(ii) The standardised work suffers from many weaknesses. Proper norms and objective interpretation are hardly available for these tests. Also they are not highly reliable and valid.
(iii) They are time-consuming both in administration and scoring.
(iv) The interpretation task is subjective and needs well-trained and experienced persons, who are generally not available.

But these above mentioned limitations on the part of projective techniques do not make them less significant. In fact, with the essential training and knowledge at his command, an expert psychologist is sure to gain important information about the subject, which is otherwise not available. On the other hand, it is also true that the projective techniques alone are not the answer to all the questions regarding human personality and adjustment. They should always be supplemented with other techniques of the personality so that comprehensive and detailed picture of the personality make-up of an individual is obtained.

SUMMARY

The task of actual measurement in the case of personality is not possible. We can only estimate and assess it by a variety of techniques like observation, situational tests, questionnaire, personality inventory, rating scale, interview and projective techniques.

In adopting observation technique, observer tries to observe the relevant activities concerning one or the other personality traits of the subject in real life situations. In the situational tests, situation are artificially created for the observation of one's behavior related to the personality traits under testing. Questionnaires as a technique of personality assessment refers to a form consisting of some questions related to the personality characteristics requiring responses on the part of the subject for the assessment of his personality.

Personality inventory resembles questionnaire in many aspects like administration, scoring, interpretations etc. However, it differs from questionnaires in the sense that it is specially designed for seeking information about the personality traits or behaviour of an individual rather than collecting all kinds of information like questionnaire. Rating scale refers to a technique of rating (telling where an individual stands in terms of some personality traits) on three, five or seven point scale for getting idea about some of the personality traits of an individual whom we don't know well from someone who knows him very well. Interview refers to a technique of getting information directly from the subject about his personality in face-to-face interactions.

Projective technique are based on the phenomenon of projection. In these techniques relatively indefinites and unstructured stimuli like vague pictures, ink blots, incompletes sentences etc. are provided to the subject and he is asked to structure them in anyway he likes. In doing so, he unconsciously projects his own desires, hopes, fears, repressed wishes etc. and then not only reveals his inner or private world but gives a proper clue for the assessment of his total personality. The various techniques involved in this category may be named as Rorschach Ink Blot Test, Thematic Apperception Test (TAT), Children Apperception Test (CAT), Word Association Test and Sentence Completion Test etc.

References and Suggested Readings

Anastasi, A, *Psychological Testing*, 2nd ed., Macmillan, New York, 1961.

roles of wife and mother may direct her energies to social or professional activities, a student quite brave but aggressive in behaviour may turn into a good player, boxer, wrestler, saviour of the weak, and martyrs. By re-directing and channeling his tremendous energies and strong will power, a young man may be found to write beautiful poems and sketch beautiful portraits and in this way may discharge or sublimate some part of the strong sexual desire he was unable to discharge directly to his beloved.

Conclusion about Defence Mechanism

All the defence mechanisms discussed above are used unconsciously by a person to protect himself, although for the time being, from psychological dangers. They are not the permanent cure of the trouble as *Morgan* observes, but "*they merely conceal or disguise the real problem. It is still there, ready to produce anxiety again and again.*" (1961, p. 143). In this way, defence mechanisms may be regarded as temporary defence against anxiety and inadequacies. Moreover, the use of such mechanisms may create new difficulties for the individual who frequently resorts to them like a person who tells a lie to save himself from a particular situation but falls on to the series of troubles on account of his telling lie.

MENTAL DISORDERS

Meaning and Definition

As emphasized earlier, an individual is said to be in satisfactory mental health to the extent he feels satisfied with himself and his environment. The disequilibrium of this balance leads to his maladjustment with the self and the environment paying the way for one or the other kind of mental disorder and mental illness. Defence mechanism, as we have just discussed, is nothing but temporary measures for defending or protecting oneself from the possible maladjustment or behaviour disorders. However, these measures often either do not prove successful or get damaged in the long run resulting into one or the other type of mental disorder or mental illness. Let us know in detail about these mental disorders that are notorious for turning an otherwise normal personality into an abnormal one.

As a matter of definition, *mental disorders represent certain types of abnormalities, malfunctioning of deficiency in the behaviour or personality of an individual resulted from his maladjustment with the self and the environment.*

Classification of Mental Disorders

For the sake of diagnosis, prevention and treatment of the various mental disorders various attempts have been made to put them into some definite categories. Mentionable among those are the attempts made by the American Psychiatric Association and World Health Organization (WHO). While the former has developed Diagnostic and Statistical Manual of Mental Disorders DSM-I (1952), DSM-II (1968), DSM-III (1980) and DSM-IV (1994), the latter has brought such classification in the chapter V of International Classification of Diseases ICD-8, (1965) and ICD-9 (1979). A close analysis of these attempts of classification may reveal that all types of mental disorders may be broadly classified into two major types—organic and psychogenic.

The organic disorder involves damages to the tissues of the brain as a result of infectious disease, injury, mental retardation, hormonal or toxic disturbances etc. As a result of such damage, the person demonstrates disturbed or disoriented behaviour like disturbance of memory, perception

and thought, sometimes mild and sometimes severe. The organic disorders are incurable in the sense that there is no way of regeneration of brain tissue once it is damaged.

The Psychogenic disorders also referred to as functional disorders involve no such brain damage or proven physical cause and the disorder does not prove as helpless and refractory to treatment as in the case of organic disorders. These disorders may be further divided into subtypes like neurotic disorders, psychotic disorders, psychosomatic disorders and personality disorders. The first two terms are quite popular in describing abnormal personalities and mentally ill. For the purpose of distinguishing, the rest two from the popular ones, neurosis and psychosis, let us give them a common name simple mental disorders (where the etiology, i.e. the causation of disorder and its treatment, is not too difficult or impossible). We are thus in a position to classify the psychogenic disorders into three types (i) Simple disorders incorporating disorders like psycho-somatic and personality disorders, (ii) neurotic disorders, and (iii) psychotic disorders. Let us now have some discussion on the above-mentioned types and sub-types of the psychogenic disorders.

PSYCHO-SOMATIC OR PSYCHO-PHYSIOLOGICAL DISORDERS

The term 'psycho-somatic' or 'psycho-physiological' disorders refer to those disorders in which both organic and psychological factors may work side by side in terms of their origin as well as treatment. Usually in such disorders, we come across changes in the psychological functioning of the individual resulting from the emotional factors and stress. Since the physical disorders are the result of the psychological factors, medicine is also required to join forces with psychology for getting desired success in the treatment. As a matter of definition, The American Psychiatric Association DSM-III, Publication States: *"Psycho-physiological disorders are characterized by physical symptoms that are caused by emotional factors and involve a single organ system, usually under automatic nervous system innervations. The physiological changes involved are those that normally accompany certain emotional states, but in these disorders the changes are more intense and sustained."* (1968, p. 46)

This definition leads us to the following characteristics of psycho-physiological disorders:

1. Psycho-physiological disorders always exhibit one or the other typical physical symptoms like pain, vomiting, difficulty in breathing, diarrhoea, etc. It is the severity of the distress caused by these symptoms that usually compels the individual to seek medical help.
2. Though the physical symptoms developed on account of the psycho-physiological disorders appear similar to those reflected in certain emotional states (anxiety, anger etc.), the visceral effects of emotional conflict in these disorders are so pronounced that actual and irreversible damage may be done to the body's structure. In this way, a so-called psychological illness or disorder turns into "a real" illness or disorder with identifiable tissue pathology.
3. In psycho-physiological disorders, emotional conflict affects the viscera through the autonomic nervous system which has two main divisions known as sympathetic and parasympathetic systems. These two systems of the autonomic nervous system are controlled by the brain in such a way that in normal conditions, the effects of the two systems are kept in approximate balance. It results in the predominance of either sympathetic or parasympathetic activity flooding a single organ system-respiratory, circulatory, etc.
4. The psycho-physiological disorders are neither exclusively caused by psychological factors nor by the organic ones but in all cases, they are brought about by an interaction of psychological and organic factors.

Major Types of Psycho-Physiological Disorders

1. **Respiratory disorders** like bronchial asthma, hay fever, common cold, rhinitis, hyperventilation etc.
2. **Gastrointestinal disorders** like peptic ulcer, mucus colitis, chronic gastritis, anorexia nervosa etc.
3. **Cardiovascular disorders** like hypertension, heart attacks, vascular spasm, migraine etc.
4. **Genitourinary disorders** like urinary disorders, menstrual disorder in women, and disorders associated with sex (impotence in men and frigidity in women).
5. **Skin disorders** like eczema, hives, dandruff, acne, herpes simplex, etc.
6. **Musculoskeletal disorders** like backache, muscle cramps, and arthritis.

For illustrating the nature of these above mentioned different types of psycho-physiological disorders, let us mention a few popular ones.

- **Migraine:** It involves extremely painful headaches. The pain usually occurs on the side of the head. Sometimes it is associated with nausea and blurred vision. The attack rarely lasts more than twenty four hours and is often much briefer. It is generally caused by the sympathetically innervated contraction followed by dilation of blood vessels in the brain. Emotional disturbance, early psychological experiences and genetic influences may be the other causes of migraine disorders in addition to or absence of the known bodily causes.
- **Anorexia nervosa:** Loss of appetite is known as anorexia. In the absence of organic disorder when it is caused by emotional factors it is referred to as anorexia nervosa. The more severe cases of anorexia nervosa are characterized by weight loss to the point of emaciation. This disorder is much more frequent among girls and young women of the middle and upper socio-economic classes with symptoms of menstrual disturbances, slow heart beat rate and constipation. Its onset often occurs during or shortly after adolescence, at the time when a young girl becomes very conscious of her weight. She goes on "crash" starvation diet. As she starves herself for becoming thinner, she may adamantly deny that she is underweight and may seem almost phobic to weight gain. Consequently, she resorts to a kind of voluntary self-starvation many times complaining that food disgusts her, or that she is afraid of choking on it or of vomiting after eating. In some cases self-induced vomiting are frequent rituals to cleanse one's body of food after the 'sin' of eating.
- **Peptic ulcer:** Peptic ulcer is an open sore (an inflamed wound) on the lining of the stomach or more frequently in duodenum (the upper portion of the small intestine). An important symptom is pain which a person experiences after meals and which can be eased only by eating. There may be nausea or vomiting along with pain. There is bleeding in severe cases. It is caused by the corrosive action of the overactivity and excessive secretion of the digestive acids on the protective mucous membranes of the stomach and small intestine. The ulcers arise from a complex interplay of emotional and organic factors. Emotional states are closely related to the physiological factors responsible for the cause of ulcer. A strong and sustained conflict evokes a chronic emotional response usually of hostility or anxiety. The inability to reduce the emotional tension in some harmless ways (like defence mechanisms or proper channelization) causes the stomach or duodenum to be susceptible to injury by its own acid secretions. It has often been found that the persistent emotional stress and the resulting autonomic nervous system activities are responsible for the

overactivity and excessive secretion of digestive acids. They cause ulcer by weakening the mucous membranes and breaking down the digestive tissues.

- **Impotence and Frigidity:** Only a few cases of these disorders are found to have an organic cause while in most cases psychological factors play a key role. Hostility towards the partner, anxiety and fear of disease, injury or pregnancy and guilt feeling concerning sex are the major sources of such disorders. As a result, the impotent male is unable to perform the sexual act and derive pleasure out of it. Similarly, in the case of frigid females there is either a pathological lack of sexual desire or a diminished desire for sex. In chronic cases, it leads to dyspareunia (painful intercourse) in which the establishment of normal heterosexual relationships becomes difficult or impossible on account of the local neuro-muscular reaction in the form of vaginal spasms.

Causes underlying psycho-physiological disorders

Psycho-physiological disorders are caused by a close interaction of organic (genetic and other biological factors) like body structure, its chemical functioning, allergies and infections and psychological factors (like conditioning and reinforcement, early deprivations, emotional problems and psychological stress).

Prevention and treatment: Genetic influences are beyond one's control. However, reasonable control may be exercised over biological and other psychological factors for the prevention.

For the treatment of these disorders, there are measures like biomedical, psycho-analytic, behaviour modification, psycho-therapies and bio feedback, etc.

PERSONALITY DISORDERS

These disorders are also often named as 'conduct' or 'character disorders'. *These are characterized by lifelong impairment of the ability to maintain normal social relationships and repeated conflict with the mores and values of the society in which one lives* (Levin, 1978, p. 526). So the individuals suffering from these disorders are those who suffer from a general failure to acquire effective habits of adjustment and adequate social relationships and as a result are found to display a lifelong pattern of disturbed or anti-social behaviour.

Adams (1972, p. 348), while describing these disorders as behaviour anomalies, brings out the following four main features of the persons suffering from these disorders:

(i) These individuals violate or do not conform to the moral or legal codes of society.
(ii) They do not complain about their disorder (not feeling discomfort) on account of their behaviour and therefore are not usually motivated to change their behaviour.
(iii) There is no failure of the cognitive apparatus as seen in the psychotic individual although their acts are often considered bizarre.
(iv) There is little evidence that they exhibit more neurotic characteristics than would be expected in the general population.

Main Type or Classes of Personality or Conduct Disorders

Usually the following types of mental disorders are included into the broad concept of personality or conduct disorders:

1. The passive-aggressive personality disorder
2. Criminal behaviour-delinquency and crime

3. Sociopathic disorders
4. Alcoholism and drug addiction
5. Sexual deviations and disorders

Let us know about these disorders in brief:

The passive-aggressive personality, according to Lazarus (1976, p. 146), shows extensive inability to deal with inter-personal relations expressing itself in one of the three patterns, passive-dependent, passive-aggressive and aggressive. All these three patterns lead to adjustive failure and maladaptive behaviour.

In the passive dependent pattern, one may be habitual to show his helplessness, indecisiveness and carelessness inviting constant emotional support and direction from others. In the passive-aggressive pattern, one is aggressive but his aggression (constant hostility) is demonstrated in passive and indirect ways like stubbornness, inefficiency, indirect obstructionism, inciting others not to follow or cooperate etc. In the last pattern, one is openly hostile and aggressive to the things, events and persons and his such behaviour is easily demonstrable through one's imitation, temper tantrums and destructive acts. The aggressive personality, whether his aggression are passive or violent, is a typical maladjusted and maladaptive personality. The causes of his such maladaptive behaviour pattern are all most psychological, the roots of which are lying in his defective socio-cultural environment.

Similarly criminal or delinquent behaviour, as we have already discussed in this text, is definitely a coefficient of friction between the psychological self and the defective socio-culture environment.

Sociopathic Disorder or Antisocial Personality

It has been defined by the American Psychiatric Association in DSM-II (Diagnostic and Statistical Manual of Mental Disorders-II) as below:

"Sociopaths (the persons suffering from sociopathic disorder) or anti-social personalities are "the individuals who are basically un-socialized and whose behaviour pattern brings them repeatedly into conflict with society." (1969, p. 43)

Explaining further D.M.S.-II mentioned the following characteristics of these individuals as below:

- They are incapable of significant loyalty to individuals, groups or social values.
- They are grossly selfish, callous, irresponsible, impulsive and unable to feel guilty or to learn from experience and punishment.
- Their frustration tolerance is low. They tend to blame others or offer plausible rationalization for their behaviour.
- A mere history of repeated legal or social offences is not sufficient to justify their diagnosis as anti-social personality, meaning hereby that they are not professional criminals. However, they (while posing as quite innocent, calm and quiet and normal) always engage themselves in anti-social activities.

Causes of the Sociopathic Disorder

There seems to be no significant positive correlation between sociopathy and defective heredity or biological make up. Sociopathy is a behavioural problem involving social and psychological maladjustment and, as a learned pattern of behaviour, is liable to be caused by environmental factors

inherent in one's family, neighbourhood, school, society or community. The child may imitate the antisocial behaviour of his father, mother or other members of the family by accepting it as a model. The uncongenial and defective family environment on account of poverty, broken or emotionally disturbed homes, faulty parent child relationships, improper upbringing, and denial of the basic needs may put a child on the track of antisocial behaviour. Thereafter, environmental factors outside the family perpetuate and nourish this tendency by encouraging and luring him into learning sociopathic behaviour.

Treatment: Punitive measures show no favourable results. Therefore proper medical or socio-psychological measures need to be taken. Anti-convulsant or depressant helps in stabilizing behaviour and reducing antisocial trends. Psychotherapy, under psychological measures, does not prove much effective with sociopaths. However, for behaviour modification of the sociopaths, behaviour therapy shows favourable results. This measure should be taken in a controlled and well-supervised special institution instead of a jail or a mental hospital.

ALCOHOLISM AND DRUG ADDICTION

Alcoholism is classified as a disorder or personality where an individual becomes addict to alcohol to the extent of harming the self and the society. The World Health Organization (WHO) in ICD-8 (International Classification of Diseases-8) brought out in 1965 has defined alcoholics as *"excessive drinkers whose dependence on alcohol has attained such a degree that they show noticeable mental disturbance or an interference with their mental and bodily health, their interpersonal relations and their smooth social and economic functioning, or who show the prodromal (beginning) sings of such developments."*

Stages in the development of the habit of alcoholism

One gradually becomes the victim of alcoholic disorder by passing through the major stages or phases, popularly known as pre-alcoholic, prodromal, crucial and chronic.

The initial **pre-alcoholic** phase lasts from two months to up to two years and is characterized by a gradual shift from infrequent or light to frequent or heavy drinking. In the second **prodromal phase**, alcohol is used more as a drug and less as a beverage. In the third **crucial phase** the dependency on alcohol increases to the extent that there is a danger of losing everything that one values. In the last **chronic phase** the individual lives only to drink.

Consequences of alcoholic disorder

An alcoholic is likely to be ruined in terms of his physical or mental health, emotional and social relationships and economic and moral assets.

Causes of alcoholic disorder

No person is born alcoholic and therefore the causes of alcoholism are purely environmental. Drinking is learned and acquired like many personality traits and later maintained on account of its physiological and psychological dependence that it provides.

Treatment of alcoholic disorder

Alcoholism is a medical and psychological problem rather than a law and order problem. For treatment, beginning is made with the diagnosis of the early warning signals of alcoholism and then followed with (i) keeping away alcoholics from any adverse life situation and controlling their behaviour; (ii) providing essential clinical investigations; (iii) detoxificating; (iv) using deterrent measured in the form of aversion therapy; (v) providing group or individual psycho-therapy for

gaining insight into behaviour and adequate adjustment; and (vi) providing socio-therapy involving modification of environmental situation and improvement of social adjustment.

DRUG ADDICTION

The American Psychiatric Association in its DSM-II has kept drug addiction in the category of personality disorders by naming it as Drug dependence. Drug addiction, like alcoholism, is also detrimental to the individual and the society. It concerns with the abnormal use of certain drugs like hashish, charas, marijuana, cocaine, LSD, mandrax, valium, dexedrine and methidrine. Excessive use of these intoxicating drugs leads to increased tolerance and physiological or psychological dependence. With prolonged use, the body system gets habituated to a particular drug so that larger doses are necessary to maintain similar intoxicating effects. Consequently, the individual develops an increasing physiological and psychological dependence on them to the extent that he feels miserable whenever the drug is not administered. He begins to show withdrawal symptoms like lack of appetite, loss of weight, constipation, restlessness, nervousness, nausea, vomiting, diarrhea, disinterest in sexual and social relationships and even epileptic seizures or acute brain syndromes in some cases. Besides, there is intense craving, anxiety, pleasant reverie and short-lived pleasing effects or state of euphoria created by the drug. Gradually, larger and larger doses are needed for similar results and one becomes dependent, physiologically as well as psychologically, on a particular drug. Thus, what begins as an innocuous experiment ends in disaster.

Causes of drug addiction

These are purely environmental and drug addiction is a matter of learned behaviour and an inadequate adjustment to the stresses of life and style of living.

Prevention and control

It involves measures like (i) Making the public aware about the causes and consequences of drug addiction; (ii) Re-structurization of unhealthy environmental conditions and reduction in the problems leading to frustration, tension and anxieties; (iii) Prohibition of drugs that have low medicinal value and are harmful; (iv) Different panel provisions against the smuggling of and trade in drugs.

Treatment

It involves (i) compulsory hospitalization; (ii) detoxification; (iii) adoption of medical measures; (iv) introduction of psychological treatment; and (v) arrangement for long-term therapy and rehabilitation.

SEXUAL DEVIATIONS AND DISORDERS

The American Psychiatric Association has kept both sexual deviations and disorders (in its DSM-II and III) in the category of personality disorders as they are bound to affect the behaviour, conduct and personality of the individual to the extent of proving harmful to the self, others or both. Let us briefly describe both these maladaptive sex behaviours.

Sexual deviations as a term may be defined as the learned persistent habit patterns of sexual behaviour which compel an individual to seek sexual gratification from unconventional sources and means other than the genital coitus with an adult member of the opposite sex irrespective of the fact that such natural gratification is available.

Major Sexual Deviations

1. **Pedophilia** involves the deviant behaviour in which an adult is sexually attracted to a child.
2. **Homosexuality** refers to the deviation in which one prefers to derive sexual pleasure from the members of the same sex.
3. **Oralism** is the dependence on oral genital contacts for gratifying sex needs.
4. **Analism** refers to exclusive reliance on anus instead of vagina for penile insertion.
5. **Sadism** is sexual gratification from the infliction of pain upon the sexual partner.
6. **Masochism** is sexual gratification from being punished or experiencing pain.
7. **Fetishism** is a compulsive and irrational sexual attraction and obtaining sexual gratification from intimate objects or part of the body other than the genitals.
8. **Bestiality** means using animals for the achievement of sexual excitation and gratification.
9. **Necrophilia** is obtaining sexual gratification through viewing or actually having sexual relations with a dead body.
10. **Incest** is sexual activity between close blood relations.
11. **Exhibitionism** is sexual gratification obtained by exposing the genitals publicly usually to member of the opposite sex or children who are involuntary observer or complete strangers.
12. **Voyeurism** is sexual gratification obtained through peeping, observing genitals or sexual behaviour of others.
13. **Frotteurism** is sexual gratification obtained by rubbing or pressing against a member of the opposite sex.
14. **Transvestism** is sexual gratification obtained by wearing clothes appropriate to the opposite sex.
15. **Transsexualism** is behaving and believing firmly in the change of his or her sex.

Causes of sexual deviations

Sexual deviations are, to a great extent, produced by the interaction of several psychological factors. The dynamics of these factors involves patterns like (i) pathogenic family environment, (ii) earlier traumatic sex-experiences, (iii) generalized inhibitions and sexual ignorance, (iv) deprivations of outlet for normal sex behaviour, (v) fears and complexes associated with opposite sex and normal sex behaviour; and (vi) conditioning and fixation of suitable abnormal pattern of sex behaviour.

Treatment

Treatment measures are psychological. Psychotherapies like behaviour therapy, analytical therapy and group therapy prove effective in dealing with the sexual deviates. These psychological treatments should be followed by an adequate follow-up programme of proper rehabilitation.

Sexual Disorders

These are psycho-physiological disturbances that interfere with the complete enjoyment of the conventional sexual relations. Impotence and frigidity are the two main disorders of such nature.

Impotence causes an impairment in desire for sexual gratification in a man or an inability to achieve it. Frigidity, the counterpart of impotence, is found in females. It creates in them a lack of interest and desire for sexual gratification or difficulty in achieving it.

Causes

In some cases, impotence and frigidity may be attributed to physical damage to sex organs or nervous system. But more often they are caused on account of psychological effects resulting from the interaction of one's environment. These disorders involving the feeling of inadequacies are the learned responses involving factors like sex guilt, fear, complexes, depressions, conflicts, frustrations, sexual perversion and bedroom mistakes.

Prevention

Preventive measures should be adopted for the avoidance of physical injury to the sex organs and nervous system. In psychological measures of prevention, proper sex education of parents, and adults members (before and after the marriage) may prove fruitful.

Treatment

The treatment often involves establishing a stable, intimate, affectionate relationship involving confidence, security and love. A number of psychological therapies like behaviour, analytical, family and couple therapy may be successfully attempted for this purpose. In some cases of impotence and frigidity, medical measures may also prove effective.

NEUROTIC DISORDERS

Neurotic disorders like psychotic disorders are purely psychogenic disorders. There is no relevant organic pathology present in these disorders and thus may be clearly distinguished from psycho-physiological disorders which are known as the disorders of the psyche as well as the body. They can also be well distinguished from the personality or conduct disorders in the sense that their maladaptive pattern of behaviour does not lead to discomfort and harm to others and they do not violate legal or moral rules any more frequently than normal individuals.

Actually in the sequence of the behavioural disorders of psychogenic origin, neurosis falls midway between minor emotional maladjustment and psychotic disorders. Consequently, it is known as more serious than a minor emotional maladjustment and less serious than a psychotic disorder. Neurotic disorders in the real sense represent the typical ways of dealing with frustrations and conflicts and the anxiety which results from these frustrations and conflicts. However, in spite of its extreme anxiety content, neurotic behaviour is not disorganized nor is neurotic personality a split personality like that of a psychotic. Most of the neurotics function adequately in the majority of life situations and unlike psychotics, their perception of reality is generally accurate and that only rarely can their behaviour be considered bizarre. However, unlike psychotics, they are usually distressed by their behaviour and in most cases realize that it is deviant.

Although the symptoms of neurosis differ from individual to individual, the common factor is a maladaptive and self defeating life pattern. Generally the neurotic reactions and disorder "anxiety" as described in DSM-II is the chief characteristic of neuroses. It may be felt and expressed directly, or it may be controlled unconsciously. It is in this context that George W. Kisker has defined neurosis as *"a pattern of maladaptive behaviour in which a person responds to life stress with persistent anxiety or other behaviour representing attempts to control the anxiety."* (1964, p. 194)

Anxiety is closely linked to an individual's needs and motives. If the essential needs linked with affection, security, self-esteem, achievement and freedom are not satisfactorily gratified, it may give rise to the feeling of excessive anxiety or guilt which in turn results in a neurotic behaviour. But it is not to be concluded that every anxiety reaction leads to neurotic behaviour. We are occasionally quite anxious, irritable, down or restless, but it does not mean that we are neurotic. It is only when the anxiety behaviour patterns become more persistent and interfere with our ability to lead a normal life and thus depict "break downs" in the adjustment mechanism, that they are usually labeled as "neurosis."

Basic Characteristics of Neurotic Behaviour

Neurotic behaviour is assumed to be characterized with certain typical personality characteristics. In this sense Coleman (1970) has narrated the following characteristics of a neurotic personality:

1. Inadequacy and low stress tolerance.
2. Egocentricity and disturbed interpersonal relationships.
3. Lack of insight and rigidity.
4. Dissatisfaction and unhappiness.
5. Anxiety and fearfulness.
6. Persistent non integrative behaviour.
7. Presence of psychological and somatic symptoms.
8. Tension and irritability.

Major Types of Neurotic Disorders

In the list of the major types of neurotic reactions (neurosis), we generally include the following sub-types:

1. Anxiety neurosis
2. Hysterical neurosis—conversion and dissociative type
3. Phobic neurosis
4. Obsessive compulsive neurosis
5. Depressive neurosis

Let us discuss these sub-types in brief:

ANXIETY NEUROSIS

Anxiety neurosis represents a maladaptive behaviour pattern dominated by chronic apprehensiveness with recurring episodes of acute anxiety, helplessness and resentment so much so that it interferes seriously with the individual's personal and social adjustment and well-being. An interesting feature of the anxiety as Lazarus (1976) puts is that it is free floating in the sense of its being non-attracted to a single situation or specified object. Neurotic person may have fear and apprehension of every or anything without having an idea of the source of danger or why he feels this way. The length to which he goes to find things to worry about is remarkable. As soon as one cause for worry is removed, he finds another until his kith and kin lose patience with him.

Similarly, while suffering from the feeling of helplessness, an anxiety neurotic does not know which way to turn. He is sure that anything he attempts will result in failure. He is likely to be dependent on others, which he does not like to do. So, resentment builds up within him and ultimately results in aggression towards the self as he does not have enough courage to attack those upon whom he is dependent.

Ultimately, the free floating excessive anxiety coupled with the feelings of helplessness and resentment leads him to an intense state of tension, stress and discomfort well exhibited through physical reaction like increase in blood pressure and pulse rate, suffocation and difficulties in breathing, disturbances of sleep and appetite, heart palpitation and faintness, skeletal motor disorders including tremors of hands and limbs, facial ties, excessive eye blinks and lip biting. In the acute anxiety reaction or panic state, these symptoms may become so severe that the individual believes that he is having a heart attack or is dying.

Hysterical Neurosis

Hysterical neurosis represents such neurotic reaction in which the individual exhibits behaviour that mimics physiological illness or disease (without an organic basis) for controlling his anxiety or solving psychological conflicts. There are two types of hysterical neurosis—conversion hysteria and dissociative hysteria.

Conversion hysteria

In such type of neurotic behaviour, the person in a threatening situation tries to convert his anxiety of psychological conflicts into physical symptoms like paralysis of legs, inability to see or hear or becoming faint and unconscious. His gains are often two-fold. First he gets to escape from the confronting problem and the second, being sick he is offered desired sympathy and comforts. An unemployed youth, for example, may become paralyzed in his legs. He now no more feels any guilt over his repeated failures in getting employment and finds desired support and comfort from his family. A newly married girl may become deaf so as to avoid listening to the bitter criticism from her in-laws and relatives for not bringing enough dowry.

Dissociative hysteria

The hysterical dissociative neurosis is maladaptive cognitive behaviour in which a person tries to control his anxiety or psychological problem by the dissociation of his self. Disturbances in consciousness and/or loss of personal identity are the main characteristics of such dissociative reactions. The four major types of such reactions are somnambulism, amnesia, fugue and multiple personality.

Somnambulism is sleepwalking. In their sleepwalk, people are known to travel long distances and do many complex activities.

Amnesia refers to the loss of memory. Here the individual forgets information causing distress and may remain in the state of not remembering for just a few minutes or for hours or days.

A fugue is combination of amnesia and physical flight. In this state, the loss of identity continues for a long period of time (may be for several years) and it is accompanied by actual flight from the customary surroundings. The person may suddenly leave home, travel to another place and sometimes begin a 'new life'.

Multiple personalities are the coexistence of two or more personalities in an individual each of whom may or may not be aware of the other.

Phobic Neurosis

The term "phobia" comes from the Greek word *phobos* which means panic, flight or fear. Phobic neurosis may be defined as a disorder of the behaviour in which a person experiences persistent, intense, irrational fear of a specific situation or object. In spite of his rational knowledge that his fear is unrealistic and overwhelming, he is forced to experience great apprehension and anxiety symptoms while in contact with the phobic object or situation.

One cannot draw any limit regarding the types or varieties of phobias as almost any object event or situation surrounding one's life may become stimulus for a phobic behaviour. As a result a neurotic may have fear of high places (Acrophobia) while others may be suffering from agoraphobia (fear of open places), claustrophobia (fear of closed spaces or confinement), hydrophobia (fear of water), nyclophobia (fear of darkness), ochlophobia (fear of crowds), pyrophobia (fear of fire), zoophobia (fear of animals or some particular animal) etc.

OBSESSIVE COMPULSIVE NEUROSIS

Obsessive behaviour represents maladaptive behaviour in which an individual is haunted with the persistent recurrence of unwelcome, absurd and disturbing idea or thought. For example, a wife may have an obsessive idea of stabbing or poisoning her husband, a mother of hurting her little girl, a son of wishing his mother's death, a husband of pushing his wife down a flight of stairs. Although the patient realizes the absurdity and irrelevance of such thoughts, he is still unable to get rid of them. The more desperately he tries to rid himself of them, the more they haunt.

Compulsive behaviour, on the other hand, represents maladaptive behaviour in which an individual is seen to perform repeated acts of unreasonable and irrelevant nature such as washing his hands again and again, checking the alarm clock several times to ensure it has been wound or returning to his house again and again to be certain that the door has been locked or following an elaborate ritualistic sequence before going to sleep. Such patterns of behaviour are maladaptive in the sense that they are unnecessary and irrational. Even the person realizes the absurdity of his compulsive acts, but he feels uncomfortable unless he performs them.

As a neurotic mental disorder, obsession and compulsions are classified together because they unusually tend to occur together. Thereby symptoms of both obsessive and compulsive behaviour are present in the obsessive and compulsive neurosis. For example a neurotic may not only worry constantly about germs and dirt (an obsession) but also be compelled to constantly wash his hands (compulsion). In doing so, he is fully assured that if he does not perform the act (like hand washing), something terrible will happen or by performing the act he has prevented certain disaster.

DEPRESSIVE NEUROSIS

This is a neurotic disorder characterized by disproportionate reactions to distressing stress situations like death of a loved one, an occupational failure or a financial set-back. In such distressing stress situation, it is not abnormal to have feelings of grief and despair in a reasonable amount. It is when these feelings become much exaggerated in intensity and duration and begin to interfere with the personal or social adjustment of an individual, that they turn into behavioural disorder—neurotic and psychotic.

Neurotic depression may be considered midway between normal depression and psychotic depression. Neurotic depressive reactions are neither too severe in degree or in duration as the psychotic depressive reactions nor as mild and simple as in normal depressive reactions.

Time is found to be a great healing factor in normal depressive reactions. In neurotic depression, however, the depressed mood does not return to normal even after a reasonable period of time as it ordinarily does in normal depressive reactions. Here the symptoms concerning depression of mood are also relatively severe. The patient may have intensive feelings of dejection, discouragement and sadness. There is a high level of anxiety and apprehensiveness and extreme feelings of self-condemnation. The person is unable to concentrate and his level of activity and initiative is lowered. In its more severe form, the anxiety and depressions are heightened to such an extent that the person is unable to work, and sits in despair viewing the dark side of life alone and sometimes thinks of committing suicide.

Depression may be viewed as hospitality or anger directed towards the self instead of being turned outward. Instead of blaming others, the person blames himself for the loss and the distressing situation. Thus, the formula for neurotic depression is self-condemnation plus an external loss. Here, the person may be viewed as punishing himself by feeling responsible for the loss or for the distress situations.

Causes of psychoneurotic disorders

The most important causative factors of all neuroses are psychological. The early unhappy experiences, repressed wishes and unresolved conflicts initiate the process. Later, unfavourable circumstances, stresses and strain provide sufficient cause for learning reactions. In many cases psychoneurotic reactions often represent learned maladaptive behaviour patterns.

Treatment

The psycho-neurotic disorders vary from each other in relation to their nature and causation. No common treatment can therefore be prescribed for all these disorders. However, neurotic patients are curable. They respond more favourably to behaviour therapy and other psycho therapies than the patients suffering from conduct disorders or functional psychosis.

PSYCHOTIC DISORDERS

Meaning

Psychotic disorders (referred to as insanity in the lay man's as well as the legal language) represent the more serious disorders of the mind and in this sense are considered the most severe form of adjustive failure and a major illness in comparison to the neurotic disorders. A psychotic behaviour is characterized by serious forms of personality disturbance in which the patient shows (i) periodic or prolonged loss of contact with the world of reality, (ii) manifests symptoms of severe nature in the form of delusions (beliefs contrary to reality), hallucinations (perception contrary to reality like hearing voices in a completely silent room), stupor (state of immobility with partial or complete unconsciousness) incoherence (disconnected and unrelated thoughts) or violent reactions. Such patients require compulsory hospitalization.

Types

Functionally, there are three main types or categories of psychotic disorders: the affective disorders, paranoid disorders and the schizophrenic disorders. Let us have a brief idea of these types of disorders.

Affective disorders

The affective disorders involve disorders of the mood or the dimension of elation and depression. Accordingly, there are three sub-types of affective disorders, namely, manic disorder, depressive disorder and manic depressive disorder.

(i) **Manic disorder** or mania is associated with the elation of mood and excessive excitement. The patient is high in spirits, overactive and bursting with energy. He is very jovial, mobile, impatient when dealing with restrains or criticism, agitated and silly to the point of being a bore. In its most extreme form, a manic patient in his wild excitement may shout and laugh constantly, tear his clothes and is likely to become dangerous both to himself and to others (quite fit for being isolated and kept in a room).

(ii) Depressive disorder: Depression is the polar opposite of mania. The patient remains spirits, feels discouraged and sad. He loses his interest in things around him and may even neglect appearance and body care. The patient's movements become slow. He may either sit doing nothing or even remain in bed in a state of stupor ignoring his surroundings and need for food and hygiene. There is a marked retardation of thought process, he has difficulty summoning enough energy to think. He talks slowly and hesitantly or not at all. Contrarily, some patients with severe depression may also show signs of agitation. They pace up and down restlessly wringing their hands in despair. Agitation and retardation have some common elements also. The element of anger (rage) is likely to be present in both as the depressed individual may express hostility inwardly and outwardly. The other common feature exhibited through retarded or agitated behaviour is a severe lack of useful energy. Loss of appetite, loss of weight and constipation are common. Sexual desire tends to diminish and the patient is likely to become frigid or impotent. The patient suffers from insomnia. Early morning wakefulness is a characteristic found in severe forms of depressive disorder.

Depressive disorder also involves delusions and hallucinations usually associated with feelings of guilt. The patient may hear voices accusing him of sins that he has committed. The ideas related with disease, unworthiness and poverty are also found. The patient may be preoccupied with disease and retains his convictions despite medical examination. Feelings of depersonalization are coloured by the mood of depressive illness, Declarations like "my mind is dead", "my legs have been turned to lead", "my liver has been taken away", often reflect the state of affective disorder in individuals. Another common feature of depressive disorder is loss of confidence and pessimistic outlook. The world looks gloomy for the patients and nothing gives delight. The profound helplessness and ideas of unworthiness may lead to suicidal attempts or passive contemplation of suicide.

(iii) Manic depressive disorder: This category of affective disorder involves reactions which are neither manic nor depressive but a blend of the two occurring in a cyclic order. Consequently in this disorder there is a manic reaction (mood of elation) followed by a depressive episode (morbid ideas and despair), which may be followed by normal affect and behaviour for a period of days or months. However, all these episodes always remain cyclic in nature having all possibilities of their reoccurrence.

PARANOID DISORDERS

Paranoid disorders involves highly systematized and stable delusions of persecution or grandeur. In the delusion of persecution, the affected person feels that an individual or a group is attempting to harm him. As a result he becomes over cautious, inordinately suspicious and on a lookout for evidence to prove that his hypothesis is true. On the other hand, under the influence of grandeur delusion the person may feel that he has been endowed with some special ability, talent, gift or that he has been chosen by the Almighty, or a supernatural or earthly power to perform a great task, an invention, some reform or rule in one way or the other.

However, here it should be made clear that a paranoid person, unlike the paranoid schizophrenic, does not suffer from hallucination, has no emotional blunting and keeps his or her personality relatively intact.

On the basis of the degree or level of the severity or disorder, the paranoid disorder may be further sub-divided into two groups—paranoia and paranoid state.

Paranoia

Paranoia, sometimes called true paranoia, is rare. It is a quite developed state achieved after passing through the paranoid state. The delusion system here becomes highly systematized, organized and stable and the patient shows little or no signs of personality disorganization or incoherence in his thinking and behaviour. Contrarily, thus the paranoid individual is very well integrated. In fact, he is better integrated than normal individuals. He is cool, calculating and well controlled. He knows his enemies and plans aggression with great care and cunningness. It is in this sense that he is to be considered dangerous. His emotional reactions are in accordance with expressed ideas. The majority of them are self supporting and capable. They often go unidentified in general population and usually try to maintain their 'crazy' behaviour despite hospitalization and treatment. It is in this sense that paranoia is considered a continuous and incurable disorder.

Paranoid state

In comparison to paranoia, a person passing through paranoid state remains in it for a brief period and then recovers. It is thus less dangerous than true paranoia. The paranoid state lies between paranoia and the paranoid schizophrenia with respect to abnormalities in behaviour and resistance to deterioration. A paranoid state is neither very logical nor complex as true, bizarre and changeable than those observed in schizophrenia, and is less reasonable and is logically elaborate than those found in paranoia. Although thinking here is somewhat disconnected and hallucinations are common, yet the patient does not show any sign of impairment in intellectual and emotional spheres with the passing of years.

SCHIZOPHRENIA

In comparison to affective and paranoid disorders or the disorders described so far in this chapter, schizophrenia represents the most serious and severe mental disorder which requires a long or sometimes the whole life hospitalization of the patient.

The term *schizophrenia* literally means "splitting of the mind". Here splitting of the mind does not mean a split personality as an amnesia and multiple personality, but a marked separation of the self from reality. "The term schizophrenia," according to Coleman, *"is now used to include a group of psychotic reactions in which there are fundamental disturbances in reality relationships and in emotional and intellectual processes.* (1970, p. 275)

Schizophrenia as a rule manifests a number of symptoms, the significant ones of which are:

1. Lack of coherence in the thought process.
2. Disorganized patterns of thinking and feeling.
3. Apathy-absence of feeling.
4. Disorganized pattern of speech.
5. Peculiarities of movements of bizarre actions.
6. Autism-preoccupation with private fantasy.
7. Withdrawal from reality or seclusiveness.
8. Neglect of conduct and personal habits.
9. Delusions and hallucinations.

Types of schizophrenia

For diagnosis as well as treatment, the schizophrenic disorders are divided depending upon the severity of the symptoms and incurability of the disease.

Simple schizophrenia, as the name suggests, is the simplest type of schizophrenia characterized by an attitude of indifference or in advanced stages by extreme apathy and complete withdrawal

from social relations. In this stage the person remains occupied with his self all the time by cutting off from the surrounding events.

There remains nothing to wish for, nothing to fight for and the person is contented to lead a simple, irresponsible, indifferent and dependent life often cared for by his or her family.

Hebephrenic schizophrenia: In this disorder, the affected person retreats from the stress of life by regressing to a silly, childish level of behaviour and by withdrawing into a fantasy world of his own, with accompanying emotional disintegration and psychological symptoms of schizophrenic behaviour.

Catatonic schizophrenia: The catatonic schizophrenia is diagnosed mainly by the patient's behaviour fluctuating between stupurous depression and wild excitement.

During his periods of stupor, the patient may remain for hours in a bizarre posture. For example, he may sit, stand, or keep his limb in a particular position for hours on end or he may manifest symptoms like muscular rigidity (rigidity of the muscles and a general resistance to movement), waxy flexibility (remaining in any position in which he is put), echopraxia (mimicry or imitation of what other do), echolatia (automatic repetition of words said by another) and negativism (resisting even the simplest request). He may repeatedly carry out complicated stereotyped movements such as hanging the parts of his chair in a certain sequence symmetrically with both hands or walking endlessly up and down the ward; some steps in one direction and an equal number of steps in the other.

In the excited phase of catatonic schizophrenia patients display typical schizophrenic thinking and affect. They may frequently experience fears, hallucinations and delusions involving ideas of grandeur and persecutions.

Paranoid schizophrenia: This type of schizophrenia resembles the already discussed paranoid reactions in so many aspects but differs in being less systematic and more bizarre delusions and/or hallucination, as well as greater disintegration of behaviour pattern.

As a result, paranoid schizophrenia is diagnosed mainly by the disorders of thought content involving frequent systematic delusions and hallucinations of persecutory nature resulting in loss of critical judgement and an unpredictable behaviour.

In the beginning, the individual who develops paranoid schizophrenia feels unworthy and suffers from the feeling of inferiority. He resorts to the defence mechanism of blaming others for his failure to achieve. He carries this defence to extremes by distrusting everyone to the extent that he feels certain that they have designs against him. Suspicion gradually grows into ideas of reference and ideas of reference, in turn, become delusions of persecution.

Hallucination and the delusion of persecution of paranoid schizophrenic may take many forms, sometimes of very peculiar nature. The patient falsely believes that an event has a particular significance for him individually. He may believe that the events described by the newsreader on the television are oblique references to his own life; the newspapers say things about him in code; there is a special meaning for him in the nods and glances exchanged by others on the train.

The persecutory beliefs and the element of mystery combine to produce a preoccupation with plots to kill or injure the patient. A businessman was sure that his partner trying to get rid of him and take over the company. Another patient used to wear a rubber suit at home to protect himself from the rays of an "influenced machine" which a spiteful neighbour was directing against him. A labourer declared that some people were going to lower him into hot acid and make hot iron out of him. The more interesting case is of a woman patient who remarked that "one of the doctors has stolen my mind out of my head and he is going to use it to make a lot of money."

The paranoid schizophrenic is inclined to be very verbal about his or her ideas and beliefs. Such patients are generally alert, agitated, talkative, aggressive but also confused and afraid. At times

when they believe that someone wants to destroy them they destroy them first in order to save themselves. The hostile attitude and aggression shown by some of the paranoid patients reflects such trends. However, as the personality deteriorates with time, the paranoid schizophrenics tend to become withdrawn, apathetic rather than aggressive.

Causes Underlying Psychotic Disorders

The causes for one's maladaptation psychotic behaviour may be first looked into one's genetic makeup. However, it can be safely said that the genetic influences are a necessary, but not sufficient cause for the development of psychotic disorders. What is acquired as predisposition to the disorder in the form of defective genes and improper biological structure is further subjected to environmental influences. The early childhood experiences and family situations coupled with the stress events of later life acts as causative as well as precipitating factors in the development of psychotic disorders. In all cases therefore, the likelihood of an individual becoming a psychotic depends upon the magnitude or degree of the genetic predisposition (genetic plus biologically makeup) and socio-psychological factors including stressful events.

Treatment of Psychotic Disorders

Psychotic disorders, besides being a learned behaviour, have a hereditary and biological base. The treatment of such disorders may, therefore, involve the physical as well as psychological methods.

Physical method or Medical therapy carries out the physiological and medical treatment of the psychotic disorders. Some of the main measures belonging to this category are drug or chemotherapy, shock therapy and brain surgery.

In drug therapy, various drugs may prove effective in reducing the severity of symptoms and make the management of the patient convenient in the hospital or at home. **Shock therapy** involves an artificial induction of deep comas, convulsions or bath by shock inducing drugs (e.g. Insulin shock therapy IST) or electric current (e.g. Electro-convulsive therapy – ECT). It is recommended to patients who are difficult to be controlled or do not benefit from drug therapy.

Psycho-therapy involves surgical operation of the patient's brain for reducing the emotional torment of disturbing thoughts, apathy, delusions and hallucinations. However, it involves considerable risk and negative consequence and should therefore, be taken as a method of last resort.

Psychological methods or psycho-therapy provides psychological treatment of the mental disorders by a trained person (therapist) through a number of systematic approaches like psychoanalytic, client centered behaviour and group therapy etc. All these different psychotherapies aim to bring about changes in the patient's perception of himself and of his environment and thus resulting in positive enduring changes in his behaviour for achieving adequate adjustment and regaining better mental heath.

DIRECT AND INDIRECT METHODS OF TENSION REDUCTION

There is a saying that "if you remain tense, you will soon become past tense". It has quite a wide meaning and important lesson for all of us. It reflects the harmful consequences and impact of being overtensed to the extent that it may end our lives. Tension, in this sense, may be viewed as such harmful psychotical state of our mind or psyche that goes in a short or long way to impair the mental and physical health of the individual.