UNIT-IV

Chapter - 1 : Psychological Disorders

Revision Notes

- **Concept of Abnormality and Psychological Disorder:**

  Most definitions of abnormal behaviour have certain common features, often called "four Ds":

  - **Deviance:** Psychological disorders are deviant- different, extreme, unusual, even bizarre.
  - **Distress:** Behaviour which is unpleasant and upsetting to the person and to the others.
  - **Dysfunction:** Behaviour which is interfering with the person's ability to carry out daily activities in a constructive way.
  - **Danger:** Behaviour which is dangerous to the person or to others.
- Abnormal literally means **"away from normal"**. It implies deviation from some clearly-defined norms or standards.
- **Conflicting views on abnormal behaviour**
  - The first approach views abnormal behaviour as deviation from social norms.
  - The second approach views abnormal behaviour as maladaptive which states the best criterion for determining the normality of behaviour is not whether the society accepts it, but whether it fosters the well being of the individual and eventually, of the group to which s/he belongs.

Well-Being

- Well-being is not simply maintenance and survival but also includes growth and fulfilment.
- "Physicians make a diagnosis looking at a person's physical symptoms". In this way, psychological disorders are diagnosed.
- In order to diagnose psychological disorders, they are classified into categories.
- The American Psychiatric Association (APA) has published an official manual describing and classifying various kinds of psychological disorders.
- The current version of it, the Diagnostic and Statistical Manual of Mental Disorders, V edition (DSM-V), evaluates the patients on five axes or dimensions rather than just one broad aspect of 'mental disorder'. These dimensions relate to biological, psychological, social and other aspects.
- The classification scheme officially used in India and elsewhere is the tenth revision of the International Classification of Diseases (ICD-10), which is known as the ICD-10 Classification of Behavioural and Mental Disorders. It was prepared by the World Health Organisation (WHO). For each disorder, a description of the main clinical features or symptoms and of other associated features including diagnostic guidelines is provided in this scheme.

Classification of Psychological disorders:

- Classification refers to a list of categories of specific Psychological disorders grouped into various classes on the basis of some shared characteristics.
- **Main Classification:**
  - **ICD-10:** Developed by WHO. This is the official classification in India. The classification is based on symptoms under broad heading, *i.e.*, Mental disorders.
  - **DSM IV:** Developed by APA. It is multiaxial. It is very comprehensive because classification is based on biological, psychological and social factors, cause and prognosis of disorders.
- **Importance:** These classifications provide standard vocabulary through which professionals universally can converse. It also helps in understanding the cause and diagnosis of mental disorders.
- **Recurring Theories to Study Abnormal Behaviour:**
  - Ancient theory suggests that some people are possessed by supernatural and magical forces such as evil spirits. Exorcism (removing the evil residing in the individual through prayer) is still commonly used. *Shaman* or medicine man has contact with supernatural forces, medium of communication between human and spirits.
  - Biological/Organic approach links defective biological processes to maladaptive behaviour.
  - According to psychological approach, problems caused by inadequacies in the way an individual thinks, feels and perceives.

- **Historical Background:**
  - Ancient Greek philosophers (Hippocrates, Socrates, Plato) developed an organismic approach—viewed disturbed behaviour arising out of conflicts between emotion and reason.
  - Galen—temperament affected by imbalance in four humours, similar to *tridoshas*. Middle ages, superstition and demonology—people with mental problems, were associated with demons. St. Augustine wrote about feelings, mental anguish and conflict—laid groundwork for modern psychodynamic theories.
  - Renaissance Period—increased humanism and curiosity about behaviour.
  - Johann Weyer—disturbed interpersonal relationships as cause of psychic disorders, mentally disturbed require medical not theological treatment.
  - Age of Reason and Enlightenment (17^{th}/18^{th} centuries)- growth of scientific method replaced faith and dogma, contributed to Reform movement.
  - **Increased compassion for those suffering—**reform of asylums, deinstitutionalisation, emphasised community care.
  - **Recent years**—convergence of approaches, resulted in interactional biopsycho- social approach.

Factors Underlying Abnormal Behaviour

- In order to understand something as complex as abnormal behaviour, psychologists use different approaches. Each approach in use today emphasises a different aspect of human behaviour and explains and treats abnormality in line with that aspect. These approaches also emphasise the role of different factors such as biological, psychological and interpersonal, and socio-cultural factors. We will examine some of the approaches which are currently being used to explain abnormal behaviour.

  (a) Biological Factors: Biological factors influence all aspects of our behaviour. A wide range of biological factors such as faulty genes, endocrine imbalances, malnutrition, injuries and other conditions may interfere with normal development and functioning of the human body. These factors may be potential causes of abnormal behaviour.

  (b) Genetic Factors: Genetic factors have been linked to mood disorders, schizophrenia, mental retardation and other psychological disorders. Researchers have not, however, been able to identify the specific genes that are the culprits. It appears that in most cases, no single gene is responsible for a particular behaviour or a psychological disorder. In fact, many genes combine to help bring about our various behaviours and emotional reactions, both functional and dysfunctional. Although, there is sound evidence to believe that genetic/ biochemical factors are involved in mental disorders as diverse as schizophrenia, depression, anxiety, etc., biology alone cannot account for most mental disorders.

Models of Abnormal Behaviour

- **Psychological Model:** There are several models which provide a psychological explanation of mental disorders. These models maintain that psychological and interpersonal factors have a significant role to play in abnormal behaviour.

  These factors include:
  - Maternal deprivation
  - Faulty parent-child relationship
  - Faulty discipline
  - Maladaptive family structure
  - Severe stress

  The Psychological models include **psychodynamic model, behavioural, cognitive and humanistic-existential models.**

  (a) Psychodynamic Model:
  - This is the oldest and most famous of the modern psychological models. Psychodynamic theorists believe that the behaviour, whether normal or abnormal, is determined by psychological forces within the person of which s/he is not consciously aware. These internal forces are considered dynamic, *i.e.*, they interact with one another and their interaction gives shape to thoughts and emotions.
  - Abnormal symptoms are viewed as the results of conflicts between these forces. The model was first formulated by Freud who believed that three central forces shape personality – instinctual needs, drives and impulses (id), rational thinking (ego), and moral standards(superego).
  - Freud stated that abnormal behaviour is a symbolic expression of unconscious mental conflicts that can be generally traced to early childhood or infancy.

(b) Behavioural Model:

- This model states that both normal and abnormal behaviours are learned and psychological disorders are the result of learning maladaptive ways of behaving. The model concentrates on behaviours that are learnt through conditioning and proposes that what has been learned can be unlearned.
- Learning can take place through classical conditioning (temporal association in which two events repeatedly occur close together in time), operant conditioning (behaviour is followed by a reward) and social learning (learning by imitating others' behaviour). These three types of conditioning account for behaviour whether adaptive or maladaptive.

(c) Cognitive Model:

- This states that abnormal functioning can result from cognitive problems. People may hold assumptions and attitudes about themselves that are irrational and inaccurate. People may also repeatedly think in illogical ways and make over generalisations, that is, they may draw broad, negative conclusions on the basis of a single insignificant event.

(d) Humanistic-existential Model:

- This model focuses on broader aspects of human existence. Humanists believe that human beings are born with a natural tendency to be friendly, co-operative and constructive, and are driven to self-actualise, *i.e.*, to fulfil this potential for goodness and growth. Existentialists believe that from birth, we have total freedom to give meaning to our existence or to avoid that responsibility. Those who shirk from this responsibility would live empty, inauthentic and dysfunctional lives.

(f) Sociocultural Model:

- Sociocultural factors such as war and violence, group prejudice and discrimination, economic and employment problems, and rapid social change, put stress in most of us and can also lead to psychological problems in some individuals. According to sociocultural models, abnormal behaviour is best understood in light of the social and cultural forces that influence an individual. As behaviour is shaped by societal forces, factors such as family structure and communication, social networks, societal labels and roles become more important. It has been found that certain family systems are likely to produce abnormal functioning individual members. Some families have an enmeshed structure in which the members are overwhelmed in each other's activities, thoughts and feelings. Children from this type of family may have difficulty in becoming independent in life. The broader social networks in which people operate include their social and professional relationships. Studies have shown that people who are isolated and lack social support, *i.e.*, strong and fulfilling interpersonal relationships in their lives are to become more depressed and remain depressed longer than those who have good friendships. Sociocultural theorists also believe that abnormal functioning is influenced by the societal labels and roles assigned to troubled people. When people break the norms of their society, they are called deviant and "mentally ill". Such labels tend to stick so that the person may be viewed as "crazy" and encouraged to act sick. The person gradually learns to accept and play the sick role, the functions of a disturbed manner.

(g) Diathesis-stress Model:

This model states that psychological disorders develop when a diathesis (biological predisposition to the disorder) is set off by a stressful situation.

This model has three components:

- The first is the diathesis or the presence of some biological aberration which may be inherited.
- The second component is that the diathesis may carry a vulnerability to develop a psychological disorder. This means that the person is "at risk" or "predisposed" to develop the disorder.
- The third component is the factors/stressors that may lead to psychopathology. If such "at risk" persons are exposed to these stressors, their predisposition may actually evolve into a disorder. This model has been applied to several disorders including anxiety, depression and schizophrenia.

Major Psychological Disorders

(a) Anxiety Disorder: The term anxiety is defined as diffuse, vague and very unpleasant feeling of fear and apprehension.

The anxious individual shows a combination of following symptoms: Rapid heart rate, shortness of breath, diarrhoa, loss of appetite, fainting, dizziness, sweating, sleeplessness, frequent urination and tremors.

Major Anxiety Disorders and their Symptoms

- **Generalised Anxiety Disorder:** Prolonged, vague, unexplained and intense fears that have no object, accompanied by hyper vigilance and motor tension.
- **Panic Disorder:** Frequent anxiety characterised by feelings of intense terror and dread; unpredictable 'panic attacks' along with physiological symptoms like breathlessness, palpitations, trembling, dizziness and a sense of loosing control or even dying.

- **Phobias:** Irrational fears related to specific objects, interactions with others and unfamiliar situations.
- **Obsessive-compulsive Disorder:** Being preoccupied with certain thoughts that are viewed by the person to be embarrassing or shameful, and being unable to check the impulse to repeatedly carry out certain acts like checking, washing, counting, etc.
- **Post-Traumatic Stress Disorder (PTSD):** Recurrent dreams, flashbacks, impaired concentration and emotional numbing followed by a traumatic or stressful event like a natural disaster, serious accident, etc.

(b) **Obsessive-Compulsive and Related Disorder:** People with OCD are unable to control their preoccupations with specific ideas or are unable to prevent themselves from repeatedly carrying out a particular act, which affects their ability to carry out normal activities. **Obsessive Behaviour:** inability to stop thinking about a particular idea or topic. **Compulsive Behaviour**: is the need to perform certain behaviours over and over again. For *e.g.*, Counting, touching, checking, washing, etc., E.g., Hoarding Disorder, Trichotillomania (hair pulling disorder), Excoriation (skin picking).

(c) **Trauma and Stress-Related Disorder:** People who are caught in natural disasters, bomb blasts, or have been in serious accidents or in a war situation, experience post-traumatic stress disorder (PTSD). **Symptoms:** Recurrent dreams, flashbacks, impaired concentration & emotional numbing. **Includes**: Adjustment disorder and Acute Stress Disorder.

(d) **Somatic Symptom and Related Disorder:** These are conditions in which there are physical symptoms in the absence of a physical disease. The individual has psychological difficulties & complains of physical symptoms, for which there is no biological cause.

- **Somatic Symptom Disorder:** Persistent body-related symptoms which may or may not be related to any serious medical condition. People with this disorder tend to be overly preoccupied with their symptoms and they continually worry about their health and make frequent visits to doctors. As a result, they experience significant distress and disturbances in their daily life.
- **Illness Anxiety Disorder:** Involves persistent preoccupation about developing a serious illness and constantly worrying about this possibility. This is accompanied by anxiety about one' s health. Individuals with illness anxiety are overly concerned about undiagnosed disease, negative diagnostic results, do not respond to assurance by doctors and are easily alarmed about illness such as hearing about someone else's ill-health or some such news. In the case of somatic symptom disorder, this expression is in terms of physical complaints while in case of illness anxiety disorder, as the name suggests, it is the anxiety which is the main concern.
- **Conversion Disorders: Symptoms:** Reported loss of a body part or some basic bodily functions. For *e.g.*, Paralysis, blindness, deafness, difficulty in walking, etc. These symptoms often occur after stressful experience & may be quite sudden.

(e) **Dissociative Disorders Dissociation:** Involves feelings of unreality, estrangement, depersonalisation & sometimes loss or shift of identity. **Dissociative Disorders:** Sudden temporary alterations of consciousness that blot out painful experiences.

(f) **Depressive Disorder/ Depression:** One of the most widely prevalent and recognised of all mental disorders is depression. Depression covers a variety of negative moods and behavioural changes. Depression can refer to a symptom or a disorder. In day-to-day life, we often use the term depression to refer to normal feelings after a significant loss, such as the break-up of a relationship or the failure to attain a significant goal. Major depressive disorder is defined as a period of depressed mood &/or loss of interest or pleasure in most of the activities together with other symptoms which may include change in body weight, constant sleep problems, tiredness, inability to think clearly, agitation, greatly slowed behaviour, thoughts of death & suicide, excessive guilt or feelings of worthlessness.

Factors predisposing towards depression:

- **Age:** *e.g.*, Women are at risk during young adulthood & men during middle age.
- **Heredity:** It is a major risk factor predisposing people to mood disorders.
- **Gender:** *e.g.*, Women in comparison to men are likely to be more depressed.
- **Other factors:** *e.g.*, Negative life events and lack of social support.

(g) **Bipolar and Related Disorder**

Mania: People suffering from mania become Euphoric (high), extremely active, extremely active, excessively talkative and easily distractable.

- Maniac episodes rarely appear by themselves, they usually alter with depression.
- Such a mood disorder, in which both mania and depression are alternatively present, is sometimes interrupted by periods of normal mood, this is known as Bipolar Mood Disorder.

Suicide: Symptoms of Suicide:

- Changes in eating or sleeping habits.
- Withdrawal from friends, family and regular activities
- Violent actions, rebellious behaviour, running away
- Drug and alcohol abuse
- Marked personality change
- Persistent boredom
- Difficulty in concentration
- Complaints about physical symptoms
- Loss of interest in pleasurable activities

Factors leading to suicide:

- Social, psychological, cultural and other factors such as mental disorders (especially depression and alcohol use disorders), going through disasters, violence, abuse or loss and isolation.
- Impulse during crisis, the capacity to deal with life stresses such as financial issues, relationship break-up, etc., breaks down.
- Previous suicidal attempt is the strongest risk factor.
- **Causes:** Inter-personal relationships, family and negative peer-pressure.
- The ramifications of suicide on social circle and communities tend to be devastating and long-lasting.

(h) Schizophrenia Disorder: Schizophrenia is the descriptive term for **a** group of psychotic disorders in which personal, social and occupational functioning deteriorates as a result of disturbed thought processes, strange perceptions, unusual emotional states and motor abnormalities. **Symptoms:** can be grouped into 3 categories- Positive (*i.e.*, excess of thought, emotion and behaviour), Negative (deficit of thought, emotion and behaviour) and Psychomotor symptoms.

(i) Disruptive, Impulse-Control and Conduct Disorder:

- **Oppositional Defiant Disorder (ODD)** display age-inappropriate amounts of stubbornness, are irritable, defiant, disobedient and behave in a hostile manner. Unlike ADHD, the rates of ODD in boys and girls are not very different.
- **Conduct Disorder and Antisocial Behaviour** refers to age inappropriate actions and attitudes that violate family expectations, societal norms and the personal or property rights of others. The behaviours, typical of conduct disorder, include aggressive actions that cause or threaten harm to people or animals, non-aggressive conduct that causes property damage, major deceitfulness or theft and serious rule violations.

  Types of aggressive behaviour:

  - **Verbal aggression** (*i.e.,* name-calling, swearing), Physical aggression (*i.e.,* hitting, fighting)
  - **Hostile aggression** (*i.e.,* directed at inflicting injury to others)
  - **Proactive aggression** (*i.e.,* dominating and bullying others without provocation)

(j) Neurodevelopmental Disorders: Manifested at an early age before schooling.

(k) Feeding & Eating Disorder (Anorexia Nervosa): The individual has a distorted body image that leads her/ him to see herself/himself as overweight. Often refusing to eat, exercising compulsively may lose large amounts of weight and even starve herself/himself to death.

(l) Bulimia Nervosa: The individual may eat excessive amounts of food, then purge her/ his body of food by using medicines such as laxatives or diuretics or by vomiting. A sense of tension and negative emotions after purging. **Binge eating:** There are frequent episodes of out-of-control eating.

(m) Substance Related and Addictive Disorder:

Alcohol:

- People who abuse alcohol drink large amounts and rely on it to help them face difficult situations.
- Eventually, the drinking interferes with their social behaviour and ability to think and work.
- Their bodies built up tolerance for alcohol and they need to drink large amounts to feel its effect.
- They also feel withdrawal symptoms when they stop drinking. Alcohol destroys millions of families, social relationships and careers. It also has serious effects on children of persons with this disorder. These children have higher rates of psychological problems, particularly anxiety, depression, phobias and substance abuse related disorders.

Heroin

- Heroin intake significantly interferes with social and occupational functioning. Most abusers further develop a dependence on heroin, revolving their lives around the substance, building up a tolerance for it and experiencing a withdrawal reaction when they stop taking it.
- The most direct danger of heroin abuse is an overdose, which slows down the respiratory centers in the brain, almost paralysing breathing and in many cases, causing deaths.

Cocaine

- Regular use of cocaine may lead to a pattern of abuse in which the person may be intoxicated throughout the day and function poorly in social relationships and at work.
- May also cause problems of short term memory and attention.
- Dependence may develop, so that cocaine dominates the person's life. More of the drug is needed to get the desired effects and stopping it results in feelings of depression, fatigue, sleep problems, irritability and anxiety. Cocaine poses serious dangers. It has dangerous effects on psychological functioning and physical well-being.

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UNIT-V

Chapter - 2 : Therapeutic Approaches

Revision Notes

Nature and Process of Psychotherapy

- **Psychotherapy** is a voluntary relationship between the one seeking treatment or the client and the one who treats or the therapist.
- **Aim:** The aim of psychotherapy is at changing the maladaptive behaviours, decreasing the sense of personal distress and helping the client to adapt better to her/his environment. All psychotherapies aim at a few or all of the following goals:
  - Reinforcing client's resolve for betterment
  - Lessening emotional pressure
  - Unfolding the potential for positive growth
  - Modifying habits
  - Changing thinking patterns
  - Increasing self-awareness
  - Improving interpersonal relations and communication
  - Facilitating decision-making
  - Becoming aware of one's choices in life
  - Relating to one's social environment in a more creative and self-aware manner
- **All psychotherapies aim at a few or all of the following goals:**
  - There is systematic application of principles underlying the different theories of therapy.
  - Persons who have received practical training under expert supervision can practice psychotherapy and not everybody.
  - The therapeutic situation involves a therapist and a client who seeks and receives help for her/his emotional problems (this person is the focus of attention in the therapeutic process).
  - The interaction of these two persons, the therapist and the client — results in the consolidation/formation of the therapeutic relationship. This is a confidential, interpersonal and dynamic relationship.

Therapeutic Relationship

- **The two major components of a therapeutic alliance are as follows:**
  - The first component is the contractual nature of the relationship in which two willing individuals, the client and the therapist, enter into a partnership which aims at helping the client overcome her/his problems.
  - The second component of therapeutic alliance is the limited duration of the therapy.
- **The properties of therapeutic alliance are:**
  - **Trust:** This relationship is a trusting and confiding relationship. The high level of trust enables the client to unburden herself/himself to the therapist and confide her/his psychological and personal problems to the latter. The therapist encourages this by being: - Accepting - Empathic - Genuine - Warm to the client.

- **Unconditional positive regard:** The therapist conveys by her/his words and behaviours that s/he is not judging the client and will continue to show the same positive feelings towards the client even if the client is rude or confides all the 'wrong' things that s/he may have done or thought about. This is the unconditional positive regard which the therapist has for the client.
- **Empathy:** The therapist has empathy for the client. Empathy is present when one is able to understand the plight of another person and feels like the other person. It means understanding things from the other person's perspective, *i.e.*, putting oneself in the other person's shoes. Empathy enriches the therapeutic relationship and transforms it into a healing relationship.
- **Confidentiality:** The therapeutic alliance also requires that the therapist must keep strict confidentiality of the experiences, events, feelings or thoughts disclosed by the client. The therapist must not exploit the trust and the confidence of the client in any way.
- **Professional:** Finally, it is a professional relationship and must remain so.
- **Sympathy:** In sympathy, one has compassion and pity towards the suffering of another but is not able to feel like the other person.
- **Intellectual Understanding:** Intellectual understanding is cold in the sense that the person is unable to feel like the other person and does not feel sympathy either.

➢ **Types and Chronological Order of Therapies**

- Psychodynamic therapy emerged first
- Behaviour therapy came next
- Existential therapies which are also called the third force, emerged last.

➢ **Classification of Therapies**

Parameter	Psychodynamic	Behavioural	Existential
Cause	**Intrapsychic conflicts:** Conflicts within the psyche of the person (dynamics between different components of psyche)	Faulty learning of behaviours and cognitions.	Questions about the meaning of one's life and existence.
Cause comes into Existence	Unfulfilled desires of childhood. Unresolved childhood fears.	Faulty conditioning patterns, learning, thinking and beliefs.	Important on present-current feelings of loneliness, alienation, sense of futility of one's existence.
Treatment	Free association and reporting of dreams-elicit the thought and feelings of the client. Interpreted to the client to help him/her to confront and resolve the conflicts.	Alternate behavioural contingencies. Cognitive methods which challenge faulty thinking patterns.	Positive, accepting, and non judgemental environment. Client is able to talk about the problems. Therapist acts as a facilitator.
Nature of Relationship	Therapist understands conflicts better than the client-interprets the thoughts and feelings of the client to his/hers.	Therapist discerns faulty behaviour and thought patterns-capable of finding out correct and adaptive patterns.	Therapist provides a warm, empathic relation-ship-client feels secure to explore the nature and causes of his/her problems by himself/herself.
Chief Benefit to Client	**Emotional insight:** Client understands conflicts intellectually; accepts the same emotionally; changes his/her emotions towards the conflicts.	Instituting adaptive or healthy behaviour and thought patterns.	**Personal growth:** The pro-cess of gaining, increasing understanding of oneself, ones aspirations, emotions and motives.
Duration	Several years (classical psychoanalysis); 10-15 sessions (recent versions).	Few months	Few months

➢ **Agents of change leading to the alleviation of psychological distress:**

- The therapist
- The therapeutic relationship
- The process of therapy (which begins by formulating the client's problem)

➢ **The following sections explain representative therapies from each of the three major systems of psychotherapy mentioned earlier.**

Behaviour Therapy

[A] Postulates

- Behaviour therapies postulate that psychological distress arises because of faulty behaviour patterns or thought patterns.
- It is, therefore, focused on the behaviour and thoughts of the client in the present.
- The past is relevant only to the extent of understanding the origins of the faulty behaviour and thought patterns. The past is not activated or relieved. Only the faulty patterns are corrected in the present.

[B] Principles

- The clinical application of learning theory principles constitutes behaviour therapy. The foundation of behaviour therapy is on formulating dysfunctional or faulty behaviours, the factors which reinforce and maintain these behaviours, and devising methods by which they can be changed.
- It is not a unified theory, which is applied irrespective of the clinical diagnosis or the symptoms present.
- The symptoms of the client and the clinical diagnosis are the guiding factors in the selection of the specific techniques or interventions to be applied.
- Treatment of phobias or excessive and crippling fears would require the use of one set of techniques, while that of anger outbursts would require another.
- A depressed client would be treated differently from a client who is anxious.

[C] Method of Treatment

- The client with psychological distress or with physical symptoms, which cannot be attributed to physical disease, is interviewed with a view to analyse her/his behaviour patterns.
- Behavioural analysis is conducted to find malfunctioning behaviours, the antecedents of faulty learning and the factors that maintain or continue faulty learning.
- Malfunctioning behaviours are those behaviours which cause distress to the client.
- Antecedent factors are those causes which predispose the person to indulge in that behaviour.
- Maintaining factors are those factors which lead to the persistence of the faulty behaviour. An example would be a young person who smokes. Behavioural analysis conducted by interviewing the client and the family members reveals that the person started smoking when he was preparing for the annual examination. Thus, anxiety- provoking situation becomes the causative or antecedent factor. The feeling of relief becomes the maintaining factor for him to continue smoking. The client has acquired the operant response of smoking, which is maintained by the reinforcing value of relief from anxiety.

Establishment of Treatment Package

- Once the faulty behaviours which cause distress, have been identified, a treatment package is chosen.
- The aim of the treatment is to extinguish or eliminate the faulty behaviours and substitute them with adaptive behaviour patterns. The therapist does this through establishing antecedent operations and consequent operations. Antecedent operations control behaviour by changing something that precedes that behaviour.
- The change can be done by increasing or decreasing the reinforcing value of a particular consequence. This is called establishing operation. For example, if a child gives trouble in eating dinner, an establishing operation would be to decrease the quantity of food served at tea time. This would increase the hunger at dinner and thereby, increase the reinforcing value of food at dinner. The antecedent operation is the reduction of food at tea time and the consequent operation is praising the child for eating dinner.

[E] Behavioural Techniques

- A range of techniques is available for changing behaviour. The principles of these techniques are to reduce the arousal level of the client, alter behaviour through classical conditioning or operant conditioning with different contingencies of reinforcements, as well as to use vicarious learning procedures, if necessary.

	Definition	Example
Negative reinforcement	Negative reinforcement refers to following an undesired response with an outcome that is painful or not liked. In other words, responses that lead organisms to get rid of painful stimuli or avoid and escape from them constitute negative reinforcement.	For example, the teacher reprimands a child who shouts in class; a teacher threatens to keep whoever is late to class standing for the whole period.

	Definition	Example
Aversive conditioning	Aversive conditioning refers to repeated association of undesired response with an aversive consequence. (e.g. Bitter taste, foul smell, etc.)	For example, an alcoholic is given a mild electric shock and asked to smell the alcohol. With repeated pairings, the smell of alcohol is aversive as the pain of the shock is associated with it and the person will give up alcohol.
Positive reinforcement	If an adaptive behaviour occurs rarely, positive reinforcement is given to increase the deficit.	For example, if a child does not do homework regularly, positive reinforcement may be used by the child's mother by preparing the child's favourite dish whenever s/he does homework at the appointed time. The positive reinforcement of food will increase the behaviour of doing homework at the appointed time.
Token economy	Persons with behavioural problems can be given a token as a reward every time a wanted behaviour occurs. The tokens are collected and exchanged for a reward. This is known as token economy.	E.g., an outing for the patient or a treat for the child.
Differential reinforcement	Unwanted behaviour can be reduced and wanted behaviour can be increased simultaneously through differential reinforcement.	E.g., giving a child an ice-cream when she/he completes her/his homework and then a vegetable she/he doesn't like when she/he doesn't.
Ignoring unwanted behaviour	The other method is to positively reinforce the wanted behaviour and ignore the unwanted behaviour.	For example, a girl who sulks and cries when she is not taken to the cinema when she asks. The parents are instructed to take her to the cinema if she does not cry and sulk, but not to take her if she does. Further, the parents are instructed to ignore the girl when she cries and sulks. The wanted behaviour of politely asking to be taken to the cinema increases and the unwanted behaviour of crying and sulking decreases.
Systematic desensitisation	Systematic desensitisation is a technique introduced by Wolpe for treating phobias or irrational fears. **(a)** The client is interviewed to elicit fear-provoking situations and together with the client, the therapist prepares a hierarchy of anxiety-provoking stimuli with the least anxiety-provoking stimuli at the bottom of the hierarchy. **(b)** The therapist relaxes the client and asks the client to think about the least anxiety. **(c)** The client is asked to stop thinking of the fearful situation if a slightest tension is felt. **(d)** Over sessions, the client is able to imagine more severe fear-provoking situations while maintaining the relaxation. The client gets systematically desensitised to the fear.	*E.g.,* a spider phobic might regard one small, stationary spider 5 meters away as only modestly threatening, but a large, rapidly moving spider 1 meter away as highly threatening.

	Definition	Example
Reciprocal inhibition	The principle of reciprocal inhibition states that the presence of two mutually opposing forces at the same time inhibits the weaker force. Thus, the relaxation response is first built up and mildly anxiety-provoking scene is imagined, and the anxiety is overcome by the relaxation.	*E.g.*, If a person with a phobia of lizards is made to imagine holding a lizard in his hand on the principles of systematic desensitisation, his anxiety might be counteracted with calming relaxation techniques.
Modeling	Modeling is the procedure wherein the client learns to behave in a certain way by observing the behaviour of a role model or the therapist who initially acts as the role model.	
Vicarious learning	Vicarious learning, *i.e.*, learning by observing others, is used and through a process of rewarding small changes in the behaviour, the client gradually learns to acquire the behaviour of the model.	

Cognitive Therapy

Cognitive therapies locate the cause of psychological distress in irrational thoughts and beliefs. Albert Ellis formulated the Rational Emotive Therapy (RET). The central basis of this therapy is that irrational beliefs mediate between the antecedent events and their consequences.

(a) ABC analysis: The first step in RET is the antecedent- belief-consequence (ABC) analysis.

- Antecedent events, which caused the psychological distress, are noted.
- The client is also interviewed to find the irrational beliefs, which are distorting the present reality. Irrational beliefs may not be supported by empirical evidence in the environment. These beliefs are characterised by thoughts with 'musts' and 'shoulds', *i.e.*, things 'must' and 'should' be in a particular manner. Examples, "One should be loved by everybody all the time", etc.
- This distorted perception of the antecedent event due to the irrational belief leads to the consequence, *i.e.*, negative emotions and behaviours.

(b) Non directive questioning: In the process of RET, the irrational beliefs are refuted by the therapist through a process of non-directive questioning. The nature of questioning is gentle, without probing or being directive. The questions make the client think deeper into her/his assumptions about life and problems.

(c) Change: Gradually, the client is able to change the irrational beliefs by making a change in her/his philosophy about life. The rational belief system replaces the irrational belief system and there is a reduction in psychological distress.

Aaron Beck's Therapy

1. **Core Schemas:** Childhood experiences provided by the family and society develop core schemas or systems, which include beliefs and action patterns in the individual. E.g., A client, who was neglected by the parents as a child, develops the core schema of "I am not wanted".
2. **Critical Incident:** During the course of life, a critical incident occurs in her/his life. This critical incident triggers the core schema leading to the development of negative automatic thoughts.
3. **Dysfunctional Cognitive Structures:** Negative thoughts are persistent irrational thoughts, such as "nobody loves me", "I am ugly", "I am stupid", "I will not succeed", etc. Such negative automatic thoughts are characterised by cognitive distortions. Cognitive distortions are ways of thinking which are general in nature but which distort the reality in a negative manner. These patterns of thoughts are called dysfunctional cognitive structures. They lead to errors of cognition about social reality.
4. **Anxiety and Depression:** Repeated occurrence of these thoughts leads to the development of feelings of anxiety and depression.
5. **Therapist's Approach:** The therapist uses questioning, which is gentle, non-threatening disputation of the client's beliefs and thoughts. Examples of such questions would be, "Why should everyone love you?", "What does it mean for you to succeed?", etc. The questions make the client think in a direction opposite to that of the negative automatic thoughts whereby s/he gains insight into the nature of her/his dysfunctional schemas and is able to alter her/his cognitive structures.

6. **Goals:** The aim of the therapy is to achieve this cognitive restructuring which, in turn, reduces anxiety and depression. It focuses on solving a specific problem of the client.
7. **Duration:** It is short, lasting between 10–20 sessions.

Cognitive Behaviour Therapy

The most popular therapy presently is the Cognitive Behaviour Therapy (CBT).

- CBT adopts a bio- psychosocial approach to the delineation of psychopathology. It combines cognitive therapy with behavioural techniques.
- The rationale is that the client's distress has its origins in the biological, psychological and social realms. It seeks to address: - The biological aspects through relaxation procedures - The psychological aspects through behaviour therapy - Cognitive therapy techniques and the social ones with environmental manipulations.
- Research into the outcome and effectiveness of psychotherapy has conclusively established CBT to be a short and efficacious treatment for a wide range of psychological disorders such as anxiety, depression, panic attacks, and borderline personality, etc.

Humanistic-Existential Therapy

1. **Principles**
   - Human beings are motivated by the desire for personal growth and self-actualisation, and an innate need to grow emotionally.
   - When these needs are curbed by society and family, human beings experience psychological distress.
   - The humanistic-existential therapies postulate that psychological distress arises from feelings of loneliness, alienation and an inability to find meaning and genuine fulfilment in life.
2. **Self Actualisation**
   - Self-actualisation is defined as an innate or inborn force that moves the person to become more complex, balanced and integrated, *i.e.*, achieving the complexity and balance without being fragmented; integrated means a sense of whole, being a complete person, being in essence the same person in spite of the variety of experiences that one is subjected to. Frustration of self-actualisation causes distress.
3. **Healing Process**
   - Self-actualisation requires free emotional expression. The family and the society curb emotional expression, as it is feared that a free expression of emotions can harm society by unleashing destructive forces. This curb leads to destructive behaviour and negative emotions by thwarting the process of emotional integration.
   - Healing occurs when the client is able to perceive the obstacles to self- actualisation in her/his life and is able to remove them.
   - Therefore, the therapy creates a permissive, non- judgmental and accepting atmosphere in which the client's emotions can be freely expressed and the complexity, balance and integration could be achieved.
4. **Role of Therapist**
   - The fundamental assumption is that the client has the freedom and responsibility to control her/his own behaviour. The therapist is merely a facilitator and guide. It is the client who is responsible for the success of therapy.
5. **Aim**
   - The chief aim of the therapy is to expand the client's awareness. Healing takes place by a process of understanding the unique personal experience of the client by herself/himself.

Existential Therapy: Logotherapy

1. **Origin:** Victor Frankl, a psychiatrist and neurologist propounded the Logotherapy. Logos is the Greek word for soul and Logotherapy means treatment for the soul. Frankl calls this process of finding meaning even in life-threatening circumstances as the process of meaning making.
2. **Basis:** The basis of meaning making is a person's quest for finding the spiritual truth of one's existence. Just as there is an unconscious, which is the repository of instincts, there is a spiritual unconscious, which is the storehouse of love, aesthetic awareness and values of life. Neurotic anxieties arise when the problems of life are attached to the physical, psychological or spiritual aspects of one's existence.
3. **Spiritual Anxieties:** Frankl emphasised the role of spiritual anxieties leading to meaninglessness and hence, it may be called an existential anxiety, *i.e.*, neurotic anxiety of spiritual origin.

4. **Goal:** The goal of logotherapy is to help the patients find meaning and responsibility in their life irrespective of their life circumstances. The goal is to facilitate the client to find the meaning of her/his being.
5. **Role of Therapist:** In Logotherapy, the therapist is open and shares her/his feelings, values and his/her own existence with the client. The emphasis is on here and now. Transference is actively discouraged. The therapist reminds the client about the immediacy of the present.

Existential Therapy: Client-Centred Therapy

1. **Origin:** Client-centred therapy was given by Carl Rogers. Rogers combined scientific rigour with the individualised practice of client- centred psychotherapy. Rogers brought into psychotherapy the concept of self, with freedom and choice as the core of one's being.
2. **Basic Principle:** The therapy provides a warm relationship in which the client can reconnect with her/his disintegrated feelings. The therapist shows: - Empathy, which sets up an emotional resonance between the therapist and the client. - Unconditional positive regard, which indicates that the positive warmth of the therapist is not dependent on what the client reveals or does in the therapy sessions. This unique unconditional warmth ensures that the client feels secure and can trust the therapist.
3. **Role of Therapist**
   - The therapist reflects the feelings of the client in a non-judgmental manner.
   - The reflection is achieved by rephrasing the statements of the client, *i.e.*, seeking simple clarifications to enhance the meaning of the client's statements.
   - This process of reflection helps the client to become integrated.
   - Personal relationships improve with an increase in adjustment.
4. **Goal:** In essence, this therapy helps a client to become her/his real self with the therapist working as a facilitator.

Existential Therapy: Gestalt Therapy

1. **Origin:** The German word gestalt means 'whole'. This therapy was given by Freiderick (Fritz) Perls together with his wife Laura Perls.
2. **Goal:** The goal of Gestalt therapy is to increase an individual's self-awareness and self- acceptance.
3. **Therapist's Role:** The client is taught to recognise the bodily processes and the emotions that are being blocked out from awareness. The therapist does this by encouraging the client to act out fantasies about feelings and conflicts. This therapy can also be used in group settings.

Factors Contributing to Healing in Psychotherapy

- **Techniques Adopted With the Patient/Client:** A major factor in the healing is the techniques adopted by the therapist and the implementation of the same with the patient/client. If the behavioural system and the CBT therapy are adopted to heal an anxious client, the relaxation procedures and the cognitive restructuring largely contribute to the healing.
- **Establishment of Therapeutic Alliance Between Client and Therapist:** The therapeutic alliance, which is formed between the therapist and the patient/client, has healing properties, because of the regular availability of the therapist and the warmth and empathy provided by the therapist.
- **Process of Catharsis and Emotional Unburdening:** At the outset of therapy while the patient/client is being interviewed in the initial sessions to understand the nature of the problem, s/he unburdens the emotional problems being faced. This process of emotional unburdening is known as catharsis, and it has healing properties.
- **Patient Variables, Non Specific Factors, Therapist Variables:**
  - There are several non-specific factors associated with psychotherapy. These factors are called non-specific because they occur across different systems of psychotherapy and across different clients/ patients and different therapists.
  - Non-specific factors attributable to the client/patient are motivation for change, expectation of improvement due to the treatment, etc. These are called patient variables.
  - Non-specific factors attributable to the therapist are positive nature, absence of unresolved emotional conflicts, presence of good mental health, etc. These are called therapist variables.

ETHICS IN PSYCHOTHERAPY

Some of the ethical standards that need to be practiced by professional psychotherapists are:

- Informed consent needs to be taken.
- Confidentiality of the client should be maintained.
- Alleviating personal distress and suffering should be the goal of all attempts of the therapist.
- Integrity of the practitioner-client relationship is important.
- Respect for human rights and dignity.
- Professional competence and skills are essential.

ALTERNATIVE THERAPIES

Alternative therapies are so called because they are alternative treatment possibilities (especially in case medication side effects are severe) to the conventional drug treatment or psychotherapy. There are many alternative therapies such as yoga, meditation, acupuncture, herbal remedies and so on. [In the past 25 years, yoga and meditation have gained popularity as treatment programmes for psychological distress]

(a) Yoga: Yoga is an ancient Indian technique detailed in the Ashtanga Yoga of Patanjali's Yoga Sutra.

(b) Meditation: Meditation refers to the practice of focussing attention on breath or an object or thought or a mantra.

(c) Sudarshan Kriya Yoga:

(i) The rapid breathing techniques to induce hyperventilation as in Sudarshana Kriya Yoga (SKY) is found to be a beneficial, low risk, low-cost adjunct to the treatment of stress, anxiety, post-traumatic stress disorder (PTSD), depression, stress related medical illnesses, substance abuse and rehabilitation of criminal offenders.

(ii) Yoga techniques enhance well-being, mood, attention, mental focus and stress tolerance.

(iii) Proper training by a skilled teacher and a 30-minute practice every day will maximise the benefits.

(iv) Kundalini Yoga- Kundalini Yoga combines pranayama or breathing techniques with chanting of mantras.

(v) Zen- Zen/ Zen Buddhism refers to a school of Mahayana Buddhism that asserts that enlightenment can be attained through meditation, self-contemplation and intuition rather than through faith and devotion. It is practiced mainly in China, Japan, Korea and Vietnam.

Rehabilitation of the Mentally Ill

Treatment of Psychological disorder:

(a) Reduction of Symptoms

(b) Improvement of the quality of life

1. The treatment of psychological disorders has two components, *i.e.*, reduction of symptoms and improving the level of functioning or quality of life.
2. In the case of milder disorders , such as generalised anxiety, reactive depression or phobia, reduction of symptoms is associated with an improvement in the quality of life. However, in the case of severe mental disorders such as schizophrenia, reduction of symptoms may not be associated with an improvement in the quality of life.
3. Many patients suffer from negative symptoms such as disinterest and lack of motivation to do work or to interact with people.
4. Rehabilitation is required to help such patients become self-sufficient. The aim of rehabilitation is to empower the patient to become a productive member of society to the extent possible.
5. In rehabilitation, the patients are given:
   - Occupational therapy (the patients are taught skills such as candle making, paper bag making and weaving to help them to form a work discipline) - Social skills training (the patients develop interpersonal skills through role play, imitation and instruction. The objective is to teach the patient to function in a social group)
   - Cognitive retraining is given to improve the basic cognitive functions of attention, memory and executive functions (cognitive restructuring occurs).
   - Vocational therapy (the patient is helped to gain skills necessary to undertake productive employment).

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UNIT-VI

Chapter - 3 : Attitude and Social Cognition

Attitude and Social Cognition

Revision Notes

Social Psychology:

- Social psychology is the scientific study of how people's thoughts, feelings, beliefs, intentions and goals are constructed within a social context by the actual or imagined interactions with others.
- It, therefore, looks at human behaviour as influenced by other people and the conditions under which social behaviour and feelings occur.

  Baron, Byrne and Suls (1989) define Social Psychology as ....

  'The scientific field that seeks to understand the nature and causes of individual behaviour in social situations'.

  Topics examined in social psychology include: the self-concept, social cognition, attribution theory, social influence, group processes, prejudice and discrimination, interpersonal processes, aggression, attitudes and stereotypes.

Social Cognition:

- The combination of social processes like attitude, impression formation, attribution and pro social behaviour is called social cognition. Social cognition refers to the mental activities related to the gathering and interpretation of information about the social world.
- Social cognition of all individuals is affected by the social environment (Societal conditions in the society-peace, harmony, trust or aggression, frustration, disharmony and distrust towards individuals, groups, people, relationships and social issues.)
- Because of social influences, people form attitudes or ways of thinking about specific topics and people. Impression formation is when we make inferences about personal qualities of people we meet. Attribution is when we assign causes to the behaviour shown in specific social situations.
- **Attitude:** Attitude is a state of mind, a set of views or thoughts, regarding some topics (called the 'attitude object'), which have an evaluative feature (positive, negative or neutral quality).
- The thought component is referred to as the cognitive aspect, the emotional component is known as the effective aspect and the tendency to act is called the behavioural (or conative) aspect. A-B-Components (Affective-Behavioural-Cognitive components) of attitude.
- **Belief:** Belief refers to the cognitive component of attitudes and form the ground on which attitudes stand, such as belief in God or belief in democracy as a political ideology.
- **Value:** Values are attitudes or beliefs that contain a 'should' or 'ought' aspect, such as moral or ethical values. One example of a value is hard work or honesty. Values are formed when a particular belief or attitude becomes an inseparable part of a person's outlook on life.
- **Features of Attitude:**
  - **Valence** (positivity or negativity).
  - **Extremeness** indicates how positive or negative an attitude is.
  - **Simplicity or Complexity** (multiplexity) refers to how many attitudes there are within a broader attitude. An attitude system is said to be 'simple' if it contains only one or a few attitudes and 'complex' if it is made up of many attitudes.
  - **Centrality:** This refers to the role of a particular attitude in the system much more than non-central (or peripheral) attitudes would.
- **Attitude Formation:** In general, attitudes are learned through one's own experiences and through interaction with others.
- **Process of Attitude Formation:**
  - Association, e.g., a positive attitude towards a subject is learned through the positive association between a teacher and a student.
  - Reward or punishment increases/decreases the further development of that attitude.

- **Modelling:** Observing others being rewarded or punished for expressing thoughts, or showing behaviour of a particular kind towards the attitude object.
- **Group or Cultural norms:** Through the norms of our group or culture which may become part of our social cognition, in the form of attitude.
- Exposure to information, e.g., positive and negative attitudes are formed through the media.

➢ **Factors that Influence Attitude Formation:**

- Family and school environment particularly in the early years of life.
- Reference Groups indicate the norms regarding acceptable behaviour/ways of thinking, reflect learning of attitudes through cultural norms, noticeable during the beginning of adolescence.
- Personal Experiences (direct)
- Media-related Influences
- Technological advances have made audio-visual media, school level textbook and the Internet very powerful sources of information.

➢ **Attitude Change:** Attitudes that are still in the formative stage and are more like opinions, are much more likely to change compared to attitudes that have become firmly established and have become a part of the individual's values.

1. **Balance or P-O-X triangle (Fritz Heider)** represents the relationships between three aspects or components of attitude.
   - P is the person whose attitude is being studied,
   - O is another person,
   - X is the topic towards which the attitude is being studied (attitude object). It is also possible that all three are persons.

➢ The basic idea is that an attitude changes if there is a state of imbalance between the P-O attitude, O-X attitude and P-X attitude. This is because imbalance is logically uncomfortable. Imbalance is found when all three sides are negative, or two sides are positive and one side is negative. Balance is found when all three sides are positive or two sides are negative and one side is positive.

2. **Cognitive Dissonance (Leon Festinger)** emphasises on the cognitive component. Cognitive components of an attitude must be constant' (opposite of 'dissonant'), i.e., they should be logically in line with each other. If an individual finds that two cognitions in an attitude are dissonant, then one of them will be changed in the direction of consonance. Both balance and cognitive dissonance are examples of cognitive consistency which means that two components or elements of the attitude, or attitude system, must be in the same direction. If this does not happen, then the person experiences a kind of mental discomfort, i.e., the sense that 'something is not quite right' in the attitude system.
3. **The Two-Step Concept (S.M. Mohsin):** According to S.M. Mohsin, attitude change takes place in the form of two steps: **(i)** The target of change (person whose attitude is to be changed) identifies with the source (person through whose influence the attitude is to be changed). Identification means that the target and the source have a mutual regard and attraction. **(ii)** The source himself/herself shows an attitude change, by actually changing his/her behaviour towards the attitude object. Observing the source's changed attitude and behaviour, the target also shows an attitude change through behaviour. This is a kind of imitation or observational learning.

➢ **Factors that Influence Attitude Change:**

- **Characteristics of the Existing Attitude:** All four properties of attitudes mentioned earlier, namely, valence (positively or negatively), extremeness, simplicity or complexity (multiplexity) and centrality or significance of the attitude, determine attitude change. Positive, less extreme, peripheral (less significant) and simpler attitudes are easier to change. In addition, one must also consider the direction and extent of attitude change- Congruent (same direction of the existing attitude) or incongruent (opposite direction). Moreover, an attitude may change in the direction of the information that is presented, or in a direction opposite to that of the information presented.
- **Source Characteristics:** These are associated with source credibility and attractiveness. Attitudes are more likely to change when the message comes from a highly credible source rather than from a low- credible source.
- **Message Characteristics:** Attitudes will change when the amount of information that is given about the topic is just enough, neither too much nor too little. Whether the message contains a rational or an emotional appeal, also makes a difference. The motives activated by the message depend on the mode of spreading the message (face-to-face transmission is more effective than indirect transmission).

- **Target Characteristics:** Qualities of the target, such as persuasibility (open and flexible personality), strong prejudices, self-esteem, more willing because they base their attitude on more information and thinking.

➢ **Attitude-Behaviour Relationship:** Psychologists have found that there would be consistency between attitude and behaviour when:

- The attitude is strong and occupies a central place in the attitude system.
- The person is aware of his/her attitude.
- There is very little or no external pressure for the person to behave in a particular way.

➢ **Prejudice and Discrimination:** Prejudices are usually negative attitudes against a particular group and in many cases, may be based on stereotypes (the cognitive component) about the specific group. A stereotype is a cluster of ideas regarding the characteristics of a specific group. The cognitive component of prejudice is frequently accompanied by dislike or hatred, the effective components of prejudice are more difficult to change.

➢ **Sources of Prejudice:**

- **Learning:** Prejudice can also be learned through association, reward and punishment, observing others, group or cultural norms and exposure to information that encourages prejudice. The family, reference groups, personal experiences and media may play a role in the learning of prejudices. People who learn prejudiced attitudes may develop a 'prejudiced personality'.
- **A Strong Social Identity and in Group Bias:** Individuals who have a strong sense of social identity and have a very positive attitude towards their own group boost this attitude by holding negative attitudes towards other groups.
- **Scapegoating:** This is a phenomenon by which majority group places the blame on minority groups for its own social, economic or political problems. The minority is too weak or too small in number to defend itself against such accusations.
- **Kernel of Truth Concept:** Sometimes people may continue to hold stereotypes because they think that there must be some truth, or 'Kernel of truth' in which everyone says about the other group.
- **Self-fulfilling Prophecy:** The group that is the target of prejudice is itself responsible for continuing the prejudice by behaving in ways that justify the prejudice or confirm the negative expectation.

➢ **Strategies for Handling Prejudice:**

The strategies for handling prejudice would be effective if they aim at:

- minimising opportunities for learning prejudices,
- changing such attitudes,
- de-emphasising a narrow social identity based on the in-group, and
- discouraging the tendency towards self-fulfilling prophecy among the victims of prejudice.

These goals can be accomplished through:

- Education and information dissemination, for correcting stereotypes related to specific target groups and tackling the problem of a strong in-group bias.
- Increasing intergroup contact that allows for direct communication, removal of mistrust between the groups, and discovery context, there is close interaction and they are not different in power or status.
- Highlighting individual identity rather than group identity, thus weakening the importance of group (both in-group and out-group) as a basis of evaluating the other person.

➢ **Social Loafing:** The larger the group, the less effort each member puts in. This phenomenon is based on diffusion of responsibility.

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UNIT-VII

Chapter - 4 : Social Influence and Group Processes

Social Influence and Group Processes

Revision Notes

Nature and Formation of Groups

➢ **Group:** An organised system of two or more individuals who are interacting and are interdependent, who have common motives, have set role relationships amongst the members and have norms that regulate the behaviour of members.

Salient Features:

- Collection of people with common goals and motives.
- Two or more people: perceive themselves as belonging to the group—each group is unique.
- Members are interdependent.
- Members interact with each other directly or indirectly.
- Members satisfy their needs through joint association—and influence each other.
- Set of norms and roles—specific functions for each member, adhere to norms on how one must behave, expected behaviour, etc.

➢ **Advantages:** We are simultaneously members of different groups; different groups satisfy different needs but could create pressures due to competing demands and expectations.

(a) Security: Groups reduce insecurity
- Being with people—sense of comfort/protection.
- People feel stronger—less vulnerable to threats.

(b) Status: Recognised group gives feeling of power and importance.

(c) Self-esteem: Feeling of self-worth and positive social identity.
- Member of prestigious group enhances self-concept.

(d) Goal Achievement: Group helps to attain some goals which can't be attained alone (power in the majority).

(e) Provides Knowledge and Information: Broadens views, helps supplement information.

(f) Satisfaction of Psychological and Social Needs: Like sense of belongingness—giving and receiving attention, love and power.

➢ **Group Formation:** Some form of contact and interaction between people is needed.
- **Proximity:** Closeness and repeated interactions with the same people (get to know their interests, attitudes and background).
- **Similarity:** People prefer consistency—consistent relationship (reinforces and validates opinions and values; feel we're right).
- **Common Motives and Goals:** Groups facilitate goal attainment.

➢ **Stages of group formation (Tuckman):**
- **Forming:** Members' first meet—there is uncertainty about group and goal and how it will be achieved. They try to get to know one another—there is excitement and apprehension.
- **Storming:** Intra-group conflict—about how the goal is to be achieved, who will be the leader and who will perform what task (hierarchy of leadership and how to achieve the goal is developed).
- **Norming:** Develop norms related to group behaviour (development of a positive group identity).
- **Performing:** Structure of the group has evolved and is accepted (towards goal achievement); as this is the last stage of group development.
- **Adjourning:** Once the function is over the group may be disbanded.

➢ **Notes:**
- Groups do not always proceed in a systematic manner.
- Stages could even take place simultaneously.
- Groups can go back and forth between stages or skip a few stages.

➢ **Group Structure:**
- Over time, there are regularities in distribution of tasks, responsibilities assigned to members and status of members.

➢ **Elements:**

1. **Roles:** Socially defined expectations that individuals in given situations are expected to fulfil, *i.e.*, typical behaviour that depicts a person in a given social context.
   - **Role Expectations:** Behaviour expected of someone in a particular role.
2. **Norms (unspoken rules):** Expected standards of behaviour and beliefs established, agreed upon and enforced by group members.
3. **Status:** Relative social position given to group members by others.
   - Ascribed (given due to one's seniority) or achieved (because of expertise or hard work).

- Members of a group—enjoy status and want to be members of prestigious groups.
- Within groups, different members have different prestige and status.

4. **Cohesiveness:** Togetherness, binding or mutual attraction among members.
   - **More Cohesiveness:** Members start thinking, feeling and acting as a social unit (no isolated individuals); there is an increased desire to remain in group (we feel sense of belongingness).
   - Extreme cohesiveness leads to group thinking and is negative.

Types of Groups:

➢ **Primary Group:**

- Pre-existing formations that are usually given to a person. People usually remain a part of it throughout their lifetime. Includes face-to-face interaction and close physical proximity. Members share warm, emotional bonds. Central to a person's functioning; major role in developing values and ideals. Boundaries are less permeable—can't choose membership, join or leave easily. Example: family, religion, caste.

➢ **Secondary Group:**

- **Groups which individuals join by choice:** Relationships among members are more impersonal, indirect and less frequent. These may or may not be short-lived. It is easy to leave and join another group. Example: Political party.
- **Formal Group:** Functions, based to be performed are explicitly stated. Formation based on specific rules or laws and members have defined roles. Set of norms helps establish order. Example: office, university.
- **Informal Group:** Roles of each member not so definite and specified. Close relationships among members exist. Formation not based on rules and laws. Example: peer group.
- **In group:** One's own group—'we' (e.g., India). Members in the group—similar, viewed favourably, have desired traits.
- **Out group:** Another group—'they' (e.g., Pakistan). Member of out-group—viewed differently, negatively in comparison to in group.

➢ **Influence of Group on Individual Behaviour:**

1. **Social Loafing:** This is the reduction in individual effort when working on a collective task.
   - Individuals performing an activity with the others as part of a larger group.
   - Individuals work less hard in a group than alone.
   - Don't know much about effort each one is putting in.
   - Presence of others leads to arousal; motivates individuals to enhance their performance (only when a person's efforts are individually evaluated).

   Causes of Social Loafing:
   - Members feel less responsible for the overall task and thus, exert less effort.
   - Performance of the group isn't compared with other groups.
   - Motivation decreases as contributions are not individually evaluated.
   - No/improper co-ordination between members.
   - Belonging to the same group is not important for members (it is only an aggregate of individuals).

   Can be reduced by:
   - Making the effort of each person identifiable.
   - Increasing pressure to work hard—make members committed, motivated.
   - Increase apparent importance and value of task.
   - Make them feel their individual contribution is important.
   - Strengthen group cohesiveness—increase motivation for successful group outcome.

2. **Group Polarisation:**
   - Groups are likely to take more extreme decisions than individuals would take alone.
   - Strengthening of a group's initial position because of group interaction.
   - Dangerous repercussions—groups may take extreme positions (very weak to very strong decisions).

   Causes of Group Polarisation:
   - In the company of like-minded people, you're likely to hear newer arguments favouring your view-points.

- Bandwagon effect—when you find others sharing your view-point, you feel your view is validated by the public.
- When people have similar views as you, you're likely to perceive them as in-group (start identifying with them, show conformity—views become strengthened).

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