PSY 202
Abnormal Psychology

Course Manual

Olley B.O. Ph.D

Abnormal Psychology

PSY202

University of Ibadan Distance Learning Centre
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Vice-Chancellor's Message

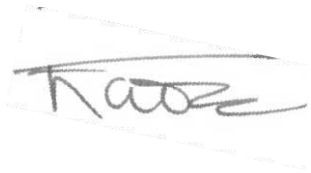
The Distance Learning Centre is building on a solid tradition of over two decades of service in the provision of External Studies Programme and now Distance Learning Education in Nigeria and beyond. The Distance Learning mode to which we are committed is providing access to many deserving Nigerians in having access to higher education especially those who by the nature of their engagement do not have the luxury of full time education. Recently, it is contributing in no small measure to providing places for teeming Nigerian youths who for one reason or the other could not get admission into the conventional universities.

These course materials have been written by writers specially trained in ODL course delivery. The writers have made great efforts to provide up to date information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly.

In addition to provision of course materials in print and e-format, a lot of Information Technology input has also gone into the deployment of course materials. Most of them can be downloaded from the DLC website and are available in audio format which you can also download into your mobile phones, IPod, MP3 among other devices to allow you listen to the audio study sessions. Some of the study session materials have been scripted and are being broadcast on the university's Diamond Radio FM 101.1, while others have been delivered and captured in audio-visual format in a classroom environment for use by our students. Detailed information on availability and access is available on the website. We will continue in our efforts to provide and review course materials for our courses.

However, for you to take advantage of these formats, you will need to improve on your I.T. skills and develop requisite distance learning Culture. It is well known that, for efficient and effective provision of Distance learning education, availability of appropriate and relevant course materials is a *sine qua non*. So also, is the availability of multiple plat form for the convenience of our students. It is in fulfillment of this, that series of course materials are being written to enable our students study at their own pace and convenience.

It is our hope that you will put these course materials to the best use.



Prof. Isaac Adewole

Vice-Chancellor

Foreword

As part of its vision of providing education for “Liberty and Development” for Nigerians and the International Community, the University of Ibadan, Distance Learning Centre has recently embarked on a vigorous repositioning agenda which aimed at embracing a holistic and all encompassing approach to the delivery of its Open Distance Learning (ODL) programmes. Thus we are committed to global best practices in distance learning provision. Apart from providing an efficient administrative and academic support for our students, we are committed to providing educational resource materials for the use of our students. We are convinced that, without an up-to-date, learner-friendly and distance learning compliant course materials, there cannot be any basis to lay claim to being a provider of distance learning education. Indeed, availability of appropriate course materials in multiple formats is the hub of any distance learning provision worldwide.

In view of the above, we are vigorously pursuing as a matter of priority, the provision of credible, learner-friendly and interactive course materials for all our courses. We commissioned the authoring of, and review of course materials to teams of experts and their outputs were subjected to rigorous peer review to ensure standard. The approach not only emphasizes cognitive knowledge, but also skills and humane values which are at the core of education, even in an ICT age.

The development of the materials which is on-going also had input from experienced editors and illustrators who have ensured that they are accurate, current and learner-friendly. They are specially written with distance learners in mind. This is very important because, distance learning involves non-residential students who can often feel isolated from the community of learners.

It is important to note that, for a distance learner to excel there is the need to source and read relevant materials apart from this course material. Therefore, adequate supplementary reading materials as well as other information sources are suggested in the course materials.

Apart from the responsibility for you to read this course material with others, you are also advised to seek assistance from your course facilitators especially academic advisors during your study even before the interactive session which is by design for revision. Your academic advisors will assist you using convenient technology including Google Hang Out, You Tube, Talk Fusion, etc. but you have to take advantage of these. It is also going to be of immense advantage if you complete assignments as at when due so as to have necessary feedbacks as a guide.

The implication of the above is that, a distance learner has a responsibility to develop requisite distance learning culture which includes diligent and disciplined self-study, seeking available administrative and academic support and acquisition of basic information technology skills. This is why you are encouraged to develop your computer skills by availing yourself the opportunity of training that the Centre’s provide and put these into use.

In conclusion, it is envisaged that the course materials would also be useful for the regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks. We are therefore, delighted to present these titles to both our distance learning students and the university's regular students. We are confident that the materials will be an invaluable resource to all.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.

Professor Bayo Okunade

Director

Course Development Team

The University of Ibadan Distance Learning Centre wishes to thank those below for their contribution to this course manual:

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Contents

About this course manual

Abnormal Psychology PSY202 has been produced by University of Ibadan Distance Learning Centre. It is structured in the same way, as other psychology course.

How this course manual is structured

The course overview

The course overview gives you a general introduction to the course. Information contained in the course overview will help you determine:

- If the course is suitable for you.
- What you will already need to know.
- What you can expect from the course.
- How much time you will need to invest to complete the course.

The overview also provides guidance on:

- Study skills.
- Where to get help.
- Course assessments and assignments.
- Activity icons.
- Study sessions.

We strongly recommend that you read the overview *carefully* before starting your study.

The course content

The course is broken down into study sessions. Each study session comprises:

- An introduction to the study session content.
- Learning outcomes.
- Content of study sessions.
- A study session summary.
- Assessments and/or assignment, as applicable.

Your comments

After completing this course, Abnormal Psychology, we would appreciate it if you would take a few moments to give us your feedback on any aspect of this course. Your feedback might include comments on:

- Course content and structure.
- Course reading materials and resources.
- Course assessments.
- Course assignments.
- Course duration.
- Course support (assigned tutors, technical help, etc).
- Your general experience with the course provision as a distance learning student.

Your constructive feedback will help us to improve and enhance this course.

Course overview

Welcome to Abnormal Psychology PSY202

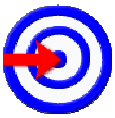
People have always been fascinated by the unusual and the bizarre behaviours around them. The scientific study of the unusual and the bizarre in human behaviours is the field of abnormal psychology, and that is the focus of this course. This course attempts to provide introduction to specific psychopathology (psychological diseases) with case illustrations, often prevalent in Nigeria.

This course manual supplements and complements PSY202 UI Mobile Class Activities as an online course. You may use this platform to interact with your tutor and submit your assignments, receive tutor feedback and course news with updates.

Abnormal Psychology PSY202—is this course for you?

PSY202 is a *required* three unit course to psychology students in 200 level. The course is divided into two parts. The first part begins with the definitions of abnormal behaviour, concept of abnormality, and the etiology and assessment of abnormal behaviour. The second part focuses on history of psychopathologies, specific psychopathologies which include the anxiety disorders, the psychoses, and abnormalities of sexual preference and deviation, and personality disorders. The course is not in any way exhaustive of psychopathologies. Rather, it is an attempt to introduce commonly seen abnormal behaviours in Nigeria.

Course outcomes



Outcomes

Upon a successful completion of Abnormal Psychology PSY202, you will be able to:

- *outline* the history of psychopathologies.
- *point out* the field of abnormal psychology.
- *classify* specific psychopathologies.
- *point out* causes of specific abnormal behaviours and how they are assessed.

Timeframe

How long?

This is a one semester course.

45 hours of formal study time is required.

Study skills

As an adult learner your approach to learning will be different to that from your school days: you will choose what you want to study, you will have professional and/or personal motivation for doing so and you will most likely be fitting your study activities around other professional or domestic responsibilities.

Essentially you will be taking control of your learning environment. As a consequence, you will need to consider performance issues related to time management, goal setting, etc. Perhaps you will also need to reacquaint yourself in areas such as essay planning, coping with exams and using the web as a learning resource. Your most significant considerations will be *time* and *space* i.e. the time you dedicate to your learning and the environment in which you engage in that learning.

We recommend that you take time now—before starting your self-study—to familiarize yourself with these issues. There are a number of excellent web links & resources on the Course Site. Go to “Self-Study Skills” menu on the course site.

Need help?

Help

As earlier noted, this course manual complements and supplements PSY202 at UI Mobile Class as an online course.

You may contact any of the following units for information, learning resources and library services.

Distance Learning Centre (DLC)
University of Ibadan, Nigeria
Tel: (+234) 08077593551 – 55
(Student Support Officers)
Email: ssu@dlc.ui.edu.ng

Head Office
Morohundiya Complex, Ibadan-Ilorin Expressway, Idi-Ose, Ibadan.

Information Centre
20 Awolowo Road, Bodija, Ibadan.

Lagos Office
Speedwriting House, No. 16 Ajanaku Street, Off Salvation Bus Stop, Awuse Estate, Opebi, Ikeja, Lagos.

For technical issues (computer problems, web access, and etcetera), please send mail to webmaster@dlc.ui.edu.ng.

Academic Support

Help

A course facilitator is commissioned for this course. You have also been assigned an academic advisor to provide learning support. The contacts of your course facilitator and academic advisor for this course are available at onlineacademicsuppor@dlc.ui.edu.ng

Activities

Activities

This manual features "Activities," which may present material that is NOT extensively covered in the Study Sessions. When completing these activities, you will demonstrate your understanding of basic material (by answering questions) before you learn more advanced concepts. You will be provided with answers to every activity question. Therefore, your emphasis when working the activities should be on understanding your answers. It is more important that you understand why every answer is correct.

Assessments

Assessments

There are three basic forms of assessment in this course: in-text questions (ITQs) and self assessment questions (SAQs), and tutor marked assessment (TMAs). This manual is essentially filled with ITQs and SAQs. Feedbacks to the ITQs are placed immediately after the questions, while the feedbacks to SAQs are at the back of manual. You will receive your TMAs as part of online class activities at the UI Mobile Class. Feedbacks to TMAs will be provided by your tutor in not more than 2 weeks expected duration.
Schedule dates for submitting assignments and engaging in course / class activities is available on the course website. Kindly visit your course website often for updates.

Bibliography

Readings

For those interested in learning more on this subject, we provide you with a list of additional resources at the end of this course manual; these may be books, articles or websites.

Getting around this course manual

Margin icons

While working through this course manual you will notice the frequent use of margin icons. These icons serve to "signpost" a particular piece of text, a new task or change in activity; they have been included to help you to find your way around this course manual.

A complete icon set is shown below. We suggest that you familiarize yourself with the icons and their meaning before starting your study.

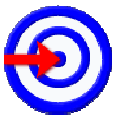
 Activity	 Assessment	 Assignment	 Case study
 Discussion	 Group Activity	 Help	 Outcomes
 Note	 Reflection	 Reading	 Study skills
 Summary	 Terminology	 Time	 Tip

Study Session 1

Concepts in Abnormal Psychology

Introduction

In this Study Session, abnormal psychology is defined and concepts of abnormality are explained based on the major dimension criteria in the literature.



Learning Outcomes

When you have studied this session, you should be able to:

i. *define* abnormal behaviour.
ii. *highlight* four criteria of defining behaviour.

1.1 The Concept of Abnormal Psychology

Abnormal psychology is the branch of psychology that concerns itself with the study and evaluation of functional and organic disease patterns in human beings. It is the study of psychopathology, how it develops and the way it manifests. The following four criteria are often used in defining abnormal behaviour:

1. **Defective Cognitive Functioning:** This considers impairment in mental or intellectual abilities in reasoning, perceiving, judgement, memory and communication.
2. **Defective Social Behaviour:** This considers abnormal behaviour as a function of the interaction of an individual with his or her environment. When an individual deviates grossly from standards and social customs of his or her environment, he or she is said to be socially defective, and his or her behaviour may constitute abnormal behaviour.
3. **Defective Self-Control:** This considers abnormal behaviour as an extreme lack of control over one's behaviour.
4. **Distress:** This considers abnormal behaviour as a breakdown of the natural coping systems in the face of an intense or persistent emotional or many stresses of life.

Tip

The four criteria often use in defining abnormal behaviour are defective cognitive functioning, defective social behaviour, defective self-control and distress.

1.2 Criteria of Abnormality Definitions

The terms **abnormality, psychopathology** and **mental illness** are often used interchangeably and both have been used in different contexts to mean exactly the same thing. Abnormality is a theoretical concept. Many academicians have attempted to define it. Based on a review of various criteria used in literature, four dimensions criteria of abnormality definitions have been identified. They are:

A. Objective Symptoms: the Biological Concept of Abnormality

According to this point of view, mental illness is defined as an underlining physical abnormality: it is an illness, just like any other illness. Thus, it is to be treated by physicians. Implicit in this concept is the assumption that the illness is universal to mankind - that is, it occurs in all cultures and socio-economic groups, in different proportions. This concept of mental illness is probably most common and is still advocated by many mental health professionals. It is based on qualitative differences, and it identifies specific abnormality defined by exclusion.

B. Statistical Normality: The Quantitative Concept of Abnormality

Normality/abnormality is almost the antithesis of the biological concept. The statistical concept of statistical normality is a quantitative concept, which classifies behaviours rather than diseases. It assumes that the behaviour of different individuals varies by imperceptible degrees, and can be averaged along a continuum which ranges, for example, from fast to slow, strong to weak, more to less, etc. The distribution of the behaviour of a random selection of a large number of people along that continuum takes the form of a bell-shaped curve (Gauss's normal law of error), with the majority clustering around a central point and the rest spread out towards the two extremes.

C. Social Mal-adjustment: The Socio-Cultural Concept of Abnormality

This is a socio-cultural concept of the origin of mental illness, which focuses on interpersonal and social behaviour. It states that mental illness is a judgement of the interaction of an individual with his or her environment. Consequently, it will vary from society to society and from one era to another. It emphasizes the use of social norms in defining mental illness.

Benedict (1934a) provided examples of behaviour, which the Western society would consider abnormal being positively valued in other societies. These include the institutionalisation of homosexuality by the ancient Greeks and Romans, the value of cataleptic seizures to the Shamans of Siberia, and the accordance of prestige to people who have passed through certain "trance" experiences by a tribe of Californian Indians.

D. Subjective Unhappiness: The Psychological Concept

The socio-cultural concept of abnormality is based upon a deviation from some social norms. In using this concept, it is necessary to specify both the norm and the criteria for deviance or mal-adjustment. In practice, the person who defines the norms and the deviations may either be the patient, or a significant other in the patient's social environment, such as a relative, physician, legal authority, etc. The psychological concept of mental illness emphasizes the subjective feelings of individuals as against mental illness as defined by environmental social norms. Like hypochondriasis, if you think you have it, then by definition, you have it.

Study Session Summary

Summary

In this Study Session, we examined definitions of abnormal behaviour. Specifically, we discussed various criteria used in defining abnormality in behaviour.

Assessment

Assessment

SAQ 1.1

1. Enumerate and explain the four criteria you would use to define abnormal behaviour. Back up your response with real life scenarios.
2. Social norms define abnormality. Discuss this statement using examples.

SAQ 1.2

1. Using sexual orientation as a case study highlight the four dimensions to abnormality.

Bibliography

McLeod, S. A. (2008). *Abnormal Psychology - Simply Psychology.* Retrieved July 2013, from http://www.simplypsychology.org/abnormal-psychology.html

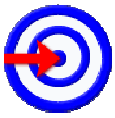
http://ccvillage.buffalo.edu/Abpsy/lecture1.html retrieved July, 2013

Study Session 2

Aetiology of Abnormal Behaviour

Introduction

In this Study Session, you will examine causes of abnormal behaviours. You will also examine classification of these causes from an holistic standpoint, using assessment process in abnormal behaviour.



Learning Outcomes

At the end of this Study Session, you should be able to:

i. *explain* causes of abnormal behaviour according to specific models of classification; and
ii. *discuss* the assessment process in abnormal behaviour.

Hint

The explanations and definitions of mental illness are usually based on the general views of some Psychologists interested in the behavioural patterns of abnormal behaviour. Likewise the causes of abnormal behaviour in psychology are traditionally classified as biological, psycho-dynamic, humanistic / existential, behavioural or social learning, socio-cultural, cognitive and lastly eclectic.

2.1 Classification of Causes of Abnormal Behaviour

2.1.1 Biological Model

This model focuses on the biological and physiological conditions that initiate abnormal behaviours. It sees all abnormal behaviours as a physical illness, which results from genetic abnormalities as well as the disease condition of the central nervous system. It also states that abnormal behaviour is a resultant of abnormality of the brain structure (brain size or as a condition of imbalance of the neuro-transmitters (biochemistry) of the brain fluid. Many studies with monozygotic twins and brain imaging have all supported the validity of medical/biological model of abnormal behaviour. An implication of the biological model is that drugs or surgery may be effective in treating psychological disorders.

2.1.2 The Psychodynamic Model

This model is loosely rooted in Freud's theory of personality. It assumes that psychological disorders result from anxiety produced by unresolved conflicts and forces of which a person is not aware of. Normally, the primary unit of socialisation is the family and Freud emphasized it, in the importance of the very elementary socialisation procedures that are inherent within the family. Many weaning and toilet training procedures bring infants' biological needs into direct conflict with the demands of

society, and it was the assumption of Freud that the form this conflict takes and how it is resolved are important determinants of the adult personality and adjustment. Three mental constructs used by Freud to explain the emergence of these conflicts are the id, the ego and the superego.

The id, which is present at birth and is the most primitive of these constructs, contains most basic urges, such as hunger, thirst, warmth and sex. Within the id are two energies that control human: the life instinct (Eros) and death instincts (Thanatos). The life energy of Eros is known as the libido, which is primarily sexual. The predominating energy of the Thanatos is aggression either turned inwards (suicide) or turned outwards (homicide). The id operates on the **pleasure principle,** which makes it seek immediate gratification. Frustration of the id to satisfy the immediate need may result into conflict that makes it engage in primary process thinking, generating mental images of desired object (fantasy). The ego is primarily conscious; it develops from the id at 6 months old. It operates on the **reality principle,** which enables it mediate between what is possible and mere fantasy.

The ego uses secondary process thinking, which involves planning and decision making. The third mental structure used by Freud is the superego: this develops through internalised societal standards, or moral values pass down through parental socializations. Proper or improper resolutions of the interaction between the three mental constructs according to Freud, determines abnormal behaviour. For example, an adult inappropriate behaviour of greed, stealing and corruption, according to Freud, would be due to the carry-over effect (fixation) of the unsocialised id impulses still embedded in such adult.

Freud further contended that development during childhood consists of successive stages, known as psycho-sexual stages of development, which he defined in terms of those parts of the body that appear to dominate the behaviour and life of the child. Freud identified these stages to include, the oral stage, (first year of life) the anal stage (second year of life) the phallic stage (around the third birthday), the latency state (about 6-8 years). Adolescence and the genital state (the end of adolescence). By the end of adolescence, the conflicts of the earlier stages should have been resolved and the resulting behavior patterns established as personality traits. Ideally, the individual has been transformed from a narcissistic, pleasure-seeking infant into a socialised reality oriented being.

2.1.3 Humanistic/Existential Model

Humanists assume that inner psychic forces are important in establishing and maintaining a normal life-style. Humanists believe that people have much more cognitive control over their lives. They focus on the self; the purposes, values, concepts, capacity for growth and subjective experiences of the person. They see human beings as relatively free (controlled by neither the environment nor biological urges). Therefore, abnormal behaviour occurs, according to the humanist model, when there is a discrepancy between self image and the actualization of self.

2.1.4 Behavioural or Social Learning Model

This model states that abnormal behaviours are caused by faulty or ineffective learning and conditioning patterns. Two fundamental assumptions of the social learning theorists are that abnormal behaviour can be reshaped, and that more appropriate and worthwhile behaviour can be substituted through traditional learning techniques. Proponents of the behavioural or social learning model, Skinner and Pallor (1969), demonstrated the systematic relationship between behaviour and forces in the environment that can control it. The social learning theorists assume that events in a person's environment reinforce or punish various behaviours selectively, and in doing so they shape personality and create maladjustment.

2.1.5 Socio-cultural Models

A culture is a way of life of a group of people, and it is distinguished from a society, which is the organized group of people who follow a particular way of life. The recognition of cultural influences on behaviour is consistent with the observation that man is a rule-following animal. His actions are not simply directed towards ends; they also conform to social standards and conventions. Unlike a calculating machine, man acts because of his knowledge of rules and objectives: The major socio-cultural variables that have been considered to function as efficient or precipitating causes of abnormal behaviour include urbanization, population density, social isolation anomie, territoriality and personal space, social class, unemployment, poverty, social mobility and such attitudes as racism and sexism.

2.1.6 Cognitive Model

This model propounds that human beings engage in both anti-social and mal-adjusted behaviours because of mal-adjusted thought processes and faulty interpretations of situational cues, which are often with reference to prior experience. The cognitive model treats people with psychological disorders by helping them develop new, thought processes that unite new values.

2.1.7 Eclectic Model

This model makes use of combination of any medical-biological model, psychodynamic, cognitive and social learning model in explaining abnormal behaviour.

2.2 Assessment Process in Abnormal Behaviour

Clinical assessments of abnormal behaviour involve several overlapping stages. It begins with the identification and clarification presenting problems by the client and other significant other and may proceed by making initial impression or formulation of the presenting complains. This is followed by having a systematic analysis of the problem using appropriate assessment techniques.

Based on these objective assessments, a psychological base formulation of the problems including diagnostic classification will be made where appropriate. This is therefore followed by recommendation of the appropriate intervention. A follow-up treatment evaluation may also ensue when necessary.

Study Session Summary

Summary

In this Study Session, you examined some causes of abnormal behaviour. In the process, you looked at some models through which the causes earlier examined could be better explained.

Assessment

Assessment

SAQ 2.1

1. Taking homicide as a case study, explain the different models to causes of abnormal behaviour.

SAQ 2.2

1. Discuss the assessment process of homicide as an abnormal behaviour.

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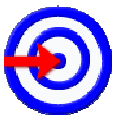
Study Session 3

The History and the Theories of Psychopathology

Introduction

In this Study Session, you will explore the history of psychopathology from the somatogenic and psychogenic perspectives.



Learning Outcomes

At the end of this Study Session, you should be able to:

i. *present* the history of psychopathology from the somatogenic and the psychogenic theoretical perspectives.

3.1 Theories on Psychopathology

The study of psychopathology is an examination of why people behave, think, and feel in unusual, surprising and even bizarre ways. The study of psychopathology has it origins in demonology. There are two opposing theories on psychopathology: the **somatogenic**, which assumes that mental illnesses are due to physical malfunction; and the **psychogenic**, which assumes that mental difficulties are explainable in psychological terms. Various theories make assumptions about the nature of abnormal behaviour, but they do not explicitly define it. The various parameters for determining abnormality of behaviour are statistical, subjective distress, impaired functioning, and norm violations.

3.1.1 Historical Development of Psychopathology: Somatogenic Theories

1. Demonology refers to a belief or doctrine that an autonomous evil being, such as the devil, lives within a person and controls his or her mind and body. The ancient Babylonians believed that a specific demon was responsible for each disease. Similar examples of such beliefs exerted in the cultures of the ancient Chinese, Egyptians, and Greeks. For those who believed in demonology, treatment of abnormal behaviour entails excorcing through flogging and starvation.

2. Hippocrates is considered the father of modern medicine because he separated medicine from religion and superstition. He also rejected the prevailing Greek belief that the gods sent serious physical and mental disturbances as punishment. Hippocrates insisted that mental disturbances were naturally caused and could be naturally treated like other diseases. Hippocrates believed that the brain was the organ of consciousness, of intellectual life, and of emotion. Thus, he stated that if someone's

thinking and behaviour were abnormal, there must be some kind of brain pathology.

Hippocrates was the earliest proponent of the view that attempted to explain abnormal behaviour. The hypothesis stated that, in a disordered person, there must be something wrong with the soma, or physical body, that disturbs mental processes. However, Hippocrates also realised that environmental and emotional stress can also impact heavily on the physical body and the mind. Hippocrates believed that there were three categories of mental disorders; mania, melancholia, and phlebitis, or brain fever.

Hippocrates believed that mental health was dependent upon a balance among four bodily fluids. These fluids were blood, black bile, yellow bile, and phlegm, Melancholia was the result of an excess of black bile; excess yellow bile resulted in anxiety; and excess blood caused mood changes. His belief was that human behaviour is influenced by bodily substances. Thus, abnormal behaviour was the result of an imbalance of these fluids. During the Dark Ages, the mentally ill were cared for in monasteries. The monk treated them by praying for them, or making potions for them to drink. Many mentally ill were homeless and became more disturbed with the passage of time.

In the latter part of the Middle Ages, some mentally disturbed people were considered to be witches. Although there were some alleged witches that were mentally disturbed, there were many more undisturbed people who were considered witches. Witchcraft or possession was only one explanation for mental disturbances and was not the primary explanation. During this time, some European laws provided for the hospitalisation of the mentally disturbed. Beginning in the 13th century, trials determined a person's sanity in England. The judgment of insanity allowed the Crown to become the guardian of the person's estate. This trial examined the person's orientation, memory, intellect, daily functioning, and habits. The explanations for abnormality were related to physical illness or emotional trauma.

3. Until the end of the Crusades, there were virtually no mental hospitals in Europe. The advent of the 16th century brought about serious attempts to place the mentally disturbed in asylums. Some of these asylums took in the poor as well as the mentally ill. The inclusion of mental patients in hospitals did not necessarily lead to more humane treatment of the mentally ill.

4. Benjamin Rush, the father of American psychiatry, believed that mental disorder was due to an excess of blood in the brain. His treatment consisted of taking large amounts of blood from the mentally disturbed person. Rush also believed that lunatics could be cured by frightening them.

5. Philippe Pinel was a major figure in the movement to treat the mentally ill more humanely. He was in charge of a French asylum during the French Revolution. Pinel removed the shackles of patients and treated them as sick human beings rather than animals. Light and airy rooms replaced dangerous enclosed rooms where they were kept. Pinel thought mental patients were essentially normal people who needed treatment that

included compassion and dignity. He believed their reason might return to them through comforting counsel and meaningful activity.

6. Physicians advocated an empirical approach to classification and physiological causes as the underlying factors in mental disorders. A textbook of psychiatry, which was first published in 1883 by Emil Kraeplin, furnished a classification system to help establish the organic basis of mental disorders. Kraeplin found that there was a tendency for a group of symptoms, referred to as a syndrome, to co-occur regularly enough to be conceptualised as having an underlying physical cause. He regarded each mental illness as unique, each having its own cause, symptoms, and prognosis.

Kraeplin proposed two major groups of severe mental disorders: dementia praecox and manic-depressive psychosis. Dementia praecox was an initial term for schizophrenia. He thought that a chemical imbalance caused schizophrenia, and an irregularity in metabolism caused manic-depressive psychosis. Kraeplin's classification system became the basis for modern diagnostic categories.

3.1.2 Hisotical Development of Psychopathology: Psychogenic Theories

7. While most psychiatrists focused on somatogenic causes, in parts of Western Europe, some other psychiatrists believed that mental disturbances were psychogenic in origin. Psychogenic proponents argued that mental illness was attributable to psychic malfunctions. Many people at this time suffered from hysteria (now termed conversion disorders), which had no apparent physical basis. Mesmer believed that hysterical disorders were due to a specific distribution of magnetic fluid in the body. He believed that one person could influence the fluid in another person's body causing changes in that person's behavior. Mesmer was an early practitioner of hypnosis.

8. Josef Breuer's patient, Anna O., had many hysterical symptoms. She suffered from paralysis and impaired vision, hearing and speech. Breuer hypnotised her. He succeeded in getting her to talk more freely and upon awakening she frequently felt better. Breuer found symptoms were relieved if the patient could remember what originally caused the symptom. This reliving of an earlier emotional trauma and the release of the emotional tension was called abreaction or catharsis. Breuer's method became know as the cathartic method.

Study Session Summary

Summary

In this Study Session, we have examined the history of psychopathology. We discussed two opposing theories of psychopathology, the somatogenic and the psychogenic views. The former attributes abnormality in behaviour to physical malfunction; the latter attributes it to the psychological break-down of men.

Assessment

Assessment

SAQ 3.1

1. Compare and contrast the somatogenic and psychogenic theories of psychopathology.

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Study Session 4

Anxiety Disorders

Introduction

In this Study Session, our concern is to examine biological concept of disease and with appropriate case illustrations on anxiety disorders. We will also examine different forms of anxiety disorder such as obsessive compulsive disorder, generalised anxiety disorder and neurotic disorder.

Learning Outcomes

At the end of this Study Session, you should be able to:

i. *distinguish* between obsession and compulsion.
ii. *point out* the symptoms of different forms of anxiety disorders.

4.1 Classifications of Anxiety Disorder

Anxiety disorder, which was formerly known as neurosis, is derived from two Greek words meaning "nerve disorders", and it was first used by William Cullen (1769) to designate a general class of diseases due to disordered notions or sensations of the nervous system. Neurosis is a relatively mild disturbance of the mental state that is primarily characterised by excessive anxiety, without a demonstrable organic basis.

Hint

This recent documentation, according to the Diagnostic and Statistical Manual (DSM-IV) classification, has made the use of neurosis as a broad classification obsolete. All other neurotic sub-classifications are known as disorders. Common reported symptoms of neurosis include: agitation, excessive sweating, hyperventilation, dilation of the pupils, hopelessness, helplessness, insomnia, loss of appetite, loss of libido, de-realization and de-personalisation. Part of these characteristics could form a cluster of symptoms of specific neurotic conditions.

Neuroses are basically psychogemic, that is, it is largely determined more, by happenings in a person's environment and past experience than by genetic constitutional or physical factors. It could be a learned response to certain traumatic situation. Human beings generally experience certain degrees of anxieties from daily hassles of life. *The difference between a normal person and a neurotic person is in the degree of anxiety experienced*.

4.2 Forms of Anxiety Disorders

4.2.1 Phobic Anxiety

Anxiety may be experienced in relation to specific situations or certain objects. When accompanied by a wish to avoid the feared situation or objects or when the situation is actually avoided, it is known as phobic anxiety state. This state is commonly divided into three groups; namely, simple phobias, social phobias and agoraphobia. The individual with a phobia feels quite helpless as does the young child and feels comfortable only when he can make changes in his life so that he avoids the particular phobic situation. Commonest fears seen in phobic neurotics are fear of open places (agoraphobia), fear of height (acrophobia), and fear of enclosed places. An example of phobia developing in a grown woman is summarised below.

Case Study 4.A

Folu, a recently married twenty-eight year old University student, has been experiencing some strange happenings for approximately year. These strange features are characterised by heart pounding without warning and her breathing becoming difficult. Her hands sweated profusely. Her stomach muscles tighten; she frequently experienced these sensations and, at times she could not stop herself from wondering if she was about to die. Somewhere, at the back of her mind, Folu knew that when she closed her eyes and rested, she would feel normal again within an hour. Folu's first experience of this attack occurred as she was leaving a crowded football stadium. The only previous event that could be connected with these feelings was a fearful reaction to a TV story about a night club fire which trapped and killed thirty people.

Folu's second experience of this phenomenon took place during an argument with her husband about whether to wear a particular dress to a family party. Folu did not remember the details surrounding the third attack or all others she had experienced since. The features are coming almost everyday now whenever anyone disagrees with her and whenever she encounters strangers. Lately, Folu has been avoiding the area where these happenings most frequently occur and consequently she has been spending a great deal of time in the house.

Two prominent features are basic to phobia in the above case study:

- Firstly, there were features suggestive of anxiety which included sweating profusely, tightening of stomach muscles and difficulty in breathing.
- Secondly, there was a tendency for Folu to avoid feared situations. These are the hallmarks of a phobic disorder.

There is no single satisfactory explanation for the occurrence of a phobic anxiety state. Nevertheless, separation anxiety has been found to be an important pathogenesis of phobia, and this is especially so in the development of school phobia. Separation anxiety is the fear experienced by a child from a significant other, usually the mother, when an

attachment bond has been established. It is often referred to as an unresolved over-dependency conflict between the mother and the child.

Dollor and Miller (1980) describe phobia as learned responses to painful experience, which are commonly expressed in children. For example, according to the psychodynamic model, the little boy‘s castration fear may be found as a corresponding factor in fantasy of previous injury to the genitals. It could also be a symbolic threat of sexual attack in girls and in boys with passive homosexual tendencies. Behavioural theory of phobia suggests that classical conditioning occurs in the formation of a phobic anxiety. For example, as was explained in the case study earlier, Folu's fear of crowd could be easily described as a fearful reaction to a television story about a night club that was set on fire where several people were killed.

Psychoanalytic theory suggests that a phobic situation is a symbolic representation of an inner conflict and in an attempt to escape the conflict, the anxiety attached to it becomes displaced unto a more easily avoidable external object or situation.

4.2.2 Obsessive-Compulsive Disorders

The term **obsessive-compulsive disorder** or obsessional neurosis is yet another type of anxiety disorder. It encompasses a number of conditions characterised by the presence of obsessions or compulsions. Obsessions are defined as recurrent persistent thoughts, ideas, images, or impulses, which are perceived as inappropriate or silly by the individual. Compulsions are motor acts, which are resisted but carried out despite being regarded as senseless. They are accompanied by a subjective sense of compulsion and resistance that may lead to increasing tension which can only be relieved by carrying out the motor act. Compulsions are often associated with obsessions and may occur alone.

Obsessions and compulsions are generally found in individuals with well-defined personality characteristics including stubbornness, rigidity, orderliness and excessive attention to details. Obsessions are often concerned with avoiding death or germs, preoccupation with sexual or hostile thoughts, which are at complete variance with the individual's very proper personality and excessive concern with one's appearance. A typical example of an obsessive individual was encountered by the author when intervening in the case of a young man who, when reading the holy bible, substitutes the word Jesus for Satan.

4.2.3 Generalized Anxiety Disorders

These constitute the commonest form of neurosis. The predominant symptom is anxiety, which may be presented either as a more or less continuous feeling of tension often with some somatic response or as periodic attacks in which the person has a desperate feeling of panic.

The new classification of anxiety, according to Diagnostic and Statistical Manual (DSM-IV), is known as Generalized Anxiety Disorder. It has also been referred to as panic attack, panic disorder or panic state. As an illness, anxiety may have an acute onset and may be severe in intensity,

appearing against a relatively normal background, or it may be of a chronic nature present from adolescent in mild degree and may fluctuate in severity, according to current stress factors. Anxiety state could be diffuse free floating or could be fixed. When anxiety is diffuse, there are feelings of tension, which cannot be attached to any object or situation. When anxiety is fixed, it is attached to a particular object or situation. Common symptoms of anxiety include feeling of inner tension and anxious expectation and they may appear in bodily or somatic symptoms, such as palpitations, pallor, sweating, goose flesh, dry mouth, anorexia, indigestion, diarrhea, wide pupils, and frequency of micturition. These somatic symptoms associated with anxiety are mediated through the autonomic nervous system and may involve all body systems. The anorexia which occurs may give rise to a loss in weight. Patients with anxiety may also manifest some emotional preoccupation, which may lead to difficulty in concentration. They may have difficulty in getting off to sleep, which may be disturbed by anxious dreams or nightmares. They may also express fears of insanity and headache. Overbreathing may occur in an acute state, and this is usually common in young women about the time of their menstrual periods.

Hint

In a primary health care study (Gureje et al 1995) there was prevalence in Nigeria which was put at 2.9%.

4.2.4 Neurotic Disorders

Traumatic Neurotic Disorder

This is the term applied to an anxiety neurosis that develops following what the patient sees as a serious threat to life. Such trauma may arise from a serious accident or from a combat stress. It could also result from minor injuries, particularly, if the patient has a predisposition to mental illness. Such patient, apart from having the clinical manifestations of anxiety already described, may frequently experience terrifying dreams in which they relive the traumatic situation. They may develop conversion symptoms, which are functional symptoms added to any physical disability that may be present.

Compensation Neurotic Disorder

Compensation neurosis is normally induced as a manifestation of hysteria, and it poses problems created by secondary gains, particularly, when monetary settlement is protracted. Let us assume that a man has suffered an injury at work, with resultant physical symptoms. He is seen by doctors and lawyers, and receives the sympathy of relatives and friends with numerous laboratory tests performed. If this attention satisfies dependency needs, such a person could hardly wish for the situation to alter too abruptly and, in fact, he may engage in the practice of malingering, particularly, if he thinks any prolongation of the illness duration will mean a judgement in his favour for greater monetary compensation. In some instances, the injury triggers off conflict or anxiety and through the unconscious mechanism of conversion, symptoms become suppurated to the initial physical ones.

Neurasthenia

This is a neurotic disorder characterized by fatigue, irritability, headache, depression, insomnia, difficulty in concentration, and lack of capacity for enjoyment (anhedonia). It may follow or accompany an infection or exhaustion, or arise from continued emotional stress. Prevalence of the neurasthenia in a study among primary health care attendees in Ibadan was 1.1% (Gureje et al. 1995).

Hypochondrias

This is a neurotic disorder in which the conspicuous features are excessive concern with one's health in general or in the functioning of some part of one's body, or less frequently, one's mind. It is usually associated with anxiety and depression. It may occur as a feature of a diagnosed mental disorder and in that case should not be classified as that but in the corresponding major category. The hypochondriac may be seen as relating to the environment in a distorted way, in the sense that he or she fails to make meaningful relationships with others. The hypochondriac feels worthless and rejected and attempts to opt out of interpersonal relationships, becoming more preoccupied with his or her bodily functions. The patient may have insight into the fact that his constant anxiety about physical illness is abnormal or excessive, but he is unable to control it. Hypochondriasis must not be confused with psychosomatic illness in which an organic illness is caused or influenced by the psychological state of individual.

Odejide, Oyewunmi and Ohaeri (1989) had identified a triad of symptoms to be found in hypochondriasis. This includes disease conviction, illness phobia and bodily preoccupation. Delusion may be a common feature in hypochondriasis; when this happens, it is known as hypochondriacal delusions.

Hypochondria are not a common psychological disorder in Nigeria. (Gureje et al 1995) found a prevalence of 1.5% among primary health care attendees in Ibadan, Nigeria.

Hysteria

Hysteria is another form of neurosis disorders that is characterized by excessive emotional outburst, suggestibility, self-centered and attention-seeking behaviour with rapid mood swings. It is commonest in young women during adolescence and early adulthood. Hysterical behaviour can be categorised into three:

1. Conversion hysteria
2. Amnesia hysteria, and
3. Dissociative hysteria.

Conversion Hysteria

This is a group of symptoms that affect the special senses or a part of the body, which is controlled by the voluntary nervous system. Body symptoms are often produced by suggestion or autosuggestion; there may be an imitative feature to them as well. Conversion symptoms include aphonia (loss of voice), blindness, deafness or paralysis of one or more extremities or parts thereof. Superficially, conversion symptoms may

resemble symptoms of a physical illness but if the patient is observed and carefully examined the differentiation will be clear.

Amnesia Hysteria

This set of symptoms consists of disturbance of memory. This may vary from total amnesia to circumscribed amnesia when only a specific experience or series of experiences are forgotten. The mechanism of repression appears responsible for the forgetting of an event or subject, which may be painful to remember.

Dissociative Hysteria

Dissociative hysteria is a condition in which a certain part of the individual's personality is 'split off' from the rest. This accounts for rare occurrences of double personality and fugue states and the much more frequent phenomenon- somnambulism (sleep-walking).

Neurotic Depression

This is characterised by disproportionate depression, which has usually recognisably ensued on a distressing experience: it does not include among its features, delusions or hallucinations. There is often preoccupation with the psychic trauma which precedes illness, for example, loss of a cherished person or possession. Anxiety is also frequently present and mixed states of anxiety and depression are also included here. Depression could also manifest as a psychotic condition. When this happens it always involves delusions and hallucinations. A comparison between neurotic and psychotic depression is made in Table 4.1.

Neurotic Depression	Psychotic Depression
Environmental changes have little or no effect on depression.	Mood may lift in cheerful company.
Sleep disturbance is always severe. Early morning waking characteristic (delayed insomnia).	Sleep disturbance may be present, if so there is difficulty getting off to sleep (initial insomnia).
Retardation of thought and action is common.	No retardation in physiological sense but may complain of fatigue.
Speech becomes slow as part of process of retardation.	Usually talkative, keen to discuss symptoms and frequently complain a lot.
Physical symptoms are marked. They include anorexia, weight loss, impotence, amenorrhea and commonly concentration	Anorexia and weight loss are less marked and may even be absent. Impotence, amenorrhea, and constipation are not associated physiological symptoms.
Delusions are commonly present	Delusions are never present.

Affected individual tends to blame himself for his state.	Affected individual usually blames others or his environment.

Note Psychotic depression will be considered in greater detail in the next Study Session.

Study Session Summary

In this Study Session, we have examined the basic classifications of anxiety disorders. We also examined different forms of anxiety disorder such as obsessive compulsive disorder, generalised anxiety disorder and neurotic disorder.

Assessment

Assessment

SAQ 4.1

1. What symptoms are usually associated with neuroses?
2. Explain the expression "degree of anxiety" in your own words.
3. Compare and contrast obsession and compulsion.

SAQ 4.2

1. Explain phobic anxiety. What are the hallmarks of a phobic disorder?
2. Explain Generalised Anxiety Disorder under DSM-IV
3. What are the common symptoms of anxiety?
4. List and discuss the different forms of neurotic disorders.
5. Compare and contrast conversion, amnesia, and dissociation hysteria.

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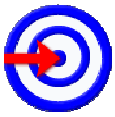
Study Session 5

Schizophrenia as Psychoses

Introduction

In this Study Session, we will discuss schizophrenia, one of the severe mental illnesses referred to as psychosis. This mental illness is mostly characterised by symptoms of faulty perceptual skills, disorganised thinking, emotional distortion, withdrawal from reality, bizarre behaviour, etc. We will also examine the sub-classifications of schizophrenia with peculiar symptoms. A case study is provided for a better understanding in this exercise.



Learning Outcomes

At the end of this Study Session, you should be able to:

i. *define* psychoses.
ii. *explain* what schizophrenia is.
iii. *point out* the known symptoms of schizophrenia.
iv. *sub-classify* schizophrenia

5.1 The Meaning of Psychoses

Delusions Unshakable false beliefs, inconsistent with reality, held in spite of evidence to the contrary.

Hallucinations The disorder of perception e.g. visual, auditory, olfactory, gustatory, somatic or tactile.

Illusion The perception of a physical stimulus that differs from the commonly expected perception.

The word ‘psychosis is derived from two Greek words, the literal translation of which is ‘mind disorder’. It was first used by Von Feuchterleben (1845) and was used synonymously with ‘insanity'. Psychoses are a group of major mental disorders. The major characteristics of these illnesses are lose of contact with reality, inappropriate behaviour, inappropriate affect or mood **delusions** and **hallucinations** and **illusions**.

5.2 Schizophrenia

The term ‘schizophrenia' originated with Bleuler, a Swiss Psychiatrist (1911). Combining ideas from Kraepelin and Freud, Bleuler conceptualised Kraepelin's syndrome as a disorder whose primary feature was an alteration of the faculty of association. Schizonphrenic disorders or illness are pulsating psychotic conditions which occur throughout the world. It is a universal ailment.

Behavioural scientists do not agree on what schizophrenia is and what it is not. However, many psychologists consider disturbed thinking as the definite feature of the syndrome.

5.2.1 Symptoms of Schizophrenia

Apart from the important characteristics of the psychotic illness highlighted above, a schizophrenic individual can also manifest the following symptoms:

1. **Faulty Perceptual Skills:** Schizophrenics frequently have problems in focusing his attention. They are easily distracted and they cannot process information. They report feelings of bombardment of incoming sensory information. One patient observed "I cannot concentrate; I am thinking of different conversations, I am like a transmitter; the sounds are coming through to me but I feel my mind cannot cope with everything".
2. **Disorganized Thinking:** Schizophrenics often have trouble in logically linking their thoughts together and solving problems.
3. **Emotional Distortions:** Schizophrenics often show irrational related problems. These include an inability to experience pleasure, flat or blunt affect and mood, feeling of apathy, anxiety. They also manifest imbalance and strong contradictory feelings on a particular subject. A typical schizophrenic patient does not talk to anybody. One schizophrenic observed, "You see, I might be talking about something quite serious to you, but other things might come into my head at the same time that are funny and this makes me laugh".
4. **Withdrawal from Reality:** Schizophrenic patients frequently withdraw from the real world and are preoccupied with inner fantasy and private experiences.
5. **Bizarre Behaviour:** Schizophrenic patients usually manifest bizarre behaviours. These include disrupted speech, verbal and physical violence, etc.

5.2.2 Sub-Classifications of Schizophrenia

Schizophrenia could be sub-classified in the following ways: Schizophreniform disorders, Paranoid schizophrenia, Catatonic schizophrenia, Hebephrenic schizophrenia, Reactive schizophrenia. These sub-classifications are sometimes referred to as types of schizophrenia in some texts.

Schizophreniform disorder

Schizophreniform disorder, formally known as the simple type of schizophrenia, is characterised by a slow outset from a previous inadequate and usually schizoid personality adjustment. Symptoms of this disorder include apathy, unresponsive affect and preoccupation with fantasies. These symptoms last less than six months. They come and go quickly and the individual resumes a normal life thereafter. Delusions and hallucinations are rare, and the condition is obviously less psychotic than the other types of schizophrenia.

Paranoid Schizophrenia

Patients with this type of schizophrenia manifest symptoms such as having bizarre images and often having auditory hallucinations. Paranoid patients may be alert, intelligent and responsive, but their delusions impair their ability to deal with reality and their abnormal behaviours. They are often unpredictable and sometimes hostile. These individuals generally complain about fear of being persecuted. They may feel that they are being chased by ghosts or intruders from extra-terrestrial planets. They have extreme delusions of persecution and occasionally of grandeur (feelings of being big and important).

A typical and famous paranoid schizophrenic patient was the person who assassinated Kennedy, "Sirhan. During his trial, Sirhan was diagnosed as a paranoid schizophrenic patient. Shortly before he assassinated Kennedy, Sirhan had a delusion that he saw Kennedy make a proposal of sending 50 aircrafts to Israel. He imagined himself acting on behalf of the Arab nations. He wrote himself numerous "kill" Kennedy orders. Sirhan's notes suggested that he also hallucinated Kennedy's face plotting out his own image in a mirror.

Catatonic Schizophrenia

This type of schizophrenia is characterised essentially by peculiar motor behaviour, muteness, motionless and unresponsive behaviour. Symptoms of catatonic schizophrenics include extreme lethargy, psychomotor, psychomotor slowing, catatonic stupor, which is a typical condition whereby the patient will sit in a very odd posture and will not respond to any stimulus in any manner. However, if his arms, legs and general body posture are moved by someone else and he still maintains this posture, this condition is known as waxy flexibility. Catatonic patient can also automatically obey commands, or imitate the action and phrases of others - these symptoms are called echopraxia and echolalia respectively.

Apart from psychomotor slowness and stupor, catatonic schizophrenics can have conditions known as agitated catatonia or catatonic excitement. This is a condition in which the patient has uncontrollable motor and verbal behaviour. He can be violent at this stage, and he is quite dangerous to himself and also difficult to manage.

Disorganised or Hebephrenic Schizophrenic

This is a typical schizophrenic disorder characterised by markedly bizarre childlike behaviour. The symptoms include public masturbation, putting fecal matters in his mouth, tying ribbons around his toes, stuffing toilet papers in his nose, wetting his pant and talking to himself in an unintelligent manner while showing a silly vacant smile. The contents of the patients' delusion and hallucination are disjointed and unreal. Their conversation is difficult to comprehend, their mannerism seems silly, and they do lots of giggling, posturing, gesturing, and grimacing. They also spend hours talking to themselves and imaginary companions.

Reactive Schizophrenia

In this form of schizophrenia, the patient has experienced a rather sudden outset of his illness with relatively normal previous adjustment. There are usually one or more factors in his recent life experience, which apparently contribute substantially to the development of the disturbance. These factors could include any type of stress situation. Such patients have a reasonably good prognosis and their recovery is sometimes nearly as rapid as the outset of their illness. An example of reactive schizophrenia would be a woman who develops an acute psychosis of a schizophrenic nature shortly following childbirth and experiences nearly complete recovery within two or three weeks. Another example is described in the case study below.

Case Study 5

A form VI student underwent a sudden personality change two months before his A' level examinations. He became seclusive, spoke harshly when his schoolmates tried to be friendly and was unable to sleep, spending much of each night in unproductive study. It was reported that he was sometimes confused and attempted to go to classrooms at meal-times. One morning, he was found under a mango tree, having not slept in his bed, and telling a rather incoherent story of being chased by robbers. During his three-week hospitalization, he gradually settled with the assistance of phenothiazine drugs. As he improved, he spoke of his responsibilities as the first-born in his large family and his worries about the examinations. When he was able to leave the hospital, he was no longer psychotic but his concentration remained impaired. It was concluded that it would be unwise for him to sit for the examinations, and he seemed relieved.

Culled from Asuni, Schoenberg and Swift (1994)

Study Session Summary

Summary

In this Study Session, we discussed schizophrenic, a psychotic condition. In the process, we explained what schizophrenia is all about as well as gave the symptoms usually associated with the psychotic condition. We also discussed various sub-classes of the schizophrenic disorder. These included schizophreniform disorder, paranoid schizophrenia, catatonic schizophrenia, disorganized or hebephrenic schizophrenia, and reactive schizophrenia

Assessment

Assessment

SAQ 5.1

1. Define and list the number of characteristics associated with psychosis.
2. Define the following terms: Delusion, Hallucination, and Illusion.

SAQ 5.2

1. How does Bleuler conceptualize schizophrenia?

SAQ 5.3

1. Enumerate the symptoms of schizophrenia

SAQ 5.4

1. Point out the sub-classification of schizophrenia and briefly discuss each.

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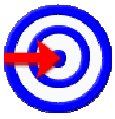
Study Session 6

Affective Disorders

Introduction

In this Study Session, we shall examine some mental disorders that are commonly referred to as mood disorders. These are explained with a case study. Furthermore, we shall make a distinction between primary and secondary depressions, as well as reactive or exogenous and endogenous depression. Furthermore, we will examine mania, and also discuss organic psychoses.



Learning Outcomes

At the end of this Study Session, you should be able to:

i. *highlight* the general features of depression.
ii. *differentiate* between primary depression and secondary depression as well as between reactive/exogenous and endogenous depression.
iii. *highlight* a case of mania.
iv. *explain* schizo-affective disorder.
v. *point out* the causes of organic psychoses.

6.1 The Meaning of Affective Disorders

Affective processes are commonly referred to as feelings, moods, emotions and temperaments. Therefore, affective disorders are referred to as the disorders of mood and subjective feelings. Two major types of this disorder are depression and hypomania or mania. They represent two extreme continuums of the disorders of mood and affects, on one extreme is depression, which is a morbid state of low mood and sadness, and the other extreme is mania, which is a state of excitement and high elation.

These disorders can be presented and manifested in the same individual at different stages of his or her illness, and when this occurs we have what is known as Bipolar Affective Disorder, that is, a state of depression and hypomania. We can also have a state where just one continuum of the illness will be present as an illness, that is, a state of recurrent depression or a state of recurrent mania. When this occurs, it is known as Unipolar Affective Disorder.

6.2 Types of Affective Disorders

6.2.1 Depression

Depression has general, psychological and physical symptoms. Among the general symptoms are low moods, sadness or discouragement. The psychological symptoms include lack of enjoyment, diminished concentration or indecisiveness, pessimistic thinking, guilt or self-blame, negative self-reproach or self-concept, and reduced libido. The physical

symptoms include reduced energy, constipation, memory impairment, psychomotor, agitation or retardation, loss of appetite, loss of weight or weight gain, and in rare, extreme cases suicide.

The mood of a depressed person does not improve substantially in circumstances where ordinary feeling of sadness would be alleviated. Depression has three major components; these are pessimistic thoughts, lack of enjoyment and psychomotor retardation.

Pessimistic thoughts are a state of depressive cognition and can be divided into three parts:

1. The first part is concerned with the patient's present circumstance; a typical patient sees the unhappy side of every event; he thinks he is failing in everything that he does and that other people see him as a failure.
2. The second group of thoughts is concerned with the future. The patient expects the worst; he foresees failure in his work, finances, misfortune of his family and consistent deterioration in his health. This idea of hopelessness is often accompanied by the thought that life is no longer worth living and that death would come as a welcome release. These gloomy preoccupations may prepare the mind of a depressed person for suicide.
3. The third group of thoughts is concerned with the past; the depressed often take the form of unreasonable guilt and self blame about minor matters. For examples, a patient may feel guilty about past trivial acts of dishonesty.

The case below illustrates how guilt could manifest as part of a major depressive disorder.

Case Study 6.A

Miss L.A. is a 24-year-old female unemployed graduate. Illness started about 18 months before presentation, when she was doing her youth service in Calabar, Cross River State of Nigeria. The problem started in Calabar as a result of a series of rituals that was being performed in the town at that time. According to the patient, a chief in the area was said to have died and there was a stay-indoors instructions. Symptoms included nightmares, insomnia, fears (free-floating) and occasional headache. On further interview, it was revealed that Miss L.A. haboured a serious guilt of unfaithfulness; she was said to have slept with a man that was not her boyfriend. This morbid feeling of guilt, together with other physical anxiety characteristics, made her seek for the help of a psychologist.

Another major part of depression is lack of interest and enjoyment. A typical depressed patient will show no enthusiasm for activities or hobbies that he will normally enjoy. He has no energy for living and for pleasure in everyday things; he often withdraws from social encounter and also has reduced energy. The last major feature is psychomotor retardation. The patients that are psychomotor-retarded are often very slow in action. This slowness is reflected in their speech, and there is a long delay before questions are answered, and they pulse in conversation. Their speech may be too long and intolerable to a non-depressed person.

A distinction has also been made between primary and secondary depressions, as well as between reactive or exogenous and endogenous depression.

Primary and Secondary Depression

Primary depressions are depressive features that are not preceded by any other psychological depression. On the other hand, secondary depression applies to all cases with a history of previous non-affective psychiatric illness (such as schizophrenia of anxiety neurosis) or of alcoholism, medical illnesses, or the taking of certain drugs (such as steroids).

Reactive and Endogenous Depression

A reactive or endogenous depression occurs in response to psychological, social or physical environmental hassles that normally accompany the day-to-day living or activities of man. Incidents such as loss of a loved family member or friend, loss of a job, being in debt and failure in an examination are parts of the factors that can predispose to any individual is developing a reactive depression. It is often a milder form of depression; though, it could be severe depending on the intensity of the precipitating factor (s) or susceptibility of the person to mental disorders.

Endogenous depressions are those features without any apparent and major precipitating environmental factors; this is usually a psychotic form of depression which the features have already been highlighted.

6.2.2 Mania

When there is a condition of extreme elation, excitement, socially disinhibitive behaviour and violence, you are most likely to have a case of mania. Other symptoms of mania include irritability, pressure of speech, flight of ideas, increased libido, excessive spending, grandiosity, excessive eating, and unusually full of energy.

Schizo-Affective Disorders

Schizoid-Affective Disorders occurs when symptoms of schizophrenia, such as hallucination, delusions of different types and disorders, such as the ones discussed above, manifest in a person.

6.2.3 Organic Psychosis

These are disorders that result from brain impairment and that have a known physical basis. Organic psychosis may be triggered off by infections (such as syphilis), traumas (such as skull fractures and concussions), nutritional deficiencies (such as pellagra), cerebrovascular disease (such as arteriosclerosis and brain hemorrhage), tumours, degenerative diseases (such as Huntington's chorea), toxins (such as lead) and endocrine dysfunctions. Basic and general symptoms of organic psychosis will include the following: (1) impaired orientation, (2) memory losses, especially, retrogressive amnesia that is loss of memory preceding an accident or illness, (3) intellectual deterioration, such as difficulty in planning, reasoning, and communication, (4) blunted or exceedingly unstable emotional responses. The case study below

provides a practical example of a person suffering from organic psychosis.

Case Study 6.B

Seun, a 32-year-old labourer, was struck by a case following an evening of heavy drinking. He was brought to the emergency ward for assessment and possible management. On investigation, it was found that Seun had fracture on the left femur, multiple abrasions and contusions, and alcohol intoxication. He was placed in traction, sedated. On the third night of admission, Seun woke up disturbing other patients, with screams and struggling. He saw and felt snakes crawling over him. Because of the traction apparatus, he was immobilised and this increased his terror. He pleaded with the nurse to save him. He was perspiring profusely, had gross and fine tremours. He was heavily sedated and in the next morning he remembered nothing. Similar episodes, although less, occurred the next two nights.

Forms of Organic Mental Disorders

Acute Brain Syndrome

Acute brain syndrome is an organic state, which is characterized by confessional states and delirium. The symptoms of confessional states include a transient awareness or clouding of consciousness. Memory impairment is common and the patient's mood is usually anxious. Insomnia and inability to concentrate are frequent complaints. Patients with this type of illness usually referred to a general hospital as a complication to some physical illness.

Chronic Brain Syndrome

This syndrome, which may also be termed organic dementia, is characterized by multiple deficits in intellectual function, performance and personality, resulting from brain damage.

Delirium Tremens

This is a special form of acute brain syndrome occurring in chronic alcoholics, especially when alcohol is withdrawn but sometimes occurring during a period of unusually excessive drinking. The symptoms of delirium tremens usually come on at night with perhaps one or two days of preceding progressive uneasiness and apprehension. Generally, the patient experiences frightening illusions or hallucinations of a visual or tactile variety. These are sometimes intensified by related delusion. The patient experiences panic and terror. He is disoriented, restless, agitated and sleepless. The symptoms often subside during the daytime. Physical illness associated with organic psychosis will include psychosis after head injuries and psychosis associated with nutritional deficiencies.

Causes of Organic Mental Disorders

Psychosis after Head Injuries

With the growth in industrialisation and the increase in highway traffic in Nigeria, organic mental disorders that result from head injuries are becoming more common. Specific symptoms are determined by the extent and the location of the injury as well as pre-morbid personality of

the individual. Conditions resulting in psychosis from head injuries include:

1. **Concussion**: This is characterised by a short period of unconsciousness following a hard blow to the head.
2. **Contusions and Lacerations**: This is characterised by the crushing or tearing of brain tissues. It usually results from a heavy blow to the head with or without skull fracture. Coma may result and the longer the coma, the greater is the likelihood that brain damage has occurred.
3. **Subdural and epidural haematoma**: This results from a bleeding head trauma.

Psychosis Associated with Nutritional Deficiencies

Deficiencies in some vital vitamins in the body, such as vitamin B, can cause symptoms of anxiety and depression followed by acute delirium and sometimes with hallucination and symptoms suggestive of schizophrenia.

Thiamine deficiency can often result in irritability, anorexia and insomnia. In its severe form, delirium can occur with amnesia, confusion and other acute symptoms as noted under delirium tremens. Another nutritional deficiency is kwashiorkor. This is a clinical condition caused by deficiency in protein calorie essential for the body, and is more frequent in young children. Abnormal behaviour associated with this calorie deficiency includes depression, apathy and a possible mental sub-normality. Korsakoff psychosis is another condition associated with thiamine deficiency resulting from taking too much of alcohol. It is a cognitive malfunctioning condition. This condition is usually irreversible, and its essential symptom includes memory impairment, especially those concerned with registration of information. This memory defect may also be associated with diffuse hemorrhagic lesions in the brain, which may prevent new materials from being added to the memory store house, thereby contributory to the loss of vital information on the materials making memory for events occurring a few minutes before the incidence deficient.

Senile Dementia

Another organic condition associated with psychosis is senile dementia. This is a mental condition produced by regression in many physical and mental aspects of individuals who are usually above the age of 70 years. Prominent symptoms of senile dementia include memory loss, lack of/reduced interests, and preoccupations with experiences of long period of time, increasing self-interest and lack of self-control. Delusions, especially persecutory delusions and hallucinations are part of the symptoms of senile dementia.

Pre-Senile Dementia

Presenile dementias are neurological conditions, which include Alzheimer's disease and Pick's disease. Alzheimer disease is a neurological condition, which occurs in an individual before the age of 65 years. It is characterised by a degenerative, slow outset of mental functioning. It has in addition a progressive deteriorating course. Symptoms include agitation, emotional outbursts, disrupted sleep and

amnesia. Pick's disease, on the other hand, is less common; it reaches its peak in the 50-70 years old age group. It is distinguished from Alzheimer's disease for its disinhibited, tactless and facetious personality deterioration. The language tends to exhibit stereotyped output, and they often exhibit echolalia and autism.

Tumours

Brain tumours and tumours of the meninges can cause general symptoms similar to those resulting from other lesions. Abnormal behaviour associated with brain tumours include speech disturbances and various personality changes and psychotic features found in chronic brain syndrome.

Psychosis Resulting from Progressive Neurological Illness

Common under the classification above is multiple sclerosis. Outstanding feature of this progressive neurological condition is euphoria. Depression is also common and eventually there is a progressive intellectual impairment. Huntington's chorea is another progressive neurological condition, which is transmitted by a dominant gene. The outset is usually between 30-40 years of age. Symptoms include incessant jerking, twisting movements of the neck, trunic and extremities as well as facial grimacing, explosive speech and ataxia.

Psychosis Associated with Severe Medical Illness

Some chronic and severe medical conditions, such as heart, liver and kidney diseases, or even cancer can predispose an individual to quite a number of abnormal behaviours. Common psychological distresses associated with these conditions include confusion, anxiety, agitation delirium and panic attack. These distresses may be caused both by anxiety arising from the knowledge of the life-threatening nature of the illness and from physical influences on the cerebral cortex, which include lowered oxygen content and unexcreted toxic substances circulating in the blood. Confusion is frequently associated with hypoglycaemia in patients with diabetes.

Study Session Summary

Summary

In this Study Session, we have examined mental disorders, which are commonly described as mood disorders. Furthermore, we made a distinction between primary depression and secondary depression as well as between reactive and endogenous depression. We also examined other forms of mental disorders such as mania, schizo-affective disorders, and organic psychoses. Lastly, we highlighted causes of organic mental disorders. Specifically we mentioned and explained the psychoses that result from head injuries; those that result from nutritional deficiencies. Senile dementia; pre-senile dementia, tumor psychoses that results from progressive neurological illness and that which results from severe medical illness.

Assessment

Assessment

SAQ 6.1

1. Distinguish between depression and hypomania.
2. Explain the expression Bipolar Affective Disorder.
3. What are the general, psychological and physical symptoms of depression?

SAQ 6.2

1. Differentiate between primary and secondary depression.
2. Using examples distinguish between reactive and endogenous depression

SAQ 6.3

1. Give a comprehensive list of symptoms of mania.

SAQ 6.4

1. What are the characteristic symptoms of schizo-affective disorders?

SAQ 6.5

1. Enumerate the basic symptoms of organic psychosis.
2. List and discuss the forms of organic mental disorders.
3. What factors could lead to organic mental disorders?

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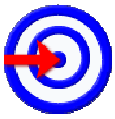
Study Session 7

Problems of Sexuality and Gender Identity

Introduction

This Study Session explains psychological disturbances often associated with the sexuality and gender orientation of human beings. These may include disorder or sexual dysfunction, and abnormality of sexual preference.



Learning Outcomes

At the end of this Study Session, you should be able to:

i. *explain* pedophilia as a psychological disturbance.
ii. *point out* the forms of abnormal sexual practices.

7.1 Sexual Dysfunctions

Sexual dysfunctions are conditions resulting from inability of a person to enjoy normal coitus. In men, sexual dysfunction refers to repeated impairment of normal sexual interest and/or performance. In women it refers to repeated inability to adhere sexual satisfaction. What is regarded as normal sexual intercourse, and therefore what is thought to be impoverished or unsatisfactory one, depends in part on the expectations of the two people concerned. For example, when the woman is regularly unable to achieve orgasm, her partner regards it as normal while another may see it as abnormal. Problems of sexual dysfunction are classified in the following ways:

1. Sexual act that results in pain: vaginismus and dysparania in women, and painful ejaculation in men.
2. The genital response (erectile impotence in men, and lack of arousal in women).
3. Orgasm (premature or retarded ejaculation in men, orgasmic dysfunction in women)

Vaginismus in women is a condition of spasm of the vagina muscles, which causes pain when intercourse is attempted and when there is no physical lesion causing the pain. The spasm is usually part of phobic response associated with fears about penetration and may be made worse by an inexperienced partner. Aetiology of sexual dysfunctions will include lack of sexual drive, anxiety, a physical or psychiatric illness.

7.2 Abnormality of Sexual Preference (Paraphilias)

Sexual deviations, otherwise known as sexual perversions, refer to sexual behaviours that are socially disapproved. It is often a classification of people, rather than diseases or forms of behaviour. Paraphilias can be classified into:

1) Abnormalities of preference of sexual object and
2) Abnormalities in the preference of sexual act.

7.2.1 Abnormality of Preference for Sexual Object

This involves intercourse or achievement of sexual excitement with an object other than another adult. Such objects may be an inanimate, as in fetishism and transvestic fetishism, or may be a child (paedophilia) or an animal (zoophilia).

Fetishism refers to the practice of achieving sexual excitement with inanimate objects or parts of the human body that do not have direct sexual associations. It is not uncommon for men to be aroused by particular items of clothing, such as stockings or by part of the female body that does not have direct sexual associations. The condition is abnormal when the behaviour takes precedence over the usual patterns of sexual intercourse.

Transvestite fetishism varies from the occasional wearing of a few articles of clothing of the opposite sex, to complete cross-dressing. Cross-dressing usually begins about the time of puberty. The person usually starts by putting on only a few garments of the opposite sex as time goes on, he adds more. Eventually he may dress up entirely in clothes of the opposite sex. Tranvestic fetishists may experience sexual arousal when cross-dressing and the behaviour often terminates with masturbation.

Pedophilia: This is a repeated sexual activity (or fantasy of such activity) with pre-pubertal children and as a preferred or exclusive method of obtaining sexual excitement. It is almost exclusively a disorder of men. A pedophilic person usually chooses a child aged between six years and puberty. The child may be of opposite sex (heterosexual pedophilia).

Necrophilia: This is an extremely rare condition of sexual arousal and excitement obtained through sexual intercourse with a dead body. Occasionally, there have been reported legal trials of men who murdered and then attempted intercourse with their victims. Other abnormalities in the preference of sexual objects are zoophilia, otherwise called "bestiality" or bestiosexuality. This is a condition where animals are used exclusively in obtaining repeated sexual excitement.

7.2.2 Preference of Sexual Act

The second group of abnormality of sexual preference involves variations in the behaviour that is carried out to obtain sexual arousal. Generally, the acts are directed towards other adults, but sometimes children are involved. Included in this category are exhibitionism, sexual sadism,

sexual masochism, voyeurism. Others include frotteurism, coprophilia, coprophasia and urophilia.

Exhibitionism: is the repeated exposing of the genitals to unprepared strangers for the purpose of achieving sexual excitement but without any attempts at further sexual activity with the other person. The urge could be persistent or episodic. The act of exposure is usually preceded by a feeling of mounting tension. When in this state of tension, he characteristically seeks to evoke a strong emotional reaction from the other person, generally, surprise and shock.

Sexual Sadism: as a phrase, this term was first used by Marquis de sade (1774-1819). This is achieving sexual arousal, habitually and in preference to heterosexual intercourse, by inflicting pain on another person by bondage or by humiliation. Beating, whipping, and tying are common sadistic activities. Repeated acts may be with a partner who is a masochist or a prostitute who is paid to take part. Sadism may be a component of homosexual as well as heterosexual acts. Rare cases of sexual sadism towards animals have also been reported.

Sexual Masochism: This is an achievement of sexual excitement, as a preferred or exclusive practice, through the experience of suffering. The condition is named after Leopoid von Sacher-Maasoch (1836-1905), an Austrian novelist, who described sexual gratification from the experience of pain.

Voyeurism (peeping): This is a derivation of sexual excitement by observing sexual activities of others. Voyeurism is also known as Scopophilia or peeping. The voyeurs may also spy on women who are undressing or without clothes, for their sexual excitement. The voyeur does not attempt any sexual activity with the woman, but masturbation is always followed. Voyeurism is common among heterosexual men with inadequate heterosexual activities.

Frotteurism: This is refers to a form of sexual excitement by applying or rubbing the male genitalia against another person, usually a stranger and unknown participant in a crowded place, such as in a bus.

Coprophilia: This is sexual arousal induced by thinking about or watching the act of defecation.

***Coprophasia*:** This is sexual arousal induced following the eating of faeces.

Urophilia: This is sexual arousal obtained by watching the act of urination, or being urinated upon, or by self urination.

Study Session Summary

Summary

In this Study Session, we examined the psychological disturbances often associated with the sexuality and gender orientation of human beings. These included disorder or sexual dysfunction and abnormality of sexual preference.

Assessment

Assessment

SAQ 7.1

1. Explain the following terms: Paraphilia, Fetchism, Pedophilia, Necrophilia.

SAQ 7.2

1. Mention sexual practices that can be classified as paraphilia.

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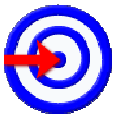
Study Session 8

Homosexuality

Introduction

This Study Session focuses on the practice of having sexual intercourse with members of the same sex. In males, these persons are referred to as homosexuals; in female, they are known as lesbians.



Learning Outcomes

At the end of this Study Session, you should be able to:

i. *discuss* the concept of homosexuality.
ii. *highlight* the determinants of homosexuality.

8.1 Features of Homosexuality

Homosexuality denotes erotic thoughts and feelings towards a person of the same sex, as well as any associated sexual behaviour. The expression of this behaviour varies with age and circumstances. It is more likely to be expressed when heterosexual behaviour is unavailable, for example in prisons. Same sex behaviour is common in both male and female. In male, it is homosexuality; in female it is known as lesbianism. Homosexuality in men involves physical intercourse, which includes oral genital contact, mutual masturbation, and less often anal intercourse. The partners usually change roles in these acts, but with some couples, one partner is always passive and the other is always active.

The relationship does not last and some homosexual men exclusively experience strong feelings of identity with other homosexuals and seek their company, most often in clubs or bars. Some adopt feminine mannerism and dress in women clothes to attract others. Most homosexual men have a way of life like that of single heterosexual men. However, few of them prefer work and leisure activities that would usually be undertaken by a woman. Most are contented as heterosexual men and have a stable relationship with their individual partners. Homosexual men vary in personality as much as heterosexual men. In homosexual men (as in heterosexual men), disorder of personality is more likely to lead to difficulty with other people or with the law and more likely to lead to referral to a psychiatrist or clinical psychology.

As regards same-sex women, tender feelings and social activities, are important source of satisfaction. Physical intercourse between them includes caressing, breast stimulation, mutual masturbation and oral-genital contact otherwise known as cunnilingus. A minority of them practice full body contact with genital friction or pressure known as tribadism. They may also engage in the use of a vibrator or artificial penis (dildo). Active and passive roles are usually exchanged although; one

partner may habitually take the active role. Social behaviour is usually like that of heterosexual women; although, some seek work and leisure activities, which are, more often that not, associated with men. A few of them dress and behave in a masculine way.

Most of them also engage in heterosexual relationships at some time; even though, they may obtain little satisfaction from them, and some may marry.

As a group, they are less promiscuous than homosexual men and are less likely to seek transient sexual relationships, in bars and other places. They are more likely to form lasting relationships and are less likely to suffer loneliness and depression in middle life. Many of them may have personality problems underlying their same-sex tendencies.

8.2 Determinants of Homosexuality

Genetic causes or abnormality of the sex chromosomes have been imputed as responsible for homosexuality or lesbianism. Also certain hormonal theories and neuro-anatomical differences have been imputed. As regards psychological causes, compared with heterosexuals, homosexual men and lesbian women have more often experienced a poor relationship with or prolonged absence of the father figure in the family. Other psychoanalysts have also reported that mothers of homosexual men are overprotective or unduly intimate. Some have also suggested that female lesbianism results from failure to resolve unduly close relationships, which the patients eyed in during early childhood, with the result that intimate involvement with men is frightening and women become the preferred object of love. In a study of homosexuals, Freedman, Kaplan, Sadock (1976) discovered that lesbian women reported a poor relationship with both mother and father. Also a quarter of the lesbian women have parents who are divorced, compared with 5% in control.

Heterosexual developments may be impeded by repressive family attitudes towards sex, by frightened early heterosexual experiences, or by lack of self-confidence with the opposite sex.

Social determinants of homosexuality vary in acceptance in different societies, and may be caused by lack of sexual outlet and sub cultural attitudes.

Study Session Summary

Summary

In this Study Session, we discussed the problems of sexuality and gender identity. Specifically, we examined the problem of homosexuality among men and lesbianism among women. We also highlighted certain determinants of homosexuality in men and lesbianism in women.

Assessment

Assessment

SAQ 8.1

1. Under what circumstances is homosexuality likely to occur.
2. What are peculiar characteristics of homosexual men and women?

SAQ 8.2

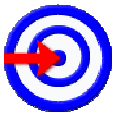
1. Discuss the theories that have been developed to explain homosexuality?

Study Session 9

Personality Disorders

Introduction

This Study Session focuses on the examination of some characteristics of individuals that, if placed outside the broad limits of socially approved norms, may be referred to as personality disorders.



Learning Outcomes

At the end of this Study Session, you should be able to:

i. *define* personality.
ii. *discuss* the characteristics of personality as well as personality disorders.

Personality is the emotional, behavioural, intellectual, and physical characteristics of an individual. When behaviours resulting from a particular personality traits or attributes, assume proportions which place them outside the broad limits of socially approved norms, one can begin to think about personality disorders. This is opposed to personality characteristics, which are evident in every human being.

9.1 Types of Personality Disorders

Common personality disorders include paranoid personality disorder, affective personality disorder, schizoid personality disorder, explosive personality disorder, anankastic personality disorder, hysterical personality disorder, asthenic personality disorder and personality disorders with predominantly tendencies.

9.1.1 Paranoid Personality Disorder

This is a personality disorder in which there is excessive sensitiveness to setbacks or what is taken to be humiliations and rebuffs. It is a tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous and a combative and tenacious sense of personal rights. There may be proneness to jealousy or excessive self-importance. Such persons may feel helplessly humiliated. Self-reference is another important characteristic of paranoid personality disorder. Self-reference refers to the overwhelming tendency in the paranoid personality to see everything in his or her surroundings, as referring or relating to himself or herself.

9.1.2 Affective Personality Disorder

These are personalities which are characterised by a lifelong predominance of a pronounced mood which may be persistently depressive, persistently elated, or alternatively more than the other.

During periods of elation, there is an unshakable optimism and enhanced activities of life. Periods of depression are marked by worry, pessimism, output of energy and sense of futility.

9.1.3 Schizoid Personality Disorder

This is a personality disorder in which there is withdrawal from affections, social and other contacts, with autistic preference for fantasy and introspective reserve. Behaviour may be slightly eccentric or indicative of avoidance of competitive situations. Apparent coolness and detachment may mask incapacity to express feeling.

9.1.4 Explosive Personality Disorder

This disorder is characterised by instability of mood with liability to intemperate outbursts of anger, hate, violence or affection. Aggression may be expressed in words or in physical violence. The outbursts cannot be readily controlled by the affected persons, who otherwise may not be prone to anti-social behaviour.

9.1.5 Anankastic Personality Disorder

This is a personality disorder in individuals, who experience feelings of personal insecurity, doubt and incompleteness, leading to excessive conscientiousness, checking, stubbornness and caution. There may be insistent and unwelcome thoughts or impulses, which do not attain the severity of an obsessional neurosis. There is perfectionism and meticulous accuracy and a need to check repeatedly in an attempt to ensure this. Rigidity and excessive doubt may be conspicuous.

9.1.6 Hysterical Personality Disorder

This personality disorder is characterised by shallow, labile affectivity, dependence on others, craving for appreciation and attention, suggestibility and theatricality. There is often sexual immaturity, e.g. frigidity and over-responsiveness to stimuli. Under stress, hysterical symptoms of neurosis may develop.

9.1.7 Asthenic Personality Disorder

The asthenic personality disorder is characterised by passive compliance with the wishes of elders and others and a weak, inadequate response to the demands of daily life. Lack of vigour may show itself in the intellectual or emotional spheres; there is little capacity for enjoyment.

9.1.8 Personality Disorders with Predominantly Sociopathic Tendencies

This appellation is given to personality disorder characterised by disregard for social obligations, lack of feeling for others, and impetuous violence or callous acts. Behaviour is not readily modifiable by experience, including punishment. People with this personality are often affectively cold and may be abnormally aggressive or irresponsive. Their tolerance to frustration is low. Furthermore, they blame others or offer

plausible rationalisations for the behaviour which brings them into conflict with society.

Study Session Summary

Summary

In this Study Session, we examined various personality disorders, which affect men negatively in society.

Assessment

Assessment

SAQ 9.1

1. Give a working definition of the term Personality.
2. Explain personality characteristics and personality disorders in humans.

SAQ 9.2

1. List and explain the different forms of personality disorder.
2. Distinguish between hysterical personality disorder and asthenic personality disorders.

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Feedbacks to Self Assessment Questions (SAQs)

SAQ 1.1

1. The four criteria that are used to define abnormal behaviour include the following: defective cognitive functioning, which includes impaired mental and intellectual abilities; defective social behaviour which means abnormality as a function of the interaction of an individual with the environment; defective self-control which refers to lack of control over one's behaviour; and distress, that means breaking of the natural coping systems against stress.
2. Abnormality varies from society to society depending on the standards and normative values they have.

SAQ 1.2

1. Using sexual orientation as an example, we can examine the different dimensions to abnormality.
   → First objectively, it may be based on an underlying physical illness. This is a qualitative dimension which tries to identify specific abnormality defined by exclusion.
   → Secondly, statistical dimension to it would examine a particular sexual orientation as a quantitative concept which assumes the behaviour of different individuals varies by imperceptible degrees.
   → Thirdly, there is the element of social maladjustment which examines it as a interaction with the environment.
   → Fourthly, subjective unhappiness identifies it as a subjective feeling of individuals rather than social norms.

SAQ 2.1

1. There are a number of ways to define the cause:
   i. Psychodynamic model: Homicide may be a result of anxiety produced by forces or conflicts a person is not aware of.
   ii. Humanistic/ Existential model: In this regard, homicide may be a result of the compelling force of inner psychic forces.
   iii. Social learning model: This means homicide may be the result of faulty or ineffective learning and conditioning patterns.
   iv. Socio-cultural model: Homicide may be a function of general way of life in a society, that is, it is a consequence

of certain societal features such as urbanization, poverty and unemployment.

v. Cognitive model: Homicide is a result of maladjusted thought process and faulty interpretation of situational cases.

vi. Eclectic model: This model assumes homicide is a result of a multiplicity of causes.

SAQ 2.2

1. The assessment process would include identification and clarification, systematic analysis using assessment techniques, diagnostic classification, recommendation of appropriate interaction, follow-up treatment.

SAQ 3.1

1. Somatogenic theory of psychopathology assumes that mental illnesses are due to physical malfunction. On the other hand, psychogenic theories assume that mental difficulties are explainable in psychological terms.

SAQ 4.1

1. Symptoms associated with neuroses include agitation, excessive sweating, hyperventilation, dilation of the pupils, hopelessness, helplessness, insomnia, loss of appetite, loss of libido, de-realization and de-personalisation.
2. Degree of anxiety is what differentiates a neurotic person from a normal person.
3. Obsessions are defined as recurrent persistent thoughts, ideas, images, or impulses, which are perceived as inappropriate or silly by the individual. Compulsions are motor acts, which are resisted but carried out despite being regarded as senseless.

SAQ 4.2

1. Phobic anxiety is anxiety accompanied by a wish to avoid the feared situation or objects or when the situation is actually avoided. Hallmarks are extreme anxiety and an avoidance of the feared phenomenon.
2. The DSM IV describes generalised anxiety disorder as panic attack, panic disorder or panic state.
3. Common symptoms of anxiety include a feeling of inner tension and anxious expectation and they may appear in bodily or somatic symptoms.
4. The different forms of neurotic disorders include hysteria, Traumatic neurotic disorder, Compensation neurotic disorder, neurasthenia, hypochondria are the examples.
5. They all affect specific bodily functions from voluntary actions with conversion hysteria to memory with amnesia hysteria.

SAQ 5.1

1. Psychoses are a group of major mental disorders. The major characteristics of these illnesses are lose of contact with reality, inappropriate behaviour, inappropriate affect or mood delusions and hallucinations and illusions.
2. Delusions are unshakeable false beliefs, inconsistent with reality, held in spite of evidence to the contrary. Hallucinations are the disorder of perception with respect to the sense organs. Illusions are perceptions of a physical stimulus that differs from the commonly expected stimulus.

SAQ 5.2

1. Bleuler conceptualised schizophrenia as a disorder whose primary feature was an alteration of the faculty of association.

SAQ 5.3

1. The known symptoms of schizophrenia are faulty perceptual skill, disorganised thinking, emotional distortions, withdrawal from reality, and bizarre behaviour.

SAQ 5.4

1. The different sub-groups are Schizophreniform disorder, paranoid schizophrenia, catatonic schizophrenia, disorganised schizophrenia, reactive schizophrenia. Explain each one describing the main signs and symptoms of each

SAQ 6.1

1. Depression is a morbid state of low mood and sadness. Hypomania, on the other hand, is a state of excitement and high elation.
2. Bipolar affective disorder is characterised by a manifestation of both depression and mania at different times in a person.
3. General symptoms include low moods, sadness and discouragement. Psychological symptoms include lack of enjoyment, diminished concentration or indecisiveness, pessimistic thinking, guilt or self-blame, negative self-reproach or self-concept, and reduced libido. The physical symptoms include reduced energy, constipation, memory impairment, psychomotor, agitation or retardation, loss of appetite among others.

SAQ 6.2

1. Primary depression are not preceded by any other psychological depression. On the other hand, secondary depression applies to all cases with a history of previous non-affective psychiatric illness or of alcoholism, medical illnesses, or the taking of certain drugs.
2. A reactive depression occurs in response to psychological, social or physical environmental incidents such as loss of a loved family member or friend. Endogenous depressions are those without any apparent and major precipitating environmental factors.

SAQ 6.3

1. Symptoms of mania include but are is not limited to extreme elation, excitement, socially disinhibitive behaviour and violence.

SAQ 6.4

1. The characteristic features of schizo-affective disorder include hallucinations and delusions.

SAQ 6.5

1. The basic symptoms of organic psychosis are impaired orientation, memory losses, especially, retrogressive amnesia that is loss of memory preceding an accident or illness, intellectual deterioration, such as difficulty in planning, reasoning, and communication, blunted or exceedingly unstable emotional responses.
2. The forms of organic mental disorders are acute brain syndrome characterised by confessional states and delirium; Chronic Brain Syndrome of deficits in intellectual capabilities; and delirium tremens which is special form of delirium in alcoholics.
3. A number of factors could lead to organic mental disorders. This includes psychosis after head injuries, psychosis associated with nutritional deficiencies, senile dementia, pre-senile dementia, tumours, psychosis from progressive neurological illness, psychosis associated with severe medical illness.

SAQ 7.1

1. Fetchism, Pedophilia, Necrophilia are forms of paraphilia and are all characterised by an abnormal sexual orientation towards objects, underage humans and dead bodies respectively
2. Forms of paraphilia include urophilia, voyeurism, and sexual masochism.

SAQ 8.1

1. Homosexuality is likely to occur when heterosexual relationships are unavailable.
2. Besides having sexual feelings towards people of the same sex male and female homosexual partners behave uniquely.

SAQ 8.2

1. There have been theories that it may be a genetic factor; others have claimed it is merely a consequence of family upbringing. This social argument looks at the relationship homosexuals had while growing up.

SAQ 9.1

1. Personality is the emotional, behavioural, intellectual, and physical characteristics of an individual.
2. Personality characteristics are present in every human being. Personality disorders, on the other hand, are traits that assume proportions, which place them outside the broad limits of socially, approved norms.

SAQ 9.2

1. Personality disorders include paranoid personality disorder, affective personality disorder, schizoid personality disorder, explosive personality disorder, anankastic personality disorder, hysterical personality disorder, asthenic personality disorder and personality disorders with predominantly tendencies. In explaining them show how each form is peculiar in their own right.
2. Hysterical personality disorder is associated with a high degree of shallowness and immaturity. Meanwhile, aesthenic personality disorder is characterised by lack of vigour in intellectual and emotional capacities.

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