PSYCHOLOGY

Combination: History-Literature in English-Psychology

Senior 6 Student Book

EXPERIMENTAL VERSION

Kigali, 2023

FOREWORD

Dear Student,

Rwanda Basic Education Board is honoured to present the Psychology Student Book for Senior Six, History-Literature in English-Psychology Combination. It was designed based on the Psychology curriculum to support its implementation.

This student book includes topics related to social psychology, health psychology and guidance and counselling. These units equip you with basic knowledge, skills and attitudes that you need to apply social psychology theories in the social context of development and engage collaboratively in conflict resolution based on social and group issues. Having the understanding of these units will help you again to act as a role model in inculcating positive attitudes and values, challenging negative motives among individuals, prevent the occurrence and worsening of psychosocial issues, guide people through difficult life course due to poor health practices or owing to psychological disorders and use appropriate techniques to provide guidance and counselling.

The student book is made of ten (10) units designed in a way that facilitates self-study. Each unit starts with a key unit competence which represents abilities you are expecting to have by the end of the unit. This competence will be built progressively throughout the unit. The key unit competence is followed by an introductory activity that you are requested to attempt before any other contact with the content under the unit. The unit is then broken down into different sub-topics to help you to go step by step. Each sub-topic starts with an activity in which you are requested to engage. The content that follows each sub-topic is a summary that gives you clear definitions of concepts, explanations to complement what you have acquired through learning activities. At the end of each unit, there are assessments tasks/activities that give you an opportunity to demonstrate the level of achievement of the key unit competence.

For effective use of this textbook, your role is to: (i) Participate and take responsibility for your own learning: you are encouraged to engage in given activities to develop cooperation, communication, critical thinking, innovation and problem solving skills; (ii) Share with your classmates, relevant information through presentations, discussions, group work, videos, visits, lesson observation, field/ classroom visit, group discussions, brainstorming, role play, case studies, interpretation of illustrations, research etc; (iii) Conduct further research to enrich information provided under each topic (iv) Draw conclusions based on the findings from the learning activities.

Enjoy learning “Psychology, Senior Six” using your book!

Dr. MBARUSHIMANA Nelson
Director General, REB

ACKNOWLEDGEMENTS

I wish to express my appreciation to all the people who played a major role in the development of this Psychology Student Book for Senior Six. It would not have been successful without active participation of different education stakeholders.

I owe gratitude to the University of Rwanda-College of Education and Teacher Training Colleges (TTCs) that allowed their staff to work with Rwanda Basic Education Board (REB) in the in-house textbooks production project.

I wish to extend my sincere gratitude to lecturers, tutors and all other individuals whose efforts in one way or another contributed to the successful production of this textbook.

Special thanks go to the team of illustrators and designers who ensured that the textbook has required illustrations and are in- design with suitable layout.

Finally, my word of gratitude goes to the Rwanda Basic Education Board staff particularly those from Curriculum, Teaching and Learning Resources Department (CTLRD) who were involved in the whole process of in-house textbook writing.

MURUNGI Joan,
Head of CTLRD, REB

TABLE OF CONTENT

UNIT 1 RATIONALE OF SOCIAL PSYCHOLOGY IN SOCIAL CONTEXT

Key unit competence: Interpret the rationale of social psychology in relationships with others.

Introductory activity:

Referring to the photo above talk about which moments do people like taking selfie photos.

Referring to those moments, describe how people behave in front of camera! Do they behave in the same way? Why?

Do all people like taking selfies? Compare a selfie taken when you were with friends and that one you took alone. Are they the same? Why?

1.1. Key concepts of Social Psychology: Social cognition, Self-concept, Social influence (conformity, compliance, and obedience)

Learning activity 1.1

Mary was sent to the market by her mother to buy school materials, on the way going she met her friend Yves and he asked her to return back home with him, Mary did not refuse but asked Yves to wait for her until she came back from the market because she would bring school materials as asked by her mother and she was together with other friends with whom she would go and come back together.

1. Describe Mary's behavior in response to her mother's request and to her friend's request?

1.1.1. Social Cognition

Social cognition is a subtopic of social psychology. Its focus is the study of how and why we perceive ourselves and others as we do.

This is important because without an understanding of our self-perception, it is impossible to fully grasp how our actions are interpreted by others. Similarly, to understand why others act as they do toward us, we must rely on our perception of their thoughts and motivations.

Social cognition is the way in which people process, remember, and use information in social contexts to explain and predict their own behaviour and that of others. Children's social cognition may be influenced by multiple factors, both external and internal to the child

Social cognition encompasses a range of processes. Some common factors that many experts have identified as being important include:

- The processes involved in perceiving other people and how we learn about the people in the world around us.
- The study of the mental processes involved in perceiving, remembering, thinking about, and attending to the other people in our social world.
- The reasons we attend to certain information about the social world, how it is stored in memory, and how it is used to interact with other people.

1.1.2. Self-concept

Self-concept is the image we have of ourselves. it is how we perceive our behaviours, abilities, and unique characteristics. For example, beliefs such as "I am a good friend" or "I am a kind person" are part of an overall self-concept.

It embodies the answer to the question: "Who am I?" If you want to find your self-concept, list things that describe you as an individual. What are your traits? What do you like? How do you feel about yourself?

Self-concept tends to be more malleable when we are younger and still going through self-discovery and identity formation. As we age and learn who we are and what's important to us, these self-perceptions become much more detailed and organized.

(i) **Rogers' Three Parts of Self-Concept**

Humanist psychologist Carl Rogers believed that self-concept is made up of three different parts:

- **Ideal self**: The ideal self is the person you want to be. This person has the attributes or qualities you are either working toward or want to possess. It's who you envision yourself to be if you were exactly as you wanted.
- **Self-image:** Self-image refers to how you see yourself at this moment in time. Attributes like physical characteristics, personality traits, and social roles all play a role in your self-image.
- **Self-esteem:** How much you like, accept, and value yourself all contribute to your self-concept. Self-esteem can be affected by a number of factors—including how others see you, how you think you compare to others, and your role in society.

(ii) **How Self-Concept Develops**

Self-concept develops, in part, through our interaction with others. In addition to family members and close friends, other people in our lives can contribute to our self-identity.

The media plays a role in self-concept development as well—both mass media and social media. When these media promote certain ideals, we're more likely to make those ideals our own. And the more often these ideals are presented, the more they affect our self-identity and self-perception. Self-concept can also be developed through the stories we hear.

1.1.3. Social influence

Social influence describes how our thoughts, feelings, and behaviours respond to our social world, including our tendencies to conform to others, follow social rules, and obey authority figures. We adjust our views to match the desires of those around us. Social influence takes two basic forms**: implicit expectations** and **explicit expectations**.

- **Implicit expectations** are unspoken rules like the unwritten laws, implicit expectations are enforced by group norms. For example, no one has to tell you that you will likely be expected to dress differently at formal religious events compared to attending a concert. Implicit expectations can be further subdivided into two types.

The first is **conformity**, which occurs when you voluntarily change your behaviour to imitate the behaviour of your peers. Twenty-five years from now, you will probably look at a current picture of yourself and wonder how you could have made such terrible fashion choices way back when. At the time, you were probably wearing what everyone else was wearing.

Conformity is matching your behaviour and appearance to the perceived social norms of a group. It is adjusting our behaviour or thinking towards some group standard.

Experiments reveal that we are more likely to conform when we:

- We are made to feel incompetent or insecure
- We are in a group with at least three people
- We are in a group in which everyone else agrees (if just one other person disagrees, we will almost surely disagree)
- We admire the group's status and attractiveness
- We have not already committed ourselves to any response
- We know that others in the group will observe our behaviour
- We are from a culture that strongly encourages respect for social standards.

A second form of implicit social influence comes from **social roles**, or expectations from a group about how certain people are supposed to look and behave. Social roles are the part people play as members of a social group. With each social role you adopt, your behavior changes to fit the expectations both you and others have of that role.

Example : Think of different roles people play in society like being son, daughter, sister, brother, students, worker, friend etc. Each social role carries expected behaviors called norms.

Social norms are the unwritten rules of beliefs, attitudes, and behaviors that are considered acceptable in a particular social group or culture. Norms provide

us with an expected idea of how to behave, and function to provide order and predictability in society. For example, we expect students to arrive to a lesson on time and complete their work.

Social norms are the accepted standards of behavior of social groups.

Norms provide order in society. It is difficult to see how human society could operate without social norms. Human beings need norms to guide and direct their behavior, to provide order and predictability in social relationships and to make sense of and understanding of each other's actions. These are some of the reasons why most people, most of the time, conform to social norms. These expectations are implicit because while everyone knows the "rules," they aren't necessarily written down or formalized.

- **Explicit expectations** are clearly and formally stated not at all subtle. There are also two forms of explicit expectations: **compliance** and **obedience**.

Compliance occurs when you behave in response to a direct or indirect request, this occurs when we simply agree to do something because another person asks us to do it, even if that person has no authority over us. Complying with authority figures such as teachers or police officers can provide considerable advantages to society. It appears that our natural tendency to affiliate leads us to behave in ways that encourage the development of relationships, including being compliant. Compliance is higher when factors that normally lead to the formation of relationships are present, such as perceived similarity and physical attraction. With compliance, there isn't necessarily any threat of punishment for not doing the behaviour it is a request, not a demand.

In contrast, **obedience** occurs when you behave in a particular way because someone of higher status has ordered you to do so. It might be your boss at work, a parent, or a professor at school; in any case, the expectation is stated clearly and often accompanied by some kind of social punishment if you fail to obey. In general, obedience can be considered a more extreme version of compliance. Obedience is defined as compliance with the request of an authority figure.

No society can exist without any obedience at all. If everyone drove a car according to his/her own ideas, chaos, not to mention a large number of accidents, would no doubt result as much as we value truth and independence, we also value our relationships with others. In cases where these values conflict, many people apparently give their social relationship the top priority. Risking rejection just to be right might directly oppose your need to remain affiliated with a group(Moscovici,1976).

However, history is full of instances where blindly following orders leads people into highly unethical behaviour. Even on a daily basis obedience to authority can overwhelm individual judgement.

Application activity 1.1

1. Which of the following strengthens conformity to a group? (Choose the letter which corresponds to the answer)
   a) Finding the group attractive
   b) Feeling secure
   c) Coming from an individualist culture
   d) Having already decided on a response
2. Humanist psychologist Carl Rogers believed that self-concept is made up of three different parts which are ……, ……... and…….
3. How do you differentiate between conformity compliance and obedience?
4. What is the difference between self-concept and self-esteem?
5. How does culture influence self-concept?

1.2. Key concepts of Social Psychology: Prejudice and stereotypes Discrimination

Learning activity 1.2

Janet has a mental disability and she is demonstrating disruptive behavior, she went to hospital for treatment because she was having dental illess. The dentist observed her and said she was not prepared to treat her because of her behaviour.

1. Describe doctor's behavior in relation to the problem of Janet?
2. Give another example related to real life in relation to this case which happened to Janet?

Prejudice

Prejudice means prejudgement which is an unfair negative attitude towards some group. The target of the prejudice is often a different cultural, ethnic or gender group. Prejudice can also be defined as a negative attitude and feeling toward an individual based solely on one's membership in a particular social group (Allport, 1954; Brown, 2010). Prejudice is common against people who are members of an unfamiliar cultural group.

Components of Prejudice

- The Cognitive Component: Stereotypes
- The Affective Component: Emotions
- The Behavioural Component: Discrimination

1. The Cognitive Component: Stereotypes

The human mind cannot avoid creating categories, putting some people into one group based on certain characteristics and others into another group based on their different characteristics (Brewer, 2007; Dovidio & Gaertner, 2010).

Just as we make sense out of the physical world by grouping animals and plants into taxonomies, we make sense out of our social world by grouping people according to characteristics that are important, most notably gender, age, and race.

We rely on our perceptions of what people with similar characteristics have been like in the past to help us determine how to react to someone else with the same ones (Andersen & Klatzky, 1987; Macrae & Bodenhausen, 2000). The resulting categories are both useful and necessary, but they have profound consequences. They do not inevitably generate prejudices, but they can be the first step.

Stereotyping, however, goes a step beyond simple categorization. A stereotype is a generalization about a group of people in which identical characteristics are assigned to virtually all members of the group, regardless of actual variation among the members.

A stereotype is also defined as a specific belief or assumption (thoughts) about individuals based solely on their membership in a group, regardless of their individual characteristics. Stereotypes can be positive or negative and when overgeneralized are applied to all members of a group

The stereotypic quality might be physical, mental, or occupational. Stereotyping can also be explained as cognitive process, and stereotypes can be positive as well as negative because If you like a group, your stereotype will be positive, but if you dislike the group, your stereotype of the same behaviour will be negative. Often, stereotyping is merely a technique that all of us use to simplify how we look at the world. It is a useful tool in the mental toolbox.

2. The Affective Component: Emotions

If you've ever argued with people who hold deep-seated prejudices, you know how hard it is to get them to change their minds. Even people who are usually reasonable about most topics become immune to rational, logical arguments when it comes to the topic of their prejudice.

Why is this so? It is primarily the emotional aspect of attitudes that makes a

prejudiced person so hard to argue with; logical arguments are not effective in countering emotions.

If you have a stereotype of a group that you know little about, and if you are not invested emotionally in that stereotype, you are likely to be open to information that disputes it.

3. The Behavioural Component: Discrimination

Discrimination is Unjustified negative or harmful action toward a member of a group solely because of his or her membership in that group. Prejudice often leads to discrimination, which is unfair treatment of members of a stigmatized group solely because of their membership in that group. The discrimination may be as official or subtle.

Discrimination can also be explained as unfair treatment of those who belong to a certain social group, community, or religion. It is the overt or behavioral manifestation of bias. In general, the individual discriminated against is denied some advantage or right that other members of society who do not belong to the minority group enjoy.

Every behavior or actions, usually negative, towards an individual or group of people, especially on the basis of sex/race/social class, etc is also discrimination.

Discrimination affects people's opportunities, their well-being, and their sense of agency. Persistent exposure to discrimination can lead individuals to internalize the prejudice or stigma that is directed against them, manifesting in shame, low self-esteem, fear and stress, as well as poor health".

Examples

- **Age discrimination:** This is a type of discrimination against a person or group on the grounds of age.
- **Gender discrimination:** In Western societies, while women are often discriminated against in the workplace, men are often discriminated against in the home and family environments.

Application activity 1.2

1. Are prejudices and discrimination the same?
2. With example define what prejudice is?
3. State one advantage and one disadvantage of stereotyping?

1.3. Nature and scope of Social Psychology

Learning activity 1.3

Based what you learnt from the unit of branches of psychology in senior four, and your experience in everyday life, explain how you understand the nature and scope of social psychology

1.3.1. Nature of social psychology

Social psychology's nature must be understood on multiple levels. Let us attempt some of them.

1. Social psychology as a science

Social psychology is a science because it evaluates and provides explanations of human behaviour. Scientific method involves systematic and detailed attempts to which includes as follows:

- The careful collection of observations or data (methodology),
- The ordered integration of these observations into hypothesis and scientific laws (theory building),
- Tests of adequacy of these laws in terms of whether they can be successfully predicting future observations (Scientific experiment and observation).

2. Social psychology focus on individual behaviour

The social thoughts and actions are taken by individuals. They might be influenced by the society. But the thought and actions are of the individuals, and not groups. The social psychology has a very strong focus on individuals, and tries to understand the behaviour of individuals. It also tries to understand various environmental influences on social thought and actions, Culture, social norms, etc. Still the focus of the social psychology enquiry is individual.

3. Understand causes of social behaviour and thought

Human social behaviour and thoughts are caused by many things. Social psychology would try to understand them. Some important factors are as follows:

- **Actions and characteristics of other persons**: We are affected by various actions of others. Our behaviour often gets affected by other's behaviour,
- **Cognitive process:** Our thinking determines what we do in social circumstances. This is studied in the area of social cognitions. Cognition is our thinking process. Our behaviour is determined by what we think

while judging another person; we heavily depend upon our memory, information- processing capacities.

- **Ecological variables:** The physical world around us to a great extend determines our behaviour. Research findings indicate that physical environmental has tremendous impact on social behaviour.
- **Cultural context:** The culture in which we stay or are born and brought up determines our behaviour.
- **Biological factors:** The biological factors influence our social behaviour. They can be understood as physiological factors and neurological factors, genetic factors, and evolutionary factors.

1.3.2. Scope of social psychology

Social psychology tries to understand the relationship between minds, groups, and behaviours in three general ways:

1. **It tries to understand how the thoughts, feelings and behaviours of individuals are influenced by the actual, imagined, or implied presence of other(s).**

This includes social perception, social interaction, and the many kinds of social influence (like trust, power, and persuasion).

It deals with questions like:

- How do small group dynamics impact cognition and emotional states?
- How do social groups control or contribute to behaviour, emotion, or attitudes of the individual members?
- How does the group impact the individual?
- How does the individual operate within the social group?

It tries to understand the influence that individual perceptions and behaviours have upon the behaviour of groups. How does persuasion work to change group behaviour, emotion or attitudes?

2. **It tries to understand the influence of individual perceptions and behaviours have upon the behaviour of groups.**

This includes looking at things like group productivity in the workplace and group decision making. It looks at questions like: What are the reasons behind conformity, diversity, and deviance?

3. **Social psychology tries to understand groups themselves as behavioural entities and the relationships and influences that one group has upon another group.**

It enquires questions like:

- What makes some groups hostile to one another, and others neutral or civil?
- Do groups behave in a different way than an individual outside the group?

Application activity 1.3

1. Why is social psychology a science?
2. Human social behavior and thoughts are caused by many things. Suggest some of them?

1.4. Importance of Social Psychology

Learning activity 1.4

Based on what you learnt from the in unit of branches of psychology in senior four, and your experience in everyday life, explain how social psychology is important.

Social psychology is a scientific study of human behaviour in society. It studies human behaviour within a group of people such that how a human behaves in presence of others or that how human behaviour is influenced by others. It attempts to understand the socio-psychological causes and motives of human behaviour in groups.

1. Social psychology and mental health

Mental health problems such as depression, anxiety, stress, phobia, schizophrenia, psychosis, and personality disorders are the growing problems of the modern world. Most mental health problems have socio-psychological causes such as stressful relationship with others, death of loved ones, marriage adjustment issues, weak family bonds, break ups, working in stressful environment and unexpected social changes. Such social circumstances become a cause of emotional disturbance, mental retardation, drug abuse, abnormal behaviour and even criminal behaviour.

Social psychology plays a significant role in addressing mental health issues. Social psychology is concerned with the diagnosis and treatment of mental illness. As most of the mental health issues nowadays have socio-psychological

causes. It is a better approach to identify these causes and address them accordingly. Social psychology provides basic knowledge and tools to identify these causes which are indirectly linked to the physical health of a person but directly originate from the social context where the person may experience these issues.

In some countries social psychologists are licenced to treat patients with mental health issues by using psychological practices of treatment in many other countries social psychologists work together with psychiatrists and medical doctors for the treatment of mental illness.

2. Social psychology and business

Business is crucial to a country's economy because it provides goods, services and jobs opportunities to the citizens. Social psychology plays a prominent role in the business sector. Nowadays business uses psychological techniques for boosting the production and sale of goods. Television advertisement for products are made on the basis of social psychological techniques of marketing. These advertisements are made to change the attitude of people towards a product in the desired way. Attitude change is a part of the subject matter of social psychology that guides how to change the attitude of others towards something positively example: by presenting products in advertisements in a way that fascinates the viewer.

3. Social psychology and education

Social psychology has also an important role in the sector of education. It helps teachers in improving their teaching skills according to the psyche of different levels or age of students so they can learn effectively. It helps students in improving their learning skills, cognition skills and intelligence level. It devises certain contextual techniques for the motivation of students and good student-teacher relationship.

Poor academic performance of students is sometimes due to socio psychological issues. A restrictive environment, lack of encouragement, punishments, overburden of studies, fear of failure in the exam and harsh treatment may destroy the student's creativity as well as their capacity to learn adequately. Since these problems originate from the contextual environment social psychology highlights these issues in the educational environment in schools, colleges and universities in order to make an environment that is supportive for effective learning. It also guides students on how to cope with stress related to their studies such as exam stress.

4. Social psychology and industry

The rapid growth of industrialization in modern societies has made it a great contributor to the economic growth of a country as well as the overall development of the country. Social psychology has also wide applicability in the industrial sector to maxims its benefits. For instance, good working relationships among the employees is an important factor in the productivity and effectiveness of the industry. However, the working environment in industries is sometimes adverse and is not conducive for good working relations among its employees. Social psychology highlights these issues which may lead to an adverse working environment and devised techniques to address these problems. The stakeholders of industries arrange training of social psychologist periodically for their employees to improve the working environment.

Motivation is another key factor in the productivity of employees. Motivation is an important subject area of social psychology that discusses how to keep people motivated for good things. These techniques are also applied to motivate employees and to refine their team work abilities in different organization.

5. Social psychology and military

Social psychology has a prominent role in military organizations. The soldiers are trained physically as well as psychologically to cope with difficult situations courageously. The psychological techniques are used to train the soldiers to become fearless strugglers and determined to the aim. The soldiers have to come across various situations in life such as wars, disasters, harsh environmental conditions and so on. The soldiers are trained to have an emotionally balanced personality to deal with such situations bravely.

This is why the selection procedures of candidates for the military service generally involves specific psychological test. The purpose of the psychological evaluation is to ensure that the candidate must have the psychological attributes required for the delivery of military services.

6. Socialization and personality development

Children are the future of the nation. A child must be raised in such a way that they develop a healthy personality and become productive citizen. when a child becomes an adult they should be capable of contributing to the development and prosperity of the society. If children are not raised with proper care, they can develop serious personality disorders, such as a sense of deprivation, inexpressiveness, shyness, mental retardation, fear, emotional disturbance and so on. These problems in the upbringing of children are resulted from socio psychological causes within the family such as quarrelling parents, ignoring children, harsh treatment towards children, discouraging environment…

Social psychology discusses the process of socialization and personality development of children in detailed manner as part of its subject matter. through social psychology we come to know how the family environment may affect the personality of a child as well as what are the important considerations for proper socialization of children so they can achieve their potentials and become productive members of society.

7. Socialization as a source of knowledge

Social psychology as a broad subject matter in addition to its practical applicability, the subject matter of social psychology serves as a source of useful knowledge, it encompasses different areas of knowledge which beneficial to researches the development community, political leaders, and scholars. These areas include perception, cognition, behaviour, motivation, leadership, attitude, group dynamics, social interaction, skills of socialization, personality development and so on.

Application activity 1.4

1. Social psychology is a scientific study of human behavior…… (individually/ in society)
2. State the importance of social psychology in the following spheres:
   a) Personality development
   b) Military
   c) Education

End of unit assessment

1. Researchers have found that a person is most likely to conform to a group if…… (choose the best answer)
   A. The group members have diverse opinions
   B. The person feels competent and secure
   C. The person admires the group's status
   D. No one else will observe the person's behavior.
2. How is self-concept developed?
3. How do our attitudes and our actions affect each other?
4. How does being physically attractive influence other's perceptions?
5. Distinguish between two basic forms of Social influence
6. On two pages explain the importance of social psychology ?

UNIT 2 KEY THEORIES OF SOCIAL PSYCHOLOGY

Key unit competence: Judge different views of social psychologists about human behaviour formation and change.

Introductory activity:

Many social psychologists have different views about human behavior formation and change.

Based on what you learned in senior four about social psychology as one of the branches of psychology, brainstorm about different social psychological theories.

2.1. Attribution theory (Weiner)

Learning activity 2.1

Roger was conducting a program on designing and implementing community gardens. During the presentation he asked participants to design and layout a sample garden Luis, who has limited artistic abilities, immediately got Roger's attention and expressed his concern regarding the assigned activity. Roger responded to Luis's concerns and provided further instruction to alleviate Luis's hesitation and perceived inevitable failure. As Luis began the activity, he realized that his lack of artistic ability would have little impact on the completion of this activity. Quickly, Luis was able to apply the previously presented content to the activity and began to feel more confident in his ability to design a community garden.

1. Which social psychology theory is described in the above scenario?
2. What do you think was Luis's concern?
3. What was the main cause of Luis doubt?

According to Weiner, attribution is the process through which people assess the success or failure of their behavior or that of others. The desire to understand the origins of behaviors keeps learners interested in the learning environment. Behavior causes are defined as an individual's attributions.

Weiner was interested in the attributions made for experiences of success and failure and introduced the idea that we look for explanations of behavior in the social world to describe their reasons for success or failure learners usually use the three aspects/areas:

1) Locus which could be internal or external,
2) Stability or instability which is whether the cause is stable or changes over time,
3) Controllability (controlled or uncontrollable).

Attribution theory is concerned with how individuals interpret events and how this relates to their thinking and behavior. Heider (1958) was the first to propose a psychological theory of attribution, but Weiner and colleagues (e.g., Jones et al, 1972; Weiner, 1974, 1986) developed a theoretical framework that has become a major research paradigm of social psychology.

Attribution theory assumes that people try to determine why people do what they do, i.e., attribute causes to behavior. A person seeking to understand why another person did something may attribute one or more causes to that behavior. A three-stage process underlies an attribution:

i. The person must perceive or observe the behavior
ii. The person must believe that the behavior was intentionally performed
iii. The person must determine if they believe the other person was forced to perform the behavior (in which case the cause is attributed to the situation) or not (in which case the cause is attributed to the other person)

Dimensions

Weiner focused his attribution theory on achievement (Weiner, 1974). He identified ability, effort, task difficulty, and luck as the most important factors affecting attributions for achievement.

According to Weiner's attributional theory of achievement motivation, internal or external locus, stability across time, and controllability are the three fundamental dimensions' people use to understand their success and failure. Fundamental emotions, as well as expectations for the future, are subsequently triggered by these qualities. Numerous academics in other fields have effectively incorporated these dimensions in their analyses of various situations, even though Weiner's work was initially intended to explain achievement behavior and then expanded into a more general theory of human motivation.

2.1.1. Locus of Causality

The locus of control dimension has two poles: internal versus external locus of control. It refers to the perception of the cause of any event as internal or external.

- **External locus of control**

People with an external locus of control tend to attribute the result of life events as coming from factors out of their control, for example, poor weather or poor treatment from others. They also tend to behave in response to external demands, for example, teachers' or bosses' demands.

- **Internal locus of control**

People with this locus perceive the outcomes in life as the result of their behavior, their agency, and their abilities. They are also more likely to behave in response to their internal demand, for example, one's goals and aspirations.

Example: If a learner believes that she/he failed her/his math test because she/he lacked ability, she is referring to her/his internal attribution. On the other hand, if she blames the teacher to be incompetent, she/he is referring to the external attribution.

Heider's internal-external divisions were referred to by Weiner as the "locus of causality." Weiner developed a better multi-dimensional approach to the

structure of perceived causality (i.e., causal dimensions), adding to Heider's ground-breaking ideas by emphasizing additional dimensions or qualities of causation.

2.2.2. Stability

The stability dimension captures whether causes change over time or not. For instance, ability can be classified as a stable, internal cause, and effort classified as unstable and internal.

A stable factor is one that is considered permanent and unchangeable such as ability.

An unstable factor is temporary and can be changed for example luck.

From the previous example, if she/he believes that she/he failed her/his math exam because of her/his inability in math, the cause is stable. The cause is more stable if she/he believes that her/his lack of ability is permanent. On the other hand, if she/he believes that she/he had not been sick, she/he could have succeeded the test, the cause is unstable, as illness is a temporary factor.

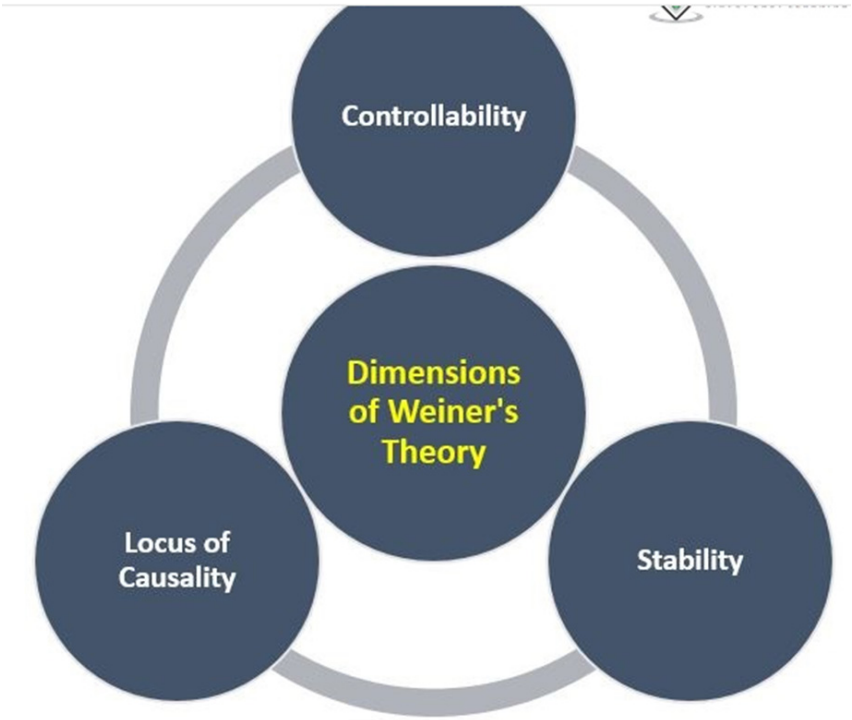
It can range from stable (permanent) to unstable (temporary). The consistency of the link between the underlying cause and the behavior's result is referred to as stability. Ability and task difficulty are relative to a consistent, long-term correlation between the causal factor and the behavior. The distinction between the two causal elements is that whereas task difficulty is thought to be externally controlled, the ability is thought to be inwardly controlled.

2.2.3. Controllability

Controllability contrasts causes one can control, such as skill/efficacy, from causes one cannot control, such as aptitude, mood, others' actions, and luck (Controllability dimension refers to whether or not the cause of any event is under the control of the learner).

From the aforementioned examples; if she/he believes that she/he could have done better in the test had she/he practiced more, the cause is controllable. On the other hand, if she/he doubts her/his ability in math, the cause is uncontrollable. Environmental or external attributions cannot be considered as controllable.

This describes the degree of volitional influence that can be applied to a cause. According to Weiner, a behavior may be under the individual's control. If the behavior is controllable, the person can influence how a task or behavior turns out; however, if the behavior is uncontrollable, the person has little to no control over how the task or behavior turns out.



Locus of Control	Stability	Controllabilty
• Attributions that are internal or external • Related to emotions of pride or shame following successful or unsuccessful outcomes	• Attributions are stable or unstable, which can change over time and is related to expectancy for future success	• Dimesions between attributions that are or are not under control of the student

Application

Weiner's theory has been widely applied in education, law, clinical psychology, and the mental health domain. There is a strong relationship between self-concept and achievement. Weiner (1980) states: "Causal attributions determine affective reactions to success and failure.

For example, one is not likely to experience pride in success, or feelings of competence, when receiving an 'A' from a teacher who gives only that grade, or when defeating a tennis player who always loses.

On the other hand, an 'A' from a teacher who gives few high grades or a victory

over a highly rated tennis player following a great deal of practice generates great positive affect."

Students with higher ratings of self-esteem and with higher school achievement tend to attribute success to internal, stable, uncontrollable factors such as ability, while they contribute failure to either internal, unstable, controllable factors such as effort, or external, uncontrollable factors such as task difficulty.

For example, students who experience repeated failures in reading are likely to see themselves as being less competent in reading. This self-perception of reading ability reflects itself in children's expectations of success on reading tasks and reasoning of success or failure of reading. Similarly, students with learning disabilities seem less likely than non-disabled peers to attribute failure to effort, an unstable, controllable factor, and more likely to attribute failure to ability, a stable, uncontrollable factor.

Weiner's Theory can also be applied in Consumer Psychology consumer researchers have been interested in Weiner's classification schema of causes, which has been applied to numerous consumer behavior studies to give insight into various consumer behavior difficulties. Both product flaws and service encounter issues were studied in research on product or service failure and attributions.

The usefulness of Weiner's attribution approach in the context of product failure and customer happiness was amply demonstrated by Folkes and her colleagues. Additionally, they showed how buyer-seller conflict brought on by divergent opinions of the reasons why a product failed might be understood in terms of the various effects of attributions for product failure.

Attributions' influence behavior

The types of attributions individuals choose to make to the causes of the events significantly impact their future behaviors in predictable ways.

Studies have found that academic achievement is improved when the learners attribute their academic outcomes to effort and study techniques rather than factors like lack of ability and health problems.

For instance, a student who blames his lack of effort to failure in examination may be motivated to study harder for the next exam in order to avoid the same outcome. However, a student who deems herself incapable of studying lacks motivation and is more likely to fail in the next examination too, solely because of her lack of effort.

Application activity 2.1

1. Many factors may affect attributions for achievement, state any 4 important of them?
2. Attributions are classified along three causal dimensions, which ones?
3. Describe a three stage process which underlies an attribution?

2.2. Self-determination theory

Learning activity 2.2

A child is playing and exploring toys without receiving external punishment or reward.

1. Why is this child actively engaged?
2. What motivates the child to keep playing?
3. Which social learning theory is reflected in this scenario?

The self-determination theory (SDT), formulated by Edward L. Deci and Richard M. Ryan, is a broad theory of human motivation for which the concept of basic or universal psychological needs for competence, relatedness, and self-determination and the differentiation of types of motivation (autonomous, controlled) are central and defining features.

Self-determination theory is a general theory of human motivation that emphasizes the extent to which behaviors are relatively autonomous (i.e., the extent to which behaviors originate from the self) versus relatively controlled (i.e., the extent to which behaviors are pressured or coerced by intrapsychic or interpersonal forces).

Self-determination theory defines motivation as psychological energy directed at a particular goal. Many theories of human behavior account for the direction of behavior, but fail to account for how that behavior is energized.

Self-determination theory has thus emphasized the importance of motivational quality in addition to its quantity. It has also offered a particularly comprehensive approach to studying health behavior via its conceptualization and measurement of autonomy, perceived competence, relatedness to others, and its emphasis on the role of the social context in supporting or thwarting optimal motivation.

Self-determination theory posits that the type, rather than amount, of motivation is the more important predictor of outcomes, and that the type of motivation is determined by the degree of satisfaction of the basic needs. The theory predicts,

and empirical evidence has confirmed, that satisfaction of the basic needs, and being motivated autonomously, are associated with important positive outcomes, such as enhanced well-being, improved learning, and greater persistence. Studies also show that when authority figures are autonomy supportive, taking the other person's perspective and providing choice, the other person tends to become more autonomously motivated.

Basic Psychological Needs

Self-determination theory proposes that, in addition to requiring various physical forms of sustenance (e.g., food and water), humans have evolved to require certain psychological experiences for optimal functioning and psychological health.

Self-determination theory has identified three psychological experiences that are universally required for optimal growth, integrity, and well-being those are:

- The needs for competence
- Relatedness
- Self-determination.

The postulate that these needs are universal means that they are essential for all people, regardless of sex, ethnicity, socioeconomic status, or cultural values.

2.2.1. The needs for competence

The needs for competence is, the feeling that one is effective in dealing with one's inner and outer worlds. This concept originated in the writings of Robert White, who spoke of being motivated by effectance. White suggested that when children play, they do it because it is fun, but children are also learning and becoming more effective or competent while they are playing.

The feeling of competence or effectance applies to learning to manage oneself, for example, learning to regulate one's emotions effectively, just as it applied to learning to function in the larger social milieu. The realization that one is improving in any important activity or meaningful aspect of one's life is very gratifying and can be understood as representing satisfaction of the basic need for competence.

2.2.2. Relatedness

The experience of relatedness is broadly defined as feeling connected to other human beings, the feeling of loving and being loved, of caring for and being cared for, of belonging to groups or collectives, and of having enduring relationships characterized by mutual trust. When someone shares a meaningful conversation, writes or receives a letter from a friend or family member, or hugs someone he or she cares for, the person is likely to experience satisfaction of the need for relatedness.

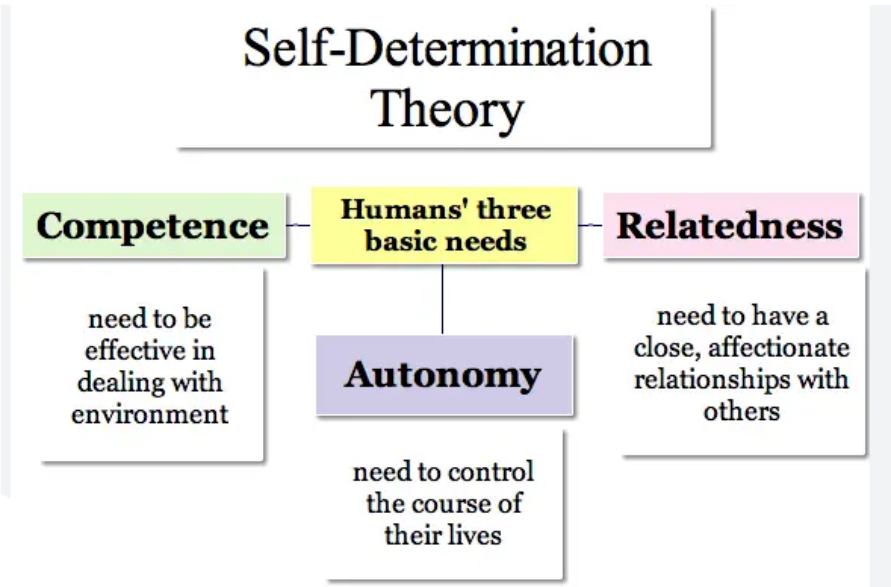
2.2.3. Autonomy or self-determination

The concept of self-determination evolved from the writings of Richard de Charms, who distinguished between internal and external perceived loci of causality. De Charms suggested that when people have an internal perceived locus of causality, they will feel as though they are the origin of their own actions, rather than being a pawn, which involves feeling pushed around by external forces.

Being self-determined involves feeling a sense of volition or full willingness, having a feeling of choice about what one is doing, of endorsing one's actions fully, and experiencing freedom in one's thoughts, feelings, and actions.

Having these experiences provides satisfaction of the basic need for autonomy or self-determination. Although other psychologists may use one or another of these terms to mean something other than what it means in self-determination theory, the use of these multiple descriptors is intended to give one a real sense of what the terms mean within self-determination theory. In short, self-determination theory maintains that human beings have a fundamental need to fully endorse their actions and to feel free with respect to constraints and pressures.

To summarize, Self-determination theory posits that each of these three types of experiences which are the experiences of competence, relatedness, and autonomy contribute importantly to people's psychological and physical well-being. To the extent that any one of these needs is thwarted or denied to people, they will suffer some type of psychological or physical decrement as a result. Furthermore, these psychological needs are identified as the sources of energy for one type of motivation referred to as intrinsic motivation



Intrinsic Motivation and Extrinsic Motivation

Intrinsic motivation is the type of motivation characterized by the experience of interest and enjoyment. The reward for intrinsic motivation is said to be in the doing of the activity rather than in what it leads to. In other words, intrinsically motivated behaviors are maintained by the spontaneous feelings that accompany the activity. Activities that you truly enjoy perhaps playing lacrosse or golf, perhaps reading or drawing, perhaps climbing a mountain or taking a dip in the ocean are intrinsically motivating.

The concept of intrinsic motivation is used to describe the full range of behaviors that are willingly enacted in the absence of contingencies of reward or punishment. The prototypic example of intrinsic motivation is a child at play, running madly around the playground, building a snowman, digging in a sandbox, or turning a large cardboard box into a clubhouse. All these activities require the exertion of energy, yet the rewards are entirely intrinsic to the activities themselves.

From self-determination theory perspective, the energy for such activities originates from the basic psychological needs (e.g., competence, relatedness, and autonomy).

The complement to intrinsic motivation, that is, the type of motivation that energizes and directs other human activities, is referred to as extrinsic motivation. This type of motivation is characterized by an instrumentality between the behavior and some separable consequence. The classic example of extrinsic motivation is doing an activity for a reward. In that case, the person is not doing the activity because the activity itself is interesting and enjoyable but rather because doing the activity allows the person to earn the reward. Doing things to avoid a punishment, to satisfy a parent or spouse, to be accepted by a group, to look better than someone else are all examples of being extrinsically motivated.

Undermining Intrinsic Motivation

One of the phenomena for which self-determination theory is well known is the undermining of intrinsic motivation by extrinsic rewards. In the early 1970s, some surprising research suggested that there might be a dark side to using task-contingent tangible rewards, such as money or prizes, to help motivate people to do interesting activities, such as learning or playing. The initial experiment by Deci found that when college students worked on interesting puzzles to earn money, they ended up finding the puzzles less interesting and enjoyable than did other students who had worked on the same puzzles without being offered money. The students who had been paid for solving the puzzles were less likely to return to the puzzle activity during a subsequent free-play period. In other words, when people were given a reward for doing an interesting activity, they lost interest in the activity and were less likely to engage the activity later.

From the perspective of SDT, the reason for this drop in intrinsic motivation

was that the rewards tended to make individuals feel controlled. They became dependent on the rewards and lost their sense of doing the activity autonomously. Because satisfaction of the need for autonomy is essential for maintaining people's interest and vitality for the activity that is, their intrinsic motivation, they lost intrinsic motivation when their behavior was controlled.

Interestingly, another early experiment by Deci showed that when people received positive feedback for doing an interesting activity, their intrinsic motivation tended to increase rather than decrease. The SDT explanation was that the information contained in the positive feedback about people's effectiveness at the activity provided satisfaction of the need for competence and enhanced their intrinsic motivation. Because positive feedback is sometimes referred to as verbal rewards, this experiment helped make the important point that rewards do not always undermine intrinsic motivation. Instead, they tend to undermine intrinsic motivation when people feel controlled by the rewards.

Autonomous Motivation and Controlled Motivation

The diminishment of intrinsic motivation by extrinsic motivators via the thwarting of people's need for autonomy raised an interesting question: Do all extrinsic motivations tend to control people? Put differently, is it possible to be self-determined while doing an extrinsically motivated activity? Self-determination theory proposes that people can internalize external prompts or contingencies and accept them as their own.

For example, a request from a parent that a child participate in the chores around the house to help the family would be an extrinsic motivator. The child might initially do the chores to please the parent. Gradually, however, the child could internalize the value of helping and the regulation of the behavior and, thus, would be more autonomous in doing the chores.

However, self-determination theory also suggests that values and regulations can be internalized to varying degrees. If the child were simply to take in the regulation and use it to force himself or herself to help, the child would still be relatively controlled. The child might be doing it to avoid feeling guilty or worthless, which, although internalized, does not represent autonomous self-regulation.

To become autonomous, the child would need to identify with the importance of the activity and integrate its value and regulation into his or her own sense of who he or she is. Considerable research has shown that it is possible to internalize and integrate values and regulations, and that doing so is associated with higher levels of psychological well-being.

Accordingly, over time, self-determination theory changed the most important differentiation in the theory from intrinsic and extrinsic motivation to autonomous and controlled motivation.

Autonomous motivation consists of intrinsic motivation plus fully internalized extrinsic motivation.

Controlled motivation, in contrast, consists of regulation by external contingencies and by partially internalized values or contingencies, what in self-determination theory are called introjects.

Being autonomously motivated involves feeling a sense of choice as one fully endorses one's actions or decisions. People do intrinsically motivated behaviors because they find the activities interesting and enjoyable; they do well-internalized extrinsically motivated behaviors because they find them personally important. So, interest and importance are the two bases of autonomous motivation, and doing activities for either reason allows people to feel satisfaction of the three basic psychological needs.

Controlled motivation, in contrast, involves acting because one feels pressured to do so, either through coercion or seduction. When controlled, people may behave because they feel lured into it by seductive rewards, feel forced into it by authority figures, or have introjected a demand and do it to bolster a fragile sense of self-esteem.

When controlled, people might feel a sense of competence or relatedness, but they will not be satisfying their need for autonomy. From the prospective of self-determination theory, satisfaction of all three of the basic psychological needs is necessary for autonomous motivation and for optimal well-being.

Positive outcomes associated with autonomous motivation

By virtue of the definition of basic needs within self-determination theory, satisfaction of these needs promotes positive psychological health. More than three decades of research has confirmed that being autonomously motivated and satisfying the psychological needs are vital to both mental and physical well-being. Greater autonomous motivation relative to controlled motivation has been linked to more positive emotions and less stress.

Autonomous motivation also leads to greater maintained lifestyle change, better conceptual understanding and deep learning, greater job satisfaction and performance, and higher creativity. The merits of autonomous motivation are numerous and varied.

Examples

- Research has demonstrated that when people are autonomously motivated to eat a healthier diet and exercise more, they tend to maintain those behaviors more effectively over the long run.
- When students in school are more autonomously motivated, they tend to get better grades and are less likely to drop out.

– Employees at large companies are more likely to receive positive work evaluations when they are autonomously motivated.
– Paintings and collages created by individuals whose motivation is autonomous are likely to be rated as more creative by expert judges.

Promoting autonomous motivation

Many studies have shown that it is possible to enhance autonomous motivation. Research has indicated that when authority figures, such as parents, managers, teachers, coaches, or physicians are more autonomy supportive, their children, subordinates, students, athletes, or patients become more autonomously motivated.

Being autonomy supportive means that authority figures consider and understand the other person's perspective and relate to that person with consideration of this perspective. For example, autonomy-supportive teachers relate to their students in terms of the students' skill levels and encourage them to move on from there.

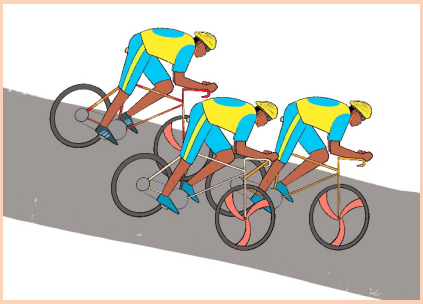
Furthermore, the autonomy-supportive authority figure offers choice, provides meaningful explanations for why requested behaviors are important, and encourages exploration and experimentation. In these ways, authority figures can facilitate autonomous motivation, basic psychological need satisfaction, and greater health and well-being.

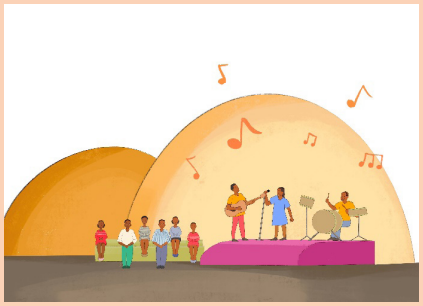
Application activity 2.2

1. Examine the effect of rewards on intrinsic motivation?
2. Describe factors that increase self-determination?
3. Explain 3 fundamental needs of self-determination theory?

2.3. Social facilitation theory

Learning activity 2.3





Look at the pictures of cyclists and a choir in actions, and answer to questions below:

Which phenomena do you think cause people sometimes to perform better or worse while working in groups?

Social facilitation refers to the finding that people sometimes show an increased level of effort as a result of the real, imagined, or implied presence of others.

In terms of a basic definition of social facilitation, social facilitation refers to improvement in performance induced by the real, implied, or imagined presence of others. It is a phenomenon where people show increased levels of effort and performance when in the presence of others, whether it can be real, imagined, implied or virtual, compared to their effort and performance levels when they are alone (a psychological concept relating to the tendency for the presence of others to improve a person's performance on a task).

2.3.1. History of Social Facilitation

Different social psychologists' theorists conducted different research about social facilitation theory, some of them are:

- **Norman Triplett**

He was an American psychologist who worked at Indiana University, most widely recognized for this work on social facilitation.

He was the first to identify this concept in 1898, when he noticed that cyclist's performance was facilitated (helped) when training as a group.

Triplett first studied bicycle racing by looking at records from a cycling association. He noticed a curious phenomenon whereby cyclists who were racing against others performed better than those who were trying to beat their own times.

He was fascinated by this idea and went on to study the same concept among

children doing a fishing reel task. His results showed that out of 40 children, half worked faster when competing with other children, one quarter worked more slowly, and one quarter showed equal performance.

His work with cyclists in 1898, is recognized today as the first published study in social psychology, which is the branch of psychology that deals with the social interactions among people.

Social facilitation theory, presented by Norman Triplett, posits that individuals will perform differently based upon the presence of observers. Specifically, individuals tend to perform better on easy or well-rehearsed tasks and worse on complex tasks or new ones.

– **Floyd H. Allport**

This is an American psychologist, who is generally acknowledged as one of the founders of the scientific discipline of social psychology. He received his Ph.D. from Harvard University in 1919 and remained as a lecturer there until 1922. One of his most notable achievements is his book titled Social Psychology, in which he integrated psychological knowledge into fields such as child development. The book also included Allport's own research on group influence, as well as a useful collection of concepts for research — e.g., social facilitation, social increment/decrement, afferent/efferent conditioning, etc.

It was him who coined the term Social Facilitation in 1924. Allport conducted various experiments placing the participants either alone or in groups. And majority of the experiments showed that people in groups performed better than those placed alone.

However, at this point in time, Social Facilitation was still limited and was simply understood as "increase in response merely from the sight or sound of others making the same movement.

Robert Zajonc

It was Robert Zajonc who provided the missing piece of the puzzle. In 1956, Zajonc conducted studies to figure out why some people performed better in the presence of others while others' performance hindered.

2.3.2. Types of social facilitation

There are two types of social facilitation: **co-action effects** and **audience effect**.

a) Co-action effects

A co-action effect refers to your performance being better on a task, merely because there are other people doing the same task as you. It is a phenomenon whereby increased task performance comes about by the mere presence of others doing the same task.

Examples

- Working at an office with co-workers instead of in a solitary environment.
- Running a 100-meter sprint against someone.

Other co-action effect studies include Chen (1937) who observed that worker ants will dig more than three times as much sand per ant when working (non-co-operatively) alongside other ants than when working alone. Platt, Yaksh and Darby (1967) found that animals will eat more of their food if there are others of their species present.

b) Audience effects

An audience effect refers to your performance being better because you are doing something in front of an audience. It refers to a type of social facilitation in which an individual's performance is influenced by the presence of others (an audience), which causes an individual's dominant response to occur. **An example** would be a pianist playing at home versus on stage in front of a crowd.

Social facilitation occurs not only in the presence of a co-actor but also in the presence of a passive spectator/audience. Dashiell (1935) found that the presence of an audience facilitated subjects' multiplication performance by increasing the number of simple multiplications completed. Travis (1925) found that well-trained subjects were better at a psychomotor task (pursuit rotor) in front of spectators. However, Pessin (1933) found an opposite audience effect, namely that subjects needed fewer trials at learning a list of nonsense words when on their own than when in front of an audience.

It seems, then, that the extent of social facilitation or inhibition depends upon the nature of the interaction between the task and the performer. In some cases, the presence of co-actors/audience improved the quality of performance (Dashiell 1935) but in others it impaired the quality (Pessin, 1933). Subsequent researchers found that performance improved as a result of the presence of others (social facilitation) whilst others found that it was impaired (social inhibition).

Whether or not social facilitation occurs depends on the type of task: people tend to experience social facilitation when they are familiar with a task or for well-learned skills. However, social inhibition (decreased performance in the presence of others) occurs for difficult or novel tasks.

However, social inhibition (decreased performance in the presence of others) occurs for difficult or novel tasks.

Social Inhibition: Refers to the tendency for one's performance to decrease or worsen in the presence of others this means that when a task is complicated or challenging, social facilitation is less likely to occur. Instead, it leads to social inhibition which is the tendency to perform tasks poorly or slowly in the presence of others.

2.3.3. Factors of social facilitation

In addition, social facilitation is thought to involve three factors: physiological factors (drive and arousal), cognitive factors (distraction and attention), and affective factors (anxiety and self-presentation).

1) Physiological factors (drive and arousal)

This refers to a higher arousal level and drive to perform that results from your physiological arousal in a situation involving social facilitation. According to Zajonc, behaviour that is either instinctive or very well-learned/ highly practiced is improved whereas behaviour that is novel or complex is impaired.

Zajonc's (1966) fundamental claim is that "an audience impairs the acquisition of new responses and facilitates the emission of well learned responses". His crucial theoretical contribution was that the presence of others enhances the emission of dominant responses. Zajonc's explanation is based upon Clark Hull's theory of motivation which states that a high level of arousal/drive will result in what is now called stress and will produce habitual behaviours (which are often incorrect).

The presence of others adds to arousal and when combined with the arousal arising from a difficult or unfamiliar task results in stress and consequent poor performance. The extra arousal contributed by the presence of others takes us past our optimum level of arousal and result in the dominant response being something we can do easily, not something which is new or demanding. This is supported by the Yerkes-Dodson theory of optimal arousal.

A dominant response is simply the response that is most likely to occur in the presence of the given array of stimuli. If a task is easy for the person, then the dominant response will be the correct one (i.e. most likely) and so the audience/ co-actor helps elicit this. In a difficult task, the dominant response is the incorrect one(s) (i.e. the most likely again) and so the audience/co-actor helps elicit this.

2) Cognitive factors (distraction conflict and attention)

This refers to the role of attention and distraction in social facilitation. For example, having people watch you do something might make you feel more focused, or it could be a distraction for you.

Distraction Conflict (Barron, 1986) theory of social facilitation suggests that rather than the mere presence of others, it is the conflict between giving attention to a person and giving attention to a task which affects performance.

This attention conflict motivates a person to pay more attention to the task and therefore will increase performance for simple well-learned tasks.

3) Affective factors (Anxiety of being evaluated)

Affective factors refer to how anxiety and self-presentation influence social facilitation.

According to Cottrell (1968), it's not the presence of other people that is important for social facilitation to occur but the apprehension about being evaluated by them. We know that approval and disapproval are often dependent on others' evaluations and so the presence of others triggers an acquired arousal drive based on evaluation anxiety.

We are aroused by audiences because we have learned that they evaluate our performance, they are not merely passive spectators, we believe. Such performance evaluation apprehension enhances drive/arousal

Other factors of social facilitation may include the following:

- ✓ If a task is difficult or complex, social facilitation is less likely to occur. Instead, impairment in task performance might happen.
- ✓ People who are more confident or look more favourably on social situations may see their performance enhanced compared to those who view them negatively or who have low self-esteem.
- ✓ Factors such as the supportiveness of the audience, how close it is, and its size may play a role in social facilitation.

Examples of Social Facilitation

You've probably experienced some of these in your own life or witnessed them among people you know or those in the public sphere. Some examples include the following:

- A musician/actor/performer who becomes energized by having an audience and does a better performance.
- Finding that you do better work if you go to a library than if you stay at home to study.
- A weightlifter who is able to lift heavier weights when doing it in front of others versus doing it alone.

2.3.4. Related Concepts

Social facilitation is related to several other concepts including the Yerkes-Dodson Law and Social Loafing.

a. Yerkes-Dodson law

The Yerkes-Dodson law relates to the theory that performance will vary depending on how easy/difficult a task is (or how familiar you are with a task). In

other words, for tasks that you know very well and that you have rehearsed, your performance will be enhanced. On the other hand, for tasks that are complex or for which you have no "dominant response," your performance will be lower. If plotted on a graph, this is thought to like an "upside down U."

As an example, consider that if you have studied well for an exam, your performance might be better in a testing situation because your alertness increases (your focus) and you work more quickly and with greater precision than when you are just testing yourself at home.

In contrast, imagine a situation in which you've barely studied at all for a test. All of a sudden, you are in a high-pressure situation needing to remember facts that you have little grasp of. This adds to your cognitive load, making your performance even worse than it might have been if you were just testing yourself at home

b. Social Loafing

However, there are instances where the presence of others has the opposite effect. That is, sometimes we don't work as hard in the presence of others as we do when we are alone, especially if our behaviour is not under surveillance. This phenomenon is known as social loafing.

Social loafing is a related but different concept from social facilitation. Social loafing refers to the idea that when a group of people is working together on a task, and no one individual is likely to be the focus (of success or failure), then performance might be decreased overall. This is thought to result because each individual person feels lower responsibility for the outcome.

Causes of social loafing

- People acting as part of group feel less accountable, so they worry less about others think of them.
- Group members may not believe their individual contributions make a difference
- Loafing is its own reward. When group members share equally in the benefits regardless of how much they contribute, some may slack off. (if you have worked on group assignment, you are probably already aware of this.) people who are not highly motivated, or who don't identify strongly with the group, may free ride on other's effort.

2.3.5. Theories on social facilitation

– **Activation theory**

This is the theory proposed by Zajonc, which explains social facilitation as the result of arousal that is triggered by the presence of others (or the perceived evaluation of others).

Alertness Hypothesis

Related to the activation theory is the alertness hypothesis, which proposes that you become more alert when you have observers and therefore perform better.

Evaluation apprehension hypothesis

The evaluation apprehension hypothesis (or evaluation approach) posits that it is the evaluation of others that matters rather than just their mere presence.

– **Self-presentation theory**

Self -presentation theory asserts that people are motivated to make good impressions with others and maintain a positive self -image. In other words, your performance will only improve when you feel like the audience is evaluating you.

– **Social orientation theory**

This theory asserts that people with a positive orientation to social situations will experience social facilitation, whereas those with a negative orientation will experience impairment.

– **Feedback loop model**

The feedback loop model proposes that when being observed by others, you become more aware of yourself, and that this state makes you more aware of differences between how you want to behave and how you actually behave. An example of this would be working more diligently on a task when others are watching, because you become more sensitive to mistakes you would normally make.

– **Capacity Model**

The capacity model refers to the idea that you have a limited capacity in terms of your working memory and that influences how tasks are affected. Those that require less working memory (easy tasks) are enhanced, while those that require more working memory (hard tasks) are done more poorly.

2.3.6. Implications of Social Facilitation

The concept of social facilitation has a long history and involves a variety of interrelated ideas. The main takeaway should be that sometimes working with others (or performing for an audience) will enhance your performance, and other times it may hinder it. If you can learn the factors that influence those outcomes,

you can put social facilitation to work for you in all situations.

- Do something alone in the beginning until you grasp complex concepts or skills, then do it in a group to improve your performance.
- Practice tasks until they become natural (or the dominant response) so that you can perform better when put in front of an audience.
- Social Facilitation Theory offers a new perspective in understanding motivation. In a normal scenario, we simply interpret one's performance based on his/her abilities.
- Understanding social facilitation theory means we understand the positive or negative effect the presence of other people has on the performer.
- Another quick way of understanding this is that the performance of any individual depends on how good he perceives himself/herself to be when being evaluated.
- Another important phenomenon to understand in the context of social psychology, along with social facilitation effect and social inhibition is social loafing.

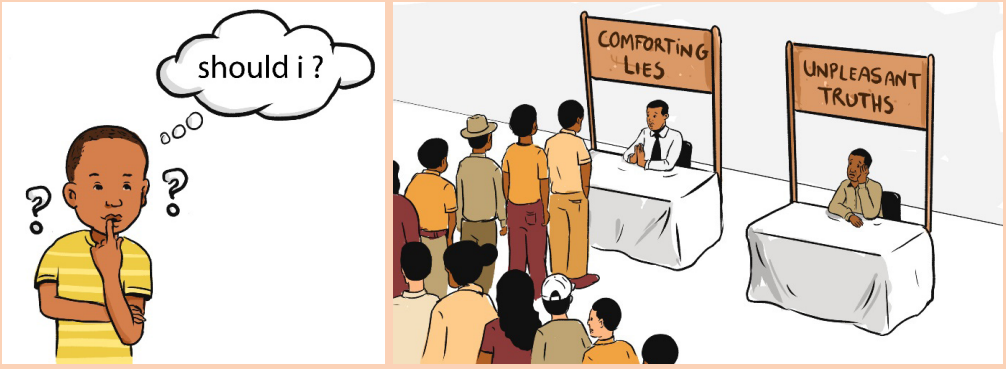
Application activity 2.3

1. People tend to exert less effort when working with a group than they would alone, which is called……...
2. How does the presence of others influence our actions?
3. In few words differentiate social facilitation from social loafing?
4. What is social facilitation and under what circumstances is it most likely to occur?

2.4. Cognitive dissonance theory (Festinger)

Learning activity 2.4

Look at picture below and answer to the following question



1. By observing these pictures, what comes to you mind?
2. Provide examples similar to the second picture?

2.4.1. Description of Cognitive dissonance theory (Festinger)

Cognitive Dissonance Theory was introduced by Leon Festinger (1957), and arguably, this classic theory is still relevant to this day. Festinger described that cognitive dissonance occurs whenever people are confronted with facts that contradict their beliefs, values, and ideas; they will thrive on finding a way to resolve the contradiction to reduce their discomfort. The theory applies to all social situations involving the formation and changes of human attitude, and it is particularly pertinent to the process of decision-making and problem-solving.

Cognitive dissonance theory (Festinger, 1957) posits that individuals seek to maintain consistency among multiple cognitions (e.g., thoughts, behaviors, attitudes, values, or beliefs). Inconsistent cognitions produce unpleasant states that motivate individuals to change one or more cognitions to restore consistency with other cognitions (i.e., consonance). Cognitive dissonance theory has become one of the most widely accepted approaches in explaining human behavioral change and many other social behaviors.

Today, as we confront the information saturation era, humanity faces desperately difficult decisions due to the information overload on the Internet. When people are exposed to opposing thoughts or arguments on the Internet, and they are not able to choose which the right one is, they experience cognitive dissonance. Most people are aware of their belief systems. Nevertheless, when people realize that there may be a whit of truth in other people's perspectives and ideas, it conflicts with their cognitive beliefs. Consequently, some of the emotions

that we experience resulting from cognitive dissonance are dread, guilt, anger, frustration, anxiety, stress, and other psychosomatic conditions (Fontanari et al., 2012).

The inconsistency between what people believe and how they behave motivates them to engage in actions that will help minimize feelings of discomfort. People attempt to relieve this tension in different ways, such as by rejecting, explaining away, or avoiding new information.

2.4.2. Signs of Cognitive Dissonance

Everyone experiences cognitive dissonance to some degree but that doesn't mean that it is always easy to recognize. Some signs that what a person is feeling might be related to dissonance include:

- Feeling uncomfortable before doing something or making a decision
- Trying to justify or rationalize a decision you've made or action you have taken
- Feeling embarrassed or ashamed about something you've done and trying to hide your actions from other people.
- Experiencing guilt or regret about something you've done in the past.
- Doing things because of social pressure or a fear of missing out even if it wasn't something you wanted to do.

Examples of Cognitive Dissonance

There are cognitive dissonance examples that people may notice in their own:

a) Some people want to be healthy, but they don't exercise regularly or eat a nutritious diet. They feel guilty as a result.

b) Some people know that smoking (or drinking too much) is harmful to their health, but they do it anyway. they rationalize this action by pointing to their high stress levels.

c) A person would like to build up his/her savings but tend to spend extra cash as soon as he/she get it. He/she regret this decision later, such as when facing an unexpected expense that he/she doesn't have the money to cover.

d) Some people have a long to-do list but spend the day watching their favorite shows instead. They don't want their spouse to know, so they try to make it look like they have worked hard all day.

2.4.3. Causes of Cognitive Dissonance

There are a number of different situations that can create conflicts that lead to cognitive dissonance.

1. Forced Compliance

Sometimes people might find themselves engaging in behaviors that are opposed to their own beliefs due to external expectations at work, school, or in a social situation. This might involve going along with something due to peer pressure or doing something at work to avoid getting fired.

2. New Information

Sometimes learning new information can lead to feelings of cognitive dissonance. For example, if a person engages in a behavior that he/she later learns is harmful, it can lead to feelings of discomfort. People sometimes deal with this by finding ways to justify their behaviors or findings ways to discredit or ignore new information.

3. Decisions

People make decisions, both large and small, on a daily basis. When faced with two similar choices, they are often left with feelings of dissonance because both options are equally appealing. Once a choice has been made, however, people need to find a way to reduce these feelings of discomfort. they accomplish this by justifying why our choice was the best option so we can believe that we made the right decision.

2.4.4. Factors Influencing Cognitive Dissonance

The degree of dissonance experienced can depend on a few different factors. Among them are how highly a particular belief is valued and the degree to which the beliefs are inconsistent.

The overall strength of the dissonance can also be influenced by several factors, including:

- **The importance attached to each belief.** Cognitions that are more personal, such as beliefs about the self, and highly valued tend to result in greater dissonance.
- **The number of dissonant beliefs.** The more dissonant (clashing) thoughts you have, the greater the strength of the dissonance.
- **Forced compliance:** A person may have to do things they disagree with as part of a job, to avoid bullying or abuse, or to follow the law.
- **Decision-making**: Everyone has limited choices. When a person must make a decision among several options they do not like or agree

with, or they only have one viable option, they may experience cognitive dissonance.

- **Effort:** People tend to value things they work hard for highly, even if those things contradict a person's values. This may be because viewing something negatively after putting in a lot of hard work would cause more dissonance. So people are more likely to view difficult tasks positively, even if they do not morally agree with them.

2.4.5. Coping with Cognitive Dissonance

When there are conflicts between cognitions (thoughts, beliefs, and opinions), people will take steps to reduce the dissonance and feelings of discomfort. They can go about this a few different ways.

- **Adding More Beliefs to Outweigh Dissonant Beliefs**. People who learn that greenhouse emissions result in global warming might experience feelings of dissonance if they drive a gas-guzzling vehicle. To reduce this dissonance, they may seek out new information that overrides the belief that greenhouse gasses contribute to global warming.
- **Reducing the Importance of the Conflicting Belief.** A person who cares about their health might be disturbed to learn that sitting for long periods during the day is linked to a shortened lifespan. Since they work all day in an office and spend a great deal of time sitting, it is difficult to change their behavior. To deal with the feelings of discomfort then, they might find some way of rationalizing the conflicting cognition. For instance, they may justify their sedentary behavior by saying that their other healthy behaviors—like eating sensibly and occasionally exercising—make up for their largely sedentary lifestyle.
- **Changing Beliefs.** Changing the conflicting cognition is one of the most effective ways of dealing with dissonance but it is also one of the most difficult—particularly in the case of deeply held values and beliefs, such as religious or political leanings.

Application activity 2.4

1. Explain how a person might deal with dissonance related to a health behavior for example individuals who continue to smoke, even though they know it is harmful to their health.
2. Explain the cognitive dissonance theory of Leon Festinger with concrete examples.

2.5. Shock experiment (Milgram)

Learning activity 2.5

Brainstorm on how authority influences odedience

The Milgram experiment was a famous and controversial study that explored the effects of authority on obedience. During the 1960s, Yale University psychologist Stanley Milgram conducted a series of obedience experiments that led to some surprising results. In the study, an authority figure ordered participants to deliver what they believed were dangerous electrical shocks to another person. These results suggested that people are highly influenced by authority, and highly obedient. More recent investigations cast doubt on some of the implications of Milgram's findings and even the results and procedures themselves. Despite its problems, the study has, without question, made a significant impact on psychology.

Milgram started his experiments in 1961, shortly after the trial of the World War II criminal Adolf Eichmann had begun. Eichmann's defense that he was merely following instructions when he ordered the deaths of millions of Jews roused Milgram's interest. In his 1974 book "Obedience to Authority," Milgram posed the question, "Could it be that Eichmann and his million accomplices in the Holocaust were just following orders? Could we call them all accomplices?"

2.5.1. Procedure in the Milgram Experiment

The participants in the most famous variation of the Milgram experiment were 40 men recruited using newspaper ads. In exchange for their participation, each person was paid $4.50.2.

Milgram developed an intimidating shock generator, with shock levels starting at 15 volts and increasing in 15-volt increments all the way up to 450 volts. The many switches were labeled with terms including "slight shock," "moderate shock," and "danger: severe shock." The final three switches were labeled simply with an ominous "XXX."

Each participant took the role of a "teacher" who would then deliver a shock to the "student" in a neighboring room whenever an incorrect answer was given. While participants believed that they were delivering real shocks to the student, the "student" was a confederate in the experiment who was only pretending to be shocked.

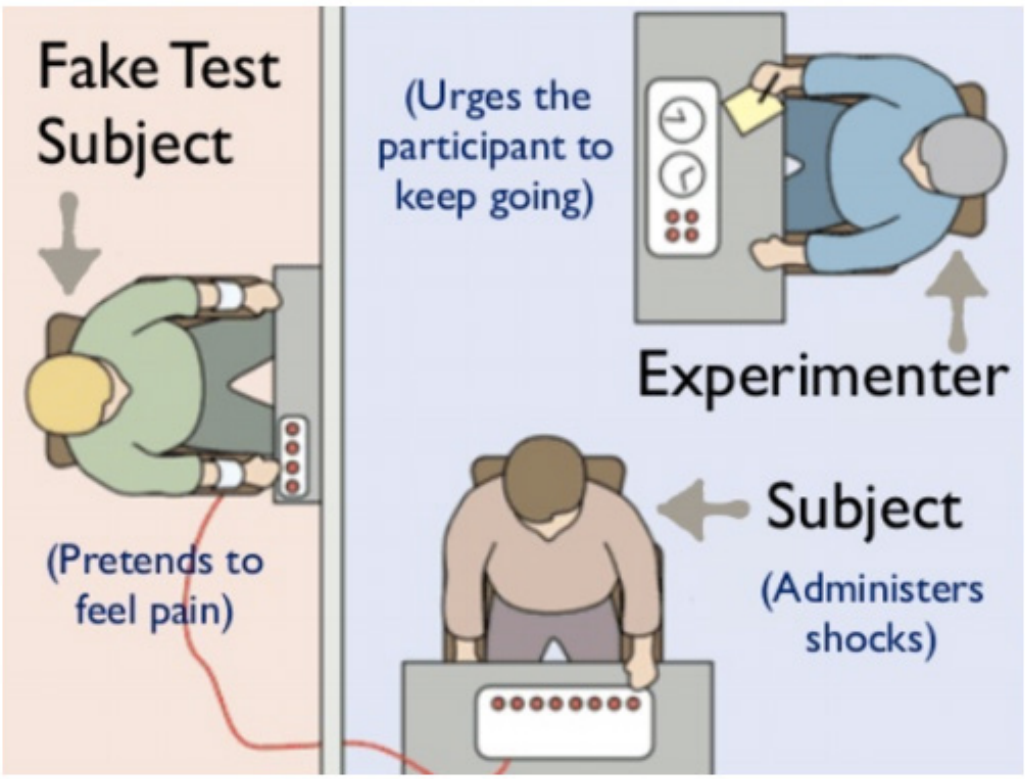
As the experiment progressed, the participant would hear the learner plead to be released or even complain about a heart condition. Once they reached the 300-volt level, the learner would bang on the wall and demand to be released.

Beyond this point, the learner became completely silent and refused to answer

any more questions. The experimenter then instructed the participant to treat this silence as an incorrect response and deliver a further shock.

Most participants asked the experimenter whether they should continue. The experimenter then responded with a series of commands to prod the participant along:

1. "Please continue."
2. "The experiment requires that you continue."
3. "It is absolutely essential that you continue."
4. "You have no other choice; you must go on."



2.5.2. Results of the Milgram Experiment

In the Milgram experiment, obedience was measured by the level of shock that the participant was willing to deliver. While many of the subjects became extremely agitated, distraught, and angry at the experimenter, they nevertheless continued to follow orders all the way to the end.

Milgram's results showed that 65% of the participants in the study delivered the maximum shocks.4 Of the 40 participants in the study, 26 delivered the maximum shocks, while 14 stopped before reaching the highest levels.

2.5.3. Factors that influence obedience

Why did so many of the participants in this experiment perform a seemingly brutal act when instructed by an authority figure? According to Milgram, there are some situational factors that can explain such high levels of obedience:

- The physical presence of an authority figure dramatically increased compliance.
- The fact that Yale (a trusted and authoritative academic institution) sponsored the study led many participants to believe that the experiment must be safe.
- The selection of teacher and learner status seemed random.
- Participants assumed that the experimenter was a competent expert.
- The shocks were said to be painful, not dangerous.

Later experiments conducted by Milgram indicated that the presence of rebellious peers dramatically reduced obedience levels. When other people refused to go along with the experimenter's orders, 36 out of 40 participants refused to deliver the maximum shocks. More recent work by researchers suggests that while people do tend to obey authority figures, the process is not necessarily as cut-and-dried as Milgram depicted it.

In a 2012 essay published in PLoS Biology, researchers suggested that the degree to which people are willing to obey the questionable orders of an authority figure depends largely on two key factors:

- How much the individual agrees with the orders.
- How much they identify with the person giving the orders.

While it is clear that people are often far more susceptible to influence, persuasion, and obedience than they would often like to be, they are far from mindless machines just taking orders.

2.5.4. Ethical Concerns in the Milgram Experiment

Milgram's experiments have long been the source of considerable criticism and controversy. From the get-go, the ethics of his experiments were highly dubious. Participants were subjected to significant psychological and emotional distress.

Some of the major ethical issues in the experiment were related to:

- The use of deception
- The lack of protection for the participants who were involved
- Pressure from the experimenter to continue even after asking to stop, interfering with participants' right to withdraw

Due to concerns about the amount of anxiety experienced by many of the participants, everyone was supposedly debriefed at the end of the experiment. The researchers reported that they explained the procedures and the use of deception.

Critics of the study have argued that many of the participants were still confused about the exact nature of the experiment, and recent findings suggest that many participants were not debriefed at all.

2.5.5. Replications of the Milgram Experiment

While Milgram's research raised serious ethical questions about the use of human subjects in psychology experiments, his results have also been consistently replicated in further experiments. One review further research on obedience and found that Milgram's findings hold true in other experiments.

In 2009, researchers conducted a study designed to replicate Milgram's classic obedience experiment. The researchers made several alterations to Milgram's experiment.

- The maximum shock level was 150 volts as opposed to the original 450 volts.
- Participants were also carefully screened to eliminate those who might experience adverse reactions to the experiment.

The results of the new experiment revealed that participants obeyed at roughly the same rate that they did when Milgram conducted his original study more than 40 years ago.

Some psychologists suggested that in spite of the changes made in the replication, the study still had merit and could be used to further explore some of the situational factors that also influenced the results of Milgram's study. But other psychologists suggested that the replication was too dissimilar to Milgram's original study to draw any meaningful comparisons.

2.5.6. Recent criticisms and new findings

Psychologist Gina Perry suggests that much of what we think we know about Milgram's famous experiments is only part of the story. While researching an article on the topic, she stumbled across hundreds of audiotapes found in Yale archives that documented numerous variations of Milgram's shock experiments.

a) Participants were often coerced

While Milgram's reports of his process report methodical and uniform procedures, the audiotapes reveal something different. During the experimental sessions, the experimenters often went off-script and coerced the subjects into continuing the shocks.

"The slavish obedience to authority we have come to associate with Milgram's experiments comes to sound much more like bullying and coercion when you listen to these recordings," Perry suggested in an article for Discover Magazine.

b) Few participants were really debriefed

Milgram suggested that the subjects were "de-hoaxed" after the experiments. He claimed he later surveyed the participants and found that 84% were glad to have participated, while only 1% regretted their involvement.

However, Perry's findings revealed that of the 700 or so people who took part in different variations of his studies between 1961 and 1962, very few were truly debriefed.

A true debriefing would have involved explaining that the shocks weren't real and that the other person was not injured. Instead, Milgram's sessions were mainly focused on calming the subjects down before sending them on their way.

Many participants left the experiment in a state of considerable distress. While the truth was revealed to some months or even years later, many were simply never told a thing.

c) Variations led to differing results

Another problem is that the version of the study presented by Milgram and the one that's most often retold does not tell the whole story. The statistic that 65% of people obeyed orders applied only to one variation of the experiment, in which 26 out of 40 subjects obeyed.

In other variations, far fewer people were willing to follow the experimenters' orders, and in some versions of the study, not a single participant obeyed.

d) Participants guessed the learner was faking

Perry even tracked down some of the people who took part in the experiments, as well as Milgram's research assistants. What she discovered is that many of his subjects had deduced what Milgram's intent was and knew that the "learner" was merely pretending.

Such findings cast Milgram's results in a new light. It suggests that not only did Milgram intentionally engage in some hefty misdirection to obtain the results he wanted but that many of his participants were simply playing along.

2.5.7. Impact of the Milgram experiment

Since there is no way to truly replicate the experiment due to its serious ethical and moral problems, determining whether Milgram's experiment really tells us anything about the power of obedience is impossible to determine.

So why does Milgram's experiment maintain such a powerful hold on our imaginations, even decades after the fact? Perry believes that despite all its ethical issues and the problem of never truly being able to replicate Milgram's procedures, the study has taken on the role of what she calls a "powerful parable."

Milgram's work might not hold the answers to what makes people obey or even the degree to which they truly obey. It has, however, inspired other researchers to explore what makes people follow orders and, perhaps more importantly, what leads them to question authority.

Milgram's experiment has become a classic in psychology, demonstrating the dangers of obedience. The research suggests that situational variables have a stronger sway than personality factors in determining whether people will obey an authority figure. However, other psychologists argue that both external and internal factors heavily influence obedience, such as personal beliefs and overall temperament.

Application activity 2.5

1. What is the shocking experiment?
2. What results were concluded from Milgram's shock experiment?
3. According to Milgram's experiment indicate factors that influence obedience?

2.6. Social learning theory (Albert BANDURA)

Learning activity 2.6

1) Make a brief comment about this Rwandan proverb "Kora ndebe iruta vuga numve".
2) What do you think will happen if a young child observes his friend being rewarded for his good performance?

2.6.1. History of Social Learning Theory

Social learning theory is also known as observational learning, modelling or imitation. It was developed by ALBERT BANDURA. It examines how people learn by observing models and imitating the behaviors of others. (Children learn through observing, modelling and imitating other's behavior) it mainly helps in the acquisition of language and behavior.

According to Bandura (1986), much of human learning is not shaped by its consequences; but is more efficiently learned directly from a mode. For example; if students see their friend rewarded for a good work done, they may work hard so that they are also rewarded.

Social learning theory posits that people learn from one another, via observation, imitation, and modeling. The theory has often been called a bridge between

behaviorist and cognitive learning theories because it encompasses attention, memory, and motivation.

Social learning theory emphasizes the importance of observing, modelling, and imitating the behaviors, attitudes, and emotional reactions of others. Social learning theory considers how both environmental and cognitive factors interact to influence human learning and behavior.

According to this theory people learn through observing others' behavior, attitudes, and outcomes of those behaviors. "Most human behavior is learned observationally through modeling: from observing others, one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action." (Bandura). Social learning theory explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences.

In social learning theory, Albert Bandura (1977) agrees with the behaviorist learning theories of classical conditioning and operant conditioning. However, he adds two important ideas:

- Mediating processes occur between stimuli & responses.
- Behavior is learned from the environment through the process of observational learning.

Individuals that are observed are called models. In society, children are surrounded by many influential models, such as parents within the family, characters on children's TV, friends within their peer group and teachers at school. These models provide examples of behavior to observe and imitate, e.g., masculine and feminine, pro and anti-social, etc.

Children pay attention to some of these people (models) and encode their behavior. At a later time, they may imitate (i.e., copy) the behavior they have observed.

They may do this regardless of whether the behavior is 'gender appropriate' or not, but there are a number of processes that make it more likely that a child will reproduce the behavior that its society deems appropriate for its gender.

- The child is more likely to attend to and imitate those people it perceives as similar to itself. Consequently, it is more likely to imitate behavior modeled by people of the same gender.
- The people around the child will respond to the behavior it imitates with either reinforcement or punishment. If a child imitates a model's behavior and the consequences are rewarding, the child is likely to continue performing the behavior.
- The child will also take into account of what happens to other people when deciding whether or not to copy someone's actions. A person

learns by observing the consequences of another person's (i.e., models) behavior, e.g., a younger sister observing an older sister being rewarded for a particular behavior is more likely to repeat that behavior herself. This is known as vicarious reinforcement.

If a parent sees a little girl consoling her teddy bear and says "what a kind girl you are," this is rewarding for the child and makes it more likely that she will repeat the behavior. Her behavior has been reinforced (i.e., strengthened)

Types of reinforcement

– **Internal and external reinforcement**

If a child wants approval from parents or peers, this approval is an external reinforcement, but feeling happy about being approved of is an internal reinforcement. A child will behave in a way which it believes will earn approval because it desires approval.

– **Positive and negative reinforcement**

Positive reinforcement is adding a factor to increase a behavior and negative reinforcement is removing a factor to increase a behavior.

Positive (or negative) reinforcement will have little impact if the reinforcement offered externally does not match with an individual's needs.

Reinforcement can be positive or negative, but the important factor is that it will usually lead to a change in a person's behavior.

This relates to an attachment to specific models that possess qualities seen as rewarding. Children will have a number of models with whom they identify. These may be people in their immediate world, such as parents or older siblings, or could be fantasy characters or people in the media. The motivation to identify with a particular model is that they have a quality which the individual would like to possess.

Identification occurs with another person (the model) and involves taking on (or adopting) observed behaviors, values, beliefs and attitudes of the person with whom you are identifying.

The term identification as used by social learning theory is similar to the Freudian term related to the Oedipus complex.

2.6.2. Components of Social Learning

a. Observation

Social learning works by observing the behavior of other people. The consequences of specific situational actions are observed, then that behavior is mirrored depending on the outcome of the consequence. In this way, people learn which behaviors are socially acceptable and which behaviors are usually criticized. Observational learning allows people to adapt and approach situations more confidently quickly.

b. Assessment

We assess whether the observed person's behavior fits our personality and whether the results and reactions of others are desirable. If we decide that we would like to be praised and recognized for something, we analyze how the observed person came to this result. There is often not enough data to know on which factors the desired reaction depends. Therefore, it is often necessary to observe similar situations repeatedly to develop a better understanding.

c. Imitation

After observation and assessment of a particular behavior, imitation follows to achieve the desired consequence. Imitation can only happen within our personal limitations, e.g. physical traits, characteristics, and experiences. In most cases, the consequences of a behavior depend on several factors. The views of the other person, place, time, one's character, the situation, everything can play a role in how others react to something. Therefore, it usually takes repeated positive feedback for a behavior to become a habit, but it only takes a little criticism to avoid it in the future.

d. Identification

A large part of social learning is based on the idea that people want to identify with others and their achievements, or earn the appreciation of those role models. As it is understood in social learning, identification is comparable to the Freudian notion of the Oedipus complex. A part of this concept is about internalizing or adopting the behaviors of other people.

e. Necessary conditions for effective modeling

The social learning theory has four mediational processes that help determine whether a new behavior is acquired.

- **Attention:** This is the degree to which we notice the behavior. A behavior must grab our attention before it can be imitated. Considering the number of behaviors, we observe and do not imitate daily indicates attention is crucial in whether a behavior influences imitation or not. Various factors increase or decrease the amount of attention paid. Includes distinctiveness, affective valence, prevalence, complexity, functional value. One's characteristics (e.g. sensory capacities, arousal level, perceptual set, past reinforcement) all these affect attentions.
- **Retention:** This is how well we remember the behavior. We cannot perform the behavior if we do not remember the behavior. So, while a behavior may be noticed, unless a memory is formed, the observer will not perform the behavior. And, because social learning is not immediate, retention is vital to behavior modeling. remembering what you paid attention to. Includes symbolic coding, mental images, cognitive organization, symbolic rehearsal, motor rehearsal.

– **Reproduction:** This is the ability to perform the behavior, it is the ability to reproduce a behavior we observe. It influences our decision about whether to try performing the behavior. Even when we wish to imitate an observed behavior, we are limited by our physical abilities, reproducing the image includes physical capabilities, and self-observation of reproduction.
– **Motivation:** This is the will to emulate the behavior. It is mediational process referred to as vicarious reinforcement. It involves learning through observing the consequences of actions for other people, rather than through direct experience. having a good reason to imitate includes motives such as past (i.e. traditional behaviorism), promised (imagined incentives) and vicarious (seeing and recalling the reinforced model).

In addition to the behavior, rewards and punishment that follow will be studied by the observer. If the observer perceives the rewards to be greater than the costs (punishment) then they will most likely imitate the behavior. If, however, the vicarious reinforcement is not valued enough by the observer, they will not model the behavior.

f. Reciprocal determinism

Bandura believed in "reciprocal determinism", that is, the world and a person's behavior cause each other, while behaviorism essentially states that one's environment causes one's behavior, Bandura, who was studying adolescent aggression, found this too simplistic, and so in addition he suggested that behavior causes environment as well. Later, Bandura soon considered personality as an interaction between three components: the environment, behavior, and one's psychological processes (one's ability to entertain images in minds and language).

Social learning theory has sometimes been called a bridge between behaviorist and cognitive learning theories because it encompasses attention, memory, and motivation. The theory is related to Vygotsky's social development theory and Lave's situated learning, which also emphasize the importance of social learning.

2.6.3. Assumptions of Social Learning Theory

Social learning theory is grounded by several key assumptions

- People learn through observation. Learners can acquire new behavior and knowledge by merely observing a model.
- Reinforcement and punishment have indirect effects on behavior and learning. People form expectations about the potential consequences of future responses based on how current responses are reinforced or punished.
- Mediational processes influence our behavior. Cognitive factors that

contribute to whether a behavior is acquired or not.

- Learning does not necessarily lead to change. Just because a person learns something does not mean they will have a change in behavior.

2.6.4. Principles of social learning

a. Direct reinforcement

It is provided by external environment for example, if a parent shows how to cook rice to his child and a child does it as required, the parent may praise or reward the child; hence direct reinforcement.

b. Vicarious learning

This refers to the learning from other's successes and failures.

Example 1: The behaviors of children, as they imitate family members, friends, famous figures and even television characters. If a child perceives there is a meaningful reward for such behavior, they will perform it at some point, if there is a punishment they will not perform it.

Example 2: A boy observes his elder brother being rewarded for his good performance; he may also learn hard so as to be rewarded.

c. Modelling

From observing others one forms an idea of how new behaviors are performed, and on later occasions, this coded information serves as a guide for action (most human behavior is learned observationally through modeling: from observing others one forms an idea of how new behaviors are performed, and on later occasions, this coded information serves as a guide for action).

2.6.5. Social learning theory examples

Social media presents plenty of social learning examples with people imitating others whether acting a movie scene, copying dance moves from a music video, and not the least, the many social media challenges people attempt. This frenzied behavior is typically spurred by the desire to be socially accepted or liked.

New employees in the workplace may imitate the behavior of their peers in an effort to conform to the work culture. Or, they may model coworkers' behavior to help earn a good standing with a superior.

Students may emulate fellow students, celebrities and mentors as a means to fit in or garner attention. While positive behaviors are imitated, problematic behaviors are modeled as well.

2.6.6. Strengths and Weaknesses of Social Learning Theory

One of the primary strengths of social learning theory is its flexibility in explaining the differences in a person's behavior or learning, i.e., when there is a change in a person's environment, the person's behavior may change.

An additional strength of the social learning theory is that it allows for different ways of learning. A person can learn through observation or direct experiences.

Where the theory falls short is where it neglects the importance of accountability in one's actions. By placing greater weight on the environment, the theory assumes one's behavior and actions are determined by society, not by how a person handles or processes information.

The social learning theory further ignores ordinary developmental milestones. Although children do not mature at identical rates, some normal milestones may still occur irrespective of the environmental setting.

The theory further fails to account for all behavior, more specifically in the case when there is no apparent role model for the observer to emulate.

2.6.7. Applications of social learning theory

Two areas of application of social learning theory in social work include research and intervention. Researchers can use the theory to understand how aggressiveness and violence can be transferred through observational learning.

The theory can further be used to investigate how positive role models can foster desirable behaviors and promote social change.

Social worker can implement social learning theory to influence positive new behaviors by altering the reinforcement, whether positive or negative, associated with the source of the issue. It is important to note that to effectively apply social learning theory principles as an intervention, it is essential a social worker includes the use of other methods of work such as symbolic coding, stress management and vicarious reinforcement.

Social learning theory posits that people emulate the behavior they observe in their environment, especially if that behavior is reinforced in others. For example, if a child observes their parents going to work every day, volunteering at a local community center and helping their significant other with tasks around the home, the child is likely to mimic those behaviors. If rewarded, these behaviors become reinforced and most likely repeated by the individual.

This premise applies to troublesome behaviors as well. A person who observes someone treating others poorly and being rewarded for it may follow suit. Social workers can use social learning theory to identify the behavioral models a client may be emulating and use that information to help correct negative behavior, such as underage drinking, drug use or unprotected sex.

Personality development and social learning theory

Personality development is the establishment of a set of patterns involving the behavior, temperament and character that a person displays on a regular basis. Social learning theory postulates that a large amount of the features of people's personalities may come from observing others in their family or society. People's temperaments may be determined by their genetics as well as their environment.

During school years, children learn how to interact with groups in more structured environments, and through observation and learning can apply self-discipline, follow rules and trust in positive outcomes. The connectedness a person feels to his or her community is greatly influenced by how heavily the society they are raised in values things like family or nationalism. Other traits that may be learned socially in childhood include:

- Activity level
- Distractibility
- Intensity
- Regularity of sleep and appetite
- Sensory threshold
- Approachability
- Adaptability
- Persistence
- Mood

Social learning theory and personality theory measurement

Social learning theory also deals with personality theory and measurement. One established set of four main personality theories include psychoanalytic, trait, humanistic and social-cognitive. Social learning theory falls within the social-cognitive umbrella, and involves personality being shaped by a person's expectations about the world and the people he or she interact with, observing and judging the actions of others, and the environment.

The foundation of social learning theory involves an understanding of a person's self-concept, as well as their social cognition, attribution theory, social influence, group traditions, prejudice, discrimination, interpersonal interactions, attitudes and aggression. A person may better be able to hone these abilities by increased interactions and social behavioral observations, as well as through third-party experiences like film, reading and television.

Family and social learning theory

Social learning theory often directly influences family psychopathology. People who observe pathological behaviors in their direct family members may see them as normal and even if they don't remember observing them, may repeat

them later in life.

On the flip side, families who embody strong positive traits will very likely raise offspring who demonstrate and value those same behaviors.

Social learning therapy

Social learning theory is also sometimes incorporated in psychotherapy. A method called social learning therapy uses the aspects of social learning theory along with the basic techniques of therapy treatment.

Social learning therapists may treat any number of conditions including post-traumatic stress disorder, anxiety, anorexia, substance abuse, anorexia, bulimia, attention-deficit hyperactivity disorder, conduct disorder, anxiety, phobias or obsessive-compulsive disorder. Since social learning theory is all about learning behaviors from watching other people, social learning therapy involves observing people behaving in ways that a patient finds challenging.

In social learning therapy, a model performs the behaviors that a therapist wants to teach his or her patient. The model or therapist provides verbal instruction, helping the observer to understand the desired behavior. Social learning therapists think that a patient's behavior is equally influenced by his or her environment, actions, and personality traits and patterns.

A social learning therapy session involves the four stages of social learning theory in a more concrete sense. Therapy for the four stages include:

- **Attention:** The therapist directs the observer to carefully watch the behavior of a model.
- **Retention and memory:** The therapist helps the observer commit their experiences and observations to memory through various questions, reinforcements and exercises.
- **Initiation and motor skills**: This involves establishing the muscle memory to recreate what the observer has learned later when they are on their own. A therapist might help their patient to build up these skills through various forms of role playing, practice exercises and brainstorming activities. One example is a recovering alcoholic who may need to practice how to react in various scenarios when they may be pressured to have a drink.
- **Motivation:** A therapist can work closely with a patient to plan out the best methods to keep them on track by getting to know them over time.

Social learning theory can be applied to several use cases outside of psychology some examples are given below:

- Human resources (HR) - In HR, professionals can increase employee retention by applying social learning theory techniques. For example,

correcting mistakes as they happen before they become routine habits, incentivizing positive behavior and giving mistakes weight.

- Training and educational development - Social learning theory in training is similar to the concept of learning by doing. New employees may best learn their role by imitating or repeating the behaviors of their boss or someone in the same position.
- Marketing - Advertisements and marketing materials can incorporate the social learning theory to reach target audiences and encourage the purchase of a product. For example, a company might suggest that a certain desired lifestyle or characteristic will be the outcome of buying their service.
- Machine learning - Social learning theory can be applied in training machine learning algorithms for purposes such as cognitive computing and robotics.
- Law enforcement - Criminal justice professionals often use social learning theory to explain or identify learned illicit behavior. Additionally, it can be used to research the effect of media violence on human behavior. Sometimes, criminal justice professionals can discover patterns of behavior in large communities and create programs and educational tools to help intervene when a crime would likely be committed.
- For instance, in an area with a high rate of theft in a secluded public parking lot, simply putting up signs reminding people to take their belonging with them or lock up their cars can greatly reduce the number of thefts in that location. In other situations, helping young adults to have healthy resources to deal with loss or grief can prevent them from acting out and getting in trouble later in life.

2.6.8. Advantages of social learning

– **Natural way to learn**

The most significant advantage of social learning is that everyone uses it naturally every day, consciously and unconsciously. You don't have to plan it separately or set aside time for it because it happens automatically over time. In the working world, this means that we observe our colleagues and notice what they do and how they do it. When a colleague is particularly praised for performance or receives a bonus, other employees analyze all by themselves what action led to it in order to work towards the same result.

– **Better skills**

These tendencies are great for leverage in organizations. By encouraging sharing thoughts, ideas, experiences, and best practices, you strengthen your employees' productivity and skills.

– **Higher learning retention**

It is scientifically proven that we only remember 10% from formal learning sources, while the remaining 90% comes from informal sources and social learning. By learning something directly from a person, we are able to remember it better because we remember things like voice pitch, images, memories, or even a joke during learning that we associate with learning content.

– **Lower costs**

Bringing employees together to share subject matter expertise costs less than a seminar or learning content on the same topic.

– **Productivity and sustainability**

When employees know who to ask about a topic, the information spreads, and, over time, a mentoring network is created within the company. This encourages sharing and reduces the need to learn from other sources.

– **Employee retention**

Many employees want to continue their education, and they want to share ideas with colleagues. Social learning enables them to do both, creating stronger bonds with each other at the same time. That, and the awareness that the company allows or even encourages this type of exchange, increases loyalty.

– **Better informed**

The more frequently employees exchange ideas with their colleagues on a wide range of topics, the more often they look beyond their horizons. This broadens their perspective and gives them impressions that help prevent mistakes and increase efficiency.

– **Collaboration**

Learning is not the only thing that is collaborative in this case. Other factors are naturally included as well. Employees help each other more often, seek advice and help, collaborate better, and learn along the way. The best time to learn is when you need the knowledge

– **Capture organizational knowledge**

By sharing knowledge within the organization, there is a greater chance of certain pieces of information being saved even after crucial employees leave the organization.

– **Problem solving in real time**

Many employees are looking for learning opportunities in a moment of actual need. The urge to solve a problem they cannot solve on their own requires collaboration. Usually, the first thing humans will do in this situation is asking others for their ideas. This is much faster than searching for answers online.

– **Inclusion of passive employees**

There are lots of people that are quiet or even afraid to ask questions. Social learning in a context of learning groups or any other group larger than 2 people makes it easier for introverts to learn by listening to other people discussing their questions

2.6.9. Disadvantages of Social Learning

Social learning also brings professional and psychological risks, which should be mentioned

– **Inner conflicts**

Since social learning is based on the idea of adapting what is perceived as successful and positive behavior in others, you are learning to behave more like someone else. If you use this tactic too often and too intensely, it can result in inner conflict if the new behaviors are contrary to your own views. In the long run, this leads to active internal resistance and prevents any learning process.

– **Less authenticity**

Contrary to what behavioral scientists have feared, social learning does not necessarily affect a person's personality. In most cases, it would take long-term, repeated imitation to adopt a new behavior as one's own or lose one's connection to one's personality. Moreover, people often notice it themselves when something doesn't feel authentic.

– **Loss of innovation**

Personal thought processes, opinions and views are often neglected, favoring behavior that promises the greatest success. However, since new and unconventional ideas tend to bring progress and innovation, this learning technique should not be used too much.

– **Unexpected obstacles**

Very few people know their limits, strengths and weaknesses really well. It is often not possible to imitate the behavior of another because unknown obstacles can arise. This can result in frustration, which leads to resignation.

– **Consequences for self-esteem**

Most people cannot tell the difference between observation or imitation and a comparison to themselves. If we compare ourselves with others, we usually compare visible indicators like performance and results. This leads to frustration and disappointment in most cases. We typically compare ourselves to people who can do something better than us in order to learn from them. As a result, such a comparison will always be to our disadvantage. For people without a solid self-esteem, such a thing can have psychological consequences in the long run. Therefore, care should be taken to distinguish social learning from

personal comparison clearly and to incorporate positive reinforcement.

- **Self-doubt**

If everyone is a teacher and a student simultaneously, there is uncertainty about quality standards, and there can be self-doubt.

- **Measuring requires modern solutions**

There are few ways to measure social learning apart from content usage unless you use a modern learning platform.

- **Negative assumptions**

Social media and videos are considered a waste of time and leisure time in many minds.

- **Necessary intervention**

Group discussions need to be led because otherwise, they quickly digress and turn into random private conversations, losing focus on the topics at hand.

- **Requirements**

Attention, retention, replicability and motivation must be present in each participant for it to work.

Application activity

1. What are the four necessary steps in social learning theory?
    A. Attention, retention, reproduction, and motivation
    B. Attention, interpretation, reproduction, and motivation
    C. Attention, reproduction, learning and motivation
2. The social learning theory was developed by _____.
    A. Psychologist Albert Bandura
    B. Psychologist B.F. Skinner
    C. Psychologist Albert Skinner
3. Complete the following sentences with the correct aspect of social learning theory
    A. The observer must be able to remember the behavior of the model that has been observed. This is ……...
    B. The person must closely watch the models behavior. This is …….
    C. The observer has to have the ability to replicate the observed behavior. This is …….
    D. Learners must want to demonstrate what they have observed. This is ……...
4. Explain the components of social learning theory?
5. Describe conditions for effective modeling?

2.7. Social identity theory (Tajfel)

Learning activity 2.7

Make a brief discussion on this Rwandan proverb “Ibisa birasabirana”.

Henri Tajfel and John Turner devised their social identity theory (SIT) in the 1970s to “supplement” Sherif’s realistic conflict theory (RCT), which was developed in the 1950s and ‘60s. Both of these theories attempt to explain intergroup behavior, and in particular conflict between groups. Intergroup behavior is between two or more individuals and their interactions are fully determined by their respective memberships in various social groups.

This is opposed to interpersonal behavior, whereby one’s interactions with

others are determined by personal traits and qualities.

One of the main claims of Sherif's realistic conflict theory is that conflict between groups exists when there is direct competition for resources. Social identity theory does not contradict this, but goes further to explain how conflict can exist even when there is no direct competition for resources. Through the four interrelated concepts of social categorization, social identity, social comparison and positive distinctiveness, Social identity theory attempts to explain why intergroup conflicts can exist even in circumstances with no direct conflict and/or competition between groups.

Tajfel and Turner's social identity theory explains that part of a person's concept of self comes from the groups to which that person belongs. An individual does not just have a personal selfhood, but multiple selves and identities associated with their affiliated groups. A person might act differently in varying social contexts according to the groups they belong to, which might include a sports team they follow, their family, their country of nationality, and the neighborhood they live in, among many other possibilities.

Henri Tajfel's greatest contribution to psychology was social identity theory. Social identity is a person's sense of who they are based on their group membership(s).

Tajfel (1979) proposed that the groups (e.g. social class, family, football team etc.) which people belonged to were an important source of pride and self-esteem. Groups give us a sense of social identity: a sense of belonging to the social world.

We divided the world into "them" and "us" based through a process of social categorization (i.e. we put people into social groups).

Henri Tajfel proposed that stereotyping (i.e. putting people into groups and categories) is based on a normal cognitive process: the tendency to group things together. In doing so we tend to exaggerate:

1. The differences between groups
2. The similarities of things in the same group.

This is known as in-group (us) and out-group (them). The central hypothesis of social identity theory is that group members of an in-group will seek to find negative aspects of an out-group, thus enhancing their self-image. When a person perceives themselves as part of a group, that is an in group for them. Other comparable groups that person does not identify with are called outgroups. We have an "us" vs. "them" mentality when it comes to us in groups and their respective outgroups.

Tajfel and Turner (1979) proposed that there are three mental processes involved in evaluating others as "us" or "them" (i.e. "in-group" and "out-group". These take place in a particular order.

There are three processes that create this in group/outgroup mentality:

Social Categorisation	→	Social Identification	→	Social Comparison

a. Social Categorization.

First, we categorize people in order to understand and identify them. Some examples of social categories include black, white, professor, student, Republican, and Democrat. By knowing what categories, we belong to, we can understand things about ourselves, and we can define appropriate behavior according to the groups that we and others belong to. An individual can belong to several groups at the same time.

b. Social Identification.

We adopt the identity of the group that we belong to, and we act in ways that we perceive members of that group act. For example, if you identify as a democrat, you will most likely behave within the norms of that group. As a consequence of your identification with that group, you will develop emotional significance to that identification, and your self-esteem will be dependent on it.

Social Identity

According to Tajfel and Turner, social identity means "aspects of an individual's self-image that derive from the social categories to which (they) perceive (themselves) as belonging". In other words, each of us belongs to numerous groups (e.g. social, family, sport, musical, religious, etc.) Our membership in each of these groups adds to our understanding of who we are as individuals. We form a personal identity based on our individual goals, achievements, etc. and we form a social identity based on the goals, achievements of groups we belong to. This sense of developing our sense of self through belonging to groups is important to understand and explain social identity theory.

c. Social comparison.

After we categorize ourselves within a group and identify ourselves as being members of that group, we tend to compare our group (the in group) against another group (an outgroup). To maintain your self-esteem, you and your group members will compare your group favorably against other ones. This helps explain prejudice and discrimination, since a group will tend to view members of competing groups negatively to increase self-esteem.

Tajfel and Turner base the concepts of social comparison and social identity on three assumptions:

– Individual's naturally try to increase their self-esteem and want to develop positive self-images.

- Belonging to particular groups can be viewed as a positive or a negative thing; this means belong to a group can influence our social identity in either a positive or negative way.
- we evaluate if it's positive or negative by comparing in-groups and out-groups.

(i) Intergroup Comparisons

There are things that tend to happen in the process of comparing an in group to an outgroup, as mentioned above. Members of an in group will tend to:

- Favor the in group over the outgroup
- Maximize the differences between the in group and the outgroup (it is necessary to maintain that the groups are distinct if a person is favoring their group over the other)
- Minimize the perception of differences between in group members (this increases in group cohesion)
- Remember more positive information about the in group and more negative information about the outgroup

(ii) The Interpersonal-intergroup continuum

Another main aspect of social identity theory is its explanation that social behavior falls on a continuum that ranges from interpersonal behavior to intergroup behavior. Most social situations will call for a compromise between these two ends of the spectrum. As an example, Henri Tajfel suggests that soldiers fighting an opposing army represent behavior at the extreme intergroup end of the interpersonal-intergroup spectrum

Conclusion

Just to reiterate, in social identity theory the group membership is not something foreign or artificial which is attached onto the person, it is a real, true and vital part of the person. Again, it is crucial to remember in-groups are groups you identify with, and out-groups are ones that we don't identify with, and may discriminate against.

Application activity 2.7

1. Describe three components of social identity theory?
2. With example explain what social identity mean?
3. The concepts of social comparison and social identity are based on three assumptions. What are they?

End of unit assessment

1. With example explain how attributions influence behavior?
2. Explain principles of social learning theory?
3. Summarize Milligram's shock experiment?
4. Discuss the application of social learning theory?
5. With examples distinguish autonomous motivation from controlled motivation?

UNIT 3 GROUP STRUCTURE AND MODELS OF SOCIAL GROUP FORMATION

Key unit competence: Criticize group structure and models of social group formation.

Introductory activity

Groups can vary drastically from one another. For example, three best friends who interact every day as well as a collection of people watching a movie in a theater both constitute a group. Researchers have identified four basic types of groups which include, but are not limited to: primary groups, secondary groups, collective groups, and categories. This unit describes the above mentioned types of groups and other various types. It also analyzes the Models of social groups development such as Tuckman's stages model, Tubb's system model, Lewin's individual change process and Fisher's theory of decision emergence group.

Use internet and other books from the library and find the group structure and models of social group formation.

3.1. Types of groups: Primary groups and secondary groups

Learning activity 3.1

Using internet and other books from the library, differentiate primary groups from secondary groups.

3.1.1. Meaning of Terms.

- **Group:** A group refers to two or more people who share a common meaning and evaluation of themselves and come together to achieve common goals. In other words, a group is a collection of people who interact with one another, accept rights and obligations as members and who share a common identity.
- **Group structure:** Group structure refers to the pattern of interrelationship that exits among group members and makes the group's functioning orderly. It is also the arrangement of individuals in their relationships both implicit and formalized, in group including positions, roles, patterns of authority, attraction and communication.

3.1.2. Types of groups

1) Primary groups

This is a small social group whose members share personal and lasting relationships. People joined in primary relationships spend a great deal of time together, engage in a wide range of activities, and feel that they know one another well.

In short, they show real concern for one another. In every society, the family is the most important primary group. Groups based on lasting friendships are also primary groups. Other examples of primary groups include crisis support groups, church groups, neighbors, peers, classmates, sororities, fraternities and love relationship groups.

Characteristics of primary groups

- **Physical proximity:** people belonging to a particular primary group, share a close and intimate relationship with one another. And that is why physical nearness, of the group members make communication easy and quick.
- **Small size:** primary groups are usually small in size. For example, in nuclear family, the mother, father and children are called primary group. Furhter, when the group is small in size, the members have strong emotional ties with one another and know each other quite well. They also develop group character.

- **Stability:** relationship between the group members can only be strong when there is some degree of stability in the group. If the members enter and exit the group frequently, intimacy may not be developed between them.
- **Similarity of background:** this means that the group members share a common experience, environment, history or circumstances.
- **Limited self-interest:** people belonging to this group subordinate their self-interest to the common interest of the group. They join the group and take part in it cooperatively.
- **Intensity of shared interest:** each member of primary group share a common interest, which is relevant for all as well as valued by all.

2) Secondary groups

In contrast to primary groups, secondary groups are large groups involving formal and institutional relationships. Secondary relationships involve weak emotional ties and little personal knowledge of one another. Most secondary groups are short term, beginning and ending without particular significance.

They may last for years or may disband after a short time. The formation of primary groups happens within secondary groups. Primary groups can be present in secondary settings. For example, attending a university exemplifies membership of a secondary group, while the friendships that are made there would be considered a primary group that you belong to. Likewise, some businesses care deeply about the well being of one another, while some immediate families have hostile relations within it.

Characteristics of secondary groups

- **Formal and impersonal relations:** As there is little to no face to face interaction between the members, the members have a very small degee of influence over one another. Also member does not know the other person very well. Hence, the relation is formal and impersonal as well.
- **Large size:** by large size, we mean that the group may be spread in large geographical area, or it may have numerous members.
- **Membership option:** becoming a member of a particular group, depends on the choice of the person (unlike the primary group, one can simply avoid being a part of a particular seconadary goroup. For intance, if you don't want to be a paert of a particular batch of dance class, you can simply change the **batch and become part of another group.**
- **Indirect relations:** as the members are spread all over the world, so the communication between them takes place by indirect means (via mobile, video conferencing, email and so forth.

- **Active and inactive members:** in secondary group, there is very little personal contact between the members. Hence, there is a lack of intimacy and so some members are active, while others are inactive.
- **Formal rules:** there is a well-established set of formal rules and regulations, which the members are expected to follow.
- **Status of individuals:** the status of the members keeps changing with time and circumstances. Moreover, the statu sis based on the role played by the members.
- **Goal-oriented:** secondary group is formed with a specific purpose or goal, and every member strives to achieve that goal.

Key Differences Between Primary Group and Secondary Groups

The difference between primary and secondary groups has been boiled down in the points given below:

Primary Groups are the groups which people experience or become part of, in their early stage of life. In this group, there is a sense of mutual cooperation, support, companionship and sharing of feelings. On the contrary, secondary groups are experienced by people in the later stages of their life. In such groups, the relations rely on reciprocal needs.

When it comes to the size of the two groups, the secondary group is larger in size both in terms of the number of members and geographical area, as compared to the primary group, which has a limited number of members. Also, the members may belong to a particular region.

Talking about the duration of the group, primary groups are long-lasting, as they persist over time. On the other hand, secondary groups are short-lived, because they are formed with a specific purpose, i.e. to carry out a certain task, and once the purpose is accomplished, these groups cease to exist.

The interest of members in case of a primary group is diffused, as each member may have different interest, however, the central interest dominates the self-interest. Conversely, in case of a secondary group, the interests of the members are common for which they join the group. For instance: People who join a gym, have one common interest, i.e. to reduce weight and keep themselves healthy and fit.

Primary Groups are commonly found in family settings, i.e. the members of the household often share a common background, and they know each other quite well. Also, they have a face to face contact with each other. As against, the secondary group is usually found in an educational and employment setting, like a class, batch, work team, etc.

Primary Group plays a very important role in the lives of people as they tend to shape the personality, behaviour and character of people. As against, the secondary group has a little significance on the life of people.

In the case of the primary group, the focus is on the relationship, but in the secondary group, the main focus is on the task or goal for which the group is joined.

The relationship between group members is direct, intimate and personal, in the primary group. Unlike, the relationship between group members is impersonal and goal-oriented.

In general, people experience or become part of the primary group in their early stage of life. But in their later stages of life, they become part of various secondary groups.

Primary Group works on the principle of particularism i.e. each individual is important. As against, the secondary group works on the principle of universalism, which means that the group is open to all and anyone can join it.

The structure of a primary group is informal, whereas secondary group has a formal structure.

In the primary group, the members know each other and they have strong bonding, so they have direct, quick and effective communication. In contrast, communication is indirect in case of a secondary group.

The best thing about the primary group is that the members have a stable role. However, in a secondary group, the role of people is interchangeable in nature.

There is direct cooperation between members of a primary group, but indirect cooperation is present in case of a secondary group.

Shortly, groups are a part of the society and every individual is a member of one or more groups. To get a better understanding of the society, one needs to learn the behaviour of the groups, as it reflects the structure of the society, they are a part of.

Application activity 3.1

1. With two examples on each distinguish between primary groups and secondary groups
2. In schools, there some teachers who promote group activities while others prefer individual activities. Discuss.

3.2. Types of groups: Collectives and categories

Learning activity 3.2

Using internet and other books from the library, diffeentiate collectives from categories, Formal and imformal as type of group.

3.2.1. Collectives

Collectives are characterized by large groups of individuals who display similar actions or outlooks. They are loosely formed, spontaneous, and brief. Examples of collectives include a flash mob, an audience at a movie, and a crowd watching a building burn.

3.2.2. Categories

Categories are characterized by a collection of individuals who are similar in some way. Categories become groups when their similarities have social implications.

For example, when people treat others differently because of certain aspects of their appearance or heritage, for example, this creates group of different races. For this reason, categories can appear to be higher in entitativity and essentialism than primary, social and collective groups.

The degree of entitativity that a group has is influenced by whether a collection of individual experience the same fate, display similarities, and are close in proximity. If individuals believe that a group is high in entitativity, then they are likely to believe that the group has unchanging characteristics that are essential to the group, known as essentialism.

Categories consist of individuals that are similar to one another in a certain way, and members of this group can be permanent in group members or temporary in group members. Examples of categories are individuals of the same ethnicity, gender, religion or nationality. This group is generally the largest type of group.

a. Formal group

A formal group is a collection of persons, who came together for achieving a specified goal. They are always created with intent to fulfil some official requirement. Formation of the group is done by the management. It possesses a systematic structure, in hierarchical form.

In general, the employees of the organisation are divided into groups, and a task is a hand over to each group. In this way, the task of the group is accomplished along with the fulfilment of organisational goals. The given are the types of formal group :

- **Command groups:** The groups that consist of managers and their subordinates.
- **Committees:** The group of people who are appointed by an organisation, to resolve the matters, referred to them are known as Committee. For example Advisory Committee, Standing Committee, etc.
- **Task Forces:** The group form to carry out a particular task is known as Task Forces

b. Informal group

The groups that are created naturally, within the organisation, due to social and psychological forces are known as Informal groups. Under this group, the employees of the organisation, themselves enter into groups, without the approval of the management to satisfy their social needs on the job.

Nobody wants to live in isolation; people generally create a circle around themselves so that they can interact and share their feelings, opinions, experiences, information, etc. These circles are known as informal groups at the workplace. These groups are formed on the basis of common likes, dislikes, prejudices, contacts, language, interests, attitudes of the members. It includes interest group and friendship group. The communication is faster in such groups, as they follow grapevine chain.

3.2.3. Key differences between Formal and Informal Groups

The groups formed by the management of the organisation for accomplishing a specific task are known as Formal Groups. The groups that are formed by the employees themselves as per their likes and prejudices is known as Informal Groups.

The formal groups are deliberately created by the organisation, whereas the informal groups are established voluntarily.

The formal groups are big in size as compared to an informal group. Moreover, there can be sub-groups in a single formal group.

The structure of a formal group is designed in a hierarchical manner while the informal group lacks structure or say it has no structure.

In a formal group, the position of a member defines its importance in the group, but in an informal group, every member is as important as any other member.

In a formal group, the relationship between the members is professional, they gather just to accomplish the task allotted to them. On the other hand, in an informal group, there is a personal relationship between members, they share their opinions, experiences, problems, information with each other.

In a formal group, the flow of communication is restricted due to the unity of command. In contrast to an informal group, the flow of communication stretches in all directions; there is no such restriction.

Application activity 3.2

1. Answer by True if the statement is correct or by False if the statement is wrong

a) The group formed by the management of the organiztion for accomplishing a specific task is known as informal groups.

b) The group that is formed by the employees themselves as per their likes and prejudices is known as formal group.

c) The group formed by only women in order to share about how to take care of their children is known as categories group.

d) A group formed by choristes of catholic church so as to plan the annual budget of their choir is known as collectives.

e) A group formed by students in the main hall to watch a movie is good example of collectives.

f) A group of students in the classroom falls under the category of informal groups.

3.3. Types of groups: Social groups, task groups, functional groups and interest groups

Learning activity 3.3

Using internet and other books from the library, and analyze social groups, task groups, functional groups, and interest groups.

3.3.1. Social groups

A social group is characterised by formally organized group of individuals who are not as emotionally involved with each other as those in primary group. These groups tend to be larger, with shorter memberships compared to primary groups.

Further, social groups do not have as stable memberships, since members are

able to leave their social group and join new groups. The goals of social groups are often task-oriented as opposed to relationship-oriented. The examples of social groups include co-workers, clubs, sports teams…

The main characteristics of social groups

- **Collection of Individuals:** Social group consists of people without individuals there can be no groups. Just as we cannot have a college or a university without students and teachers we cannot have a group in the absence of people.
- **Interaction Among Members:** Social interaction is the very basis of group life. Hence mere collection of individuals does not make a group the members must have interaction. A social group, is in fact a system of social interaction. The limits of social group are marked by the limits of social interaction.
- **Mutual awareness:** Group life involves mutual awareness. Group members are aware of one another and their behavior is determined by this mutual recognition. This may be due to what Giddings calls 'the consciousness of kind".
- **'We-feeling':** 'We-feeling' refers to the tendency on the part of the members to identify themselves with the groups. It represents group unity. 'we-feeling' creates sympathy in and fosters co-operation among members. It helps group members to defend their interests collectively.
- **Group Unity and Solidarity:** Group members are tied by a sense of unity. The solidarity or integration of a group is largely dependent upon the frequency, the variety, and the emotional quality of the interactions of its members. A family or a friends' group, or a religious group is highly united and integrated, because its members are related by several common interests and have frequent social contacts with one another and express a high degree of morale and of loyalty. Unity is maintained more often by conscious effort.
- **Common Interest:** The interests and ideals of group are common. Groups are mostly formed or established for the fulfillment of certain interests. In fact, men not only join groups but also form group for the realization of their objectives or interests. Form of the groups differs depending upon the common interests of the group. Hence, there are political groups, religious groups, economic groups, educational groups, racial groups, national groups and so on.
- **Similar behavior:** The members of the group behave in more or less similar way for the pursuit of common interests. Social groups represent collective behavior.

- **Group Norms:** Every group has its own rules or norms which the members are supposed to follow. These norms may be in the form of customs, folkways, mores, traditions, conventions, laws, etc. they may be written or unwritten norms or standards. Every group has its own ways and means of punishing or correcting those who go against the rules. The continued group-life of man practically become impossible without some norms.
- **Size of the Group:** Every group involves an idea of size. Social groups vary in size. A group may be as small as that of dyad (two members' group e.g., husband-and-wife-family) or as big as that of a political party having lakhs of members. Size will have its own impact on the character of the group.'
- **Groups are Dynamic:** Social groups are not static but dynamic. They are subject to changes whether slow or rapid. Old members die and new members are born. Whether due to internal of external pressures or forces, groups undergo changes.
- **Stability:** groups are stable or unstable, permanent or temporary in character. Some groups like, the crowd, mob, audience, spectators' group etc., are temporary and unstable. But many groups are relatively permanent and stable in character.

Note that, social groups directly or indirectly shape the personality of their members. They also provide opportunities for the expression of individuality.

3.3.2. Task groups

These groups consist of people who work together to achieve a common task. Members are brought together to accomplish a narrow range of goals within specified time period. Task groups are also commonly referred to a task force. The organisation appoints members and assigns the goal to be accomplished. Examples of assigned tasks are the development of a new product, the improvement of production process, or designing the syllabus under semester system. Other common task groups are ad hoc committees, project groups, and standing committees. Ad hoc committees are temporary groups created to resolve a specific complaint or develop a process.

3.3.3. Functional groups

A functional group is created by the organization to accomplish specific goals within an unspecified time frame. Functional groups remain in existence after achievement of current goals and objectives. For example, marketing department, a customer service department, or an accounting department.

3.3.4. Interest group

Interest groups usually continue overtime and may last longer than general informal groups. Members of interest groups may not be part of the same organisational department but they are bound together by some other common interest. The goals and objectives of group interests are specific to each group and may not be related to organizational goals and objectives. An example of an interest group would be students who come together to form a study group of a specific class.

Application activity 3.3.

Complete the sentences below with an appropriate type of group

a) The organization appoints a group of members and assigns them the to be accomplished within a specific time period. This type of group is known as……..,

b) The examples of ……., include co-workers, sports teams and clubs.

c) ……., remain in existence after achievement of current goals and objectives.

d) The goals and objectives of ……., are specific to each group and may not be related to organizational goals and objectives

3.4. Types of groups: Reference groups, Friendly groups, Formal group, Informal group, Organized group. Spontaneous group, Command group

Learning activity 3.4

Using internet and other books from the library, and describe the following types of group:

Reference groups, Friendly groups, Formal group, Informal group, Organized group. Spontaneous group, Command group and temporary groups.

3.4.1. Reference groups

A reference group is a type of that people use to evaluate themselves. The main objectives of reference group are to seek social validation and social comparison. Social validation allows individuals to justify their attitudes and values while social comparison helps individuals evaluate their own actions by comparing themselves to others.

Reference groups have a strong influence on members' behaviour. Such groups are formed voluntarily. Family friends, and religious affiliations are strong reference groups for most individuals.

Important characteristics of reference group

- The individual or group considers the behavior of the other individual or group as ideal behavior and imitates it.
- The individual or group compares himself or itself with the other individual or group.
- In Reference Group Behavior the individual or group desires to rise higher in the social scale and as such the group or individual comes to feel it's or his defects or weaknesses.
- The feeling of relative weaknesses or defects leads to the feeling of relative deprivation in the individual or group.

3.4.2. Friendly groups

Friendship groups are formed by members who enjoy similar social activities, political beliefs, religious values, or other common bonds. Members enjoy each other's company and often meet after work to participate in these activities. For example, a group of employees who form a friendship group may have a yoga group, a ketty party lunch once a month.

3.4.3. Organized groups

These are the groups which are formed for specific purpose and are carefully planned. The family, the school, etc are also called organized groups.

1. **Spontaneous groups**

These are groups that are formed without any careful planning. Audience may be considered as spontaneous group after listening to the speech by a speaker.

2. **Command group**

Command groups are specified by the organizational chart. It consists of a supervisor and the subordinates that report to the supervisor.

3. **Temporary groups**

Contemporary groups come together for a certain purpose and disburse after the task is over. These groups have their own unique sequencing of actions.

4. **In-group/we group**

Here we identify ourselves with that group which has a common objective and common interest. They have a sense of 'we' feeling. The members of the in-groups treat others as outsiders. These groups can be formed on the basis of relationship, same country, similar political interests and economic interests etc.

5. **Out-group**

This is the group in which the members are considered as outsiders by us. Groups other than the in-group are generally called out-groups. It is formed based on the rules and norms.

It is impotant to note that groups are the units of social organisation. Therefore, the integration and disintegration of social organisation are dependent upon the integration or disintegration of the groups. In group, social relationship is a very important factor. The first and foremost social relationship indicates the relationship among the family members.

Application activity 3.4

Match the type of group and its corresponding meaning from the tablbe below

Type of group	Meaning of group
1. Temorary group	a. Social validation allows individuals to justify their attitudes and values while social comparison helps individuals evaluate their own actions by comparing themselves to others.
2. In-group	b. It is a group which is formed for specific purpose and is carefully planned like school.
3. Out-group	c. Group formed by members who enjoy similar political beliefs, religious values and other common bonds
4. Reference group	d. It is the group in which the members are considered as outsiders by us
5. Organized group	e. Audience after listening to the speech by the speaker that is formed without any careful training.
6. Spontaneous group	f. This group is determined by an institutional chart and consists of a supervisor and the subordinates that report to the supervisor.
7. Friendly group	g. This a group that can be formed on the basis of relationship, same country, similar political interests and economic interests
8. Command group	h. This is the group that has its own unique sequencing of actions and disburses after the task is over.

3.5. Models of social groups development: Tuckman's stages model

Learning activity 3.5.

Using internet and other books from the library, explain how groups develop according to Tuckman's stages model.

In his theory, Bruce Wayne Tuckman (1938-2016) stated that teams/groups would go through five stages of development (Forming, Storming, Norming, Performing and adjourning). These stages supposedly start when the group first meets and last until the project ends. Each of these rhyming stages plays a significant role in building a highly functioning business team/group.

3.5.1. The five stages of development of the group/team

1. **Forming**

The first stage of group/team development is forming. The team/group members have just been introduced to each other and the task has been allocated. This is an interesting psychological moment as group members tend to behave independently at this stage. Whilst there may be good spirits and good interactions, the trust won't be there.

Goals at this stage:

- Break down barriers and encourage group members to get to know one another and interact frequently
- Analyse everyone's skills, background and interest
- Define group's structure, purpose and goals
- Set timeline
- Create rules or regulations
- Understand individual roles and responsibilities each member will play

It is important to note that the group starts to develop an understanding of the part each person will play.

The forming stage requires the most meetings. Team members need frequent direction and feedback, so you should anticipate a lot of meetings between members and leadership.

While the forming stage is useful in establishing objectives, members rarely branch out from their individual roles. As the group process starts to gel, leadership needs to provide enough structure and direction so that team

members feel confident enough in their roles to take risks and assume more responsibility. During this period of team formation, it's critical that the leader encourages members to go outside of the comfort zone and explore new ways of working together.

2. **Storming**

The storming stage of group development is one of the most critical stages, but it's also the most dreaded. This stage is marked with turmoil and interpersonal conflict as group dynamics are established and members compete for their ideas to be heard.

This stage is like the teenage phase of group development – boundaries are tested, and arguments are inevitable. In this stage, individual members vie for leadership roles while others chafe at their team members giving them direction. Cliques and subgroups start to form, and members value competition more than collaboration. Different working styles clash, and productivity decreases. At this stage, looking to a strong leader for guidance is vital.

Goals at this stage:

- Establish effective conflict resolution techniques to prevent tension from causing deeper damage
- Create a culture of open dialogue that ensures all issues are raised and nothing goes unchecked
- Introduce a system of rewards and consequences to reinforce the ground rules identified during forming stage.

In order to move on to the next stage, embolden high-performing team members to step into leadership roles, while taking care to actively involve all team members. To avoid power struggles, this is the time to invest in team building and conflict resolution exercises. It's critical to move your team beyond the teenage mentality of testing boundaries and towards a problem-solving mentality. Learn how to listen to team members. To move to the next stage, your team needs less oversight on the project itself and more team building facilitation.

3. **Norming**

This is the stage where things tend to settle down. Your team/group can get into the groove of working together towards a common goal. However, during the norming stage, there can be a few overlaps with storming. As new tasks appear, there may still be some incidents of conflict.

It is a stage in which team members start to offer new ideas and suggestions. Problem solving becomes a core part of the process of collaboration, and members take responsibility for their outcomes. The team utilizes all resources to meet milestones, and team members step up to support each other

Goals at this stage:

- Provide constructive feedback to all group members to ensure continuous growth and alignment with group objectives
- Remove certain elements of the group's structure to encourage individuals to greater responsibility
- Continue creating opportunities for collaboration and teamwork to maximize the creativity and camaraderie present in this stage.

While the norming stage sounds ideal, they must move on to the performing stage for true interdependence. To facilitate this group development, leaders should continue to give constructive feedback and support, and make collaboration as easy as possible. At this stage, things are going so well that team members might fear the breakup of the team if further risks and innovations are taken. Encourage your team to continue to break out of their comfort zone to achieve better results.

4. **Performing**

The performing stage is where the group/team can hit its stride. Each group member understands everyone's strengths and weaknesses and they are familiar enough with each other to help. This is the stage where each member is confident and motivated. It is also where they can operate without strict supervision. Some groups/teams don't make it to this stage, so if you do it's a real achievement. It's the stage that every group will hope to make as it's when you can get your best work done.

The team is truly interdependent. Teamwork and creativity is at an all time high, and team members step up to take ownership over multiple parts of the project. Leaders provide little direction, meanwhile team members share new information and solutions constantly. In this stage, everyone is working towards the team's goals, and group cohesion is at an all time high.

Goals at this stage:

- Continue to encourage collaboration and teamwork by reinforcing the norms that have been established to this point
- Measure individual and team performance to track progress and identify areas of strength and opportunities for improvement
- Minimize concerns around the potential for the team to lose momentum od dissolve by managing change and future expectations.

All good things must come to an end, and at a certain point, the project will wrap up. To ensure a smooth transition to the Adjourning stage of the project's end, it's important to recognize and reward everyone's efforts, and carry the collaborative effort on to the next project, if applicable.

5. **Adjourning**

This stage stipulates that when the project ends, the group will disband. If they have reached the performing stage, then there could be a sense of mourning if they have grown close. However, having positive shared experiences will make it easier if you work with some of these people again. Meanwhile, as the project is waning, team members are more focused on the next opportunity than finishing the project. The high energy of collaboration and creativity slows down, as team members check out mentally

Goals at this stage:

- Ensure all tasks and responsibilities are fully completed and there are no big issues to be solved
- Measure both group's and each individual's overall performance to quantify all contributions
- Recognize key successes and accomplishments and reward good work

While there are no stages left, it's important to ensure that your project ends on a high note. This may be the time for more oversight, similar to the forming stage, to encourage the tying up of loose ends. This is also an important time to meet with team members, provide feedback, and discuss next steps.

Although Tuckman's stages of group development were first written about in 1965, they remain a useful tool even today in learning what creates high-performing teams. Stages of group development examples can help you understand that what your team is going through is completely normal. Understanding the five stages and how to keep your team moving through each of them helps bolster productivity and foster a creative and collaborative team.

Application activity 3.5.

Match the description with its appropriate corresponding stage of team/ group development accoding to Bruce Tuckman.

Desrciption of the stage	Stage
1. Group members are familiar with one another and assist each other. They work without being told to do so. Hence, they are rsponsible of the task maening, the take the task as their own.	a) Forming
2. Group members sit down and enjoy their fully completed tasks and responsibilities without big issues. They recognize key successes and accomplishmemts so as to reward good work.	b) Storming
3. Group members are aware of the raeson and the motive of accomplishing the task inspite of some disagreements on some issues.	c) Norming
4. Group members strive to work together to accomplish a common task but the cases of conflict maya gain occur.	d) Performing
5. Among group members, there is a good mood but no trust though the tasks were distibuted.	e) Adjourning

3.6. Models of social groups development: Kurt Lewin's individual change process

Learning activity 3.6.

Using internet and other books from the library explain explain the stages involved in Kurt Lewin's change model.

Kurt Lewin (1890-1947) was a German-American psychologist. He developed a change model involving three stages namely unfreezing, changing and refreezing. The model represents a very simple and practical for understanding the change process. For Lewin, the process of change entails creating the perception that a change is needed, then moving toward the new, desired level behaviour and finally, solidifying that new behaviour as the norm. The model is still widely used and serves as the basis for many modern change models.

3.6.1. Three steps that are involved in Kurt Lewin's change model

1. **Unfreezing**

Before a change can be implanted, it must go through the initial step of unfreezing. Because many people will naturally resist change, the goal during the unfreezing stage is to create awareness of how the current level of acceptability, is hindering the organization in some way.

Old behaviours, ways of thinking, process, people and organization must all be carefully examined to show employees how necessary change is for the organisation to create or maintain a competitive advantage of the marketplace. Communication is is especially important during unfreezing stage so that employees can become informed about the imminent change, the logic behind it and how it will benefit each employee. The idea is that the more we know about a change and the more we feel it is necessary and urgent, the more motivated we are to accept change.

2. **Changing**

Lewin recognized that change is a process where the organization must transition into the new state of being. Changing step, also referred to as transitioning or moving is marked by the implantation of change. This is when the change becomes real. It is also the time that most people struggle with the new reality. It is a time marked with uncertainty and fear, making it the hardest step to overcome.

During the changing step people begin to learn the new behaviours, processes and ways of thinking. The more prepared they for this step, the easier it is to complete. For this reason, education, communication, support and time are critical for employees as they become familiar with change. Again, change is a process that must be carefully planned and executed. Throughout this process, employees should be reminded of the reasons for the change and how it will benefit them once fully implanted.

3. **Refreezing**

Lewin called the final stage of his change model freezing, but many refer to it as refreezing to symbolize the act of reinforcing, stabilizing and solidifying the new state after the change. The changes made to organizational processes, goals, structure, offerings or people are accepted and refrozen as the new norm.

Lewin found the refreezing step to be especially important to ensure that people do not revert back to their old ways of thinking or doing prior to the implantation of the change. Efforts must be made to guarantee the change is not lost, rather

it needs to be cemented into the organisation's culture and maintained as the acceptable way of thinking or doing. Positive rewards and acknowledgement of individualized efforts are often used to reinforce the new state because it is believed that positively reinforced behaviour will likely be repeated.

Application activity 3.6

Suppose you need to make change in your group/organiztion, propose the strategies you will use to make group members accept your idea ?

3.7. Models of social groups development: Tubb's systems model

Learning activity 3.7.

Use internet and other books from library and describe the stages involved in Tubb's system model.

Stewart L. Tubbs, 80 years of age is an American dean of the college of Business at Eastern Michigan University. His study about the interaction within small groups led him to create a four-phase model for group development. The Tubbs System Model. The Tubbs system model is a linear model of group development. This model consists of the following phases:

3.7.1. Orientation

In this first stage, the various group members get to know each other. Together, they begin talking about the problem or project, begin to discuss problems and research common limitations, opportunities, strengths and weaknesses related to the project or the joint task.

When comparing this model to other models of group development, it becomes apparent that some features from this phase are similar to features from the formation phase. In the formation phase, the group has just gotten together, and feeling of anxiety and insecurity often dominates.

In the beginning, the group members are often discrete, which results from the desire to be accepted by everyone in the group. Wherever possible, conflicts, misunderstandings, personal opinions and controversies are avoided.

However, the members begin to form impressions of each other and the project, and slowly but surely an image arises of what the group will be doing together.

It is important to note that, typical outcomes of this phase of the Tubbs Systems Model include gaining insight into the project group's goal, deciding how the group should be organised and should be responsible for what. Furthermore, the important project milestones are discussed, and general group rules are formulated as well.

3.7.2. Conflicts

In this phase, the group's problem or task is analysed and each group member tries to find a solution by utilising his/her perspective. This leads to increased individual participation in the group. If the work is considered too much from an individual's perspective, this can lead a too high level of individuality. This can lead to conflicts. Conflicts are a necessary and inevitable part of the development of the group as a whole. Conflicts allow the group to evaluate ideas. As well as help the group to prevent groupthink and conformity.

In this phase, important answers are found to questions related to leadership, authority, rules, and policy within the group. Responsibilities too are extensively discussed. However, just as structure, evaluation criteria and reward system. These things need to be clear before the step to the next phase can be taken

3.7.3. Consensus

Once conflicts have been resolved, the group enters the consensus phase of the Tubbs System Model. This is where group members compromise, select ideas, and come to agree about possible alternative solutions to problems found. They do so base on the input of each group member.

Working in this phase is more pleasant than the first phases of group development. Interaction between members becomes lighter, simpler, more cooperative and more productive.

A feeling of connectedness and mutual respect abounds, and communication between group members and the project manager is open and honest. Nevertheless, a conflict or dispute may still arise, but it will be solved in time, without the group's work running into a delay or a loss of quality.

Note that during this phase, members develop most on an individual level. Group members become more flexible, interdependent, and come to trust each other completely.

Leadership is distributive, which means different people can take the lead under different circumstances. Members are also willing to adjust their own behaviour or work to the needs of the group as a whole.

3.7.4. Closure

During the closure phase, the end result is announced and the group members confirm their support for the decision. This phase may be confusing and is usually reached when the project has been successfully completed.

At the end of this stage, the project is finished, and project members will depart in various directions for new projects.

Application activity 3.7

Match the type of Tubbs' system model phase with its corresponding description

Tubbs' system model phase	Short description
1. Closure	a. In this phase, the group's problem or task is analysed and each group member tries to find a solution by utilising his/her perspective.
2. Conflict	b. Working in this phase is more pleasant than the first phases of group development. Interaction between members becomes lighter, simpler, more cooperative and more productive.
3. Orientation	c. It marks the end of the project and project members go for different directions for new projects
4. Sensensus	d. In this stage, group members research common limitations, opportunities, strengths and weaknesses related to the project or the joint task.

3.8. Models of social groups development: Fisher's theory of decision emergence group

Learning activity 3.8

Use internet and books in the library and describe the Fisher's theory of decision emergence group.

Irving Fisher (1867-1947) was an American economist, statistician, inventor, eugenicist and progressive social campaigner.

Fisher developed the theory of Decision Emergence which includes four phases which a group goes through in the decision making process. According to him, the distribution of different tasks and decision making changes a team and, when managed successfully, it makes the team stronger.

When it comes to work projects, members of a group need to engage and pass a number of different phases before thorough and accurate decision-making can take.

3.8.1. The phases of Fisher's theory of Decision Emergence.

1. **Orientation**

This is when the group itself is formed. At this stage, issues between group members can also arise due to uniformity or previous tensions. Communication is absolutely key at this stage as well, so that participants can get to know each other and create a standard of communication. This will set the foundation for the rest of the project, including imitations, rules and good practices that should be considered.

2. **Conflict**

This is where ideas are discussed between members of the group. Conflict may arise if the proponents of one idea refuse to budge or take on board other ideas and comments. However, if orientation is successful, the negative impact of conflict will be minimized. If not, conflict has the potential to carry on throughout the process, hindering results.

3. **Emergence**

This is where the emergence of a plan or idea comes from conflict. At this point, personal ideas and beliefs need to be set aside to prioritize the overall success of the group task. Those who are happy with the direction of the project and the decisions being made should take a step back to allow others to contribute as well.

4. **Reinforcement**

At this stage, members of the workgroup need to commit to the ideas presented and conform to following the plan set in place in order to achieve the overall goal. Whether individuals agree entirely or not, at this stage, everyone in the group will need to collaborate and work to the best of their abilities. Motivation to complete the project is also key.

3.8.2. Advantages of group decision making

- ✓ Drawing from the experiences and perspectives of a larger number of individuals. Hence, they have the potential to be more creative and lead to a more effective decision. In fact, group may sometimes achieve results beyond what they could have done as individuals.
- ✓ Groups also make the task more enjoyable for membership in question.
- ✓ When the decision is made by a group rather than a single individual, implantation of decision will be easier because group members will be invested in the decision. If the group is diverse, better decisions may be

made because different group members may have different ideas based on their backgroung and experiences.

In almost all cases, the main issue that groups can run into is conflict between participants. Whether that's over personal reasons or directly related to the project and decisions being made, this is one of the main factors that will halt progress from one phase to another. Likewise, the less conflict that comes up in previous phases, the smoother the rest of the process is likely to go.

Application activity 3.8

Answer by **True** if the statement is correct and by **False** if the statement is False

1. According to Fisher's theory of Decision Emegence, in the reinforcement phase, issues between group members arise due to uniformity or previous tensions.
2. Personal ideas and beliefs need to be set aside to prioritize the overall success of the group task. This corresponds to emergence phase.
3. In the conflict phase, the issues are discussed between group members which may lead to disagreement due to the refusal of comments from others.
4. In the emergence phase, group members commit themselves to achieve the overall goal of the group.
5. Conflicts in group are necessary beacause they can be origin of new plan or idea.

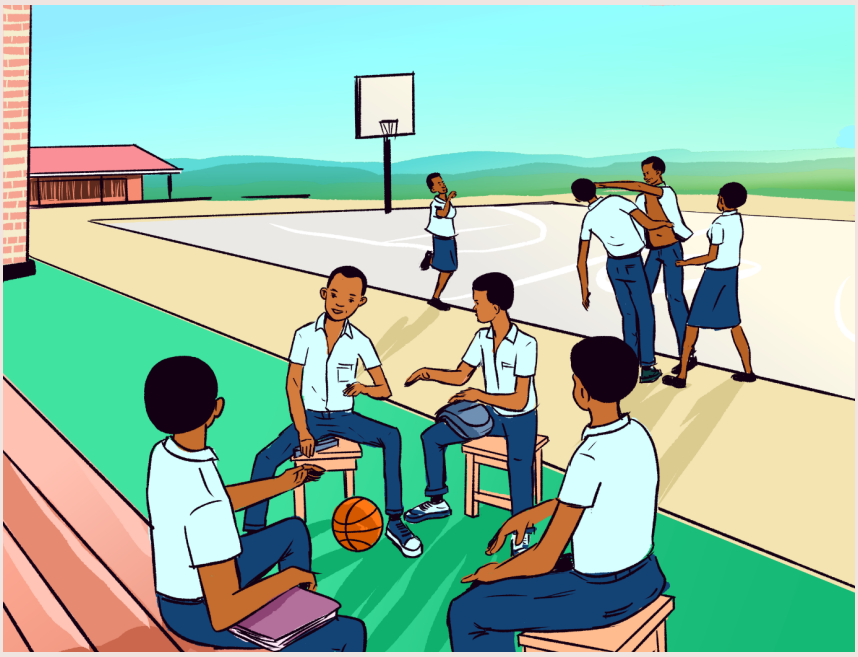
End of unit assessment

1. Propose the factors that lead to the formation of groups in any institution
2. After deep observation and analysis of how fifferent groups are formed in our communities, what have noticed in terms of characteristics in all groups?
3. Imagine you are a leader of a certain group in your community, how will you make it enjoyable and productive ?

UNIT 4 INTRAGROUP AND INTERGROUP DYNAMICS

Key unit competence: Assess group phenomenon and their effect on people's behavior

Introductory activity:



- Look ata the picture above and describe it. What are characteristics of those students in the picture.
- Use internet and books from library and describe intragroup and intergroup dynamics.

Group dynamics refers to the study of forces within a group. It deals with the attitudes and behavioural patterns of a group. Group dynamics concern how groups are formed, what is their structure and which processes are followed in their functioning. Thus, it is concerned with the interactions and forces operating

between groups. Therefore, this unit describes topics including in-group and out-group dynamics, group boundaries, group values and culture, relationship between groups, intergroup conflicts and intergroup conflict resolution strategies, contact hypothesis (intergroup conflict theory and subordinate identities and interdependence).

4.1. In-group and out-group Dynamics

Learning activity 4.1

Use internet and books from library and describe intragroup dynamics and intergroups dynamics.

An in-group is a group of people who identify with each other based on a variety of factors including gender, race, religion or geography. Our tendency to distinguish between in-group and out-group members has moral implications.

People may harm those whom they perceive to be in an out-group in ways that they would not harm in-group members. For example, one study showed that when soccer fans viewed fans of their own team being harmed, they felt empty. But when they viewed fans of a rival team being similarly harmed, they felt pleasure.

Likewise, people tend to make different normal judgements based on in-group and out-group distinctions. When someone in our in-group misbehaves, the natural reaction is often to dismiss the behaviour as no big deal. But when someone in our out-group does the same thing, we will tend to judge the behaviour much more harshly.

1. In-group and out-group dynamics

An in-group is a social category or group with which a person psychologically identifies strongly as being a member. By contrast, an out-group, is a social category or group with which an individual does not identify. It is important to highlight that people may for example identify with their peer group, family, community, sports team, political party, gender, sexual orientation, religion, or nation. Note also that the psychological membership of social groups and categories is associated with a wide variety of phenomena.

An important characteristic of the in-out group is that groups mark their identities communicatively by the distinct language and speech styles they create and use, the dress codes they adopt, and the festivals that highlight their unique traditions and rituals.

2. **Intragroup dynamics**

Intragroup dynamics also referred to as in-group dynamics or within-group are the underlying processes that give to a set of norms, roles, relations and common goals that characterize a particular social group. Examples of groups include religious, political, military, and environmental groups, sports teams, work groups, and therapy groups.

Amongst the members of a group, there is a state of interdependence, through which the behaviors, attitudes, opinions and experiences of each member are collectively influenced by the other group members in many fields of research, there is an interest in understanding how group dynamics influence individual behavior, attitudes and opinions.

The dynamics of a particular group depend on how one defines the boundaries of the group. Often, there are distinct subgroups within a more broadly group. For example, one could define Rwanda residents (Rwandans) as a group, but cold also define a more specific set of Rwanda residents (For example, Rwandans in the southern province). For each of these groups, there are distinct dynamics that can be discussed.

3. **Intergroup dynamics**

Intergroup dynamics or intergroup relations refers to behavior and psychological relationship between two or more groups. This includes perceptions, attitudes, opinions and behaviors towards one's group, as well as those towards another group**.**

In some cases, intergroup dynamics is prosocial, positive, and beneficial for example, when multiple research teams work together to accomplish a task or a goal). In other cases, intergroup dynamics can create conflict.

Application activity 4.1

Differentiate intergroup dynamics from intragroup dynamics

4.2. Group boundaries

Learning activity 4.2

Use internet and books in library and find group boundary and examples of group boundaries.

4.2.1. Meaning of boundary.

People use boundaries every day of life. The ability or inabability to say yes or no to a certain request is a boundary. Boundaries are limitations that persons set for themselves and for their relationships. Essentially, boundaries are what is and is not acceptable for a person to give and receive when it comes to other people**.**

Personal boundaries are most typically used in close relationships with other people, such as family, significant others, and friends. These people are the people that have the most impact on a person's life and often times request the most action or the most time.

Boundaries can also be relevant in a person's work life, such as when they work off the clock and what accepting new projects looks like.

4.2.2. Types of boundaries

1. **Healthy boundaries**

These boundaries vary from person to person. No person is the same and no relationship is the same, so each set of boundaries looks different. That being said, healthy boundaries have some commonalities. A person who has healthy boundaries is about to say no when she does not want to do something, or when she/he feels that she/he is being taken advantage off. While she/he is capable of saying no, she/he is still capable of maintaining close relationships, while still understanding what is and is not acceptable within that relationship. Just because the answer is no, does not mean that the relationship is damaged or over.

2. **Social boundaries.**

Social boundaries are boundaries tht indicate specific actions that are followed by most individuals. They are typically directed by society and what an individual experiences by being part of group. Social boundaries are also experiences that are considered normal within society. These boundaries are learned throuph observation, most of the time observed from childhood all the way to adulthood.

Social boundaries are characterised by what is acceptable within a certain

group of people, in Rwandan culture, eating cow is acceptable, whereas, in Indian culture, it is not acceptable to eat a cow. In India, eating a cow is social boundary that is not crossed.

Social boundaries can also look like understanding common social cues of a group and adhering to those cues. When one does not understand the common social cues, she/he is breaking social boundaries. Another example of this may be belching at the table, in some social boundaries, it is acceptable, in others, it is not.

It is important to note taht social boundaries are boundarise that **dictate the behavior** of a group of people. And are boundaries that the general society considers to be good. It is unspoken set of rules to benefit the greater society.

3. **Physical boundaries**

These are boundaries around what kind of physical touch is acceptable. If someone does not like to be hugged, that is physical boundary. Maintaining physical/ space and eye contact are also physical boundaries.

4. **Emotional boundaries**

Emotional boundaries are those boundaries that protect thoughts and feelings. They allow individuals to validate their own emotions and expect the same validation and suuport from others.

Additionally, within these types of boundaries are three subssets. They are called rigid, diffuse and healthy.

- Diffuse boundaries are those that are not very strong. Individuals do not often stand up for themselves and whatever boundaries they do have, they will let down if it is asked of them.
- Rigid boundaries are boundaries that are too strong. This person has up too many boundaries and does not let them down for anything or anyone.

Note that, healthy boundaries is a good mixture of diffuse and rigid boundaries. A person can say no to a request, but they can also say yes to the request as they will, without feeling like the relationship is damaged.

Application activity 4.2

1. Describe at least three types of group boundaries
2. Analyse the culture of Rwanda and assess the social boundaries within Rwandan society.

4.3. Group values and culture

Learning activity 4.3

Use internet and books in the library and describe group values and culture

1. **Group values** are goals or ideas that serve as guiding principles for the group like norms, values, may be communicated either explicitly or on an ad hoc basis. Values can serve as a rallying point for the team. However, some values such as conformity can also dysfunction and lead to poor decisions by the team.
2. **Group culture** is a collection of values, behaviors, working practices, and beliefs that group members share while aiming to fulfill their collective purpose. Every group has a culture. Inen if you've never thought of it in those terms, consider all the ways in which your team interacts, what you value, and what is important to you as a proup. That is your culture.

Note that a group culture is a reflection of shared values and working practices, and i twill be formed by both collective and individual actions within the group.

➢ **A good and strong group culture**

A strong group culture is one where everyone in the group is aligned on purpose, values, behaviors, and working practices while also feeling they are celebrated as individual.

In a good group culture, members of a group understand group and individual purpose as well as their role within the group. It is vital to know why you are doing the work you are doing and believe in the goals and purpose of the team.

While the group culture can emerge organically, it's important that you come together to define your culture and align on what it is and how you live it. This might mean creating a cultiure statement or code of conduct, or simply working to strengthen the bonds and shared understanding between your group.

➢ **Some of the major elements of good group culture**

- Well defined purpose and goals
- Alignement of group values and working practices
- Space for personal and professional growth
- Regular opportunities for open, honest discussion
- Flexible working hours
- Wellbeing programs

- Supportive policies on illness and vaccination
- Group or team code of condact
- Transparent, communicative management
- Thoughtful systems for feedback
- Time and space to have fun as a team.

➢ **Importance of group culture**

- With a healthy group culture, everyone in the group can be happier, more engaged, and productive in the work that he/she does
- A healthy group culture can make a workplace successful or unbearable
- With healthy group culture, wanted group interactions, working practices and behaviors are enhanced
- Good team culture is an important ingredient in attracting and retaining great talents

Application activity 4.3

What do you think are the strategies that can be used maintain group values and culture ?

4.4. Relationship between groups.

Learning activity 4.4

Use internet and books from library and analyze the relationship that exists between groups.

4.4.1. Relations between groups

Intergroup relations refer to interactions between individuals in different social groups, and to interactions taking place between the groups themselves collectively.

The relationship between groups is often characterized by conflict and hostility. The basis of this conflict may be competition for limited resources and/or the desire for individuals to enhance the status of groups to which they belong.

Social identity theorists argue that part of each individual's identity is formed by the groups to which they belong. In order to have a positive social identity, individuals favor their own group and discriminate against out-groups (groups

that they do not belong). Individuals are typically more attracted to their own group than to out-groups. Similarity and proximity generally leads individuals to be more attracted to in-group members. However, similarity and proximity enhance conflict and discrimination against out-groups. Ambivalence, such as feeling both attraction to and hostility towards the out-group, often is resolved by increased hostility toward and rejection of the out-group.

There is a tendency for people to perceive their own group as being heterogeneous (composed of members with different characteristics), but the out-group is viewed as homogeneous (composed of similar members). This leads to reduced interaction with out-group members because of the belief that similarity with the out-group can be achieved by interactions with few members.

Stereotypes are cognitive representations of groups of people. The stereotype is a simplified picture of the group that is used to describe all members of the group or category. The relationship between groups can be improved by repeated contact between group members. The most beneficial contact results when the members have equal status and cooperate to achieve a common (superordinate) goal. Cooperation is more effective than helping because helping relationships typically divide groups between powerful/competent parties and powerless/incompetent parties. Improving the relationship between groups is generally a slow process that occurs overtime and repeated encounters.

Note that the most of interest in intergroup relations found its energy within the paradigm of prejudice and discrimination. The paradigm focuses on the characteristics like race, education, religion, sex, childhood experiences, role model, physical characteristics,).

4.4.2. Causes of negative relations/conflicts between groups

- Stereotypes of certain groups
- Placing two groups in a situation involving competition and conflict
- Competition over limited resources (materials, power, territory) leads to hatred between groups
- Competitive situation is particularly corrosive to the relationship between groups because groups are more competitive than individuals acting alone (competition can create hostility between groups).
- Group/organizational structure
- Limitation on resources
- Favoritism among groups in an institution
- Goal incompatibility

- Personality differences
- Communication challenges
- Task interdependence

4.4.3. Strategies of improving relationships between groups

- Encourage two or more groups to combine efforts to achieve a superordinate goals (groups work together to achieve the goal)
- Encourage cooperative efforts to improve positive relationships between the groups
- Avoid/ do not tolerate all kinds of discrimination between groups
- Encourage the practice of patience and sensitivity when dealing with intergroup issues.
- Offer training to group managers to help them understand the best ways to handle intergroup conflicts
- Create conditions for positive contact and reduce prejudice and stereotypes
- Encourage friendship and connection between groups
- Mobilize group members to accept other group members as they are
- Tell/teach group members about themselves
- Invite groups to assume that other groups want to form a relationship too

Application activity 4.4

1. Answer by **True** if the statement is correct and **False** if the statement is wrong
   a) In line with relationships between groups, similarity and proximity lead individuals to be more attracted to out-group members.
   b) In line again with relationships between groups, similarity and proximity enahance conflict and discrimination against out-groups.
   c) Regular and repeated contact between group members can improve the relationship between groups
   d) Most if interest in intergroup relations found its energy within the paradigm of prejudice and discrimination.
2. Based on your own understanding, what do you think could be the causes of discrimanation between groups ?

4.5. Inter-group conflicts and Inter-group conflicts resolution strategies

Learning activity 4.5

Use internet and books in the Library and find the conflict that may arise within the group and the strategies of managing them.

Conflict is a form of interaction among parties that differ in interests, perception and preferences. Overt conflict involves adversarial interaction that range from mild disagreements through various degree of fights.

Conflict can arise in a variety of social and professional situations, so it's important for individuals to understand how to overcome it. Social scientists have used several concepts, including conflict theory, to analyze these situations and why they occur. Understanding this theory can help you determine why conflict might arise and how to mediate them when they happen to help foster a positive and collaborative workplace.

4.5.1. Intergroup conflicts

Intergroup conflict occurs when two groups of people are trying to achieve oppositional goals or when there is social conflict between their groups. This type of conflict is similar to interpersonal conflict in that there may or may not be a specific power imbalance, but often, the two groups have different ideas about how to use resources or achieve an organizational goal.

Fostering open communication and collaboration within a group can motivate these groups to share their oppositional ideas and reach a mutual understanding.

Apart from intergroup conflict, there is also ideological conflict which can occur when two people have very different values or belief systems where many professionals try to limit conversations about social values or political or religious beliefs. Still because many people enjoy sharing their personal opinions with colleagues, an ideological conflict may arise. If the conflict is particularly intense, it can impact work performance for one or both parties involved, so it is important for a workplace to provide support and assistance to help mediate these conversations and ensure employees feel valued and heard.

Within an institution, there is also **role conflict** which occurs when two members of an organization have goals or objectives in direct conflict with one another. For example, a customer service representative may want a customer to receive a refund after his/her product malfunctioned, while the sales team feels it's the customer's responsibility to purchase a new product since the

company's warrant didn't cover the product malfunction. This opposition to goals can cause conflict between the customer service representative and the sales team, and overcoming these challenges can ensure all team members' goals with the organization's objectives.

In addition to the above types of conflict within an institution, we have also **maturity conflict** which occurs when employees feel they are not given adequate resources, opportunities and challenges for continued growth with their organization. This conflict always occurs between an individual and institution rather than between two or more individuals, as in the most other examples of workplace conflict. Organizations can try to prevent this type of conflict by providing employees with career development and training programs to support their personal and professional growth.

Finally, there is **interpersonal conflict** that occurs when two people have extremely different personalities and struggle to find a way to communicate and collaborate effectively. Interpersonal conflict can occur at any level of an organization and between employees, whether there is a traditional power or resource imbalance or not. Instead, interpersonal conflict usually results from disagreements about how to use shared power or resources, so addressing these issues can help create a more cohesive team and promote positive communication strategies.

4.5.2. Helpful strategies for conflict management/resolution

- **Address it early:** As soon as you see the signs of a conflict, take steps to mitigate any damage.
- **Avoid speaking angrily:** Use first-person language that focuses on how you feel rather than second-person language that may seem as if you are blaming the other person.
- **Meet privately:** Whenever possible, meet with the person or people involved in the conflict privately rather than in a public setting.
- **Seek the underlying issue:** try to identify the underlying cause of the conflict. Consider the examples of conflict theory and what power imbalances might worsen the issue.
- **Encourage empathy:** Look for ways to empathize with the other party involved in the conflict. Seeing the issue from their perspective can help you find effective solutions more easily.
- **Allow feeling to settle:** If emotions are intense, take the time to let your feelings reset before meeting with the other parties involved in the conflict.

- **Look for comprise:** if there's on obvious solution that benefits all parties, look for a comprise that will satisfy at least some of the needs of everyone involved. Think creatively and seek input from external sources if needed.
- **Employ active listening:** listen closely and actively to the others involved in the conflict. Show that you care about finding a solution that meets everyone's needs and that you are ready to move past the issue.
- **Find positive aspects:** look for the positives in the situation. For example, if the conflict is over how to meet a customer's needs, remind everyone that all parties share the same goal to help a customer.
- **Focus on the future:** keep the conversation focused on how to avoid conflict moving forward by recognizing the various types of conflict and how they may impact relationships and projects in the future.
- **Know when to address it:** Some conflicts are worth extensive conversation and mediation, while others are not. If the conflict is relatively minor and doesn't impact productivity or company culture significantly, consider managing it personally rather than through mediation.
- Encourage cooperative learning in the classroom
- Training individuals to overcome cognitive biases and reduce implicit bias.

Application activity 4.5

1. What will be the impact of conflict on the productivity of a group/ institution ?

4.6. Contact Hypothesis (intergroup conflict Theory : Allport)

Learning activity 4.6

Use internet and books from library and describe the contact hypothesis of Allport

Contact hypothesis/Intergroup Contact Theory was proposed by Gordon W. Allport (1897-1967) and states that social contact between social groups is sufficient to reduce intergroup prejudice. The hypothesis has been described as the best way to improve relations among groups that are experiencing conflict.

Contact hypothesis also states that contact with members of another social group in the appropriate circumstances can lead to a reduction of prejudice between majority and minority group members. If one has the opportunity to communicate with others they are able to understand and appreciate different points of views involving their way of life

William Graham Sumner (1906), a sociologist, believed that intergroup contact almost inevitably leads to conflict. He believed that because most groups believe themselves to be superior, intergroup hostility and conflict were natural and inevitable outcomes of contact.

Baesd of several studies, sociologists offered different propositions on intergroup relations that constituted an initial formation of intergroup conflict theory. Those propositions generally stressed that intergroup contact reduce prejudice when:

- ✓ The two groups share similar status, interests and tasks
- ✓ The situation fosters personal, intimate intergroup contact
- ✓ Participants do not fit stereotypical conceptions of their group members
- ✓ The activities cut across group lines

There are three psychological processes underlying the contact hypothesis:

- Learning about the out-group through direct contact,
- Fear and anxiety reduction when interacting with the out-group,
- Increased ability to perspective take and empathize with the out-group which results in reduced negative evaluation.

As a result of new appreciation and understanding, prejudice should diminish. Issues of stereotyping, prejudice and discrimination are commonly occurring

issues between rival groups. Allport's proposal was that properly managed contact between the groups should reduce these problems and lead to better interactions.

Contact fails to cure conflict when contact situations create anxiety for those who take part. Contact situations need to be long enough to allow this anxiety to decrease and the members of the conflicting groups to feel comfortable with one another.

Additionally, if the members of the two groups use this contact situation to trade insults, argue with each other, resort to physical violence, and discriminate against each other, then contact should not be expected to reduce conflict between groups. To obtain beneficial effects, the situation must include positive contact. Some of the criteria/conditions are as follow:

- ✓ **Equal status:** Both groups must engage equally in relationship. Members of the group should have similar backgrounds, qualities and characteristics. Differences in academic backgrounds, wealth, skill or experiences should be minimized if these qualities will influence perceptions of prestige and rank group.
- ✓ **Intergroup cooperation:** both groups must work together for their common goals without completion. Groups need to work together in the pursuit of common goals
- ✓ **Support of authorities, law, or customs:** Both groups must acknowledge some authority that supports the contact and interactions between the groups. The contact should encourage friendly and helpful attitudes and condemn in-group/out-group comparisons.
- ✓ **Personal interaction:** the contact situation needs to involve informal, personal interaction with outgroup members. Members of the conflicting groups need to mingle with one another. Without this criterion they learn very little about each other and cross-group friendships do not occur.

  Note that, the contact hypothesis is the idea that intergroup contact under particular conditions can reduce prejudice between majority and minority group membersand. It is lso based on the idea that peaceful and friendly interpersonal contact can help in reducing prejudices between groups and foster better cooperation and friendly relationships. When the interactions, face-to-face contacts, cooperation and friendly relationships are encouraged among group members and groups, prejudices and conflict will be significantly reduced.

  For example, if certain individuals in the group hold negative stereotypes about members in the other group, according to contact hypothesis, those

stereotypes should be reduced by having the individuals from the first group interact with individuals of the other group in a supportive and friendly environment.

Application activity 4.6

Explain how contact hypothesis/intergroup contact theory can be used to reduce intergroup confict.

4.7. Subordinate identities and Interdependence

Learning activity 4.7

Use internet and books in library, and describe a subordinate person, subordinate group and interdependence among group members

4.7.1. Subordinate identities

A subordinate is someone who is in a secondary rank. In a business setting, a subordinate is simply an employee who is not of management level and responds to either manager or a group of managers. Generally, a **subordinate person** is a person who is under the authority or control of another person

A subordinate group or a minority group is a group whose members have significantly less control or power over their own lives than do the members of a dominant or majority group.

A subordinate group or a minority group is a subordinate group whose members have significantly less control or power over their own lives than do the members of a dominant.

Examples of subordinate identities: Ethnic minority gay men, ethnic minority women, religious groups, race/color, homosexual, lesbians…such individuals tend to be marginal members within marginalized groups. They are not widely accepted as their counterparts.

❖ **Types of subordinate groups**

- **Racial groups:** groups of people who are marginalized based on their physical differences as opposed to cultural distinctions
- **Ethnic groups:** These are differentiated from the dominant groups on the basis of cultural differences such as language, attitudes towards marriage and parenting, and food habits. These are groups set apart

from others because of their national origin or distinctive cultural patterns.

- **Religious groups:** They are differentiated from the dominant groups on the basis of religious beliefs.
- **Gender groups:** Gender is another attribute that creates dominant and subordinate groups. Males are the social majority; females, although numerous, are relegated to the position of the social minority. Women are considered a minority even though they do not exhibit all the characteristics. Women encounter prejudice and discrimination and are physically distinguishable. Group membership is involuntary, and many women have developed a sense of sisterhood. Women who are members of racial and ethnic minorities face a special challenge to achieving equality. They suffer from greater inequality because they belong to two separate minority groups: a racial or ethnic group plus a subordinate gender group.

❖ Characteristics of a subordinate or a minority group

- Members of a subordinate group experiences **unequal treatment** and have less power over their lives than members of a dominant group have over theirs. This social inequality is created by prejudice, discrimination, segregation and even extermination.
- Members of subordinate group share **physical or cultural characteristics** such as skin color or language that distinguish them from the dominant group.
- Membership in dominant or minority group is not voluntary: People are born into the group. A person does not choose to be Rwandan or American.
- Minority group members have a strong sense of group solidarity (people make distinctions between members of their own group/in-group and everyone else/out-group).
- Members of a minority group generally marry others from the same group. A member of a dominant group often is unwilling to join a supposedly inferior minority by marrying one of its members. In addition, the minority group's sense of solidarity encourages marriage within the group and discourages marriage to outsiders.

❖ Subordinate role and relationships

A subordinate's role in a workplace means that the person reports to someone else but his/her specific roles and duties depend on his/her level.

The definition of a subordinate relationship is one in which two people interact at different levels. The direct subordinate reports to the supervisor and relies on the supervisor for direction, leadership and feedback. In addition, it is the responsibility of the supervisor in this relationship to lead and help develop the skills of the subordinate.

❖ Tips for being effective subordinate

- **Continue learning:** Subordinate should keep willingness to learn whatever is necessary to be successful in his/her position.
- **Prioritize professionalism:** Acting in a professional way when at work helps subordinate earn the respect of his/her managers and remain effective at the job. Examples of professionalism within the workplace include arriving at work on time or early every day, following the dress code…, the more professional she/he is, the more the employer will trust in him/her.
- **Work hard:** Being productive and respected employee requires hard work every day. This means he/she arrives ready to give his/her work the full attention and she/he strives to complete the tasks assigned in an efficient manner. She/he should also assist the team members and ask questions when he/she needs clarifications to show he/she listens and understands job's objectives.
- **Limit distractions:** There are countless distractions in today's workplace, from cellphones to email to social media. Shutting off phone or keeping it on silent and avoiding distractions while on the job is an important part of being the best employee as possible.

Ways that un employer can use to encourage constructive relationship between him/herself and subordinates

- **Encourage open communication:** Listen to your subordinates' concerns and take their opinions seriously. One way to encourage communication is to practice an open door policy and face-to face interactions. When a subordinate comes to you with concerns, ideas or complaints, be sure that you are attentive and considerate.
- **Be clear about job expectations:** Clearly define the responsibilities for each position within the organization so as to help subordinates to more effectively meet their goals and increase productivity.

- **Offer constructive feedback:** As a supervisor, it is your job to understand your subordinates' strengths and weaknesses and work to develop their skills in their respective positions. To do this, use constructive feedback, focusing on specific issues and remaining positive and encouraging. When offering feedback, make sure to cite the challenge and give ways the subordinate can overcome the obstacle in the future.

4.7.2. Interdependence.

Interdependence, refers to how group members must depend on one another to achieve their collective and individual goals. It doesn't just apply to the group's goals, but members may also depend on one another to determine their behavior, thoughts or feelings.

Different groups may have different levels of interdependence. Some groups can achieve their goals independently, however, for other groups, interdependence can mean the difference between life and death, such military platoon.

There are also techniques for reducing prejudice that utilize interdependence between two or more groups. That is, members across groups have to rely on one another to accomplish some goal or task.

Interdependence was used by many researchers to reduce conflicts between groups.

For example, Robbers Cave Experiment, Sherif used this strategy to reduce conflict between groups. Elliot Aronson's Jigsaw Classroom also uses this strategy of interdependence.

Meanwhile, in any institution there are superordinate and subordinate and all of them are important for the institution to function. Thus, they should work hand in hand for the success and productivity of the institution.

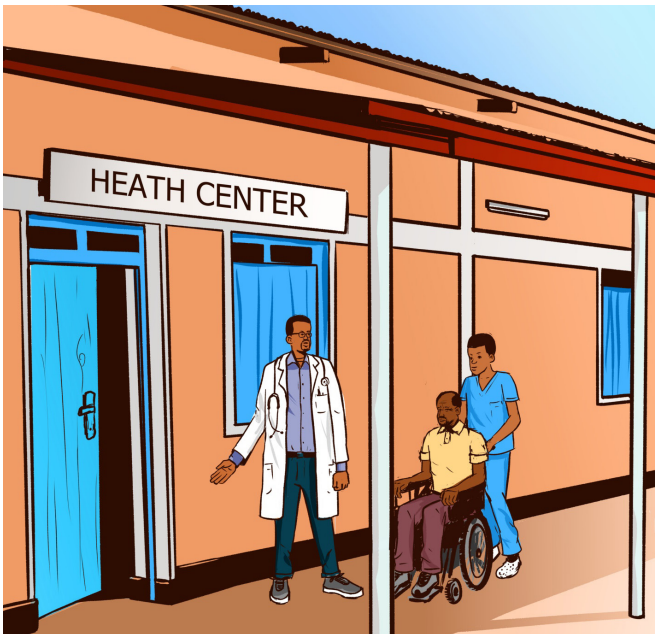
Application activity 4.7

1. Complete the sentences with appropriate word
   a) The dominant figure in the nuclear family is……..
   b) ……group iis a group whose members have significantly more control or power over their own lives than do the members of a minority/subordinate group.
   c) Referring to how group activities are done within the group/groups, whict technical that implies that members across groups have to rely on one another to accomplish some goal or task.
2. Provide the examples of subordinate identities

End of unit assessment

1) Evaluate the advantages of working in group as an individual
2) Propose the strategies of encouraging relations among different groups
3) What do you think are the factors behind conflict between groups ?
4) Discuss the conditions of minimizing the prejudice among groups

UNIT 5 INTRODUCTION TO HEALTH PSYCHOLOGY



Key unit competence: Assess how individuals have control over their health and helping them make better choices of wellness.

Introductory activity: A case study

Mary hasn't been well for the last month. She suffered from a headache and had a fever. She was cold even though it was like sunshine. Her spouse advised her to go to the nearby health center to see a doctor. When she got there, she was diagnosed with malaria and given appropriate medication. Despite being consulted by a doctor, Mary felt unconvinced of the positive effects of the medication provided. Without informing her husband, she decided to consult a traditional healer one hour away from her home. The traditional healer informed her that she was possessed by evil spirits and that the neighbors were involved in her bad situation. Since then, Mary has been behaving like a ghost possessed and is no longer taking the medication as

recommended by the doctor. She is stressed because she is possessed by evil spirits, she has stopped eating and she is arguing with her husband whom she accuses of not helping her.

1. Why do you think Mary has stopped taking medications as recommended by doctors?
2. How will her behavior affect her health?
3. Explain how you could help Mary recover from this situation.
4. Do you know other cases like Mary's in your location? Explain your answer.

5.1. Understanding health psychology

Learning activity 5.1

1. Explain the term psychology.
2. In your opinion, what do you understand by the term health?
3. Can you provide examples of good health?
4. What are barriers to good health in your location?
5. What is the importance of understanding health psychology?

5.1.1 Definition of health psychology

Health psychology is an area within psychology dedicated to understanding psychological influences on health-related processes, e.g. why people get sick, how they react to illness, how they recover from an illness or adapt to chronic illness, or how they stay healthy in the first place. The discipline is concerned with understanding how psychological, behaviors, and cultural factors contribute to physical health and illness. Health psychology deals with the etiology (refers to the origins and causes of illness) and connections of health, illness and disability, with the prevention and treatment of disease, with adaptation during and after disease, and with health promotion.

Health psychology is a specialty area within psychology. Health psychology has been specifically defined as "the aggregate of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness and related dysfunction and to the analysis and improvement of the health care system and health policy formation". (Matarazzo, 1982). This definition has been adopted by the American Psychological Association (APA), the British Psychological Society and other organizations. It serves as health psychologies' 'official' definition.

According to health psychology, the whole person should be treated, not just the physical changes caused by the illness. This may include behavior changes, encouraging changes in beliefs and coping strategies, and adhering to medical recommendations. Since the whole person is treated, the patient becomes partly responsible for his treatment. For example, she may be responsible for taking medication and changing beliefs and behaviors.

5.1.2 Aims of health psychology

Health psychology emphasizes the role of psychological factors in the cause, progression and consequences of health and illness. The aims of health psychology can be divided into (1) understanding, explaining, developing, and testing theory and (2) putting this theory into practice.

(1) **Health psychology aims to understand, explain, develop, and test theory by :**

- ***Evaluating the role of behaviour in the etiology of illness. For example :***
  - Coronary heart disease is related to behaviors such as smoking, food intake, lack of exercise.
  - Many cancers are related to behaviors such as diet, smoking, alcohol and failure to attend for screening or health check-ups.
  - A stroke is related to smoking, cholesterol and high blood pressure.
  - An often overlooked cause of death is accidents. These may be related to alcohol consumption, drugs and careless driving.
- ***Predicting unhealthy behaviors.*** **For example :**
  - Smoking, alcohol consumption and high fat diets are related to beliefs.
  - Beliefs about health and illness can be used to predict behaviour.
- ***Evaluating the interaction between psychology and physiology.*** **For example :**
  - The experience of stress relates to appraisal, coping and social support.
  - Stress leads to physiological changes which can trigger or exacerbate illness.
  - Pain perception can be exacerbated by anxiety and reduced by distraction.

- ***Understanding the role of psychology in the experience of illness.*** **For example :**
    - Understanding the psychological consequences of illness could help to alleviate symptoms such as pain, nausea and vomiting.
    - Understanding the psychological consequences of illness could help alleviate psychological symptoms such as anxiety and depression
- ***Evaluating the role of psychology in the treatment of illness.*** **For example :**
    - If psychological factors are important in the cause of illness they may also have a role in its treatment.
    - Changing behaviour and reducing stress could reduce the chances of a further heart attack.
    - Treatment of the psychological consequences of illness may have an impact on longevity.

(2) **Health psychology also aims to put theory into practice.**

This can be implemented by :

- ***Promoting healthy behaviour.*** **For example :**
    - Understanding the role of behaviour in illness can allow unhealthy behaviors to be targeted.
    - Understanding the beliefs that predict behaviors can allow these beliefs to be targeted.
    - Understanding beliefs can help these beliefs to be changed.
- ***Preventing illness.*** **For example :**
    - Changing beliefs and behaviour could prevent illness onset.
    - Modifying stress could reduce the risk of a heart attack.
    - Behavioral interventions during illness (e.g. stopping smoking after a heart attack) may prevent further illness.
    - Training health professionals to improve their communication skills and to carry out interventions may help to prevent illness.

5.1.3 Health psychologists

Psychologists who strive to understand how biological, behaviors, and social factors influence health and illness are called health psychologists.

- Health psychologists use their knowledge of psychology and health to promote general well-being and understand physical illness. They are specially trained to help people deal with the psychological and emotional aspects of health and illness.
- Many health psychologists focus on prevention research and interventions designed to promote healthier lifestyles and try to find ways to encourage people to improve their health. For example, they may help people to lose weight or stop smoking.
- Health psychologists also use their skills to try to improve the healthcare system. For example, they may advise doctors about better ways to communicate with their patients.
- Health psychologists focuses on health promotion and maintenance, which includes issues such as how to get children to develop good health habits, how to promote regular exercise, and how to design a media campaign to get people to improve their diets.
- Health psychologists study the psychological aspects of the prevention and treatment of illness. A health psychologist might teach people in high stress occupations how to manage stress effectively to avoid health risks. A health psychologist might work with people who are already ill to help them follow their treatment regimen.
- Health psychologists also focus on etiology and correlates of health, illness and dysfunction. Health psychologists especially address the behaviors and social factors that contribute to health, illness and dysfunction, such as alcohol consumption, smoking, exercise, the wearing of seat belts, and ways of coping with stress.
- Finally, health psychologists analyse and attempt to improve the health care system and the formulation of health policy.

Health psychologists study the role of psychology in all areas of health and illness, including :

a. What people think about health and illness ;

b. The role of beliefs and behaviors in becoming ill ;

c. The experience of being ill in terms of adaption to illness ;

d. Contact with health professionals ;

e. Coping with illness ;

f. Compliance with a range of interventions ; and

g. The role of psychology in recovery from illness, quality of life and longevity.

5.1.4 Relating health psychology to other science fields

Knowledge in health psychology is greatly enriched by information from many other disciplines, including some disciplines within psychology, such as the clinical and social areas; medicine, including psychiatry and pediatrics; and allied fields, such as nursing, nutrition, pharmacology, biology, and social work. We will look at four fields that are especially important because they provide both information and a context for health psychology.

Related Fields

To understand health psychology fully, we need to know the context in which health and illness exist. The field of epidemiology—the scientific study of the distribution and frequency of disease and injury— provides part of this context. Researchers in this field determine the occurrence of illness in a given population and organize these data in terms of when the disease or injury occurred, where, and to which age, gender, and racial or cultural groups. Then they attempt to discover why specific illnesses are distributed as they are.

Another discipline of importance to health psychology is public health, the field concerned with protecting, maintaining, and improving health through organized effort in the community. People who work in public health do research and set up programs dealing with immunizations, sanitation, health education and awareness, and ways to provide community health services. This field studies health and illness in the context of the community as a social system. The success of public health programs and the way individual people react to them are of interest to health psychologists.

Two other related fields are sociology and anthropology. Sociology focuses on human social life ; it examines groups or communities of people and evaluates the impact of various social factors, such as the mass media, population growth, epidemics, and institutions. Medical sociology is a subfield that studies a wide range of issues related to health, including the impact of social relationships on the distribution of illness, social reactions to illness, socioeconomic factors of health care use, and the way hospital services and medical practices are organized.

Anthropology includes the study of human cultures. Its subfield, medical anthropology, examines differences in health and health care across cultures : How do the nature and definition of illness vary across different cultures ? How

do people in these cultures react to illness, and what methods do they use to treat disease or injury ? How do they structure health care systems ? Without the knowledge from sociology and anthropology, health psychologists would have a very narrow view. Knowledge from sociology and anthropology gives us a broad social and cultural view of medical Issues and allows us to consider different ways to interpret and treat illness.

The combined information health psychologists obtain from epidemiology, public health, sociology, and anthropology paints a broad picture for us. It describes the social systems in which health, illness, and the person exist and develop.

Application activity 5.1

1. What are the aims of health psychology?
2. Put the following terms in front of their meaning: (i) epidemiology, (ii) public health, (iii) sociology, (iv) anthropology, (v) health psychologists, (vi) health psychology.

Definition	Concept
▪ It is dedicated to understanding psychological influences on health related processes.	
▪ The field concerned with protecting, maintaining, and improving health through organized effort in the community	
▪ The study of human cultures	
▪ A person who strives to understand how biological, behaviors, and social factors influence health and illness.	
▪ The scientific study of the distribution and frequency of disease and injury	
▪ Focuses on human social life; it examines groups or communities of people and evaluates the impact of various social factors,	

3. How important is it for a health psychologist to have knowledge in areas such as epidemiology, sociology, anthropology and public health?

5.2. Brief history of health psychology

Learning activity 5.2

1. What is the official definition of health psychology?
2. According to health psychology, the whole person should be treated, not just the physical changes caused by the illness. What does this sentence evoke in you?

5.2.1 The background to health psychology

During the nineteenth century, modern medicine was established. 'Man' (the nineteenth century term) was studied using dissection, physical investigations and medical examinations. Darwin's thesis, The Origin of Species, was published in 1856 and described the theory of evolution. This revolutionary theory identified a place for Man within Nature and suggested that we were part of nature, that we developed from nature and that we were biological beings. This was in accord with the biomedical model of medicine, which studied Man in the same way that other members of the natural world had been studied in earlier years. This model described human beings as having a biological identity in common with all other biological beings. The biomedical model will be discussed in point 5.6 of this manual.

5.2.2 The twentieth century

Throughout the twentieth century, there were challenges to some of the underlying assumptions of biomedicine. These developments have included the emergence of psychosomatic medicine, behaviors health, behaviors medicine and, most recently, health psychology. These different areas of study illustrate an increasing role for psychology in health and a changing model of the relationship between the mind and body.

- **Psychosomatic medicine**

The earliest challenge to the biomedical model was psychosomatic medicine. This was developed at the beginning of the twentieth century in response to Freud's analysis of the relationship between the mind and physical illness. At the turn of the century, Freud described a condition called 'hysterical paralysis', whereby patients were presented with paralyzed limbs with no obvious physical cause and in a pattern that did not reflect the organization of nerves. Freud argued that this condition was an indication of the individual's state of mind and that repressed experiences and feelings were expressed in terms of a physical problem. This explanation indicated an interaction between mind and body and

suggested that psychological factors may not only be consequences of illness but may contribute to its cause.

- **Behavioral health**

Behavioral health again challenged the biomedical assumptions of a separation of mind and body. Behavioral health was described as being concerned with the maintenance of health and prevention of illness in currently healthy individuals through the use of educational inputs to change behaviour and lifestyle. The role of behaviour in determining the individual's health status indicates an integration of the mind and body.

- **Behavioral medicine**

A further discipline that challenged the biomedical model of health was behavioral medicine, which has been described by Schwartz and Weiss (1977) as being an amalgam of elements from the behavioral science disciplines (psychology, sociology, health education) and which focuses on health care, treatment and illness prevention. Behavioral medicine was also described by Pomerleau and Brady (1979) as consisting of methods derived from the experimental analysis of behaviour, such as behaviour therapy and behaviour modification, and involved in the evaluation, treatment and prevention of physical disease or physiological dysfunction (e.g. essential hypertension, addictive behaviors and obesity). It has also been emphasized that psychological problems such as neurosis and psychosis are not within behavioral medicine unless they contribute to the development of illness. Behavioral medicine therefore included psychology in the study of health and departed from traditional biomedical views of health by not only focusing on treatment, but also focusing on prevention and intervention. In addition, behavioral medicine challenged the traditional separation of the mind and the body.

- **Health psychology**

Health psychology is probably the most recent development in this process of including psychology into an understanding of health. It was described by Matarazzo as the « aggregate of the specific educational, scientific and professional contribution of the discipline of psychology to the promotion and maintenance of health, the promotion and treatment of illness and related dysfunction » (Matarazzo, 1980 :815).

Health psychology again challenges the mind–body split by suggesting a role for the mind in both the cause and treatment of illness but differs from psychosomatic medicine, behavioral health and behavioral medicine in that research within health psychology is more specific to the discipline of psychology.

Health psychology therefore attempts to move away from a simple linear model of health and claims that illness can be caused by a combination of biological (e.g. a virus), psychological (e.g. behaviors, beliefs) and social (e.g. employment) factors. This approach reflects the biopsychosocial model of health and illness, which was developed by Engel (1977, 1980) and is illustrated in Figure …. The biopsychosocial model represented an attempt to integrate the psychological (the 'psycho') and the environmental (the 'social') into the traditional biomedical (the 'bio') model of health as follows :

- The bio contributing factors included genetics, viruses, bacteria and structural defects.
- The psycho aspects of health and illness were described in terms of cognitions (e.g. expectations of health), emotions (e.g. fear of treatment), and behaviors (e.g. smoking, diet, exercise or alcohol consumption).

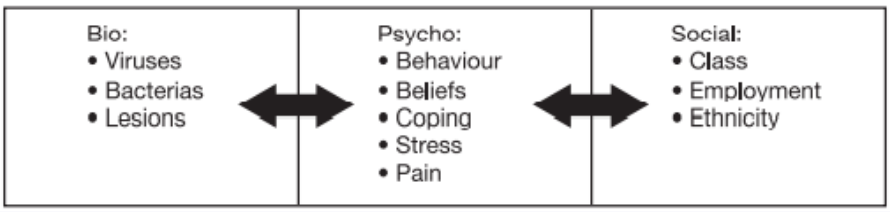


Figure: The biopsychosocial model of health and illness (Engell, 1977)

Application activity 5.2

1. How did modern medicine established in the 19th century studied 'Man'?
2. How did health psychology challenge the mind-body split in the 19th century?
3. How did health psychology differ from psychosomatic medicine, behavioral health and behavioral medicine?

5.3. Factors that influence health psychology

Learning activity 5.3

1. With example, explain how health psychology can help you in life.
2. Brainstorm factors that you think influence health psychology.

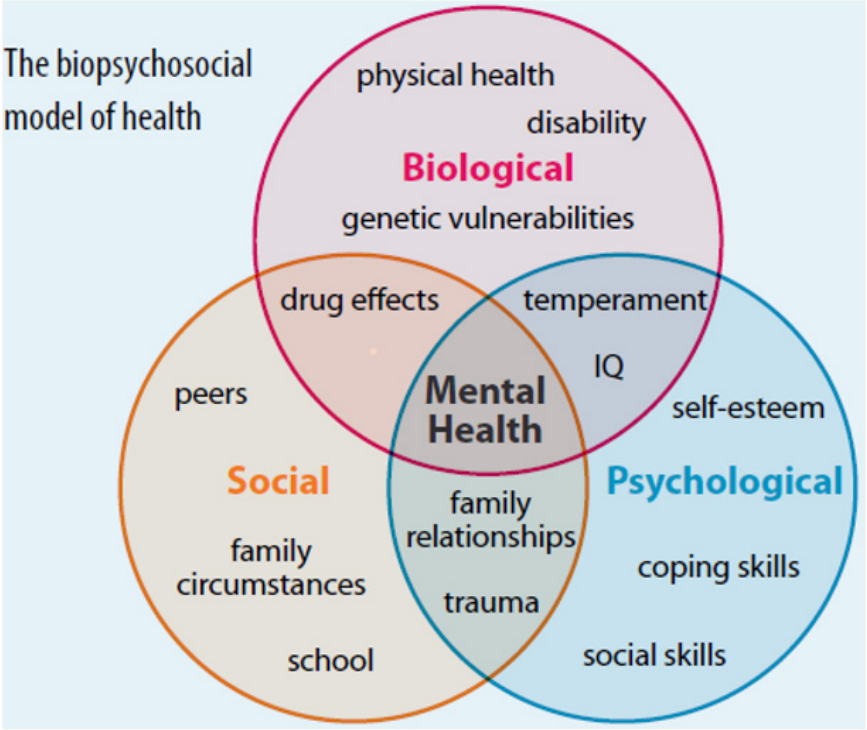
5.3.1 Introduction

Today, the main approach used in health psychology is known as the biopsychosocial model. According to this view, illness and health are the results of a combination of biological, psychological, and social factors.

- Biological factors include inherited personality traits and genetic conditions.
- Psychological factors involve lifestyle, personality characteristics, and stress levels.
- Social factors include such things as social support systems, family relationships, and cultural beliefs.

5.3.2 The Biopsychosocial perspective

The Biopsychosocial (BPS) is mainly used in treating mental health. The BPS model of mental health offers a holistic description of the biological, psychological, and social factors that interact to influence the presence and severity of mental health issues in the population.



Source : ***Information compiled by Sullivan, (2019)***

The Biopsychosocial (BPS) model of mental health offers a holistic description of the biological, psychological and social factors that interact to influence the presence and severity of mental health issues in the population. The BPS model explains that individuals are influenced by (a) broader contextual factors in the social sphere (e.g. family & community), (b) individual factors such as

their experience and behaviour and (c) biological factors such as individuals' nervous or immune systems. These systems interact and have implications for the cause and treatment of various mental health issues. For example, depression can be influenced by neurobiological features (*Biological*) in addition to an individuals' coping style (*Psychological*) and their level of familial support (*Social*). Clinicians' capacity to design effective treatment pathways is improved when due consideration is given to these distinct, though inter-related, factors (Deacon, 2013).

The holistic approach of the BPS model seeks to empower individuals by helping them become cognisant of how factors beyond the physiological are maintaining their mental health issues. The BPS model encourages clients to accept that their mental health and wellbeing are not purely in the hands of medical experts. The facilitation of a sense of control on the clients' part can help clients to maintain an engagement in the therapeutic process and aid their recovery (Black, 2015).

- **The role of biological factors**

What is included in the term biological factors ? This term includes the genetic materials and processes by which we inherit characteristics from our parents. It also includes aspects of the person's physiological functioning—for example, whether the body (1) contains structural detects, such as a malformed heart valve or some damage in the brain, that impair the operation of these organs ; (2) responds effectively in protecting itself, such as by fighting infection; and (3) overreacts sometimes in the protective function, as happens in many allergic reactions to harmless substances, such as pollen or dust.

The body is made up of enormously complex physical systems. For instance, it has organs, bones, and nerves, and these are composed of tissues, which in turn consist of cells, molecules, and atoms. The efficient, effective, and healthy functioning of these systems depends on the way these components operate and interact with each other.

- **The role of psychological factors**

When we discussed the role of lifestyle and personality in health and illness earlier, we were describing behavior and mental processes, in other words, psychological factors. Behavior and mental processes are the focus of psychology, and they involve cognition, emotion, and motivation.

a. ***Cognition*** is a mental activity that encompasses perceiving, learning, remembering, thinking, interpreting, believing, and problem solving. How do these cognitive Factors affect health and illness ? Suppose you develop a pain in your abdomen, and you remember having had a similar symptom in the past that disappeared in a couple of days. Would you

seek treatment ? Probably not. This example is just one of the countless ways cognition plays a role in health and illness.

b. ***Emotion*** is a subjective feeling that affects and is affected by our thoughts, behavior, and physiology. Some emotions are positive or pleasant, such as joy and affection, and others are negative, such as anger, fear, and sadness. Emotions relate to health and illness in many ways. For Instance, people whose emotions are relatively positive are less disease-prone and more likely to take good care of their health and to recover quickly from an illness than are people whose emotions are relatively negative. Emotions can also be important in people's decisions about seeking treatment. People who are frightened of doctors and dentists may avoid getting the health care they need.

c. ***Motivation*** is a term applied to explanations of why people behave the way they do---why they start some activity, choose its direction, and persist in it. A person who is motivated to feel and look better might begin an exercise program, choose the goals to be reached, and stick with it. Many people are motivated to do what important people in their lives want them to do. Parents who quit smoking because their children plead with them to protect their health are an example.

The role of social factors

People live in a social world. We have relationships with individual people (an acquaintance, a friend, or a family member) and with groups. As we interact with people, we affect them and they affect us. But our social world is larger than just the people we know or meet, and it contains levels of social spheres, such as our community and our family, and each level affects the others.

On a fairly broad level, our society affects the health of individuals by promoting certain values of our culture. One of these values is that being fit and healthy is good. Often the mass media (television, newspapers, and so on) reflect these values by setting good examples and urging us to eat well, not to use drugs, and not to drink and drive. The mass media can do much to promote health. But sometimes these media encourage unhealthful behavior, such as when we observe celebrities on television smoking cigarettes or drinking excessively. Can individuals affect society's value? Yes. As part of society, we can affect its values by writing our opinions to the mass media, selecting which television shows and movies to watch, and buying healthful products, for example.

Families can also encourage children to perform healthful behaviors and praise them when they do. Moreover, as we have said, an individual can influence the larger social unit. A family may stop eating certain nutritious foods, such as sprouts or fish, because one of the children has a tantrum when these foods are served.

The role of biological, psychological, and social factors in health and illness is not hard to see. What is more difficult to understand is how health is affected by the interplay of these components, as the Biopsychosocial model proposes.

Application activity 5.3.

1. Explain the biopsychosocial model of health psychology.
2. Based on the 3 aspects of BPS, provide 3 examples of factors that influence health psychology
3. With an example, explain ways cognition plays a role in health and illness.

5.4. Understanding health and illness

Learning activity 5.4

With the outbreak of Covid-19 in Rwanda in 2020, measures were taken to protect the population. A total lockdown was recommended, and it was not possible to visit each other. The population were asked to put on masks when entering public places. They also had to clean regularly with clean water and soap or with sanitizer. Churches, bars, and schools have been closed to prevent large numbers of people from gathering. People were urged to get tested to see if or not they had Covid 19. Public servants have been asked to work from home, with exception of, for example, those working in banks or hospitals. Infected people were put in isolation, some of them were hospitalized for serious illness, and a small number of them died. After a few months, vaccination campaigns against Covid-19 begin. Each person was advised to get three doses of Covid-19 vaccine. These actions significantly increased quality of life, which led to a slowdown in the number of infections. Later on, once things had changed for the better, some precautions were lifted.

1. Describe the effects that the scenario's situation had on people's health.
2. Why do you believe that the Rwandan people were subjected to these measures?
3. List at least three practices that contributed to this scenario's health improvement.
4. Does the fact that Covid 19 instances have dramatically decreased indicate the absence of illness? Describe your response.

Everyone involved in health and social care occupation starts with the knowledge and understanding of health. The views and perception of health are different from person to person and culture to culture. There is a general view of health, a general belief about what health is and this belief has been on for decades and has been passed on from generations to generations.

5.4.1 Definition of health, disease and illness

The concepts of 'health' and 'ill health' reach far beyond the individual and can be difficult to define and measure. They encompass a wide range of experiences and events, and their interpretation may be relative to social norms and context. As such, individuals, groups and societies may have very different interpretations of what constitutes illness and what it means to be in good health.

a. Health

Health has two general widespread meanings on a daily usage, one negative and one positive. The negative definition of health is the absence of disease or illness. This is the meaning of health within the western scientific medical model. The positive and most widely accepted definition of health was set out in the preamble to the Constitution of the World Health Organization (WHO) in 1946. WHO encourages a holistic concept of health, defining health as '*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*' (WHO, 1946). This definition includes mental and social dimensions and moves the focus beyond individual physical abilities or dysfunction.

Some other professional authors with experience in the field of health have argued that health holistic and includes different dimension which must be put into consideration when defining health (Aggleton and Homans, 1987 ; Ewles and Simnett, 1992). Holistic health means taking account of the separate influences and interaction of these dimensions :

- Physical health has to do with the body whereas mental health is associated with the ability to think and make judgments.
- Emotional health refers to the recognition and appropriate discharge of feeling states.
- Social health deals with the integration of somebody in a network of social relationships.
- Spiritual health is the recognition and ability to put into practice moral or religious principles or beliefs.
- Sexual health is the acceptance and ability to achieve a satisfactory expression of one's sexuality (Naidoo and Jane Wills, 1994).

Aside from these six distinguished dimensions of health, there are other two broader dimensions of health which affect the individual.

Australia's health 2014 takes this broad view of health and functioning, incorporating both physical and mental dimensions, and genetic, cultural, socioeconomic, and environmental determinants. It is based on the following concepts :

- Health is an important part of wellbeing of how people feel and function.
- Health contributes to social and economic wellbeing.
- Health is not simply the absence of disease or injury, and there are degrees of good health.
- Managing health includes being able to promote good health, identify and manage risks and prevent disease.
- Disease processes can develop over many years before they show themselves through symptoms.

b. Disease, illness and ill health

A disease is a physical or mental disturbance involving symptoms, dysfunction or tissue damage. (AIHW 2010). There are many diseases that can afflict the human body, ranging from common colds to cancers. The 2 main categories of disease that may lead to ill health are infectious and chronic diseases.

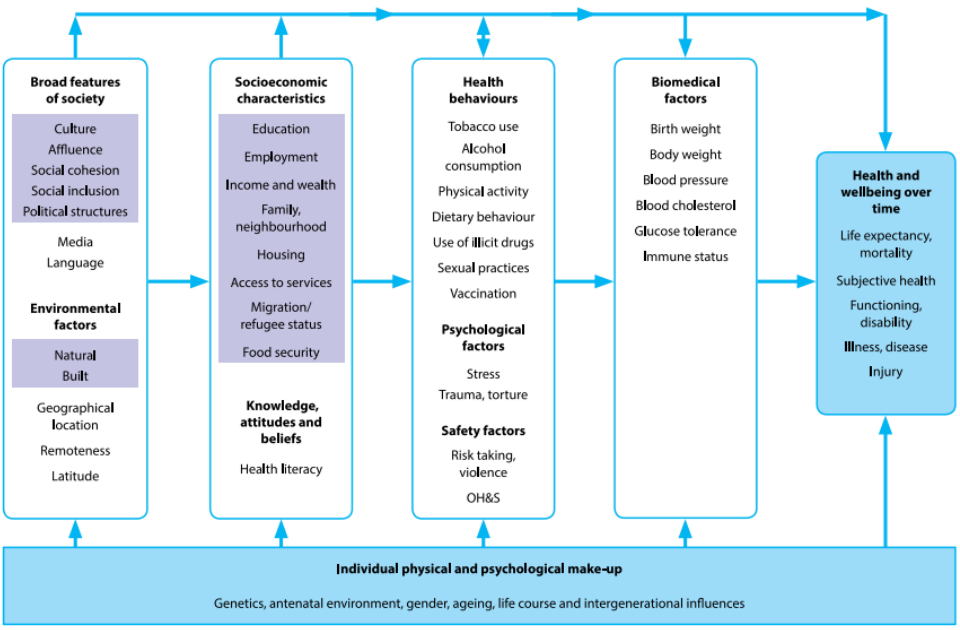
- Infectious diseases are caused by pathogens and can be spread from person to person by air, food, water, inanimate objects, insects or by direct or indirect contact with an infected person. Examples of infectious diseases include influenza, malaria and human immunodeficiency virus (HIV).
- Chronic diseases are caused by multiple factors, including a person's genetic make-up lifestyle and environment. They are long-term conditions and cannot be directly spread from one person to another. Examples of chronic diseases include diabetes, asthma and heart disease.

Illness is the subjective experience of loss of health. This is couched in terms of symptoms, for example, the reporting of aches or pains, or loss of function. Illness and disease are not the same, although there is a large degree of co-existence. For example, someone may be diagnosed as having Leukemia through screening without previously having or reported any symptoms.

Meaning anyone may be diagnosed with a particular disease although they have not reported any illness. When a patient complains of a symptom and further investigation is carried out such as blood test or screening which then proves a disease presence, the two concepts, disease and illness, coincide. In these instances, the term ill health is used. Ill health is therefore an umbrella term used to refer to the experience of disease and illness. (Naidoo and Jane Wills, 1994).

5.4.2 Determinants of health

Determinants of health are divided into 4 major groups : (1) Broad features of the society and environmental factors, (2) socio-economic characteristics, knowledge, attitudes and beliefs, (3) health behaviour, psychological factors and safety factors, and (5) biomedical factors. A combination of all those factors leads to individual health and wellbeing over time.



Note: Purple shading highlights selected social determinants of health.

A framework for the determinants of health

Source: AIHW, (2014)

5.4.3 Threats to health

It must be clear by now that many of the diseases and threats to health which ultimately reduce longevity are related to the ways we behave and conduct ourselves. In order to ameliorate such conditions, we need to adopt a lifestyle consisting of certain do's and don'ts. Unfortunately, people develop habits that often create problems. They indulge in many self-destructive behaviors. Some of the important ones which increase the risk for health are as follows.

a. **Alcohol and drug use** : In the modern period these are the most common health impairing habits. Taken in an overdose they can immediately kill people. The addiction to alcohol and drugs often damages the respiratory system, intestine, liver in particular, and other bodily systems in general. The thinking capacity and decision making also get affected. Alcohol adversely affects the liver and may produce cirrhosis.

b. **Smoking** : Studies clearly show that the chances of lung cancer and heart disease go high among smokers. Smoking leads to chronic bronchitis and respiratory disorders. Interestingly the dangers of smoking are not confined to smokers alone. The spouses, family members and co-workers who live with smokers are also prone to a variety of health disorders. Accompanied by over-weight and stress, smoking becomes more dangerous.

c. **Use of tobacco** : The studies indicate that use of tobacco is related to mouth cancer. It adversely affects oral hygiene and may even involve gums and teeth.

d. **Poor nutritional habits :** In recent years there has been an increase in following poor dietary practices. Use of junk food (fast food !) and eatables which are imbalanced in terms of cholesterol, fats, calories etc. have become the order of the day. Awareness needs to be generated in public about the benefits of eating raw food and lots of fruits. The meals should be programmed for healthy living. To experiment with new tastes, people often go for nutritionally imbalanced food. Uncontrolled food may lead to obesity.

e. **Modern life values, white collar jobs increasingly lead to sedentary life.** They lack time and skills for exercise. A healthy body requires adequate exercise for the entire body. On account of laziness, time pressure and ignorance about the body system many people avoid exercises. As a result, the body becomes weak and sick and premature ageing begins.

f. **Unsafe Sex :** HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) is a fatal disease found among drug users (by needle sharing), homosexuals, and people engaging in sexual intercourse with a number of partners. It is estimated that approximately 6.5 million people have died because of AIDS. Following transmission, the virus grows rapidly and spreads throughout the body. The person infected by is virus suffers from many abnormalities including neuro-endocrine and cardio-vascular functioning.

5.4.4 Health promoting behaviors

Achieving health requires following certain patterns of behaviour. The important behaviors are described below :

1. **Relaxation**

Relaxation is very useful for stress reduction. Meditation, which involves focusing attention on an object, word, or phrase has been found to have a calming effect. Another kind of relaxation is called progressive muscle relaxation. It involves systematically tensing and then relaxing the muscles while lying down or sitting comfortably. Relaxation often involves deep breathing. By holding one's breath for a few seconds and exhaling slowly.

2. **Exercise**

Regular exercise helps in maintaining physical and mental health. It strengthens the heart and lungs and improves the use of oxygen by the body. Jogging, running, bicycling and aerobic exercise are quite useful to this end. The benefits include cardiovascular fitness and endurance, improved capacity for physical work, optimization of body weight, improvement of muscle tone and strength, control of hypertension, improved stress tolerance, and focusing of attention and concentration. In order to benefit from exercise, it should be done regularly.

3. **Weight control**

Regulation of food intake is determined by a complex system. In fact, a set of biochemical processes control it. Poor regulation of food leads to high accumulation of body fat. The resulting obesity works as a risk factor because it increases blood pressure and cholesterol level. Obesity has been found to be a cause of early mortality. Genetic factors and stress both are found to contribute to obesity. Weight control is very difficult. Dietary intervention is necessary but often insufficient for producing lasting weight loss. Fasting, yoga, surgery, use of appetite suppressing drugs are also used for this purpose.

A multi-pronged approach to weight control is found better. Analysis of eating habits is used to make people aware of their eating patterns. The analysis of stimuli that affect eating provides insights to regulate eating. People are trained to modify the stimuli in their environment that have previously elicited and maintained over-eating. The patients are trained to control the eating process itself. Developing a sense of self control overeating contributes to weight control.

4. **Diet**

A healthy diet should be a goal for every one of us. Studies indicate that dietary habits are critically involved in the development of diseases like cancer, hypertension, and cardiovascular diseases. A low fat and low-cholesterol diet reduces the incidence of cardiac disease. Dietary control involves meal planning, cooking methods and eating habits. It has been noted that intervention with family is useful for promoting and maintaining dietary change.

Application activity 5.4

1. Put each example of determinant of health under its appropriate major group: Culture, education, tobacco use, alcohol consumption, geographical location, social cohesion, political structure, family, stress, employment, glucose tolerance, immune status, remoteness, trauma.

Broad features of society	Socioeconomic characteristics	Health behaviors	Biomedical factors
Environmental factors		Psychological factors	

2. Innocent has begun to consume fatty foods and enjoys a lot of sweets. In addition to enjoying meat, he has an alcohol addiction. Innocent is an officer and a bank and works from 8:00 until 5:00 p.m. He doesn't have time for a walk. When he travels to and from work, he takes public transportation. He visited the clinic last week since he wasn't feeling well. The doctor discovered that Innocent had high blood pressure and hypertension. Innocent said that he does not have time for health practices when the doctor inquired about them.

   a) What health risks do you see in the scenario for Innocent?

   b) What advice would you give Innocent to improve his health, if you were the doctor?

5.5. Models of health and illness

Learning activity 5.5

Mbarubukeye lives in a rural region far from the city. He was unable to pursue an education. His family strongly believes in witchcraft. One of his five children has been diagnosed with epilepsy. During some crisis periods, the child's brain activity changes abnormally, leading to seizures or other strange behavior, feelings, and occasionally the youngster loses consciousness. The infant should go to hospital, Mbarubukeye was repeatedly instructed, but she refused on the grounds that the child was possessed by bad spirits. He employs Rwandan proverbs "Akaje karemerwa" and "Akaje gahimwa n'akakazanye" to be explicit. Nothing can be done to help the child. He will wait for a miracle to occur so that the child can be released because the circumstances surrounding the child are out of his control.

1. Has a similar situation occurred in your area?
2. What views do residents in your area have on dealing with various illnesses?
3. How can you influence Mbarubukeye's decision-making?

Why do we need to study health models ? Because the model of health and illness adopted by society can have many important implications. It not only influences the line of treatment but also influences people's perception, attitude and cultural beliefs. Another benefit we can gain from studying these health models is that they can help us in appreciating their role in establishing health psychology as a separate branch.

5.5.1 Medical models of health and illness

What images come to your mind with the word : hospital, patients resting on beds, X-ray machines, patients standing in the queue for their turn to see the doctor, the smell of drugs, injection and many more ? Even though this description of contemporary treatment setup looks like a part of our common sense, it would not have been for our great-great-grandfathers and other ancestors. Why ? Because this conception of medical treatment is recent. Since the 19th century, the medical model has been the most prevalent model of health and illness among contemporary healthcare practitioners.

The medical model is also known as "Biomedical model". The term 'biomedical' comes from the Greek word bios (meaning 'life') and the Latin word medicus (meaning 'healing'). But ironically, healing is not a part of the practicing medical professionals as it focuses only on the physical aspect of the disease. To understand the medical model, we will discuss some of its major characteristics:

- **Cause of disease :** This model considers health as equivalent to a state of absence of disease and symptoms. The root cause of a disease according to this model is always some external pathogenic agents like virus, bacteria or some other physiological problem or cellular abnormalities. (Guttmacher, 1979). Further, it denies any role of emotional and psychological factors in disease.
- **Responsibility for disease** : This model considers that the cause of illness is not dependent on the individual. Due to this reason, individuals are not seen as responsible for their illness. Patients are considered as only victims of some external factor or internal abnormalities.
- **Treatment :** Since the focus of the medical model is always on biological or physical aspect. Therefore, treatment also focuses only on the human body's physical aspect. It involves removal of pathogenic agents either through drugs or through interventional strategies like surgery. The objective of treatment is the removal of symptom and relief from any type of pain.
- **Techno-oriented model** : This is the only model of health which relies heavily on machines and technologies. From making a generic drug to performing surgery, everything here requires technology.
- **Practitioner-Physician relationship** : This model considers that physicians possess all the required knowledge, expertise, and skill to treat patients. The medical model further considers patients as only passive recipients of their physician's expertise and expects patients to only cooperate with their treatment regime. Thus, the model considers practitioners superior to patients.

There is no doubt that the medical model is very effective in critical medical conditions. Therefore, it is often referred to as "quick fix" approach. It can provide immediate relief and quickly minimize the symptoms of the disease.

Limitations

- It has a reductionist approach to the human body and views it in the mechanistic framework. It does not give importance to the concept of 'mind' and considers mind-body dualism.
- It ignore any role of social, emotional, spiritual and psychological factors in health and illness. Thus, it does not talk about the wellbeing or healing aspect of the disease.
- It is not always effective in treating many diseases. Specifically, any psychosomatic diseases, chronic and lifestyle-related diseases.
- The issue of affordability is also associated with this model. Hospital treatment offers impersonal professional care, leading to a burden on one's pocket because of high fees. Its accessibility also depends on one's socioeconomic status.

5.5.2 Holistic model of health

In response to the various limitations of the medical model, many scholars came up with new models for health and illness. One such model is known as the holistic model. The term Holistic medicine refers to conceptualizing health as a 'whole'. Guttmacher (1979) has suggested that holistic model considers health as equivalent to "a sense of wellbeing" and disease is not considered as a presence or absence of a pathogenic agent only. Instead, according to the holistic model, a disharmony between social, psychological and spiritual dimensions of one's life causes disease. In this way, the holistic model puts responsibility for ill health on the individual also. This model also gives equal importance to the role of practitioners and patients. Unlike biomedical model, it considers a practitioner as a mentor and role model, whose role is to motivate patients to be self-responsible for their health instead of having blind faith in practitioners' efficacy.

According to American Holistic Medical Association (n.d.), holistic medicine is "the art and science of healing that addresses care of the whole person-body, mind, and spirit. The practice of holistic medicine integrates conventional and complementary therapies to promote optimal health and prevent and treat disease by addressing contributing factors". Based on this definition and earlier discussion we can conclude following points about the holistic model :

- Holism refers to a complete and comprehensive analysis of health and illness.
- We need to understand health from multiple perspectives as there is no single cause of illness.
- A holistic practitioner may treat patients from a wide range of healthcare options, that is, he/she may use medication along with alternative therapies.

As a result, many researchers called for an alternative model which can incorporate all dimensions of health and treats health as a whole. The first holistic model "Biopsychosocial" was proposed by Engel in 1977.

Table: A Summary of major differences between the medical model and holistic model

S/N	Medical model	Holistic model
1	Health: Absence of disease.	Health: A sense of wellbeing.
2	Disease: Pathogenic agents such as chemical irritant or bacteria or cellular abnormalities and can be identified by distinctive symptoms.	Disease: Disharmony between the individual and his/her own environment or a disintegration social, psychological, and spiritual dimension.
3	Healing: Is the treatment of physical symptoms.	Healing: Healing must entail a reintegration of basic dimensions.

4	Role of practitioner: Possesses the necessary specialized knowledge and technical skills to cure disease.	Role of practitioner: Guide, mentor and role model.
5	Role of the patient: The patient must co-operate with the physician and comply with instructions.	Role of the patient: Individual patient is essentially responsible for the outcome of an illness episode.
6	Treatment outcomes: Immediate relief, long-term complications, lowering of health-related-quality of life (HR-QoL) psychological problems such as depression and anxiety, dependency on drugs, and lower self-responsibility.	Treatment outcomes: Long-term relief, fewer complications, higher HR-QoL, fewer psychological problems, lesser dependency on drugs and, higher self-responsibility.

Source : Ignou, B. A. (2020, p.28)

5.5.3 Biopsychosocial model

In this section, we will discuss the most famous holistic model, Biopsychosocial model developed by George Engel.

Biopsychosocial model, as the name suggests, conceptualizes health as consisting of multiple dimensions (Engel, 1977). The medical or biomedical model focuses only on the physical aspect of health, but Engel's new model includes psychological and social aspects as well. It is based on the idea that "humans are inherently biopsychosocial organisms in which the biological, psychological, and social dimensions are inextricably intertwined". Engel did not completely reject the benefits of the medical model but emphasised on giving equal importance to psychological and social factors in the process of treatment. This model suggests that other than physiological abnormalities, germs and viruses, our behaviors, thoughts, and feelings may also influence our physical state. Further, Engel also argued that physicians should also give importance to subjective experiences of their patients.

Broadly, there are three areas in which the biopsychosocial model has offered new insights :

- Patient's subjective experience is as important as objective biomedical data,
- A comprehensive causation can give fuller and deeper understanding of our health and illness, and
- Patients should not be treated as passive recipients of the treatment. They should be given more power in the clinical process.

The main advantage of this model is that it leads to numerous developments in technology and research. It also contributes to the diagnoses and effective treatment of varied illnesses. It also leads to an increase in life expectancy and enhancement of life expectancy. Though the model tends to rely on technology and thus could be cost ineffective and may not be affordable. The focus of this mode is also more on treatment than on actual promotion of good health.

5.5.4. Social model of health

The social model of health finds its roots in the social model of disability and as such is a reaction to the medical model. In this model various factors that play an important role in health, like social, political, economic, cultural and even environmental are taken into consideration. For instance, environmental pollution can lead to detrimental effects on health. This model can be termed as a community-based approach where the focus is on prevention of illnesses/ diseases. Thus, relevance is given to the awareness programs and policies related to health to modify the lifestyle and health related behaviour of the individuals so as to promote their health and wellbeing. Thus, according to this model health can be promoted by keeping in mind the social, political, economic, cultural and environmental factors.

The main characteristics of this model are as follows (Yuill, Crinson & Duncan, 2010):

- The social context in which the individual exists has a significant influence on the health-related experiences, choices and behaviour of the individual. The social context includes class, ethnicity, gender and so on.
- The human body is social, psychological, and biological simultaneously.
- Cultural variations exist in the way health and illness are perceived.
- Though biomedicine and medicine are relevant in the context of health, there are other aspects as well that play a role.
- Health and social determinants of health are influenced by political decisions.
- The opinions of people from non-medical background are relevant as they may provide a different perspective on health.

The social model thus focuses on social responsibility in order to ensure that people have a healthy lifestyle and environment. And strategies at varied levels, like economic, political and so on, need to be developed in order to promote health amongst individuals. Thus, the social model of health focuses on varied determinants of health and strives towards decreasing social inequalities. It focuses on empowerment of not only individuals but communities as well.

Some of the major advantages of this model are that this model promotes education amongst individuals and is also cost effective. It also puts the onus on the individual so that he/ she develops a healthy lifestyle. The model is based on community approach and seeks involvement of both governmental and non-governmental agencies. Despite the advantages, the social model may also display some issues or disadvantages. Individuals may not be motivated or may lack awareness regarding health, behaviour, and lifestyle. Further, bringing about change in an individual's health-related behaviour is not easy. This is a long-term measure and thus quick results may not be achieved.

Application activity 5.5

1. How can you explain the psychosocial model of health?
2. Why is medical model characterised as techno-oriented model?
3. What are the three areas in which the biopsychosocial model has offered new insights?

5.6. Understanding illness in health psychology

Learning activity 5.6

1. With an example, explain the following sentence: "Illness and disease are not the same, although there is a large degree of co-existence".
2. Differentiate between illness and disease.

Health psychology is the study of physical illness and addresses problems such as obesity, diabetes, cancer, and coronary heart disease (CHD) with a focus on health behaviors (eg. diet, exercise, sleep, help-seeking, medication adherence), illness beliefs, behavior change, and health outcomes. This lesson will explore topics such as the biopsychosocial model, health and illness as a continuum, becoming ill and the role of illness cognitions and, the Self-Regulatory Model of illness behavior.

5.6.1 Current perspectives on health and illness

Once we add the person to the biomedical model, we have a different and broader picture of how health and illness come about. This new perspective, called the biopsychosocial model, expands the biomedical view by adding to biological factors the influence of psychological and social factors (Engel, 1977. 1980; Schwartz, 1982). This new model proposes that all three factors affect and are affected by the person's health. Before we describe in detail the biopsychosocial model, let us first clarify what exactly the biomedical model is.

5.6.2 The biomedical model

The biomedical model can be understood in terms of its answers to the following questions :

1 What causes illness ? According to the biomedical model of medicine, diseases either come from outside the body, or originate as internal involuntary physical changes. Such diseases may be caused by several

factors such as chemical imbalances, bacteria, viruses and genetic predisposition.

- ✓ Who is responsible for illness ? Because illness is seen as arising from biological changes beyond their control, individuals are not seen as responsible for their illness. They are regarded as victims of some external force causing internal changes.
- ✓ How should illness be treated ? The biomedical model regards treatment in terms of vaccination, medication, chemotherapy, and surgery, all of which aim to change the physical state of the body.
- ✓ Who is responsible for treatment ? The responsibility for treatment rests with the medical profession. The professionals are considered to be experts whose recommendations must be followed in order for the treatment to be successful.
- ✓ What is the relationship between health and illness ? Within the biomedical model, health and illness are seen as qualitatively different - you are either healthy or ill, there is no continuum between the two.
- ✓ What is the role of psychology in health and illness ? According to the biomedical model of medicine, the mind and body are separate entities ; they function independently of each other. This is comparable to a traditional dualistic model of the mind-body split. From this perspective, the mind is incapable of influencing physical matter. The mind is seen as abstract and relating to feelings and thoughts, and the body is seen in terms of physical matter such as skin, muscles, bones, brain and organs. Changes in the physical matter are regarded as independent of changes in the state of mind.
- ✓ What is the role of psychology in health and illness ? Within traditional biomedicine, illness may have psychological consequences, but not psychological causes. For example, cancer may cause unhappiness, but mood is not seen as related to either the onset or progression of the cancer.

5.6.4 Health psychology and its focus on the biopsychosocial model

Health psychology challenges the mind-body split by suggesting a role for the mind in both the cause and treatment of illness. Health psychology is the only field that completely adheres to the biopsychosocial model.

(1) **What causes illness ?** Health psychology suggests that human beings should be seen as complex systems and that illness is caused by a multitude of factors and not by a single causal factor. Health psychology therefore attempts to move away from a simple linear model of health and claims that illness can be caused by a combination of biological

(e.g., a virus), psychological (e.g., behaviors, beliefs) and social (e.g., employment) factors.

(2) **Who is responsible for illness ?** Because illness is regarded as a result of a combination of factors, the individual is no longer simply seen as a passive victim. For example, the recognition of a role for behavior in the cause of illness means that the individual may be held responsible for their health and illness.

(3) **How should illness be treated ?** According to health psychology, the whole person should be treated, not just the physical changes that have taken place. This can take the form of behavior change, encouraging changes in beliefs and coping strategies and compliance with medical recommendations.

(4) **Who is responsible for treatment ?** Because the whole person is treated, not just their physical illness, the patient is therefore in part responsible for their treatment. This may take the form of responsibility to take medicine, responsibility to change beliefs and behaviors. Patients are not seen as victims.

(5) **What is the relationship between health and illness ?** From a biopsychosocial perspective, health and illness are not qualitatively different, but exist on a continuum. Rather than being either healthy or ill, individuals progress along this continuum from healthiness to illness and back again

(6) **What is the relationship between mind and body ?** The twentieth century has seen a challenge to the traditional separation of mind and body suggested by the dualistic model of health and illness, with an increasing focus on an interaction between the mind and the body. This shift in perspective is reflected in the development of a holistic or a whole-person approach to health. Health psychology therefore maintains that the mind and body interact. *However,* although this represents a departure from the traditional medical perspective, in that these two entities are seen as influencing each other, they are still categorized as separate - the existence of two different terms (the mind and the body) suggests a degree of separation and «interaction» can only occur between distinct structures.

(7) **What is the role of psychology in health and illness ?** Health psychology regards psychological factors not only as possible consequences of illness, but as contributing to its etiology as well.

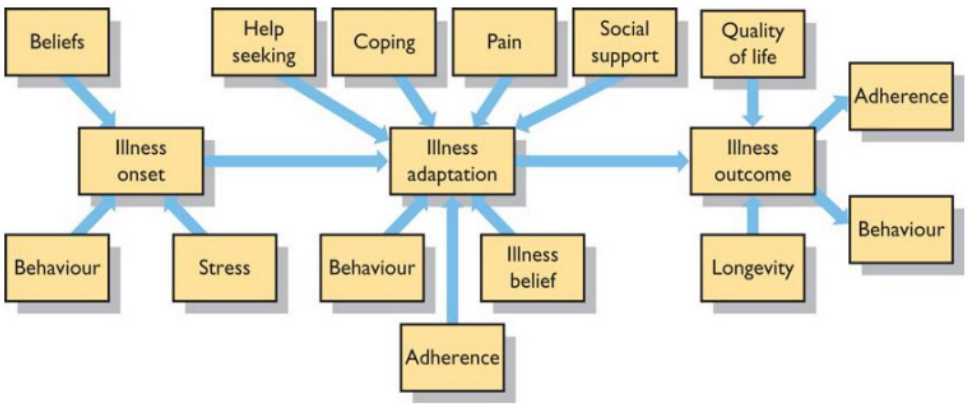
5.6.6 Application of the biopsychosocial model to health promotion

By using the biopsychosocial model as a guide, researchers have discovered ways to promote people's health and recovery from illness. For example, consider the following discoveries :

1. Using psychological methods to reduce anxiety of patients who are awaiting surgery enables them to recover more quickly and leave the hospital sooner.
2. Programs that teach safer sex practices have dramatically reduced risky sexual behavior and the spread of HIV infection.
3. People who have a high degree of social support from family and Friends are healthier and live longer than people who do not.
4. Stress impairs the functioning of the immune system.
5. Applying psychological and educational programs for cancer patients reduces their feelings of depression, improves their immune system functioning, and enables them to live longer.
6. Biofeedback and other psychological techniques can reduce the pain of people who suffer from chronic, severe headaches.

5.6.7 Health and illness as a continuum

Health psychology emphasizes health and illness as being on a continuum and explores the ways in which psychological factors impact health at all stages. Therefore, psychology is involved in illness onset (e.g. beliefs, behaviors (smoking, diet), stress), help-seeking (e.g. symptom perception, illness cognitions, Doctor/patient communication), illness adaptation (e.g. coping, behavior change, social support, pain perception), illness progression (e.g. stress, behavior change) and health outcomes (e.g. Quality of Life, longevity). This perspective is illustrated in this figure



Health and illness as a continuum

Source : Ogden, (2018, p. 8)

5.6.8. Becoming ill and the role of illness cognitions

People have beliefs about illness and these beliefs relate to how they behave when they are ill, whether or not they seek help and the communication they then have with their health professional. We are going to describe illness beliefs in the context of a model called the Self-Regulatory Model (SRM). It will then describe the factors relating to help-seeking behavior which includes symptom perception and illness beliefs and then explore medical consultation and the role of the health professional's own beliefs in the clinical decision-making process.

What are illness beliefs ?

Howard Leventhal and his colleagues (Leventhal et al. 2008) defined illness beliefs as "a patient's own implicit common-sense beliefs about their illness". They proposed that these beliefs provide patients with a framework or a schema for coping with and understanding their illness and telling them what to look out for if they are becoming ill. There are 5 core beliefs identified by researchers :

1. **Identity** : This refers to the label given to the illness (the medical diagnosis) and the symptoms experienced (e.g. "I have a cold" – the diagnosis, "with a runny nose" – the symptoms).
2. **The perceived cause of the illness** : These causes may be biological, such as a virus or a lesion, or psychosocial, such as stress or health-related behavior. In addition, patients may hold representations of illness that reflect a variety of different causal models (e.g. "My cold was caused by a virus", "My cold was caused by being run down").
3. **Timeline** : This refers to the patients' beliefs about how long the illness will last, whether it is acute (short-term) or chronic (long-term) (e.g. "My cold will be over in a few days").

4. **Consequences** : This refers to the patient's perceptions of the possible effects of the illness on their life. Such consequences may be physical (e.g. pain, lack of mobility), emotional (e.g. loss of social contact, loneliness) or a combination of factors (e.g. "My cold will prevent me from playing football, which will prevent me from seeing my friends").

5. **Curability and controllability** : Patients also represent illnesses in terms of whether they believe that the illness can be treated and cured and the extent to which the outcome of their illness is controllable either by themselves or by powerful others (e.g. "If I rest, my cold will go away", "If I get medicine from my doctor my cold will go away").

5.6.9 Self-regulatory model of illness behavior

Leventhal incorporated his description of illness beliefs into his Self-Regulatory Model of Illness Behavior (SRM). This model is based on approaches to problem-solving and suggests that illness/symptoms are dealt with by individuals in the same way as any other problem. It is assumed that, given a problem or a change in the status quo, the individual will be motivated to solve the problem and re-establish their state of normality. Traditional models describe problem-solving in three stages :

i. Interpretation (making sense of the problem);

ii. Coping (dealing with the problem in order to regain the status quo); and

iii. Appraisal (assessing how successful the coping stage has been).

According to models of problem-solving, these three stages will continue until the coping strategies are deemed to be successful and a state of equilibrium has been attained. In terms of health and illness, if healthiness is an individual's normal state, then any onset of illness will be interpreted as a problem and the individual will be motivated to re-establish their state of health (i.e. illness is not the normal state).

Stage 1 : Interpretation

An individual may be confronted with the problem of a potential illness through two channels : *symptom perception* ("I have a pain in my chest") or *social messages* ("the doctor has diagnosed this pain as angina"). The individual is then motivated to return to a state of "problem-free" normality which involves assigning meaning to the problem which is done by accessing the individual's illness beliefs in terms of the following dimensions : identity, cause, consequences, timeline, and cure/control. These illness beliefs will give the problem meaning and will enable the individual to develop and consider suitable coping strategies. However, an illness belief is not the only consequence of symptom perception and social

messages, and a person will also show changes in their emotional state. For example, perceiving the symptoms of pain and receiving the social message that this pain may be related to coronary heart disease may result in anxiety. Therefore, any coping strategies have to relate to both the illness belief and the emotional state of the individual.

Stage 2 : Coping

The next stage in the self-regulatory model is the development and identification of suitable coping strategies. Coping can take many forms, however, there are two broad categories of coping which incorporate the multitude of other coping strategies : approach coping (e.g. taking pills, going to the doctor, resting, talking to friends about emotions) and avoidance coping (e.g. denial, wishful thinking, drinking too much alcohol). When faced with the problem of illness, the individual will develop coping strategies in an attempt to return to a state of healthy normality.

Stage 3 : Appraisal

The third stage of the Self-Regulatory Model is appraisal. This involves individuals evaluating the effectiveness of the coping strategy and determining whether to continue with this strategy or whether to try an alternative one. Therefore, not only do people have beliefs about their health behaviors such as diet, exercise, and smoking but also about their illnesses. These illness beliefs seem to be made up of 5 core beliefs and are central to how people make sense of their illness. This, in turn, influences the choice of coping strategies and the ultimate outcome of their health condition as illustrated by the SRM.

Conclusion

The biopsychosocial model takes a global vision of health and illness and does not separate both in the treatment of patients. Health cannot be understood without a good analysis of illness. For this reason, biological, psychological, and social factors altogether must be considered when dealing with health matters.

Application activity 5.6

1. How do people make sense of their illnesses?
2. What are the stages of the SRM?
3. You are provided with 5 core beliefs identified by researchers: identity, timeline, curability and controllability, consequences, the perceived cause of illness. Examples of patient perceptions are also given to you in the table; however, they are not arranged in any particular sequence. Match each belief to its correct example.

Examples of patient's perceptions	Core beliefs
a) If I rest, my cold will go away.	i. The perceived cause of the illness
b) My cold will be over in a few days	ii. Identity
c) "I have a cold" – the diagnosis, "with a runny nose" – the symptoms).	iii. Consequences
d) My cold will prevent me from playing football, which will prevent me from seeing my friends.	iv. Timeline
e) My cold was caused by a virus".	v. Curability and controllability

End of unit assessment 2

1. Provide examples of how you can prevent illness in your life.
2. One of the aims of health psychology is about putting theory into practice. Explain how this aim can be implemented.
3. Provide examples of psychological aspects of health and illness.
4. Give an example showing how emotion can be very important in people's decision about seeking health treatment.
5. Explain how Rwandan government used the biopsychosocial model of health to fight against Covid-19 pandemic.
6. Enumerate any five examples of health threats.
7. Complete the following table to compare medical model and holistic model of health by describing the three elements of comparison: disease, role of practitioner.

S/N	Medical model	Holistic model
1	Disease:	Disease:
2	Role of practitioner:	Role of practitioner:
3	Role of the patient:	Role of the patient:

8. What are some of the advantages of the social model of health?
9. Complete both sentences with appropriate terms:

a) ---------- regards treatment in terms of vaccination, medication, chemotherapy, and surgery, all of which aim to change the physical state of the body.

b) The first stage of SRM model explains that an individual may be confronted with the problem of a potential illness through two channels: ---------- ("I have a pain in my chest") or ---------- ("the doctor has diagnosed this pain as angina").

UNIT 6 EMOTIONS

Key unit competence: Illustrate proper coping with and management of emotions

Introductory activity:

Look at these different faces and interpret them

Choose each face that corresponds to the following scenarios and show how your face will be expressed:

a) Your boss has just increased your workload and you have yet to finished your previous assignment.
b) An employee who always interrupts during meetings and conversations.
c) A Top performer suddenly feeling de-motivated.
d) Average worker unable to thrive in developing relationships and maintaining them.
e) How does employee handle, when the boss yells and screams at his/her employees in front of the rest of the department?
f) Business priorities change, how your team understands and carries out the shifted goals. What is their reaction and response?
g) When the boss provides negative feedback, how does the employee respond?

6.1. The meaning and types of emotions

Learning activity 6.1

1. How do you express emotion or feeling when you communicate?
2. What are some examples of emotional expression?

Emotion is derived from the Latin term «Emovere,» which means to stir, agitate, or move. As a result, an Emotion is defined as a heightened state of agitation. Emotions, in other words, are reactions that humans have in response to events or situations. For example, when a person receives good news, the person feel joy. When a person is threatened, the person experiences fear.

Types of emotions

As mentioned, psychologist Paul Ekman established the following six universal emotions :

(1) **Happiness :** Many people strive for happiness because it is a pleasant emotion that is accompanied by feelings of well-being and fulfillment. Smiling or speaking in an upbeat tone of voice are common ways to express happiness.

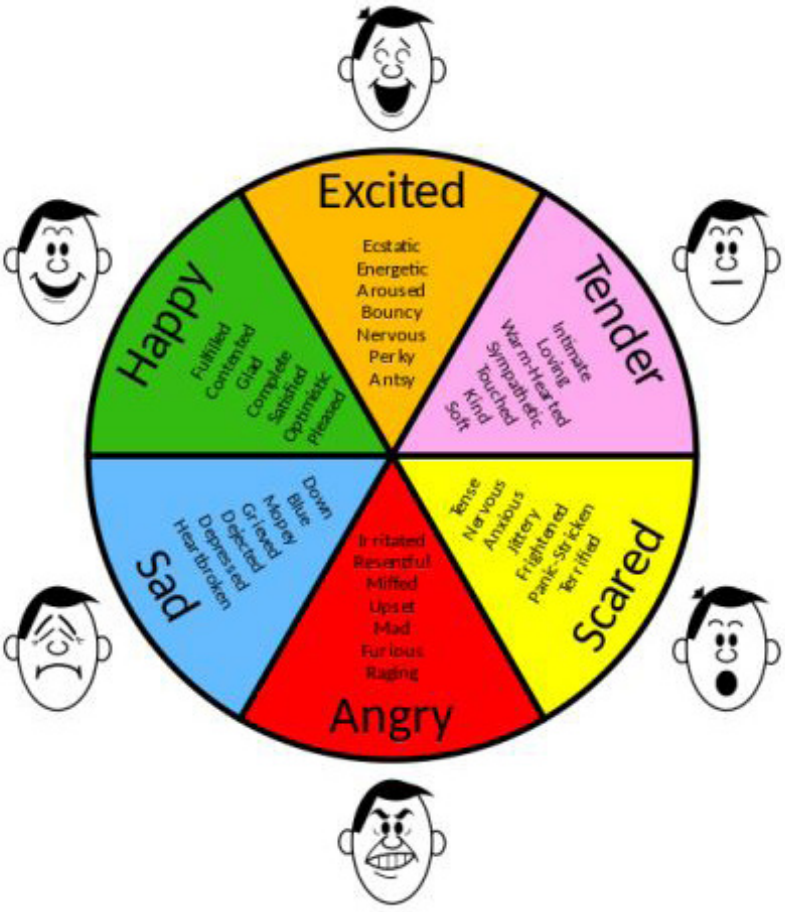
(2) **Sadness :** We all experience sadness from time to time. Someone may express their sadness by crying, remaining silent, and/or withdrawing from others. Sadness can manifest as grief, hopelessness, or disappointment.

(3) **Fear :** Fear can cause an increase in heart rate, racing thoughts, or the fight-or-flight response. It can be in response to real or perceived threats. Some people enjoy the adrenaline rush that comes with fear, such as when they watch scary movies, ride roller coasters, or skydive.

(4) **Disgust :** Disgust can be provoked by a physical experience, such as seeing or smelling decaying food, blood, or other bodily fluids. or a lack of hygiene. Moral disgust can occur when someone witnesses another person doing something immoral or distasteful to them.

(5) **Anger :** Anger can be shown through facial expressions such as frowning, yelling, or violent behavior. Anger can motivate people to make changes in their lives, but they must find a healthy outlet for their anger so that it does not harm them or others.

(6) **Surprise :** A pleasant or unpleasant surprise. When surprised, a person may open his or her mouth or gasp. Like fear, surprise can set off the fight-or-flight response.



Emotional Development is a process that most life forms go through as a child grows from dependence to fully functioning adulthood. It refers to the ability to recognize, express, and manage feelings at various stages of life, as well as to feel empathy for the feelings of others. Emotional development begins around the age of 2. It is one of the major aspect of human growth and development. Emotions development reaches its maximum during in the period of adolescence, the emotions fluctuate very frequently and current of emotional flow is also intense. We have noticed that emotional restlessness and instability, sometimes makes the boys and girls moody. And sometimes they are depressed, violent, desperate and delinquent.

Application activity 6.1

1. Explain the types of emotions and its effect on human behaviour
2. Describe a time when you used nonverbal behaviours to express your emotions or to detect the emotions of others. What specific nonverbal techniques did you use to communicate?

6.2. Theories of Emotions

Learning activity 6.2

Imagine that you are on a plane that you know is going to crash. What emotions would you experience, and how would you respond to them? Would the rush of fear cause you to panic, or could you control your emotions?

6.2.1. Physiological theories of emotions

a. **Evolutionary Theory of Emotion :**

Naturalist Charles Darwin proposed that emotions evolved because they are necessary for humans and animals to survive and reproduce.

For Example : Feelings of love and affection lead people to seek mates and reproduce. Feelings of fear compel people to fight or flee the source of danger, fear evolved because it helped people to act in ways that enhanced their chances of survival. Darwin believed that facial expressions of emotion are innate (hard-wired). He pointed out that facial expressions allow people to quickly judge someone's hostility or friendliness and to communicate intentions to others.

Evolutionary theorists believe that all human cultures share several primary emotions, including happiness, contempt, surprise, disgust, anger, fear, and sadness. They believe that all other emotions result from blends and different intensities of these primary emotions.

b. **James – Lange Theory** :

The James-Lange theory was developed in the late 1800s by William James and Carl Lange, who each separately published similar writings about the nature of emotion. According to this theory, an external stimulus leads to a physiological reaction. Our emotional reaction is dependent upon how we interpret those physical reactions. This theory believes that physiological changes associated with emotion follow the individual's conscious experience. As a result, we cry when we are sad, run when we are afraid, and fight when we are angry.

According to this theory, seeing an external stimulus causes a physiological reaction. Your emotional reaction is determined by how you interpret the physical reactions.

Examples

To understand the James-Lange theory, consider the following example. Imagine you're walking on a darkened road and you hear a rustling in the bushes nearby. Your heart starts racing and you feel ready to start running if need be. According

to James, these bodily sensations would constitute an emotion—in this case, the feeling of fear. Importantly, our heart doesn't start beating faster because we feel afraid ; instead, these changes in our body comprise the emotion of fear.

The theory seeks to explain not just negative states—like fear and anger—but positive ones as well. For example, the emotion of amusement is typically accompanied by laughter.

c. Cannon-Bard Theory of Emotion

The theory was developed in 1927 by Walter B. Cannon and his graduate student, Philip Bard. It was established as an alternative to the James-Lange theory of emotion. According to the Cannon-Bard theory of emotion, stimulating events cause feelings and physical reactions to occur at the same time.

For example, seeing a snake may cause both fear (an emotional response) and a racing heartbeat (a physical reaction). According to Cannon-Bard, both of these reactions occur simultaneously and independently. In other words, the physical reaction is not determined by the emotional response, and vice versa.

Cannon-Bard proposes that both of these reactions originate simultaneously in the thalamus. This is a small brain structure responsible for receiving sensory information. It relays it to the appropriate area of the brain for processing.

When a triggering event occurs, the thalamus might send signals to the amygdala. The amygdala is responsible for processing strong emotions, such as fear, pleasure, or anger. It might also send signals to the cerebral cortex, which controls conscious thought. Signals sent from the thalamus to the autonomic nervous system and skeletal muscles control physical reactions. These include sweating, shaking, or tense muscles. Sometimes the Cannon-Bard theory is referred to as the thalamic theory of emotion.

Examples of Cannon-Bard

Cannon-Bard can be applied to any event or experience that causes an emotional reaction. The emotion can be positive or negative. The scenarios described below show how this theory is applied to real-life situations. In all these scenarios, the Cannon-Bard theory states the physical and emotional reactions happen simultaneously, rather than one causing the other.

A job interview. Many people find job interviews stressful. Imagine you have a job interview tomorrow morning for a position you really want. Thinking about the interview might leave you feeling nervous or worried. You might also feel physical sensations such as tremors, tense muscles, or a rapid heartbeat, especially as the interview approaches.

Moving into a new home. For many people, moving into a new home is a source of happiness and excitement. Imagine you've just moved into a new home with your partner or spouse. Your new home is larger than the apartment you lived in before. It has enough space for the children you hope to have together. As you unpack boxes, you feel happy. Tears well in your eyes. Your chest is tight, and it's almost difficult to breathe.

Divorce of parents. Children also experience physical and emotional effects in response to significant events. An example is the separation or divorce of their parents. Imagine you're 8 years old. Your parents just told you that they're separating and will probably get a divorce. You feel sad and angry. Your stomach is upset. You think you might be sick.

6.2.2. Cognitive theories of emotions

All people experience the world differently. Individuals may take the same route to the same school at the same time as all their friends, and yet experience it in very different ways. The same is true for how they respond emotionally.

Cognitive Theory of Emotion : refers to a family of theories of emotion that suggests that emotional experiences must be accompanied by thinking or cognition. It refers to theories of emotion that try to answer this question : «How do feelings and thinking interact ?» Do our thoughts affect how we frame a situation emotionally ? If so, what factors play the largest role in how we react ? Maybe it's our culture, past experiences, or even the scary movie we watched last night. The cognitive theory of emotion, emphasizes how much the cognitive process can impact how individuals feel and experience emotions.

The following are two categories of cognitive theories of emotion

a. Cognitive Arousal Theory of Emotion

The cognitive arousal theory of emotion was originally formed by Stanley Schachter and Jerome Singer, now formally known as the Schachter-Singer Cognitive Theory of Emotion. This theory is based on other biological theories of emotion such as the James-Lange and Cannon-Bard theories of emotion. However, the biggest difference is that the Schachter-Singer cognitive theory of emotion is a two-factor theory. Two-Factor Theory states that emotions have two components : physical arousal and cognitive appraisal which occur together. In other words, people must be both physically aroused and able to cognitively label their arousal in order for them to experience emotion. By «label», we mean that we consciously interpret our emotions based on the situation, others' reactions, and our past experiences through a process called attribution (the process of appropriately labeling the source of our arousal). The environment can also play a large role in how we label our emotional responses.

Spillover Effect

Have you ever been around that friend who just kind of panics ? In almost every situation, they can't help but freak out. You're usually pretty even-tempered, but you've noticed that sometimes, you would pick up on their anxious emotions. Schachter and Singer would call this phenomenon the spillover effect. Spillover Effect refers to our tendency to allow the emotions of other people around us to affect our own. Another way to think of this cognitive theory of emotion is that arousal starts the engine of emotion while cognition directs the car.

b. Cognitive Appraisal Theory of Emotion

According to some psychologists such as Robert Zajonc and Joseph LeDoux, some emotional responses require no conscious thinking at all, specifically those required for survival such as fear. Zajonc and LeDoux suggested that this is why some of us immediately feel fear when we see a spider when we know it won't hurt us or make snap judgments about whether a person is trustworthy or not.

Researcher, Richard Lazarus agreed with Zajonc and LeDoux's theory that some conscious thinking isn't required for all emotional responses. But he did believe that since most of our emotions are rather automatic and under the radar, perhaps there are cognitive processes that are occurring but they are simply too subtle for us to really notice. If we are aware enough to react to an emotional response, then there must be some level of mental function and cognitive appraisal.

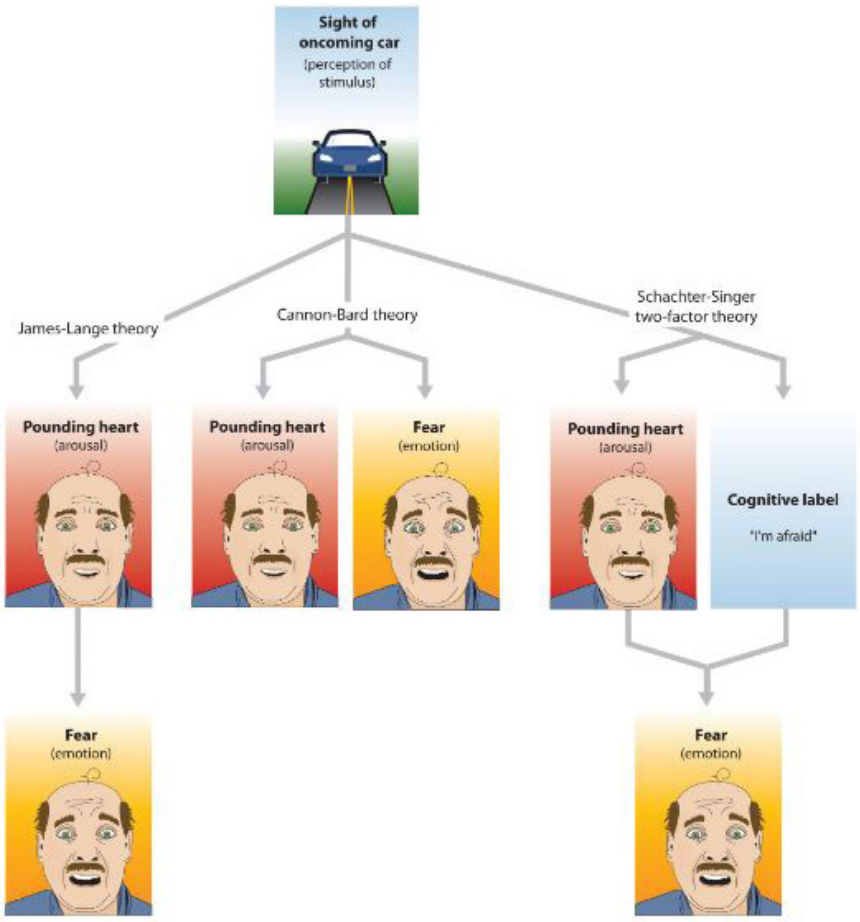
Lazarus' cognitive appraisal theory of emotion suggests that, even if we are not consciously aware of it, emotional arousal occurs due to our cognitive appraisal of whether a situation is dangerous or harmless.

Lazarus' cognitive theory of emotion may even help explain why emotional reactions can differ across cultures. Something that symbolizes death in one culture may symbolize life in another. This can impact how we cognitively appraise a situation and thereby how we emotionally respond.

Example : Lazarus Cognitive-Appraisal Theory of Emotion :

When you initially heard the tapping on the window, you appraised the situation as potentially dangerous, and so you felt fear the very moment you heard the sound. You had little time to even process that it could be an intruder. Then, when you cognitively appraised it was just the wind and the situation was harmless, your fear subsided. The summary of three theories

Figure three : Three Theories of Emotion. The Cannon-Bard theory proposes that emotions and arousal occur at the same time. The James-Lange theory proposes the emotion is the result of arousal. Schachter and Singer's two-factor model proposes that arousal and cognition combine to create emotion.



Application activity 6.2

1. Compare and contrast theories of emotions.
2. Consider the three theories of emotion that we have discussed and provide an example of a situation in which a person might experience each of the three proposed patterns of arousal and emotion.

6.3. Stress and its effect on health

Learning activity 6.3

While waiting to pay for foodstuffs at a certain shop, Mugisha had to wait about 20 minutes in a long line at the checkout because only one cashier was on duty. When Mugisha was finally ready to pay, his debit card was declined because he did not have enough money left in his checking account. Because Mugisha had left his credit cards at home, he had to place the foodstuffs back into the cart and head home to retrieve a credit card. While driving back to his home, traffic was backed up two miles due to an accident.

Bases on this event, provide another example of a stressful situation that may cause a person to become seriously ill.

Stress is a normal bodily reaction to change, resulting in physical, emotional, and cognitive responses. In fact, the human body is designed to experience and respond to stress. When you face changes or challenges (stressors), your body responds physically and mentally. That is the result of stress.

Stress responses assist your body in adapting to new situations. Stress can be beneficial in that it keeps us alert, motivated, and ready to avoid danger. If you have an important test coming up, for example, a stress response may help your body work harder and stay awake longer. However, stress becomes an issue when stressors persist without relief or periods of relaxation.

6.3.1. Causes of stress

Almost anything can cause stress, depending on the situation and individual's ability to cope with it, but here are some of the more common stressors :

Job and workplace : Deadlines, challenging bosses, troublesome colleagues, office politics, even harassment and discrimination in the workplace—all these

things can keep a person awake at night with worry and fear. A job is a big part of individual's daily life. When things aren't going well, stress at work can mount. On the other hand, if a person is unemployed, stress factors may be related to loss of income, and basic necessities such as food and shelter.

Money and finances : Pending bills, credit card debt, bill collectors, identity theft and fraud, even the act of checking someone's savings account balance, can all inspire stress. For most people, money is a necessity. Some people are struggling just to make ends meet and others are unemployed or underemployed. Worries may swirl around how to buy groceries, pay the electric bill, pay the doctor's bill, and how to pay the rent or mortgage. The effects of stress can make surviving even more challenging.

Disasters and trauma : Natural or man-made disasters and traumatic events can have major impacts on someone's life. Tornadoes, wildfires, hurricanes, and flooding, can lead to loss of life, home, and community. This kind of stress can become overwhelming. The stress of traumatic events like being the victim of an attack or in a serious accident can likewise lead to deep and long-lasting stress and health issues.

Relationships and family : Children, divorce, separation, loneliness, and even the responsibility of caring for a family can have stress impacts. For those dealing with the death of a loved one, sickness, or having to play a role as caregiver for an ill or elderly family member, stress also plays a major role in health and wellness.

6.3.2. The following are Common effects of stress :

On the individual's body	On the individual's mood	On the individual's behavior
Headache	Anxiety	Overeating or undereating
Muscle tension or pain	Restlessness	Angry outbursts
Chest pain	Lack of motivation or focus	Drug or alcohol misuse
Fatigue	Feeling overwhelmed	Tobacco use
Change in sex drive	Irritability or anger	Social withdrawal
Stomach upset	Sadness or depression	Exercising less often

Application activity 6.3

Consider a time when you experienced stress and how you responded to it. Do you now have a better understanding of the dangers of stress?

6.4. Stress management

Learning activity 6.4

Read this scenario and answer to the question.

You've been on your phone all day, and the battery is running low. You don't have your charger with you, and it will not last much longer. What could you have done before?

When managed, the stress impact on health can be lessened. The following are tips when managing the stress :

Tip 1 : Identify the sources of stress in life

Stress management starts with identifying the sources of stress in life. This isn't as straightforward as it sounds. While it's easy to identify major stressors such as changing jobs, moving, or going through a divorce, pinpointing the sources of chronic stress can be more complicated. It is all too easy to overlook how individual own thoughts, feelings, and behaviors contribute to his/her everyday stress levels.

Sure, people may know that they are constantly worried about work deadlines, but maybe it is their procrastination, rather than the actual job demands, that is causing the stress.

Until they accept responsibility for the role they play in creating or maintaining it, their stress level will remain outside their control.

Tip 2 : Practice the 4 A's of stress management

While stress is an automatic response from the nervous system, some stressors arise at predictable times : commute to work, a meeting with the boss, or family gatherings, for example. When handling such predictable stressors, the situation or reaction can be changed. When deciding which option to choose in any given scenario, it's helpful to think of the four A's : avoid, alter, adapt, or accept.

The four A's – Avoid, Alter, Adapt & Accept

(i) **Avoid**

1. **Avoid unnecessary stress** : It is not healthy to avoid a stressful situation that needs to be addressed, but individual may be surprised by the number of stressors in life that can be eliminate.
2. **Learn how to say "no."** Know your limits and stick to them. Whether in your personal or professional life, taking on more than you can handle is a certain recipe for stress. Distinguish between the "shoulds" and the "musts" and, when possible, say "no" to taking on too much.

3. **Avoid people who stress you out.** If someone consistently causes stress in your life, limit the amount of time you spend with that person, or end the relationship.
4. **Take control of your environment.** If the evening news makes you anxious, turn off the TV. If traffic makes you tense, take a longer but less-traveled route. If going to the market is an unpleasant chore, do your grocery shopping online.
5. **Cut down your to-do list.** Analyze your schedule, responsibilities, and daily tasks. If you have got too much on your plate, drop tasks that aren›t truly necessary to the bottom of the list or eliminate them entirely.

(ii) **Alter the situation**

- **If a stressful situation can't be avoided, try to alter it.** Often, this involves changing the way to communicate and operate in daily life.
- **Express your feelings instead of bottling them up**. If something or someone is bothering you, be more assertive and communicate your concerns in an open and respectful way. If you've got an exam to study for and your chatty roommate just got home, say up front that you only have five minutes to talk. If you don't voice your feelings, resentment will build and the stress will increase.
- **Be willing to compromise**. When you ask someone to change their behavior, be willing to do the same. If you both are willing to bend at least a little, you'll have a good chance of finding a happy middle ground.
- **Create a balanced schedule.** All work and no play is a recipe for burnout. Try to find a balance between work and family life, social activities and solitary pursuits, daily responsibilities and downtime.

(iii) **Adapt to the stressor**

If you can't change the stressor, change yourself. You can adapt to stressful situations and regain your sense of control by changing your expectations and attitude.

- **Reframe problems**. Try to view stressful situations from a more positive perspective. Rather than fuming about a traffic jam, look at it as an opportunity to pause and regroup, listen to your favorite radio station, or enjoy some alone time.
- **Look at the big picture**. Take perspective of the stressful situation. Ask yourself how important it will be in the long run. Will it matter in a month ? A year ? Is it really worth getting upset over ? If the answer is no, focus your time and energy elsewhere.

- **Adjust your standards.** Perfectionism is a major source of avoidable stress. Stop setting yourself up for failure by demanding perfection. Set reasonable standards for yourself and others, and learn to be okay with "good enough."
- **Practice gratitude**. When stress is getting you down, take a moment to reflect on all the things you appreciate in your life, including your own positive qualities and gifts. This simple strategy can help you keep things in perspective.

(iv) **Accept the things you can't change**

Some sources of stress are unavoidable. You can't prevent or change stressors such as the death of a loved one, a serious illness, or a national recession. In such cases, the best way to cope with stress is to accept things as they are. Acceptance may be difficult, but in the long run, it's easier than railing against a situation you can't change.

- **Don't try to control the uncontrollable.** Many things in life are beyond our control, particularly the behavior of other people. Rather than stressing out over them, focus on the things you can control such as the way you choose to react to problems.
- **Look for the upside.** When facing major challenges, try to look at them as opportunities for personal growth. If your own poor choices contributed to a stressful situation, reflect on them and learn from your mistakes.
- **Learn to forgive.** Accept the fact that we live in an imperfect world and that people make mistakes. Let go of anger and resentments. Free yourself from negative energy by forgiving and moving on.
- **Share your feelings**. Expressing what you're going through can be very cathartic, even if there's nothing you can do to alter the stressful situation. Talk to a trusted friend or make an appointment with a therapist.

Tip 3: Get moving

When you're stressed, the last thing you probably feel like doing is getting up and exercising. But physical activity is a huge stress reliever—and you don›t have to be an athlete or spend hours in a gym to experience the benefits. Exercise releases endorphins that make you feel good, and it can also serve as a valuable distraction from your daily worries.

While you'll get the most benefit from regularly exercising for 30 minutes or more, it's okay to build up your fitness level gradually. Even very small activities can add up over the course of a day. The first step is to get yourself up and moving. Here are some easy ways to incorporate exercise into your daily schedule :

- Put on some music and dance around.
- Walk or cycle to the grocery store.
- Pair up with an exercise partner and encourage each other as you work out.
- Play different games such as ping-pong or an activity-based video game with your kids.

Tip 4: Connect to others

There is nothing more calming than spending quality time with another human being who makes you feel safe and understood. In fact, face-to-face interaction triggers a cascade of hormones that counteracts the body's defensive "fight-or-flight" response. It's nature's natural stress reliever (as an added bonus, it also helps stave off depression and anxiety). So make it a point to connect regularly—and in person—with family and friends.

Keep in mind that the people you talk to don't have to be able to fix your stress. They simply need to be good listeners. And try not to let worries about looking weak or being a burden keep you from opening up. The people who care about you will be flattered by your trust. It will only strengthen your bond.

Of course, it's not always realistic to have a friend close by to lean on when you feel overwhelmed by stress, but by building and maintaining a network of close friends you can improve your resiliency to life›s stressors.

Tips for building relationships

- ✓ Reach out to a colleague at work.
- ✓ Help someone else by volunteering.
- ✓ Have lunch or coffee with a friend.
- ✓ Ask a loved one to check in with you regularly.
- ✓ Accompany someone to the movies or a concert.
- ✓ Call or email an old friend.
- ✓ Go for a walk with a workout buddy.
- ✓ Schedule a weekly dinner date.
- ✓ Meet new people by taking a class or joining a club.
- ✓ Confide in a clergy member, teacher, or sports coach.

Tip 5: Make time for fun and relaxation

Beyond a take-charge approach and a positive attitude, you can reduce stress in your life by carving out "me" time. Don't get so caught up in the hustle and bustle of life that you forget to take care of your own needs. Nurturing yourself is a necessity, not a luxury. If you regularly make time for fun and relaxation, you'll be in a better place to handle life's stressors.

- **Set aside leisure time.** Include rest and relaxation in your daily schedule. Don't allow other obligations to encroach. This is your time to take a break from all responsibilities and recharge your batteries.
- **Do something you enjoy every day**. Make time for leisure activities that bring you joy, whether it be stargazing, playing the piano, or working on your bike.
- **Keep your sense of humor.** This includes the ability to laugh at yourself. The act of laughing helps your body fight stress in a number of ways.
- **Take up a relaxation practice.** Relaxation techniques such as yoga, meditation, and deep breathing activate the body›s relaxation response, a state of restfulness that is the opposite of the fight or flight or mobilization stress response. As you learn and practice these techniques, your stress levels will decrease and your mind and body will become calm and centered.

Tip 6: Manage your time better

Poor time management can cause a lot of stress. When you're stretched too thin and running behind, it's hard to stay calm and focused. Plus, you'll be tempted to avoid or cut back on all the healthy things you should be doing to keep stress in check, like socializing and getting enough sleep. The good news : there are things you can do to achieve a healthier work-life balance.

- **Don't over-commit yourself**. Avoid scheduling things back-to-back or trying to fit too much into one day. All too often, we underestimate how long things will take.
- **Prioritize tasks**. Make a list of tasks you have to do, and tackle them in order of importance. Do the high-priority items first. If you have something particularly unpleasant or stressful to do, get it over with early. The rest of your day will be more pleasant as a result.
- **Break projects into small steps**. If a large project seems overwhelming, make a step-by-step plan. Focus on one manageable step at a time, rather than taking on everything at once.
- **Delegate responsibility**. You don't have to do it all yourself, whether at home, school, or on the job. If other people can take care of the task, why not let them ? Let go of the desire to control or oversee every little step. You'll be letting go of unnecessary stress in the process.

Tip 7: Maintain balance with a healthy lifestyle

In addition to regular exercise, there are other healthy lifestyle choices that can increase your resistance to stress.

- **Eat a healthy diet.** Well-nourished bodies are better prepared to cope with stress, so be mindful of what you eat. Start your day right with

breakfast, and keep your energy up and your mind clear with balanced, nutritious meals throughout the day.

- **Reduce caffeine and sugar.** The temporary "highs" caffeine and sugar provide often end with a crash in mood and energy. By reducing the amount of coffee, soft drinks, chocolate, and sugar snacks in your diet, you'll feel more relaxed and you'll sleep better.
- **Avoid alcohol, cigarettes, and drugs**. Self-medicating with alcohol or drugs may provide an easy escape from stress, but the relief is only temporary. Don't avoid or mask the issue at hand ; deal with problems head on and with a clear mind.
- **Get enough sleep**. Adequate sleep fuels your mind, as well as your body. Feeling tired will increase your stress because it may cause you to think irrationally.

Tip 8: Learn to relieve stress in the moment

When you are exhausted by your morning commute, stuck in a stressful meeting at work, or fried from another argument with your colleague, you need a way to manage your stress levels right now. That's where quick stress relief comes in.

The fastest way to reduce stress is by taking a deep breath and using your senses—what you see, hear, taste, and touch—or through a soothing movement. By viewing a favorite photo, smelling a specific scent, listening to a favorite piece of music, tasting a piece of gum, or hugging a pet, for example, you can quickly relax and focus yourself.

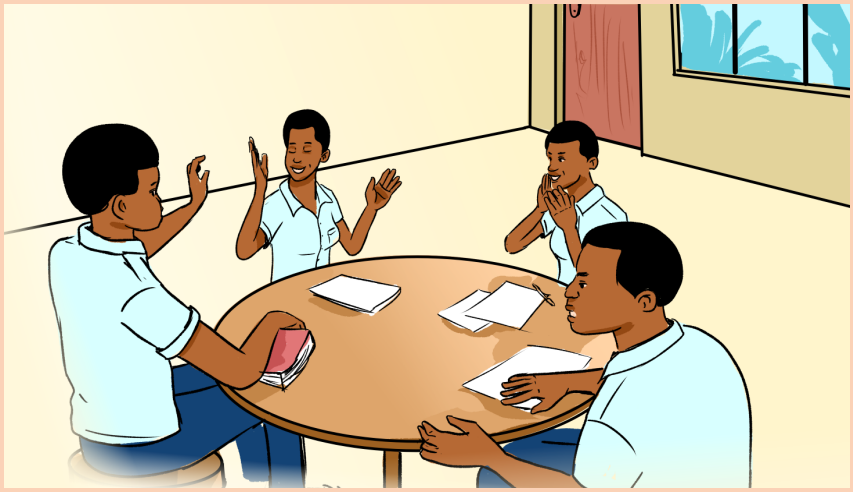
Of course, not everyone responds to each sensory experience in the same way. The key to quick stress relief is to experiment and discover the unique sensory experiences that work best for you.

Application activity 6.4

Develop tips which may help individuals cope with and manage stress.

6.5. Well-being

Learning activity 6.5



Observe the pictures above and answer to questions below:
Describe emotional states of people which are on the picture above.

Wellbeing is not about being happy, wealthy or beautiful. Wellbeing is not about just one piece of who you are—you are more valuable than that. Wellbeing is a combination of our physical self, our financial security, loving what we do each day, the quality of our relationships and contributing to our communities. Wellbeing is about a mindful, purposeful life. And it looks different for every person.

6.5.1. The Elements of Wellness

Well-being is actually a combination of 8 elements : "physical/nutritional, emotional, social, spiritual, intellectual, financial, and environmental" and occupational wellness.

1. **Physical/Nutritional** : Focuses on physical activity, diet, sleep and nutrition.
2. **Emotional :** Focuses on navigating through feelings and being able to share those feelings with others.
3. **Social :** Focuses on developing a sense of connection, belonging, and a well-developed support system.
4. **Spiritual** : Focuses on expanding our sense of purpose and meaning in life.
5. **Intellectual** : Focuses on creating abilities and finding ways to expand knowledge and skills.
6. **Financial :** Focuses on having satisfaction with current and future financial situations.

7. **Environmental** : Focuses on your personal surrounding and how your environment supports your health, wellbeing and safety.
8. **Occupational** : Focuses on personal satisfaction and enrichment derived from one's work.

6.5.2. Factors affecting well-being

The well-being of individuals and careers is affected by a variety of factors that may be social, economic, cultural or physical. Some examples include :

a. **Adverse Childhood Experiences**. These can include abuse, neglect, being brought up in a household where there is domestic violence, drug abuse, alcohol abuse, parental separation. 'Evidence shows children who experience stressful and poor quality childhoods are more likely to develop health-harming and anti-social behaviours, more likely to perform poorly in school, more likely to be involved in crime and ultimately less likely to be a productive member of society.'

b. **Home background**. A supportive and caring background provides the foundations for positive social development and provides positive role models. Mental illness, substance abuse, unemployment, violence and poverty may have a negative impact on the well-being of individuals and careers. Drug and alcohol abuse may lead to physical and emotional neglect.

c. **Looked after children and young people**. Individuals who have had a lack of consistency in care in early years or have come from abusive backgrounds may have had disrupted educations and poor educational achievements. These individuals are more likely to have a low well-being compared with those living in stable environments.

d. **Positive, consistent and caring relationships**. These support social development and confidence and positive role models. Individuals who move home frequently or have changes in family members or careers have a lower level of well-being than those with consistent relationships.

e. **Secure attachment**. Where an individual has secure attachments, they are self-confident and will participate readily in activities, supporti ng well-being.

f. **Enjoyable and fulfilling career**. Individuals who have jobs they enjoy and that challenge and fulfil them experience high levels of satisfaction and well-being.

g. **Social deprivation**. If an individual does not have opportunities to meet or mix with others they will experience social deprivation and become isolated, affecting their well-being.

h. **Environment**. A stimulating, safe, caring and supportive environment supports well-being and positive outcomes. An environment that encourages exercise (e.g. cycling, walking) with available sports facilities supports well-being. High quality water supplies, lack of pollution and chemical hazards and good housing support health and well-being. Individuals living in cramped conditions or sharing bedrooms and lacking privacy experience a lower level of well-being.

i. **Educational experiences**. Good educational experiences support confidence, knowledge and well-being. Consistent education in childhood supports well-being and academic achievement. Adult education and community classes support the development of new skills and confidence.

j. **Economic factors**. Where an individual experiences poverty and has limited opportunities, poor diet or suffers from neglect there is an impact on their well-being and health. Having enough money and no financial stresses supports well-being.

k. **Disabilities and physical ill-health.** Disabilities and ill-health may impact on an individual's ability to exercise and socialize, and they may become isolated.

l. **Sensory needs**. Sensory difficulties may result in social isolation or communication difficulties.

m. **Diet**. A healthy diet supports good health, healthy weight and well-being.

n. **Exercise.** An individual who does not have the opportunity to exercise may become unfit and overweight and this will impact on their self-esteem as well as their health. For many adults, exercise also brings social contact within a community that supports well-being.

o. **Religion and culture.** An individual's values, behavior and expectations may be defined by their religion and culture.

p. **Stress**. Chronic stress can hinder brain development and ability to learn or concentrate.

q. **Sleep, relaxation and rest**. Sleep, relaxation and rest has a positive impact on well-being. Relaxation (e.g. through hobbies and sports) has an important role in developing a healthy lifestyle.

6.5.3. Interventions for promoting well being

Everyone wishes to live a long and productive life that is also productive and healthy. We can learn about it from those who have succeeded in achieving this enviable goal. When we look at people who have aged well, we notice that they differ from the rest in three ways : diet, physical activity, and involvement in community life. These people, in particular, preferred leafy green and root

vegetables, fresh milk, and fresh fruits, and they ate a low to moderate amount of food. They consume low to moderate amounts of calories per day. They also maintain their involvement in family and community affairs while engaging in physical activity and walking on a regular basis. According to various studies, it is believed that ensuring health and wellness is possible with the help of certain preventive strategies. The following is a brief description of these strategies :

- **Primary Prevention :** It trie to reduce or eliminate the occurrence of preventable illness and injury. It involves helping people learn about behaviour and health, promoting motivation and necessary skills to practice healthy behaviour, and modifying poor health practices. It also involves generating awareness about immunization.
- **Secondary Prevention :** The major goal of this kind of prevention is to decrease the severity of illness which a person suffers. With the help of early detection, using diagnostic tests that screen the disease, steps may be taken for cure. People can learn methods of self-examination of body parts, and functioning of various organs, that may help in prevention of disease.
- **Changing the Life Style :** It must be noted that medicine alone is not sufficient to cure disease, when life style is faulty. It is necessary to understand that the way we think and the way we behave are interrelated. Mind and body both go together. The various types of illnesses are often caused by our beliefs and habits. In achieving the optimum state of health it is important to achieve the harmony of body and mind. It is with this in view that Ayurveda, the Indian system of medicine, suggests that health and wellbeing depend upon proper Ahara (diet), Vihar (recreation), Achara (conduct) and Vichara (thought). The key principles that need our attention in these areas are as follows :
- **Ahara (Diet)** Vegetarian food is safe and invigorating for the body, Fresh fruit and green vegetables rich in fiber contents, honey and curd provide vitamins, antioxidants, iron etc. necessary for health, Avoidance of food having opposite effects (e.g., hot milk and ice cream should be avoided).
- **Achar (Conduct)** Daily routine should be organized according to season, Drinking lot of water, regular massage, exercises and yogic asanas help to keep body fit and active, Develop skills for proper time management.

- **Vihar and Vichar (Recreation and Thought)** Develop accommodative intellect, acceptance of criticism, understanding of the emotional needs of others, Practice self-control and one should not be driven by lust and greed, Should not be dominated by negative emotions like fear, anger, jealousy and worry, Develop enduring friendships and social relations, Developing awareness of self, connectivity with others and spiritual inclination.

Application activity 6.5

1. What are the important factors found in the people who show successful ageing?
2. Enumerate steps for primary prevention.
3. Describe the components of Ayurvedic view of life-style.

End of unit assessment

Illustrate proper coping with and management of emotions

UNIT 7 INTRODUCTION TO PSYCHOLOGICAL DISORDERS

Key unit competence: Determine the effects of psychological disorders on individuals' thoughts, feelings and actions.

Introductory activity

Paul, 26, laughed as the nurse escorted him to the ward – it looked like he was having a good time. Before the nurse could introduce him to the staff, he said, "Basketball, I love basketball ! I've never played basketball in my life, but that is what I am going to do while I am here. I will be the world's greatest basketball player ! Then he continued talking about his mother and then suddenly described what he had for dinner the night before. A few days ago, Paul had spent all his money and that of his aging parents and bought an expensive professional camera. With no formal training in photography, he thought he could set up the best studio in town and make a lot of money.

Questions :

1. Does anything about Paul seem strange ?
2. How would you feel if you were to see someone like Paul walking in your neighborhood ?
3. If you think Paul is abnormal, on what basis is Paul judged to be abnormal?

7.1. Psychological disorders: Definition and historical background

Learning activity 7.1

1. Why is it believed that psychological disorder is something to be ashamed of stigma ?
2. Provide Kinyarwanda names which are used in your location to refer to people with psychological disorders ? (Take your location as an example).
3. Can we support these kinds of appellations ? Explain your answer.

7.1.1 Definitions of key terms

a) Abnormality

Although many definitions of abnormality have been used over the years, none has won universal acceptance. Still, most definitions have certain common features, often called the 'four Ds': deviance, distress, dysfunction, and danger. That is, psychological disorders are **deviant** (different, extreme, unusual, even bizarre), **distressing** (unpleasant and upsetting to the person and to others), **dysfunctional** (interfering with the person's ability to carry out daily activities in a constructive way), and possibly **dangerous** (to the person or to others). This definition is a useful starting point from which we can explore psychological abnormality. Since the word 'abnormal' literally means "away from the normal", it implies deviation from some clearly defined norms or standards.

The current diagnostic procedures used in the mental health community rely on four important ways in which abnormality can be defined.

- **Impairment :** According to this criterion, maladaptive behaviors that prevent an individual from functioning in daily life can be considered abnormal. Impairment refers to a reduction in a person's ability to function at an optimal or average level. For example, when a woman consumes psychoactive substances (drugs), her cognitive and perceptual abilities are impaired, and she would be at risk if she drives in this state.

- **Distress :** This criterion suggests that behaviors should be considered abnormal if the individual suffers discomfort as a result of the behaviors and wishes to get rid of them. However, here the intensity of pain is so high that it interferes with the person's daily living. For example, a victim of an extremely traumatic event may experience unrelenting pain or emotional turmoil and may not be able to cope in daily life.

- **Risk to self or other people :** When an individual's actions pose a threat to one's own life or to the life of others, the behaviour is considered to be abnormal. A severely depressed individual is at risk of committing suicide and therefore the condition is referred to as abnormal. Similarly, a person suffering from Schizophrenia is out of touch with reality and may put oneself and/ or others at risk.

- **Socially and culturally unacceptable behaviour :** Behaviors that are not in line with social or cultural norms are considered abnormal. Certain behaviors may be acceptable in some cultures but considered odd in certain others. For e.g., In India, the phenomenon of being possessed by God is a common practice during Navratri or other festivals, but the same behaviour would be considered abnormal in most of the other countries. Thus, the social context needs to be considered while judging behaviour as normal or abnormal.

Causes of abnormality

Although we will discuss the perspectives of abnormality later in topic 2, let's have a brief look at the biopsychosocial factors involved in the development of abnormality.

- **Biological causes :** In understanding what causes abnormality from the biological perspective, mental health professionals focus on the processes in a person's body, such as genetic inheritance or physical disturbances. Many disorders run in the family. For example, the chances of the son or daughter developing schizophrenia are greater if either of their parents is suffering from it as compared to children of parents who do not have the disorder. Other factors such as medical conditions (thyroid), brain damage (head trauma), exposure to certain environmental stimuli (toxic substances, allergens), ingestion of certain medicines, illicit drugs, etc., can cause disturbances in the physical functioning that cause emotional or behavioral disturbances.

- **Psychological causes:** Traumatic life experiences that have an impact on the individual's personality constitute the psychological factors in the development of abnormality. For example, an irrational fear of the marketplace may be caused due to a childhood experience of having been lost in the market. Early interpersonal relationships may lead to distortions in perception and faulty thought processes. For example, a boy who is very upset because his girlfriend didn't call back may realize that his reaction stems from his history of being disappointed by his unreliable parents, and having internalised the idea that important people tend to disappoint. Unrealistic expectations, learned helplessness, focusing on the

negative, blaming, dichotomous thinking (seeing things as black or white), catastrophising (exaggerating) etc., can trigger psychological difficulties.

- **Sociocultural causes:** The term sociocultural refers to the sources of social influence in one's life. The most immediate circle that has an impact on a person comprises of family members and friends - troubled relationships can make one feel depressed. Similarly, a failed lover may become suicidal. The next circle involves extended family, neighbors with whom there is less interaction. Nonetheless their behaviors, standards, attitudes and expectations do influence individuals. Society plays a decisive role in most people's lives. Political turmoil, even at the local level, can leave one feeling anxious or fearful. Discrimination on the basis of gender, caste, sexual orientation, disability can have an impact on individuals. As seen earlier, social and cultural norms determine what would be called abnormal, to a large extent.

b) Abnormal behaviour

Abnormal behavior may be defined as behavior that is disturbing (socially unacceptable), distressing, maladaptive (or self- defeating), and often the result of distorted thoughts (cognitions). There are different ways of defining abnormality, but the following characteristics are usually included:

- Abnormal behavior occurs infrequently.
- Abnormal behavior creates distress.
- Abnormal behavior affects a person's ability to function.
- Abnormal behavior is socially disruptive.

c) Psychological disorder

A psychological disorder is an ongoing dysfunctional pattern of thought, emotion, and behaviour that causes significant distress, and that is considered deviant in that person's culture or society (Butcher, Mineka, & Hooley, 2007). Psychological disorders have much in common with other medical disorders. They are out of the patient's control, they may in some cases be treated by drugs, and their treatment is often covered by medical insurance. Like medical problems, psychological disorders have both biological (nature) as well as environmental (nurture) influences. These causal influences are reflected in the bio-psycho-social model of illness (Engel, 1977).

d) Abnormal psychology

Abnormal psychology is the branch of psychology that deals with studying, explaining and treating 'abnormal' behaviour. Although there is obviously a great deal of behaviour that could be considered abnormal, this branch of psychology deals mostly with that which is addressed in a clinical context. In effect, this

means a range of behaviors, emotions and thinking that tend to result in an individual seeing a mental health professional, such as a psychiatrist or a clinical psychologist.

Abnormal psychology attracts researchers who investigate the causes of abnormal behaviour and try to find the most effective treatments for them, whether these involve medication or a talking cure or a combination. There are also practitioners and psychologists who use their knowledge of theory and research to deliver treatment to people in a therapeutic setting.

7.1.2 Historical background of psychological disorders

To understand psychological disorders, we would require a brief historical account of how these disorders have been viewed over the ages. When we study the history of abnormal psychology, we find that certain theories have occurred repeatedly.

One ancient theory that is still encountered today holds that abnormal behaviour can be explained by the operation of supernatural and magical forces such as evil spirits, or the devil (shaitan). Exorcism, i.e. removing the evil that resides in the individual through counter magic and prayer, is still commonly used. In many societies, the shaman, or medicine man is a person who is believed to have contact with supernatural forces and is the medium through which spirits communicate with human beings. Through the shaman, an afflicted person can learn which spirits are responsible for her/his problems and what needs to be done to appease them.

A recurring theme in the history of abnormal psychology is the belief that individuals behave strangely because their bodies and their brains are not working properly. This is the **biological** or **organic** approach. In the modern era, there is evidence that body and brain processes have been linked to many types of maladaptive behaviour. For certains types of disorders, correcting these defective biological processes results in improved functioning.

Another approach is the psychological approach. According to this point of view, psychological problems are caused by inadequacies in the way an individual thinks, feels, or perceives the world. All three of these perspectives — supernatural, biological or organic, and psychological — have recurred throughout the history of Western civilisation. In the ancient Western world, it was philosopher physicians of ancient Greece such as Hippocrates, Socrates, and in particular Plato who developed the **organismic approach** and viewed disturbed behaviour as arising out of conflicts between emotion and reason. Galen elaborated on the role of the **four humors** in personal character and temperament. According to him, the material world was made up of four elements, viz. Earth, air, fire, and water which combined to form four essential body fluids, viz. Blood, black bile, yellow bile, and phlegm. Each of these fluids

was seen to be responsible for a different temperament. Imbalances among the humors were believed to cause various disorders.

In the **Middle Ages**, demonology and superstition gained renewed importance in the explanation of abnormal behaviour. Demonology related to a belief that people with mental problems were evil and there are numerous instances of 'witch-hunts' during this period. During the early Middle Ages, the Christian spirit of charity prevailed, and St. Augustine wrote extensively about feelings, mental anguish and conflict. This laid the groundwork for modern psychodynamic theories of abnormal behaviour.

The Renaissance period was marked by increased humanism and curiosity about behaviour. Johann Weyer emphasised psychological conflict and disturbed interpersonal relationships as causes of psychological disorders. He also insisted that 'witches' were mentally disturbed and required medical, not theological, treatment.

The seventeenth and eighteenth centuries were known as the **Age of Reason and Enlightenment**, as the scientific method replaced faith and dogma as ways of understanding abnormal behaviour. The growth of a scientific attitude towards psychological disorders in the eighteenth century contributed to the **Reform Movement** and to increased compassion for people who suffered from these disorders. Reforms of asylums were initiated in both Europe and America. One aspect of the reform movement was the new inclination for **deinstitutionalisation** which placed emphasis on providing community care for recovered mentally ill individuals. In recent years, there has been a convergence of these approaches, which has resulted in an **interactional, or bio-psycho-social approach**. From this perspective, all three factors, i.e. biological, psychological and social play important roles in influencing the expression and outcome of psychological disorders.

In the late **1800's and early 1900's**, Sigmund Freud (studied in S5), developed theories about the effects of unconscious drives on behaviour. That is, psychological disorders are **deviant** (different, extreme, unusual, even bizarre), **distressing** (unpleasant and upsetting to the person and to others), **dysfunctional** (interfering with the person's ability to carry out daily activities in a constructive way), and possibly **dangerous** (to the person or to others).The Freudians became especially known for their use of free association to interpret dreams, analyze memories, and make people aware of their unconscious conflicts.

Later in the **1900's,** researchers proposed several other theories and treatments of abnormal psychology. These proposals centered on the relationship of psychological, physical, and social conditions in the individual and society.

Application activity 7.1

1. Most definitions have certain common features, often called the 'four Ds'. Explain each of them.
2. With an example, explain the role of biological causes in understanding the causes of psychological disorders.

7.2. Perspectives on abnormality

Learning activity 7.2

1. In your own words, explain the term abnormal behaviour.
2. Write all practices of people in your location to deal with a person with psychological disorder.
3. Talk about how you can assist someone who has recently experienced a psychological illness.

7.2.1 Introduction

Those in the field of abnormal psychology study people's emotional, cognitive, and/or behaviors problems. **Abnormal behavior** may be defined as behavior that is disturbing (socially unacceptable), distressing, maladaptive (or self-defeating), and often the result of distorted thoughts (cognitions). Several perspectives (models, approaches derived from data) and theories attempt to explain the causes of abnormal behavior.

7.2.2 Main perspectives of abnormality

The medical perspective

Those who hold a medical perspective focus on biological and physiological factors as causes of abnormal behavior, which is treated as a disease, **or mental illness**, and is diagnosed through symptoms and cured through treatment. Hospitalization and drugs are often preferred methods of treatment rather than psychological investigation.

The psychodynamic perspective

The psychodynamic perspective, proposed as an alternative to the medical model, evolved from Freudian psychoanalytic theory, which contends that psychological disorders are the consequence of anxiety produced by unresolved, unconscious conflicts. Treatment focuses on identification and resolution of conflicts.

The behavioral perspective

Those espousing a behaviors perspective contend that abnormal behavior results from faulty or ineffective learning and conditioning. Treatments are designed to reshape disordered behavior and, using traditional learning procedures, to teach new, more appropriate, and more adaptive responses. For example, a behaviors analysis of a case of child abuse might suggest that a father abuses his children because he learned the abusive behavior from his father and must now learn more appropriate parenting tactics.

The cognitive perspective

According to the cognitive perspective, people engage in abnormal behavior because of particular thoughts and behaviors that are often based upon their false assumptions. Treatments are oriented toward helping the maladjusted individual develop new thought processes and new values. Therapy is a process of unlearning maladaptive habits and replacing them with more useful ones.

The social-cultural perspective

From the social-cultural perspective, abnormal behavior is learned within a social context ranging from the family to the community, to the culture. Cultural variables, acquired through learning and cognitive processes, are believed to be important in producing abnormal behavior. Anorexia nervosa and bulimia, for example, are psychological disorders found mostly in Western cultures, which value the thin female body.

7.2.3 Treating psychological disorders using a biomedical perspective

Biomedical therapies are physiological interventions that focus on the reduction of symptoms associated with psychological disorders. Three procedures used are drug therapies, electroconvulsive (shock) treatment, and psychosurgery.

(i) **Drug therapies**

Drug therapies (psychopharmacotherapy), which rely on medication for the treatment of mental disorders, are sometimes used by professionals with appropriate medical or pharmacological training in conjunction with psychotherapy. Therapeutic drugs for psychological problems fall into three major groups. Commonly used types of each and their generic names, trade names (and chemical names) follow.

- **Antianxiety drugs** (mild tranquilizers) are used to relieve anxiety.
- **Benzodiazepines** : Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide).
- **Barbiturates** : Miltown (meprobamate).

- **Hypnotics** : Halcion (triazolam), Dalmane (flurazepam).

When people discontinue these drugs after taking them for a long time, they may suffer **rebound anxiety** (a reoccurrence of the earlier anxiety).

- **Antipsychotic drugs** (also called **major tranquilizers** or **neuroleptics**) are used primarily to treat schizophrenia and to reduce psychotic symptoms such as hyperactivity, hallucinations, delusions, and mental confusion.
- **Phenothiazines** : Mellaril (thioridazine), Thorazine (chlorpromazine), Prolixin (fluphenazine).
- **butyrophenones** : Haldol (haloperidol).

Pharmacotherapy treatment may produce side effects such as drowsiness, constipation, and dry mouth. Antipsychotic drug treatment may cause a severe and lasting problem called **tardive dyskinesia**, a neurological disorder characterized by involuntary writhing and tic like movements of the mouth, tongue, face, hands, or feet.

(i) **Antidepressant drugs** are used to elevate mood and to treat depressions. Three principal classes of antidepressants are:

- **Tricyclics**: Trofranil (imipramine), Elavil (amitriptyline)
- **Monoamine oxidase (MAO) inhibitors**: Nardil (phenelzine), Marplan (isocarboxazid)
- **Selective serotonin reuptake inhibitors (SSRIs)**: Zoloft (sertraline), Prozac (fluoxetine), Paxil (paroxetine). Some patients taking Prozac have developed suicidal tendencies.

- **Lithium (lithium carbonate)** is used to treat patients with bipolar mood disorders to control mood swings. The drug may have dangerous side effects, however, such as kidney and thyroid damage.

(ii) **Electroconvulsive therapy**

In **electroconvulsive therapy (ECT)**, a therapeutic procedure developed in the 1930s before many of today's psychopharmacological drugs had been developed, an electric shock is given to lightly anesthetized patients to produce a brief cortical seizure. The shock is administered to one side or sometimes to both sides of the brain through electrodes placed over the temporal lobes. The electric current produces a brief convulsive seizure during which the patient becomes unconscious. ECT was widely used in the 1940s and 1950s; its use has declined, but not entirely stopped, as treatment with new drugs has grown in favor. While favorable results with ECT have been reported for some cases, marked controversy still exists concerning whether it is effective and whether it produces permanent intellectual impairment.

(iii) **Psychosurgery**

Psychosurgery, a surgical procedure designed to change psychological or behaviors reactions (also developed in the 1930s), is more controversial than ECT and is rarely used today. The most widely used was **lobotomy**, also called **prefrontal lobotomy**, which requires the severing of nerve pathways linking the cerebral cortex to the lower brain centers as a means of controlling a patient's violent or aggressive tendencies. However, even if the procedure is successful in controlling violence, it often produces other side effects. More recently, different and technically more sophisticated (but still very experimental) surgical procedures for controlling some mental disorders are being investigated (such as electrical stimulation of a brain area to treat Parkinson's disease).

Application activity 7.2

1. Differentiate between medical perspective and psychodynamic perspective of abnormality.
2. How does social-cultural perspective explain abnormal behaviour?

7.3. Anxiety disorders

Learning activity 7.3

One day while driving home, Bwiza felt his heart beating rapidly, he started sweating abundantly, and even felt short of breath. He was so scared that he stopped the car and stepped out. In the next few months, these attacks increased and now he was hesitant to drive for fear of being caught in traffic during an attack. Bwiza started feeling that he had gone crazy and would die. Soon he remained indoors and refused to move out of the house.

1. Is the behaviour of Bwiza normal or not ? Explain your position.
2. From which signs can you confirm that Bwiza really has a problem?

7.3.1 Introduction

Many psychologists have argued that fear is a fundamentally adaptive reaction to stressors (specifically, threat). It's generally considered abnormal only when it's disproportionate to objective circumstances. Fear probably evolved as an alarm signal to warn organisms of potential danger. But some people tend to feel afraid even when there's no (objective) threat present : these «false alarms» are what we call anxiety disorders. (Gross, 2005, p.776). Anxiety is a normal reaction to stress. It helps one deal with a tense situation in the office, study harder for an exam, and keep focused on an important speech. But when anxiety becomes an excessive, irrational dread of everyday situations, it has become a disabling disorder.

7.3.2 Definition of anxiety

The term anxiety is usually defined as a diffuse, vague, very unpleasant feeling of fear and apprehension. DSM-III-R defines anxiety as «apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external". (APA, 1987, p. 392). For Halonen & Santrock (1999, p.415), anxiety is a diffuse, vague, highly unpleasant feeling of fear and apprehension. People with high levels of anxiety worry a lot.

The anxious individual also shows combinations of the following symptoms : rapid heart rate, shortness of breath, diarrhea, loss of appetite, fainting, dizziness, sweating, sleeplessness, frequent urination and tremors.

Anxiety can be understood as having three separate dimensions (Lang, 1970):

i) Verbal reports of subjective experiences (eg: tension, apprehension, sense of impending danger, expectations of an inability to cope in the future).

ii) Behaviors responses (eg: avoidance, impaired speech and motor coordination, performance deficits).

iii) Physiological responses (eg: muscle tension, increased heart rate, elevated blood pressure, rapid respiration, dryness of the mouth, nausea).

Normal anxiety

Anxiety can be quite adaptive. It is not necessarily pathological. Without anxiety, the human race would have undoubtedly died off long ago. Anxiety acts as an important signal that danger or threat is imminent. It signals to us to attend to important stimuli. Anxiety provides information to the individual. Thus, we are able to activate protective responses, actions that help us survive when confronted with danger and trouble. Anxiety signals us to make adaptive responses.

Example :

- slow down on a slippery road ;
- avoid dark alleys ;

- go for medical checkups ;
- return library books…

Abnormal anxiety

Anxiety is abnormal when it is persistent and coupled with no objective danger or threat, leading to ineffective and self-defeating behavior. Example: I can't tell you why I'm afraid of rats. They fill me with terror. Even if I just see the word «rat» my heart starts pounding. I worry about rats in restaurants I go to, in my kitchen cupboard, and anywhere I hear a noise that sounds like a small animal scratching or running.

Abnormal anxiety can have serious implications for an individual. These include :

a. Emotional consequences: feelings of fear, unhappiness, guilt;
b. Cognitive consequences: impaired concentration and problem-solving;
c. Behaviors consequences: avoidance of every-day situations and activities, breakdown of complex behaviors;
d. Physiological consequences: long term anxiety has been shown to produce actual physical damage. Eg: Anxiety/stress has been shown to interfere with the immune system. Anxiety has been linked to a wide range of physical ailments such as ulcers, headaches, and even cancer.

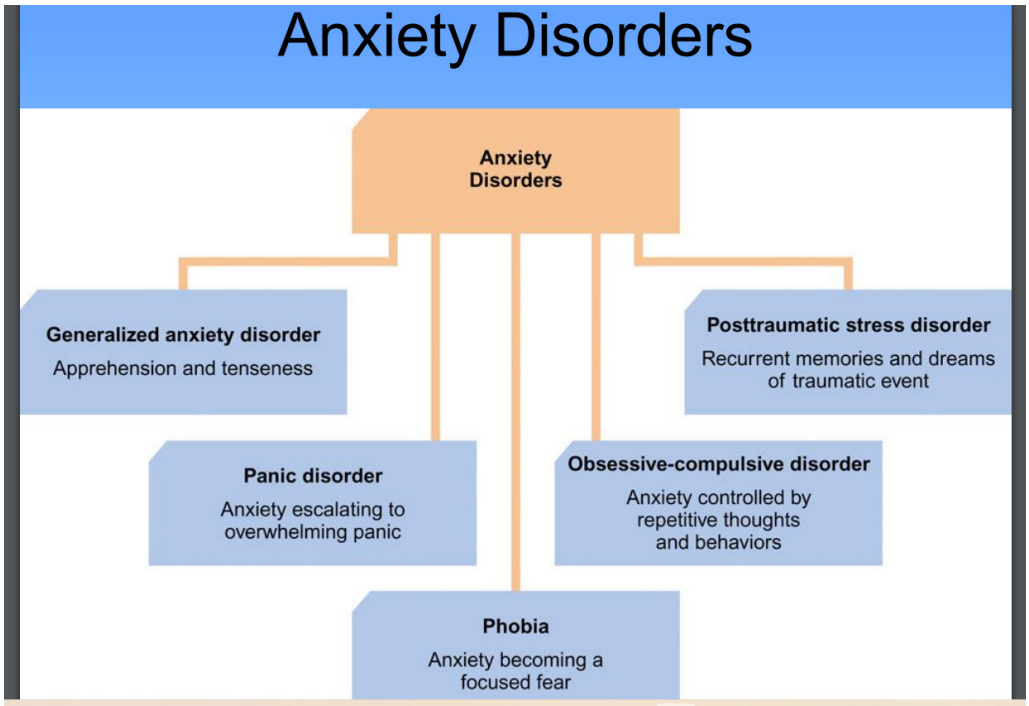
7.3.3 Distinction between Anxiety and other disorders

Anxiety differs from other types of disorders, especially schizophrenia and mood disorders.

- **Anxiety and schizophrenia** : What distinguish the anxiety disorders from the more severe mental illnesses, such as schizophrenia, is that a person with an anxiety disorder is typically :
  - Able to maintain reality contact - there are no gross distortions of external reality.
  - «ambulatory" : he or she can still cope with day-to-day life, however poorly and inefficiently ; there is usually no need to institutionalize the person.
  - «sane" : there is no gross disorganization of his/her personality or behavior.
- **Anxiety and mood disorders** : What distinguishes anxiety disorders from mood disorders is : mood disorders involve states of persistent positive or negative emotion, or mood, typically elation and/or depression. The anxiety disorders, however, refer to states of perceived threat, tension, apprehension, impending danger and so on.

7.3.4 Types of anxiety disorders

There are many types of anxiety disorders. They include generalized anxiety disorder, panic disorder, phobias, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) as depicted in this **figure four**



Source: Ho (2014)

a) **Generalized anxiety disorder**

Generalized anxiety consists of prolonged, vague, unexplained and intense fears that are not attached to any particular object. The symptoms include worry and apprehensive feelings about the future; hypervigilance, which involves constantly scanning the environment for dangers. It is marked by motor tension, as a result of which the person is unable to relax, is restless, and visibly shaky and tense.

In other words, people with this disorder live in a relatively constant state of diffuse and unfocused anxiety, apprehension and dread, what Freud called «free floating» anxiety. Thus, this disorder is something much more severe than the common brief periods of mild anxiety that most of us experience. The DSM requires that the anxiety be present six months or more, for more days than not, before a diagnosis is made.

For example, you may feel intense worry about your safety or that of your loved ones, or you may have a general sense that something bad is about to happen. Your anxiety, worry or physical symptoms cause you significant distress in social, work or other areas of your life.

b) **Panic disorder**

Panic consists of recurrent anxiety attacks in which the person experiences intense terror. A panic attack denotes an abrupt surge of intense anxiety rising to a peak when thoughts of a particular stimuli are present. Such thoughts occur in an unpredictable manner. The clinical features include shortness of breath, dizziness, trembling, palpitations, choking, nausea, chest pain or discomfort, fear of going crazy, losing control or dying. Panic attacks typically occur several times a week, or even daily, and may continue to recur for years. According to the DSM-III-R, Panic Disorder is the most common anxiety disorder among people seeking treatment.

There are two types of panic disorder: Panic attack ad agoraphobia. They are explained in the following paragraphs.

- **Panic attacks** is similar to Generalized Anxiety Disorder in that there is an anxiety response while there may be no clear life circumstance that would trigger such a response (there is evidence, however, that the initial panic attack is typically preceded by an identifiable stressful life event, such as divorce [Foa, Steketee & Young, 1984]).

  Example of panic attack : For example, someone with panic disorder might feel their heart pounding and assume they're having a heart attack. This may lead to a vicious cycle, causing a person to experience panic attacks seemingly out of the blue, the central feature of panic disorder.

- **Agoraphobia :** A frequent complication of panic disorder is agoraphobia. It is defined as «the fear of being in places or situations from which escape might be difficult or in which help might not be available in the event of a panic attack» (APA, 1987, p.236). One popular view held by psychologists is that agoraphobics are afraid of their own internal sensations of anxiety and panic. Because of their fear of these attacks, and the distress caused by the unexpectedness of the attack, the individual will end up restricting travel away from home, or else enduring intense anxiety if travel becomes necessary. **Example:** A man who is increasingly fearful about walking alone, driving his car, and using public transportation.

c) **Phobias**

The DSM-III-R defines a phobia as «a persistent, irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity or situation» (APA, 1987, p.403), although the person is aware that his or her fear is unreasonable and excessive. Phobias often develop gradually or begin with a generalised anxiety disorder.

The DSM-III-R groups the phobias into 3 general types : Agoraphobia, Social

Phobia and Simple Phobia.

- **Agoraphobia (without history of panic disorder):** Agoraphobia involves fearing and avoiding places or situations that might cause panic and feelings of being trapped, helpless or embarrassed. You may fear an actual or upcoming situation. **For example** : fear of using public transportation, being in open or enclosed spaces, standing in line, or being in a crowd.
- **Social phobia :** Characterized by a persistent fear of one or more social situations where one might be exposed to the scrutiny and attention of others, as well as the fear that one may do something in those situations that will be humiliating or embarrassing. **Example :** stage fright, fear of public speaking, generalized fear of most social situations.
- **Simple phobia** : A miscellaneous category made up of irrational fears of specific objects or situations not covered by agoraphobia or social Phobia. **Example :** fear of animals (dogs, cats, snakes, etc.), blood, closed spaces, heights, airplanes. Barlow (1988) states that fear of animals is the most common simple phobia. Exposure to the feared object will typically result in an immediate anxiety response. The feared object is therefore avoided.

d) **Obsessive compulsive disorder**

Obsessive behaviour is the inability to stop thinking about a particular idea or topic. The person involved often finds these thoughts to be unpleasant and shameful. Compulsive behaviour is the need to perform certain behaviors repeatedly. Many compulsions deal with counting, ordering, checking, touching and washing.

- **Obsessions** : Persistent thoughts, impulses, or images that are experienced as intrusive and distressing. Obsessions are internal, intrusive and anxiety provoking, and will occur daily if not many times a day. ***Most common*** : Aggressive impulses (eg: killing one's child), contamination (eg: becoming infected by touching people), doubt (eg: wondering if you turned off the gas stove or not), sex (eg: images of culturally unacceptable sexual practices), concern over health (eg: worrying about the preservatives in your food), need for symmetry (eg: worrying that one's desk is not rigidly organized) (Akhtar, Wig, Verma, Pershad & Verma, 1975; Jenike, Baer & Minichiello, 1986).
- **Compulsions :** Repetitive and intentional behaviors or cognitions performed in response to an obsession. The compulsion is designed to neutralize the anxiety caused by the obsession. Whatever else the person has attempted to reduce the anxiety, it has not worked. Where his/her control over the anxiety producing obsessions seems hopeless,

he/she resorts to magic and ritual in a vain attempt to re-establish safety (Barlow, 1988).

Common types of compulsive behaviour in people with OCD include :

- Cleaning and hand washing
- Checking – such as checking doors are locked or that the gas is off
- Counting
- Ordering and arranging
- Hoarding
- Asking for reassurance
- Repeating words in their head
- Thinking «neutralising» thoughts to counter the obsessive thoughts.

e) **Post-traumatic stress disorder**

Post-traumatic stress disorder **(PTSD)** is a mental disturbance that develops through exposure to a traumatic event (such as war), a severely oppressive situation (such as the holocaust and genocide), severe abuse (as in rape), a natural disaster (such as a flood or tornado), or an accidental disaster (such as a plane crash). The disorder is characterized by anxiety symptoms that either immediately follow the trauma or are delayed by months or even years. (Halonen & Santrock, 1999, p. 418). The anxiety disorder occurs in response to an extreme psychological or physical trauma outside the range of normal human experience. PTSD symptoms vary widely but may include recurrent dreams, flashbacks, impaired concentration, and emotional numbing.

Major characteristics of post-traumatic stress disorder

A. **Increased arousal :** severe anxiety, irritability, insomnia, poor concentration. There may also be panic attacks and episodes of aggression.

B. **Persistent defenses of avoidance and repression :** avoidance of reminders of the events, difficulty in recalling the events at will, detachment, inability to feel emotion («numbness»), diminished interest in activities.

C. **Intrusions :** memories of traumatic events break through the repression as repeated, intense imagery («flashbacks»), and distressing dreams. Anxiety increases further during flashbacks and reminders of the event.

D. There may also be additional maladaptive coping responses, such as excessive use of alcohol and drugs. (Gross, 2005, p.783).

Conclusion

We have reviewed some of the disorders classified by the DSM-3-R as anxiety disorders. Undoubtedly, you have experienced some of these symptoms to one degree or another at some time in your life. Such experiences are not abnormal. Anxiety becomes abnormal when it becomes excessive, irrational, and chronic. The anxiety experienced by people suffering from these disorders is intrusive and disruptive to their everyday lives.

Application activity 7.3

1. **What is the type of anxiety described here :** a mental disturbance that develops through exposure to a traumatic event, a severely oppressive situation, severe abuse, a natural disaster or an accidental disaster.
   a) Agoraphobia
   b) Post traumatic stress disorder
   c) Panic disorder
   d) Obsessive compulsive disorder
2. Differentiate between anxiety and mood disorders.
3. What kind of phobia described in this sentence : A man who is increasingly fearful about walking alone, driving his car, and using public transportation ?
4. Here below is a scenario representing different types of anxiety. Give the name of the types of anxiety described in each scenario and explain the reason why you give this type of anxiety.

Scenario : I wish I could tell you what the matter is. Sometimes I feel like something terrible has just happened when actually nothing has happened at all. Other times, I'm expecting the sky to fall down any minute. Most of the time I can't point my finger at something specific. The fact is that I am tense and jumpy almost all the time. Sometimes my heart beats so fast, I'm sure it's a heart attack. Little things can set it off. The other day I thought a supermarket clerk had overcharged me a few cents on an item. She showed me that I was wrong, but that didn't end it. I worried the rest of the day. I kept going over the incidence in my mind, feeling terribly embarrassed at having raised the possibility that the clerk had committed an error. The tension was so great ; I wasn't sure I'd be able to go to work in the afternoon.

7. 4. Somatoform disorders

Learning activity 7.4

Have you ever « played sick » in order to get out of something ? How did that work out (did you get what you wanted)?

7.4.1 Definition of somatoform disorders

A somatoform disorder is a mental disorder characterised by a group of conditions in which the physical pain and symptoms a person feels are related to psychological factors. A mental disorder characterised by physical symptoms that suggest physical illness or injury symptoms that cannot be explained fully by a general medical condition or by the direct effect of a substance and are not attributable to another mental disorder. In somatoform disorders, the individual has psychological difficulties and complains of physical symptoms, for which there is no biological cause.

7.4.2 Types of somatoform disorders

Somatoform disorders include pain disorders, somatisation disorders, conversion disorders, body dysmorphic disorders, and hypochondriasis.

a) **Pain disorders**

Pain disorders involve reports of extreme and incapacitating pain, either without any identifiable biological symptoms or greatly more than what might be expected to accompany biological symptoms. How people interpret pain influences their overall adjustment. Some pain sufferers can learn to use active

coping, i.e. remaining active and ignoring the pain. Others engage in passive coping, which leads to reduced activity and social withdrawal.

Features :

- Physical symptom of pain-one or more anatomic sites.
- May occur with a general medical condition.
- Pain –not relieved by analgesics.
- Onset, severity, exacerbation, and maintenance are affected by psychological stressors.

b) **Somatisation disorders**

Patients with **somatisation disorders** have multiple and recurrent or chronic bodily complaints. These complaints are likely to be presented in a dramatic and exaggerated way. Common complaints are headaches, fatigue, heart palpitations, fainting spells, vomiting, and allergies. Patients with this disorder believe that they are sick, provide long and detailed histories of their illness, and take large quantities of medicine.

Features :

- Multiple recurrent physical complaints over many years.
- No organic etiology for these complaints.
- Begins by age 30.
- Pain, sexual, pseudoneurologic symptoms : impaired coordination or balance, paralysis or localized weakness, difficulty swallowing, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, amnesia, sensory losses, loss of consciousness (APA 2000 DSM IV-TR).
- May be connected to antisocial personality disorder.
- Difficult to treat (reassurance, stress reduction, more adoptive methods of interacting with family are encouraged).

c) **Conversion disorders**

The symptoms of conversion disorders are the reported loss of part or all of some basic body functions. Paralysis, blindness, deafness and difficulty in walking are generally among the symptoms reported. These symptoms often occur after a stressful experience and may be quite sudden.

Features :

- Physical malfunctioning without any physical or organic pathology
- Malfunctioning often involves sensory-motor areas suggesting neurologic origin. Mainly example losing function in limbs.

- Statistics :
  - Rare condition, with a chronic intermittent course
  - Seen primarily in females, with onset usually in adolescence
  - Not uncommon in some cultural and/or religious groups

d) **Body dysmorphic disorders**

Body dysmorphic disorder (BDD), or body dysmorphia, is a mental health condition where a person spends a lot of time worrying about flaws in their appearance. These flaws are often unnoticeable to others. People of any age can have BDD, but it's most common in teenagers and young adults. It affects both men and women. They have a preoccupation with an imagined defect in the appearance of a normal appearing person.

You might have BDD symptoms if you :

- Worry a lot about a specific area of your body (particularly your face),
- Spend a lot of time comparing your looks with other people's,
- Look at yourself in mirrors a lot or avoid mirrors altogether,
- Go to a lot of effort to conceal flaws – for example, by spending a long time combing your hair, applying make-uk or choosing clothes,
- Pick at your hair, applying make-up or choosing clothes,
- Pick at your skin to make it smooth.

BDD can seriously affect your daily life, including your work, social life and relationships.

e) **Hypochondriasis**

Hypochondriasis is diagnosed if a person has a persistent belief that s/he has a serious illness, despite medical reassurance, lack of physical findings, and failure to develop the disease. Hypochondriacs have an obsessive preoccupation and concern with the condition of their bodily organs, and they continually worry about their health.

Hypochondriasis is characterised by 6 months or more of a general and non-delusional preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.

Clinical features :

- Patients with hypochondriasis believe that they have a serious disease that has not yet been detected.
- They may maintain a belief that they have a particular disease or, as time progresses, they may transfer their belief to another disease.
- The client is preoccupied with fear that he/she has or will get a serious disease.

- History of seeing many doctors.
- Misinterpretation of bodily sensations or functions despite medical evaluations and reassurance.
- Preoccupation with symptoms is not as intense or distorted as in delusional disorder.
- Their convictions persist despite negative laboratory results.
- Hypochondriasis is often accompanied by symptoms of depression and anxiety and commonly coexists with a depressive or anxiety disorder.
- Significant distress/impairment in function.
- Dependent behaviors/desires, demands attention.

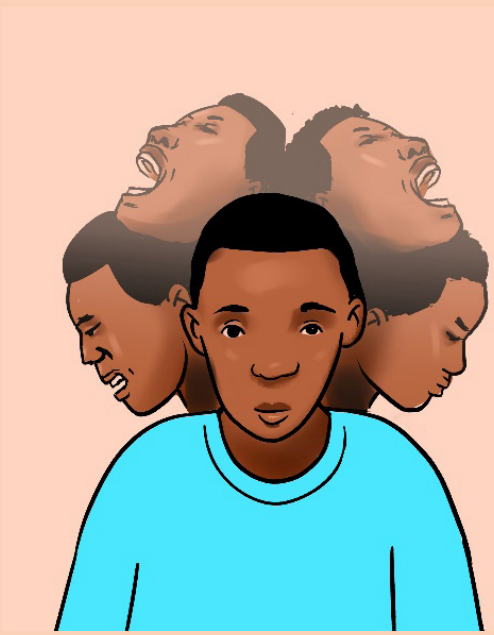
Application activity 7.4

1. Anna worries a lot about a particular body part (particularly her face). She frequently examines herself in mirrors or stays away from them altogether as she spends a lot of time comparing her appearance to others'. She makes a lot of effort to hide her defects, such as spending a lot of time brushing her hair, using makeup, or picking out clothes. She recently saw a psychiatric and she was diagnosed of :
   a) Pain disorder
   b) Somatization disorder
   c) Hypochondriasis
   d) Body dysmorphic disorder
2. When an individual is suffering from body dysmorphic disorder the symptoms include:
   a) Having unnecessary invasive procedures
   b) Becoming obsessionally concerned about imagined or minor physical defects in their appearance.
   c) Feelings of hopelessness
   d) All of the above

7.5. Dissociative disorders

Learning activity 7.5

Observe well the picture presented to you. With reference to psychological disorders, comment on the picture



7.5.1. Introduction

Dissociation is a disconnection between a person's thoughts, memories, feelings, actions or sense of who he or she is. This is a normal process that everyone has experienced. Women are more likely than men to be diagnosed with a dissociative disorder.

7.5.2 Meaning

The word "dissociation" means to be disconnected from others, from the world around you, or from yourself. The term "dissociative disorders" describes a persistent mental state that is marked by feelings of being detached from reality, being outside of one's own body, or experiencing memory loss (amnesia).

Sudden temporary alterations of consciousness that blot out painful experiences are a defining characteristic of dissociative disorders. Dissociative disorders are characterized by an individual becoming split off, or dissociated, from their core sense of self. Memory and identity become disturbed ; these disturbances have a psychological rather than physical cause.

Dissociative disorders are mental disorders that involve experiencing a disconnection and lack of continuity between thoughts, memories, surroundings, actions and identity. People with dissociative disorders escape reality in ways that are involuntary and unhealthy and cause problems with functioning in everyday life. Dissociative disorders involve problems with memory, identity, emotion, perception, behavior and sense of self. Dissociative symptoms can potentially disrupt every area of mental functioning.

7.5.3 Symptoms

Symptoms of dissociative disorder can vary but may include :

- Feeling disconnected from yourself and the world around you
- Forgetting about certain time periods, events and personal information
- Feeling uncertain about who you are
- Having multiple distinct identities
- Feeling little or no physical pain

Dissociation is a way the mind copes with too much stress. Periods of dissociation can last for a relatively short time (hours or days) or for much longer (weeks or months). It can sometimes last for years, but usually if a person has other dissociative disorders. Many people with a dissociative disorder have had a traumatic event during childhood. They may dissociate and avoid dealing with it as a way of coping with it.

7.5.4 Types of dissociative disorders

Five conditions are included in this group : dissociative amnesia, dissociative fugue, dissociative trance disorder**,** dissociative identity disorder, and depersonalization.

a) **Dissociative amnesia**

Amnesia refers to the partial or total forgetting of some experience or event. An individual with **dissociative amnesia** is unable to recall important personal information, usually following an extremely stressful or traumatic experience such as combat, natural disasters, or being the victim of violence. Memory impairments are not caused by ordinary forgetting. Memory loss has no known organic cause (e.g., head injury). The main symptom is difficulty remembering important information about one's self. Some people cannot

remember anything about their past. Others can no longer recall specific events, people, places, or objects, while their memory of other events remains intact. This disorder is often associated with overwhelming stress.

The onset for an amnesic episode is usually sudden, and an episode can last minutes, hours, days, or, rarely, months or years. There is no average for age onset or percentage, and a person may experience multiple episodes throughout her life.

In severe cases you might struggle to remember :

- Who you are,
- What happened to you, or
- How you felt at the time of the trauma.

b) Dissociative fugue

Dissociative fugue has, as its essential feature, an unexpected travel away from home and workplace, the assumption of a new identity, and the inability to recall the previous identity. The fugue usually ends when the person suddenly 'wakes up' with no memory of the events that occurred during the fugue.

c) Dissociative trance disorder

Dissociative trance disorder is an altered state of consciousness in which the person believes firmly that he or she is possessed by spirits; considered a disorder only where there is distress and dysfunction. Trance and possession are a common part of some traditional religious and cultural practices and are not considered abnormal in that context.

d) Dissociative identity

By far, the most well-known dissociative disorder is **dissociative identity disorder** (formerly called multiple personality disorder). People with dissociative identity disorder exhibit two or more separate personalities or identities, each well-defined and distinct from one another. They also experience memory gaps for the time during which another identity is in charge (e.g., one might find unfamiliar items in their shopping bags or among their possessions), and in some cases may report hearing voices, such as a child's

voice or the sound of somebody crying (APA, 2013). Dissociative identity disorder is often referred to as multiple personality and is the most dramatic of the dissociative disorders. It is often associated with traumatic experiences in childhood. In this disorder, the person assumes alternate personalities that may or may not be aware of each other.

e) **Depersonalization**

Depersonalization is defined as feelings of "unreality or detachment from, or unfamiliarity with, one's whole self or from aspects of the self". Individuals who experience depersonalization might believe their thoughts and feelings are not their own; they may feel robotic as though they lack control over their movements and speech; they may experience a distorted sense of time and, in extreme cases, they may sense an "out-of-body" experience in which they see themselves from the vantage point of another person.

Depersonalization involves a dreamlike state in which the person has a sense of being separated both from self and from reality. In depersonalization, there is a change of self-perception, and the person's sense of reality is temporarily lost or changed.

7.5.5 Causes of dissociative disorders

The causes of dissociative disorders are not well understood :

- They may be related to a previous traumatic experience, or a tendency to develop more physical than psychological symptoms when stressed or distressed.
- Someone with a dissociative disorder may have experienced physical, sexual or emotional abuse during childhood.
- Some people dissociate after experiencing war, kidnapping or even an invasive medical procedure.
- Switching off from reality is a normal defense mechanism that helps the person cope during a traumatic time.
- It's a form of denial, as if «this is not happening to me».
- It becomes a problem when the environment is no longer traumatic, but the person still acts and lives as if it is and has not dealt with or processed the event.

7.5.6 Diagnosis

Diagnosis of dissociative disorders involves a review of symptoms and the person's life history. Physical tests may be performed to rule out physical or medical conditions that could cause symptoms such as memory loss or feelings of unreality. Such conditions might include head injury, brain tumor, sleep problems, or drug or alcohol use. Once physical causes are ruled out, a mental health specialist will step in to analyze the details of the individual's case.

7.5.7 Treatment

With appropriate treatment, many people are successful in addressing the major symptoms of dissociative identity disorder and improving their ability to function and live a productive, fulfilling life.

(i) **Treatment with medications**

Medications are often used to address the many other mental health conditions that individuals with dissociative identity disorders (DID) tend to have like depression, severe anxiety, anger, and impulse control problems. However, particular caution is appropriate when treating people with DID with medications because any effects they may experience good or bad, may cause the controlled, and therefore traumatized yet again. As DID is often associated with episodes of severe depression, electroconvulsive therapy(ECT) can be a viable treatment when the combination of psychotherapy and medication does not result in adequate relief of symptoms.

(ii) **Treatment with psychotherapy**

Psychotherapy is generally considered the main component of treatment for dissociative identity disorder. In treating individuals with DID, therapists usually use individual, family, and/or group psychotherapy to help clients improve their relationships with others and to experience feelings they have not felt comfortable being touch with or openly expressing in the past. It is carefully paced in order to prevent the person with DID from becoming overwhelmed by anxiety, risking a figurative repetition of their traumatic past being inflicted by those very strong emotions.

Mental health professionals also often guide clients in finding a way to have each aspect of them co-exist and work together. As well as developing crisis prevention, techniques and finding ways of coping with memory lapses that occur during times of dissociation. The goal of achieving a more peaceful existence of the persons multiple personality quite different from the reintegration of all those aspects into just one identity states. While reintegration used to be the goal of psychotherapy, it has frequently found to leave individual with DID feeling as if the goal of the practitioners is to get rid of or kill parts of them.

Hypnosis sometimes helps increase the information that the person with DID has about their symptoms/ identity states, thereby increasing the control they have over those states when the change of personality from one personality state to another. This occurs by enhancing the communication that aspects of the person's identity have others.

Application activity 7.5

1. What are the main types of dissociative disorders ?
2. By far, the most well-known dissociative disorder is :
   i. Dissociative amnesia
   ii. Dissociative fugue
   iii. Dissociative identity disorder
   iv. Depersonalization
3. Differentiate between dissociative amnesia and dissociative identity disorder.
4. Explain any three symptoms of dissociative disorders.
5. Dissociative amnesia normally manifests itself as a retrospectively reported gap or serious of gaps in the individual's ability to verbally recall aspects of their life history, and these gaps are often related to
   a) traumatic or stressful experiences
   b) involvement in a natural or man-made disaster
   c) being in an accident
   d) All of the above
6. The basic feature of dissociative fugue is that the individual:
   a) suddenly and unexpectedly develops anterograde amnesia
   b) suddenly and unexpectedly develops retrograde amnesia
   c) suddenly and unexpectedly travels away from home or from their customary place of daily activities.
   d) suddenly and unexpectedly develops an alternative personality.

7. 6. Personality disorders

Learning activity 7.6

Mr. K. is 35-year-od man with no prior psychological problems and history of chronic diseases. He was brought to Ndera hospital by police for concerns of psychosis and delusions. Records stated that Mr. K. is delusional, in a state of significant psychosis and is easily disturbed. Upon initial contact with the emergency department psychiatrist, the patient reported feeling that the staff at the hospital were against him. He reported never having seen a psychiatrist before, although he reported having taken strong medication in the past to help him deal with his problems. He did not fully cooperate with the interview, was guarded and evasive, and often said, "You don't need to know". His mental status examination was notable for disorganized process and paranoid content. During subsequent interviews, Mr. K. became loud, intrusive, and agitated. He pounded his cane on the ground and threw it to the floor in a threatening manner.

Question: List down all elements in the scenario that support Mr. K. having a psychological disorder and being disturbed.

7.6.1. Introduction

Personality traits were defined as»: «Enduring patterns of perceiving, relating to, and thinking about the environment and oneself.» These patterns or traits «are exhibited in a wide range of important social and personal contexts» (APA, 1987, p.335). With personality disorders we are talking about deeply ingrained, basic patterns of relating to the world and oneself; patterns that characterize the person's long-term functioning. Such personality disturbances are often seen early in the person's life, and they continue through adulthood.

7.6.2 Definition

DSM-III-R definition of «Personality Disorders»: When personality traits «are inflexible and maladaptive and cause either significant impairment or subjective distress» (APA, 1987, p.335). In other words, Individuals with personality disorders exhibit recurrent maladaptive behaviors in a wide range of areas, especially in their interpersonal relationships. These people are often quite dissatisfied with their lives. Not surprisingly, anxiety and depression are common complications.

7.6.3 Categories of personality disorders

The DSM-III-R groups the personality disorders into three clusters :

Cluster A : disorders marked by odd or eccentric behaviors :

i. Paranoid
ii. Schizoid
iii. Schizotypal

Cluster B : disorders characterized by dramatic, emotional or erratic behaviors :

i. Antisocial
ii. Borderline
iii. Histrionic
iv. Narcissistic

Cluster C : disorders characterized by anxious or fearful behaviors :

i. Avoidant
ii. Dependent
iii. Obsessive compulsive
iv. Passive aggressive

Paranoid Personality Disorder

Individuals with this disorder have significant problems in their relationships. Indeed, they shun intimacy. They are rigid and uncompromising ; hostile, stubborn, and defensive (Marmar, 1987). That is pervasive and long-standing suspiciousness and mistrust of people ; hypersensitivity and difficulty in getting along with others. These people rarely seek help (which is to be expected, given the nature of the disorder). The disorder is more common in men.

Schizoid Personality Disorder

Persons with Schizoid Personality Disorder are «loners». They are excessively self-absorbed and detached, both socially and emotionally. They do better at work (especially when contact with others is not necessary) than they do in interpersonal relationships. While these patterns typically begin in childhood, that is not to suggest that all shy children go on to develop a schizoid personality disorder. In short, they are characterized by social withdrawal and lack of normal emotional relationships with others.

If you have schizoid personality disorder, it's likely that you :

- Prefer being alone and choose to do activities alone

- Don't want or enjoy close relationships
- Feel little if any desire for sexual relationships
- Feel like you can't experience pleasure
- Have difficulty expressing emotions and reacting appropriately to situations
- May seem humorless, indifferent or emotionally cold to others
- May appear to lack motivation and goals
- Don't react to praise or critical remarks from others

Schizotypal Personality Disorder

This disorder is apparently related to Schizophrenia, both in symptomatology and etiology. ***Symptoms :*** peculiar and bizarre thoughts, beliefs, behaviors, emotions, perceptions, etc. However, these symptoms are much less severe than that found in schizophrenia. ***Etiology :*** Schizotypal Personality Disorder seems to share a genetic relationship with schizophrenia : relatives of Schizophrenic persons are more likely to exhibit schizotypal symptoms than are genetically unrelated persons (Kendler, 1985).

Antisocial Personality Disorder

Unlike the other personality disorders, where the individual usually harms him/herself more than he/she harms others, the person with an antisocial personality disorder harms others: chronic indifference and violation of others' rights (Cadoret, 1986), what colloquially we call the «psychopath». This personality disorder is the most widely researched personality disorder, and the most reliably diagnosed.

Though signs of an antisocial personality become apparent before the age of fifteen, the condition is not diagnosed as an antisocial disorder until age eighteen. In individuals younger than eighteen, it is referred to as conduct disorder. These youngsters have serious behaviour problems, including truancy, running away from home, fighting, cruelty, destruction of property, stealing, and habitual lying. The problems continue in adulthood, revealing themselves in impulsiveness, recklessness, blatant disregard for the truth, excessive irritability and aggression, repeated violations of the law, irresponsible parenting, the inability to hold a steady job, failure to honor financial obligations, and an incapacity for normal friendship or love (Camille B.W. et al., 1999).

Note : Detailed explanation are provided in the last topics about Psychosocial deviances.

Borderline Personality Disorder

There is instability in behavior, mood and self-image. There is thus often considerable interference with social and occupational functioning. When they

do form relationships, they are usually intense and stormy, with great highs and lows. One day the friend or lover is idealized and pursued, the next day, scorned and rejected.

Histrionic Personality Disorder

People with this disorder are lively and dramatic, always drawing attention to themselves. While they may be attractive and appealing initially, relationships with them are superficial. They are sometimes described as excessively flirtatious.

Narcissistic Personality Disorder

Here is the person who tends to describe her/himself in grandiose terms. Narcissistic individuals crave the attention and admiration of others and are constantly trying to impress. They greatly fear failure and are highly sensitive to criticism. Always envious of those who seem smarter, more handsome, or more successful than themselves, they cannot empathize with others' feelings and tend to exploit friendships for their own ends (Camille, et al., 1999).

Avoidant Personality Disorder

Unlike Schizoid Personality Disorder, in Avoidant Personality Disorder there is a desire for social involvement. The individual yearns for affection and acceptance but is immobilized by his/her timidity and hypersensitivity, especially regarding fear of rejection. The difference between this type of personality disorder and social phobia is that social phobia is usually of a specific situation, not interpersonal relationships.

Dependent Personality Disorder

The key features are excessive dependent, submissive and passive behavior patterns. The individual seems incapable of making his/her own decisions or living independently. The individual will be little what skills he/she does have. Being alone is painful; the individual is frequently depressed and anxious.

Obsessive Compulsive Personality Disorder

This is different from the anxiety disorder known as obsessive compulsive disorder. In the anxiety disorder, there are intrusive and unwanted thoughts and possible accompanying compulsive behaviors. In Obsessive Compulsive Personality Disorder, there are no true obsessions or compulsions. Rather, there is the pervasive general drive for perfectionism and inflexibility. The two disorders can, however, coexist. So are preoccupation with rules, order, organization, efficiency and detail ; rigidity and inability to express warm emotions or take pleasure in normally pleasurable activities, symptoms of Obsessive Compulsive Personality Disorder.

Passive Aggressive Personality Disorder

An individual with this disorder is thus indirect in his/her communications and actions. Rather than just saying «no, I don't want to», he/she engages in all sorts of indirect resistances. She/he finds ways of not doing what she/he is supposed to, but never through direct refusal ; rather she/he procrastinates, dawdles, makes mistakes, etc.

The name of this disorder implies that the passive behaviors are a cover for feelings of resentfulness and hostility. So, rather than directly expressing the anger, the person passively expresses it through indirect means.

7.6.4. Conclusion

We have reviewed some of the disorders classified by the DSM-3-R as Anxiety Disorders. Undoubtedly, you have experienced some of these symptoms to one degree or another at some time in your life. Such experiences are not abnormal. Anxiety becomes abnormal when it becomes excessive, irrational, and chronic. The anxiety experienced by people suffering from these disorders is intrusive and disruptive to their everyday lives. But why do some people suffer from Anxiety Disorders, while others do not ? What are the causes of these disorders ?

We have looked at the various Personality Disorders as defined by the DSM-III-R. These people are very difficult to relate to on a personal level. People diagnosed with some of these disorders (especially borderline, dependent, narcissistic and passive-aggressive) have even been described as the «hateful patients» because of the manipulative and rejecting behaviors common with these people.

Application activity 7.6

1. You are given a list of types of personality disorder : Dependent, Histrionic, paranoid, schizoid, narcissistic, antisocial, avoidant, passive aggressive, obsessive compulsive, schizotypal, borderline. Put them under their correct clusters in the table below.

Cluster A (disoreders marked by odd or eccentric behaviors)	**Cluster C (disorders marked by anxious or fearful behaviors)**	**Cluster B (disorders charcterised by dramatic, emotional or erratic behaviors)**

2. Differentiate between narcissistic personality disorder and histrionic personality disorder.

3. The typical behaviours or strategies found in ----------personality disorder might include seclusion or staying away from others.

   a) schizoid
   b) obsessive compulsive
   c) schizotypal
   d) antisocial

4. In avoidant personality disorder, beliefs about others might be

   a) they are critical and judging
   b) they are competent, strong, nurturing
   c) they are untrustworthy, malevolent
   d) they are incompetent, sloppy, lacking in standards

7.7 Mood disorders

Learning activity 7.7

You may have got some bad news in the family (for example, death of a close relative) or got less marks than you hoped for or lost money (a lot of money). This may have made you sad and depressed and hopeless about the future. Try and recall such incidents in your life. List the situations that led to this reaction. Compare your list and reactions with those of others in class.

7.7.1. Introduction

Mood Disorders are characterized by prolonged and persistent positive and/or negative emotions, which are of such intensity that they can color and interfere with all aspects of one's life. The key ingredient here is mood. Although thoughts may also be disturbed, thought disorder (ie: impairment of intellectual functioning – reflected by incoherence, unconnected, chaotic thoughts, bizarre speech and the like) is not a defining feature (Thought disorder is central to Schizophrenia)

The emotions experienced in these disorders are typically thought to exist along a continuum with normal emotions (Beck, 1967; Reus, 1988). For example, we've all experienced sadness at some point in our lives. But such experiences do not warrant a diagnosis. As we shall see, clinical depression is very different from sadness.

The most common mood disorder is **depression**, which covers a variety of negative moods and behavioral changes. Depression can refer to a symptom or a disorder. In day-to-day life, we often use the term depression to refer to normal feelings after a significant loss, such as the break-up of a relationship, or the failure to attain a significant goal.

7.7.2 Types of mood disorders

The main types of mood disorders include depressive, manic and bipolar disorders.

(i) **Major depressive disorder**

Major depressive disorder is defined as a period of depressed mood and/or loss of interest or pleasure in most activities, together with other symptoms which may include change in body weight, constant sleep problems, tiredness, inability to think clearly, agitation, greatly slowed behaviour, and thoughts of death and suicide. Other symptoms include excessive guilt or feelings of worthlessness.

Factors Predisposing towards Depression : Genetic make-up, or heredity is an important risk factor for major depression and bipolar disorders. Age is also a risk factor. For instance, women are particularly at risk during young adulthood, while for men the risk is highest in early middle age. Similarly gender also plays a great role in this differential risk addition. For example, women in comparison to men are more likely to report a depressive disorder. Other risk factors are experiencing negative life events and lack of social support.

(ii) **Mania**

Another less common mood disorder is **mania**. People suffering from mania become euphoric ('high'), extremely active, excessively talkative, and easily distractible. Manic episodes rarely appear by themselves ; they usually alternate with depression. Such a mood disorder, in which both mania and depression are alternately present, is sometimes interrupted by periods of normal mood. This is known as bipolar mood disorder.

(iii) **Bipolar mood disorders**

Bipolar mood disorders were earlier referred to as manic-depressive disorders. Among the mood disorders, the lifetime risk of a suicide attempt is highest in case of bipolar mood disorders. Several risk factors in addition to mental health status of a person predict the likelihood of suicide. These include age, gender, ethnicity, or race and recent occurrence of serious life events. Teenagers and young adults are as much at high risk for suicide, as those who are over 70 years. Gender is also an influencing factor, i.e. men have a higher rate of contemplated suicide than women. Other factors that affect suicide rates are cultural attitudes toward suicide. In Japan, for instance, suicide is the culturally appropriate way to deal with feeling of shame and disgrace. Negative expectations, hopelessness, setting unrealistically high standards, and being over-critical in self-evaluation are important themes for those who have suicidal preoccupations.

Suicide can be prevented by being alert to some of the symptoms which include:

- Changes in eating and sleeping habits
- Withdrawal from friends, family and regular activities
- Violent actions, rebellious behaviour, running away
- Drug and alcohol abuse
- Marked personality change
- Persistent boredom
- Difficulty in concentration
- Complaints about physical symptoms, and
- Loss of interest in pleasurable activities

However, seeking timely help from a professional counsellor/psychologist can help to prevent the likelihood of suicide.

7.7.3 Etiology of mood disorders

In medicine the term etiology is defined as the cause, set of causes, or manner of causation of a disease or condition. The most studied factors of psychological disorders include (1) psycho-social factors and (2) biological factors.

1) **Psycho-Social Factors**

i. Vulnerability

Numerous factors that have been identified may predispose someone to Mood Disorder. These factors, while not directly causing depression or other disorders, reduce a person's psychological resources (eg: self-esteem) making it more difficult for the person to cope with problems when they do arise.

- **Personality :** It has been suggested that certain personality characteristics predispose one to abnormal affect. The major problem is a lifelong personality disturbance that, on occasion, breaks down into, say, Major Depression. For example : People who tend to be introspective, introverted, and dependent are more likely to be depressed.
- **Upbringing** : Past experiences in one's life can have a significant impact on one's current situation. Research has shown that various family characteristics are associated with Mood Disorders. For example, some of the things which are associated with vulnerability to depression include :
    - Parents who had their own psychological problems
    - An alcoholic family member
    - Loss of a parent or other important person
- **Learning** : It is thought that certain forms of depression may be due to a person having learned to be helpless. When they are confronted with difficulties and stress, they become depressed because they believe they have no control over the situation. In other words, their belief in their own helplessness predisposes them to develop depression.
- **Social factors** : A variable that is commonly found to be associated with Mood Disorder is the lack of an intimate, confiding relationship. Other factors that have been identified include the loss of a parent or sibling by death or separation before the age of 11, and unemployment.

ii. Provoking factors

One of the most commonly identified psycho-social «provoking agents» is stress. That is, when confronted with threatening situations or negative life events, a person who is already vulnerable to depression, is more likely to develop a disorder.

Examples of stress that may provoke a Mood Disorder include :

- Death of a friend, family member, etc.
- Illness/accident
- Important news, decisions, disappointment
- Burglary
- Illness/accident to others
- Role or job change
- Residence change

iii. Mediating factors

a) **Cognitive processes :** the most well researched psycho-social mediating factor is our cognitions and cognitive processes - our thoughts, beliefs, and memories. These factors have been shown to have a significant impact on things like the severity and duration of a disorder.

Cognitive processes include ***appraisal*** (how one appraises his or her experience will determine the nature of the emotional reaction), ***social Support*** (limited social support has been associated with numerous problems, such as depression, schizophrenia, and physical illness), ***memory*** (Our memories in general are biased in numerous ways and this can lead someone to develop Mood Disorders), ***network theory*** **(**network models of memory are typically proposed to account for these memory bias effects. So, if you think a sad thought, you increase the probability that you will think another sad thought, and so**)** and s**elf-Complexity** (in this theory, it is argued that the more qualities one uses in representing one's self the more able one is at avoiding or coping with depression and illness).

b) **Social Support :** The presence of others in a person's life who will support him or her during times of stress has been identified as a key buffer against the unhealthy consequences of stress. When someone must rely solely on their own resources, they are much less likely to cope effectively.

2) Biological Factors

There seems to be growing evidence that there may be at least two distinct types of depressive disorders : Type A and Type B.

Type A: Type A depression refers to a disorder with a genetic or biochemical basis. As such, we use the term «endogenous» (**caused from within**) to refer to this type of depression. The term «melancholia» overlaps significantly with the symptoms of endogenous depression. Research suggests the following distinguishing characteristics for endogenous depression (Akiskal, 1983):

- Tends to recur - acute episodes, severe
- May become psychotic, or switch to mania
- Hereditary background
- Once established, pursues autonomous course
- Abnormal hormone secretion

- Psychomotor disturbances
- Sleep disturbances : worse in morning, early morning wakening
- Marked weight loss
- Loss of ability to experience pleasure
- Favorable response to drug therapies
- Psycho-social provoking factors are absent or trivial

Type B: This type of depression refers, in general, to depression **externally caused**. It has been called exogenous, characterologic, personal, reactive and neurotic (Akiskal, 1983). We use the term reactive depression to highlight the presumed importance of environmental precipitating events. In other words, something occurs in the person's life, and he or she reacts to it. In this case, the reaction is depression.

Characteristics include:

- Chronic
- Less incapacitating
- Long-standing personality instability
- Reactive to environment
- Insomnia at beginning of sleep
- Variable prognosis
- More responsive to psychotherapy
- Precipitated by some event

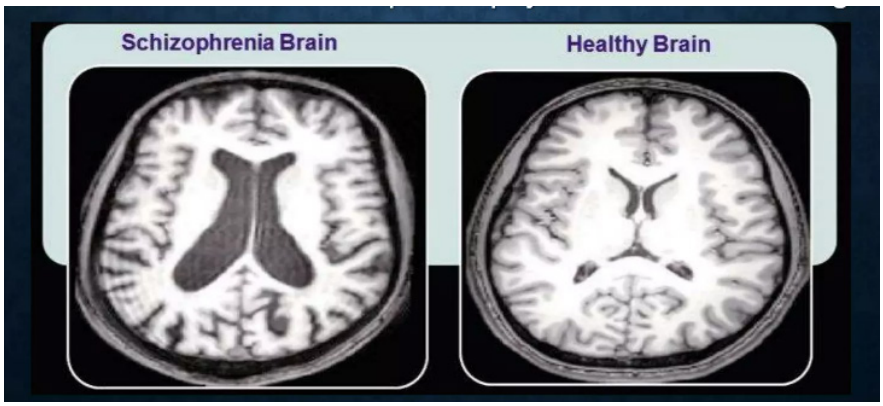
Application activity 7.7

1. Read the following two cases and write down the type of mood disorder described in each case study. Then after, provide the characteristics of each type.
   - **Case study 1:** a 32-year-old woman, periodically hospitalized because of her extreme moods, would become «overactive and exuberant in spirits and visited her friends, to whom she outlined her plans for reestablishing different forms of lucrative business. She purchased many clothes, bought furniture and rings without funds. She played her music until late in the night, smoked excessively, took out insurance on a car that she had not yet bought. Contrary to her usual habits, she swore frequently and loudly, (and) created a disturbance in a club to which she did not belong. On the day prior to her second admission to the hospital, she purchased 57 hats.

- **Case study 2:** «I was seized with an unspeakable physical weariness. There was a tired feeling in the muscles unlike anything I had ever experienced. My nights were sleepless. I lay with dry, staring eyes gazing into space...The most trivial duty became a formidable task. Finally, mental and physical exercises were impossible; the tired muscles refused to respond, my «thinking apparatus» refused to work, ambition was gone. My general feeling might be summed up in the familiar saying «What's the use.» I had tried so hard to make something of myself, but the struggle seemed useless. Life seemed utterly futile»

2. Provide examples of stress that may provoke a Mood Disorder.
3. Differentiate type A and type B of depressive disorders.

7. 8. Schizophrenia



Learning activity 7.7

Susan, a young woman, placed by her school in a class for the emotionally disturbed : She talked at length about her interests and occupations. She said she made a terrible robot from spare computer parts. The robot was going to cause great damage.

When pressed on details of how this worked, she became increasingly vague, and when asked to draw a picture of one of her inventions, drew a picture of luxurious car and went into what appeared to be complex mathematical calculations, but which in fact consisted of meaningless repetitions of symbols (eg: plus, minus, divide, multiply). When the interviewer expressed some gentle incredulity, she blandly replied that many people did not believe that she was a super genius.

She also talked about her unusual ability to hear things other people cannot hear, and said she was in communication with some sort of creature. She thought she might be haunted, or perhaps the creature was a being from another planet. She could hear his voice talking to her and asking her questions.

1. Write down all the unusual behaviors of Susan.
2. Explain the reasons why you think they are unusual.

7.8.1 Definition

Schizophrenia is the descriptive term for a group of psychotic disorders in which personal, social and occupational functioning deteriorate as a result of disturbed thought processes, strange perceptions, unusual emotional states, and motor abnormalities. It is a debilitating disorder. The social and psychological costs of schizophrenia are tremendous, both to patients as well as to their families and society. Schizophrenia is often termed psychotic to distinguish it from the milder «neurotic» disorders (Anxiety and Mood disorders). Schizophrenia affects all areas of functioning : thought, perception, emotion, behavior. A Schizophrenic individual suffers from impairment in multiple areas of functioning.

7.8.2 Symptoms of schizophrenia

The symptoms of schizophrenia can be grouped into three categories : positive symptoms (i.e. excesses of thought, emotion, and behaviour), negative symptoms (i.e. deficits of thought, emotion, and behaviour), and psychomotor symptoms.

1. Positive symptoms

Positive symptoms are 'pathological excesses' or 'bizarre additions' to a person's behaviour. Delusions, disorganised thinking and speech, heightened perception and hallucinations, and inappropriate affect are the ones most often found in schizophrenia.

Many people with schizophrenia develop **delusions**. A delusion is a false belief that is firmly held on inadequate grounds. It is not affected by rational argument and has no basis in reality.

a) ***Delusion of persecution :*** Delusions of persecution are the most common in schizophrenia. People with this delusion believe that they are being plotted against, spied on, slandered, threatened, attacked or deliberately victimised.

b) ***Delusion of reference :*** People with schizophrenia may also experience delusions of reference in which they attach special and

personal meaning to the actions of others or to objects and events.

c) ***Delusion of grandeur :*** In delusions of grandeur, people believe themselves to be specially empowered persons.

d) ***Delusion of control :*** In delusions of control, people believe that their feelings, thoughts and actions are controlled by others.

People with schizophrenia may not be able to think logically and may speak in peculiar ways. These **formal thought disorders** can make communication extremely difficult. These include rapidly shifting from one topic to another so that the normal structure of thinking is muddled and becomes illogical (loosening of associations, derailment), inventing new words or phrases (neologisms), and persistent and inappropriate repetition of the same thoughts (perseveration).

Schizophrenics may have **hallucinations**, i.e. perceptions that occur in the absence of external stimuli.

- ***Auditory hallucinations*** are most common in schizophrenia. Patients hear sounds or voices that speak words, phrases and sentences directly to the patient (second person hallucination) or talk to one another referring to the patient as s/he (third person hallucination).
- ***Tactile hallucinations*** (i.e. forms of tingling, burning),
- ***Somatic hallucinations*** (i.e. something happening inside the body such as a snake crawling inside one's stomach),
- ***Visual hallucinations*** (i.e. vague perceptions of colour or distinct visions of people or objects),
- ***Gustatory hallucinations*** (i.e. food or drink taste strange),
- ***Olfactory hallucinations*** (i.e. smell of poison or smoke).

People with schizophrenia also show inappropriate affect, i.e. emotions that are unsuited to the situation.

2. Negative symptoms

Negative symptoms are 'pathological deficits' and include poverty of speech, blunted and flat affect, loss of volition (volition is explained as inadequate self-initiated behavior. Eg: inability to meet goals or complete tasks.), and social withdrawal. People with schizophrenia show **alogia** or poverty of speech, i.e. a reduction in speech and speech content. Many people with schizophrenia show less anger, sadness, joy, and other feelings than most people do. Thus, they have **blunted affect**. Some show no emotions at all, a condition known as flat affect. Also patients with schizophrenia experience **avolition**, or apathy and an inability to start or complete a course of action. People with this disorder may withdraw socially and become totally focused on their own ideas and fantasies.

3. Psychomotor symptoms

People with schizophrenia also show **psychomotor symptoms**. They move less spontaneously or make odd grimaces and gestures. These symptoms may take extreme forms known as **catatonia**. People in a **catatonic stupor** remain motionless and silent for long stretches of time. Some show **catatonic rigidity**, i.e. maintaining a rigid, upright posture for hours. Others exhibit **catatonic posturing**, i.e. assuming awkward, bizarre positions for long period of time.

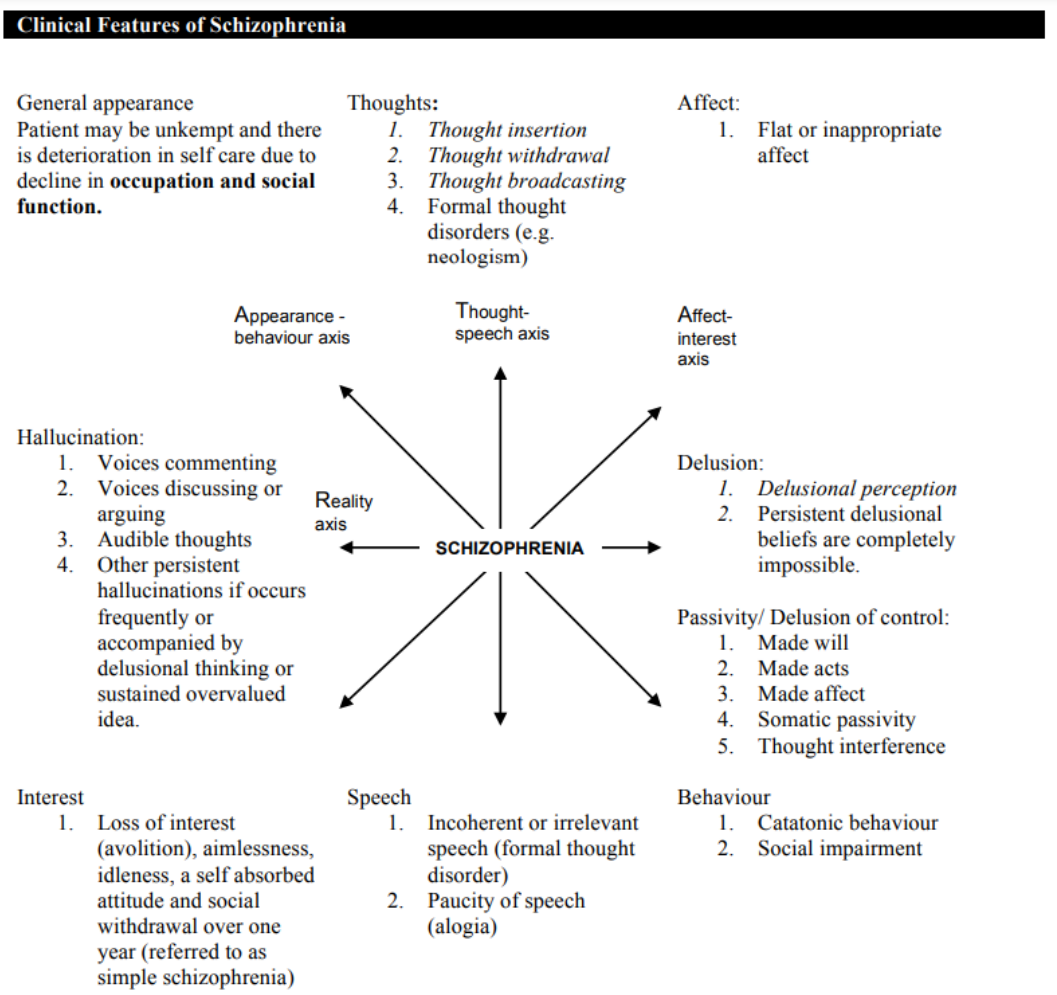


Figure : Clinical features of schizophrenia (Zhang, Cheok, Yeong, Cheng, Shakar, Sockalingam, Cheng & Ho, 2015, p. 22)

7.8.3 Sub-type of schizophrenia

According to DSM-IV-TR, the sub-types of schizophrenia and their characteristics are :

- **Paranoid type :** Preoccupation with delusions or auditory hallucinations; no disorganized speech or behaviour or inappropriate affect. For example, the individual may become extremely suspicious that everyone at work is trying to kill him, or that he possesses some profound or even divine powers. Hallucinations will often accompany these delusions, often reinforcing the false beliefs.
- **Disorganized type (previously known as hebephrenia) :** A particularly severe (although also less common) type of Schizophrenia, characterized by incoherent behaviors, thoughts, disorganized speech and behaviour ; inappropriate or flat affect ; no catatonic symptoms. There is extreme loosening of associations. The individual seems to become increasingly indifferent and infantile. Giggling, silliness, weeping, anger and other reactions inexplicable and inappropriate to the situation are common. In some cases, the incoherence progresses to the point where the person «makes no sense at all».
- **Catatonic type :** The essential feature is serious motor behavior disturbance. Such disturbance can take various forms : Stupor (marked decrease in responsiveness to environment, reduction in spontaneous movements, mutism); Negativism (resistance to all instructions or attempts to be moved); Rigidity (maintaining a rigid posture against all efforts to be moved); Excitement (purposeless and excited activity and movements); Posturing (voluntary assumption of inappropriate or bizarre postures, often for extended periods of time).
- **Undifferentiated type:** A «waste basket» category, for those individuals who do not fit neatly into the other categories, but who do show prominent psychotic symptoms (delusions, hallucinations, incoherence, grossly disorganized behavior).
- **Residual type:** Has experienced at least one episode of schizophrenia; no positive symptoms but shows negative symptoms. Nevertheless, the individual still exhibits signs of disorder (eg: marked social isolation or withdrawal, peculiar behavior, inappropriate affect, illogical thinking, mild loosening of associations).

7.8.4 Etiology of schizophrenia

The exact causes of schizophrenia are unknown. Research suggests a combination of physical, genetic, psychological and environmental factors can make a person more likely to develop the condition.

Some people may be prone to schizophrenia, and a stressful or emotional life event might trigger a psychotic episode. However, it's not known why some people develop symptoms while others do not.

A. **Increased risk**

- **Genetics:** Schizophrenia tends to run in families, but no single gene is thought to be responsible. It's more likely that different combinations of genes make people more vulnerable to the condition. However, having these genes does not necessarily mean you'll develop schizophrenia.

  Evidence that the disorder is partly inherited comes from studies of twins. Identical twins share the same genes. In identical twins, if a twin develops schizophrenia, the other twin has a 1 in 2 chance of developing it, too. This is true even if they're raised separately. In non-identical twins, who have different genetic make-ups, when a twin develops schizophrenia, the other only has a 1 in 8 chance of developing the condition.

  While this is higher than in the general population, where the chance is about 1 in 100, it suggests genes are not the only factor influencing the development of schizophrenia.

- **Brain development:** Studies of people with schizophrenia have shown there are subtle differences in the structure of their brains. These changes are not seen in everyone with schizophrenia and can occur in people who do not have a mental illness. But they suggest schizophrenia may partly be a disorder of the brain.

- **Neurotransmitters:** Neurotransmitters are chemicals that carry messages between brain cells. There's a connection between neurotransmitters and schizophrenia because drugs that alter the levels of neurotransmitters in the brain are known to relieve some of the symptoms of schizophrenia. Research suggests schizophrenia may be caused by a change in the level of 2 neurotransmitters: dopamine and serotonin. Some studies indicate an imbalance between the 2 may be the basis of the problem. Others have found a change in the body's sensitivity to the neurotransmitters is part of the cause of schizophrenia.

- **Pregnancy and birth complications:** Research has shown people who develop schizophrenia are more likely to have experienced complications before and during their birth, such as: **(a)** a low birthweight**, (b)** premature labour **and, (c)** a lack of oxygen (asphyxia) during birth. It may be that these things have a subtle effect on brain development.

B. **Triggers**

Triggers are things that can cause schizophrenia to develop in people who are at risk. These include:

- **Stress:** The main psychological triggers of schizophrenia are stressful life events, such as bereavement, losing your job or home, divorce, the end of a relationship, physical, sexual or emotional abuse, etc. These kinds of experiences, although stressful, do not cause schizophrenia. However, they can trigger its development in someone already vulnerable to it.
- **Drug abuse:** Drugs do not directly cause schizophrenia, but studies have shown drug misuse increases the risk of developing schizophrenia or a similar illness. Certain drugs, particularly cannabis, cocaine, or amphetamines, may trigger symptoms of schizophrenia in people who are susceptible. Using amphetamines or cocaine can lead to psychosis, and can cause a relapse in people recovering from an earlier episode. Research has shown that teenagers and young adults who use cannabis regularly are more likely to develop schizophrenia in later adulthood.

7.8.5 Integrated treatment of schizophrenia

Schizophrenia is caused by complex interactions between biological, genetic and environmental factors; as a consequence, patients affected by the disorder should receive integrated treatments that include drugs and psychosocial therapy, care of physical health and treatment of comorbidities. In general, drugs are administered in the initial phases of schizophrenia when symptoms lead to an individual to consult psychiatric services. Thus, the psychiatrist should be part of a multidisciplinary team, composed of mental health professionals and other medical specialists, as well as providers of social services and other relevant entities (e.g. authorities who organise housing and employment).

Treatment with antipsychotics

Antipsychotics are a fundamental element of treatment of schizophrenia. Undoubtedly, they are very effective in reducing the positive symptoms of schizophrenia. Clinical studies have consistently demonstrated that antipsychotics reduce positive symptoms such as delirium and hallucinations. Behavioral symptoms such as hostility and aggression are common in schizophrenia, and there is evidence that these symptoms are susceptible to antipsychotic drugs.

However, at present, the available antipsychotics have significant limitations ; in particular, negative symptoms and cognitive alterations are not treated adequately, and many patients continue to present persistent psychotic symptoms. In addition, the lack of insight that accompanies schizophrenia is a partially unsolved problem.

Table five : Potential benefits and limitations of antibiotic medication

Benefits	Limitations
Reduction of positive symptoms	Limited efficacy against negative symptoms
Treatment of acute episodes	Inadequate treatment of cognitive impairment
Reduced risk of relapse	Troubling side effects or tolerability issues
Provision of stability and platform for other treatments	Low acceptability to some patients ▪ Poor adherence ▪ Negative perceptions
Reduction of aggression and hostility	
Reduced suicidal behaviors	

Source : Altamura, A. C., Fagiolini, A., Galderisi, S., Rocca,P. & Rossi, A. (2015, p. 169). Integrated treatment of schizophrenia. *Journal of Psychopathology*, 21:168-193.

Psychosocial therapies

Therapies have the aim of improving the functioning of the patient in the community, which can also lead to clinical improvement, such as a reduction in the number of relapses or hospitalisations. The use of psychosocial therapies is supported by substantial evidence ; these include cognitive behavioral therapy (CBT) for psychosis, in addition to cognitive remediation and functional skills training. Schizophrenia associated disabilities often involve several areas, and psychosocial therapies can be combined to confront a range of problems. For example, social skills training can be used as part of an integrated program that includes family psychoeducation, cognitive remediation and CBT.

Table six : Potential benefits of psychosocial therapies

Intervention	Potential benefits
• Assertive community treatment	• Reduction in rates of homelessness and length of hospital stays
• Cognitive behavioral therapy for psychosis	• Decreases in both positive and negative symptoms and mood disturbances, and improved social functioning
• First episode intervention for psychosis	• Improvements in quality of life, social functioning and adherence
• Cognitive remediation	• Improvements in cognition and psychosocial functioning
• Family psychoeducation	• Some improvement in social functioning and family coping and empowerment

• Peer support and illness self-management training	• Enhancement of empowerment and ability to cope with the illness
• Social skills training	• Improvements in social functioning
• Supported employment	• Increases in employment rates, hours worked and wages earned. Gains in self-esteem and quality of life
• Integrated treatment for coexisting substance abuse disorder	• Reductions in substance use and arrests; improved functioning

Source: Altamura et al. (2015)

Application activity 7.7.

1. Explain the three categories of symptoms of schizophrenia.
2. Categorize the sub-type of schizophrenia.
3. People who believe themselves to be specially empowered persons have developed a type of delusion called:
   a) Delusion of persecution
   b) Delusion of reference
   c) Delusion of grandeur
   d) Delusion of control
4. These days, Mukamwiza hear sounds or voices that speak words, sentences, phrases and sentences to her. She is suspected to have :
   a) Visual hallucinations
   b) Auditory hallucinations
   c) Somatic hallucinations
   d) Olfactory hallucinations
5. What is meant by (a) avolition, (b) alogia ?
6. Provide examples of (a) catatonic rigidity. Examples : maintaining a rigid, upright posture for hours. (b) catatonic posture : Example : assuming awkward, bizarre positions for long period of time.
7. Provide at least 2 triggers of schizophrenia

7. 9. Psychosexual disorders

Learning activity 7.9

This time next week, I will be marking my second anniversary in starting a new life--and living a new dream -- in Kigali. I have been to France just once, for all of three weeks. Yet those 20 days were the happiest days of my life. For the first time in a long, long time (the only other time being in Nairobi, Kenya), I experienced true freedom -- the freedom to be myself, without having to suffer the backward glances, the rude remarks and the incessant gossips. But see, here's the thing. I'm gay. I'm not ashamed of it, not by a long shot.

Question : Assume that this person comes to see you as a patient. You discover that he is gay during history taking and that he faces a lot of stress. What is your view as a doctor?

7.9.1 Introduction

Sex is an important part of our lives but often much confusion about what is really going on during sex. It is easy for sex to get less exciting ; repetitious and understanding biological processes can help find ways to avoid this. The best way to develop a healthy attitude towards sex is to demystify it - sex is very private but something we all do after a certain age so knowledge can be beneficial. Sexual problems that are psychological in origin, rather than physiological, are called psychosexual disorders.

7.9.2 Definition

Psychosexual disorders are defined as **the sexual problems that are psychological in origin and occur in absence of any pathological disease**. They often arise because of physical, environmental, or psychological factors, and at times it is difficult to separate one from the other.

The psychological component may be predominant in psychosexual disorders ; however, sometimes one condition may lead to another, for example, erectile dysfunction (ED) caused by diabetes may cause depression, which may then lead to hypoactive sexual desire. They may arise due to guilt, stress, anxiety, nervousness, worry, fear, depression, distorted body image, physical or emotional trauma, abuse, and rape. In addition, ignorance, misinformation, superstition, and improper sex education contribute toward these disorders.

Sometimes conflict of values arises between sexual feelings during adolescence and those that are represented by family or religion (for example, the attitude that sex is dirty, sinful, or a shame). Marital discord can also act as a trigger for

psychosexual disorders. Symptoms of psychosexual disorders vary with gender and are different for everyone, and sometimes they may not conform to the different categories mentioned in the literature. They may be categorized as sexual dysfunctions, paraphilias, and gender identity disorders. In this review, we will discuss the etiology and management of common sexual disorders and the role of dermatologists in the management of such disorders.

7.9.3 The orgasm : The peak of sexual pleasure

It is generally acknowledged that the orgasm is the peak of sexual pleasure. However, the orgasm itself is a part of a four-stage sexual response cycle. Using physiological recording devices and motion picture cameras, the physician William H. Masters and the psychologist Virginia E. Johnson studied the actual sexual responses of volunteer subjects (Frnak, 2002).

Here are the four stages of the sexual response cycle : (1) excitement, (2) plateau, (3) orgasm, and (4) resolution. **Excitement** is characterized by increases in blood pressure, pulse, and respiration rate. The individual is highly responsive to erotic stimulation. This varies greatly, of course, from person to person, and is largely a matter of individual differences, perception, and sexual preferences. In males, the penis becomes erect. In females, the clitoris swells in size. In general, there is an intensified flow of blood to the genital area.

During the stage of **plateau**, prior increases in physiological activity are maintained at a more or less constant level. In males, the penis becomes somewhat larger. In females, the clitoris retracts a little. The variation in the time associated with the plateau stage is considerable. The stage can last two minutes, twenty minutes, or more. Some of this is under the control of the individual. Plateau can be shortened or increased based on voluntary responses, responses that aim to diminish or amplify the momentary intensity of erotic stimulation.

The **orgasm** is an involuntary response in both sexes. Although it can be induced by sexual behavior, it cannot be directly willed. Brief in duration, it is experienced as intensely pleasurable. Blood pressure and similar measures increase in intensity. In the male, there is an ejaculation accomplished by compressor muscles in the penis. In the female, there are waves of contractions in the pubococcygeus (PC) muscle, a muscle surrounding the channel of the vagina.

During the stage of **resolution,** the individual becomes temporarily unresponsive to sexual stimulation. Stimulation that had erotic value only a few minutes ago has no capacity to induce excitement. Blood pressure and other physiological measures decline. The duration of the stage of resolution varies from individual to individual. For some individuals in some instances, it may last for only a few minutes. For others, the duration may be twenty minutes, an hour or two, or longer.

One of the important findings associated with the Masters and Johnson research is that some individuals are capable of multiple orgasms (Frank, 2002). **Multiple orgasms** take place when a person has an orgasm, remains excited (or possibly experiences the resolution stage very briefly), and has at least one more orgasm. It is necessary to speak of the sexes separately when discussing multiple orgasms. Women have substantially greater multiorgasmic capacity than do men. Women who have second and even third orgasms report them to be more pleasurable than the first orgasm. It is estimated that about 15 percent of women sometimes have multiple orgasms.

Sexual dysfunction

A sexual dysfunction exists when the sexual response cycle manifests one of its stages in an abnormal, unsatisfactory manner. The word dysfunction means, loosely, "working wrong." The various sexual dysfunctions are characterized by such problems as lack of sexual desire, inability to become sexually excited, inability to attain an orgasm, and other related problems. Either sex can be troubled with a sexual dysfunction.

Sexual disorders can be divided into problems of desire, arousal, and function ; however, these problems are often interlinked to each other (Narang, T., Garima, Singh S.M., 2016). For example, impaired sexual function, such as some degree of erectile dysfunction, can cause hypoactive sexual disorder in men. Similarly, dyspareunia in females can cause hypoactive sexual disorder or anorgasmia. Sexual desire is regularly expressed in all individuals ; however, it may be decreased in frequency in patients suffering from chronic illnesses such as heart disease, cerebrovascular trauma, hemiplegia, or any other major surgery.

7.9.4 Male sexual dysfunction

There are three sexual dysfunctions associated primarily with males : (1) male erectile disorder, (2) premature ejaculation, and (3) male orgasmic disorder.

(i) **Erectile dysfunction (ED)**

Male erectile disorder exists when the male is either unable to attain an erection at all or is unable to attain an erection that is sufficient to complete an act of sexual intercourse. An older term for this disorder, now considered to be somewhat out of date, is **impotence**, meaning "lack of power." Psychogenic ED may be attributed to stress in relationship, performance anxiety, decreased self-esteem, stress or shame arising due to chronic or infective dermatological diseases, such as genital vitiligo and herpes, or overt psychological disorders such as depression and anxiety.

Therapy : Treatment modalities include lifestyle modification, psychosexual therapy, injection therapies, testosterone therapy, and penile devices. In patients with significant psychological problems, psychosexual therapy such as sex education, and interpersonal therapy can be tried.

(ii) Premature ejaculation (PE)

It exists when the span of time between excitement and orgasm is overly brief. There is no precise definition of "overly brief." In general, if a male attains his orgasm before a female is able to attain hers, both the duration and the outcome of sexual intercourse are considered to be unsatisfactory to both participants. It can cause severe psychological distress, reduced self-esteem, anxiety, and depression, significantly impairing the quality of life for the patient as well as his partner.

Etiology :

- Robust cortical representation of the pudendal nerve,
- Hypersensitivity of the glans penis,
- Disturbances in central serotonergic neurotransmission
- Medications, recreational drugs, and
- Thyroid disorders.

Management :

Management of PE is complex and requires a combination of pharmacological, psychological, and behaviors treatments. Various behaviors changes include :

- Semans' "stop-start" technique (ceasing genital stimulation until heightened arousal sensation subsides) and
- Masters and Johnson's "squeeze technique" (where the glans is squeezed at heightened arousal).
- The use of multiple condoms and pelvic floor exercises.
- Use of drugs have been shown to improve ejaculatory control and reduce personal distress.

(iii) Male orgasmic disorder

Male orgasmic disorder exists when the male is unable, after both excitement and a sustained period of plateau, to attain an orgasm. This dysfunction is also known as retarded ejaculation.

(iv) Male hypoactive sexual desire disorder

The DSM-V diagnosis of Hypoactive Sexual Desire Disorder (HSDD) requires that two criteria be met : (1) **Criterion A:** Persistent or recurrent deficient (or absent) sexual fantasies and desire for sexual activity; and (2) **Criterion B:** The disturbance causes marked distress or interpersonal difficulty. Prevalence studies on low desire in men have mostly found a positive correlation with age.

Men with HSDD are more likely to have depressed mood as well as hyperprolactinemia, suggesting that these factors may exert a greater influence on men's desire than testosterone. HSDD patients experiences greater stress at work, had more disturbed domestic relationships, and had a higher relational component, which is defined as having a partner with an illness that negatively affects sexual activity, having a partner with low desire, and/or having a menopausal partner. **Treatments** that increase testosterone levels have been tried with variable results.

(v) Somatoform disorders

These are complex psychosomatic disorders in which sociocultural factors play an important role. The two important disorders are the Koro syndrome and Dhat syndrome.

- **The Koro syndrome** is characterized by episodes of sudden and intensive fear that the penis could be drawn back into the body and possibly causes death. This fear often occurs as a mass phenomenon in which many men hold onto their penis or try to prevent the presumed event by placing wooden tongs on their penis.
- **Dhat syndrome** : Dhat syndrome is a culture based phenomena characterized by preoccupation of loss of semen, usually in a young man, during micturition, defecation, or in night falls. The preoccupation of loss of semen is also associated with vague and multiple somatic and psychological complaints such as fatigue, listlessness, loss of appetite, lack of physical strength, poor concentration, and forgetfulness. Some patients may have accompanying anxiety or depressive symptoms and sexual dysfunction, which are usually psychological in nature. The patients usually attribute all their symptoms (somatic symptoms and sexual dysfunction) to the passage of semen.

  Management : At present, there is very little research on the treatment of Dhat syndrome. Few studies have reported that benzodiazepines, antidepressants, and psychotherapy could be beneficial. Medical and sexual education are also recommended.

7.9.5 Female sexual dysfunction

There are three sexual dysfunctions associated primarily with females:(1) female sexual arousal disorder, (2) female orgasmic disorder, and (3) vaginismus.

(i) **Hypoactive sexual desire disorder**

Female sexual arousal disorder exists when the female does not respond to the kind of stimulation that is otherwise expected to induce excitement. An older term for this disorder, now considered to be obsolete, is **frigidity**. The female may herself be either surprised or distressed by the inability of her partner's efforts to bring forth the first stage of the sexual response cycle.

(i) **Female orgasmic disorder**

Female orgasmic disorder exists when the female is seldom, or never, able to attain an orgasm during sexual activity. A female suffering from the disorder often experiences a normal level of excitement. This leads to a prolonged plateau period, and then excitement subsides without the satisfaction of an orgasm. The individual feels she was on the verge of an orgasm, but it can't seem to be triggered. Females regularly report the experiences associated with the disorder to be frustrating and disconcerting.

(ii) **Vaginismus**

Vaginismus exists when the muscle associated with the vaginal entrance cramps, making entry into the channel both difficult and painful. The causal factors associated with the female disorders include poor health, chronic fatigue, hormonal imbalances, anxiety, feelings of guilt and shame, disgust with sexual activity, fear of pregnancy, an unresolved Oedipus complex, emotional conflicts, boredom with a particular partner, and hostility toward a particular partner. The factors both overlap and interact. When physicians and therapists treat a sexual disorder, the individual history of a particular patient must be taken into account. There is no one general, sweeping explanation for a particular person's suffering.

7.9.6 Dysfunctions affecting either sex : When desire is absent

There are three dysfunctions that affect either sex. These are: (1) hypoactive sexual desire disorder, (2) sexual aversion disorder, and (3) dyspareunia.

(1) **Hypoactive sexual desire disorder** exists when the individual's desire for sex is absent. He or she neither fantasizes about sexual relations nor seeks sexual contact as a goal. A term frequently used in psychoanalysis and psychiatry for this condition is **loss of libido**. Psychosexual energy is simply not present. In the vast majority of cases, hypoactive sexual desire disorder is preceded by a sustained period of normal sexual desire.

(2) **Sexual aversion disorder** exists when the individual finds the thought of sexual relations revolting, disgusting, or nauseating. The individual may think of sexual intercourse as "dirty" or "messy." Sexual aversion disorder may be present from early adolescence. Or, in other cases, it may follow a sustained period of normal sexual attraction.

(3) **Dyspareunia** exists when sexual intercourse is painful. In the case of females, vaginismus, already noted, can be a factor in dyspareunia. In the case of males, thickening of the fibrous connective tissue within the penis, which induces the erect penis to bend at an angle, can be a cause of dyspareunia. In either sex, genital infections, often associated with sexually transmitted diseases, can play a role in dyspareunia.

7.9.7 Sexual Variance : Of Fetishes and Voyeurism

The term sexual variance is used to characterize sexual behaviors that are statistically deviant. This means only that these are behaviors that most people do not engage in. Statistical variance does not necessarily imply pathology, meaning sickness. A person who exhibits a form of sexual variance may be emotionally troubled or suffer from a mental disorder, but not necessarily.

The classical term for the behaviors identified in this section is **paraphilias**. This term comes from Greek roots meaning, roughly, "love on the edge" or "love on the borderline." This term is still employed widely in both psychiatry and general psychology. Here are the principal paraphilias, or kinds of sexual variance, that will be identified in this section : (1) bestiality, (2) exhibitionism, (3) fetishism, (4) incest, (5) masochism, (6) pederasty, (7) pedophilia, (8) sadism, (9) sodomy, (10) transsexualism, (11) transvestic fetishism (transvestism), and (12) voyeurism. A discussion of the relationship between homosexual behavior and sexual variance will be included toward the end of the section.

(i) Bestiality

Bestiality refers to sexual contact between a human being and an animal. Another term for this kind of behavior is **zoophilia**. Although about 2 to 3 percent of females and about 6 to 8 percent of males report at least one sexual contact with an animal, overall sexual contact with animals tends to be low—probably less than 1 percent.

(ii) Exhibitionism

Exhibitionism is characterized by sexual excitement associated with the voluntary exposure of one's body, including the genitals. The large majority of exhibitionism is associated with the self-exposure of a male to a female stranger. A common pattern is exhibition with simultaneous masturbation.

(iii) **Fetishism**

Fetishism is characterized by the use of an inanimate object such as a stocking, a pair of underwear, or a shoe as a sexual stimulus. A person who manifests fetishism finds the object capable of inducing sexual excitement. A relatively common practice is to masturbate in association with the object.

(iv) **Incest**

Incest refers to sexual relations with a close relative such as a parent or a sibling. In Rwandan culture, the most common form of incest is the mother and son. The next most common is father and daughter. The least common is between siblings. Although a sexual relationship between, for example, a stepfather and a stepdaughter does not qualify as biological incest, it may qualify as psychological incest, meaning that the emotional aspects of the behavior resemble those associated with incest in general. It is the forbidden aspect of incest that formed the core of Freud's concept of the Oedipus complex.

(v) **Masochism**

Masochism refers to extracting sexual pleasure from physical or psychological pain. The term masochism is derived from the writings of the nineteenth century Austrian novelist Leopold V. Sacher-Masoch. A person with masochistic tendencies sometimes requires physical pain or insults as a condition for reaching an orgasm. Masochism is somewhat more common in women than in men.

(vi) **Pederasty**

Pederasty refers to homosexual relations between an adult male and a prepubertal male. Sometimes the term us used to refer to male homosexual relations in general ; however, this is not correct. Also, pederasty carries the implication that anal intercourse is a component of the sexual behavior. Pederasty is related to pedophilia (see below).

(vii) **Pedophilia**

Pedophilia is characterized by the sexual attraction of an adult to a prepubertal child. Although the term can be used to apply to an adult who engages in fantasies containing children, it is more commonly applied to adults who act upon their desires. An adult who manifests pedophilia is sometimes referred to as a pedophile.

(viii) **Sadism**

Sadism refers to inflicting psychological or physical pain on another person in association with sexual gratification. The term sadism is derived from the literary works of the eighteenth-century author Donatien Alphonse François, the

Marquis de Sade. He described sexual relations that included general abuse of a partner, including insults, chaining, and whippings. It should be noted that a sexual relationship can be **sado-masochistic**, meaning that one partner manifests primarily sadistic tendencies and the other partner manifests primarily masochistic tendencies. Such a relationship is often relatively stable because each partner meets the other one's needs.

(ix) Sodomy

Sodomy refers to sexual practices thought by a given society or culture to be in violation of natural behavior patterns. The term comes from the biblical city Sodom, a community that was removed from the face of the Earth because of the wickedness of its inhabitants. In practice, the term sodomy is usually used to refer to the practice of anal intercourse. Less frequently, sodomy is used to make a reference to bestiality.

(x) Transsexualism

Transsexualism is characterized by a strong desire to become a person of the opposite sex. The individual is unhappy with his or her own biological gender, and often fantasizes about the emotional and sexual gratification that would be obtainable if only it were possible to experience a transformation of body and self. The American Psychiatric Association's diagnostic manual classifies transsexualism as a gender identity disorder. The term gender identity disorder refers to a state of dissatisfaction with one's own biological gender, and, consequently, has approximately the same meaning as transsexualism. Treatment consists of psychotherapy and, more infrequently, sex reassignment surgery.

(xi) Transvestic fetishism (transvestism)

It is characterized by dressing in the clothing of the opposite sex (i.e., cross-dressing). (The root "vest" refers to clothing.) A person who manifests transvestic fetishism finds cross-dressing to be sexually exciting. This kind of fetishism should not be confused with transsexualism. Transvestic fetishism usually has a heterosexual orientation, and the individual who practices it does not have a desire to become a member of the opposite sex.

(xii) Voyeurism

Voyeurism is characterized by using a visual stimulus as a primary way to induce sexual excitement. Examples of visual stimuli include a photograph, a videotape, or an actual person. A common practice is to masturbate in association with the stimulus. If a partner is present, masturbation may take the place of sexual intercourse. A certain amount of gratification in connection with looking is standard sexual practice. However, if an individual usually prefers visual stimulation over physical contact, then the individual is manifesting voyeurism. Secret viewing is frequently a component of voyeurism.

7.9.8. Homosexuality and Lesbianism

Homosexual behavior is no longer listed as a kind of sexual variance or paraphilia. In older editions of the American Psychiatric Association's diagnostic manual, it was listed. In the current manual, it is not. Homosexual behavior is characterized by sexual relations with a member of the same sex. The term can be applied to both male and female behavior. However, lesbianism refers exclusively to female homosexual behavior. (The term is derived from Lesbos, a Greek island. It is legend that in the sixth century B.C. the writer Sappho and her followers, residents of the island, practiced homosexual behavior.)

Application activity 7.9

1. **Categorize the sexual dysfunctions of male and female in this table.**

Male sexual dysfunctions	Female sexual dysfunction

2. What are the other names attributed to : a) Erectile dysfunction ? b) Hypoactive sexual desire disorder for a female ?
3. What are the three dysfunctions that affect either sex ?
4. When does hypoactive sex desire disorder exist ?
5. What is meant by dyspareunia ?
6. Which term do we use to characterize sexual behaviour that are statistically deviant?

7. 10. Psychosocial deviances

Learning activity 7.10

A forty-five-year-old man in one of the districts of Rwanda allegedly murdered his wife and the man was arrested by the police. The police found that the man chopped the body of his wife into pieces and dipped them into a lake to dispose of them for some time. The body parts were found in 2 sacks as well as sharp-edged weapons used in cutting the body at his house. Sources say he was not scared of having killed his wife, but still, nobody could imagine how he managed to kill his wife, the mother of his children. The case has shocked Rwandans especially people in that district.

1. Is this story an imaginary story or real story ?
2. Are you shocked by the story ? What shocked you ?
3. Using 1 word, how can you describe this man ?
4. Have you ever heard other similar stories ? Explain.

7.10.1 Introduction

This category regroups anti-social personality disorders mostly characterised by anti-social behaviours. In this topic we start by explaining the anti-social behaviour and their typology. The two most types of psychosocial deviances (psychopathy and sociopathy) will be explained with details.

7.10.2 Definition of anti-social behaviour

The subjective nature of the concept makes it difficult to identify a single definition of anti-social behaviour. What may be considered anti-social behaviour to one person can be seen as acceptable behaviour to another. To overcome this issue, we propose two important definitions of anti-social behaviour.

Antisocial behavior is a description for all behaviors, attitudes, and personality traits that people engage in that appear to be dysfunctional, in that they often have negative interpersonal and societal outcomes (Hashmani & Jonason, 2017). The Crime and Disorder Act definition (1998) cited in Home Office (2004, p. 1) defines anti-social behaviour as 'Acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as (the defendant).'

7.10.3 Typology of antisocial behaviour

Although there are many types of anti-social behaviour, in this lesson, we will describe the two most known types of anti-social behaviour: Psychopathy and Sociopathy. But before describing these two main types let us have a look at the typology of antisocial behaviour. The list of all anti-social behaviour is not exhaustive. You can add to it any behaviour that is judged anti-social by people in your region.

Table : Typology of anti-social behaviour

Misuse of public space	Disregard for community/ personal well-being	Acts directed at people	Environmental damage
1. Drug/substance misuse & dealing : • Taking drugs • Sniffing volatile substances • Discarding needles/drug paraphernalia • Crack houses • Presence of dealers or users	**1. Noise** • Noisy neighbours • Noisy cars/ motorbikes • Loud music • Alarms (persistent ringing/ malfunction) • Noise from pubs/ clubs • Noise from business/ industry	**1.Intimidation/ harassment** • Groups or individuals making threats. • Verbal abuse • Bullying • Following people • Pestering people • Voyeurism • Sending nasty/ offensive letters • Obscene/ nuisance phone calls • Menacing gestures ***Can be on the grounds of***: Race, Sexual orientation, Gender, Religion, Disability Age	**1. Criminal damage/ vandalism** • Graffiti • Damage to bus shelters • Damage to phone kiosks • Damage to street furniture • Damage to buildings • Damage to trees/plants/ hedges

2. Street drinking	**2. Rowdy behaviour** • Shouting & swearing • Fighting • Drunken behaviour • Hooliganism/ loutish behaviour		**2. Litter/rubbish** • Dropping litter • Dumping rubbish • Fly-tipping • Flyposting
3. Begging	**3 Nuisance behaviour** • Urinating in public • Setting fires (not directed at specific persons or property) • Inappropriate use of fireworks • Throwing missiles • Climbing on buildings • Impeding access to communal areas Games in restricted/ inappropriate areas • Misuse of air guns • Letting down tyres		
4. Prostitution • Soliciting • Discarded condoms	**5. Hoax calls** • False calls to emergency services		

5. Kerb crawling • Loitering • Pestering residents	**6. Animal-related problems** Uncontrolled animals		
6. Sexual acts • Inappropriate sexual conduct • Indecent exposure			
7. Vehicle-related nuisance & inap-propriate vehicle use • Inconvenient/ illegal parking • Car repairs on the street/in gardens • Setting vehicles alight • Joyriding • Racing cars • Off-road motor-cycling • Cycling/ska-teboarding in pedestrian areasfootpaths			

Source: Home office (2004, p. 4)

Hashmani and Jonason summarizes the anti-social behaviour in a table below

Table: A summary of ten common antisocial behaviors and their hypothetical adaptive costs and benefits

Antisocial behaviors	Cost	Benefits
Aggression	Possibility of death from injury. Possibility of incarceration leads to being relinquished from society and, thus, reproductive opportunities.	Increases attention from the opposite sex – seen as "competent." Means of gaining power and having increased access to resources and potential mates
Bullying	Lack of mutual relationships formed – loss of protection/support if in danger or need of resources.	Rising to the top of social hierarchies by gaining popularity. Reduces competition from others for desired resources. Develops physical self-protection from one's "tough" appearance.
Casual/exploitive sex	Increased risk of disease. Passing on poor/unwanted genes.	Increased reproductive outlets. More offspring.
Deception	If discovered as a liar, one may be socially shunned and ostracized by society.	Self-deception: we deceive ourselves to protect against attacks to our happiness and well-being. Deceiving others is a means to achieving one's goals, at the expense of others' success.
Domestic violence	Possible repercussions or attacks by other members of society. Possible physical injury from victim.	Means of keeping one's reproductive partner, rather than spending resources looking for another mate.
Future discounting/impulsivity	Long-term needs and desires possibly ignored. May have chosen a smaller reward, rather than waiting for a larger reward (i.e., less gain if ignoring future discounting).	Short-term/immediate gains. If limited quantities of resources (e.g., scarce food), the impulsive individual will obtain the reward, while others fail.

Psychopathy	Lacks ability to create close connections with others – can be viewed as an outcast by society. Can scare off potential mates.	Lack of "normal" emotions (guilt and shame) can assist in selfish advantage. For example, these emotions can be disabling and mentally exhausting. Lack of empathy depersonalizes the victim and facilitates crime.
Prejudice/racism	Limits reproductive outlets to one's own race/social group. Limited options lead to less success and less possibilities to spread genes.	In social living, one must respond functionally to the affordances of others. In order to obtain cooperative groups, one must recognize outsiders with potential threats.
Substance use	Increased risk of death by substance abuse. Can lead to addiction, and, thus, one must allocate financial resources for more substances.	Substances lower one's inhibitions and fears. Can lower and mask physical or emotional pain.
Theft	Possible risk of attack by victim. Risk of incarceration.	Increased accumulation of resources and assets.

Source: Hashmani & Jonason (2017)

7.10.4 Antisocial Personality Disorder

Antisocial Personality Disorder (ASPD) is a disorder characterized as a pervasive pattern of disregard for, and violation of, the rights of others. This pattern should have begun in childhood or early adolescence and continued into adulthood. Individuals diagnosed with this disorder can exhibit a range of behaviors, including lack of remorse, social irresponsibility, deceitfulness, repeated, or frequent lying, lack of empathy, and aggressiveness, to name a few. People with this disorder also frequently engage in behavior that is illegal or lawbreaking, such as destruction of property, stealing, or harassment.

Despite their continued participation in illegal activities, ASPD-diagnosed individuals are not always in trouble with the police. This disorder has also been referred to as psychopathy or sociopathy. Antisocial personality disorder can only be diagnosed if the individual is 18 years or older, however they must have a history of displaying some of the symptoms of conduct disorder before this age, which then continue into adulthood.

Individuals with antisocial personality disorder repeatedly perform acts that go against societal norms and they may disregard or break the law on more than one occasion. They may engage in behaviour such as destroying property, physically assaulting or abusing others or theft. Individuals with this disorder typically lack empathy, and disregard the wishes, feelings or rights of others. They may also be manipulative or deceitful for either personal profit or pleasure.

Individuals with antisocial personality disorder typically display behaviour that is irresponsible, they may fail to plan ahead and may make impulsive decisions, and this can impact on their ability to keep a steady job. They may also show financial irresponsibility by incurring large debts or failing to provide financial support to dependents. Individuals with this disorder often also engage in spousal or child abuse and neglect. These individuals may justify or rationalize their behaviour towards others, for example by saying that they are just looking out for themselves, or that certain people deserve to be mistreated.

Common symptoms

1. Repeatedly performing acts that are against the law and are grounds for arrest. For example, destruction of property, theft or physical assault
2. Deceitfulness or manipulation. For example, repeatedly lying or conning others, whether for personal profit or pleasure
3. Impulsivity or failure to plan ahead
4. Aggression or irritability. For example, frequent physical fights or assaults on others
5. A reckless disregard the safety of others as well as personal safety
6. Frequent irresponsible behaviour. For example, the failure to keep a steady job, or the failure to meet financial obligations
7. A lack of remorse for negative behaviour. This may include a rationalisation or justification of the acts
8. The individual displayed symptoms of conduct disorder as a child/ adolescent

Causes :

There are a number of risk factors that could contribute to the development of antisocial personality disorder. Conduct disorder and attention deficit/ hyperactivity disorder in childhood increases the likelihood of developing the disorder as an adult. Childhood abuse and neglect may also increase the chances of conduct disorder developing into antisocial personality disorder. The disorder is also more common among first degree relatives of and individual with antisocial personality disorder. The prevalence of the disorder has also been found to be higher in areas of low socioeconomic status and urban settings.

7.10.5 Psychopathy

Definition

Psychopathy is a disorder marked by a constellation of maladaptive personality traits. It is a neuropsychiatric disorder marked by deficient emotional responses, lack of empathy, and poor behavioral controls, commonly resulting in persistent antisocial deviance and criminal behavior. Psychopaths are responsible for an inordinate proportion of crime committed, and their conning manipulative interpersonal style typically has a broad, destructive impact on an individual's life, work, and relationships (Dennis E. Reidy, 2013).

What is Psychopathic ?

It is a chronic condition in which the violent behavior or abnormal behavior a person might suffer from and can lead to criminal behavior or illegal things that are against society's norms or legal justice system (Fitzgerald, 2020).

Checkley's list of psychopathic characteristics:(Cristina Crego, 2015)

- Untruthfulness and insincerity.
- Unreliability.
- Pathological egocentricity and incapacity for love.
- Suicide is rarely carried out.
- Absence of "nervousness" or psychoneurotic manifestations.
- Superficial charm and good intelligence.
- Absence of delusions and other signs of irrational thinking.
- Lack of remorse and shame.
- Inadequately motivated antisocial behavior.
- Poor judgment and failure to learn by experience.
- General poverty in major affective reactions.
- Specific loss of insight.
- Unresponsiveness in general interpersonal relations.
- Fantastic and uninviting behavior with drink and sometimes without.
- Failure to follow any life plan.

Signs and Symptoms of Psychopaths :

- Manipulating others and can manipulate emotions.
- Liars and cheaters.
- Lack of emotions.
- They are impulsive and tend to blame others for being responsible for it.

- Less responsible.
- Lack of goals in life.
- They usually have a parasitic lifestyle.
- Can involve in criminal offenses. (Lynam, 1998)

Causes which lead to become Psychopaths :

- Genetic heritance
- Environment and surroundings
- Brain injury

7.10.4 Introduction to Sociopathy

Understanding the term sociopath

Sociopath is a term used to describe someone who has antisocial personality disorder (ASPD). People with ASPD can't understand others' feelings. They will often break rules or make impulsive decisions without feeling guilty for the harm caused. Sociopaths may also use "mind games" to control people around them and even strangers. They may also be perceived as charismatic or charming.

What Does the Term Sociopath Stands for ?

The person showing the least interests in socializing showing antisocial behavior around is generally categorized under sociopath. It can be caused by any trauma experienced early in their life or some unpleasant or unexpected experiences that caused them to be sociopaths or antisocial. (Crystal, 2020) What is Sociopathic ? It is also known as Antisocial Personality Disorder. Sociopathic is classified under mental disorders, in which a person may tend to overlook the right and wrong or sometimes feelings of others or can treat others harshly and showing no guilt for their behavior.

Some traits of sociopaths (Perry, 2015)

- Doesn't respect social norms or laws : they often break the laws made by society and cross the boundaries.
- Lies deceive others, use false identities or nicknames, and use others for personal benefits : they tend to look for their benefits out from the surroundings.
- Doesn't make any long-term plans : they don't see the pros and cons of the actions made by them.
- How aggressive or aggravated behavior is : they get indulged into physical fights often.
- Doesn't consider their safety or the safety of others : doesn't care about the security of an individual.
- Doesn't follow up on personal or professional responsibilities : this can include repeatedly missing deadlines, being late to work, and many more.

- Don't feel guilt or remorse : if they harm somebody or hurt people around them, they don't feel guilty about it.

Signs and Symptoms of Sociopaths :

- They are generally arrogant in nature.
- Tend to be liars in many cases and cheaters.
- Generally, have bad relationships or abusive relationships with people.
- Irresponsible and fails at work or in life.
- They don't show empathy to others around them.
- Impulsive.
- They can be destructive in nature.
- Aggressive towards living beings (humans and animals).

Causes which lead to become a Sociopaths :

- Genetic heritance.
- Traumatic experiences.
- The way of thinking patterns or after some diagnoses.

Table: Difference between Psychopaths and Sociopaths

Sociopaths	Psychopaths
Make it clear that they don't care what others feel.	They pretend to care.
They usually behave aggressively and impulsively.	They show cold-hearted behavior.
They are prone to fits of anger and rage.	They usually fail to recognize other people's stress.
They rationalize their behavior.	They have relationships that are shallow, empty, and fake.
They fail to maintain work and personal life.	They maintain a normal life as a cover for criminal activity.
It is difficult for them but can form emotional attachments.	They don't form genuine emotional attachments but may love people in their own way.

Source: ***Pemment, (2013)***

Application activity 7.10

1. Provide at least five examples of anti-social behaviours.
2. If sociopaths fail to maintain work and personal life, what about psychopaths?

End of unit assessment

1. How does social cultural perspective explain abnormal behaviour?
2. Here are 3 scenarios representing different types of anxiety. Give the name of the types of anxiety described in each scenario and explain the reason why you give this type of anxiety.

Scenario 1: It happened without any warning, a sudden wave of terror. My heart was pounding like mad, I couldn't catch my breath, and the ground underfoot seemed unstable. I was sure it was a heart attack. It was the worst experience of my life.

Scenario 2: I can't tell you why I'm afraid of rats. They fill me with terror. Even if I just see the word «rat» my heart starts pounding. I worry about rats in restaurants I go to, in my kitchen cupboard, and anywhere I hear a noise that sounds like a small animal scratching or running.

Scenario 3: Before I come home from work, I spend half my time wondering whether a burglar has broken into the apartment. As soon as I get home I check every room, under the bed, and in the closets. Before going to sleep I probably check the lock on the front door fifty times. I feel better after each check, but then my concern wells up and I have to go check again.

3. Which of the following is a basic feature of Conversion Disorder?
   a) Symptoms or deficits affecting voluntary motor or sensory function suggestive of an underlying medical or neurological condition.
   b) These symptoms must cause the individual significant distress.
   c) Impair social, occupational or other functioning.
   d) All of the above
4. Somatoform disorders include which of the following:
   a) conversion disorder
   b) somatization disorder
   c) hypochondriasis
   d) all of the above
5. Dissociative identity disorder is a disorder where
   a) the individual becomes confused and disoriented
   b) the individual displays two or more distinct identities
   c) the individual is unable to recall events that occurred during a specific time period
   d) suddenly and unexpectedly travels away from home or from their customary place of daily activities.

6. persistent or recurrent episodes of depersonalization are the central features of Depersonalization Disorder. These symptoms are characterised by:
   a) feelings of detachment of estrangement from the self
   b) the sense of living in a dream or in a film
   c) a sense of not being in control of their behaviour
   d) all of the above
7. Cluster----------personality disorders marked by dramatic, emotional, or erratic behaviours.
   a) Cluster A
   b) Cluster B
   c) Cluster C
8. What are the potential limitations of antibiotic medication for schizophrenia?
9. Explain the potential benefits of cognitive behaviour therapy for psychosis.
10. Which sexual variance is described here: "extracting sexual pleasure from physical or psychological pain".
    a) Incest
    b) Fetichism
    c) Exhibitionist
    d) Masochism
11. What is the other term used to characterize the term bestiality?
12. Distinguish between transsexualism and transvestism.
13. Doing masturbation in front of a partner is regarded as:
    a) Voyeurism
    b) Pederasty
    c) Sodomy
    d) None of the above
14. Provide at least 4 symptoms of anti-social personality disorder.

UNIT 8 PREVENTION OF PSYCHOLOGICAL DISORDERS

Key unit competence: Apply preventive measures to counter abnormal thoughts and behaviours.

Introductory activity: A case study

The scenario

Instructions : *Read the scenario carefully and discuss the related questions*

Mukeshimana was a stock personnel in a cleaning company. One day she was caught stealing some cleaning materials and was sacked. After a few days her husband had a fatal accident and died. He left Mukeshimana with three children who were enrolled in a private primary school where they were paying a high amount of school fees. These children dropped out of school. Mukeshimana overwhelmed by the problems chooses to drink alcohol as a way to get rid of the problems. It got to the point that she looked mad because of alcohol. She could day dream, talk to herself when walking alone, she could not remember what she had said, etc. At a time, she even tempted to commit suicide but people caught her before she terminated her life. She is now under survayance and children were adopted by some family relatives.

Questions :

1. *What psychological disorders is Mukeshimana suffering from ?*
2. *What could have been done to prevent the consequences of her losing of job and husband from worsening to that level ?*

8.1. Risk factors influencing psychological disorders: Anxiety; PTSD

Learning activity 8.1

Discuss how biological, genetic and psychological factor scan influence psychological disorders

8.1.1 Introduction

Although many definitions of abnormality have been used over the years, none has won universal acceptance. Still, most definitions have certain common features, often called the 'four Ds': deviance, distress, dysfunction and danger.

Therefore, Psychological disorders are deviant (different, extreme, unusual, even bizarre), distressing (unpleasant and upsetting to the person and to others), dysfunctional (interfering with the person's ability to carry out daily activities in a constructive way), and possibly dangerous (to the person or to others).

This definition is a useful starting point from which we can explore psychological abnormality. Since the word 'abnormal' literally means "away from the normal", it implies deviation from some clearly defined norms or standards. Weiser (2014) defined psychological disorder as a condition characterized by abnormal thoughts, feelings, and behaviors. The concept of psychopathology goes together with psychological disorders. Psychopathology is the study of psychological disorders, including their symptoms, etiology (i.e., their causes), and treatment.

In psychology, we have no 'ideal model' or even 'normal model' of human behaviour to use as a

base for comparison. Various approaches have been used in distinguishing between normal and abnormal behaviours.

Practical example:

If you ask a classmate for a date and you are rejected, you probably would feel a little dejected. Such feelings would be normal. If you felt extremely depressed—so much *so that you lost interest in activities, had difficulty eating or sleeping, felt utterly worthless, and contemplated suicide*—your feelings would be atypical, would *deviate from the norm*, and could signify the presence of a psychological disorder.

The second approach views abnormal behaviour as maladaptive. Many psychologists believe that the best criterion for determining the normality of behaviour is not whether society accepts it but whether it fosters the well-being

of individual and eventually of the group to which s/he belongs. Well-being is not simply maintenance and survival but also include growth and fulfilment i.e. the actualisation of potential, which you must have studied in Maslow's need hierarchy theory.

8.1.2. Factors underlying abnormal behaviour

In order to understand something as complex as abnormal behaviour, psychologists use different approaches. These approaches also emphasise the role of different factors such as biological, psychological and interpersonal, and socio-cultural factors. We will examine some of the approaches which are currently being used to explain abnormal behaviour. In order to understand psychological disorders, we need to begin by classifying them. A classification of such disorders consists of a list of categories of specific psychological disorders grouped into various classes on the basis of some shared characteristics.

a) **Biological factors influence all aspects of our behaviour.** A wide range of biological factors such as faulty genes, endocrine imbalances, malnutrition, injuries and other conditions may interfere with normal development and functioning of the human body. These factors may be potential causes of abnormal behaviour. We have already come across the biological model. According to this model, abnormal behaviour has a biochemical or physiological basis. Biological researchers have found that psychological disorders are often related to problems in the transmission of messages from one neuron to another.

When an electrical impulse reaches a neuron's ending, the nerve ending is stimulated to release a chemical, called a neurotransmitter. Studies indicate that abnormal activity by certain neurotransmitters can lead to specific psychological disorders. Anxiety disorders have been linked to low activity of the neurotransmitter *gamma aminobutyric acid* (GABA), schizophrenia to excess activity of dopamine, and depression to low activity of serotonin.

b) **Genetic Factors have been linked to mood disorders, schizophrenia, mental retardation and other psychological disorders**. Researchers have not, however, been able to identify the specific genes that are the culprits.

It appears that in most cases, no single gene is responsible for a particular behaviour or a psychological disorder. Infact, many genes combine to help bring about our various behaviours

and emotional reactions, both functional and dysfunctional.

c) **Psychological Factors**

Biology alone cannot account for most mental disorders. There are several psychological models which provide a psychological explanation of mental disorders. These models maintain psychological and interpersonal factors have a significant role to play in abnormal behaviour. These factors include maternal deprivation

(separation from the mother, or lack of warmth and stimulation during early years of life), faulty parent-child relationships (rejection, overprotection, overpermissiveness, faulty discipline, etc.),

maladaptive family structures (inadequate or disturbed family), and severe stress.

d) **Socio-cultural Factors**

In addition to the biological and psychosocial factors, socio-cultural factors such as war and violence, group prejudice and discrimination, economic and employment problems, and rapid social change, put stress on most of us and can also lead to psychological problems in some individuals. According to the sociocultural model, abnormal behaviour is best understood in light of the social and cultural forces that influence an individual. As behaviour is shaped by societal forces, factors such as family structure and communication, social networks, societal conditions, and societal labels and roles become more important. It has been found that certain family systems are likely to produce abnormal functioning in individual members.

8.1.3. Risk Factors for Major Psychological Disorders

(1) **Anxiety disorders**

a) **Symptoms of anxiety disorders**

Common anxiety signs and symptoms include:

- Feeling nervous, restless or tense
- Having a sense of impending danger, panic or doom
- Having an increased heart rate
- Breathing rapidly (hyperventilation)
- Sweating
- Trembling
- Feeling weak or tired
- Trouble concentrating or thinking about anything other than the present worry

- Having trouble sleeping
- Experiencing gastrointestinal (GI) problems
- Having difficulty controlling worry
- Having the urge to avoid things that trigger anxiety

b) **Causes of anxiety disorders**

The causes of anxiety disorders aren't fully understood. Life experiences such as traumatic events appear to trigger anxiety disorders in people who are already prone to anxiety. Inherited traits also can be a factor.

Anxiety can be linked to an underlying health issue. In some cases, it's signs and symptoms are first indicators of a medical condition. The medical problems that can be linked to anxiety include:

- Heart disease
- Diabetes
- Thyroid problems, such as hyperthyroidism
- Respiratory disorders, such as chronic obstructive pulmonary disease (COPD) and asthma
- Drug misuse or withdrawal
- Withdrawal from alcohol, anti-anxiety medications (benzodiazepines) or other medications
- Chronic pain or irritable bowel syndrome
- Rare tumors that produce certain fight-or-flight hormones
- Sometimes, it can be side effects of a certain medication

c) **Risk Factors that can increase anxiety disorders**

- **Trauma:** Children who endured abuse or trauma or witnessed traumatic events are at higher risk of developing an anxiety disorder at some point in life. Adults who experience a traumatic event also can develop anxiety disorders.
- **Stress due to an illness:** Having a health condition or serious illness can cause significant worry about issues such as your treatment and your future.
- **Stress buildup:** A big event or a buildup of smaller stressful life situations may trigger excessive anxiety — for example, a death in the family, work stress or ongoing worry about finances.
- **Personality:** People with certain personality types are more prone to anxiety disorders than others are.

- **Other mental health disorders:** People with other mental health disorders, such as depression, often also have an anxiety disorder.
- **Having blood relatives with an anxiety disorder:** Anxiety disorders can run in families.
- **Drugs or alcohol:** Drug or alcohol use or misuse or withdrawal can cause or worsen anxiety.

d) Complications

Having an anxiety disorder does more than make you worry. It can also lead to, or worsen, other mental and physical conditions, such as:

- Depression (which often occurs with an anxiety disorder) or other mental health disorders
- Substance misuse
- Trouble sleeping (insomnia)
- Digestive or bowel problems
- Headaches and chronic pain
- Social isolation
- Problems functioning at school or work
- Poor quality of life
- Suicide

(2) Post-Traumatic Stress Disorder (PTSD)

Very often people who have been caught in a natural disaster (such as tsunami) or have been victims of bomb blasts by terrorists, or been in a serious accident or in a war-related situation, experience posttraumatic stress disorder (PTSD). PTSD symptoms vary widely but may include recurrent dreams, flashbacks, impaired concentration, and emotional numbing.

The strong evidences concluded that the cause of PTSD can be a certain other "risk factor" or the PTSD can develop when such risk factors have occurred.

Risk factors for PSTD

- Trauma experience, greater trauma severity, lack of immediate social support, and more subsequent life stress.
- Traumatic events that involve harm by others (e.g., combat, rape, and sexual molestation) carry greater risk.

- Factors that increase the risk of PTSD include female gender, low socioeconomic status, low intelligence, personal history of mental disorders, history of childhood adversity (abuse or other trauma during childhood), and family history of mental disorders.
- Personality characteristics such as neuroticism and somatization (the tendency to experience physical symptoms when one encounters stress) have been shown to elevate the risk of PTSD.
- People who experience childhood adversity and/or traumatic experiences during adulthood are at significantly higher risk of developing PTSD.

Application activity 8.1

In your groups, descuss the possible causes and risk factors that can influence Posttraumatic stress disorders (PTSD).

8.2. Risk Factors Influencing Psychological Disorders: Somatoform disorders; Dissociative disorders; Mood disorders; Schizophrenia

Learning activity 8.2

With reference to the previous description of somatoform disorders, dissociative disorders, the factors that can worsen the disorders (risk factors).

8.2.1. Somatoform Disorders

Somatoform Disorders are conditions in which there are physical symptoms in the absence of a physical disease. In somatoform disorders, the individual has psychological difficulties and complains of physical symptoms, for which there is no biological cause. Somatoform disorders include pain disorders, somatisation disorders, conversion disorders, and hypochondriasis.

- Pain disorders involve reports of extreme and incapacitating pain, either without any identifiable biological symptoms or greatly in excess of what might be expected to accompany biological symptoms. How people interpret pain influences their overall adjustment. Some pain sufferers can learn to use active coping, i.e. remaining active and ignoring the pain. Others engage in passive coping, which leads to reduced activity and social withdrawal.

- Patients with somatisation disorders have multiple and recurrent or chronic bodily complaints. These complaints are likely to be presented in a dramatic and exaggerated way. Common complaints are headaches, fatigue, heart palpitations, fainting spells, vomiting, and allergies. Patients with this disorder believe that they are sick, provide long and detailed histories of their illness, and take large quantities of medicine.
- The symptoms of conversion disorders are the reported loss of part or all of some basic body functions. Paralysis, blindness, deafness and difficulty in walking are generally among the symptoms reported. These symptoms often occur after a stressful experience and may be quite sudden.
- Hypochondriasis is diagnosed if a person has a persistent belief that s/he has a serious illness, despite medical reassurance, lack of physical findings, and failure to develop the disease. Hypochondriacs have an obsessive preoccupation and concern with the condition of their bodily organs, and they continually worry about their health.

Symptoms:

a. Constant worry about potential illness
b. Viewing normal physical sensations as a sign of severe physical illness
c. Fearing that symptoms are serious, even when there is no evidence
d. Thinking that physical sensations are threatening or harmful
e. Feeling that medical evaluation and treatment have not been adequate
f. Fearing that physical activity may cause damage to your body
g. Repeatedly checking your body for abnormalities
h. Frequent health care visits that don't relieve your concerns or that make them worse
i. Being unresponsive to medical treatment or unusually sensitive to medication side effects
j. Having a more severe impairment than is usually expected from a medical condition

Causes:

The exact cause of somatic symptom disorder isn't clear, but any of these factors may play a role:

- Genetic and biological factors, such as an increased sensitivity to pain
- Family influence, which may be genetic or environmental, or both
- Personality trait of negativity, which can impact how you identify and perceive illness and bodily symptoms

- Decreased awareness of or problems processing emotions, causing physical symptoms to become the focus rather than the emotional issues
- Learned behavior — for example, the attention or other benefits gained from having an illness; or "pain behaviors" in response to symptoms, such as excessive avoidance of activity, which can increase your level of disability

Risk factors:

Risk factors for somatic symptom disorder include:

- Having anxiety or depression
- Having a medical condition or recovering from one
- Being at risk of developing a medical condition, such as having a strong family history of a disease
- Experiencing stressful life events, trauma or violence
- Having experienced past trauma, such as childhood sexual abuse
- Having a lower level of education and socio-economic status

Complications:

Somatic symptom disorder can be associated with:

- Poor health
- Problems functioning in daily life, including physical disability
- Problems with relationships
- Problems at work or unemployment
- Other mental health disorders, such as anxiety, depression and personality disorders
- Increased suicide risk related to depression
- Financial problems due to excessive health care visits

8.2.2. Dissociative disorders:

Dissociation can be viewed as severance of the connections between ideas and emotions. Dissociation involves feelings of unreality, estrangement, depersonalisation, and sometimes a loss or shift of identity. Sudden temporary alterations of consciousness that blot out painful experiences are a defining characteristic of dissociative disorders. Four conditions are included in this group: *dissociative amnesia*, dissociative fugue, dissociative identity disorder, and depersonalisation.

- Dissociative amnesia is characterised by extensive but selective memory loss that has no known organic cause (e.g., head injury). Some people cannot remember anything about their past. Others can no longer recall specific events, people, places, or objects, while their memory for other events remains intact. This disorder is often associated with an overwhelming stress.
- Dissociative fugue has, as its essential feature, an unexpected travel away from home and workplace, the assumption of a new identity, and the inability to recall the previous identity. The fugue usually ends when the person suddenly 'wakes up' with no memory of the events that occurred during the fugue.
- Dissociative identity disorder, often referred to as multiple personality, is the most dramatic of the dissociative disorders. It is often associated with traumatic experiences in childhood. In this disorder, the person assumes alternate personalities that may or may not be aware of each other.
- Depersonalisation involves a dreamlike state in which the person has a sense of being separated both from self and from reality. In depersonalisation, there is a change of self-perception, and the person's sense of reality is temporarily lost or changed.

Symptoms: Signs and symptoms depend on the type of dissociative disorders you have, but may include:

- Memory problems that are not linked to physical injury or medical conditions: memory loss (amnesia) of certain time periods, events, people and personal information
- A sense of being detached from yourself and your emotions (identity confusion)
- A perception of the people and things around you as distorted and unreal
- A blurred sense of identity
- Significant stress or problems in your relationships, work or other important areas of your life
- Inability to cope well with intense emotional or professional stress
- Mental health problems, such as depression, anxiety, and suicidal thoughts and behaviors.
- Sudden and unexpected shifts in mood – for example, feeling very sad for no reason
- Depression or anxiety problems, or both
- Feeling as though the world is distorted or not real (called 'derealisation')

- Other cognitive (thought-related) problems such as concentration problems
- Significant memory lapses such as forgetting important personal information
- Feeling compelled to behave in a certain way

Risk factors

Those who have suffered from long-term sexual, emotional or physical abuse during childhood often have the greatest risk of developing dissociative identity disorder and other dissociative disorders.

Adults and children who have experienced other stressful and traumatic events, for example, kidnapping, war, torture, natural disasters or stressful medical procedures, are also susceptible to developing this condition.

Complications

Individuals who have been diagnosed with dissociative identity disorder have their risk for a number of complications, as well as other associated disorders increased. These include:

- Suicidal thoughts and/or behaviour
- Self-harm
- Self-mutilation
- Drug and alcohol abuse
- Personality disorders
- Anxiety and depression disorders
- Eating disorders
- PTSD (post-traumatic stress disorder)
- Sleep disorders (insomnia, sleep walking, nightmares)
- Significant difficulties and issues in work and personal (social) relationships
- Sexual dysfunction

8.2.3. Mood Disorders

Mood disorders are characterised by disturbances in mood or prolonged emotional state. The most common mood disorder is depression, which covers a variety of negative moods and behavioural changes. Depression can refer to a symptom or a disorder. In day-to-day life, we often use the term depression to refer to normal feelings after a significant loss, such as the break-up of a relationship, or the failure to attain a significant goal. The main types of mood disorders include *depressive*, *manic* and *bipolar disorders*.

Major depressive disorder is defined as a period of depressed mood and/or loss of interest or pleasure in most activities, together with other symptoms which may include change in body weight, constant sleep problems, tiredness, inability to think clearly, agitation, greatly slowed behaviour, and thoughts of death and suicide. Other symptoms include excessive guilt or feelings of worthlessness. *Factors Predisposing towards Depression*: Genetic make-up, or heredity is an important risk factor for major depression and bipolar disorders. *Age* is also a risk factor. For instance, women are particularly at risk during young adulthood, while for men the risk is highest in early middle age. Similarly gender also plays a great role in this differential risk addition. For example, women in comparison to men are more likely to report a depressive disorder. Other risk factors are experiencing negative life events and lack of social support. Another less common mood disorder mania. People suffering from mania become euphoric ('high'), extremely active, excessively talkative, and easily distractible. Such a mood disorder, in which both mania and depression are alternately present, is sometimes interrupted by periods of normal mood. This is known as bipolar mood disorder. Bipolar mood disorders were earlier referred to as manic-depressive disorders. Among the mood disorders, the lifetime risk of a suicide attempt is highest in case of bipolar mood disorders. Several risk factors in addition to mental health status of a person predict the likelihood of suicide. These include age, gender, ethnicity, or race and recent occurrence of serious life events. Teenagers and young adults are as much at high risk for suicide, as those who are over 70 years.

Risk factors for Major depressive disorder

- It is more common among women than among men.
- Unemployment (including homemakers);
- Being separated, divorced or widowed

Prevention of suicide

Suicide can be prevented by being alert to some of the symptoms which include:

- Changes in eating and sleeping habit
- Withdrawal from friends, family and regular activities
- Violent actions, rebellious behaviour, running away
- Drug and alcohol abuse
- Marked personality change
- Persistent boredom
- Difficulty in concentration
- Complaints about physical symptoms, and
- Loss of interest in pleasurable activities.

Risk factors for suicide

- Suicidal risk is especially high among people with substance abuse problems
- Individuals with alcohol dependence are at 10 times greater risk for suicide than the general population.
- The risk of suicidal behavior is especially high among those who have made a prior suicide attempt.
- Possession of firearm in the home
- Withdrawal from social relationships, feeling as though one is a burden to others, and engaging in reckless and risk-taking behaviors may be precursors to suicidal behaviour.
- Cyber bullying among adolescents
- Media: televised stories
- Brain chemistry: disturbances in the functioning of serotonin are linked to suicidal behaviour. Low levels of serotonin predict future suicide attempts and suicide completions, and low levels have been observed post-mortem among suicide victims.
- Suicidal thoughts, plans, and even off-hand remarks, for example "I might kill myself this afternoon".

8.2.4. Schizophrenic Disorders

Schizophrenia is the descriptive term for a group of psychotic disorders in which personal, social and occupational functioning deteriorate as a result of disturbed thought processes, strange perceptions, unusual emotional states, and motor abnormalities. It is a debilitating disorder. The social and psychological costs of schizophrenia are tremendous, both to patients as well as to their families and society.

Symptoms

Schizophrenia involves a range of problems with thinking (cognition), behavior and emotions. Signs and symptoms may vary, but usually involve delusions, hallucinations or disorganized speech, and reflect an impaired ability to function. Symptoms may include:

- **Delusions:** These are false beliefs that are not based in reality. For example, you think that you're being harmed or harassed; certain gestures or comments are directed at you; you have exceptional ability or fame; another person is in love with you; or a major catastrophe is about to occur. Delusions occur in most people with schizophrenia.

- **Hallucinations:** These usually involve seeing or hearing things that don't exist. Yet for the person with schizophrenia, they have the full force and impact of a normal experience. Hallucinations can be in any of the senses, but hearing voices is the most common hallucination.
- **Disorganized thinking (speech):** Disorganized thinking is inferred from disorganized speech. Effective communication can be impaired, and answers to questions may be partially or completely unrelated. Rarely, speech may include putting together meaningless words that can't be understood, sometimes known as word salad.
- **Extremely disorganized or abnormal motor behaviour:** This may show in a number of ways, from childlike silliness to unpredictable agitation. Behavior isn't focused on a goal, so it's hard to do tasks. Behavior can include resistance to instructions, inappropriate or bizarre posture, a complete lack of response, or useless and excessive movement.

Negative symptoms: This refers to reduced or lack of ability to function normally. For example, the person may neglect personal hygiene or appear to lack emotion (doesn't make eye contact, doesn't change facial expressions or speaks in a monotone). Also, the person may lose interest in everyday activities, socially withdraw or lack the ability to experience pleasure.

Suicidal thoughts and behavior are common among people with schizophrenia. If you have a loved one who is in danger of attempting suicide or has made a suicide attempt, make sure someone stays with that person.

Symptoms in teenagers

Schizophrenia symptoms in teenagers are similar to those in adults, but the condition may be more difficult to recognize. This may be in part because some of the early symptoms of schizophrenia in teenagers are common for typical development during teen years, such as:

- Withdrawal from friends and family
- A drop in performance at school
- Trouble sleeping
- Irritability or depressed mood
- Lack of motivation

Risk factors

Although the precise cause of schizophrenia isn't known, certain factors seem to increase the risk of developing or triggering schizophrenia, including:

- Having a family history of schizophrenia
- Some pregnancy and birth complications, such as malnutrition or exposure to toxins or viruses that may impact brain development

- Taking mind-altering (psychoactive or psychotropic) drugs during teen years and young adulthood.

Application activity 8.2

Elaborate on the risk factors for

- Somatoform
- Dissociative
- Mood disorders

8.3. Risk Factors Influencing Psychological Disorders: Personality disorders; Disorders in childhood; Psychosexual disorders; Psychosocial deviances

Learning activity 8.3

Discussion question :

With reference to the previous knowledge about personality disorders, disorders in childhood, psychosexual disorders and psychosocial deviances, discuss the possible causes of those disorders.

8.3.1. Personality Disorders

People with personality disorders exhibit a personality style that differs markedly from the expectations of their culture, is pervasive and inflexible, begins in adolescence or early adulthood, and causes distress or impairment (APA, 2013).

Generally, individuals with these disorders exhibit enduring personality styles that are extremely troubling and often create problems for them and those with whom they come into contact. Their maladaptive personality styles frequently bring them into conflict with others, disrupt their ability to develop and maintain social relationships, and prevent them from accomplishing realistic life goals.

Table: Types of personality disorders

Personality Disorder	Description	Cluster
Paranoid	Harbors a pervasive and unjustifiable suspiciousness and mistrust of others; reluctant to confide in or become close to others; reads hidden demeaning or threatening meaning into benign remarks or events; takes offense easily and bears grudges; not due to schizophrenia or other psychotic disorders.	A
Schizoid	Lacks interest and desire to form relationships with others; aloof and shows emotional coldness and detachment; indifferent to approval or criticism of others; lacks close friends or confidants; not due to schizophrenia or other psychotic disorders, not an autism spectrum disorder.	A
Schizotypal	Exhibits eccentricities in thought, perception, emotion, speech, and behavior; shows suspiciousness or paranoia; has unusual perceptual experiences; speech is often idiosyncratic; displays inappropriate emotions; lacks friends or confidants; not due to schizophrenia or other psychotic disorder, or to autism spectrum disorder.	A
Antisocial	continuously violates the rights of others; history of antisocial tendencies prior to age 15; often lies, fights, and has problems with the law; impulsive and fails to think ahead; can be deceitful and manipulative in order to gain profit or pleasure; irresponsible and often fails to hold down a job or pay financial debts; lacks feelings for others and remorse over misdeeds	B
Histrionic	excessively overdramatic, emotional, and theatrical; feels uncomfortable when not the center of others' attention; behavior is often inappropriately seductive or provocative; speech is highly emotional but often vague and diffuse; emotions are shallow and often shift rapidly; may alienate friends with demands for constant attention.	B
Narcissistic	overinflated and unjustified sense of self-importance and preoccupied with fantasies of success; believes he is entitled to special treatment from others; shows arrogant attitudes and behaviors; takes advantage of others; lacks empathy	B

Borderline	unstable in self-image, mood, and behavior; cannot tolerate being alone and experiences chronic feelings of emptiness; unstable and intense relationships with others; behavior is impulsive, unpredictable, and sometimes self-damaging; shows inappropriate and intense anger; makes suicidal gestures.	B
Avoidant	socially inhibited and oversensitive to negative evaluation; avoids occupations that involve interpersonal contact because of fears of criticism or rejection; avoids relationships with others unless guaranteed to be accepted unconditionally; feels inadequate and views self as socially inept and unappealing; unwilling to take risks or engage in new activities if they may prove embarrassing.	C
Dependent	allows others to take over and run her life; is submissive, clingy, and fears separation; cannot make decisions without advice and reassurance from others; lacks self-confidence; cannot do things on her/his own; feels uncomfortable or helpless when alone.	C
Obsessive-Compulsive	pervasive need for perfectionism that interferes with the ability to complete tasks; preoccupied with details, rules, order, and schedules; excessively devoted to work at the expense of leisure and friendships; rigid, inflexible, and stubborn; insists things be done his/her way; miserly with money.	C

Cluster A: People with these disorders display a personality style that is odd or eccentric.

Cluster B: People with these disorders usually are impulsive, overly dramatic, highly emotional, and erratic.

Cluster C: People with these disorders often appear to be nervous and fearful.

a. Risk Factors for Antisocial personality disorder

- It is more likely to occur in men who are younger, widowed, separated, divorced, of lower socioeconomic status.
- Compared to men with antisocial personality disorder, women with the disorder are more likely to have experienced emotional neglect and sexual abuse during childhood, and they are more likely to have had parents who abused substances and who engaged in antisocial behaviors themselves.

- Parental violence; Parental criminality; Poor family management; Family conflicts; Parental attitudes favourable to violence; Frequent moves; Peer delinquency; Gang membership; Economic deprivation; Community disorganization; Availability of drugs; Neighbourhood adults involved in crimes.

b. Causes of personality disorders

Personality is the combination of thoughts, emotions and behaviors that makes you unique. It's the way you view, understand and relate to the outside world, as well as how you see yourself. Personality forms during childhood, shaped through an interaction of:

- **Your genes:** Certain personality traits may be passed on to you by your parents through inherited genes. These traits are sometimes called your temperament.
- **Your environment:** This involves the surroundings you grew up in, events that occurred, and relationships with family members and others.

Personality disorders are thought to be caused by a combination of these genetic and environmental influences. Your genes may make you vulnerable to developing a personality disorder, and a life situation may trigger the actual development.

Risk factors

Although the precise cause of personality disorders is not known, certain factors seem to increase the risk of developing or triggering personality disorders, including:

- Family history of personality disorders or other mental illness
- Abusive, unstable or chaotic family life during childhood
- Being diagnosed with childhood conduct disorder
- Variations in brain chemistry and structure

8.3.2. Disorders in Childhood

There are a group of conditions that, when present, are diagnosed early in childhood, often before the time a child enters school. They are termed "neurodevelopmental disorders" and involve developmental problems in personal, social, academic, and intellectual functioning (APA, 2013). In this section, we will discuss two such disorders: **attention deficit/ hyperactivity disorder and autism.**

(1) Attention Deficit/Hyperactivity Disorder (ADHD)

Some of the signs of inattention include great difficulty with and avoidance of tasks that require sustained attention (such as conversations or reading), failure to follow instructions (often resulting in failure to complete school work and other duties), disorganization (difficulty keeping things in order, poor time management, sloppy and messy work), lack of attention to detail, becoming easily distracted, and forgetfulness.

Hyperactivity is characterized by excessive movement, and includes fidgeting or squirming, leaving one's seat in situations when remaining seated is expected, having trouble sitting still (e.g., in a restaurant), running about and climbing on things, blurting out responses before another person's question or statement has been completed, difficulty waiting one's turn for something, and interrupting and intruding on others. Frequently, the hyperactive child comes across as noisy and boisterous.

Children with ADHD face severe academic and social challenges. Compared to their non-ADHD counterparts, children with ADHD have lower grades and standardized test scores and higher rates of expulsion, grade retention, and dropping out (Loe & Feldman, 2007). they also are less well liked and more often rejected by their peers (Hoza et al., 2005).

Causes and risk factors of ADHD

Risk factors of ADHD

There are no definite causes that have been found to trigger ADHD in a child. Scientists are studying cause(s) and risk factors in an effort to find better ways to manage and reduce the chances of a person having ADHD. The cause(s) and risk factors for ADHD are unknown, but current research shows that genetics plays an important role. However, the following factors may contribute to a raised risk of the condition:

- **Altered anatomy or function of the brain** – Brain injury: Brain scans have shown that some areas of the brain especially those related to activity and attention spans are different among children and adults with ADHD. Some studies reveal that the frontal lobe of the brain (lies in the forefront of the brain) is different among people with ADHD. This area is related to decision making. There may also be derangement of neurotransmitters like dopamine and noradrenaline in the brain which leads to dopamine deficit. These neurotransmitters are chemical messengers of the brain.
- **Genetics** – ADHD sometimes may be inherited. There are studies that have found several genes that are related to ADHD causation.

- **Being male** – Boys and men are more at risk of developing ADHD than girls and women. This could be due to genetic factors or hormonal factors. Studies suggest that since ADHD is commonly associated with violent and hyperactivity symptoms, many girls who have predominant inattentive type of ADHD maybe missed out while diagnosing. These girls often grow up to manifest the condition as adolescents or young adults.
- **Maternal drug abuse, alcohol intake and smoking**– Some studies have shown that pregnant women who smoke, take alcohol or use recreational drugs are at a higher risk of giving birth to children who go on to develop ADHD. The exact pathology behind this association is not well known. However, it is speculated that this type of abuse in utero, or within the womb, reduces the neuronal activity and alters the nerve messenger chemicals neurotransmitters. Pregnant women who are exposed to environmental toxins are also at risk of giving birth to babies who may develop ADHD.
- **Exposure to toxins** – Toddlers and preschoolers who are exposed to environmental poisons and toxins are also at higher risk of behavioural problems. Notable among these is lead exposure from paint and pipes in old buildings that has been linked to short attention spans and violent behaviour in some children.
- **Traumatic brain injury** – Brain injury has also been linked to ADHD in some studies. However, the number of children who have suffered such brain injuries is too small to explain the rising prevalence of ADHD.
- **Additives** – Some food additives such as preservatives and artificial colouring have been linked to aggravation and increased risk of ADHD. Detailed research in this area is warranted as there is no definitive evidence.
- **Sugar** – Studies and common belief says excess sugar in a child's diet often leads to behavioural problems. However, detailed studies have shown that there is no association between excess sugar in diet and raised risk of ADHD or even worsening of symptoms in children diagnosed with ADHD.
- **Food intolerance** – Certain food intolerance like that to milk, wheat and nuts has also been linked to raised risk of ADHD.
- **Exposure to television** – There have been concerns that excessive exposure to television at a young age may lead to an increased risk of ADHD. Although there are no studies that actually prove this association; there is evidence that exposure to excessive television may lead to inattentiveness and risk of ADHD later in life.

Alcohol and tobacco use during pregnancy.

Other risk factors – These include being born prematurely before 37 weeks of gestation and being born with a low birth weight. Brain damage in utero, or in the first few years of life, or having impaired hearing is also linked to ADHD.

Life problems from ADHD (Consequences)

- Had worse educational attainment (more likely to have dropped out of high school and less likely to have earned a bachelor's degree);
- Had lower socioeconomic status;
- Held less prestigious occupational positions;
- Were more likely to be unemployed;
- Made considerably less in salary;
- Scored worse on a measure of occupational functioning (indicating, for example, lower job satisfaction, poorer work relationships, and more firings);
- Scored worse on a measure of social functioning (indicating, for example, fewer friendships and less involvement in social activities);
- Were more likely to be divorced;
- Were more likely to have non-alcohol-related substance abuse problems.

(2) Autism Spectrum Disorder (ASD)

It was characterized mainly by an inability to form close emotional ties with others, speech and language abnormalities, repetitive behaviors, and an intolerance of minor changes in the environment and in normal routines.

The qualifier "spectrum" in autism spectrum disorder is used to indicate that individuals with the disorder can show a range, or spectrum, of symptoms that vary in their magnitude and severity: some severe, others less severe.

Children with this disorder show signs of significant disturbances in three main areas:

(a) deficits in social interaction, (b) deficits in communication, and (c) repetitive patterns of behavior or interests.

The child with autism spectrum disorder might exhibit deficits in social interaction by not initiating conversations with other children or turning their head away when spoken to.

These children do not make eye contact with others and seem to prefer playing alone rather than with others.

In a certain sense, it is almost as though these individuals live in a personal and isolated social world others are simply not able to penetrate.

Communication deficits can range from a complete lack of speech, to one word responses (e.g., saying "Yes" or "No" when replying to questions or statements that require additional elaboration), to echoed speech (e.g., parroting what another person says, either immediately or several hours or even days later), to difficulty maintaining a conversation because of an inability to reciprocate others' comments.

They have problems in using and understanding nonverbal cues (e.g., facial expressions, gestures, and postures) that facilitate normal communication.

Autism spectrum disorder is not the same thing as intellectual disability, although these two conditions are often comorbid. Its symptoms are not explained by intellectual disability.

a) Life Problems from ASD

Some individuals with autism spectrum disorder, particularly those with better language and intellectual skills, can live and work independently as adults.

However, most do not because the symptoms remain sufficient to cause serious impairment in many realms of life.

b) Causes of ASD

- Early theories of autism placed the blame squarely on the shoulders of the child's parents, particularly the mother, but no scientific evidence exists supporting this claims.
- The exact causes of autism spectrum disorder remain unknown despite massive research efforts over the last two decades.
- Autism appears to be strongly influenced by genetics, as identical twins show concordance rates of 60%–90%, whereas concordance rates for fraternal twins and siblings are 5%–10%.
- Many different genes and gene mutations have been implicated in autism.
- Among the genes involved are those important in the formation of synaptic circuits that facilitate communication between different areas of the brain.
- Environmental factors are also thought to be associated with increased risk for autism spectrum disorder, at least in part, because they contribute to new mutations: exposure to pollutants, such as plant emissions and mercury, urban versus rural residence, and vitamin D deficiency.

c) **Risk Factors**

There is not just one cause of ASD. There are many different factors that have been identified that may make a child more likely to have ASD, including environmental, biologic, and genetic factors. Although we know little about specific causes, the available evidence suggests that the following may put children at greater risk for developing ASD:

- **Sex:** Autism spectrum disorder is four times more likely in boys than in girls. Having certain genetic or chromosomal conditions, such as fragile X syndrome or tuberous sclerosis
- **Family history of autism**: Having a sibling with ASD
- Preterm birth (before 26 weeks' gestation)
- Experiencing complications at birth
- Being born to older parents: older parents are associated with autism because they are more likely to have autism themselves.
- People with autism often have other physical issues related to immune deficiency. The National Institutes of Health (NIH), however, states that the evidence is not yet strong enough to show a causal relationship.

There is also some evidence that children with autism are more prone to gastrointestinal (GI) problems, allergies, and food intolerances than other children, but no evidence that these cause autisms.

8.3.3. Psychosexual Disorders

Psychosexual disorders have been defined as the sexual problems that are psychological in origin and occur in absence of any pathological disease. They often arise because of physical, environmental, or psychological factors, and at times it is difficult to separate one from the other.

Sexual disorders can be divided into problems of desire, arousal, and function; however, these problems are often interlinked to each other. For example, impaired sexual function, such as some degree of erectile dysfunction, can cause hypoactive sexual disorder in men. Similarly, dyspareunia in females can cause hypoactive sexual disorder or anorgasmia.

The following are risk factors that can increase the problem:

- Having any of the mental health problems that cause it
- Problems at work
- Problems with the people in a person's life
- Hormone changes or postpartum depression from having a baby
- Worrying about your sexual orientation
- Worrying about having sex

- Prior bad feelings or pain
- Conflict with your partner
- Guilt or worry because of religion or the way of life where you live
- Money problems
- Family problems
- Abuse from your partner

8.3.4. Risk Factors for Psychosocial Deviances

Some types and examples of deviant behaviours in many societies include: armed robbery, murder, examination mal-practice, rape, forgery, drug abuse and addiction (smoking and drinking), bribery and corruption, homo-sexuality, vandalization, gangsterism, intimidating behaviours, keeping late hours, sexual harassment and indecent dressing (such as transparent and tied cloths for girls, and radical wears or appearance like coiling of hairs etc for boys), disobedience to parents, elders, and other social authorities, addicted to party, gossiping, greed, jealousy, truancy, among others. Definition of deviance differs from time to time, place to place and from group to group. Behaviour that may be considered deviant in one culture may not be in another.

In reality, there are likely many factors that play a role in deviant behavior. These include genetics, personality, upbringing, environment, and societal influences. Other factors—including sex and socioeconomic status—also influence the informal and unwritten social rules and expectations that people are expected to conform to.

(i) Psychological Factors

Psychological theories of deviant behavior come from a variety of perspectives. The psychoanalytic approach, for example, might suggest that all people have repressed, unconscious urges that lead to social deviance.

Learning theories, on the other hand, might suggest that these behaviors are learned by watching others engage in deviant behaviors. In the context of substance use, this would suggest that people begin using drugs or misusing alcohol as a result of witnessing other people use substances. Research does suggest that social influences can play an important part in the onset of substance use and addiction.

(ii) Biological Factors

Biological explanations for deviance suggest that genetic influences play a significant role in deviant behavior. When it comes to addiction, for example, research has found that genes play a significant part in the development of substance use problems. Research has concluded that between 40% and 60% of risks of developing addiction is due to genetics.

(iii) **Sociological Factors**

One sociological explanation is Merton's strain theory, which suggests that there is a tension between a society's goals and the means that people have to reach those goals. As a result, people often turn to deviant behavior (such as stealing or selling drugs) as a way to attain socially acceptable societal ideals (such as having wealth).

Sociological factors facilitating deviances have been shared and they include:

- **Faulty socialisation**: the individual becomes a social deviant when he/she fails to conform to the norms of the group. The school as a socialisation agent may fail to inculcate in the new students the strong morals. For example, deviance proneness is more potential in the lower classes mainly because of failure in socialisation.
- **Weak sanctions:** Sanctions refer to the rewards or punishments used to establish social control or to enforce norms in a society. If the positive sanctions (rewards) for conformity and the negative sanctions (punishments) for deviance are weak, the individual may simply neglect them.
- **Poor enforcement of the law**: Even though the sanctions are stronger they are often not enforced effectively due to the too small enforcement staff. Because of this the validity of the norm is weakened. For example, it is not possible for a handful of traffic police staff to enforce traffic rules on all vehicle riders. The result is, many ignore and some even openly violate traffic rules.
- **Ease of rationalisation:** the violators of norms try to satisfy their conscience by inventing some plausible rationalisation. Such people have constructed an intricate system of 'ego defense' or defense mechanisms which they use to brush aside the reactions and comments of other people. For example, the police officers may rationalise their regular habit of taking bribes by saying that they are paid very low salary.
- **Unjust or corrupt enforcement:** People may lose respect for law and norms when they have no faith in law enforcement agency or authority. It is known that police corruption and illegal violence damage very much respect for the law in the areas affected by such practices.
- **Ambivalence of the Agents of Social Control**: Ambivalence refers to the co-existence in one person of opposing emotional attitudes towards the same object. For example, A doctor with such ambivalent attitude may inflict sexual crime on young and beautiful female patients. Policemen, teachers, parents, business superiors, all may have such complex personalities with unconscious deviant tendencies.

- **Sub-cultural support of deviances:** Different groups have different ideas of permissible behaviour. The range of acts that would be approved by the working class people differs from that which would be approved by the middle class people. What is non-conforming in the outside world becomes conforming in the group. For example, the frustrated children of the working class flock together in little gangs. The subculture of this gang may emphasise malice and negativism.
- **Sentiments of Loyalty to Deviant Groups:** When once a person is involved in a deviant group he is obliged to co-operate with other members. He will find it difficult to 'betray' his co- members and suffer their disapproval and rejection. He is forced to approve of the behaviour even if he no longer believes in their activities.
- **Indefinite Range of Norms:** Some norms relating to some values are not probably specified. For example, the scope of patriotism and freedom (political values) is not clearly defined. Hence, some even defend their deviant behaviour in the name of patriotism and freedom. Thus, one may use harsh language against another in the name of freedom.
- **Secrecy of Violations:** Some susceptible persons are more prone to commit deviant acts if they are assured that such acts are not going to be made public. For example, sex crimes and illegal abortions very often take place because of the confidence on the part of the actors that their behaviour would remain secret.

Application activity 8.3

Question 1 :

Psychosocial deviants can be rehabilitated but some sociological factors may worsen the condition if no measures are taken. Discuss those factors.

Question 2 :

In addition to the factors elaborated in the handout, find out similar factors in the Rwandan context.

8.4. Prevention strategies for psychological disorders: Anxiety disorders; Obsessive-Compulsive disorders; Posttraumatic Stress Disorders (PTSD); Somatoform disorders.

Learning activity 8.4

Discussion question :

In your respective groups, discuss what might be the prevention strategies for the following disorders : anxiety, obsessive-compulsive disorders, posttraumatic stress disorders, somatoform disorders.

8.4.1. Prevention strategies for Anxiety Disorders

The development of effective prevention of anxiety disorders will require

- Comprehensive knowledge of the risk and protective factors as well as their complex interrelationships during different periods in development;
- Advances in methods to detect the presence and/or absence of these factors;
- Interventions that increase protective factors and/or reduce risk factors, or both. The goal of such programs is to reduce the enormous individual and societal burdens imposed by anxiety disorders.

a) **Symptoms of anxiety disorders**

- Restlessness, and a feeling of being “on-edge”
- Uncontrollable feelings of worry
- Increased irritability
- Concentration difficulties
- Sleep difficulties, such as problems in falling or staying asleep

While these symptoms might be normal to experience in daily life, people with Generalised Anxiety Disorders (GAD) will experience them to persistent or extreme levels. GAD may present as vague, unsettling worry or a more severe anxiety that disrupts day-to-day living.

b) **Prevention of anxiety disorders**

There are ways to reduce the risk of anxiety disorders. Remember that anxious feelings are a natural factor of daily life, and experiencing them does not always indicate the presence of a mental health disorder.

Take the following steps to help moderate anxiety:

a. Reduce intake of caffeine, tea, cola, and chocolate.
b. Before using over-the-counter (OTC) or herbal remedies, check with a doctor or pharmacist for any chemicals that may make anxiety symptoms worse.
c. Maintain a healthy diet.
d. Keep a regular sleep pattern.
e. Avoid alcohol, cannabis, and other recreational drugs: Alcohol and drug use can cause or worsen anxiety. If you're addicted to any of these substances, quitting can make you anxious. If you can't quit on your own, see your doctor or find a support group to help you.
f. Get help early: Anxiety, like many other mental health conditions, can be harder to treat if you wait.
g. Stay active: Participate in activities that you enjoy and that make you feel good about yourself. Enjoy social interaction and caring relationships, which can lessen your worries.

8.4.2. Prevention of Obsessive-Compulsive Disorders (OCD)

Obsessive-compulsive disorder (OCD) is a condition in which you have frequent unwanted thoughts and sensations (obsessions) that cause you to perform repetitive behaviors (compulsions). The repetitive behaviors can significantly interfere with social interactions and performing daily tasks. OCD is usually a life-long (chronic) condition, but symptoms can come and go over time.

Everyone experiences obsessions and compulsions at some point. For example, it's common to occasionally double-check the stove or the locks. People also often use the phrases "obsessing" and "obsessed" very casually in everyday conversations. But OCD is more extreme. It can take up hours of a person's day. It gets in the way of normal life and activities. Obsessions in OCD are unwanted, and people with OCD don't enjoy performing compulsive behaviors.

a) **Diagnosing OCD**

There's no test for OCD. A healthcare provider makes the diagnosis after asking you about your symptoms and medical and mental health history. Providers use criteria explained in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) to diagnose OCD.

The criteria include:

- Having obsessions, compulsions or both.
- The obsessions or compulsions take up a lot of time (more than an hour per day).

- The obsessions or compulsions cause distress or affect your participation in social activities, work responsibilities or other life events.
- The symptoms aren't caused by substances, alcohol, medications or another medical condition.
- The symptoms aren't explained by a different mental health condition, such as generalized anxiety disorder, eating disorder or body image disorder.

b) Treatment of OCD

The most common treatment plan for OCD involves psychotherapy (talk therapy) and medication. If this treatment doesn't help your OCD symptoms and your symptoms are severe, your provider may recommend transcranial magnetic stimulation (TMS).

c) Psychotherapy for OCD

Psychotherapy, also called talk therapy, is a term for a variety of treatment techniques that aim to help you identify and change unhealthy emotions, thoughts and behaviors. You work with a mental health professional, such as a psychologist.

There are several types of psychotherapy. The most common and effective forms for treating OCD include:

- Cognitive behavioral therapy (CBT): During CBT, a therapist will help you examine and understand your thoughts and emotions. Over several sessions, CBT can help alter harmful thoughts and stop negative habits, perhaps replacing them with healthier ways to cope.
- Exposure and response prevention (ERP): ERP is a type of CBT. During ERP, a therapist exposes you to your feared situations or images and has you resist the urge to perform a compulsion. For example, your therapist may ask you to touch dirty objects but then stop you from washing your hands. By staying in a feared situation without anything negative happening, you learn that your anxious thoughts are just thoughts and not necessarily reality.
- Acceptance and commitment therapy (ACT): ACT helps you learn to accept obsessive thoughts as just thoughts, taking the power away from them. An ACT therapist will help you learn to live a meaningful life despite your OCD symptoms.

d) Preventing OCD

You can't prevent OCD. But early diagnosis and treatment can help reduce its symptoms and its effects on your life.

e) **Caring for the person with OCD**

Aside from seeking medical treatment for OCD, practicing self-care can help manage your symptoms. Examples include:

- Getting quality sleep.
- Exercising regularly.
- Eating a healthy diet.
- Spending time with loved ones who support you and understand OCD.
- Practicing relaxation techniques, such as meditation, yoga, massage and visualization.
- Joining an in-person or online support group for people who have OCD.

8.4.3. Preventing Posttraumatic Stress Disorders (PTSD)

a) **Psychotherapy**

Several types of psychotherapy, also called *talk therapy*, may be used to treat children and adults with PTSD. Some types of psychotherapy used in PTSD treatment include:

- Cognitive therapy. This type of talk therapy helps you recognize the ways of thinking (cognitive patterns) that are keeping you stuck — for example, negative beliefs about yourself and the risk of traumatic things happening again. For PTSD, cognitive therapy often is used along with exposure therapy.
- Exposure therapy. This behavioral therapy helps you safely face both situations and memories that you find frightening so that you can learn to cope with them effectively. Exposure therapy can be particularly helpful for flashbacks and nightmares. One approach uses virtual reality programs that allow you to re-enter the setting in which you experienced trauma.
- Eye movement desensitization and reprocessing (EMDR). EMDR combines exposure therapy with a series of guided eye movements that help you process traumatic memories and change how you react to them.

b) **Medications**

Several types of medications can help improve symptoms of PTSD:

- **Antidepressants.** These medications can help symptoms of depression and anxiety. They can also help improve sleep problems and concentration. The selective serotonin reuptake inhibitor (SSRI) medications sertraline (Zoloft) and paroxetine (Paxil) are approved by the Food and Drug Administration (FDA) for PTSD treatment.

- **Anti-anxiety medications**. These drugs can relieve severe anxiety and related problems. Some anti-anxiety medications have the potential for abuse, so they are generally used only for a short time.
- **Prazosin.** While several studies indicated that prazosin (Minipress) may reduce or suppress nightmares in some people with PTSD, a more recent study showed no benefit over placebo. But participants in the recent study differed from others in ways that potentially could impact the results. Individuals who are considering prazosin should speak with a doctor to determine whether or not their particular situation might merit a trial of this drug.

c) Coping mechanisms

If stress and other problems caused by a traumatic event affect your life, see your doctor or mental health professional. You can also take these actions as you continue with treatment for post-traumatic stress disorder:

- **Follow your treatment plan:** Although it may take a while to feel benefits from therapy or medications, treatment can be effective, and most people do recover. Remind yourself that it takes time. Following your treatment plan and routinely communicating with your mental health professional will help move you forward.
- **Learn about PTSD**: This knowledge can help you understand what you're feeling, and then you can develop coping strategies to help you respond effectively.
- **Take care of yourself**: Get enough rest, eat a healthy diet, exercise and take time to relax. Try to reduce or avoid caffeine and nicotine, which can worsen anxiety.
- **Don't self-medicate**: Turning to alcohol or drugs to numb your feelings isn't healthy, even though it may be a tempting way to cope. It can lead to more problems down the road, interfere with effective treatments and prevent real healing.
- **Break the cycle:** When you feel anxious, take a brisk walk or jump into a hobby to re-focus.
- **Stay connected:** Spend time with supportive and caring people — family, friends, faith leaders or others. You don't have to talk about what happened if you don't want to. Just sharing time with loved ones can offer healing and comfort.
- **Consider a support group:** Ask your mental health professional for help finding a support group, or contact veterans' organizations or your community's social services system. Or look for local support groups in an online directory.

8.4.4. Prevention of Somatoform Disorders

(1) Diagnostic consideration

The category of somatoform disorders arises from the assumption that medically unexplained somatic distress and worry can be attributed to psychopathology.

The diagnostic criteria for somatoform disorders raise a number of thorny diagnostic problems including:

i. When is a symptom medically unexplained?
ii. When is worry or distress excessive?
iii. When can a symptom said to be 'psychogenic', that is, predominately caused by psychological factors?

(2) Treatment of somatoform disorder

In mild cases, these principles of initial basic care can be sufficient, combined with a "watchful waiting" attitude and follow-up contacts. If these principles turn out not to be sufficient, try, in extended basic care, some of the following:

- Introduce context factors as amplifiers rather than causes for the patient's symptoms. Build an effective, blame-free narrative that is linked to physical as well as psychosocial mechanisms and makes sense to the patient.
- Encourage—and monitor—more functional attitudes and behaviors, such as positive thinking, relaxation techniques, graded exercise, self-help guides, and groups. Set realistic goals together with the patient.
- Provide symptomatic measures such as pain relief or digestives; allow measures from complementary medicine according to patient's wishes; explain that these measures are temporarily helpful but less effective than self-management.
- Consider antidepressant medication if there is predominant pain or depression.
- If appropriate, set appointments at regular intervals rather than waiting for them to be patient initiated.

If these measures are still not sufficient, consider the following:

- Ensure that traumatic stressors and maintaining context factors, such as domestic violence, medication misuse, factitious symptoms, or litigation, are assessed.
- If applicable, carefully frame a referral to a psychotherapist in addition to reappointment with you.

- If applicable, consult with the psychotherapist on diagnosis, possible difficulties, and further treatment planning.
- When outpatient care is not available or seems insufficient, consider integrated care with multidisciplinary treatment, including symptomatic measures, activating physiotherapy, and occupational therapy, as well as psychotherapy.

Psychotherapy is an established treatment modality in patients with SSD:

- Clarify motivation of the patient for psychotherapeutic consultation. If applicable, confirm to the patient that you acknowledge his/her initial view that the symptoms have an, as yet, undetected organic basis and that he/she may "only" accept the consultation to please others.
- Use measures described above as appropriate.
- Listen attentively to bodily complaints and relationship experiences connected to them (with doctors and other health professionals, with relatives, colleagues, etc). Give feedback on the emotional aspects of these experiences (anger, disappointment, fear, etc).
- In more chronic patients, give support in organizing the history of presenting complaints (and experiences) into a coherent narrative.
- Encourage patients to extend their view of the possible influence of psychosocial, as well as biological context factors, eg, through time -limited use of a symptom-context diary (not recommended for patients with very high health anxiety). Do not attempt to "reattribute" symptoms to a predominantly psychosocial cause.
- Negotiate realistic (ie, modest) treatment goals. Advocate "better adaptation" and "coping"; avoid "cure" as a treatment goal.
- Resist the temptation to concentrate on psychosocial issues too early and too independently of lead complaints. If necessary, "somatize," ie, enquire about current bodily symptoms.
- Liaise with others involved in the care of the patient in order to obtain relevant information, especially concerning the necessity of further somatic diagnostic and therapeutic interventions, but also to send the message to the patient that constructive cooperation in caring for him/her is possible.

(3) **Prevention**

Little is known about how to prevent somatic symptom disorder. However, these recommendations may help.

- If you have problems with anxiety or depression, seek professional help as soon as possible.

- Learn to recognize when you're stressed and how this affects your body — and regularly practice stress management and relaxation techniques.
- If you think you have somatic symptom disorder, get treatment early to help stop symptoms from getting worse and impairing your quality of life.
- Stick with your treatment plan to help prevent relapses or worsening of symptoms.

(4) **Complications/Consequences**

Somatic symptom disorder can be associated with:

- Poor health
- Problems functioning in daily life, including physical disability
- Problems with relationships
- Problems at work or unemployment
- Other mental health disorders, such as anxiety, depression and personality disorders
- Increased suicide risk related to depression
- Financial problems due to excessive health care visits

Application activity 8.4

Match the prevention strategy to its best corresponding disorder

S/N	Prevention strategies	Disorders
1	Reduce intake of caffeine, tea, cola, and chocolate.	Obsessive-Compulsive Disorders
2	Practicing relaxation techniques, such as meditation, yoga, massage and visualization.	Anxiety
3	Learn to recognize when you're stressed and how this affects your body — and regularly practice stress management and relaxation techniques.	Somatoform
4	Stay active : Participate in activities that you enjoy and that make you feel good about yourself. Enjoy social interaction and caring relationships, which can lessen your worries.	PTSD
5	If you think you have somatic symptom disorder, get treatment early to help stop symptoms from getting worse and impairing your quality of life.	Anxiety
6	Stay connected: Spend time with supportive and caring people — family, friends, faith leaders or others. You don't have to talk about what happened if you don't want to.	Somatoform
7	Spending time with loved ones who support you and understand OCD.	Anxiety
8	Don't self-medicate: Turning to alcohol or drugs to numb your feelings isn't healthy, even though it may be a tempting way to cope. It can lead to more problems down the road, interfere with effective treatments and prevent real healing.	Obsessive-compulsive disorder
9	Exercising regularly.	Obsessive-Compulsive Disorders
10	Keep a regular sleep pattern.	PTSD

8.5. Prevention Strategies for Pyschological Disorders: Dissociative disorders; Mood disorders; Schizophrenia; Personality disorders.

Learning activity 8.5

Discussion question :

From the description you have for Dissociative, mood disorders, discuss what will happen (consequences) if prevention or treatment is not done/not well done.

8.5.1 Prevention of Dissociative disorders

Dissociative disorders are mental disorders that involve experiencing a disconnection and lack of continuity between thoughts, memories, surroundings, actions and identity. People with dissociative disorders escape reality in ways that are involuntary and unhealthy and cause problems with functioning in everyday life.

Dissociative disorders usually develop as a reaction to trauma and help keep difficult memories at bay. Symptoms — ranging from amnesia to alternate identities — depend in part on the type of dissociative disorder you have. Times of stress can temporarily worsen symptoms, making them more obvious.

Treatment for dissociative disorders may include talk therapy (psychotherapy) and medication. Although treating dissociative disorders can be difficult, many people learn new ways of coping and lead healthy, productive lives.

(1) Symptoms

Signs and symptoms depend on the type of dissociative disorders you have, but may include:

- Memory loss (amnesia) of certain time periods, events, people and personal information
- A sense of being detached from yourself and your emotions
- A perception of the people and things around you as distorted and unreal
- A blurred sense of identity
- Significant stress or problems in your relationships, work or other important areas of your life
- Inability to cope well with emotional or professional stress
- Mental health problems, such as depression, anxiety, and suicidal thoughts and behaviors

(2) **Risk factors:**

- People who experience long-term physical, sexual or emotional abuse during childhood are at greatest risk of developing dissociative disorders.
- Children and adults who experience other traumatic events, such as war, natural disasters, kidnapping, torture, or extended, traumatic, early-life medical procedures, also may develop these conditions.

(3) **Complications**

People with dissociative disorders are at increased risk of complications and associated disorders, such as:

- Self-harm or mutilation
- Suicidal thoughts and behavior
- Sexual dysfunction
- Alcoholism and drug use disorders
- Depression and anxiety disorders
- Post-traumatic stress disorder
- Personality disorders
- Sleep disorders, including nightmares, insomnia and sleepwalking
- Eating disorders
- Physical symptoms such as lightheadedness or non-epileptic seizures
- Major difficulties in personal relationships and at work

(4) **Prevention**

Children who are physically, emotionally or sexually abused are at increased risk of developing mental health disorders, such as dissociative disorders. If stress or other personal issues are affecting the way you treat your child, seek help.

- Talk to a trusted person such as a friend, your doctor or a leader in your faith community.
- Ask for help locating resources such as parenting support groups and family therapists.
- Look for churches and community education programs that offer parenting classes that also may help you learn a healthier parenting style.

If your child has been abused or has experienced another traumatic event, see a doctor immediately. Your doctor can refer you to a mental health professional who can help your child recover and adopt healthy coping skills.

8.5.2. Prevention of Mood Disorders

a) **Introduction**

Mood disorders may involve depression only (also referred to as "unipolar depression") or they may include manic episodes (as in bipolar disorder, which is classically known as "manic depressive illness"). Individuals with mood disorders suffer significant distress or impairment in social, occupational, educational or other important areas of functioning.

Symptoms	
Depression	**Mania**
• Feeling worthless, helpless or hopeless • Loss of interest or pleasure (including hobbies or sexual desire) • Change in appetite • Sleep disturbances • Decreased energy or fatigue (without significant physical exertion) • Sense of worthlessness or guilt • Poor concentration or difficulty making decisions	• Excessively high or elated mood • Unreasonable optimism or poor judgement • Hyperactivity or racing thoughts • Decreased sleep • Extremely short attention span • Rapid shifts to rage or sadness • Irritability

b) **Treatment of Mood Disorders**

Mood disorders are treatable. Many people with a mood disorder fail to seek treatment, however, and suffer needlessly. Of those who seek treatment, many remain undiagnosed or receive either incorrect medication or inadequate doses. The delay in seeking and receiving a diagnosis and treatment may be due to a number of factors, such as stigma, lack of knowledge, a lack of human resources and availability or accessibility of services.

- Current initiatives to relieve the burden of mood disorders include not only improved recognition and use of effective treatments, but also education for individuals and families and for the community.
- Primary care settings play a critical role in both recognizing and treating these illnesses. Innovative practice models have shown that effective interventions can decrease symptoms and increase work days.
- Effective early treatment of mood disorders can improve outcomes and decrease the risk of suicide.
- Antidepressant medications and education in combination with various forms of psychotherapy, such as cognitive-behavioural therapy, have demonstrated their effectiveness in treating depression.

- Educating family and primary care providers is essential not only to ensure the recognition of early warning signs of depression, mania and suicide and to implement appropriate treatment, but also to ensure adherence to treatment in order to minimize future relapses.
- Sound support networks are crucial during both the acute phase of the illness and the post-illness adjustment to daily life.
- Major depression results in poor productivity and sick leave from the workplace. The workplace, therefore, is an important area for addressing mental health issues.
- Supporting the development of healthy work environments, educating employers and employees in the area of mental health issues, and providing supportive reintegration into the work environment for those experiencing mental illness would go a long way toward minimizing the effect of major depression on the workplace.
- Individuals with mood disorders may require hospitalization to adjust medication, to stabilize the disorder or to ensure protection against self-destructive behaviour.

c) Complications

If mood disorders are not well treated or if there is no effective prevention, the situation may become worse and the following are consequences:

- Disability ranging from mild to complete inability to function, maintain social interaction, and participate in routine activities
- Impaired food intake: the person may lose appetite
- Severe anxiety: the anxiety becomes more and more abnormal. This is because to some extent anxiety is normal and needed for people to improve.
- Other substance use disorders: some people tend to consume much alcohol as a means to forget their problems but they remain. They can also use some drugs like cocaine, marijuana, etc.
- Suicide or suicide attempts: some people chose to terminate their life when they are overwhelmed with problems.
- Legal or financial problems
- Damaged relationships
- Poor work or school performance

8.5.3. Prevention of Schizophrenic Disorders

Although there is no proven way to prevent schizophrenia, scientists are looking for ways to make it less likely. Schizophrenia is a complex illness that may partly involve your genes. But events in your life may also play a role. In addition, researchers hope that learning more about risk factors for schizophrenia may lead to earlier diagnosis and treatment.

a. Prevention strategies

- **Don't use drugs:** This is especially important for teens, because their brains are still developing. Remember, alcohol is a drug, so you should limit or avoid it. Substance abuse is strongly linked to schizophrenia, with regular drug users more likely to suffer from the condition and a high percentage of schizophrenic patients who have a history of drug abuse.
- **Avoid abusive or traumatic situations:** If you're in an abusive relationship or you're going through trauma, get help.
- **Keep strong social ties:** Socializing helps you maintain self-esteem, lower stress, not feel lonely, and keep busy. Teens, especially, should be encouraged to connect with friends and avoid isolation.
- **Learn how to manage stress:** Ongoing stress and anxiety are bad for your health.

These tips may help you to manage stress:

- Keep a positive attitude.
- Accept that there are events that you cannot control.
- Be assertive instead of aggressive. Assert your feelings, opinions, or beliefs instead of becoming angry, defensive, or passive.
- Learn to manage your time more effectively.
- Set limits appropriately and say no to requests that would create excessive stress in your life.
- Make time for hobbies and interests.
- Don't rely on alcohol, drugs, or compulsive behaviors to reduce stress. Drugs and alcohol can stress your body even more.
- Seek out social support. Spend enough time with those you love.
- Seek treatment with a psychologist or other mental health professional trained in stress management or biofeedback techniques to learn healthier ways of dealing with the stress in your life.

- Take care of your body: Good nutrition and plenty of exercise are important. Take steps to protect yourself from head injuries, too. For example, wear helmets when biking or playing contact sports.
- Try fish oil: One study suggests that omega-3 fatty acids (found in fish oil) may help prevent psychotic disorders from getting worse, and might even prevent them in young children who are at risk of them.
- Take steps to stay well if you're pregnant or trying to get pregnant. Make sure you get good medical care for your physical and mental health.
- See a psychiatrist: If you have any symptoms, such as feeling suspicious or having unusual thoughts, see a psychiatrist. Cognitive behavioral therapy (a type of counseling) may help you better spot the early signs of schizophrenia and limit its impact on your work, school, and social life. In this type of therapy, a trained psychiatrist, psychologist, or social worker helps people recognize negative patterns of thought and come up with new ways of thinking about problems.

b. Complications if schizophrenia is not treated.

Left untreated, schizophrenia can result in severe problems that affect every area of life. Complications that schizophrenia may cause or be associated with include:

- Suicide, suicide attempts and thoughts of suicide
- Anxiety disorders and obsessive-compulsive disorder (OCD)
- Depression
- Abuse of alcohol or other drugs, including nicotine
- Inability to work or attend school
- Financial problems and homelessness
- Social isolation
- Health and medical problems
- Being victimized
- Aggressive behavior, although it's uncommon

8.5.4. Prevention of Personality disorders

Personality disorders is a definition used for the common physical, mental and spiritual characteristics. In the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) by the American Psychiatric Association (APA) classification system for mental disorders, personality disorder defined as, long-term adjustment disorder and strict disposition manifested by individual distress or social occupational functional disorder. Individuals with personality disorders have problems in their relationships with their environment and have high probability of attempting suicide and self-harm and harm to their surroundings. Therefore, personality disorders also cause deaths at an early age.

a. Therapies for personality disorders

Therapy is a general term for the application of techniques used to improve a person's mental or physical well-being. Psychotherapy is the main way of dealing with and treating mental conditions like personality disorders. Also called "talk therapy," therapists deal with the patients by encouraging them to talk about their condition, feelings, thoughts, mood and behavior. Several types of psychotherapy for mental illnesses include:

- Cognitive Analytic Therapy (CAT): CAT is a time-limited, integrated therapy that uses an object relations informed approach to cognitive therapy.
- Cognitive behavioral therapy (CBT): Most therapists combine cognitive and behavioral therapies to replace a person's unhealthy thoughts with positive and healthier perceptions. It's also used alongside antidepressants or medications during hospitalization, and it is a recommended therapy for people of all ages who have mental conditions.
- Dialectical behavior therapy (DBT): Dialectical behaviour therapy (DBT) is a type of talking therapy. It's based on cognitive behavioural therapy (CBT), but it's specially adapted for people who feel emotions very intensely. The aim of DBT is to help you understand and accept your difficult feelings. DBT has proven to be effective for treating and managing a wide range of mental health conditions, including:
    - ❖ Borderline personality disorder (BPD).
    - ❖ Self-harm.
    - ❖ Suicidal behavior.
    - ❖ Post-traumatic stress disorder (PTSD).
    - ❖ Substance use disorder.
    - ❖ Eating disorders, specifically binge eating disorder and bulimia.
    - ❖ Depression.
    - ❖ Anxiety.

- Interpersonal therapy (IPT): The goals of interpersonal therapy (IPT) are to help you communicate better with others and address problems that contribute to your depression. Several studies found that IPT may be as effective as antidepressant medication for treating depression. Psychiatrists will sometimes use IPT together with medication.

  IPT is not just for depression.

Interpersonal therapy can have a number of important benefits, including:

- Improved relationships: IPT can help patients understand how their relationships affect their life. The goal is two-fold: to help patients function better socially and to reduce their feelings of depression.
- Decreased depression: This form of psychotherapy is based on the notion that depression occurs in the context of relationships. In other words, your relationships can potentially increase or decrease your depression, and feeling depressed can impact your relationships. As such, the goal of IPT is to relieve your depressive symptoms by improving the way you interact with others.

Family-focused therapy:

- If you have a family member who has been diagnosed with Borderline Personality Disorder (BPD), you may wonder what role the family plays in the treatment of the condition.
- You may think that BPD treatment is strictly relegated to one-on-one interaction between a therapist and a patient. And although treatment does incorporate the standard therapist/patient model, it also involves group therapy with other BPD patients and, ideally, some type of family therapy.
- Family involvement by parents, siblings, and spouses when treating BPD can be beneficial for all involved. Many family members struggle with understanding the behaviors and symptoms of Borderline Personality Disorder.
- The symptoms of BPD can have a negative impact on how a family functions, while a dysfunctional family can exacerbate BPD symptoms. These two factors can create a negative cycle that worsens BPD symptoms and further impairs a family's functioning. Family therapy can be very effective in helping to identify these cycles and control the potential damage to both the family and the patient.
- Successful family therapy can help manage BPD symptoms and improve overall family functioning.
- Emotion regulation training (ERT): psychoeducation program that is based upon Systems Training for Emotional Predictability and Problem Solving for adult borderline personality disorder.

- Emotion regulation therapy (ERT) is a type of psychotherapy that has been successfully tested in adults with generalized anxiety disorder (GAD) and those with co-occurring GAD and major depressive disorder (MDD).
- ERT is a present-focused, structured psychotherapy that emphasizes awareness of emotions, acknowledgment of the conflict between desires for safety and value-guided action, creation of a healthy distance from harsh, critical thoughts about the self, and adoption of a more compassionate view of the self.
- Emotional awareness is developed through education about the purpose of feelings. The use of meditation exercises aimed to help reduce emotional avoidance—to improve tolerance of the presence of multiple, sometimes conflicting, emotions and sensations.

Mentalization-Based Treatment for Adolescents (MBT-A):

Mentalization-Based Treatment for Adolescents (MBT-A) is a treatment approach for working with adolescents presenting with a wide range of mental health needs including; interpersonal difficulties, emotional dysregulation, impulsivity and self-harm. MBT-A combines individual weekly sessions for adolescents along with Mentalization-based family therapy sessions (MBT-F) and aims to enhance an adolescent's capacity to represent their own and others' feelings accurately and in emotionally challenging situations.

Mentalization-based therapy can be an effective treatment for increasing the capacity to mentalize in people with borderline personality disorder, antisocial personality, addiction, eating disorders, and depression, even when other treatments have been unsuccessful. Mentalization-Based Treatment for Adolescents (MBT-A) is a practical guide for child and adolescent mental health professionals to help enhance their knowledge, skills and practice.

Omega-3 Fatty Acid Supplementation.

Available data indicate that marine omega-3 fatty acids improve symptoms of BPD, particularly impulsive behavioral dyscontrol and affective dysregulation.

There are no medications specifically designed to treat borderline personality disorder. Antidepressants, or "mood-stabilizing" agents, or antipsychotic medications may help reduce the severity of some of the symptoms. However, the response to these treatments is highly variable. There is strong need for more options with less risk for side effects. Emerging research points to a possible benefit from omega 3 fatty acids.

Omega-3 fatty acids are important components of cell membranes, and they seem to be particularly important in brain function. Omega-3s such as EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid) are present in the

brain and exist in relatively high concentrations in the nerve terminal regions, where most cell-to-cell communication takes place.

Depression is less common in people whose regularly consume omega-3-rich foods such as fish. Even schizophrenia appears to be less disabling in countries with higher consumption of vegetables or fish.

In human studies, researchers have repeatedly discovered associations between omega-3 fatty acid levels and symptoms of psychosis, depression, impulsivity and self-harm.

Complications if personality disorders are not treated effectively

Untreated personality disorders may result in:

- Poor relationships.
- Occupational difficulties.
- Impaired social functioning.
- Elevated rates of:
    a. Unemployment.
    b. Divorce.
    c. Domestic abuse.
    d. Substance use.
    e. Homelessness.
    f. Crime (especially antisocial personality disorder).

Application activity 8.5

In your groups/individually, evaluate the relevance of prevention or treatment for the Dissociative disorders in terms of consequences if they are not well done.

8.6. Prevention Strategies for Psychological Disorders: Childhood Disorders; Psychosexual disorders; Psychosocial deviances.

Learning activity 8.6

Scenario :

One day, in one city, there were two people a guy and a lady travelling. They were in car and suddenly they stopped the car in the middle of the busy road and started romancing without caring about the other road users. They caused jam because other cars queued front and back as they could not pass. The police intervened and the lady jumped out the car just to insult the police officer for interfering with their enjoyment. The police officer took the lady to the station. She was jailed for three days waiting for the court to do its job. In the meantime, the lady was released after bribing the chief of the police station.

Questions about the scenario :

1. How do you qualify the behaviour of the guy and the lady romancing in the car ?
2. Was the behaviour adequately corrected ? If no, what do you think would be the consequences ?

8.6.1. Prevention of Childhood Disorders

(1) Early Interventions for Attention Deficit Hyperactivity Disorder (ADHD)

Attention-deficit/hyperactivity disorder (ADHD) is an early emerging neurodevelopmental disorder that persists into adolescence and early adulthood for a substantial portion of afflicted individuals.

In addition to the "core symptoms" of inattention, impulsiveness, and hyperactivity that define the disorder, a substantial portion of individuals diagnosed with ADHD present with an array of neurocognitive deficits, psychiatric comorbidities, and social and emotional difficulties.

- There are several evidence-based pharmacological and psychosocial interventions that are effective for treating the core symptoms and, to a lesser extent, the associated features in youth with ADHD.
- Early intervention targets the child at a time when the brain is more "plastic" and perhaps more amenable to lasting "rewiring."

- Furthermore, early intervention can potentially be used during the beginning stages of ADHD, before complicating factors, such as comorbid psychiatric disorders, academic failure, poor social relationships, low self-esteem, and negative parent and family attitudes become barriers to successful treatment.
- Through the identification of young, "at-risk" children, who may not meet full diagnostic criteria for ADHD, it may be possible to use developmentally sensitive preventive interventions that will not only alter the chronically impaired course of ADHD, but will prevent the onset of many of the social, emotional, and academic difficulties that impede successful treatment during later phases of development.

(2) **Prevention of ADHD**

Though there is no way to prevent ADHD, there are ways to help all children feel and do their best at home and at school.

- **Good Prenatal Care**: Complications of pregnancy are linked to ADHD. You can increase the chance of your child not having ADHD by staying healthy throughout your pregnancy. A healthy diet and regular doctor visits are important. So is avoiding the use of alcohol and drugs.
- **Healthy Diet:** Giving your child a healthy, balanced diet from an early age is good for all children, whether or not they have ADHD. Some experts believe that altering a child's diet may reduce hyperactive behavior. Parents are encouraged to try cutting certain foods from their children's diet if they feel the foods affect behavior negatively.
- **Structured Routines**: All children, and especially those with ADHD, can benefit from structured routines and clear expectations. Once the schedule is set, follow it as closely as possible each day. If there are going to be any disruptions in the schedule, explain them in advance to your child. Though posting a schedule doesn't prevent ADHD, it should help improve your child's ability to stay on task. Post a daily schedule where your child can see it, so they know what to expect:
    - Waking up
    - Eating meals
    - Playing
    - Doing homework
    - Doing chores
    - Watching TV
    - Taking part in after-school activities
    - Going to bed

- **Behaviour management:** Many therapists believe you can impact your child's behavior by using behavior management.
- Spending quality time with your child each day "special time". During this time, let them pick an activity. Then simply focus on enjoying your child and their interests.
- Use positive reinforcement when your child behaves well. Experts encourage parents to notice their child's good behavior at least five times a day and offer simple praise for it.
- **Keep your expectations reasonable**: Base them on what's appropriate for your child's age and focus on only a few tasks at a time. Clearly explain what type of behavior you expect from your child in order to be rewarded. If you have several appropriate rewards, let the child choose from among them to increase ownership in the program.
- **Using negative consequences**: The last step in behavioral management is providing negative consequences for bad behavior. It is important to explain bad behavior to your child clearly. That way you can make sure they understand what is expected. Then explain the negative consequences for bad behavior. Be consistent. Don't be too harsh. Using negative consequences for unacceptable behavior is controversial, and negative consequences should never be cruel, abusive, or a reflection of your own emotions, no matter how frustrated you may feel.
- **Start teaching attention skills early**: If you have a preschooler, play games, build with blocks, and do puzzles together. It's a good practice for building attention skills. Reading to your child is another good way to teach them how to pay attention. Showing them lots of affection can also help a child calm down and pay attention.

(3) Autism Spectrum Disorder (ASD)

Autism spectrum disorder (ASD) is a developmental disability caused by differences in the brain. Some people with ASD have a known difference, such as a genetic condition. Other causes are not yet known. Scientists believe there are multiple causes of ASD that act together to change the most common ways people develop. We still have much to learn about these causes and how they impact people with ASD.

(4) Symptoms of ASD

The symptoms of a person with ASD are manifested in three categories: (1) Social interaction; (2) Communication (verbal and non-verbal); (3) Thinking and behavioral skills. The following is the list of symptoms falling under these three categories:

- Not maintaining an eye contact or lacking smile when doing so
- Not reacting or inconsistently reacting when their name is called out
- Hypersensitivity to noise
- Lost in own thoughts
- Hitting or biting themselves
- Not using gestures while communicating
- Inability to follow objects visually
- Inability to make friends
- Repetitive body movements or repeating their own sentences

(5) Prevention Strategies for Autism Spectrum Disorders

Pregnant women should take extra care to prevent Autism in children.

These precautions include:

Regular visits to doctor and checking on your medication: In order to prevent Autism, it is important to take your medical check ups and medications seriously during the course of your pregnancy. This will help you keep track of all the changes in your body and the baby's body. This is also a key time, as the habits you will form during your pregnancy, will eventually be responsible for the brain development of your child.

Less exposure to air-pollution: A study by Haravard School of Public Health concluded that the risk of developing Autism doubles in an infant in the third trimester of the mother, if she is exposed to too much of pollution. The particular pollutants responsible for the same are yet to be mentioned, but staying indoors when pollution levels are high, or sticking to indoor exercises and activities will surely help.

Intake of folic acid, as per the doctor's prescription: The U.S department of Health and Human Services recommends pregnant woman to consume 400 to 800 mcg of folic acid daily. Research shows that women who take less folic acid during pregnancy may lead to their child developing Autism.

Space out pregnancies: Studies have found that pregnancies when spaced between the time period of two and five years have the lowest chance of developing Autism. Research has shown that children that were conceived within 12 months of the first pregnancy were 50 per cent more likely to develop Autism. Autism risk also increases if the parents are older in age, therefore consulting your doctor before starting a family is necessary.

Avoid drinking alcohol and taking drugs: Consumption of drugs and alcohol during pregnancy increases the chances of your child developing Autism. This is because the chemical property present in these two can severely affect the development of a child's brain and hence should not be consumed at any cost.

8.6.2. Prevention for Psychosexual Disorders

There is no way to prevent psychosexual dysfunction. Partners are advised to talk to each other if the problem arises. Up to 54% of women and 35% of men may experience sexual problems, and yet many can find these issues difficult to talk about.

Talking is a key part of treating a psychosexual disorder – in the first instance to identify the problem and the history of the patient. If the patient is in a relationship, talking to the patient's partner can also play a key part in these discussions.

Once the nature and characteristics of the problem have been identified, a personalised treatment plan for the patient can be agreed. This may include psychotherapy which can help establish ways to deal with stressful or painful issues, or behavioural therapy such as CBT (Cognitive Behavioural Therapy) which is used to help 'unlearn' automatic behaviours displayed in specific situations. Often a combination of these will be used to help the patient overcome their psychosexual issues.

In addition to the advice mentioned, you may be able to reduce your risk of certain types of dysfunction by adopting certain healthy habits for example:

- Stop smoking or don't start
- Get regular exercise, including aerobic exercise
- Maintain a healthy weight
- Eat a well-balanced diet
- Limit alcohol intake to a maximum of two drinks per day
- Don't use illegal drugs
- If you have chronic diseases, like heart disease or diabetes, take steps to control your condition and improve your overall health

8.6.3. Prevention of Psychosocial Deviances

The prevention of social deviances is of paramount importance in many countries. Its solution goes to the state level, making the prevention and correction of deviant behavior among adolescents and children the most important social and educational problem of today. But there was difficulties implementing those correctional measures for quite a number of reasons. The present section will elaborate on methods of correction of deviant behaviours.

In relation to the correction of deviant behavior, two approaches can be distinguished – sociological and psychological.

(1) Sociological approach

The correction is carried out with the help of social norms and values produced by the society in the process of communication and cooperation between people. The society exercises social control over the individual, which should ideally be developed into self-control.

It should be noted that the United States and Western Europe, particularly the UK and Germany, have accumulated considerable practical experience of social and correctional work with deviant adolescents. At the highest, state, level, working with deviant adolescents provides for the adoption of laws and regulations aimed at the development and implementation of state programs for the socialization of the individual and his/her adaptation to the modern society

At the level of individual states, counties or lands, special social centers also develop specific preventive and resocialisational technologies. For example, in all the counties of the UK a social care service "Guidance" was created, which provides adolescents with all the necessary assistance. This service carries out the organizational and integrating activity of education, healthcare and socialograms for the socialization of the individual and his/her adaptation to the modern society.

In Rwanda, the national policy against delinquency was developed through a consultative process, involving various stakeholders and beneficiaries. The rationale for the policy is to provide high-level political framework within which everyone involved in the fight against delinquency will work through elaborate priority policy actions. The vision is to have a delinquency free Rwanda society. There are various private rehabilitation centers across the country that rehabilitate male and female delinquents across the country. They provide rehabilitation services (psychosocial and medical treatment) as well as different educational programs. Their activities are coordinated by the NRS.

Table: The list of private rehabilitation centers that work with NRS

S/N	Private Rehabilitation	Location
1	Centre Cyprien & Dafrose Rugamba (CECYDAR)	Kicukiro
2	Les Enfants de Dieu	Gasabo
3	Centre Marembo	Gasabo
4	Abadacogora n'Intwari	Bugesera
5	CPAJ	Kicukiro
6	Karibu Center	Kayonza
7	SACCA	Kayonza
8	Point d'Ecoute	Rubavu
9	Baho Neza Mwana	Rusizi
10	Imizi Children's Village	Rwamagana

11	Nyampinga	Huye
12	OPDE	Huye
13	Intiganda	Huye
14	S.O.S Rwanda	Kigali

These private rehabilitation centers follow the guidelines set by the NRS.

(2) **Psychological Approach**

The approach uses the interaction between experts in various fields. Assistance to children is offered using three main areas: clinical, psychological and pedagogical assistance.

A comprehensive study of the child and the expert's opinion on the state of health, mental development and the level of his/her adaptation helps to create an individual remedial program, the main steps of which include: the formulation of a social and educational problem, the advancement of hypotheses about the causes of deviant behavior, diagnostics, the choice of methods and techniques of diagnostic work, the development of the remedial program, the

implementation of the program, control over its progress and effectiveness.

The implementation of psycho-correctional programs is based on a number of fundamental principles:

The principle of the unity of diagnosis and correction as the integrity of the process of psychological assistance. The effective remedial work can be built only on the basis of a preliminary thorough psychological examination.

The principle of normative development. The main concepts here are "age norm", "individual norm".

The principle of the systematic development of the mental activity. This principle sets the need to take into account the preventive and developmental tasks in the remedial work.

The pragmatist principle of correction, according to which the remedial work should be directed at the targeted formation of generalized methods of orientation of the adolescent in the various fields of activity, interpersonal interactions and a social situation of development.

Other researchers came up with other preventive measures based on the causes of the deviant behaviours. A. Bandura suggested the following:

- ✓ The establishment of trusting relationships in the family, an increase of the educational potential of parents and their cultural and educational level, knowledge of the characteristics of psychology and physiology of the adolescent in the period of pubertal development, as well as fears and concerns of the child is an indispensable condition for the prevention of deviant behavior at the family level.

- ✓ Improvement of the quality of training and education of the younger generation (Kandugasheva, 2015). At the same time, particular importance should be given to the activities aimed at developing the sense of identity with the school and the community in children and adolescents.
- ✓ The activity of leisure centers, year-round and seasonal camps for study and work, the development and implementation of various programs, aimed at assisting in the choice of profession, professional improvement, the development of skills and abilities required to solve life problems.

In general, the main preventative measures of deviant behavior currently are as follows:

- ✓ Provision of the reliable psychological protection of children and adolescents;
- ✓ Formation of socially valuable traditions among adolescents, which could displace criminal and addictive actions;
- ✓ Support of youth organizations with positive goals and prohibition of the activity of anti-social groups;
- ✓ Adoption of the youth policy that meets modern requirements;
- ✓ Support of the institution of the family, struggling with orphancy;
- ✓ Promotion of the development of social work and its modernization;
- ✓ Active work with “difficult families”;
- ✓ Provision of equal opportunities in education;
- ✓ Provision of information for prospective parents about education, the improvement of the level of social responsibility and literacy of the population;
- ✓ An increase in the role of the family and the school in the society;
- ✓ Improvement of the laws to protect children’s rights and creation of organizations aimed at helping children and adolescents.

Learning activity 8.6

Question

In groups or individually, explain the preventive measures that societies should take to eradicate deviances.

End of unit assessment

Question 1: Explain the risk factors influencing Anxiety disorders

Question 2: a) Describe the typical symptoms of schizophrenia for teenagers

b) What factors can trigger schizophrenic disorders?

Question 3. Explain the tips for behaviour management for a child with ADHD

UNIT 9 PROFESSIONAL GUIDANCE AND COUNSELING

Key unit competence: Use effective listening to apply principles of guidance and counselling

Introductory activity

In everyday life, a person meets different life challenges and problems related to Social, Emotionaal Moral, and Personality development that may affect his/her interaction with both inside and outside the home environment. Think and answer to the following questions:

1. What can a person do, when she/he has a problem or a challenge that is beyond his/her capacity?
2. Where does this person need support for overcoming that problem?
3. How confident is a person when exposing his/her problem to the relied person?
4. To what extend does a person expect his/her problem get to be solved?

9.1. Key concepts in guidance and counselling

Learning activity 9.1

Create a mind map and write all words do you think may be related to guidance and counselling

a. Guidance

Guidance is a "process of giving advice". It is a continuous process of helping the individual development in the maximum of their capacity in the direction most beneficial to himself and to society. It involves listening carefully to the problems of the burdened individuals and discussing possible ready-made solutions that could help solve or at least alleviate the problem discussed at hand. In this way, the person who is in dilemma can choose whether or not to accept the given solution or ignore it. Guidance in education is defined as the help all students/ learners receive from teachers, parents, community members, and others to assist with educational and career development.

b. Counselling

It is the process of giving professional help and advice to someone to resolve personal or psychological problems. It is also a method that helps the client to use a problem solving process to recognize and manage stress and that facilitates interpersonal relationship among clients, family, and health care team. It involves a number of sessions that includes talking, listening, discussing the problem at hand and sharing relevant information that could help the person understand the problem and make his/her own decision or course of action.

c. Counsellor

A counsellor is a person trained to give guidance on personal or psychological problems

d. Guidance and counselling:

Guidance and Counselling is defined as a planned and organized work aimed at assisting the trainee to understand himself and his abilities and develop his potentialities in order to solve his problems and achieve psychological, social, educational and professional compatibility, and also to achieve his objectives within the framework of teachings. Guidance and Counselling complement each other though there are some differences.

Guidance and counselling is the process of helping individuals realize their potentials and develop them into skills. It is also a way of helping individuals understand their problems and deal with them effectively.

e. Career guidance

Refers to the career-orientating activities typically provided by school's counsellors and teachers as they help students to become aware of the work world, the value of planning and self attributes that may relate to various career options. A career guidance program develops an individual's competencies in self-knowledge and self-understanding, educational, occupational, exploration and career planning.

f. Therapy

Therapy, also called psychotherapy, is the process of meeting with a therapist to resolve problematic behaviours, beliefs, feelings, relationship issues, and/or somatic responses (sensations in the body). Through therapy, individuals can change self-destructive behaviours and habits, resolve painful feelings, improve their relationships, and more. It is also a treatment that is meant to cure a physical or mental disorder."Psychotherapy" is generally a longer-term treatment that focuses more on gaining insight into chronic physical and emotional problems. Its focus is on the person's thought processes, and how these may be influenced by past events such that they cause problems in the present.

g. Advising

Advising is a process in which advisor and advisee enter a dynamic relationship respectful of the student's concerns. It is a plan to aid students in developing self-awareness, option awareness, and decision-making skills. Ideally, the teacher serves as advisor and guide in an interactive partnership aimed at enhancing the student's self-awareness and fulfilment. This aims of helping students diminish the confusion that comes with a new environment, clarify their goals and get the most out of their education. Advising is also a process of giving students guidance, support and encouragement. Academic advising is an interactive process in which the adviser helps the student set and achieves academic goals, acquire relevant information and services, and make responsible decisions consistent with interests, goals, abilities, and degree requirements. Decisions concerning careers and/or graduate study may be part of the advising process. Advising should be personalized to consider the special needs of each student, which may include appropriate referral services. It is also a comprehensive system to provide students with skills and knowledge to make decisions about his/her education and career. A process to help each student improve his/her chances for long-term employment.

h. Mentorship

Mentoring is a human development activity, in which a person known as a mentor possesses good knowledge and experience shares it with another person called mentee who normally has less knowledge and expertise to help him out in the

development of his career, improving his self-esteem, enhancing productivity, etc. It is all about general development and psychological well-being of a person. Mentoring is a career development initiative taken by the management, in which an experience person guides and motivates a less experienced one, in gaining competencies for professional development. It provides encouragement, insight, and counselling to the maintenance for the development of person's career. The relationship between the parties is considered as mentorship, which is a long-term informal one. The mentor may include teacher, guide, adviser, consultant, host, counsellor, etc. The main purpose behind mentoring is to provide open and face to face communication between the mentor and mentee to help an employee to attain social & emotional maturity and effectiveness.

Table 12: Difference between Guidance and Counselling

	Guidance	Counselling
1) To whom Given	Students; Nurses, any person facing problems	Students; Nurses, any person facing problems
2) By whom given	Teachers; Parent; Counsellors	Counsellors i.e., specially trained professional people with counselling skills.
3) Where	Schools, home; everywhere; womb to tomb.	In a special setting conductive to giving and receiving help for interviewing.
4) How given	By way of giving educational, vocational information and helping individuals to understand themselves	Giving guidance with a view to enabling individuals to make decisions for himself/herself and coming to terms with life…….
5) Purpose	Optimum development of individual student for ultimate development for school.	Helping individuals develop self confidence and adjust to life strategies and schooling problems

In summary:

Counselling is an inward analysis of the individual whereas guidance involves an external analysis of the individual and his problems. Counselling in an in-depth analysis and has a narrower perspective wherein the individual understands his problems in depth whereas guidance is a broader and a more comprehensive approach. Counselling is generally provided for personal and social issues whereas guidance is usually provided for education and career related problems. Counselling focuses on making the individual understand the problem and, therefore, brings about behavioural changes in the individual so that he can adjust to the problem. On the other hand, guidance focuses on finding a solution

to the problem whereby the solution may bring about a change in the attitudeof the individual.

Application activity 9.1

1. Compare and contrast guidance and conselling
2. What are the similarities between conselling and therapy?

9.2. Types of guidance

Learning activity 9.2

Read this small scenario and reflect on it, by using questions below.

Maria is a student of senior three. She must choose the option to study in upper secondary school but she doesn't know exactly what option to choose.

- *What is thevproblem does Maria have?*
- *In case Maria approaches you, how could you assist her?*

9.2.1. Personal guidance

Personal guidance helps in the emotional, physical, spiritual, social mental development of an individual. These problems can be related to family, friends, parents, teachers and so on. If personal guidance is not provided to a person at the right time, they may develop low self-esteem which will eventually make them feel insecure in whatever they do. Thus, personal guidance helps an individual to understand himself and deal with personal problems in a mature manner. It enables an individual to take the necessary decisions based on right judgment. Personal guidance also helps an individual to view the social world in the right perspective and make the necessary social and personal adjustments to lead a happier life. Personal guidance is required in all stages of life and must be furthered by educational institutions as a mandatory part of education. At the elementary school stage, personal guidance helps the individual to deal with insecurity, social acceptance and discipline and enables an individual to be expressive enough to deal with personal problems.

At the stage of adolescence, personal guidance plays an important role in the lives of adolescents who undergo social, physical and attitudinal changes. Personal guidance at this stage helps the individuals to adjust personally as well as socially. At the stage of adulthood, personal guidance enables an individual to address personal problems in the context of family. It enables an individual

to adjust mentally, physically and emotionally with various people who form a part of the family and this in turn helps the individual to adjust with the kinds of people existing in the society. Thus, the scope of guidance at this stage is the widest. Personal guidance in essence helps an individual to address the various problems that are confronted in life at the various stages. It enables an individual to emerge as a stronger person both physically and mentally.

9.2.2. Educational guidance

Educational Guidance is a process of helping students to achieve the selfunderstanding and self-direction assisting them to make informed choices and move toward personal goals. It helps the students in choosing the courses of study, planning for their future on completion of their secondary/higher secondary schooling and promoting proper adjustment. Educational guidance is required at each level during the individual's education.

Educational guidance has specific functions at different stages :

- **Primary and Secondary Stage :**

At the primary stage, educational guidance will help in assisting students make a proper beginning in school and preparing them to enter the secondary stage.

At the secondary stage, educational guidance is intended to assist students to make an appraisal of their interests, abilities, and skills, to make progress in their education and to build motivation for study.

- **Higher Secondary Stage :**

At this stage guidance helps in the selection of courses, or vocation in tune with their abilities and interests and understanding the objectives of higher education and plan for their future career plans. Information regarding admissions to polytechnic institutions, colleges and university and vocational information provided will also help. Proper guidance will help in building a positive attitude, bring about self-confidence and be able to cope with academic stress.

- **College and University Stage:**

"What shall I do in life ? And what am I best suited for" ? This is a normal question which we ask ourselves.

9.2.3. Vocational guidance

Technological development has opened the avenues for several occupations and specialized jobs. This leads to an increased need for vocational guidance. Vocational guidance deals with assisting an individual for the right occupation or job. Vocational guidance helps an individual choose the right occupation and then also prepare for it and track his progress accordingly. The main aim of

vocational guidance is to help individuals build a better future and choose the right career. Vocational guidance helps an individual to realize his potential and skills and then on this basis decide the right career. It also helps an individual to develop the right attitude towards work.

Vocational education helps an individual to evaluate every job and career option available critically and then choose the right one. At the elementary stage, no formal vocational guidance may be required but training can be provided to develop skill that are of vocation significance like cooperation, use of hands, respect for manual work, development of interpersonal relationships and so on. At the secondary stage, vocational guidance can be provided to help students identify their areas of vocational interest and to develop employment readiness. At this stage, vocational guidance can help the students to take the right decisions related to their career. At the tertiary stage, vocational guidance must be provided in a more formal manner. At this stage, guidance must be provided to students to inform them about the various career options available, the career options that match their skills, the training facilities available in relation to the various career options and also the various apprenticeship programmes available. Vocational training must enable the students choose the right career option and develop the essential skills that would prepare them to enter the career field opted by them.

9.2.4. Social guidance

Most people face a lot of problems when it comes to social relationships. People develop their social interactions and social relationships in schools where they meet others from different backgrounds, different economic and social status and, therefore, some students may face problems adjusting to the environment. Social guidance plays an important role here as it helps the individuals to develop feelings of social acceptance and social adjustment. Social guidance teaches individuals to be tolerant towards others and helps them to develop a feeling of social security. Social guidance can be provided formally in educational institutions whereas informal social guidance can be provided by the family, media and so on. Social guidance must be provided at the very basic level in the family so that individuals learn to adjust with various people in the society.

9.2.5. Moral guidance

Moral guidance plays an important role in shaping the ideals and beliefs of the indivifuals. Moral guidance prevents people from being affected by factors that lead them to indulge in undesirable practices. This type of guidance must be provided at all stages of life so that an individual remains on the right path and also facilitates the all-round development of the individual.

9.2.6. Health guidance

Health guidance aims at preventive and curative health of individuals. Health guidance is essential for adolescents as it enables them to develop healthy eating habits and for them to know about various diseases including HIV/ AIDS. Health guidance must be provided at all stages of life to students and must form a part of education right from the elementary level. Imparting education and information relating to health must be made mandatory in schools for proper and healthy development of the students. Health guidance given to students must be a cooperative effort on the part of principals, doctors and psychologists.

9.2.7. Avocational / leisure guidance

Avocational guidance helps an individual to manage and use his leisure time in an effective manner. Avocational guidance is essential as co-curricular activities play an important role in the development of the student. It helps the students choose the right activities in which their energies can be properly channelized. This type of guidance enables the individual to participate effectively in co-curricular activities and, thus, helps them to develop interpersonal skills and also widen their outlook

Aims of guidance

- Guidance aims to help the individual in realizing his potentialities and to make maximum contribution towards the society.
- It aims to help the individual to solve his problems and make proper choice and adjustment.
- It provides help to the individual to lay a permanent foundation for sound and mature adjustment.
- To help the individual to live a well-balanced life in all aspects— physical, mental, emotional and social.

Application activity 9.2

1. Differenciate the types of guidance and discuss its aims.
2. Suppose that you are in charge of youth at your sector, which types of guidance could you give to them?

9.3. Types of counseling

Learning activity 9.3

With your partener, prapare a role play, act it and by after reflect to the following questions.

- Who has a major role in your simulated counselling ? A counsellor or a counsellee ?
- what was the role of counsellor in your role play?

Counselling can be categorized into the following three types based on the role of the counsellor and the nature of the counselling function.

a) **Directive counselling**: in directive counselling the counsellor plays a major role in solving the problem. The counsellor identifies, defines, diagnoses the problem and then provides a solution. The counsellor has a major role to play in directive counselling as he directs thinking by informing, explaining, interpreting and advising the client. The counsellor in directive counselling performs the following activities:

- The counsellor conducts an analysis, which entails collecting data from various sources so that the problem of the client can be understood.
- He puts together data which involves interpreting and organizing the data collected to know about the client's strengths, weaknesses and so on.
- He identifie the nature of the problem and also what causes the problem.
- He conducts a prognosis which involves predicting the development of the problem in the future.
- He conducts a follow-up which involves helping the client time and again or when the client faces the same type of problem again.

The merits of the directive counselling process are as follows:

- It is economical and does not take much time.
- The client gets a solution to the problem for sure.
- The method focuses on intellectual adjustment of the client rather than emotional adjustment.

The following are the demerits of this approach :

- The process is counsellor oriented and, therefore, the client becomes dependent on the counsellor.
- The approach is undemocratic as it does not give any rights to the client.
- The client in most cases becomes helpless and waits for the counsellor toprovide a solution.

b) **Non-directive counselling:** Non-directive counselling is client-centred counselling where the client is allowed free expression and the counsellor only directs and guides. The counsellor asks a few questions to the client so that he can think of the possible solutions. The counselee is an active participant, who discusses his problem with the counsellor, and with the help of the counsellor arrives at a solution and takes a decision. The role of the counsellor is a passive one. The main role of the counsellor is to create an atmosphere where the client is able to work on his own and find solution to problem. This approach focuses on the emotional aspect of the client rather than the intellectual one.

The merits of the non-directive counselling approach are the following:

- This approach provides freedom to the person seeking counselling.
- It provides a tension free and stress free environment wherein the client can work at ease.
- The counsel seeker is not dependent on the counsellor for finding solution to the problem and, therefore, works towards self-acceptance.
- Since the counsel seeker gets a positive atmosphere, he can confront his weaknesses easily.

The demerits of non-directive counselling are the following :

- It is a time-consuming process as the counselee is not a professional who can quickly find a solution.
- Since the process is client-centred, the solution to the problem may not be accurate because the judgment and wisdom of the client cannot be relied upon entirely. This is because the client is the one facing the problem and he may be under stress and tension and, therefore, may arrive at the wrong solution.
- Non-directive counselling relies on discussion of the problem with the counsellor and then finding a solution through discussion. However, all problems cannot be solved simply by discussion and may need other techniques and tools as well.

c) **Eclectic counselling**

Eclectic counselling revolves around the use of coordinative methods. The client and the counsellor cooperate and work actively in finding a solution to the problem. The process focuses on the personality and the needs of the client and then finds techniques that can be used to find a solution to the problem faced by the counselee. Some techniques that can be used in this process may include reassurance, testing, case history and providing the essential information to the client so that the problem can be solved.

The steps involved in eclectic counselling are the following :

- The counsellor studies the needs and personality of the client.
- The counsellor selects the appropriate techniques after consulting the client.
- The techniques are applied to solve the problem.
- The techniques and the counselling process are evaluated to know whether it has been effective or not.
- Counselling is then done by the counsellor.
- The counsellor seeks the opinion of the client on whether the technique and counselling provided have been of help or not.

The merits of eclectic counselling are as follows :

- The counsellor as well as the counsellee is active and so a more practical solution can be arrived at.
- The approach is applicable practically in most cases.
- The approach enables the counselee to get a better insight of his strengths and weaknesses.

The demerits of eclectic counselling are as follows :

- The approach is considered to be vague and opportunistic.
- There is no rule that states the extent of freedom that can be given to the client when it comes to finding a solution to the problem.
- Many people are of the view that both the counselee and counsellor cannot be given equal rights and cannot be active at the same time in finding a solution to the problem.

There are several spheres of life in which people need counselling. The above types of counselling are applied in the following areas:

- **Education:** Students during their school and college years may face several problems related to education, learning and teaching. Such problems are addressed by educational counselling and by counsellors who are experts and experienced in this specific area
- **Marriage :** Marital counselling is often required by those who face problems in their married life. These problems may begin as soon as the question of spouse selection comes to the fore. Marriage counsellors handle such problems and provide the necessary solutions to the problem.
- **Personal :** Many people face several problems in their life which bring about changes in their attitude and are often considered a hindrance in leading a normal life. Personal counselling looks into the personal

problems of an individual and enables an individual to overcome these problems.

- **Social** : Social problems may be faced by individuals wherein they are unable to maintain social relationships and fail to adjust to the society and its ways and norms. Social counselling is provided to such people so that they can develop the skills of social acceptance, tolerance towards others and are able to lead a life in tandem with the society.
- **Rehabilitation :** Sometimes, the life of an individual is disrupted because of accidents, mishaps and so on. Such people often develop depression, low self-esteem and in most cases are unable to get over the disruption of life. Rehabilitation counselling is provided to such people so that they can develop life skills that can enable them to lead a normal life.
- **Vocational :** Most people face problems in deciding about the right career option and are unable to adjust to their work area, the people around and also the work environment. Such people are not able to work productively. Vocational counselling is made available to such people so that they can make the right career choices and are able to adjust to their work environment so that they are able to work productively.

Application activity 9.3

1. In which area do firstly students need counselling ? Explain.
2. Compare and contrast direct counselling and non-direct counselling. Which one favour the free expression of the counsellee ?

9.4. Principles of guidance and counselling

Learning activity 9.4

Brainstorm and find out the points that guide the counsellor during guidance and counselling.

Basic principles of couselling are:

a. **Principle of acceptance**: This principle says that every person seeking counselling must be treated as an individual who has unique needs. In other words, no two people in general seek counsel for the same reason and this fact must be accepted by the counsellor.

b. **Principle of permissiveness :** According to this principle of counselling, the process of counselling must permit the environment to be developed

as per the individual's needs. Also the process of counselling must develop optimism in the individual.

c. **Principle of respect :** This principle states that counselling must respect an individual's feelings. In other words, respecting the feelings of the person seeking a counsellor must be integral to the process of counselling.

d. **Principle of thinking with the individual** : Counselling as a process emphasizes on thinking with the individual. In other words, a counsellor must be able to think in a manner that matches the thought process of the individual because only then can the counsellor work collectively with the individual to find a solution to the problem.

e. **Principle of learning** : As per this principle, counselling as a process entails learning and is also based on learning and several elements associated with learning.

f. **Principle of consistency with ideals of democracy** : Counselling and all its other principles are associated with the ideals of democracy. The ideals of democracy basically emphasize on accepting an individual and showing respect. In fact, respect is considered to be the right of an individual when it comes to the ideals of democracy. Counselling as has already been stated accepts and respects an individual and his unique needs and, thus, is based upon the ideals of democracy. Counselling also respects the different needs and behaviours of the various individuals who seek counselling.

Ethical principles of counselling:

a. **Being Trustworthy :** According to this principle, a counsellor must be trustworthy in the sense that he must act in accordance with the client's trust shown in him. Since during counselling, a client reveals details to the counsellor, the counsellor must regard the confidentiality of the client as an obligation and, therefore, must not share any information about the client with anyone.

b. **Autonomy :** This principle emphasizes the client's right to be self-governing. In other words, the principle of autonomy says that the client must be willing to participate in the counselling process. The client must voluntarily participate in the process and the counsellor has no right to manipulate his clients

c. **Beneficence** : This principle says that the counsellor must carry out counselling that promotes the well-being of the client. The counsellor must work in the best interests of the client and for this must make use of the available resources in the best possible manner.

d. **Non-maleficence :** This principle states that the counsellor must ensure that the client is not harmed in any manner. Non-maleficence basically suggests that the client must not be exploited in any manner—financially, emotionally and sexually. This also implies the fact that the counsellor must avoid indulging in any kind of malpractices.

e. **Justice :** The principle of justice says that the counsellor must provide the best services to the clients based on their different needs. The principle also emphasizes fair and impartial treatment of all clients in the most competent manner by the counsellor. It also entails the counsellor providing adequate services to all clients based on the different needs and reasons for counselling.

f. **Self- respect :** According to this principle, the counsellor must foster self- respect by imbibing sufficient and significant knowledge about profession and also by caring for self. This is essential to boost the confidence of the counsellor and for enabling him to indulge in the profession in the best possible manner.

Rotimo (2014), determined other principles of guidance and counselling in other way :

i. Guidance and Counselling is for everyone. The service is not only for those with disabilities but it is also meant for all people without disabilities, developing children and adults;

ii. Guidance and Counselling activities should be based on the need and total development of every person. It is the duty of all personnel in a setting to identify the needs of individuals so that programme activities can be designed to meet such needs;

iii. Guidance and Counselling must be provided in a way that ensures human dignity and worth. The full and adequate development of the individual must be given preference. It should be seen as encouraging individuals to attain maximum satisfaction, to realize their potentials and to be aware to self. No one who has gone through counselling should feel inadequate;

iv. Guidance and Counselling is a sequential, continuous and developmental process, which starts from birth to death. This means that guidance and counselling run from the nursery school through primary, secondary to the tertiary institutions. It is not a once and-for-all event but a process which is an integral part of the total educational programme throughout the school life of an individual;

v. There is a close relationship between counselling activities and the instructional process, each contributing to the other. Counselling can help make the instructional activities to be more relevant and meaningful

to the needs of students, while the instructional activities can help to give necessary information and directives to a student in planning his/her life goals;

vi. All guidance activities must emphasize the will for each student to learn more about himself in an accurate and systematic manner. Through the use of well-planned instructional strategies and appraisal techniques, individuals can become more knowledgeable about themselves and about the world around them. Without such knowledge, an individual cannot exercise intelligently the rights to free choice in educational, vocational and personal social fields.

vii. Every member of staff in a school and non-school setting should assume responsibility for guidance activities. The principal, teachers and counsellors are all members of the guidance team and each member has prescribed functions and roles.

viii. Effective leadership is the watchword for any effective guidance and counselling programme. Guidance counsellors who are qualified, well-trained and competent are expected to function in schools and other settings. Such professionals would be able to enlist the support of staff members in effecting guidance activities.

ix. The practitioners should practice within ethical and moral limits. The ethical and moral guidelines should be such that clients would feel secure and confident in using the services provided. This also guarantees that counsellors will not use techniques and/or approaches for which they do not have competence; and

x. The objectives of counselling should be based on clients' needs and not on the needs of the counsellors. In pursuing such needs of the client, the counsellors must present a positive image.

Application activity 9.4

List five principles of guidance and counselling and explain them

9.5. Effective counselling techniques

Learning activity 9.5

With your partner prepare and act the role play. One is will the counsellor, the other one will be the counsellee. By after, answer to the following question

- How did the counsellor get the information from the counsellee ?
- How did he/she save the information from the inrofmation from the counsellee?

a) **Observation**

This is an oral and visual way of measuring what a person says and what a person does. It is basic to other guidance techniques which do not necessarily pertain only to verbal language. In this technique, behaviour is studied through observation by a trained observer. The effectiveness of the technique depends upon the skilfulness of the observer. An observer is expected to observe well defined behaviours free from biases and prejudices. Parent, teacher, and counsellor should know what to observe, how and what to describe and how to interpret. Observational techniques are useful in the study of students and individuals but their usefulness depends upon the manner and purpose with which they are conducted. It takes time which is made on several occasions and records will reveal the personality and a portion of the totality of the individual

The following are the two types of observations:

Natural observation : In natural observation, the specific behavioural characteristics of the individual in a natural setting are observed. This means that during observation, the individual does not get conscious of someone observing his behaviour. Thus, this type of observation can help to observe the real behaviour of the individual and, hence, brings out the hidden aspects of his personality.

Participant observation: In this type of observation, the observer becomes a part of the group which he wants to observe. The observer builds a rapport with the group and the group members are not aware of his intentions and so behave in a natural manner.

The advantages of the observation method are the following:

- These are reliable, valid and scientific.
- Observations are the most economical method of data collection.
- Observations can be flexibly used in various situations.
- Observations can be applied to people of all ages.

- Observations can be applied to groups as well the individual.
- These do not require much training.

The disadvantages of the observation method include the following:

- Observations are subjective.
- These can be used to observe the external behaviour and not the internal feelings.
- The observation records many not be accurate and may be biased. Sampling and observer error may take place in observations which make the information invalid and unusable

b) **Interview**

The interview technique is used for collecting information's about the individual by interview his parents and peers or other family members. If a counsellee is a child, it is usually advisable for interviews to be held with at least one of the parents and preferably both. The conference will be facilitated or hindered by the general attitude on the part of the parents toward the child, and by the community's conception of the role of the teacher.

A counselling interview should typically cover the following areas:

- The reason for conducting the interview
- Previous work history
- Educational history
- Hobbies
- Interests
- Family situation and background
- Social Activities
- Physical conditions
- Self-evaluation of appearance, abilities and personality

The advantages of a counselling interview are as follows:

- It is the best technique using which information about the individual can be gathered.
- It is more like a conversation and so the counsellee feels comfortable.
- It is very easy to conduct.
- It helps the counselee to get an insight and solve his problems

The disadvantages of the counselling interview are as follows:

- It is subjective and time-consuming.
- The interview needs to be conducted by experts.

- In some cases, it is difficult to interpret the results.
- It may not always produce the desired results

c) Cumulative record

The cumulative record has been defined as "a method of recording, filing and using information essential. It is a record of information concerned with the appraisal of an individual. The information which is obtained periodically through various sources, techniques, tests, interviews, observations, case study and the like, is assembled in a summary form on a cumulative record card, so that it may be used for example when the student needs advice for the solution of some educational or vocational problem.

A cumulative record card supplies information on points such as the following:

- Personal: (i) name, (ii) date of birth, (iii) place of birth, (iv) sex, (v) colour, (vi) residence.
- Home: (i) names of parents, (ii) occupations of the parents, (iii) parents alive or dead, (iv) economic status, (v) number of siblings, older or younger, (vi) language spoken at home.
- Test scores: (i) general intelligence, (ii) achievement, (iii) other test scores, and (iv) personality traits.
- School attendance: (i) days present or absent each year, (ii) schools attended with dates.
- Health: record of physical disabilities, vaccination record, diseases suffered from.
- Miscellaneous: (i) vocational plans, (ii) extracurricular activities, (iii) employment during studies, and (iv) counsellor's note.

The cumulative records about students provide useful information to teachers, counsellors and administrators.

d) Questionnaire

A questionnaire is a list of questions to be answered by an individual or a group of individuals, especially to get facts or information. It should be elaborated to match with other techniques. Questions are designed to get information about conditions and practices about which the respondents are presumed to have the knowledge. Questions should be few in number and simple to be understood and answered. They should directly cover the point of information.

e) Case study

A Case study basically involves studying about the individual in detail. A case study is a systematic process that aims at complete and intense study of the individual including his family background, physical, social, emotional and

intellectual environment. According to American psychologist, Ruth Strang, The case study or history is a synthesis and interpretation of information about a person and his relationship to his environment collected by means of many techniques. Case study is an assessment method that typically studies learning difficulties, emotional disturbances and, other behavioural problems that the individual faces in his normal routine, which is detrimental to his overall development

The following information needs to be collected for a case study:

- **Preliminary information :** This information is about the name, age, sex, parent's age, education, occupation, income, number of children and social status of the individual.
- **Past history :** Past history refers to any information that has affected the development of the individual. For instance, information about past history may include information related to the individual's social, physical, mental illness or relationship with others.
- **Present condition :** Information about the present condition of the individual may be related to his physical, medical, intellectual, emotional, social and interest information.

Advantages of a case study are as follows:

- It can be used as a basis for diagnosis and treatment of the individual.
- It gives in-depth information about the individual.
- It enables a person to make suitable adjustments for overall development.

Disadvantages of a case study are as follows :

- It is a very time-consuming process.
- A case study is a subjective technique.
- It is a difficult method that can be carried out by experts and professionals.
- Interpreting the results of a case study is also a tough task

Application activity 9.5

Read this scenario and answer to related questions.

A young boy of 12 years comes to you with tears in his eyes. You find out that his father is very sick in the hospital. His father works for Department of Education and they stay in a government house. His mother told him that his father might die and they will be forced to leave their home. There will be no money for his school fees.

Questions:

1. Identify techniques that you may use when conducting guidance and counselling to this child.
2. How will you use those identified techniques?

9.6. Phases / steps of counselling

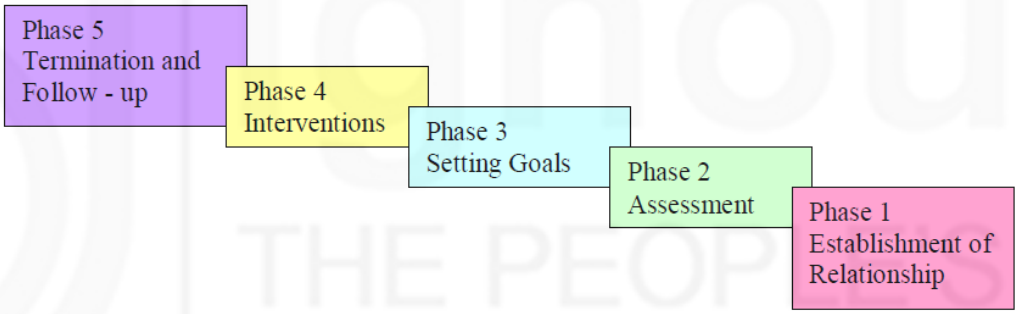
Learning activity 9.6

Sometimes you will be communicating with someone who differs from you in terms of his or her social status, gender or education. How will this affect the counselling process ?

There are five different phases/steps of counselling process although it is difficult to divide such a complex process into clearly defined phases. These phases include :

(i) Establishing Relationship
(ii) Making Assessment
(iii) Setting Goals
(iv) Interventions
(v) Termination and Follow up.

The phases may overlap each other, e.g., the assessment may begin even while the phase of establishing relationship is still going on or goal setting may start while assessment it still going on. These phases are in progressive movement and collectively described the counselling process, as depicted in the following figure.



(i) Establishing Relationship

Establishing productive Relationship is the core phase in the process of counselling. It affects the progress of the process and acts as a curative agent in itself. It should be recognized that each counsellee-counsellor relationship is unique and hence it is not possible to have a generalized that each counselee-counsellor relationship. It includes such factors as respect, trust, and a sense of psychological comfort which help in formation and sustaining good relationship. Although each counsellor has her own style of building up a relationship, but a few guidelines will be useful. These are :

Begins the phase with adequate social skills

- Introduce yourself
- Listen attentively and remember the client's name
- Always address the individual by his/her preferred name
- Ensure physical comfort
- Do not interrupt the individual while s/he is speaking
- Observe non-verbal communications.

(ii) Assessment

Making assessment is a phase in which individuals are encouraged to talk about their problems; counsellor asks questions, collects information, seeks his/her views, observes and possibly helps the individual to clearly state his/her problems. This is the data collecting phase, and involves several specific skills such as:

- Observation
- Enquiry
- Making associations among facts
- Recording
- Making educated guesses and interpretations
- Recording of information should be done systematically.

(iii) **Setting Goals**

Setting goals is phase based on educated based on educated guesses/ interpretations made in the previous phase. The major purpose of this phase is to provide direction to the conditions, a course of action, or an outcome. Sometimes the individual may be concluded. Setting goals may be of two types- immediate and ultimate.

The process of setting goals is cooperatively done by the counsellor and the individual.

It requires the skills of:

- Drawing inference,
- Differentiation, and
- Educating individuals to think realistically.

It should be emphasized that goals are not fixed for all time to come and can be changed whenever new information is received or new insight is developed.

(ii) **Intervention**

Intervention is a phase which is more influenced by the view points a counsellor holds about the counselling process. After setting goals the question that follows is 'How shall we accomplish these goals'? The intervention used will depend upon the problem area and the nature of specific problem and the individual. Hence, the choice of the intervention is a process of adaptation and the counsellor should be prepared to change the intervention when the selected intervention is not working. This is similar to medical treatment. When one treatment does not work, the practitioner tries the alternative treatment. The counselling skills neededare skills in handling the interventions, knowledge of its effects and ability to read client's reactions. Individuals can be asked in the beginning about what interventions they have tried earlier so that other intervention can be used.

(iv) **Termination and Follow up**

All counselling has as its ultimate criterion a successful termination. It must be done without destroying the accomplishments gained and should be done with sensitivity, intention and by phasing. It is not unusual for the individual to have a of a sense of loss; hence termination should be planned over few sessions. Follow-up appointments can also be fixed for some time.

Application activity 9.6

After learning this lesson: discuss briefly the steps of counselling?

9.7. Challenges in guidance and counselling

Learning activity 9.7

With your partner, discuss and find out problems that may occur during guidance and counselling?

The challenges and problems of guidance and counselling are as follows:

i. **Lack of cooperation**

While guidance and counselling is certainly an effective way of providing assistance to someone who needs it, not everyone may be willing to accept the advice given to them. Many individuals may not cooperate with the advice given to them which can cause an obstruction in the way of guidance.

ii. I**nadequate Facilities**

To ensure the proper functioning and efficiency of guidance and counselling services, proper facilities are needed. Facilities such as a guidance and counselling room, proper furniture, bookshelves, and the like are necessary.

iii. **Lack or Absence of Funding**

Guidance and counselling take place in an atmosphere surrounded by motivation and positivity. However, this is not possible if there are no adequate facilities. To ensure the adequacy of facilities, funding is needed and many educational institutions suffer a lack of funding when it comes to guidance and counselling.

iv. **Shortage of Professionals**

Guidance and counselling are terms that are often used interchangeably. However, they do have a slight difference. While guidance can be given by anyone, counselling can only be given by an expert in the field. Hence, finding a professional counsellor can be difficult.

Shortage of counselling personnel : Professionally trained counsellors are in short supply in our schools. Many Universities do not train counselors with specialized training ; hence most schools make use of teachers as counsellors and career masters who do not have deep knowledge of counselling programme.

v. **Lack of Support**

Although there is a rise in the awareness of the need for guidance and counselling in the educational sphere, there is still an air of neglect that hangs when it comes to the implementation of these services.

vi. **Lack of Time**

Along with the lack of funding and sufficient resources, there is also a shortage of time. School timetables cannot seem to fit in some space for guidance and counselling.

vii. **Neglect from Parents**

For the implementation of guidance and counselling to be successful, there needs to support from everyone including the school, teachers, parents, and the learners themselves. However, many parents may not give guidance and counselling enough consideration and importance to it thereby causing an obstruction in the implementation of these services.

viii. Confidentiality

There is the tendency for individuals to keep their needs, worries and problems secrets until, in many cases they get out of hands. These hinder counselling activities and the smooth discharge of the work of the counsellor. Many of the clients may refuse to discharge their minds in the presence of others for fear of being found by others. Some who are interested in discussing in the presence of others are often shy, not wanting others to know that they have problems. There is also the interference and conflict of cultural belief and professional ethics. Clients need the assurance that their secrets will be kept in confidence. The information from a counsellee should never divulged. This is against the ethics of the profession of counselling.

ix. Problem inherent in counseling personnel

Counsellors themselves have sometime constituted great problems for themselves. Some of them are not fully committed to the profession. Some counsellors do not give enough time for the counselling interaction. Also with regards to the counsellor, some have created problems concerning his/her age. Some people have come to conclusion that older counsellors are better than young ones because of the experience they have passed through.

Application activity 9.7

After learning this lesson, describe different challenges in guidance and counselling

9.8. Qualities of a good counsellor

Learning activity 9.8

Considering the attributes of a counsellor, What could be the diffrence between a counsellor and any other person ? What do you think could be the particular characteridtics of a counsellor.

Professional counsellors are licensed mental health therapists who provide assessment, diagnosis and counselling to people facing a variety of life stresses and psychological problems. They help people with relationship issues, family problems, job stress, mental health disorders such as depression and anxiety, and many other challenging problems that can impact feelings of well-being and happiness. To be effective in their roles, counsellors should enjoy helping others and possess specific attributes and skills.

i. Be a good listener.

The first thing that comes to mind is that school counsellors must be able to listen. To their students, parents, and other faculty members…A large portion of a counsellor's time is spent listening and processing the information given to you by others. Remember to listen first and ask questions later. If you need clarification on something, always speak up but be sure to add details that let the person know you heard what they said in the first place. Listening is a crucial trait for any school counsellor to possess.

ii. Be able to assess.

Part of a counsellor's job is to make accurate assessments of their students to prepare them for life beyond school. If you want to work in a high school setting, this includes being able to accurately assess a student's successes and shortcomings when it comes to making college choices, where to apply, and helping them narrow down what can be a daunting list of choices. Making these assessments accurately – and being able to report your findings to parents, another faculty, or higher education institutions – is an important part of counselling.

iii. Be an excellent communicator.

Having excellent communication skills is one of the most important skills a school counsellor can have. Being able to communicate ideas, thoughts, and feelings verbally is a trait that can never go unsung as a school counsellor. Often, you will be bouncing ideas off a student to help them reach a crucial decision – or discussing a student with their parent or a team of faculty members. Making sure that you can convey your assessment of your student verbally is vital.

iv. Appreciate diversity.

Students come from a multitude of backgrounds, and being able to accept and embrace diversity is another trait that is crucial of a school counsellor. Students come from all walks of life and all types of families, and helping students learn to accept and embrace their own diversity in a school setting is critical to a counsellor's success.

v. Be friendly.

School counsellors must be warm and approachable to their students, and also to parents and faculty members. Being open and gregarious will often mean that students will trust you more than they trust their parents, and getting students to open up and let go of their burdens is one of the most rewarding things a school counsellor can accomplish. Often, students are overworked and set with heavy accomplishment lists, so having someone to listen to their troubles is a way to make students feel less stressed.

vi. Be authoritative.

When the situation calls for it, a guidance counsellor must cross the boundary from friend to professional. If abuse or neglect is suspected or present, or if a student is engaging in risky or harmful behaviour, a counsellor must know when to show their authority and take the proper steps to ensure their student's safety.

vii. Be well-rounded.

A school counsellor will often have a wide range of interests outside of work, and you never know when one of these interests will resonate with a student and prompt a connection that gets your student to open up to you. Having a variety of hobbies and talents outside of the office makes school counsellor happier and friendlier. Being able to speak about your experiences in life will allow you to bridge gaps with students and offer advice and share tips and building blocks for social development that you may not have otherwise had.

viii. Be able to coordinate.

Counsellors serve as coordinators for many school programs and activities. From college visits, setting standardized test schedules, and even administrative tasks – the counsellor must be able to coordinate a number of tasks at a time. Making sure these things dovetail and all run smoothly (even when they may look chaotic on the outside) is a vital part of what makes a successful school counsellor.

ix. Have good evaluation skills

Counsellors spend a lot of their time evaluating test scores or administering tests to students. Being able to accurately evaluate and translate these results

to discuss a student's academic performance, or aid a professor in making an accurate assessment of a student's skills is vital. Being able to evaluate the results of these exams as more than just numbers on paper, and seeing the meaning beyond the exam is a part of what makes an effective school counsellor. Often, students will see their test scores as very black-and-white in regards to their future prospects. It is the job of their guidance counsellor to offer the many shades of grey in between and explore all opportunities available to their students, regardless of test scores.

x. Have a sense of humour

Often, having a sense of humour will be a school counsellor's biggest asset in gaining a student's trust. Being able to laugh at yourself, and offer amusing anecdotes for what you have experienced in life will show students that you're surprisingly human, too! Being able to see things with a side of laughter is a crucial trait for any school counsellor, and goes a long way toward making your days brighter.

Lidiya (2019) clarified that counselling children or young adults is different from counselling adults.

xi. Be open and friendly.

People open up about their issues depending on the environment. If they feel safe and free, they will talk about any issues that the counsellor brings up.

Sometimes parents are too harsh or have high expectations of their children. Children from such homes tend to hide their issue until they find a friendly setting. A good school counsellor bridges the gap between parents and children.

The counsellor must be open and friendly enough for people to open up and tell the truth.

Five indispensable Skills Every Counselor Should Possess

- **Communication Skills :** An excellent counselor can convey information in a concise way that ensures that a client understands the counselor's concerns, advice, etc. This way, a client can leave a session without feeling confused and assured that the counselor answered all of his or her questions.
- **Listening and Attending :** Counselors need more than excellent listening and comprehension skills. During a session with a client, counselors must also project that they have a vested and genuine interest in the client's well being. They do this by making eye contact and using appropriate body language – counseling skills and techniques that also apply to the psychiatry and therapy fields.

- **Focusing and Paraphrasing :** When a client first meets with a counselor, he or she may not know their problems' root cause(s). The counselor must identify the client's issues and help the client decide which are causing the most harm. This way, the counselor and client can focus on those issues and develop solutions.
- **Validating and Challenging :** As counselors provide mental health services, they must make clients feel validated – that it is normal to feel upset, nervous, angry, etc. However, counselors must also challenge clients to adopt actions or mindsets that go against these feelings, ones that clients may not want to give up. Effective challenging requires excellent interpersonal and diplomatic skills.
- **Multicultural Competencies :** Counselors, especially guidance and school counselors, must possess multicultural competencies. In other words, a counselor should understand how a client's racial, cultural, and socioeconomic background affects them. Counselors can use this knowledge to better empathize with clients, gain their trust, and develop effective solutions.

Attributes of a Counsellor

In order to provide effective counselling services, the counsellor needs to demonstrate certain attributes. Some of these attributes which makes a person a good counsellor are as under :

i) **Self-Awareness and Understanding** : A person who has awareness of her needs, motivation for helping, feelings, personal strengths and weakness acts as a good counsellor. These people do not use projection (for example : "I had a very aggressive counselee" instead of "I felt angry with the counselee"), defensiveness (for example : instead of responding to the counselee's feelings to a question" whether counselling will do any good", she may express her personal feeling to insecurity by raising her voice or other non-verbal behaviour.

ii) **Good Mental Health** : Although no person is totally problem free but a person with less problems of good mental health can be a good cousellor, otherwise their own problems will jeopardize the a process of counselling.

iii) **Sensitivity :** A person who is aware of resources, limitations, and vulnerability of other persons as well as is keenly perceptive to other persons feelings and needs are considered to have sensitivity. A person having the understanding of individual will act as a good counsellor. (A person who can put one's foot into other's shoe).

iv) **Open-Mindedness** : A person who is free from fixed or pre-conceived ideas. It does not mean that they have no personal values or beliefs, but they are aware of their own values and beliefs and are able to distinguish them from the beliefs and values of others. They do not thrust their values on others.

v) **Objectivity :** A person with the ability of not getting involved with the other person and at the same time, stand back and see accurately what is happening. (Not to get drowned while saving others.)

vi) **Approachability :** A person who has some resemblance with other known pleasant and friendly person, who is friendly, has positive attitudes about others and can be approached without a feeling of apprehension.

Application activity 9.8

1. What attributes make a good counsellor ?
2. Explain five essential skills that a consellor should possess

End of unit assessment

1. Draw the difference between guidance and counselling
2. Why do think many people commit suicide in these days ?
3. Identify problems related to academic, career, social, emotional and intellectual capability that adolescent face and how to respond to those problems.
4. In groups, role-play as a counsellor helping adolescent to overcome different problems identified in question 3 and then evaluate how succefull was your counselling on the side of counsellor and the counselling process

UNIT 10 COUNSELING THEORIES AND APPROACHES

Key unit competence: Apply varied thoughts imbedded in guidance and counseling approaches.

Introductory activity

There was a lady who always had issues with her husband. The conflict was around children's behaviour. The mother was supporting her daughter who was wearing mini-skirts but the father was against. The family was christian in one denomination. One day, the lady got stressed and went to see the pastor for guidance and counseling over the family issue.

Upon arrival, the pastor gave her a seat in front of him and they were separated by a table. They started a conversation. The pastor was reading the Bible while the lady was narrating her problems. The lady could ask : « Pastor, are we together ! » When the lady mentioned that the conflict is about their daughter, the pastor laughed at her and said : « I suspected that ! what did she do ? ». the lady replied that their daughter was wearing a mini-skirt and the father got annoyed. The pastor : « I hope that you did not support her. Your husaband is right ! If I were him, I would have beaten her and you who are supporting, thank God you are not my wife ! ». The lady started crying and the pastor told her that she was wasting his time and threw her out of his office. He immediately called her husaband and told him that his wife is complaining about the husband for harassing their daughter. The pastor warned the lady not to come back in his office with such nonsense.

Question :

Question 1. What did the counselor do well and what did he do wrong in the counseling session ?

Question 2. What should he have done for the counseling session to be successful ?

Question 3 : What was the best technique to deal with the problem ?

10.1. Psychoanalysis theory

Learning activity 10.1

In your groups, discuss the techniques used by a psychoanlyist during counseling session.

10.1. Psychoanalytic counselling therapies

Introduction

These are based on an individual's unconscious thoughts and perceptions that have developed throughout their childhood, and how these affect their current behaviour and thoughts. Its main method is historical reconstruction. It aims to unearth the past in the hope of loosening its bonds on the present.

A psychodynamic approach provides a broad range of therapeutic approaches. Psychodynamic therapy helps in counselling clients understand the root cause of their problems and issues. It also helps equip them with knowledge and suggestions to enable them to cope with further difficulties. With a strong emphasis on the trust between a client and counsellor or psychotherapist, psychodynamic therapy provides the tools required to make progress.

This form of counselling has roots in the theories of Sigmund Freud, and was initially developed in the 1940s. It focuses on the belief that our emotions, thoughts and behaviour stem from the unacceptable thoughts from one's childhood that are allowed to influence the current thinking. These repressed thoughts and feelings eventually manifest as depression, fears and conflicts. The therapy is relationship centered and is powered by one's interactions with close friends and family.

10.1.1. Psychoanalytic techniques

Psychoanalysts use a variety of techniques to gain insight into your behavior. Some of the more popular techniques include:

- **Dream interpretation**: According to Freud, dream analysis is by far the most important psychoanalytic technique. He often referred to dreams as "the royal road to the unconscious." Psychoanalysts may interpret dreams to get insight into the workings of your unconscious mind.
- **Free association**: Free association is an exercise during which the psychoanalyst encourages you to freely share your thoughts. This can lead to the emergence of unexpected connections and memories. You begin by relaxing, perhaps lying on a couch. The psychoanalysts who sits out of your line of vision, asks you to say aloud whatever comes to your mind.

At one moment, you are relating your childhood memory, at another you are describing your dream or recent experience. It sounds easy, but you will notice how often you edit your thoughts as you speak. You pause for a second before describing an embarrassing thought. You skip things that seem trivial, off point, or shameful. Sometimes, your mind goes blank, unable to remember important details. You may joke or change the subject to something less threatening.

- **Transference**: Transference occurs when you project your feelings about another person onto the psychoanalyst. You'll then interact with them as if they were that other person. This technique can help your psychoanalyst understand how you interact with others.

Psychoanalysts spend a lot of time listening to people talk about their lives, which is why this method is often referred to as "the talking cure."

10.1.2. Areas of intervention with Psychoanalytic therapy

Psychoanalytic therapy may be used to treat a number of different psychological conditions, including:

- Anxiety
- Depression
- Emotion struggles or trauma
- Identity problems
- Self-esteem issues
- Self-assertion
- Psychosomatic disorders
- Relationship issues
- Self-destructive behavior
- Sexual problems

10.1.3. Benefits of Psychoanalytic Therapy

The comparison of psychoanalytic therapy with other theories (for example Cognitive Behavioural Therapy-CBT) identified seven features that distinguish this theory and makes it outstanding.

- **Focuses on emotions**: Where CBT is centered on cognition and behaviors, psychoanalytic therapy explores the full range of emotions that a patient is experiencing.
- **Explores avoidance**: People often avoid certain feelings, thoughts, and situations they find distressing. Understanding what a client is avoiding can help both the psychoanalyst and the client understand why such avoidance comes into play.

- **Identifies recurring themes**: Some people may be aware of their self-destructive behaviors but unable to stop them. Others may not be aware of these patterns and how they influence their behaviors.
- **Exploration of the experienced past**: Other therapies often focus more on the here-and-now, or how current thoughts and behaviors influence how a person functions. The psychoanalytic approach helps people explore their pasts and understand how it affects their present psychological difficulties. It can help patients shed the bonds of past experience to live more fully in the present.
- **Explores interpersonal relationships**: Through the therapy process, people are able to explore their relationships with others, both current and past.
- **Emphasizes the therapeutic relationship**: Because psychoanalytic therapy is so personal, the relationship between the psychoanalyst and the patient provides a unique opportunity to explore and reword relational patterns that emerge in the treatment relationship.
- **Free-flowing**: Where other therapies are often highly structured and goal-oriented, psychoanalytic therapy allows the patient to explore freely. Patients are free to talk about fears, fantasies, desires, and dreams.

10.1.4. Strengths and limitations of psychoanalytic counselling

Strengths:

- The importance of sexuality and the unconscious in human behaviour.
- The approach lends itself to empirical studies. Freud's proposals have generated a tremendous amount of research since the early 1900s. Usually psychoanalytic research is based on case histories
- Provides a theoretical base of support for a number of diagnostic instruments.
- The approach reflects the complexity of human nature.
- The approach has grown and developed through the years. There are several modified forms of psychoanalysis, such as ego psychology or object-relations theories.
- The approach appears to be effective for those who suffer from a wide variety of disorders, such as hysteria, narcissism, obsessive-compulsive reactions, character disorders, anxiety, phobias, and sexual difficulties.
- The approach stressed the importance of developmental stages, the knowledge of which is essential for treatment plans. Moreover, this also provided basis for the development of other personality theories, such as those of Erikson and Levinson.

- Some psychological tests, such as the Thematic Apperception Test or the Rorschach Ink Blots, are rooted in psychoanalytic theory.

10.1.5. Limitations/weaknesses

Despite the unique emphasis of psychoanalysis, most modern professional counsellors do not use the approach. The reasons are numerous, but among them are following limiting factors:

- Time consuming and expensive.
- The approach does not seem to lend itself to working with older clients.
- Based on many concepts not easily communicated or understood. These concepts not only are difficult to test but also have inadequate evidence for their existence.
- Overemphasis on biology and unconscious forces
- Sexism
- Lack of Cross-cultural support
- The approach is deterministic.
- Counsellors and psychologists without medical degrees have had a difficult time getting extensive training in psychoanalysis.

Application activity 10.1

Question : Discuss the benefits of psychoanalytic theory of counseling

10.2. Behavioral approaches/therapies

Learning activity 10.2

Discussion question :

Behavioural Therapy is used to change people's maldaptive (bad) behaviours. Discuss the learnt behaviours that this theory will eradicate ?

10.2.1 Introduction

Behavioral therapy is a term that describes a broad range of techniques used to change maladaptive behaviors. The goal is to reinforce desirable behaviors and eliminate unwanted ones. This therapy focuses on an individual's learnt, or conditioned, behaviour and how this can be changed. The approach assumes

that if behaviour can be learnt, then it can be unlearnt (or reconditioned). So it is useful for dealing with issues such as phobias or addictions. Examples of this therapy are behaviour therapy and cognitive behaviour therapy.

10.2.2. Types of Behavioral Therapy

There are a number of different types of behavioral therapy. The type of therapy used can depend on a variety of factors, including the condition being treated and the severity of the person's symptoms.

- **Applied behavior analysis** uses operant conditioning to shape and modify problematic behaviors.
- **Cognitive behavioral therapy (CBT)** relies on behavioral techniques, but adds a cognitive element, focusing on the problematic thoughts behind behaviors.
- **Cognitive behavioral play therapy** utilizes play to assess, prevent, or treat psychosocial challenges. The therapist may use play to help a child learn how to think and behave differently.
- **Dialectical behavioral therapy (DBT**) is a form of CBT that utilizes both behavioral and cognitive techniques to help people learn to manage their emotions, cope with distress, and improve interpersonal relationships.
- **Exposure therapy** utilizes behavioral techniques to help people overcome their fears of situations or objects. This approach incorporates techniques that expose people to the source of their fears while practicing relaxation strategies. It is useful for treating specific phobias and other forms of anxiety.
- **Rational emotive behavior therapy (REBT)** focuses on identifying negative or destructive thoughts and feelings. People then actively challenge those thoughts and replace them with more rational, realistic ones.
- **Social learning theory** centers on how people learn through observation. Observing others being rewarded or punished for their actions can lead to learning and behavior change.

10.2.3. Problems requiring Behavioural Therapy

Behavioral therapy can be utilized to treat a wide range of psychological conditions and disorders, including:

- Bipolar disorder
- Alcohol and substance use disorders
- Anxiety

- Attention-deficit/hyperactivity disorder (ADHD)
- Autism spectrum disorders
- Borderline personality disorder (BPD)
- Depression
- Eating disorders
- Panic disorder
- Phobias
- Obsessive-compulsive disorder

10.2.4. Techniques in Behavioural Therapy

The techniques used in this type of treatment are based on the theories of classical conditioning and operant conditioning.

a) **Classical Conditioning**

Classical conditioning is one way to alter behavior. Several different techniques and strategies are used in this approach to therapy.

- **Aversion therapy**: This process involves pairing an undesirable behavior with an aversive stimulus in the hope that the unwanted behavior will eventually be reduced. For example, someone with an alcohol use disorder might take Antabuse (disulfiram), a drug that causes severe symptoms (such as headaches, nausea, anxiety, and vomiting) when combined with alcohol.
- **Flooding**: This process involves exposing people to fear-invoking objects or situations intensely and rapidly. It is often used to treat phobias. During the process, the individual is prevented from escaping or avoiding the situation.
- **Systematic desensitization**: In this technique, people make a list of fears and then learn to relax while concentrating on these fears. Starting with the least fear-inducing item and working their way to the most fear-inducing item, people systematically confront these fears under the guidance of a therapist. Systematic desensitization is often used to treat phobias and other anxiety disorders.

b) **Operant Conditioning**

Operant conditioning focuses on how reinforcement and punishment can be utilized to either increase or decrease the frequency of a behavior. Behaviors followed by desirable consequences are more likely to occur again in the future, while those followed by negative consequences become less likely to occur.

Behavioral therapy techniques use reinforcement, punishment, shaping, modeling, and related techniques to alter behavior. These methods have the benefit of being highly focused, which means they can produce fast and effective results.

- **Contingency management**: This approach uses a formal written contract between a client and a therapist (or parent or teacher) that outlines behavior-change goals, reinforcements, rewards, and penalties. Contingency contracts can be very effective in producing behavior changes since the rules are spelled out clearly, preventing both parties from backing down on their promises.
- **Extinction**: Another way to produce behavior change is to stop reinforcing behavior in order to eliminate the response. Time-outs are a perfect example of the extinction process. During a time-out, a person is removed from a situation that provides reinforcement. By taking away what the person found rewarding, unwanted behavior is eventually extinguished.
- **Behavior modeling**: This technique involves learning through observation and modeling the behavior of others. Rather than relying simply on reinforcement or punishment, modeling allows individuals to learn new skills or acceptable behaviors by watching someone else perform those desired skills.
- **Token economies**: This strategy relies on reinforcement to modify behavior. Parents and teachers often use token economies, allowing kids to earn tokens for engaging in preferred behaviors and lose tokens for undesirable behaviors. These tokens can then be traded for rewards such as candy, toys, or extra time playing with a favorite toy.

c) Contributions of Behavior Therapy

Advantages:

- Behavioral therapists use empirically tested techniques, assuring that clients are receiving both effective and brief treatment
- Evidence-based therapies (EBT) are a hallmark of both behavior therapy and cognitive behavior therapy
- Cummings (2002) believes evidenced-based therapies will be mandatory for third party reimbursement in the future
- Behavior therapists are willing to examine the effectiveness of their procedures in terms of generalizability, meaningfulness, and durability of change

- Most studies show that behavior therapy methods are more effective than no treatment
- Emphasis on ethical accountability (does not dictate whose behaviour or what behavior should be changed)
- Address ethical issues by stating that therapy is basically an education process; an essential feature of behavior therapy involves collaboration between therapist & client.
- Wide variety of specific techniques
- Behavioral therapy has been extended to more areas of human functioning than have any of the other therapeutic approaches.
- Major contribution is its emphasis on research into & assessment of treatment outcome (i.e. if progress not being made, must look carefully at original analysis & treatment plan).
- The behavioural approach and techniques have been subjected to the most empirical research.

d) Limitations and criticism of Behavioural Therapy

- Behavior therapy may change behaviors, but it does not change feelings
- Behavior therapy ignores the important relational factors in therapy
- Behavior therapy does not provide insight
- Behavior therapy treats symptoms rather than causes
- Behavior therapy involves control & manipulation by therapist

Application activity 10.2

Discuss the advantages and disadvantages of behavioural therapy.

10.3. Client-Centered Therapy

Learning activity 10.3

Discussion question :

What do you think are the benefits of client-centered approach whereby the counselor meet the client face-to-face ?

10.3.1. Introduction

Client-centered therapy or person-centered approach is a technique developed by Carl Rogers (1902-1987) from the concepts of humanistic psychology. It focuses on person's conscious self-perceptions. It is non-directive whereby the therapist listens without judging or interpreting, and refrains from directing the client toward certain insights.

Rogers The humanistic approach "views people as capable and autonomous, with the ability to resolve their difficulties, realize their potential, and change their lives in positive ways" (Seligman, 2006).

a. Three qualities of a therapist in client-centered therapy

- **Unconditional Positive Regard**: As mentioned above, unconditional positive regard is an important practice for the client-centered therapist. The therapist needs to accept the client for who they are and provide support and care no matter what they are going through.
- **Genuineness**: A client-centered therapist needs to feel comfortable sharing his or her feelings with the client. Not only will this contribute to a healthy and open relationship between the therapist and client, but it also provides the client with a model of good communication and shows the client that it's okay to be vulnerable.
- **Empathetic Understanding**: The client-centered therapist must extend empathy to the client, both to form a positive therapeutic relationship and to act as a sort of mirror, reflecting the client's thoughts and feelings back to them; this will allow the client to better understand themselves.

Rogers encourages therapists to be active listeners. The therapists are thus advised to echoes, restate, and clarify what the client expresses (verbally or non-verbally). The therapist has to acknowledge those expressed-feelings. Active listening is has been accepted as part of counselling practices in many schools, colleges, and clinics. They interrupt only to restate and confirm feelings, to accept what was said and to check their understanding of something.

For example:

Therapist: *You mean you are not feeling well? I did not get it well, good! I see, you are worried, right?*

Client: *Yeah!*

Therapist: *Your son went with the house girl and came back coughing. Are you saying your son might have been fed with bad food? Is that what you insinuate?*

Client: *exactly!*

b. Tips for improving communication between the therapist and the client by listening more actively include:

- Summarise: check your understanding by repeating the other person's statements in your own words.
- Invite clarification: "what might an example of that?" may encourage the person to say more.
- Reflect feelings: "It sounds frustrating" might mirror what you are sensing from the person's body language and emotional intensity.

c. Conditions for success in client-centered therapy

Rogers identified six conditions that are required for success in client-centered therapy:

- The client and counselor are in psychological contact (a relationship).
- The client is emotionally upset, in a state of incongruence.
- The counselor is genuine and aware of their own feelings.
- The counselor has unconditional positive regard for the client.
- The counselor has an empathic understanding of the client and their internal frame of reference and looks to communicate this experience with the client.
- The client recognizes that the counselor has unconditional positive regard for them and an understanding of the difficulties they are facing (Noel, 2018).

d. Techniques for successful client-centred therapy

In addition to active listening, Saul McLeod (2015) outlines ten techniques to facilitate successful therapy session which are described as follows:

(i) **Set clear boundaries**

Boundaries are vital for any relationship, but they are especially important for therapeutic relationships. Both the therapist and the client need healthy boundaries to avoid the relationship becoming inappropriate or ineffective, such as ruling out certain topics of discussion. There are also more practical boundaries that must be set, for example, how long the session will last.

(ii) **Remember – the client knows best**

As mentioned earlier, this therapy is founded on the idea that clients know themselves, and are the best sources of knowledge and insight about their problems and potential solutions. Do not lead the client or tell them what is wrong, instead let them tell you what is wrong.

(iii) **Act as a sounding board**

Active listening is key, but it's also useful to reflect what the client is saying back to them. Try to put what they are telling you into your own words. This can help the client clarify their own thoughts and understand their feelings better.

(iv) **Don't be judgmental**

Another vital component of client-centered therapy is to refrain from judgment. Clients are often already struggling with feelings of guilt, low self-worth, and the belief that they are simply not good enough. Let them know you accept them for who they are and that you will not reject them.

(v) **Don't make decisions for your clients**

Giving advice can be useful, but it can also be risky. In client-centered therapy, it is not seen as helpful or appropriate to give advice to clients. Only the client should be able to make decisions for themselves, and they have full responsibility in that respect. The therapist's job is to help clients explore the outcomes of their decisions rather than guide them to any particular decisions.

(vi) **Concentrate on what they are really saying**

This is where active listening can be put to use. Sometimes a client will feel uncomfortable opening up at first, or they will have trouble seeing something just below the surface. In these situations, be sure to listen carefully and keep an open mind – the problem they come in with may not be the real problem.

(vii) **Be genuine**

As mentioned earlier, the client-centered therapy must be genuine. If the client does not feel their therapist is authentic and genuine, the client will not trust you. In order for the client to share personal details about their own thoughts and feelings, they must feel safe and comfortable with you. Present yourself as you really are, and share both facts and feelings with the client. Of course, you don't have to share anything you don't feel comfortable sharing, but appropriate sharing can help build a healthy therapeutic relationship.

(viii) **Accept negative emotions**

This is an important technique for any therapist. To help the client work through their issues and heal, it is vital to let them express their emotions – whether positive or negative. The client may even express anger, disappointment, or irritation with you at one point or another.

Learn to accept their negative emotions and practice not taking it personally. They may need to wrestle with some difficult emotions, and as long as they are not abusing you, it is beneficial to just help them through it.

(ix) **How you speak can be more important than what you say**

Your tone of voice can have a huge impact on what the client hears, understands, and applies. Make sure your tone is measured, and make sure it matches your non-judgmental and empathetic approach.

You can also use your voice to highlight opportunities for clients to think, reflect, and improve their understanding; for example, you can use your tone to slow down the conversation at key points, allowing the client to think about where the discussion has led and where s/he would like it to go next.

(x) **I may not be the best person to help**

It is vital that you know yourself as a therapist and are able to recognize your own limits. No therapist is perfect, and no mental health professional can give every single client exactly what they need.

e. The benefits/advantages of client-centered therapy to the client

The advantages of client-centered therapy are reflected in how it can benefit the client and below are nine benefits this type of therapy carries:

- **The focus is on you:** When you're in Rogerian therapy, your needs, and choices matter. You aren't there to find out what someone else thinks. Instead, your goals are your own, and your way of approaching them is honored.
- **You get support and understanding:** For many people, just having someone listen intently to what they say is enough to make a difference. Such empathetic support may be hard to find in the business of daily life. The therapist aims to understand your circumstances, which can be extremely beneficial for clients who feel like those around them may not see what they are going through.
- **You're the Decision-Maker:** The non-directive approach of Client-Centered counseling never puts you in a position where you're receiving a confusing diagnosis or a treatment plan that you are not comfortable with. If a client does not believe something they are facing or is doing is

a problem, they will not change it. Instead, the client gets to decide what to work on and how to go about the process.

- **You're treated with respect:** No matter what a client is facing, their therapist will respect them. They will never take a higher position or allow a client to believe they are lesser of a person. Client-centered counseling works by allowing the client to work as a partner in the treatment, rather than having the therapist control all decision-making.
- **You're Treated as A Whole Person:** In Client-Centered Therapy, clients are treated as whole people. The lack of diagnosis allows clients not to be treated in a certain way simply because of their label or what their chart says. They will always be treated in a way they feel comfortable with and how they feel produces the results they are looking for. With the client viewed positively, the therapist can care for their client and strive to help them make the desired changes. This ensures the maximum effectiveness of client-centered humanistic therapy.
- **You Aren't Judged or Analyzed:** Client-Centered Therapists never judge a client. No matter what life choices are brought up, no judgments will occur. This goes back to respect, as well. If any judgments are made in person-centered therapy, they will come from the client, and the therapist will likely help relieve them of the negative thoughts.
- **You Aren't Saddled with A Diagnosis:** Some clients may appreciate having a diagnosis. It can make them feel their symptoms are valid and that they are not alone in experiencing them. However, if a client does not want a label left on their chart for what may be their entire life, Rogerian Therapists are a great choice.
- **The Process Encourages Independence:** Client-Centered counseling helps the client to become more independent. They get to practice making their own decisions and approaching life's difficulties in their own way. Because their therapist offers support and a positive attitude, they may even gain confidence and independence throughout their sessions.
- **You Work Towards The Goals That Are Important To You:** In traditional therapy, some clients may feel they are being pushed toward a goal they do not want or need to pursue. In Client-Centered Therapy, creating their own goals can release this frustration. A client's feelings are best expressed by the client, not the therapist, which is one of the major aspects of client-centered counseling that helps establish its success as a therapeutic technique.

Table: The strengths and weaknesses of the client-centered therapy

STRENGTHS	WEAKNESSES
• Offers a perspective that is up-to-date and optimistic (Seligman, 2006)	• The approach may lead therapists to just be supportive of clients without challenging them (Corey, 2005).
• Many aspects are relevant to a multicultural perspective (Seligman, 2006).	• Difficulty in therapists allowing clients to find their own way (Corey, 2005).
• Has provided a basis for many other therapies such as the emphasis on the client-therapist relationship (Seligman, 2006).	• Could be an ineffective way to facilitate therapy if the therapist is non-directive and passive (Corey, 2005).
• Research has substantiated the importance of the client-therapist relationship (Seligman, 2006).	• Simplistic and unrealistically optimistic (Seligman, 2006).
• Clients have a positive experience in therapy when the focus is on them and their problems.	• Person-centred therapy does not draw on developmental, psychodynamic or behavioural therapy thus limiting the overall understanding of clients (Seligman, 2006).
• Clients feel they can express themselves more fully when they are being listened to and not judged.	• Listening and caring may not be enough (Seligman, 2006).
• Clients feel empowered from person-centred therapy as the responsibility is on them to make decisions.	• Not appropriate for those who are not motivated to change.
	• May not be useful with significant psychopathology (Seligman, 2006).
	• Fails to prepare clients for the real world due to the unconditional positive regard of the therapist (Seligman, 2006).
	• Lacks techniques to help clients solve problems (Seligman, 2006).

Application activity 10.3

Discussion question :

Describe in your groups, the techniques that would make the client-centered approach effective :

10.4. Cognitive Approaches

Learning activity 10.4

Discussion question :

Cognitive therapy focuses on the present. This means that issues from the past that are influencing current thinking, are acknowledged but not concentrated on. They focus on changing the automatic negative thoughts that can contribute to and worsen our emotional difficulties, depression, and anxiety.

Question : What do you think could be the techniques used by Cognitive Therapy to successfully reach its goal ?

10.4.1. Introduction

Cognitive therapy centres on the belief that our thoughts are influenced by how we feel. There are a number of different cognitive therapies, including Cognitive-Behavioural, Reality, Rational Emotive and Transactional Analysis. Each of these cognitive approaches to counselling can help a client through the counselling process, by providing further understanding of the way our thoughts are sometimes distorted.

Cognitive therapy focuses on the present. This means that issues from the past that are influencing current thinking, are acknowledged but not concentrated on. Instead a counsellor will work with the client on identifying what is causing distress in present thinking. What links these different forms of cognitive therapy is the way in which the counselling relationship, between a counsellor and client, develops.

10.4.2. Forms of Cognitive therapy:

- **Cognitive Behavioural Therapy (CBT)**: This cognitive approach to counselling is based on the belief that learning comes from personal experience. Counselling will focus on a client's ability to accept behaviour, clarify problems and difficulties and understand the reasoning behind the importance of setting goals.

- **Virtual Reality Therapy (VRT)**: This form of therapeutic approach works well in treating fears and phobias. This is because virtual reality therapy (VRT) concentrates on accurately duplicating the distressing situations. Counsellors who use this form of cognitive approach, during counselling sessions, will recreate situations in order to expose the client to what triggers their fear. VRT also works well in treating anxiety disorders.
- **Rational Emotive Therapy (RET)**: Rational Emotive Behaviour therapy (REBT) centres on the belief that human beings have a tendency to develop irrational behaviour and beliefs. These are the 'musts' and 'shoulds' that many people fill their lives with, and which influence thought and deed.
- **Transactional Analysis (TA)**: Transactional Analysis is based on the notion that our personality consists of three states of ego – parent, adult and child. During interaction with others one of our ego states will predominate, depending on the situation we find ourselves in. Certain types of behaviour are associated with each of the ego roles, and using this form of cognitive approach to counselling allows the client to understand the different ego stages and how they interact with each other.

10.4.3. Cognitive Behavioural Therapy

Cognitive behavioral therapy is defined as "psychotherapy that combines cognitive therapy with behavior therapy by identifying faulty or maladaptive patterns of thinking, emotional response, or behavior and substituting them with desirable patterns of thinking, emotional response, or behavior.

Cognitive behavioral therapy focuses on changing the automatic negative thoughts that can contribute to and worsen our emotional difficulties, depression, and anxiety. These spontaneous negative thoughts also have a detrimental influence on our mood.

Through CBT, faulty thoughts are identified, challenged, and replaced with more objective, realistic thoughts.

10.4.3. Types of Cognitive Behavioural Therapy

Some of the specific types of therapeutic approaches that involve cognitive behavioral therapy include:

- **Cognitive therapy** centers on identifying and changing inaccurate or distorted thought patterns, emotional responses, and behaviors.3
- **Dialectical behavior therapy (DBT)** addresses destructive or disturbing thoughts and behaviors while incorporating treatment strategies such as emotional regulation and mindfulness.
- **Multimodal therapy** suggests that psychological issues must be treated by addressing seven different but interconnected modalities: behavior,

affect, sensation, imagery, cognition, interpersonal factors, and drug/ biological considerations.4

- **Rational emotive behavior therapy (REBT)** involves identifying irrational beliefs, actively challenging these beliefs, and finally learning to recognize and change these thought patterns.=

10.4.4. Cognitive Behavioural Therapy Techniques

CBT is about more than identifying thought patterns. It uses a wide range of strategies to help people overcome these patterns. Here are just a few examples of techniques used in cognitive behavioral therapy.

- **Identifying Negative Thoughts:** It is important to learn what thoughts, feelings, and situations are contributing to maladaptive behaviors.

  This process can be difficult, however, especially for people who struggle with introspection. But taking the time to identify these thoughts can also lead to self-discovery and provide insights that are essential to the treatment process.
- **Practicing New Skills:** In cognitive behavioral therapy, people are often taught new skills that can be used in real-world situations. For example, someone with a substance use disorder might practice new coping skills and rehearse ways to avoid or deal with social situations that could potentially trigger a relapse.
- **Goal-Setting:** Goal setting can be an important step in recovery from mental illness, helping you to make changes to improve your health and life. During cognitive behavioral therapy, a therapist can help you build and strengthen your goal-setting skills.

  This might involve teaching you how to identify your goal or how to distinguish between short- and long-term goals. It may also include helping you set SMART goals (specific, measurable, attainable, relevant, and time-based), with a focus on the process as much as the end outcome.
- **Problem-Solving:** Learning problem-solving skills during cognitive behavioral therapy can help you learn how to identify and solve problems that may arise from life stressors, both big and small. It can also help reduce the negative impact of psychological and physical illness.

Problem-solving in CBT (cognitive behavioural therapy) often involves five steps:

- Identify the problem
- Generate a list of potential solutions
- Evaluate the strengths and weaknesses of each potential solution

- Choose a solution to implement
- Implement the solution6

- **Self-Monitoring:** Also known as diary work, self-monitoring is an important cognitive behavioral therapy technique. It involves tracking behaviors, symptoms, or experiences over time and sharing them with your therapist.

Self-monitoring can provide your therapist with the information they need to provide the best treatment. For example, for people with eating disorders, self-monitoring may involve keeping track of eating habits, as well as any thoughts or feelings that went along with consuming a meal or snack.

10.4.5. The benefits of Cognitive Behavioural Therapy

The goal of cognitive behavioral therapy is to teach people that while they cannot control every aspect of the world around them, they can take control of how they interpret and deal with things in their environment.

CBT is known for providing the following key benefits:

- It helps you develop healthier thought patterns by becoming aware of the negative and often unrealistic thoughts that dampen your feelings and moods.
- It is an effective short-term treatment option as improvements can often be seen in five to 20 sessions.
- It is effective for a wide variety of maladaptive behaviors.
- It is often more affordable than some other types of therapy.
- It is effective whether therapy occurs online or face-to-face.
- It can be used for those who don't require psychotropic medication.
- It helps clients develop coping skills that can be useful both now and in the future.

10.4.6. Challenges faced when using Cognitive Behavioural Therapy

There are several challenges that people may face when engaging in cognitive behavioral therapy. Here are a few to consider.

- **Change can be difficult**: Initially, some patients suggest that while they recognize that certain thoughts are not rational or healthy, simply becoming aware of these thoughts does not make it easy to alter them.
- **CBT is very structured**: Cognitive behavioral therapy doesn't focus on underlying, unconscious resistance to change as much as other approaches such as psychoanalytic psychotherapy. Instead, it tends to

be more structured, so it may not be suitable for people who may find structure difficult.

- **You must be willing to change**: For cognitive behavioral therapy to be effective, you must be ready and willing to spend time and effort analyzing your thoughts and feelings. This self-analysis can be difficult, but it is a great way to learn more about how our internal states impact our outward behavior.
- **Progress is often gradual**: In most cases, CBT is a gradual process that helps you take incremental steps toward behavior change. For example, someone with social anxiety might start by simply imagining anxiety-provoking social situations. Next, they may practice conversations with friends, family, and acquaintances. By progressively working toward a larger goal, the process seems less daunting and the goals easier to achieve.

10.4.7. Steps to follow in Cognitive Behavioural Therapy

- **Consult with your physician** and/or check out the directory of certified therapists offered by the National Association of Cognitive-Behavioral Therapists to locate a licensed professional in your area. You can also do a search for "cognitive behavioral therapy near me" to find local therapists who specialize in this type of therapy.
- **Consider your personal preferences**, including whether face-to-face or online therapy will work best for you.
- **Contact your health insurance** to see if it covers cognitive behavioral therapy and, if so, how many sessions are covered per year.
- **Make an appointment with the therapist** you've chosen, noting it on your calendar so you don't forget it or accidentally schedule something else during that time.
- **Show up to your first session** with an open mind and positive attitude. Be ready to begin to identify the thoughts and behaviors that may be holding you back, and commit to learning the strategies that can propel you forward instead.

Application activity 10.4

Discuss the possible benefits of cognitive behavioural therapy

10.5. Humanistic Approaches

Learning activity 10.5

Discussion question : In your respective groups, discuss the problems addressed by Humanistic Approaches

10.5.1. Introduction

Humanistic therapy, also known as the humanistic approach, is an umbrella term that covers several types of therapy, including *person-centred therapy*, *Gestalt*, *existential therapy, solution-focused therapy* and transactional analysis.

10.5.2. The goal of humanistic therapy

Humanistic perspective emphasizes people's innate potential for self-fulfilment. Humanistic therapies attempt to reduce inner conflicts that interfere with natural development and growth. To achieve this goal, humanistic therapists try to give clients new insights. Since they share this goal, humanistic and psychodynamic therapies are often referred to as **insight therapies**. But humanistic therapies differ from psychodynamic therapies in many other ways:

- Humanistic therapists aim to boost people's self-fulfilment by helping them grow in self-awareness and self-acceptance
- Promoting growth, not curing illness, is the therapy focus. Thus, those in therapy become "client" or just "persons" rather than "patients". The change that many other therapists adopted.
- The path to growth is taking immediate responsibility for one's feelings and actions, rather than uncovering hidden causes.
- Conscious thoughts are more important than the unconscious.
- The present and future are more important than the past. Therapy thus focuses on exploring feelings as they occur, rather than on gaining insights into the childhood origins of those feelings.

10.5.3. Types of humanistic therapy

There are a number of different types of humanistic therapy. Some of these include:

- **Client-centered therapy**: Also known as person-centered therapy, this approach involves the therapist taking a non-directive approach to the therapy process. The individual acts as an equal partner, while the therapist offers empathy and unconditional positive regard.

- **Existential therapy**: This is a philosophical approach to therapy that works to help people better understand their place in the universe. It works by helping people explore the things that bring meaning to their life. People learn to accept responsibility for their own choices and recognize that they have the power to make changes in order to bring more meaning and purpose to their lives.
- **Gestalt therapy**: This form of humanistic therapy focuses on a person's current life and experiences rather than looking at their past. It places a great deal of emphasis on how the individual perceives and makes meaning out of their experiences. Gestalt therapy puts the focus on the here and now.
- **Logotherapy**: This type of therapy focuses on helping people find ways to endure life's difficulties and find a sense of purpose and meaning. It proposes that finding meaning in life can help improve mental well-being and relieve symptoms of conditions including depression, grief, and trauma.
- **Narrative therapy**: This approach to therapy helps people identify their values and skills by focusing on their personal stories and experiences. It strives to help people see that they are separate from their problems.
- **Solution-focused therapy**: Solution-Focused Brief Therapy (SFBT) is a short-term goal-focused evidence-based therapeutic approach, which incorporates positive psychology principles and practices, and which helps clients change by constructing solutions rather than focusing on problems. In the most basic sense, SFBT is a hope friendly, positive emotion eliciting, future-oriented vehicle for formulating, motivating, achieving, and sustaining desired behavioral change.
- **Solution-Focused therapy:** practitioners develop solutions by first generating a detailed description of how the client's life will be different when the problem is gone or their situation improved to a degree satisfactory to the client. Therapist and client then carefully search through the client's life experience and behavioral repertoire to discover the necessary resources needed to co-construct a practical and sustainable solution that the client can readily implement.

10.5.4. Techniques in Humanistic Therapy

Humanistic therapists use a number of techniques that are designed to support people as they work toward change. Some of the main techniques that are frequently used include:

- **Congruence**: This technique is essential to humanistic therapy and involves the therapist being authentic, open, and genuine as they interact with the individual who is in therapy.
- **Empathetic understanding**: This involves the therapist not only understanding what the client is feeling and saying, but also communicating that understanding to the client. The individual should feel heard, seen, and understood.
- **Reflective listening**: This involves actively listening to the individual and then summarizing what the client has said in their own words. This strategy can help reinforce what the client is saying, allow them to reflect back on their own words, and clear up potential misunderstandings.
- **Unconditional positive regard**: This technique involves the therapist accepting the individual without judgment. It is characterized by a caring attitude that plays an important role in fostering self-worth, personal growth, and self-awareness.

10.5.5. Problems addressed by Humanistic Therapy

Humanistic therapy has been used to treat a range of different mental health conditions. Some of these include:

- Anxiety
- Depression
- Low self-esteem
- Panic disorder
- Personality disorders
- Post-traumatic stress disorder (PTSD)
- Psychosis8
- Relationship problems
- Substance use
- Trauma

Effectiveness

Research suggests that humanistic therapy can be an effective treatment approach when dealing with a range of disorders and other difficulties.

- Research found that client-centered therapy was an effective approach in the treatment of depression, psychosis, relationship problems, and trauma.
- Young people experiencing psychological distress showed improvement in emotional symptoms after receiving humanistic counseling.
    - An exploratory trial compared client-centered therapy to trauma-focused cognitive behavior therapy in the treatment of mothers and children who had experienced trauma. While the results indicated that client-centered therapy led to significant symptom reduction in children, CBT was found to be much more effective at reducing symptoms in mothers

10.5.6. Advantages and disadvantages of humanistic approaches

Table: advantages and disadvantages that characterize the humanistic approach to learning.

Advantages	Disadvantages
• Emphasises autonomy and free will when choosing behaviour- The approach aims to find an alternative approach to scientific psychology (concentrates on the subjective experiences of individuals and its meaning which cannot be studied in experiments) • It's the only approach in psychology which places the individual's subjective experience and meanings at the centre • It is not reductionist- Individual is not seen as the product of neurons firing or stimulus-response links • It is holistic- Places focus on the whole of the individual • Client-Centred Therapy (CCT) is supportive of individuals with problems and treats them with respect- it is seen as a non-directive form of therapy	• It is too positive when regarding human behaviour- this means that it assumes individuals are intrinsically good and will choose positive paths for their lives- however free will and choice is limited for some individuals • There is too much emphasis on subjective experience- Hard to study • Approach is not scientific- Does not use any rigorous, objective methods and doesn't make predictions that can be proved or disproved • Places emphasis on conscious awareness- this limits the scope of the humanistic approach as it ignores things that are out of conscious awareness • Client-Centred Therapy is of limited help for individuals with complex problems • Hard to falsify • Lacks empirical support

• Views the person as an active agent • Promotes the idea of personal responsibility • States that the subjective experiences are of importance and value • Client-Centred Therapy is used by psychologists and counsellors in therapy today	

Application activity 10.5

Question 1 : Briefly describe the techniques used in humanistic approaches to support people as they work toward change.

10.6. Systemic Approaches

Learning activity 10.6

Discussion question :

The systemic therapy focuses on relationships between a group of people. Discuss the concerned groups and problems in groups of people that can require systemic approaches to counseling.

10.6.1. Introduction and definitions

Systemic therapy focuses on relationships between a group of people, rather than solely on an individual's thoughts and feelings.

It's often used as an umbrella term to cover family therapy or couples therapy. But it's much broader than this. It can help any group or system where people work together or have a relationship.

"Systemic therapy gives people a safe space to explore the system they are in - whether personal or professional. "It helps with the relationships and connections between people within the system."

10.6.2. Target people for systemic therapy

- The system in question can be a family, a pair or group of friends, work colleagues, or another set of people whose relationship is key to their success – such as a music group or sports team.
- It's for any group of people where their system has become dysfunctional;
- There's often a family dynamic in these groups, even though they're not families.
- If part of the system is broken, then the whole system is broken.
- It may feel like something jars. It's not working smoothly. That's when the group may seek professional help.

10.6.3. Techniques to Try in Systemic Therapy

There are several tools available for Systems Therapy; we describe three of our favorites below:

- **Vision statement:** A vision statement can help when working with a family to help them see themselves now and where they would like to be in the future (Rogers & Cooper, 2020). For example, asking a parent or carer what they think their children would say about them now and what they would like their children to say about them in 10 years can generate potent insights. Through visualization, it provides information regarding the gap to fill or a goal to work toward, and identifies what must change.

  Vision statements are a more positive and motivating approach than the therapist telling the family members the issues and difficulties they have uncovered (Rogers & Cooper, 2020).
- **Circular questioning:** There is a great deal of value to be found in getting clients to look at things from a new perspective. It can be helpful to ask one family member or member of a couple to look at a situation or problem through the eyes of another (Rogers & Cooper, 2020). For example, asking a son why his father gets angry when he stays out late at night can lead to insights and a deeper understanding of how the parent perceives his actions and the impact they are having. Circular questions can help define a problem, show how situations have changed, explore the impact of behavior, and invite individuals to change (Evans & Whitcombe, 2015).
- **Taking a one-down position:** Rather than trying to get one-up on the other person or winning the (perceived) battle, it can be helpful to give ground. Stepping down or back can help either the therapist working with a client or a family member engaged with another, by (Watson, 2012):
  - Disarming the other person concerned with losing dominance

- Avoiding walking into an ambush. For example, a couple may decide not to try to impress difficult family members.
- Admitting impotence and letting the client or family retain ownership when a complainer repeatedly ignores advice. Ultimately, this approach elevates the other person's perceived importance and lets them save face (Watson, 2012)

10.6.3. How Systemic Therapy works

- Systemic therapy focuses on the interactions and relationships between the group to help them address any problems and to move on. It gives all the members of the group the chance to explore their feelings and say what they think in a safe, non-judgmental environment.
- Therapy seeks to identify deeply entrenched patterns within an individual's relationships and also with group members. The process helps to uncover the ways in which members communicate and behave within a system, based on beliefs about their respective roles.
- The therapist will help them to understand their differences and what may be causing them problems. They work with every member of the group, so that no one feels isolated or like other members of the group are ganging up on them.
- It's a safe and secure space to explore the key issues affecting the group - whether it's issues brought up from the past or things from the present. I help them to make sense of it – the present and the past. That may be about attachments to each other, resentment or betrayals (Stefan, n.d).

10.6.4. The benefits of Systemic Therapy

- Systemic therapy can help to identify and address the issues that were causing the problems within the group.
- It can help people within the system empathise and sympathise with each other.
- Overall, systemic therapy can help to improve communication, build stronger relationships and enable the group to move on from their problems.
- It can help to repair wounds. It's a healing process.

10.6.5. Advantages and disadvantages of Family therapy

a. Advantages

Family therapy can be incredibly helpful for all members of a family if everyone is willing to participate and examine their own actions and reactions to one another. Family therapy can become a little more challenging when some members won't participate, or if there are issues with self-reflection.

Working on the health of your family system can positively impact your interactions with your family members, as well as with others. Issues within family systems are often multigenerational, meaning that the issues that show up in your family are likely patterns that were developed and passed down generations ago.

Family therapy can assist families with:

- Working through addiction (with one or more family members actively or previously using)
- Improving communication and listening skills
- Understanding each other's needs
- Cultivating individual insight and emotional intelligence which positively impacts relationship health
- Transitioning through a divorce and/or step-family situation
- Co-parenting after a breakup or divorce
- Multi-generational issues if non-immediate family members live within the same household
- Processing an individual and/or familial trauma
- Strengthening parenting skills

b. Disadvantages

Family therapy can cause issues if one or more members refuse to participate. Think of it this way- families seek homeostasis (balance), even if it's unhealthy. This means that every person within the family has a role to play to maintain the structure of the family.

***Some challenges are*:**

- Expose you and/or other members of your family to hurtful and painful issues that you were previously unaware of- can be very intense, lead to feeling isolated, and emotionally drained if you don't have a supportive family structure (note that this may be temporary if your family is willing to stick with counseling)
- Once family therapy begins, it can be difficult to see family situations as you used to and your perceptions may be altered. This can lead to

negative feelings, especially if others within your family are not willing to follow through with therapy or are in denial of unhealthy family patterns

- Family issues can temporarily intensify as unhealthy patterns and behaviors become more apparent- in therapy, issues tend to get worse as they are uncovered and explored, before they get better.

Application activity 10.6

Question 1. Briefly explain how systemic therapy works

Question 2. Explain the benefits of a systemic therapy.

10.7. Holistic/Integrative Approaches

Learning activity 10.7

Question :

What do you think the holistic approaches will focus on when counseling an individual ?

10.7.1. Introduction and Definition

Holistic therapy is often used as a supplement to traditional addiction treatment, as it works to help treat the person on the whole, rather than focus on just one area of their being.

Holistic therapy is a form of therapy for various medical and emotional disorders and involves approaches that are outside of conventional, mainstream treatment. *It takes a whole person approach that emphasizes not looking at just any one aspect of a person's health, but instead, improving and treating all the aspects of one's life*.

In an integrated approach, conventional and alternative therapies are used together, such as using psychotherapy and medication along with acupuncture and yoga.

Ideally, holistic therapy works as a result of a collaboration between a professional and the individual in treatment. They come together to develop an individualized treatment plan that includes both traditional and alternative therapies — such as holistic therapy. The holistic approach will utilize scientific approaches, focus on prevention when possible, and harness the power of the body to heal itself.

Overall, the goal of holistic therapy is to help a person gain a greater understanding of themselves and increase self-esteem and self-confidence.

Holistic therapists focus on a person's physical, emotional, social, and spiritual well-being. They might use expressive arts, using dance, art, or music to work with people, or use mindfulness practices, including meditation and relaxation techniques, as well as physical approaches (yoga, dance therapy, recreational activities, etc).

10.7.2. Examples of Holistic Therapies Used in Addiction Treatment

Numerous therapies might be used in addiction treatment, and the program should individualize the holistic therapies used in the treatment that works best for the person. Some examples of the more commonly used holistic therapies used to help treat addiction include the following:

- Mindfulness incorporates techniques such as meditation that incorporate affect regulation, which means that mindfulness can help a person accept distressing emotions, which is thought to help reduce the urge to use substances.
- Yoga, uses relaxation techniques, controlled breathing, and certain physical poses that all work together to focus on improving the health of both mind and body.
- General types of exercise, such as walking or aerobics.
- Expressive therapy, such as using dance, music, or art therapy, can be used to help treat substance use disorders. For example, a program used an art project to help participants express their life events related to the initiation of substance use.

10.7.3. Benefits of Holistic Therapies

There are several positive aspects to a holistic mental health approach, and it's been found beneficial in a number of studies.

- **Greater understanding of the whole being**: One of the major benefits of holistic therapies is that the whole-body approach allows you to look at all parts of your being. By addressing your physical, mental, and spiritual health, you might be able to really connect the dots between these different parts of your life. Additionally, you can gain a deeper understanding of how each of these factors affects your overall well-being.
- **Learn coping mechanisms**: Techniques you learn during your sessions can be applied outside a holistic therapist's office. Coping mechanisms like breathing techniques and meditation can help you deal with stress in your daily life. If you're suddenly triggered by anxiety, stress, or a difficult moment in general, you're better equipped with the tools you need to navigate tough moments.

- **Cost**: Some research shows that holistic therapy is a cost-effective approach to physical and mental health.
- **Adaptability**: Studies have shown that meditation and mindfulness used for stress and anxiety reduction can be easily adapted to other areas of life.
- **Beneficial to both mental and physical health**: Deep breathing techniques that are used in holistic therapy have been shown to reduce stress levels while promoting relaxation. Both of these are known to benefit mental and physical health.

10.7.4. Types of holistic therapy

- **Mind-body therapy**

Mind-body therapy uses a group of holistic practices to increase relaxation. Each focuses on improving overall health by enhancing how your mind interacts with your bodily function.

Techniques might include:

- Hypnosis
- Relaxation
- Meditation and guided imagery
- Visual and guided imagery
- Biofeedback
- Group support
- Expressive art therapy (music, art, dance)
- Breathwork
- Massage therapy
- Yoga

- **Eclectic or integrative therapy**

Eclectic or integrative therapy uses multiple techniques to serve the goal of healing or making mental health progress. By taking a multifaceted approach to therapy, you might be able to address your specific and unique needs to promote real healing and growth. This approach combines multiple therapies and their elements to create a more holistic approach that is tailored and specific to each patient.

- **Spiritual therapy**

Spiritual therapy uses both spiritual faith and your belief system to explore and address any problems you might be dealing with. This form of therapy seeks to treat your soul as well as your mind by using the faith you have in your higher power to analyze and address conflicts you face in life.

- **Somatic therapy**

Somatic counseling is a body-centric therapy technique that uses multiple strategies to help you heal from trauma, mental health conditions, stress, and more. During somatic therapy sessions, the focus is on breathwork, meditation, or even dance.

Application activity 10.7.

Question : Discuss the benefits of holistic therapy.

10.8. Family Systems Approaches

Learning activity 10.8.

In your respective groups, discuss all the possible problems that would require « family systems approach »

10.8.1. Introduction and definition

Family systems therapy is a form of psychotherapy that focuses on the family as a whole unit. A central tenet of this approach is that a family is an emotional unit and individual behavior must be considered from the context of the family. People are influenced by their family but each person also influences their entire family.

10.8.2. Key Concepts in Family Systems Therapy

Family systems therapy is based on the work of Murray Bowen, a psychoanalyst who developed family systems theory. According to Bowen, family systems theory is rooted in eight interlocking concepts.

These eight concepts are:

- **Triangles**: A three-person relationship system that acts as a building block for other emotional systems.
- **Differentiation of the self**: This refers to the ability to maintain individuality. People with high levels of differentiation are able to independently pursue goals while those with poor differentiation rely more on getting validation from other people.
- **Nuclear family emotional process**: This refers to how the family operates in their emotional interactions. These patterns can include marital conflict, dysfunction in a spouse, impairment of one or more children, and emotional distance.

- **Family projection process**: Parents can also transmit their problems and anxieties onto their children. This can affect how kids develop and can create emotional problems for other members of the family.
- **Multigenerational transmission process**: This describes how people choose partners who have similar levels of differentiation as themselves. Subsequent generations each have progressively lower levels of differentiation.
- **Emotional cut-off**: In order to manage conflicts within a family, some members may distance or cut themselves off from other members of the group. Cutting off old relationships without resolving the conflict can add pressure and stress to future relationships.
- **Sibling position**: Bowen believed that birth order had an impact on family dynamics including in areas such as parental expectations, sibling relationships, and parental discipline patterns.
- **Societal emotional process:** This concept suggests that many of the things that impact families also affect societies as well. Societal attitudes, cultural shifts, and conflicts can often play a part in affecting families.

10.8.3. Techniques of Family Systems Therapy

Types of therapy utilizing this theory may employ a number of different techniques that are designed to help both individuals and the entire family unit. Some of the different types of techniques that may be used depending on the needs of the family include:

- **Couples therapy**: When a couple is having issues, it can affect the entire family. Couples therapy may be used to help people in a relationship resolve conflict and improve communication.
- **Intergenerational family therapy**: This technique focuses on understanding how generational influences have affected both individual behavior and how the family unit functions. It helps families understand how patterns acquired from previous generations are affecting the family and learn new ways of interacting.
- **Narrative therapy**: This is an approach in which people develop a story of their life that helps them better understand their experiences, behaviors, and roles.
- **Psychoeducation**: This involves teaching members of the family about different aspects of mental health and treatment. This can be helpful when one family member is dealing with a mental health condition. By educating family members, the individual's support system can respond more effectively and empathetically to their needs.

- **Structural family therapy**: SFT focuses on helping people identify and understand how the family is structured. The goal is to help people improve this organization as needed and learn how to communicate with one another more effectively.
- **Strategic family therapy**: This technique focuses on identifying interventions to address specific problems. Each problem requires a novel approach that is specifically designed to address the unique issue the family is facing.

10.8.4. Problems requiring family system therapy

Therapy approaches that are focused on families can be helpful for a number of different issues that affect family members. Some conditions and problems that it may be used to treat include:

- Addiction and substance abuse problems
- Anger management problems
- Anxiety
- Bipolar disorder
- Challenges caused by things such as divorce, job loss, or financial difficulties
- Depression
- Dysfunctional relationships
- Eating disorders
- Marital conflicts, infidelity and divorce
- Parenting issues and conflicts
- Personality disorders
- Stress and trauma
- Sudden or traumatic loss of a loved one
- Prolonged illness of a family member
- Relocation or job change
- Birth of a child
- Adoption
- Child behavior issues
- Teen behavior issues
- Child/parent conflicts
- Sibling rivalry
- Child separation anxiety
- Communication issues
- In-law interference

It can also be helpful for addressing conflict within families, whether these center on problems in relationships between siblings or between parents and children. It can also be helpful for families dealing with life challenges or with chronic health conditions that may affect one or more family members.

When it comes to treating individual mental health problems, family systems therapy often looks at how factors within the family may contribute to the onset or maintenance of such conditions. If one person has a substance use disorder, for example, this type of therapy would help members of the family understand how things like codependent relationships allow the addiction to continue.

10.8.5. Benefits of Family Systems Therapy

This type of therapy has been shown to be helpful for a diverse range of problems. By improving behavioral, emotional, and psychological functioning, family systems therapy can address a wide range of symptoms or difficulties that affect individuals and families.

Some key benefits include:

- **Better functioning families**: One of the key benefits of family systems therapy is that it can improve how the family unit functions. It also benefits individual family members in a variety of ways. First, it can be helpful for treating different types of mental health issues. And by improving their family support system, this type of therapy ensures that family members also have the empathy and support they need going forward.
- **Stronger connections**: Another benefit of family systems therapy is that it promotes openness, empathy, and honesty in families. This can strengthen relationships and improve communication, which can address current problems and prevent future issues.
- **More cohesiveness**: Family systems therapy characterizes families as a team. During treatment, each person works individually and collaboratively to come up with solutions that will make the team stronger and healthier.
- **Healthier communication**: Family systems therapy can help identify communication problems, power imbalances, and dysfunctional patterns that affect the well-being of each family member as well as the functioning of the entire family unit.
- **Cost-effective**: Systematic family therapy can also be a cost-effective approach to treatment. A 2013 study comparing services provided by marriage and family therapists compared to individual therapy found that family therapy services were the least expensive option.

According to one report, family systems therapy helps prevent long-term problems by supporting families during challenges and changes. Other important benefits include strengthening relationships, improving communication patterns, increasing resilience, and encouraging supportive family networks.

10.8.6. Advantages and Disadvantages of Family Systems Therapy

a. Advantages

- **Increases family bond**: Family therapy can have a strong impact on the overall bond of a family. It allows family members to see the struggles of one of their own – and understand what they are going through.
- **Raises awareness**: Family therapy is often required when one member of the family is engaging in behaviour that is having a negative impact on the rest of the family. Family therapy allows the person to see the impact of their actions on the family.
- **Family members respect the person**: Similar to the above, family members might not realise what their member is going through, and may not be aware that they have a mental health condition.
- **Results in happier family**: Usually, Family therapy is able to restore a family's bond, eliminate any negative atmosphere and overall, make the family have a healthier relationship.
- **Useful tools**: Family members will learn a lot during the therapy. They will learn tools to help them support one another in the long-term. This can help guard against future relapses and problems.
- **Grievances can be aired**: It is likely that all members of the family will have plenty to say regarding the situation. Family therapy gives each family member an opportunity to talk about their feelings in a controlled environment, where the therapist will ensure that everyone has a chance to speak.

b. Disadvantages

- **Requires active participation by all**: In order for Family therapy to work at an optimum level, it requires active participation from the whole family. The entire family needs to be committed to the process, with no dissidents. All it takes is one member not being committed to the therapy, and it won't have the same effect.
- **Time commitment**: Family therapy is something that can't improve the dynamics of the family overnight – it requires time to work. Sessions take place over a course of a few months, and needs plenty of sessions for meaningful change to be accomplished.

- **Lacks individual focus**: Commonly, multiple members of the family will require individual therapy to get over their problems. Family therapy addresses the issue at a group level, and therefore doesn't focus on individuals, which could have a bad effect on overall effectiveness.
- **Some circumstances require intensive treatment**: As mentioned above, Family therapy takes time. But many mental health conditions require more intensive treatment to work. Some people with severe cases of Depression, Bipolar Disorder or Schizophrenia may need instant treatment, rather than over months.
- **Family therapy can potentially worsen family relations**: While Family therapy aims to bring a family together, it can potentially have the opposite effect. Past memories and difficulties can lead to arguments, and instances where different family members have arguments are very common. If arguments become heated, it is possible for the family's bond to weaken even further.
- **Requires a strong mediator**: The role of the therapist is to teach techniques, listen, and above all – mediate. It is important to choose an experienced therapist with plenty of knowledge about mental health and families. Choosing an inexperienced therapist or someone with a hidden agenda could have disastrous consequences.

Application activity 10.8.

Discuss the techniques used in family systems approach

End of unit assessment

Question 1: Discuss the limitations of psychoanalytic theory of counselling

Question 2: Discuss the disadvantages of client-centered approach

Question 3: explain the qualities of a good therapists in client-centered approach

Question 4: Discuss the effectiveness of humanistic therapy

REFERENCES

Okumu, A. (2018). Introduction to Guidance and counselling.https://www.sweducarebd.com/2017/08/major-theories-of-emotion-psychology.html

Cherry, Kendra. "The Schachter-Singer Two-Factor Theory of Emotion." *Verywell Mind* (2019, May 4). https://www.verywellmind.com/the-two-factor-theory-of-emotion-2795718

Cherry, Kendra. "Understanding the Cannon-Bard Theory of Emotion." Verywell Mind (2018, Nov. 1). https://www.verywellmind.com/what-is-the-cannon-bard-theory-2794965

James, William. "Discussion: Th e Physical Basis of Emotion." Psychological Review 1.5 (1894): 516-529. https://psycnet.apa.org/record/2006-01676-004

James, William. "The Emotions." The Principles of Psychology, vol. 2., Henry Holt and Company, 1918, 442-485. http://www.gutenberg.org/ebooks/57628

Keltner, Dacher, Keith Oatley, and Jennifer M. Jenkins. Understanding Emotions. 3rd ed., Wiley, 2013. https://books.google.com/books/about/Understanding_Emotions_3rd_Edition.html?id=oS8cAAAAQBAJ

Vandergriendt, Carly. "What Is the Cannon-Bard Theory of Emotion?" Healthline (2017, Dec. 12). https://www.healthline.com/health/cannon-bard

https://www.studysmarter.co.uk/explanations/psychology/individual-differences-psychology/cognitive-theory-of-emotion/

Schachter, S., & Singer, J. (1962). Cognitive, social, and physiological determinants of emotional state. Psychological Review, 69(5), 379–399.

https://doi.org/10.1037/h0046234

Gallup, G., & Hill, E. (1960). *The secrets of a long life*. New York: Bernard Geis.

Schelling, T.C. (1978). Egonomics, or the art of self-management. *The American Economic Review*, *68*(2), 290-294.

Sibold, J.S., & Berg, K. (2009, May 29). *Mood enhancement persists for up to 12 hours following aerobic exercise*. Poster session presented at the annual meeting of the American College of Sports Medicine, Seattle, WA.

Andersen, P. (2007). *Nonverbal communication: Forms and functions* (2nd ed.). Long Grove, IL: Waveland Press.

Damasio, A. (2000). *The feeling of what happens: Body and emotion in the making of consciousness*. New York, NY: Mariner Books.

Damasio, A. R. (1994). *Descartes' error: Emotion, reason, and the human brain*. New York, NY: Grosset/Putnam.

Selye, H. (1956). *The stress of life.* New York, NY, US: McGraw-Hill.

AIHW (Australian Institute of Health and Welfare). (2010). *Australia's health 2010*. Cat no. AUS 122. Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2014). *Australia's health 2014*. Cat no. AUS 178. Canberra: AIHW.

APA (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd Edition - Revised). Washington, D.C.: APA.

Bambamhani, R. S. & Prakar, S. (2021). Psychopathy and sociopathy: A modern understanding of antisocial personality disorder. (Review Literature). *Indian Journal of Social Studies and Humanities*, 1(5), 17-23.

Bootzin, R.R. & Max, D. (1980). Learning and Behaviors Theories. In I.L. Kutash & L.B. Schlesinger (Eds.), *Handbook on Stress and Anxiety: Contemporary Knowledge, Theory & Treatment*. San Francisco: Jossey-Bass, Inc.

Butcher, J., Mineka, S., & Hooley, J. (2007). *Abnormal psychology and modern life* (13th ed.). Boston, MA: Allyn & Bacon.

Cristina Crego, T. A. (2015). Cleckley's Psychopaths: Revisited. *Journal of Abnormal Psychology*.

Crystal, G. (2020, 12 28). Retrieved from Wisegeek : https://www.wisegeek.com/what-is-a-sociopath.htm

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical psychology review*, *33(7),* 846-861.

Dennis E. Reidy, M. C. (2013). Reducing Psychopathic Violence: *A Review of the Treatment Literature*. researchgate.

Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129.

Fitzgerald, M. (2020). Criminal Atistic Psychopathy. NOVA.

Foa, E.B., Steketee, G., & Young, M.C. (1984). Agoraphobia: Phenomenological Aspects, Associated Characteristics, and Theoretical Considerations. *Clinical Psychology Review*, 4, 431-457.

Frank, J. B. (2002). *Psychology. A self-teaching guide*. New Jersey : Jonh Wiley & Sons, Inc.

Ewles, L. and Simneth, I. (1992): *Promoting health: A practical guide to health education*. London: Scutari Press

Naidoo, J and Wills, J. (1994): *Health promotion, foundations for practice*. London: Bailliere Tindall

Guttmacher, S. (1979). Whole in Body, Mind, and Spirit: Holistic Health and the Limits of Medicine. The Hasting Center Report, 9(2), 15-21.

Hashmani, T. & Jonason, P. K. (2017). *Anti social behaviour*, Waterloo. Canada.

Ho, R. (2014). *Psychosexual disorders* [Power Point Slides], Singapore: National University of Singapore.

Home Office (2004). *Defining and measuring anti-social behaviour*. Home Office Development and Practice Report. Lodon: Author.

Ignou, B. A. (2020). *Models of health and illness*. [Course material]. New Delhi.

Lang, P.J. (1970). Stimulus Control, Response Control, and Desensitization of Fear. In D. Levis (Ed.), Learning Approaches to Therapeutic Behavior Change. Chicago: Aldine.

Leventhal, H., Weinman, J., Leventhal, E. A., & Phillips, A. (2008). Health psychology: The psychology of health and illness: *Annual Review of Psychology*. 59; 8.1-8.28.

Lynam, D. R. (1998). Early Identification of the Fledgling Psychopath:Locating the Psychopathic Child in the Current Nomenclature. Journal of Abnormal Psycology, 107(4), 566-575.

Marks, I.M. & Lader, M. (1973). Anxiety States (anxiety neurosis): A Review. *Journal of Nervous and Mental Disease*, 156, 3-18.

Matarazzo, J. D. (1982). Behaviors health's challenge to academic, scientific, and professional psychology. *American Psychologist, 37*(1), 1–14. https://doi.org/10.1037/0003-066X.37.1.1

Matarazzo, J.D. (1980) Behaviors health and behaviors medicine: Frontiers for a new health psychology, *American Psychologist*, 35: 807–17.

Naidoo, J and Wills, J. (1994): *Health promotion, foundations for practice*. London: Bailliere Tindall.

Narang, T., Garima, Singh S.M. (2016). Psychosexual disorders and dermatologists. *Indian Dermatol Online* Journal, 7:149-58.

Odgen, J. (2018). *The psychology of health and illness: An open access course*. London: McGraw-Hill Education.

Odgen, J. (2004). *Health psychology*. A textbook. 3rd ed. London : McGraw-Hill Education.

Pemment, J. (2013). Psychopathy versus sociopathy: Why the distinction has become crucial. Elsevier, AVB0

Pomerleau, O.F. and Brady, J.P. (1979) *Behaviors Medicine: Theory and Practice*. Baltimore: Williams and Wilkins.

Perry, C. (2015). The» Dark Traits» of Sociopathic Leaders: Could They Be a Threat to Universities?. . 57(1), 17- 25.

Schwarzer, R. & Gutierrez-Dona, B. (2000) *International handout of psychology*. London : SAGE Publications Ltd.

Schwartz, G.E. and Weiss, S.M. (1977) *Yale Conference on Behaviors Medicine*. Washington, DC: Department of Health, Education and Welfare; National Heart, Lung, and Blood Institute.

Sullivan, M. J. (2019). "Reunification Family Therapy: A Treatment Manual by Jan Faust," Book *Review for Family Court Review*, Vol. 57, no. 1, 2019.

Taylor, S. E. (2018). *Health psychology*. 10th ed. New York : McGraw-Hill Education.

Yuill, C., I. Crinson, and E. Duncan. (2010). *Key Concepts in Health Studies*. Sage Key Concepts. 2010, Los Angeles; London: Sage.

Zhang, M. W.B., Cheok, C. CS., Yeong, N. B., Cheng, L., Shakar, R., Sockalingam, S., Cheng,

M. & Ho, R. CM. (2015). *Mastering psychiatry. A core textbook for undergraduates* (4th ed.). Singapore : The ScreenwrittersAssociation Singapore & Samuel SeowLaw Corporation.

https://www.sweducarebd.com/2017/08/major-theories-of-emotion-psychology.html

Cherry, Kendra. "The Schachter-Singer Two-Factor Theory of Emotion." *Verywell Mind* (2019, May 4). https://www.verywellmind.com/the-two-factor-theory-of-emotion-2795718

Cherry, Kendra. "Understanding the Cannon-Bard Theory of Emotion." Verywell Mind (2018, Nov. 1). https://www.verywellmind.com/what-is-the-cannon-bard-theory-2794965

James, William. "Discussion: The Physical Basis of Emotion." Psychological Review 1.5 (1894): 516-529. https://psycnet.apa.org/record/2006-01676-004

James, William. "The Emotions." The Principles of Psychology, vol. 2., Henry Holt and Company, 1918, 442-485. http://www.gutenberg.org/ebooks/57628

Keltner, Dacher, Keith Oatley, and Jennifer M. Jenkins. Understanding Emotions. 3rd ed., Wiley, 2013. https://books.google.com/books/about/Understanding_Emotions_3rd_Edition.html?id=oS8cAAAAQBAJ

Vandergriendt, Carly. "What Is the Cannon-Bard Theory of Emotion?" Healthline (2017, Dec. 12). https://www.healthline.com/health/cannon-bard

https://www.studysmarter.co.uk/explanations/psychology/individual-differences-psychology/cognitive-theory-of-emotion/

Schachter, S., & Singer, J. (1962). Cognitive, social, and physiological determinants of emotional state. Psychological Review, 69(5), 379–399. https://doi.org/10.1037/h0046234

Gallup, G., & Hill, E. (1960). *The secrets of a long life*. New York: Bernard Geis.

Schelling, T.C. (1978). Egonomics, or the art of self-management. *The American Economic Review*, *68*(2), 290-294.

Sibold, J.S., & Berg, K. (2009, May 29). *Mood enhancement persists for up to 12 hours following aerobic exercise*. Poster session presented at the annual meeting of the American College of Sports Medicine, Seattle, WA.

Deci, E. L., Koestner, R., & Ryan, R. M. (1999). A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation. Psychological Bulletin, 125, 627-668.

Deci, E. L., & Ryan, R. M. (1985). Intrinsic motivation and self-determination in human behavior. New York: Plenum.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development and well-being. American Psychologist, 55, 68-78.

White, R. W. (1959). Motivation reconsidered: The concept of competence. Psychological Review, 66, 297-333.

Weiner, B. (1972). Attribution theory, achievement motivation, and the educational process. Review of educational research, 42(2), 203-215

Milgram, S. (1974). Obedience to Authority: An Experimental View. New York: Harper and Row. An excellent presentation of Milgram's work is also found in Brown, R. (1986). Social Forces in Obedience and Rebellion. Social Psychology: The Second Edition. New York: The Free Press.

Turner, John C. Tajfel, Henri. Chapter 1, "The Social Identity Theory of Intergroup Behaviour". P7-24. Accessed from: (Link)

McLeod, S. A. (2019, October 24). Social identity theory. Simply Psychology.

www.simplypsychology.org/social-identity-theory.html

Cooper, J. (2007). *Cognitive dissonance: 50 Years of a classic theory*. SAGE Publications.Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford University Press.

Andersen, P. (2007). *Nonverbal communication: Forms and functions* (2nd ed.). Long Grove, IL: Waveland Press.

Damasio, A. (2000). *The feeling of what happens: Body and emotion in the making of consciousness*. New York, NY: Mariner Books.

Damasio, A. R. (1994). *Descartes' error: Emotion, reason, and the human brain*. New York, NY: Grosset/Putnam.

Selye, H. (1956). *The stress of life.* New York, NY, US: McGraw-Hill.

http://ijern.com/journal/2016/November-2016/37.pdf

https://files.eric.ed.gov/fulltext/EJ1118929.pdf

McLeod, S. A. (2008). Prejudice and discrimination. Simply Psychology. *www.simplypsychology.org/prejudice.html*

Mayo Foundation for Medical Education and Research (2023). Anxiety disorders https://www.mayoclinic.org/diseases-conditions/anxiety/symptoms-causes/syc-20350961

Mayo Foundation for Medical Education and Research (MFMER) (2023). Somatic Symptom Disorder. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/somatic-symptom-disorder/symptoms-causes/syc-20377776

Mayo Foundation f or Medical Education and Research (MFMER) (202). Schizophrenia. https://www.mayoclinic.org/diseases-conditions/schizophrenia/symptoms-causes/syc-20354443

Mayo Foundation for Medical Education and Research (MFMER) (2023). Personality Dosrders. https://www.mayoclinic.org/diseases-conditions/personality-disorders/symptoms-causes/syc-20354463

Ananya Mandal (2019). ADHD Causes and Risk factors. https://www.news-medical.net/health/ADHD-Causes-and-Risk-factors.aspx

Republic of Rwanda. National Rehabilitation Service (NRS). https://www.nrs.gov.rw/index.php?id=101

Risa Jo Rudy (2021). Causes and Risk Factors of Autism in Verywell Health. https://www.verywellhealth.com/autism-causes-4014494

Narang T, Garima, Singh SM. Psychosexual disorders and dermatologists. Indian Dermatol Online J 2016;7:149-58.

Neucleus Medical Media, Inc. (n.d). Psychosexual Dysfunction. Health Library. https://www.winchesterhospital.org/health-library/article?id=96748#

Elizabeth Hartney (2022). What Is Deviant Behavior? The Difference Between Socially Acceptable and Deviant Behavior. https://www.verywellmind.com/socially-acceptable-to-socially-deviant-addictions-22243?print

Pranav Dua (n.d). Essay on the Factors Facilitating Deviance-Shared article. https://www.shareyouressays.com/essays/essay-on-the-factors-facilitating-deviance/87149

Evans. Et al (2005). Prevention of Anxiety Disorders. https://doi.org/10.1093/9780195173642.003.0012

Browne & Felman (2020). What to know about anxiety. https://www.medicalnewstoday.com/articles/323454

American Psychiatric Assiciation (APA) (2022). What Is Obsessive-Compulsive Disorder? (https://www.psychiatry.org/patients-families/ocd/what-is-obsessive-compulsive-disorder)

Mayo Foundation for Medical Education and Research (MFMER) (2023)

Henningsen (2022). Management of somatic symptom disorder. https://www.tandfonline.com/doi/full/10.31887/DCNS.2018.20.1/phenningsen

Mayo Foundation for Medical Education and Research (MFMER) (2023). Dissociative disorders. https://www.mayoclinic.org/diseases-conditions/dissociative-disorders/symptoms-causes/syc-20355215?p=1

Meyer Robinson (2014). Can you prevent schizophrenia ? https://www.webmd.com/schizophrenia/features/is-it-possible-to-prevent-schizophrenia

Sura Sanem Köse & Oytun Erba' (2020). Personality disorders diagnosis, causes, and treatments.
Demiroglu Science University Florence Nightingale Journal of Transplantation 2020;5(1-2):22-31
doi: 10.5606/dsufnjt.2020.013.

Chanen & Thompson (2014). Preventive Strategies for Borderline Personality Disorder in Adolescents. Current Treatment Options in Psychiatry (2014) 1:358–368 DOI 10.1007/s40501-014-0029-y

https://link.springer.com/article/10.1007/s40501-014-0029-y

Cleveland Clinic (2023). Dialectical Behavior Therapy (DBT). https://my.clevelandclinic.org/health/treatments/22838-dialectical-behavior-therapy-dbt

Nancy (2021). What Is Interpersonal Therapy (IPT)? https://www.verywellmind.com/interpersonal-therapy-1067404

Jeffrey M. Halperin & Anne-Claude V. Bédard &Jocelyn T. Curchack-Lichtin (2012). Preventive Interventions for ADHD: A Neurodevelopmental Perspective. Neurotherapeutics (2012) 9:531–541 DOI 10.1007/s13311-012-0123-z

Bennet, Coleman & Co.Ltd (2022). Autism- Causes, Signs, Symptoms & Prevention. https://timesofindia.indiatimes.com/life-style/health-fitness/health-news/autism-causes-signs-symptoms-prevention/articleshow/61655180.cms

Private Psychiatry LLP (2021). PSYCHOSEXUAL DISORDERS. https://www.privatepsychiatry.co.uk/psychosexual-disorders

Debra Fulghum Bruce (2021). Can You Prevent ADHD?. WebMD, LLC.

https://www.webmd.com/add-adhd/childhood-adhd/preventing-adhd#:~:text=A%20healthy%20diet%20and%20regular,may%20be%20linked%20to%20ADHD.

Natalya V.Vist (2016). Psychological and Pedagogical Conditions for the Prevention of Deviant Behavior among Adolescents. INTERNATIONAL JOURNAL OF ENVIRONMENTAL & SCIENCE EDUCATION 2016, VOL. 11, NO. 15, 8536-8551. https://files.eric.ed.gov/fulltext/EJ1117749.pdf

REB, (2020), Foundations of Education for TTCs Year 2, Kigali-Rwanda

REB, (2020), Foundations of Education for TTCs Year 3, Kigali-Rwanda

David G. Myers/C. NATHAN Dewall (2017), Psychology in everyday life fourth edion, Worth Publishers, New York Plaza.