# UNIT 2 CONCEPTS OF NORMAL AND ABNORMAL BEHAVIOUR AND CLASSIFICATION OF MENTAL ILLNESS

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## 2.0 OBJECTIVES

After going through this unit, you should be able to:

- define behaviour, normalcy and abnormalcy;
- list the characteristics of mentally healthy individual;
- discuss the misconcepts about mental illness;
- discuss the conceptual models of abnormal behaviour;
- describe the causative factors of mental disorders;
- state the types of classification of mental disorders; and
- describe the salient features of each.

## 2.1 INTRODUCTION

Behaviour is defined as everything that an organism does from the day of conception till death. Everything includes knowing (cognition), feeling (affection) and doing (cognition). Knowing consists of thinking, recalling, recognition, judgment, and so forth. These processes are considered to be aspects of primary mental functions, which help the organism to become aware of, and understand the self and environment. Feeling consists of emotional component of an individual. It includes happiness, sorrowfulness, fear, and anger, etc. These emotions arise in accordance with the 'knowing' part of the individual.

Doing, consists of psychomotor activities of an organism. An individual exercises his/her energy to perform the activities with different degrees based upon the knowing and feeling components.

From this we understand that, when an organism acts, all the above three components function in a unified and coordinated manner, and that is considered to be normal. If any disturbances occur, either in knowing, feeling or doing, or in combination, the individual is said to be behaving abnormally.

In this text you will also learn about the concept of normal and abnormal behaviour through various conceptual models. Characteristics of mentally healthy individual and misconcepts about mental illness will also be discussed. Abnormal behaviour can be due to organic, psychosocial and socio-cultural causes. Based on the causes, the prognosis and symptoms of diseases, the classification of mental disease is done which you will read in this unit.

## 2.2 CONCEPTS OF NORMAL AND ABNORMAL BEHAVIOUR

The word 'abnormal' means literally means 'away from the normal'. It implies deviation from some clearly defined 'norm' or 'standard'. Therefore, acceptable definitions of abnormal rest on an adequate definition of 'normal'. The term 'normal' itself is derived from the Latin word *'norma',* which refers to a carpenter's square or rule.

It is not easy to define the concepts of 'normal' and 'abnormal'. It is possible to define concepts in hard sciences, like physics or chemistry in precise terms, e.g. when a patient has the temperature of 30° Celsius, you will call it normal, and wide deviations, such as 35°C or 40°C, you will consider abnormal, needing immediate medical attention. Such standard measurement is universal. There are no universal standard measurement of behaviour. These concepts are influenced by socio-cultural factors. For instance, in Indian hospitals it is common to see most people beating their chests and weeping on the death of an important member of their family. This behaviour is considered normal by us, but the same behaviour is considered abnormal by the Americans.

A sharp dividing line does not simply exist between normal and abnormal. There are not normal people on one hand and abnormal on the other. Most people are moderately well adjusted, with minor maladaptive pattern; a few at one extreme enter mental hospitals or clinics and a few at the other extreme lead unusually satisfying and effective lives.

There are several dimensions related to distinguish the concepts of abnormal from normal. Let us first discuss who is a normal person or what are the characteristics of mentally healthy person.

Mental health is the ability to cope with the recurrent stress of living and to achieve a relatively effective adjustment. The American Psychiatric Association (APA) defines mental health as simultaneous success at working, living and creating with the capacity for mature and flexible resolution of conflicts between instincts, conscience, significant other people and reality. The mental health of an individual may be an outcome of the influence of his emotional, social and psychological strengths, the events s/he has experienced throughout her/his life the pressures s/he is currently undergoing and the expectations that society has established for her/him.

If a person is unsuccessful in dealing with environmental stresses because of faulty inherited characteristics, poor nurturing during childhood or negative life circumstances, mental illness may develop. The American Psychiatric Association defines mental illness as an illness with psychological or behavioural manifestations and/or impairment in functioning due to a social, psychological, genetic, physical/chemical or biological disturbance.

**Check Your Progress 1**

1) Define behaviour.

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2) How are the terms 'normal' and 'abnormal' behaviour different from each other?

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## 2.3 CHARACTERISTICS OF MENTALLY HEALTHY INDIVIDUAL

The WHO definition emphasizes the positive state of well being and does not focus on the lack of illness, disease or disorder. Mental health is an important component of health. In the state of emotional well being a mental health, the person functions comfortably within his society and is satisfied with himself and his achievements. Mental health implies mastery in areas of life involving love, work and play. The characteristics of mentally healthy individual are as below:

i) Mentally healthy person feels comfortable about himself:

— S/he feels reasonably secure and adequate.

— Knows and accepts his/her strengths and weaknesses.

— S/he has self respect.

— S/he has personal identity. S/he knows who S/he is, to which group S/he belongs and feels as part of the group.

ii) Mentally healthy person feels right towards others:

— A mentally healthy person respects others.

— S/he is interested in others and is able to love others.

— S/he has friendship that is satisfying and lasting.

— S/he feels part of the group.

— S/he is able to trust others.

— Develops ability to give and take.

— Takes responsibility for his neighbours and fellow men.

iii) Mentally healthy person is able to meet demands of life:

— A mentally healthy person is able to solve his/her problems.

— S/he is able to cope or adjust with a crises of stressful situation.

— S/he is able to think for herself/himself and takes her/his own decisions.

— S/he sets reasonable goals to herself/himself.

— S/he shoulders her/his responsibility.

— S/he is not taken over by her/his own emotions of fear, anger, love and guilt.

Mentally healthy persons are described as those who have:

— Self-awareness

— Knowledge of their strengths and weakness

— Self respect and respect for others

— Satisfying relationship with others

— Ability to give and receive

— Behaviour i.e. generally acceptable

— Ability to cope up with stress

(*Source*: Kapoor, Bimla, *Text Book of Psychiatric Nursing*, Vol. I, 2nd ed., 2001).

There are many misconcepts about mental illness still exist in the society. Lets see which are the common misconcepts about mental illness.

## 2.4 MISCONCEPTS ABOUT MENTAL ILLNESS

You have learnt in Unit 1 that belief about mental disorders have been generally characterized by superstitions, ignorance and fear. Scientific understanding of abnormal behaviour has described many false belief, but in our society a number of popular misconceptions about mental illness still exists. The common misconceptions about mental illness described by Bimla Kapoor (2001), are:

i) *Misconceptions that normal people will never be abnormal:* It is very difficult to say that all the time a person is healthy. The term abnormal covers a wide range of behaviours. A normal person also may exhibit abnormal behaviour during certain stressful situations. For example at the time of natural calamities like earthquake normal people may exhibit abnormal behaviour like panic attacks, depression etc. normal persons can develop mental illness at any time of their life.

ii) *Misconception that mentallv ill person's behaviour is bizarre.*
Bizzare behaviour is when mentally ill patient shows behaviour like laughing without any reason, crying, getting violent. There will be very few patients who may show this kind of behaviour.

iii) *Misconception that patient admitted to mental hospital are more dangerous than those admitted to general hospitals for other physical illness*

iv) *Misconception that mental health is not related to physically health*

v) *Misconception that mental illness prevalence is low in India*

vi) *Misconception that mental illness once acquired is lifelong*

vii) *Misconception that mentally ill should only be treated in asylums*

viii) *Misconception that mental illness is something to be ashamed of*

(*Source*: Bimla Kapoor, *Text Book of Psychiatric Nursing,* Vol. I, 2nd ed., 2001).

## 2.5 MODELS OF NORMALCY AND ABNORMALCY

Models follow a strategy of successive findings and can be readily modified and flexible to accommodate new evidence. You can very well justify the behaviour by learning the following models. They are:

- Medical model
- Psychoanalytic model
- Socio-cultural model
- Statistical model

### 2.5.1 Medical Model

This model considers organic pathology to be definite cause of the mental disorder. All persons suffering from mental disorder are considered to be abnormal, unhealthy and ineffective. This concept of mental illness is called the organic view of point or medical model. Abnormal people are the ones who have disturbances in thought, perception and psychomotor activities. The normal are free from these disturbances. The medical model has been very useful in simplifying treatment practices and in contributing to improved methods of controlling diseases, both physical and mental. Pathological symptoms vary in degree from individual to individual. Hence, at what degree he or she is to be judged as abnormal is not explained in this model.

### 2.5.2 Psycho-analytical Model

The first systematic step toward understanding psychological factors in mental disorders were contributed by Sigmud Freud. The major principles of his model were derived from the clinical study of individual neurotic patients.

The general principles and subsystem of the model are as follows:

a) **Id, Ego and Super ego:** Basically the individual's behaviour results from the interaction of three key subsystems within the personality i.e. the Id, ego and super ego.

**The Id**: The *Id* is the source of instinctual drives, which are of two types:

i) ***Constructive drives:*** Primarily of a sexual nature, which constitutes a basic energy of life called *Libido.*

ii) ***Destructive drives:*** Which tend toward aggression, destruction and eventual death.

Freud used the term "sex" in a broad sense to refer to almost anything pleasurable from eating to creativity.

The *Id* is completely selfish with the immediate gratification of instinctual needs without reference to reality or moral consideration. Hence, it operates in terms of the pleasurable principle. While the *Id* can generate mental images and wish fulfilling fantasies, called **primary thinking process;** it cannot take the action needed to meet instinctual demands.

**The Ego:** It mediates between the demands of the ld and the realities of the external world for the survival of the individual. Ego's such adaptive measures are called **secondary thinking process** thus **ego** operates in terms **of the reality principle.**

**The Super ego:** The **Super ego** is same as "conscience" comes into being by learning the taboos and moral values of society. It is concerned with right and wrong. It is an inner control system coming into operation to cope with the uninhibited desires of the *Id.*

These intrapsychic subsystem of Id, ego and super ego is important in determining behaviour. Inner conflicts arise because each subsystem sets different goals. Neuroses and other mental disorders result when the individual is unable to resolve these conflicts.

There has been much criticism about psychoanalytic model. But it is a fact that Freud greatly advanced our understanding of both normal and abnormal behaviour.

### 2.5.3 Socio-cultural Model

In addition to the biological and psychosocial factors as conducive to abnormal behaviour, socio-cultural factors are also considered important causative factors. Problems of war and violence, group prejudice and discrimination, economic and employment issue, effects at rapid social change, and existential anxiety are the important conditions that put stress, directly or indirectly, on most of the people. Some people are able to core up win it, others may get so much stress that they express symptom of mental sickness.

### 2.5.4 Statistical Model

It involves the analysis either of responses on a test or questionnaire or observation on some particular behavioural variable or variables. The degree of deviation from the standard norms, arrived at statistically, characterizes the degree of abnormality. For example, in the case of intelligence, where the I.Q. of 100 is considered as normal, interpreting the measure at the two ends of the normal distribution curve becomes difficult. For instance according to this model an I.Q. of 150, what is above average, becomes an index of abnormality when the statistical criterion is applied to it.

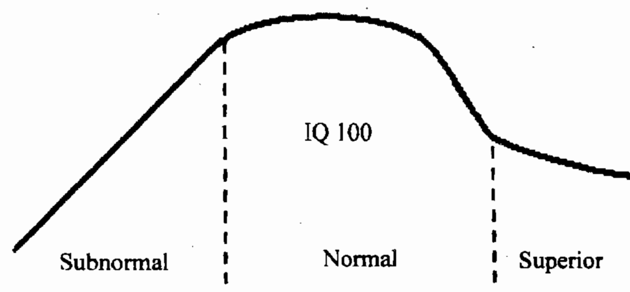


**Fig. 2.1: Normal I.Q. Distribution Curve**

Low I.Q. may be proper subject for study of abnormal psychology, but can the opposite, high I.Qs be considered as abnormal? Similarly majority of population has behaviour which lies towards the middle of normal distribution graph. There are very few percentage of people who have behaviours in extreme. Hence, this model also has a drawback that, when the statistical model is adopted, the

question of establishing a point beyond which behaviour is regarded as abnormal must be considered. Therefore, although providing a partial description of abnormality, the statistical model must be considered rather inadequate.



From these discussions, it is indicated that every individual behaves in a given situation based upon her/his physical competencies and the type of learning s/he has from society. As long as the individual adjusts well within ourself and with others in society, s/he may be called as normal or mentally healthy.

## 2.6 CAUSATIVE FACTORS OF MENTAL DISORDERS

The term aetiology is used for the study of the causation of abnormal behaviour. It ranges from purely genetic to environmental. For some disorders, both heredity and environment have equal roles. However, the causes of abnormal behaviour are brought under these three categories:

- Organic or biological factors
- Psychosocial factors
- Socio-cultural factors

### 2.6.1 Organic or Biological Factors

Biological factors influence our behaviour e.g. intellectual abilities, basic temperament and stress tolerance etc. to consider what causes mental illness in particular are genetic defects, constitutional liabilities, physical deprivations, disruptive emotional process and brain pathology.

i) **Genetic Defects**

The three defects under these are:

a) ***Chromosomal aberration:*** The example of this is Down's syndrome – a type of mental retardation due to presence of an extra chromosome, involving a trisomy of one autosomal pair.

b) ***Faulty genes:*** The example of this is gene mutation due to ionizing radiation and certain drugs and chemicals, which are known to cause gene damage e.g. among the children of survivors of the nuclear bombings at Hiroshima and Nagasaki higher incidence of mental retardation was found.

c) ***Genetic predisposition to specific mental disorders:*** For example the incidence of schizophrenia is much higher among all degree of blood relationship to the schizophrenia than in the general population, with an increasing degree of blood relationship e.g. 7.1% in half-siblings of schizophrenia to 86.2% in identical twins.

ii) **Constitutional Liabilities**

The term constitution includes both genetic and environmental influences e.g. physique.

a) ***Physique:*** Sheldon and his associates (1954) concluded that there are three types of body built-up, each associated with particular tempera-mental and other personality characteristics. This is given in the table below:

**Table 2.1: Describing Physique, Treatment and Psychopathology**

| | Endomorphic | Mesomorphic | Ectomorphic |
|---|---|---|---|
| Physique | Soft, round | Strong, muscular athletic | Slender, fragile |
| Temperament | Comfort-loving sentimental, pleasure seeking, socializing | Active, energetic less religious, more achievement, oriented aggressive | Senstive, dedicate, intellectual, more religious, withdrawing |
| Most likely psychopathology | Severe mood alterations involving extreme elations or depression (particularly the later) | Delinquency, criminal behaviour mood alternations involving extreme elation or depression. | Schizophrenia, anxiety neurosis, peptic ulcers. |

b) ***Chronic physical illness:*** Persons suffering from any chromic physical illness like cancer, leprosy, AIDS and incapacitating physical injuries such as spinal cord injuries etc. may cause difficulties in adjustment. Long term suffering may become a causative factor for mental illness or psychological disturbances.

iii) **Physical Deprivations**

It includes (a) malnutrition, and (b) sleep deprivation and fatigue.

a) ***Malnutrition:*** Severe malnutrition during infancy not only impairs physical development but also stunts brain growth and results in lowered intelligence. Robinson and Winnik (1973) have reported high incidence of psychoses and other mental disturbances among individuals who were on "crash diet" involving semi starvation and rapid weight loss.

b) ***Sleep deprivation and fatigue:*** Sleep deprivation over a sustained period of time can cause symptoms of mental disorders. Sleep disturbances are common in schizophrenia, anxiety states and other mental illnesses. Two out of three hospitalized mental patients do suffer severe sleep disturbance before being hospitalized.

When we do not take adequate rest, various nutrients and good sleep we get physically and mentally fatigued and become vulnerable to stress.

iv) **Brain Dysfunction and Neural Plasticity**

Significant damage of brain tissue causes psychopathology. It is common the elderly, mostly because of again process itself e.g. Alzheimer's disease.

## 2.6.2 Psycho-social Factors

We are born with few built in patterns and a great capacity to learn from experiences. Some good experiences in childhood prepare us to face the stress in future. Some bad experiences make us vulnerable to psychological disorders. There are four categories of psychological causal factors. These are (i) early deprivation or trauma (ii) inadequate parenting styles (iii) marital discord and divorce structures (iv) maladaptive peer relationships. Such factors interact with each other and do not operate alone. Now we will see one by one.

i) **Early Deprivation or Trauma**

When child is deprived of food, shelter, love and attention it may leave him/ her with deep and sometimes irreversible psychic scars.

Parental deprivation can occur in several forms e.g. parents due to mental illness or unwilling to provide close human contact. Further specific causes of early deprivation are:

a) ***Institutionalization:*** When children are raised in an institution as compared with ordinary home, there is less warmth, physical contact, less intellectual, emotional and social stimulation. If they experience these in infancy and early childhood they show maladaptive personality development.

b) ***Deprivation and Abuse in the Home:*** Deprivation does not mean separation from parents only but children may suffer from inadequate care at home i.e. parents give little time and attention to children or are rejecting. Parental rejection may be by physical neglect, denial of love and affection, lack of interest in the child's activities and achievements, failure to spend time with the child, lack of respect for the children's rights and feelings. In some cases it involves cruel and abusive treatment. These children develop behavioural problems. Children who are abused may become overly aggressive. They also have difficulty in interpersonal relationship.

c) ***Other Childhood Traumas***: The 'psychic trauma' is described as any unpleasant experience that has harmful psychological effects on an individual that causes insecurity and inadequacy e.g. suddenly 11 years old boy came to know from his step brother that he is not real member of this family, he is an adopted child. His parents are not real ones and they do not actually love him.

### ii) Inadequate Parenting Styles

The behaviour of each person affects the behaviour of the other, thus influence of a parent on his or her child is likely to be more important in shaping a child's behaviour. This is explained as below:

a) ***Parental Psychopathology:*** It is seen that parents who have various forms of psychopathology e.g. schizophrenia, depression antisocial personality disorder and alcoholism, their children are at more risk for developmental difficulties. Children of alcoholics have increased rates of truancy and substance abuse and dropping out of school. If the child has another adult in the family who has a warm and maturing relationship, even if the parents has serious psychopathology, that child grows normal and have good intellectual, social and academic competence.

b) ***Parenting Style:*** Warmth and control – four types of parenting styles have been identified as Authoritative parenting – Authoritarian parenting style is high on control but low on warmth and their children tend to be conflicted, irritable and moody. In permissive-indulgent parenting the parents are high on warmth but low on discipline and control, which leads to impulsive and aggressive behaviour in children. In neglectful-uninvolved parenting, parents are low both on warmth and on control. This style causes disruptions in attachment during childhood and with moodiness, low self-esteem and conduct problems later in childhood. Parents sometimes discourage a child from asking questions or fail to give information which helps the child to develop essential competencies. Children are often exposed to high levels of anger and conflict. The causes of anger can be marital discord;abuse or parental psychopathology and these are associate with psychological problem in children.

### iii) Marital Discord and Divorce

a) ***Marital Discord:*** It means one or both the parents is not gaining

satisfaction from the relationship. One spouse may express feelings of frustration and disillusionment in hostile ways such as nagging, criticizing and doing things purposely to annoy the other person seriously discordant relationships for longtime effects their children. They find it difficult to establish and maintain and other intimate relationships.

b) ***Divorced Families:*** Family may be incomplete due to death, divorce, separation or some other circumstances. In U.S. about 20 per cent of children under the age of 18 are living in a single parent household. Divorce can have traumatic effects on children feelings of insecurity and rejection they may develop. Delinquency and other psychological problems are more among children and adolescents.

### 2.6.3 Socio-cultural Factors

In the same way as genetic inheritance, a socio-cultural inheritance shapes up our behaviour. Pathogenic societal influences may be the cause of mental disorders.

These are as follows:

i) **Low Socio-economic Status and Unemployment**

It is seen that the lower the socio-economic class, the higher the incidence of abnormal behaviour. Even there is a strong relationship between the poverty status of parents and lower IQs in children. Other problems associated with poverty are poor physical health, less cognitive stimulation in the home environment.

Studies have also shown relationship of unemployment with high rates of abnormal behaviour, demoralization and emotional disturbances. Unemployment adversely affects mental and physical health. In particular, rates of depression, marital problems and somatic complaints increase during periods of unemployment.

ii) **Conflicting Social Roles**

These can happen in an organized society. For example in war soldiers are asked by their superiors to kill the other human beings and they may subsequently develop serious feelings of guilt as their roles are in conflict with societal and their own personal values (according to which killing or hurting someone is a sin).

iii) **Prejudice and Discrimination in Race, Gender and Culture**

People are globally subjected to demoralizing stereotypes and overt discrimination according to their race, gender and culture in employment, education and housing. Prejudice against minority groups leads to increased prevalence of certain mental disorders. There is a difference in men and women roles as women must cope with a wide variety of roles assigned to them such as mothers, homemakers and employees. They suffer from various emotional disorders more than men for example depression and anxiety.

iv) **Social Change and Uncertainty**

We are in a fast changing world. All aspects of our lives are affected – education, jobs, families, leisure time, finances, beliefs and values. Constant adjustment to change causes stress. Thus despair, demoralization and sense of helplessness are abnormal reactions to stressful events.

**Activity 1**

Visit a nearby psychiatric hospital or psychiatric ward of your own hospital and make notes on causes of mental illness.

**Check Your Progress 2**

1) Write three factors leading to abnormal behaviour and give examples.

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2) Write short notes on:

a) Medical model

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b) Statistical model

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c) Socio-cultural model

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d) Psycho-analytical model

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## 2.7 CLASSIFICATION OF MENTAL ILLNESS

The first systematic classification of mental disease was made by Kraepelin in the later part of the nineteenth century.

At present we have three types of classification.

### 2.7.1 International Classification of Disease

With the expansion of psychiatric services all over the world, the need for an international classification of diseases (ICD) was felt. The World Health Organization (WHO) brought out, in 1965, the ICD-8, but it was not very comprehensive. Then in 1979, WHO brought out another classification ICD-9. The tenth revision of the international classification of diseases and related health problems (ICD-10) was released developed by WHO in 1992.

### 2.7.2 Diagnostic and Statistical Manual

The American Psychiatric Association (APA) brought out its revised diagnostic and statistical manual II, (DSMII) in 1968. Attempts at further revision of this classification have resulted in the emergence of DSM III and DSM III R, DSM IV and DSM IV (TR).

### 2.7.3 Indian Classification

In India, Vahia (1961), Neki (1963), Wig and Singer (1967) and Verma (1971) have attempted some modifications of ICD-8 to suit Indian conditions. They are broadly grouped into:

i) Neurosis

ii) Psychosis

iii) Special disorders like:

   a) Childhood disorders

   b) Personality disorders

   c) Substance use disorders

   d) Somatoform disorders

   e) Mental retardation

Although, as per the latest classification systems of ICD and DSM, the term 'psychosis' and 'neurosis' have been deleated, we will discuss them briefly to develop an understanding about the difference between Neurosis and Psychosis.

**Psychosis**

It is a severe type of mental illness, in which the patient talks and behaves very abnormally. There is a loss of reality testing and impairment of ego functioning manifested by delusions, hallucinations, confusion and impaired memory. They also have social withdrawal and inability to perform the usual household and occupational roles. He is not aware of his illness, and can refuse to take treatment. Psychosis can be further divided into:

The differences between psychosis and neurosis are as given below:

| Psychosis | Neurosis |
|---|---|
| 1. Socially speaking psychosis is a severe personality disorder, preventing or seriously interfering with the patient's relationships with other persons and groups. Vocational, social and sexual adjustments are markedly affected. | 1. Neurosis is less severe disorder of the personality. Social, vocational and sexual adjustments are often impaired but not as a rule. |
| 2. Etiologically speaking psychosis may be brought on by organic (including toxic) or by psychological factors or by a combination of the two. | 2. Neurosis is brought on by psychological factors. There are various stressors which cause psychoneurotic changes in an individual. |
| 3. Descriptively speaking psychosis involves severe disorganization of the various personally functions, perception, memory, judgement etc. The patient is usually not aware of the fact (do not have insight) that they have a personality disorder. | 3. Neurosis involves decreased efficiency, but much less disorganization of personality functions. The neurotics are usually aware (have insight) that they have a personality disorder. |
| 4. Clinically speaking the psychotics usually have one or more of such symptoms as delusions, hallucinations and illusions. | 4. The neurotics do not have delusions and hallucinations, illusions are quite infrequent. Symptoms include such varieties as convulsions, obsessions, compulsion and phobias. |
| 5. Therapeutically speaking the psychotics usually require hospitalization. | 5. The neurotics usually do not require hospitalization. |
| 6. Psychodynamically speaking there is a serious impairment of ego functions in psychosis. Reality testing is impaired. Previously suppressed and repressed conflicts between id and ego and between ego and environment are mobilized. | 6. There is partial impairment of ego strength in neurosis. The neurotic attempts to deal with conflicts by suppression and repression. |

i) ***Functional Psychosis***

It includes:

a) *Schizophrenia:* The onset ages are 15-25 years for men and 25-35 years for women. Symptoms include delusions, hallucinations, disorganized speech, emotional blunting and autism (preoccupation with inner fantasies).

b) *Affective Psychosis:* This includes disorders such as Manic-depressive psychosis and involution melancholia. Manic-depressive reaction is manifested by mood swings, elation and over activity or depression and under activity or a combination or alteration of these and poorly systematized delusions and hallucinations. Involution melancholia includes depression with agitation, hopelessness and guilt.

ii) ***Organic Psychosis***

These disorders are also called organic brain disorders. They may be

classified as acute brain disorders and chronic brain disorders. Acute brain disorders (delirium) are caused by diffuse impairment of brain function, which result from a variety of conditions, such as, drug intoxication, nutritional deficiencies and mild head injury etc.

Chronic Brain Disorders (dementias) involve permanent destruction of brain tissue as a result of brain injury, degenerative disease of the central nervous system (such as, senile dementia, Parkinson's disease etc), intra-cranial space occupying lesions, drug intoxication etc.

**Check Your Progress 3**

List any three psychotic disorders.

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### Neurosis

It is usually a mild type of mental illness wherein the patient shows either excessive or prolonged emotional reaction to any stress. He has symptoms like anxiety, fear, sadness, vague aches and pains, and other bodily symptoms. He is aware of his problems, and seeks professional help. Some of the common forms of neurosis are:

i) ***Anxiety Disorder***

It's a diffuse, unpleasant, vague sense of apprehension often accompanied by autonomic symptoms such as headache, perspiration, palpitations, tightness in the chest mild stomach discomfort and restlessness as indicated by an inability to sit or stand still for long.

**Check Your Progress 4**

Mention five features of anxiety disorder.

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ii) ***Dysthymia***

Death or separation of loved ones, loss of status, money or property, failure and frustrations can cause depression. The patient comes with the complaints of headache, bodyache, weakness, nervous debility, lack of appetite, constipation sleeplessness; and on enquiry accepts that he feels sad, weeps, no interest in anything, and prefers to die.

iii) ***Conversion Reaction***

Some people cannot communicate directly about their problems. Either they do not know how to do it or are afraid to communicate because of the consequence that follow. But they want to communicate. They want others to know their problems and want sympathy, support and help. Hence, they develop hysterical neuroses. They develop physical symptoms or some known illnesses. These symptoms are manifested through the working of the

unconscious mind for they do not know the relationship between the physical symptoms from which they are suffering and the conflicts they are having. They feel happy because they get attention and sympathy from others when they are ill.

iv) ***Obsessive Compulsive Disorder***

The patient gets persistent thought or impulses, which he himself recognizes as irrational but which he is unable to control or prevent. He indulges in unnecessary actions like repeated hand-washing, plate cleaning etc. to reduce anxiety.

v) ***Phobic Anxiety Disorders***

It consists of agoraphobia and social phobia. In agoraphobia there is marked and consistent fear or avoidance of at least two situations such as crowds, public places or traveling alone or traveling away from home. In social phobias, the fears are manifested in social situations. For example eating or speaking in public.

vi) ***Somatoform Disorders***

These are characterized by the presence of one or more physical complaints for which an adequate physical or laboratory explanation cannot be found.

vii) ***Dissociative Disorders***

The hallmark symptoms of these disorders is a sudden, usually temporary alteration in the normally integrated functions of consciousness, identity and motor behaviour such that one or two of these functions cease to perform together with the others. For example a persons may be alert, conscious and behaving normally but not able to remember his or her name, address, or occupation. Such a person is classified as having dissociate disorder specifically psychogenic amnesia. These disorders also include psychogenic fugue, multiple personality disorders, depersonalization.

**Check Your Progress 5**

What do you mean by Phobic Anxiety disorder?

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**Special Disorders**

i) ***Childhood Disorders***

Children can also have mental illness, what is manifested in the form of behavioural problem like hyperactivity, bed wetting, antisocial activities, scholastic backwardness etc.

ii) ***Personality Disorders***

These are a group of disorders characterized by deeply ingrained, socially maladaptive behaviors, generally recognizable by the time of adolescence or earlier and continuing throughout or most of the adult life. This category of disorders includes antisocial personality, alcoholism, drug dependence and sexual deviations.

People with antisocial personalities are mostly ego-centric, impulsive, irresponsible, prone to thrill-seeking, poor judgment, lack of anxiety or guilt, unable to profit from mistakes, hostile towards authority and a great burden on the family.

iii) ***Psychoactive substance use disorders***

It refers to behavioural changes associated with more or less regular intake of substance that affects the central nervous system. As a consequence of substance abuse, the patient shows impairment in social or occupational functions, inability to control use of the substance. He develops serious withdrawal symptoms after cessation of or reduction in substance use.

iv) ***Psychophysiological disorders***

These are classified according to the organic system affected, but they are caused and maintained primarily by psychological and emotional factors rather than organic ones. When an individual is not happy and is suffering from mental stress and strain, he expresses it though bodily symptoms like aches and pains or weakness (psychosomatic illness).

Some individuals, who have diabetes or hypertension or cancer, become very disturbed and worry a lot about themselves and their family's future. Their condition worsens when they do not get required love and support from the concerned people. They may develop psychotic or neurotic features. (Somato-psychic illness).

v) ***Mental Retardation***

It is not an illness but a condition. It is a subnormal state of intelligence. Mentally retarded individuals have less mental abilities and poor social learning.

**Check Your Progress 6**

1) Name five disorders included under special disorders, while classifying mental diseases.

   a) ..........................................................................................

   b) ..........................................................................................

   c) ..........................................................................................

   d) ..........................................................................................

   e) ..........................................................................................

2) Discuss the major classification of mental illness used in Indian psychiatric set up.

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3) Define neuroses.

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## 2.8 LET US SUM UP

We have discussed the meaning of behaviour and its components and characteristics of mentally healthy individuals. We have also discussed the misconcepts about mental illness, concept of abnormal behaviour through medical, statistical and socio-cultural models.

Further we have discussed the causes of abnormal behaviour, these are either predisposing factors with which an individual is born, and/or based on the past life events. Precipitating factors are considered to be the life stress or the crisis wherein an individual fails in his/her coping abilities' and may develop the abnormal behaviour. These factors could be organic or biological, psychosocial and socio cultural in origin.

In mental illness, there are behaviour changes and changes in the functions of body and mind. The patient's individual and social activities are disturbed. These illnesses are classified in different ways.

Generally classification of abnormal behaviour is based on similarities of different kinds, like similarity of behaviour, similarities of aetiology or causes, and similarity of prognosis or outcome. The first systematic classification of mental illness was made by Kraepelin. On the basis of this, each country attempted its own classification.

To remove the difficulties in communication due to different classification in different countries, WHO brought out an International Classification of Diseases (ICD-8) in 1965 and revised in 1992 at ICD-10. The American Psychiatric Association, the British Psychiatric Society and the Indian Psychiatric Society adopted this with some modifications in the sub-categories only.

In the Indian set up, the classification of mental illness was based on the causes of psychogenic origin as psychoses, neuroses; based on organic brain pathology, depending on the reversibility of the brain pathology as acute and chronic. Special disorders included the childhood disorders, personality disorders, substance abuse, psychophysiological disorders and mental retardation. By reading this unit you must have got as overview about the mental disorders.

## 2.9 KEY WORDS

**Delusion** : Unshakable, false belief

**Emotion** : A strong feeling or aroused mental state directed towards a definite objective, giving rise to some evidence, physical expression.

**Hallucination** : Patient's response to false sensory stimuli in the absence of an actual external stimulus.

**Intelligence** : It is an ability of an individual to think rationally, to act purposefully and deal effectively in a given situation.

**I.Q.** : Intelligence Quotient. It is a unit of measurement of intelligence

**Irrational** : Meaningless or purposeless act.

**Perception** : Giving meaning and interpretation to experienced stimuli.

**Premorbid Personality** : Personality before the occurrence of illness.

**Questionnaire** : Set of questions to explore information on a particular theme.

**Scholastic backwardness** : Poor performance in studies.

**Variable** : Information on a particular item.

## 2.10 ANSWERS TO CHECK YOUR PROGRESS

**Check Your Progress 1**

1) Behaviour is defined as "everything that an organism does from the time of conception till death." Everything includes knowing (cognitive behaviour), feeling (affective behaviour) and doing (psychomotor activities/conative behaviour).

2) 'Normal' is a term derived from Latin Word 'Norma' and refers to a carpenter's square or rule. When an individual's knowing, feeling and doing components of behaviour function in a unified and coordinated manner, he is considered to be normal or mentally healthy.

   The word 'abnormal' literally means 'away from the normal'. It is implies deviation from some gearly defined 'norm' or 'standard'. There are several dimensions, like medical, statistical and cultural norm, use to distinguish the concept of abnormal from normal. Abnormal behaviour is based on social norms and the self-expectation of an individual.

3) Conceptual models are organization of complex body of knowledge.

**Check Your Progress 2**

1)

| **Factors** | **Example** |
|---|---|
| Organic factors | Downs's syndrome |
| | Psychosis, Head injury leading to memory loss<br>Hypoglycemia leading to lethargy |
| Psychological Factors | Pathogenic family pattern, over protection, marital discord, sibling rivalry. |
| Socio cultural factors | Wars, changes in family structure, stressful situation. |

2) a) **Medical Model**

   This model considers organic pathology to be define cause to the mental disorder.

   b) **Statistical Model**

   This model involves the analysis either of responses on a test or a questionnaire or observations on some particular behavioural variables. The degree of deviation from the standard norms arrived at statistically, characterizes the degree of abnormally.

   c) **Socio-cultural Model**

   According to this model the behaviour, normal or abnormal is according to the social setting and cultural to which an individual belongs.

d) **Psycho-analytical Model**

The first systematic step toward understanding psychological factors in mental disorders were contributed by Sigmud Freud. The major principles of his model were derived from the clinical study of individual neurotic patients.

**Check Your Progress 3**

a) Functional Psychosis

b) Affective Psychosis

c) Organic Psychosis

**Check Your Progress 4**

a) Complains of uneasiness

b) Vague fear

c) Palpitation

d) Dryness of mouth

e) Sleep disturbance

**Check Your Progress 5**

It consists of agoraphobia and social phobia. In agoraphobic, there is marked and consistent or avoidance of at least two situations such as crowds, public places or travelling alone or travelling away from home. In social phobias, the fears are manifested in social situations. For example, eating or speaking in public.

**Check Your Progress 6**

1) a) Childhood disorders

   b) Personality disorders

   c) Substance abuse

   d) Psychophysiological disorders

   e) Mental retardation

2) The major classification of mental illness used in Indian psychiatric set up:

   i) Psychosis

   ii) Neurosis

   iii) Special disorders like:

      a) Childhood disorders

      b) Personality disorders

      c) Substance abuse

      d) Psycho physiological disorders

      e) Mental retardation

3) Neurosis is a mild type of mental illness where in the patient shows either excessive or prolonged emotional reaction to any given stress. He has symptoms like anxiety, fear, sadness, vague aches and pain and other bodily symptoms. He is aware of his problems and seeks professional help.

## 2.11 FURTHER READINGS

Coleman, C. (1976), *Abnormal Psychology and Modern Life*, Bombay, D.B. Tarpolewala Sons and Co.

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