ABNORMAL PSYCHOLOGY

(PAPER-I)

V SEMESTER

CORE COURSE

For

B.Sc. COUNSELLING PSYCHOLOGY

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UNIVERSITY OF CALICUT

SCHOOL OF DISTANCE EDUCATION

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<table>
<thead>
<tr>
<th>CONTENT</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODULE -1</td>
<td>05-24</td>
</tr>
<tr>
<td>MODULE -1I</td>
<td>25-31</td>
</tr>
<tr>
<td>MODULE -1II</td>
<td>32-65</td>
</tr>
</tbody>
</table>
MODULE 1

NORMALITY AND ABNORMALITY

Concept of Normality and Abnormality
Psychology studies the behavior of individuals, behavior being a manifestation of personality. Thus the study of psychology comprehends both personality and behavior.

CHARACTERISTICS OF NORMAL PERSON
According to G. W. Kisker,”The word normal comes from the Latin names which means a carpenter’s square. A norm, therefore becomes a rule or pattern or standard, and it was in this sense that the word introduced into the English language.” The following are the chief characteristics of the normal individual:

1. Sociability. A social environment is what man lives in, and every society has its own traditions, modes of accepted behavior, forms and functions, that prevail in it. An individual who conforms to them in his conduct is called normal. In this manner, all normal individuals conform to the social code and general ethos of their society, and steer meticulously clear of all temptations that may invite the scorn and contempt of society. Their desires of day-to-day life are satisfied in socially accepted and accredited modes, they take regular and appropriate part in the festivals and social programmes organized from time to time. They share their life with the community members and obey any mandates that their group may choose to issues to them. The normal individual is very social, a being afraid of ill-will and a redoubtable reputation, a being interested in winning esteem and respect. His own self-interest is not his sole occupation, he is also concerned with the well being and pleasure of others.

2. Balance and fulfillment of Needs. Besides sociability, another quality of the normal being is his complete fulfillment of his needs, which makes for balance and strength that retains a balanced outlook. An individual of this kinds is not inclined to become distributed at the smallest problem, illness, trouble, exhaustion, deterrent, etc but makes concerted efforts to solve them. His routine of life is regular source such as employment in offices or business. They are more inclined to combat their difficulties, to come to some reasonable compromise with them, as also to avoid extremes in most matters. They are aware of their own qualities and shortcomings, and also of the value of friendship and affection.

3. Health, Security and Balance. The normal individuals make conscious or unconscious effort to maintain their social, economic, physical and psychological health, as well as security. In a general sort of way, their behavior does not violate the cannons of morality. They are usually aware of the objectives of their life and they exert themselves to achieve
this. Success makes them more enthusiastic, but failure does not deter them. Their past experience are lessons for them, and their future an opportunity to benefit by them. Peace, comfort and security is what they want in life. Such qualities as hope, balance, thoughtfulness, work, effort, practically and self-guidance are part of their mental makeup. Ambition is natural to them as it is to all others, but it is never allowed to blur all other things to their vision.

4. CHARACTERISTICS OF ABNORMAL PERSON

According to Kissler, “Human behavior and experiences which are strange, unusual or different from ordinary are considered abnormal.” An abnormal person is quite often the victim of mental deficiency or mental disease. In some abnormal individuals the intellectual level is fairly high, but their balance is quite disturbed. Emotional instability and inconsistency is more or less a common trait in most abnormal individuals. Abnormal individuals, as a class, are comprised of mentally diseased, juvenile delinquents, unsocial and anti-social individuals.

1. Criminal and juvenile delinquents. The criminal or the juvenile delinquent is in some measure abnormal, his mind an inferno of various kinds of conflicts which sometime take destructive and heinous forms. He is self-centered and vagrant, full of the feeling of vengeance, a composite of the unsociable, irritable, quarrelsome, cruel, hypersexual, and destructive traits.

he does not hesitate to inflict much damage and pain on others where his own interest is involved. His drives are very powerful, intense, but very momentary. His practical life is anything but satisfactory, his ideals low, if any. The juvenile delinquent indulges in many activities that do not benefit him in the least while they do considerable damage to others.

2. Mentally Diseased. All mentally diseased individuals are considered abnormal, usually, most abnormal people exhibit lack of love and sympathy, sense of emotional insecurity and all kinds of emotional complexes. While the balanced and normal individual manifests self-evaluation, adaptability, maturity, regular life, lack of excess, satisfactory social adjustment, contentment with the main occupation of his life, the unbalanced and abnormal individual exhibits an absence of almost all these qualities. Such an individual does not understand his own faults, and is more inclined to blame the world for them. Immaturity is evident in his mental and emotional make up. His sexual life is not normal, and he may also exhibit various kinds of sexual perversities.

3. Unsocial and Anti-social. The abnormal individual is unsocial, incapable of distinguishing between right and wrong and also of attaching any importance to the socially accepted notions of them. It is not necessary that the abnormal individual be accepted notions of them. It is not necessary that the abnormal individual be also immoral, but the excessively and almost completely abnormal individual is in some respect necessarily immoral. The abnormal individual is not inclined to set much store by the social ethos and moral point of view. On the one hand, he lives a secluded life and wants to have nothing to do with the society at large. He has not the least hesitation in doing things that harm other people.
CRITERION OF ABNORMALITY

The understanding of abnormality requires that a survey of its various criteria be made, and these criteria and their respective viewpoints be understood. The main criteria are the following:

1. **Statistical Approach.** One quite prevalent criteria for determining and establishing abnormality is the statistical approach. In this method, the mean and average of the various traits of personality and character are calculated. The average level, and as the individual moves higher or lower of this average, normalcy will decrease and abnormality increase. In this manner, a person will be considered abnormal to the degree in which he deviates, in average and in the mean, from the average quality or the mean quality. Abnormal individuals have much less traits of personality and character than the normal individual has of the same, while the superior person has much more of them than either, particularly-than the normal and average.

2. **Pathological Approach.** Some people consider abnormality from the pathological viewpoint. According to this opinion, abnormal individuals are those who are in some manner suffering from some or the other mental perversion. The behavior of the abnormal and the mentally diseased individual differs from those of normal persons. His mind is more a battlefield for conflicts and frustrations than for anything else. His efficiency is far less than that of the normal person. His character evinces all kinds of perversions and distortions.

   Every normal individual exhibits signs of some or the mental aberration, but only when these aberrations and perversions assume startling proportions is the person certified as abnormal. Presence of the ordinary type of perversion in the individual does not create any obstacles in his social adjustment, behavior and personality, but if the perversion increase alarmingly his own life is made infinitely more difficult besides creating a problem for others as well.

3. **Adjustive Approach.** According to abnormal psychologists, the biggest single factor at the root of mental aberrations is improper and incomplete adjustment, and it is also true that mental distortion spoils adjustment. Some thinkers accept adjustment as the criterion of normality and abnormality. According to this view, the person’s adjustment to his social environment should be considered normal while the one failing to do this be considered abnormal. The normal individual acquiesces in the social customs, beliefs and traditions, and in the necessity to live in accordance with them. On the other hand, the abnormal individual does not bother with them, or hesitate to act in direct contradiction, nor is he inclined to offer any respect to them. Making an adjustment with circumstances and then retaining it helps the individual to keep his balance and his normality. On the other hand, if this adjustment is some how disturbed the individual cannot retain his balance and sanity, he becomes the victims of abnormality.
4. **Dichotomous Approach.** Some people turn to the dichotomous approach in trying to determine abnormality, a viewpoint that adopts the quantitative as well as the qualitative approach. For example, the symptoms that are most prominent in a mentally diseased individual are the facts responsible for his abnormality, whereas when the same symptoms and the same disease is present in other individuals in a lesser degree of intensity, these latter are not regarded as abnormal but treated as quite normal. On the other hand, where the approach is qualitative, the difference between the normal and the abnormal is more of degree.

5. **Eclectic Approach.** Abnormal person can be recognized if he is observed from the statistical, pathological, adjustive and other viewpoints almost simultaneously. Hence in this problem it would probably be best to adopt the eclectic approach. In the eclectic approach every other viewpoint has appropriate place, and hence in the definition of the abnormal, the eclectic viewpoint is probably the most superior. From the eclectic viewpoint it is quite tenable to assert that in any population group there are, or would be, some ten per cent of individuals whose social adjustment would or does leave much to be desired, and that they are suffering from one or other mental aberration. Their personality is disorganized, their character defiled, and their life low and unsocial.

**CONCEPT OF HEALTHY PERSONALITY**

1. **Realistic self appraisals.**

   The well adjusted person sees himself as he is, not as he would like to be. The gap between the real and ideal self concepts is very much smaller among the well adjusted. Since the well adjusted person can appraise himself his abilities and his achievements realistically, he does not need to use defense mechanisms to try to convince himself and others that his failure to come up to his expectations is the fault of others or of environmental conditions over which he has no control.

   The person who is realistic about himself does not have to try to devaluate the source of unfavorable social evaluations in an attempt to prove to himself or others that the evaluations are incorrect. Instead he accepts adverse evaluations as a form of constructive criticism & tries to improve qualities that other judge unfavorably.

2. **Realistic appraisal of situations**

   A well adjusted person does not expect to be perfect, nor does expect the situations in which he finds himself to be perfect. He approaches situations with a realistic attitude, accepting the bad with the good. This does not mean that he has a defeatist attitude or that he projects the blame into someone else when things are not to his liking. Rather, he is willing to do what he can to make the situation more to his liking. Such a person has a constructive approach to life.

   In his realistic appraisal of situations the well adjusted person recognizes that no one can be a law into himself – that he can do whatever he wants when he wants. He
realizes that there must be rules of conduct which protect the right of others & himself, & he is willing to abide by them even when they are not entirely to his liking.

The well adjusted person’s realistic appraisal of situation is shown by his realization that success is not handed to a person on a silver platter. He recognizes that success come only with hard work, the willingness to make personal sacrifices & pass up immediate pleasures in favor of the long term gains he is striving for. The person who is able to appraise a situation realistically recognizes that some situations are work situations and others are play situations. He then knows when to work and when to play.

3. Realistic evaluation of achievements

A well adjusted person is able to evaluate his achievements realistically & to react them in a rational way. The well adjusted person draw lessons from his defeats,. He assesses them rationally to see where the blame lies instead of assuming that he was not at fault. He assesses the tasks in which he has achieved success or failure, according to the judgments of others, to determine what his performance actually was. He evaluates his failures realistically to see if they were actually failures for him or whether they were due to competition with persons whose abilities were greater than his. He also considers whether he tried hard enough and if he did not, whether his lack of effort was due to laziness, fear of failure or some other causes. Also he assesses his aspirations to see if they were realistic, and if not, he profits by his failure, setting his future aspirations at a more realistic level.

4. Acceptance of reality

One of the characteristics of healthy personality is his willingness to accept reality instead of running away from it. While he may not like things as they are. He is realistic enough to know that he can either change them or change to a locale where things will be more to his liking.

Acceptance of reality is essential to a healthy personality. The person must learn to accept his limitations, either physical or psychological. If he cannot change them and to do what he can with what he has. He can also compensate for his limitations by improving those characteristics in which he is strongest.

A realistic person accepts the fact that life is often difficult. He recognizes that his successes and satisfactions to a large extent compensate for his failures &disappointments. The people who accept reality knows that no one can turn back the hands of the clock. He knows that he must live in the present, even though he feels that the past or the future would be more to his liking.

5. Acceptance of responsibility

Well adjusted person is a responsible person. He feels confident of his ability to cope with life and its problems & to take responsibilities suited to his age & level of ability. The well adjusted person is enough of a realist to recognize that he should not accept responsibilities that he is unprepared to carry out successfully. A well adjusted person accepts responsibility in a number of areas. He accepts responsibility for himself and for
his behavior. If things go wrong and if he is criticized he accepts the blame & is willing to admit that he made a mistake. When a problem arises, the well adjusted person accepts the responsibility for tackling that problem & trying to solve it.

When the well adjusted person meets obstacles in his path he has decided to follow, he assumes responsibility for coping with these obstacles instead of responsibility means that the well adjusted person is dependable.

6. Autonomy
Well adjusted person is not only independent in thought & actions. He is self directing and self governing in that he charts the course of his life to meet his needs & wants. Since he is self directing, he can respectable himself as an individual who has selected his life pattern to meet his own needs & wants just as he can respect others, even though he may not approve the life patterns they have selected. Well adjusted person shows autonomy in several ways. In decisions with a minimum of worry, conflict, advice seeking & other types of running away behavior. Autonomous person does not depend on others when he is capable of being independent.

7. Acceptable emotional control
The person must assume the responsibility for keeping his emotions under control so that they will not hurt others or himself. A well adjusted person can live comfortably with his emotions. This is possible because he had developed. Over a period, a degree of stress tolerance, depression tolerance and pain & privation tolerance.

8. Goal orientation
Well adjusted set realistic goals and in later. if they find that these goals are unrealistic goals. Well adjusted make goal setting their business to acquire the knowledge & skills needed to reach their goals. Even if they encounter occasional se backs, they do not give up. They improve their knowledge or skills or they lower their goals to more realistic levels. A well adjusted person is a well-organized one. He integrates his various functions & roles in life according to a consistent, harmonious pattern.

9. Outer orientation
Well adjusted people are outer oriented and are extroverted. When a person is outer oriented. He shows an interest in people, situation and things. He derives more satisfaction from social than self contacts. Well adjusted person is unselfish about his time, effort & material possessions. He is willing to respond in any way he can to the needs of others & does not regard it as an imposition.

Well adjusted person is able to recognize & acknowledge his feelings & reactions. If he does not like what he sees, he is ready to change; he is kind in his reactions to others, even when they are unkind to him. He likes & respects others, it willing to disclose to them his thoughts & feelings. Self disclosure is a common characteristic of well adjusted people.

10. Social acceptance
Well adjusted see themselves as adequate to meet social challenges, demands and expectations and so they are willing to participate in social activities and are highly capable
of identifying with other people. A person who is well accepted has no need for boasting, showing off, or other patterns of behavior characteristic of maladjusted people who are trying to win greater social acceptance.

11. Philosophy of life directed.
Well adjusted person direct their lives by a philosophy which helps them to formulate plans to meet their goals in a socially approved ways. This philosophy of life may be based on mainly on what they believe is right because it is best for all concerned, or it may be based on personal experiences.

Historical views of abnormal behavior

ABNORMAL BEHAVIOR IN ANCIENT TIMES

Although human life presumably appeared on earth some 3 million or more years ago, written records extend back only a few thousand years. Thus our knowledge of our early ancestors is limited.

Two Egyptian papyri dating from the sixteenth century B.C. have provided some clues into the earliest interest in the treatment of diseases and behavior disorders. The Edwin Smith papyrus (named after its nineteenth century discoverer) contains detailed descriptions of the treatment of wounds and other surgical operations. In it, the brain is described—possibly for the first time in history—and the writing clearly shows that the brain was recognized as the site of mental functions. The Ebers papyrus provides another perspective on treatment. It covers internal medicine and the circulatory system but relies more on incantations and magic for explaining and curing diseases that had unknown causes.

Demonology, Gods, and Magic

References to abnormal behavior in early writings show that the Chinese, Egyptians, Hebrews, and Greeks often attributed such behavior to a demon or god who had taken possession of a person.

The decision as to whether the “possession” involved good spirits or evil spirits usually depended on an individual’s symptoms. If a person’s speech or behavior appeared to have a religious or mystical significance, it was usually thought that he or she was possessed by a good spirit or god. Such people were often treated with considerable awe and respect, for it was thought that they had supernatural powers.

Most possessions, however, were considered to be the work of an angry god or an evil spirit, particularly when a person became excited or overactive and engaged in behavior contrary to religious teachings.

The primary type of treatment for demonic possession was exorcism, which included various techniques for casting an evil spirit out of an afflicted person. These techniques varied considerably but typically included magic, prayer, incantation, noisemaking, and the use of various horrible-tasting concoctions, such as purgatives made from sheep’s dung and wine. More
sever measures, such as starving or flogging, were sometimes used in extreme cases to make the body of a possessed person such an unpleasant place that an evil spirit would be driven out. Exorcism was originally the task of shamans or persons regarded as having healing powers.

**Hippocrates, Early Medical Concept**

Hippocrates denied that deities and demons intervened in the development of illnesses and insisted that mental disorders had natural causes and required treatments like other diseases. He believed that the brain was the central organ of intellectual activity and that mental disorders were due to brain pathology. He also emphasized the importance of heredity and predisposition and pointed out that injuries to the head could cause sensory and motor disorders.

Hippocrates classified all mental disorder into three general categories—mania, melancholia, and phrenitis (brain fever)—and gave detailed clinical descriptions of the specific disorders included in each category. For the treatment of melancholia, for example, he prescribed a regular and tranquil life, sobriety and abstinence from all excesses, a vegetable diet, celibacy, exercise short of fatigue, and bleeding if indicated.

Hippocrates had little knowledge of physiology. He believed that hysteria (the appearance of physical illness in the absence of organic pathology) was restricted to women and was caused by the uterus wandering to various parts of the body, pining for children. For this “disease,” Hippocrates recommended marriage as the best remedy. He also believed in the existence of four bodily fluids or humors—blood, black bile, yellow bile, and phlegm.

**Early Philosophical Conceptions of Consciousness and Mental Discovery**

The problem of dealing with mentally distributed individuals who have committed criminal acts was studied by the Greek philosopher Plato (429-347 B.C.). He wrote that such persons were in some “obvious” sense not responsible for their acts and should not receive punishment in the same way as normal persons; “... Someone may commit an act when mad or afflicted with disease....[if so,] let him pay simply for the damage: let him be exempt from other punishment.”

**Insanity** is a legal term for mental disorder that implies a lack of understanding of what is right or wrong as required by law and therefore a lack of responsibility for one’s acts and an inability to manage one’s affairs.

The celebrated Greek philosopher Aristotle (384-322 B.C.), who was a pupil of Plato, wrote extensively on mental disorders. Among his most lasting contributions to psychology are his description of consciousness. Aristotle generally believed the Hippocratic theory of disturbance in the bile generated amorous desires, verbal fluency, and suicidal impulses.

**Later Greek and Roman Thought**

Hippocrates’ work was continued by some of the later Greek and Roman physicians. Pleasant surroundings were considered of great therapeutic value for mental patients, who were provided with constant activities, including parties, dances, walks in the temple gardens, rowing along the Nile, and musical concerts.
One of the most influential Greek physicians was Galen (A.D 130-200), who practiced in Rome. He made a number of original contributions the anatomy of the nervous system. Galen also maintained a scientific approach to the field, dividing the causes of psychological disorders into physical and mental categories. Among the causes he named were injuries to the head, alcoholic excess, shock, fear, adolescence, menstrual changes, economic reverses, and disappointment in love.

Roman physicians wanted to make their patients comfortable and thus used pleasant physical therapies, such as warm baths and massages. They also followed the principle of *contrariis contrarias* (opposite by opposite) - for example, having their patients chilled wine they were in a warm tub. “Dark Ages” in the history of abnormal psychology began much earlier, with Galen’s death in A. D. 200. The contributions of Hippocrates and the later Greek and Roman physicians were soon lost in the welter of popular superstition.

**Views of Abnormality During the Middle Ages**

During the Middle Ages, the more scientific aspects of Greek medicine survived in the Islamic countries of the Middle East. The first mental hospital was established in Baghdad in A. D 792; it was soon followed by others in Damascus and Aleppo (Polvan, 1969). In these hospitals, the mentally disturbed individuals received humane treatment. The outstanding figure in Islamic medicine was Avicenna from Arabia (c. 980-1037), called the “prince of physicians” (Campbell, 1926) and author of *The Canon of Medicine*, perhaps the most widely studied medical work ever written. In his writings, Avicenna frequently referred to hysteria, epilepsy, manic reactions, and melancholia.

During the Middle Ages in Europe (c. 500-1500), scientific inquiry into abnormal behavior was limited, and the treatment of psychologically disturbed individuals was more often characterized by ritual or superstition than by attempts to understand an individual’s condition.

Mental disorders were quite prevalent throughout the Middle Ages in Europe. During this time, supernatural explanations of the causes of mental illness grew in popularity.

During the last half of the Middle Ages in Europe, a peculiar trend emerged in efforts to understand abnormal behavior. It involved **mass madness** - the widespread occurrence of group behavior disorders that were apparently cases of hysteria. Whole groups of people were affected simultaneously. Dancing manias (epidemics of raving, jumping, dancing, and convulsions) were reported as early as the tenth century. One such episode, occurring in Italy early in the thirteenth century was known as **tarantism**. This dancing mania later spread to Germany and the rest of Europe, where it was known as **Saint Vitus’s dance**.

Isolated rural areas were also afflicted with outbreaks of **lycanthropy** - a condition in which people believed themselves to be possessed by wolves and imitated their behavior.

**Exorcism and Witchcraft.** In the Middle Ages in Europe, management of the mentally disturbed was left largely to the clergy. During the early part of the medieval period, the mentally disturbed
were, for the most part, treated with considerable kindness. “Treatment” consisted of prayer, holy water, sanctified ointments, the breath or spittle of the priests, the touching of relics, visits to holy places, and mild forms of exorcism.

**Toward Humanitarian Approaches**

During the latter part of the Middle Ages and the early Renaissance, scientific questioning reemerged and a movement emphasizing the importance of specifically human interests and concerns began—a movement (still with us today) that can be loosely referred to as humanism.

**The Resurgence of Scientific Questioning in Europe**

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

During the sixteenth century, Teresa of Avila (1515-1582) a Spanish nun who was later canonized, made an extraordinary conceptual leap that has influenced thinking to the present day. Teresa, in charge of a group of cloistered nuns who had become hysterical and were therefore in danger from the Spanish Inquisition, argued convincingly that her nuns were not possessed but rather were “as if sick” (comas enfermas). Apparently she did not mean that they were sick of body. Rather, in the expression “as if,” we have what is perhaps the first suggestion that a mind can be ill just as a body can be ill.

Johann Weyer (1515-1588), a German physician and writer who wrote under the Latin name of Joannus Wirus, was so deeply disturbed by the imprisonment, torture, and burning of people accused of witchcraft that he made a careful study of the entire problem. About 1563 he published a book, *The Deception of Demons*, which contain a step-by-step rebuttal of the *Malleus Maleficarum*, a witch-hunting handbook published in 1486 for use in recognizing and dealing with those suspected of being witches. Weyer was one of the first physicians to specialize in mental disorders.

**The Establishment of Early Asylums and Shrines**

From the sixteenth century on, special institutions called asylums, meant solely for the care of the mentally ill, grew in number. Although scientific inquiry into understanding abnormal behavior was on the increase, most early asylums, often referred to as madhouses, were not pleasant places or storage places for the insane.

These early asylums were primarily modifications of penal institutions, and the inmates were treated more like beasts than like human beings.

**Humanitarian Reform**
The humanitarian treatment of patients received great impetus from the work of Philippe Pinel (1745-1826) in France.

**Pinel’s Experiment**

In 1792, shortly after the first phase of the French Revolution, Pinel was placed in charge of La Bicetre in Paris. In this capacity, he received the grudging permission of the Revolutionary Commune to remove the chains from some of the inmates as an experiment to test his views that mental patients should be treated with kindness and consideration—as sick people, not as vicious beasts or criminals. Had his experiment proved a failure, Pinel might have lost his head, but fortunately it was a great success. Chains were removed; sunny rooms were provided; patients were permitted to exercise on the hospital grounds; and kindness was extended to these poor beings, some of whom had been chained in dungeons for 30 years or more. Jean Esquirol (1772-1840), continued Pinel’s good work at La Salpetriere and, in addition, helped establish ten new mental hospitals.

**Tuke’s Work in England**

At about the same time that Pinel was reforming La Bicetre, an English Quaker named William Tuke (1732-1822) established the York Retreat, a pleasant county house where mental patients lived, worked, and rested in a kindly religious atmosphere.

**Rush and Moral Management in America**

The success of Pinel’s and Tuke’s humanitarian experiments revolutionized the treatment of mental patients throughout the Western world. In the United States, this revolution was reflected in the work of Benjamin Rush (1745-1813), the founder of American psychiatry, Rush encouraged more humane treatment of the mentally ill; wrote the first systematic treatise on psychiatry in America, *Medical Inquiries and Observations upon the Diseases of the Mind* (1812); and was the first American to organize a course in psychiatry.

During the early part of this period of humanitarian reform, the use of moral management—a wide-ranging method of treatment that focused on a patient’s social, individual, and occupational needs—became relatively widespread.

**Dix and the Mental Hygiene Movement**

Dorothea Dix (1809-1887) was an energetic New England schoolteacher who became a champion of poor and “forgotten” people in prisons and mental institutions for decades during the nineteenth century.

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

In the early part of the nineteenth century, mental hospitals were controlled essentially by lay persons because of the prominence of moral management in the treatment of “lunatics.” Medical professionals—or alienists, as psychiatrists were called at this time in reference to treating the “alienated,” or insane—had a relatively inconsequential role in the care of the insane and management of the asylums of the day. Effective treatments for mental disorders were unavailable, however, during the latter part of the century, alienists gained control of the insane
asylums and incorporated the traditional moral management therapy into their other rudimentary physical-medical procedures.

**Changing Attitudes Toward Mental Health in the Early Twentieth Century**

In America, the pioneering work of Dix was followed by that of Clifford Beers (1876-1943), whose book *A Mind That Found Itself* was published in 1908.

**THE BEGINNING OF THE MODERN ERA**

**Brain Pathology as a Causal Factor**

With the emergence of modern experimental science in the early part of the eighteenth century, knowledge of anatomy, physiology, neurology, chemistry, and general medicine increased rapidly. These advances led to the gradual identification of the biological, or organic, pathology underlying many physical ailments. Scientists began to focus on diseased body organs as the cause of physical ailments. It was only another step for these researchers to assume that mental disorder was an illness based on the pathology of an organ—in this case, the brain.

**The Beginnings of a classification System**

Emil Kraepelin (1856-1926) played a dominant role in the early development of the biological viewpoint. The most important of these contributions was his system of classification of mental disorders, which became the forerunner of today’s DSM-IV.

**Establishing the Psychological Basis of Mental Disorder**

Despite the emphasis on biological research, understanding of the psychological factors in mental disorders was progressing, too, with the first major steps being taken by Sigmund Freud (1856-1939), generally acknowledged as the most frequently cited psychological theorist of the twentieth century. Freud developed a comprehensive theory of psychopathology that emphasized the inner dynamics of unconscious motives (often referred to as *psychodynamics*) that are at the heart of the **psychoanalytic perspective**. The methods he used to study and treat patients came to be called **psychoanalysis**.

**Mesmerism** our efforts to understand psychological causation of mental disorder start with Franz Anton Mesmer (1734-1815), an Austrian physician who further developed Paracelsus’ ideas about the influence of the planets on the human body. Mesmer believed that the planets affected a universal magnetic fluid in the body, the distribution of which determined health or disease. In attempting to find cures for mental disorders, Mesmer concluded that all people possessed magnetic forces that could be used to influence the distribution of the magnetic fluid in other people, thus effecting cures.

**The Beginnings of psychoanalysis** The first systematic attempt to answer this question was made by Sigmund Freud (1856-1939). Freud directed his patients to talk freely about their problems while under hypnosis. The patients usually displayed considerable emotion, and on awakening from their hypnotic states felt a significant emotional release, which was called a **catharsis**. This simple innovation in the use of hypnosis proved to be great significance.
It was this approach that thus led discovery of the unconsciously - that portion of the mind that contains experience of which a person is unaware-and with it the belief that processes outside of a person’s awareness can play an important role in the determination of behavior. Two related methods allowed him to understand patients’ conscious and unconscious thought processes. One method, free association, involved having patients talk freely about themselves, thereby providing information about their feelings, motives, and so forth. A second method, dream analysis, involved having patients record and describe their dreams. These techniques helped analysts and patients gain insights and achieve a more adequate understanding of emotional problems.

The Early Psychological Laboratories  In 1879 Wilhelm Wundt established the first experimental psychology laboratory at the university of Leipzig. Lightner Witmer (1867-1956), combined research with application and established the first American psychological clinic at the University of Pennsylvania. Witmer, considered to be the founder of clinical psychology (McReynolds, 1996, 1997), was influential in encouraging others to become involved in the new profession.

The behavioral perspective is organized around a central theme; the role of learning in human behavior.

Classical Conditioning  The origins of the behavioral view of abnormal behavior and its treatment are tied to experimental work on the form of learning known as classical conditioning. This work began with the discovery of the conditioned reflex by Russian physiologist Ivan Pavlov. Watson thus changed the focus of psychology to the study of overt behavior, an approach he called behaviorism.

Operant Conditioning  While Pavlov and Watson studying antecedent stimulus conditions and their relation to behavioral responses, E. L. Thorndike (1874-1949) and subsequently B.F. Skinner (1904-1990) were exploring a different kind of conditioning – one in which the consequences of behavior influence behavior. Behavior that operates on environment may be instrumental in producing certain outcomes, and those outcomes, in turn, determine the likelihood that the behavior will be repeated on similar occasions.

CAUSAL FACTORS OF ABNORMALITY

Biological causal factors

The biological viewpoint focuses on mental disorders as disease, many of the primary symptom of which are cognitive or behavioral rather than physiological or anatomical. Mental disorders are thus viewed as disorders of the central nervous system, the autonomic nervous system, or the endocrine system, that are either inherited or caused by some pathological process.

Neurotransmitter and Hormonal Imbalances
In order for the brain to function adequately neurons, or excited nerve cells, need to be able to communicate effectively with one another. The site of communication from the axon of one neuron to the dendrites or cell body of another neuron is the **synapse** (or synaptic cleft) —a tiny filled space between neurons. These interneuronal (or transsynaptic) transmissions are accomplished by chemicals called **neurotransmitters** that are released into the synaptic cleft by the presynaptic neuron when a nerve impulse occurs. There are many different kinds of neurotransmitters; some increase the likelihood that the postsynaptic neuron will “fire” (produce an impulse), while others inhibit the impulse. Whether the neural message is successfully transmitted to the postsynaptic neuron depends, among other things, on the concentration of certain neurotransmitters within the synaptic cleft.

**Imbalances of Neurotransmitters** The belief that neurotransmitter imbalances in the brain can result in abnormal behavior is one of the basic tenets of the biological perspective today, sometimes psychological stress can bring on neurotransmitter imbalances. Although there are dozens of different kinds of neurotransmitters, there are four that have been most extensively studied in relationship to psychopathology: (1) norepinephrine, (2) dopamine, (3) serotonin, and (4) GABA. The first three are all part of a class of neurotransmitters called **monoamines** because they are each synthesized from a single amino acid (monoamine means one amine). Dopamine and norepinephrine are most closely related to one another (both are called **catecholamines**) because they are both synthesized from a common amino acid. Norepinephrine has been implicated as playing an important role in the emergency reactions our bodies show when we are exposed to an acutely stressful or dangerous situation. Dopamine has been implicated in schizophrenia. Serotonin is synthesized from a different amino acid than are the catecholamines and is called an **indolamine**. It has been found to have important effects in the way we process information from our environment and seems to play a role in emotional disorders such as anxiety and depression as well as suicide. Finally, GABA (short for **gamma aminobutyric acid**) was the most recently discovered of the neurotransmitters and its is strongly implicated in anxiety.

**Hormonal imbalance**

Some forms of psychopathology have also been linked to hormonal imbalances. Hormones are chemical messengers secreted by a set of endocrine glands in our bodies. Each of the endocrine glands produce and release its own set of hormones, which travel through our bloodstream and affect various parts of our brain and body. Our central nervous system is linked to the endocrine system (in what is known as the **neuroendocrine system**) by the effects of the hypothalamus on the pituitary gland, which is the master gland of the body that produces a variety of hormones that regulate or control the other endocrine glands. One particularly important set of interactions occurs in the hypothalamic-pituitary-adrenal-cortical axis. Activation of this involves messages from the hypothalamus to the pituitary, which then stimulates the cortical part of the adrenal gland (located on top of the kidney) to produce epinephrine (adrenaline) and the stress hormone cortisol. Malfunction of this system has been implicated in various forms of psychopathology. Sex
hormones are produced by the gonadal glands, and imbalance in these (such as the male hormones-the androgens) can also contribute to maladaptive behavior.

**Genetic Vulnerabilities**
Substantial evidence shows that some mental disorders have a hereditary component. The genetic transmission of traits or vulnerabilities from one generation to the next is, by definition, a biological process. Thus, the many recent studies suggesting that heredity is an important predisposing causal factor for a number of different disorders-such as depression, schizophrenia, and alcoholism-support the biological viewpoint. Many broad temperamental features of newborns and children are genetically influenced. For example, some children are just naturally more shy or anxious, while others are more outgoing.

**Chromosomal Abnormalities**
Chromosomal abnormalities-irregularities in the chromosomal structure-even before birth, thus making it possible to study their effects on future development and behavior. Research in development genetics has shown that abnormalities in the structure or number of the chromosomes are associated with a wide range of malformations and disorders.

**Constitutional Liabilities**
The term constitutional liability is used to describe any detrimental characteristic that is either innate or acquired so early-often prenatally—and in such strength that it is functionally similar to a genetic characteristic. Physical handicaps and temperament are among the many traits included in this category. We will briefly explore the role of these constitutional factors in the etiology of maladaptive behavior.

**Physical handicaps** Embryologic abnormalities or environmental conditions operating before or after birth may result in physical defects. The most common birth difficulty associated with later mental disorders (including learning disabilities, and emotional and behavioral disturbances) is low birth weight (5 pounds or less) low birth weight is most often a factor in premature births but can also occur in full-term births. Prenatal conditions that can lead to premature birth and to low birth weight include nutritional deficiencies, disease, exposure to radiation, drugs, severe emotional stress, or the mother’s excessive use of alcohol or tobacco.

**Temperament**
Newborns differ in how they react to particular kinds of stimuli. Some are startled by slight sound or cry if sunlight hits their faces; others are seemingly insensitive to such stimulation. these reactions differ from baby to baby and are example of characteristic behaviors that appear to have been established before any extensive interaction with the environment. Our early temperament is thought to be substrate from which our personality develops. Starting at about 2 to 3 months of age, approximately five dimensions of temperament can be identified,
although some of these emerge later than others: (1) fearfulness, (2) irritability and frustration, (3) positive affect, (4) activity level, and (5) intentional persistence. These seem to be related to the three important dimensions of adult personality: (1) neuroticism or negative emotionality, (2) extraversion or positive emotionality, and (3) constrain (conscientiousness and agreeableness. The infant dimensions of fearfulness and irritability correspond to the adult dimension of neuroticism—the disposition to experience negative affect. The infant dimensions of positive affect and possibly activity-level seem related to the adult dimension of extraversion, and the infant dimension of attentional persistence seems related to adult dimension of constraint or control. Temperament may also set the stage for the development of various forms of psychopathology later in life.

**Brain Dysfunction and Neural Plasticity**

Significant damage of brain tissue places a person at risk for psychopathology, but specific brain lesions are rarely a primary cause of psychiatric disorder. Brain damage in the elderly sometimes leads to abnormal behavior. In addition, it also increase vulnerability by making a person less able to cope.

**Physical Deprivation or Disturbance** Depressions, for example, frequently accompany significant physical illnesses. In part because illnesses painfully remind us of the limits of our control over our lives. Even without serious illness or disability people may experience challenges to their equilibriums.

**Deprivation of basic Physiology Needs** The most basic human requirements are those for food, oxygen, water, sleep, and the elimination of wastes. Insufficient rest, inadequate diet, or working too hard when ill, can all interfere with a person’s ability to cope and predispose him or her to a variety of problems. It is also now recognized that chronic but even relatively mild sleep deprivation can have adverse emotional consequences in children and adolescents. Prolonged food deprivation also affects psychological functioning. In some parts of the world 3 to 7 percent may suffer from severe malnutrition, which is associated with a host of other potentially damaging variables such as parental neglect and limited access to health care (Brozek & Schurch, 1984; Lozoff, 1989) impairs physical development and lowers resistance to disease but it also stunts brain growth, results in markedly lowered intelligence, and enhances risk for disorders such as attention-deficit disorder.

**Psychosocial causal factor**

Psychosocial factors are those developmental influences that may handicap a person psychologically, making him or her less resourceful in coping with events. We will focus on four categories of psychosocial causal factors that exemplify the range of factors that have been studied; (1) early deprivation or trauma, (2) inadequate parenting styles, (3) marital discord and divorce structures, and (4) maladaptive peer relationships.

**Our Views of the World and of Ourselves; Schemas and Self-Schemas**
A schema is an organized representation of prior knowledge about a concept or about some stimulus that helps guide our processing of current information (Alloy & Tabachnik, 1984; Fiske & Taylor, 1991). Our schemas about the world around us and about ourselves are our guides, one might say, through the complexities of living in the world as we understand it. We all have schemas about other people (for example, expectations that they are lazy or ambitious, or that they are very career-oriented or very marriage-minded), as well as schemas about social roles (for example, expectations about what appropriate behaviors for a widow are) and about events (for example, what appropriate sequences of events are for a particular situation such as someone coping with a loss).

Our self-schemas include our views on what we are, what we might become, and what is important to us. Other aspects of our self-schema concern our notions of the various roles we occupy or might occupy in our social environment, such as woman, man, student, parent, physician, American, older person, and so no.

**Variations in Schemas and Personal Growth** A person’s failure to acquire appropriate principles or rules in cognitive organization can make him or her vulnerable to psychological problems later in life.

**Early Deprivation or Trauma** The deprivation of needed resources normally supplied by parents or parental surrogates is one such circumstance. The needed resources range from food and shelter, to love and attention. Parental deprivation of such resources can occur in several forms. For example, it can occur even in intact families where, for one reason or another, parents are unable (for instance, because of mental disorder) or unwilling to provide for a child’s needs for close and frequent human contact. But the most severe manifestations of deprivation are usually seen among abandoned or orphaned children who may either be institutionalized or placed in a succession of unwholesome foster homes.

**Institutionalization** As noted, in some cases children are raised in an institution where, compared with an ordinary home, there is likely to be less warmth and physical contact; less intellectual, emotional, and social stimulation; and a lack of encouragement and help in positive learning. It is clear that many children deprived of normal parenting in infancy and early childhood show maladaptive personality development and are at risk for psychopathology.

**Deprivation and Abuse in the Home** Most infants subjected to parental deprivation are not separated from their parents, but rather suffer from inadequate care at home. In these situations parents typically neglect or devote little attention to their children and are generally rejecting. Parental rejection of a child may be demonstrated in various ways—by physical neglect, denial of love and affection, lack of interest in the child’s activities and achievements, failure to spend time with the child, and lack of respect for the child’s rights and feelings. In a minority of cases, it also involves cruel and abusive treatment. Parental rejection may be partial or complete, passive or active, or subtly or overtly cruel, the effects of such deprivation and rejection may be very serious. Outright parental abuse (physical or sexual or both) of children has also been associated with many other negative effects on the development of its victims, although some studies have
suggested that, at least among infants, gross neglect may be worse than having an abusive relationship. Abused children often have a tendency to be overly aggressive (both verbally and physically) and some even respond with anger and aggression to friendly overtures from peers.

**Other Childhood Traumas** The term psychic trauma is used to describe any aversive (unpleasant) experience that has harmful psychological effects on an individual.

**Parental Psychopathology** in general, it has been found that parents who have various forms of psychopathology, including schizophrenia, depression, antisocial personality disorder, and alcoholism, tend to have children who are at heightened risk for a wide range of developmental difficulties. Although some of these effects undoubtedly have a genetic component, many researchers believe that genetic effects cannot account for all of the adverse effects that parental psychopathology has on children.

In addition, children of alcoholics have elevated rates of truancy and substance abuse and a greater likelihood of dropping out of school, as well as higher levels of anxiety and depression and lower levels of self-esteem (Chassin, Rogosch, & Barrera, 1991; Gotlib & Avison, 1993), although many children of alcoholics do not have difficulties.

**Parenting Styles; Warmth and Control** four types of parenting styles have been identified that seem to be related to different developmental outcomes for the children: (1) authoritative, (2) authoritarian, (3) permissive/indulgent, and (4) neglectful/uninvolved. These styles vary in the degree of *parental warmth* (amount of support, encouragement, and affection versus shame, rejection, hostility) and in the degree of *parental control* (extent of discipline and monitoring versus being largely unsupervised).

**Authoritative Parenting** The authoritative style is one in which the parents are both very warm and very careful to set clear limits and restrictions regarding certain kinds of behaviors, but also allow considerable freedom within certain limits. This style of parenting is associated with the most positive early social development, with the children tending to be energetic and friendly and showing development of general competencies for dealing with others and with their environments.

**Authoritarian Parenting** Parents with an authoritarian style are high on control but low on warmth, and their children tend to be conflicted, irritable, and moody (Baumrind, 1975, 1993). When followed into adolescence, these children had more negative outcomes, with the boys doing particularly poorly in social and cognitive skills. If such authoritarian parents also use overly severe discipline in the form of physical punishment—as opposed to the withdrawal of approval and privileges—the result tends to be increased aggressive behavior on the part of the child.

**Permissive indulgent Parenting** A third parenting styles the permissive-indulgent style, in which parents are high on warmth but low on discipline and control. This style of parenting is associated with impulsive and aggressive behavior in children. Overly indulged children are characteristically spoiled, selfish, inconsiderate, and demanding.
Inadequate, Irrational, and Angry Communication  Parents sometimes discourage a child from asking questions and in other ways fail to foster the information exchange essential for helping the child develop essential competencies. Inadequate communication may take a number of forms. Some parents are too busy or preoccupied with their own concerns to listen to their children and to try to understand the conflicts and pressures they are facing. As a consequence, these parents often fail to give needed support and assistance, particularly when there is a crisis. Other parents have forgotten that the world often looks different to a child or adolescent—rapid social changes can lead to a communication gap between generations. In other instances, faulty communication may take more deviant forms in which messages become completely garbled because a listener distorts, disconfirms, or ignores a speaker’s intended meaning.

Marital Discord and Divorce

Disturbance family structure is an overarching risk factor that increases an individual’s vulnerability to particular stressors. We will distinguish between intact families where there is significant marital discord and families that have been disrupted by divorce or separation.

Marital Discord

One spouse may express feelings of frustration and disillusionment in hostile ways such as nagging, criticizing, and doing things purposely to annoy the other person. Whatever the reasons for the difficulties, seriously discordant relationships of long standing are likely to be frustrating, hurtful, and generally damaging in their effects on the adults and their children. One recent study found that children could be buffered against many of the damaging effects of marital conflict if one or both parents had the following characteristics: warmth, proneness to giving praise and approval, and ability to inhibit rejecting behavior toward their children.

Divorced families  In many cases a family is incomplete as a result of death, divorce, separation, or some other circumstance.

Maladaptive Peer Relationships

Another important set of relationships outside the family usually begins in the preschool years—those involving age-mates, or peers. A child who fails to establish a satisfactory relationship with peers during the developmental years is deprived of a crucial set of background experience and is at higher-than-average risk for a variety of negative outcomes in adolescence and adulthood (Burks et al., 1995; Kupersmidt et al., 1990). Peer social problems in childhood have been linked to a variety of breakdowns in later adaptive functioning, including depression, school dropout, and delinquency.

Socio cultural causal factor

The Sociocultural Environment

In much the same way that we receive a genetic inheritance that is the end product of millions of years of biological evolution, we also receive a sociocultural inheritance that is the end product of thousands of years of social evolution. Subgroups within a general sociocultural environment such
as family, sex, age, class, occupational, ethnic, and religious groups—foster beliefs and norms of their own, largely by means of social roles that their members learn to adopt. Expected role behavior exist for a student, a teacher, an army officer, a priest, a nurse, and so on. Because most people are members of various subgroups, they are subject to various role demands, which also change overtime. In fact, an individual’s life can be viewed as a succession of roles—child, student, worker, spouse, parent, and senior citizen. When social roles are conflicting, unclear, or uncomfortable, or when an individual is unable to achieve a satisfactory role in a group, healthy personality development may be impaired.

**Low Socioeconomic Status and Unemployment**

In our society, an inverse correlation exists between socioeconomic status (SES) and the prevalence of abnormal behavior—the lower the socioeconomic class, the higher the incidence of abnormal behavior. There is evidence that some people with mental disorders slide down to the lower rungs of the economic ladder and remain there because they do not have the economic or personal resources to climb back up (Gottesman, 1991). These people will often have children who also show abnormal behavior for a whole host of reasons, including biological reasons such as increased risk for prenatal complications leading to low birth weight. At the same time, more affluent people are better able to get prompt help or to conceal their problems. In addition, it is almost certainly true that people living in poverty encounter more, severe, stressors in their lives than do people in the middle and upper classes, and they usually have fewer resources for dealing with them. Thus the tendency for some forms of abnormal behavior to appear more frequently in lower socioeconomic groups may be at least partly due to increased stress in the people at risk.
MODULE- 2

STRESS AND BEHAVIOR

STRESS DISORDER

What is stress?

The term stress has typically been used to refer both to the adjustive demands placed on an organism and to the organism’s internal biological and psychological responses to such demands. We will refer to adjustive demands as stressors, to the effects they create within an organism as stress, and to efforts to deal with stress as coping strategies.

According to Canadian physiologist Hans Selye (1956, 1976a), the notion of stress can be broken down further into eustress (positive stress) and distress (negative stress). (In most cases, the stress experienced during a wedding would be eustress; during a funeral, distress.) Both types of stress tax a person’s resources and coping skills, though distress typically has the potential to do more damage.

Categories of stressors

Adjustive demands, or stressors, stem from sources that fall into three basic categories; (1) frustration, (2) conflict, and (3) pressure.

Frustrations when a person’s strivings are thwarted, either by obstacles that block progress toward a desired goal or by the absence of an appropriate goal, frustration occurs. Frustrations can be particularly difficult for a person to cope with because they often lead to selfdevalution, making the person feel that he or she has failed in some way or is incompetent.

Conflicts in many instances stress results from the simultaneous occurrence of two or more incompatible needs or motives;

Pressures Stress may stem not only from frustrations and conflicts but also from pressures to achieve specific goals or to behave in particular ways. In general, pressure forces us to speed up, intensify effort, or change the direction of goal-oriented behavior. All of us encounter many everyday pressures, and we often handle them without undue difficulty.

Factors Predisposing a Person to Stress

The severity of stress is gauged by the degree to which it disrupts functioning. The actual degree of disruption that occurs or is threatened depends partly on a stressor’s characteristics and partly on a person’s resources, both personal and situational, for meeting the demands resulting from the stress and the relationship between the two.

The Nature of the Stressor The impact of stressors depends on a wide range of factors—among them the importance of the stressors to the person, the duration of the stress, the cumulative effect of stressors in the person’s life, whether the stressor appear along with other stressors, whether the stressor is “natural” or artificial and whether it has prominence in the...
person’s life, and whether or not that stressor is seen by the victim as being within his or her control. Although most minor stressors, such as misplacing one’s keys, may be dealt with as a matter of course, stressors that involve important aspects of a person’s life—such as the death of a loved one, a divorce, a job loss, or a serious illness—tend to be highly stressful for most people.

The Experience of Crisis From time to time, most of us experience periods of especially acute (sudden and intense) stress. The term crisis is used to refer to times when a stressful situation approaches or exceeds the adaptive capacities of a person or group. Crises are often especially stressful because the stressors are so potent that the coping techniques we typically use do not work.

Life Changes It is important to remember that life changes, even some positive ones such as getting a desired promotion or getting married, place new demands on us and thus may be stressful. Our psychological environments (including such things as our friendships networks, work relationships, and social resources) can play a significant role in the cause or precipitation of the onset of disorders, even in biological disorders such as bipolar disorder.

A person’s Perception of the Stressor Most of us are well aware that, in some cases, one person’s stressor is another person’s thrill. Some look forward to a chance to be on stage; others dread it. The different reactions people have to environmental events is due in part to the way in which they perceive the situation—the same event will be interpreted differently by different people.

The Individual’s Stress Tolerance People who do not handle changing life circumstances well might be particularly vulnerable to the slightest frustration or pressure. Those who are generally unsure of their adequacy and worth are much more likely to experience threat than those who feel generally confident and secure. The term stress tolerance refers to a person’s ability to withstand stress without becoming seriously impaired. People vary greatly in overall vulnerability to stressors.

A lack of External Resource and Social Supports Considerable evidence suggests that positive social and family relationships can moderate the effects of stress on a person and can even reduce illness and early death (Monroe & Steiner, 1986). Conversely, the lack of external supports, either personal or material, can make a given stressor more potent and weaken a person’s capacity to cope with it.

REACTION TO COMMON LIFE STRESSOR

ADJUSTMENT DISORDER: REACTONS TO COMMON LIFE STRESSORS

A person whose response to a common stressor such as marriage, divorce, childbirth, or losing a job is maladaptive and occurs within three months of the stressor can be said to have an adjustment disorder. The person’s reaction is considered maladaptive if he she is unable to function as usual or if the person’s reaction to the particular stressor is excessive. In adjustment
disorder, the person’s maladjustment lessens or disappears when (1) the stressor has subsided or (2) the individual learns to adapt to the stressor.

**Stress from Unemployment**

Work–related problems can produce great stress in employees (Williams, Barefoot et al.1997). One extremely stressful situation that occurs all too frequently in today’s business climate is loss of gainful employment. Managing the stress associated with unemployment requires great coping strength, especially for people who have previously earned an adequate living.

**Stress from Bereavement**

The sudden unexpected death of a loved one accounts for about one-third of all PTSD cases seen in a community (Breslau, Kessler, Chilcoat et al.,1998). When someone close to us dies, we are psychologically capsized. Often the first reaction is disbelief. Then, as we begin to realize the significance of the death, our feelings of sadness, grief, and despair (even, perhaps, anger at the departed person) frequently overwhelm us.

Grief over the loss of a loved one is a natural process that allows the survivors to mourn their loss and then free themselves for life without the departed person. Some people do not go through the typical process of grieving, perhaps because of their personality makeups (defensive coping styles) or as a consequence of their particular situations. A person may, for instance, be expected to be stoical about his or her feelings or may have to manage the family’s affairs. Another person may develop exaggerated or prolonged depressions after the grieving process should have ended. A normal grieving process typically lasts up to about a year and may involve negative health effects such as high blood pressure, changes in eating habits, and even thoughts of suicide.

Complicated or prolonged bereavement is often found in situations where there has been an untimely or unexpected death (Kim & Jacobs,1995). Pathological reactions to death are also more likely to occur in people who have a history of emotional problems or who harbor a great deal of resentment and hostility toward the decreased, thus experiencing intense guilt.

**Stress from Divorce or Separation**

The deterioration or ending of an intimate relationship is a potent stressor and a frequent reason why people seek psychological treatment. Divorce, through more generally accepted today, is still a tragic and usually stressful outcome to a once close and trusting relationship. Marital disruption is a major source of vulnerability to psychopathology; people who are recently divorced or separated are markedly overrepresented among people with psychological problems.

Many factors make a divorce or separation unpleasant and stressful for everyone concerned: the acknowledgment of failure in a relationship important both personally and culturally; the necessity of explaining the failure to family and friends; the loss of valuable friendships that often accompanies the rupture; the economic uncertainties and hardships that both partners frequently
experience and when children are involved, the problem of custody, including court battles, living arrangements and so on.

**REACTIONS TO SEVERE LIFE STRESSORS**

**POST-TRAUMATIC STRESS DISORDER: REACTIONS TO CATASTROPHIC EVENTS**

Many potential sources of trauma exist in contemporary society, and post-traumatic stress disorder symptoms are by no means rare in the general population. Accidents for example, are quite common. Many people, if not most, who are exposed to plane crashes, automobile accidents, explosions, fires, earthquakes, tornadoes, sexual assaults, or other terrifying experiences show psychological shock reactions such as confusion and disorganization. The symptoms may vary greatly, depending on the nature and severity of the terrifying experience, the degree of surprise, and the personality makeup of the person.

Post-traumatic stress disorder includes the following symptoms;

- **The traumatic event is persistently reexperienced by the person**. He or she may have intrusive, recurring thoughts or repetitive nightmares about the event (Joseph, Williams, & Yule, 1995). A study of college students who experienced the Loma Prieta earthquake in 1989 in the San Francisco area confirmed this long-held belief about traumatic events influencing the experience of nightmares. Wood and colleagues (19920 found that students who experienced the earthquake had substantially more nightmares and more nightmares about earthquakes than students who did not experience the earthquake.

- **The person persistently avoids stimuli associated with the trauma**. For example, he or she tries to avoid activities related to the incident or blocks out the memory of certain aspects of the experience. Situations that recall the traumatic experience provoke anxiety.

- **The person may experience persistent symptoms of increased arousal**. These may include chronic tension and irritability, often accompanied by insomnia, the inability to tolerate noise, and the complaint that “I just can’t seem to relax.”

- **The individual may experience impaired concentration and memory**.

- **The person may experience feelings of depression**. In some cases he or she may withdraw from social contact and avoid experiences that might increase excitation –commonly manifested in the avoidance of interpersonal involvement, loss of sexual interest, and an attitude of “peace and quiet at any price.”

A victim’s initial responses following a disaster typically involve three stages: (1) the shock stage, in which the victim is stunned, dazed, and apathetic; (20 the suggestible, and willing to take directions from rescue workers or others; and (3) the recovery stage, in which the victim may be tense and apprehensive and show generalized anxiety, but gradually regains psychological equilibrium often showing a need to repeatedly tell about the catastrophic event. It is in the third stage that post-traumatic stress disorder may develop. Recurrent nightmares and the typical need to tell the same story about the disaster again and again.
appear to be mechanisms for reducing anxiety and desensitizing the self to the traumatic experience. Tension apprehensiveness, and hypersensitivity appear to be residual effects of the shock reaction and to reflect the person’s realization that the world can become overwhelmingly dangerous and threatening.

**The Trauma of Military Combat**

Many people who have been involved in the turmoil of war experience devastating psychological problems for months or even years afterward.

**Prisoners of War and Holocaust Survivors**

Among the most stressful and persistently troubling wartime experiences is that of being a prisoner of war (Beal, 1995; Page Engdahl et al., 1997). Although some people have been able to adjust to the stress (especially if part of a supportive group), the past shows us that the toll on most prisoners is great.

**The Trauma of Being Held Hostage**

Hostage taking seems to increase each year. Clearly such situations can produce disabling psychological symptoms in victims (Allodi, 1994). The following case reported by Sonnenberg.

**Psychological Trauma among Victims of Torture**

Among the most highly stressful experiences human beings have reported have been those inhuman acts perpetrated upon them by other human beings in the form of systematic torture. From the beginning of human history to the present, some people have been subjecting other people to pain, humiliation, and degradation for political or inexplicable personal reasons. Psychological symptoms experienced after torture have been well documented and involve a range of problems, including physical symptoms (such as pain, nervousness, insomnia, tremors, weakness, fainting, sweating, and diarrhea); psychological symptoms (such as night terrors and nightmares, depression, suspiciousness, social withdrawal and alienation, irritability, and aggressiveness); cognitive impairments (such as concentration problems, disorientation, confusion, and memory deficits); and unacceptable behaviors (such as aggressiveness, impulsivity, and suicidal attempts).

**TREATMENT AND PREVENTION OF STRESS DISORDERS**

In general, the more stable and better-integrated a personality and the more favorable a person’s life situation, the more quickly he or she will recover from a severe stress reaction. Many people who experience a disaster benefit from at least some psychological counseling, no matter how brief, to begin coping with their experience (Shelby & Tredinnick, 1995). Brom, Kleber, and Defares (1989) conducted a controlled study of the effectiveness of brief therapy with people experiencing PTSD and found that treatment immediately following the traumatic event significantly reduced the PTSD symptoms. Sixty
percent of the treated persons showed improvement while only 26 percent of the untreated group improved. They also found, however, that treatment did not benefit everyone and that some people maintained their PTSD symptoms even after therapy was terminated.

Treatment is often required, too, for disaster area workers. Many people called to the scene of a disaster to assist victims later experience post-traumatic stress disorder themselves. Epstein, Fullerton, Ursano (1998) found that workers who provide support to bereaved families of disaster victims are at risk for increased illness, psychiatric symptoms, and negative psychological well-being for up to 18 months following the disaster. They also reported that individuals with lower levels of education, those who had exposure to grotesque burns, and had strong feelings of numbness following exposure, were more likely to experience later psychological symptoms following an air disaster. Supportive therapy and proper rest (induced by sedatives if necessary) usually can alleviate symptoms that lead to post-traumatic stress disorder (Morgan, 1995; Everly, 1995). Repetitive talking about the experience and constantly reliving it in fantasies or nightmares may serve as built-in repair mechanisms to help a person adjust to the traumatic event.

**Stress Prevention or Reduction**

If we know that extreme or prolonged stress can produce maladaptive psychological reactions that have predictable courses, is it possible to intervene early in the process to prevent the development of emotional disorder? In some situations it may be possible to prevent maladaptive responses to stress by preparing a person in advance to deal with the stress. This approach to stress management has been shown to be effective in cases where the person is facing a known traumatic event, such as major surgery or the breakup of a relationship. In these cases a professional attempts to prepare the person in advance to cope better with the stressful event through developing more realistic and adaptive attitudes about the problem.

When a predictable and unusually stressful situation is about to occur, is it possible to inoculate a person by providing information about likely stressors ahead of time and suggesting ways of coping with them? If preparation for battle stressors can help soldiers avoid breakdowns, why not prepare other people to effectively meet anticipated stressors? The use of cognitive-behavioral techniques to help people manage potentially stressful situations or difficult events has been widely explored (Beech, Burns, & Sheffield, 1982; MacDonald & Kuiper, 1983: Meichenbaum & Cameron, 1983). This preventive strategy, often referred to as **stress-inoculation training**, prepares people to tolerate an anticipated threat by changing the things they say to themselves before the crisis.
Treatment of Post-traumatic Stress Symptoms

Medications several medications are used to provide relief for intense PTSD symptoms of depression, intrusion, and avoidance.

Crisis Intervention Therapy

A brief problem-focused counseling approach referred to as crisis intervention may aid a victim of a traumatic event in readjusting to life after the stressful situation has ended. In brief crisis-oriented therapy with people in a crisis situation, the disaster victim is provided emotional support and is encouraged to talk about their experiences during the crisis (Cigrang, Pace, & Yasuhara, 1995). People who are able to deal with their emotional reactions during the crisis are better able to adjust to life circumstances following the disaster.

Direct Therapeutic Exposure One behaviorally oriented treatment strategy that has been used effectively with PTSD clients is direct therapeutic exposure (Fairbank et al., 1993). In this approach, the client is exposed or reintroduced to stimuli that have come to be feared or associated with the traumatic event (McLvor & Turner, 1995). This procedure involves repeated or extended exposure, either in vivo or in the imagination, to objectively harmless but feared stimuli for the purpose of reducing anxiety (Fairbank et al., 1993). Exposure to stimuli that have come to be associated with fear-producing situations might also be supplemented by other behavioral techniques in an effort to reduce the symptoms of PTSD.
MODULE 3
PERSONALITY AND ANXIETY DISORDERS

PERSPECTIVES
BIOLOGICAL PERSPECTIVE

The biological viewpoint focuses on mental disorders as diseases, many of the primary symptoms of which are cognitive or behavioral rather than physiological or anatomical. Mental disorders are thus viewed as disorders of the central nervous system, or the endocrine system, that are either inherited or caused by some pathological process.

The bizarre thought content of delusions and other abnormal mental states is probably never, in itself, the direct result of brain damage. Clearly, a person’s behavioral impairment (such as memory loss) may be readily accounted for by structural damage to the brain, but it is not so apparent how such damage produces the sometimes bizarre content of the person’s thoughts or behavior.

Neurotransmitter and Hormonal Imbalances

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

Imbalances of Neurotransmitters  The belief that neurotransmitter imbalances in the brain can result in abnormal behavior is one of the basic can result in abnormal behavior is one of the basic tenets of the biological perspective today, sometimes psychological stress can bring on neurotransmitter imbalances. Although there are dozens of different kinds of neurotransmitters, there are four that have been most extensively studied in relationship to psychopathology: (1) norepinephrine, (2) dopamine, (3) serotonin, and (4) GABA. The first three are all part of a class of neurotransmitters called monamines because they are each synthesized from a single amino acid (monoamine means one amine). Dopamine and norepinephrine are most closely related to one another (both are called catecholamines ) because they are both synthesized from a common amino acid, Norepinephrine has been implicated as playing an important role in the emergency reactions our bodies show when we are exposed to an acutely stressful or dangerous situation.
Dopamine has been implicated in schizophrenia; Serotonin is synthesized from a different amino acid than are the catecholamines and is called an indolamine. It has been found to have important effects in the way we process information from our environment and seems to play a role in emotional disorders such as anxiety and depression as well as suicide. Finally, GABA (short for gamma aminobutyric acid) was the most recently discovered of the neurotransmitters and its is strongly implicated in anxiety.

**Hormonal imbalance**

Some forms of psychopathology have also been linked to hormonal imbalances. Hormones are chemical messengers secreted by a set of endocrine glands in our bodies. Each of the endocrine glands produces and releases its own set of hormones, which travel through our bloodstream and affect various parts of our brain and body. Our central nervous system is linked to the endocrine system (in what is known as the neuroendocrine system) by the effects of the hypothalamus on the pituitary gland, which is the master gland of the body that produces a variety of hormones that regulate or control the other endocrine glands. One particularly important set of interactions occurs in the hypothalamic-pituitary-adrenal-cortical axis. Activation of this involves messages from the hypothalamus to the pituitary, which then stimulates the cortical part of the adrenal gland (located on top of the kidney) to produce epinephrine (adrenaline) and the stress hormone cortisol. Malfunction of this system has been implicated in various forms of psychopathology. Sex hormones are produced by the gonadal glands, and imbalance in these (such as the male hormones—the androgens) can also contribute to maladaptive behavior.

**Genetic Vulnerabilities**

Substantial evidence shows that some mental disorders have a hereditary component. The genetic transmission of traits or vulnerabilities from one generation to the next is, by definition, a biological process. Thus, the many recent studies suggesting that heredity is an important predisposing causal factor for a number of different disorders—such as depression, schizophrenia, and alcoholism—support the biological viewpoint. Many broad temperamental features of newborns and children are genetically influenced. For example, some children are just naturally more shy or anxious, while others are more outgoing.

**Chromosomal Abnormalities**

Chromosomal abnormalities—irregularities in the chromosomal structure—even before birth, thus making it possible to study their effects on future development and behavior. Research in development genetics has shown that abnormalities in the structure or number of the chromosomes are associated with a wide range of malformations and disorders.

**Constitutional Liabilities**

The term constitutional liability is used to describe any detrimental characteristic that is either innate or acquired so early—often prenatally—and in such strength that it is functionally similar to a genetic characteristic. Physical handicaps and temperament are among the many traits included
in this category. We will briefly explore the role of these constitutional factors in the etiology of maladaptive behavior.

**Physical Handicaps** Embryologic abnormalities or environmental conditions operating before or after birth may result in physical defects. The most common birth difficulty associated with later mental disorders (including learning disabilities, and emotional and behavioral disturbances) is low birth weight (5 pounds or less). Low birth weight is most often a factor in premature births but can also occur in full-term births. Prenatal conditions that can lead to premature birth and to low birth weight include nutritional deficiencies, disease, exposure to radiation, drugs, severe emotional stress, or the mother’s excessive use of alcohol or tobacco.

**Temperament**

Newborns differ in how they react to particular kinds of stimuli. Some are startled by slight sound or cry if sunlight hits their faces; others are seemingly insensitive to such stimulation. These reactions differ from baby to baby and are example of characteristic behaviors that appear to have been established before any extensive interaction with the environment. Our early temperament is thought to be substrate from which our personality develops. Starting at about 2 to 3 months of age, approximately five dimensions of temperament can be identified, although some of these emerge later than others: (1) fearfulness, (2) irritability and frustration, (3) positive affect, (4) activity level, and (5) intentional persistence. These seem to be related to the three important dimensions of adult personality: (1) neuroticism or negative emotionality, (2) extraversion or positive emotionality, and (3) constrain (conscientiousness and agreeableness). The infant dimensions of fearfulness and irritability correspond to the adult dimension of neuroticism—the disposition to experience negative affect. The infant dimensions of positive affect and possibly activity-level seem related to the adult dimension of extraversion, and the infant dimension of attentional persistence seems related to adult dimension of constraint or control. Temperament may also set the stage for the development of various forms of psychopathology later in life.

**Brain Dysfunction and Neural Plasticity**

Significant damage of brain tissue places a person at risk for psychopathology, but specific brain lesions are rarely a primary cause of psychiatric disorder. Brain damage in the elderly sometimes leads to abnormal behavior. In addition, it also increase vulnerability by making a person less able to cope.

**Physical Deprivation or Disturbance** Depressions, for example, frequently accompany significant physical illnesses. In part because illnesses painfully remind us of the limits of our control over our lives. Even without serious illness or disability people may experience challenges to their equilibriums.

**Deprivation of basic Physiology Needs** The most basic human requirements are those for food, oxygen, water, sleep, and the elimination of wastes. Insufficient rest, inadequate diet, or working too hard when ill, can all interfere with a person’s ability to cope and predispose him or her to a
variety of problems. It is also now recognized that chronic but even relatively mild sleep deprivation can have adverse emotional consequences in children and adolescents.

Prolonged food deprivation also affects psychological functioning. In some parts of the world 3 to 7 percent may suffer from severe malnutrition, which is associated with a host of other potentially damaging variables such as parental neglect and limited access to health care (Brozek & Schurch, 1984; Lozoff, 1989) impairs physical development and lowers resistance to disease but it also stunts brain growth, results in markedly lowered intelligence, and enhances risk for disorders such as attention-deficit disorder.

**PSYCHOSOCIAL PERSPECTIVE**

**The structure of personality: Id, Ego, and Superego**

Freud theorized that a person’s behavior results from the interaction of three key components of personality or psyche: the id, ego, and superego. The **id** is the source of instinctual drives and the first structure to appear in infancy. These drives are inherited and considered to be of two opposing types: (1) **life instincts**, which are constructive drives primarily of a sexual nature and which constitute the **libido**, the basic energy of life; and (2) **death instincts**, which are destructivves and tend toward aggression, destruction, and eventual death. Freud used the term sexual in a broad sense to refer to almost anything **pleasure principle**, engaging in completely selfish and pleasure-oriented behavior, concerned only with the immediate gratification of instinctual needs without reference to reality or moral considerations. Although the id can generate mental images and wish-fulfilling fantasies, referred to as **primary process thinking**, it cannot undertake the realistic actions needed to meet instinctual demands.

Consequently, after the first few months of life a second part of the personality, as viewed by Freud, develops—the ego. The **ego** mediates between the demands of the id and the realities of the external world. For example, during toilet training the child learns to control a bodily function to meet parental-societal expectations, and it is the developing ego that takes the role of mediating between the physical needs of the body/id and the need to find an appropriate place and time. The basic purpose of the ego is to meet id demands, but in such a way as to ensure the wellbeing and survival of the individual. This role requires the use of reason and other intellectual resource in dealing with the external world, as well as the exercise of control over id demands. The ego’s adaptive measures are referred to as **secondary process thinking**, and the ego operates on the **reality principle**. Freud viewed id demands, especially sexual and aggressive strivings, as inherently in conflict with the rules and prohibitions imposed by society.

As a child grows and gradually learns the rules of parents and society regarding right and wrong, Freud postulated that a third part of the personality gradually emerges from the ego—the **superego**. The superego is the outgrowth of internalizing the taboos and moral values of society. It is essentially what we refer to as the conscience; it is concerned with right and wrong. As the superego develops, it becomes an inner control system that deals with the uninhibited desires of the id. The superego operates through the ego system and strives to compel the ego to inhibit
desires that are considered wrong or immoral. Because the ego mediates between fulfilling the desires of the id, the demands of reality, and the moral constraints of the superego, it is often called the executive branch of the personality.

Freud believed that the interplay of id, ego, and superego is of crucial significance in determining behavior. Often inner mental conflicts arise because the three subsystems are striving for different goals. These conflicts are called intrapsychic conflicts and, if unresolved, led to mental disorder

**Anxiety, Defense Mechanisms, and the Unconscious**

The concept of anxiety—generalized feelings of fear and apprehension— is prominent in the psychoanalytic viewpoint because it is an almost universal symptom of neurotic disorders. Indeed, Freud believed that anxiety played a key causal role in most of the forms of psychopathology that will be discussed in this book. Sometimes the anxiety is overtly experienced and sometimes it is repressed, and then transformed into, and manifested in other overt symptoms. Freud distinguished three types of anxiety, or “psychic pain,” that people can suffer: (1) reality anxiety, arising from actual dangers or threats in the external world; (2) neurotic anxiety, caused by the id’s impulses threatening to break through ego controls into behavior that will be punished in some way; and (3) moral anxiety, arising from a real or contemplated action that is in conflict with an individual’s superego and arouses feelings of guilt.

**Psychosexual Stages of Development**

In addition to his concept of the structure of personality, Freud also conceptualized five psychosexual stages of development that we all pass through from infancy through puberty. Each stage is characterized by a dominant mode of achieving libidinal (sexual) pleasure:

**Oral stage:** during the first two years of life, the mouth is the principal erogenous zone; an infant’s greatest source of gratification is sucking, a process that is necessary for feeding.

**Anal stage:** From ages 2 to 3, the anus provides the major source of pleasurable stimulation during the time when toilet training is often going on and there are urges both for retention and eliminations.

**Phallic stages:** From ages 3 to 5 or 6, self-manipulation of the genitals provides the major source of pleasurable sensation.

**Latency stages:** from ages 6 to 12, sexual motivations recede in importance as a child becomes preoccupied with developing skills and other activities.

**Genital stages:** after puberty, the deepest feelings of pleasure come from sexual relations.

Freud believed that appropriate gratification during each stage is important if a person is not to be stuck or fixated at that level. For example, he maintained that an infant who does not receive adequate oral gratification may be prone to excessive eating or drinking in adult life.

**The Oedipus Complex and the Electra Complex**

In general, each stage of development places demands on an individual and arouses conflicts that Freud believed must be resolved, one of the most important conflicts occurs during the phallic
stage, when the pleasures of self-stimulation and accompanying fantasies pave the way for the **Oedipus complex**. Oedipus, according to Greek mythology, unknowingly killed his father and married his mother, each young boy, Freud thought, symbolically relives the Oedipus drama. He longs for his mother sexually and views his father as a hated rival; however, each young boy also fears that his father will take revenge on his son’s lust by cutting off his penis. This **castration anxiety** forces the boy to repress his sexual desire for his mother and his hostility toward his father and comes to have only harmless affection for his mother.

The Electra complex is the female counterpart of the Oedipus complex and is also drawn from a Greek tragedy. It is based on the view that each girl desires to possess her father and to replace her mother. Freud also believed that each girl at this experiences penis envy so that she can be more like her father and brothers. While the boy renounces his lust for his mother out of fear of castration, no such threat can realistically be posed for the girl. Her emergence from the complex is milder and less complete than the boy’s. She essentially settles for a promissory note: one day she will have a man of her own who can give her a baby—which unconsciously serves as a type of penis substitute.

The psychoanalytic perspective holds that the best we can hope for is a compromise among our warring inclinations, and to realize as much instinctual gratification as possible with minimal punishment and guilt. This perspective thus presents a deterministic view of human behavior that minimizes rationality and freedom of self-determination. On a group level, it interprets violence, war, and related phenomena as the inevitable products of the aggressive and destructive instincts present in human nature.

**INTERPERSONAL PERSPECTIVE**

The **interpersonal perspective** abnormal behavior has a great deal of impact on our relationships with other people. Hence it should not be surprising that many theorists conclude that abnormal behavior is best understood by analyzing our relationships, past and present, with other people. This is the focus of the **interpersonal perspective**.

**Sullivan’s Interpersonal theory** Sullivan offered a comprehensive and systematic theory of personality that was explicit interpersonal. Sullivan (1953) maintained that the concept of personality had meaning only when defined in terms of a person’s characteristic ways of relating to others. He argued that personality development proceeded through various stages involving different patterns of interpersonal relationships. Early in life, for example, a child becomes socialized mainly through interaction with parents, and somewhat later peer relationships become increasingly important. In young adulthood, intimate relationships are established, culminating typically in marriage. Failure to progress satisfactorily through these various stages paves the way for maladaptive behavior.

Sullivan was concerned with the anxiety-arousing aspects of interpersonal relationships during early childhood (rather than Freud’s emphasis on anxiety as being a signal of unconscious conflict). Because an infant is completely dependent on parents and siblings for meeting all needs, a lack of love and care leads to insecurity and what can be an overwhelming sense of anxiety. He
also believed that anxiety about anxiety is fundamental to much psychopathology was even greater than Freud’s (Greenberg & Mitchell, 1983). Sullivan also emphasized the role of early childhood relationships in shaping the self-concept. For example, if a little girl perceives that others are rejecting her, she may view herself in a similar light and develop a negative self-image that almost inevitably leads to maladjustment.

**THE BEHAVIORAL PERSPECTIVE**

The behavioral perspective is organized around a central theme: the role of learning in human behavior.

**Classical conditioning** a specific stimulus may come to elicit a specific response through the process of classical conditioning. The chief importance of classical conditioning in abnormal psychology is the fact that many physiological and emotional responses can be conditioned, including those relating to fear, anxiety, sexual arousal, and those stimulated by drugs of abuse. Thus, for example, one can learn a fear of the dark if fear-producing stimuli (such as frightening dreams or fantasies) occur regularly during conditions of darkness, or one can acquire a fear of snakes if bitten by a snake.

**Instrumental Conditioning** in instrumental (or operant) conditioning an individual learns how to achieve a desired goal. The goal in question may be to obtain something rewarding or to escape from something that is unpleasant. Essential here is the concept of reinforcement, which refers to the delivery of a reward or a pleasant stimulus, or to escape from an aversive stimulus. New responses are learned and tend to recur if they are reinforced.

**Observational learning** Human and nonhuman primates are also capable of learning through observation alone—that is, without directly experiencing an unconditioned stimulus (for classical conditioning) or a reinforcement (for operant conditioning). For example, children can acquire fear simply through observing a parent or peer behaving fearfully with some object or situation that the child was not initially afraid of. In this case, the fear of the parent or peer is experienced vicariously and becomes attached to the formerly neutral object.

**COGNITIVE PERSPECTIVE**

The cognitive-behavioral perspective on abnormal behavior focuses on how thoughts and information processing can become distorted and lead to maladaptive emotions and behavior.

**Attributions, Attributional Style, and Psychopathology** Attribution theory has also contributed significantly to the cognitive-behavioral approach (Anderson, Krull, & Weiner, 1996; Fiske & Taylor, 1991; Heider, 1958). Attributions simply refer to the process of assigning causes to things that happen. We may attribute causes to external events, such as rewards or punishments (“He did it for the money”): or we may assume that the causes are internal—that they derive from traits within ourselves or others. Causal attributions help us explain our own or other people’s behaviors and make it possible to predict what we or others are likely to do in the future.
student who fails a test may attribute the failure to lack of intelligence (a personal trait) or to ambiguous test questions or unclear directions (environmental cause).

Attribution theorists have been interested in whether different forms of psychopathology are associated with characteristic attributional styles. Attributional style refers to characteristic ways that an individual may tend to make attributions for bad events or for good events. For example, depressed people tend to attribute bad events to internal, stable, and global causes (“I failed the test because I’m stupid as opposed to “I failed the test because the teacher was in a bad mood and graded it unfairly”). However inaccurate our attributions may be, they become important parts of our view of the world and can have significant effects on our emotional wellbeing. They can also make us see other people and ourselves as unchanging and unchangeable, leading us to be inflexible in our relationships (Abramson, Seligman, & Teasdale, 1978; Buchanan & Seligman, 1995).

Personality Disorder

Personality disorders, which were formerly known as character disorders. Personality disorder typically do not stem from debilitating reactions to stress, as in post-traumatic stress disorder or many cases of major cases of major depression. Rather, the disorders to be examined here stem largely from the gradual development of inflexible and distorted personality and behavioral patterns, which result in persistently maladaptive ways of perceiving, thinking about, and relating to the world. These maladaptive approaches usually significantly impair at least some aspects of functioning and in some cases cause a good deal of subjective distress. For example, People with avoidant personality disorder are so shy and hypersensitive to rejection that they actively avoid most social interactions.

The category of personality disorders is broad, encompassing behavioral problems that differ greatly in form and severity. In milder cases we find people who generally function adequately but who would be described by their relatives, friends, or associates as troublesome, eccentric, or difficult to get to know. They have characteristic ways of approaching situations and people that make them either have difficulties developing close relationships with others, or have difficulties getting along with those with whom they have close relationships. However, they are often quite capable or even gifted in some ways. In more severe cases, we find people whose extreme and often unethical “acting out” against society makes them less able to function in a normal setting.

CLINICAL FEATURES OF PERSONALITY DISORDERS

People with personality disorders often causes at least as much difficulty in the lives of others as in their own lives. Other people tend to find the behavior of individuals with personality disorders confusing, exasperating, unpredictable, and, in varying degrees, unacceptable—although rarely as bizarre or out of contact with reality as that of people with psychotic disorders. Some people with personality disorders experience a good deal of emotional suffering, although others do not, at least not obviously. Their behavioral deviations are persistent and seem to be intrinsic to their personalities. They have difficulty taking part in mutually respectful and satisfying social relationships. Whatever the particular trait patterns affected individuals have developed
(obstinacy, covert, hostility, suspiciousness, or fear of rejection, for example), these patterns color their reaction to each new situation and lead to a repetition of the same maladaptive behaviors. For example, a dependent person may wear out a relationship with someone, such as a spouse, by incessant and extraordinary demands such as never leaving them alone; after that partner leaves, the person may go immediately into another dependent relationship and repeat the behavior. Thus personality disorders are marked by considerable consistency over time, with no apparent learning from previous troubles.

Personality characteristics referred to as temperament or character traits, suggesting the possibility of hereditary or constitutional influences. Temperament is that it lays the early foundation for the development of the adult personality, but it is not the sole determinant of adult personality.

**DSM –IV’s Five Criteria**

The essential feature of Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture.

- **Criterion A**: this pattern must be manifested in at least two of the following areas; cognitive, affectivity, interpersonal functioning, or impulse control.
- **Criterion B**: this enduring pattern must be inflexible and pervasive across a broad range of personal and social situations.
- **Criterion C**: this pattern leads to clinically significant distress.
- **Criterion D**: the pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
- **Criterion E**: the pattern is not better accounted for as a manifestation or consequence of another mental disorder.

**CATEGORIES OF PERSONALITY DISORDERS**

The DSM-IV personality disorders are grouped into three cluster on the basis of similarities among the disorders

- **Cluster A**: Includes paranoid, schizoid, and schizotypal personality disorders. People with these disorders often seem odd or eccentric, with unusual behavior ranging from distrust and suspiciousness to social detachment.
- **Cluster B**: Includes histrionic, narcissistic, antisocial, and borderline personality disorders. These disorders have in common a tendency to be dramatic, emotional, and erratic. Their impulsive behavior, often involving antisocial activities, is more colorful, more forceful, and more likely to bring them into contact with mental health or legal authorities than the behaviors characterizing disorders in the first cluster.
- **Cluster C**: Includes avoidant, dependent and obsessive-compulsive personality disorders. In contrast to the clusters, anxiety and fearfulness are often part of these disorders, making it difficult in some cases to distinguish them from anxiety-based disorders. People with these disorders, because of their anxieties, are more likely to seek help.
Two additional personality disorders—depressive and passive-aggressive personality disorders—are listed in DSM-IV.

**Paranoid Personality Disorder**

Individuals with paranoid personality disorder have a pervasive suspiciousness and distrust of others. They tend to see themselves as blameless, instead finding fault for their own mistakes and failures in others—even to the point of ascribing evil motives to others. Such people are constantly expecting trickery and looking for clues to validate their expectations, while disregarding all evidence to the contrary. They are often preoccupied with doubts about the loyalty of friends, leading to a reluctance to confide in others. They also may be hypersensitive, as indicated by a tendency to read threatening meanings into benign remarks. They also commonly bear grudges, are unwilling to forgive perceived insults and slights, and are quick to react with anger (Bernstein, Useda, & Siever, 1995; Widiger & Frances, 1994). It is important to keep in mind that paranoid personalities are not usually psychotic; that is, most of the time they are in clear contact with reality, although they may experience transient psychotic symptoms (Thompson-Pope & Turkat, 1993). An other disorder, paranoid schizophrenia. Paranoid schizophrenics have additional problems, however, including more persistent loss of reality contact and extreme cognitive and behavioral disorganization, such as delusions and hallucinations.

This pervasive suspiciousness and mistrust of other people leave a paranoid personality prone to numerous difficulties and hurts in interpersonal relationships. These difficulties typically lead the person to be continually “on guard” for perceived attacks by others.

**Schizoid Personality Disorder**

Individual with schizoid personality disorder usually shown inability to form social relationships and a lack of interest in doing so. Consequently they typically do not have good friends, with the possible expectation of close relatives. Such people are unable to express their feelings and are seen by others as cold and distant; they often lack social skills and can be classified as loners or introverts, with solitary interests and occupations (Widiger & Frances, 1994). They tend not to take pleasure in many activities, including sexual activity. Commonly they may even appear indifferent to praise or criticism from others. More generally, they are not very emotionally reactive emotions, which contributes to their appearing cold and aloof (Widiger et al., 1994)

Early theorists considered a schizoid personality to be a likely precursor to the development of schizophrenia.

In short, the central problem of the person with a schizoid personality is that they neither desire nor enjoy close relationships with other people. It is as though the needs for love, belonging, and approval fail to develop in these people—or if they had been there earlier in development they had somehow disappeared at an early stage. The result is a profound barrenness of interpersonal experience.
Schizotypal Personality Disorder

Individuals with schizotypal personality disorder are not only excessively introverted and have pervasive social and interpersonal deficits; they also have cognitive and perceptual distortions and eccentricities in their communication and behavior (Widiger & Frances, 1994). Although schizotypal and schizoid personalities are both characterized by social isolation and withdrawal, the two can be distinguished in that schizotypal personality—but not schizoid personality—also involves oddities of thought, perception, or speech. Although reality contact is usually maintained, highly personalized and superstitious thinking are characteristic of people with schizotypal personality, and under extreme stress they may experience transient psychotic symptoms (Thompson-pope & Turkat, 1993; Widiger & Frances, 1994). Indeed, they often believe that they have magical powers and may engage in magical rituals. Their oddities in thinking, talking, and other behaviors are similar to those often seen in more severe forms in schizophrenia patients; in fact, they are sometimes first diagnosed as exhibiting simple or latent schizophrenia.

The distinguishing feature of a schizotypal person is peculiar thought patterns, with a loosening—although not a complete rupture—of ties to reality. The individual appears to lack some key integrative competence of the sort that enables most of us to “keep it all together” and move our lives toward some personal goals. As a result, many basic abilities, such as being able to communicate clearly, are never fully mastered, and the person tends to drift aimlessly and unproductively through the adult years.

Histrionic Personality Disorder

Excessive attention-seeking behavior and emotionality are the key characteristics of individuals with histrionic personality disorder. They tend to feel unappreciated if not the center of attention, and their lively, dramatic, and often excessively extraverted styles often ensure that they can charm others into attending to them. But these qualities do not lead to stable and satisfying relationships because others tire of providing this level of attention. In seeking attention, their appearance and behavior are often quite theatrical and emotional, as well as sexually provocative and seductive. Their style of speech may be dramatic but is also quite impressionistic and lacking in details. People with histrionic personality disorder are often highly suggestible and consider relationships to be closer than they are. Their sexual adjustment is usually poor (Apt & Hurlbert, 1994) and their interpersonal relationships are stormy because they may attempt to control their partner through seductive behavior and emotional manipulation, but they also show a good deal of dependence. Usually they are considered to be self-centered, vain, and overconcerned about the approval of others, who see them as overly reactive, shallow, and insincere.
Narcissistic Personality Disorder

Individual with narcissistic personality disorder show an exaggerated sense of self-importance, a preoccupation with being admired, and a lack of empathy for the feelings of others (Blais, Hilsenroth, & Castlebury, 1997). Ronningstam and Gunderson (1989) reported that grandiosity was the most generalizable criterion for diagnosing narcissistic patients and was used most often in making a diagnosis, although they later found in a prospective study that grandiosity was the symptom most likely to diminish with time (Ronningstam et al., 1995). The grandiosity of narcissistic patients is manifested by a strong tendency to overestimate their abilities and accomplishments, while often concurrently underestimate the abilities and accomplishments of others. Their sense of entitlement is frequently a source of astonishment to others, although they themselves seem to regard their lavish expectations as merely what they deserve. They behave in stereotypical ways (for example, with constant self-references and bragging) to gain the acclaim and recognition that feeds their grandiose expectations and their fantasies of unlimited success, power, beauty, or brilliance. Because they believe they are so special, they often think they can only be understood by other high-status people, or should only associate with such people. These tactics, to those around them, appear to be excessive efforts to make themselves look good.

Narcissistic personalities share another central element- they are unwilling to take the perspective of others, to see things other than “through their own eyes”. In more general terms, they lack the capacity for empathy, which is an essential ingredient for mature relationships. In this sense all children begin life as narcissists and only gradually acquire a perspective-taking ability. For reason that are far from entirely understood, some children do not show normal progress in this respect, and indeed, in extreme cases, show little or none. The latter may grow up to become adult narcissistic persons not uncommonly take advantage of others to achieve their own ends and often show arrogant, snobbish, or haughty behaviors and attitudes. Finally, they are often very envious of other people, or believe that other people are envious of them.

People with narcissistic personality disorder have a very fragile sense of self-esteem underneath all their grandiosity. This may be why they are often preoccupied with what others think, why they show such a great need for admiration, and why they are so preoccupied with fantasies of outstanding achievement. Not surprisingly, they are also very sensitive to criticism, which may leave them feeling humiliated, empty, or full of rage.

Narcissistic personality disorder may be more frequently observed in men than in women. Individual with narcissistic personality patterns may not seek psychological treatment because they view themselves as nearly perfect and in no need of change. Those who do enter treatment often do so at the insistence of another person, such as a husband or wife, and may terminate therapy prematurely-particularly if their self-serving behavior.
Antisocial Personality Disorder

Individuals with antisocial personality disorder (ASPD) continually violate and show disregard for the rights of others through deceitful, aggressive, or antisocial behavior, typically without remorse or loyalty to anyone. They tend to be impulsive, irritable, and aggressive, and show a pattern of generally irresponsible behavior. Moreover, according to the DSM, this pattern of behavior must have been occurring since the age of 15, and before age 15, the person must have had symptoms of conduct disorder, a similar disorder occurring in children and young adolescents who show persistent patterns of aggression toward people or animals, destruction of property, deceitfulness or theft, and serious violation of rules at home or in school. Some people with antisocial personalities have enough intelligence and social charm to devise and carry out elaborate schemes for conning large numbers of people. Impostors frequently fit into this category. This disorder is much more common in men than in women, with a lifetime prevalence of about 3 percent in men and about 1 percent in women.

Borderline Personality Disorder

Individuals with borderline personality disorder (BPD) show a pattern of behavior characterized by impulsivity and instability in interpersonal relationships, self-image, and moods. The term borderline personality has a long and rather confusing history (Widiger & Trull, 1993). Originally it was most often used to refer to a condition that was thought to occupy the “border” between neurotic and psychotic disorder (as in the term borderline schizophrenia).

People with borderline personalities show serious disturbances in basic identity. Their sense of self is highly unstable. Given this extremely unstable self-image, it is not surprising that they also have highly unstable interpersonal relationships. For example, they may make desperate efforts to avoid real or imagined abandonment, perhaps because their fears of abandonment are so intense. Feeling slighted, they might, for example, become verbally abusive toward loved ones or might threaten suicide over minor setbacks. Given such behaviors, it is not surprising that they commonly have a history of intense but stormy relationships, typically involving overidealizations of friends or lovers that later end in bitter disillusionment and disappointment (Gunderson, Zanarini, & Kisiel, 1995). Their mood is also highly unstable. For example, they may display intense outbursts with little provocation and have difficulty controlling their anger. They tend to have a low tolerance for frustration, as well as chronic feelings of emptiness. Associated with the sense of emptiness is common intolerance for being alone. Their extreme affective instability is reflected in drastic mood shifts and impulsive or erratic self-destructive behaviors, such as binges of gambling, sex, substance abuse, binge-eating, or reckless driving. Suicide attempts, often flagrantly manipulative are frequently part of the clinical picture (Soloff et al., 1994), and self-mutilation is one of the most discriminating signs for borderline personality (Widiger et al., 1986). In some cases
the self-injurious behavior is associated with relief from anxiety or dysphoria and research has documented that it may even be associated with analgesia (absence of the experience of pain in the presence of a theoretically painful stimulus).

Clinical observation of people with borderline personality disorder points strongly to a problem of achieving a coherent sense of self as a key predisposing causal factor. These people somehow fail to complete the process of achieving a coherent and stable self-identity, and this failure leads to complications in interpersonal relationships.

Although people with borderline personality disorder are usually aware of their circumstances and surroundings, they may have relatively short or transient episodes in which they appear to be out contact with reality and experience delusions or other psychotic-like symptoms, such as hallucinations, paranoid beliefs, body image distortions, or dissociative symptoms. Among inpatients with severe borderline personality disorder the frequency and duration of psychotic symptoms may be greater.

**Avoidant Personality Disorder**

Individuals with avoidant personality disorder have a pattern of extreme social inhibition and introversion leading to lifelong patterns of limited social relationships and reluctance to enter into social interactions. Because of their hypersensitivity to, and their fear of, criticism and rebuff, they do not seek out other people; yet they desire affection and are often lonely and bored. Unlike schizoid personalities, they do not enjoy their aloneness; their inability to relate comfortably to other people causes acute anxiety and is accompanied by low self-esteem and excessive self-consciousness. Because of their hypersensitivity to any sign of rejection or social derogation, they may readily see ridicule or disparagement.

Such people cannot face even the slightest risk of embarrassment or criticism. They want guarantees of success before they will participate—and if they cannot have them, they just will not play the game.

Avoidant personality may be a biologically based disorder often starting in infancy or childhood that is reinforced by environmental factors to become a highly stable and chronic behavioral pattern (Alden & Kapp, 1988; kagan, 1997; Kagan, Rwznick, & Snidman, 1988). The key difference between the loner who is avoidant is that the one with an avoidant personality is hypersensitive to criticism, shy, and insecure, while the one with a schizoid personality is aloof, cold, and indifferent to criticism (Millon & Martinez, 1995.). Dependent personalities have great difficulty separating in relationships because of feelings of incompetence on their own, while avoidant personalities have problems initiating them because of fearing criticism or rejection (Millon & Martinez, 1995). In addition, the primary focus of the dependent personality is on being taken care of, whereas the primary focus of the avoidant personality is on avoidance of humiliation and rejection.
Dependent Personality Disorder

Individuals with dependent personality disorder show extreme dependence on other people, particularly the need to be taken care of, which leads to clinging and submissive behavior. They also show acute discomfort—even panic—at the possibility of separation or sometimes of simply having to be alone, often leading to excessive reliance on emergency medical services (Bornstein, 1992, 1997). These individuals usually build their lives around other people and subordinate their own needs or views to keep these people involved with them, often leading to indiscriminate selection of mates. They often fail to get appropriately angry with others because of a fear of losing their support, which means that they may remain in psychologically or physically abusive relationships. They have great difficulty making even simple everyday decisions without a great deal of advice and reassurance. This may be because they lack self-confidence and feel helpless even when they have actually developed good work skills or other competencies. They may function well as long as they are not required to be on their own.

As a result of their lack of confidence, dependent personalities passively allow other people to take over the major decisions in their lives—such as where they will live and work, what friend they will have, and even how they will spend their time. These individuals typically appear “selfless” and bland, since they usually feel they have no right to express even mild individuality. They are often preoccupied with a fear of being left to take care of themselves, and if one relationship ends they often will seek out a new one with great urgency.

Some features of dependent personality disorder overlap with those of borderline, histrionic, and avoidant personality disorders, but there are differences as well. For example, both borderline personalities and dependent personalities fear abandonment. The dependent personality reacts initially with submissiveness and appeasement, and if abandonment occurs with an urgent seeking of a new relationship. Moreover, the dependent personality does not have the pattern of intense and stormy relationships that the borderline does. Histrionic and dependent personalities both have stormy relationships that the borderline does. Histrionic and dependent personalities both have strong needs for reassurance and approval. However, the style of the histrionic personality is much more gregarious, flamboyant, and actively demanding of attention, whereas the dependent is more docile and self-effacing. The avoidant and dependent personalities share feelings of inadequacy and hypersensitivity, but the avoidant personality is more socially timid and avoids relationships rather than be rejected, whereas the dependent seeks out relationships with others in spite of the fear of being rejected (Hirschfeld, Shea, & Weise, 1995).
Obsessive-Compulsive Personality Disorder

Perfectionism and an excessive concern with maintaining order characterize those individuals with obsessive-compulsive personality disorder (OCPD). They are also preoccupied with maintaining mental and interpersonal control through careful attention to rules and schedules. They are very careful in what they do so as not to make mistakes, and they will often repeatedly check for possible mistakes. Because the details they are preoccupied with are often trivial, they therefore use their time poorly. This perfectionism is also often quite dysfunctional in that it can result in their never finishing projects. They also tend to be devoted to work to the exclusion of leisure activities may have difficulty relaxing or doing anything just for fun (widiger & Frances, 1994).

According to current views, the central feature of people with obsessive-compulsive personality disorder is that they are exceptionally conscientious, which includes the disposition to be deliberate, disciplined, competent, achievement-striving, and organized as well as quite inflexible about moral or ethical issues (Widiger & Frances, 1994). They may also have difficulty getting rid of old and worn out household items and may be quite stingy or miserly as well. At an interpersonal level, they have difficulty delegating tasks to others and are quite rigid and stubborn. Not surprisingly, other people tend to view obsessive-compulsive personalities as rigid, stiff, and cold.

Individuals with both obsessive-compulsive and narcissistic personality disorder may be highly perfectionistic, but the narcissistic individual is more grandiose and likely to believe he or she has achieved perfection, whereas the obsessive-compulsive personality is often quite self-critical. Individuals with narcissistic and antisocial personality disorder may also share the lack of generosity toward others that characterizes obsessive-compulsive personality, but the former tend to indulge themselves, whereas obsessive-compulsive are equally unwilling to be generous with themselves and others. Finally, both the schizoid and the obsessive-compulsive personality may have a certain amount of formality and social detachment, but only the schizoid personality lacks the capacity for close relationships. The obsessive-compulsive personality has difficulty in interpersonal relationships because of excessive devotion to work and because of difficulty expressing emotions.

Provisional Categories of Personality Disorder in DSM-IV

Passive-Aggressive Personality Disorder

One of the most controversial personality disorder is passive-aggressive personality disorder. One reason for the controversy over this diagnosis is that empirical support for the reliability and validity of this diagnosis is limited. This is part because it may be more of a situational reaction than a personality trait, occurring particularly in situations where the person resents being confined and having to follow various rules and regulations.

People with passive-aggressive personality disorder show a pervasive pattern of passive resistance to demands in social or work situations. They also show a strong pattern of negativistic attitudes...
unrelated to any concurrent diagnosis of major depressive disorder or dysthymia. Their passive resistance to demands is shown in many ways, ranging from simple resistance to fulfilling routine tasks, to being sullen or argumentative, or alternating between defiance and submission. They commonly complain of being misunderstood and unappreciated, and at the same time may be highly critical or scornful of authority. They also complain about their personal misfortunes and are envious of others who appear more fortunate.

Depressive Personality Disorder  A second provisional category in the DSM-IV Appendix is depressive personality disorder. People with this disorder show a pattern of depressive cognitions and behaviors that begins by early adulthood and is pervasive in nature. Their usual mood state is one of unhappiness or dejection and they tend to feel inadequate, worthless, or guilty. They tend to be highly self-critical and may be judgmental toward others as well. They also tend to be pessimistic and prone to worry. Although the emphasis here is more on distorted cognitions and interpersonal traits than is true for dysthymic disorder, many questions remain about the validity of the distinction between these two diagnoses (Hirshfeld, 1994). In particular, it may not be possible to distinguish early-onset dysthymia from depressive personality disorder. Nevertheless, Klein and colleagues (Klein et al., 1993; klein & shih, 1998) have provided preliminary evidence that the depressive personality diagnosis is somewhat distinct and that most patients who receive the diagnosis do not meet the criteria for dysthymia; it appears to be associated with fewer depressive symptoms than dysthymia (see also Hirshfeld, 1994). Thus, it remains possible that the pervasive cognitive traits of pessimism, guilt, and self-criticism seen in depressive personality disorder may not be best characterized as a disorder in mood regulation, which is the way dysthymia is characterized.

CAUSAL FACTORS IN PERSONALITY DISORDERS

Biological causal factors

Of possible biological factors, it has been suggested that infants’ constitutional reaction tendencies (high or low vitality, behavioral inhibition, and so on) may predispose them to the development of particular personality disorders. Given that most personality traits have been found to be moderately heritable (e.g., Carey & DiLalla, 1994), it is not surprising that there is increasing evidence for genetic contributions to certain personality disorders (Livesley et al., 1994; Nigg & goldsmith, 1994; Plomin et al., 1997; Siever & Davis, 1991). For example, some research suggests that genetic factors may be important for the development of paranoid personality disorder (Nigg & Goldsmith, 1994), schizotypal personality disorder (Kendler et al., 1991; Nigg & Goldsmith, 1994), borderline personality.

Patients with borderline personality disorder may also show disturbances in the regulation of noradrenergic neurotransmitters (the deficits may be in function, receptors, or concentration) that are similar to those seen in chronic stress conditions such as PTSD. In particular, their hyperresponsive noradrenergic system may be related to their hypersensitivity to environmental
changes (Figueroa & Silk, 1997). In addition, deficits in the dopamine systems may be related to a disposition toward transient psychotic symptoms.

**Psychological causal Factors**

**Early Learning Experiences** Among psychological factors, early learning is usually assumed to contribute the most in predisposing a person to develop a personality disorder, yet there is little research to support this belief. A significant number of studies have suggested that abuse and neglect in childhood may be related to the development of certain personality disorders. Patients with borderline personality disorder reported significantly higher rates of abuse than patients with other personality disorders: repeated sexual abuse was usually by someone other than a parent and almost always occurred in conjunction with at least one other type of abuse and neglect. Overall about 90 percent of patients with borderline personality disorder reported some type of childhood abuse and neglect. This and many other related studies (e.g., Norden et al., 1995) are suggestive that borderline personality disorder (and perhaps other personality disorders as well) is often associated with early childhood trauma.

**The Psychodynamic View** Psychodynamic theorists such as Otto Kernberg (1984; 1996) and Heinz Kohut (1977) have also written a great deal in recent years about the origins of several of the personality disorders-most notably borderline, antisocial, histrionic, and narcissistic personality disorder. Kohut argues that all children go through a phase of primitive grandiosity during which they think that all events and needs revolve around them. For normal development beyond this phase to occur, according to this view, parents must do some mirroring of the infant’s grandiosity. This helps the child develop normal levels of self-confidence. So for example, Kohut argued “however grave the blows may be to which the child’s grandiosity is exposed by the realities of life, the original omnipotence, to be retained as the nucleus of the self-confidence and inner security about one’s worth that sustain the healthy person throughout his life” (Kohut & Wolff, 1978, p. 182; from Widiger & Trull, 1993). Kohut further proposed that narcissistic personality disorder is likely to develop if parents are neglectful, devaluing, or unempathetic to the child; this individual will be perpetually searching for affirmation of this idealized and grandiose sense of self. Theodore Millon- a personality disorder researcher from the social learning tradition of Bandura-has argued quite the opposite. He believes that narcissistic personality disorder comes from parental overvaluation (Millon & Davis, 1996). For example, he has proposed that “these parents pamper and indulge their youngsters in ways that teach them that their every wish is a command, that they can receive without getting in return, and that they deserve prominence without even minimal effort”.

**Sociocultural Causal Factors**

Sociocultural factors contributing to personality disorders are even less well defined. We do know that the incidence and form of psychopathology in general vary somewhat with time and place and the same may be true for personality disorders, although evidence on this point is sketchy at best. Moreover, some clinicians believe that personality disorders have increased in American
society in recent years. If this claim is true, we can expect to find the increase related to changes in our culture’s general priorities and activities.

**SEXUAL DEVELOPMENT AND ORIENTATION DISTURBANCES**

**The Paraphilias**

The paraphilias are a group of persistent sexual behavior patterns in which unusual objects, rituals, or situations are required for full sexual satisfaction. Paraphilic individuals may or may not have persistent desire to change their sexual preferences. The DSM-IV recognizes eight specific paraphilias: (1) fetishism, (2) transvestic fetishism, (3) voyeurism, (4) exhibitionism, (5) sexual sadism, (6) sexual masochism, (7) pedophilia, and (8) frotteurism (rubbing against a non-consenting person). An additional category, paraphilias Not Otherwise Specified, includes several rarer disorders such as telephone scatologia (obscene phone calls), necrophilia (sexual desire for corpses), and coprophilia (sexual arousal to feces).

**Fetishism** In fetishism, sexual interest typically centers on some inanimate object, such as an article of clothing, or some body part. As is generally true for the paraphilias, males are most commonly involved in cases of fetishism; reported cases of female fetishistic are extremely rare (Mason, 1997). The range of fetishistic objects includes hair, erogenous zones, hands, underclothing, shoes, perfume, and similar objects associated with the opposite sex. The mode of using these objects to achieve sexual excitement and gratification varies considerably, but it commonly involves kissing, fondling, tasting, or smelling the objects. Fetishism does not normally interfere with the rights of others, except in an incidental way such as asking the partner to wear the object during sexual encounters.

To obtain the required object, a fetishistic person may commit burglary, theft, or even assault. Probably the articles most commonly stolen by fetishistic individuals are women’s undergarments.

**Transvestic Fetishism** the achievement of sexual arousal and satisfaction by “cross-dressing” - that is, dressing as a member of the opposite sex - is called transvestic fetishism. Typically, the onset of transvestism is during adolescence and involves masturbation while wearing female clothing or undergarments.

**Voyeurism** the synonymous terms voyeurism, scatophilia, and inspectionism refer to the achievement of sexual pleasure through clandestine peeping. It occurs as a sexual offense primarily among young men. These peeping Toms, as they are commonly called, usually observe females who are undressing or couples engaging in sexual relations. Frequently they masturbate during their peeping activity.

First, viewing the body of an attractive female seems to be quite stimulating sexually for many, if not most, men. In addition, the privacy and mystery that have traditionally surrounded sexual activities tend to increase curiosity about them. Second, if a young man with such curiosity feels shy and inadequate in his relations with the other sex, it is not too surprising for him to accept the substitute of voyeurism. In this way he satisfies his curiosity and to some extent meets his sexual needs without the trauma of actually approaching a female, and thus without the rejection and
lowered self-status that such an approach might bring. In fact voyeuristic activities often provide important compensatory feelings of power and secret domination over an unsuspecting victim, which may contribute to the maintenance of this pattern.

**Exhibitionism** the word exhibitionism (*indecent exposure* in legal terms) describes the intentional exposure of the genitals to others (generally strangers) in inappropriate circumstances and without their consent. The exposure may take place in some secluded location, such as a park, or in a more public place, such as a department store, church, theater, or bus. In cities an exhibitionist often drives by schools or bus stops, exhibits himself while in the car, and then drives rapidly away. In many instances the exposure is repeated under fairly constant conditions, such as only in churches or buses, or in the same general vicinity and at the same time of day.

**Sadism** the term sadism is derived from the name of the Marquis de Sade (1740-1814), who for sexual purpose inflicted such cruelty on his victims that he was eventually committed as insane. Achievement of sexual stimulation and gratification by inflicting physical or psychic pain or humiliation on a sexual partner. A closely related pattern is the practice of “bondage and discipline” (B & D), which may include tying a person up hitting or spanking, and so on, to enhance sexual excitement. These elements of a sadist’s erotic interest suggest a psychological association with rape. The pain may be inflicted by such means as whipping, biting, or pinching; the act may vary in intensity, from fantasy to severe mutilation and even murder.

In some cases, sadistic activities lead up to or terminate in actual sexual relations; in others full sexual relations; in others, full sexual gratification is obtained from the sadistic practice alone. A sadist, for example, may slash a woman with a razor or stick her with a needle, experiencing an orgasm in the process.

**Masochism** the term masochism is derived from the name of the Austrian novelist Leopold v. Sacher-Masoch (1836-1895), whose fictional characters dwelt lovingly on the sexual pleasure of pain. As in the case of the term sadism, the meaning of masochism has been broadened beyond sexual connotations, so that it includes deriving pleasure from self-denial, from expiatory physical suffering, such as that of the religious flagellants, and from hardship and suffering in general.

In masochism, a person experiences sexual stimulation and gratification from the experience of pain and degradation in relating to a lover. Interpersonal masochistic activities requires the participation of at least two people—one superior “disciplinarian” and one obedient “slave”. Such arrangements are not uncommon in either heterosexual or homosexual relationships. Masochists do not usually want, or cooperate with, true sexual sadists, but with individuals willing to hurt or humiliate them within limits they set.

One particularly dangerous form of masochism, called autoerotic asphyxia, involves self-strangulation to the point of oxygen deprivation.

**Gender Identity disorders**

*Gender identity* refers to one’s sense of maleness or femaleness and may be distinguished from *gender role*, which refers to the masculinity and femininity of one’s overt behavior (Money, 1988,
Of all behavioral traits, gender identity may have the strongest correlation with biological sex, but the correlation is imperfect. Some rare individuals feel extreme discomfort with their biological sex and strongly desire to change to the opposite sex. Indeed, some adults with gender identity disorders, often called transsexuals, do opt for expensive and complicated surgery to accomplish just that. In DSM-IV gender identity disorder is characterized by two components: (1) a strong and persistent cross-gender identification—that is the desire to be, or the insistence that one is, of the opposite sex; and (2) gender dysphoria—persistent discomfort about one’s biological sex or the gender role of that sex is inappropriate

**Gender Identity Disorder of Childhood**

Boys with gender identity disorder show a marked preoccupation with traditionally feminine activities (Zucker & Bradley, 1995). They may prefer to dress in female clothing. They enjoy stereotypical games of girls, such as playing dolls, house (in which they usually play the mother), drawing pictures of beautiful girls, and watching television programs with favorite female characters. They usually avoid rough-and-tumble play. They may express the desire to be a girl. Girls with gender identity disorder typically balk at parents’ attempts to dress them in traditional feminine clothes such as dresses. They prefer boys’ clothing and short hair, and they may be misidentified by strangers as boys.

**Transsexualism**

Transsexuals are adults with gender identity disorder. Many, perhaps most, transsexuals desire to change their sex, and surgical advances have made this goal partially feasible, although expensive. Until recently, most researchers assumed that transsexualism was the adult version of childhood gender identity disorder, and indeed this is often the case. That is, many transsexuals had gender identity disorder as children (despite the fact that most children with gender identity disorder do not become transsexual), and their adult behavior is analogous. This appears to be the case for all female-to-male transsexuals (i.e., individuals born female who become male). Virtually all such individuals recall being extremely tomboyish, with masculinity persisting unabated until adulthood. Most, but not all, female-to-male transsexuals are sexually attracted to women. In contrast to female-to-male transsexuals, there are two kinds of male-to-female transsexuals, with very different causes and developmental courses; homosexual and autogynephilic transsexuals (Blanchard, 1989). Homosexual transsexuals generally have gender identity disorder from childhood. Autogynephilic transsexualism (Blanchard, 1989, 1992) appears to occur only in genetic males, and its primary clinical feature is autogynephilia—a paraphilia characterized by sexual arousal at the thought of fantasy of being a woman.

**SEXUAL ABUSE**

Sexual abuse is sexual contact that involves physical or psychological coercion, or at least one individual who cannot reasonably consent to the contact (e.g., a child). Such abuse includes pedophilia, rape, and incest, and concerns society more than any other sexual problem.
Pedophilia
Pedophilia is a paraphilia in which an adult’s preferred or exclusive sexual partner is a prepubertal child. Nearly all pedophiles are male, and about two-thirds of their victims are girls, typically between the ages of 8 and 11. Pedophilia frequently involves manipulation of the child’s genitals.

Incest
Culturally prohibited sexual relations (up to and including coitus) between family members, such as a brother and sister or a parent and child, are known as incest. Incest often produces children with mental and physical problems. Incest is traditionally defined as sex between biological relatives.

Rape
The term rape describes sexual activity that occurs under actual or threatened forcible coercion of one person by another.

Dysfunctions of Sexual Desire
Sexual Desire Disorders The first is hypoactive sexual desire disorder. It is a dysfunction in which either a man or a woman shows little or no sexual drive or interest. Sex actually becomes psychologically aversive, and warrants a diagnosis of sexual aversion disorder, the second type of sexual desire disorder. With this disorder the person shows extreme aversion to, and avoidance of, all genital sexual contact with a partner.

Dysfunctions of Sexual Arousal
Male Erectile Disorder Inability to achieve or maintain an erection sufficient for successful sexual intercourse was formerly called impotence. It is now known as male erectile disorder or erectile insufficiency.

Female Sexual Arousal Disorder Formerly and somewhat pejoratively referred to as frigidity, female sexual arousal disorder--the absence of sexual arousal feelings and an unresponsiveness to most or all forms of erotic stimulation.

Anxiety Disorder
Overwhelming stress, as we noted in the last chapter, can produce psychological problems in anyone. Even stable, well-adjusted people may break down if forced to face extensive combat stress, torture, or devastating natural disaster, for example. But for some people, everyday problems can be disturbing. Faced with the normal demands of life-socializing with friends, waiting in line for a bus, being on an airplane, touching a doorknob—they experience the arousal of serious fear or anxiety. In the most severe cases, people with anxiety problems may be unable even to leave their homes or may spend much of their time in maladaptive behavior, such as constant hand washing.

Anxiety—a general feeling of apprehension about possible danger—was in Freud’s formulation a sign of an inner battle or conflict between some primitive desire (from the id) and prohibitions against its expression (from the ego and superego). Sometimes this anxiety seemed evident to him in clients who were obviously fearful and nervous. Historically, anxiety disorders were considered to be examples of neurotic behavior, which involved the exaggerated use of avoidance behaviors (such as not leaving home) or defense
mechanisms (such as rationalizing that making a trip by car is “more convenient” than confronting the feared airplane ride). Although neurotic behavior is maladaptive and self-defeating, a neurotic person is not out of touch with reality, incoherent, or dangerous. Nevertheless, such a person’s social relations and work performance are likely to be impaired by their efforts to cope with their fear.

The idea of neurosis has a long history and is still used in psychodynamic professional circles and in casual conversation by the general public. Freud challenged earlier long-held beliefs that neurosis was due to neurological malfunction and argued instead that it was caused by intrapsychic conflict. To Freud, neurosis was a psychological disorder that resulted when there was anxiety that was a sign of intrapsychic conflict.

Since 1980, the approach of each edition of the DSM has been to avoid such inferences about the causes of disorders. Therefore, although we still hear and use the term neurosis, the DSM has separated what used to be officially called neuroses into different categories based on their symptoms, which can be observed and measured. People with anxiety disorders, which we shall be considering in this chapter, show prominent symptoms of anxiety.

Anxiety seems to be experienced as an unpleasant inner state in which we are anticipating some dreadful thing happening that is not entirely predictable from our actual circumstances. Anxiety involves negative mood, worry about possible future threat or danger, self-preoccupation, and a sense of being unable to predict the future threat or to control it if it occurs (Barlow, 1988; Barlow et al., 1996).

OVERVIEW OF THE ANXIETY DISORDERS

An anxiety disorder, as the term suggests, has an unrealistic, irrational fear or anxiety of disabling intensity at its core and also as its principal and most obvious manifestation. DSM-IV recognizes seven primary types of anxiety disorder: phobic disorders of the “specific” or of the “social” type, panic disorder with or without agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder. The last of these, basically a prolonged reaction to traumatic stressors, Anxiety disorders are relatively common, affecting more than 23 million Americans each year and costing the United States $46.6 billion in 1990 in direct and indirect costs (nearly one-third of the nation’s total mental health bill of $148 billion) (National Institute of Mental Health, 1998). In the National Comorbidity Survey, the most recent large epidemiological study, anxiety disorders as a group were the most common kind of disorder for women, affecting approximately 30 percent of the female population at some point in their lives, and the second most common kind of disorder for men, affecting approximately 19 percent of the male population at some point.

PHOBIC DISORDERS

A phobia is a persistent and disproportionate fear of some specific object or situation that presents little or no actual danger to a person. When a person with a phobia encounters a feared object, he or she will often experience the fight-or-flight. Which prepares the person to escape from the situation. Thus, physiologically and behaviorally the phobic response is often identical to
that which would occur in an encounter with an objectively terrifying situation, such as being chased down a hiking trail by a grizzly bear. In the phobic’s case, however, the situation eliciting this response is not especially dangerous—it could be a bridge or a bus, for example. In DSM-IV there are three main categories of phobias: (1) specific phobia, (2) social phobia, and (3) agoraphobia. Specific phobias (formerly known as simple phobias) may involve fears of other species (snake and spider phobias being the most common) or fears of various aspects of the environment, such as water, heights, tunnels, or bridges. Social phobias involve fears of social situations in which a person is exposed to the scrutiny of others and is afraid of acting in humiliating or embarrassing way. Social phobias may be circumscribed (as in fear of public speaking) or generalized (as in fear of many different sorts of social interactions). Traditionally, agoraphobia was thought to involve, somewhat paradoxically, a fear of both open and enclosed spaces. However, as discussed later, it is now understood that agoraphobia most often stems from anxiety about having a panic attack (discussed below and the basic activation of the fight-or-flight response discussed above) in situations where escape might prove difficult or embarrassing.

**Specific Phobias**

A person is diagnosed as having a specific phobia if he or she shows strong and persistent fear triggered by the presence of (or anticipation of an encounter with) a specific object or situation. The level of fear must also be excessive or unreasonable relative to the actual danger posed by the object or situation. When individuals with specific phobias encounter a phobic stimulus, they almost always show an immediate fear response. The avoidance of the feared situation, or the distress experienced in the feared situation, must also interfere significantly with normal functioning or produce marked distress. In DSM-IV there are now five subtypes of specific phobias listed: (1) animal subtype (e.g., snakes or spider); (2) natural environment subtype (e.g., heights or water); (3) blood-injection-injury subtype; (4) situational subtype (e.g., airplanes or elevators); (5) atypical subtype (e.g., choking or vomiting).

Some of these specific phobias involve exaggerated fears of things that many of us fear to some extent, such as darkness, fire, disease, spiders, and snakes. Others, such as phobias of water or crowds, involve situations that do not elicit fear in most people. Many of us have at least a few minor irrational fears, but in phobic disorders such fears are intense and often interfere significantly with everyday activities. For example, claustrophobic persons may go to great lengths to avoid entering a small room or an elevator. This avoidance is a cardinal characteristic of phobias: it occurs both because the phobic response itself is so unpleasant and because of phobic person’s irrational appraisal of the likelihood that something terrible will happen.

People who suffer from phobias usually know that their fears are somewhat irrational, but they say that they cannot help themselves. If they attempt to approach the phobic situation, they are overcome with fear or anxiety, which may vary from mild feelings of apprehension and distress (usually while still at some distance) to a full-fledged activation of the fight-or-flight response very similar to a panic attack.
Psychodynamic viewpoint  According to the *psychodynamic view* of the origins of phobias, represent a defense against anxiety that stems from repressed impulses from the id. Because it is too dangerous to “know” the repressed id impulse, the anxiety is displaced onto some external object or situation that has some symbolic relationship to the real object of the anxiety.

Phobias as Learned Behavior  More generally, there are many instances in which the principles of classical conditioning appear to account for the acquisition of irrational fears and phobias. The fear response has been shown in countless experiments to be readily conditioned to previously neutral stimuli when they are paired with traumatic or painful events. Moreover, from the principles of classical conditioning we would also expect that, once acquired, phobic fears would generalize to other similar objects or situations.

Much human learning, including the learning of fears, is observational. Simply watching a frightening event can be distressing, and this includes watching a phobic person behaving fearfully with his or her phobic object. In this case, fears can be transmitted from one person to another through a process of vicarious or observational classical conditioning. Merely observing the fear of another in a given situation may cause the observer to acquire a fear of that situation.

Genetic and Temperamental Causal Factors  Firstly, genetic and temperamental or personality variables are known to affect the speed and strength of conditioning of fear (Eysenck, 1965; Gray, 1987; Pavlov, 1927). That is, people are more or less likely to acquire phobias depending on their temperament or personality. There are several studies suggesting a modest genetic contribution to the development of specific phobias. For example, one study found that there was an elevated risk of specific phobias (but not social phobia or panic disorder) in first degree relatives of those who had been diagnosed with specific phobia.

Treating Specific Phobias  The behavior therapy most commonly used in the treatment of specific phobias involves controlled *exposure* to the stimuli or situations that elicit phobic fear. Here clients are gradually placed-symbolically or increasingly under “real life” conditions-in those situations they find most frightening. In the original variant known as *systematic desensitization*, clients are first trained in the techniques of deep muscle relaxation and asked to develop a hierarchy of situations they fear, ranging at the bottom from only mildly anxiety-provoking to the top at maximally fear-provoking. Then, while remaining in a state of relaxation, they are asked to imagine their fear-producing situations, starting with those lowest in a hierarchy and gradually moving up the hierarchy as the fear of the scenes lower in the hierarchy extinguishes.

Social Phobia  Fear of negative evaluation by others may be the hallmark of social phobia. People with *specific social phobia* have disabling fears of one or more discrete social situations in which they fear they may be exposed to the scrutiny of others and may act in an embarrassing or humiliating manner (e.g., public speaking, urinating in a public bathroom, or eating or writing in public). Because of their fears, they either avoid these situations or endure them with great distress. Intense fear of public speaking is the single most common specific social phobia. Individuals with *generalized*
Abnormal Psychology

social phobia have significant fears of most social situations (including both public performance situations and situations requiring social interaction).

Interaction of Psychosocial and Biological Causal Factors
Social phobias involve learned behavior that have been shaped by evolutionary factors. Such learning is most likely to occur in people who are genetically or temperamentally at risk.

Social Phobias as Learned Behavior like specific phobias, social phobias seem to often originate out of simple instance of direct or vicarious classical conditioning, such as experiencing or witnessing a perceived social defeat or humiliation, or being witnessing the target of anger or criticism.

Genetic and Temperamental Factors As with specific phobias, not all persons who undergo or witness traumatic social humiliation or defeat go on to develop full blown social phobia. Recent results from a very large study of female twins suggests that there is modest genetic contribution to social phobia; estimates were that the proportion of variance due to genetic factors was about 30 percent (Kendler et al., 1992b). the temperamental variable that appears to be of greatest importance is behavioral inhibition. Infants who are easily distressed by unfamiliar stimuli are at increased risk for becoming fearful during childhood, and by adolescence show increased risk of developing social phobia.

Cognitive variable Cognitive factors play in the onset and maintenance of social phobia. Beck and colleagues (1985) suggested that social phobics tend to expect that other people will reject or negatively evaluate them, leading to a sense of vulnerability in the presence of other persons who might potentially pose a threat. These danger schemas of social phobics lead them to be hypervigilant to cues that people around them are negative or critical, leading them to spend a great deal of their time paying attention to and evaluating possible negative evaluations by others.

Treating Social Phobia categories of drugs are more effective (den Boer et al., 1996). These including the monoamine oxidase inhibitors and the selective-serotonin-reuptake inhibitors and some ant anxiety or anxiolytic drugs. There are also very effective forms of behavior therapy, and of cognitive-behavior therapy, for social phobia. Behavioral treatments were developed first and generally involve prolonged exposure to social situations that evoke fear, often in a graduated manner. As research has revealed the underlying distorted cognitions that characterize social phobia, cognitive techniques have been added to these behavioral techniques, generating a form of cognitive-behavior therapy. Here a therapist attempts to help clients with social phobia identify their underlying negative automatic thoughts (“I’ve got nothing interesting to say” or “no one is interested in me”), which are often irrational and generally involve discrete predictions about what will happen to them in various social situations. After helping clients understand that these automatic thoughts often involve cognitive distortions, the therapist then helps the clients change these inner thought and beliefs through logical reanalysis.

PANIC DISORDER WITH AND WITHOUT AGORAPHOBIA
Diagnostically, panic disorder is defined and characterized by the occurrence of “unexpected” panic attacks that often seem to come “out of the blue”. According to the DSM-IV definition, the
person must have experienced recurrent unexpected attacks and must have been persistently concerned about having another attack or worried about the consequences of having an attack (e.g., of “losing control” or “going crazy”) for at least a month. To qualify as a full-blown panic attack, there must be abrupt onset of at least 4 of 13 symptoms (such as shortness of breath, heart palpitations, sweating, dizziness, depersonalization (a feeling of being detached from one’s body) or derealization (a feeling that the external world is strange or unreal), fear of dying, of “going crazy”, or of losing control”. Such attacks are often “unexpected” or “uncued” in the sense that they do not appear to be provoked by identifiable aspects of the immediate situation. Indeed, they sometimes occur in situations in which they might be least expected, such as during relaxation or during sleep (known as nocturnal panic). In other cases, however, the panic attacks are said to be “situationally predisposed” in that they only occur sometimes while in a particular situation, such as while driving a car or being in a crowd. The stark terror of a panic attack typically subsides within a matter of minutes.

Agoraphobia
Historically, agoraphobia was thought to involve a fear of the “agora”- the Greek word for public places of assembly (Marks, 1987). And indeed the most commonly feared and avoided situations for agoraphobics include streets and crowded places such as shopping malls, movie theaters, and sports arenas. Agoraphobics, concerned they may have a panic attack or get sick, are anxious about being in places or situations from which escape would be physically difficult or psychologically embarrassing, or in which immediate help would be unavailable in the event that something bad happened. In cases of moderate severity these people may even be uncomfortable venturing outside their homes alone, doing so only with significant anxiety. In very severe cases agoraphobia is terribly disabling disorder in which a person cannot go beyond the narrow confines of home, or even particular parts of the home.

Agoraphobia Without Panic
Although agoraphobia is a frequent complication of panic disorder, it can also occur in the absence of prior full-blown panic attacks. In the latter instance a common pattern is that of a gradually spreading fearfulness in which more and more aspects of the environment outside the home acquire threatening properties.

Biological Causal Factors
Panic disorder results from a biochemical abnormality in the brains of clients with the disorder.
The Role of Norepinephrine and Serotonin  The biochemical dysfunction hypothesis appears to be supported by numerous studies over the past 30 years that have shown that panic clients are much more likely to experience panic attacks in studies in which they are exposed to a variety of biological challenge procedures than are normal people or other psychiatric controls. These biological challenge procedures (ranging from taking various drugs to inhaling air with altered amounts of carbon dioxide) put stress on certain neurobiological systems, which in turn produce intense physical symptoms (such as increased heart rate and blood pressure) often culminating in a panic attack for clients with panic disorder.
Panic and the Brain
One prominent theory about the neurobiology of panic implicates a particular area of the brain—the locus coeruleus in the brain stem—and a particular neurotransmitter—norepinephrine—which is centrally involved in brain activity in this area.

Genetic Factors there is also evidence that panic disorder tends to run in families. Many studies have shown that first-degree relatives of panic clients are more likely to experience panic disorder than are relatives of controls (Mackinnon & Foley, 1996; McNally, 1994), and monozygotic twins are somewhat more likely to be concordant for the diagnosis than are dizygotic twins.

Cognitive and Behavioral Causal Factors
One early hypothesis about the origins of panic and agoraphobia was the “fear of fear” hypothesis (Goldstein & Chambless, 1978). According to this theory, agoraphobics come to fear the experience of a panic attack because it is so terrifying. They become hyperalert to their bodily sensations and begin to interpret mild signs of anxiety as a signal that a panic attack may occur; they then react with anxiety to their anxiety. If they gradually also come to fear a range of places in which panic might occur, they develop agoraphobic avoidance. In a more recent elaboration of this model, they have argued that agoraphobia also involves a fear of other emotions such as anger and depression.

The Cognitive theory of Panic
Building on these behavioral hypotheses, Beck and Emery (1985) and Clark (1986, 1988, 1997) proposed a cognitive model of panic. According to this model, panic clients are hypersensitive to their bodily sensations and are very prone to giving them the direst possible interpretation. Clark refers to this as a tendency to catastrophize about the meaning of their bodily sensations. For example, a panic patient might notice that his heart is racing and conclude that he is having a heart attack. That very frightening thought causes many more physical symptoms of fear or anxiety, which provides further fuel for the catastrophic thoughts, leading to a vicious cycle culminating in a panic attack.

Anxiety Sensitivity as a Vulnerability factor for Panic
Another possible explanation for why only some people develop catastrophic misinterpretations of their bodily sensations may be that people who are prone to developing panic disorder have previously developed beliefs that their bodily sensations are harmful or dangerous (a milder form of catastrophic cognitions). Researchers proposed that people prone to developing panic are those who have high levels of preexisting anxiety sensitivity (a high level of belief that certain bodily symptoms may have harmful consequences) (Reiss and McNally, 1985; McNally, 1994; Cox, 1996). For example, someone high on anxiety sensitivity would endorse statement like: “When I notice that my heart is beating rapidly, I worry that I might have a heart attack.” We know that people with panic disorder score higher on a measure of anxiety sensitivity than do clients with other anxiety disorders (e.g., Taylor, 1995), but this could be a consequence of having panic disorder rather than a cause. However, there are now several good prospective studies showing that people high in anxiety sensitivity are indeed more prone to developing panic attacks and perhaps panic disorder.
Cognitive Biases and the Maintenance of Panic
Finally, there are also many studies that underscore the fact that people with panic disorder are biased in the way they process threatening information. In summary, research into both biological and psychological factors involved in panic disorder in the 15 years since it was first identified as a distinct disorder. It seems unlikely that research from either tradition alone will ever be able to provide a complete account of this disorder, and we eagerly await more attempts at synthesizing and integrating findings from these different traditions (McNally, 1994).

Treating Panic Disorder and Agoraphobia

Medications Many clients with panic disorder (with or without agoraphobia) are prescribed drugs from the benzodiazepine category such as Xanax. They frequently show some symptom relief with these minor tranquilizers or (anxiolytics or antianxiety drugs), and some are able to function more effectively. However, the effects are generally much smaller (when compared with the effects of placebo) than is generally recognized by the public. These drugs also tend to lose their effectiveness after a number of weeks (Barlow, 1988).

GENERALIZED ANXIETY DISORDER

Generalized anxiety disorder (GAD) is characterized by chronic excessive worry about a number of events or activities. This state was originally described as free-floating anxiety because it was not anchored to a specific object or situation as with specific or social phobias. DSM-IV criteria specify that the worry must occur more days than not for at least six months and that it must be experienced as difficult to control. The subjective experience of excessive worry must also be accompanied by at least three of the following six symptoms: (1) restlessness or feelings of being keyed up or on edge, (2) a sense of being easily fatigued, (3) difficulty concentrating or mind going blank, (4) irritability, (5) muscle tension, and (6) sleep disturbance.

General characteristics
The general picture of people suffering from generalized anxiety disorder is that they live in a relatively constant state of tension, worry, and diffuse uneasiness. The fundamental process is one of anxious apprehension, which is defined as a future-oriented mood state in which a person attempts to be constantly ready to deal with upcoming negative events (Barlow et al., 1996; Brown et al., 1993). This mood state is characterized by high levels of negative effect, chronic overarousal, and a sense of uncontrollability. In addition to their excessive levels of worry and anxious apprehension, people with generalized anxiety disorder often have difficulty concentrating and making decisions, dreading to make a mistake. They may engage in certain subtle avoidance activities such as procrastination or checking, but these are generally not very effective in reducing anxiety. They also tend to show a marked vigilance for possible signs of threat in their environment. Commonly, they complain of muscle tension, especially in the neck and upper shoulder region, and sleep disturbances including insomnia and nightmares.

No matter how well things seem to be going, people with generalized anxiety disorder are apprehensive and anxious. Their nearly constant worries leave them continually upset, uneasy,
and discouraged. In one study their most common spheres of worry were found to be family, work, finances, and personal illness. Not only do they have difficulty making decisions, after they have managed to make a decision they worry endlessly over possible errors and unforeseen circumstances that may prove the decision wrong and lead to disaster. Even after going to bed, people suffering from GAD are not likely to find relief from their worries. Often, they review each mistake, real or imagined, recent or regretting the events of the past, they are anticipating all the difficulties that may arise in the future. They have no appreciation of logic most of us use in concluding that it is pointless to torment ourselves about possible outcomes over which we have no control. Although it may seem at times that they are actually looking for things to worry about, it is their feeling that they cannot control their tendency to worry.

**Psychosocial Causal Factors**

According to the psychoanalytic viewpoint, generalized or free-floating anxiety results from an unconscious conflict between ego and id impulses that is not adequately dealt with because the person’s defense mechanisms have broken down. Freud believed that it was primarily sexual and aggressive impulses that had been either blocked from expression or punished upon expression that led to free-floating anxiety. Defense mechanisms may become overwhelmed when a person experience frequent and extreme levels of anxiety, as might happen if expression of id impulses were frequently blocked from expression (e.g., under periods of prolonged sexual deprivation). In other cases adequate defense mechanisms may never have developed.

**Classical Conditioning to Many Stimuli**

According to early behavioral formulations, generalized anxiety stems from classical conditioning of anxiety to many environmental cues in the same general way that phobias are conditioned. In effect, this formulation sees generalized anxiety disorder as involving phobic-like responses to many aspects of the external environment, ranging from light and shade contrasts to amorphous noises and the passage of time.

**The Role of Unpredictable and Uncontrollable Events**

One prominent theme of research on fear and anxiety for the past 25 years has been the importance of uncontrollability and unpredictability. Uncontrollable and unpredictable aversive events are much more stressful than are controllable and predictable aversive events, and so it is perhaps not surprising that they also create more fear and anxiety. This has led researchers to hypothesize that people with GAD may have a history of experiencing many important events in their lives as unpredictable and/or uncontrollable. For example, having a boss or spouse who has unpredictable bad moods and temper tantrums for seemingly trivial or nonexistent reasons might lead to person being in a chronic state of anxiety.

Some of the tension and hyper-vigilance (the sense of always looking for signs of threat) that persons with generalized anxiety disorder experience may stem from their lacking safety signals in their environment. If a person has primarily had experience with predictable stressors (e.g., on
Mondays the boss is always in a bad mood and is likely to be highly critical, he or she can predict when something bad is likely to happen through the occurrence of a cue or signal.

**A Sense of Mastery: Immunizing Against Anxiety**

Although many of these ideas about unpredictability and uncontrollability as they apply specifically to our understanding of generalized anxiety disorder are somewhat speculative at this point, they have received a great deal of attention in recent years and provide many ideas for future research (Barlow et al., 1996; Mineka, 1985a; Mineka & Zinbarg, 1996).

**The Content of Anxious Thoughts**

Generalized anxiety disorder focuses both on the content of anxious cognitions and on the effects that anxiety has on our processing of threatening information. Common automatic thoughts included “I will make a fool of myself,” “people will laugh at me,” “what if I fail?” “I won’t have time to do a good job,” and “I’ll never be as capable as I should be” (Beck & Emery, 1985, p.106).

**The Nature and Function of Worry**

Automatic thoughts can be distinguished from worry in that they occur more rapidly (indeed almost reflexively) and often in imaginal shorthand or telegraphic form; worry involves more extended and involved rumination and appraisal about possible future threats. Nevertheless, it may be the occurrence of negative automatic thoughts that initiates about of worrying on a particular topic (Wells & Butler, 1997). The five most common benefits people with GAD think derive from worrying are; (1) superstitious avoidance of catastrophe (“worrying makes it less likely that the feared event will occur”); (2) actual avoidance of catastrophe (“worrying helps to generate ways of avoiding or preventing catastrophe”); (3) avoidance of deeper emotional topic I worrying about most of the things I worry about is a way to distract myself from worrying about even more emotional things, things that I don’t want to think about”); (4) coping and preparation (“worry about a predicted negative event helps me to prepare for its occurrence”); (5) motivating device (“worrying helps to motivate me to accomplish the work that needs to be done”) (Borkovec, 1994, pp.16-17).

When people with GAD worry, their emotional and physiological response to aversive imagery is actually suppressed. This suppression of emotional and aversive physiological responding serves to reinforce (that is, increase the probability of) the process of worry. Because worry suppresses physiological responding, it also serves to keep the person from fully experiencing or processing the topic that is being worried about and it is known that such full processing is necessary if extinction of that anxiety is to occur (Borkovec, 1994). Thus the threatening meaning of the topic being worried about is maintained.

Worry serve an immediate dampening function for physiological arousal, it is associated with a more long-term maintenance of emotional disturbance. Wells and Butler (1997, p. 167) concluded “individuals who are prone to worry... perhaps to avoid images, are likely to engage in an activity that pollutes the stream of consciousness with an increasing frequency of intrusive thoughts.”
Cognitive Biases for Threatening Information
In addition to having frequent thoughts with threatening content, people with GAD process threatening information in a biased way. This automatic, unconscious attentional bias would seem to have the effect of reinforcing or even enhancing the person’s current emotional state. That is, if one is already anxious, one’s attention is automatically drawn toward threat cues in the environment, this would only seem to make the anxiety worse. Generally anxious people also have a much stronger tendency to interpret ambiguous information in a threatening way than do nonanxious individuals. Given these strong attentional and interpretive biases for threat cues, one might well expect that anxious person would also be especially likely to remember the threat cues they have encountered.

Treating Generalized Anxiety Disorder
Many clients with generalized anxiety disorder are seen by family physicians rather than by mental health professionals; they are seeking relief from their “nerves” or anxieties and/or their various functional (psychogenic) physical problems. Most often in such cases drugs from the benzodiazepine (anxiolytic) category such as Valium are used - and misused - for tension relief and for relaxation; they also reduce subjective anxiety and may reduce emotional reactivity to new stressors. Cognitive-behavior therapy for generalized anxiety disorder has also become increasingly effective in recent years as refinements in the techniques are made. It usually involves a combination of behavioral techniques such as training in deep muscle relaxation and cognitive restricting techniques aimed at reducing worry and its negative content. Although GAD initially appeared to be among the most difficult of the anxiety disorders to treat, recent advances have been made, and a number of studies have now shown very effective treatment outcomes for 60 to 70 percent with the condition.

OBSESSIVE-COMPULSIVE DISORDER
Diagnostically obsessive-compulsive disorder (OCD) is defined by the occurrence of unwanted and intrusive obsessive thoughts or distressing images; these are usually accompanied by compulsive behaviors designed to neutralize the obsessive thoughts or images or to prevent some dreaded event or situation. More specifically, according to DSM-IV, obsessions involve persistent and recurrent intrusive thoughts, images, or impulses that are experienced as disturbing and inappropriate. People who have such obsessions try to ignore or suppress them, or to neutralize them with some other thought or action. Compulsions can involve either overt repetitive behaviors (such as hand washing, checking, or ordering) or more covert mental acts (such as counting, praying, or saying certain words silently). A person with this disorder usually feels driven to perform this compulsive behavior in response to an obsession, and there are often very rigid rules regarding how the compulsive behavior should be performed. The compulsive behaviors are performed with the goal of preventing or reducing distress or preventing some dreaded event or situation, even though they are not usually very realistically connected with what they are not usually very realistically connected with what they are designed to neutralize or prevent, or are
clearly excessive American Psychiatric Association, 1994). In addition, the person must recognize that the obsession is the product of his own mind rather than being imposed from without (as might occur in schizophrenia). It is also now recognized that there is a continuum of “insight” among obsessive-compulsives about exactly how senseless and excessive their obsessions and compulsions are (Riggs & Foa, 1993). In most cases these people do have some recognition that their obsessions or compulsions are excessive or unreasonable, but they cannot seem to control them; in a minority of cases this insight is absent most of the time. Finally, the DSM-IV diagnosis requires that this seemingly involuntary behavior cause a person marked distress, consume excessive time (over an hour a day), or interfere with occupational or social functioning.

Characteristics of OCD

Most people with obsessive-compulsive disorder who present for treatment experience both obsessions and compulsions. Most of us have experienced minor obsessive thoughts, such as whether we remembered to lock the door or turn the stove off. In addition, most of us occasionally engaged in repetitive or stereotyped behavior, such as checking the stove or the lock on the door, or stepping over cracks on a sidewalk. In the case of obsessive-compulsive disorder, however, the thoughts are much more persistent and distressing, they generally appear irrational or excessive to the individual, and along with the associated compulsive acts they interfere considerably with everyday behavior.

Types of Obsessive Thoughts

Obsessive thoughts involving themes of violence or aggression might include a wife being obsessed with the idea that she might poison her husband, or a daughter constantly imagining pushing her mother down a flight of stairs. Even though such obsessive thoughts are only very rarely carried out in action, they remain a source of often excruciating torment to a person plagued with them.

Types of Compulsions

People with OCD feel compelled to perform repeatedly acts that often seem pointless and absurd even to them and that they in some sense do not want to perform. These compulsive acts in patient samples are of five primary types: cleaning, checking, repeating, ordering/arranging, and counting (Antony et al., 1998), with many people showing multiple kinds of rituals. For a smaller number the compulsions are to perform various everyday acts such as eating or dressing extremely slowly (primary obsessional slowness), and for others the compulsions are to have things exactly symmetrical or “evened up” (Rasmussen & Eisen, 1991). Washing rituals vary from relatively mild ritual-like behavior, such as spending 15 to 20 minutes washing one’s hands after going to the bathroom, to more extreme behavior, such as washing one’s hands with disinfectants for hours every day to the point that the hands bleed.

Psychosocial Causal Factors

According to Freud’s psychoanalytic view, a person with OCD has been unable to cope with the instinctual conflict of the Oedipal stage and has either never advanced beyond this stage or has regressed back to an earlier stage of psychosexual development. Specifically, such a person is
thought to be fixated in the anal stage of development (about 2 years of age) when children are thought to derive sensual pleasure from defecating, both as physical release and as a creative act (“Mommy, see what I made!”). This is also the time at which parents are often attempting to toilet train their children, which involves learning to control and delay these urges. If parents are too harsh and make the child feel bad and dirty about soiling himself or herself, they may instill range in the child, as well as guilt and shame about these drives. According to this theory, the intense conflict that may develop between impulses from the id to let go, and the ego to control and withhold, leads to the development of defense mechanisms that may ultimately produce obsessive-compulsive symptoms.

The Behavioral Viewpoint  The dominant behavioral view of obsessive-compulsive disorder derives from O.H. Mowrer’s two-process theory of avoidance learning (1947). According to this theory, neutral stimuli become associated with aversive stimuli through a process of classical conditioning and come to elicit anxiety. For example, touching a doorknob or shaking hands might become associated with the “scary” idea of contamination. Once having made this association, the person may discover that the anxiety produced by shaking hands or touching a doorknob may be reduced by an activity like hand washing. By washing his or her hands extensively, the anxiety would be reduced and the washing response would be reinforced, making it more likely to occur again in the future when anxiety about contamination was evoked in other situations (Rachman & Shafran, 1998). Once learned, such avoidance responses are extremely resistant to extinction.

Biologic Causal Factors  Some studies have sought to discover whether there is a genetic contribution to this disorder. Others have explored whether there are structural brain abnormalities associated with OCD, and yet others whether there are abnormalities in specific neurotransmitter systems associated with OCD. The accumulating evidence from all three kinds of studies is that biological causal factors are probably more clearly implicated in the causes of OCD than in any of the other anxiety disorders.

Genetic Influences  Genetic studies have included both twin studies and family studies. Evidence from twin studies reveals a moderately high concordance rate for monozygotic twins and a lower rate for dizygotic twins.

Treating Obsessive-Compulsive Behavior  With OCD, a behavioral treatment involving a combination of exposure and (compulsive) response prevention may be in the long run the most effective approach to the difficult problem of obsessive-compulsive disorders (e.g., Foa, Franklin, & Kozak, 1998; Steketee, 1993). This treatment involves having the OCD client repeatedly expose himself or herself to stimuli that will provoke their obsession (such as touching the bottom of their shoe or a toilet seat in a public bathroom for someone with compulsive washing), and then prevent them from engaging in their compulsive rituals, which they ordinarily would engage in to reduce the anxiety/distress provoked by their obsession. Preventing the rituals is essential so that they can see that the anxiety created by the obsession will dissipate naturally if they allow enough time to pass.