ABNORMAL AVOIDANCE AND NEED

Abnormal avoidance is an abnormal response to an object or 'thing' leading a person to take steps to avoid contact with the object or 'thing'.

Abnormal need involves a failure to resist acting on impulse, that could be harmful to the individual, has an increased sense of tension prior to the action, has the experience of gratification or release at the time of action.

PATHOLOGICAL GAMBLING

Kumeil is a 22 year old auto mechanic, a father of two, married to a factory worker. Two years ago, he went to the local race track with a friend, who showed him how to bet on horses. To his surprise, Kumail made some good bets and came home with a $50 profit. Buoyed by his success, he made repeated trips to the track and in time, began taking days off from work to bet on the races. On one of these occasions, Kumeil won $5000. This made him feel extremely proud of his betting expertise and convinced him that he had special skills at picking the right horses. Even though he was losing many of his bets, he now felt certain that his winnings would more than compensate. He had a feeling of self-confidence that, for once in his life, he was a success. To keep up his image, Kumail started to make larger and larger bets on long shots that failed to pay off. As his losses accumulated into the tens of thousands of dollars, he grew panicky and felt driven to bet even more.

Judging from written history and the studies of anthropologies, gambling has occurred and continues to occur almost universally and among all social strata. Gambling addiction, also known as compulsive gambling, may be a type of impulse-control disorder. Compulsive gamblers keep gambling whether they're up or down, broke or flush, happy or depressed. Even when they know the odds are against them, even when they can't afford to lose, people with a gambling addiction can't "stay off the bet." Problem and pathological gambling may affect anywhere from 2 to 4 percent of the population.

Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:

- **Preoccupation:** The person is preoccupied with gambling and has frequent thoughts about gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble, etc.
- **Tolerance:** Similar to drug tolerance, the person needs to gamble with increasing amounts of money in order to achieve the desired excitement or "rush"
- **Loss of Control:** The person has made repeated unsuccessful efforts to control, cut back, or stop gambling
- **Withdrawal:** The person is restless or irritable when attempting to cut down or stop gambling
- **Escape:** The person gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
- **Chasing:** After losing money gambling, the person often returns another day to get even ("chasing" one's losses)
- **Lying:** Lies to family members, therapist, or others to conceal the extent of involvement with gambling
- **Illegal Activity:** The person has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
- **Risked Relationships:** The person has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
- **Bailout:** Relies on others, such as friends or family, to provide money to relieve a desperate financial situation caused by gambling

The gambling behavior is not better accounted for by a Manic Episode.

KLEPTOMANIA

Sammar is a 45 year old well-dressed and attractive executive with a comfortable salary and a busy lifestyle. For the past few years, she has been under considerable stress and has worked long hours as the result of reorganizations in her company. As a teenager, Sammar occasionally took small, inexpensive items, such as hair clips and nail polish, from the drug store, even though she could afford to pay for them. Lately, Sammar has started shoplifting again. This time, her behavior has an intensity that she cannot control. During her lunch hour, Sammar often visits one of the large department stores near her office building, walks around until she finds something that catches her eye, and then slips it into her purse or pocket. Although she has sworn to herself that she will never steal again, every few days she finds the tension so great that she cannot stay out of the stores.

Kleptomania is an impulse control disorder characterized by a recurrent failure to resist stealing. Kleptomania is a complex disorder characterized by repeated, failed attempts to stop stealing. It is often seen in patients who are chemically dependent or who have a coexisting mood, anxiety, or eating disorder. Other coexisting mental disorders may include major depression, panic attacks, social phobia, anorexia nervosa, bulimia nervosa, substance abuse, and obsessive-compulsive disorder. People with this disorder have an overwhelming urge to steal and get a thrill from doing so. The recurrent act of stealing may be restricted to specific objects and settings, but the affected person may or may not describe these special preferences. People with this disorder usually exhibit guilt after the theft.

Detection of kleptomania, even by significant others, is difficult and the disorder often proceeds undetected. There may be preferred objects and environments where theft occurs. One theory proposes that the thrill of stealing helps to alleviate symptoms in persons who are clinically depressed.

The handbook used by mental health professionals to diagnose mental disorders is the *Diagnostic and Statistical Manual of Mental Disorders*. Published by the American Psychiatric Association, the *DSM* contains diagnostic criteria and research findings for mental disorders. It is the primary reference for mental health professionals in the United States. The 2000 edition of this manual (fourth edition, text revision), known as the *DSM-IV-TR*, lists some diagnostic criteria for kleptomania:

- Repeated theft of objects that are unnecessary for either personal use or monetary value.
- Increasing tension immediately before the theft.

- Pleasure or relief upon committing the theft.
- The theft is not motivated by anger or vengeance, and is not caused by a delusion or hallucination.
- Thefts are not committed as a result of delusions, hallucinations or as acts of revenge or anger

EVALUATION

The cause of kleptomania is unknown, although it may have a genetic component and may be transmitted among first-degree relatives. There also seems to be a strong propensity for kleptomania to coexist with obsessive-compulsive disorder, bulimia nervosa, and clinical depression. A number of individual case reports have been published relating compulsive stealing to various brain disorders and brain defects (Goldman, 1991). According to the medical model the cause of kleptomania may involve low brain serotonin levels (Aizley, 1992).

Early psychoanalytic writers viewed compulsive stealing as a means of compensating for lack of affection in early life or as a defense against "castration anxiety". However, these elaborate speculations are very difficult to evaluate and explore empirically.

Kleptomaniacs have argued that stealing may have an antidepressant effect by temporarily relieving feelings of tension (Fishbrain 1987).

Studies suggest that 0.6% of the general population may have this disorder and that it is more common in females. In patients who have histories of obsessive-compulsive disorder, some studies suggest a 7% correlation with kleptomania. Other studies have reported a particularly high (65%) correlation of kleptomania in patients with bulimia.

TREATMENT

Once the disorder is suspected and verified by an extensive psychological interview, therapy is normally directed towards impulse control, as well as any accompanying mental disorder(s).

Relapse prevention strategies, with a clear understanding of specific triggers, should be stressed. Treatment may include psychotherapies such as cognitive-behavioral therapy and rational emotive therapy. Recent studies have indicated that fluoxetine (Prozac) and naltrexone (Revia) may also be helpful. In some cases, Prozac, an antidepressant that boosts levels of serotonin, has been found to be useful in treatment of kleptomania.

- Covert sensitization, in which you picture yourself stealing and then facing negative consequences, such as being caught.

- Aversion therapy, in which you practice mildly painful techniques, such as holding your breath until you become uncomfortable, when you get an urge to steal.

- Systematic desensitization, in which you practice relaxation techniques and picture yourself controlling urges to steal.

SYSTEMATIC DESENSITIZATION

Jones (1924) showed that fear responses could be eliminated if children were given candy and other incentives in the presence of the feared object. Jones' method involved gradually introducing the feared object, bringing it closer and closer to the children whilst at the same time giving them candy, until they elicited no anxiety to its presence. For many years, Jones' work went unrecognized. In the 1950s, however, Wolpe (1958) popularized and refined it under the name systematic desensitization.

The therapy requires that an individual initially constructs an anxiety hierarchy, that is, a series of scenes or events that are rated from lowest to highest in terms of the amount of anxiety they elicit. For example, on a scale of one (little anxiety) to ten (extreme anxiety), a person with a phobia of spiders might rate seeing a picture of a spider as 1 but rate being in a room with a spider as 10.

Once the hierarchy has been constructed, relaxation training is given. This will be the adaptive substitute response and is the one that most therapists use. The training aims to achieve complete relaxation, the essential task being to respond quickly to suggestions to feel relaxed and peaceful. After relaxation training, the person is asked to imagine as vividly as possible the scene at the bottom of the hierarchy that was constructed. Simultaneously, the person is told to remain calm and relaxed.

One of the problems with systematic desensitization is its dependence on a person's ability to ***conjure*** (imagine/ make up plan in mind) up 'vivid images of encounters with a phobic object or situation. One way of overcoming this is to use photographs or slides displaying the feared object or situation. Another approach involves live or in vivo encounters. For example, a person who is afraid of spiders may be desensitized by gradually approaching spiders. According to Wilson & O'Leary (1978), in vivo desensitization is almost always more effective and longer lasting than other desensitization techniques.

COVERT SENSITIZATION

Silverstein (1972) has argued that aversion therapy is unethical and has the potential for misuse and abuse. As a response to this criticism, some therapists use covert sensitization as an alternative and 'milder' form of aversion therapy. The therapy is a mixture of aversion therapy and systematic desensitization. Essentially, people are trained to punish themselves through using their imaginations (hence the term covert). Sensitization is achieved by associating the undesirable behaviour with an exceedingly disagreeable consequence.

A heavy drinker, for example, might be asked to imagine being violently sick all over him- or herself on entering a bar, and feeling better only after leaving the bar and breathing fresh air. The individual is also instructed to rehear an alternative 'relief' scene in which the decision not to drink, say, is accompanied by pleasurable sensations. According to some researchers (e.g. Cautela, 1967), covert sensitization can be helpful in controlling overeating and cigarette smoking as well as excessive drinking.

Other forms of therapy, such as psychodynamic therapy, family therapy or marriage counseling, also may be helpful.

PHOBIAS

Zain is a quiet sort of a guy. He is reasonably well-liked, mainly because he doesn't step on anyone's toes and is always willing to go along with other people's suggestions. His acquaintances sometimes laugh about how shy he is, and how odd it is that a grown man can blush for no apparent reason. "What color's red, Zain? "is always guaranteed to get a few laughs. For everyone except Zain, of course. He's also popular with the boss at work, as he gets on with the job without too much fuss and doesn't waste time standing around telling jokes and getting mixed up in office politics. His boss can't quite understand why Zain turns down opportunities for advancement, but he figures that he must be happy to stay just where he is. The reason is that all of those things cause Zain to feel intensely anxious. So anxious that he can't think straight. Often he can't even talk properly because his heart is pounding so hard he can't hear his own voice. Zain suffers from social phobia.

A phobia is a type of anxiety disorder characterized by an overwhelming fear of something that poses no real or immediate danger. Spiders and flying in a plane are common phobias. Often, people with phobias are afraid of something that could potentially be dangerous (spiders can bite, planes occasionally crash) – but the fear and feelings of anxiety are excessive. People who struggle with this type of anxiety disorder often feel embarrassed and stupid because they know their fear is excessive.

The specific phobias are unjustified fears caused by the presence or expectation of an appearance of a certain object or situation. Many specific fears do not cause problems that are invalidating to the point where a person will try to seek outside help. If, for example, a person living in an urban area who suffers from an extreme fear of snakes will not likely have much real, direct contact with the object of the fear itself and will thus become convinced he or she does not suffer from a serious problem. The situation would be entirely different if the same person were living in an area where a large number of snakes might be found. The term 'phobia' generally implies a subjective psychological sufferance and impaired social or occupational functioning as a consequence of the related anxiety.

The prevalence of these disorders is set at around 7% in men and 16% in women (Kessler et al., 1994; Magee et al.,1996). The content of the specific phobias may vary quite considerably between one culture and another. in China for example 'pa-leng' is a fear of the cold, in which the person fears that the loss of body heat may threaten his/her existence. This fear appears to be correlated with the Chinese philosophical Yin/Yang concept, whereby 'yin' indicates the 'cold' and 'windy' aspects of life which decrease one's energy level. The most widespread convictions within a particular culture therefore appear capable of channelling individual fears towards particular situations or objects.

Social Phobia, also referred to as a social anxiety disorder, is defined as an irrational and persistent fear generally linked to the presence of other persons. This condition can be extremely debilitating as those who suffer from it try to avoid a particular situation in which they might be the object of evaluation on the part of other people and revealing signs of anxiety or embarrassing behaviour. The social phobias can be of the generalized or the specific type, depending on the array of situations that are feared and avoided. In individuals suffering from the generalized type, the disorder has an earlier onset and is often accompanied by a higher tendency to present depression and alcohol abuse.

The social phobias are rather common, with a lifetime prevalence of 11% in men and 15% in women (Kessler et al., 1994; Magee et al., 1996). Their onset often occurs during adolescence, when social awareness and the interaction with others assume a much greater importance in people's lives. It is not a rare occurrence however to find these fears becoming manifest also amongst children. As in the case of specific phobias, the content of social phobias varies on the basis of one's culture of origin. In Japan for example, the fear of offending or harming others is a primary preoccupation, while in the United States the fear of being judged in a negative way is much more common.

SELECTIVE MUTISM

Selective mutism was first described in the 1870s, at which time it was called "aphasia voluntaria." This name shows that the absence of speech was considered to be under the control of the child's will. In 1934 the disorder began to be called selective mutism, a name that still implied purposefulness on the part of the silent child.

Selective Mutism symptoms and diagnostic criteria follow below. While some of these Selective Mutism symptoms may be recognized by family, teachers, legal and medical professionals, and others, only properly trained mental health professionals (psychologists, psychiatrists, professional counselors etc.) can or should even attempt to make a mental health diagnosis. Many additional factors are considered in addition to the Selective Mutism symptoms in making proper diagnosis, including frequently medical and psychological testing considerations.

Associated features of Selective Mutism may include excessive shyness, fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, negativism, temper tantrums, or controlling or oppositional behavior, particularly at home. There may be severe impairment in social and school functioning. Teasing by peers is common. Although children with this disorder generally have normal language skills, there may occasionally be an associated Communication Disorder or a general medical condition that causes abnormalities of articulation. Mental Retardation, hospitalization, or extreme psychosocial stressors may be associated with the disorder. In addition, in clinical settings, children with Selective Mutism are almost always given an additional diagnosis of an Anxiety Disorder (especially Social Phobia).

Diagnostic criteria for Selective Mutism

A. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.
B. The disturbance interferes with educational or occupational achievement or with social communication.
C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
E. The disturbance is not better accounted for by a Communication Disorder (e.g., Stuttering) and does not occur exclusively during the course of a Pervasive Development Disorder, Schizophrenia, or other Psychotic Disorder.

Immigrant children who are unfamiliar with or uncomfortable in the official language of their new host country may refuse to speak to strangers in their new environment. This behavior should not be diagnosed as Selective Mutism. Selective Mutism is slightly more common in females than in males.

Selective Mutism is apparently rare and is found in fewer than 1% of individuals seen in mental health settings. Onset of Selective Mutism is usually before age 5 years, but the disturbance may not come to clinical attention until entry into school. The degree of persistence of the disorder is variable. It may persist for only a few months or may continue for several years. In some cases, particularly in those with severe Social Phobia, anxiety symptoms may become chronic.

The cause has not been established. Recent systematic research studies suggest the possibility of a genetic influence or vulnerability for Selective Mutism. The majority of families who have contacted the Foundation have described either themselves or other family members as previously or currently experiencing Selective Mutism, extreme shyness, social anxiety, or other anxiety disorders.

The symptoms of selective mutism are fairly obvious. The child does not talk in one or more social situations in which speech is commonly expected and would facilitate understanding. Some children with selective mutism do not communicate in any way in certain settings, and act generally shy and withdrawn. The disorder is also often associated with crying, clinging to the parent, and other signs of social anxiety. Other children with the disorder, however, may smile, gesture, nod, and even giggle, although they do not talk.

Consensus regarding the most common causes of selective mutism has changed significantly over time. When the disorder was first studied, and for many years thereafter, it was thought to be caused by severe trauma in early childhood. Some of these causative traumas were thought to include rape, molestation, incest, severe physical or emotional abuse , and similar experiences. In addition, many researchers attributed selective mutism to family dynamics that included an overprotective mother and an abnormally strict or very distant father. As of 2002, these factors have not been completely eliminated as causes of selective mutism in most cases, but it is generally agreed that they are not the most common causes.

Instead, selective mutism is frequently attributed at present to high levels of social anxiety in children and not to traumatic events in their early years. Children with selective mutism have been found to be more timid and shy than most children in social situations, and to exhibit signs of depression, obsessive-compulsive disorder , and anxiety disorders. Some children have been reported to dislike speaking because they are uncomfortable with the sound of their own voice or because they think their voice sounds abnormal.

Many links have also been found between selective mutism and speech development problems. Language reception problems have also been documented in selectively mute children. Although there is no evidence indicating that selective mutism is the direct result of any of these difficulties in language development, possible connections are being explored

Assignment!

Press the button

Skinner outlined schedules of reinforcement, one of which is the variable ratio schedule. This means that a reward might be given 10 times in every 100. The compulsive gambler just needs to watch very carefully and choose when to press the button.

(a) Describe what psychologists have found out about abnormal avoidance and need. [8]

(b) Evaluate what psychologists have found out about abnormal avoidance and need. [10]

(c) Giving reasons for your answer, suggest how an abnormal need may be treated. [6]