Psychology

PERSPECTIVES IN HUMAN BEHAVIOUR

REVISED AND ENLARGED EDITION

Edited by

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DR B.O. OLLEY

PSYCHOLOGY
Perspectives in Human Behaviour

(Revised and Enlarged Edition)

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CHAPTER FOURTEEN

Abnormal Psychology

B.O. OLLEY

INTRODUCTION

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

This chapter is divided into two parts. The first part begins with the definitions of abnormal behaviour, concept of abnormality, the etiology and assessment of abnormal behaviour. The second part considers specific psychopathologies which include the anxiety disorders, the psychoses (functional or organic), abnormalities of sexual preference and deviation, and personality disorders. The chapter is not in any way exhaustive of psychopathologies but, rather, an attempt to introduce commonly seen abnormal behaviours in Nigeria.

DEFINITIONS

Abnormal psychology is the branch of psychology that concerns itself with the study and evaluation of functional and organic disease patterns in human beings. It is the study of psychopathology, how it develops and the way it manifests.

There has been considerable controversy surrounding the concepts and definitions of 'normal' and abnormality (Scott, 1958). The following criteria are often used in defining abnormal behaviour:

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

CONCEPTS OF ABNORMALITY

The terms "abnormality", "psychopathology" and "mental illness" are often used interchangeably and all have been used in different contexts to mean exactly the same thing. Abnormality is a theoretical concept and many academicians have attempted to define it. Based on review of various criteria used in the literature, four dimensions criteria of its definitions have been identified and as such will constitute

the following discussion.

1. Objective Symptoms: The biological concept of abnormality.
2. Statistical Normality.
3. Social Maladjustment: The sociocultural concept; and
4. The Subjective Unhappiness: The psychological concept.

1. Objective Symptoms: The Biological Concepts of Abnormality

According to this point of view, mental illness is defined as an underlining physical abnormality: it is an illness, just like any other illness, and is to be treated by physicians. Implicit in this concept is the assumption that the illness is universal to mankind — that is, it occurs in all cultures and socioeconomic groups, in different proportions.

This concept of mental illness is probably most common and is still advocated by many mental health professionals. It is based on qualitative differences, and identifies specific abnormality defined by exclusion.

2. Statistical Normality

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

3. Social Maladjustment

This is a sociocultural concept of the origin of mental illness which focuses on interpersonal and social behaviour. It states that mental illness is a judgement of the interaction of an individual with his or her environment. It will consequently vary from society to society and from era to era. It emphasises the use of social norms in defining mental illness.

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

4. Subjective Unhappiness: The Psychological Concept

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

AETIOLOGY OF ABNORMAL BEHAVIOUR

The above explanation and definitions of mental illness are based on general views that have been propounded by social scientists interested in the behavioural patterns of abnormal behaviour. The causes of abnormal behaviour are traditionally in psychology classified into: biological, psychodynamic, humanistic/essential, behavioural or social learning, sociocultural, cognitive and lastly, eclectic.

1. Biological Model

This model focuses on the biological and physiological conditions that initiate abnormal behaviours. It sees all abnormal behaviour as a physical illness and that which results from genetic abnormalities as well as the disease condition of the central nervous system. It also contends that abnormal behaviour is a resultant of abnormality of the brain structure (brain size, or as a condition of imbalance of the neuro-

transmitters (biochemistry) of the brain fluid. Many studies with monozygotic twins and brain imaging have all supported the validity of medical/biological model of abnormal behaviour. An implication of the biological model is that drugs or surgery may be effective in treating psychological disorders.

2. The Psychodynamic Model

This model is loosely rooted in Freud's theory of personality. It assumes that psychological disorder results from anxiety produced by unresolved conflicts and forces of which a person is not aware of.

Normally, the primary unit of socialisation is the family and Freud emphasised it in the importance of the very elementary socialisation procedures inherent in family situation. Many weaning and toilet training procedures bring infants' biological needs into direct conflict with the demands of society, and it was the assumption of Freud that the form this conflict takes and how it is resolved are important determinants of the adult personality and adjustment. Three mental constructs used by Freud to explain the emergence of these conflicts are the id, ego and the superego. The id which is present at birth and is the most primitive of these constructs contains most basic urges such as hunger, thirst, warmth and sex. Within the id are two energies that control humans: the life instinct (Eros) and death instinct (Thanatos). The life energy of Eros is known as the libido, which is primarily sexual. The predominating energy of the Thanatos is aggression either turned inward (suicide) or turned outward (homicide). The id operates on the pleasure principle which makes it. seeks immediate gratification. Frustration of the id to satisfy the immediate need may result into conflict that makes it engage in primary process thinking, generating mental images of desired object (fantasy). The ego is primarily conscious, it develops from the id at six months old. It operates on the reality principle; which enables it mediate between what is possible and to mere fantasy. The ego uses secondary process thinking, which involves planning and decision-making. The third mental structure used by Freud is the superego: this develops through internalised societal standards, or moral values passed down through parental socialisations. Proper or improper resolutions of the interaction between the three mental constructs, according to Freud, determine abnormal behaviour. For example, an adult inappropriate behaviour of greed, stealing and corruption, according to Freud, would be due to the carry-over effect (fixation) of the unsocialised id impulses still embedded in such adult.

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

3. Humanistic/Existential Model

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

4. Behavioural or Social Learning Model

This model states that abnormal behaviours are caused by faulty or ineffective learning and conditioning patterns. Two fundamental assumptions of learning theorists are that (1) abnormal behaviour can be reshaped and (2) that more appropriate and worthwhile behaviour can be substituted through traditional learning techniques. Proponents of behavioural or learning model, Skinner and Pallor (1969), demonstrate the systematic relationship between behaviour and forces in the environment

that can control it. The learning theorists assume that events in a person's environment reinforce or punish various behaviours selectively and in doing so they shape personality and create maladjustment.

5. Sociocultural Models

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

6. Cognitive Model

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

7. Eclectic Model

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

ASSESSMENT PROCESS IN ABNORMAL BEHAVIOUR

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

i. Use of psychological test
ii. Direct behavioural observation
iii. Personality inventories or questionnaires.

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

CLASSIFICATIONS OF ABNORMAL BEHAVIOUR

Following consideration of the definitions and aetiology of abnormal behaviour in the preceding part, it is appropriate to turn to a description of the abnormalities themselves. It is pertinent to note that an introductory text of this nature may not be able to cover the diverse and abundant areas of psychology of abnormal behaviour. Readers are advised to consult specific text of abnormal psychology.

The concern of this text, therefore, is to discuss from the "biopsychosocial" concept of disease and with appropriate case illustrations, the anxiety disorders the psychoses, disorders of sexual dysfunctions, psychosomatic disorders and personality disorders.

Anxiety Disorders

Anxiety disorders, which is formally known as neuroses is derived from two Greek words meaning "nerve disorders" and was first used by William Cullen (1769) to designate a general class of diseases due to disordered notions or sensations of the nervous system. Neurosis is a relatively mild disturbance of mental state, characterised primarily by excessive anxiety, without a demonstrable organic basis. Basically, insight is preserved, though current findings indicate that insight may not necessarily be preserved as in the case of hypochondriasis and hysteria. This recent documentation according to the DSMIV classification, has made the use of neurosis as a broad classification obsolete. Nevertheless, neurosis and neurotic disorders are

used interchangeably in this text and both mean the same. All other neurotic classifications are known as disorders. Common reported symptoms of neurosis include; agitation, excessive sweating, hyperventilation, dilation of the pupils, hopelessness, helplessness, insomnia, loss of appetite, loss of libido, de-realisation and de-personalisation. Part of these characteristics could form a cluster of symptoms of specific neurotic conditions.

Neuroses are basically psychogemic, that is, they are largely determined more by happenings in individual's environment and past experience than by genetic constitutional or physical factors. It could be a learned response to certain traumatic situations.

Human beings generally experience certain degrees of anxiety from the daily hassles of life. The difference between a normal person and a neurotic person is in the degree of anxiety experienced. Most of the acute anxiety symptoms felt by the neurotic patient is what often leads him to seek psychological therapeutic help and intervention.

Phobic Anxiety

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

An example of phobia developing in a grown woman is summarised below.

CASE STUDY A

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

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

Two prominent features are basic to phobia in the above case study. Firstly, there are features suggestive of anxiety which include sweating profusely, tightening of stomach muscles and difficulty in breathing. Secondly, there is a tendency for Folu to avoid feared situations. These are the hallmark of a phobic disorder.

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

Dollard and Miller (1980) describe phobia as learned responses to painful experiences which are common in children. For example, according to the psychodynamic model the little boy castration fear may be found as a corresponding factor in fantasy of previous injury to the genital. It could also be a symbolic threat of sexual attack in girls and in boys with passive homosexual tendencies. Behavioural theory to phobia suggests that classical conditioning

occurs in the formation of phobic anxiety. For example, as was illustrated by the preceding case study, Folu's fear of a crowd could be easily connected with a fearful reaction to a television story about a nightclub that was set on fire where several people were killed.

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

OBSESSIVE-COMPULSIVE DISORDERS

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

Obsessions and compulsions generally are found in individuals with well-defined personality characteristics including stubbornness, rigidity, orderliness and excessive attention to detail.

Obsessions are often concerned with avoiding death of germs, preoccupation with sexual or hostile thoughts which are at complete variance with the individual's very proper personality and excessive concern with one's appearance.

A typical example of an obsessive individual was encountered by the author when intervening in the case of a young man who, when reading the Bible, substitutes the word Jesus for satan.

GENERALISED ANXIETY DISORDERS

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

The new classification of anxiety according to Diagnostic and Statistical Manual (DSM-IV) is known as Generalised Anxiety Disorder. It has also been referred to as panic attack, panic disorder or panic state. Anxiety as an illness may have an acute onset and be severe in intensity, appearing against a relatively normal background, or it may be of a chronic nature present from adolescent in mild degree and may fluctuate in severity according to current stress factors. Anxiety state could be diffuse or free floating or could be fixed. When anxiety is diffuse it is a situation where feelings of tension cannot be attached to any object or situation. When anxiety is fixed, it is attached to a particular object or situations. Common symptoms of anxiety include feelings of inner tension and anxious expectation and they may appear in bodily or somatic symptoms such as palpitations, pallor, sweating, goose flesh, dry mouth, anorexia, indigestion, diarrhoea, dilated pupils, and frequency of micturition. These somatic symptoms associated with anxiety are mediated through the autonomic nervous system and may involve all body systems. The anorexia which occurs may give rise to a loss in weight. Patients with anxiety may also manifest some emotional preoccupation, which may lead to difficulty in concentration. They may have difficulty in getting off to sleep, which may be disturbed by anxious dreams or nightmares. They may also express fears of insanity and headache. Overbreathing may occur in an acute state and is usually common in young women about the time of their menstrual periods.

In Nigeria, a prevalence rate of 2.9% was found in a primary health care study (Gureje, *et. al.*, 1995).

Traumatic Neurotic Disorder

This is the term applied to an anxiety neurosis that develops following what the patient sees as a serious threat to life. Such trauma may arise from a serious accident or from a combat stress. it could also result from minor injuries, particularly if the patient concerned has a predisposition to mental illness. Such patient, apart from having the clinical manifestations of anxiety already described, may frequently experience terrifying dreams in which he or she relives the traumatic situation. He or she may develop conversion symptoms, which are functional

symptoms added to any physical disability that may be present.

Compensation Neurotic Disorder

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

Neurasthenia: This is a neurotic disorder characterised by fatigue, irritability, headache, depression, insomnia, difficulty in concentration, and lack of capacity for enjoyment (anhedonia). It may follow or accompany an infection or exhaustion, or arise from continued emotional stress. Prevalence of the neurasthenia in a study among primary health care attendees in Ibadan was 1. 1% (Gureje, *et. al.,* 1995).

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

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

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

Neurotic Depression: This is a neurotic disorder characterised by disproportionate depression, which usually ensues as a result of recognisable distressing experience: it does not include among its features, delusions or hallucinations. There is often preoccupation with the psychic trauma which preceded illness, e.g., loss of a cherished person or possession. Anxiety is also frequently present and mixed states of anxiety and depression should be included here. Depression could also manifest as a psychotic condition. When this happens it always involves delusions and hallucinations. Psychotic depression will be considered in more details in subsequent parts. However, a comparison between neurotic and psychotic depression are highlighted in the following table (next page).

HYSTERICAL DISORDERS

Hysterical disorder is characterised by excessive emotional outburst, suggestibility, self-centred and attention-seeking behaviour with rapid mood change. This form of neurosis is commonest in young women during adolescence and early adulthood. Hysterical behaviour can be separated into three general types: 1. Conversion hysteria 2. Amnesia and 3. Dissociative hysteria.

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

PSYCHOTIC DEPRESSION	NEUROTIC DEPRESSION
1. Environmental changes have little or no effect on depression.	1. Mood may lift in cheerful company.
2. Sleep disturbance always severe. Early morning waking characteristic (delayed insomnia).	2. Sleep disturbance may or may not be present, if so there is difficulty getting off to sleep (initial insomnia).
3. Retardation of thought and action is common.	3. No retardation in physiological sense but may complain of fatigue.
4. Speech slowed as part of process of retardation.	4. Usually talkative, keen to discuss symptoms and frequently complain a lot.
5. Physical symptoms are marked. They include anorexia, weight loss, impotence, amenorrhoea and commonly concentration.	5. Anorexia and weight loss is less marked and may even be absent, impotence, amenorrhea, and constipation are not associated physiological symptoms.
6. Delusions are commonly present.	6. Delusions never present.
7. Individual tends to blame himself for his state.	7. Individual usually blames others or his environment.

and examined carefully, the differentiation usually presents no problem.

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

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

PSYCHOSES

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

Delusions are unshakable false beliefs inconsistent with reality, held in spite of evidence to the contrary. Hallucinations are the disorder of perception, e.g., visual, auditory, olfactory, gustatory, somatic or tactile. Illusion is the perception of a physical stimulus that differs from the commonly expected perception.

A. Schizophrenia

The term 'schizophrenia' originated with Bleuler, a Swiss psychiatrist (1911). Combining ideas from both Kraepelin and Freud, Bleuler conceptualised Kraepelin's syndrome as a disorder whose primary feature was an alteration of the faculty of association. Schizophrenic disorders or illnesses are pulsating psychotic conditions which occur throughout the world. It is a universal ailment. Behavioural scientists do not agree on what schizophrenia is and what it is not. However, many psychologists considered a disturbed thinking as the definite feature of the syndrome.

Symptoms of Schizophrenia

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

1. ***Faulty perceptual skills:*** Schizophrenics frequently have trouble focusing their atten-

tion. They are easily distracted and they cannot process information. They report feelings of bombardment of incoming sensory information. One patient observed: "I cannot concentrate, I am thinking of different conversations, I am like a transmitter, the sounds are coming through to me but I feel my mind cannot cope with everything".

2. ***Disorganised thinking:*** Schizophrenics often have trouble linking their thoughts together logically and solving problems.

3. ***Emotional distortions:*** Schizophrenics often show irrationality related problems. These include an inability to experience pleasure, flat or blunt affect and mood, feeling of apathy, anxiety, imbalance and strong contradictory feelings on a particular subject. A typical schizophrenic patient does not talk to anybody. One schizophrenic observed, "You see, I might be talking about something quite serious to you and other things come into my head at the same time that are funny and this makes me laugh".

4. ***Withdrawal from reality:*** Schizophrenic patients frequently feel normal about the real world and are preoccupied with inner fantasy and private experiences.

5. ***Bizarre behaviour:*** These include disrupted speech, verbal and physical violence.

SUBCLASSIFICATION OF SCHIZOPHRENIA

Schizophrenia is subclassified into, schizophreniform disorders, paranoid schizophrenia, catatonic schizophrenia, schizophrenia, reactive schizophrenia.

Schizophreniform Disorder

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

Paranoid Schizophrenia

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

A typical and famous paranoid schizophrenic patient during his trial Sirhan, the convicted assassin of Robert Kennedy, was diagnosed as paranoid schizophrenic. Shortly before Kennedy's assassination, Sirhan deluded that he (Kennedy) had proposed sending 50 aircrafts to Israel. He harboured intense delusions against Kennedy. He imagined himself acting on behalf of the Arab nations. He wrote himself numerous "Kill Kennedy" orders. Sirhan's note suggests that he also hallucinated Kennedy's face plotting out his own image in a mirror.

Catatonic Schizophrenia

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

Apart from psychomotor slowness and stupor,

catatonic schizophrenics can have conditions known as agitated catatonia or catatonic excitement. This is a condition where the patients have uncontrollable motor and verbal behaviour. They can be violent at this stage and are quite dangerous to themselves and also difficult to manage.

Disorganised or Hebephrenic Schizophrenia

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

Reactive Schizophrenia

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

CASE STUDY B

A Form VI student underwent a sudden personality change two months before his A'Level examinations. He became seclusive, spoke harshly when his schoolmates tried to be friendly and was unable to sleep, spending much of each night in unproductive study. It was reported that he was sometimes confused and attempted to go to classrooms at meal-times. One morning he was found under a mango tree not having slept in his bed and telling a rather incoherent story of being chased by robbers. During his three-week hospitalisation he gradually settled with the assistance of phenothiazine drugs. As he improved, he spoke of his responsibilities as the first-born in his large family and his worries about the examinations. When he was able to leave the hospital he was no longer psychotic, but his concentration remained impaired. It was concluded that it would be unwise for him to sit for the examinations until he seemed relied. Culled from Asuni, Schoenberg and Swift (1994)

B. Affective Disorders

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

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

DEPRESSION

The central features of depression can be subsumed into general, physical, symptoms of depression. Among the general features are low mood, sadness or discouragement. The psychological features include lack of enjoyment, diminished concentration or indecisiveness, pessimistic thinking, guilt or self-blame, negative self-reproach or self-concept, and reduced libido. The physical features will include reduced energy, constipation, memory impairment, psychomotor, agitation or retardation, loss of appetite, loss of weight or weight gain, and in rare extreme

cases suicide.

The moods of a depressed patient are a mystery. This mood does not improve substantially in circumstances where ordinary feeling of sadness would be alleviated. Three major components are vital to depression: these are pessimistic thoughts, lack of enjoyment and psychomotor retardation.

Pessimistic thought is a state of depressive cognition and can be divided into three parts:

A. The first part is concerned with the patient's present circumstance, a typical patient sees the unhappy side of every event. He thinks he is failing in everything that he does and that other people see him as a failure.

B. The second group of thought is concerned with the future. The patient expects the worst. He foresees failure in his work, finances, misfortune of his family and an enviable deterioration in his health. This idea of hopelessness is often accompanied by the thought that life is no longer worth living and that death would come as a welcome release. These gloomy preoccupations may prepare the plans for suicide.

C. The third group of thought is concerned with the past. They often take the form of unreasonable guilt and self-blame about minor matters. For example, a patient may feel guilty about past trivial act of dishonesty.

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

CASE STUDY C

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

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

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

PRIMARY AND SECONDARY DEPRESSION

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

REACTIVE AND ENDOGENOUS DEPRESSION

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

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

HYPOMANIA

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

SCHIZO-AFFECTIVE DISORDERS

A condition exists when symptoms of schizophrenia such as hallucination, delusions of different types and disorders affect one, such as the ones discussed above. When we have such, there is what is known as Schizo-Affective disorders.

ORGANIC PSYCHOSIS

These are disorders that result from brain impairment and which have a known physical basis. Organic psychosis may be triggered by infections (such as syphilis), traumas (such as skull fractures and concussions), nutritional deficiencies (such as pellagra), cerebrovascular disease (such as arteriosclerosis and brain hemorrhage), tumours, degenerative diseases (such as Hutington's chorea), toxins (such as lead) and endocrine dysfunctions. Basic and general features in organic psychosis will include: (1) Impaired orientation, (2) Memory loss, especially retrograde amnesia, that is, loss of memory preceding an accident or illness, (3) Intellectual deterioration, such as difficulty in planning, reasoning, and communication, (4) Blunted or exceedingly unstable emotional responses. The undermentioned case study will suffice a typical organic patient.

CASE STUDY-D

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

ACUTE BRAIN SYNDROME

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

CHRONIC BRAIN SYNDROME

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

DELIRIUM TREMENS

This is a special form of acute brain syndrome occurring in chronic alcoholics, especially when alcohol is withdrawn but sometimes occurring during a period of unusually excessive drinking. The symptoms of delirium tremens usually come on at night with perhaps one or two days of preceding progressive uneasiness and apprehension. The patient experiences frightening illusions or hallucinations generally of a visual or tactile variety. These are sometimes intensified by related delusion. The patient experiences panic and terror. He is disoriented, restless, agitated and cannot sleep. The symptoms often subside during the daytime.

Physical illness associated with organic psychosis will include psychosis after head injuries and psychosis associated with nutritional deficiencies.

PSYCHOSIS AFTER HEAD INJURIES

With the growth in industrialisation and the increase in highway traffic in Nigeria, organic mental disorders resulting from head injuries are becoming more

common. Specific symptoms are determined by the extent and the location of the injury as well as premorbid personality of the individual. Conditions resulting in psychosis from head injuries include:

i. Concussions: Characterised by a short period of unconsciousness following a blow to the head.
ii. Contusions and Lacerations: Characterised by crushing or tearing of brain tissues usually resulting from a heavy blow to the head with or without skull fracture. Coma may result and the longer the coma the greater is the likelihood that brain damage has occurred.
iii. Subdural and epidural haematoma; this results from bleeding head trauma.

PSYCHOSIS ASSOCIATED WITH NUTRITIONAL DEFICIENCIES

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

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

SENILE DEMENTIA

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

PRESENILE DEMENTIA

Presenile dementias are neurological conditions which include Alzheimer's disease and Pick's disease. Alzheimer disease is a neurological condition which occurs in an individual before the age of 65 years. It is characterised by a degenerative, slow onset of mental functioning. It has in addition a progressive deteriorating course. Symptoms include agitation, emotional outbursts, disrupted sleep and amnesia. Pick's disease, on the other hand, is less common and reaches its peak in the 50-70 years old age group. It is distinguished from Alzheimer's disease for its disinhibited, tactless and facetious personality deterioration, the language tends to stereotyped output, and they often exhibit echolalia and autism.

TUMOURS

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

PSYCHOSIS RESULTING FROM PROGRESSIVE NEUROLOGICAL ILLNESS

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

and extremities as well as facial grimacing, explosive speech and ataxia.

PSYCHOSIS ASSOCIATED WITH SEVERE MEDICAL ILLNESS

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

PROBLEMS OF SEXUALITY AND GENDER IDENTITY

Psychological disturbances often associated with the sexual and gender orientation in human beings will include disorder of sexual dysfunction, sexual deviation and homosexuality.

SEXUAL DYSFUNCTIONS

Sexual dysfunctions are conditions resulting from inability of a person to enjoy normal coitus. In men sexual dysfunction is referred to as repeated impairment of normal sexual interest and/or performance. In women it is referred often to as repeated unsatisfactory quality to the experience of intercourse. Sexual intercourse can be completed but may be without enjoyment. What is regarded as normal sexual intercourse, and, therefore, what is thought to be impoverished or unsatisfactory, depend in part on the expectations of the two people concerned. For example, when the woman is regularly unable to achieve orgasm, her partner regards it as normal while another may see it as abnormal. Problems of sexual dysfunction are classified into those affecting:

a. Sexual desire and sexual enjoyment, problems resulting in pain: vaginismus and dysparania in women, and painful ejaculation in men.
b. The genital response (erectile impotence in men, and lack of arousal in women).
c. Orgasm (premature or retarded ejaculation in men, orgasmic dysfunction in women).

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

ABNORMALITY OF SEXUAL PREFERENCE (PARAPHILIAS)

Sexual deviations otherwise known as perversions is referred to as sexual behaviour that are socially disapproved. It is often a classification of people, rather than diseases or behaviour. Paraphilias can be classified into: (1) Abnormalities of the preference of sexual object and (2) Abnormalities in the preference of sexual act. Abnormality of preference for sexual object involves intercourse or achievement of sexual excitement with an object other than another adult. Such objects may be an inanimate, as in fetishism and transvestic fetishism, or may be a child (paedophilia) or an animal (zoophilia).

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

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

with masturbation.

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

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

PREFERENCE OF SEXUAL ACT

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

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

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

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

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

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

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

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

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

HOMOSEXUALITY

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

The relationship does not last and some homosexual men exclusively experience strong feelings of identity with other homosexuals and seek their company, most often in clubs or bars. Some adopt

feminine mannerisms and dress in women clothes to attract others. Most homosexual men have a way of life like that of single heterosexual men, but a few of them prefer work and leisure activities that would usually be undertaken by a woman. Most are contented as heterosexual men and have a stable relationship with a partner. Homosexual men vary in personality as much as heterosexual men. In homosexual men (as in heterosexual men) disorder of personality is more likely to lead to difficulty with other people or with the law and more likely to lead to referral to a psychiatrist or clinical psychology.

As regard homosexual women, tender feelings and social activities are important sources of satisfaction. Physical intercourse between them includes caressing, breast stimulation, mutual masturbation and oral-genital contact otherwise known as cunnilingus. A minority of them practise full body contact with genital friction or pressure known as tribadism, or they may engage in the use of a vibrator or artificial penis. Active and passive roles are usually exchanged, although one partner may habitually take the active role. Social behaviour is usually like that of heterosexual women, although some seek work and leisure activities more often associated than with men. A few of them dress and behave in a masculine way.

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

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

DETERMINANTS OF HOMOSEXUALITY

Genetic causes such as what obtained in abnormality of the sex chromosomes have been implicated among homosexuals. Also, certain hormonal theories and neuroanatomical differences have been implicated. As regards psychological causes, compared with heterosexuals, homosexual men and women have more often experienced a poor relationship with or prolonged absence of the father. Other psychoanalysts have also reported that mothers of homosexual men are overprotective or unduly intimate. Some also suggested that female homosexuality results from failure to resolve unduly close relationships with the patients in early childhood, with the result that intimate involvement with men is frightening and women become the preferred object of love. In a study of homosexual, Freedman, Kaplan, Sadock (1976) found that homosexual women reported a poor relationship with both mother and father. Also a quarter of the homosexual women had parents who are divorced compared with 5% in the controls.

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

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

PERSONALITY DISORDERS

Personality is the emotional, behavioural, intellectual, and physical characteristics of an individual. Behaviours resulting from a particular personality traits or attributes, assume proportions which places it outside the broad limits of socially approved norms, one can begin to think about personality disorders as opposed. This is opposed to characteristics, which are evident in every human being. Common personality disorders include: paranoid personality disorder, affective personality disorder, schizoid personality disorder, explosive personality disorder, anankastic personality disorder, hysterical personality disorder, asthenic personality disorder and personality disorders with predominantly tendencies.

PARANOID PERSONALITY DISORDER

This is a "personality disorder in which there is excessive sensitiveness to setbacks or what are taken to be humiliations and rebuffs, is a tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous and a combative and tenacious sense of personal rights. There may be a proneness to jealousy or excessive self-importance. Such persons may feel helplessly humiliated. Self-reference is another important characteristics of paranoid personality

disorder. 'Self-reference' refers to the overwhelming tendency in the paranoid personality to see everything in his or her surroundings as referring or relating to himself or herself.

AFFECTIVE PERSONALITY DISORDER

These are personalities which are characterised by a lifelong predominance of a pronounced mood which may be persistently depressive, persistently elated, or alternatively one than the other. During periods of elation there is an unshakable optimism and enhanced activities of life. Periods of depression are marked by worry, pessimism, low output of energy and sense of futility".

SCHIZOID PERSONALITY DISORDER

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

EXPLOSIVE PERSONALITY DISORDER

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

ANANKASTIC PERSONALITY DISORDER

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

HYSTERICAL PERSONALITY DISORDER

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

ASTHENIC PERSONALITY DISORDER

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

PERSONALITY DISORDERS WITH PREDOMINANTLY SOCIOPATHIC TENDENCIES

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

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