functional origin; self-centered; demands attention
4	Psychopathic Deviate	Asocial or antisocial; rebellious; impulsive, poor judgment
5	Masculinity–Femininity	Male: aesthetic interests Female: assertive; competitive; self-confident
6	Paranoia	Suspicious, sensitive; resentful; rigid; may be frankly psychotic
6	Paranoia	Suspicious, sensitive; resentful; rigid; may be frankly psychotic
7	Psychasthenia	Anxious; worried; obsessive; lacks self-confidence; problems in decision making
8	Schizophrenia	May have thinking disturbance, withdrawn; feels alienated and unaccepted
9	Hypomania	Excessive activity; lacks direction; low frustration tolerance; friendly
0	Social-Introversion	Socially introverted; shy; sensitive; overcontrolled; conforming

- Before considering the possible clinical significance of a person's MMPI-2 profile, the psychologist will examine a number of validity scales, which reflect the patient's attitude toward the test and the openness and consistency with which the questions were answered.
- The L (Lie) Scale is sensitive to unsophisticated attempts to avoid answering in a frank and honest manner.
- Examples of items of MMPI 2
  1. I like automobile magazines.
  2. I wake up with lots of energy most mornings.
  3. I am startled by loud noises.

Advantages of MMPI-2
1. The MMPI-2 provides information about the person's test-taking attitude, which alerts the clinician to the possibility that clients are careless, defensive, or exaggerating their problems.
2. The MMPI-2 covers a wide range of problems in a direct and efficient manner

3. Because the MMPI-2 is scored objectively, the initial description of the person's adjustment is not influenced by the clinician's subjective impression of the client.
4. The MMPI-2 can be interpreted in an actuarial fashion, using extensive banks of information regarding people who respond to items in a particular way.

Limitations of MMPI-2
1. The test is not particularly sensitive to certain forms of psychopathology, especially those that have been added with the publication of DSM-III and DSM-IV-TR.
2. The test depends on the person's ability to read and respond to written statements.

Other Self-Report Inventories
- Many other questionnaires and checklists have been developed to collect information about adjustment problems, including subjective mood states such as depression and anxiety, patterns of obsessive thinking, and attitudes about drinking alcohol, eating, and sexual behavior.
- The format of most self-report inventories is similar to that employed with objective personality tests like the MMPI-2.
- The primary difference is the range of topics covered by the instrument.
- Self-report inventories usually don't include validity scales, and they may not be standardized on large samples of normal subjects prior to their use in a clinical setting.
- Self-report inventories offer many advantages as supplements to information that is collected during clinical interviews.
- Self-report inventories can lead to serious problems if they are used carelessly.

Intelligence Tests
What is intelligence? What is IQ and how are intelligence tests important in psychopathology? Intelligence refers to your overall adjustment. IQ is your intelligence quotient score which refers to intelligence level.
- IQ is your intelligence quotient .IQ refers to a score on an intelligence test.
- Intelligence can be measured by
- Puzzles and riddles you can solve
- Difficult questions you can correctly answer
- Standardized intelligence tests
- Intelligence tests developed for one specific purpose to predict who will do well in school. In 1904, a French psychologist Alfred Binet and Theodore Simon were commissioned by the French government to identify slow learners in class to benefit from remedial help. They developed the intelligence test that was designed to predict academic success. The test provided a known as intelligence quotient, or IQ. The IQ is calculated by
- IQ= MA/CA X 100
- A child who passed all items on the test of 8 year old gets a mental age of 8 where as the actual age of the child may be 6years now put these values in the formula
- IQ= 8/6X 100=

Otis Quick Scoring Mental Ability Test
> Otis quick scoring mental ability test consists of 80 items which relates to general intelligence, vocabulary, arithmetic ability and general knowledge. The test is a speeded test i.e. the number of items is large and the time allotted is short and no one can finish the test in time. Power test is a test which has no time constraint but some of the items in the test are so difficult that no one can correctly respond to them.

Wechsler Intelligence Scales
- David Wechsler introduced Wechsler Preschool And Primary Scale of Intelligence –Revised (WPPSI-R) intelligence scale for preschool children for kinder- garden.
- He gave the WECHSLER INTELLIGENCE SCALE FOR CHILDREN (WISC-III).

- He introduced WECHSLER ADULT INTELLIGENCE SCALE (WAIS-III).
- Both the scales consist of 11 sub tests measuring the intelligence level of children and adults.
- All these tests have verbal scales and performance scales.
- The verbal scales measure vocabulary, knowledge of facts, short term memory and verbal reasoning.
- The performance scales assess psycho-motor abilities, nonverbal reasoning and ability to learn new relations.
- Intelligence tests are reliable measures of academic success
- In abnormal psychology we use these tests to measure cognitive impairment (reflected in low IQ)
- DELIRIUM

Mental Retardation (Slow Learners)
Intelligence test measures abilities such as attention, perception, and memory, reasoning and verbal comprehension. Intelligence measures the ability of an individual to adapt to the environment, the ability to generate new ideas and the ability to process information efficiently.

Projective Personality Tests
Psychoanalytic personality theorists have developed several assessment measures known as projective tests. They include a variety of methods in which ambiguous stimuli, such as pictures of people, or things are presented to a person who is asked to describe what he or she sees. The theory here is that people 'project' their own personality, their needs, their wishes, their desires and their unconscious fears on other people and things such as ink blots, pictures, sometimes vague and sometimes structure. Projective tests are based on psychoanalytic theory. They have been and they still remain, controversial. Some of the most widely used projective tests are Rorschach Ink Blot Test, the Thematic Apperception Test (TAT), House Tree Person (HTP) and the Rotter's Incomplete Sentence Blank (RISB).

- In **projective tests,** the person is presented with a series of ambiguous stimuli.
- The known projective test, introduced in 1921 by Hermann **Rorschach, a Swiss psychiatrist,** is based on the use of inkblots.
- Projective techniques such as the Rorschach test were originally based on psychodynamic assumptions about the nature of personality and psychopathology.
- Considerable emphasis was placed on the importance of unconscious motivations —conflicts and impulses of which the person is largely unaware.
- More recent approaches to the use of projective tests view the person's descriptions of the cards as a sample of his or her perceptual and cognitive styles. This test consists of ten standardized ink blots. That serves as ambiguous stimuli. The examiner presents the inkblots one by one to the person being examined, who responds by telling what he or she sees. The therapists may encourage the subject to give more detailed answers and you may get different responses on the same inkblot. Exner's system of administering and scoring the Rorschach inkblot test specifies how the card should be presented, what should the examiner say and how the responses should be recorded.
- The Thematic Apperception Test (TAT) consists of a series of drawings that depict human figures in various ambiguous situations.
- The person is asked to describe the identities of the people in the cards and to make up a story about what is happening. Morgan and Murray at the Harvard Psychological Clinic developed the TAT. It consists of 31 cards, 30 with pictures on them and one blank card. The picture card is shown to the subject and the therapist asks the subject to tell a dramatic story about the picture. The instructions of the test begin 'this is a test of imagination, one form of intelligence. Let your imaginations have its way as in a fairy story and tell what the people in the picture card are doing.' The story should have a title, a beginning, a middle part and an end. The basic assumption is that most of the subjects will reveal their unconscious mental processes, their needs, desires on the characters of their stories about the pictures. Their have been several variations of the TAT for different groups e.g. CAT- Children Apperception Test and SAT A Senior Apperception Technique.

Rotter's Incomplete Sentence Blank Test

This test consists of a series unfinished sentences that people are asked to complete, usually it is considered a good spring board to explore and pinpoint areas of an individual's life that are problematic or conflicting. The sentences are usually, I wish _____. My father is _____. Girls are _____. Home is a place _____. This test explores an individual's social, familial and general attitudes towards life. This test has 40 items which are in form of incomplete sentences. This test has qualitative and quantitative scoring procedures.

House Tree and Person (HTP)

This is a test which tells us about the evaluations of the drawings based on the quality and shape of the drawing, solidity of a pencil line, location of the drawing on the paper, the size of the figure, features of the figures, use of the background and comments made by the respondent during the drawing task. The house reflects individual's interpersonal relationships, the tree reflects ego development and functioning and the person reflects the individual self perception and perception of the other gender.

Advantages of Projective Tests
1. Some people may feel more comfortable talking in an unstructured situation than they would if they were required to participate in a structured interview or to complete the lengthy MMPI.
2. Projective tests can provide an interesting source of information regarding the person's unique view of the world, and they can be a useful supplement to information obtained with other assessment tools.
3. To whatever extent a person's relationships with other people are governed by unconscious cognitive and emotional events, projective tests may provide information that cannot be obtained through direct interviewing methods or observational procedures.

Limitations of Projective Tests
1. Lack of standardization in administration and scoring is a serious problem.
2. Little information is available on which to base comparisons to normal adults or children.
3. Some projective procedures, such as the Rorschach, can be very time-consuming.
4. The reliability of scoring and interpretation tends to be low.
5. Many self-report inventories, rating scales, and behavioral coding systems have been designed for the assessment of marital relationships and family systems.
6. One popular self-report inventory is the Family Environment Scale (FES), which is composed of 90 true–false items and was designed to measure the social characteristics of families.

ASSESSMENT of PERSONALITY II

Projective Personality Tests
In **projective tests,** the person is presented with a series of ambiguous stimuli. The best known projective test, introduced in 1921 by Hermann Rorschach, a Swiss psychiatrist, is based on the use of inkblots. Projective techniques such as the Rorschach test, Thematic Apperception Test (TAT), House Tree Person (HTP) and Rotter's Incomplete Sentence Blank (RISB) were originally based on psychodynamic assumptions about the nature of personality and psychopathology.

Considerable emphasis was placed on the importance of unconscious motivations —conflicts and impulses of which the person is largely unaware. More recent approaches to the use of projective tests view the person's descriptions of the cards as a sample of his or her perceptual and cognitive styles.

The Thematic Apperception Test (TAT) consists of a series of drawings that depict human figures in various ambiguous situations. The person is asked to describe the identities of the people in the cards and to make up a story about what is happening.

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Neuropsychological Tests
Neuropsychological tell us about the problems in personality or behavior caused by neurological damage in the brain or alterations in brain activity due to head injury, brain tumors, brain malfunctions, blood vessel diseases, alcoholism and infections in the brain. Neurological problems can be detected with brain X-Rays, computerized axial tomogram CAT scan. Neuropsychological testing, measures individual's abilities in areas such as language, attention and concentration, memory, motor skills, perceptual abilities and learning. In other words, this method of testing assesses brain impairment by observing its affects on the person's ability to perform certain tasks. Although, you do not see damage, you can see its effect. A fairly simple neuropsychological test used with children is the Bender Visual Motor Gestalt Test. A child is given a series of cards on which various lines and shapes are drawn. The shapes include triangles, circle, rectangle and squares. The task is to copy what is drawn on the card. The errors on the test are compared to test results of normal children of the same age, if the number of errors exceeds a certain amount then brain impairment or dysfunction is detected. The most popular advanced test of organic damage includes Leuria Nebraska neuropsychological battery. Halstead Reitan Neuropsychological battery is another important test. The skills measured in neuropsychological test are also assessed in intelligence test. There is a great deal of over lapping in the two approaches.

There are some neuropsychological tests that help to identify neurological problems by measuring a person's cognitive, perceptual and motor skills.

1. The Bender Visual Motor Gestalt Test.
   This test consists of 9 cards, each displaying a simple design, the subject sees the designs one at a time and copy each one on piece of paper. Later they try to reproduce a design from their memory.
2. There are some other neuropsychological tests such as, Luria-Nebraska Neuropsychological Battery
3. Strength of grip test, which compares the grip of right and left hands.

Psycho-physiological Assessment
Psycho-physiology refers to measurable changes in the nervous system that reflect emotional or psychological events. The measurements may be taken either directly from the brain or from parts of the body.

- The autonomic nervous system is highly reactive to environmental events and can provide useful information about a person's internal states, such as emotion.
- Recording procedures have been developed to measure variables such as respiration rate, heart rate, and skin conductance.
- As the person becomes aroused, activity levels change in these systems.
- Psycho-physiological measures can therefore, provide sensitive indices of the person's internal state.
- It must be emphasized, however, that all of these measures do not act together.
- If several physiological responses are measured at the same time, they may not all demonstrate the same strength, or even direction, of response.
- Moreover, physiological measures frequently disagree with the person's own subjective report.
- Therefore, as with other assessment procedures, physiological recordings should be used in conjunction with other measures. EEG electroencephalogram, measuring electrical activity in the brain related to the firing of specific groups of neurons reveals brain wave activity. The low voltage electrical current going in the brain can be directly observed by EEG patterns. The EEG is one of the primary diagnostic tools for measuring seizure disorders.

Galvanic Skin Response (GSR)
A galvanometer with sensitive electrodes is attached to the forehead or palms of the hands, gives reading when sweat breaks out as an individual is passing through an emotional state. So GSR is a measure of sweat glands activity controlled by peripheral nervous system. In certain disorders such as Post Traumatic Stress Disorder the patient experiences severe emotional reaction, which is directly measured by GSR.

Biofeedback
In biofeedback, the levels of physiological responding such as blood pressure, readings are told to the patient provided by BP apparatus so that client can try to control his blood pressure without the readings being provided. So biofeedback teaches, the client to control blood pressure, heart beat, body temperature and physical pain by gaining conscious control over involuntary indicators . Those who master it are called Swami's.

Advantages of Physiological Procedures
1. Psycho-physiological recording procedures do not depend on self-report and, therefore, may be less subject to voluntary control.
2. Some of these measures can be obtained while the subject is sleeping or while the subject is actively engaged in some other activity.

Limitations of Physiological Procedures
1. The recording equipment and electrodes may be frightening or intimidating to some people.
2. There are generally low correlations between different autonomic response systems.

3. Physiological reactivity and the stability of physiological response systems vary from person to person.
4. Physiological responses can be influenced by many other factors. Some are person variables, such as age and medication, as well as psychological factors, such as being self-conscious or fearing loss of control.

Brain Imaging Techniques

- Precise measures of brain structure can be obtained with **magnetic resonance imaging (MRI).**
- In MRI, images are generated using a strong magnetic field rather than X rays.
- **Positron emission tomography (PET)** is one scanning technique that can be used to create functional brain images.
- This procedure is much more expensive than the other imaging techniques because it requires a nuclear cyclotron to produce special radioactive elements.
- The newest and most exciting method of imaging brain functions involves **functional MRI (FMRI).**
- In FMRI, a series of images is acquired in rapid succession.
- Small differences in signal intensity from one image to the next provide a measure of moment-to-moment changes in the amount of oxygen in blood flowing to specific areas of the brain.

Advantages of Brain Imaging Techniques

1. In clinical practice, imaging techniques can be used to rule out various neurological conditions that might explain behavioral or cognitive deficits.
2. Procedures such as FMRI and PET can help research investigators explore the relation between brain functions and specific mental disorders.

Limitations of Brain Imaging Techniques

1. These procedures are relatively expensive—especially PET scans and FMRI—and some procedures must be used cautiously because the patient may be exposed to radioactive substances.

We should not assume that all cognitive processes, emotional experiences, or mental disorders are necessarily linked to activity (or the absence of activity) in a specific area of the brain.

PSYCHOTHERAPY I

Psychotherapy refers to special and systematic process for helping people to overcome their psychological difficulties.

Example: Some psychological difficulties include anxiety, fear and phobia. All forms of Psychotherapy have three things in common:

     1- Sufferer who seeks help whom we call patient or client
     2- A healer who is the therapist and
     3- A series of contacts between the client and therapist (number of sessions between the client and the therapist)

A system of therapy is a set of principles and techniques employed in accordance with a particular theory of change. As many as 400 distinct forms of therapy are being practiced today. Two broad categories are

1. Global Therapies
Global therapies help people recognize and change general features of their personalities that the therapist believe are the root cause of their problem. They are

- Psychodynamic or psychoanalytic
- Humanistic
- Existential
- Client centered therapy
- Gestalt

2. Problem Focused Therapies
Problem focused therapies focus on the symptoms and specific complaints of the person. They include

- Behavioral therapies
- Cognitive therapies
- Biological therapies

Therapy format is
- Individual therapy
- group therapy
- family therapy
- Couple therapy

Individual therapy is in which the therapist sees the alone for some period of time usually weekly.

Group therapy is in which the therapist sees the group of clients such as psychodrama and self help groups.

Family therapy is a format in which the therapists meet with all members of family and point out problematic behavior and interactions and work on whole family to change.

In **couple therapy** the therapist works with two people who share a long term relationship.

Whether the psychotherapy is beneficial or not

The critical question to be asked is about all these psychotherapies treatments is whether or not they actually help people to cope with and overcome their psychological problems.
What do you say?
What do you think?

Four general conclusions have been reached

1- People in therapy are better off than people with similar problems who receive no treatment.
2- Various therapies do appear to differ in their effectiveness.
3- Certain therapies appear to be effective than others for certain disorders
4- A combination of therapy approaches is more effective than a single approach in treatment of certain disorders.

Important Concerns of Psychotherapy
- Psychotherapy is the use of psychological techniques and the therapist–client relationship to produce emotional, cognitive, and behavioral change.
- Today, the largest group of mental health professionals describe themselves as eclectic, meaning they use different treatments for different disorders.

- Psychotherapy outcome research examines whether and when treatments are effective, while psychotherapy process research searches for the "active ingredients" in psychotherapy, that is, the therapeutic activities that promote positive change.
- Research shows that therapy is more effective when therapists appropriately reveal a bit about their own, similar struggles.

- Unfortunately, some therapists do not offer or even educate their clients about more and less effective treatments, and there is an even bigger problem: Most people who need it do not get *any* psychological help.
- Eighty-seven percent of people with a diagnosable mental disorder have *not* received treatment in the past year, including many people with common, severe, and treatable disturbances.

- Therapists working within the biological, psychodynamic, cognitive behavioral, and humanistic paradigms would approach treatment and evaluate a mentally ill person in very different ways.

TABLE 3–1 Comparison of Biological, Psychodynamic, Behavioral, and Humanistic Treatments

Topic	Biological	Psychodynamic	Behavioral	Humanistic
Goal of treatment:	Alter biology to relieve psychological distress	Gain insight into defenses/ unconscious motivations	Learn more adaptive behaviors/cognitions	Increase emotional awareness
Primary methods:	Diagnosis, medication	Interpretation of defenses	Instruction, guided learning, homework	Empathy, support, exploring emotions
Role of therapist:	Active, directive, diagnostician	Passive, nondirective, interpreter (may be aloof)	Active, directive, nonjudgmental, teacher	Passive, nondirective, warm, supporter
Length of treatment:	Brief, with occasional follow-up visits	Usually long term; some new short-term treatments	Short term, with later "booster" sessions	Varies; length not typically structured

Brief Historical Perspective

- We can trace the roots of the treatment of psychological disorders to two broad traditions of healing: the spiritual/religious tradition and the naturalistic/scientific tradition.
- The spiritual/religious tradition is an ancient one that attributes both physical and mental ailments to supernatural forces.
- We see in our culture that people go to saints, faqirs and peers for dam and dua.
- One of the earliest examples of this tradition is the practice of trephining—chipping a hole through the unfortunate sufferer's skull with a crude stone tool—presumably, to allow evil spirits to escape.
- The influence of spiritual beliefs and rituals should not be ignored since believing is a powerful part of healing.
- Naturalistic/scientific approaches to helping the mentally disturbed also have ancient roots.
- Hippocrates recommended treatments such as rest, exercise, and a healthy diet.
- In the 1600s, "insane asylums" were developed as a new treatment for the mentally ill.
- One rationale for these institutions was to remove disturbed individuals from society; another was the hope that rest and isolation would alleviate their bizarre behavior.
- General paresis is an example not only of the hope of the biological approach to etiology and treatment but also of the medical model of research.
- First, a diagnosis is developed and refined.
- Second, clues about causes are put together like pieces of a puzzle to form a picture of the specific etiology of the disease.
- Third, scientists experiment with various treatments for preventing or curing the disorder until they find an effective treatment.
- Most mental disorders appear to be caused by many factors.
- Because of this, scientists often search for biological treatments without knowing a disorder's specific cause.
- These treatments focus on *symptom alleviation,* reducing the dysfunctional symptoms of a disorder but not eliminating its root cause.

1-Electroconvulsive Therapy

- Electroconvulsive therapy (ECT) involves deliberately inducing a seizure by passing electricity through the brain.
- Approximately 100 volts of electric current is passed through a patient's brain in *bilateral ECT,* where electrodes are placed on the left and right temples, and the current passes through both brain hemispheres.
- In *unilateral* ECT, the electric current is passed through only one side of the brain, the non-dominant hemisphere.
- ECT can be effective in treating severe depressions that do not respond to other treatments, especially for a patient at high risk for suicide.

2-Psychosurgery

- Psychosurgery is a controversial biological treatment, as it involves the surgical destruction of specific regions of the brain.
- Prefrontal lobotomy is a procedure in which the frontal lobes of the brain are surgically and irrevocably severed.

- The procedure has limited effectiveness and causes frequent and severe side effects, including a significant mortality rate, excessive tranquility, and the absence of emotional responsiveness.
- Although prefrontal lobotomies are no longer performed, some forms of highly circumscribed psychosurgery are used today to treat severe disorders.

3-Psychopharmacology

- Psychopharmacology—the study of the use of medications to treat psychological disturbances—has been the most promising avenue of biological treatment.

- In recent years, scientists have developed new medications that have increasingly specific effects on emotional states and mental disorders.

- There is a variety of psychotropic medications, chemical substances that affect psychological state.
- The success of psychopharmacology is evident in the expanding development and use of psychotropic medications.
- Evidence indicates that medication often is an effective and safe treatment for many mental disorders.

- Although psychotropic medications do not cure underlying causes, symptom alleviation is extremely important.
- All medications have side effects, some of which are very unpleasant.
- Partly as a result of unpleasant side effects, many patients do not take their medication as prescribed, and they may experience a relapse as a result.
- Many psychotropic drugs must be taken for long periods of time.
- Despite the effectiveness of many psychotropic medications, we share some concerns that we sometimes look to medication to solve problems that may have psychological or social roots.
-

4- Hypnosis
- An early influence on the psychodynamic approach to therapy was Joseph Breuer, who used hypnosis to induce troubled patients to talk freely about problems in their lives.
- Upon awakening from a hypnotic trance, many patients reported relief from their symptoms.
- Breuer attributed their improvement to catharsis, the release of previously unexpressed feelings, pent up emotion that Breuer assumed was responsible for his patients' psychological problems. (covered in lecture 21)

PSYCHOTHERAPY II

Global Therapies
Following are the global therapies-which help people to recognize and change features of their personality that are the root of their problem.

- Psychodynamic
- Humanistic
- Existential
- Gestalt

Problem based therapies
Problem based therapies focus on the symptoms and specific complaints. It includes cognitive, behavioral and biological therapies.

Psychoanalytic therapy
Psychoanalytic therapy focuses on the unconscious motives, repressed wishes and childhood experiences
Techniques of psychoanalysis includes

- Free association, dream analysis, analysis of resistance , transference
- Positive transference
- Negative transference
- Ambivalent transference
- Counter transference

Humanistic therapies
Humanistic therapists help their clients to look at them selves and their situations more accurately and acceptingly with the aim of actualizing their full potential as human beings.
Focus on self actualization. Client centered therapy tries to create a very supportive climate in which clients can see themselves more honestly and begin to accept what they discover themselves to be.

Gestalt therapy
Gestalt therapy make clients recognize and accept their needs through techniques of role playing, exercises and games.

Existential therapies
Existential therapists form close relationships with clients and encourage them to accept responsibility for their lives, to recognize their freedom to choose a different course of action.
Existential neurosis: When a person suffers from meaninglessness in life.

Behavioral therapies
The goal of behavioral therapies is to identify the client's problem causing behaviors and to replace them with more appropriate ones.
- Aversion
- Flooding/ implosion
- Systematic desensitization

Cognitive therapies
Cognitive therapies based on the premise that abnormal functioning is caused by maladaptive assumptions and thoughts.

•Rational emotive behavioral therapy

•Beck's cognitive therapy

Biological therapies
Biological therapies include physical, chemical methods developed to help overcome their psychological problems

- Psychopharmacology
- ECT
- Psychosurgery

Psychoanalytic Therapy
Psychodynamic therapists believe that today's mental disorder is the result of yesterday's emotional trauma.

- Focus is on childhood experiences as agents of mental disorders
- From Freudian psychoanalysis to modern therapies all are based on object relations theory or self theory.
- The goal of psychodynamic therapy is
- to help clients uncover past traumatic events and the inner conflicts that have resulted from them
- To resolve, settle these conflicts
- To resume the interrupted personal development

- The psychodynamic therapy is considered the insight therapy
- This process of gaining insight is not to be rushed or imposed
- The therapist must guide the therapeutic discussions so that the clients must discover for themselves

Techniques of psychoanalysis
The techniques of psychoanalysis include

•Free association

•Dream analysis –interpretation of dreams

•Slip of tongue-- psychopathology of everyday life

• slip of pen

•Transference

•Positive transference

•Negative transference

•Counter transference

•Catharsis—sweeping the chimney phenomena

Freudian Psychoanalysis

- Breuer's collaborator, Sigmund Freud, adopted the hypnotic method for a time, but he soon concluded that hypnosis was not necessary to encourage open expression.
- Instead, Freud used a method called free association, in which he simply told his patients to speak freely about whatever thoughts crossed their mind, without censoring them. Usually due to unconscious control blocking and resistance results. when a client says that I forgot that I had an appointment with you or I can not recall events of the past, well he is being defensive, guarded and he is resisting self disclosure.

- This method of Free Association became a cornerstone of Freud's famous treatment, psychoanalysis.
- The true benefit of free association, in Freud's view, was that it revealed aspects of the unconscious mind.
- Freud also believed that dreaming and slips of the tongue (now called Freudian slips) provided especially revealing information about the unconscious.
- Thus, according to Freud, free association, dreams, and slips of the tongue are valuable because they serve as "windows into the unconscious."
- The ultimate goal of psychoanalysis is to bring formerly unconscious material into conscious awareness.
- This is what Freud called insight.
- Freud asserted that insight is sufficient for curing psychological disorders.
- The analyst's main tool for promoting insight is interpretation.
- In offering an interpretation, the analyst suggests hidden meanings to patients' accounts of their past and present life.
- One essential element in probing the unconscious mind and offering interpretations is therapeutic neutrality.
- Psychoanalysts maintain a distant stance toward their patients in order to minimize their influence on free association.
- The analyst's distant stance is thought to encourage transference, the process whereby patients transfer their feelings about some key figure in their life onto the shadowy figure of the analyst.
- Insight into the transference relationship presumably helps patients understand how and why they are relating to the analyst in the same dysfunctional manner in which they related to a loved one.
- A common misconception about psychoanalysis is that the ultimate goal of insight is to rid the patient of all defenses.
- According to Freud, defenses are essential for the functioning of a healthy personality.
- Thus, rather than ridding the patient of defenses, one goal of psychoanalysis is to replace them.
- Defenses such as denial and projection are confronted because they distort reality dramatically, whereas "healthier" defenses, such as rationalization and sublimation, are left unchallenged.
- A second goal of psychoanalysis is to help patients become more aware of their basic needs or drives so that they may find socially and psychologically appropriate outlets for them.

The Decline of Freudian Psychoanalysis

Because psychoanalysis requires substantial time, expense, and self-exploration, it is accessible only to people who are relatively well functioning, introspective, and financially secure.
In many respects, psychoanalysis now is viewed as a process of self-understanding, not a treatment for specific emotional disorders.

Although Freudian psychoanalysis has declined greatly, the approach spawned numerous therapeutic variations broadly referred to as psychodynamic psychotherapy.
Psychodynamic psychotherapists often are more engaged and directive in therapy and treatment may be relatively brief in comparison to psychoanalysis.

PSYCHOTHERAPY III

The Decline of Freudian Psychoanalysis
Although Freudian psychoanalysis has declined greatly, the approach spawned numerous therapeutic variations broadly referred to as **psychodynamic psychotherapy.**

Ego Analysis
Ego analysis originated in the work of a number of therapists trained in psychoanalysis but who developed somewhat different theories and techniques.
Whereas Freud emphasized the role of the id, these new theorists focused much more on the ego.
The patient's past and present interpersonal relationships are of greatest importance according to Harry Stack Sullivan, an influential ego analyst.

Other influential ego analysts include **Erik Erikson** and **Karen Horney**.

Horney's lasting contribution was her view that people have conflicting ego needs: to move toward, against, and away from others.
Erikson introduced the argument that an individual's personality is not fixed by early experience but continues to develop as a result of predictable psychosocial conflicts throughout the life span.

John Bowlby's **attachment theory** perhaps has had the greatest effect on contemporary thought about interpersonal influences on psychopathology.
Unlike Freud, Bowlby elevated the need for close relationships to a primary human characteristic.

Psychodynamic Psychotherapy
The approaches of the ego analysts seek to uncover hidden motivations and emphasize the importance of insight. However, psychodynamic psychotherapists are much more actively involved with their patients. They are more ready to direct the patient's recollections, to focus on current life circumstances, and to offer interpretations quickly and directly.

Short-term psychodynamic psychotherapy is a form of treatment that uses many psychoanalytic techniques.
Therapeutic neutrality is typically maintained, and transference remains a central issue, but the short-term psychodynamic therapist actively focuses on a particular emotional issue rather than relying on free association.

Cognitive Behavior Therapy
Cognitive behavior therapy involves teaching new ways of thinking, acting, and feeling using different, research-based techniques. In contrast to the psychodynamic approach, cognitive behavior therapists focus on the present and on behavior, adhering to the concept that, "Actions speak louder than words."

The beginnings of behavior therapy can be traced to John B.Watson's

Watson viewed the behavior therapist's job as being a teacher. The therapeutic goal is to provide new, more appropriate learning experiences. More recently, behavior therapy has been extensively influenced by the findings of cognitive psychology.

Cognitive behavior therapy is a practical approach oriented to changing behavior rather than trying to alter the dynamics of personality. One of the most important aspects of cognitive behavior therapy is its embrace of empirical evaluation. This anxiety hierarchy places situations in increasing order of fearfulness. The patient does not have to confront the hierarch items physically but, after relaxation, the patient imagines the each situation in turn until no anxiety is felt.

The behavioral therapists claim high transfer from imagined to real.

Systematic Desensitization
Systematic desensitization is a technique for eliminating fears that has three key elements.
The first is relaxation training using *progressive muscle relaxation,* a method of inducing a calm state through the tightening and subsequent relaxation of all of the major muscle groups.

The second is the construction of a *hierarchy of fears* ranging from very mild to very frightening, a ranking that allows clients to confront their fears gradually.
The third part of systematic desensitization is the *learning process,* namely, the gradual pairing of ever-increasing fears in the hierarchy with the relaxation response.

Systematic desensitization involves imagining increasingly fearful events while simultaneously maintaining a state of relaxation.
Evidence shows that systematic desensitization can be an effective treatment for fears and phobias, but it is not clear whether classical conditioning accounts for the change.

Other Exposure Therapies
Although many factors contribute to effective cognitive behavior therapy, most investigators agree that exposure is the key to fear reduction.

Vivo **desensitization** involves gradually confronting fears in real life simultaneously maintaining a state of relaxation while **Flooding** involves helping clients to confront their fears at full intensity.

Case: person suffers from snake phobia
Technique: Systematic Desensitization
Steps involved
       1- Relaxation exercise
       2- Phobia hierarchy
       3- Gradual confrontation of Phobia hierarchy in imagination
Example
The patient is relaxed
    1- Show picture of snake
    2- Movies of snake
    3- Zoo where sees snakes
    4- Visit a snake charmer
    5- Handle a snake with gloves
    6- Handle snake without gloves
At every step the patient should be relaxed otherwise the session can not proceed.

Aversion Therapy
The goal in **aversion therapy** is to use classical conditioning to create, not eliminate, an unpleasant response. The technique is used primarily in the treatment of substance use disorders such as alcoholism and cigarette smoking. Aversion treatments often achieve short-term success, but relapse rates are high.

Aversion therapy is used to treat inappropriate or excessive attraction to people or objects such as excessive alcohol consumption or Smoking or overeating
Presentation of the stimulus in reality is accompanied by an aversive stimulus with an electric shock or drug induced nausea. Individual is forced to give up alcohol.

Contingency Management
Contingency management is an operant conditioning technique that directly changes rewards and punishments for identified behaviors.

A **contingency** is the relationship between a behavior and its consequences; thus, contingency management involves changing this relationship.

The goal of contingency management is to reward desirable behavior systematically and to extinguish or punish undesirable behavior.

Token economy

The **token economy** is an example of contingency management that has been adopted in many institutional settings. In a token economy, desired and undesired behaviors are clearly identified, contingencies are defined, behavior is carefully monitored, and rewards or punishments are given according to the rules of the token economy.

Tokens are specialized currency that can be exchanged for food or other goods or privileges.

Example

The token economy program can be applied in a class room where children were behaving disruptively or doing poorly in their studies.

The children earned tokens when they did well on daily reading tests or successfully performed other targeted behaviors they could then exchanged these   rewards (token) such as extra recess time or seeing a movie

Research shows that contingency management successfully changes behavior for diverse problems such as institutionalized clients with schizophrenia and juvenile offenders in group homes.

However, improvements often do not generalize to real life situations where the therapist cannot control rewards and punishments.

Time out

The **time out** is another technique of contingency management

When a child is involved in an inappropriate behavior such as using abusive language or stealing or lying he is asked to go to his room and stay there alone and not permitted to go out to friends or party.

Modeling

The **modeling** is technique pioneered by Albert Bandura. The basic design is for therapist to demonstrate appropriate behaviors for clients, who through a process of imitation and rehearsal, then acquire the ability to perform the behaviors in their own lives.

Therapists model new emotional responses for clients.

Example therapists calmly handle snakes to show snake phobic clients that it is possible to be relaxed in the presence of these animals. After several modeling sessions, clients themselves are encouraged to interact with snakes.

Social Skills Training

The goal of **social skills training** is to teach clients new ways of behaving that are both desirable and likely to be rewarded in everyday life.

Two commonly taught skills are assertiveness and social problem solving.

The goal of **assertiveness training** is to teach clients to be direct about their feelings and wishes.

Social problem solving is a multi-step process that has been used to teach children and adults ways to go about solving a variety of life's problems.

The first step involves assessing and defining the problem in detail, breaking a complex difficulty into smaller, more manageable pieces.

"Brainstorming" is the second step in social problem solving.

The third step involves carefully evaluating the options generated during brainstorming.

Finally, the best solution is chosen and implemented, and its success is evaluated objectively.

If the option does not work, the entire process can be repeated until an effective solution is found.

Cognitive Techniques
All of the cognitive behavior therapies we have discussed so far have foundations in either classical or operant conditioning. More recent techniques are rooted in cognitive psychology.

One example is **attribution retraining**, which is based on the idea that people are "intuitive scientists" who are constantly drawing conclusions about the causes of events in their lives. These perceived causes, which may or may not be objectively accurate, are called attributions. Attribution retraining involves trying to change attributions, often by asking clients to abandon intuitive strategies. Instead, clients are instructed in more scientific methods, such as objectively testing hypotheses about themselves and others.

Self-instruction training is another cognitive technique that is often used with children. In Meichenbaum's self-instruction training, the adult first models an appropriate behavior while saying the self-instruction aloud. This procedure is designed as a structured way of developing *internalization,* helping children to learn internal controls over their behavior.

Beck's Cognitive Therapy
Aaron Beck's **cognitive therapy** was developed specifically as a treatment for depression.
Beck suggested that depression is caused by errors in thinking.
These hypothesized distortions lead depressed people to draw incorrect, negative conclusions about themselves, thus creating and maintaining the depression.

Beck's cognitive therapy involves challenging these negative distortions by gently confronting clients' cognitive errors in therapy, and asking clients to see how their thinking is distorted based on their own analysis of their life.

Rational-Emotive Therapy
Albert Ellis's **rational–emotive therapy (RET)** is also designed to challenge cognitive distortions.
According to Ellis, emotional disorders are caused by *irrational beliefs,* absolute, unrealistic views of the world.
The rational–emotive therapist searches for a client's irrational beliefs, points out the impossibility of fulfilling them, and uses any and every technique to persuade the client to adopt more realistic beliefs.

Integration and Research
What unites cognitive behavior therapists is a commitment to research, not to a particular form of treatment.
Cognitive behavior therapists have been vigorous in conducting psychotherapy outcome research, and they generally embrace any treatment with demonstrated effectiveness.

For this reason, we envision what is now called cognitive behavior therapy as becoming the integrated, systems approach to treatment, as more and more therapists offer eclectic but effective treatments for different disorders.

Effectiveness of behavioral approaches
- They seem more effective because they focus on symptom removal which is easier to observe and measure as in case of phobias than in self actualization.
- The duration of the therapy is short.
- The cost in terms of money and manpower is low.

Limitations of behavioral therapies
- The improvements learned in clinic or hospital settings do not extend to real life situations.

- These therapies do not appear to be particularly effective with complex, broad and vaguely defined disorders.
- Token economy being used without their permission raises ethical questions.

PSYCHOTHERAPY IV

Humanistic Psychotherapy
Humanistic psychotherapy originally was promoted as a "third force" in psychotherapy. Humanistic therapists believe that that each of us has the responsibility for finding meaning in our own lives.

Therapy is seen only as a way to help people to make their own life choices and resolve their own dilemmas. To help clients make choices, humanistic therapists strive to increase emotional awareness. Given the emphasis on emotional genuineness, humanistic psychotherapists place a great deal of importance on the therapist–client relationship.

Most other approaches also recognize the importance on the therapist–client relationship, but they view the relationship primarily as a means of delivering the treatment.
In humanistic therapy, the relationship is the treatment.

Client-Centered Therapy
Carl Rogers and his client-centered therapy provide a clear example of the humanistic focus on the therapeutic relationship. Rogers wrote extensively about the process of fostering a warm and genuine relationship between therapist and client. He particularly noted the importance of **empathy,** or emotional understanding.

Empathy involves putting yourself in someone else's shoes and conveying your understanding of that person's feelings and perspectives. The client-centered therapist does not act as an "expert" who knows more about the client than the client knows about himself or herself. Rather, the therapeutic goal is to share honestly in another human's experience.

Rogers encouraged self-disclosure on the part of the therapist, intentionally revealing aspects of the therapist's own, similar feelings and experiences as a way of helping the client. Rogers also felt that client-centered therapists must be able to demonstrate unconditional positive regard for their clients.

Unconditional positive regard involves valuing clients for who they are and refraining from judging them. Because of this basic respect for the client's humanity, client-centered therapists avoid directing the therapeutic process.

According to Rogers, if clients are successful in experiencing and accepting themselves, they will achieve their own resolution to their difficulties. Thus client-centered therapy is nondirective.

Gestalt therapy
Gestalt therapy is a humanistic form of treatment developed by Perls. Perls viewed life as a series of figure-ground relationships. For example a picture is hanging on a wall. The picture is a figure and the wall is the background. For a healthy person current needs can be perceived clearly in that person's life, just as figure can be perceived against a distinct ground (background).when current needs are satisfied, they fade into the ground and are replaced by new needs, which stand out in their turn and are equally recognizable.

Perls believed that mental disorders represent disruptions in these figure- ground relationships. People who are unaware of their needs or unwilling to accept or express them are avoiding their real inner selves. They lack self awareness and self acceptance, they fear judgment of others. The technique of role playing that is to act out various roles assigned by the therapist.
Role reversal
Clients are told to talk as the other person and feel as the other person.
Example: employee-/employer, or mother /daughter.

Existential therapy

Existential therapists encourage clients to accept responsibility, for their lives and for their problems, to recognize their freedom to choose a different course and to choose to live an authentic life, one full of meaning and values. The therapist and client must be open to each other, work hard together, and try to share, learn and grow. The therapist pushes hard for the client to accept responsibility for her choices in therapy and life.

A Means, Not an End?

Little research has been conducted on whether or not humanistic therapy is an effective treatment for abnormal behavior.

- Psychotherapy process research shows that the bond or **therapeutic alliance** between a therapist and client is crucial to the success of therapy—no matter what approach is used.
- A therapist's caring, concern, and respect for the individual are important to the success of *all* treatments for psychological disorders.
- Psychotherapy *outcome* research shows that psychotherapy *does* work—for many people and for many problems.
- Psychotherapy *process* research indicates that most approaches to psychotherapy share many "active ingredients" and these commonalities contribute to making most types of treatment at least somewhat helpful.
- Contemporary research demonstrates more and more that different treatments are more effective for helping different disorders.

Does Psychotherapy Work?

Psychotherapy outcome research examines the outcome, or result, of psychotherapy—its effectiveness for relieving symptoms, eliminating disorders, and/or improving life functioning.
Hundreds of studies have compared the outcome of psychotherapy with alternative treatments or with no treatment at all.

In order to summarize findings across all of these studies, psychologists have invented a new statistical technique called **meta-analysis,** a statistical procedure that allows researchers to combine the results from different studies in a standardized way.
Meta-analysis indicates that the average benefit produced by psychotherapy is .85 standard deviation units.

The statistic indicates that the average client who receives therapy is better off than 80 percent of untreated persons.
A .85 standard deviation change also shows that roughly two-thirds of clients who undergo psychotherapy improve significantly, whereas about one-third of people who receive no treatment improve over time.

Thus, we can conclude that therapy "works," but you should remember a very important qualification: Research shows that many benefits of psychotherapy diminish in the year or two after treatment ends.

Do People Improve without Treatment?

Psychologists widely accept that about two-thirds of clients improve in the short term as a result of psychotherapy.
Some skeptics have suggested, however, that far more than one-third of untreated emotional disorders have a *spontaneous remission,* that is, the problems may improve without any treatment at all.

It is hard to know how many people with psychological problems improve without treatment.
Researchers have found that as many as one-half of people seeking psychotherapy improve as a result of simply having unstructured conversations with a professional.

The Placebo Effect
Placebos are any type of treatment that contains no known active ingredients for treating the condition being evaluated.
The **placebo effect,** the powerful healing produced by apparently inert treatments, has been demonstrated widely and repeatedly in psychotherapy, dentistry, optometry, cardiovascular disease, cancer treatment, and even surgery.

Experts agree that many of the benefits of physical and psychological treatments are produced by placebo effects, which apparently are caused by the recipient's belief in a treatment and expectation of improvement. Research shows that the "active ingredients" in placebos include heightened expectations for improvement and classical conditioning owing to past, successful treatment.

Placebo Control Groups
The ultimate goal of treatment research is to identify therapies that produce change above and beyond placebo effects.
Many investigations in medicine and psychotherapy include *placebo control groups* in which patients are given treatments that are intentionally designed to have no active ingredients.

The **double-blind study** is a study in which neither the physician nor the patient knows whether the prescribed pill is the real medication or a placebo.
Unfortunately, a double-blind study cannot be used in psychotherapy outcome research.

Efficacy and Effectiveness

Tightly controlled experiments provide important information about the *efficacy* of psychotherapy, that is, whether the treatment *can* work under prescribed circumstances.
However, such studies provide little information about the *effectiveness* of the treatment—whether the therapy *does* work in the real world.

The magazine *Consumer Reports* (1995, November) surveyed nearly 3,000 readers who had seen a mental health professional in the past three years, and the respondents generally rated psychotherapy highly.
Of the 426 people who were feeling "very poor" at the beginning of treatment, 87 percent reported feeling "very good," "good," or at least "so-so" when they were surveyed.

When Does Psychotherapy Work?
What predicts when treatment is more or less likely to be effective?
- The most important predictor is the nature of a client's problems—the diagnosis.
- If therapy is going to be effective, it usually will be effective rather quickly.
- Clients' background characteristics also predict outcome in psychotherapy.
- The acronym YAVIS was coined to indicate that clients improve more in psychotherapy when they are "young, attractive, verbal, intelligent, and successful."
- This finding has caused considerable concern, for it seems to indicate that psychotherapy works best for the most advantaged members of our society.
- Another concern is that men are considerably less likely than women to seek therapy.
- The masculine role seems to discourage appropriate help seeking.

Psychotherapy Process Research
Psychotherapy process research is an approach that examines what aspects of the therapist–client relationship predict better outcome.
A classic study by Sloane and colleagues found that the different paradigms share some surprising similarities.

In this study, 90 patients who had moderate difficulties with anxiety, depression, or similar problems were assigned at random to receive either psychodynamic psychotherapy, behavior therapy, or no treatment.

All three groups, including the no-treatment group, improved over time, but the treated groups improved significantly more than the untreated group.
Behavior therapy was more effective in a few instances, but on most measures, there were no differences between the two treatment groups.
Much of the effectiveness of different forms of psychotherapy is explained by common factors.

TABLE 3–4 Common Factors in Effective Brief Psychotherapies

1. Treatment is offered soon after the problem is identified.
2. Assessment of the problem is rapid and occurs early in treatment.
3. A therapeutic alliance is established quickly, and it is used to encourage change in the client.
4. Therapy is designed to be time-limited, and the therapist uses this to encourage rapid progress.
5. The goals of therapy are limited to a few specified areas.
6. The therapist is directive in managing the treatment sessions.
7. Therapy is focused on a specific theme.
8. The client is encouraged to express strong emotions or troubling experiences.
9. A flexible approach is taken in the choice of treatment techniques.

Source: Adapted from M.P. Koss and J.M. Butcher, 1986, Research on brief psychotherapy. In S.L. Garfield and A.E. Bergin (Eds.), *Handbook of Psychotherapy and Behavior Change*, 3rd ed., pp. 627–670. New York: Wiley.

Therapy as Social Support

The therapist–client relationship is one essential common factor across different approaches to therapy. Carl Rogers argued that warmth, empathy, and genuineness formed the center of the healing process, and research on psychotherapy process indicates that a therapist's supportiveness is related to positive outcomes across approaches to treatment.

Objective indicators of a therapist's support are less potent predictors of successful outcome than are a client's rating of the therapist.
Clients may perceive different therapeutic stances as supportive, depending on the particular types of relationships with which they are most comfortable.

Therapy as Social Influence

Psychotherapy is a process of social influence as well as of social support.
Jerome Frank, an American trained in psychology and psychiatry, argued that, in fact, psychotherapy is a process of persuasion—persuading clients to make beneficial changes in their emotional lives.
Psychotherapy process research clearly demonstrates the therapist's social influence.

Psychotherapy is not value free.
There are values inherent in the nature of therapy itself—for example, the belief that talking is good.
Moreover, the values of individual therapists about such topics as love, marriage, work, and family necessarily influence clients.

Couples Therapy or Marital Therapy

Couples therapy involves seeing intimate partners together in psychotherapy.
The goal of couple's therapy typically is to improve the relationship, and not to treat the individual.
Couples therapists typically help partners to improve their *communication* and *negotiation* skills.

Research shows that couples therapy can improve satisfaction in marriages.
When couples therapy is used in conjunction with individual treatment, the combined approach often is more effective than individual therapy alone.

Family Therapy

Family therapy might include two, three, or more family members in a treatment designed to improve communication, negotiate conflicts, and perhaps change family relationships and roles.
Parent management training is an approach that teaches parents new skills for rearing troubled children.
In conjoint family therapy, the therapist focuses on communication to the family system, helping members recognize harmful patterns of communication appreciate the impact of such patterns on other family members and change the patterns. A therapist helps a mother, father, and a son to identify their faulty communication patterns and to modify them for help.

As with individual and couples therapy, there are many different theoretical approaches to family therapy.
Many approaches to family therapy are distinguished, however, by their longstanding emphasis on systems theory.

In applying systems theory, family therapists emphasize interdependence among family members and the paramount importance of viewing the individual within the family system.
A common goal in systems approaches to family therapy is to strengthen the alliance between the parents, to get parents to work together and not against each other.
Group therapy involves treating a collection of people with similar emotional problems
Psychodrama and self help groups
Psychodrama was pioneered by Moreno.
Group members act out dramatic roles as if they are participants or actors in a drama.
There is a stage, background scenery, audience, director (therapist) and supporting actors or auxiliary egos.
The techniques of psychodrama include role playing, role rehearsal, role reversal, the magic shop and the mirroring technique. In role reversal, two group members play each other's role such as the role of an employee an employer, father / son, teacher and student. In magic shop, participants exchange one of their undesirable personal characteristics for a quality that they desire.
In mirroring technique, the group member portrays another individual thus showing how he or she appears to others. Just as a mirror, gives a reflection, of our own image.

Self Help Groups
They are made up of people, who have similar problems and they come together to help and support one another with the direct leadership of a clinician. These groups help people in problems like compulsive gambling, alcoholism, rape victims, divorced people, etc. In the self help groups, they encourage more people to help among others by members, so a veteran member of an existing self help group is assigned a number of new members to be helped.

Encounter Groups
Encounter groups or sensitivity groups develop with Carl Rodgers client center therapy and with Perls Gestalt therapy. In encounter groups all the members are strangers and the leader is the therapist. The groups consists of some six to eleven people smaller the group, more the interaction. Larger the group, less is the interaction. Encounter groups do not provide therapy. They provide help with greater understanding

of group processes and group interaction. Encounter groups are sponsored by employers to improve their employee work performance.

Group Therapy

Group therapy involves treating a collection of several people who are facing similar emotional problems or life issues.
Psycho-educational groups are designed to teach group members specific information or skills relevant to psychological well-being.
In **experiential group therapy** the relationships formed between group members in a unique setting become the primary mode of treatment.

In an **encounter group**, group members may question self-disclosure when it is "phony" but support more honest appraisals of oneself.
Self-help groups bring together people who face a common problem and who seek to help themselves and each other by sharing information and experiences.

Technically, self-help groups are not therapy groups, because typically a professional does not lead them.
Available evidence suggests that self-help groups can be beneficial even when they are delivered by **paraprofessionals**—people who do have limited professional training, but who have personal experience with the problem.

Prevention

Community psychology is one approach within clinical psychology that attempts to improve individual well-being by promoting social change.
Primary prevention tries to improve the environment in order to prevent new cases of a mental disorder from developing.
In primary prevention, community workers focus on improving community attitudes and policies with the goal of preventing mental disorders. They work hard in providing recreational programs such as providing parks for people or child care facilities, or help the school board to formulate the curriculum or offer public workshops on stress reduction.
The community workers may consult school teachers, ministers, or police officers to teach them how to involve persons in treatment. They may also offer 'hotlines' or walk in clinics that encourage individuals to make early treatment contacts before their immediate psychological difficulties become extended.
Tertiary prevention may involve any of the treatments discussed in this chapter, because the intervention occurs after the illness has been identified.
Community workers with the help of day centers or day hospitals, or half way houses or sheltered workshops provide treatment, residential facility and protective supervised occupational training. These tertiary prevention services in most communities provide with proper care and help to these rehabilitated people facing psychological difficulties.
In addition to providing treatment, however, tertiary prevention also attempts to address some of the adverse, indirect consequences of mental illness.
Many prevention efforts face an insurmountable obstacle: We simply do not know the specific cause of most psychological disorders.
Computer Therapy
Computers are powerful holders and sorters of information. They were created to liberate people from time consuming repetitive tasks, and much of psychological assessment and diagnosis fits that description well. Many clinicians now use computer programs to help them gather client's histories, assess self-report inventories, and even make preliminary diagnoses. Such uses of computer programs can save time and make psychological resting widely available.
Two computer centered therapies, one Eliza program developed in 1966 designed to simulate the CCT Therapy session.

No. 2 Plato DCS, developed in 1980 is a computer counseling system that helps people to articulate their problems in form of 'if- then' statements. Computers may never fully substitute a trained therapist because the language, intelligence, emotion and training of a therapist is unique and cannot be replaced by a computer.

Contemporary psychotherapy researchers are advancing knowledge by studying factors common to all therapies.
The ultimate goal of treatment research, however, is to identify different therapies that have specific active ingredients for treating specific disorders.
The identification of effective treatments for specific disorders is necessary if clinical psychology is to fulfill its scientific promise.
The challenge for the mental health professional is to approach treatment both as a scientist and as a practitioner.

ANXIETY DISORDERS I

Anxiety disorder is the most complex and mysterious disorder.
Have you ever experienced anxiety?
Do you feel anxious when you have an exam or a test?
I feel anxious going to a hospital for a check up?
My friend experiences anxiety visiting his dentist?
My student reports anxiety related to attending his sick mother at an intensive care unit.
So what is anxiety?
Anxiety is a mood- state, characterized by marked negative affect, bodily symptoms of tension, restlessness and apprehension about future.

- Anxiety is very hard to study. In humans a sense of uneasiness, looking worried and anxious.
- The physiological response of anxiety is reflected in increased heart beat and muscle tension.
- Anxiety is not pleasant, it is some unpleasant thing, usually students say they can do well on test if they have no examination anxiety.
- But moderate amount of anxiety is needed for optimal performance of people
- Moderate anxiety creates a feeling of preparation in people
- So anxiety is future oriented mood state
- So when a student says that I better study hard for my examination, so as to respond adequately to difficult questions of the exam as well.
- What is anxiety?
- Is it that anxiety, fear and panic are the same phenomena? So let us explore
- Anxiety , fear and panic
- Anxiety is mood state characterized negative affect, tension, apprehension of future.
- Fear is an immediate alarm reaction to danger. It protects us by activating a massive response
- In fear there is an increased heart beat, blood pressure and subjective feeling of escape of an individual from danger or terror, so either flight from or to fight the enemy.
- In fear an individual has fight- flight response or reaction situation.
- Panic is an abrupt experience of intense fear or acute discomfort accompanied by physical symptoms of heart palpitations, chest pains, shortness of breath and dizziness.
- Three basic types of panic attacks
- 1-Situationally bound: when you know you are afraid of high places or afraid of driving over long bridges you have situation bound panic disorder (cued).
- 2- Unexpected: you may experience an unexpected panic attack disorder (uncued).
- 3-Situationally predisposed: you are more likely to have a panic attack where you had before. Both 1 and 2 are included.
- Panic and anxiety combine to form different anxiety disorders
- 1- Generalized Anxiety Disorder (GAD)
- 2- panic with agoraphobia
- 3-Specific phobia
- 4- Social phobia
- 5-Post Traumatic Stress Disorder (PTSD)
- 6-Obsessive Compulsive Disorder (OCD)
- Generalized Anxiety Disorder is unfocused, prolonged anxiety and worry.
- Anxiety is about minor every day events
- Genetics and psychological factors responsible for GAD.
- Panic with and without agoraphobia
- It is fear and avoidance of situations considered to be safe Anxiety is focused on next panic attack.
- Agoraphobia is marketplace or public place phobia.
- In Specific phobia a person avoids specific situations that produce severe anxiety or panic.

- Social phobias is fear of being around others, particularly to be in situations that call for some kind of performance in front of other people e.g. meeting strangers in part
- Post Traumatic Stress Disorder (PTSD) it focuses on avoiding thoughts or images of some past traumatic experiences
- The PTSD is a traumatic experience and the intensity of the experience seems to be a factor in development.
- Example the 8th October 2005, earthquake affected of our country show symptoms of PTSD.
- Obsessive Compulsive Disorder (OCD) it focuses on avoiding frightening or intrusive thoughts (obsessive)
- Leading to ritualistic behaviors (compulsions)
- Washing and checking of locks, doors.
- Influences in anxiety disorders
- Biological influences
- Behavioral influences
- Social influences
- Emotional and cognitive influences
- Treatments for anxiety disorders
- 1- drug therapy
- 2-Cognitive – behavioral therapy
- 3-Other treatments
- Taken together, the various forms of anxiety disorders—including phobias, obsessions, compulsions, and extreme worry—represent the most common type of abnormal behavior.
- Anxiety disorders share several important similarities with mood disorders.
- From a descriptive point of view, both categories are defined in terms of negative emotional responses.
- Stressful life events seem to play a role in the onset of both depression and anxiety.
- Cognitive factors are also important in both types of problems.
- From a biological point of view, certain brain regions and a number of neurotransmitters are involved in the etiology of anxiety disorders as well as mood disorders.
- People with anxiety disorders share a preoccupation with, or persistent avoidance of, thoughts or situations that provoke fear or anxiety.
- Anxiety disorders frequently have a negative impact on various aspects of a person's life.

- Anxious mood is often defined in contrast to the specific emotion of fear, which is more easily understood.
- **Fear** is experienced in the face of real, immediate danger.
- In contrast to fear, **anxiety** involves a more general or diffuses emotional reaction—beyond simple fear—that is out of proportion to threats from the environment.

- Rather than being directed toward the person's present circumstances, anxiety is associated with the anticipation of future problems.
- Anxiety can be adaptive at low levels, because it serves as a signal that the person must prepare for an upcoming event.
- An anxious mood is often associated with pessimistic thoughts and feelings.
- The person's attention turns inward, focusing on negative emotions and self-evaluation rather than on the organization or rehearsal of adaptive responses that might be useful in coping with negative events.

Excessive Worry

- Worrying is a cognitive activity that is associated with anxiety.

- **Worry** can be defined as a relatively uncontrollable sequence of negative, emotional thoughts that are concerned with possible future threats or danger.
- Worriers are preoccupied with "self-talk" rather than unpleasant visual images.

- The distinction between pathological and normal worry hinges on quantity—how often the person worries and about how many different topics the person worries.
- It also depends on the quality of worrisome thought.
- Excessive worriers are more likely than other people to report that the content of their thoughts is negative, that they have less control over the content and direction of their thoughts, and that in comparison to other adults, their worries are less realistic.

Anxiety Disorders

Anxiety Disorder	Description and Symptoms
Generalized anxiety disorder (GAD)	Excessive anxiety and worry that occur on most days for a period of six months about events ad activities such as work or school; symptoms include restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance.
Specific phobia (sometimes called simple phobia)	Persistent, excessive, and unrealistic fear triggered by the presence of a particular situation or object.
Social phobia	Persistent and marked fear of one or more social or performance situations.
Agoraphobia	The fear of experiencing the symptoms of fear and the fear of being in places from which escape might be difficult. (It is also possible to experience agoraphobia without panic.)
Panic attack	A discrete period of intense fear or discomfort that appears abruptly and unexpectedly and peaks within ten minutes; symptoms include pounding heart, shaking, trembling, shortness of breath, sweating, abdominal distress, lightheadedness, and fear of losing control. Panic attacks can occur with or without *agoraphobia*.
Obsessive-compulsive disorder (OCD)	May be defined by either obsessive or. compulsive symptoms; *obsessions* are recurrent and persistent thoughts or images that cause distress and are experienced as intrusive and inappropriate, and *compulsions* are repetitive behaviors that the person feels driven to perform.
Posttraumatic stress disorder (PTSD)	The persistent experiencing of a traumatic event (e.g., in images or dreams) and the avoidance of stimuli associated with the trauma; symptoms include sleep disturbances, difficulty concentrating, angry outbursts, or an exaggerated startle response
Acute stress disorder	Resembles PTSD, but symptoms persist for at least two days but less than four weeks

Source: DSM-IV. Reprinted with permission from The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Copyright © 1994 American Psychiatric Association

- Is it normal to be anxious?
- Almost everyone can recall at least one episode of anxious arousal and fear — an experience of worry tension, a racing heart, sweaty palms, or an upset stomach. Indeed, anxiety and fear can serve an adaptive function: Anxious arousal tells us to take special action, to fight what is threatening us or to flee. The fact that most of us experience some degree of anxiety suggests that is a part of normal functioning.
- **Is being entirely anxiety-free normal or even desirable?**
- **If we are anxiety free are we better off?**
- **The answer is no.**

- **Very low levels of anxiety, like high levels, can be detrimental to performance:**
- **With few exceptions, we perform best when we experience mild levels of anxiety.**
- Example when you have anxiety for your examination you will be pushed to study otherwise you will not prepare for examination.

The Interaction of Person And Situation Anxiety
- Does anxiety come entirely from within the person?
- Is it the result of a chemical imbalance or of maladaptive thinking?
- Or is it caused by environmental conditions?

1-Biological causes

The areas of the brain are affected by different neurotransmitter systems, some of which, in turn, play an important role in the experience of fear and anxiety, and the way these events are interpreted by the person is important in the shaping of anxiety disorders. A model of anxiety disorders must include biological vulnerabilities that affect arousal and activation in interaction with personal, psychological, and environmental characteristics.

2-The *diathesis-stress model,* is one offshoot of this **interactional perspective,** which holds that individual dispositions (diathesis) and situational influences (such as stress) interact to create and maintain psychological disorders (Magnusson & Ohman, 1987).

Theories about Anxiety Disorders
Each of the following theoretical perspectives — biological, cognitive, behavioral, and psychodynamic — has generated extensive literature on anxiety and the development of anxiety disorders. In addition to the interactional (diathesis-stress) perspective just described, we consider how these four major perspectives explain anxiety and anxiety disorders.

Biological Theories
Anxiety and the anxiety disorders are often linked to the body's physical systems of arousal. In times of heightened distress, our bodies react. When we turn a corner in our neighborhood and see the smoke of a burning home, when we receive a phone call from a hospital late in the evening, or when we see but can't stop a toddler who is wandering in a busy parking lot, our bodies do indeed react.

The autonomic nervous system carries messages between the brain and major organs of the body — the heart, stomach, and adrenal glands. In turn, the adrenal glands release a hormone, adrenaline that activates this system. When signals of distress are legitimate, adrenaline galvanizes the individual to action. In the absence of crisis, however excessive adrenaline can cause anxious distress.

The biological perspective considers the roles of genetic and constitutional factors, biological reactivity, endocrinological and neurotransmitter factors, and brain anatomy and functioning in the development of anxiety and anxiety disorders.

The term selective association accounts for the finding that humans are apparently more easily conditioned to some stimuli than to others.

Based on this, one hypothesis holds that humans and many animals learn fears. Phobias may be learned.
Medications for Anxiety Disorders. Because anxiety symptoms often co-occur with depression, it should not be surprising that some of the antidepressants also reduce anxiety.

Panic disorders, in particular, respond relatively well to antidepressants. According to one published report, 60 to 90 percent of such patients display significant improvements when treated with antidepressants (see also Ballenger, Burrows & Dupont, 1988).

In some cases of posttraumatic stress disorder, researchers have claimed that antidepressants are effective as well (Davidson et al., 1990).

Cognitive Causes The basic idea underlying cognitive approaches is that anxiety results when we try to understand the events and experiences that we are a part of in distorted irrational ways.

Ellis posited that people with unhealthy emotional lives are also victims of cognitive irrationality — they view the world based on self- defeating assumptions.

Examples
1-To become afraid on a camping trip when you are familiar with the territory of your camping trip, is an irrational fear.
2-To be unwilling to participate in a new game for fear that you won't be the absolute best player is irrational.
Dog lovers, when approached by a dog, might perceive the dog in any of several ways — in terms of attractiveness, breed, grooming, or posture. But people with a dog phobia (an excessive fear of dogs) have a narrow and negative view of dogs, seeing them in terms of their size and ferocity. They never see the dog's tail wagging; they see only teeth (Landau, 1980)

Consider the following example of cognitive influences in the experience of deleterious anxiety. Sam is waiting for his mother to pick him up after school. Most of the other children have already gone home. Sam thinks to himself, "Why is she late?" In itself, this thought is not detrimental; many children in the same situation might ask themselves the same question and he continues to worry. Rather than using the time to complete a homework assignment or talk with friends or teachers, the anxious youngster engages in task-irrelevant thought. He may question why she is late and respond by himself due to the fact she does not love me while the fact is she is late due to traffic block or car trouble.

Anxiety disorders have multiple causes and multiple expressions. As we discussed, several forces interact in the development of disorders of anxiety, and not all expressions of these disorders are the same. Indeed, several different types of anxiety disorder appear in contemporary classification schemes.

Behavioral Causes
Behavioral explanations of anxiety emphasize the processes involved in the acquisition of anxiety responses. Behaviorists hold that persons who suffer distressing levels of anxiety have learned to behave in an anxious manner through classical conditioning, operant conditioning, or modeling.
Modeling, also called observational learning, is another behavioral explanation for anxiety responses. Unlike conditioning, modeling produces learning without personal experience with a situation or object. Thus, an individual can develop an emotional response after watching someone else experience an aversive emotional condition.

Example.
An adolescent boy observed the adolescent girl receive the ridicule from peers might stay away from those same peers hoping to avoid similar teasing and rejection. He didn't experience the rejection directly, but he observed it and learned to avoid it from the vicarious experience.
Therapies Procedures such as
1-Systematic Desensitization and exposure treatments are the treatment of specific anxiety disorders these behavioral techniques typically emphasize and focus on the client's cognitive and behavioral functioning.
2- Rational Emotive Behavior Therapy the focus is on modifying the irrational, illogical belief system.
3-A paradoxical intervention encourages the client to intend or wish for exactly what is feared.

Example I think I will faint in the examination hall, you try hard to faint in the examination hall.
The person does not faint.
 The paradoxical therapists believe that people's attempts to solve their problems often cause them to maintain the very problems they are trying to solve. The paradoxical therapist thus provides directives that are designed to help clients give up their "problem- maintaining solutions".

ANXIETY DISORDERS II

Before GAD can be diagnosed, several criteria must be met. According to DSM-IV, the excessive and unrealistic anxiety and worry must be present for a minimum of six months; impulses must be experienced as difficult to control; and they must be associated with at least three of the following symptoms:
- Restlessness, feeling on the edge
- Easily fatigued
- Difficulty in concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance (difficulty falling or staying asleep, or restless and unsatisfying sleep)
- Although 98.6 percent of GAD patients meet the criterion of three out of six symptoms, a large percentage of patients with other anxiety disorders also fulfill this criterion. Raising the criterion to four or more symptoms increases diagnostic accuracy.

Treating GAD

Borkovec and his colleagues (1983) have provided some interesting information about the ability of clients to learn how to manage their worrying.

In one study clients reported that worry consumed approximately 50 percent of each day and caused those major problems. During an intervention, the clients participated in a program that included (1) establishing a specified half-hour period (same place, same time) for daily worrying, (2) identifying negative thoughts and task- relevant thoughts, (3) postponing worrying until the allotted time, and (4), at the time assigned for worrying, engaging in intense worry and problem solving. After four weeks, the treated subjects showed a reduction in the percentage of time they spent worrying.

Apparently, providing a time and place for worrying (stimulus control) reduces its detrimental effects.

Phobic disorders are tied to specific objects or situations. **Phobias** are intense, recurrent, and irrational fears that are disproportionate to the actual situation. **Claustrophobia,** the fear of closed spaces, is a common example of a phobia. Small room or lift etc.

Most of us have some discomfort or fear associated with fire, disease, snakes, and being in small and enclosed places. Youngsters have been known to avoid walking near an abandoned "haunted house," and college students may avoid biology courses because they are uneasy about the blood that is rumored to be a part of the lab work. To a degree, these fears are rational but Phobic reactions are irrational.

Phobias involve specifiable fear reactions —

Clients with phobias recognize that their fears are excessive and unreasonable, and they work to avoid the phobic stimulus.

Symptoms such as headaches, dizziness, stomach pains, and other general physical complaints are often reported in association with phobias. Lack of self-confidence and mild depression may also accompany phobic conditions. Fainting has been reported in phobic exposed to the feared situation or object (such as the sight of blood), but these reports are not as prevalent as once thought.

Some phobias, such as those provoked by small animals, are present in early childhood, but phobic disorders typically begin in adolescence or early adulthood.

Who Is Affected with Phobias? Phobic disorders are the most common of the anxiety disorders, with a lifetime prevalence of 14.2 percent of the population (Eaton, Dryman & Weissman, 1991).

Using current diagnostic criteria, and sampling from more than eight thousand people from non-institutional households, Magee and associates (1996) reported lifetime prevalence of 13.3 percent for social phobia, 11.3 percent for specific phobia, and 6.7 percent for agoraphobia.

Specific (Simple) Phobias   Specific phobias are pathological (excessive and unrealistic) fears of specific animals, objects, or situations.
Common examples include phobias of the needles, elevators, dogs, snakes, storms, blood, dentists, and tightly enclosed spaces although the phobic individual may be reasonably well adjusted when not directly faced by the phobic stimulus, he or she experiences anticipatory anxiety when aware of an impending situation that could force a confrontation with the object of fear. When the phobic individual is actually exposed to the phobic stimulus, there is almost invariably an intense and immediate anxiety response.
 For example, the person with needle phobia who comes in contact with a needle will report sweating, difficulty breathing, and a racing heart. The phobic stimulus is viewed as powerful indeed, as this example illustrates. In an experiment conducted in the Netherlands. Women with phobias were shown various, slides of phobic stimuli and given very mild shock. The researchers concluded that because phobic stimuli cause such discomfort, they are routinely avoided rather than faced directly and endured.

Social Phobias
It refers to being asked to perform before an audience will produce some anxiety in almost all of us. The thought of having nothing to say or of saying something inappropriate causes us to become self-conscious and nervous. These are normal, rational fears. Social phobias, however, involve a persistent fear of being in a social situation in which one is exposed to scrutiny by others and a related fear of acting in a way that will be humiliating or embarrassing. As self-focus increases, so does the anticipation of anxiety (Woody, 1996).
Phobic and non-phobic individuals have comparable concerns, but the intensity, extremeness, and irrationality of the reactions of social phobic set them apart from their non-phobic counterparts.

Examples of social phobias include irrational reactions to eating in public places, using public restrooms, or speaking in front of large groups of people. Like the specific phobic, the social phobic experiences marked anxiety when anticipating the phobic situation and therefore usually avoids it. This avoidance interferes with the person's daily routine and can potentially ruin his or her career.

Agoraphobia
The term *agoraphobia,* which is derived from the Greek word *agora,* meaning marketplace, was originally used to refer to a pathological fear of open or public places.
At present, agoraphobia is considered a fear of being alone or of being in public places where escape is difficult or where help is not readily available in case of a panic attack that the person fears would be overwhelming. The agoraphobic might experience intense fear in shopping malls during the holidays, in crowds at concerts or sports events, and in tunnels, bridges, or in public transport.
 Agoraphobia also occurs within an interrelated and overlapping cluster of phobias, such as a phobia of cars, buses, planes, and trains. As a result of agoraphobia, the sufferer restricts travel or requires a companion when away from home.

Label	Fear
Agoraphobia	Open places
Aichmophobia	Pointed objects
Algophobia	Pain
Arachnophobia	Spiders
Astraphobia	Storms; thunder and lightning
Claustrophobia	Closed spaces; confinement
Hydrophobia	Water

Nyctophobia	Darkness
Ophidiophobia	Snakes
Pyrophobia	Fire
Thanatophobia	Death
Xenophobia	Strangers

Causes of Phobias
Phobic disorders have been explained in several ways, according to the various models of psychopathology. For example, the psychodynamic explanation of phobia is that the anxiety expressed toward the phobic object or situation is actually displacement of an internal anxiety.

From this perspective, then, a snake phobia is more than a fear of snakes — it represents some other underlying anxiety. The phobia is seen as having arisen because the patient lacks understanding about this underlying anxiety and uses displacement as a defense mechanism.

Some evidence of a genetic predisposition for phobic disorder exists (Torgersen, 1983). First, regarding incidence of behaviors that are relevant to the study of social phobia (such as eating in public, being observed at work), monozygotic twins are more alike than dizygotic twins. Second, parents of children who are diagnosed with a childhood phobic disorder are themselves more likely to meet the criteria for this disorder. Although these findings suggest that the pattern can be genetic or learned.
One model of the development of agoraphobia specifically includes cognitive and behavioral processes
  o A case of agoraphobia.
  o Persons with agoraphobia hold biased emotional expectations; they expect unwanted emotional arousal, are overly alert to cues that signal anxiety, and are highly motivated to avoid anxiety- provoking stimuli.
  o In persons with agoraphobia, have an unwillingness to approach or to try to master stressful situations is accompanied by a sense of loss of control.

Treating Phobias
Specific phobias have been successfully treated with **systematic desensitization**, where anxiety is paired with relaxation with imagined (or real) scenes involving the client in anxiety-producing situations**.**
Systematic desensitization is a behavior therapy procedure developed by Joseph Wolpe *(1995,* 1982).where old maladaptive associations are replaced by newer, more adaptive ones.
Behavioral exposure treatments, both flooding and desensitization, do provide evidence of clients' newly acquired knowledge and ability to manage anxiety. As the clients come to experience and accept the ability to cope with once-feared situations, self-efficacy increases and remains with the clients as part of their newly acquired sense of mastery over prior phobia.
To paraphrase a familiar maxim: Nothing succeeds like a belief in success.

Panic Disorder
The term *panic* originated with Pan, the Greek god who was said to be a happy but an ugly man: He had the horns, ears, and legs of a goat. When in a bad mood, he enjoyed scaring away travelers — hence the word *panic* (Ley, 1987). Experiences that may well be called panic have been around for a long but it was not until recently that consistency in research findings and clinical practice led to the identification of panic disorder as a separate type of anxiety disorder.
A person suffering from panic disorder is vulnerable to frequent **panic attacks** — discrete instances of fear or discomfort. Panic attacks are unexpected in the sense that they do not occur in a predictable context or immediately before a situation that almost always causes anxiety reactions; they are not the result of

evaluation of the person or of scrutiny by others. In these ways, panic disorder is differentiated from specific phobia and social phobia, which do involve situational determinants.

Who Is Affected with Panic Disorder? Panic attacks occur in panic disorder, but they are also sometimes reported in patients with phobias, substance-abuse disorder, and mild depression. In one study, researchers interviewed 1,306 residents of San Antonio, Texas, and found that *5.6* percent reported panic attacks, but only 3.8 percent met criteria for panic disorder.

Panic disorder in women typically occurs at more than twice the frequency of panic disorder in men. However, research conducted in Australia determined that, in terms of symptoms, age of onset, cognition, and duration, there are no significant differences between male and female patients with panic attacks (Oei, Wanstall & Evans, 1990).

1. Palpitations pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath
5. Feeling of choking
6. Chest pain or discomfort,
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, lightheaded,
9. Derealization (feelings of unreality) or depersonalization (feeling detached from oneself)
10. Fear of losing control or going crazy
11. Fear of dying
12. Numbness or tingling sensations
13. Chills or hot flashes
Source: Adapted from DSM-1V Reprinted with permission from *The Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Copyright **@** 1994 American Psychiatric Association.

Are Panic Attacks Biological?
Are panic attacks specifically associated with biological factors?

Proponents of a biological model cite studies showing that panic patients responded distinctively to a variety of "challenges" they faced in the laboratory. Other proponents of a biological model have suggested that patients with panic disorder have a dysfunctional heart.

Panic is a fear response to unexpected and unexplained somatic events (Clark, 1989). It is as if changes in bodily functions that can't be easily explained (such as a sudden change in breathing) prompt the panic sufferer to anticipate the worst and to experience fear and panic (see also McNally & Eke, 1996).
According to Clark (1986), misinterpretation of the arousal cues is causally linked to panic. Thus, although persons with panic attack with a history of it and those without such a history both experience similar arousal (as a result of, say, hyperventilation), only the subjects with panic disorder view these physiological cues as indications that a catastrophe is forthcoming. Somatic complaints precede the fear, and the somatic changes are frightening to the panic sufferer.

In general, research has supported the idea that panic attacks result from the client's fear response to certain bodily sensations.

Obsessive-Compulsive Disorder (OCD)

Have you ever found yourself humming a commercial jingle — a tune that stays in your mind longer than you want it to? In a small way, this experience is like an obsession. **Obsessions** are persistent and unwanted thoughts, ideas, or images that a person does not intentionally produce. Rather, the unwanted thoughts are perceived as invading the person's thinking. The recurring thoughts are troublesome, unnecessary, and distracting, and the person tries to be rid of them.

Features of OCD   The content and form of normal and abnormal obsessions are similar. **Abnormal obsessions, however, are more frequent, more intense, and of longer duration; they produce more discomfort; and they are more associated with compulsions than are normal obsessions.**
Is heightened emotional intensity possibly an important aspect of the intrusive quality of obsessions? (Clark & de Silva, *1985)*. The studies to date, using nonclinical cases, support this hypothesis and suggest that reducing the frequency of any negative cognition will increase the client's ability to dismiss such thoughts.
Although compulsions appear to be purposeful behaviors, they are essentially nonfunctional and ritualistic. The compulsion reported most often is checking, which results from pathologic doubt linked to repeated attempts to "make sure".

An obsessive- compulsive person might fear that the front door was left unlocked and so repeatedly return to the door to check that it is locked. Other common examples of compulsive checking include repetitions intended to determine that gas and water taps are shut and lights and appliances are off. Still other cases highlight a need for organization — checking that kitchen utensils are properly aligned, cupboard contents are correctly arranged, and closets are organized in the "right" order. Some common rituals include repeatedly putting clothes on and taking them off; hoarding items such as newspapers, mail, or boxes; and repeating certain actions such as going through a doorway.

Compulsive hand washing is linked to a preoccupation with dirt and contamination and may be tinged with reports of disgust regarding urine and feces. Compulsive hand washers avoid public restrooms, doorknobs, shaking hands, and money, all of which are viewed as contaminated. Patients may wash as many as eighty times a day, often causing damage to their skin.

Causes of OCD

Researchers have speculated that the obsessions and compulsions reflect fixed-action patterns that are "wired" into the brain. When stressful conditions stimulate the person's perception of danger, these fixed action patterns may be inappropriately activated. Normal individuals cease performing an action when their senses tell them that the action has been completed, whereas, according to the theory just described, persons with OCD become helpless victims of their repeating patterns. Example hand washing.

Treating OCD

The impatient friend of an obsessive person advises, "Just don't think about it." But the person's unwanted thoughts persist nonetheless.
The spouse of a compulsive checker shouts, "We're going to be late. Stop that damn checking." But the checking continues. The experience of nonprofessionals is that obsessive- compulsive disorder is very resistant to direct instructions. Indeed, obsessive patients have thought and thought about matters that they feel are major, and they frequently do not respond to the suggestions of others. Compulsive persons, too, are said to be resistant to advice.
Treatment of OCD especially of chronic cases is difficult earlier the treatment begins the better it is and when it is becomes chronic or it goes without any treatment for some time then patient takes time to respond to any therapy.

Posttraumatic Stress Disorder (PTSD)

Psychologically speaking, what is similar about the experiences of rape, torture, military combat, airplane crash, earthquake, a disastrous fire, and the collapse of a large building? Each can cause severe trauma. Posttraumatic stress disorder **(PTSD)** is a cluster of psychological symptoms that can follow a psychologically distressing event. Stressors that produce PTSD would produce marked distress in almost anyone, and they are outside the range of normal, common stressors such as chronic illness, marital separation, or business failure. Although not all disasters result in psychopathology (Rubonis & Bickman, 1991) — indeed, some people seem invulnerable to the distress — certain individuals do develop severe disorders related to trauma.

The typical symptoms of PTSD occur following a recognizable stressor (traumatic event) that has involved intense fear and horror. They include re-experiencing of the traumatic event, persistent avoidance of any reminders of the event, numbing of general responsiveness, and increased arousal. To warrant a diagnosis of PTSD, a client must experience these symptoms for at least one month. Acute stress disorder, a recent addition to DSM, refers to PTSD-like reactions that persist for at least two days but less than four weeks.

Who Is Affected with PTSD? According to recent epidemiological data (Kessler et al., *1995),* the estimated lifetime prevalence of PTSD is 7.8 percent. The trauma most commonly associated with posttraumatic stress disorder among men is combat exposure, which is rated the most upsetting trauma for 28.8 percent of men with PTSD. Among women, rape is most commonly associated with PTSD; it is rated most upsetting by 29.9 percent of women with PTSD. Fifty-eight percent of battered women also report high rates of PTSD (Astin, Ogland-Hand, Coleman & Foy, *1995).*

Military-combat-produced PTSD is not new; writers described its occurrence after the Civil War, World Wars I and II, and the Korean War. Early reference was made to "shell shock" or "battle fatigue" to refer to an array of symptoms seen in men whose military experience included exposure to artillery fire, attack, and bombings. In the United States, the Centers for Disease Control conducted a four-year epidemiological study of approximately 15,000 Vietnam veterans and reported that 15 percent suffered from combat-related PTSD since their discharge (Roberts, 1988).

Catastrophes such as aircraft disasters, tornadoes, and fires can also produce widespread and serious emotional problems. An aircraft crash at a major airport can cause emotional stress reactions in any of the surviving passengers or flight crew as well as in witnesses to the crash, in members of the families or work associates waiting for passengers to arrive, and in the airport employees who are asked to assist in the emergency services and crash cleanup. Only some of those involved actually suffer diagnosed PTSD or acute stress disorder, but case reports nevertheless indicate widespread distress. After mobilizing energies and working cooperatively during the immediate time of the emergency, people soon tire. When the event has passed and is no longer the topic of conversation, people report loss of sleep, a reliving of the experience, and fearful dreams.

Treating PTSD

The psychological treatment of clients with posttraumatic stress disorder has generated interest and enthusiasm. The research literature is young, however, because PTSD did not appear as an identifiable form of disorder until 1980. An early and practical first step was Operation Outreach, a program designed specifically for Vietnam combat veterans. At Operation Outreach, any veteran can find a needed outlet for his or her emotional distress.

An approach has proved effective in the management of PTSD among rape victims. Edna Foa and her colleagues (1991) reported that a cognitive-behavioral treatment and a prolonged exposure treatment (at follow-up) were more effective in reducing PTSD symptoms.

Many of the rape victims who were offered treatment declined to participate. This may be related to rape victims' tendency to avoid confrontation of the rape memory, a tendency that is symptomatic of PTSD. In addition, some rape victims may not show symptoms of any disorder or may not see themselves as patients in need of treatment. Nevertheless, cognitive-behavioral and exposure treatments seem to be helpful to PTSD sufferers, whether veterans or rape victims.

CLASSIFYING AND TREATING ANXIETY DISORDERS

"Neuroses Are No Longer a Psychological Problem!" If such a headline had appeared in the newspaper, it would have been technically accurate, because, the DSM IV TR system abandoned the use of terms and categories related with neurosis. For example, phobic neurosis is now called specific phobia or social phobia, and obsessive-compulsive neurosis became obsessive- compulsive disorder.

Panic and anxiety combine to form different anxiety disorders

1- Generalized Anxiety Disorder (GAD)

2- panic with agoraphobia

3-Specific phobia

4- social phobia

5-Post Traumatic Stress Disorder (PTSD)

6-Obessive Compulsive Disorder (OCD)

Anxiety is very hard to study. In humans a sense of uneasiness, looking worried and anxious.

The physiological response of anxiety is reflected in increased heart beat and muscle tension.

Anxiety is not pleasant; it is some unpleasant thing most commonly observed.

MOOD DISORDERS I

MOOD DISORDERS are the most common psychological disorders and the risk of developing them is increasing all over the world especially among the young people.
- It is really something which scares us.
- Mood or affective disorders are syndromes of depressions or a combination of depression and mania.
- Normal mood depression which last for a few moments or hours.
- In depression there is altered energy level, motivation, behavior, bodily functioning
- Modification in sleep and eating patterns
- When these symptoms persist they greatly impair individual's ability
- At work and at home and relationships at both places.
- Unipolar depression
- Bipolar depressions

Depression is one of the most prevalent of all clinical disorders co-occurring with other medical and psychological disorders.
- I have missed placed my important documents I am sad
- My car has been stolen I am pretty sad
- My purse has been snatched with all my money I am sad
- My student has lost her father in death she refuses to come to college
- All these are events which make an individual become sad but after some time we get over them and move on.
- You do not encounter any such event but you are sad most of the day, irritable, tired, your appetite and sleep patterns are irregular so you suffer from mood disorder.
- What is depression?
- A mood state.
- Why do we get depress?
- We think we are the only ones with this disorder
- What are the symptoms of depression?
- Emotional, cognitive and behavioral
- Give me one symptom of depression observed in most people
- Being isolated
- Alone
- Seclusion.
- Major depression is the leading cause of disability worldwide.
- **Emotion** refers subjective states of feeling, such as sadness, anger, and disgust.
- **Affect** refers to the pattern of observable behaviors, such as facial expression, that are associated with these subjective feelings.
- **Mood** refers to a pervasive and sustained emotional response that, in its extreme form, can color the person's perception of the world.
- Depression can refer either to a mood or to a clinical syndrome, a combination of emotional, cognitive, and behavioral symptoms.
- The feelings associated with a depressed mood often include disappointment and despair.
- Although sadness is a universal experience, profound depression is not.
- In the syndrome of depression, which is also called **clinical depression,** a depressed mood is accompanied by symptoms, such as
    - fatigue,
    - loss of energy,
    - difficulty in sleeping, and
    - changes in appetite.

- **Mania,** the flip side of depression, also involves a disturbance in mood that is accompanied by additional symptoms.
  - Mania is an elated mood, is the opposite emotional state from a depressed mood.
  - It is characterized by an exaggerated feeling of physical and emotional well-being.
- Manic symptoms that frequently accompany an elated mood include
  - inflated self-esteem,
  - decreased need for sleep,
  - distractibility,
  - pressure to keep talking, and
  - the subjective feeling of thoughts racing through the person's head faster than they can be spoken.
- **Mood disorders** are defined in terms of *episodes*—discrete periods of time in which the person's behavior is dominated by either a depressed or manic mood.
- **Unipolar mood disorder** is a mood disorder in which the person experiences only episodes of depression.
- **Bipolar mood disorder** is a mood disorder in which the person experiences episodes of mania as well as depression.
- Years ago, bipolar mood disorder was known as *manic–depressive disorder.*
- Although this term has been replaced in the official diagnostic manual, some clinicians still prefer to use it because it offers a more direct description of the patient's experience.

Important Considerations in Distinguishing Clinical Depression from Normal Sadness
1. The mood change is pervasive across situations and persistent over time.
2. The mood change may occur in the absence of any precipitating events, or it may be completely out of proportion to the person's circumstances.
3. The depressed mood is accompanied by impaired ability to function in usual social and occupational roles.
4. The change in mood is accompanied by a cluster of additional signs and symptoms, including cognitive, somatic, and behavioral features.
5. The nature or quality of the mood change may be different from that associated with normal sadness.

Emotional Symptoms
- Depressed, or **dysphonic** (unpleasant), mood is the most common and obvious symptom of depression.
- In contrast to the unpleasant feelings associated with clinical depression, manic patients experience periods of inexplicable and unbounded joy known as euphoria.

- Many depressed and manic patients are irritable.
- Anxiety is also common among people with mood disorders, just as depression is a common feature of some anxiety disorders.

Cognitive Symptoms
- People who are clinically depressed frequently note that their thinking is slowed down, that they have trouble concentrating, and that they are easily distracted.
- Guilt and worthlessness are common preoccupations.
- They focus considerable attention on the most negative features of themselves, their environments, and the future—a combination known as the "depressive triad."
- In contrast to the cognitive slowness associated with depression, manic patients commonly report that their thoughts are speeded up.
- Manic patients can also be easily distracted, responding to seemingly random stimuli in a completely uninterpretable and incoherent fashion.

- Inflated self esteem is also characteristic features of mania.
- Many people experience self-destructive ideas and impulses when they are depressed.
- Interest in suicide usually develops gradually and may begin with the vague sense that life is not worth living.

Somatic Symptoms
- The **somatic symptoms** of mood disorders are related to basic physiological or bodily functions.
- They include fatigue, aches and pains, and serious changes in appetite and sleep patterns.
- Trouble getting to sleep is common.
- In the midst of a manic episode, a person is likely to experience a drastic reduction in the need for sleep.
- Although some depressed patients report that they eat more than usual, most reduce the amount that they eat; some may eat next to nothing.
- People who are severely depressed commonly lose their interest in various types of activities that are otherwise sources of pleasure and fulfillment.
- Some patients complain of frequent headaches and muscular aches and pains.

Behavioral Symptoms
- The symptoms of mood disorders also include changes in the things that people do and the rate at which they do them.
- The term **psychomotor retardation** refers to several features of behavior that may accompany the onset of serious depression.
- The most obvious behavioral symptom of depression is slowed movement.
- Patients may walk and talk as if they are in slow motion.
- Others become completely immobile and may stop speaking altogether.
- Some depressed patients pause for much extended periods, perhaps several minutes, before answering a question.
- In marked contrast to periods when they are depressed, manic patients are typically gregarious and energetic.

Other Problems Commonly Associated with Depression
- Within the field of psychopathology, the simultaneous manifestation of a mood disorder and other syndromes is referred to as comorbidity, suggesting that the person exhibits symptoms of more than one underlying disorder.
- Alcoholism and depression are clearly related phenomena.
- Eating disorders and anxiety disorders are also more common among first-degree relatives of depressed patients than among people in the general population.

Brief Historical Perspective
- The first widely accepted classification system was proposed by the German physician Emil Kraepelin.
- Kraepelin divided the major forms of mental disorder into two categories: *dementia praecox,* which we now know as schizophrenia, and *manic–depressive psychosis.*
- He based the distinction on age of onset, clinical symptoms, and the course of the disorder (its progress over time).
- The manic–depressive category included all depressive syndromes, regardless of whether the patients exhibited manic and depressive episodes or simply depression.
- In comparison to dementia praecox, manic–depression typically showed an episodic, recurrent course with a relatively good prognosis.
- Despite the widespread acceptance and influence of Kraepelin's diagnostic system, many alternative approaches have been proposed.

- Two primary issues have been central in the debate regarding definitions of mood disorders.
- First, should these disorders be defined in a broad or a narrow fashion?
- A narrow approach to the definition of depression would focus on the most severely disturbed people—those whose depressed mood is entirely pervasive and associated with a wide range of additional symptoms.
- A broader approach to definition would include mild depression, which lies somewhere on the continuum between normal sadness and major depression.
- The second issue concerns heterogeneity.
- All depressed patients do not have exactly the same set of symptoms, the same pattern of onset, or the same course over time.
- Are there qualitatively distinct forms of mood disorder, or are there different expressions of the same underlying problem?
- Is the distinction among the different types simply one of severity?

Contemporary Diagnostic Systems
- The DSM-IV-TR approach to classify mood disorders recognizes several subtypes of depression, placing special emphasis on the distinction between unipolar and bipolar disorders.
- The overall scheme includes two types of unipolar mood disorder and three types of bipolar mood disorder.

TABLE 5-3   DSM-IV-TR System for Classifying Mood Disorders

UNIPOLAR DISORDERS

Major Depressive Disorder
- One or more major depressive episode
- No manic or unequivocal hypomanic episodes

Dysthymic Disorder
- Depressed mood for at least 2 years
- Never without these symptoms for more than 2 months during this period
- No major depressive episode during first 2 years

BIPOLAR DISORDERS

Bipolar I Disorder
- One or more manic episodes

Bipolar II Disorder
- One or more major depressive episodes
- At least one hypomanic episode
- No manic episodes

Cyclothymic Disorder
- Numerous periods with hypomanic symptoms and numerous periods with depressed mood for at least 2 years
- Never without these symptoms for more than 2 months during 2-year period
- No major depressive episodes
- No manic episode during first 2 years

Unipolar Disorders
- The unipolar disorders include two specific types: major depressive disorder and dysthymia.
- In order to meet the criteria for major depressive disorder, a person must experience at least one major depressive episode in the absence of any history of manic episodes.

TABLE 5–4   Symptoms Listed in DSM IV-TR for Major Depressive Episode

A. Five or more of the following symptoms have been present during the same 2 week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (for example, feels sad or empty) or observation made by others (for example, appears tearful). Note: in children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain (for example, a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day (not merely self reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

- **Dysthymia** differs from major depression in terms of both severity and duration.
- Dysthymia represents a chronic mild depressive condition that has been present for many years.
- In order to fulfill DSM-IV-TR criteria for this disorder, the person must, over a period of at least 2 years, exhibit a depressed mood for most of the day on more days than not.

Two or more of the following symptoms must also be present for a diagnosis of dysthymia:
1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness

The distinction between major depressive disorder and dysthymia is somewhat artificial because both sets of symptoms are frequently seen in the same person.
In such cases, rather than thinking of them as separate disorders, it is more appropriate to consider them as two aspects of the same disorder, which waxes and wanes over time.

Bipolar Disorders
- All three types of bipolar disorders involve manic or hypomanic episodes.
- The mood disturbance must be severe enough to interfere with occupational or social functioning.
- A person who has experienced at least one manic episode would be assigned a diagnosis of bipolar I disorder.
- To be fully discussed in lecture no 27.

TABLE 5-5   Symptoms Listed in DSM IV-TR for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three or more of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

   1. Inflated self esteem or grandiosity.

   2. Decreased need for sleep—for example, feels rested after only 3 hours of sleep.

   3. More talkative than usual, or pressure to keep talking.

   4. Flight of ideas or subjective experience that thoughts are racing.

   5. Distractibility—that is, attention too easily drawn to unimportant or irrelevant external stimuli.

   6. Increase in goal directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

   7. Excessive involvement in pleasurable activities that have a high potential for painful consequences—for example, the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments.

MOOD DISORDERS II

DIAGNOSIS
Unipolar Disorders
- The unipolar disorders include two specific types: major depressive disorder and dysthymia.
- In order to meet the criteria for major depressive disorder, a person must experience at least one major depressive episode in the absence of any history of manic episodes.

TABLE 5–4   Symptoms Listed in DSM IV-TR for Major Depressive Episode

A. Five or more of the following symptoms have been present during the same 2 week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (for example, feels sad or empty) or observation made by others (for example, appears tearful). Note: in children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain (for example, a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.
4. Insomnia or hypersomnia nearly every day.
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6. Fatigue or loss of energy nearly every day.
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- **Dysthymia** differs from major depression in terms of both severity and duration.
- Dysthymia represents a chronic mild depressive condition that has been present for many years.
- In order to fulfill DSM-IV-TR criteria for this disorder, the person must, over a period of at least 2 years, exhibit a depressed mood for most of the day on more days than not.

- **Two or more of the following symptoms must also be present for a diagnosis of dysthymia:**
    1. **Poor appetite or overeating**
    2. **Insomnia or hypersomnia**
    3. **Low energy or fatigue**
    4. **Low self-esteem**
    5. **Poor concentration or difficulty making decisions**
    6. **Feelings of hopelessness**

- These symptoms must not be absent for more than 2 months at a time during the 2-year period.
- If at any time during the initial 2 years the person met criteria for a major depressive episode, the diagnosis would be major depression rather than dysthymia.
- As in the case of major depressive disorder, the presence of a manic episode would rule out a diagnosis of dysthymia.
- The distinction between major depressive disorder and dysthymia is somewhat artificial because both sets of symptoms are frequently seen in the same person.

- In such cases, rather than thinking of them as separate disorders, it is more appropriate to consider them as two aspects of the same disorder, which waxes and wanes over time.

Bipolar Disorders
- All three types of bipolar disorders involve manic or hypomanic episodes.
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TABLE 5–5   Symptoms Listed in DSM IV-TR for Manic Episode

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1. Inflated self esteem or grandiosity.
2. Decreased need for sleep—for example, feels rested after only 3 hours of sleep.
3. More talkative than usual, or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility—that is, attention too easily drawn to unimportant or irrelevant external stimuli.
6. Increase in goal directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences—for example, the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments.

- **Hypomania** refers to episodes of increased energy that are not sufficiently severe to qualify as full-blown mania.
- A person who has experienced at least one major depressive episode, at least one hypomanic episode, and no full-blown manic episodes would be assigned a diagnosis of *bipolar II disorder.*

- The differences between manic and hypomanic episodes involve duration and severity.
- The symptoms need to be present for a minimum of only 4 days to meet the threshold for a hypomanic episode (as opposed to 1 week for a manic episode).
- The mood change in a hypomanic episode must be noticeable to others, but the disturbance must not be severe enough to impair social or occupational functioning or to require hospitalization.

- **Cyclothymia** is considered by DSM-IV-TR to be a chronic but less severe form of bipolar disorder.
- In order to meet criteria for cyclothymia, the person must experience numerous hypomanic episodes and numerous periods of depression (or loss of interest or pleasure) during a period of 2 years.
- There must be no history of major depressive episodes and no clear evidence of a manic episode during the first 2 years of the disturbance.

Further Descriptions and Subtypes
- DSM-IV-TR includes several additional ways of describing subtypes of the mood disorders.
- These are based on two considerations:
    1) more specific descriptions of symptoms that were present during the most recent episode of depression (known as *episode specifiers*) and
    2) more extensive descriptions of the pattern that the disorder follows over time (known as *course specifiers*).

- One episode specifier allows the clinician to describe a major depressive episode as having melancholic features.
- **Melancholia** is a term that is used to describe a particularly severe type of depression.
- In order to meet the DSM-IV-TR criteria for melancholic features, a depressed patient must either
- lose the feeling of pleasure associated with all, or almost all, activities or
- Lose the capacity to feel better—even temporarily—when something good happens.
- The person must also exhibit at least three of the following to meet the criteria of melancholia:
- the depressed mood feels distinctly different from the depression a person would feel after the death of a loved one;
- the depression is most often worst in the morning;
- the person awakens early, at least 2 hours before usual;
- marked psychomotor retardation or agitation;
- significant loss of appetite or weight loss; and
- excessive or inappropriate guilt.
- Another episode specifier allows the clinician to indicate the presence of *psychotic features*— hallucinations or delusions—during the most recent episode of depression or mania.
- Depressed patients who exhibit psychotic features are more likely to require hospitalization and treatment with a combination of antidepressant and antipsychotic medication.
- Another episode specifier applies to women who become depressed or manic following pregnancy.
- A major depressive or manic episode can be specified as having a *postpartum onset* if it begins within 4 weeks after childbirth.
- Because the woman must meet the full criteria for an episode of major depression or mania, this category does not include minor periods of postpartum "blues," which are relatively common.
- A mood disorder (either unipolar or bipolar) is described as following a seasonal pattern if, over a period of time, there is a regular relationship between the onset of a person's episodes and particular times of the year.
- Researchers refer to a mood disorder in which the onset of episodes is regularly associated with changes in seasons as **seasonal affective disorder.**

Unipolar Disorders
- People with unipolar mood disorders typically have their first episode in middle age; the average age of onset is in the mid-forties.
- DSM-IV-TR sets the minimum duration at 2 weeks, but they can last much longer.
- In one large-scale follow-up study, 10 percent of the patients had depressive episodes that lasted more than 2 years.
- Most unipolar patients will have at least two depressive episodes.
- The mean number of lifetime episodes is five or six.
- When a person's symptoms are diminished or improved, the disorder is considered to be in **remission,** or a period of recovery.
- **Relapse** is a return of active symptoms in a person who has recovered from a previous episode.
- Approximately half of all unipolar patients recover within 6 months of the beginning of an episode.
- The probability that a patient will recover from an episode decreases after 6 months, and 10 to 20 percent do not recover after 5 years.
- Among those who recover, 50 percent relapse within 3 years.

Bipolar Disorders
- Onset of bipolar mood disorders usually occurs between the ages of 28 and 33 years, which is younger than the average age of onset for unipolar disorders.
- The first episode is just as likely to be manic as depressive.
- The average duration of a manic episode runs between 2 and 3 months.
- The long-term course of bipolar disorders is most often episodic, and the prognosis is mixed.
- Most patients have more than one episode, and bipolar patients tend to have more episodes than unipolar patients.
- Several studies that have followed bipolar patients over periods of up to 10 years have found that 40 to 50 percent of patients are able to achieve a sustained recovery from the disorder.

Incidence and Prevalence
- Unipolar depression is one of the most common forms of psychopathology.
- Among people who were interviewed for the ECA study, approximately 6 percent were suffering from a diagnosable mood disorder during a period of 6 months.
- The ratio of unipolar to bipolar disorders is at least 5:1.
- Lifetime risk for major depressive disorder was approximately 5 percent, averaged across sites in the ECA program.
- The lifetime risk for dysthymia was approximately 3 percent and the lifetime risk for bipolar I disorder was close to 1 percent.
- Almost half the people who met diagnostic criteria for dysthymia had also experienced an episode of major depression at some point in their lives.
- The National Comorbidity Survey produced even higher figures for the lifetime prevalence of mood disorders; therefore the prevalence estimates for mood disorders in the ECA study are probably conservative.
- Slightly more than 30 percent of those people in the ECA study who met diagnostic criteria for a mood disorder made contact with a mental health professional during the 6 months prior to their interview.

Gender Differences
- Women are two or three times more vulnerable to depression than men are.
- The increased prevalence of depression among women is apparently limited to unipolar disorders.
- Possible explanations for this gender difference have focused on a variety of factors, including sex hormones, stressful life events, and childhood adversity as well as response styles that are associated with gender roles.

Cross-Cultural Differences
- Comparisons of emotional expression and emotional disorder across cultural boundaries encounter a number of methodological problems.
- One problem involves vocabulary.
- Cross-cultural differences have been confirmed by a number of research projects that have examined cultural variations in symptoms among depressed patients in different countries.
- These studies report comparable overall frequencies of mood disorders in various parts of the world, but the specific type of symptom expressed by the patients varies from one culture to the next.
- In Chinese patients, depression is more likely to be described in terms of somatic symptoms, such as sleeping problems, headaches, and loss of energy.
- Depressed patients in Europe and North America are more likely to express feelings of guilt and suicidal ideas.

- These cross-cultural comparisons suggest that, at its most basic level, clinical depression is a universal phenomenon that is not limited to Western or urban societies.
- They also indicate that a person's cultural experiences, including linguistic, educational, and social factors, may play an important role in shaping the manner in which he or she expresses and copes with the anguish of depression.

Risk for Mood Disorders Across the Life Span
- Data from the ECA project suggest that mood disorders are most frequent among young and middle-aged adults.
- Prevalence rates for major depressive disorder and dysthymia were significantly lower for people over the age of 65.
- The frequency of bipolar disorders was also low in the oldest age groups.
- The frequency of depression is much higher among certain subgroups of elderly people.
- The prevalence of depression is particularly high among those who are about to enter residential care facilities.
- Elderly people in nursing homes are more likely to be depressed in comparison to a random sample of elderly people living in the community.
- People born after World War II seem to be more likely to develop mood disorders than were people from previous generations.
- The average age of onset for clinical depression also seems to be lower in people who were born more recently; a pattern sometimes called a birth cohort trend.
- At low levels and over brief periods of time, depressed mood may help us refocus our motivations and it may help us to conserve and redirect our energy in response to experiences of loss and defeat.
- A disorder that is as common as depression must have many causes rather than one.
- The principle of equifinality, which holds that there are many ways to reach the same outcome, clearly applies in the case of mood disorders.

Social Factors
- The experience of stressful life events is associated with an increased probability that a person will become depressed.
- Prospective studies have found that stressful life events are useful in predicting the subsequent onset of unipolar depression.
- Although many kinds of negative events are associated with depression, a special class of circumstances—those involving major losses of important people or roles—seem to play a crucial role in precipitating unipolar depression.

- Brown and his colleagues believe that depression is more likely to occur when severe life events are associated with feelings of humiliation, entrapment, and defeat.
- Variations in the overall prevalence of depression are driven in large part by social factors that influence the frequency of stress in the community.

Social Factors and Bipolar Disorders
- Some studies have found that the weeks preceding the onset of a manic episode are marked by an increased frequency of stressful life events.
- The kinds of events that precede the onset of mania tend to be different from those that lead to depression.
- While the latter include primarily negative experiences involving loss and low self-esteem, the former include schedule-disrupting events (such as loss of sleep) as well as goal attainment events.

- Some patients experience an increase in manic symptoms after they have achieved a significant goal toward which they had been working.

- Aversive patterns of emotional expression and communication within the family can also have a negative impact on the adjustment of people with bipolar mood disorders.

- Bipolar patients who have less social support are more likely to relapse and recover more slowly than patients with higher levels of social support.
- Stressful life events can also delay recovery from an episode of depression in bipolar patients.
- The course of bipolar mood disorder can be influenced by the social environment in which the person is living.

SUICIDE

No one commits suicide out of joy it is the psychological pain and agony that one wants to avoid.

Suicide has been observed throughout the history. It has been recorded among the ancient Chinese, Greeks, and Romans. And in more recent times, suicides by such famous people as Ernest Hemingway and Marilyn Monroe have both shocked and fascinated society.

Today suicide ranks among the top ten causes of death in Western society. According to the World Health Organization, approximately 120,000 deaths by suicide occur each year. More than 30,000 suicides are committed annually in the United States alone, by 12.8 out of every 100,000 inhabitants, accounting for almost 2 percent of all deaths in the nation (McIntosh, 1991; National Center for Health Statistics, 1988). It is also estimated that each year more than 2 million other persons throughout the world- 600,000 in the United States- make unsuccessful attempts to kill themselves; these people are called **parasuicides** (McIntosh, 1991).

What is Suicide?

One of the most influential writers on this topic defines *suicide* as **an *intentioned* death- a self-inflicted death in which one makes an *intentional, direct,* and conscious effort to end one's life.** Most theorists agree that the term "suicide" should be limited to deaths of this sort.

Intentioned deaths may take various forms. Consider the following three imaginary instances. Although all of these people intended to die, their precise motives, the personal issues involved, and their suicidal actions differed greatly.

Precipitating Factors in Suicide

i) Stressful Events and Situations

Researchers have repeatedly counted more undesirable events in the recent lives of suicide attempters than in those of matched control subjects. In one study, suicide attempters reported twice as many stressful events in the year before their attempt as non-suicidal depressed patients or non-depressed psychiatric patients. An attempt may be precipitated by a single recent event or, a series of events that have combined impact.

ii) Abusive Environment

Suicide is sometimes committed by victims of an abusive or repressive environment from which there is little or no hope of escape. Prisoners of war, victims of the Holocaust, abused spouses, and prison inmates have attempted to end their lives. Like those who have serious illnesses, these people may have been in constant psychological or physical pain, felt that they could endure no more suffering, and believed that there was no hope for improvement in their condition.

iii) Occupational Stresses

Certain jobs create ongoing feelings of tension or dissatisfaction that can precipitate suicide attempts. Research has found particularly high suicide rates among psychiatrists and psychologists, physicians, dentists, lawyers and unskilled laborers.

iv) Role Conflict

Another long-term stress linked to suicide is role conflict. Everyone occupies a variety of roles in life. The role of a spouse, employee, parent and colleague are some of the few to name. These different roles maybe in conflict with one another and they may cause considerable stress. In recent years researchers have found that women who hold jobs outside of the home often experience role conflicts-conflicts between their family demands and job requirements, for example, or between their social needs and vocational goals- and that these conflicts are reflected in a higher suicide rate.

v) Mood and Thought Changes
Many suicide attempts are preceded by a shift in the person's mood and thought. Although these shifts may not be severe enough to warrant a diagnosis of a mental disorder, they typically represent a significant change from the person's past mood or point of view.
"No one commits suicide out of joy. Pain is what the suicidal person seeks to escape".
In the cognitive realm, many people on the verge of suicide frequently develop a sense of hopelessness- a pessimistic belief that their present circumstances, problems, and negative will not change.

vi) Alcohol Use
Studies indicate that between 20 and 90 percent of those who commit suicide drink alcohol just before the act (Hirschfeld & Davidson, 1988). Autopsies reveal that about one-fifth of these people are intoxicated at the time of death.

vii) Mental Disorders
As we noted earlier, people who attempt suicide do not necessarily have a mental disorder. On the other hand, between 30 and 70 percent of all suicide attempters do display a mental disorder.

VIEWS ON SUICIDE
i) The Psychodynamic View
Psychodynamic theorists believe that suicide usually results from a state of depression and a process of self-directed anger. This theory was first stated by Wilhelm Stekel at a meeting in Vienna in 1910, when he proclaimed that "no one kills himself who has not wanted to kill another or at least wished the death of another".
Freud (1917) and Abraham (1916,1911) proposed that when people experience the real of symbolic loss of a loved one, they come to "introject" the lost person; that is, they unconsciously incorporate the person into their own identity and feel toward themselves as they had felt toward the other.

ii) The Biological View
Until the 1970s the belief that biological factors contribute to suicidal behavior was based primarily on family studies. Researchers repeatedly found higher rates of suicidal behavior among the parents and close relatives of suicidal people than among those of nonsuicidal people, suggesting that genetic, and biological, factors were at work. Studies of twins also were consistent with this view of suicide (Lester, 1986). A study of twins born in Denmark between 1870 and 1920, for example, located nineteen identical pairs and fifty-eight fraternal pairs in which at least one of the twins had committed suicide. In four of the identical pairs the other twin also committed suicide (21 percent), while the other twin never committed suicide among the fraternal pairs.

Suicide in Different Age Groups
The likelihood of committing suicide generally increases with age, although individuals of all ages may try to kill themselves. Recently particular attention has been focused on self-destruction in three age groups- *children*, partly because suicide at a very young age contradicts society's perception that childhood is an enjoyable period of discovery and growth; *adolescents and young adults,* because of the steady and highly publicized rise in their suicide rate; and the *elderly*, because suicide is more prevalent in this age group than any other.

Adolescents and Young Adults
Suicidal actions become much more common after the age of 14 than at any earlier age. In the United States more than 6,000 adolescents and young adults kill themselves each year; that is, more than 13 of every 100,000 persons between the age of 15 and 24 (Center for Disease Control, 1987).
Teenagers
Approximately 3,000 teenagers commit suicide in the United States each year, and as many as 250,000 may make attempts. Moreover, in a recent Gallup Poll (1991) a full third of teenagers surveyed said they had considered suicide, and 15 percent said they had thought about it seriously.

Some of the major warning signs of suicide in teenagers are **tiredness and sleep loss, loss of appetite, mood changes, decline in school performance, withdrawal, increased smoking, drug or alcohol use, increased letter to friends, and giving away valued possessions**

College Students
The suicide rate tends to be higher for 18-to-24 -year-old college students than for other young people in the same age range. Again, female students are more likely to attempt suicide, but fatal suicides are more numerous among males. Furthermore, studies suggest that as many as 20 percent of college students have suicidal thoughts at some point in their college career (Carson & Johnson, 1985).

Rising Suicide Rate
The suicide rate for adolescents and young adults is not only high but increasing. The suicide rate for this age group has more than doubled. Several theories, each pointing to societal changes, have been proposed to explain why the suicide rate among adolescents and young adults has risen dramatically during the past few decades. First, noting the overall rise in the number and proportion of adolescents and young adults in the general population **Paul Holinger and his colleagues (1991, 1988, 1987, 1984, 1982) have suggested that the competition for jobs, college positions, and academic and athletic honors keeps intensifying in this age group, leading increasingly to shattered dreams and frustrated ambition, which in turn lead to suicidal thinking and behavior.**

Treatment and Suicide
Treatment of people who are suicidal falls into two major categories:

  (1) Treatment after suicide has been attempted and

  (2) Suicide prevention.

  Today special attention is also given to relatives and friends (Carter & Brooks, 1991; Farberow, 1991) whose bereavement, guilt, and anger after a suicide fatality or attempt can be intense. Although many people require psychotherapy or support groups to help them deal with their reaction to a loved one's suicide, the discussion here will be limited to the treatment afforded suicidal people themselves.

I) Treatment after Suicide Attempt
After a suicide attempt, the victims' primary need is medical care. Some are left with severe injuries, brain damage, or other medical problems. Once the physical damage is reversed, or at least stabilized, a process of psychotherapy may begin. Unfortunately, even after trying to kill themselves, many suicidal people fail to become involved in therapy.

II) Suicide Prevention
During the past thirty years emphasis has shifted from suicide treatment to suicide prevention. The emphasis on suicide prevention is labeled as *suicide prevention programs.*
In addition, many mental health centers, hospital emergency rooms, pastoral counseling centers, and poison control centers now include suicide prevention programs among their services.
Suicide prevention centers **define suicidal people as people *in crisis* –that is, under great stress, unable to cope, feeling threatened or hurt, and interpreting their situations as unchangeable. Accordingly, the centers try to help suicidal people perceive things more accurately, make better decisions, act more constructively, and overcome their crisis. Because crises can occur at any time, the centers have 24-hour-a-day telephone service ("hot lines") and also welcome clients to walk in without appointments. Those who call reach a counselor, typically a *paraprofessional* –a person without previous professional training who provides services under the supervision of a mental health professional (Heilig et al., 1983**).

Although specific features vary from center to center, the general approach used by the Los Angeles Suicide Prevention Center reflects the goals and techniques of many of them. During the initial contact, the counselor has several tasks: establishing a positive relationship, understanding and clarifying the problem, assessing suicide potential, assessing and mobilizing the caller's resources, and formulating a plan to overcome the crisis.

The Effectiveness of Suicide Prevention

Do suicide prevention centers reduce the number of suicides in a community? Clinical researchers do not know. It is important to note, however, that the increase in suicide rates found in some studies may reflect society's overall increase in suicidal behavior. One investigation found that although suicide rates did increase in certain cities with prevention centers, they increased *even more in cities* without such centers.

After trying to kill themselves, some suicidal people receive therapy. The goal of therapy is to help the client achieve a non-suicidal state of mind and develop more constructive ways of handling stress and solving problems. Various therapy systems and formats have been employed.

Over the past thirty years, emphasis has been shifted form suicide treatment to suicide prevention because the last opportunity to keep many suicidal people alive comes before their first attempt. **Suicide prevention programs** generally consist of 24-hour-a-day "hot lines" and walking centres operated by **paraprofessionals.** During their initial contact with someone considered suicidal, these counsellors seek to establish a positive relationship, to understand and clarify the problem, to assess the suicide potential, to assess and mobilize the caller's resources, and to formulate a plan for overcoming the crisis. Although such **crisis intervention** may be sufficient treatment for some suicidal people, longer-term therapy is needed for up to 60 percent of them. Apparently, only a small percentage of suicidal people contact prevention centres.

While clinical scientists know a great deal about suicide, they do not yet fully comprehend why people kill themselves. Furthermore, myths about suicide and suicide intervention abound, perhaps contributing to tragedies that might otherwise be averted.

STRESS I
What is stress?
Stress is a process of adjusting to circumstances that disrupt or threaten a person's equilibrium. Scientists define **stress** as any challenging event that requires physiological, cognitive, or behavioral adaptation.

Why study stress?
Scientists once thought that stress contributed only to a few physical diseases, like ulcers, migraine headaches, hypertension (high blood pressure), asthma, and other **psychosomatic disorders,** a term indicating that a disease is a product of both the *psyche* (mind) and the *soma* (body).
Today, the term "psychosomatic disorder" is old-fashioned.

How stress effects us?
Medical scientists now view *every* physical illness—from colds to cancer and AIDS—as a product of the interaction between the mind and body.

Behavioral medicine is a multidisciplinary field that includes both medical and mental health professionals who investigate psychological factors in the symptoms, cause, and treatment of physical illnesses.
Psychologists who specialize in behavioral medicine often are called ***health psychologists***.
Learning more adaptive ways of **coping** responses aimed at diminishing the burden of stress, can limit the recurrence or improve the course of many physical illnesses.
Examples
1- A works at an office for ten hours a day, in her office on most days of the week there is no electricity, even when there is electricity the AC does not work. By the end of the day the A is tired, depressed, hot and irritable.
2- Mr. x is waiting for an important job interview, he hopes to get the job with his charming manners and personality because his grades are average his mouth is dry, his heart beats faster, sweat breaks out on his forehead.
3- I have pain in my tooth , I need to see my dentist but the very thought of his dental clinic makes me shiver, I am nervous, I sweat, my heart beats faster and I have all sorts of strange feelings in my stomach.
All of these three examples on stress involve a relationship between people and their environments or between **stressors** and **stress reactions.**
Stressors are events and situations to which people adjust (exam, job interview, an operation). **Stress** reactions are the physiological, cognitive and behavioral responses that people display to stress (nausea, nervousness and tired).
Major stressors may be the pleasant events such as promotion more responsibility and wedding also acts as stressors. The unpleasant events such as being fired at work, retirement, death of a loved one, divorce etc are events that involve frustration, pressure, boredom, trauma, conflict, or change.

How do we measure stress?
We have psychological tests like
   1- The Social Readjustment Rating Scale (SRRS)
   2- The Daily Hassles and Uplifts Scale
Thomas Holmes and Richard Rahe in the SRRS, included a wide range of change related stressors in the 43 items of SRRS developed in 1967. They asked people to rate these 43 stressors in terms of **life change units** that is the amount of change and demand for adjustments, these given stressors introduce into an individual's life. In the daily hassles and uplifts scale the respondent is asked to identify which of these items in the list she experienced in the past month and to rate them on a three point scale. Hassles include losing things or getting late for work. Uplifts include saving money, eating out, relaxing and getting a present.
Scientists continue to debate whether stress is best defined as
     1- Stress as a Life Event itself

2- Stress as *Appraisal* of Life Events, the event plus the individual's reaction to it.

.1- Stress as a Life Event
Researchers often define stress as a life event—a difficult circumstance regardless of the individual's reaction to it. For example, Holmes and Rahe's Social Readjustment Rating Scale (SRRS) assigned stress values to life events based on the judgments of a large group of normal adults. The SRRS views stressors that produce more *life change units* as causing more stress. Researchers consistently link stress ratings on the SRRS and similar instruments to a variety of physical illnesses. The same stressor does have different meanings for different people. Because of this variability, many experts believe stress must be defined by the combination of an event plus each individual's reaction to it.

2- Stress as Appraisal of Life Events
i- Richard Lazarus defined stress by the individual's **appraisal (perception) of a challenging life event**. Your **primary appraisal** is **your assessment** of the challenge, threat, or harm posed by a particular event. Your **secondary appraisal** is **your assessment** of your abilities and resources for coping with that event. The appraisal approach recognizes that the same event is more or less stressful for different people.
ii- The renowned American physiologist Walter Cannon, one of the first and foremost stress researchers, recognized the adaptive, evolutionary aspects of stress. Cannon viewed stress as the activation of the **fight or flight response.** The fight or flight response has obvious survival value. Cannon observed, however, that fight or flight is a *maladaptive* reaction to much stress in the modern world such as being reprimanded by your boss or giving a speech before a large audience.

Psychophysiological Responses to Stress
Physiologically, the fight or flight response activates your *sympathetic nervous system:* Your heart and respiration rates increase, blood pressure rises, your pupils dilate, blood sugar levels elevate, and your blood flow is redirected in preparation for muscular activity. When a perceived threat registers in the cortex, it signals, the brain structure primarily responsible for activating the stress response, which in turn secretes a hormone that stimulates the brainstem to activate the sympathetic nervous system. In response to the sympathetic arousal, the *adrenal glands* release two key hormones.
  • One is commonly known as **adrenaline**, which activates the sympathetic nervous system.
  • The second key adrenal hormone is **cortisol,** often called the "stress hormone" because its release is so closely linked with stress.
One function of cortisol is "containment" of pathogens in the body. In fact, research in this area has started a new field of study, **psychoneuroimmunology (PNI),** the investigation of the relation between stress and immune function. PNI research shows that particularly vulnerable to stress are *T cells,* one of the two major types of *lymphocytes,* white blood cells that fight off *antigens,* foreign substances like bacteria that invade the body. Decreased T cell production makes the body more susceptible to infectious diseases during times of stress. Recent evidence suggests that **stress may both inhibit and enhance immune functioning. Short-term stressors and physical threats *enhance* certain immune responses,** particularly aspects of immune functioning that respond quickly, require little energy, and may contain infection due to an injury. When repeated over the time, your physiological reactions to stress can leave you vulnerable to illness. **Cannon** hypothesized this occurs because intense or chronic stress overwhelms the body's **homeostasis** (a term he coined), the tendency to return to a steady state of normal functioning. He suggested that, over time, the prolonged arousal of the sympathetic nervous system eventually damages the body, because it no longer returns to its normal resting state.

Canadian physiologist **Hans Selye** offered a different hypothesis based on his concept of the **general adaptation syndrome (GAS).** Seyle's GAS consists of three stages: alarm, resistance, and exhaustion. The stage of *alarm* occurs first and involves the mobilization of the body in reaction to threat. The stage of *resistance* comes next and is a period of time during which the body is physiologically activated and prepared to respond to the threat. *Exhaustion* is the final stage, and it occurs if the body's resources are depleted by chronic stress. Selye viewed the stage of exhaustion as the key in the development of physical illness from stress. At this stage, the body is damaged by continuous failed attempts to reactivate the GAS. Stress may create physical illness in both ways, but a third mechanism may be as important. Because the stress response

uses so much energy, the body may not be able to perform many routine functions, such as storing energy or repairing injuries. The result is greater susceptibility to illness.

Coping
Two general coping strategies are problem-focused and emotion-focused coping.
Problem-focused coping involves attempts to change a stressor.
 Emotion-focused coping is an attempt to alter internal distress.
Studies of animals and humans show that *predictability* and *control* can dramatically reduce stress. Even the *illusion* of control can help to alleviate stress in humans. However, the perception of control can increase stress when people believe they can exercise control but fail to do so, or when they lose control over a formerly controllable stressor. In short, control alleviates stress when it can be exercised or even when it is illusory, but failed attempts at control intensify stress. Research also indicates that responding with physical activity reduces physiological reactions to stress.
Repression is one form of emotion-focused coping that can be maladaptive physically.
Psychophysiological reactions to stress also are greater for "defensive deniers"—people who report positive mental health but whom clinicians judge to have emotional problems.

Optimism
Optimism is a basic key to effective coping. People with an optimistic coping style have a positive attitude toward dealing with stress, even when it cannot be changed, while pessimists are defeated from the outset. Positive thinking is linked with better health habits and less illness in general, and for those with heart disease, AIDS and other serious physical illnesses. For many people, religious and philosophical beliefs are essential to cope with stress. Emerging evidence demonstrates the health value of religious practices, for example, mortality risk is lower among those who attend church services, probably as a result of improved health behavior.

Health Behavior
Stress may also cause illness indirectly by disrupting healthy behavior. **Health behavior** is action that promotes good health, including positive efforts like eating, sleeping, and exercising adequately and avoiding unhealthy activities such as cigarette smoking, excessive alcohol consumption, and drug use. ***Illness behavior***—behaving as if you are sick—also appears to be stress related. Considerable research indicates that increased stress is correlated with such illness behaviors as making more frequent office visits to physicians or allowing chronic pain to interfere with everyday activities. ***Social support*** is important in coping with stress. Social support not only can encourage positive health behavior, but research shows that social support can have direct, physiological benefits. Of all potential sources of social support—or conflict—a good marriage may be most critical to physical health.

Illness as a Cause of Stress
Stress can cause illness, but illness also causes stress. Helping children, adults, and families cope with chronic illness is another important role of experts in behavioral medicine. Historically, the only physical illnesses thought to be affected by stress were a few psychosomatic disorders, such as ulcers and asthma. The field of psychosomatic medicine was dominated by psychoanalytic psychiatrists who endorsed the idea that specific personality types caused specific psychosomatic diseases.
At the beginning of the twentieth century, infectious diseases were the most common causes of death in the United States. Thanks to advances in medical science, and especially in public health, far fewer people are dying of infectious diseases at the beginning of the twenty-first century. Today, most of the leading causes of death are *lifestyle diseases* that are affected in many ways by stress and health behavior.

STRESS II

What is stress?

Stress is a process of adjusting to circumstances that disrupt or threaten a person's equilibrium.

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Why study stress?

Scientists once thought that stress contributed only to a few physical diseases, like ulcers, migraine headaches, hypertension (high blood pressure), asthma, and other psychosomatic disorders, a term indicating that a disease is a product of both the *psyche* (mind) and the *soma* (body).

How stress effects us?

Medical scientists now view *every* physical illness—from colds to cancer and AIDS—as a product of the interaction between the mind and body.

Stressors and Stress Reactions

Stressors are events and situations to which people adjust (exam, job interview, an operation).

Stress reactions are the responses to stress which can be physiological, cognitive and behavioral.

Examples: nausea, nervousness and tired.

Psychophysiological Responses to Stress

Canadian physiologist Hans Selye offered a different hypothesis based on his concept of the general adaptation syndrome (GAS).

Seyle's GAS consists of three stages: alarm, resistance, and exhaustion.

The stage of *alarm* occurs first and involves the mobilization of the body in reaction to threat.

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Positive thinking is linked with better health habits and less illness in general, and for those with heart disease, AIDS and other serious physical illnesses.

Health Behavior

Stress may also cause illness indirectly by disrupting healthy behavior.

Health behavior is action that promotes good health, including positive efforts like eating, sleeping, and exercising adequately and avoiding unhealthy activities such as cigarette smoking, excessive alcohol consumption, and drug use.

Stress may also be related to the very important health behavior of following medical advice, something that as many as 93 percent of all patients *fail* to do fully.

Illness behavior—behaving as if you are sick—also appears to be stress related.

Considerable research indicates that increased stress is correlated with such illness behaviors as making more frequent office visits to physicians or allowing chronic pain to interfere with everyday activities.

The fact that many people consult physicians for psychological rather than physical concerns underscores the value of *social support* in coping with stress.

Social support not only can encourage positive health behavior, but research shows that social support can have direct, physiological benefits.

Of all potential sources of social support—or conflict—a good marriage may be most critical to physical health.

Stress can cause illness, but illness also causes stress.

Helping children, adults, and families to cope with chronic illness is another important role of experts in behavioral medicine or health psychologists.

At the beginning of the twentieth century, infectious diseases were the most common causes of death in the United States.

Thanks to advances in medical science, and especially in public health, far fewer people are dying of infectious diseases at the beginning of the twenty-first century.

Today, most of the leading causes of death are *lifestyle diseases* that are affected in many ways by stress and health behavior.

1- Cancer

- Cancer is the second leading cause of mortality in the United States today, accounting for 23 percent of all deaths.
- Psychological factors are associated with the course of cancer.
- All cancer patients often are anxious or depressed, and their negative emotions can lead to increase in negative health behavior such as alcohol consumption and decrease in positive health behavior such as exercise.
- Cancer patients who are emotionally more expressive have fewer medical appointments, better quality of life, and better health status.
- The absence of social support also can undermine compliance with unpleasant but vitally important medical treatments for cancer.
- Some research also indicates that stress may *directly* affect the course of cancer.
- Adverse effects on the immune system may explain how stress may exacerbate the course of cancer.
- Various psychological treatments have been offered to cancer patients in an attempt to improve their quality of life.

2- Acquired Immune Deficiency Syndrome (AIDS)

Acquired immune deficiency syndrome (AIDS) is caused by the **human immunodeficiency virus (HIV),** which attacks the immune system and leaves the patient vulnerable to infection, neurological complications, and cancers that rarely affect those with normal immune function.

Behavioral factors play a critical role in the transmission of AIDS.

Scientists and policymakers have launched large-scale media campaigns to educate the public about HIV and AIDS and to change risky behavior.

Recent evidence has linked increased stress with a more rapid progression of HIV, and the availability of social support is associated with a more gradual onset of symptoms.

3- Pain Management

Some evidence links reports of increased pain with depression and anxiety, and conversely, higher levels of positive affect predict lower levels of reported pain.

People who are anxious or depressed may be more sensitive to pain, less able to cope with it, and more willing to complain than are people who have similar levels of suffering.

Psychologists have tried a number of treatments to reduce pain.

Direct treatments include hypnosis, biofeedback, relaxation training, and cognitive therapy.

Researchers report a degree of success with each of these approaches, but pain reduction typically is modest.

As a result, most current efforts focus on *pain management,* not pain reduction.

The goal of pain management is to help people to cope with pain in a way that minimizes its impact on their lives, even if the pain cannot be eliminated or controlled entirely.

4- Sleep Disorders

In 1994, DSM first included a diagnostic category for **primary sleep disorder,** a condition where the difficulty in sleeping is the principal complaint.

Two types of primary sleep disorders are listed in DSM-IV-TR.

Dysomnias are difficulties in the amount, quality, or timing of sleep.

Parasomnias are characterized by abnormal events that occur during sleep, for example, nightmares.

The **dyssomnias** include primary insomnia, primary hypersomnia, narcolepsy, breathing-related sleep disorder, and circadian rhythm sleep disorder.

Primary insomnia involves difficulties initiating or maintaining sleep, or poor quality of sleeping (e.g., restless sleep) that last for at least a month and significantly impair life functioning.

Effective treatments have been developed for insomnia that involve stimulus control (only staying in bed during sleep) and resetting circadian rhythms by going to bed and getting up at set times, as well as not napping, regardless of the length of sleep.

Primary hypersomnia is excessive sleepiness characterized by prolonged or daytime sleep, lasting at least a month and significantly interfering with life functioning.

Primary hypersomnia is similar to **narcolepsy**, irresistible attacks of refreshing sleep, lasting at least 3 months.

Breathing related sleep disorder involves the disruption in sleep due to breathing problems such as **sleep apnea,** the temporary obstruction of the respiratory airway.

Circadian rhythm sleep disorder is a mismatch between the patients' 24-hour sleeping patterns and their 24-hour life demands that causes significant life distress.

The parasomnias include nightmare disorder, sleep terror disorder, and sleepwalking disorder.

People with **nightmare disorder** are frequently awakened by terrifying dreams.

Sleep terror disorder also involves abrupt awakening from sleep, typically with a scream, but it differs from nightmare disorder in important respects.

People with nightmare disorder recall their dreams and quickly orient to being awaken; people with sleep terror disorder recall little of their dreams, show intense autonomic arousal, and are difficult to soothe.

Moreover, a person with sleep terror typically returns to sleep fairly quickly and recalls little, if anything happen, about the episode the following morning.

Sleepwalking disorder involves rising from the bed during sleep and walking about in a general unresponsive state.

Occasional episodes of sleepwalking are fairly common, especially among children.

Like all sleep disorders, sleepwalking disorder tends to be diagnosed only if it causes significant distress or impairs the person's ability to function.

5- Cardiovascular disease (CVD)

Cardiovascular disease (CVD) is a group of disorders that affect the heart and circulatory system.

The most important of these illnesses are **hypertension** (high blood pressure) and **coronary heart disease (CHD).**

The most deadly and well-known form of coronary heart disease is **myocardial infarction (MI),** commonly called a heart attack.

Hypertension increases the risk for CHD, as well as for other serious disorders, such as stroke.

Cardiovascular disorders are the leading cause of mortality not only in the United States, where they account for over one-third of all deaths, but also in most industrialized countries.

An individual's risk for developing CVD, and particularly CHD, is associated with a number of health behaviors, including weight, diet, exercise, and cigarette smoking.

In addition to health behavior, personality styles, behavior patterns, and forms of emotional expression appear to contribute directly to the development of CVD.

Symptoms of Hypertension and CHD
Hypertension is often referred to as the "silent killer" because it produces no obvious symptoms.
Generally, hypertension is defined by a systolic reading above 140 and/or a diastolic reading above 90 when measured while the patient is in a relaxed state.

Diagnosis of CVD
Myocardial infarction and angina pectoris are the two major forms of coronary heart disease.
Angina pectoris involves intermittent chest pains that are usually brought on by some form of exertion.
Attacks of angina do not damage the heart, but the chest pain can be a sign of underlying pathology that puts the patient at risk for a myocardial infarction.
MI (heart attack) does involve damage to the heart, and as noted, it often causes sudden cardiac death, which is usually defined as death within 24 hours of a coronary episode.

Hypertension can be primary or secondary.
Secondary hypertension results from a known problem such as a diagnosed kidney or endocrine disorder. It is called secondary hypertension because the high blood pressure is secondary to—that is, a consequence of—the principal physical disorder.
Primary or **essential hypertension** is the major concern of behavioral medicine and health psychology. In case of essential hypertension, the high blood pressure is the principal disorder.
Multiple physical and behavioral risk factors contribute to the elevated blood pressure.

Frequency of CVD
Men are twice as likely to suffer from CHD as are women, and sex differences are even greater with more severe forms of the disorder.
For men, risk for CHD increases in a linear fashion with increasing age after 40.
For women, risk for CHD accelerates more slowly until they reach menopause and increases sharply afterwards.
Rates of CHD also are higher among low-income groups, a finding that likely accounts for the higher rates of CHD among black than among white Americans.
Finally, a positive family history is also linked to an increased risk for CHD, due at least in part to genetic factors.
The risk for CHD is two to three times greater among those who smoke a pack or more of cigarettes a day.
Obesity, a fatty diet, elevated serum cholesterol levels, heavy alcohol consumption, and lack of exercise also increase the risk for CHD.
CHD also is associated with psychological characteristics, including depression.
About 30 percent of all U.S. adults suffer from hypertension, and many of the same risk factors that predict CHD also predict high blood pressure, including genetic factors, a high-salt diet, health behavior, and lifestyle factors.
Hypertension is more common in industrialized countries; and in the United States, high blood pressure is found with greater frequency among men, African Americans, low-income groups, and people exposed to high levels of chronic life stress.

Causes of CVD
- The immediate cause of CHD is the deprivation of oxygen to the heart muscle.
- No permanent damage is caused by the temporary oxygen deprivation (*myocardial ischemia*) that accompanies angina pectoris, but part of the heart muscle dies in cases of myocardial infarction.
- Oxygen deprivation can be caused by temporarily increased oxygen demands on the heart, for example, as a result of exercise.
- More problematic is when atherosclerosis causes the gradual deprivation of the flow of blood (and the oxygen it carries) to the heart.

- The immediate biological causes of hypertension are less well understood, as are the more distant biological causes of both hypertension and CHD.
- A positive family history is a risk factor for both hypertension and CHD, and most experts interpret this as a genetic contribution.
- However, research using animal models of CVD suggests that heritable risk interacts with environmental risk.
- The most important of the known psychological contributions to CVD are the wide variety of health behaviors that (1) have a well-documented association with heart disease; (2) decrease the risk for CVD when they are modified; and (3) often are difficult to change.
- Improved health behavior—including avoiding or quitting smoking, maintaining a proper weight, following a low-cholesterol diet, exercising frequently, monitoring blood pressure regularly, and taking antihypertensive medication as prescribed—can reduce the risk of heart disease.
- Stress also contributes to CVD, in two different ways.
- First, stress taxes the cardiovascular system through increased heart rate and blood pressure and can precipitate immediate symptoms or broader episodes of CHD.
- Second, over the long run, the heart may be damaged by constant stress.
- We consider four areas that this can happen: cardiovascular reactivity to stress, actual exposure to life stress, characteristic styles of responding to stress, and depression and anxiety.
- In a study of patients with coronary artery disease, patients who reacted to mental stress in the laboratory with greater myocardial ischemia (oxygen deprivation to the heart) had a higher rate of fatal and nonfatal cardiac events over the next 5 years in comparison to their less reactive counterparts.
- In fact, mental stress was a better predictor of subsequent cardiac events than was physical stress (exercise testing).
- Research shows that exposure to chronic stress increases risk for cardiovascular disease.
- Several studies have found a relationship between job strain and CHD.
- Such strains are not limited to employment, but include work that is performed in other life roles.
- Characteristic styles of responding to stress may also increase the risk for CVD, particularly the **Type A behavior pattern**—a competitive, hostile, urgent, impatient, and achievement-striving style of responding to challenge.
- **Type B** individuals, in contrast, are more calm and content.
- The National Blood, Heart, and Lung Institute concluded in 1981 that Type A was a risk factor for CHD, independent of other risks, for example, diet.
- Many studies conducted since 1980 have failed to support earlier findings.
- *Hostility* predicts future heart disease better than other aspects of Type A behavior or the pattern as a whole.
- Depression is three times more common among patients with CHD than in the general population, and depression doubles the risk for future cardiac events.
- Anxiety seems to be associated with one crucial aspect of CHD: sudden cardiac death.
- Social factors can influence the risk for CVD in many ways.
- Friends and family members can encourage a healthy—or an unhealthy—lifestyle.
- Interpersonal conflict can create the anger and hostility that can increase the risk for coronary heart disease, whereas a spouse's confidence in coping with heart disease predicts patients' increases survival over 4 years.
- Economic resources, being married, and/or having a close confidant all predict a more positive prognosis among patients with coronary artery disease.
- Finally, societal values, such as attitudes about health behaviors like smoking and cultural norms about competition in the workplace also can affect the risk for CVD.
- CVD is an excellent example of the value of the systems approach.
- CVD is caused by a combination of genetic makeup, an occasional structural defect, maintenance in the form of health behavior, and how hard the heart is driven by stress, depression, coping, and societal standards.

Prevention and Treatment of CVD

- Several medications known as **antihypertensive** are effective treatments for reducing high blood pressure.
- Numerous public service advertisements attempt to prevent CVD by encouraging people to quit smoking, eat well, exercise, monitor their blood pressure, and otherwise improve their health behavior.
- The treatment of essential hypertension is one of the most important attempts at the secondary prevention of CHD.
- **Treatments of hypertension fall into two categories.**
- **One focuses on improving health behavior**, and the other emphasizes **stress management,** attempts to teach more effective coping skills.
- The major form of stress management used to treat hypertension is behavior therapy, particularly relaxation training and biofeedback.
- **Biofeedback** uses laboratory equipment to monitor physiological processes that generally occur outside conscious awareness and to provide the patient with conscious feedback about these processes.
- Biofeedback tries to teach the person to control the functions of their autonomic nervous system.
- Both relaxation training and biofeedback produce reliable, reductions in blood pressure.
- Unfortunately, the reductions are small, often temporary, and considerably less than those produced by antihypertensive medications.
- Overall, stress management appears to improve quality of life but has little effect on disease.
- Biofeedback is a particularly dubious treatment, one that some well-respected investigators suggest should be abandoned as a treatment for hypertension.
- The Trials of Hypertension Prevention (TOHP) is an important ongoing study of whether stress management and health behavior interventions succeed in lowering high blood pressure.
- Results from Phase I of the study indicated that only the weight reduction and the salt reduction programs were successful in lowering blood pressure over a follow-up period of up to 11.2 years.
- Findings from Phase II of the TOHP underscored the importance of weight loss, as even a modest reduction in weight lowered produced clinically significant reductions in blood pressure.
- The Multiple Risk Factor Intervention Trial (MRFIT) is another important investigation, of over 12,000 men at risk for CHD who were assigned at random to intervention and control groups.
- Carefully developed intervention programs, including both education and social support, produced improved health behavior, including reduced smoking and lower serum cholesterol.
- However, the men randomly assigned to the treatment groups did not have a lower incidence of heart disease during the 7 years following intervention.
- Tertiary prevention of CHD targets patients who have already had a cardiac event, typically a myocardial infarction.
- The hope is to reduce the incidence of recurrence of the illness.
- Exercise programs are probably the most common treatment recommended for cardiac patients, but evidence of their effectiveness is limited.
- The most effective programs are individualized for each patient.
- Some of the most optimistic evidence on the treatment of CHD comes from studies of interventions designed to alter the Type A behavior pattern, a somewhat surprising circumstance given the controversies about the risk research on Type A.
- Some valuable treatments focus on the effects of heart disease on life stress rather than the other way around.
- The link between stress and physical health clearly is a reciprocal one.

ACUTE AND POSTTRAUMATIC STRESS DISORDERS

What is stress?
Stress is a process of adjusting to circumstances that disrupt or threaten a person's equilibrium.
Scientists define **stress** as any challenging event that requires physiological, cognitive, or behavioral adaptation.
Stress is an inevitable, and in some cases a desirable, fact of everyday life.
Some stressors, however, are so catastrophic and horrifying that they can cause serious psychological harm.
Such **traumatic stress** is defined in DSM-IV-TR as an event that involves actual or threatened death or serious injury to self or others and creates intense feelings of fear, helplessness, or horror.
1-Acute stress disorder (ASD) occurs within 4 weeks after exposure to traumatic stress and is characterized by dissociative symptoms, re-experiencing of the event, avoidance of reminders of the trauma, and marked anxiety or arousal.
2-Posttraumatic stress disorder (PTSD) is also defined by symptoms of re-experiencing, avoidance, and arousal, but in PTSD the symptoms either are longer lasting or have a delayed onset.

- Dissociation is the disruption of the normally integrated mental processes involved in memory, consciousness, identity, or perception.
- The DSM-IV-TR classifies PTSD as an anxiety disorder, however, PTSD is of unique importance and is characterized by mixed symptoms of anxiety and dissociation.

Symptoms of ASD and PTSD
1-People who have been confronted with a traumatic stressor *re-experience* the event in a number of different ways.
2-Many people with ASD or PTSD have repeated intrusive **flashbacks,** sudden memories during which the trauma is replayed in images or thoughts—often at full emotional intensity.
3-In rare cases, re-experiencing occurs as a *dissociative state,* and the person feels and acts as if the trauma actually were recurring in the moment.
4-Marked or persistent avoidance of stimuli associated with the trauma is another symptom of ASD and PTSD. Trauma victims may attempt to avoid thoughts or feelings related to the event, or they may avoid people, places, or activities that remind them of the trauma.
5- PTSD, the avoidance also may manifest itself as a general *numbing of responsiveness.* People suffering from PTSD often complain that they suffer from "emotional anesthesia"—their feelings seem dampened or even nonexistent.
6- Despite their general withdrawal from feelings, people, and painful situations, people with ASD and PTSD also experience increased arousal and anxiety following the trauma, a symptom which predicts a worse prognosis when it is more severe.
7-A number of people with PTSD or ASD also have an *exaggerated startle response,* excessive fear reactions to unexpected stimuli, such as loud noises.

- Symptoms of anxiety and arousal are the reason why traumatic stress disorders are grouped with the anxiety disorders in DSM-IV-TR.
- Acute stress disorder is characterized by explicit dissociative symptoms.
- Many people become less aware of their surroundings following a traumatic event.
- They report feeling dazed, and they may seem "spaced out" to other people.
- 8-Other people experience *depersonalization,* feeling cut off from themselves or their environment. People with this symptom may report feeling like a robot or as if they were sleepwalking.
- *9-Derealization* is characterized by a marked sense of unreality about yourself or the world around you.
- ASD also may be characterized by features of *dissociative amnesia,* specifically the inability to recall important aspects of the traumatic experience.

- DSM-IV-TR lists a sense of numbing or detachment from others as dissociative symptoms that characterize acute stress disorder.
- A very similar symptom is listed as an indicator of avoidance, not dissociation, in the diagnosis of PTSD.
- This discrepancy in diagnostic criteria reflects some of the broader controversy about whether ASD and PTSD should be classified as dissociative or anxiety disorders.

Diagnosis of ASD and PTSD
- Maladaptive reactions to traumatic stress have long been of interest to the military.
- Historically, most of the military's concern has focused on battle dropout, that is, men who leave the field of action as a result of what has been called "shell shock" or "combat neurosis."
- During the Vietnam War, however, battle dropout was less frequent than in earlier wars, but delayed reactions to combat were much more common.
- This change prompted much interest in PTSD, a condition first listed in the DSM in 1980 (DSM-III).
- The basic diagnostic criteria for PTSD—re-experiencing, avoidance, and arousal—have remained more or less the same in revisions of the DSM.
- However, two significant changes in the classification of traumatic stress disorders were made with the publication of DSM-IV in 1994: Acute stress disorder was included as a separate diagnostic category, and the definition of trauma was altered.
- The diagnostic criteria for ASD and PTSD are essentially the same.
- The two exceptions are that ASD explicitly includes dissociative symptoms and lasts no longer than 4 weeks, whereas PTSD continues for at least 1 month after a trauma or it has a delayed onset.
- Not surprisingly, many people suffer from ASD after experiencing trauma, and the presence of ASD may predict future PTSD.

TABLE 7–1 DSM-IV-TR Diagnostic Criteria for Posttraumatic Stress Disorder (PTSD)

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
2. The person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions
2. Recurrent distressing dreams of the event
3. Acting or feeling as if the traumatic event were recurring
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect
7. Sense of a foreshortened future

D. Persistent symptoms of increased arousal, as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response

D. Persistent symptoms of increased arousal, as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response

E. Duration of the disturbance is more than 1 month

Specify if:
Acute: If duration of symptoms is less than 3 months
Chronic: If duration of symptoms is 3 months or more
Specify if:
With delayed onset: If onset of symptoms is at least 6 months after the stressor

TABLE 7-2   DSM-IV-TR Diagnostic Criteria for Acute Stress Disorder (ASD)

A. The person has been exposed to a traumatic event in which both of the following were present:

   1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

   2. The person's response involved intense fear, helplessness, or horror.

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

   1. A subjective sense of numbing, detachment, or absence of emotional responsiveness

   2. A reduction in awareness of his or her surroundings (e.g., "being in a daze")

   3. Derealization

   4. Depersonalization

   5. Dissociative amnesia (i.e., the inability to recall an important aspect of the trauma)

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

- Earlier versions of DSM defined trauma as an event "outside the range of usual human experience.
- Even before September 11, however, researchers discovered that, unfortunately, many traumatic stressors are a *common* part of human experience in the United States today.

- Thus DSM-IV-TR defines trauma as (1) the experience of an event involving actual or threatened death or serious injury to self or others and (2) a response of intense fear, helplessness, or horror in reaction to the event.
- The psychological effects of exposure to natural or man-made disasters, like September 11 or the Oklahoma City bombing in 1995 are of great concern.
- September 11 also called attention to the trauma experienced by emergency workers.

Frequency of Trauma, PTSD, and ASD
1-The National Comorbidity Survey found that nearly 8 percent of people living in the United States will experience PTSD at some point in their lives, including about 10 percent of women and 5 percent of men.
2-Research finds that women are especially likely to develop PTSD as a result of rape, while combat exposure is a major risk factor for PTSD among men.
- PSTD is also commonly found among crime victims.
- Still, the single most common cause of PTSD is the sudden, unexpected death of a loved one.
- In general, trauma does not occur completely at random.
- The development of PTSD following a trauma is also not random.
- Researchers have found that people who suffer from ASD are more likely to develop PTSD subsequently.
- The prediction is far from perfect, however, and two caveats bear special scrutiny.
- First, people with *subclinical* ASD, that is, with symptoms that are not severe or pervasive enough to meet diagnostic criteria, nevertheless are at greater risk for PTSD than trauma victims with relatively few psychological symptoms.
- Second, the different symptoms of ASD are not equally good in predicting future PTSD.
- The presence of three symptoms—numbing, depersonalization, and a sense of reliving the experience—are the best predictors of PTSD.
- Other research shows how the symptoms of PTSD diminish gradually as time passes.
- However, PTSD can be a chronic disorder.

- Scientists studying social factors and the risk for PTSD have focused primarily on (1) the nature of the trauma and the individual's level of exposure to it and (2) the availability of social support following the trauma.
- Victims of trauma are more likely to develop PTSD when the trauma is more intense, life-threatening, and involves greater exposure.
- As with less severe stressors, social support after a trauma can play a crucial role in alleviating long-term psychological damage.
- A lack of social support is thought to have contributed to the high prevalence of PTSD found among Vietnam veterans.
- In an analysis of more than 4,000 twin pairs, researchers found that MZ twins had a higher concordance rate than DZ twins for experiencing trauma, specifically exposure to combat.
- Following exposure to trauma, identical twins also had higher concordance rates for PTSD symptoms than did fraternal twins.
- A very different line of research focuses on the biological *consequences* of exposure to trauma and how these consequences may play a role in the maintenance of PTSD.
- People with PTSD show alterations in the functioning and perhaps even the structure of the amygdala and hippocampus, two biological findings consistent, respectively, with the experience of heightened fear reactivity and intrusive memories.
- Other evidence finds that PTSD is associated with increased levels of circulating norepinephrine and general psychophysiological arousal, for example, an increased resting heart rate.
- Together, the pattern of biological findings suggests that the sympathetic nervous system is aroused and the fear response is sensitized in PTSD.
- The heightened reactivity may be due to the failure of the stress response system to shut down.
- According to two-factor theory, classical conditioning *creates* fears when the terror inherent in trauma is paired with the cues associated with the traumatic event.
- Operant conditioning, in turn, *maintains* the fears.
- Specifically, when fear-producing situations are avoided, the avoidance is negatively reinforced by the reduction of anxiety.
- More recent psychological perspectives focus on individual differences in the risk for ASD and PTSD.
- In addition to preexisting mental health problems, research indicates that cognitive factors such as expectancies, preparedness, and control influence the risk for PTSD following a trauma.
- Some theories suggest that dissociation is an unconscious defense that helps victims to cope with trauma.
- However, research indicates that dissociation is associated with more not less PTSD.
- Dissociation may not be adaptive, but most theorists agree that victims of trauma must, over time, find a balance between gradually facing their painful emotions while not being overwhelmed by them.
- Psychologist Edna Foa, a leading PTSD researcher, has highlighted the importance of *emotional processing,* which involves facing fear, diminishing its intensity, and coming to some new understanding about the trauma and its consequences.
- Integrating the experience of trauma with broader memories and beliefs involves the task of *meaning making*—finding some broader reason or higher value for enduring the trauma.
- The combined evidence suggests alternative pathways can lead to ASD and PTSD.
- Anyone might develop ASD or PTSD given a critical level of exposure and a trauma of sufficient intensity.
- The development of PTSD results from a combination of factors, including personality characteristics that predate the trauma, exposure during the trauma, and emotional processing and social support afterwards.

Prevention and Treatment of ASD and PTSD

- The potential for preventing PTSD is so important that the federal Emergency Management Agency, the government agency that deals with natural and manmade disasters, is required to provide special funding to community mental health centers during disasters.
- Perhaps the most widely used early intervention is critical incident stress debriefing (CISD), a single 1 to 5 hour group meeting offered within 1 to 3 days following a disaster.
- CISD involves several phases where participants share their experiences, reactions, group leaders offer education, assessment, and referral if necessary.
- Since World War I, interventions with soldiers who drop out of combat have been based on the three principles of offering (1) immediate treatment in the (2) proximity of the battlefield with the (3) expectation of return to the front lines upon recovery.
- The trauma of combat and the structure of the military make generalization of these principles to other traumas difficult, but the goals are logical ones to modify to fit the unique circumstances of other traumas.
- Few studies of the treatment of ASD have been conducted, a circumstance that is not surprising given that the diagnosis was developed only recently.
- Nevertheless, some research indicates that structured interventions with ASD *can* lead to the prevention of future PTSD.
- Psychotherapists who specialize in PTSD suggest some general principles for the psychological treatment of the disorder.

In the order in which they are likely to be addressed in therapy, these include

1) Establishing a trusting therapeutic relationship
2) Providing education about the process of coping with trauma
3) Stress-management training
4) Encouraging the re-experience of the trauma and
5) Integrating the traumatic event into the individual's experience.

DISSOCIATIVE AND SOMATOFORM DISORDERS I

What is stress?
- Stress is a process of adjusting to circumstances that disrupt or threaten to disrupt person's equilibrium.
- Scientists define **stress** as any challenging event that requires physiological, cognitive, or behavioral adaptation.
- Stress is an unavoidable, and in some cases a desirable, fact of everyday life.
- Some stressors, however, are so catastrophic and horrifying that they can cause serious psychological harm.
- Such **traumatic stress** is defined in DSM-IV-TR as an event that involves actual or threatened death or serious injury to self or others and creates intense feelings of fear, helplessness, or horror.

1-Acute stress disorder (ASD) occurs within 4 weeks after exposure to traumatic stress and is characterized by dissociative symptoms, re-experiencing of the event, avoidance of reminders of the trauma, and marked anxiety or arousal.

2-Posttraumatic stress disorder (PTSD) is also defined by symptoms of re-experiencing, avoidance, and arousal, but in PTSD the symptoms either are longer lasting or have a delayed onset.

Symptoms of ASD and PTSD

1-People who have been confronted with a traumatic stressor *re-experience* the event in a number of different ways.

2-Many people with ASD or PTSD have repeated and intrusive **flashbacks,** sudden memories during which the trauma is replayed in images or thoughts—often at full emotional intensity.

3-In rare cases, re-experiencing occurs as a *dissociative state,* and the person feels and acts as if the trauma actually were recurring in the moment.

4-Marked or persistent avoidance of stimuli associated with the trauma is another symptom of ASD and PTSD.

Example
    1- December 2004 tsunami trauma
    2- September 11th 2001 trauma
    3- October 8th trauma

Trauma victims may attempt to avoid thoughts or feelings related to the event, or they may avoid people, places, or activities that remind them of the trauma.

5-In PTSD, the avoidance also may manifest itself as a general *numbing of responsiveness.*
People suffering from PTSD often complain that they suffer from "emotional anesthesia"—their feelings seem dampened or even nonexistent.

6- People with ASD and PTSD also experience increased arousal and anxiety following the trauma, a symptom which predicts a worse prognosis when it is more severe.

7-A number of people with PTSD or ASD also have an *exaggerated startle response,* excessive fear reactions to unexpected stimuli, such as loud noises.

8-Other people experience *depersonalization,* feeling cut off from themselves or their environment. People with this symptom may report feeling like a robot or as if they were sleepwalking.

9-*Derealization* is characterized by a marked sense of unreality about yourself or the world around you.

ASD also may be characterized by features of *dissociative amnesia,* specifically the inability to recall important aspects of the traumatic experience.

DSM-IV-TR lists a sense of numbing or detachment from others as dissociative symptoms that characterize acute stress disorder.

Diagnosis of ASD and PTSD
Maladaptive reactions to traumatic stress have long been of interest to the military.

Historically, most of the military's concern has focused on men who leave the field of action as a result of what has been called "shell shock" or "combat neurosis."

The basic diagnostic criteria for PTSD—re-experiencing, avoidance, and arousal—have remained more or less the same in revisions of the DSM.

However, two significant changes in the classification of traumatic stress disorders were made with the publication of DSM-IV in 1994: Acute stress disorder was included as a separate diagnostic category, and the definition of trauma was altered.

Prevention and Treatment of ASD and PTSD

Mounting evidence supports the effectiveness of various cognitive behavioral treatments.

A recent consensus statement on the treatment of PTSD concluded that antidepressant medication and psychotherapy involving therapeutic re-exposure are the two "first-line" therapies for PTSD.

Let us talk about dissociative disorders.

- Is it possible to forget who are you?
- It is really possible to forget your past?
- Can you have no recollection of your family at all?
- Is it actually possible to have no memory of your personal identity or family or work role?
- And is it true that there are more cases today than even before?

Dissociative Disorders

Individuals with a dissociative disorder experience a severe disruption or alteration of their identity, memory, or consciousness. It is based on the unbelievable.

Example

A housewife forgets her name her entire past life has dissociative disorder.

A policeman, who abandoned his family, has dissociative disorder.

They are characterized by persistent, maladaptive disruptions in the integration of memory, consciousness, or identity the person with a dissociative disorder may be unable to remember many details about the past; he or she may wander far from home and perhaps assume a new identity; or two or more personalities may coexist within the same person.

Dissociative disorders once were viewed as expressions of hysteria.

In Greek, *hysteria* means "uterus," and the term **hysteria** reflects ancient speculation that these disorders were caused by frustrated sexual desires, particularly the desire to have a baby.

Janet was a French philosophy professor who conducted psychological experiments on dissociation and both Janet and Freud were eager to explain and treat hysteria, and the problem led both of them to develop theories about unconscious mental processes.

Janet saw dissociation as an abnormal process.

In contrast, Freud considered dissociation as a normal process, a routine means through which the ego defended itself against unacceptable unconscious thoughts.

Freud saw dissociation and repression as similar processes, and in fact, he often used the two terms interchangeably.

Hypnosis is in which subjects experience loss of control over their actions in response to suggestions from the hypnotist, is a topic of historical importance and contemporary debate about the unconscious mind.

All agree that demonstrations of the power of hypnotic suggestion are impressive.

However, some experts assert that hypnosis is the dissociative experience of an altered state of consciousness.

Symptoms of Dissociative Disorders

1-The symptoms of dissociative disorders apparently involve mental processes that occur outside of conscious awareness.

2-Extreme cases of dissociation include a split in the functioning of the individual's some researchers and clinicians argue that DID is linked with a past trauma, particularly with child's physical or sexual abuse.

A related issue is very controversial topic of **recovered memories,** dramatic recollections of long-ago traumatic experiences supposedly blocked from the conscious mind by dissociation.

3-Depersonalization is a form of dissociation wherein people feel detached from themselves or their social or physical environment.

4-**Amnesia**—the partial or complete loss of recall for particular events or for a particular period of time.

5-Brain injury or disease can cause amnesia.

6-But **Psychogenic Amnesia** (psychologically caused amnesia) results from traumatic stress or other emotional distress.

• Psychogenic amnesia may occur alone or in conjunction with other dissociative experiences.

7-It is widely accepted that fugue and psychogenic amnesia are usually precipitated by trauma, thus providing another link between dissociation and traumatic stress disorders.

• Much more controversial is the role that trauma might play in dissociative identity disorder (DID).

Diagnosis of Dissociative Disorders

For centuries, theorists considered dissociative and somatoform disorders as alternative forms of hysteria.

• However, the descriptive approach to classification introduced in DSM-III (1980) led to the separation of dissociative and somatoform disorders into discrete diagnostic categories.

• The distinction is preserved in DSM-IV-TR (2000), because the symptoms of the two disorders differ greatly.

• The types of dissociative disorders discussed in this lecture are dissociative amnesia, dissociative fugue, dissociative identity disorder and depersonalized disorder. Although dissociative disorders typically involve disruption of identity, dissociative amnesia can involve loss of memory without loss of identity.

• The term *psychogenic* was used in the names of these disorders- as in psychogenic amnesia and psychogenic fugue - to indicate that the fugue or memory loss is not physically caused.

1-   Dissociative Amnesia

• Each of us, throughout our lives, has forgotten certain things- a person's name, a friend's birthday, the need to stop at a store on the way home. Forgetfulness, however, is not yet the same as memory loss. The person with memory loss is unable to recall important personal information too extensive to be viewed in terms of forgetfulness. When there is actual damage to the brain, from injury or disease, the information that isn't recalled is lost forever.

• But in dissociative (psychogenic) amnesia, the memory system is not physically damaged, yet there is selective psychologically motivated forgetting. Often, what has been forgotten is traumatic for the individual. It sometimes be retrieved from memory.

• There are two main types of amnesia: selective and generalized. In cases of **selective dissociative amnesia**, a person forgets some but not of what happened during a certain period of time.

• In contrast to the selective dissociative amnesia, the person who is suffering from generalized dissociative amnesia forgets one's entire life history.

• What did you eat for breakfast today? When is your birthday? These questions do not tax our memory system and appear easy to answer. When you read a textbook but struggle to answer exam questions, you might complain that just "can't remember." Why?

1- Forgetting happens as a routine part of life, and there are several explanations for why you forget. *Decay theory* maintains that loss of memory is a result of disuse and the passage of time; if information is not used or rehearsed it fades over time.

2- *Interference theory* suggests that memory has a limited capacity; when its capacity is reached; you are susceptible to confusion and forgetting.

3- Another theory suggests that forgetting occurs when there is failure in the *process of retrieving information.* The information is there, stored away, but it appears to have been forgotten because you cannot retrieve it.

- *Repression,* then, is motivated forgetting, or the burying of unwanted memories in the unconscious where they stay largely unreachable.

2- Dissociative fugue

The fugue state involves physical retreat; during a fugue, the individual suddenly and unexpectedly departs. Two important features for diagnosing **dissociative (psychogenic) fugue** are listed in DSM-IV: a sudden unexpected travel away from home or work with an inability to recall one's past, and confusion about personal identity. Marked confusion about personal identity interferes with routine daily activities, so, in an effort to adjust and relate to others, the person assumes a new identity. Despite the new assumed identity, characteristics of the "old self" are recognizable. Often, complicated behaviors are carried out during the fugue. A victim may drive a long distance, find a place to live, obtain employment, and begin a new life.

Who is Affected with Dissociative Amnesia and Fugue?

Both dissociative amnesia and fugue are rare. Reports of case suggest that these disorders can appear at any point in the life span, though less among the elderly. Amnesia is most frequent among adolescent and young women, but its incidence increases slightly among men.

Treating Dissociative Amnesia and Fugue

Not surprisingly, a person in an amnesic or in a fugue state who is unaware of important facts about his or her own identity is often equally uninformed about the need for therapy. Typically, dissociative amnesic and fugue patients do not seek treatment themselves but, rather, are referred to a therapist after an episode has occurred. The therapy itself often addresses clients' need for more adaptive ways to manage personal distress and conflict.

- Stress management programs, may be used to treat dissociative amnesia and fugue.

3- Dissociative Identity Disorder (DID)

- Also known as **multiple personality disorder**, is characterized by the existence of two or more distinct personalities in a single individual.
- At least two of these personalities repeatedly take control of the person's behavior, and the individual's inability to recall information is too extensive to be explained by ordinary forgetfulness.
- The original personality especially is likely to have amnesia for subsequent personalities, which may or may not be aware of the "alternates."
- DID has received considerable public attention, but where does it fit among the many different types of psychological disorders? Readers may wonder whether it is related to the *personality disorders.* It is not: Unlike DID, personality disorders involve clusters of behavioral traits that are excessive, maladaptive, lifelong, and pervasive. Also, although DID may resemble a "split mind," which is the literal translation of the word *schizophrenia.*

Examples

1-"Sybil," a girl with sixteen personalities, DID is characterized by the presence of two or more distinct personalities of personality states within one individual patterns.

2-The Three Faces of Eve, who describes a client, whose three different personalities virtual opposites in terms of their emotional and behavioral patterns. Eve White was the quiet, polite, hard-working, and conservative mother of a young daughter; Eve Black was seductive, impulsive, risk-taking, and adventure-seeking. Jane, the third personality, was a confident and capable woman.

Who Is Affected with DID?

DID has been found to occur many time more often in women than in men (estimated rates are three to nine times higher in women). The most common explanations offered for this variance are that

women are typically more exposed to sexual abuse, women may handle their psychological traumas in "internal" ways and finally women tend to seek help more than men do.

Treating DID
Antidepressants and anti-anxiety drugs would be the medications commonly used in these circumstances. Once DID is detected, however, the typical treatment involves psychotherapy aimed at helping replace the patients' internal division with a unity of personalities (Putnam, 1989).

4- Depersonalization disorder
- Depersonalization disorder is a less dramatic problem that is characterized by severe and persistent feelings of being detached from oneself.
- Depersonalization experiences include such sensations as feeling as though you were in a dream or were floating above your body and observing yourself acted.

Diagnosis of Dissociative Disorders (continued)
Occasional depersonalization experiences are normal and are reported by about half of the population.

Causes of Dissociative Disorders
The onset of dissociative amnesia and fugue usually can be traced to a specific traumatic experience.

DISSOCIATIVE and SOMATOFORM DISORDERS II

Individuals with a dissociative disorder experience a severe disruption or alteration of their identity, memory, or consciousness. It is based on the unbelievable things.
Example
A housewife forgets her name her entire past life she has dissociative disorder.

Kinds of Dissociative disorders
The types of dissociative disorders discussed in this lecture are dissociative amnesia, dissociative fugue, dissociative identity disorder and depersonalized disorder. Although dissociative disorders typically involve disruption of identity, dissociative amnesia can involve loss of memory without loss of identity.

Diagnosis of Dissociative Disorders
- For centuries, theorists considered dissociative and somatoform disorders as alternative forms of hysteria.
- However, the descriptive approach to classification introduced in DSM-III (1980) led to the separation of dissociative and somatoform disorders into discrete diagnostic categories.
- The distinction is preserved in DSM-IV-TR (2000), because the symptoms of the two disorders differ greatly.

1- The symptoms of dissociative disorders apparently involve mental processes that occur outside of conscious awareness.
2- Extreme cases of dissociation include a split in the functioning of individual's sense of self.
3- *Depersonalization* is a form of dissociation wherein people feel detached from themselves or their social or physical environment.
4- Amnesia—the partial or complete loss of recall for particular events or for a particular period of time.
5- Brain injury or disease can cause amnesia.
6- But **Psychogenic Amnesia** (psychologically caused) results from traumatic stress or other emotional distress. Psychogenic amnesia may occur alone or in conjunction with other dissociative experiences.
7- It is widely accepted that psychogenic fugue and psychogenic amnesia are usually precipitated by trauma, thus providing another link between dissociation and traumatic stress disorders.

Some researchers and clinicians argue that DID is linked with a past trauma, particularly with child's physical or sexual abuse. The term *psychogenic* was used in the names of these disorders- as in psychogenic amnesia and psychogenic fugue - to indicate that the fugue or memory loss is not physically caused.

1-Dissociative Amnesia   each of us, throughout our lives, has forgotten certain things- a person's name, a friend's birthday, the need to stop at a store on the way home. Forgetfulness, however, is not yet the same as memory loss. The person with memory loss is unable to recall important personal information too extensive to be viewed in terms of forgetfulness. When there is actual damage to the brain, from injury or disease, the information that isn't recalled is lost forever.
- But in dissociative (psychogenic) amnesia, the memory system is not physically damaged, yet there is selective psychologically motivated forgetting. Often, what has been forgotten is traumatic for the individual. It can sometimes be retrieved from memory.
- There are two main types of amnesia: selective and generalized. In cases of **selective dissociative amnesia**, a person forgets some but not of what happened during a certain period of time.
- In contrast to the selective dissociative amnesia, the person who is suffering from generalized dissociative amnesia forgets one's entire life history.

2-Dissociative fugue   the fugue state involves physical retreat; during a fugue, the individual suddenly and unexpectedly departs. Two important features for diagnosing **dissociative (psychogenic) fugue** are listed in DSM-IV: a sudden unexpected travel away from home or work with an inability to recall one's past, and confusion about personal identity. Marked confusion about personal identity interferes with routine daily activities, so in an effort to adjust and relate to others, the person assumes a new identity. Despite the new assumed identity, characteristics of the "old self" are recognizable. Often, complicated behaviors are carried out during the fugue. A victim may drive a long distance, find a place to live, obtain employment, and begin a new life.

3-Dissociative identity disorder (DID), also known as **multiple personality disorder**, is characterized by the existence of two or more distinct personalities in a single individual.
- At least two of these personalities repeatedly take control of the person's behavior, and the individual's inability to recall information is too extensive to be explained by ordinary forgetfulness.
- The original personality especially is likely to have amnesia for subsequent personalities, which may or may not be aware of the "alternates."
- *Examples*

1-"Sybil," a girl with sixteen personalities, DID is characterized by the presence of two or more distinct personalities of personality states within one individual patterns.
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4-Depersonalization disorder is a less dramatic problem that is characterized by severe and persistent feelings of being detached from oneself.
- Depersonalization experiences include such sensations as feeling as though you were in a dream or were floating above your body and observing yourself as acting.

Somatoform Disorders

- Do some individuals really need a cabinet full of medicines to deal with their many ailments, or they might benefit more from psychological counseling?
- Do we sometimes respond physically- for example, by becoming paralyzed- to psychological stress?
- When mind-body interactions are maladaptive, a somatoform disorder may result. Somatoform disorders involve physical symptoms, in the absence of physical illness for which there is no adequate explanation. (*Soma* means body, and *somatoform* means "bodylike." One patient with a somatoform disorder may report being blind but according to medical tests, have normal functioning eyes.

Somatoform disorders are problems characterized by unusual physical symptoms that occur in the absence of a known physical illness.

1-There is no demonstrable physical cause for the symptoms of somatoform disorders. They are somatic (physical) in form only— their name.
2-All somatoform disorders involve complaints about physical symptoms, but not caused by physical impairments. There is nothing physically wrong with the patient.
3-The physical problem is very real in the mind, though not the body, of the person with a somatoform disorder.
4-The physical symptoms can take a number of different forms substantial impairment of a somatic system, particularly a sensory or muscular system. The patient will be unable to see, for example, or will report a paralysis in one arm.
5-In other types of somatoform disorder, patients experience multiple physical symptoms usually numerous, complaints about such problems as chronic pain, upset stomach, and dizziness.
6-Finally, some types of somatoform disorder are defined by a preoccupation

A- With a particular part of the body say eyes or stomach or
B- With fears about a particular illness.
The patient may constantly worry that he or she has contracted some deadly disease, for example, and the anxiety persists despite negative medical tests and clear reassurance by a physician.
7-People with somatoform disorders typically do not bring their problems to the attention of a mental health professional.
Instead, they repeatedly consult their physicians about their "physical" problems. This often leads to unnecessary medical treatment.

Kinds of Somatoform Disorders

DSM-IV-TR lists five major subcategories of somatoform disorders:
(1) Conversion disorder
(2) Somatization disorder
(3) Hypochondriasis
(4) Pain disorder
(5) Body Dysmorphic disorder

1- Conversion Disorder

- The symptoms of conversion disorder often mimic those found in neurological diseases, and they can be dramatic.
- "Hysterical" blindness or "hysterical" paralysis are examples of conversion symptoms. Although conversion disorders often resemble neurological impairments, they sometimes can be distinguished from these disorders because they make no anatomic sense. The term *conversion disorder* accurately conveys the central assumption of the diagnosis—the idea that psychological conflicts are converted into physical symptoms.
- One or more symptoms or deficits affecting voluntary sensory or motor functioning that cannot be explained by a neurological or general medical condition (after appropriate investigation) and is not a culturally sanctioned behavior. Psychological factors (though not intentional) are judged to be involved because symptoms are exacerbated under stress and the symptoms are useful for the patient's avoidance of stress. The symptoms or deficits cause clinically significant distress or impairment in social, occupational, other important areas of functioning.

2-Somatization disorder

- Somatization disorder is characterized by a history of multiple somatic complaints in the absence of organic impairments.
- In order to be diagnosed with somatization disorder, the patient must complain of at least eight physical symptoms and must involve multiple somatic systems.
- Patients with somatization disorders sometimes present their symptoms in a *histrionic* manner—a vague but dramatic, self-centered, and seductive style. Patients also may exhibit *la belle indifference* ("beautiful indifference"), a flippant lack of concern about the physical symptoms.

TABLE 7–5   DSM-IV-TR Diagnostic Criteria for Somatization Disorder

A. A history of many physical complaints beginning before age 30 that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.

B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance.
1. Four pain symptoms: A history of pain related to at least four different sites or functions (for example, head, abdomen, back, joints, extremities, chest, rectum, during menstruation, or sexual intercourse, or during urination)
2. Two gastrointestinal symptoms: A history of at least two gastrointestinal symptoms other than pain (for example, nausea, diarrhea, bloating, vomiting other than during pregnancy, or intolerance of several different foods)
3. One sexual symptom: A history of at least one sexual or reproductive symptom other than pain (for example, sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)
4. One pseudoneurologic symptom: A history of at least one symptom or deficit suggesting a neurological disorder not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)

3-Hypochondriasis
- Hypochondriasis is a problem characterized by a fear or belief that one is suffering from a physical illness.
- Hypochondriasis is much more serious than normal and fleeting worries.
- The preoccupation with fears of disease extends over long periods of time.
- In addition, in hypochondriasis, a thorough medical evaluation or examination does not alleviate the fear of the disease.
- Based on misinterpretations of bodily reactions, the sufferer is preoccupied with fears of having a serious disease. Though not a delusion, the fear persists despite medical evaluations. The preoccupation causes clinical distress of at least six months duration.

4-Pain disorder
- Pain disorder is characterized by preoccupation with pain.
- Complaints seem excessive and apparently are motivated at least in part by psychological factors.
- As with hypochondriasis and somatization disorder, pain disorder can lead to the repeated, unnecessary use of medical treatments.

5-Body dysmorphic disorder
- Body dysmorphic disorder is a somatoform disorder in which the patient is preoccupied with some imagined defect in appearance.
- The preoccupation typically focuses on some facial feature, such as the nose or mouth, and in some cases may lead to repeated visits to a plastic surgeon.
- Preoccupation with the body part far exceeds normal worries about physical imperfections.
- Preoccupation with and imagined defect in appearance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

5-Somatoform disorders must be distinguished from **malingering,** pretending to have a somatoform disorder in order to achieve some external gain, such as a disability payment.

6-A related diagnostic concern is **factitious disorder,** a fake condition that, unlike malingering, is motivated primarily by a desire to assume the sick role rather than a desire for external gain.

7-A rare, repetitive pattern of factitious disorder is sometimes called **Munchausen syndrome,** named after Baron Karl Friedrich Hieronymus von Munchausen, an eighteenth-century writer known for his tendency to embellish the details of his life.

Frequency of Somatoform Disorders

Conversion disorders are rare, perhaps as infrequent as 50 cases per 100,000 population. Most other somatoform disorders also appear to be relatively rare. For example, one study found a 0.7 percent prevalence of body dysmorphic disorder.

Hypochondriasis is also quite rare, although less severe worrying about physical illness is quite common. The lifetime prevalence of somatization disorder in the United States is only 0.13 percent. With the exception of hypochondriasis, all other forms of somatoform disorder are more common among women. This is particularly true of somatization disorder, which may be as much as10 times more common among women than men.

In addition to gender, socioeconomic status and culture are thought to contribute to somatization disorder. In the United States, somatization is more common among lower socioeconomic groups and people with less than a high school education. It is four times more common among African Americans. Somatoform disorders typically occur with other psychological problems, particularly depression and anxiety. Finally, somatization disorder has frequently been linked with antisocial personality disorder, a lifelong pattern of irresponsible behavior that involves habitual violations of social rules.

The two disorders do not typically co-occur in the same individual, but they often are found in different members of the same family. An obvious—and potentially critical —biological consideration in somatoform disorders is the possibility of misdiagnosis. A patient may be incorrectly diagnosed as suffering from a somatoform disorder when, in fact, he or she actually has a real physical illness that is undetected or is perhaps unknown. Because mental health professionals cannot demonstrate psychological causes of physical symptoms objectively and unequivocally, the identification of somatoform disorders involves a process called *diagnosis by exclusion.*

The physical complaint is assumed to be a part of a somatoform disorder only when various known physical causes are excluded or ruled out. Initially, both Freud and Janet assumed that conversion disorders were caused by a traumatic experience. Freud later came to believe that dissociation and other intrapsychic defenses protected individuals from their unacceptable sexual impulses, not from their intolerable memories. In Freud's view, conversion symptoms were expressions of intolerable unconscious psychological conflicts. In Freudian terminology, this is the ***primary gain*** of the symptom. Freud also suggested that hysterical symptoms could produce ***secondary gain,*** for example, avoiding work or responsibility or to gain attention and sympathy.

Social and cultural theorists offer a straightforward explanation of the physical symptoms of somatization disorder, hypochondriasis, and pain disorder. Patients with these disorders are experiencing some sort of underlying psychological distress. However, they describe their problems as physical symptoms and, to some extent, experience them that way because of limited insight and/or the lack of social tolerance of psychological complaints.

Treatment of Somatoform Disorders

1- Cognitive behavior therapy is effective in reducing physical symptoms in somatization disorder, hypochondriasis, and body dysmorphic disorder.

2-Recent evidence also indicates that antidepressants may be helpful in treating somatoform disorders.

PERSONALITY DISORDERS I

We often hear remarks that some people have a pleasing personality while others have charming and fascinating personality. Some political leaders have charismatic personality while others have repulsive and annoying personality. So the question comes to your mind that

What is personality?
Personality refers to characteristic ways a person behaves and thinks.
Example
- A is shy and timid.
- B is sensitive and gets upset easily.
- C is suspicious of friends and family.
- D is confident and successful.

Definition of Personality
Personality refers to enduring patterns of thinking and behavior that define the person and distinguish him or her from other people.

These patterns are ways of expressing emotion as well as patterns of thinking about ourselves and other people. When enduring patterns of behavior and emotion bring the person into repeated conflicts with others, and when they prevent the person from maintaining close relationships with others, an individual's personality may be considered disordered.

All of the personality disorders are based on exaggerated personality traits that are frequently disturbing or annoying to other people. In order to qualify for a personality disorder diagnosis in DSM-IV-TR, a person must fit the *general definition* of personality disorder (which applies to all 10 subtypes) and must also meet the *specific criteria* for a particular type of personality disorder. The specific criteria consist of a list of traits and behaviors that characterize the disorder. The general definition of personality disorder presented in DSM-IV-TR emphasizes the duration of the pattern and the social impairment associated with the traits in question.
The pattern must be evident in two or more of the following domains:
1- Cognition (such as ways of thinking about the self and other people)
2- Emotional responses
3- Interpersonal functioning
4- Impulse control.

This pattern of maladaptive experience and behavior must also be:
      1- Inflexible and pervasive across a broad range of personal and social situations,
      2- The source of clinically significant distress or impairment in social, occupational, or other important areas of functioning,
      3- Stable and of long duration, with an onset that can be traced back at least to adolescence or early adulthood.

The concept of social dysfunction plays an important role in the definition of personality disorders. It provides a large part of the justification for defining these problems as mental disorders. Personality disorders are among the most controversial categories in diagnostic system for mental disorders.
1- They are difficult to identify reliably, their etiology is poorly understood, and there is relatively little evidence to indicate that they can be treated successfully.
2- Although they are difficult to define and measure, but personality disorders are also important in the field of psychopathology.

Several observations support this argument.
- First, personality disorders are associated with significant social and occupational impairment.
- Second, the presence of pathological personality traits during adolescence is associated with an increased risk for the subsequent development of other mental disorders.
- Third, in some cases, personality disorders actually represent the beginning stages of the onset of a more serious form of psychopathology.
- Finally, the presence of a comorbid personality disorder can interfere with the treatment of a disorder such as depression.

Most other forms of mental disorder, such as anxiety disorders and mood disorders, are ego-dystonic; that is, people with these disorders are distressed by their symptoms and uncomfortable with their situations. Personality disorders are usually ego-syntonic—the ideas or impulses with which they are associated are acceptable to the person. People with personality disorders frequently do not see themselves as being disturbed. We might also say that they do not have insight into the nature of their own problems.

The ego-syntonic nature of many forms of personality disorder raises important questions about the limitations of self-report measures—interviews and questionnaires—for their assessment. Many people with personality disorders are unable to view themselves realistically and are unaware of the effect that their behavior has on others. The specific symptoms that are used to define personality disorders represent maladaptive variations in several of the building blocks of personality.

Causes of Personality Disorders
These causes include motives, cognitive perspectives regarding the self and others temperament and personality traits.

1- Motive
- The concept of a motive refers to a person's desires and goals.
- Motives (either conscious or unconscious) describe the way that the person would like things to be, and they help to explain *why* people behave in a particular fashion.
- The most important motives in understanding human personality are *affiliation*—the desire for close relationships with other people —and *power*—the desire for impact, prestige, or dominance.
- Individual differences with regard to these motives have an important influence on a person's health and adjustment.
- Many of the symptoms of personality disorders can be described in terms of maladaptive variations with regard to needs for affiliation and power.

2- Cognitive Perspectives
- Our social world also depends on mental processes that determine knowledge about us and other people which includes the mental process of perception. When distortions take place in these mechanisms we come across personality disorders.
- When we misperceive the intentions and motives and abilities of other people, our relationships can be severely disturbed.
- Many elements of social interaction also depend on being able to evaluate the nature of our relationships with other people and then to make accurate judgments about appropriate and inappropriate behaviors.

3- Temperament and Personality Traits
- *Temperament* refers to a person's most basic, characteristic styles of relating to the world, especially those styles that are evident during the first year of life.
- Experts disagree about the basic dimensions of temperament and personality. Some theories are relatively simple, using only three or four dimensions. While others are more complicated and consider as many as 30 or 40 traits.

- One point of view that has come to be widely accepted is known as the five factor model of personality.
- The basic traits (also known as domains) included in this model are neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness.
- Taken as a whole, the five-factor model provides a relatively comprehensive description of any person's behavior.
- The authors of DSM-IV-TR have organized ten specific forms of personality disorder into three clusters on the basis of broadly defined characteristics.

TABLE 9–2   Personality Disorders Listed in DSM-IV-TR

Cluster A includes people who often appear odd or eccentric

Paranoid	Distrust and suspiciousness of others.
Schizoid	Detachment from social relationships and restricted range of expression of emotions.
Schizotypal	Discomfort with close relationships; cognitive and perceptual distortions; eccentricities of behavior.

Cluster B includes people who often appear dramatic, emotional, or erratic

Antisocial	Disregard for and frequent violation of the rights of others.
Borderline	Instability of interpersonal relationships, self-image, emotions, and control over impulses.
Histrionic	Excessive emotionality and attention seeking.
Narcissistic	Grandiosity, need for admiration, and lack of empathy.

Cluster C includes people who often appear anxious or fearful

Avoidant	Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
Dependent	Excessive need to be taken care of, leading to submissive and clinging behavior.
Obsessive–compulsive	Preoccupation with orderliness and perfectionism at the expense of flexibility.

- The behavior of people who fit the subtypes in cluster A is typically odd, eccentric, or asocial. All three types share similarity with the symptoms of schizophrenia.
- One implicit assumption in the DSM-IV-TR system is that these types of personality disorder may represent behavioral traits or interpersonal styles that precede the onset of full-blown psychosis.
- Because of their close association with schizophrenia, they are sometimes called *schizophrenia spectrum disorders.*

1- Paranoid Personality
Paranoid personality disorder is characterized by the pervasive tendency to be inappropriately suspicious of other people's motives and behaviors. Because paranoid people do not trust anyone, they have trouble maintaining relationships with friends and family members.

2- Schizoid Personality
Schizoid personality disorder is defined in terms of a pervasive pattern of indifference to other people, coupled with a diminished range of emotional experience and expression. These people are loners; they prefer social isolation to interactions with friends or family.

3- Schizotypal Personality
Schizotypal personality disorder centers on peculiar patterns of behavior rather than on the emotional restriction and social withdrawal that are associated with schizoid personality disorder. People with this

disorder may report bizarre fantasies and unusual perceptual experiences. Their speech may be slightly difficult to follow because they use words in an odd way or because they express themselves in a vague or disjointed manner. In spite of their odd or unusual behaviors, people with schizotypal personality disorder are not psychotic or out of touch with reality. According to DSM-IV-TR, these disorders are characterized by dramatic, emotional, or erratic behavior, and all are associated with marked difficulty in sustaining interpersonal relationships.

4- Antisocial Personality

Antisocial personality disorder is defined in terms of a persistent pattern of irresponsible and antisocial behavior that begins during childhood or adolescence and continues into the adult years. The DSM-IV-TR definition is based on features that, beginning in childhood, indicate a pervasive pattern of disregard for, and violation of, the rights of others. Once the person has become an adult, these difficulties include persistent failure to perform responsibilities that are associated with occupational and family roles.

5- Borderline Personality

Borderline personality disorder is a diffuse category whose essential feature is a pervasive pattern of instability in mood and interpersonal relationships. People with this disorder find it very difficult to be alone.
They form intense, unstable relationships with other people and are often seen by others as being manipulative. Many clinicians consider identity disturbance to be the diagnostic hallmark of borderline personality disorder. People with this disturbance presumably have great difficulty maintaining an integrated image of them that simultaneously incorporates their positive and negative features.

6- Histrionic Personality

Histrionic personality disorder is characterized by a pervasive pattern of excessive emotionality and attention seeking behavior. People with this disorder thrive on being the center of attention and they want the spotlight on them at all times. They are self-centered, vain, and demanding, and they constantly seek approval from others. The concept of histrionic personality disorder overlaps extensively with other types of personality disorder, especially borderline personality disorder. There may also be an etiological link between histrionic and antisocial personality disorders. Both may reflect a common, underlying tendency toward lack of inhibition. People with both types of disorder form shallow, intense relationships with others, and they can be extremely manipulative.

7- Narcissistic Personality

The essential feature of narcissistic personality disorder is a pervasive pattern of grandiosity, need for admiration, and inability to empathize with other people.
- Narcissistic people have a greatly exaggerated sense of their own importance.
- They are preoccupied with their own achievements and abilities.
- There is a considerable amount of overlap between narcissistic personality disorder and borderline personality disorder.
- Both types of people feel that other people should recognize their needs and do special favors for them.
- They may also react with anger if they are criticized.
- The distinction between these disorders hinges on the inflated sense of self-importance that is found in narcissistic personality disorder and the deflated or devalued sense of self found in borderline personality disorder.
- The common element in all three disorders is presumably anxiety or fearfulness.
- This description fits most easily with the avoidant and dependent types.
- In contrast, obsessive–compulsive personality disorder is more accurately described in terms of preoccupation with rules and with lack of emotional warmth than in terms of anxiety.

8- Avoidant Personality
- Avoidant personality disorder is characterized by a pervasive pattern of social discomfort, fear of negative evaluation, and timidity.
- People with this disorder tend to be socially isolated when outside their own family circles because they are afraid of criticism.
- Unlike people with schizoid personality disorder, they want to be liked by others, but they are extremely shy—easily hurt by even minimal signs of disapproval from other people.
- Thus they avoid social and occupational activities that require significant contact with other people.
- Avoidant personality disorder is often indistinguishable from generalized social phobia.
- Some experts have argued that they are probably two different ways of defining the same condition.
- Others have argued that people with avoidant personality disorder have more trouble than people with social phobia in relating to other people.

9-Dependent Personality
- The essential feature of dependent personality disorder is a pervasive pattern of submissive and clinging behavior.
- People with this disorder are afraid of separating from other people on whom they are dependent for advice and reassurance.
- Often unable to make everyday decisions on their own, they feel anxious and helpless when they are alone.

10- Obsessive–Compulsive Personality Disorder (OCPD
- Obsessive–compulsive personality disorder (OCPD) is defined by a pervasive pattern of orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency.
- People with this disorder set ambitious standards for their own performance that frequently are so high as to be unattainable.
- The central features of this disorder may involve a marked need for control and lack of tolerance for uncertainty.

PERSONALITY DISORDERS II

Personality refers to enduring patterns of thinking and behavior that define the person and distinguish him or her from other people.

These enduring patterns are ways of expressing emotion as well as patterns of thinking about ourselves and other people. When enduring patterns of behavior and emotion bring the person into repeated conflicts with others, and when they prevent the person from maintaining close relationships with others, an individual's personality may be considered disordered. Personality disorders are among the most controversial categories in the diagnostic system for mental disorders.
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Several observations support this argument.
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- Second, the presence of pathological personality traits during adolescence is associated with an increased risk for the subsequent development of other mental disorders.
- Third, in some cases, personality disorders actually represent the beginning stages of the onset of a more serious form of psychopathology.
- Fourth, the presence of a co-morbid personality disorder can interfere with the treatment of a disorder such as depression.
- The specific symptoms that are used to define personality disorders represent maladaptive variations in several of the building blocks of personality.
- These include
  1- Motives
  2- Cognitive perspectives regarding the self and others
  3- Temperament and personality traits.
- The authors of DSM-IV-TR have organized ten specific forms of personality disorder into three clusters on the basis of broadly defined characteristics.

TABLE 9-2	Personality Disorders Listed in DSM-IV-TR
Cluster A includes people who often appear odd or eccentric	
Paranoid	Distrust and suspiciousness of others.
Schizoid	Detachment from social relationships and restricted range of expression of emotions.
Schizotypal	Discomfort with close relationships; cognitive and perceptual distortions; eccentricities of behavior.
Cluster B includes people who often appear dramatic, emotional, or erratic	
Antisocial	Disregard for and frequent violation of the rights of others.
Borderline	Instability of interpersonal relationships, self-image, emotions, and control over impulses.
Histrionic	Excessive emotionality and attention seeking.
Narcissistic	Grandiosity, need for admiration, and lack of empathy.
Cluster C includes people who often appear anxious or fearful	
Avoidant	Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
Dependent	Excessive need to be taken care of, leading to submissive and clinging behavior.
Obsessive–compulsive	Preoccupation with orderliness and perfectionism at the expense of flexibility.

- The behavior of people who fit the subtypes in cluster A is typically odd, eccentric, or asocial. All three types share similarity with the symptoms of schizophrenia.
- The close association with schizophrenia, they are sometimes called *schizophrenia spectrum disorders.*

1- Paranoid Personality
- Paranoid personality disorder is characterized by the pervasive tendency to be inappropriately suspicious of other people's motives and behaviors.
- Paranoid people do not trust anyone; they have trouble maintaining relationships with friends and family members.

Example
Client A was frequently complaining about her boss, co-workers, teachers, father and friends. She watched everyone closely, did not accept food or medicine from anyone for the fear that it would contain poison. She did not go out with friends and co-workers that they might kill her.

2- Schizoid Personality
- Schizoid personality disorder is defined in terms of a pervasive pattern of indifference to other people, coupled with a diminished range of emotional experience and expression.
- These people are loners; they prefer social isolation to interactions with friends or family.

Example
Client B would follow her class mates to school but would hurry back to her hostel room where she would stay alone most of the time and was completely uninterested in others.

3- Schizotypal Personality
Schizotypal personality disorder centers on peculiar patterns of behavior rather than on the emotional restriction and social withdrawal that are associated with schizoid personality disorder. People with this disorder may report bizarre fantasies and unusual perceptual experiences.

Example
Client A was a young man with vague complaints of stuttering, feeling of indifference towards one's self and wanted to study stars. He had peculiar, odd language and perceptual experiences.

- The cluster B includes Antisocial, Borderline, Histrionic, and Narcissistic Personality   disorders.
- According to DSM-IV-TR, the cluster B disorders are characterized by dramatic, emotional, or erratic behavior, and all are associated with marked difficulty in sustaining interpersonal relationships.

4- Antisocial Personality
Antisocial personality disorder is defined in terms of a persistent pattern of irresponsible and antisocial behavior that begins during childhood or adolescence and continues into the adult years.
The pattern shows disregard for, and violation of the rights of others.
Once the person has become an adult, these difficulties include persistent failure to perform responsibilities that are associated with occupational and family roles.

Example
Client D is a young man who has just knocked out a man with his beer bottle because he thinks that he was insulted.
The same client has history of being kicked out of school, fighting with neighbors and he does what pleases him not what is right or wrong.

5- Borderline Personality
- Borderline personality disorder is a diffuse category whose essential feature is a pervasive pattern of instability in mood and interpersonal relationships.
- People with this disorder find it very difficult to be alone.
- They form intense, unstable relationships with other people and are often seen by others as being manipulative.

Example
Client C is a man who has been thrown out of his father's house because of bad temper and undependability. He is depressed to the point of suicidal feelings.

6- Histrionic personality
- Histrionic personality disorder is characterized by a pervasive pattern of excessive emotionality and attention seeking behavior.
- People with this disorder thrive on being the center of attention and they want the spotlight on them at all times.
- They are self-centered, vain, and demanding, and they constantly seek approval from others.

Example
Client C is an attractive woman with a lovely smile used by her to get the attention of people. Her habit of trying to be the centre of attention is annoying to others. She is moody and seemed to over-dramatize minor problems.

7- Narcissistic Personality
- The essential feature of narcissistic personality disorder is a pervasive pattern of grandiosity, need for admiration, and inability to empathize with other people.
- Narcissistic people have a greatly exaggerated sense of their own importance.
- They are preoccupied with their own achievements and abilities.

Example
Client D is a lawyer of outward charm and good looks who has won the bar elections. He has written books and has a media following. He is a man preoccupied by appearance, wealth, power and fame.

8- Avoidant Personality
- Avoidant personality disorder is characterized by a pervasive pattern of social discomfort, fear of negative evaluation, and timidity.
- People with this disorder tend to be socially isolated when they are outside their own family circle because they are afraid of criticism.

Example
Client D is a woman who has taken a job in night shift where she can have minimal contact. Off duty she spends time alone, worrying less that she may behave stupidly.

9- Dependent Personality
- The essential feature of dependent personality disorder is a pervasive pattern of submissive and clinging behavior.
- People with this disorder are afraid of separating from other people on whom they are dependent for advice and reassurance.
- Often unable to make everyday decisions on their own, they feel anxious and helpless when they are alone.

Example
Client A has lacked self confidence since childhood, relying on her mother to choose what to wear, what friends to have, which courses and classes to study.

10- Obsessive–Compulsive Personality
- Obsessive–compulsive personality disorder (OCPD) is defined by a pervasive pattern of orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency.
- People with this disorder set ambitious standards for their own performance that frequently are so high as to be unattainable.
- The central features of this disorder may involve a marked need for control and lack of tolerance for uncertainty.

- Obsessive–compulsive personality disorder should not be confused with obsessive–compulsive disorder (OCD), a type of anxiety disorder. A pattern of intrusive, unwanted thoughts accompanied by ritualistic behaviors is used to define OCD. The definition of obsessive–compulsive personality disorder, in contrast, is concerned with personality traits, such as excessively high levels of conscientiousness.

Example
Client A has a reputation of being careful and conscientious and careful.
He works long hours and brings a lot of money to the firm but he is humorless but takes a lot time in procedural details in staff meetings.

The common element in all three disorders is presumably anxiety or fearfulness.
This description fits most easily with the avoidant and dependent types. In contrast, obsessive–compulsive personality disorder is more accurately described in terms of preoccupation with rules and with lack of emotional warmth than in terms of anxiety. Like people with avoidant personality disorder, they are easily hurt by criticism, extremely sensitive to disapproval, and lacking in self confidence. One difference between them is that people who are avoidant have trouble initiating a relationship (because they are fearful). People who are dependent have trouble being alone or separating from other people with whom they already have a close relationship.

The Diagnosis
The diagnosis of Personality Disorders is not an easy and simple task because
1- There are a lot of people with serious personality problems who do not fit the official DSM-IV-TR subtypes.
2- Another frequent complaint about the description of personality disorders is the considerable overlap among categories.
3- Many patients meet the criteria for more than one type.

   Thus, for diagnosis of personality disorders many experts favor the proposal to use the five-factor model of personality as the basic structure for a comprehensive description of personality problems.
4- There is also extensive overlap between personality disorders and disorders that are diagnosed on Axis I of DSM-IV-TR.

   Approximately 75 percent of people who qualify for a diagnosis on Axis II also meet criteria for a syndrome such as major depression, substance dependence, or an anxiety disorder.

Gender Differences
The overall prevalence of personality disorders is approximately equal in men and women.
Antisocial personality disorder is unquestionably much more common among men than among women.
Almost nothing is known about the extent of potential gender differences for the other types of personality disorder.
Borderline personality disorder and dependent personality disorder may be somewhat more prevalent among women than men, but the evidence is not strong.

Stability of Personality Disorders over Time
Temporal stability is one of the most important assumptions about personality disorders.
Evidence for the assumption that personality disorders appear during adolescence and persist into adulthood has, until recently, been limited primarily to antisocial personality disorder.

The rate of personality disorders was relatively high in this sample: Seventeen percent of the adolescents received a diagnosis of at least one personality disorder.

Viewed from a dimensional perspective, the maladaptive traits that represent the core features of the disorders remained relatively stable between adolescence and young adulthood.

Several studies have examined the stability of personality disorders among people who have received professional treatment for their problems, especially those who have been hospitalized for schizotypal or borderline disorders.
Recovery rates are relatively high among patients with a diagnosis of borderline personality disorder.

ALCOHOLISM AND SUBSTANCE RELATED DISORDERS I

Personality refers to enduring patterns of thinking and behavior that define the person and distinguish him or her from other people. These enduring patterns are ways of expressing emotion as well as patterns of thinking about ourselves and other people. When enduring patterns of behavior and emotion bring the person into repeated conflict with others, and when they prevent the person from maintaining close relationships with others, an individual's personality may be considered disordered.

The authors of DSM-IV-TR have organized ten specific forms of personality disorder into three clusters on the basis of broadly defined characteristics.

TABLE 9–2	**Personality Disorders Listed in DSM-IV-TR**
Cluster A includes people who often appear odd or eccentric	
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Classification of Personality Disorders
1-Paranoid personality disorder
2-Schizoid personality disorder
3-Schizotypal personality disorder
4-Antisocial personality disorder
5-Borderline personality disorder
6-Histrionic personality disorder
7-Narcissistic personality disorder
8-Avoidant personality disorder
9-dependent personality disorder
10-Obsessive–compulsive personality disorder

Alcoholism and Substance Related Disorders

Examples
- We take aspirin to reduce headache.
- We take an antibiotic to fight an infection.
- We take tranquilizer to calm us after facing a trauma.
- We drink coffee or tea to get going in the morning.
- Smoke a cigarette to relax our nerves.
- We take valium to go to sleep.

There are many substances that are capable of harming the body or adversely affecting the behavior and mood. The misuse of drugs has become one of the most disabling problems of the society.
Examples
- Sherlock Holmes fictional character who took drugs stimulants to alert him.
- Sportsmen take drugs to enhance their performance but in the long run their body develops drug dependence.

The term drug applies to any substance other than food that changes our bodily and mental functioning. Drug misuse may lead to a temporary mental syndrome such as intoxication but chronic excessive use of drugs can lead to a substance use disorder.

Substance use disorder can take two forms
1- Substance abuse
2- Substance dependence

1- Substance Abuse
A pattern in which people rely heavily on a drug and they structure their lives around the drug.

2- Substance Dependence
In which people show all symptoms of substance abuse plus physical dependence on the drug.

Drug Addiction
- Drug addiction is in which people show all symptoms of substance abuse plus physical dependence on the drug.
- But now we use the term substance dependence and not addiction.

Drug Tolerance
- People who need increased doses of drug in order to get its effect.
- **Withdrawal symptoms** emerge when individual suddenly stops taking drugs or reduces their dosage.
- These symptoms include muscle aches, pains and cramps, vomiting, nausea.

- It is believed that approximately 7 % of all adults in United States currently display some form of substance use disorder.

Poly Drug Use
When an individual uses two or more drugs at the same time we label it as poly drug use.

Cross Tolerance
- When people take more than one drug at a time and the drugs interact with each other. Some time the two drugs display cross tolerance

- Cross tolerance is that the drugs act similarly on the brain and taking one drug will affect person's tolerance for the other.

Synergistic Effect
When different drugs enhance each other's effect, they have a combined impact known as a synergistic effect.

The drugs that we will focus in this chapter fall into three categories

1- Depressants are substances which slow the activity of central nervous system they include.
The important depressants are

- Alcohol
- Sedative-Hypnotic drugs
- Opioids

2- Stimulants are substances that increase the activity of the central nervous system, resulting in the increased blood pressure, heart rate, intensified activity, thought processes and alertness.
The important stimulants are

- Cocaine
- Amphetamines
- Nicotine
- Caffeine

3- Hallucinogens are substances that cause changes primarily in sensory perception. They include

- LSD
- Cannabis drugs

The explanation for drug abuse can be done by using four perspectives
1- Biological
2- Psychodynamic
3- Behavioral
4- Socio-cultural

The biological view or perspective suggests that people inherit a predisposition to drug addiction based on their research of twin and adoptee studies.

The psycho dynamic perspective view that people who turn to drugs have an inordinate dependency needs and they turn to drugs.

Behavioral perspective suggests that drug use is reinforced because it reduces tension and raises spirits.

Socio-cultural perspective suggests that the people most likely to develop a pattern of drug abuse are those where societies create stress and their families tolerate drug abuse.

Treatment for Substance Abuse Disorders
Treatment for substance abuse disorders include
1- Insight therapy
2- Aversive therapy
3- Behavioral self control training
4- Relapse prevention training
5- Self help groups
6- Therapeutic communities

The goals of treatment for substance use disorders are a matter of controversy. Some clinicians believe that the only acceptable goal is total absence from drinking or drug use. Others have argued that, for some people, a more reasonable goal is the moderate use of legal drugs.

Detoxification
- Alcoholism and related forms of drug abuse are chronic conditions.
- Treatment is typically accomplished in a sequence of stages, beginning with a brief period of **detoxification**—the removal of a drug on which a person has become dependent—for 3 to 6 weeks.

Medications
- Following the process of detoxification, treatment efforts are aimed at helping the person maintain a state of remission.
- Several forms of medication are used to help the person refrain from drinking.

Self-Help Groups: Alcoholics Anonymous
- Alcoholics Anonymous (AA) is maintained by alcohol abusers for the sole purpose of helping other people who abuse alcohol become and remain sober.
- AA is not officially associated with any other form of treatment or professional organization.
- The viewpoint espoused by AA is fundamentally spiritual in nature.
- DSM-IV-TR uses two terms to describe substance use disorders, and these terms reflect different levels of severity.

Substance Dependence, the more severe of the two forms, refers to a pattern of repeated self-administration that often results in tolerance, the need for increased amounts of the drug to achieve intoxication; withdrawal, unpleasant physical and psychological effects that the person experiences when he or she tries to stop taking the drug; and compulsive drug-taking behavior.

Substance Abuse describes a more broadly conceived, less severe pattern of drug use that is defined in terms of interference with the person's ability to fulfill major role obligations at work or at home, the recurrent use of a drug in dangerous situations, and repeated legal difficulties associated with drug use.

Addiction is another, older term that is often used to describe problems such as alcoholism.

The term has been replaced in official terminology by the term substance dependence, with which it is synonymous, but it is still used informally by many lay people.

A **drug of abuse,** sometimes called a psychoactive substance, is a chemical substance that alters a person's mood, level of perception, or brain functioning.

People with a substance use disorder frequently abuse several types of drugs; this condition is known as **poly-substance abuse.**

Alcohol
- Alcohol affects virtually every organ and system in the body.
- After alcohol has been ingested, it is absorbed through membranes in the stomach, small intestine, and colon.
- The rate at which it is absorbed is influenced by many variables, including the concentration of alcohol in the beverage, the volume and rate of consumption, and the presence of food in the digestive system.
- After it is absorbed, alcohol is distributed to all the body's organ systems.
- Almost all the alcohol that a person consumes is eventually broken down or metabolized in the liver.
- If the person's consumption rate exceeds this metabolic limit, then blood alcohol levels will rise.
- Blood alcohol levels are measured in terms of the amount of alcohol per unit of blood.

- According to DSM-IV-TR, the symptoms of alcohol intoxication include slurred speech, lack of coordination, an unsteady gait, nystagmus (involuntary to-and-fro movement of the eyeballs induced when the person looks upward or to the side), impaired attention or memory, and stupor or coma.

- The prolonged use and abuse of alcohol can have a devastating impact on many areas of a person's life.
- 1-The disruption of relationships with family and friends can be especially painful.
- 2-Regular heavy use of alcohol is also likely to interfere with job performance.
- 3-Many heavy drinkers encounter problems with legal authorities.
- On a biological level, prolonged exposure to high levels of alcohol can disrupt the functions of several important organ systems, especially the liver, pancreas, gastrointestinal system, cardiovascular system, and endocrine system.
- In fact, over an extended period of time, alcohol dependence has more negative health consequences than abuse of any other drug, with the exception of nicotine. The misuse of alcohol leads to an enormous number of severe injuries and premature deaths in every region of the world.

ALCOHOLISM AND SUBSTANCE RELATED DISORDERS II

Why do we need to study drug use?
   1-We take aspirin to reduce headache.
   2-We take an antibiotic to fight an infection.
 3-We take tranquilizer to calm ourselves after facing a trauma.
   4- We drink coffee or tea in the morning to get going.
   5- Smoke a cigarette to relax our nerves.
Examples
1- Sherlock Holmes a famous detective, a fictional character   who took drug stimulants to keep himself alert.
2- Sportsmen take drugs to enhance their performance but in the long run their body develops drug dependence.

The term drug applies to any substance other than food that changes our bodily and mental functioning. There are many substances that are capable of harming the body or adversely affecting the behavior and mood. The misuse of drugs has become one of the most disabling problems of the society. Drug misuse may lead to a temporary mental syndrome such as intoxication but chronic excessive use of drugs can lead to a substance use disorder.

Substance use disorder can take two forms
   1- Substance abuse
   2- Substance dependence

1- Substance abuse
A pattern in which people rely heavily on a drug and they structure their lives around a drug.

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In which people show all symptoms of substance abuse plus physical dependence on the drug.

It is believed that approximately 7 % of all adults in United States currently display some form of substance use disorder.

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   The Concept of Substance Dependence
Many psychological features or problems are associated with dependence on chemical substances. One such feature involves **_craving_**.
Craving is a forceful urge to use drugs, but the relationship between craving and drug use is actually very complex. People who are dependent on drugs often say that they take the drug to control how they are feeling. Some clinicians refer to this condition as **psychological dependence.** As the problem progresses, it is not unusual for the person who abuses drugs to try to stop. Unfortunately, efforts at self-control are typically short-lived and usually failed. Tolerance and withdrawal are usually interpreted as evidence of **physiological dependence.**

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2- Psychodynamic
3- Behavioral
4- Socio-cultural

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- The psycho dynamic perspective view that people who turn to drugs have an inordinate dependency needs and they turn to drugs.
- Behavioral perspective suggests that drug use is reinforced because it reduces tension and raises spirits.
- Socio-cultural perspective suggests that the people most likely to develop a pattern of drug abuse are those where societies create stress and their families tolerate drug abuse.

Integrated Systems
- We can conclude that alcoholism and other forms of addiction clearly result from an interaction among several types of systems.
- Various social, psychological, and biological factors influence the person's behavior at each stage in the cycle, from initial use of the drug through the eventual onset of tolerance and withdrawal.

The drugs that we will focus in this chapter fall into three categories
1- Depressants are substances which slow the activity of central nervous system they include
- Alcohol
- Sedative-Hypnotic drugs
- Opioids.

2- Stimulants are substances that increase the activity of the central nervous system, resulting in the increased blood pressure, heart rate, intensified activity, thought processes and alertness.
The important stimulants are
- Cocaine
- Amphetamines
- Nicotine
- Caffeine

3- Hallucinogens are substances that cause changes primarily in sensory perception.
They include
- LSD
- Cannabis drugs

1- Depressants
  a- Alcohol
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- Almost all the alcohol that a person consumes is eventually broken down or metabolized in the liver.
- According to DSM-IV-TR, the symptoms of alcohol intoxication include slurred speech, lack of coordination, an unsteady gait, nystagmus (involuntary to-and-fro movement of the eyeballs

induced when the person looks upward or to the side), impaired attention or memory, and stupor or coma.

- The prolonged use and abuse of alcohol can have a devastating impact on many areas of a person's life.

  i- The disruption of relationships with family and friends can be   especially painful.

  ii- Regular heavy use of alcohol is also likely to interfere with job performance.

  iii- Many heavy drinkers encounter problems with legal authorities.

  iv- On a biological level, prolonged exposure to high levels of alcohol can disrupt the functions of several important organ systems, especially the liver, pancreas, gastrointestinal system, cardiovascular system, and endocrine system.

  In fact, over an extended period of time, alcohol dependence has more negative health consequences than abuse of any other drug, with the exception of nicotine.

  v- The misuse of alcohol leads to an enormous number of severe injuries and premature deaths in every region of the world.

b- Sedative-hypnotic Drugs
This group of depressants includes Barbiturates and Benzodiazepines.
Barbiturates
i- They relax the muscles
ii- Produce feeling of well being and
iii- They are used to induce sleep.
Example
Marilyn Monroe's death is attributed to excessive use of alcohol and barbiturates.
Benzodiazepines or Antianxiety drugs
They reduce anxiety.
Example: valium.

c- Opioids
- These include Opium and drugs derived from it such as heroine and morphine.
- Opium is a substance derived from the sap of the opium poppy seed.
- It was widely used in the past because of its ability to reduce both physical and emotional pain.
- Morphine, its name is derived from Morpheus   the Greek god of sleep.
- It is an effective pain reliever and helps to put person to sleep.
- In USA its use accelerated during civil war when wounded soldiers received its injections but it soon became clear that its repeated administrations lead to addiction.

  Heroine
- Morphine was converted into a new pain reliever called heroine for years heroine was viewed as the wonder drug.
- Used as medicine but due to its addictive qualities it is illegal in USA under all circumstances.
- The various Opioid drugs are known collectively as narcotics.
- Narcotics can be smoked, inhaled and injected.
- Worries, tensions and pain subside but the person becomes unconcerned about the food and bodily needs.
- The person becomes lazy and lethargic.

2- Stimulants
Stimulants are substances that increase the activity of the central nervous system, resulting in the increased blood pressure, heart rate, intensified activity, thought processes and alertness.
Some important stimulants are
a- Cocaine
b- Amphetamines
c- Nicotine tobacco products such as cigarettes.

d- Caffine such as in coffee, chocolate and many soft drinks.

a-   Cocaine
- Cocaine is the central active ingredient of the coca plant it is the most powerful natural stimulant. People use to chew coca leaves for energy and alertness.
- Processed cocaine is an odorless, fluffy white powder.
- It can be inhaled or injected
- Smoking coca base in pipe or cigarette.
- Serious side effects the users can become irritable, depressed, paranoid and unable to control their emotions.
- It can even create fatal heart problems heart beating rapidly and irregularly.
- It can even cause the breathing function and heart function to come to sudden halt.

b- Amphetamines
- Amphetamines are stimulant drugs. They were first used in treatment of asthma.
- These drugs soon became popular amongst people trying to loose weight.
- Athletes seeking an extra bust of energy.
- Soldiers, truck drivers and pilots trying to stay awake.
- Students studying for exams throughout night.
- Amphetamines are most often taken in pill or capsule or injection form.
- People using amphetamines reduce their appetite and weight.

c- Nicotine
- Nicotine is the active ingredient in tobacco, which is its only natural source.
- Nicotine is almost never taken in its pure form because it can be toxic.
- The effects of nicotine on the peripheral nervous system include increases in heart rate and blood pressure.

d- Caffeine
- It is called the gentle stimulant used by some 90% of the people.
- It is found in tea, coffee and cola drinks.

i- It elevates mood
ii- Reduces fatigue
iii- When denied it causes headaches, drowsiness and unpleasant mood.

- In the central nervous system, nicotine has pervasive effects on a number of neurotransmitter systems.
- Nicotine has a complex influence on subjective mood states.
- Nicotine is one of the most harmful and deadly addicting drugs.

3- Hallucinogens
- Hallucinogens are substances that cause changes primarily in sensory perception.
- The sight, sound, smell, feelings and even taste are distorted sometimes in dramatic ways when in under the effect of Hallucinogens.
- They include
    - a-   LSD
    - b-   Cannabis drugs

a- Lysergic acid diethylamide or LSD
Lysergic acid diethylamide or LSD it is a naturally occurring derivates of the grain fungus but it can be synthetically produced. It causes a profound perceptual changes and hallucinations.
b- Cannabis
- Cannabis is a hemp plant from where we get hashish and marijuana.

- Both impair motor and cognitive functions.
- It contributes to lung disease.

Treatment for substance abuse disorders

Treatment for substance abuse disorders include
1-Biological therapy
2-Insight therapy
3-Behavioral techniques (Aversive therapy and Relapse prevention training)
4- Self help groups
5-Therapeutic communities

The goals of treatment for substance use disorders are a matter of controversy.
1- Some clinicians believe that the only acceptable goal is total absence from drinking or drug use.
2- Others have argued that, for some people, a more reasonable goal is the moderate use of legal drugs.

1- Biological Therapy
   a- Detoxification
- Alcoholism and related forms of drug abuse are chronic conditions and their treatment is typically accomplished in a sequence of stages, beginning with a brief period of **detoxification**—the removal of a drug on which a person has become dependent—for 3 to 6 weeks.

   b- Medications
- Following the process of detoxification, treatment efforts are aimed at helping the person to maintain a state of remission.
- Several forms of medication are used to help the person refrain from drinking.
- If a person who is taking medicine consumes even a small amount of alcohol, he or she will become severely ill.

2- Insight Therapy
- Insight therapies try to help the clients become aware of and address the psychological factors that contribute to their pattern of drug use.

3- Behavioral Techniques
   a- Cognitive Behavior Therapy
- Cognitive behavior therapy teaches people to identify and respond more appropriately to circumstances that regularly precipitate drug abuse.
- One element of cognitive behavior therapy involves training in the use of social skills, which might be used to resist pressures to drink heavily.
- Most people who have been addicted to a drug will say that quitting is the easy part of treatment.
- The more difficult challenge is to maintain this change after it has been accomplished.

   b- Relapse Prevention Model
- Alan Marlatt, a clinical psychologist at the University of Washington, and his colleagues have proposed a cognitive behavioral view of the relapse process.
- The relapse prevention model addresses several important issues that confront the addict in trying to deal with the challenges of life without drugs.
- Another important feature of the relapse prevention model is concerned with the guilt and perceived loss of control that the person feels whenever he or she slips and finds himself or herself having a drink (or a cigarette or whatever drug is involved) after an extended period of absence.

c- Aversive Therapy
   Aversive conditioning in which an unpleasant stimulus is paired with the drug that the person is taking.

4-Self-Help Groups:
   Alcoholics Anonymous
   • Alcoholics Anonymous (AA) is maintained by alcohol abusers for the sole purpose of helping other people who abuse alcohol become and remain sober.
   • AA is not officially associated with any other form of treatment or professional organization.
   • The viewpoint espoused by AA is fundamentally spiritual in nature.
   • In this 12 step procedure in which the first step is the person must acknowledge that he or she is powerless over alcohol and unable to manage his or her drinking.
   • The remaining steps involve spiritual and interpersonal matters such as accepting "a Power greater than ourselves" that can provide the person with direction; recognizing and accepting personal weaknesses; and making amends for previous errors, especially instances in which the person's drinking caused hardships for other people.

5- Therapeutic communities
   • Therapeutic communities or residential therapeutic communities where addicts live, work and socialize in a drug free environment.
   • There is social and cultural disapproval and unacceptability for drinking, smoking and use of drugs because it has become one of the most disabling problems of the society.
   • Just say no to drugs.
   • It feels good.
   • YOU can get help in saying no to drugs from your own self, family, friends and others.

SCHIZOPHRENIA I

Schizophrenia is a psychotic disorder. The most common symptoms of schizophrenia include changes in the way a person thinks, feels, and relates to other people and environment. Psychosis is a state in which individuals lose contact with reality. It frequently appears in the form of schizophrenia, a disorder in which previously adaptive levels of social, personal, and occupational functioning deteriorate into distorted perceptions, disturbed thought processes, deviant emotional states, and motor abnormalities. Approximately 1 percent of the world's population suffers from this disorder. Many clinicians believe that schizophrenia is a group of distinct disorders that share some common feature

1- Loss of contact with reality.
2- Deterioration at social, personal, and occupational level of functioning.
3-Distorted perceptions, disturbed thought processes, deviant emotional states, and motor abnormalities.
4- **Delusions** defined as false beliefs based on incorrect inferences about reality.
5- **Hallucinations** are sensory experiences that are not caused by actual external stimuli.

Examples
i) Mr. A was first hospitalized for hearing voices ten years ago when he was in senior school. His medications have now seemed to prevent his bizarre beliefs and odd behavior but he has never been able to stay at school or work.
ii) Mr. B had his first psychotic episode during college, he manifested paranoid delusions that his mind was controlled by forces that broadcast to him through radio waves and that he was sure that there was a plot to kill him.
iii) A homeless woman collects empty bottles, cans and cartons from trash and last week she set up a camp under a tree and spent days there. Regardless of the weather she wears in layers all the clothing she possesses.
iv) A student reported to the department chairperson that one of her professors is plotting against her, all the students are after her and the university doctor has plans to kill her.
These are all examples of people suffering from Schizophrenia.

- Is Schizophrenia a disease like diabetes?
- Or some overwhelming stress leads to Schizophrenia?
- Do Schizophrenic people perceive and experience reality differently?
- Can Schizophrenia be cured?
- Why study Schizophrenia?

The answer to all these questions is complex and difficult.
- The most common symptoms of schizophrenia include changes in the way a person thinks, feels, and relates to other people and the outside environment.
- No single symptom or specific set of symptoms is characteristic of all schizophrenic patients.
- Schizophrenia is officially defined by various combinations of psychotic symptoms in the absence of other forms of disturbance, such as mood disorders (especially manic episodes), substance dependence, delirium, or dementia.

Is Schizophrenia a disease like diabetes?
- Schizophrenia is a devastating disorder for both the patients and their families.
- It can disrupt many aspects of the person's life, well beyond the experience of psychotic symptoms.

Why study Schizophrenia?
- Schizophrenia also has an enormous impact on society.

- Among mental disorders, it is the second leading cause of disease burden.
- The onset of schizophrenia typically occurs during adolescence or early adulthood.
- The period of risk for the development of a first episode is considered to be between the ages of 15 and 35.

The problems of most patients can be divided into three phases of variable and unpredictable duration: prodromal, active, and residual.

1- Prodromal Phase
- The **prodromal phase** precedes the active phase and is marked by an obvious deterioration in role functioning as a student, employee, or homemaker.
- Prodromal signs and symptoms are similar to those associated with schizotypal personality disorder. They include peculiar behaviors (such as talking to one's self in public), unusual perceptual experiences, outbursts of anger, increased tension, and restlessness.
- Social withdrawal, indecisiveness, and lack of willpower are often seen during the prodromal phase.
- Symptoms such as hallucinations, delusions, and disorganized speech are characteristic of the active phase of the disorder.

2- Residual Phase
- The **residual phase** follows the active phase of the disorder and is defined by signs and symptoms that are similar in many respects to those seen during the prodromal phase.
- At this point, the most dramatic symptoms of psychosis have improved, but the person continues to be impaired in various ways.
- The symptoms of schizophrenia can be divided into three dimensions: positive symptoms, negative symptoms, and disorganization.

a) Positive symptoms, also called *psychotic symptoms.*
- They are active manifestations of abnormal behaviors or an excess or distortion of normal behavior include *hallucinations* and delusions.
- The symptoms of schizophrenia can be divided into three dimensions: positive symptoms, negative symptoms, and disorganization.
- Positive symptoms are characterized by the presence of an aberrant response (such as hearing a voice that is not really there).

b) Negative symptoms, on the other hand, are characterized by the absence of a particular response (such as emotion, speech, or willpower).
- **Hallucinations** are sensory experiences that are not caused by actual external stimuli.
- Although hallucinations can occur in any of the senses, those experienced by schizophrenic patients are most often auditory.
- Hallucinations should be distinguished from the transient mistaken perceptions that most people experience from time to time.
- Hallucinations strike the person as being real, in spite of the fact that they have no basis in reality.
- They are also persistent over time.
- Many schizophrenic patients express **delusions,** or idiosyncratic beliefs that are rigidly held in spite of their preposterous nature.
- Delusions have sometimes been defined as false beliefs based on incorrect inferences about reality.
- This definition has a number of problems, including the difficulty of establishing the ultimate truth of many situations.
- In the most obvious cases, delusional patients express and defend their beliefs with utmost conviction, even when presented with contradictory evidence.
- Delusional patients typically are unable to consider the perspective that other people hold with regard to their beliefs.

- Common delusions include the belief that thoughts are being inserted into the patient's head, that other people are reading the patient's thoughts, or that the patient is being controlled by mysterious, external forces.
- Many delusions focus on grandiose or paranoid content.
- In actual clinical practice, delusions are complex and difficult to define.
- Their content is sometimes bizarre and confusing.
- In contrast, **negative symptoms involve deficits in normal behavior in the areas of speech emotion and motivation**, such as lack of initiative, social withdrawal.
- Some additional symptoms of schizophrenia, such as incoherent or disorganized speech, do not fit easily into either the positive or negative types.
- Negative symptoms of schizophrenia are defined in terms of responses or functions that appear to be missing from the person's behavior.
- In that sense, they may initially be more subtle or difficult to recognize than the positive symptoms of this disorder.
- Negative symptoms tend to be more stable over time than positive symptoms, which fluctuate in severity as the person moves in and out of active phases of psychosis.
- **Blunted affect,** or *affective flattening,* involves a flattening or restriction of the person's nonverbal display of emotional responses.
- Another type of emotional deficit is called **anhedonia,** which refers to the inability to experience pleasure.
- Many people with schizophrenia become socially withdrawn.
- The withdrawal seen among many schizophrenic patients is accompanied by indecisiveness, ambivalence, and a loss of willpower.
- This symptom is known as **avolition.**
- A person who suffers from avolition becomes apathetic and ceases to work toward personal goals or to function independently.
- Another negative symptom involves a form of speech disturbance called **alogia,** which refers to impoverished thinking.
- In one form of alogia, known as *poverty of speech,* patients show remarkable reductions in the amount of speech.
- In another form, referred to as *thought blocking,* the patient's train of speech is interrupted before a thought or idea has been completed.

c) Disorganization
- Verbal communication problems and bizarre behavior represent this third dimension, which is sometimes called disorganization.
- Some symptoms of schizophrenia do not fit easily into either the positive or negative type.
- Thinking disturbances and bizarre behavior represent a third symptom dimension, which is sometimes called disorganization.
- One important set of schizophrenic symptoms, known as **disorganized speech,** involves the tendency of some patients to say things that don't make sense.
- Signs of disorganized speech include making irrelevant responses to questions, expressing disconnected ideas, and using words in peculiar ways.
- This symptom is also called *thought disorder,* because clinicians have assumed that the failure to communicate successfully reflects a disturbance in the thought patterns that govern verbal discourse.
- Common features of disorganized speech in schizophrenia include shifting topics too abruptly, called **loose associations** or **derailment***;* replying to a question with an irrelevant response, called **tangentiality***;* or persistently repeating the same word or phrase over and over again, called **perseveration***.*
- Schizophrenic patients may exhibit various forms of unusual motor behavior.

- **Catatonia** most often refers to immobility and marked muscular rigidity, but it can also refer to excitement and overactivity.
- Catatonic posturing is often associated with a *stuporous state,* or generally reduced responsiveness.
- Another kind of bizarre behavior involves affective responses that are obviously inconsistent with the person's situation.
- The most remarkable features of **inappropriate affect** are incongruity and lack of adaptability in emotional expression.

Brief Historical Perspective
- Descriptions of schizophrenic symptoms can be traced far back in history, but they were not considered to be symptoms of a single disorder until late in the nineteenth century.
- At that time, Emil Kraepelin, a German psychiatrist, suggested that several types of problems that previously had been classified as distinct forms of disorder should be grouped together under a single diagnostic category called **dementia praecox**.
- This term referred to psychoses that ended in severe intellectual deterioration (dementia) and that had an early or premature (praecox) onset, usually during adolescence.
- Kraepelin argued that these patients could be distinguished from those suffering from other disorders (most notably manic–depressive psychosis) largely on the basis of changes that occurred as the disorder progressed over time, primarily those changes involving the integrity of mental functions.
- In 1911, Eugen Bleuler published an influential monograph in which he agreed with most of Kraepelin's suggestions about this disorder.
- He did not believe, however, that the disorder always ended in profound deterioration or that it always began in late adolescence.
- Kraepelin's term *dementia praecox* was, therefore, unacceptable to him.
- Bleuler suggested a new name for the disorder—*schizophrenia.*
- This term referred to the *splitting of mental associations,* which Bleuler believed to be the fundamental disturbance in schizophrenia.
- DSM-IV-TR lists several specific criteria for schizophrenia.
- The first requirement (Criterion A) is that the patient must exhibit two (or more) active symptoms for at least 1 month.
- The DSM-IV-TR definition also takes into account social and occupational functioning as well as the duration of the disorder (Criteria B and C).

TABLE 13–1 DSM-IV-TR Diagnostic Criteria for Schizophrenia

A. Characteristic Symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. Delusions
2. Hallucinations
3. Disorganized speech (such as frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms, such as affective flattening, alogia, or avolition

(*Note:* Only one A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.)

B. Social/Occupational Dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care is markedly below the level achieved prior to the onset.

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms that meet criterion A (active phase symptoms), and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (such as odd beliefs, unusual perceptual experiences).

- The DSM-IV-TR definition requires evidence of a decline in the person's social or occupational functioning as well as the presence of disturbed behavior over a continuous period of at least 6 months.
- The final consideration in arriving at a diagnosis of schizophrenia involves the exclusion of related conditions, especially mood disorders.

Subtypes

DSM-IV-TR recognizes five subtypes of schizophrenia.

i) The **catatonic type** is characterized by symptoms of motor immobility (including rigidity and posturing) or excessive and purposeless motor activity.

ii) The **disorganized type** of schizophrenia is characterized by disorganized speech, disorganized behavior, and flat or inappropriate affect.

iii) The most prominent symptoms in the **paranoid type** are systematic delusions with persecutory or grandiose content.

iv) The **undifferentiated type** of schizophrenia includes schizophrenic patients who display prominent psychotic symptoms and either meet the criteria for several subtypes or otherwise do not meet the criteria for the catatonic, disorganized, or paranoid types.

v) The **residual type** includes patients who no longer meet the criteria for active phase symptoms but nevertheless demonstrate continued signs of negative symptoms or attenuated forms of delusions, hallucinations, or disorganized speech. They are in "partial remission."

Schizoaffective disorder is defined by an episode in which the symptoms of schizophrenia partially overlap with a major depressive episode or a manic episode.

People with **delusional disorder** do not meet the full symptomatic criteria for schizophrenia, but they are preoccupied for at least 1 month with delusions that are not bizarre.

Brief psychotic disorder is a category that includes those people who exhibit psychotic symptoms—delusions, hallucinations, disorganized or grossly speech.

Course and Outcome
- Schizophrenia is a severe, progressive disorder that most often begins in adolescence and typically has a poor outcome.
- Follow-up studies of schizophrenic patients have found that the description of outcome can be a complicated process.
- Many factors must be taken into consideration other than whether the person is still in the hospital. Disorganized or catatonic behavior—may last for at least 1 day but no more than 1 month.
- One of the most informative ways of examining the frequency of schizophrenia is to consider the *lifetime morbidity risk*—that is, the proportion of a specific population that will be affected by the disorder at some time during their lives.
- Most studies in Europe and the United States have reported lifetime morbid risk figures of approximately 1 percent.
- Most epidemiological studies have reported that across the life span men and women are equally likely to be affected by schizophrenia.
- The average age at which schizophrenic males begin to exhibit overt symptoms is younger by about 4 or 5 years than the average age at which schizophrenic women first experience problems.
- Male patients are more likely than female patients to exhibit negative symptoms, and they are also more likely to follow a chronic, deteriorating course.

Cross-Cultural Comparisons
- Schizophrenia has been observed virtually in every culture that has been subjected to careful scrutiny. Two large-scale epidemiological studies, conducted by teams of scientists working for the World Health Organization (WHO), indicate that the incidence of schizophrenia is relatively constant across different cultural settings.

SCHIZOPHRENIA II

1- What is Schizophrenia?
- Schizophrenia is a disorder that includes changes in the way a person thinks, feels, and relates to other people and the outside environment.
- It is a disorder in which previously adaptive levels of social, personal, and occupational functioning deteriorate.
- No single symptom or specific set of symptoms is characteristic of all schizophrenic patients.

2- Is Schizophrenia a disease like diabetes?
- It is a disease like diabetes.
- Where the whole life pattern is modified.
- Schizophrenia is a devastating disorder for both the patients and their families.

3- Or some overwhelming stress that leads to Schizophrenia?
- Psychological stressors contribute to Schizophrenia.

4- Do Schizophrenic people Perceive and experience reality differently?
- Yes Schizophrenic people Perceive and experience reality differently.

5- Can Schizophrenics be cured?
The treatment includes
- Medication
- Psychotherapy
- Rehabilitation

6- Why we study Schizophrenia?
- Schizophrenia has an enormous impact on society. Among mental disorders, it is the second leading cause of disease burden.

The problems of most patients can be divided into three phases of variable and unpredictable duration: prodromal, active, and residual.

i) The **prodromal phase** precedes the active phase and is marked by an obvious deterioration in role functioning as a student, employee, or homemaker.

Prodromal signs and symptoms are similar to those associated with schizotypal personality disorder. They include peculiar behaviors (such as talking to one's self in public), unusual perceptual experiences, outbursts of anger, increased tension, and restlessness.

ii) Social withdrawal, indecisiveness, and lack of willpower are often seen during the prodromal phase. Symptoms such as hallucinations, delusions, and disorganized speech are characteristic of the **active phase** of the disorder.

iii) The **residual phase** follows the active phase of the disorder and is defined by signs and symptoms that are similar in many respects to those seen during the prodromal phase. The symptoms of schizophrenia can be divided into three dimensions: positive symptoms, negative symptoms, and disorganization.

a) Positive Symptoms
- Positive symptoms, also called *psychotic symptoms*. Positive symptoms are characterized by the presence of a response (such as hearing a voice that is not really there).
- Hallucinations are sensory experiences that are not caused by actual external stimuli.

- Although hallucinations can occur in any of the senses, those experienced by schizophrenic patients are most often auditory.
- Hallucinations strike the person as being real, in spite of the fact that they have no basis in reality. They are also persistent over time. Many schizophrenic patients express delusions, or false beliefs that are rigidly held. Delusions have sometimes been defined as false beliefs based on incorrect inferences about reality. In the most obvious cases, delusional patients express and defend their beliefs with utmost conviction, even when presented with contradictory evidence.

b) Negative Symptoms
- In contrast, **negative symptoms** involve deficits in normal behavior in the areas of speech emotion and motivation, such as lack of initiative, social withdrawal.
- **Blunted affect,** or *affective flattening,* involves a flattening or restriction of the person's nonverbal display of emotional responses. Another type of emotional deficit is called **anhedonia**, which refers to the inability to experience pleasure.
- A person who suffers from **avolition** becomes apathetic and ceases to work toward personal goals or to function independently. Another negative symptom involves a form of speech disturbance called **alogia**. In one form of alogia, known as *poverty of speech,* patients show remarkable reductions in the amount of speech.
- In another form, referred to as *thought blocking,* the patient's train of speech is interrupted before a thought or idea has been completed.

c) Disorganization
- Verbal communication problems and bizarre behavior represent this third dimension, which is sometimes called disorganization. Common features of disorganized speech in schizophrenia include shifting topics too abruptly, called loose associations or derailment*;* replying to a question with an irrelevant response, called tangentiality*;* or persistently repeating the same word or phrase over and over again, called perseveration.

DSM-IV-TR lists several specific criteria for schizophrenia. The first requirement (Criterion A) is that the patient must exhibit two (or more) active symptoms for at least 1 month. The DSM-IV-TR definition also takes into account social and occupational functioning as well as the duration of the disorder (Criteria B and C). The DSM-IV-TR definition requires evidence of a decline in the person's social or occupational functioning as well as the presence of disturbed behavior over a continuous period of at least 6 months.

The final consideration in arriving at a diagnosis of schizophrenia involves the exclusion of related conditions, especially mood disorders. DSM-IV-TR recognizes five subtypes of schizophrenia.
i) The **catatonic type** is characterized by symptoms of motor immobility (including rigidity and posturing) or excessive and purposeless motor activity.
ii) The **disorganized type** of schizophrenia is characterized by disorganized speech, disorganized behavior, and flat or inappropriate affect.
iii) The most prominent symptoms in the **paranoid type** are systematic delusions with persecutory or grandiose content.
iv) The **undifferentiated type** of schizophrenia includes schizophrenic patients who display prominent psychotic symptoms and either meet the criteria for several subtypes or otherwise do not meet the criteria for the catatonic, disorganized, or paranoid types.
- The most prominent symptoms in the paranoid type are systematic delusions with persecutory or grandiose content.
- The undifferentiated type of schizophrenia includes schizophrenic patients who display prominent psychotic symptoms and either meet the criteria for several subtypes or otherwise do not meet the criteria for the catatonic, disorganized, or paranoid types.

v) The **residual type** includes patients who no longer meet the criteria for active phase symptoms but nevertheless demonstrate continued signs of negative symptoms or forms of delusions, hallucinations, or disorganized speech.
- They are in "partial remission."

Related Psychotic Disorders
- Schizoaffective disorder is defined by an episode in which the symptoms of schizophrenia partially overlap with a major depressive episode or a manic episode. People with delusional disorder do not meet full symptomatic criteria for schizophrenia, but they are preoccupied for at least 1 month with delusions that are not bizarre.
- Brief psychotic disorder is a category that includes those people who exhibit psychotic symptoms—delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior—for at least 1 day but no more than 1 month. Schizophrenia is a severe, progressive disorder that most often begins in adolescence and typically has a poor outcome. Follow-up studies of schizophrenic patients have found that the description of outcome can be a complicated process. Many factors must be taken into consideration other than whether the person is still in the hospital.
- One of the most informative ways of examining the frequency of schizophrenia is to consider the *lifetime morbidity risk*—that is, the proportion of a specific population that will be affected by the disorder at some time during their lives.
- Most studies in Europe and the United States have reported lifetime morbid risk figures of approximately 1 percent.

Gender Differences
Most epidemiological studies have reported that across the life span men and women are equally likely to be affected by schizophrenia.

Cross-Cultural Comparisons
Schizophrenia has been observed virtually in every culture that has been subjected to careful scrutiny. Two large-scale epidemiological studies, conducted by teams of scientists working for the World Health Organization (WHO), indicate that the incidence of schizophrenia is relatively constant across different cultural settings.

Causes of Schizophrenia
An interaction of sociological, biological, and psychological factors seem to contribute to schizophrenia.

1- Socio-cultural Factors
The socio-cultural view is based on the principle that society has certain expectations in regard to the behavior of a person who is labeled as schizophrenic, and that these expectations may promote the development of symptoms.

2- Biological Factors
- The family history data twin and adoption studies are consistent with the hypothesis that transmission of schizophrenia is influenced by genetic factors.
- One of the most exciting areas of research on genetics and schizophrenia focuses on the search for genetic linkage. Studies of this type are designed to identify the location of a specific gene that is responsible for the disorder (or some important component of the disorder).
- Linkage analysis has not been able to identify a *specific gene* for schizophrenia, but it has implicated *regions* on a small number of chromosomes that may contribute to the etiology of the disorder.
- For example, reports of positive linkage on regions of chromosomes 6, 8, 13, and 22 have been verified by more than one laboratory.

3- Pregnancy and Birth Complications

- People with schizophrenia are more likely than the general population to have been exposed to various problems during their mother's pregnancy and to have suffered birth injuries. Problems during pregnancy include the mother's contracting various types of diseases and infections.
- Birth complications include extended labor, breech delivery, forceps delivery, and the umbilical cord wrapped around the baby's neck.

4- Viral Infections

- Some speculation has focused on the potential role that viral infections may play in the etiology of schizophrenia.
- One indirect line of support for this hypothesis comes from studies indicating that people who develop schizophrenia are somewhat more likely than other people to have been born during the winter months. Exposure to infection presumably interferes with brain development in the fetus. Research support for the hypothesis remains inconsistent.

5- Neuropathology

- Many investigations of brain structure in people with schizophrenia have employed magnetic resonance imaging (MRI).
- Schizophrenia seems to affect many different regions of the brain and the ways in which they connect or communicate with each other.
- Most MRI studies have reported a decrease in total volume of brain tissue among schizophrenic patients.
- The most consistent findings point toward structural as well as functional irregularities in the frontal cortex and limbic areas of the temporal lobes, which play an important role in cognitive and emotional processes.

6- Neurochemistry

Scientists have proposed various neurochemical theories to account for the etiology of schizophrenia. The most influential theory, known as the *dopamine hypothesis,* focuses on the function of specific dopamine pathways in the limbic area of the brain. Several studies have found decreased serotonin receptor density in cortical areas of schizophrenic patients. Brain imaging studies that point to problems in the prefrontal cortex have also drawn attention to glutamate and GABA (gammaaminobutyric acid), the two principal neurotransmitters in the cerebral cortex.

7- Social Factors

The evidence supporting an inverse relationship between social class and schizophrenia is substantial. Adverse social and economic circumstances may increase the probability that persons who are genetically predisposed to the disorder will develop its clinical symptoms.

Treatment
1-Antipsychotic Medication

- Antipsychotic drugs reduce the severity and sometimes eliminate psychotic symptoms. Classical antipsychotics are also known as *neuroleptic* drugs because they also induce side effects that resemble the motor symptoms of Parkinson's disease. In the case of antipsychotic drugs, the most obvious and troublesome side effects are called *extrapyramidal symptoms* (EPS) which include neurological disturbances, such as muscular rigidity, tremors, restless agitation, peculiar involuntary postures, and motor inertia.
- Atypical antipsychotics also produce side effects, such as weight gain and obesity.
- All antipsychotic medications—both traditional and atypical forms—act by blocking dopamine receptors in the cortical and limbic areas of the brain.
- They also affect a number of other neurotransmitters, including serotonin and acetylcholine.

2-Psychosocial Treatment
- Family treatment programs attempt to improve the coping skills of family members, recognizing the burdens that people often endure while caring for a family member with a chronic mental disorder. There are several different approaches to this type of family intervention. Most include an educational component that is designed to help family members understand and accept the nature of the disorder.
  i- *Social skills training* (SST) is a structured, educational approach that involves modeling, role playing, and the provision of social reinforcement for appropriate behaviors.
  ii- *Assertive community treatment* (ACT) is a psychosocial intervention that is delivered by an interdisciplinary team of clinicians.
- They provide a combination of psychological treatments—including education, support, skills training, and rehabilitation—as well as medication.
- Some patients are chronically disturbed and require long-term institutional treatment Social learning programs, sometimes called *token economies,* can be useful for these patients. In these programs specific behavioral contingencies are put into place for all of the patients on a hospital ward. The goal is to increase the frequency of desired behaviors, such as appropriate grooming and participation in social activities, and to decrease the frequency of undesirable behaviors, such as violence or incoherent speech.
- Carefully structured inpatient programs, especially those that follow behavioral principles, can have important positive effects for chronic schizophrenic patients, Fountain house.

DEMENTIA DELIRIUM AND AMNESTIC DISORDERS I

Formerly called organic mental disorders, now the new name according to DSM-IV-TR is cognitive disorders or cognitive impairment disorders.

Dementia
Dementia is a gradual worsening loss of memory and related cognitive functions, including the use of language, as well as reasoning and decision making.

Delirium
Delirium is a state of confusion and disorientation that develops over a short period of time and is often associated with agitation and hyperactivity.

Amnesia
People with Amnesia disorders experience memory impairments that are more limited than those seen in dementia or delirium.

Examples
- Miss A looks pretty and physically healthy even in her late seventies. She has always been sweet and a patient person but now she has become verbally abusive, suspicious, and forgetful.
- Mr. B was injured in a car accident, he had a head injury. His whole life has changed its sad to watch the decline of a successful and intelligent man.
- Miss. C was shot as an innocent bystander in a robbery. She is physically fine but has almost no ability to recall recent events.
- Muhammad Ali one of the greatest heavy weight boxing champions of all times suffers from Parkinson disease caused by repeated blows to the head during his boxing career.
- Two term U.S. president and famous handsome actor Ronald Regan suffered from Alzhemeir's which altered his life preventing the public appearances that ex- presidents enjoy.

Research on brain and its role on psychopathology have increased in recent years. The term organic mental disorder was dropped and the term cognitive mental disorder was adopted.
Cognitive disorders signify the impairment of cognitive abilities such as
1. memory
2. attention
3. perception
4. thinking

Cognitive disorders generally first appear during the patient's 50's or 60's and accelerate after the age of 70.

Cognitive Impairment Disorders
Cognitive impairment disorders include
1. Dementia
2. Delirium
3. Amnesia

Degenerative Brain Diseases
Some degenerative brain diseases include
1-Alzheimer's dementia
2-Parkinson's disease
3-Huntington's disease
4-Pick's disease

Causes of Cognitive Impairment Disorders
   1- Old age
   2- Improper use of medications
   3- Head injuries
   4- Various types of brain traumas.

Treatment of Cognitive Impairment Disorders
There are two types of treatments one for patients and other for caregivers
   1-Treatment for patients
      a- Psychotropic Medications
      b- Behavioral Programs
      c- Cognitive Rehabilitation
   2-Treatment of Caregivers

DELIRIUM
- Delirium is a confusional state that develops over a short period of time and is often associated with agitation and hyperactivity.
- Delirium the primary symptom of delirium is clouding of consciousness in association with a reduced ability to maintain and shift attention.
- The person's thinking appears disorganized, and he or she may speak in a rambling, incoherent fashion.
- Fleeting perceptual disturbances, including visual hallucinations, are also common in delirious patients.
- The symptoms of delirium follow a rapid onset—from a few hours to several days—and typically fluctuate throughout the day.
- The person may alternate between extreme confusion and periods in which he or she is more rational and clearheaded.
- Symptoms are usually worse at night.

- If the condition is allowed to progress, the person's senses may become dull and he or she may eventually lapse into a coma.
- It isn't always easy to recognize the difference between dementia and delirium, especially when they appear simultaneously in the same patient.

Difference between dementia and delirium
These are four in number
- One important consideration involves the period of time over which the symptoms appear.

TABLE 14–1   DSM-IV-TR Criteria for Delirium

A. **Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.**

B. **A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.**

C. **The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.**

1. Delirium has a rapid onset, whereas dementia develops in a slow, progressive manner.
2. In dementia, the person usually remains alert and responsive to the environment.
3. Speech is most often coherent in demented patients, at least until the end stages of the disorder, but it is typically confused in delirious patients.
4. Finally, delirium can be resolved, whereas dementia cannot.

Causes of Delirium

1- Medical conditions
- It has been observed that many medical conditions impair brain function such as intoxication by drugs, poisons, alcohol.
- Head injuries
- Various types of brain traumas

2- Factors other than medical conditions can trigger delirium which include
- Age the older people are more at risk for developing delirium than young people.
- Sleep deprivation, immobility and excessive stress can also cause delirium.

3- Delirium can also be brought on by improper use of medication it can be a particular problem for older people because they tend to use prescription medication more than any other age group. The risk of the problem in the elderly is increased further because they tend to eliminate drugs from their systems less efficiently than younger people.

4- Delirium may be experienced by children who have high fevers or who are taking certain medications and they are mistaken for noncompliance.
- The underlying mechanisms responsible for the onset of delirium undoubtedly involve neuropathology and neurochemistry.
- Delirium can be caused by many different kinds of medication.
- Delirium also develops in conjunction with a number of metabolic diseases as well as endocrine diseases.
- Various kinds of infection can lead to the onset of delirium.

Example
- An old gentleman was brought to the hospital he did not know his name and at times he did not recognize his daughter. He appeared confused, disoriented and agitated.
- He could not focus his attention to answer even the most basic questions.

DEMENTIA
- Dementia appears in people whose intellectual abilities have previously been unimpaired.
- Dementia is a gradual worsening loss of memory and related cognitive functions, including the use of language, as well as reasoning and decision making.
- The earliest signs of dementia include difficulty remembering recent events and the names of people and familiar objects.
- The distinguishing features of dementia include cognitive problems in a number of areas, ranging from impaired memory and learning to deficits in language and abstract thinking.
- By the final stages of dementia, intellectual and motor functions may disappear almost completely.
- The diagnostic hallmark of dementia is memory loss.
- Retrograde amnesia refers to the loss of memory for events prior to the onset of an illness or the experience of a traumatic event.
- Anterograde amnesia refers to the inability to learn or remember new material after a particular point in time.
- Anterograde amnesia is usually the most obvious problem during the beginning stages of dementia.

Language functions can also be affected in dementia.

    1- **Aphasia** is a term that describes various types of loss or impairment in language that are caused by brain damage.

    2- In addition to problems in understanding and forming meaningful sentences, the demented person may also have difficulty in performing purposeful movements in response to verbal commands, a problem known as **apraxia**.

    3- Some patients with dementia have problems identifying stimuli in their environments.

- The technical term for this phenomenon is **agnosia**, which means "perception without meaning."
- The person's sensory functions are unimpaired, but he or she is unable to recognize the source of stimulation.

    4- Another manifestation of cognitive impairment in dementia is loss of ability to think in abstract ways.

- Related to deficits in abstract reasoning is the failure of social judgment and problem-solving skills.

Causes of Dementia

The common causes of dementia include

    1- Medications
    2- Vitamin B1 deficiency
    3- Chronic alcoholism
    4- Tumors or infections of brain
    5- Metabolic imbalances resulting from kidney, thyroid and liver.
    6- Age
    7-Twin studies confirm that genetic factors play an important role in the development of dementia.

- Three genes (located on chromosomes 21, 14, and 1) have been identified that, when mutated, cause early-onset forms of Alzheimer's disease.
- A fourth gene, located on chromosome 19, serves as a risk factor for late-onset forms of the disorder.

Degenerative Brain Diseases

Some degenerative brain diseases include

    1- Alzheimer's dementia
    2- Parkinson's disease
    3- Huntington's disease
    4- Pick's disease
    5- Stroke
    6- Head traumas

1- Alzheimer's Dementia

- The speed of onset serves as the main feature to distinguish Alzheimer's disease from the other types of dementia listed in DSM-IV-TR.
- In this disorder, the cognitive impairment appears gradually, and the person's cognitive deterioration is progressive.
- In Alzheimer disease there is both behavioral and cognitive impairment.
- Patients display problems in memory and language. People forget important events and lose objects.

2- Parkinson's Disease

- A disorder of the motor system, known as *Parkinson's disease,* is caused by a degeneration of a specific area of the brain stem known as the substantia nigra and loss of the neurotransmitter dopamine, which is produced by cells in this area.
- Typical symptoms include tremors, rigidity, postural abnormalities, and reduction in voluntary movements.
- Unlike people with Huntington's disease, most patients with Parkinson's disease do not become demented.

3- Huntington's Disease

- Unusual involuntary muscle movements known as chorea represent the most distinctive feature of Huntington's disease.
- These movements are relatively slow at first, with the person appearing to be merely restless or fidgety.
- As the disorder progresses, sustained muscle contractions become difficult.
- Movements of the face, trunk, and limbs eventually become uncontrolled.

4- Pick's Disease

It is a rare type of neurological disorder and its cause is not known but it produces a dementia like Alzheimer's.

5- Stroke

- A *stroke,* the severe interruption of blood flow to the brain, can produce various types of brain damage, depending on the size of the affected blood vessel and the area of the brain that it supplies.
- There are instances, however, in which the stroke affects only a very small artery and may not have any observable effect on the person's behavior.

6- Head Trauma

Head trauma, injury to the head and therefore to the brain is typically caused by accidents and can lead to cognitive impairments in all (memory loss).

Example

Mrs. D at the age of 45 was a successful legal assistant, wife, mother but she began to experience memory lapses and she thought it was being caused by tension at work. Her medical examination and MRI revealed damage to the brain caused by stroke causing dementia.

DEMENTIA DELIRIUM AND AMNESTIC DISORDERS II

Recap lecture no 40
- Formerly called organic mental disorders now the new name according to DSM-IV-TR is cognitive disorders or cognitive impairment disorders.
- It includes Delirium, Dementia and Amnesia.

Dementia
Dementia is a gradual worsening loss of memory and related cognitive functions, including the use of language, as well as reasoning and decision making.

Delirium
Delirium is a state of confusion and disorientation that develops over a short period of time and is often associated with agitation and hyperactivity.

Amnesia
People with Amnesia disorders experience memory impairments that are more limited than those seen in dementia or delirium.

Research on brain and its role on psychopathology have increased in recent years. The term organic mental disorder was dropped and the term cognitive mental disorder was adopted.

Cognitive disorders signify the impairment of cognitive abilities such as
- memory
- attention
- perception
- thinking

Cognitive disorders generally first appear during the patient's 50's or 60's and accelerate after the age of 70.

Cognitive impairment disorders include
- Dementia
- Delirium
- Amnesia

Some degenerative brain diseases include
1. Alzheimer's dementia
2. Parkinson's disease
3. Huntington's disease
4. Pick's disease

Causes of Cognitive Impairment Disorders
1. old age
2. improper use of medications
3. head injuries
4. Various types of brain traumas.

Treatment of Cognitive Impairment Disorders
1. Treatment of the Patient
   a. Psychotropic Medications
   b. Behavioral Programs

c. Cognitive Rehabilitation

2. Treatment of Caregivers

- Because of the close link between cognitive disorders and brain disease, patients with these problems are often diagnosed and treated by neurologists, physicians who deal primarily with diseases of the brain and the nervous system.
- Multidisciplinary clinical teams study and provide care for people with dementia and amnestic disorders.
- Direct care to patients and their families is usually provided by nurses and social workers.
- Neuropsychologists have particular expertise in the assessment of specific types of cognitive impairment.
- Changes in emotional responsiveness and personality typically accompany the onset of memory impairment in dementia.
- In some cases, personality changes may be evident before the development of full-blown cognitive symptoms.

Assessment of Cognitive Impairment

There are many ways to measure a person's level of cognitive impairment.

a. One is the **Mini-Mental State Examination**.
- Some of the questions on this exam are directed at the person's orientation to time and place.
- Others are concerned with anterograde amnesia, such as the ability to remember the names of objects for a short period of time.

b. **Neuropsychological assessment** can be used as a more precise index of cognitive impairment.
- This process involves the evaluation of performance on psychological tests to indicate whether a person has a brain disorder.
- The best-known neuropsychological assessment procedure is the Halstead-Reitan Neuropsychological Test Battery, which includes an extensive series of tests that tap sensorimotor, perceptual, and speech functions.
- Some neuropsychological tasks require the person to copy simple objects or drawings.

c. **Personality and Emotion**
- The emotional consequences of dementia are quite varied.
- Some demented patients appear to be apathetic or emotionally flat.
- At other times, emotional reactions may become exaggerated and less predictable.
- Depression is another problem that is frequently found in association with dementia.

d. **Motor Behaviors**
- Demented persons may become agitated, pacing restlessly or wandering away from familiar surroundings.
- In the later stages of the disorder, patients may develop problems in the control of the muscles by the central nervous system.
- Some specific types of dementia are associated with involuntary movements, or dyskinesia—tics, tremors, and jerky movements of the face and limbs called chorea.

Amnesia

- Some cognitive disorders involve more circumscribed forms of memory impairment than those seen in dementia.
- In amnestic disorders, a person exhibits a severe impairment of memory while other higher level cognitive abilities are unaffected.
- The memory disturbance interferes with social and occupational functioning and represents a significant decline from a previous level of adjustment.
- The most common type of amnestic disorder is alcohol-induced persisting amnestic disorder, also known as Korsakoff's syndrome.

- In this disorder, which is caused by chronic alcoholism, memory is impaired but other cognitive functions are not.
- One widely accepted theory regarding this condition holds that lack of vitamin B1 (thiamine) leads to atrophy of the medial thalamus.

Brief Historical Perspective
- Alois Alzheimer, a German psychiatrist, worked closely in Munich with Emil Kraepelin, who is often considered responsible for modern psychiatric classification.
- Alzheimer's most famous case involved a 51-year-old woman who had become delusional and also experienced a severe form of recent memory impairment, accompanied by apraxia and agnosia.
- This woman died 4 years after the onset of her dementia.
- Following her death, Alzheimer conducted a microscopic examination of her brain and made a startling discovery: bundles of neurofibrillary tangles and amyloid plaques.
- Alzheimer presented the case at a meeting of psychiatrists in 1906 and published a three-page paper in 1907.
- Emil Kraepelin began to refer to this condition as Alzheimer's disease in the eighth edition of his famous textbook on psychiatry, published in 1910.
- Until recently, the diagnostic manual classified the various forms of dementia as Organic Mental Disorders because of their association with known brain diseases.
- In order to be consistent with the rest of the diagnostic manual, and so as to avoid falling into the trap of simplistic mind–body dualism, dementia and related clinical phenomena are now classified as Cognitive Disorders in DSM-IV-TR.
- These disorders are divided into three major headings: deliria, dementias, and amnestic disorders.

Frequency of Delirium and Dementia
- The incidence of dementia will be much greater in the near future, because the average age of the population is increasing steadily.
- By the year 2030, more than 9 million people in the United States will be affected by Alzheimer's disease.
- Epidemiological studies must be interpreted with caution, of course, because of the problems associated with establishing a diagnosis of dementia.
- Definitive diagnoses depend on information collected over an extended period of time so that the progressive nature of the cognitive impairment, and deterioration from an earlier, higher level of functioning, can be documented.
- Unfortunately, this kind of information is often not available in a large-scale epidemiological study.
- Also bear in mind the fact that the diagnosis of specific subtypes of dementia requires microscopic examination of brain tissue after the person's death.

Prevalence of Cognitive Impairment Disorders
- Studies of community samples in North America and Europe indicate that the prevalence of dementia in people between the ages of 65 and 69 is approximately 1 percent.
- For people between the ages of 75 and 79, the prevalence rate is approximately 6 percent, and it increases dramatically in older age groups.
- Almost 40 percent of people over 90 years of age exhibit symptoms of moderate or severe dementia.
- Survival rates are reduced among demented patients.
- There are no obvious differences between men and women with regard to the overall prevalence of dementia, broadly defined.
- It seems, however, that dementia in men is more likely to be associated with vascular disease or to be secondary to other medical conditions or to alcohol abuse.

- Alzheimer's disease appears to be the most common form of dementia, accounting for perhaps half of all cases.
- Dementia with Lewy bodies may be the second leading cause of dementia; studies report prevalence rates between 12 and 27 percent for DLB among patients with primary dementia.
- Prevalence rates for vascular dementia are similar to those for DLB.
- Pick's disease is much less common than Alzheimer's disease, vascular dementia, or DLB.
- Huntington's disease is rare by comparison.
- It affects only 1 person in every 20,000.

Cross cultural Comparisons
- Alzheimer's disease may be more common in North America and Europe, whereas vascular dementia may be more common in Japan and China.
- There are also some tentative indications that prevalence rates for dementia may be significantly lower in developing countries than in developed countries.

Treatment and Management
- When a person clearly suffers from a primary type of dementia, such as dementia of the Alzheimer's type, a return to previous levels of functioning is extremely unlikely.
- No form of treatment is presently capable of producing sustained and clinically significant improvement in cognitive functioning for patients with Alzheimer's disease.
- Realistic goals include helping the person to maintain his or her level of functioning for as long as possible in spite of cognitive impairment and minimizing the level of distress experienced by the person and the person's family.

1. Medication
- Some drugs are designed to relieve cognitive symptoms of dementia by boosting the action of acetylcholine (ACh), a neurotransmitter that is involved in memory and whose level is reduced in patients with Alzheimer's disease.
- New drug treatments are being pursued that are aimed more directly at the processes by which neurons are destroyed.
- Although the cognitive deficits associated with primary dementia cannot be completely reversed with medication, neuroleptic medication can be used to treat some patients who develop psychotic symptoms.

2. Environmental and Behavioral Management
- Patients with dementia experience fewer emotional problems and are less likely to become agitated if they follow a structured and predictable daily schedule.
- Severely impaired patients often reside in nursing homes and hospitals.
- The most effective residential treatment programs combine the use of medication and behavioral interventions with an environment that is specifically designed to maximize the level of functioning and minimize the emotional distress of patients who are cognitively impaired.
- One important issue related to patient management involves the level of activity expected of the patient.
- It is useful to help the person remain active and interested in everyday events.
- Patients who are physically active are less likely to have problems with agitation, and they may sleep better.
- Social interactions are often troublesome for patients with dementia due to distorted views of reality.
- Creative problem-solving strategies that accommodate the patient's distorted view of reality are sometimes useful in this type of situation.

3. Support for Caregivers
- In the United States, spouses and other family members provide primary care for more than 80 percent of people who have dementia of the Alzheimer's type.
- Their burdens are often overwhelming, both physically and emotionally.
- In addition to the profound loneliness and sadness that caregivers endure, they must also learn to cope with more tangible stressors, such as the patient's incontinence, functional deficits, and disruptive behavior.
- Some treatment programs provide support groups, as well as informal counseling and ad hoc consultation services, for spouses caring for patients with Alzheimer's disease.
- Some treatment programs arrange for direct assistance in addition to social support.
- Respite programs provide caregivers with temporary periods of relief away from the patient.

MENTAL RETARDATION AND DEVELOPMENTAL DISORDERS I

Mental Retardation
Example: A is a teenage boy who has shown problems in intellectual and social functioning; he needs help to eat, to bath and to dress up.

- What is mental retardation?
- Why study mental retardation?
- All people with mental retardation have impaired intellectual abilities, but they vary widely in academic ability, social functioning, and life skills.
- Some people with profound retardation require total care and live their entire lives in institutions.
- However, most people with mental retardation learn self-care and vocational skills that allow them to live in the community.
- Many people with mental retardation suffer from emotional difficulties, a fact that is overlooked all too often.

What is Mental Retardation?
Mental retardation is
  1- Significant limitations in intellectual functioning
  2- Significant limitations in adaptive functioning
  3- Onset before age 18 years.

- The American Association on Mental Retardation (AAMR), the leading organization for professionals concerned with mental retardation, defines mental retardation somewhat differently than DSM-IV-TR. However, both definitions generally agree on the three major criteria for mental retardation, mentioned above.
- The AAMR and DSM-IV-TR both define subaverage intellectual functioning in terms of a score on an individualized *intelligence test,* a standardized measure for assessing intellectual ability.
- Intelligence tests yield a score called the intelligence quotient, or IQ, the test's rating of an individual's intellectual ability.

TABLE 15–1 DSM-IV-TR Diagnostic Criteria for Mental Retardation
A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning).
B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.
C. Onset is before age 18 years.

Symptoms of Mental Retardation
Defining *intelligence* can be controversial, and definitions and measures of intellectual ability have changed over the years. Early versions of intelligence tests derived an IQ by dividing the individual's "mental age" by his or her chronological age. Mental age was determined by comparing an individual's test results with the average obtained for various age groups. Contemporary intelligence tests have abandoned the concept of

mental age and instead have adopted the concept of the "deviation IQ". According to this theory of "deviation IQ", intellectual ability follows the normal distribution in the population, a bell-shaped frequency distribution.

The individual's IQ is determined based on how the person scores on an intelligence test relative to the norms for his or her age group. IQ tests are widely used, and they have demonstrated value for predicting performance in school. Moreover, IQ is a trait that is stable over time.

Despite the value of IQ tests in predicting academic performance, a number of important questions have been raised about them. One of the most controversial questions is whether intelligence tests are "culture-fair." Culture-fair tests contain material that is equally familiar to people who differ in their ethnicity, native language, or immigrant status. Tests that are *culturally biased* contain language, examples, or other assumptions that favor one ethnic group, particularly members of the majority group, over another.

Another controversy is how well intelligence is measured among people with mental retardation. Many people with mental retardation have sensory or physical disabilities that impede their performance on standard IQ tests; thus they must take tests that are not influenced by their particular disability. Despite the difficulties, evidence indicates that, if anything, the IQ test scores of people with mental retardation are *more* reliable and valid than IQ scores in the normal range. Common sense, social sensitivity, and "street smarts" are also part of what most of us would consider intelligence, and they are not measured by IQ tests.

Both the AAMR and DSM recognize that intelligence is more than an IQ score; thus they include adaptive behavior as a part of their definitions of mental retardation. The most basic concern about intelligence tests is the most important one: What is intelligence? Intelligence tests measure precisely what their original developer, **Alfred Binet**, intended them to measure: potential for school achievement. IQ tests predict school achievement fairly well. However, school achievement is not the same as "intelligence."

The AAMR suggests that adaptive behavior includes conceptual, social, and practical skills.
- *Conceptual skills* focus largely on community self-sufficiency, and incorporate communication, functional academics, self-direction, and health and safety from DSM-IV-TR.
- *Social skills* focus on understanding how to conduct oneself in social situations and include social skills and leisure from the DSM-IV-TR list.
- *Practical skills* focus on the tasks of daily living and include self-care, home living, community use, health and safety, and work from the DSM-IV-TR.

Adaptive skills are difficult to quantify. As with the definition of IQ, the AAMR now defines a significant limitation in adaptive behavior as a score that is two standard deviations below the mean on a standardized measure of adaptive behavior in conceptual, social, or practical skills.

An argument has been made for defining retardation solely on the basis of intelligence testing, because current measures of adaptive skills are imprecise. However, the adaptive skills criterion highlights the importance of assessing life functioning in borderline cases, as well as the need for services among people with mental retardation.

The third criterion for defining mental retardation is onset before 18 years of age. This criterion excludes people whose deficits in intellect and adaptive skills begin later in life as a result of brain injury or disease. People with mental retardation have not lost skills they once had mastered, nor have they experienced a notable change in their condition.

Diagnosis of Mental Retardation
- In 1866, the British physician Langdon Down first described a subgroup of children with mental retardation who had a characteristic appearance.
- Down's classification helped subsequent scientists to establish a specific etiology for what we now know as Down syndrome.

- The creation of IQ tests in the early twentieth century also greatly furthered the classification of mental retardation.
- Once academic potential could be measured, controversy grew about what IQ score cutoff should define mental retardation.
- The AAMR has set the cutoff at two standard deviations below the mean (70).
- Today, mental retardation can be classified according to two different criteria.
- One criterion is based on IQ scores; the other is according to known or presumed etiology.
- The AAMR uses a multiaxial diagnosis of mental retardation in which health, including etiological factors, is rated on a separate axis.
- A more controversial aspect of the AAMR sub-classification is the ratings of four levels of "intensity of needed support" across nine different areas of functioning.
- Today, mental retardation can be classified according to two different criteria.
- One criterion is based on IQ scores; the other is according to known or presumed etiology.

The goal in rating support intensities is to acknowledge the diversity of skills and needs among people with mental retardation both as people and for treatment planning.
In adopting the support intensities approach, AAMR abandoned a long tradition still followed in the DSM-IV-TR of dividing mental retardation into four levels primarily based on IQ scores: mild, moderate, severe, and profound.

Levels of Mental Retardation
1- Mild mental retardation is the designation for those with IQ scores between 50–55 and 70. People with mild mental retardation typically have few, if any, physical impairments, generally reach the sixth-grade level in academic functioning, acquire vocational skills, and typically live in the community with or without special supports.

2- People with **moderate mental retardation** have IQs between 35–40 and 50–55. They may have obvious physical abnormalities such as the features of Down syndrome. Academic achievement generally reaches second-grade level, work activities require close training and supervision, and special supervision in families or group homes is needed for living in the community.

3- Severe mental retardation is defined by IQ scores between 20–25 and 35–40. At this severity level, motor development typically is abnormal, communicative speech is sharply limited, and close supervision is needed for community living.

4- Profound mental retardation is characterized by an IQ below 20–25. Motor skills, communication, and self-care are severely limited, and constant supervision is required in the community or in institutions.

- A diagnosis of mental retardation literally might mean a difference between life and death.
- The United States Supreme Court recently ruled that the death penalty is "cruel and unusual punishment" for someone with mental retardation, and therefore is prohibited.

Frequency of Mental Retardation
- The best estimate is that only 1 percent of the population has mental retardation.
- Mental retardation in the United States is more common among the poor and, as a result, among certain ethnic groups.

Causes of Mental Retardation

1- Biological Abnormalities
About one-half of all cases of mental retardation are caused by known biological abnormalities.
i. Down syndrome

- The most common known biological cause of mental retardation is the chromosomal disorder Down syndrome.
- The cause of Down syndrome is the presence of an extra chromosome.
- The incidence of Down syndrome is related to maternal age.
- In general, children and adults with Down syndrome function within the moderate to severe range of mental retardation.

ii. Fragile-X syndrome

- Another chromosomal abnormality, fragile-X syndrome, is the most common known *genetic* cause of mental retardation.
- Fragile-X syndrome is indicated by a weakening or break on one arm of the X sex chromosomes, and it is transmitted genetically.
- Not all children with the fragile-X abnormality have mental retardation.

iii. Phenylketonuria

- Phenylketonuria or PKU, is one of these.
- PKU is caused by abnormally high levels of the amino acid *phenylalanine,* usually due to the absence of or an extreme deficiency in *phenylalanine hydroxylase,* an enzyme that metabolizes phenylalanine.
- Retardation typically progresses from the severe to profound range.
- Fortunately, PKU can be detected by blood testing in the first several days after birth.

2- Infectious Diseases

- Mental retardation can also be caused by various infectious diseases.
- Damaging infections may be contracted during pregnancy, at birth, or in infancy to early childhood.

i. Rubella (German measles) is a viral infection that may produce few symptoms in the mother but can cause severe mental retardation and even death in the developing fetus.

ii. The human immunodeficiency virus (HIV) can be transmitted from an infected mother to a developing fetus.

- The effects on the child are profound, including mental retardation, visual and language impairments, and eventual death.

iii. Syphilis is a bacterial disease that is transmitted through sexual contact.

- Infected mothers can pass the disease to the fetus.
- If untreated, syphilis produces a number of physical and sensory handicaps in the fetus, including mental retardation.
- One infectious disease that occurs after birth *meningitis* can cause mental retardation.

3- Environmental Toxins

- Exposure to a variety of environmental toxins can also cause mental retardation.
- Both legal and illegal drugs pose a risk to the developing fetus.
- Toxins also present a potential hazard to intellectual development after birth.

4- Pregnancy and birth complications

- Pregnancy and birth complications also can cause mental retardation.
- One major complication is *Rh incompatibility.*
- Another pregnancy and birth complication that can cause intellectual deficits is premature birth.
- Other pregnancy and birth complications that can cause mental retardation include extreme difficulties in delivery, particularly *anoxia,* or oxygen deprivation; severe *malnutrition;* and the seizure disorder *epilepsy.*

5- Cultural-familial Retardation

- As the term suggests, cultural-familial retardation tends to run in families and is linked with poverty.

- A controversial issue is whether this typically mild form of mental retardation is caused primarily by genes or by psychosocial disadvantage.
- Grossly abnormal environments can produce gross abnormalities in intelligence.
- Cultural-familial retardation is found far more frequently among the poor.
- Part of this is explained by the fact that lower intelligence causes lower social status.
- Impoverished environments lack the *stimulation* and *responsiveness* required to promote children's intellectual and social skills throughout their development.

Treatment: Prevention and Normalization
    Three major categories of intervention are essential in the treatment of mental retardation.
- First, many cases of both organic and cultural-familial mental retardation can be prevented through adequate maternal and child health care, as well as early psycho-educational programs.
- Second, educational, psychological, and biomedical treatments can help people with mental retardation to raise their achievement levels.
- Third, the lives of people with mental retardation can be normalized through mainstreaming in public schools and promoting care in the community.

- The availability and use of good maternal and child health care is one major step toward the primary prevention of many biological causes of mental retardation.
- Planning for childbearing can also help prevent mental retardation.
- Early social and educational interventions can lead to the secondary prevention of cultural-familial retardation.

The most important current secondary prevention is:
i. Careful assessment early in life is critical to tertiary prevention.
ii. Medical screening is essential for detecting conditions like PKU.
iii. Accurate detection is important, because early interventions can help.
iv. Treatment of the social and emotional needs of people with mental retardation may include teaching basic self-care skills, such as feeding, toileting and dressing, during the younger ages and various "life-survival" skills at later ages.
v. Medical care for physical and sensory handicaps is also critical in the treatment of certain types of mental retardation. Medication is not especially helpful in treating the intellectual or socio-emotional problems of people with mental retardation.
vi. Normalization means that people with mental retardation are entitled to live as much as possible like other members of society. The major goals of normalization include mainstreaming children with mental retardation into public schools and promoting a role in the community for adults with mental retardation.
For many children with mental retardation, the least restrictive environment means mainstreaming them into regular classrooms.

MENTAL RETARDATION AND DEVELOPMENTAL DISORDERS II

Developmental psychopathology is the study of how disorders arise and change with time. These changes usually follow a pattern, with child mastering one skill before acquiring the next, it implies that any disruption in the acquisition of early skills by the very nature of the developmental process also disrupt the development of later skills. Developmental Psychopathology approach is absolutely essential to disorders of children, because children change rapidly during the first 20 years of life. Psychologists become concerned only when a child's behavior deviates substantially from developmental norms, behavior that is typical for children of a given age.

1- Attention Deficit Hyperactivity Disorder
- The primary characteristics of people with attention deficit hyperactivity disorder are the pattern inattention (such as not paying attention to school-or work related tasks) or hyperactivity-impulsivity, or both.
- These deficits can significantly disrupt academic efforts and social relationships.

2- Learning Disorders
DSM-IV-TR groups the learning disorders as
- reading disorder
- Mathematics disorder
- Disorder of written expression

All are defined by performance that fall far short of expectations based on intelligence and school preparation.

3- Verbal or communication disorders
Verbal or communication disorders seem closely related to learning disorders.
- They include stuttering, stammering, disturbance in speech fluency, expression, language disorder, a very limited speech in all situations.
- Selective mutism.

4- Pervasive Developmental Disorder
- People with pervasive developmental disorder experience trouble progressing in language, socialization and cognition. The use of word pervasive means that these are not relatively minor problems (like learning disabilities) but conditions that significantly affect how individuals live.

Kinds of Pervasive Developmental Disorder
(i) Autistic Disorder
(ii) Attention Deficit Hyperactivity Disorder (ADHD)
(iii) Oppositional Deficit Disorder (ODD)
(iv) Conduct Disorder
(v) Asperger's Disorder
(vi) Childhood Disintegrative Disorder
(vii) Rett's Disorder

- Mental retardation and Pervasive Developmental Disorders (PDD) involve serious disruptions in development.
- Both disorders are either present at birth or begin early in life.
- Both affect many areas of intellectual, social, and life functioning.
- Autism is the most familiar PDD, and, in fact, professionals often use the term *autistic spectrum disorders* as a synonym for PDD.

- PDD are distinguished by dramatic, severe, and unusual symptoms.
- Socially, the child not only lives in a world of his own but also in a world apart.
- Many children with PDD also cannot communicate.
- In addition, children with PDD are preoccupied with unusual repetitive behavior, like needing to preserve rigid routines or rocking back and forth endlessly.
- All people with mental retardation have impaired intellectual abilities, but they vary widely in academic ability, social functioning, and life skills.
- Some people with profound retardation require total care and live their entire lives in institutions.
- However, most people with mental retardation learn the self-care and vocational skills that allow them to live in the community.
- All people with mental retardation have impaired intellectual abilities, but they vary widely in academic ability, social functioning, and life skills.
- Some people with profound retardation require total care and live their entire lives in institutions.
- However, most people with mental retardation learn the self-care and vocational skills that allow them to live in the community.
- Pervasive developmental disorders (PDDs) begin early in life and involve severe impairments in a number of areas of functioning.
- People with PDD exhibit profound disturbances in relationships, engage in unusual behaviors, and typically have substantial communication difficulties.

1- Autistic Disorder (Autism)
- Autistic disorder (autism) is characterized by profound indifference to social relationships, odd, stereotypical behaviors, and severely impaired or nonexistent communication skills.
- Early onset is a defining feature of autism.
- Because babies with autism look normal, the condition may not be accurately diagnosed for a few years, as infants and toddlers fail to reach developmental milestones and social achievement.
- Communication problems range from few difficulties disorder to profound impairments in many cases of autism.
- According to field studies conducted for DSM-IV, 54 percent of patients with autism remain mute, as do 35 percent of patients with other PDD.
- Echolalia is a common problem.
- Those with autism or other PDD frequently repeat phrases that are spoken to them, or sometimes repeatedly echo a phrase they heard at an earlier time.
- Another common language problem is pronoun reversal, which involves confusing the pronoun "you" with the pronoun "I."
- The inability to relate to others is another central feature of autistic disorder.
- One view is that people with autism lack a theory of mind—that is, they fail to appreciate that other people have a point of reference that differs from their own.
- Another defining symptom of autism is restricted, repetitive, and stereotyped patterns of behavior, interests, and activities.
- These odd preoccupations and rituals create social complications.
- Rituals such as flapping a string or spinning a top seem to serve no other function than providing sensory feedback or *self-stimulation.*
- *Self-injurious behavior* is one of the most bizarre and dangerous difficulties that can accompany PDD.

Frequency of Autism and PDD
- Upper level estimates now suggest that as many as 60 in 10,000 children suffer from autism.
- Three to four times as many boys as girls suffer from autism, suggesting a gender-linked etiology.
- Autism also is much more common among siblings of a child with autism, suggesting possible genetic causes.

2- Attention-deficit/hyperactivity disorder (ADHD)

- Attention-deficit/hyperactivity disorder (ADHD) is characterized by hyperactivity, attention deficit, and impulsivity.
- The symptoms of hyperactivity and attention deficit each have been viewed as being the core characteristics of ADHD.

TABLE 16–1   DSM-IV-TR Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder

A. Either (I) or (II):

(II) Inattention: Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
2. Often has difficulty sustaining attention in tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.
5. Often has difficulty organizing tasks and activities.
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.
7. Often loses things necessary for tasks or activities.
8. Is often easily distracted by extraneous stimuli.
9. Is often forgetful of daily activities.

(II) Hyperactivity and Impulsivity: Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

1. Often fidgets with hands or feet or squirms in seat.
2. Often leaves seat in classroom or in other situations in which remaining seated is expected.

Hyperactivity
1. Often fidgets with hands or feet or squirms in seat.
2. Often leaves seat in classroom or in other situations in which remaining seated is expected.
3. Often runs about or climbs excessively in situations in which it is inappropriate.
4. Often has difficulty playing or engaging in leisure activities quietly.
5. Is often "on the go" or often acts as if "driven by a motor."
6. Often talks excessively.

Impulsivity
7. Often blurts out answers before questions have been completed.
8. Often has difficulty awaiting turn.
9. Often interrupts or intrudes on others.

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings.

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

Code Based on Type

Combined Type: Criteria for I and II are met for past 6 months.

Predominantly Inattentive Type: Criteria for I are met but Criteria for II are not met for past 6 months.

Predominantly Hyperactive-Impulsive Type: Criteria for II are met but Criteria for I are not met for past 6 months.

3-Oppositional Defiant Disorder (ODD)
- Oppositional defiant disorder (ODD) is defined by a pattern of negative, hostile, and defiant behavior.
- The rule violations in ODD typically involve minor transgressions, such as refusing to obey adult requests, arguing, and acting angry.
- A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
  - Often loses temper.
  - Often argues with adults.
  - Often actively defies or refuses to comply with adults' requests or rules.
  - Often deliberately annoys people.
  - Often blames others for his/her mistakes or misbehavior.
  - Is often touchy or easily annoyed by others.
  - Is often angry and resentful.
  - Is often spiteful and vindictive.
- The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
- *Note:* Consider a criterion only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.
- Professionals have long debated whether ADHD and ODD are the same or separate disorders.
- The current consensus is that the two disorders are separate but frequently comorbid.
- Not only ADHD and ODD are highly comorbid, but about 25 percent of children with each problem also have a learning disorder.

4-Conduct Disorder (CD)
- Conduct disorder (CD) is defined primarily by a persistent and repetitive pattern of serious rule violations, most of which are illegal as well as antisocial—for example, assault or robbery.
- DSM-IV-TR distinguishes the age of onset in defining conduct disorders—a distinction between adolescent-limited versus life-course patterns of antisocial behavior.

TABLE 16–3   DSM-IV-TR Diagnostic Criteria for Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to People and Animals
1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others.
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim.
7. Has forced someone into sexual activity.

Destruction of Property
8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others' property.

Deceitfulness or Theft
10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors to avoid obligations.
12. Has stolen items of nontrivial value without confronting a victim.

Deceitfulness or Theft
10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors to avoid obligations.
12. Has stolen items of nontrivial value without confronting a victim.

Serious Violations of Rules
13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in parental or parental surrogate home.
15. Is often truant from school, beginning before age 13 years.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

Code Type Based on Age at Onset

Conduct disorder Childhood-Onset Type: Onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years.

Conduct disorder Adolescent-Onset Type: Absence of any criteria characteristic of Conduct Disorder prior to age 10 years.

- Most of the symptoms of conduct disorder involve index offenses—crimes against people or property that are illegal at any age.
- A few diagnostic criteria are comparable to status offenses—acts that are illegal only because of the youth's status as a minor.
- However, juvenile delinquency is a *legal* classification, not a mental health term.
- Anywhere from 5 to 15 percent of youth in the United States may have ODD and/or CD.
- After the first few years of life, from two to ten times as many boys as girls have an externalizing disorder.

- Except for the normative increase during adolescence, the prevalence of externalizing behavior generally declines with age, although it declines at much earlier ages for girls than for boys.
- Externalizing disorders are associated with various indicators of family adversity, a fact highlighted by British psychiatrist Michael Rutter.
- Rutter's Family Adversity Index includes six family predictors of behavior problems among children:
  - low income,
  - overcrowding in the home,
  - maternal depression,
  - paternal antisocial behavior,
  - conflict between the parents, and
  - removal of the child from the home.

5- Asperger's Disorder
The new diagnosis for Asperger's disorder refers to people who show the symptoms of autism but do not have major problems in communication and generally function higher in other areas as well.

6- Childhood Disintegrative Disorder
Childhood disintegrative disorder refers to a poorly understood and somewhat controversial condition characterized by severe problems in social interaction and communication, in addition to stereotyped behavior.

7- Rett's Disorder
Rett's disorder is a clearly distinct condition characterized by at least 5 months of normal development followed by

- a deceleration in head growth,
- loss of purposeful hand movements,
- loss of social engagement,
- poor coordination, and
- a marked delay in language.

Treatment of PDD (continued)
1- A huge variety of medications have been used to treat autism, including antipsychotics, antidepressants, amphetamines, psychedelics, and megavitamins.
Unfortunately, none of these medications is an effective treatment for autism, and few show much promise.

2- Intensive behavior modification using operant conditioning techniques called *Applied Behavior Analysis (ABA)* is the most promising approach to treating autism.
ABA therapists focus on treating the specific symptoms of autism, including communication deficits, lack of self-care skills, and self-stimulatory or self-destructive behavior.

3- Behavior therapists have been fairly successful in teaching self-care skills and less successful in teaching social responsiveness.

4- One of the most actively researched residential programs is *Achievement Place,* a group home that operates according to highly structured behavior therapy principles.
Achievement Place homes, like many similar residential programs, are very effective in improving aggression and noncompliance while the adolescent is living in the treatment setting.

PSYCHOLOGICAL PROBLEMS OF CHILDHOOD

Developmental Psychopathology approach is absolutely essential to disorders of childhood, because children change rapidly during the first 20 years of life. Psychologists become concerned only when a child's behavior deviates substantially from developmental norms, behavior that is typical for children of a given age.

Psychological problems that commonly begin during childhood are listed in the DSM-IV-TR category Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.
Other than mental retardation and pervasive developmental disorders, the most important disorders in this category are the various externalizing disorders.
Two kinds of disorders
1- Externalizing Disorders
2- Internalizing Disorders

1- Externalizing Disorders
Externalizing disorders create difficulties for the child's external world. Externalizing disorders are characterized by children's failure to control their behavior according to the expectations of parents, peers, teachers, and/or legal authorities—for example, as a result of hyperactive behavior or conduct problems.

Kinds of Pervasive Developmental Disorder
i. Autistic Disorder
ii. Attention Deficit Hyperactivity Disorder (ADHD)
iii. Oppositional Deficit Disorder (ODD)
iv. Conduct Disorder
v. Asperger's Disorder
vi. Childhood Disintegrative Disorder
vii. Rett's Disorder

Symptoms of Externalizing Disorders
Many externalizing symptoms involve violations of age-appropriate social rules, including disobeying parents or teachers, violating social or peer group norms (e.g., annoying others), and perhaps violating the law.

Some misconduct is normal, perhaps even healthy, for children.
However, the rule violations in externalizing disorders are not trivial and are far from "cute." Externalizing behavior is a far greater concern when it is frequent, intense, lasting, and pervasive.

2- Internalizing Disorders
Internalizing disorders are psychological problems that primarily affect the child's internal world—for example, excessive anxiety or sadness.
DSM-IV-TR does not list internalizing disorders as separate psychological disorders of childhood; rather, the manual notes that children may qualify for many "adult" diagnoses, such as anxiety or mood disorders.

Symptoms of Internalizing Disorders
Children's internalizing symptoms include sadness, fears, and somatic complaints, as well as other indicators of mood and anxiety disorders—for example, feeling worthless or tense.
DSM-IV-TR does not have a separate category for children's internalizing disorders, but the manual does identify some unique ways in which children experience the symptoms.
In assessing children's internalizing problems, mental health professionals must obtain information from *multiple informants*—parents, teachers, and the children themselves.

When assessing children directly, child clinical psychologists are sensitive to different signs that may be indicative of depression at different ages.

Depression in children and adolescents often is comorbid both with externalizing problems and with anxiety.

Three findings from fear research are important to note.

- First, children develop different fears for the first time at different ages, and the onset of new fears may be sudden and have no apparent cause in the child's environment.
- A second finding is that some fears, particularly fears of uncontrollable events such as disasters, are both common and relatively stable across different ages.
- Third, many other fears, especially specific ones like fears of monsters or normal worries about death, become less frequent as children grow older.

Kinds of Internalizing Disorders

1- DSM-IV-TR contains a diagnosis for **separation anxiety disorder**, which is defined by symptoms such as persistent and excessive worry for the safety of an attachment figure, fears of getting lost or being kidnapped, nightmares with separation themes, and refusal to be alone.

Separation anxiety disorder is especially problematic when it interferes with school attendance.

2- School refusal, also known as *school phobia,* is characterized by an extreme reluctance to go to school, and is accompanied by various symptoms of anxiety, such as stomachaches and headaches.

Children with internalizing or externalizing problems often have troubled peer relationships.

In 1896, the psychologist Lightner Witmer established the first psychological clinic for children in the United States.

Despite the early origins of child clinical psychology, children were largely ignored in early classifications of mental disorders.

DSM-I contained only two separate diagnoses for children, and DSM-II listed only seven childhood disorders.

DSM-III recognized a much wider range of childhood disorders, and in fact, contained a proliferation of diagnostic categories, 40 in all.

Although laudable, the new effort was overly ambitious.

Many of the new diagnoses were severely criticized and subsequently were dropped.

TABLE 16–5	**DSM-IV-TR Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence**
Attention-Deficit and Disruptive Behavior Disorders	
Attention-deficit/hyperactivity disorder	
Combined type	
Predominantly inattentive type	
Predominantly hyperactive-impulsive type	
Conduct disorder	
Oppositional defiant disorder	
Learning Disorders	
Reading disorder	
Mathematics disorder	
Disorder of written expression	
Motor Skills Disorder	
Developmental coordination disorder	
Communication Disorders	
Expressive language disorder	
Mixed receptive-expressive language disorder	
Phonological disorder	
Stuttering	
Feeding and Eating Disorders of Infancy or Early Childhood	
Pica	
Rumination disorder	
Feeding disorder of infancy or early childhood	

Feeding and Eating Disorders of Infancy or Early Childhood
Pica
Rumination disorder
Feeding disorder of infancy or early childhood

Tic Disorders
Tourette's disorder
Chronic motor or vocal tic disorder
Transient tic disorder

Elimination Disorders
Encopresis
 With constipation and overflow incontinence
 Without constipation and overflow incontinence
Enuresis

Other Disorders of Infancy, Childhood, and Adolescence
Separation anxiety disorder
Selective mutism
Reactive attachment disorder of infancy or early childhood
Stereotypic movement disorder

Note: This listing does not include mental retardation or pervasive developmental disorders, which we discussed in Chapter 15. It also does not include "Not Otherwise Specified" (NOS) subtypes of the diagnoses. NOS subtypes exist for many of the disorders listed here, and they are used when a child meets many but not all of the diagnostic criteria for the specific disorder.

3- Pica is the persistent eating of nonnutritive substances, such as paint or dirt.
Many infants and toddlers put nonnutritive substances in their mouths, but the feeding disorder pica is rarely diagnosed, except among mentally retarded children.
4- Rumination disorder, the repeated regurgitation and rechewing of food, is another infrequent feeding disorder.
5- Tourette's disorder is a rare problem (4 to 5 cases per 10,000 people) that is characterized by repeated motor and verbal tics.
6- Stereotypic movement disorder is self-stimulation or self-injurious behavior that is serious enough to require treatment, as may occur in mental retardation or pervasive developmental disorder.
7- Selective mutism involves the consistent failure to speak in certain social situations (for example, in school) while speech is unrestricted in other situations (for example, at home).
8- Reactive attachment disorder is another rarely diagnosed problem, although it may be more prevalent than we would hope.
Reactive attachment disorder is characterized by severely disturbed and developmentally inappropriate social relationships.
9- Encopresis and enuresis are common problems. The terms refer, respectively, to inappropriately controlled defecation and urination.
Eating disorders have increased dramatically since thinness has become a national obsession.
10- Victims of **anorexia nervosa** so relentlessly pursue extreme thinness that they may starve themselves to death.
11- Victims of **bulimia nervosa** go on frequent eating binges, then take laxatives or force themselves to vomit to keep from gaining weight. These eating disorders, which share many important features, are disproportionately prevalent among adolescent girls and young women.
Primary hypersomnia is excessive sleepiness characterized by prolonged or daytime sleep, lasting at least a month and significantly interfering with life functioning.
Primary hypersomnia is similar to narcolepsy, irresistible attacks of refreshing sleep, lasting at least 3 months.
12- Breathing-related sleep disorder involves the disruption in sleep due to breathing problems such as the temporary obstruction of the respiratory airway.
The **parasomnias** include nightmare disorder, sleep terror disorder, and sleepwalking disorder.
13- People with nightmare disorder are frequently awakened by terrifying dreams.

14- Sleep terror disorder also involves abrupt awakening from sleep, typically with a scream, but it differs from nightmare disorder in important respects.

15- Sleepwalking disorder involves rising from the bed during sleep and walking about in a generally unresponsive state.

Occasional episodes of sleepwalking are fairly common, especially among children.

Like all sleep disorders, sleepwalking disorder tends to be diagnosed only if it causes significant distress or impairs the person's ability to function.

Many listed childhood disorders not in fact mental disorders.

Child's behavior is intimately linked with the family, school, and peer contexts.

Because of this, some experts have suggested that diagnosing individual children is misleading and misguided.

Instead, children's psychological problems could be classified within the context of key relationships, particularly the family.

Frequency of Internalizing Disorders
- The prevalence of externalizing disorders generally decreases as children grow older, but the opposite is true for internalizing disorders.
- Suicide is the leading cause of death among teenagers, trailing only automobile accidents and natural causes.
- In comparison to adult suicide attempts, suicide attempts among adolescents are more impulsive, more likely to follow a family conflict, and are more often motivated by anger rather than depression.
- Evidence simply is lacking or inadequate on the development of many other psychological problems of childhood.

Treatment of Internalizing Disorders
- Relatively few treatments for anxiety or mood disorders have been developed or studied specifically as they apply to children.
- For example, medications known to alleviate depression in adults have rarely been studied among children and adolescents, and may be no more effective than placebos in treating their depression.
- Researchers already have begun to correct the neglect of treatment research on children's internalizing disorders.
- Some forms of cognitive behavior therapy and interpersonal therapy show promise for treating children's depression, and cognitive behavior therapy and family therapy have produced positive results in treating children's anxiety.

LIFE CYCLE TRANSITIONS AND ADULT DEVELOPMENT

In gerontology, the multidisciplinary study of aging, it is common to distinguish among the young-old, the old-old, and the oldest-old.
1- Young-old 65-74
2- The old-old 74-84 and
3- The oldest-old 85-and up

Gero-psychology focuses on the mental health problems of later adulthood. Gero-psychologists focus on exploring and assessing mental health problems of later adulthood as compared to young people.

One out of every four people getting psychotherapy does *not* have a mental disorder. The well-functioning people seeking treatment due to their *psychological pain,* difficult but normal emotions (for example, feeling "hurt") that can result from difficult life events.

DSM-IV-TR tries to categorize these sorts of issues that bring mentally healthy clients into therapy.
1- One possible diagnosis is *adjustment disorder,* the development of clinically significant symptoms in response to stress (that are *not* severe enough to classify as mental disorder).
2- DSM-IV-TR also includes a list of *other conditions that may be a focus of clinical attention,* such as a "partner relational problem," "bereavement," and "phase of life problem."
3- Psychologists have learned much about *adult development,* the occurrence of fairly predictable challenges in relationships, work, life goals, and personal identity during adult life. Several theorists divide adult development into three periods—early, middle, and later life.

- Consistent with this division are the three major life-cycle transitions, struggle in the process of moving from one stage of adult development into a new one.
- The *transition to adult life* is a time for grappling with the major issues related to identity, career, and relationships.
- *Family transitions* in the middle years may include very happy events, like the birth of the first child, or very unhappy ones, like a difficult divorce.
- The *transition to later life* may involve major changes in life roles (e.g., retirement), grief over the death of loved ones, and more abstract issues that accompany the inevitability of aging and mortality.
- Life-cycle transitions not only may cause otherwise well-functioning adults to seek professional help, but also pose special challenges to those already suffering from a mental disorder.
- Life-cycle transitions differ greatly, and different people respond to the same event in different ways.
- The psychologist Erik Erikson highlighted *conflict* as a common theme.
- By definition, transitions involve change, and conflict is a frequent consequence of change.

1- Erik Erikson highlighted that development does not end with childhood but continues throughout adult life.
- His theory of psychosocial development includes four stages of adult development:
    (1) Identity versus role confusion,
    (2) Intimacy versus self-absorption,
    (3) Generativity versus stagnation, and
    (4) Integrity versus despair.
- Erikson focused on the psychological side of psychosocial development, whereas many contemporary approaches emphasize social relationships.

2- Psychologist **Daniel Levinson** emphasizes three major (and many minor) transitions or "seasons" in adult life.

- The *early adult transition* involves moving away from family and assuming adult roles.
- The *midlife transition*—often called a "midlife crisis"—is a time for becoming less driven and developing more compassion.
- The *late adult transition* is characterized by the changing roles and relationships of later life.
- Still, the outlines offered by Erikson and Levinson capture broad commonalities in the experiences of many great people.
- Most of us create social clocks—age-related goals for ourselves—and we evaluate our achievements to the extent that we are "on time" or "off time."
- Erikson focused on the *identity crisis* as the central psychological conflict during the transition to adult life.
- Identity conflicts are epitomized by the searching question "Who am I?"
- Other things also change during the transition to adulthood.
- Young adults must make decisions about whether and where to go to college and what career paths to pursue.

3- The theory of the ego psychologist **Karen Horney**, claim that people have competing needs to move toward, to move away from, and to move against others.

- *Moving toward* others fulfills needs for love and acceptance.
- *Moving away* from others is a way of establishing independence and efficacy.
- *Moving against* others meets the individual's need for power and dominance.
- According to Horney, relationship difficulties come from conflicts among these three basic needs.

Aging

- Typically, adults become increasingly aware of aging in their forties and fifties.
- Concerns about physical health increase for both men and women in their sixties, seventies, and eighties.
- Death is an inevitability that confronts all of us.
- With advancing age, we must face both the abstraction of our own mortality and our specific fears about a painful and prolonged death.
- Bereavement is a part of life for older adults, as friends fall ill and die.
- Older adults often confront a form of social prejudice known as **ageism**, a term that encompasses a number of misconceptions and prejudices about aging.
- Older adults experience the full range of human interests and concerns, and we must guard against forming stereotypes based on our prejudices or fears about aging.
- Physical functioning and health decline with age, but the loss of health and vigor is not nearly as rapid as stereotypes suggest.
- The functioning of all sensory systems declines gradually throughout adult life.
- The amount of muscle in our bodies also declines with age, but, like sensory function, the loss is gradual until advanced age.
- The fact that aging is accompanied by gradual declines in physical health does *not* mean that older adults experience similar declines in psychological well-being.
- In fact, older adults report more positive relationships and a greater sense of mastery over their environment than do adults who are young or in midlife.
- On the other hand, older adults do report less of a sense of purpose in life and less satisfaction with personal growth in comparison to younger adults.
- Older adults also report greater satisfaction with their jobs than younger people, but this may be a result of self-selection.
- According to Erik Erikson many older adults do wonder about the meaning of their lives when they look back from the perspective of their later years.

- The presence of a supportive close relationship is an important predictor of psychological well-being during adult life.
- Family relationships are of key importance to psychological well-being throughout the life span.
- Grief is the emotional and social process of coping with a separation or a loss.
- Bereavement is a specific form of grieving in response to the death of a loved one for example, when the loss of a mate occurs early in adult life or when a child dies before a parent.
- Psychological disorders are an important concern among older adults; this is especially true of depression, which may be more profound, lasting, and debilitating among older than younger adults.
- Classification of adults in later life typically divides categories based on age and health status.
- In gerontology, the multidisciplinary study of aging, it is common to distinguish among the young-old, the old-old, and the oldest-old.
- The *young-old* are adults roughly between the ages of 65 and 75.
- However, the category is defined less by age than by health and vigor.
- The *old-old* are adults between the ages of approximately 75 and 85 who suffer from major physical, psychological, or social (largely economic) problems.
- They require some routine assistance in living, although only about 6 percent of Americans in this age group live in a nursing home.
- The *oldest-old* are the adults 85 years old or older.
- People in this category are a diverse group and include some adults who maintain their vigor and others in need of constant assistance.
- Widowed women and low-income groups are found disproportionately among the oldest-old. Twenty-two percent of the oldest-old live in nursing homes.

Psychological Stresses for Older People
1- Grief is the emotional and social process of coping with a separation or a loss.
- Bereavement is a specific form of grieving in response to the death of a loved one for example, when the loss of a mate occurs early in adult life or when a child dies before a parent.
2- Some old people lose a sense of meaning and purpose after retirement or chronic illness.
3- Depression is the most common mental problems of older people; the prevalence is higher among women than men.
4- Elderly people suffer from generalized anxiety disorder, phobias and panic disorders.
5- Minor lapses in memory or intellectual functioning increases as one gets older, the frequency of Dementias, Alzheimer, Parkinson, Huntington's chorea and Pick's increases.
6- The abuse of street drugs or the abuse of prescription of drugs is commonly alarming.
7- Some people also show alcohol related problems.
8- Elderly also exhibit psychotic disorders such as schizophrenia or paranoid disorder.

Treatment of Psychological Problems in Later Life
1- Good medical care is of great importance to older adults, not only for treating disease but also for promoting physical health and psychological well-being.
•   Because health behavior is critical to the quality of life among older adults, experts view health psychology and behavioral medicine as central components of medical care.

2- In fact, a new sub-discipline of these fields, called behavioral gerontology, has been developed specifically for studying and treating the behavioral components of health and illness among older adults.
•   The same psychological and biological therapies used to treat emotional disorders among younger adults can be used to treat these problems among the aged.
•   However, older adults may have misconceptions about psychotherapy.

3- Health care professionals must focus not only on improving quality of life among older adults, but on maintaining integrity in death.

- *Health behavior* is particularly important to the physical and psychological well-being of older adults.

4- In addition to appropriate health behavior, important psychological contributions to adjustment in later life include the availability of close relationships and the experience of loss.

5- Numerous social factors are linked with a happier transition to later life, especially material well-being and participation in recreational activities.

6- Religion is also very important to many older adults, and religious affiliations have been found to moderate the ill effects of bereavement, particularly among men.

7- Other research indicates that integration into the community is a major contribution to adjustment to later life.