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BPCG-175

Block-III

Self, Maladjustment and Mental Disorders

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UNIT 7 SELF AND MALADJUSTMENT*

Structure

7.1 LEARNING OBJECTIVES

After studying the Unit, you would be able to:

- *Know the concept of anxiety and its symptoms;*
- *Understand stress and methods of managing stress;*
- *Understand impulsivity and its manifestation;*
- *Differentiate between adaptive and maladaptive coping;*
- *Explain cognitive rigidity and ways to address it; and*
- *Understand the concept of dysfunctional thinking, methods of assessment, and modification.*

7.2 INTRODUCTION

'Self' refers to a person's sense of who he/she is. The experience of one's self is composed of awareness of one's physical attributes and psychological attributes, such as thoughts, feelings, goals, values, preferences that distinguish one individual from another. You have read in detail about the meaning, components, and correlates of self in the earlier units. In the present Unit, we will discuss how one's sense of self can havea tremendous influence on one's thought process, emotions, and behavior. Individuals often think, feel and behave in a certain way

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to preserve their sense of self. Thus, the sense of self you possess has profound implications for your adjustment to the needs or demands in the environment.

Maladjustment can occur when our sense of self prevents us from making a normal adjustment to some need or demand in our environment. Let us see the examples below.

When Rama went to another city for her college education, she had to stay in the hostel there, sharing the room with another girl from a different culture than her own. Rama, being the single child of her parents, had never experienced staying with others on a continuous basis and requiring to adjust to so many things. She has always perceived herself as being independent, and her needs to be fulfilled on a priority basis. She faced a lot of difficulties in adjusting to staying with a roommate in the hostel, and it resulted in frequent arguments and fights with her roommate.

Rajesh, an idealistic young man, frequently had disputes with his wife Seema, because he was often finding faults with her. Rajesh had unreasonable expectations from his wife, and he would constantly compare her actions to his fixed standards. When she didn't match his standards, he became angry and even aggressive towards her. Seema became quite frustrated as it continued for long term and told him several times that she would consider divorce if he continues to behave in the same way. Despite the fact that his marriage is in jeopardy, Rajesh refuses to change his behavior due to his rigid thinking patterns.

Anu, an intelligent and high-performing student, scored less than expected in her annual exam. Looking at her exam results, she realized that though she had passed her examinations, she had scored far lower than she had ever previously. Thus made her very frustrated and depressed as she was to apply for studies abroad based on the performance in this exam. Now she cannot apply and lost the opportunity. She was quite dejected and rushed to her room immediately without talking to anyone. She closed the door of her room and consumed an overdose of sleeping tablets her grandfather takes, to put an end to her suffering immediately. Anu's impulsivity made her engage in self-harm behavior without considering the impact of her actions on herself and her loved ones.

We can see from the above examples that various factors can contribute to maladjustments, such as a sense of impulsivity, cognitive rigidity, and faulty or maladaptive coping. Further, our perception of ourselves in terms of our thinking, personality, emotions, etc., can create a dysfunctional attitude and lead to dysfunctional relationships. The outcome of all these may beanxiety and stress experienced in relation to oneself, and also with family, friends, and at the workplace. In addition, it may also lead to various mental disorders (you will learn about it in detail in the next Unit 8).

In the following sections, you will learn about two significant manifestations of maladjustment as 'anxiety' and 'stress'. Thereafter you will learn about important factors contributing to maladjustments such as impulsivity, cognitive rigidity, maladaptive coping, and dysfunctional attitude.

7.3 ANXIETY

Anxiety is a very commonly used term which almost all of us experience in our daily life. It refers to an unpleasant feeling resulting from the perception of danger.

Such perceived danger can be real, or it can be imagined. It can be noted here that anxiety is different from fear. Fear is an alarm reaction to the real immediatedanger.When the cause of danger is evident, the emotion felt is called asfear (e.g., you are about to step on a snake as you are walking, and you immediately jump aside with increased heartbeats and sweating). However, in anxiety, we often cannot explicitly specify thedanger (e.g., feeling anxious regarding your job interview next week or appearing in the final board exam).

There are various symptoms based on which we can identify that anxiety is being experienced by an individual.

7.3.1 Common Symptoms of Anxiety

- **Physical symptoms:** Shortness of breath, restlessness, palpitations, sweating, dry mouth, nausea, fatigue, sleep disturbances.
- **Cognitive and Emotional symptoms:** Poor concentration, negative thoughts, irritability, uneasiness, worry, apprehension, feeling overwhelmed, nervousness.
- **Behavioral Symptoms**
    - Avoidance of situations or objects which produce anxiety.
    - Involving in high-risk or self-destructive behaviors (excessive smoking, drinking alcohol, or drug consumption with the intention of getting rid of anxiety).
    - Safety behaviors to prevent anticipated anxieties from coming true and to feel more comfortable (a person with social anxiety might carry a water bottle while facing any social situations so that he/she can drink water if they feel anxious, excessive preparation etc.)
    - Limiting one's daily activities to reduce anxiety (e.g., remaining at home most of the time to feel safe).
    - Getting excessively attached to an object/individual producing a sense of safety (e.g., not going out, to school/college, or work to avoid getting separated from the object or the individual who produces a sense of safety).

When does anxiety become a mental disorder? When anxiety goes beyond the normal level and starts interfering with day-to-day functioning, it results in disorder. Occasional anxiety is completely normal and inevitable. However, persistent, intense, or pervasive anxiety might have a negative impact on one's overall health and can interrupt daily functioning, indicating an anxiety disorder. Anxiety can be a disorder when it is disproportionate to the situation and results in considerable avoidance of the problem, and interferes with one's day-to-day functions.

7.3.2 Types of Anxiety Disorders:

- ***Social Phobia (Social anxiety disorder)*** refers toan intense and irrational fear of a specific social situation. For example, speaking in public, using public toilets/bathrooms, or eating when one is in the company of others,

etc. In such situations, the person feels frightened that she/he may be negatively evaluated by others or that she/ he might end up acting in an embarrassing manner. Because of the intense fear, the person with social phobia either avoids such situations altogether or faces them with intense distress.

- ***Specific Phobia*** is characterized by an intense and irrational fear of some specific object, such as an animal or an insect (e.g., cat, spider, cockroach,etc.) or a situation, like being inside an elevator or enclosed places.
- ***Generalized Anxiety Disorder*** involves excessive and irrational anxiety and worries about various everyday events of life (including trivial events). For instance, the person might get excessive worries regarding his/her own safety or the safety of one's loved ones, or the person might get worried that something bad might happen to him/her or their close relatives.
- ***Panic Disorder*** is characterized by recurring panic attacks and a fear of getting a panic attack.Panic attacks are brief episodes of excessive anxiety accompanied by physical symptoms such as dizziness, increased heartbeat, difficulty in breathing, sweating, and nausea. The person might also fear that he would lose control over his/her body, or he/she would go crazy or might die due to a heart attack.

7.3.3 Causes of Anxiety

Following are some of the important psychosocial and biological causal factors in anxiety.

Psychosocial Factors:

- ***Learning through Conditioning***

  Anxiety reactions can be easily conditioned to previously neutral stimuli when such stimuli are associated with traumatic/ painful events, and then they may be generalized to other similar objects/situations which were not there in the initial situation. For example, a person who has been exposed to multiple incidents of being locked in closets as a child might show an intense and irrational fear of elevators as well as other enclosed places.

- ***Learning through Observation (Vicarious Learning*)**

  Many times, individuals learn to show anxious responses simply by observing or watching another person behaving anxiously towards a particular object or situation. This is because anxiety can be transferred from one individual to another through vicarious learning. For instance, a child who observers his/her parent showing anxious response to the sight of pet animals like dog or cat might herself /himself develop an intense fear of such animals.

- ***Stressors in the Environment (Environmental Stressors)****:* Relationship breakups, job loss, increased work pressure, or ongoing interpersonal issues with family members may also be responsible for the development of anxiety in individuals.

- **Biological Factors**

  Most of us can experience occasional anxiety. However, some individuals are more prone to anxiety due to their biological makeup. Because of the

genes inherited or difficult temperaments, perhaps as a result of under-or over-activity of specific areas in the brainor because of neurochemical imbalances,some individuals are more vulnerable to react with anxiety to neutral stimuli or situations that are not actually dangerous.

7.3.4 Managing Anxiety and Anxiety Disorders

Various counseling techniques and interventions can help reduce anxiety in individuals. Further, medication and psychotherapies are useful in the treatment of anxiety disorders.

Psychotherapy: Anxiety disorders can be usually treated successfully with psychotherapyalone or often in combination with pharmacotherapy.

Cognitive-Behavioral Therapy (CBT) is one of the most effective treatment options for anxiety. In CBT, the person learns mainly to challenge his/her distortedor rigid patterns of thinking,which produce distress along with other behavioral techniques.

Exposure therapy, in which the person is gradually and safely exposed to objects/ situations triggering anxiety so that they no longer avoid them, is an important behavioral technique in the treatments for anxiety.

Relaxation Techniques like progressive muscle relaxation, deep breathing, guided imagery, mindfulness meditation are often used in managing the increased physiological arousal associated with anxiety.

Lifestyle Changes: These are simple yet powerful tools in managing anxiety. Exercising, having a balanced diet, practicing healthy sleep habits are often recommended in addition to psychotherapies and medications in the long-term management of anxiety.

Pharmacological Treatment (Medication): Various types of medications are used to treat anxiety disorders,such as anti-anxiety drugs, beta-blockers, and antidepressants. Pharmacotherapy is mainly intended to manage the symptoms rather than cure the underlying causes of anxiety.

7.4 STRESS

Like anxiety, stress is also a commonly used term and is also experienced by all individuals. It can be described as an unpleasant emotional experience accompanied by physiological, cognitive, and behavioral changes which are either intended to alter the sources of stress (the stressors) or adapt to its effects. The crucial question here is we need to know why does stress occur. You may have noticed that the same situation, e.g., appearing in an exam or speaking on stage in the college function, can create different levels of stress in individuals. So, there are individual differences in experiencing stress. Here it is important to know how do we perceive the situation, assess or appraise it and what coping resources we have to deal with the situation. This will determine our level of stress.

Thus, stress is the result of a person's appraisal process. The transactions in stress usually involve an assessment process known as **cognitive appraisal.** There are two types of cognitive appraisals:

- ***Primary appraisal***

  Primary appraisal refers to assessing the meaning or significance of the stressor for one's well-being, such as whether the stressor is posing any threat or whether it is challenging. Primary appraisal tries to answer questions like, "Whether it is upsetting or painful to me?" "Is this challenging or threatening?". Events can be assessed as harmful, challenging, and threatening, and so on.

- ***Secondary appraisals***

  Secondary appraisal refers to the assessment of resources that one has to deal with the stressor. Although these assessments are carried out on an ongoing basis in our day-to-day life, it is more evident when we perceive a situation as stressful and try to figure out whether the resources we have are sufficient to address the stressor we are facing. For instance, based on the availability of resources, we may say, "I will be able to handle it," "I don't think I can do it."

It is important to remember here that stress can be a motivator also to put your best foot forward and give your best in any situation. For instance, the stress associated with completing a project in a time-bound manner makes you give your best effort to it. However, one needs to be cautious as to when this positive stress turns into negative and affects your mental health and functioning. That is, stress can be helpful up to a point, and beyond that, it affects the individual negatively. This optimal point will vary from individual to individual.

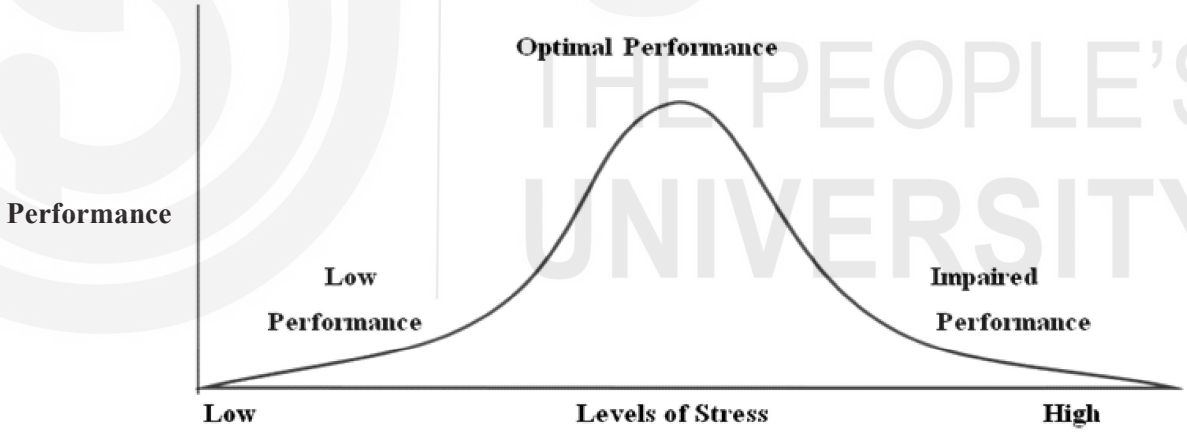

Fig. 7.1 Relationship Between Stress and Performance
(Adapted from Yerkes&Dodson, 1908, p.479.)

7.4.1 Types of Stress

Stress may arise from various sources and thus can be of varied types. But it can broadly be categorized under two types of stress:

- **Eustress:** Eustress refers to a positive response to a stressor that may rely on factors such as one's current sense of control, desirability, place, and time of the stressor, etc.One of the characteristics of eustress includes responding to a stressor with a sense of meaning and hope, e.g., starting a new job on a voluntary basis, receiving a job promotion, going on a holiday, having a child, etc. These are the events and situations we want for ourselves, and we knowingly take the stresses associated with these.

- **Distress** is the most frequently referred to form of stress, having negative consequences. Persistent stress,which is not addressed through coping or adaptation, is known as distress. Physical signs of distress often include prolonged increased blood pressure, increased gastric acid secretions, and some of the psychological signs of distress are depression, anxiety, insomnia.

7.4.2 Types of Stressors

A stressor refers to "any event, experience or environmental stimulus which causes stress to the person." The person perceives such events, experiences, stimuli as either threats or challenges to himself/herself. A stressor can be either physical or psychological. The following are various types of stressors:

- **Crises or catastrophes**: refers to unforeseen/ unpredictable events, and therefore, they are usually not underthe control of individuals, for example, natural disasters, such as major floods, hurricane, earthquakes, tsunami, etc.
- **Major life events:** involves marriage, going to school or college, the death of close relatives or loved ones, the birth of a child, shifting to a new house, etc. These events, whether positive or negative, can create a sense of uncertainty or fear which will lead to stress.
- **Daily hassles or micro stressors:** are encountered on a day-to-day basis, such as making decisions, meeting deadlines at work or college, traffic jams, meeting with irritating or annoying personalities, etc. This type of stressor also includes conflicts with other people.
- **Ambient stressors:**These are low-level global stressors that are usually part of the background environment, e.g., noise, pollution, crowding, heavy traffic, etc.

7.4.3 Effect of Stress on Our Health

Research studies (Mishra et. al., 2020; Sarkar et. al., 2018) have found that stress affects our physical health as well as mental health and well-being.

There may be long-term negative consequences of stress on health. Usually, the ability of the ***immune system*** to stop inflammation gets impaired due to chronic stress. Thus, stress may compromise the functioning of the immune system.

Stress can cause ***cardiovascular reactivity*** and thereby lead to the development of coronary heart disease.

Metabolic syndrome is a series of risk factors, such as high levels of cholesterol and other blood fats, increased blood pressure, impaired insulin capacity to promote the transfer of glucose out of the bloodstream, and higher deposits of fat in the abdomen. This can also be caused due to stress.

Stress-related psychosocial factors have also been shown to predict the course of cancer and also the chances of survival and death from cancer**.**

Psycho-physiological Disorders refer to physical symptoms that result from the interaction of various physiological and psychological factors. Some of the

common psycho-physiological illnesses aredigestive system disorders such as ulcers, irritable bowel syndrome**,** asthma, headache **(**tension-headache or migraine headache), and other disorders like dysmenorrhea, rheumatoid arthritis, eczema, psoriasis.

What is the mechanism through which stress impacts our health? The following can be cited as the mechanisms/processes through which stress has an effect on our physical and mental health.

- **Alters physiological functioning**

  Stress can alter physiological functioning by interacting with existing risk factors or genetic predispositions and determine the kind of illness a person develops. Some of the direct physiological effects of stress include increased blood pressure, a decreased immune system that affects the body's ability to control infection, alteration in lipids. All these may lead to various physical health problems and illnesses.

- **It affects the health habits negatively**

  People exposed to chronic stress have negative health habits such as consumption of substances/drugs, alcohol, unhealthy eating, and sleeping habits. These poor health habits might lead to specific illnesses in the long run.

- **Affects psychosocial resources**

  Social support can protect our health, but a person who is experiencing chronic stress might avoid social contacts or behave in ways that might make other people stay away from the person. Further, stress hinders our ability to think clearly and respond to situations in a proper manner.

7.4.4 Management of Stress

Stress is a fact of life. So, the key to deal with stress is to manage stress in an effective way. Management includes ways/strategies to *reduce the potential for stress* as well as *reduce stress reaction*. Some of the stress management techniques are as follows:

- **Reframing or Cognitive Restructuring:** It is a process in which thoughts or beliefs provoking stress reactions are replaced with more constructive and realistic thoughts or beliefs.This can help ease orreduce the unpleasant feelings that are generated when we appraise the situation as threatening or harmful.

- **Problem Solving**: One of the main sources of stress is inability or difficulty in solving problems. Finding a solution to the problem becomes much easier if it is approached in a systematic and rational manner. There are fourbasic steps in problem-solving (a) defining the problem, i.e., diagnosing the situation so that focus is on the problem, not just on its symptoms, (b) generating alternative solutions, (c) evaluating and selecting an alternative, (d) implementing and following up on the solution.

- **Time Management:** It includes actively planning ahead and exercising deliberate control over the amount of time spent on specific tasks in

order to maximize one's performance, level of productivity, or efficiency. One of the common methods used is prioritization based on criteria such as the importance of the task.

- **Relaxation:** Relaxation is a mechanism that reduces the impact of stress on the mind and body. Relaxation exercises can help you deal with daily stress and stress-related to different health conditions. Following are some of the relaxation techniques used to manage stress:
    - *Progressive muscle relaxation:* This involves focusing your attention on specific muscle groups as you alternately tighten and loosen these muscles.
    - *Autogenic training:* is a method of relaxation which teaches your body to respond to your verbal commands. These commands instruct your body to relax and control breathing, heartbeat,blood pressure, and temperature of the body. The purpose of autogenic training is to attain deep relaxation and reduction of Stress. Autogenic training comprises six standard exercises which make the body feel warm, heavy, and relaxed.
    - *Self-hypnosis and Imagery:* In this method of relaxation, the person uses auto-suggestion as well as imagery to calm oneself down. This technique uses both relaxation and affirmative statements to induce relaxation and relieve stress.
- **Physical Activities and Diet**

  Practicing different physical exercises and yoga 'asana' (yoga postures) canhelp you in reducingstress.It can also improve your mood and sense of well-being. As stress affects the brain and its many nerve connections, the rest of the body is also affected. A number of yoga poses, also known as postures, can have a positive impact on the brain and the nervous system. Physical activities produce a chemical called "endorphins" in the brain, which acts as natural painkillers. In addition to this, they can improve your sleep, which in turn can reduce your stress.

  Healthy and balanced foods are the simplest means of stress relief. Consumption of foods with enough vitamins and minerals can help in reducing stress levels. Certain foods and drinks such as tea, coffee, cocoa, energy drinks, fast food, sugar, alcohol, and soft drinks may trigger or increasestress. These should be consumed in moderation.

Self Assessment Questions 1

I. Fill in the blanks with appropriate words:

1. When the source of danger is obvious, the experienced emotion is called as ————, and a general feeling of apprehension about unknown danger, whether real or imagined, is called ————————.
2. Anxiety can be a disorder when it is ————————————to the situation and results in considerable ————————————of the situation and interferes with one's day to day functioning.

3. ——————————refers to a positive response one has to a stressor. Persistent stress that is not resolved through coping or adaptation is known as——————————.

4. —————————— is any event, experience, or environmental stimulus that causes stress in an individual.

II. Each of the questions or incomplete statements below is followed by four suggested answers or completions. In each case, select the one that best answers the question or completes the statement.

1. Shortness of breath, restlessness, palpitations, sweating, dry mouth, and nausea are some of the —————————— symptoms of anxiety.

   (A) Cognitive (B) Behavioural

   (C) Physical (D) Emotional

2. Avoiding to face anxiety-producing situations is one of the ———— ——————————symptoms of anxiety.

   (A) Cognitive (B) Physical

   (C) Unusual (D) Behavioural

3. All of the following are anxiety disorders EXCEPT:

   (A) Generalized Anxiety Disorder (B) Panic Disorder

   (C) Maj————or Depressive Disorder (D) Specific Phobia

4. Many a time, individuals learn to show anxious responses simply by watching another person behaving anxiously towards a particular object or situation. This is called as ——————————

   (A) Classical Conditioning (B) Vicarious Learning

   (C) Motivational Learning (D) Environmental Learning

5. Following are all different management approaches to anxiety EXCEPT:

   (A) Cognitive Behaviour Therapy (B) Exposure Therapy

   (C) Avoidance Therapy (D) Pharmacotherapy

6. Devastating natural disasters, such as major floods or earthquakes, are examples for:

   (A) Major life events (B) Crises/catastrophes

   (C) Ambient stressors (D) Micro Stressors

7. Transactions in stress generally involve an assessment process that is called as ————————

   (A) Cognitive perception (B) Stress evaluatin

   (C) Cognitive appraisal (D) Situational assessment

8. Seeking answers to such questions as, "what does this mean to me?" and "Will I be okay or will end up in trouble?" are examples for:

   (A) Secondary appraisal (B) Primary appraisal

   (C) Problem solving (D) Self reflection

9. ———————— refers to our assessment of the resources we have available for coping with stress.

   (A) Secondary appraisal (B) Primary appraisal

   (C) Self-appraisal (D) Personal assessment

10. ————————————is not one of the stress management techniques.

    (A) Time management (B) Relaxation

    (C) Rumination (D) Problem solving

Now let us discuss the various factors contributing to maladjustment.

7.5 IMPULSIVITY

Impulsivity refers to "an inability to wait, a preference for risky outcomes, a tendency to act without foresight, without sensitivity to the consequences, and/or an inability to inhibit inappropriate behaviors." Purchasing things that you did not intend, interrupting others who are talking, blurting out something that you later wish you should not have said - these are all examples of impulsivity. Impulsivity is like not being able to press a 'pause button, for example, not being able to stop speaking or doing things without thinking about the possible consequences. Being impulsive can be useful, as well as problematic. Following an idea without thinking can sometimes work out well, such as a quick action taken during an emergency or any spontaneous action. However, in most situations, impulsivity can be problematic or dangerous and may have serious negative consequences, e.g., buying things that are not affordable, gambling, overspeeding the car when you are on highway enjoying a trip with your friends.

There are mainly three aspects to impulsivity:

- An immediate and unplanned reaction to stimuli before processing the information adequately.
- A decreased sensitivity to negative consequences of behavior
- Lack of regard for long-term consequences of a behavior

7.5.1 Classification of Impulsivity

Impulsivity is primarily classified as impulsive choice (or decision making) and Impulsive action (or disinhibition)

- **Impulsive Choice (or decision making):** This can be evident when one has to make a choice, i.e., a choice between rewards with various costs. Such choices typically involve choosing between a lower reward at a

lower cost and a higher reward at a higher cost, for example, randomly choosing to watch a TV show instead of doing exercises that could have greater benefits of good health, physical fitness, etc. in the long term.

- **Impulsive Action (or disinhibition**): refers to a lack of inhibition or difficulty in withholding the reaction. This usually involves acting without foresight, not paying attention to the consequences of one's actions, and lack of inhibition of inappropriate behavior.There are two types of impulsive actions. They are:

    - **Waiting impulsivity**: In waiting impulsivity, one can't wait for the required period of time, and he/she prematurely respond to a situation. For instance, while waiting in the signal, you are expecting a traffic signal to change, but you might respond prematurely by pushing the accelerator before the signal actually changes.

    - **Stopping Impulsivity**: In stopping impulsivity the person fails to stop an action or behavior when necessary. For instance, you reach out to touch a prohibited object and fail to stop reaching the object even when told not to touch it, and doing so will result in negative consequences.

Serious Impulsive Behaviours

Some of the impulsive behaviors are more serious than others as they can have serious consequences on health and other major areas of a person's life such as relationship, finance, occupation. Individuals who engage in impulsive behaviors such as substance abuse or binging, impulsive overeating, impulsive shoplifting, gambling, self-harm might require immediate intervention from mental health professionals as they are more serious.

7.5.2 Management of Impulsivity

Following strategies can be used in managing impulsivity:

- **Identify and manage the triggers:**

  Identify internal and external triggers (emotions, events) that provoke the urge to engage in impulsive behaviors and manage the triggers using stimulus control. For instance, if you find that keeping the wallet filled with money or having a credit card in your wallet tempts you to go shopping which you have not planned or intended, then do not keep extra money /credit card in your wallet.

- **Replacing impulsive behaviors with alternative healthy behaviours:**

  Impulsive behaviors may be serving some purpose at the moment. For example, they may be helping you in coping with your unpleasant emotion. Therefore, one way of stopping impulsive behaviors is finding another, healthier behavior thatwould serve a similar purpose such as, writing about the distressing experience and associated emotions, talking to a friend, or any other healthy behavior which can relieve your emotional pain. For example, an alternative to interrupting conversations due to impulsivity is to write the thought down (on paper or on a cell phone)

- **Involve significant others**

  Ask your loved ones or significant others to indicate when you engage in impulsive behaviors. They can also be informed to use verbal and nonverbal prompts to stimulate you to engage in healthy alternative behaviors.

- **Practice conscious decision-making:**

  Following the steps of decision-making will help you in dealing with impulsive decision-making. The following steps can be followed while taking important decisions –(1) Defining the nature of the decision you need to make, (2) Gathering relevant information,(3) Identifying the alternatives,(4) Placing the alternatives in priority order,(5) Choosing among alternatives, (6) Taking action, and (7) Reviewing your decision and its consequences.

7.6 COGNITIVE RIGIDITY

Cognitive rigidity is the "inability to mentally adapt to new demands or information." In other words, it is the difficulty in changing one's mental set. An individual with cognitive rigidity is unable to switch from thinking about things in one way to think about them in a different way. Individuals who can do this easily are called cognitively flexible.

All of us might have experienced cognitive rigidity at some point. For example, it is common to think that you can only solve certain things your way. Also, some people are convinced that their values and beliefs are universal truths. However, excessive and pervasive cognitive rigidity can affect your everyday functioning and important areas of life such as work, social function, and interpersonal relationships.

7.6.1 Characteristics of Cognitive Rigidity

Following are some of the characteristics observed in individuals with cognitive rigidity:

- **Intolerance of uncertainty:** The person might show a high need for structure.

  A cognitively rigid person is likely to show a preference for order and predictability.

  Often, he/she is compelled to impose structure in order to dissipate uncertainty and ambiguity.

- **Inability to adapt to change:** To be able to adapt to change effectively, one is often required to change his/her perspective, which is difficult for a person with high cognitive rigidity. For example, a person with high cognitive rigidity might quit a newly joined course because the college management has added extracurricular activities as a major area of evaluation, and he/she thinks that it is completely a waste of time and plans to quit the course. The person here is not able to come up with a different perspective about this situation other than the one perspective

which he/she has, i.e., it is a waste of time, and there is no relevance of extracurricular activities in academic training centers.

- **Difficulty in prioritizing:** Individuals with high cognitive rigidity can mis-prioritize, failing to fulfil major responsibilities, such as a deadline at work while spending endless hours on something trivial.
- **Restricted by fixed rules:** people with high cognitive rigidity often go by fixed rules of their own.
- **High need for cognitive closure:** The person shows a high need for cognitive closure, i.e., s/he assigns explanations prematurely to things with a determination that this is true and finding that resolution of the dissonance as reassuring as finding the truth.

Thus, cognitively rigid people do not adopt flexible ways of responding to dealing with life stressors, and they are also likely to use inflexible problem-solving. This, in turn, can affect a person's capacity to cope and can predispose him/her to various mental health problems. Individuals with cognitive rigidity are more vulnerable to repetitious behavior, extreme perfectionism, compulsive behaviors, self-injurious and suicidal behaviors.Cognitive rigidity is often associated with reduced ability to regulate destructive emotions such as anger, aggression, and interpersonal behavioral difficulties such as relational problems, and social avoidance, and isolation.

7.6.2 Techniques to Overcome Cognitive Rigidity

The world around us can be largely unstructured and unpredictable. This climate of change can be distressing for some individuals. However, this does not always have to be the case. A flexible mind can help us overcome extreme thinking, which leads to negative consequences. Following are some of the techniques which can be practiced to overcome cognitive rigidity:

- **Monitoring:** Many times, people are not aware when they are having a rigid pattern of thinking. If you want to change your rigid thinking pattern, first, it is important that you have to become aware of it when you are engaging in such a thinking pattern. Usually, when you are using rigid thinking patterns, you tend to use absolutistic or generalized vocabularies such as "must,""should," "shouldn't,", "not right", "always", "never" etc. These are red flags that your thinking pattern is moving towards rigidity. Catch yourself when you are using such vocabularies. You can also ask your family members, partners, friends to indicate to you when you use such vocabularies in your speech. Spend a few days observing your routines, interaction with other people, how you solve day-to-day problems and make decisions.
- **Cost-benefit analysis:** Listing out the advantages and disadvantages of rigid thinking patterns which you might have identified, and spend some time every day reading these advantages and disadvantages. Also, come up with an alternative thought which is more flexible.
- **Identify the fixed rules and challenge them:**

  Individuals who are high in cognitive rigidity often tend to have several fixed rules for themselves, others, and the world, and they go by them.

For example, "one should always be perfect if one has to be an efficient worker,""I will be loved by others only if I keep myself fit and attractive." Identify such fixed rules and challenge them. Check whether your rules correspond with the facts. Identify the evidences for and against the identified fixed rules (Evidences have to be based on facts. Your belief can't be produced as evidence). Find out whether you are missing out a lot of factual information which does not fit with your rules or which is contradictory to that.

- **Practice viewing situations from multiple perspectives:**

  Examine different situations you encounter every day from various perspectives by considering different possibilities and different sides of the situations. Remeber that there are different ways of viewing the same situation.

- **Use positive coping statements:**

  After you challenge your fixed rules, make a positive coping statement. Such statements can be used to address the fixed rules such as, "I will try to do this task up to the standard I have kept, but if I don't succeed, it doesn't make me a failure as a person." or they can be used to encourage yourself such as "I can do it on time," "I like to keep myself fit and attractive but sometimes it is all right if I don't look fit and attractive.", "People can like me for various other reasons even if I don't look physically attractive."

- **Practice mindfulness:** Practice paying attention to your moment-to-moment experiences (sensations, thoughts, and feelings) as they unfold without being judgemental. This might help you in not getting trapped by your thought processes and to be more open and acceptable towards yourself and others.

Self Assessment Questions 2

I. Fill in the blanks with appropriate words:

1. ———————————— refers to an inability to wait, a preference for risky outcomes, a tendency to act without forethought, an insensitivity to consequences, and/or an inability to ————————————inappropriate behaviors.

2. ————————————is like not being able to press a 'pause' button.

3. ———————————— is the inability to mentally adapt to new demands or information.

4. People who can switch from thinking about things in one way to thinking about them in a different way easily are called ———————————————-.

II. Each of the questions or incomplete statements below is followed by four suggested answers or completions. In each case, select the one that best answers the question or completes the statement.

1. Which among the following is not an aspect of impulsivity:

(A) Decreased sensitivity to negative consequences of behavior.

(B) Immediate and unplanned reaction to stimuli before processing the information thoroughly.

(C) Being able to inhibit inappropriate behaviors.

(D) No regard for long-term consequences of a behavior.

2. The driver anticipates a traffic signal changing but accelerate before the signal actually changes. This can be an example for:

(A) Impulsive decision making (B) Stopping impulsivity

(C) Waiting impulsivity (D) Breaking impulsivity

3. Which of the following is one of the serious impulsive behaviors?

(A) Self-harm

(B) Acting quickly and saving a life in an emergency

(C) Engaging in a spontaneous creative action

(D) Helping someone who is in need

4. Arrange the below-mentioned steps in decision making in the appropriate order:

1. Take action, 2. Place the alternatives in priority order, 3.Review your decision and its consequences, 4. Gather relevant information, 5. Identify the alternatives, 6. Define the nature of the decision you need to make, 7. Choose among alternatives

(A) 1,2,3,4,5,6,7 (B) 6,4,5,2,7,1,3

(C) 2,4,5,1,3,7,6 (D) 7,6,5,4,3,2,1

5. Purchasing things that you are not intended without forethought can be an act of

(A) Thoughtfulness (B) Impulsivity

(C) Ambitiousness (D) Laziness

6. Which of the following is not a characteristic of a person with cognitive rigidity?

(A) Inability to adapt to change

(B) Difficulty in Prioritizing

(C) Being able to think from multiple perspectives

(D) Restricted by fixed rules

7. Individuals with high cognitive rigidity might fail to meet big obligations, like a deadline at work, while spending countless hours on something insignificant. This is mainly because they have _____

(A) Difficulty in prioritizing

(B) Low brain capacity to understand the projects

(C) High creativity (C) Remarkable flexibility

8. Cognitively rigid people are more susceptible to develop various mental health problems mainly because they are more likely to use————————

(A) Flexible problem solving (B) Inflexible problem solving

(C) Openness and acceptance (C) Creativity

9. Listing out the advantages and disadvantages of rigid thinking patterns and spending sometime every day reading these advantages and disadvantages is called as ————————.

(A) Budget line (B) Cost-Benefit analysis

(C) Monitoring (D) Mindfulness

10. Catch yourself when you are using absolutistic or generalized vocabularies such as "must,""should," "shouldn't," "not right,""always,""never" because you may be engaging in ————————-

(A) Flexible thinking pattern (B) Rigid thinking pattern

7.7 MALADAPTIVE COPING

People respond to stress in various ways, many of which are called as "coping." Coping is defined as "constantly changing cognitive and behavioral efforts to manage the stress." Coping can be either adaptive coping or maladaptive coping. **Adaptive coping** involves confronting the stressful situation directly by appraising the stressful situations in a realistic manner and recognizing and managing the resulting unpleasant feelings without causing adverse effects on the body and mind. **Maladaptive coping** on the other hand, involves using various cognitive and behavioral strategies to deal with stress and associated negative emotional reactions, which can result in adverse effects on the body and mind.

Why do people use maladaptive coping? People use maladaptive coping strategies because they can temporarily relieve or diminish the intense and overwhelming unpleasant feelings they are experiencing. However, in the long term, such coping strategies might intensify the perceived stress or maintain the unpleasant emotions experienced by the individual.

7.7.1 Maladaptive Coping Strategies

Maladaptive coping strategies are usually based on an emotion-focused coping style in which the individual uses cognitive and behavioral efforts to alter the emotional reactions triggered by the stressor. Though the emotion-focused coping style itself is not maladaptive, some of the strategies used in such a coping style can become maladaptive, specifically when the strategies used are characterized by avoidance, distortion of reality, and results in maintenance of the problem.

Following are some of the maladaptive coping strategies adopted by individuals to deal with the perceived stress and anxiety:

- **Escapism:** Escapism is a coping strategy in which an individual avoids stressful situations or negative thoughts and emotions by engaging in activities involving imagination and entertainment. For example, you have an annual examination coming in the next week, and you are feeling anxious because you have not prepared well. Instead of finding better ways of preparing for the exam in the available time, you might engage in watching television or sleep excessively to escape from anxiety.

- **Wishful thinking:** is a coping strategy in which the individual thinks what is pleasing or according to his wishes rather than evidence, rationality, or fact. For example, You are expected to finish your under-graduation course, say a maximum of 6 years, and you are in the 6th year with a backlog. When it is few days for the exam, you feel tensed and start thinking that in case if you don't manage to pass the exam this year, you might still get a chance in the next year to write the exam since you have cleared all the other papers and have only one paper pending which is considered toughest by most of the people, though such information is not provided by the concerned university board.

- **Using substances:** This involves using alcohol, tobacco, drugs, or any other addictive substances to get temporary relief from the negative thoughts, emotions, or unpleasant bodily experiences or to enhance positive feelings. For instance, you have a job interviewthe next day, and you start feeling very anxious the previous day. In order to get rid of the anxiety and to focus better on interview preparation, you order an alcoholic beverage and go on drinking till you get intoxicated and do not feel anxiety. Though substances can help the individual in getting rid of the negative feelings in the short run, they might have serious negative consequences and intensify the stress in the long run.

- **Emotional eating:** Emotional eating refers to eating as a response to negative emotion or mood. This kind of hunger does not emerge from the stomach, such as hunger pangs, but tends to begin when an individual thinks about a craving or wants some specific food to eat. Feelings of heightened tension and low energy are primarily involved in emotional eating since they usually underlie the unpleasant mood (depression/ anxiety). In an attempt to self-medicate and self-regulate the mood, the individual uses food.

- **Procrastination:** is a voluntary delay of the intended task, despite being aware of negative consequences for doing so. The task so delayed is usually perceived as difficult or stressful. For example, if someone has a week to finish an assignment, and he/she keeps postponing working on it until right before the deadline, despite the fact that he/she requires a minimum of one week time to finish the work assigned. In this case, the person is procrastinating on the assigned task.

- **Self-harm:** refers to "the act of deliberately inflicting physical injury on oneself." Some of the self-harm behaviors are inflicting cut on the body, deliberately ingesting toxic substances, banging, slamming against hard

surfaces. Individuals engage in self-harm behaviors because doing so provides them an outlet for the expression of their pent-up unpleasant feelings. Self-harm behaviors are also thought to provide temporary relief from stress and other negative emotions through the body's physiological response to pain.

- **Denial:** Denial is a coping strategy in which you try to protect yourself from unpleasant thoughts and feelings by refusing to accept the truth about something that is happening in your life, which is stressful. For instance, your boyfriend or girlfriend broke up with you a week before, and he/she made it very clear that your relationship is not going to work out and he/she is getting married in a week. However, you think that he/she was just disturbed last week and it was not a breakup.You fail to accept the breakup because thinking so is so unpleasant for you, and you might not even be aware that you are denying it.

- **Self-Blame:** In Self-blame, a person blames himself/herself or attributes the occurrence of a stressful event or negative consequences to oneself. For example, a mother, after knowing that her daughter has failed in the exam, says to herself, "It's my fault that she failed in the exam; if I had motivated her to study regularly, she would not have failed."

- **Rumination:** Rumination refers to "repetitive and passive focus on the causes and consequences of one's distress without actively engaging in solving the problem to ease the distress." For example, ruminative thoughts can go like this "Why do I feel so bad?" "Why can't I sleep?", "I will never get a job. What am I doing?" Rumination can be dangerous to your mental health, as it can prolong or intensify the distress.

7.8 DYSFUNCTIONAL ATTITUDE

Attitudes represent our evaluation of people, groups, objects, self, events, things, or experiences. Attitudes may be positive or negative. According to Baron & Byrne (1984),"attitudes are relatively lasting clusters of feelings, beliefs, and behavior tendencies directed towards specific persons, ideas, objects or groups." The multi-component model of attitude posits that attitude has cognitive, affective, and behavioral components. The affective component refers to the object-related feelings; the cognitive component refers to the object-related beliefs, thoughts, and attributes. Cognitive, affective, and behavioral components are interrelated, while cognitive and emotional components predict how an individual behaves in a particular situation (Eagly & Chaiken, 1993; Zanna & Rempel, 1988).

Dysfunctional attitudes are negatively biased, rigid, maladaptive beliefs/assumptions and about self, the world, future, things, or experiences. Dysfunctional attitudes are said to act as vulnerability factors that predispose individuals to develop psychological disorders.

7.8.1 Characteristics of Dysfunctional Attitudes

Dysfunctional attitudes involve rigid, if-then, conditional beliefs for evaluating the situations/experiences. They are often illogical and interferes with the well-being and functioning of the individual (Weissman & Beck, 1978), for example,

'If I fail partly, it is as bad as being a complete failure,' 'I can be happy only if I am loved by other people,' 'One is safe only when there is no danger at all', 'Unless I do something perfectly, it will be viewed as useless,' 'If I let people see the real me, they will reject me,' etc. In the short run, they may be useful but, in the long run,they can lead to harmful patterns.

Dysfunctional attitudes are said to develop through early experiences of the person and get modified or strengthened through the experiences an individual goes through. Though dysfunctional beliefs may be present in all individuals, those who develop psychological problems are found to be more rigid and have a higher conviction (stronger belief) in their belief and do not change their beliefs in the presence of contrary evidence/information. Whereas beliefs of individuals without any psychological disorders are found to be amenable for change, more flexible, and do not lead to dysfunctional behaviors or distress.

Dysfunctional attitudes are said to be dormant until the individual faces a stressful situation beyond their resources to cope (critical incident). When these dysfunctional attitudes are activated, it is said to result in biased/distorted information processing (biased interpretations such as all-or-none thinking, arbitrary inference, overgeneralization etc.).

7.8.2 Models of Dysfunctional Attitudes

The cognitive model of depression by Beck (1967) proposes that dysfunctional thinking acts as a vulnerability factor when associated with stressful life events and results in depression (diathesis-stress model). According to Beck, certain individuals have higher dysfunctional thinking styles (depressogenic schemata), which are understood as cognitive vulnerability. When these individuals are faced with life stressors, the dysfunctional thoughts are activated, leading to negative beliefs about self, the world, and the future, ultimately resulting in depression. Similarly, dysfunctional attitudes related to self, i.e.,being vulnerable, lacking skills/abilities, problems as difficult challenges that one is not equipped to manage are associated with anxiety disorders. Research studies demonstrate that dysfunctional attitudes predispose individuals to develop anxiety and mood disorders (Kendler, 1996). A higher level of dysfunctional attitudes is associated with a longer duration of an ongoing episode and a shorter time to relapse (Scott et al., 1995; Lam et al., 1996; Weich et al., 2003).

Another important cognitive theory proposed by Albert Ellis (1955) talks about irrational beliefs. He posits that emotional dysfunction is caused by irrational thoughts and beliefs. He has given 11 types of irrational beliefs, which were subsequently divided into 4 categories: (1) demandingness – absolutistic demands placed on self and others, e.g.,"musts" "shoulds,""have to's,""oughts";(2) awfulizing (or catastrophizing) - evaluation of a bad event as worse than it should be;(3) low frustration tolerance – belief that it is not possible to bear certain circumstances which cause distress; and (4) global evaluation (or self-downing) - pervasive negative evaluation of oneself and the world.

Assessment of dysfunctional attitudes

One of the popular and most frequently used across the disorders and in the general population is the Dysfunctional attitude scale (DAS) by Weissman and Beck (1978). This is a self-report scale to measure the presence and intensity of

dysfunctional attitudes. It consists of 40 items rated on a 7-point Likert scale (7 = fully agree; 1 = fully disagree). Some of the examples of the items are, "I should be happy all the time" and "My life is wasted unless I am a success."The total score ranges from 40–280. A higher score indicates a more dysfunctional attitude of an individual. The scale is found to have good psychometric properties. The revised scale of DAS (form A) has 17 items with 2 domains - 'dependency' and 'perfectionism/performance evaluation' (Graaf, Roelofs, & Huibers, 2009).

Common Beliefs Survey-III (CBS-III) by Thorpe, Parker, & Barnes (1992) is a 54-item measure with six subscales and a 5-point Likert-type scale for each item; 29 items pertaining to irrationality, and 25 items pertaining to rationality. The scale showed good psychometric properties.

Evaluative Beliefs Scale (EBS) by Chadwick, Trower, and Dagnan (1999) is a cognitive measure of negative evaluative beliefs. It is an 18-item, self-report instrument rated on a 5-point scale, which measures negative person evaluations across three dimensions: where aperson believes that others are making evaluations of him/her, where the person makes an evaluation of himselfor herself, and where the person evaluates others. The scale is found to predict anxiety and depressive symptoms.

In addition to a number of scales to assess dysfunctional thinking, thought monitoring methods like dysfunctional thought diaries/records, which are maintained by the individuals, are widely used in Cognitive Behaviour Therapy (CBT).

7.8.3 Modifying Dysfunctional Attitudes

Maladaptive cognitions, including negative automatic thoughts, dysfunctional attitudes, and schemas/core beliefs, are directly addressed in Cognitive Behaviour Therapy (CBT). Though other therapies also address unhelpful thoughts, CBT specifies methods used for modification of thoughts and beliefs. Both behavioral and verbal reattribution methods are used in CBT. The methods used for modifying the negative thoughts and dysfunctional attitudes and schemas are called cognitive restructuring methods. The cognitive restructuring aims at bringing about changes in the way one appraises and makes sense of events. It uses a set of techniques for becoming more aware of and for modifying them. This process is also called reappraisal, relabeling, reframing, and attitude adjustment. However, one needs to note that changing the beliefs is a slow process, and one needs to consciously make an effort for it.

Steps in modifying beliefs:

- Awareness – recognizing and recording the thoughts when it occurs (thought diary)
- Reappraisal – logical analysis of the thoughts/beliefs (examining the evidence for the thoughts) and generating adaptive thoughts/beliefs (consider all possibilities/ alternative hypotheses to the belief).
- Adapting alternative/helpful ways of thinking
- Evaluating the results/consequences with respect to emotions, behaviors, and outcomes in the interpersonal context.

Techniques of modifying dysfunctional beliefs:

There are a number of verbal reattribution strategies used in the modification of dysfunctional attitudes. A few examples of such methods are given below.

Pie chart: This method is used for an inflated sense of responsibility, e.g., blaming oneself for all the hardships of the family. Here the person is made to consider many factors which may have contributed to a particular outcome rather than blaming it on self or considering a single factor as responsible.

Perspective-taking: Thinking from the perspective of others to broaden the view. When individuals are distressed, they may not be able to think from different perspectives, which makes them become narrowly focusing on one/few things.

Thinking in shades of grey: Rather than thinking about all-or-nothing extremes, assess situations on a scale of 0 to 100. Instead of saying either success or failure, one might consider saying partial success.

The double-standard method: Often, people use different standards to evaluate themselves as opposed to others. They may be more strict or critical when it comes to self/others. This method helps in being more compassionate towards self and others.

The semantic method: Substitute language that is less colorful and emotionally charged. For example, instead of telling yourself, "I shouldn't have made that mistake," you can say, "It would have been better if I hadn't made that mistake."

Analysis of benefits/disadvantages of the belief: Listing out the benefits and disadvantages of holding a certain belief, e.g.,'I am inadequate.' This would make the person realize the negative consequences of the belief and would reduce importance given to such belief as well as taking actions based on them.

Socratic Questioning: This is a method of questioning that helps the individual to challenge irrational, illogical thinking. Some of the examples of the questions are: 'Is this thought realistic?' 'Am I basing my thoughts on facts or on feelings?' 'What is the evidence for this thought?' 'Could I be misinterpreting the evidence?' etc.

The behavioral methods of modifying beliefs would include behavioral experiments to test the beliefs, role play, exposing/facing the situations to modify the dysfunctional/unrealistic beliefs about certain situations, people events, etc.

Logical disputation: Asking the individual whether or not the belief held is logical and asking for evidences for the belief, and examining if the belief is helpful (consequences of the belief).

Self Assessment Questions 3

I. Fill in the blanks with appropriate words:

1. _____ involves using various cognitive and behavioural strategies to manage stress and associated negative emotional reactions, which can result in adverse effects on body and mind.
2. People use maladaptive coping strategies because they can temporarily _____the intense and overwhelming _____ they are experiencing.

3. The first step in modifying dysfunctional beliefs is ————————.
4. Absolutistic demands placed on self and others according to Ellis theory is termed as ————————————.
5. Using different standards to evaluate themselves as opposed to others is called————————————.
6. ———————————— is a method of questioning which helps in challenging irrational thinking.

II. Each of the questions or incomplete statements below is followed by four suggested answers or completions. In each case, select the one that best answers the question or completes the statement.

1. Using any addictive substances to get temporary relief from stress is an example for

   (A) Healthy Coping (B) Maladaptive Coping

   (C) Self-coping (D) Adaptive Coping

2. ———————————— refers to eating in response to negative emotion or mood.

   (A) Emotional eating (B) Obesity

   (C) Healthy eating (D) Depressed eating

3. Which of the following is not a maladaptive coping?

   (A) Using excessive alcohol (B) Problem solving

   (C) Denial (D) Procrastination

4. ———————————— involves a repetitive and passive focus on the causes and consequences of one's distress without engaging in active coping or problem solving to alleviate the distress.

   (A) Wishful thinking (B) Rumination

   (C) Denial (D) Self-blame

5. ———————————— is a coping strategy in which you try to protect yourself from unpleasant thoughts and feelings by refusing to accept the truth about something that is happening in your life which is stressful.

   (A) Self-blame (B) Denial

   (C)Wishful thinking (D) Self-harm

7.9 LET US SUM UP

The present Unit focused on maladjustment in relation to the self. We discussed two significant manifestations of maladjustment, such as anxiety and stress, and also focussed on a few important factors that can contribute to maladjustments, such as impulsivity, cognitive rigidity, maladaptive coping, and dysfunctional attitude.

Anxiety is an unpleasant feeling resulting from the perception of danger that can be real or imagined. Whereas occasional anxiety is normal and inevitable, anxiety can be a disorder when it is disproportionate to the situation and results in considerable avoidance of the problem, and interferes with one's day to day functions. Social Phobia, specific phobia, generalized anxiety disorder, panic disorder are different types of anxiety disorders. Interaction of a number of psychosocial and biological factors are indicated in the causal factors of Anxiety. Psychotherapy, specifically cognitive behavioral therapy (CBT), is one of the most effective treatment options for anxiety. **Stress** is an unpleasant emotional experience accompanied by physiological, cognitive, and behavioral changes which are either intended to alter the stressor or adapt to its effects. Eustress refers to a positive response to a stressor, whereas distress is persistent stress,which is not addressed either through coping or adaptation. Cognitive appraisal plays an important role in the assessment and perception of stress. Intervention strategies mainly use cognitive restructuring to modify the thought processes related to stress.Time management, relaxation, physical activities are some of the other techniques used to manage stress.

Impulsivity refers to an immediate and unplanned reaction to stimuli before processing the information thoroughly and a decreased sensitivity to negative consequences of behavior. It is primarily classified as Impulsive choice (or decision making) and Impulsive action (or disinhibition). Substance abuse or binging, impulsive overeating, impulsive shoplifting, gambling, self-harm are a few of the serious impulsive behaviors.Various behavioral and cognitive strategies can be used in managing impulsivity.

Cognitive Rigidity is the inability to mentally adapt to new demands or information. Cognitively rigid people adopt less flexible ways of responding to dealing with life stressors. One can use various cognitive and behavioral techniques to overcome cognitive rigidity, such as monitoring, cost-benefit analysis, viewing situations from multiple perspectives, using positive coping statements, and practicing mindfulness.

Maladaptive Coping involves using various cognitive and behavioural strategies to manage Stress and associated negative emotional reactions which can result in adverse effects on body and mind. People use maladaptive coping strategies because they can temporarily relieve or diminish the intense and overwhelming unpleasant feelings they are experiencing. Maladaptive coping strategies are usually based on *emotion-focused coping style* in which the individual uses cognitive and behavioral efforts to alter the emotional reactions triggered by the stressor. Individuals might use various maladaptive coping strategies to deal with the perceived stress. Escapism, wishful thinking, substance use, emotional eating, procrastination, self-harm, denial, self-blame, ruminations are some of the most commonly used maladaptive coping strategies.

Dysfunctional attitudes are negatively biased, rigid, maladaptive beliefs and assumptions about self, the world, future, things, or experiences. Such irrational thoughts and beliefs lead to emotional dysfunction, as proposed by the cognitive theory of Albert Ellis. Awareness, reappraisal, adapting alternative ways of thinking, and evaluating the consequences are the steps in modifying dysfunctional attitudes. Various techniques like pie chart, perspective taking, thinking in shades

of grey, analysis of benefits/disadvantage of the belief, socratic questioning and logical disputation can be used to modify dysfunctional beliefs/attitudes.

7.10 KEYWORDS

Maladjustment occurs when our sense of self prevents us from making a normal adjustment to some need or demand in our environment.

Self refers to a person's sense of oneself which is composed of awareness of one's physical attributes and psychological attributes, such as thoughts, feelings, goals, values, preferences that distinguish one individual from another.

Cognitive-Behavioral Therapy (CBT) aims at challenging one's distorted or rigid patterns of thinking which produce distress in the individual.

Eustress refers to a positive response to a stressor where a positive event/situation creates stress that is taken by the person with a willingness.

Micro stressors are the daily hassles that are encountered on a day-to-day basis.

Cognitive Restructuring is a process in which thoughts or beliefs provoking stress reactions are replaced with more constructive and realistic thoughts or beliefs.

Autogenic training is a method of relaxation which teaches your body to respond to your verbal commands.

Adaptive coping involves confronting the stressful situation directly by appraising the stressful situations in a realistic manner and recognizing and managing the resulting unpleasant feelings without causing adverse effects on the body and mind.

Rumination refers to repetitive and passive focus on the causes and consequences of one's distress without actively engaging in solving the problem to ease the distress.

Socratic Questioning is a method of questioning that helps the individual to challenge irrational, illogical thinking.

7.11 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

I. 1) Fear, Anxiety 2) Disproportionate, Avoidance 3) Eustress, Distress 4) Stressor

II. 1) C, 2) D, 3) C, 4) B, 5) C, 6) B, 7) C, 8) B, 9) A, 10) C

Self Assessment Questions 2

I. 1) Impulsivity, Inhibit 2) Impulsivity 3) Cognitive Rigidity 4) Cognitively Flexible

II. 1) C, 2) C, 3) A, 4) B, 5) B, 6) C, 7) A, 8) B, 9) B, 10) B

Self Assessment Questions 3

I. 1) Maladaptive Coping 2) Relieve or Diminish, Unpleasant feelings 3) Awareness 4) Demandingness 5) Double standards 6) Socratic questioning

II. 1) B, 2) A, 3)B, 4)B, 5)B

7.12 UNIT END QUESTIONS

1. What is anxiety? Explain different types of anxiety disorders and various causal factors in anxiety.
2. What is stress? Elucidate long-term negative effects of stress on health and various stress management techniques.
3. Give the classification of impulsivity. Name some of the serious impulsive behaviors and explain various strategies one can use to manage impulsivity.
4. Distinguish between adaptive and maladaptive coping. Explain various maladaptive strategies used by individuals to deal with perceived stress and experienced unpleasant emotions.
5. Describe the common characteristics observed in individuals with high cognitive rigidity.
6. Write a short note on the role of cognitive rigidity in mental health and various techniques to overcome cognitive rigidity.
7. List out the techniques used in changing maladaptive thinking.
8. What are dysfunctional attitudes, and how do you assess them.
9. Describe the models which explain dysfunctional attitudes.
10. What are the steps in modifying dysfunctional beliefs?

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7.14 FURTHER LEARNING RESOURCES

Books

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UNIT 8 MENTAL DISORDERS*

Structure

8.1 LEARNING OBJECTIVES

After studying the Unit, you would be able to:

- *Explain the meaning, types, causal factors, and treatment used for mood disorders;*
- *Explain the meaning, types, causal factors, and treatment used for eating disorders;*
- *Explain the meaning, causal factors, and treatment used for Internet gaming disorders;*
- *Explain the meaning, types, causal factors, and treatment used for personality disorders; and*
- *Explain the meaning, types, causal factors, and treatment used for substance use disorders.*

8.2 INTRODUCTION

In the previous Unit, you learned about how maladjustment can affect the development and functioning of oneself in a negative way. In severe cases, it can result in various mental disorders also. In this Unit, we will focus on understanding the various mental disorders.

According to American Psychiatric Association (2018), mental disorders are clinically significant conditions characterized by changes in thinking, emotions

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or behaviours. These conditions are also associated with significant distress and /or lead to impaired functioning.In simple terms, it means that mental disorders may interfere in carrying out day to day activities efficiently such as daily routine, studies, work, household chores, and interaction with others etc. and cause distress to self and others.

Mental health disorders are common and can occur to anyone. In 2017, 197·3 million people were found to have mental disorders in India (Sagar, et al., 2020). National Mental Health Survey (2015-16) has estimated that 150 million people in India require mental health care at any given point. It is also important to note that not all human distress are mental disorders. One incident or occasional maladaptive behaviour or disruption in the normal functioning does not signify the presence of mental illness. In order to be considered as mental disorder, these dysfunctional behaviours must persistently occur and cause significant impairment in personal-socio-occupational functioning. To diagnose and accurately identify symptoms of mental illness, mental health professionals use the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, or *International Classification of Diseases* (ICD) by the World Health Organization (WHO). Both systems of classification of mental disorders have set criteria specifying clinical presentation, course, intensity and duration of symptoms to officially diagnose and classify these as mental disorders. Currently we have DSM 5 version and ICD 11 version of the classification system.

Generally there are a number of factors implicated in any mental disorder ranging from biological to psychological and socio-cultural aspects. It is important to remember that some factors may act as risk factors for the disorder, and some may play a role in maintaining the disorder. Thus one needs to do a holistic assessment involving the individual as well as their family members, parents, siblings, peer, colleagues, teachers etc. who can contibute information about the individual. This helps in understanding the disorder and adopt appropriate treatment and intervention measures.

In the present Unit we will discuss a few most commonly occuring mental disorders such as mood disorder (bipolar and related disorder and depressive disorder), eating disorder, internet gaming disorder, personality disorder,and substance use disorder.

8.3 MOOD DISORDERS

Human beings experience a varietyof emotions over a course of time. All emotions are important for rich and fulfilling life. You may feel joy when you get surprise visit or gift from friend, you may feel down after getting low grade in exam or because of relationship problems or financial problem or because you had a bad day at work. These are normal ups and down and different range of emotions that come and go in their own course. But, in mood disorder, people experience emotions that are extreme and often disproportionate to the context. So, mood disorders can be understood as characterized by a drastic and extreme shift in mood that disrupts daily life activities. It can be understood as agroup of mental disorders in which the root problem centres on person's ongoing emotional state (their mood). Mood disorders also formally called as "affective disorders".

Mood disorders can have depressive episode only (also known as "unipolar depression") or they may include one or more manic episodes (referred to as bipolar disorder). Mood disorders createsevere distress and impairment in social, occupational, educational and other essential areas of functioning.

Meaning and Prevalence

In mood disorder, the disturbances of mood are intense and persistent enough to be evidently maladaptive and can lead to serious problems in functioning. Mania and depression are two key mood states involved in mood disorders. Mania is often characterized by intense feelings of euphoria and elation, whereas depression involves feelings of persistent and pervasive sadness and dejection. Mood disorder is an episodic illness which means a person with mood disorder may experience manic episodes at certain time points and depressive episodes at other times. Normal mood is at the middle of mood continuum whereas manic and depressive mood states are at the opposite ends of a mood continuum. Normal mood can occur between two episodes. It is also important to note that the symptoms of mania and depression can also occur during the same time period which is termed as mixed-episode. In mixed episodes, a person experiences rapid cycling of mood states such as sadness, euphoria, and irritability, all within the same episode of illness.

In India, bipolar affective disorder was detected more among males of the urban metro areas (National Health Survey, 2016).Women are twice as likely as men to suffer from depression, with almost one-quarter of women experiencing a depressive episode at some point in their lives. Depression is the most prevalent mood disorder, according to the World Health Organization (WHO), and is listed as the leading cause of disability worldwide.

Types of Mood Disorder

Mood disorder can be categorised into '**bipolar and related disorder'**and **depressive disorder**. Let us first discuss the 'bipolar and related disorder'. 'Bipolar and related disorder' is identified by at least one manic or mixed episode (mania and depression) with or without a history of major depression.

Bipolar and Related Disorder

There are three types of bipolar and related disorder.

- ***Bipolar I Disorder-*** The sign of Bipolar I disorder includes manic episodes that last at least for 7 days, or by manic symptoms that are so serious and disruptive that the person needs immediate hospital care. The episode of depression might also occur for at least consecutively 2 weeks. Episodes of depression with mixed features (having depressive and manic symptoms in one episode) are also possible under this category.
- ***Bipolar II Disorder -*** A presence of depressive episodes and hypomanic episodes are indicators of Bipolar II disorder. However, the full-blown manic episodes that are typical of Bipolar I Disorder should not be present. Hypomanic episode means a milder intensity of symptoms which are found in manic episodes and duration needs to be of 4 days. Because of milder form of mania in bipolar II disorder, hospitalization is generally not required.

- ***Cyclothymic Disorder (Cyclothymia) -*** Cyclothymia is characterized by the presence of hypomanic episodes as well as periods of depressive symptoms lasting for longer duration of at least 2 years (1 year in children and adolescents).

The following case illustrates symptom manifestation in Bipolar disorder:

Mr M, a 36-year-old married male, separated from his wife was brought to hospital by his family members.

They gave a history of the last 1 month where M was restless, over talkative and felt a decreased need for sleep. The current episode was precipitated by verbal fight with his wife. Family member reported that he was found to be awake most part in night and would engage himself in some non important task. He keeps on shifting to several tasks and was found overly active and hasten over everything he engages in. He was also found to be overly interested in religious activity. His family members' complaint about over- aggressive behaviour also which leads to verbal and physical fight.

A detailed clinical assessment involving detailed history and mental status examination revealed that there have been 2 past episodes of similar kind. On account of his past and current history, he was diagnosed with Bipolar affective disorder currently in manic episode.

The bipolar disorder in its severe form may also be presented with psychotic symptoms like hallucinations or delusions. Bipolar disorder is often a chronic condition which has its onset in childhood and requires long term treatment. Diagnosing bipolar disorder can be sometime difficult due to presence of comorbid conditions such as anxiety, substance abuse, attention deficit hyperactive disorder etc.

Depressive Disorder

Depression is a common disorder that affects over 264 million people worldwide (WHO, 2019). The symptoms of depressive disorder are the presence of low or irritable mood, with somatic and cognitive changes that significantly affects person's daily functioning. In depression, life seems negative and future looks gloomy. Person would also experience feelings of worthlessness and exhibit loss of interest in nearly everything even in those activities that used to be pleasurable earlier. Suicidal thinking, difficulty sleeping, socially withdrawal, and changes in appetite are also commonly seen in depression. Therefore, it often affects weight due to either loss of interest in eating or may feel overly hungry and gain excess weight.

Consider the feelings presented in following verbatim from a person, who was diagnosed with 'major depressive disorder':

I didn't want to face anyone; I didn't want to talk to anyone. I didn't really want to do anything for myself…I couldn't sit down for a minute really to do anything that took deep concentration…It was like I had big huge weights on my legs and I was trying to swim and just kept sinking. And I'd get a little bit of air, just enough to survive and then I'd go back down again. It was just constantly, constantly just fighting, fighting, fighting, fighting... (National Institute of Mental Health, 2010).

Suicide death is very common in people suffering from major depression. Depression may also involve psychotic features as well like delusional thinking and may experience hallucinations.

In DSM-5, the **types of depressive disorders** include the following:

- ***Disruptive mood dysregulation disorder*** is commonly found among children consulting in pediatric mental health clinics. Chronic and constant irritability is the core of disruptive mood dysregulation disorder. Frequent temper outbursts and chronic, irritable or angry mood that is present between the severe temper outbursts are two clinical manifestations found in children presented with disruptive mood dysregulation disorder.
- ***Major depressive disorder (including major depressive episode)***. For diagnosis of major depressive disorder,the symptoms need to be present nearly every day, for at least two consecutive weeks. The symptoms include either markedly depressed moods or marked loss of interest in pleasurable activities. In addition to one or both of these symptoms, the person must experience additional cognitive and vegetative symptoms in the same time duration.
- ***Persistent depressive disorder (dysthymia)*** is usually mild to moderate intensity depressive disorder and its core feature is its chronicity. For the diagnosis of persistent depressive disorder a person must have a persistently depressed mood most of the dayfor at least 2 years (1 year for children and adolescents). The intermittent normal mood can also occur in dysthymic disorder.
- ***Premenstrual dysphoric disorder***. It is a form of depression which can be considered as an extension of premenstrual syndrome (PMS). Mood changes is common in both PMS and Premenstrual dysphoric disorder (PMDD), but they are more intense and disturb areas of daily functioning in PMDD. The symptoms usually start before 7-10 days of menstrual cycle in PMDD.
- ***Substance/Medication-induced Depressive Disorder***. Some medical conditions and injection/inhalation of a substance (e.g., drug of abuse, toxin, psychotropic medication, and other medication) can also trigger depressive disorder. These categories are known as substance/medication-induced depressive disorder.

Causal Factors of Mood Disorder

Mood disorder can be explained from a combination of behavioural, social, cognitive and biological perspective.

Biological explanation focuses on brain chemicals such as serotonin, norepinephrine, and dopamine. The medication given for treatment of depression and mania usually affects these three neurotransmitters, either alone or in combination (Cummings & Coffey, 1994; Ruhe et al., 2007). Mood disorders have a strong genetic basis, because they are heritable (Berrettini, 2006).There are a few structural differences noticed in the brain with mood disorder from those without them.

While biological factors play a significant role in the onset of bipolar disorder, psychosocial factors have also been implicated in the disorder's aetiology. Of all psychological factors, stressful life events, lack of social support, certain personality traits and cognitive styles have been given more importance because of their most influencing role in mood disorders. Stressful life events can also trigger manic episodes (Goodwin & Jamison, 2007). Moreover, it can also affect the onset and timing of episodes.

There are social contextual factors that may influence the maintenance of bipolar disorder. According to a study, people with bipolar disorder who reported low social support showed more depressive recurrences over a 1-year follow-up, independent of the effects of stressful life events, which also predicted more recurrences (Cohen et al., 2004).The relapse and recurrences also get affected by personality and cognitive factor which further interact with stressful life events and determine the likelihood of relapse. From social cognitive perspective, depressed people persistently have negative, self-defeating and self depreciating thoughts about themselves which is called as depressogenic cognitions, which maintain their depression. Social cognitive theorists pointed towards the role of various cognitive distortions like maximisation and minimization etc. in the onset of mood disorders (Beck, 1979).

Treatment of Mood Disorders

There are wide varieties of treatments available for treating mood disorder. Treatment is found to be effective in most severe cases of mood disorder as well. The combination of medication and psychotherapy makes a successful and effective management plan for mood disorders.

- ***Pharmacotherapy***

  Antidepressant, mood-stabilizers, and antipsychotic class of medications are used in the treatment of mood disorders.

- ***Electroconvulsive therapy (ECT)***

  ECT is often used in severe depressive cases who do not respond to drug therapy, are psychotic, or are suicidal or dangerous to themselves.

- ***Cognitive behavioural therapy (CBT)***

  This kind of treatment focuses on changing dysfunctional thinking and behaviour. Recent evidences suggest that CBT and medications are equally effective in the treatment of severe depression (DeRubeis et al., 1999; Hollon et al., 2006).

- ***Behavioral activation treatment***

  Behavioural activation is relative new but effective form of treatment particularly used for depression.This approach focuses intensively on making people with depression more active and engaged with their environment and life.

- ***Interpersonal and social rhythm therapy***

  This approach deals with interpersonal relationship pattern, and helps the person understand and change maladaptive interaction patterns

(Bleiberg & Markowitz, 2008). Individuals with chronic depression can benefit from interpersonal therapy as it helps in reducing the rate of relapse also. Regular daily schedule and maintaining routine act as preventing factor in reducing onset of manic episodes.

- ***Family focused therapy/marital therapy***

  This form of treatment helps in enhancing family coping strategies, such as recognising new episodes early and helping their loved one. This therapy alsoimproves communication, problem solving, leadership and support among family members.

Self Assessment Questions 1

1. What are the two key mood states involved in mood disorder?
2. In which condition an individual is likely to have a decreased need of sleep - depressed episode or manic episode?
3. Name the type of depressive disorder which is also known as dysthymia.
4. What are the brain chemicals involved in the biological explanation of mood disorder?
5. Mention non-pharmacotherapy methods used in the treatment of mood disorder.

8.4 EATING DISORDERS

Eating disorders are often fatal illnesses characterised by changes in people's eating patterns, as well as associated thoughts and emotions. The excessive preoccupation with food, body weight, and body shape are the indicators of eating disorders. According to the DSM-5 (APA, 2013), persistent disturbance in eating behaviour is the core feature of eating disorders. Anintense fear of becoming overweight and associated behaviours directed towards desire of thinness is common in all eating disorder which sometimes can lead to uncontrollable behaviour and serious consequences.

According to National survey report, 20 million women and 10 million men in the United States will suffer from an eating disorder at some stage in their lives. (Wade, Keski-Rahkonen, & Hudson, 2011). Eating disorders can affect individuals of all ages or gender, but prevalence rates are found to be higher in women. It is most often seen in females during adolescence and young adulthood. Eating disorders has affected at least 9% of the population worldwide (Galmiche et al, 2019). The rate of anorexia nervosa as per an Indian study from Tamil Nadu is ten per 100,000 in Indian males, and 37.2 per 100,000 in Indian females (Mohandoss, 2018).

The persistent disturbance of eating or eating-related behaviors often results in the disturbed metabolism that significantly impairs physical health as well as psychosocial functioning.

Symptoms of Eating Disorders

Let us now look at the common signs and symptoms of eating disorder before we discuss the types of eating disorder.

Emotional and behavioral

- Behaviour indicating weight loss, dieting, and control of food as they become the primary concerns in individuals life.
- Preoccupation with food related measurements like weights, calories, carbohydrates intake etc.
- Excessive avoidance of certain kinds of food item leading to strict restrictions in food items (like no fatty or carbohydrates containing food items etc.)
- Apprehension about eating in public
- Performing food related rituals (e.g., eats only a particular food category)
- Excessive and frequent dieting plans
- Withdrawal from usual friends and social and recreational activities
- Constantly inspecting one's appearance in the mirror for perceived defects or flaws

Along with the above mentioned symptoms, ***physical symptoms*** like noticeable fluctuations in weight and other non-specific gastrointestinal complaints, disturbed blood reports on laboratory findings (anemia, fluctuations in thyroid level and other hormones levels, low white and red blood cell counts), dizziness, excessive weakness and fatigue, impaired immune functioning etc are also common in eating disorders.

Case example

B was 20 years old single, Hindu female. She was second year graduation student of fashion designing course. She had been staying with her aunt in different city for educational purpose. Among her classmates, she was the youngest and was in the company of weight conscious mates and elders.B recalled an incident where her friend made a remark that she looked obese. She reported that the statement from her friend prompted her to take care of her food intake and she started exercising regularly. She decreased intake of fat and carbohydrates and started taking only salads, fruit and juices. This was accompanied by rigorous workout daily. The aim was to get thin. She reported that she "felt fat" during history taking. Her BMI was calculated and found much less than appropriate at her age. After knowing her BMI, she kept a close watch on her weight and food intake.She also began having binge eating episodes, in which she would consume big amounts of sweet and fried foods on one day and then consume no solids or even semisolids for many days. She also began using laxatives such as Isabgol 4 teaspoon following her periodic binges, which occurred once every two weeks. (Mendehkar, Arora, Jiloha & Baweja, 2003).

There are a number of famous celebrities who have struggled and came out to speak about their struggle and challenges of eating disorder. Celebrities are often put under a lot of pressure and scrutiny from media and public to look a certain way, which can lead to excessive dieting and eating disorders. Read the following newspaper report to get a sense of a celebrity's struggle with eating disorder.

When speaking at an event in 2012, Lady Gaga opened up about her struggles with eating disorders. "I used to throw up all the time in high school. So I'm not that confident," she said "I wanted to be a skinny little ballerina but I was a voluptuous little Italian girl whose dad had meatballs on the table every night." At one point, her bulimia started to affect her singing. "It made my voice bad, so I had to stop." (Greenwald, 2012).

Types of Eating Disorders

There are three types of eating disorders which include anorexia nervosa, bulimia nervosa, and binge-eating disorder.

- ***Anorexia Nervosa***

  A type of eating disorder in which an individual restricts food intake to the level that 15 percent weight loss which is below the ideal body weight or more occurs. The three characteristics of anorexia nervosa are: excessive food intake restriction, excessive fear of being overweight or persistent behaviour that may lead to preventing weight gain, and disturbance in body image.There is also behaviour like weighing oneself repeatedly, persistently restricting food intake, exercising excessively, and/or they may even do forceful vomiting or use laxatives for losing weight. The long term physical effect may develop overtime like irregular hormone secretion particularly in the thyroid and adrenal glands, which can have long-term physical consequences. Heart muscles weaken, and heart rhythms can change.Diarrhea, loss of body tissue, loss of sleep, low blood pressure, and lack of menstruation in females are some of the other physical consequences of anorexia.

- ***Bulimia Nervosa***

  Bulimia nervosa, also known as bulimia, is a type of eating disorder in which an individual begins a cycle of "bingeing," or consuming a large amount of food in one sitting, and then uses unhealthy strategies to prevent weight gain (Rideout, 2005).The three characteristics features of bulimia nervosa are: Recurrent periods of binge eating, recurrent unhealthy compensatory activities to avoid weight gain, and self-evaluation influenced by body appearance and weight. The symptoms must occur on an average, at least once per week for 3 months. Bulimia nervosa patients may be slightly underweight, medium weight, or overweight. Most people with bulimia engage in "purging" behaviours like intentionally vomiting after a binge or abusing laxatives, but others don't, opting instead for other unhealthy weight-loss strategies like fasting for a day or two after the binge or engaging in excessive exercise. (American Psychiatric Association, 2000).

- ***Binge-Eating Disorder***

  People who suffer from binge eating disorder lose control over their eating. Periods of binge-eating are not accompanied by compensatory strategies like purging, excessive exercise, or fasting, as is the case for bulimia nervosa. Consequently, binge-eating disorder often lead to making individual overweight or obese. Eating excessively large

quantities of food in a short period of time, such as two hours and eating even when not hungry, eating alone or in secret to prevent embarrassment, and feeling distressed, ashamed, or guilty about eating later are all symptoms of binge eating disorder.

Causal Factors of Eating Disorder

A dynamic interaction among genetic, biological, psychological, and social factors influences the onset of eating disorders.

Genetics: People who have first-degree relatives, siblings or parents, with eating disorder tend to be at a higher risk of having one as well. Thehormone named serotonin is also found to be involved in eating disorder.

Social factors: People are put under undue pressure to meet unrealistic expectations by cultural forces that idealise a specific body type. Thinness (for women) or muscularity (for men) are often associated with popularity, success, strength, happiness and beauty in popular culture and media depictions. This can be a very strong force when it comes to young people. Other factors like peer pressure can occur in the form of teasing, bullying or humiliating because of one's appearance and can lead to developing eating disorder.

Psychological factors: Perfectionism, impulsive behaviour, and challenging and difficult relationships can all lower a person's self-esteem and make him more prone to eating disorders. Although there is no single cause of eating disorders, studies suggest that body dissatisfaction is the most prominent and well researched factor in the development of anorexia and bulimia nervosa. (Stice & Whitenton, 2002). Factors like anxiety, depression, and addiction can run in families and have been linked to an increase in the likelihood of developing an eating disorder.

Treatment of Eating Disorder

Eating disorder treatment usually consists of a combination of psychological and dietary counselling, as well as medical and psychiatric supervision. An effective treatment plan would focus on both symptoms and medical effects of the eating disorder, as well as the psychological, biological, interpersonal, and cultural forces that lead to or contribute in maintenance of the disorder.

- **Medications**

  While there is no evidence that antidepressants are particularly effective in the treatment of eating disorders, they are sometimes used. Many individuals who suffer from an eating disorder may also have a comorbid condition such as depression or anxiety, and they find that these medications help them deal with their underlying problems(Hudson et al., 2007; O'Brien & Vincent, 2003; Brown & Keel, 2012b)

- **Psychotherapy**

  In the treatment of eating disorders, cognitive-behavioral therapy (CBT), which consists of modifying behaviour and maladaptive thought patterns, has proven to be very effective (Vitousek, 2002; Wilson, 2010). Family-based counselling, in which parents of adolescents with anorexia nervosa participate in the treatment process tends to be very effective in helping

people gain weight, change eating patterns, and improve their moods (le Grange & Lock, 2005).

Self Assessment Questions 2

1. What kind of fear is seen in eating disorders?
2. Name the type of eating disorder in which an individual sees himself as fat, even when he is underweight.
3. Name the type of eating disorder in which a person has recurrent and frequent episodes of eating excessively large amounts of food and feeling a lack of control and guilt over these episodes.
4. What psychological factors can cause eating disorder?
5. Mention two therapies which are found effective in eating disorder.

INTERNET GAMING DISORDER

A 16-year-old boy, student of class XI was among the top three students in school. He received a computer after his midterm examinations. During school vacations, he started playing online video games. Subsequently, he started spending 12–14 hours a day on the computer, started skipping his classes and his academic drastically declined. He could not clear his final examination. Following which, he stopped going to school and has not been interacting with his friends.He preferred to take all his meals at his computer table and even play while eating his meals. He did not even watch television and abandoned his hobby of playing basketball. His behaviour became oppositional; he would break things and tear clothes if he was asked to stay away from the computer. He experienced neck pain and eye strain as a result of his prolonged and excessive online activities but he continued to play online games amid his problems.

The example above highlights the transition of normal behaviour into addictive behaviour.

Playing video games can be a source of entertainment, and it's easy to get caught up in the competition, but are they also addictive? This is an issue that researchers and health practitioners are still debating. Internet gaming disorder is one type of behaviour addiction that has gained popularity in recent years, although there is still a lot of controversy on whether it should be considered as a separate disorder. Regardless of its exact medical status, gaming addiction has caused untold suffering to countless people over the last few decades.

Gaming disorder is defined in the 11th Revision of the International Classification of Diseases (ICD-11) as a pattern of gaming behaviour characterised by a loss of control over gaming, making gaming a higher priority than other activities to the point where gaming takes precedence over other interests, and continuing gaming despite negative consequences.To be diagnosed with gaming disorder, the behaviour pattern must be severe enough to cause significant impairment in personal, family, social, educational, occupational, or other significant areas of functioning over a period of at least 12 months.

It may be noted here that gaming disorder and Internet Addiction are two entirely different categories (Griffiths, & Pontes, 2014; Griffiths, 2018). Internet addiction

disorder (IAD) is characterized by excessive or poorly controlled preoccupations, urges, or behaviors regarding Internet use that lead to impairment or distress. Person with this kind of behavioural addiction may use the Internet for extended periods, isolating themselves from other forms of social contact, and focus almost entirely on the Internet rather than broader life events. Internet addiction Disorder (IAD) was considered in 2013 for inclusion in DSM-5 but is not yet recognised as a disorder; however, internet gaming disorder was listed in the appendix of DSM-5 for future review and study.

Gaming must cause "serious disability or distress" in several areas of a person's life. This proposed condition only applies to gaming and excludes concerns with general internet use, online gambling, social media, or smartphone use. The proposed symptoms of internet gaming disorder include:

- Preoccupation/salience with gaming
- Withdrawal symptoms when gaming is taken away (sadness, anxiety, irritability)
- Tolerance, the need to spend more and more time gaming to satisfy the urge
- Unsuccessful attempts to quit gaming
- Abandoning other hobbies and interest, loss of interest in previously enjoyed activities as gaming becomes most important activity
- Continuing to game despite problems
- Lying to family members or others about how much time you spend gaming
- The use of video games to alleviate emotions like shame or hopelessness.
- Possibility of endangering or losing a job or relationship as a result of gaming.

Five or more of the above symptoms are required to diagnose with internet gaming disorder.The duration of experiencing these symptoms can be within a year.

The prevalence of Internet gaming disorder in adolescents ranged from 1.3 percent to 19.9 percent, with males showing higher prevalence than females (Mihara & Higuchi, 2017). Different findings have been published in epidemiological studies on the prevalence of Internet gaming disorder owing to the use of various assessment methods and criteria. Due to unavailability of enough research evidence and no consensus about the types of internet gaming disorder among researchers, there are no well-researched subtypes for Internet gaming disorder to date. Some researchers suggested that an individual's addiction to gaming may be either online or offline, while others pointed out that massively multiplayer online role-playing games are linked to substantially more disability than other types of Internet gaming.

Causal Factors ofInternet Gaming Disorder

Online gaming disorder is the product of a variety of interconnected causes. Researchers assume that problematic online gaming might share similar

neurobiological mechanism as pathological gambling and substance dependence (Kuss et al., 2018). Personality traits can play a role in addictive behaviour. Problematic players are thought to spend more time gaming in order to escape real-life social interactions that seem intimidating due to poor social skills or stressful situation. Online environments may seem secure to certain people, and they may prefer them to real-life circumstances.

Certain risk factors, in particular, have been described as leading to higher rates of video game addiction. These include: low self-esteem, neglected parenting, mood modifying qualities in gaming, neuroticism, loneliness etc. In addition to these there are some motivational aspects. Multiple reinforcements are used in online gaming, and different features can be more or less rewarding to different people. In order to keep the diverse gaming community engaged, the games are constructed and designed to satisfy as many different psychological needs as possible. Therefore, there are some structural aspects of the game itself that contribute to its addictive quality.

Treatment of Internet Gaming Disorder

- **Medications**

  People with internet gaming disorder are prescribed antidepressant medication to alleviate the underlying symptoms. Medications can be used in treating the consequences or condition accompanying disorder like an addict suffering from sleeplessness may need sleeping pills.One drug that has recently been used to treat this addiction is ibupropion. The medication works by changing the chemistry of the brain, which helps to alleviate video game cravings.

- **Psychotherapy**

  Therapies which are found effective for other behavioral addictions like behavioral therapy, cognitive behavioral therapy (CBT), motivational interviewing are mostly used for internet gaming disorder as well. CBT focuses on improving problem solving skills and also strengthen adaptive coping skills to prevent relapse. Having support groups (online or in vivo) along with therapy is found to be helpful.Finding new and adaptive ways to meet underlying needs that were previously met by dysfunctional behaviour is often critical in preventing relapse in addictive disorder (Griffiths, 2008).

Self Assessment Questions 3

1. Is internet gaming disorder a category in main section of DSM-5?
2. Name few psychological factors which are considered as risk factors for gaming behaviour.
3. Which psychological treatment are used for internet gaming disorder?

8.6 PERSONALITY DISORDERS

Personality disorders are a set of mental disorders which develop early and are characterized by maladaptive patterns of behaviour, cognition (thinking) and

feeling which deviate from expectations of his/her cultural background and social norms, is exhibited across the situations, lasts over time, causes dysfunction in personal, interpersonal, social and occupational domains and distress to the person and significant others. The disturbance in functioning caused by personality disorder is similar to that of a major mental illness. Higher rates of interpersonal difficulties such as separation and divorce; unemployment; poor quality of life for themselves and family members; and poor social functioning; and higher suicidal risk are reported in literature (Moran et.al., 2016; Nakao, Gunderson, Phillips, 1992; Oldham, 1994; Singh, Sharma, Janardhan Reddy, 1999). They often do not recognize that they have problems which might make it difficult to treat.

Roughly 10-13% of the general population and up to half of the psychiatric patients were found to have personality disorder in developed countries (de Girolamo & Reich, 1993); and

0-2.8% in the Indian context (Reddy & Chandrashekar, 1998). In patients attending a psychiatric hospital, one of the Indian studies found that 1.07% were diagnosed with personality disorder (Gupta & Mattoo, 2012).

For a diagnosis of personality disorder the person has to meet the following DMS-5 criteria:

- Chronic and pervasive patterns of behavior that affect social functioning, work, school, and close relationships
- Symptoms that affect two or more of the following four areas: thoughts, emotions, interpersonal functioning, impulse control
- Onset of patterns of behavior that can be traced back to adolescence or early adulthood
- Patterns of behaviors that cannot be explained by any other mental disorders, substance use, or medical conditions

Classification of Personality Disorders

DSM-5 lists 10 personality disorders clustered into three groups.

Cluster A Personality Disorders:

These disorders are also termed as odd and eccentric disorders, and are often associated with schizophrenia; however, they have a better sense of connection with reality as compared to schizophrenia. Individuals with cluster A personality disorder have a higher probability to have a family member/first degree relative with schizophrenia. They exhibit odd and eccentric modes of speaking, are suspicious, and have difficulty in relating to others. The three disorders classified under this category are:

Paranoid personality disorder.Individuals with paranoid personality disorder have a pervasive, chronic mistrust of others; they suspect that they are being misled or exploited by others, and they view people's motivations as malevolent.

Schizoid personality disorder. These individuals detach from social relationships, they are not interested in relationships, appear cold and withdrawn, and are restricted in emotional expression.

Schizotypal personality disorder. These individuals experience extreme discomfort interacting socially, and have distorted cognition and perceptions. They exhibit odd speech, behavior, and appearance, often have difficulty in forming relationships and hold strange beliefs.

Cluster B Personality Disorders:

They experience intense emotions, engage in extremely impulsive, dramatic, promiscuous, or law-breaking behaviors. Following are the disorders under this cluster.

Antisocial personality disorder. These individuals show disregard for rules and social norms, they violate rights of others, lack empathy, do not show remorse for their acts, they show manipulative and impulsive behaviours.

Borderline personality disorder. they show pervasive pattern of dysregulation of emotions, instability in relationships, problems in self-image and identity, involve in maladaptive behaviors to manage affect such as self-harm behaviours, substance use, impulsive behaviours etc.

Histrionic personality disorder. Individuals with this disorder show pervasive pattern of attention seeking behavior, excessive emotionality often resulting in socially inappropriate behaviour. They often use physical attractiveness to get attention.

Narcissistic personality disorder.They have high need for admiration, exhibit pervasive pattern of superiority/grandiosity and self-centeredness, they lack empathy. They have difficulty trusting people, they demand excessive attention, and take advantage of others.

Cluster C Personality Disorders:

Individuals having the cluster C traits experience excessive anxiety and fears and tend to involve in maladaptive behaviours to reduce their anxiety.

Avoidant personality disorder. They experience pervasive feelings inadequacy and as a result they are social inhibited, are extreme sensitivity to negative evaluation.

Dependent personality disorder. These individuals have pervasive psychological need to be cared by other significant people in their lives. They feel helpless, withdraw from responsibilities, they see themselves as incompetent, show dependency in taking decisions, ask for reassurance, and fear being abandoned by significant people in their lives.

Obsessive-compulsive personality disorder: They hold rigid set of rules and adhere closely to the rules; they are perfectionistic to the extent of dysfunction and often expect things to be in their way and get distressed when there are deviances from the perfection.

Case example:

M, age 32, single woman without a job, presented with depressed mood, suicidal thoughts and complete withdrawal from social life. She had spent the last six months alone in her apartment, lying in bed, eating junk food and watching TV. Herfamily includes parents and two siblings. She is the middle of three children.

Her elder sister is manager in multinational company and younger brother is doing graduation. Her mother seems to value perfections and has shown dissatisfaction over her academic, career and personal life. She felt alone through her school years and reportedly had no close friends. In college, she had fights with a roommate and a professor. She reported that people take undue advantage of her and she has no trust on anyone and that is why she kept herself distant from close relationships. M sometimes cut herself when she feels empty and depressed. Occasionally, she would act on impulse with great risk to her safety by involving in drug abuse and reckless driving. She feels better for short term after doing these impulsive acts.

She could not stay at several previous jobs due to interpersonal conflicts with either boss or colleagues. M was found to have problems with anger control, impulsive acts, self-harm (such as cutting), feeling empty and depressed.

After detailed history taking and assessments, she was diagnosed with borderline personality disorder and major depressive disorder.

Causal Factors of Personality Disorders

Multiple causes have been identified to play a role in the development of personality disorders. While further research is required to fully understand the causes, genetic and environmental factors have been identified as important contributors.

A systematic review by Stepp, Lazarus, and Byrd (2016) found that several contributory factors play a role in developing personality disorder. Some of the social-environmental and individual factors included low socio-economic status, stressful life events, and family adversity; maternal psychopathology and parenting styles which involved low warmth, hostility, harsh punishment; and exposure to physical or sexual abuse or neglect; and low IQ, high levels of negative affectivity and impulsivity, and internalizing and externalizing psychopathology in the child.

There was significant relationship found between a history of childhood trauma and verbal abuse, and personality disorders. It was found that children who experience verbal abuse were three times more likely to develop borderline, narcissistic, obsessive-compulsive or paranoid personality disorders in adulthood (APA, 2010).

Treatment of Personality Disorders

Psychological interventions are recommended as primary treatment for personality disorders and pharmacotherapy is used only as an adjunct treatment. However, the evidence base for effectiveness of psychotherapy is insufficient. Most research focuses on borderline personality disorder compared to other disorders. Unlike other mental disorders, personality disorders require longer therapy and follow-up. The goal of therapy in personality disorders include the following: reducing subjective distress and symptoms such as anxiety and depression, insight facilitation, changing maladaptive behaviours, addressing the interpersonal difficulties as well as improving quality of life.

A few frequently researched therapies are given below.

- **Dialectical behavior therapy (DBT)** is specifically developed for Borderline personality disorder by Marsha M. Linehan (and currently

used for other disorders such as substance abuse, mood disorders, eating disorders, suicidal ideation, post traumatic stress disorder etc. It uses a biosocial approach to understand the development of personality pathology and uses a number of cognitive behavioural strategies in therapy. This therapy teaches a set of coping methods for handling urges related to self-harm, suicidal behaviours, substance use etc. It includes four sets of skills (a) mindfulness skills (b) emotion regulation (c) distress tolerance and (d) interpersonal effectiveness. The duration of therapy is generally one year to one and half years carried out in individual as well as group sessions. It is one of the most effective therapies for Borderline personality disorder.

- **Schema therapy (ST)** developed by Young et al (2003) has been found to be effective for personality disorders as well other chronic disorders such as depression. It incorporated concepts from attachment theory, cognitive behaviour therapy, gestalt therapy and cognitive behaviour therapy. We use schema to better understand ourselves, the behavior of others, and events in the world. Schemas are mental representations of what we learn and experience. Schemas are mental structures for organizing the stimuli into psychologically relevant aspects. When a number of maladaptive schemas are active in an individual, it might result in a dysfunctional schema.

  People with personality problems have developed maladaptive schemas and therefore handle life in a less effective way. According to Young et al. (2005), these maladaptive schemas are developed at an early age as a result of the interactions between factors such as the temperament of the child, the parenting style of the parents, and any significant adverse relational experiences resulting in basic psychological needs being unmet. When the schemas are activated an individual may respond using maladaptive coping methods such as 'giving up' 'overcompensation' or 'avoidance'.

  The main focus of the schema therapy is to address the early maladaptive schemas and the schema modes of the person. Early maladaptive schemas can be defined as stable, trait-like, enduring beliefs about oneself and the world that are rooted in early adverse childhood experiences (Young et al., 2003). It has a number of cognitive behavioural and experiential techniques to change the schema modes, schemas and coping methods used by the individual. Experiential techniques such as imagery rescripting, chair work, role play is found to be effective. The therapist assumes a supportive role in facilitating the change process.

- **Mentalization-based therapy (MBT).** Mentalization refers to the process by which we make sense of others as well as ourselves.It teaches people to notice and reflect on their internal states of mind and those of others. Deficits in mentalization are seen across various mental disorders. MBT developed by Bateman & Fonagy (2004) is found to be effective for borderline personality disorders, post traumatic stress disorder (PTSD), depression and eating disorders. The therapy aims to stabilize emotional expression and reinstate the mentalizing abilities in the patients. It borrows techniques from a number of schools of therapy (Bateman & Fonagy, 2010).

- **Transference focused therapy:** It is a psychoanalytic therapy for severe personality disorders based on object relations theory of Kernberg (2006). The dominant object relations are addressed in the therapy by activation of these relationships within the transference relationship of therapy. The split between the idealized and persecutory parts of the object is addressed in order to foster the development of normal identity (Yeomans, Clarkin, & Kernberg, 2015).

Most of these therapies are largely tried out in Borderline personality disorder and other personality disorders are not explored much. There is a need for establishing the effectiveness of these therapies across other personality disorders.

Self Assessment Questions 4

1. Name the personality disorder under cluster A.
2. What is common defining feature of cluster B personality disorders?
3. Which cluster includes Obsessive-compulsive personality disorder?
4. Name the therapies which are used in the treatment of personality disorder.
5. Name the four sets of skills included in Dialectical behavior therapy.

8.7 SUBSTANCE USE DISORDER

National Mental Health Survey (NMHS-2016) by NIMHANS, Bangalore conducted across the 12 States of India shows that alcohol use disorder was found in 4.6% of the adults, tobacco use disorder was found in 13.1%, other substance use disorders was 0.6%, mental and behavioural disorders due to substance use is 5%. Overall, 22.4% of the adults across the States had one or the other substance use disorder. Higher percentage of males have alcohol, tobacco use and other substance use disorders (32.8, 9.1, and 1.1 respectively) compared to females (9.8, 0.5, and 0.1 respectively).

DSM 5 defines Substance Use Disorder (SUD) as "persistent use of substances (drugs) despite experiencing substantial harm and adverse consequences". Individuals with SUD experience significant dysfunction in areas of health, family relationships, work/school, roles and responsibilities. The SUD includes misuse of both illicit/illegal (marijuana/hashish, cocaine, heroin, inhalants etc.)substances as well as legal substances (alcohol, nicotine, prescription drugs).

DSM-5 lists out a set of symptoms to diagnose SUD:

- Persistent use of substance despite knowing/having the negative consequences (physical, social, psychological, financial, work) of the same.
- Though they may want to stop and have persistent wish to stop but they fail to reduce or control substance use.
- They experience withdrawal symptoms when not using substance, they use larger amounts over the time to get the same effect as earlier.
- They spend lot of time and money to obtain the substance

- Give priority to substance over other domains of life such as work, family, relationships, responsibilities, hobbies etc.
- They experience strong urge to use the substance.

The severity of the SUD is determined based on how many of the above criteria the person fulfils. The severity is categorised as mild, moderate and severe.

The international Classification of diseases 11th revision (ICD-11) categorise the SUDs into two: (i) Harmful pattern of substance use (clinically significant harm/ damage to the person's physical, mental, social and behavioural domains), and (ii) Substance dependence. ICD-11 defines the substance dependence as a "disorder of regulation of the use of a psychoactive substance as a resultant of repeated/continuous use of substance". They emphasize on impaired control over substance use in terms of onset, quantity, circumstances, and termination. Substance taking becomes the priority over other things in life and they continue to use despite negative consequences/problems. The physiological manifestations include (a) tolerance, (b) withdrawal symptoms when not using or reducing substance use, and (c) using the substance to prevent/reduce withdrawal symptoms.

Types of Substance Use Disorders

The most commonly used substances are as follows:

Alcohol: An alcoholic drink contains ethanol. It produces euphoria, reduces anxiety, and increases sociability, sedation, results in impairment in cognition, memory, motor function and acts as a central nervous system depressant. The alcohol is formed using different procedures and accordingly it is categorised as fermented alcohols (beer, wine, cider), distilled alcohols (vodka, gin, rum, brandy etc), and others (cocktail bitters, alcopopos). Excessive use causes damage to brain, liver, heart and development of hypertension.

Opioids: They are naturally found in opium poppy plant. It works on the brain to produce relief in pain. So, it is frequently used in the health set up to relieve pain. It includes both legal (codeine, morphine, oxycodone etc.) and illegal drugs (e.g. heroin). Misuse results in dependence, severe respiratory depression and even death.

Stimulants: They include amphetamines, methamphetamines and cocaine. They increase the heart rate, alertness, and blood pressure. Misuse of the drug can result in seizures, heart failure as well as hostility and psychosis.

Hallucinogens: These substances distort the perception, awareness of the surroundings, thoughts and feeling. Persons using these substances also experience hallucinations. These substances are found in natural substances (mushrooms, peyote etc.) as well as chemically synthesized (phencyclidine, lysergic acid diethylamide etc.).

Cannabis : Also known as marijuana, cannabis is a substance obtained from plant.These are used for medicinal purposes and for recreation. Excessive use of this drug causes memory problems, difficulty in learning, thinking, problem solving skills, perception, and loss of motor coordination. Excessive use increases the risk for cognitive difficulties and mental illness.

Tobacco: It is a leafy plant, the dried leaves are used for smoking (cigarettes, cigars, pipes, snuff, chewing tobacco). It contains stimulant substance nicotine. It increases the risk of cancer, coronary heart disease, lung and liver damage.

Case example

F, 32 years old single male, engineer by profession. He was brought by his family to the hospital. F started consuming heroin when he was 25 years old. For few initial months, he has been taking drugs in the company of his peers. His needs keptincreasing and he started taking it secretly. He has been seen to have increased irritability and aggressive behaviour, disturbances in sleep and appetite, severe withdrawal, severe craving and use of injectable.He hadbecomecompletely dependent on family for financial assistance. He was not motivated to leave drugs and never felt the need for treatment. Initial few weeks of the treatment were spent educating him about drug dependence and in enhancing his motivation.

Causal Factors of Substance Use Disorder

Multiple biopsychosocial factors contribute to developing SUDs. Some of the identified factors include: alcohol use in parents, which acts as both biological vulnerability as well as learning through observation. In addition, children in these families may not consider alcohol use as having negative consequences or may use as a coping method. When individuals start using alcohol early on, they have higher risk for having SUD as an adult.

In adolescents the risk factors identified include:

- familial factors – substance abuse in the family, lower psychoeducation in the parents, neglectful (failure to provide basic facilities, like food, clothing, health care, safety) and abusive parenting
- adverse experiences - such as physical, sexual or emotional abuse
- social factors – deviant peer relationships, bullying experiences, involving in gang activities/substance abuse for recognition in the group
- mental health – Attention deficit hyperactivity disorder, and depression (NIDA, 2020; Whitesell et al 2013)

In adults, social and family factors such as being divorced, separated, being single, experiences of loss, financial difficulties or having more financial resources are associated with risk of SUD (Kuerbis et al. 2014)

Some of the common risk factors identified in the clinical literature are being a male, age under 25 years; having other mental health problems; lack of family support, and monitoring/supervision; personality factors such as high sensation seeking, impulsivity, aggressive behaviour, neuroticism, openness to experience and low conscientiousness (Bartoli et. al., 2020; Belcher et. al., 2014).

Assessment

There are a number of screening tools used in the assessment of SUDs apart from the clinical interview and substance use history. A few instruments with sound psychometric properties are given below:

- CAGE: developed by Ewing (1984) assesses lifetime alcohol or drug consumption. It has 4 questions and each scored as yes or no, each "yes"

response receives 1 point. A score of 2 or higher indicates clinically significant substance use problem.

- The Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organization in 1982. This is used as a screening tool to identify people who are at risk for developing alcohol problems (preliminary signs of harmful drinking and dependence). It has 10 items; 3 to assess hazardous alcohol use; 3 for dependence symptoms and 4 for harmful alcohol use. Each item is rated on a 5 point scale with higher score indicating greater risk.
- Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS): Consists of 2 formats, screening (TAPS-1) followed by a brief assessment (TAPS-2) for those who screen positive. It can be used as a self-administered tool or administered by a clinician. It assesses the substance use over 12 months period. The risk is assessed as 0 – if there is no use in the past 3 months, 1 if there is problem use, and 2+ if there is higher risk.

Intervention for Substance Use Disorder

Both pharmacological and psychosocial interventions/treatments are used for substance use disorders. Often combination of both are found to be effective than single therapy (Douaihy et al 2013).

- **Pharmacological management**

  Pharmacological management is used for management of acute withdrawal syndromes resulting from detoxification, to reduce the craving for using the drug, and to prevent relapse**.**

  Nicotine replacement therapy (NRT) is one of the most frequently used pharmacological treatment for nicotine dependence. NRTs use medication to replace the effect of nicotine such that the withdrawal symptoms (cold turkey) are taken care of. Some of the NRT formulations include the transdermal nicotine patch, nicotine gum, nicotine lozenge, nicotine vapor inhaler, and nicotine nasal spray.

- **Psychosocial interventions**

  Generally, the psychosocial interventions are combined with pharmacological treatments. They aim at reducing the craving, withdrawal symptoms as well as factors maintaining the substance abuse. Some of the commonly used interventions are described below ((Jhanjee, 2014):

Brief intervention (BI)

This is a brief intervention aims at educating the patient about the risk of the substance use and motivate them to reduce or stop use of the substance.The session usually lasts from 5 – 30 minutes done in the outpatient, primary health care, general hospital and specialist hospital settings. This is largely useful for those with risky substance use, and those with serious substance use problems might require more intense therapy. The main components of this therapy would include feedback, responsibility, advice, menu of options, empathy and self-efficacy, popularly used acronym is FRAMES. It is found to be highly cost-effective therapy.

Motivational enhancement/interviewing (MI)

MI aims to explore and resolve the ambivalence about the substance use in people with SUD thus facilitating the change in the beliefs and behaviours. The main principles of MI include: the therapist expresses empathy through reflective listening, facilitates developing discrepancy between patients' goals or values and their current behaviors, avoid argument and direct confrontation, adjusts to client resistance and support self-efficacy and optimism. MI is found to be one of the most cost-effective psychosocial intervention. It is used as stand-alone therapy as well as with pharmacotherapy.

Cognitive Behaviour Therapy (CBT)

CBT is a structured time limited therapy based on learning principles and cognitive theories. It focuses on identifying and modifying the irrational thoughts/beliefs, negative moods and behaviours that maintain the substance use and leading to relapse. *Behvaioural techniques*include exposure to the cues, promoting non-drug related healthy activities, coping with urge, contingency management, relaxation training, effective problems solving and communication skills. It is one of the most effective interventions across all SUDs.

Relapse prevention strategies developed based on CBT principles are also found to be effective. It emphasizes on identifying high-risk situations and triggers for craving, developing skills to manage cravings, difficult emotions, and coping with lapses and relapses and develop skills to lead a balanced life.

Contingency management based on behavioural principles is also found to be effective. In this approach, positive behavioursare encouraged through positive reinforcement and negative behaviours are punished or reduced through withholding the positive reinforcement. Rewards/positive reinforcers such as vouchers, privileges, prizes, and money are used.

Therapeutic communities

These are residential rehabilitation programs, where people with SUDs live and work. The aim of these programs is to help people develop skills to live without use of substance. A number of skills such as life skill, employment, education, vocational skills etc. are taught to prepare them to return to the community. This is not a well-researched therapy in SUDs.

Self-help groups

These self-help groups are formed on the basis of Narcotics Anonymous and Alcoholics Anonymous (AA). They emphasize on complete abstinence. They use behavioral, spiritual and cognitive principles to facilitate the process of recovery. They acknowledge the damage caused by the substance and trust the higher power to help them in recovery.

Self Assessment Questions 5

1. What are the effects of misuse of stimulants?
2. Name the screening tool used to identify people who are at risk for developing alcohol problems.
3. Name few screening tools used in the assessment of SUDs.

4. What is the name of pharmacological treatment used for nicotine dependence?
5. Mention few psychosocial interventions used in substance use disorder.

8.8 LET US SUM UP

In this Unit you learned about various mental disorders that may be manifestations of maladjustment. These disorders were described in terms of their clinical features, types, causal factors and treatment/ intervention procedures.

Mood disorders can be understood by extreme change in mood states that can lead to significant disturbance in daily life activities. It represents a category of mental illnesses in which the prominent problem centres on person's persistent emotional state. There are several inter related biological, social, cognitive factors which contributes to mood disorders. The treatment of mood disorder is largely pharmacotherapy but the combination of psychotherapy along with pharmacotherapy are found to be most effective.

Eating disorder is characterized by persistent disturbance in eating behaviour which is accompanied by an intense fear of becoming overweight/ fat and an accompanying pursuit of perfect body appearance. There are various causal factors which in combination and individually contribute to precipitate eating disorder. The multidisciplinary approach including psychological and dietary counselling, along with medical monitoring is proved to be effective treatment for eating disorder.

Internet gaming disorderis one of the most recent forms of addiction to emerge. To be diagnosed with gaming disorder, the behaviour pattern must be severe enough to cause significant impairment in important areas of functioning over a period of at least 12 months. Internet gaming disorder is the consequence of many different integrated factors involving biological, motivational, cognitive, behaviours and personality factors. Treatment focusing on underlying condition along with addictive behaviour is found to be effective for treating gaming disorder.

Personality disorders are a set of mental disorders which develop early and are characterized by maladaptive patterns of behaviour, cognition (thinking) and feeling and causes significant distress across different domains of the individual's life. DSM-5 lists 10 personality disorders clustered into three groups: Cluster A, B and C. Multiple factors are found to contribute to the development of personality disorder. Both genetic and environmental factors are identified to play an important role in the development of personality disorders. Psychological interventions are recommended as primary treatment for personality disorders and pharmacotherapy is used only as an adjunct treatment.

Substance use disorder (SUD) is defined as"persistent use of substances (drugs) despite of experiencing substantial harm and adverse consequences" by the DSM 5. Commonly used substances include alcohol, cannabis, tobacco, opioids, stimulants and hallucinogens. Multiple biopsychosocial factors contribute to development of SUDs such as family factors, individual factors and environmental factors. A combination of both pharmacological and psychosocial interventions/ treatments are found to be effective than single therapy.

8.9 KEY WORDS

Manic Episode: Manic episode is characterized by intense feelings of euphoria and elation, increased talkativeness, over activity and over religiosity and when manic symptoms are serious and disruptive the person needs immediate hospital care.

Depressive Disorder: depressive disorder is marked by presence of persistent low moods or marked loss of interest in pleasurable activities, with somatic and cognitive changes that significantly affects person's daily functioning. The symptoms need to be present nearly every day, for at least two consecutive weeks

Anorexia Nervosa: A type of eating disorder in which an individual restricts food intake to the level that 15 percent weight loss which is below the ideal body weight or more occurs.

Bulimia nervosa: Bulimia nervosa is a type of eating disorder in which an individual begins a cycle of "bingeing," or consuming a large amount of food in one sitting, and then uses unhealthy strategies to prevent weight gain.

Binge-Eating Disorder: it is a type of eating disorder in which person lose control over their eating. Binge-eating disorder often lead to making individual overweight or obese

Cognitive behaviour therapy: It is a type of psychotherapy approach which focuses on changing dysfunctional thinking and behaviour.

Gaming disorder: it is a kind of behavioural addiction in which a pattern of gaming behaviour characterised by a loss of control over gaming, making gaming a higher priority than other activities to the point where gaming takes precedence over other interests, and continuing gaming despite negative consequences occurs.

Personality disorder: Personality disorders are a set of mental disorder which are characterized by maladaptive patterns of behaviour, cognition (thinking) and feeling which deviate from expectations of his/her cultural background and social norms, is exhibited across the situations, lasts over time, causes dysfunction in personal, interpersonal, social and occupational domains and distress to the person and significant others.

Substance Use Disorder: Substance Use Disorder can be definedas persistent use of substances (drugs) despite experiencing substantial harm and adverse consequences.

Contingency management: A techniques based on behavioural principles in which positive behaviours are encouraged through positive reinforcement and negative behaviours are punished or reduced through withholding the positive reinforcement.

Relapse: a relapse is the worsening of a medical condition that had previously improved. Relapse is defined as the recurrence of behavioral or other substantive indicators of active disease after a period of remission.

Withdrawal: Withdrawal is the combination of physical and mental effects that a person experiences after they stop using or reduce their intake of a substance such as alcohol and prescription or other drugs.

8.10 ANSWERS TO SELF ASSESSMENT QUESTIONS

Answers to Self Assessment Questions 1

1. Euphoria/elation and depressed/ sad
2. Manic episode
3. Persistent depressive disorder
4. Serotonin, norepinephrine, and dopamine
5. Cognitive behaviour therapy, Behaviour activation, Interpersonal and social rhythm therapy

Answers to Self Assessment Questions 2

1. Intense fear of becoming overweight and fat
2. Anorexia nervosa
3. Bulimia nervosa
4. Perfectionism, body dissatisfaction and low self esteem
5. Cognitive behaviour therapy and family therapy

Answers to Self Assessment Questions 3

1. No
2. low self-esteem, neglected parenting, neuroticism, depression, loneliness etc
3. Behavioral therapy, cognitive behavioral therapy (CBT), motivational interviewing

Answers to Self Assessment Questions 4

1. Paranoid personality disorder, Schizoid personality disorder and Schizotypal personality disorder
2. Individuals withCluster B disorders are known to have emotional, dramatic/ erratic behaviours
3. Cluster C
4. Dialectical behavior therapy (DBT, Schema Therapy, Mentalization-based therapy (MBT), Transference focused therapy
5. (a) mindfulness skills (b) emotion regulation (c) distress tolerance and (d) interpersonal effectiveness

Answers to Self Assessment Questions 5

1. Misuse of the stimulants can result in seizures, heart failure as well as hostility and psychosis.
2. Alcohol Use Disorders Identification Test (AUDIT)
3. CAGE, Alcohol Use Disorders Identification Test (AUDIT), Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)

4. Nicotine replacement therapy (NRT)
5. Motivational enhancement/interviewing (MI), Brief Intervention (BI), Cognitive Behaviour Therapy (CBT)

8.11 UNIT END QUESTIONS

1. Discuss the symptoms and types of depressive disorder.
2. Compare and contrast manic and depressive episode.
3. Explain various causal factors of eating disorder.
4. What are the clinical features of binge eating disorder?
5. Differentiate between anorexia nervosa and bulimia nervosa.
6. Explain the risk factor for developing internet gaming disorder.
7. Define personality disorders.What are the criteria for diagnosing personality disorders?
8. Explain the causal factors contributing to the development of personality disorders.
9. Define substance use disorders. What are the psychosocial factors causing SUD?
10. Describe the psychosocial interventions in SUD.

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8.13 FURTHER LEARNING RESOURCES

Websites

American Psychiatric Association

http://www.psychiatry.org

American Psychological Association

http://www.apa.org/

National Alliance for the Mentally Ill

http://www.nami.org/

National Institute of Mental Health

http://www.nimh.nih.gov/

Mental Health America

http://www.nmha.org/

https://www.who.int/news-room/q-a-detail/addictive-behaviours-gaming-disorder

https://www.uk-rehab.com/behavioural-addictions/gaming/

https://www.psychguides.com/behavioral-disorders/video-game-addiction/

https://anad.org/get-informed/about-eating-disorders/eating-disorders-statistics/

https://www.nationaleatingdisorders.org/treatment

https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools

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https://youtu.be/UP8JwNYZBpI Cognitive Behaviour Therapy - Vicious Cycles

https://youtu.be/lDnvZS5DP68 What is Dialectical Behavior Therapy?

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