“A Study of Personality Correlates of Phobic Reactions among Children”

CHAPTER I

Introduction

Personality psychology

Personality psychology is a branch of psychology that studies personality and individual differences. Its areas of focus include:

- Constructing a coherent picture of a person and his or her major psychological processes
- Investigating individual differences, that is, how people can differ from one another
- Investigating human nature, that is, how all people's behaviour is similar

"Personality" can be defined as a dynamic and organized set of characteristics possessed by a person that uniquely influences his or her cognitions, motivations, and behaviors in various situations. The word "personality" originates from the Latin persona, which means mask. Significantly, in the theatre of the ancient Latin-speaking world, the mask was not used as a plot device to disguise the identity of a character, but rather was a convention employed to represent or typify that character.

The pioneering American psychologist Gordon Allport (1937) described two major ways to study personality: the nomothetic and the idiographic. Nomothetic psychology seeks general laws that can be applied to many different people, such as the principle of self-actualization, or the trait of extraversion. Idiographic psychology is an attempt to understand the unique aspects of a particular individual.

The study of personality has a broad and varied history in psychology, with an abundance of theoretical traditions. The major theories include dispositional (trait) perspective, psychodynamic, humanistic, biological, behaviorist and social learning
perspective. There is no consensus on the definition of "personality" in psychology. Most researchers and psychologists do not explicitly identify themselves with a certain perspective and often take an eclectic approach. Some research is empirically driven such as the "Big 5" personality model whereas other research emphasizes theory development such as psychodynamics. There is also a substantial emphasis on the applied field of personality testing. In psychological education and training, the study of the nature of personality and its psychological development is usually reviewed as a prerequisite to courses in abnormal or clinical psychology.

**Philosophical assumptions**

Many of the ideas developed by historical and modern personality theorists stem from the basic philosophical assumptions they hold. The study of personality is not a purely empirical discipline, as it brings in elements of art, science, and philosophy to draw general conclusions. The following five categories are some of the most fundamental philosophical assumptions on which theorists disagree:

1. **Freedom versus Determinism**

   This is the debate over whether we have control over our own behavior and understand the motives behind it (Freedom), or if our behavior is causally determined by forces beyond our control (Determinism). Determinism has been considered unconscious, environmental, or biological by various theories.

2. **Hereditity versus Environment**

   Personality is thought to be determined largely by genetics and biology, by environment and experiences, or by some combination resulting thereof. There is evidence for all possibilities. Contemporary research suggests that most personality traits are based on the joint influence of genetics and environment. One of the forerunners in this arena is C. Robert Cloninger with the Temperament and Character model.
3. Uniqueness versus Universality

The argument over whether we are all unique individuals (Uniqueness) or if humans are basically similar in their nature (Universality). Gordon Allport, Abraham Maslow, and Carl Rogers were all advocates of the uniqueness of individuals. Behaviorists and cognitive theorists, in contrast, emphasized the importance of universal principles such as reinforcement and self-efficacy.

4. Active versus Reactive

Do we primarily act through our own initiative (Active), or react to outside stimuli (Reactive)? Behavioral theorists typically believe that humans are passively shaped by their environments, whereas humanistic and cognitive theorists believe that humans are more active.

5. Optimistic versus Pessimistic

Personality theories differ on whether people can change their personalities (Optimism), or if they are doomed to remain the same throughout their lives (Pessimism). Theories that place a great deal of emphasis on learning are often, but not always, more optimistic than theories that do not emphasize learning.

Personality theories

Critics of personality theory claim personality is "plastic" across time, places, moods, and situations. Changes in personality may indeed result from diet (or lack thereof), medical effects, significant events, or learning. However, most personality theories emphasize stability over fluctuation. The definition of personality that is most widely supported to date is attributed to the neurologist Paul Roe. He stated personality to be "an individual's predisposition to think certain patterns of thought, and therefore engage in certain patterns of behaviour".
**Trait theories**

According to the *Diagnostic and Statistical Manual* of the American Psychiatric Association, personality traits are "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts." Theorists generally assume a) traits are relatively stable over time, b) traits differ among individuals (e.g. some people are outgoing while others are reserved), and c) traits influence behavior.

The most common models of traits incorporate three to five broad dimensions or factors. The least controversial dimension, observed as far back as the ancient Greeks, is simply extraversion and introversion (outgoing and physical-stimulation-oriented vs. quiet and physical-stimulation-averse).

- Gordon Allport delineated different kinds of traits, which he also called dispositions. *Central traits* are basic to an individual's personality, while *secondary traits* are more peripheral. *Common traits* are those recognized within a culture and thus may vary from culture to culture. *Cardinal traits* are those by which an individual may be strongly recognized.

- Raymond Cattell's research propagated a two-tiered personality structure with sixteen "primary factors" (16 Personality Factors) and five "secondary factors."

- Hans Eysenck believed just three traits—extraversion, neuroticism and psychoticism—were sufficient to describe human personality. Differences between Cattell and Eysenck emerged due to preferences for different forms of factor analysis, with Cattell using oblique, Eysenck orthogonal rotation to analyse the factors that emerged when personality questionnaires were subjected to statistical analysis. Today, the Big Five factors have the weight of a considerable amount of empirical research behind them, building on the work of Cattell and others.

- Lewis Goldberg proposed a five-dimension personality model, nicknamed the "Big Five":

---

4
1. **Openness to Experience**: the tendency to be imaginative, independent, and interested in variety vs. practical, conforming, and interested in routine.

2. **Conscientiousness**: the tendency to be organized, careful, and disciplined vs. disorganized, careless, and impulsive.

3. **Extraversion**: the tendency to be sociable, fun-loving, and affectionate vs. retiring, somber, and reserved.

4. **Agreeableness**: the tendency to be soft-hearted, trusting, and helpful vs. ruthless, suspicious, and uncooperative.

5. **Neuroticism**: the tendency to be calm, secure, and self-satisfied vs. anxious, insecure, and self-pitying.

The Big Five contain important dimensions of personality. However, some personality researchers argue that this list of major traits is not exhaustive. Some support has been found for two additional factors: excellent/ordinary and evil/decent. However, no definitive conclusions have been established.

- John L. Holland's **RIASEC** vocational model, commonly referred to as the Holland Codes, stipulates that six personality traits lead people to choose their career paths. In this circumplex model, the six types are represented as a hexagon, with adjacent types more closely related than those more distant. The model is widely used in vocational counseling.

Trait models have been criticized as being purely descriptive and offering little explanation of the underlying causes of personality. Eysenck's theory, however, does propose biological mechanisms as driving traits, and modern behavior genetics researchers have shown a clear genetic substrate to them. Another potential weakness of trait theories is that they may lead some people to accept oversimplified classifications—or worse, offer advice—based on a superficial analysis of personality. Finally, trait models often underestimate the effect of specific situations on people's behavior. It is important to remember that traits are statistical generalizations that do not always correspond to an individual's behavior.
Type theories

Personality type refers to the psychological classification of different types of people. Personality types are distinguished from personality traits, which come in different levels or degrees. For example, according to type theories, there are two types of people, introverts and extraverts. According to trait theories, introversion and extraversion are part of a continuous dimension, with many people in the middle. The idea of psychological types originated in the theoretical work of Carl Jung and William Marston, whose work is reviewed in Dr. Travis Bradberry's *Self-Awareness*. Jung's seminal 1921 book on the subject is available in English as *Psychological Types*.

Building on the writings and observations of Jung, during World War II, Isabel Briggs Myers and her mother, Katharine C. Briggs, delineated personality types by constructing the Myers-Briggs Type Indicator. This model was later used by David Keirsey with a different understanding from Jung, Briggs and Myers. In the former Soviet Union, Lithuanian Aušra Augustinavičiūtė independently derived a model of personality type from Jung's called Socionics.

The model is an older and more theoretical approach to personality, accepting extraversion and introversion as basic psychological orientations in connection with two pairs of psychological functions:

- **Perceiving functions**: sensing and intuition (trust in concrete, sensory-oriented facts vs. trust in abstract concepts and imagined possibilities)
- **Judging functions**: thinking and feeling (basing decisions primarily on logic vs. considering the effect on people).

Briggs and Myers also added another personality dimension to their type indicator to measure whether a person prefers to use a judging or perceiving function when interacting with the external world. Therefore they included questions designed to indicate whether someone wishes to come to conclusions (judgment) or to keep options open (perception).[^1]
This personality typology has some aspects of a trait theory: it explains people's behaviour in terms of opposite fixed characteristics. In these more traditional models, the sensing/intuition preference is considered the most basic, dividing people into "N" (intuitive) or "S" (sensing) personality types. An "N" is further assumed to be guided either by thinking or feeling, and divided into the "NT" (scientist, engineer) or "NF" (author, humanitarian) temperament. An "S", by contrast, is assumed to be guided more by the judgment/perception axis, and thus divided into the "SJ" (guardian, traditionalist) or "SP" (performer, artisan) temperament. These four are considered basic, with the other two factors in each case (including always extraversion/introversion) less important. Critics of this traditional view have observed that the types can be quite strongly stereotyped by professions (although neither Myers nor Keirsey engaged in such stereotyping in their type descriptions), and thus may arise more from the need to categorize people for purposes of guiding their career choice. This among other objections led to the emergence of the five-factor view, which is less concerned with behavior under work conditions and more concerned with behavior in personal and emotional circumstances. (It should be noted, however, that the MBTI is not designed to measure the "work self", but rather what Myers and McCaulley called the "shoes-off self.") Some critics have argued for more or fewer dimensions while others have proposed entirely different theories (often assuming different definitions of "personality").

Type A and Type B personality theory: During the 1950s, Meyer Friedman and his co-workers defined what they called Type A and Type B behavior patterns. They theorized that intense, hard-driving Type A personalities had a higher risk of coronary disease because they are "stress junkies." Type B people, on the other hand, tended to be relaxed, less competitive, and lower in risk. There was also a Type AB mixed profile. Dr. Redford Williams, cardiologist at Duke University, refuted Friedman's theory that Type A personalities have a higher risk of coronary heart disease; however, current research indicates that only the hostility component of Type A may have health implications. Type A/B theory has been extensively criticized by psychologists because it tends to oversimplify the many dimensions of an individual's personality.
Psychoanalytic theories

Psychoanalytic theories explain human behavior in terms of the interaction of various components of personality. Sigmund Freud was the founder of this school. Freud drew on the physics of his day (thermodynamics) to coin the term psychodynamics. Based on the idea of converting heat into mechanical energy, he proposed psychic energy could be converted into behavior. Freud's theory places central importance on dynamic, unconscious psychological conflicts.

Freud divides human personality into three significant components: the id, ego, and super-ego. The id acts according to the pleasure principle, demanding immediate gratification of its needs regardless of external environment; the ego then must emerge in order to realistically meet the wishes and demands of the id in accordance with the outside world, adhering to the reality principle. Finally, the superego (conscience) inculcates moral judgment and societal rules upon the ego, thus forcing the demands of the id to be met not only realistically but morally. The superego is the last function of the personality to develop, and is the embodiment of parental/social ideals established during childhood. According to Freud, personality is based on the dynamic interactions of these three components.

The channeling and release of sexual (libidal) and aggressive energies, which ensues from the "Eros" (sex; instinctual self-preservation) and "Thanatos" (death; instinctual self-annihilation) drives respectively, are major components of his theory. It is important to note that Freud's broad understanding of sexuality included all kinds of pleasurable feelings experienced by the human body.

Freud proposed five psychosexual stages of personality development. He believed adult personality is dependent upon early childhood experiences and largely determined by age five. Fixations that develop during the Infantile stage contribute to adult personality and behavior.

One of Sigmund Freud's earlier associates, Alfred Adler, did agree with Freud early childhood experiences are important to development, and believed birth order may influence personality development. Adler believed the oldest was the one that set high
goals to achieve to get the attention they lost back when the younger siblings were born. He believed the middle children were competitive and ambitious possibly so they are able to surpass the first-born's achievements, but were not as much concerned about the glory. He also believed the last born would be more dependent and sociable but be the baby. He also believed that the only child loves being the center of attention and matures quickly, but in the end fails to become independent.

Heinz Kohut thought similarly to Freud's idea of transference. He used narcissism as a model of how we develop our sense of self. Narcissism is the exaggerated sense of one self in which is believed to exist in order to protect one's low self esteem and sense of worthlessness. Kohut had a significant impact on the field by extending Freud's theory of narcissism and introducing what he called the 'self-object transferences' of mirroring and idealization. In other words, children need to idealize and emotionally "sink into" and identify with the idealized competence of admired figures such as parents or older siblings. They also need to have their self-worth mirrored by these people. These experiences allow them to thereby learn the self-soothing and other skills that are necessary for the development of a healthy sense of self.

Another important figure in the world of personality theory was Karen Horney. She is credited with the development of the "real self" and the "ideal self". She believes all people have these two views of their own self. The "real self" is how you really are with regards to personality, values, and morals; but the "ideal self" is a construct you apply to yourself to conform to social and personal norms and goals. Ideal self would be "I can be successful, I am CEO material"; and real self would be "I just work in the mail room, with not much chance of high promotion".

**Behaviorist theories**

Behaviorists explain personality in terms of the effects external stimuli have on behavior. It was a radical shift away from Freudian philosophy. This school of thought was developed by B. F. Skinner who put forth a model which emphasized the mutual interaction of the person or "the organism" with its environment. Skinner believed children do bad things because the behavior obtains attention that serves as a
reinforcer. For example: a child cries because the child's crying in the past has led to attention. These are the *response*, and *consequences*. The response is the child crying, and the attention that child gets is the reinforcing consequence. According to this theory, people's behavior is formed by processes such as operant conditioning. Skinner put forward a "three term contingency model" which helped promote analysis of behavior based on the "Stimulus - Response - Consequence Model" in which the critical question is: "Under which circumstances or antecedent 'stimuli' does the organism engage in a particular behavior or 'response', which in turn produces a particular 'consequence'?"

Richard Herrnstein extended this theory by accounting for attitudes and traits. An attitude develops as the response strength (the tendency to respond) in the presences of a group of stimuli become stable. Rather than describing conditionable traits in non-behavioral language, response strength in a given situation accounts for the environmental portion. Herrstein also saw traits as having a large genetic or biological component as do most modern behaviorists.

Ivan Pavlov is another notable influence. He is well known for his classical conditioning experiments involving dogs. These physiological studies led him to discover the foundation of behaviorism as well as classical conditioning.

**Social cognitive theories**

In cognitive theory, behavior is explained as guided by cognitions (e.g. expectations) about the world, especially those about other people. Cognitive theories are theories of personality that emphasize cognitive processes such as thinking and judging.

Albert Bandura, a social learning theorist suggested the forces of memory and emotions worked in conjunction with environmental influences. Bandura was known mostly for his "Bobo Doll experiment". During these experiments, Bandura video taped a college student kicking and verbally abusing a bobo doll. He then showed this video to a class of kindergarten children who were getting ready to go out to play. When they entered the play room, they saw bobo dolls, and some hammers. The
people observing these children at play saw a group of children beating the doll. He called this study and his findings observational learning, or modeling.

Early examples of approaches to cognitive style are listed by Baron (1982). These include Witkin's (1965) work on field dependency, Gardner's (1953) discovering people had consistent preference for the number of categories they used to categorise heterogeneous objects, and Block and Petersen's (1955) work on confidence in line discrimination judgments. Baron relates early development of cognitive approaches of personality to ego psychology. More central to this field have been:

- Self-efficacy work, dealing with confidence people have in abilities to do tasks;
- Locus of control theory dealing with different beliefs people have about whether their worlds are controlled by themselves or external factors;
- Attributional style theory dealing with different ways in which people explain events in their lives. This approach builds upon locus of control, but extends it by stating we also need to consider whether people attribute to stable causes or variable causes, and to global causes or specific causes.

Various scales have been developed to assess both attributional style and locus of control. Locus of control scales include those used by Rotter and later by Duttweiler, the Nowicki and Strickland (1973) Locus of Control Scale for Children and various locus of control scales specifically in the health domain, most famously that of Kenneth Wallston and his colleagues, The Multidimensional Health Locus of Control Scale. Attributional style has been assessed by the Attributional Style Questionnaire, the Expanded Attributional Style Questionnaire, the Attributions Questionnaire, the Real Events Attributional Style Questionnaire and the Attributional Style Assessment Test.

Walter Mischel (1999) has also defended a cognitive approach to personality. His work refers to "Cognitive Affective Units", and considers factors such as encoding of stimuli, affect, goal-setting, and self-regulatory beliefs. The term "Cognitive Affective Units" shows how his approach considers affect as well as cognition.
Personal Construct Psychology (PCP) is a theory of personality developed by the American psychologist George Kelly in the 1950s. From the theory, Kelly derived a psychotherapy approach and also a technique called The Repertory Grid Interview that helped his patients to uncover their own "constructs" (defined later) with minimal intervention or interpretation by the therapist. The Repertory Grid was later adapted for various uses within organizations, including decision-making and interpretation of other people's world-views. From his 1963 book, A Theory of Personality, pp. 103–104:

- Fundamental Postulate: A person's processes are psychologically channelized by the ways in which the person anticipates events.
- Construction Corollary: A person anticipates events by construing their replications.
- Individuality Corollary: People differ from one another in their construction of events.
- Organization Corollary: Each person characteristically evolves, for convenience in anticipating events, a construction system embracing ordinal relationships between constructs.
- Dichotomy Corollary: A person's construction system is composed of a finite number of dichotomous constructs.
- Choice Corollary: People choose for themselves the particular alternative in a dichotomized construct through which they anticipate the greater possibility for extension and definition of their system.
- Range Corollary: A construct is convenient for the anticipation of a finite range of events only.
- Experience Corollary: A person's construction system varies as the person successively construes the replication of events.
- Modulation Corollary: The variation in a person's construction system is limited by the permeability of the constructs within whose ranges of conveniences the variants lie.
- Fragmentation Corollary: A person may successively employ a variety of construction subsystems which are inferentially incompatible with each other.
• Commonality Corollary: To the extent that one person employs a construction of experience which is similar to that employed by another, the psychological processes of the two individuals are similar to each other.

• Sociality Corollary: To the extent that one person construes another's construction processes, that person may play a role in a social process involving the other person.

**Humanistic theories**

In humanistic psychology it is emphasized people have free will and they play an active role in determining how they behave. Accordingly, humanistic psychology focuses on subjective experiences of persons as opposed to forced, definitive factors that determine behavior. Abraham Maslow and Carl Rogers were proponents of this view, which is based on the "phenomenal field" theory of Combs and Snygg (1949).

Maslow spent much of his time studying what he called "self-actualizing persons", those who are "fulfilling themselves and doing the best they are capable of doing". Maslow believes all who are interested in growth move towards self-actualizing (growth, happiness, satisfaction) views. Many of these people demonstrate a trend in dimensions of their personalities. Characteristics of self-actualizers according to Maslow include the four key dimensions:

1. Awareness - maintaining constant enjoyment and awe of life. These individuals often experienced a "peak experience". He defined a peak experience as an "intensification of any experience to the degree there is a loss or transcendence of self". A peak experience is one in which an individual perceives an expansion of his or herself, and detects a unity and meaningfulness in life. Intense concentration on an activity one is involved in, such as running a marathon, may invoke a peak experience.

2. Reality and problem centered - they have tendency to be concerned with "problems" in their surroundings.

3. Acceptance/Spontaneity - they accept their surroundings and what cannot be changed.
4. Unhostile sense of humor/democratic - they do not like joking about others, which can be viewed as offensive. They have friends of all backgrounds and religions and hold very close friendships.

Maslow and Rogers emphasized a view of the person as an active, creative, experiencing human being who lives in the present and subjectively responds to current perceptions, relationships, and encounters. They disagree with the dark, pessimistic outlook of those in the Freudian psychoanalysis ranks, but rather view humanistic theories as positive and optimistic proposals which stress the tendency of the human personality toward growth and self-actualization. This progressing self will remain the center of its constantly changing world; a world that will help mold the self but not necessarily confine it. Rather, the self has opportunity for maturation based on its encounters with this world. This understanding attempts to reduce the acceptance of hopeless redundancy. Humanistic therapy typically relies on the client for information of the past and its effect on the present, therefore the client dictates the type of guidance the therapist may initiate. This allows for an individualized approach to therapy. Rogers found patients differ in how they respond to other people. Rogers tried to model a particular approach to therapy- he stressed the reflective or empathetic response. This response type takes the client's viewpoint and reflects back his or her feeling and the context for it. An example of a reflective response would be, "It seems you are feeling anxious about your upcoming marriage". This response type seeks to clarify the therapist's understanding while also encouraging the client to think more deeply and seek to fully understand the feelings they have expressed.

**Biopsychological theories**

Some of the earliest thinking about possible biological bases of personality grew out of the case of Phineas Gage. In an 1848 accident, a large iron rod was driven through Gage's head, and his personality apparently changed as a result (although descriptions of these psychological changes are usually exaggerated.

In general, patients with brain damage have been difficult to find and study. In the 1990s, researchers began to use Electroencephalography (EEG), Positron Emission Tomography (PET) and more recently functional Magnetic Resonance Imaging
(fMRI), which is now the most widely used imaging technique to help localize personality traits in the brain. One of the founders of this area of brain research is Richard Davidson of the University of Wisconsin–Madison. Davidson's research lab has focused on the role of the prefrontal cortex (PFC) and amygdala in manifesting human personality. In particular, this research has looked at hemispheric asymmetry of activity in these regions. Neuropsychological experiments have suggested that hemispheric asymmetry can affect an individual's personality (particularly in social settings) for individuals with NLD (non-verbal learning disorder), which is marked by the impairment of nonverbal information controlled by the right hemisphere of the brain. Progress will arise in the areas of gross motor skills, inability to organize visual-spatial relations, or adapt to novel social situations. Frequently, a person with NLD is unable to interpret non-verbal cues, and therefore experiences difficulty interacting with peers in socially normative ways.

One integrative, biopsychosocial approach to personality and psychopathology, linking brain and environmental factors to specific types of activity, is the hypostatic model of personality, created by Codrin Stefan Tapu.

**Personality tests**

There are two major types of personality tests. Projective tests assume personality is primarily unconscious and assess an individual by how he or she responds to an ambiguous stimulus, like an ink blot. The idea is unconscious needs will come out in the person's response, e.g. an aggressive person may see images of destruction. Objective tests assume personality is consciously accessible and measure it by self-report questionnaires. Research on psychological assessment has generally found objective tests are more valid and reliable than projective tests.

- Forte Communication Style Profile
- Holland Codes
- Keirsey Temperament Sorter
- Kelly's Repertory Grid
- Minnesota Multiphasic Personality Inventory
- Morrisby Profile
Personality and inner experience

Psychology has traditionally defined personality through behavioral patterns, and more recently with neuroscientific study of the brain. In recent years, some psychologists have turned to the study of inner experiences for insight into personality and individuality. Russel Hurlburt, a psychologist at the University of Nevada, Las Vegas has studied personality by having individuals record their individual experiences at random times throughout the day. In analyzing the mental freeze-frames that his subjects report, he has found significant variation in inner mental life, and several correlations with behavioral patterns.

Psychosexual development

In Freudian psychology, psychosexual development is a central element of the psychoanalytic sexual drive theory, that human beings, from birth, possess an instinctual libido (sexual appetite) that develops in five stages. Each stage — the oral, the anal, the phallic, the latent, and the genital — is characterized by the erogenous zone that is the source of the libidinal drive. Sigmund Freud proposed that if the child experienced anxiety, thwarting his or her sexual appetite during any libidinal (psychosexual) development stage, said anxiety would persist into adulthood as a neurosis, a functional mental disorder.

Freudian psychosexual development

Sexual infantilism — In pursuing and satisfying his or her libido (sexual drive), the child might experience failure (parental and societal disapproval) and thus might associate anxiety with the given erogenous zone. To avoid anxiety, the child becomes
fixated, preoccupied with the psychologic themes related to the erogenous zone in question, which persist into adulthood, and underlie the personality and psychopathology of the man or woman, as neurosis, hysteria, personality disorders, et cetera.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Age Range</th>
<th>Erogenous zone</th>
<th>Consequences of psychologic fixation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Birth–1 year</td>
<td>Mouth</td>
<td>Orally aggressive: chewing gum and the ends of pencils, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Orally Passive: smoking, eating, kissing, oral sexual practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Oral stage fixation might result in a passive, gullible, immature, manipulative personality.</td>
</tr>
<tr>
<td>Anal</td>
<td>1–3 years</td>
<td>Bowel and bladder elimination</td>
<td>Anal retentive: Obsessively organized, or excessively neat</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anal expulsive: reckless, careless, defiant, disorganized, coprophiliac</td>
</tr>
<tr>
<td>Phallic</td>
<td>3–6 years</td>
<td>Genitalia</td>
<td>Oedipus complex (in boys)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Electra complex (in girls)</td>
</tr>
<tr>
<td>Latency</td>
<td>6–puberty</td>
<td>Dormant sexual feelings</td>
<td>Sexual unfulfillment if fixation occurs in this stage.</td>
</tr>
<tr>
<td>Genital</td>
<td>Puberty–death</td>
<td>Sexual interests mature</td>
<td>Frigidity, impotence, unsatisfactory relationships</td>
</tr>
</tbody>
</table>

Oral stage

The first stage of psychosexual development is the oral stage, spanning from birth until the age of two years, wherein the infant’s mouth is the focus of libidinal gratification derived from the pleasure of feeding at the mother’s breast, and from the
oral exploration of his or her environment, i.e. the tendency to place objects in the mouth. The id dominates, because neither the ego nor the super ego is yet fully developed, and, since the infant has no personality (identity), every action is based upon the pleasure principle. Nonetheless, the infantile ego is forming during the oral stage; two factors contribute to its formation: (i) in developing a body image, he or she is discrete from the external world, e.g. the child understands pain when it is applied to his or her body, thus identifying the physical boundaries between body and environment; (ii) experiencing delayed gratification leads to understanding that specific behaviors satisfy some needs, e.g. crying gratifies certain needs.

Weaning is the key experience in the infant’s oral stage of psychosexual development, his or her first feeling of loss consequent to losing the physical intimacy of feeding at mother’s breast. Yet, weaning increases the infant’s self-awareness that he or she does not control the environment, and thus learns of delayed gratification, which leads to the formation of the capacities for independence (awareness of the limits of the self) and trust (behaviors leading to gratification). Yet, thwarting of the oral-stage — too much or too little gratification of desire — might lead to an oral-stage fixation, characterised by passivity, gullibility, immaturity, unrealistic optimism, which is manifested in a manipulative personality consequent to ego malformation. In the case of too much gratification, the child does not learn that he or she does not control the environment, and that gratification is not always immediate, thereby forming an immature personality. In the case of too little gratification, the infant might become passive upon learning that gratification is not forthcoming, despite having produced the gratifying behavior.

Anal stage

The second stage of psychosexual development is the anal stage, spanning from the age of fifteen months to three years, wherein the infant’s erogenous zone changes from the mouth (the upper digestive tract) to the anus (the lower digestive tract), while the ego formation continues. Toilet training is the child’s key anal-stage experience, occurring at about the age of two years, and results in conflict between the Id (demanding immediate gratification) and the Ego (demanding delayed
gratification) in eliminating bodily wastes, and handling related activities (e.g. manipulating feces, coping with parental demands). The style of parenting influences the resolution of the Id–Ego conflict, which can be either gradual and psychologically uneventful, or which can be sudden and psychologically traumatic. The ideal resolution of the Id–Ego conflict is in the child’s adjusting to moderate parental demands that teach the value and importance of physical cleanliness and environmental order, thus producing a self-controlled adult. Yet, if the parents make immoderate demands of the child, by over-emphasizing toilet training, it might lead to the development of a compulsive personality, a person too concerned with neatness and order. If the child obeys the Id, and the parents yield, he or she might develop a self-indulgent personality characterized by personal slovenliness and environmental disorder. If the parents respond to that, the child must comply, but might develop a weak sense of Self, because it was the parents’ will, and not the child’s ego, who controlled the toilet training.

Phallic stage

The third stage of psychosexual development is the phallic stage, spanning the ages of three to six years, wherein the child’s genitalia are his or her primary erogenous zone. It is in this third infantile development stage that children become aware of their bodies, the bodies of other children, and the bodies of their parents; they gratify physical curiosity by undressing and exploring each other and their genitals, and so learn the physical (sexual) differences between “male” and “female” and the gender differences between “boy” and “girl”. In the phallic stage, a boy’s decisive psychosexual experience is the Oedipus complex, his son–father competition for possession of mother. This psychological complex derives from the 5th-century BC Greek mythologic character Oedipus, who unwittingly killed his father, Laius, and sexually possessed his mother, Jocasta. Analogously, in the phallic stage, a girl’s decisive psychosexual experience is the Electra complex, her daughter–mother competition for psychosexual possession of father. This psychological complex derives from the 5th-century BC Greek mythologic Electra, who plotted matricidal revenge with Orestes, her brother, against Clytemnestra, their mother, and Aegisthus,
their stepfather, for their murder of Agamemnon, their father, (cf. Electra, by Sophocles).

Initially, Freud equally applied the Oedipus complex to the psychosexual development of boys and girls, but later developed the female aspects of the theory as the feminine Oedipus attitude and the negative Oedipus complex; yet, it was his student–collaborator, Carl Jung, who coined the term Electra complex in 1913. Nonetheless, Freud rejected Jung’s term as psychoanalytically inaccurate: “that what we have said about the Oedipus complex applies with complete strictness to the male child only, and that we are right in rejecting the term ‘Electra complex’, which seeks to emphasize the analogy between the attitude of the two sexes”.

Oedipus — Despite mother being the parent who primarily gratifies the child’s desires, the child begins forming a discrete sexual identity — “boy”, “girl” — that alters the dynamics of the parent and child relationship; the parents become the focus of infantile libidinal energy. The boy focuses his libido (sexual desire) upon his mother, and focuses jealousy and emotional rivalry against his father — because it is he who sleeps with mother. To facilitate uniting him with his mother, the boy’s id wants to kill father (as did Oedipus), but the ego, pragmatically based upon the reality principle, knows that the father is the stronger of the two males competing to possess the one female. Nevertheless, the boy remains ambivalent about his father’s place in the family, which is manifested as fear of castration by the physically greater father; the fear is an irrational, subconscious manifestation of the infantile Id.

Electra — Whereas boys develop castration anxiety, girls develop penis envy that is rooted in anatomic fact: without a penis, she cannot sexually possess mother, as the infantile id demands. Resultantly, the girl redirects her desire for sexual union upon father; thus, she progresses towards heterosexual femininity that culminates in bearing a child who replaces the absent penis. Moreover, after the phallic stage, the girl’s psychosexual development includes transferring her primary erogenous zone from the infantile clitoris to the adult vagina. Freud thus considered a girl’s Oedipal conflict to be more emotionally intense than that of a boy, resulting, potentially, in a submissive woman of insecure personality.
Psychologic defense — In both sexes, defense mechanisms provide transitory resolutions of the conflict between the drives of the Id and the drives of the Ego. The first defense mechanism is repression, the blocking of memories, emotional impulses, and ideas from the conscious mind; yet it does not resolve the Id–Ego conflict. The second defense mechanism is identification, by which the child incorporates, to his or her ego, the personality characteristics of the same-sex parent; in so adapting, the boy diminishes his castration anxiety, because his likeness to father protects him from father’s wrath as a rival for mother; by so adapting, the girl facilitates identifying with mother, who understands that, in being females, neither of them possesses a penis, and thus they are not antagonists.

Dénouement — Unresolved psychosexual competition for the opposite-sex parent might produce a phallic-stage fixation leading a girl to become a woman who continually strives to dominate men (viz. penis envy), either as an unusually seductive woman (high self-esteem) or as an unusually submissive woman (low self-esteem). In a boy, a phallic-stage fixation might lead him to become an aggressive, over-ambitious, vain man. Therefore, the satisfactory parental handling and resolution of the Oedipus complex and of the Electra complex are most important in developing the infantile super-ego, because, by identifying with a parent, the child internalizes morality, thereby, choosing to comply with societal rules, rather than having to reflexively comply in fear of punishment.

Latency stage

The fourth stage of psychosexual development is the latency stage that spans from the age of six years until puberty, wherein the child consolidates the character habits he or she developed in the three, earlier stages of psychologic and sexual development. Whether or not the child has successfully resolved the Oedipal conflict, the instinctual drives of the id are inaccessible to the Ego, because his or her defense mechanisms repressed them during the phallic stage. Hence, because said drives are latent (hidden) and gratification is delayed — unlike during the preceding oral, anal, and phallic stages — the child must derive the pleasure of gratification from secondary process-thinking that directs the libidinal drives towards external activities, such as schooling,
friendships, hobbies, et cetera. Any neuroses established during the fourth, latent stage, of psychosexual development might derive from the inadequate resolution either of the Oedipus conflict or of the Ego’s failure to direct his or her energies towards socially acceptable activities.

**Genital stage**

The fifth stage of psychosexual development is the genital stage that spans puberty and adult life, and thus occupies most of the life of a man and of a woman; its purpose is the psychologic detachment and independence from the parents. The genital stage affords the person the ability to confront and resolve his or her remaining psychosexual childhood conflicts. As in the phallic stage, the genital stage is centered upon the genitalia, but the sexuality is consensual and adult, rather than solitary and infantile. The psychological difference between the phallic and genital stages is that the ego is established in the latter; the person’s concern shifts from primary-drive gratification (instinct) to applying secondary process-thinking to gratify desire symbolically and intellectually by means of friendships, a love relationship, family and adult responsibilities.

**Criticism**

**Feminist**

Contemporaneously, Sigmund Freud’s psychosexual development theory is criticized as sexist, because it was informed with his introspection (self-analysis). To integrate the female libido (sexual desire) to psychosexual development, he proposed that girls develop “penis envy”. In response, the German Neo-Freudian psychoanalyst Karen Horney, counter-proposed that girls instead develop “Power envy”, rather than penis envy. She further proposed the concept of “womb and vagina envy”, the male’s envy of the female ability to bear children; yet, contemporary formulations further develop said envy from the biologic (child-bearing) to the psychologic (nurturance), envy of women’s perceived right to be the kind parent.
Scientific

A usual criticism of the scientific (experimental) validity of the Freudian psychology theory of human psychosexual development is that Sigmund Freud (1856–1939) was personally fixated upon human sexuality, therefore, he favored defining human development with a normative theory of psychologic and sexual development. Hence, the phallic stage proved controversial, for being based upon clinical observations of the Oedipus complex.

In *Analysis of a Phobia in a Five-year-old Boy* (1909), the case study of the boy “Little Hans” (Herbert Graf, 1903–73) who was afflicted with equinophobia. The relation between Hans’s fears — of horses and of father — derived from external factors, the birth of a sister, and internal factors, the desire of the infantile id to replace father as companion to mother, and guilt for enjoying the masturbation normal to a boy of his age. Moreover, his admitting to wanting to procreate with mother was considered proof of the boy’s sexual attraction to the opposite-sex parent; he was a heterosexual male. Yet, the boy Hans was unable to relate fearing horses to fearing his father. The psychoanalyst Freud noted that “Hans had to be told many things that he could not say himself” and that “he had to be presented with thoughts, which he had, so far, shown no signs of possessing”.

Anthropologic

Contemporary criticism also questions the universality of the Freudian theory of personality (Id, Ego, Super-ego) discussed in the essay *On Narcissism* (1917), wherein he said that “it is impossible to suppose that a unity, comparable to the ego can exist in the individual from the very start”. Contemporary cultural considerations have questioned the normative presumptions of the Freudian psychodynamic perspective that posits the son–father conflict of the Oedipal complex as universal and essential to human psychologic development.

The anthropologist Bronislaw Malinowski’s studies of the Trobriand islanders challenged the Freudian proposal that psychosexual development (e.g. the Oedipus complex) was universal. He reported that in the insular matriarchal society of the
Trobriand, boys are disciplined by their maternal uncles, not their fathers; impartial, avuncular discipline. In *Sex and Repression in Savage Society* (1927), Malinowski reported that boys dreamed of feared uncles, not of beloved fathers, thus, Power — not sexual jealousy — is the source of Oedipal conflict in such non–Western societies. In *Human Behavior in Global Perspective: an Introduction to Cross-Cultural Psychology* (1999), Marshall H. Segall et al. propose that Freud based the theory of psychosexual development upon a misinterpretation. Furthermore, contemporary research confirms that although personality traits corresponding to the oral stage, the anal stage, the phallic stage, the latent stage, and the genital stage are observable, they remain undetermined as fixed stages of childhood, and as adult personality traits derived from childhood.

**KAREN Horney (1885 - 1952)**

Horney's theory is perhaps the best theory of neurosis we have. First, she offered a different way of viewing neurosis. She saw it as much more continuous with normal life than previous theorists. Specifically, she saw neurosis as an attempt to make life bearable, as a way of "interpersonal control and coping." This is, of course, what we all strive to do on a day-to-day basis, only most of us seem to be doing alright, while the neurotic seems to be sinking fast.

In her clinical experience, she discerned ten particular patterns of neurotic needs. They are based on things that we all need, but they have become distorted in several ways by the difficulties of some people's lives:

Let's take the first need, for affection and approval, as an example. We all need affection, so what makes such a need neurotic? First, the need is unrealistic, unreasonable, indiscriminate. For example, we all need affection, but we don't expect it from everyone we meet. We don't expect great outpourings of affection from even our close friends and relations. We don't expect our loved ones to show affection at all times, in all circumstances. We don't expect great shows of love while our partners are filing out tax forms, for example. And, we realize that there may be times in our lives where we have to be self-sufficient.
Second, the neurotic's need is much more intense, and he or she will experience great anxiety if the need is not met, or if it even appears that it may not be met in the future. It is this, of course, that leads to the unrealistic nature of the need. Affection, to continue the example, has to be shown clearly at all times, in all circumstances, by all people, or the panic sets in. The neurotic has made the need too central to their existence.

The neurotic needs are as follows:

1. The neurotic need for affection and approval, the indiscriminate need to please others and be liked by them.

2. The neurotic need for a partner, for someone who will take over one's life. This includes the idea that love will solve all of one's problems. Again, we all would like a partner to share life with, but the neurotic goes a step or two too far.

3. The neurotic need to restrict one's life to narrow borders, to be undemanding, satisfied with little, to be inconspicuous. Even this has its normal counterpart. Who hasn't felt the need to simplify life when it gets too stressful, to join a monastic order, disappear into routine, or to return to the womb?

4. The neurotic need for power, for control over others, for a facade of omnipotence. We all seek strength, but the neurotic may be desperate for it. This is dominance for its own sake, often accompanied by a contempt for the weak and a strong belief in one's own rational powers.

5. The neurotic need to exploit others and get the better of them. In the ordinary person, this might be the need to have an effect, to have impact, to be heard. In the neurotic, it can become manipulation and the belief that people are there to be used. It may also involve a fear of being used, of looking stupid. You may have noticed that the people who love practical jokes more often than not cannot take being the butt of such a joke themselves!

6. The neurotic need for social recognition or prestige. We are social creatures, and sexual ones, and like to be appreciated. But these people are overwhelmingly
concerned with appearances and popularity. They fear being ignored, be thought plain, "uncool," or "out of it."

7. The neurotic need for personal admiration. We need to be admired for inner qualities as well as outer ones. We need to feel important and valued. But some people are more desperate, and need to remind everyone of their importance -- "Nobody recognizes genius," "I'm the real power behind the scenes, you know," and so on. Their fear is of being thought nobodies, unimportant and meaningless.

8. The neurotic need for personal achievement. Again, there is nothing intrinsically wrong with achievement -- far from it! But some people are obsessed with it. They have to be number one at everything they do. Since this is, of course, quite a difficult task, you will find these people devaluing anything they cannot be number one in! If they are good runners, then the discus and the hammer are "side shows." If academic abilities are their strength, physical abilities are of no importance, and so on.

9. The neurotic need for self-sufficiency and independence. We should all cultivate some autonomy, but some people feel that they shouldn't ever need anybody. They tend to refuse help and are often reluctant to commit to a relationship.

10. The neurotic need for perfection and unassailability. To become better and better at life and our special interests is hardly neurotic, but some people are driven to be perfect and scared of being flawed. They can't be caught making a mistake and need to be in control at all times.

As Horney investigated these neurotic needs, she began to recognize that they can be clustered into three broad coping strategies:

I. Compliance, which includes needs one, two, and three.

II. Aggression, including needs four through eight.

III. Withdrawal, including needs nine, ten, and three. She added three here because it is crucial to the illusion of total independence and perfection that you limit the breadth of your life!
In her writings, she used a number of other phrases to refer to these three strategies. Besides compliance, she referred to the first as the moving-toward strategy and the self-effacing solution. One should also note that it is the same as Adler's getting or leaning approach, or the phlegmatic personality.

Besides aggression, the second was referred to as moving-against and the expansive solution. It is the same as Adler's ruling or dominant type, or the choleric personality.

And, besides withdrawal, she called the third moving-away-from and the resigning solution. It is somewhat like Adler's avoiding type, the melancholy personality.

**Development**

It is true that some people who are abused or neglected as children suffer from neuroses as adults. What we often forget is that most do not. If you have a violent father, or a schizophrenic mother, or are sexually molested by a strange uncle, you may nevertheless have other family members that love you, take care of you, and work to protect you from further injury, and you will grow up to be a healthy, happy adult. It is even more true that the great majority of adult neurotics did not in fact suffer from childhood neglect or abuse! So the question becomes, if it is not neglect or abuse that causes neurosis, what does?

Horney's answer, which she called the "basic evil," is parental indifference, a lack of warmth and affection in childhood. Even occasional beatings or an early sexual experience can be overcome, if the child feels wanted and loved.

The key to understanding parental indifference is that it is a matter of the child's perception, and not the parents' intentions. "The road to hell," it might pay to remember, "is paved with good intentions." A well-intentioned parent may easily communicate indifference to children with such things as showing a preference for one child over another, blaming a child for what they may not have done, overindulging one moment and rejecting another, neglecting to fulfill promises, disturbing a child's friendships, making fun of a child's thinking, and so on. Please notice that many parents -- even good ones -- find themselves doing these things
because of the many pressures they may be under. Other parents do these things because they themselves are neurotic, and place their own needs ahead of their children's.

Horney noticed that, in contrast to our stereotypes of children as weak and passive, their first reaction to parental indifference is anger, a response she calls basic hostility. To be frustrated first leads to an effort at protesting the injustice!

Some children find this hostility effective, and over time it becomes a habitual response to life's difficulties. In other words, they develop an aggressive coping strategy. They say to themselves, "If I have power, no one can hurt me."

Most children, however, find themselves overwhelmed by basic anxiety, which in children is mostly a matter of fear of helplessness and abandonment. For survival's sake, basic hostility must be suppressed and the parents won over. If this seems to work better for the child, it may become the preferred coping strategy -- compliance. They say to themselves, "If I can make you love me, you will not hurt me."

Some children find that neither aggression nor compliance eliminate the perceived parental indifference. They "solve" the problem by withdrawing from family involvement into themselves, eventually becoming sufficient unto themselves -- the third coping strategy. They say, "If I withdraw, nothing can hurt me."

**Self theory**

Horney had one more way of looking at neurosis -- in terms of self images. For Horney, the self is the core of your being, your potential. If you were healthy, you would have an accurate conception of who you are, and you would then be free to realize that potential (self-realization).

The neurotic has a different view of things. The neurotics self is "split" into a despised self and an ideal self. Other theorists postulate a "looking-glass" self, the you you think others see. If you look around and see (accurately or not) others despising you, then you take that inside you as what you assume is the real you. On the other hand, if you are lacking in some way, that implies there are certain ideals you should be living
up to. You create an ideal self out of these "shoulds." Understand that the ideal self is not a positive goal; it is unrealistic and ultimately impossible. So the neurotic swings back and forth between hating themselves and pretending to be perfect.

Horney described this stretching between the despised and ideal selves as "the tyranny of the shoulds" and neurotic "striving for glory:"

The compliant person believes "I should be sweet, self-sacrificing, saintly."
The aggressive person says "I should be powerful, recognized, a winner."
The withdrawing person believes "I should be independent, aloof, perfect."

And while vacillating between these two impossible selves, the neurotic is alienated from their true core and prevented from actualizing their potentials.

JEAN PIAGET (1896 – 1980)

Jean Piaget began his career as a biologist -- specifically, a malacologist! But his interest in science and the history of science soon overtook his interest in snails and clams. As he delved deeper into the thought-processes of doing science, he became interested in the nature of thought itself, especially in the development of thinking. Finding relatively little work done in the area, he had the opportunity to give it a label. He called it genetic epistemology, meaning the study of the development of knowledge.

He noticed, for example, that even infants have certain skills in regard to objects in their environment. These skills were certainly simple ones, sensori-motor skills, but
they directed the way in which the infant explored his or her environment and so how they gained more knowledge of the world and more sophisticated exploratory skills. These skills he called schemas.

For example, an infant knows how to grab his favorite rattle and thrust it into his mouth. He’s got that schema down pat. When he comes across some other object -- say daddy’s expensive watch, he easily learns to transfer his “grab and thrust” schema to the new object. This Piaget called assimilation, specifically assimilating a new object into an old schema.

When our infant comes across another object again -- say a beach ball -- he will try his old schema of grab and thrust. This of course works poorly with the new object. So the schema will adapt to the new object: Perhaps, in this example, “squeeze and drool” would be an appropriate title for the new schema. This is called accommodation, specifically accommodating an old schema to a new object.

Assimilation and accommodation are the two sides of adaptation, Piaget’s term for what most of us would call learning. Piaget saw adaptation, however, as a good deal broader than the kind of learning that Behaviorists in the US were talking about. He saw it as a fundamentally biological process. Even one’s grip has to accommodate to a stone, while clay is assimilated into our grip. All living things adapt, even without a nervous system or brain.

Assimilation and accommodation work like pendulum swings at advancing our understanding of the world and our competency in it. According to Piaget, they are directed at a balance between the structure of the mind and the environment, at a certain congruency between the two, that would indicate that you have a good (or at least good-enough) model of the universe. This ideal state he calls equilibrium.

As he continued his investigation of children, he noted that there were periods where assimilation dominated, periods where accommodation dominated, and periods of relative equilibrium, and that these periods were similar among all the children he looked at in their nature and their timing. And so he developed the idea of stages of cognitive development. These constitute a lasting contribution to psychology.
The sensor motor stage

The first stage, to which we have already referred, is the sensorimotor stage. It lasts from birth to about two years old. As the name implies, the infant uses senses and motor abilities to understand the world, beginning with reflexes and ending with complex combinations of sensorimotor skills.

Between one and four months, the child works on primary circular reactions -- just an action of his own which serves as a stimulus to which it responds with the same action, and around and around we go. For example, the baby may suck her thumb. That feels good, so she sucks some more... Or she may blow a bubble. That’s interesting so I’ll do it again....

Between four and 12 months, the infant turns to secondary circular reactions, which involve an act that extends out to the environment: She may squeeze a rubber duckie. It goes “quack.” That’s great, so do it again, and again, and again. She is learning “procedures that make interesting things last.”

At this point, other things begin to show up as well. For example, babies become ticklish, although they must be aware that someone else is tickling them or it won’t work. And they begin to develop object permanence. This is the ability to recognize that, just because you can’t see something doesn’t mean it’s gone! Younger infants seem to function by an “out of sight, out of mind” schema. Older infants remember, and may even try to find things they can no longer see.

Between 12 months and 24 months, the child works on tertiary circular reactions. They consist of the same “making interesting things last” cycle, except with constant variation. I hit the drum with the stick -- rat-tat-tat-tat. I hit the block with the stick -- thump-thump. I hit the table with the stick -- clunk-clunk. I hit daddy with the stick -- ouch-ouch. This kind of active experimentation is best seen during feeding time, when discovering new and interesting ways of throwing your spoon, dish, and food.

Around one and a half, the child is clearly developing mental representation, that is, the ability to hold an image in their mind for a period beyond the immediate
experience. For example, they can engage in deferred imitation, such as throwing a tantrum after seeing one an hour ago. They can use mental combinations to solve simple problems, such as putting down a toy in order to open a door. And they get good at pretending. Instead of using dollies essentially as something to sit at, suck on, or throw, now the child will sing to it, tuck it into bed, and so on.

**Preoperational stage**

The preoperational stage lasts from about two to about seven years old. Now that the child has mental representations and is able to pretend, it is a short step to the use of symbols.

A symbol is a thing that represents something else. A drawing, a written word, or a spoken word comes to be understood as representing a real dog. The use of language is, of course, the prime example, but another good example of symbol use is creative play, wherein checkers are cookies, papers are dishes, a box is the table, and so on. By manipulating symbols, we are essentially thinking, in a way the infant could not: in the absence of the actual objects involved!

Along with symbolization, there is a clear understanding of past and future. For example, if a child is crying for its mother, and you say “Mommy will be home soon,” it will now tend to stop crying. Or if you ask him, “Remember when you fell down?” he will respond by making a sad face.

On the other hand, the child is quite egocentric during this stage, that is, he sees things pretty much from one point of view: his own! She may hold up a picture so only she can see it and expect you to see it too. Or she may explain that grass grows so she won’t get hurt when she falls.

Piaget did a study to investigate this phenomenon called the mountains study. He would put children in front of a simple plaster mountain range and seat himself to the side, then ask them to pick from four pictures the view that he, Piaget, would see. Younger children would pick the picture of the view they themselves saw; older kids picked correctly.
Similarly, younger children center on one aspect of any problem or communication at a time. For example, they may not understand you when you tell them “Your father is my husband.” Or they may say things like “I don't live in the USA; I live in Pennsylvania!” Or, if you show them five black and three white marbles and ask them “Are there more marbles or more black marbles?” they will respond “More black ones!”

Perhaps the most famous example of the preoperational child’s centrism is what Piaget refers to as their inability to conserve liquid volume. If I give a three year old some chocolate milk in a tall skinny glass, and I give myself a whole lot more in a short fat glass, she will tend to focus on only one of the dimensions of the glass. Since the milk in the tall skinny glass goes up much higher, she is likely to assume that there is more milk in that one than in the short fat glass, even though there is far more in the latter. It is the development of the child's ability to decenter that marks him as having moved to the next stage.

**Concrete operations stage**

The concrete operations stage lasts from about seven to about 11. The word operations refers to logical operations or principles we use when solving problems. In
this stage, the child not only uses symbols representationally, but can manipulate those symbols logically. Quite an accomplishment! But, at this point, they must still perform these operations within the context of concrete situations.

The stage begins with progressive decentering. By six or seven, most children develop the ability to conserve number, length, and liquid volume. Conservation refers to the idea that a quantity remains the same despite changes in appearance. If you show a child four marbles in a row, then spread them out, the preoperational child will focus on the spread, and tend to believe that there are now more marbles than before.

Or if you have two five inch sticks laid parallel to each other, then move one of them a little, she may believe that the moved stick is now longer than the other.

The concrete operations child, on the other hand, will know that there are still four marbles, and that the stick doesn’t change length even though it now extends beyond the other. And he will know that you have to look at more than just the height of the milk in the glass: If you pour the milk from the short, fat glass into the tall, skinny glass, he will tell you that there is the same amount of milk as before, despite the dramatic increase in milk-level!
By seven or eight years old, children develop conservation of substance: If I take a ball of clay and roll it into a long thin rod, or even split it into ten little pieces, the child knows that there is still the same amount of clay. And he will know that, if you rolled it all back into a single ball, it would look quite the same as it did -- a feature known as reversibility.

By nine or ten, the last of the conservation tests is mastered: conservation of area. If you take four one-inch square pieces of felt, and lay them on a six-by-six cloth together in the center, the child who conserves will know that they take up just as much room as the same squares spread out in the corners, or, for that matter, anywhere at all.

If all this sounds too easy to be such a big deal, test your friends on conservation of mass: Which is heavier: a million tons of lead, or a million tons of feathers?

In addition, a child learns classification and seriation during this stage. Classification refers back to the question of whether there are more marbles or more black marbles? Now the child begins to get the idea that one set can include another. Seriation is putting things in order. The younger child may start putting things in order by, say size, but will quickly lose track. Now the child has no problem with such a task. Since arithmetic is essentially nothing more than classification and seriation, the child is now ready for some formal education!
Formal operations stage

But the concrete operations child has a hard time applying his new-found logical abilities to non-concrete -- i.e. abstract -- events. If mom says to junior “You shouldn’t make fun of that boy’s nose. How would you feel if someone did that to you?” he is likely to respond “I don’t have a big nose!” Even this simple lesson may well be too abstract, too hypothetical, for his kind of thinking.

Don’t judge the concrete operations child too harshly, though. Even adults are often taken-aback when we present them with something hypothetical: “If Edith has a lighter complexion than Susan, and Edith is darker than Lily, who is the darkest?” Most people need a moment or two.

From around 12 on, we enter the formal operations stage. Here we become increasingly competent at adult-style thinking. This involves using logical operations, and using them in the abstract, rather than the concrete. We often call this hypothetical thinking.

Here’s a simple example of a task that a concrete operations child couldn’t do, but which a formal operations teenager or adult could -- with a little time and effort. Consider this rule about a set of cards that have letters on one side and numbers on the other: “If a card has a vowel on one side, then it has an even number on the other side.” Take a look at the cards below and tell me, which cards do I need to turn over to tell if this rule is actually true? You’ll find the answer at the end of this chapter.

E K 4 7

It is the formal operations stage that allows one to investigate a problem in a careful and systematic fashion. Ask a 16 year old to tell you the rules for making pendulums swing quickly or slowly, and he may proceed like this:
His experiment -- and it is an experiment -- would tell him that a short string leads to a fast swing, and a long string to a slow swing, and that the weight of the pendulum means nothing at all!

The teenager has learned to group possibilities in four different ways:

By conjunction: “Both A and B make a difference” (e.g. both the string’s length and the pendulum’s weight).

By disjunction: “It’s either this or that” (e.g. it’s either the length or the weight).

By implication: “If it’s this, then that will happen” (the formation of a hypothesis).

By incompatibility: “When this happens, that doesn’t” (the elimination of a hypothesis).

On top of that, he can operate on the operations -- a higher level of grouping. If you have a proposition, such as “it could be the string or the weight,” you can do four things with it:

Identity: Leave it alone. “It could be the string or the weight.”

Negation: Negate the components and replace or’s with and’s (and vice versa). “It might not be the string and not the weight, either.”

Reciprocity: Negate the components but keep the and’s and or’s as they are. “Either it is not the weight or it is not the string.”

Correlativity: Keep the components as they are, but replace or’s with and’s, etc. “It’s the weight and the string.”

**Erikson**

Erikson is a Freudian ego-psychologist. This means that he accepts Freud's ideas as basically correct, including the more debatable ideas such as the Oedipal complex, and accepts as well the ideas about the ego that were added by other Freudian
loyalists such as Heinz Hartmann and, of course, Anna Freud. However, Erikson is much more society and culture-oriented than most Freidians, as you might expect from someone with his anthropological interests, and he often pushes the instincts and the unconscious practically out of the picture. Perhaps because of this, Erikson is popular among Freidians and non-Freidians alike!

The epigenetic principle

He is most famous for his work in refining and expanding Freud's theory of stages. Development, he says, functions by the epigenetic principle. This principle says that we develop through a predetermined unfolding of our personalities in eight stages. Our progress through each stage is in part determined by our success, or lack of success, in all the previous stages. A little like the unfolding of a rose bud, each petal opens up at a certain time, in a certain order, which nature, through its genetics, has determined. If we interfere in the natural order of development by pulling a petal forward prematurely or out of order, we ruin the development of the entire flower.

Each stage involves certain developmental tasks that are psychosocial in nature. Although he follows Freudian tradition by calling them crises, they are more drawn out and less specific than that term implies. The child in grammar school, for example, has to learn to be industrious during that period of his or her life, and that industriousness is learned through the complex social interactions of school and family.

The various tasks are referred to by two terms. The infant's task, for example, is called "trust-mistrust." At first, it might seem obvious that the infant must learn trust and not mistrust. But Erikson made it clear that there it is a balance we must learn: Certainly, we need to learn mostly trust; but we also need to learn a little mistrust, so as not to grow up to become gullible fools!

Each stage has a certain optimal time as well. It is no use trying to rush children into adulthood, as is so common among people who are obsessed with success. Neither is it possible to slow the pace or to try to protect our children from the demands of life. There is a time for each task.
If a stage is managed well, we carry away a certain virtue or psychosocial strength which will help us through the rest of the stages of our lives. On the other hand, if we don't do so well, we may develop maladaptations and malignancies, as well as endanger all our future development. A malignancy is the worse of the two, and involves too little of the positive and too much of the negative aspect of the task, such as a person who can't trust others. A maladaptation is not quite as bad and involves too much of the positive and too little of the negative, such as a person who trusts too much.

**Children and adults**

Perhaps Erikson's greatest innovation was to postulate not five stages, as Freud had done, but eight. Erikson elaborated Freud's genital stage into adolescence plus three stages of adulthood. We certainly don't stop developing -- especially psychologically -- after our twelfth or thirteenth birthdays; It seems only right to extend any theory of stages to cover later development!

Erikson also had some things to say about the interaction of generations, which he called mutuality. Freud had made it abundantly clear that a child's parents influence his or her development dramatically. Erikson pointed out that children influence their parents' development as well. The arrival of children, for example, into a couple's life, changes that life considerably, and moves the new parents along their developmental paths. It is even appropriate to add a third (and in some cases, a fourth) generation to the picture: Many of us have been influenced by our grandparents, and they by us.

A particularly clear example of mutuality can be seen in the problems of the teenage mother. Although the mother and her child may have a fine life together, often the mother is still involved in the tasks of adolescence, that is, in finding out who she is and how she fits into the larger society. The relationship she has or had with the child's father may have been immature on one or both sides, and if they don't marry, she will have to deal with the problems of finding and developing a relationship as well. The infant, on the other hand, has the simple, straight-forward needs that infants have, and the most important of these is a mother with the mature abilities and social support a mother should have. If the mother's parents step in to help, as one would
expect, then they, too, are thrown off of their developmental tracks, back into a lifestyle they thought they had passed, and which they might find terribly demanding. And so on....

The first stage

The first stage, infancy or the oral-sensory stage, is approximately the first year or year and a half of life. The task is to develop trust without completely eliminating the capacity for mistrust.

If mom and dad can give the newborn a degree of familiarity, consistency, and continuity, then the child will develop the feeling that the world -- especially the social world -- is a safe place to be, that people are reliable and loving. Through the parents' responses, the child also learns to trust his or her own body and the biological urges that go with it.

If the parents are unreliable and inadequate, if they reject the infant or harm it, if other interests cause both parents to turn away from the infants needs to satisfy their own instead, then the infant will develop mistrust. He or she will be apprehensive and suspicious around people.

Please understand that this doesn't mean that the parents have to be perfect. In fact, parents who are overly protective of the child, are there the minute the first cry comes out, will lead that child into the maladaptive tendency Erikson calls sensory maladjustment: Overly trusting, even gullible, this person cannot believe anyone would mean them harm, and will use all the defenses at their command to retain their pollyanna perspective.

Worse, of course, is the child whose balance is tipped way over on the mistrust side: They will develop the malignant tendency of withdrawal, characterized by depression, paranoia, and possibly psychosis.

If the proper balance is achieved, the child will develop the virtue hope, the strong belief that, even when things are not going well, they will work out well in the end. One of the signs that a child is doing well in the first stage is when the child isn't
overly upset by the need to wait a moment for the satisfaction of his or her needs: Mom or dad don't have to be perfect; I trust them enough to believe that, if they can't be here immediately, they will be here soon; Things may be tough now, but they will work out. This is the same ability that, in later life, gets us through disappointments in love, our careers, and many other domains of life.

**Stage two**

The second stage is the anal-muscular stage of early childhood, from about eighteen months to three or four years old. The task is to achieve a degree of autonomy while minimizing shame and doubt.

If mom and dad (and the other care-takers that often come into the picture at this point) permit the child, now a toddler, to explore and manipulate his or her environment, the child will develop a sense of autonomy or independence. The parents should not discourage the child, but neither should they push. A balance is required. People often advise new parents to be "firm but tolerant" at this stage, and the advice is good. This way, the child will develop both self-control and self-esteem.

On the other hand, it is rather easy for the child to develop instead a sense of shame and doubt. If the parents come down hard on any attempt to explore and be independent, the child will soon give up with the assumption that cannot and should not act on their own. We should keep in mind that even something as innocent as laughing at the toddler's efforts can lead the child to feel deeply ashamed, and to doubt his or her abilities.

And there are other ways to lead children to shame and doubt: If you give children unrestricted freedom and no sense of limits, or if you try to help children do what they should learn to do for themselves, you will also give them the impression that they are not good for much. If you aren't patient enough to wait for your child to tie his or her shoe-laces, your child will never learn to tie them, and will assume that this is too difficult to learn!
Nevertheless, a little "shame and doubt" is not only inevitable, but beneficial. Without it, you will develop the maladaptive tendency Erikson calls impulsiveness, a sort of shameless willfulness that leads you, in later childhood and even adulthood, to jump into things without proper consideration of your abilities.

Worse, of course, is too much shame and doubt, which leads to the malignancy Erikson calls compulsiveness. The compulsive person feels as if their entire being rides on everything they do, and so everything must be done perfectly. Following all the rules precisely keeps you from mistakes, and mistakes must be avoided at all costs. Many of you know how it feels to always be ashamed and always doubt yourself. A little more patience and tolerance with your own children may help them avoid your path. And give yourself a little slack, too!

If you get the proper, positive balance of autonomy and shame and doubt, you will develop the virtue of willpower or determination. One of the most admirable -- and frustrating -- thing about two- and three-year-olds is their determination. "Can do" is their motto. If we can preserve that "can do" attitude (with appropriate modesty to balance it) we are much better off as adults.

**Stage three**

Stage three is the genital-locomotor stage or play age. From three or four to five or six, the task confronting every child is to learn initiative without too much guilt.

Initiative means a positive response to the world's challenges, taking on responsibilities, learning new skills, feeling purposeful. Parents can encourage initiative by encouraging children to try out their ideas. We should accept and encourage fantasy and curiosity and imagination. This is a time for play, not for formal education. The child is now capable, as never before, of imagining a future situation, one that isn't a reality right now. Initiative is the attempt to make that non-reality a reality.

But if children can imagine the future, if they can plan, then they can be responsible as well, and guilty. If my two-year-old flushes my watch down the toilet, I can safely
assume that there were no "evil intentions." It was just a matter of a shiny object going round and round and down. What fun! But if my five year old does the same thing... well, she should know what's going to happen to the watch, what's going to happen to daddy's temper, and what's going to happen to her! She can be guilty of the act, and she can begin to feel guilty as well. The capacity for moral judgement has arrived.

Erikson is, of course, a Freudian, and as such, he includes the Oedipal experience in this stage. From his perspective, the Oedipal crisis involves the reluctance a child feels in relinquishing his or her closeness to the opposite sex parent. A parent has the responsibility, socially, to encourage the child to "grow up -- you're not a baby anymore!" But if this process is done too harshly and too abruptly, the child learns to feel guilty about his or her feelings.

Too much initiative and too little guilt means a maladaptive tendency Erikson calls ruthlessness. The ruthless person takes the initiative alright; They have their plans, whether it's a matter of school or romance or politics or career. It's just that they don't care who they step on to achieve their goals. The goals are everything, and guilty feelings are for the weak. The extreme form of ruthlessness is sociopathy.

Ruthlessness is bad for others, but actually relatively easy on the ruthless person. Harder on the person is the malignancy of too much guilt, which Erikson calls inhibition. The inhibited person will not try things because "nothing ventured, nothing lost" and, particularly, nothing to feel guilty about. On the sexual, Oedipal, side, the inhibited person may be impotent or frigid.

A good balance leads to the psychosocial strength of purpose. A sense of purpose is something many people crave in their lives, yet many do not realize that they themselves make their purposes, through imagination and initiative. I think an even better word for this virtue would have been courage, the capacity for action despite a clear understanding of your limitations and past failings.
**Stage four**

Stage four is the latency stage, or the school-age child from about six to twelve. The task is to develop a capacity for industry while avoiding an excessive sense of inferiority. Children must "tame the imagination" and dedicate themselves to education and to learning the social skills their society requires of them.

There is a much broader social sphere at work now: The parents and other family members are joined by teachers and peers and other members of he community at large. They all contribute: Parents must encourage, teachers must care, peers must accept. Children must learn that there is pleasure not only in conceiving a plan, but in carrying it out. They must learn the feeling of success, whether it is in school or on the playground, academic or social.

A good way to tell the difference between a child in the third stage and one in the fourth stage is to look at the way they play games. Four-year-olds may love games, but they will have only a vague understanding of the rules, may change them several times during the course of the game, and be very unlikely to actually finish the game, unless it is by throwing the pieces at their opponents. A seven-year-old, on the other hand, is dedicated to the rules, considers them pretty much sacred, and is more likely to get upset if the game is not allowed to come to its required conclusion.

If the child is allowed too little success, because of harsh teachers or rejecting peers, for example, then he or she will develop instead a sense of inferiority or incompetence. An additional source of inferiority Erikson mentions is racism, sexism, and other forms of discrimination: If a child believes that success is related to who you are rather than to how hard you try, then why try?

Too much industry leads to the maladaptive tendency called narrow virtuosity. We see this in children who aren't allowed to "be children," the ones that parents or teachers push into one area of competence, without allowing the development of broader interests. These are the kids without a life: child actors, child athletes, child musicians, child prodigies of all sorts. We all admire their industry, but if we look a little closer, it's all that stands in the way of an empty life.
Much more common is the malignancy called inertia. This includes all of us who suffer from the "inferiority complexes" Alfred Adler talked about. If at first you don't succeed, don't ever try again! Many of us didn't do well in mathematics, for example, so we'd die before we took another math class. Others were humiliated instead in the gym class, so we never try out for a sport or play a game of raquetball. Others never developed social skills -- the most important skills of all -- and so we never go out in public. We become inert.

A happier thing is to develop the right balance of industry and inferiority -- that is, mostly industry with just a touch of inferiority to keep us sensibly humble. Then we have the virtue called competency.

**Stage five**

Stage five is adolescence, beginning with puberty and ending around 18 or 20 years old. The task during adolescence is to achieve ego identity and avoid role confusion. It was adolescence that interested Erikson first and most, and the patterns he saw here were the bases for his thinking about all the other stages.

Ego identity means knowing who you are and how you fit in to the rest of society. It requires that you take all you've learned about life and yourself and mold it into a unified self-image, one that your community finds meaningful.

There are a number of things that make things easier: First, we should have a mainstream adult culture that is worthy of the adolescent's respect, one with good adult role models and open lines of communication.

Further, society should provide clear rites of passage, certain accomplishments and rituals that help to distinguish the adult from the child. In primitive and traditional societies, an adolescent boy may be asked to leave the village for a period of time to live on his own, hunt some symbolic animal, or seek an inspirational vision. Boys and girls may be required to go through certain tests of endurance, symbolic ceremonies, or educational events. In one way or another, the distinction between the powerless,
but irresponsible, time of childhood and the powerful and responsible time of adulthood, is made clear.

Without these things, we are likely to see role confusion, meaning an uncertainty about one's place in society and the world. When an adolescent is confronted by role confusion, Erikson say he or she is suffering from an identity crisis. In fact, a common question adolescents in our society ask is a straightforward question of identity: "Who am I?"

One of Erikson's suggestions for adolescence in our society is the psychosocial moratorium. He suggests you take a little "time out." If you have money, go to Europe. If you don't, bum around the U.S. Quit school and get a job. Quit your job and go to school. Take a break, smell the roses, get to know yourself. We tend to want to get to "success" as fast as possible, and yet few of us have ever taken the time to figure out what success means to us. A little like the young Oglala Lakota, perhaps we need to dream a little.

There is such a thing as too much "ego identity," where a person is so involved in a particular role in a particular society or subculture that there is no room left for tolerance. Erikson calls this maladaptive tendency fanaticism. A fanatic believes that his way is the only way. Adolescents are, of course, known for their idealism, and for their tendency to see things in black-and-white. These people will gather others around them and promote their beliefs and life-styles without regard to others' rights to disagree.

The lack of identity is perhaps more difficult still, and Erikson refers to the malignant tendency here as repudiation. They repudiate their membership in the world of adults and, even more, they repudiate their need for an identity. Some adolescents allow themselves to "fuse" with a group, especially the kind of group that is particularly eager to provide the details of your identity: religious cults, militaristic organizations, groups founded on hatred, groups that have divorced themselves from the painful demands of mainstream society. They may become involved in destructive activities, drugs, or alcohol, or you may withdraw into your own psychotic fantasies. After all, being "bad" or being "nobody" is better than not knowing who you are!
If you successfully negotiate this stage, you will have the virtue Erikson called fidelity. Fidelity means loyalty, the ability to live by societies standards despite their imperfections and incompleteness and inconsistencies. We are not talking about blind loyalty, and we are not talking about accepting the imperfections. After all, if you love your community, you will want to see it become the best it can be. But fidelity means that you have found a place in that community, a place that will allow you to contribute.

**Stage six**

If you have made it this far, you are in the stage of young adulthood, which lasts from about 18 to about 30. The ages in the adult stages are much fuzzier than in the childhood stages, and people may differ dramatically. The task is to achieve some degree of intimacy, as opposed to remaining in isolation.

Intimacy is the ability to be close to others, as a lover, a friend, and as a participant in society. Because you have a clear sense of who you are, you no longer need to fear "losing" yourself, as many adolescents do. The "fear of commitment" some people seem to exhibit is an example of immaturity in this stage. This fear isn't always so obvious. Many people today are always putting off the progress of their relationships: I'll get married (or have a family, or get involved in important social issues) as soon as I finish school, as soon as I have a job, as soon as I have a house, as soon as.... If you've been engaged for the last ten years, what's holding you back?

Neither should the young adult need to prove him- or herself anymore. A teenage relationship is often a matter of trying to establish identity through "couple-hood." Who am I? I'm her boy-friend. The young adult relationship should be a matter of two independent egos wanting to create something larger than themselves. We intuitively recognize this when we frown on a relationship between a young adult and a teenager: We see the potential for manipulation of the younger member of the party by the older.

Our society hasn't done much for young adults, either. The emphasis on careers, the isolation of urban living, the splitting apart of relationships because of our need for
mobility, and the general impersonal nature of modern life prevent people from naturally developing their intimate relationships. I am typical of many people in having moved dozens of times in my life. I haven't the faintest idea what has happened to the kids I grew up with, or even my college buddies. My oldest friend lives a thousand miles away. I live where I do out of career necessity and, until recently, have felt no real sense of community.

Before I get too depressing, let me mention that many of you may not have had these experiences. If you grew up and stayed in your community, and especially if your community is a rural one, you are much more likely to have deep, long-lasting friendships, to have married your high school sweetheart, and to feel a great love for your community. But this style of life is quickly becoming an anachronism.

Erikson calls the maladaptive form promiscuity, referring particularly to the tendency to become intimate too freely, too easily, and without any depth to your intimacy. This can be true of your relationships with friends and neighbors and your whole community as well as with lovers.

The malignancy he calls exclusion, which refers to the tendency to isolate oneself from love, friendship, and community, and to develop a certain hatefulness in compensation for one's loneliness.

If you successfully negotiate this stage, you will instead carry with you for the rest of your life the virtue or psychosocial strength Erikson calls love. Love, in the context of his theory, means being able to put aside differences and antagonisms through "mutuality of devotion." It includes not only the love we find in a good marriage, but the love between friends and the love of one's neighbor, co-worker, and compatriot as well.

**Stage seven**

The seventh stage is that of middle adulthood. It is hard to pin a time to it, but it would include the period during which we are actively involved in raising children. For most people in our society, this would put it somewhere between the middle
twenties and the late fifties. The task here is to cultivate the proper balance of generativity and stagnation.

Generativity is an extension of love into the future. It is a concern for the next generation and all future generations. As such, it is considerably less "selfish" than the intimacy of the previous stage: Intimacy, the love between lovers or friends, is a love between equals, and it is necessarily reciprocal. Oh, of course we love each other unselfishly, but the reality is such that, if the love is not returned, we don't consider it a true love. With generativity, that implicit expectation of reciprocity isn't there, at least not as strongly. Few parents expect a "return on their investment" from their children; If they do, we don't think of them as very good parents!

Although the majority of people practice generativity by having and raising children, there are many other ways as well. Erikson considers teaching, writing, invention, the arts and sciences, social activism, and generally contributing to the welfare of future generations to be generativity as well -- anything, in fact, that satisfies that old "need to be needed."

Stagnation, on the other hand, is self-absorption, caring for no-one. The stagnant person ceases to be a productive member of society. It is perhaps hard to imagine that we should have any "stagnation" in our lives, but the maladaptive tendency Erikson calls overextension illustrates the problem: Some people try to be so generative that they no longer allow time for themselves, for rest and relaxation. The person who is overextended no longer contributes well. I'm sure we all know someone who belongs to so many clubs, or is devoted to so many causes, or tries to take so many classes or hold so many jobs that they no longer have time for any of them!

More obvious, of course, is the malignant tendency of rejectivity. Too little generativity and too much stagnation and you are no longer participating in or contributing to society. And much of what we call "the meaning of life" is a matter of how we participate and what we contribute.

This is the stage of the "midlife crisis." Sometimes men and women take a look at their lives and ask that big, bad question "what am I doing all this for?" Notice the
question carefully: Because their focus is on themselves, they ask what, rather than whom, they are doing it for. In their panic at getting older and not having experienced or accomplished what they imagined they would when they were younger, they try to recapture their youth. Men are often the most flamboyant examples: They leave their long-suffering wives, quit their humdrum jobs, buy some "hip" new clothes, and start hanging around singles bars. Of course, they seldom find what they are looking for, because they are looking for the wrong thing!

But if you are successful at this stage, you will have a capacity for caring that will serve you through the rest of your life.

**Stage eight**

This last stage, referred to delicately as late adulthood or maturity, or less delicately as old age, begins sometime around retirement, after the kids have gone, say somewhere around 60. Some older folks will protest and say it only starts when you feel old and so on, but that's an effect of our youth-worshipping culture, which has even old people avoiding any acknowledgement of age. In Erikson's theory, reaching this stage is a good thing, and not reaching it suggests that earlier problems retarded your development!

The task is to develop ego integrity with a minimal amount of despair. This stage, especially from the perspective of youth, seems like the most difficult of all. First comes a detachment from society, from a sense of usefulness, for most people in our culture. Some retire from jobs they've held for years; others find their duties as parents coming to a close; most find that their input is no longer requested or required.

Then there is a sense of biological uselessness, as the body no longer does everything it used to. Women go through a sometimes dramatic menopause; Men often find they can no longer "rise to the occasion." Then there are the illnesses of old age, such as arthritis, diabetes, heart problems, concerns about breast and ovarian and prostrate cancers. There come fears about things that one was never afraid of before -- the flu, for example, or just falling down.
Along with the illnesses come concerns of death. Friends die. Relatives die. One's spouse dies. It is, of course, certain that you, too, will have your turn. Faced with all this, it might seem like everyone would feel despair.

In response to this despair, some older people become preoccupied with the past. After all, that's where things were better. Some become preoccupied with their failures, the bad decisions they made, and regret that (unlike some in the previous stage) they really don't have the time or energy to reverse them. We find some older people become depressed, spiteful, paranoid, hypochondriacal, or developing the patterns of senility with or without physical bases.

Ego integrity means coming to terms with your life, and thereby coming to terms with the end of life. If you are able to look back and accept the course of events, the choices made, your life as you lived it, as being necessary, then you needn't fear death. Although most of you are not at this point in life, perhaps you can still sympathize by considering your life up to now. We've all made mistakes, some of them pretty nasty ones; Yet, if you hadn't made these mistakes, you wouldn't be who you are. If you had been very fortunate, or if you had played it safe and made very few mistakes, your life would not have been as rich as is.

The maladaptive tendency in stage eight is called presumption. This is what happens when a person "presumes" ego integrity without actually facing the difficulties of old age. The malignant tendency is called disdain, by which Erikson means a contempt of life, one's own or anyone's.

Someone who approaches death without fear has the strength Erikson calls wisdom. He calls it a gift to children, because "healthy children will not fear life if their elders have integrity enough not to fear death." He suggests that a person must be somewhat gifted to be truly wise, but I would like to suggest that you understand "gifted" in as broad a fashion as possible: I have found that there are people of very modest gifts who have taught me a great deal, not by their wise words, but by their simple and gentle approach to life and death, by their "generosity of spirit."
The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides a common language and standard criteria for the classification of mental disorders. It is used in the United States and in varying degrees around the world, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, and policy makers. The DSM has attracted controversy and criticism as well as praise. There have been five revisions since it was first published in 1952, gradually including more mental disorders, although some have been removed and are no longer considered to be mental disorders, most notably homosexuality.

The manual evolved from systems for collecting census and psychiatric hospital statistics, and from a manual developed by the US Army, and was dramatically revised in 1980. The last major revision was the fourth edition ("DSM-IV"), published in 1994, although a "text revision" was produced in 2000. The fifth edition ("DSM-5") is currently in consultation, planning and preparation, due for publication in May 2013.

ICD-10 Chapter V: Mental and behavioural disorders, part of the International Classification of Diseases produced by the World Health Organization (WHO), is another commonly used guide, more so in Europe and other parts of the world. The coding system used in the DSM-IV is designed to correspond with the codes used in the ICD, although not all codes may match at all times because the two publications are not revised synchronously.

Uses

Many mental health professionals use the manual to determine and help communicate a patient's diagnosis after an evaluation; hospitals, clinics, and insurance companies in the US also generally require a 'five axis' DSM diagnosis of all the patients treated. The DSM can be used clinically in this way, and also to categorize patients using diagnostic criteria for research purposes. Studies done on specific disorders often recruit patients whose symptoms match the criteria listed in the DSM for that disorder. An international survey of psychiatrists in 66 countries comparing use of the
ICD-10 and DSM-IV found the former was more often used for clinical diagnosis while the latter was more valued for research.

The DSM, including DSM-IV, is a registered trademark belonging to the American Psychiatric Association (APA). It is a bestselling publication from which APA makes "huge profits" and gains considerable clout in world psychiatry, especially as many reputed research journals require studies to use DSM classification in order to be published.

**History**

The initial impetus for developing a classification of mental disorders in the United States was the need to collect statistical information. The first official attempt was the 1840 census which used a single category, "idiocy/insanity". In 1917, a "Committee on Statistics" from what is now known as the American Psychiatric Association (APA), together with the National Commission on Mental Hygiene, developed a new guide for mental hospitals called the "Statistical Manual for the Use of Institutions for the Insane", which included 22 diagnoses. This was subsequently revised several times by APA over the years. APA, along with the New York Academy of Medicine, also provided the psychiatric nomenclature subsection of the US medical guide, the "Standard Classified Nomenclature of Disease", referred to as the "Standard".

**DSM-I (1952)**

World War II saw the large-scale involvement of US psychiatrists in the selection, processing, assessment and treatment of soldiers. This moved the focus away from mental institutions and traditional clinical perspectives. A committee that was headed by psychiatrist Brigadier General William C. Menninger developed a new classification scheme called Medical 203 that was issued in 1943 as a "War Department Technical Bulletin" under the auspices of the Office of the Surgeon General. The foreword to the DSM-I states the US Navy had itself made some minor revisions but "the Army established a much more sweeping revision, abandoning the basic outline of the Standard and attempting to express present day concepts of mental disturbance. This nomenclature eventually was adopted by all Armed Forces", and
"assorted modifications of the Armed Forces nomenclature [were] introduced into many clinics and hospitals by psychiatrists returning from military duty."

The Veterans Administration also adopted a slightly modified version of Medical 203.

In 1949, the World Health Organization published the sixth revision of the International Statistical Classification of Diseases (ICD) which included a section on mental disorders for the first time. The foreword to DSM-1 states this "categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature." An APA Committee on Nomenclature and Statistics was empowered to develop a version specifically for use in the United States, to standardize the diverse and confused usage of different documents. In 1950 the APA committee undertook a review and consultation. It circulated an adaptation of Medical 203, the VA system and the Standard's Nomenclature, to approximately 10% of APA members. 46% replied, of which 93% approved, and after some further revisions (resulting in it being called DSM-I), the Diagnostic and Statistical Manual of Mental Disorders was approved in 1951 and published in 1952. The structure and conceptual framework were the same as in Medical 203, and many passages of text identical. The manual was 130 pages long and listed 106 mental disorders.

**DSM-II (1968)**

Although the APA was closely involved in the next significant revision of the mental disorder section of the ICD (version 8 in 1968), it decided to also go ahead with a revision of the DSM. It was also published in 1968, listed 182 disorders, and was 134 pages long. It was quite similar to the DSM-I. The term “reaction” was dropped but the term “neurosis” was retained. Both the DSM-I and the DSM-II reflected the predominant psychodynamic psychiatry, although they also included biological perspectives and concepts from Kraepelin's system of classification. Symptoms were not specified in detail for specific disorders. Many were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis (roughly, anxiety/depression broadly in touch with reality, or hallucinations/delusions appearing disconnected from reality). Sociological
and biological knowledge was also incorporated, in a model that did not emphasize a clear boundary between normality and abnormality.

Following controversy and protests from gay activists at APA annual conferences from 1970 to 1973, as well as the emergence of new data from researchers such as Alfred Kinsey and Evelyn Hooker, the seventh printing of the DSM-II, in 1974, no longer listed homosexuality as a category of disorder. But through the efforts of psychiatrist Robert Spitzer, who had led the DSM-II development committee, a vote by the APA trustees in 1973, and confirmed by the wider APA membership in 1974, the diagnosis was replaced with the category of "sexual orientation disturbance".

**DSM-III (1980)**

In 1974, the decision to create a new revision of the DSM was made, and Robert Spitzer was selected as chairman of the task force. The initial impetus was to make the DSM nomenclature consistent with the International Statistical Classification of Diseases and Related Health Problems (ICD), published by the World Health Organization. The revision took on a far wider mandate under the influence and control of Spitzer and his chosen committee members. One goal was to improve the uniformity and validity of psychiatric diagnosis in the wake of a number of critiques, including the famous Rosenhan experiment. There was also a need to standardize diagnostic practices within the US and with other countries after research showed that psychiatric diagnoses differed markedly between Europe and the USA. The establishment of these criteria was also an attempt to facilitate the pharmaceutical regulatory process.

The criteria adopted for many of the mental disorders were taken from the Research Diagnostic Criteria (RDC) and Feighner Criteria, which had just been developed by a group of research-orientated psychiatrists based primarily at Washington University in St. Louis and the New York State Psychiatric Institute. Other criteria, and potential new categories of disorder, were established by consensus during meetings of the committee, as chaired by Spitzer. A key aim was to base categorization on colloquial English descriptive language (which would be easier to use by Federal administrative offices), rather than assumptions of etiology, although its categorical approach
assumed each particular pattern of symptoms in a category reflected a particular underlying pathology (an approach described as "neo-Kraepelinian"). The psychodynamic or physiologic view was abandoned, in favor of a regulatory or legislative model. A new "multiaxial" system attempted to yield a picture more amenable to a statistical population census, rather than just a simple diagnosis. Spitzer argued, “mental disorders are a subset of medical disorders” but the task force decided on the DSM statement: “Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome.”

The first draft of the DSM-III was prepared within a year. Many new categories of disorder were introduced; a number of the unpublished documents that aim to justify them have recently come to light. Field trials sponsored by the U.S. National Institute of Mental Health (NIMH) were conducted between 1977 and 1979 to test the reliability of the new diagnoses. A controversy emerged regarding deletion of the concept of neurosis, a mainstream of psychoanalytic theory and therapy but seen as vague and unscientific by the DSM task force. Faced with enormous political opposition, so the DSM-III was in serious danger of not being approved by the APA Board of Trustees unless “neurosis” was included in some capacity, a political compromise reinserted the term in parentheses after the word “disorder” in some cases. Additionally, the diagnosis of ego-dystonic homosexuality replaced the DSM-II category of "sexual orientation disturbance”.

Finally published in 1980, the DSM-III was 494 pages long and listed 265 diagnostic categories. It rapidly came into widespread international use by multiple stakeholders and has been termed a revolution or transformation in psychiatry. However Robert Spitzer later criticized his own work on it in an interview with Adam Curtis saying it led to the medicalization of 20-30 percent of the population who may not have had any serious mental problems.

**DSM-III-R (1987)**

In 1987 the DSM-III-R was published as a revision of DSM-III, under the direction of Spitzer. Categories were renamed, reorganized, and significant changes in criteria were made. Six categories were deleted while others were added. Controversial
diagnoses such as pre-menstrual dysphoric disorder and Masochistic Personality Disorder were considered and discarded. "Sexual orientation disturbance" was also removed, but was largely subsumed under "sexual disorder not otherwise specified" which can include "persistent and marked distress about one’s sexual orientation."

Altogether, DSM-III-R contained 292 diagnoses and was 567 pages long.

**DSM-IV (1994)**

In 1994, DSM-IV was published, listing 297 disorders in 886 pages. The task force was chaired by Allen Frances. A steering committee of 27 people was introduced, including four psychologists. The steering committee created 13 work groups of 5–16 members. Each work group had approximately 20 advisers. The work groups conducted a three step process. First, each group conducted an extensive literature review of their diagnoses. Then they requested data from researchers, conducting analyses to determine which criteria required change, with instructions to be conservative. Finally, they conducted multicenter field trials relating diagnoses to clinical practice. A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning”.


A "Text Revision" of the DSM-IV, known as the DSM-IV-TR, was published in 2000. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged. The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes in order to maintain consistency with the ICD.

**DSM-IV-TR: the current version**

**Categorization**

The DSM-IV is a categorical classification system. The categories are prototypes, and a patient with a close approximation to the prototype is said to have that disorder.
DSM-IV states, “there is no assumption each category of mental disorder is a completely discrete entity with absolute boundaries...” but isolated, low-grade and no criterion (unlisted for a given disorder) symptoms are not given importance. Qualifiers are sometimes used, for example mild, moderate or severe forms of a disorder. For nearly half the disorders, symptoms must be sufficient to cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning”, although DSM-IV-TR removed the distress criterion from tic disorders and several of the paraphilias. Each category of disorder has a numeric code taken from the ICD coding system, used for health service (including insurance) administrative purposes.

**Multi-axial system**

The DSM-IV organizes each psychiatric diagnosis into five dimensions (axes) relating to different aspects of disorder or disability:

- **Axis I**: Clinical disorders, including major mental disorders, and learning disorders
- **Axis II**: Personality disorders and intellectual disabilities (although developmental disorders, such as Autism, were coded on Axis II in the previous edition, these disorders are now included on Axis I)
- **Axis III**: Acute medical conditions and physical disorders
- **Axis IV**: Psychosocial and environmental factors contributing to the disorder
- **Axis V**: Global Assessment of Functioning or Children's Global Assessment Scale for children and teens under the age of 18

Common Axis I disorders include depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, anorexia nervosa, bulimia nervosa, and schizophrenia.

Common Axis II disorders include personality disorders: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, and intellectual disabilities.
Common Axis III disorders include brain injuries and other medical/physical disorders which may aggravate existing diseases or present symptoms similar to other disorders.

Cautions

The DSM-IV-TR states, because it is produced for the completion of federal legislative mandates, its use by people without clinical training can lead to inappropriate application of its contents. Appropriate use of the diagnostic criteria is said to require extensive clinical training, and its contents “cannot simply be applied in a cookbook fashion”. The APA notes diagnostic labels are primarily for use as a “convenient shorthand” among professionals. The DSM advises laypersons should consult the DSM only to obtain information, not to make diagnoses, and people who may have a mental disorder should be referred to psychological counseling or treatment. Further, a shared diagnosis or label may have different causes or require different treatments; for this reason the DSM contains no information regarding treatment or cause. The range of the DSM represents an extensive scope of psychiatric and psychological issues or conditions, and it is not exclusive to what may be considered “illnesses”.

Criticism

Validity and reliability

The most fundamental scientific criticism of the DSM concerns the validity and reliability of its diagnoses. This refers, roughly, to whether the disorders it defines are actually real conditions in people in the real world, that can be consistently identified by its criteria. These are long-standing criticisms of the DSM, originally highlighted by the Rosenhan experiment in the 1970s, and continuing despite some improved reliability since the introduction of more specific rule-based criteria for each condition.

Proponents argue that the inter-rater reliability of DSM diagnoses (via a specialized Structured Clinical Interview for DSM-IV (SCID) rather than usual psychiatric
assessment) is reasonable, and that there is good evidence of distinct patterns of mental, behavioral or neurological dysfunction to which the DSM disorders correspond well. It is accepted, however, that there is an "enormous" range of reliability findings in studies, and that validity is unclear because, given the lack of diagnostic laboratory or neuroimaging tests, standard clinical interviews are "inherently limited" and only a ("flawed") "best estimate diagnosis" is possible even with full assessment of all data over time.

Critics, such as psychiatrist Niall McLaren, argue that the DSM lacks validity because it has no relation to an agreed scientific model of mental disorder and therefore the decisions taken about its categories (or even the question of categories vs. dimensions) were not scientific ones; and that it lacks reliability partly because different diagnoses share many criteria, and what appear to be different criteria are often just rewordings of the same idea, meaning that the decision to allocate one diagnosis or another to a patient is to some extent a matter of personal prejudice.

**Superficial symptoms**

By design, the DSM is primarily concerned with the signs and symptoms of mental disorders, rather than the underlying causes. It claims to collect them together based on statistical or clinical patterns. As such, it has been compared to a naturalist’s field guide to birds, with similar advantages and disadvantages. The lack of a causative or explanatory basis, however, is not specific to the DSM, but rather reflects a general lack of pathophysiological understanding of psychiatric disorders. As DSM-III chief architect Robert Spitzer and DSM-IV editor Michael First outlined in 2005, "little progress has been made toward understanding the pathophysiological processes and etiology of mental disorders. If anything, the research has shown the situation is even more complex than initially imagined, and we believe not enough is known to structure the classification of psychiatric disorders according to etiology." However, the DSM is based on an underlying structure that assumes discrete medical disorders that can be separated from each other by symptom patterns. Its claim to be "atheoretical" is held to be unconvincing because it makes sense if and only if all mental disorder is categorical by nature, which only a biological model of mental
disorder can satisfy. However, the Manual recognizes psychological causes of mental disorder, e.g. PTSD, so that it negates its only possible justification.

The DSM's focus on superficial symptoms is claimed to be largely a result of necessity (assuming such a manual is nevertheless produced), since there is no agreement on a more explanatory classification system. Reviewers note, however, that this approach is undermining research, including in genetics, because it results in the grouping of individuals who have very little in common except superficial criteria as per DSM or ICD diagnosis.

Despite the lack of consensus on underlying causation, advocates for specific psychopathological paradigms have nonetheless faulted the current diagnostic scheme for not incorporating evidence-based models or findings from other areas of science. A recent example is evolutionary psychologists' criticism that the DSM does not differentiate between genuine cognitive malfunctions and those induced by psychological adaptations, a key distinction within evolutionary psychology, but one widely challenged within general psychology. Another example is a strong operationalist viewpoint, which contends that reliance on operational definitions, as purported by the DSM, necessitates that intuitive concepts such as depression be replaced by specific measurable concepts before they are scientifically meaningful. One critic states of psychologists that "Instead of replacing 'metaphysical' terms such as 'desire' and 'purpose', they used it to legitimize them by giving them operational definitions...the initial, quite radical operationalist ideas eventually came to serve as little more than a 'reassurance fetish' (Koch 1992) for mainstream methodological practice."

**Dividing lines**

Despite caveats in the introduction to the DSM, it has long been argued that its system of classification makes unjustified categorical distinctions between disorders, and uses arbitrary cut-offs between normal and abnormal. A 2009 psychiatric review noted that attempts to demonstrate natural boundaries between related DSM syndromes, or between a common DSM syndrome and normality, have failed. Some argue that
rather than a categorical approach, a fully dimensional, spectrum or complaint-oriented approach would better reflect the evidence.

In addition, it is argued that the current approach based on exceeding a threshold of symptoms does not adequately take into account the context in which a person is living, and to what extent there is internal disorder of an individual versus a psychological response to adverse situations. The DSM does include a step ("Axis IV") for outlining "Psychosocial and environmental factors contributing to the disorder" once someone is diagnosed with that particular disorder.

Because an individual's degree of impairment is often not correlated with symptom counts, and can stem from various individual and social factors, the DSM's standard of distress or disability can often produce false positives. On the other hand, individuals who don't meet symptom counts may nevertheless experience comparable distress or disability in their life.

Despite doubts about arbitrary cut-offs, yes/no decisions often need to be made (e.g. whether a person will be provided a treatment) and the rest of medicine is committed to categories, so it is thought unlikely that any formal national or international classification will adopt a fully dimensional format.

**Cultural bias**

Some psychiatrists also argue that current diagnostic standards rely on an exaggerated interpretation of neurophysiological findings and so understate the scientific importance of social-psychological variables. Advocating a more culturally sensitive approach to psychology, critics such as Carl Bell and Marcello Maviglia contend that the cultural and ethnic diversity of individuals is often discounted by researchers and service providers. In addition, current diagnostic guidelines have been criticized as having a fundamentally Euro-American outlook. Although these guidelines have been widely implemented, opponents argue that even when a diagnostic criteria set is accepted across different cultures, it does not necessarily indicate that the underlying constructs have any validity within those cultures; even reliable application can only demonstrate consistency, not legitimacy. Cross-cultural psychiatrist Arthur Kleinman
contends that the Western bias is ironically illustrated in the introduction of cultural factors to the DSM-IV: the fact that disorders or concepts from non-Western or non-mainstream cultures are described as "culture-bound", whereas standard psychiatric diagnoses are given no cultural qualification whatsoever, is to Kleinman revelatory of an underlying assumption that Western cultural phenomena are universal. Kleinman's negative view towards the culture-bound syndrome is largely shared by other cross-cultural critics, common responses included both disappointment over the large number of documented non-Western mental disorders still left out, and frustration that even those included were often misinterpreted or misrepresented. Many mainstream psychiatrists have also been dissatisfied with these new culture-bound diagnoses, although not for the same reasons. Robert Spitzer, a lead architect of the DSM-III, has held the opinion that the addition of cultural formulations was an attempt to placate cultural critics, and that they lack any scientific motivation or support. Spitzer also posits that the new culture-bound diagnoses are rarely used in practice, maintaining that the standard diagnoses apply regardless of the culture involved. In general, the mainstream psychiatric opinion remains that if a diagnostic category is valid, cross-cultural factors are either irrelevant or are only significant to specific symptom presentations.

**Drug companies and medicalization**

It has also been alleged that the way the categories of the DSM are structured, as well as the substantial expansion of the number of categories, are representative of an increasing medicalization of human nature, which may be attributed to disease mongering by pharmaceutical companies and psychiatrists, whose influence has dramatically grown in recent decades. Of the authors who selected and defined the DSM-IV psychiatric disorders, roughly half had had financial relationships with the pharmaceutical industry at one time, raising the prospect of a direct conflict of interest. In 2005, then American Psychiatric Association President Steven Sharfstein released a statement in which he conceded that psychiatrists had "allowed the biopsychosocial model to become the bio-bio-bio model".
However, although the number of identified diagnoses has increased by more than 200% (from 106 in DSM-I to 365 in DSM-IV-TR), psychiatrists such as Zimmerman and Spitzer argue it almost entirely represents greater specification of the forms of pathology, thereby allowing better grouping of more similar patients.

**Political controversies**

There is scientific and political controversy regarding the continued inclusion of sex-related diagnoses such as the paraphilias (sexual fetishes) and hypoactive sexual desire disorder (low sex drive). Critics of these and other controversial diagnoses often cite the DSM's previous inclusion of homosexuality, and the APA's eventual decision to remove it, as a precedent for current disputes. A survey has suggested however that around the world a majority of psychiatrist view homosexuality as indicating a mental illness. Stanton Jones, Ph.D. and Mark Yarhouse, Psy.D challenge studies which have run tests on "a group of "healthy" homosexuals and compared those results with results from a group of heterosexuals." as being "the logical equivalent" to if a "sample of intellectually gifted women performed as well as a sample of men on a math test." Jones and Yarhouse agree however that such studies have proven "it is not the case that all homosexuals are manifestly disturbed." The consensus though from the American Psychiatric Association, American Psychological Association, and other institutions in other countries, is that the research and clinical literature demonstrate that same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality. Leaders of the Hearing Voices Network such as psychiatrist Marius Romme have claimed that many people who hallucinate "are like homosexuals in the 1950s -- in need of liberation, not cure."

Disputes over inclusion or exclusion can underscore the fact that reevaluation of controversial disorders can be viewed as a political as well as scientific decision. Indeed, Robert Spitzer, a past editor and leading proponent of scientific impartiality in the DSM, conceded that a significant reason that certain diagnoses (the paraphilias) would not, in his opinion, be removed from the DSM is because "it would be a public relations disaster for psychiatry". A similar line of criticism has appeared in non-
specialist venues. In 1997, Harper's Magazine published an essay, ostensibly a book review of the DSM-IV, that criticized the lack of hard science and the proliferation of disorders. The language of the DSM was described as "simultaneously precise and vague" in order to provide an aura of scientific objectivity yet not limit psychiatrists in a semantic or financial sense, and the manual itself compared to "a militia's Web page, insofar as it constitutes an alternative reality under siege" by critics.

**Consumers**

A Consumer is a person who has accessed psychiatric services and been given a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders*. Some consumers are relieved to find that they have a recognized condition to which they can give a name. Indeed, many people self-diagnose. Others, however, feel they have been given a "label" that invites social stigma and discrimination, or one that they simply do not feel is accurate. Diagnoses can become internalized and affect an individual's self-identity, and some psychotherapists find that this can worsen symptoms and inhibit the healing process. Some in the Consumer/Survivor/Ex-Patient Movement actively campaign against their diagnosis, or its assumed implications, and/or against the DSM system in general. It has been noted that the DSM often uses definitions and terminology that are inconsistent with a recovery model, and that can erroneously imply excess psychopathology (e.g. multiple "comorbid" diagnoses) or chronicity.

**DSM-5: the next version**

The next (fifth) edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), DSM-5, is currently in consultation, planning and preparation. It is due for publication in May 2013. APA has a website about the development, including draft versions, of what it is now referring to as the DSM-5 (rather than the roman numeral). It includes several changes, including proposed deletion of several types of schizophrenia.
Phobia

A phobia (from the Greek: φόβος, meaning "fear" or "morbid fear") is defined as a persistent fear of an object or situation in which the sufferer commits to great lengths in avoiding despite the fear, typically disproportional to the actual danger posed, often being recognized as irrational. In the event the phobia cannot be avoided entirely, the sufferer will endure the situation or object with marked distress and significant interference in social or occupational activities. The terms distress and impairment as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR) should also take into account the context of the sufferer's environment if attempting a diagnosis. The DSM-IV-TR states that if a phobic stimulus, whether it be an object or a social situation, is absent entirely in an environment - a diagnosis cannot be made. An example of this situation would be an individual who has a fear of mice (Suriphobia) but lives in an area devoid of mice. Even though the concept of mice causes marked distress and impairment within the individual, because the individual does not encounter mice in the environment no actual distress or impairment is ever experienced. Proximity and the degree to which escape from the phobic stimulus should also be considered. As the sufferer approaches a phobic stimulus, anxiety levels increase (e.g. as one gets closer to a snake, fear increases in Ophidiophobia), and the degree to which escape of the phobic stimulus is limited has the effect of varying the intensity of fear in instances such as riding an elevator (e.g. anxiety increases at the midway point between floors and decreases when the floor is reached and the doors open). Finally, a point warranting clarification is that the term phobia is an encompassing term and when discussed is usually done in terms of specific phobias and social phobias. Specific phobias are nouns such as arachnophobia or acrophobia which, as the name implies, are specific, and social phobia are phobias within social situations such as public speaking and crowded areas. The following article will be broken down into two sections: Specific Phobias and Social Phobias. Focal points that will be addressed are areas such as epidemiology, etiology, criteria for diagnosis etc.
Specific Phobias

As briefly mentioned above, a specific phobia is a marked and persistent fear of an object or situation which brings about an excessive or unreasonable fear when in the presence of, or anticipating, a specific object; furthermore, the specific phobias may also include concerns with losing control, panicking, and fainting which is the direct result of an encounter with the phobia. The important distinction from social phobias are specific phobias are defined in regards to objects or situations whereas social phobias emphasizes more on social fear and the evaluations that might accompany them.

Diagnosis

The diagnostic criteria for 300.29 Specific Phobias as outlined by the DSM-IV-TR:

1. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
2. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
3. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
4. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
5. The avoidance, anxious anticipation or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
6. In individuals under age 18 years, the duration is at least 6 months.
7. The anxiety, panic attack, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated
with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

**Etiology**

**Environmental**

This is caused by what are called neutral, unconditioned, and conditioned stimuli, which trigger either conditioned or unconditioned responses. An example would be a person who was attacked by a dog (the unconditioned stimulus) would respond with an unconditioned response. When this happens, the unconditioned stimulus of them being attacked by the dog would become conditioned, and to this now conditioned stimulus, they would develop a conditioned response. If the occurrence had enough of an impact on this certain person then they would develop a fear of that dog, or in some cases, an irrational fear of all dogs.

Phobias are known as an emotional response learned because of difficult life experiences. Generally phobias occur when fear produced by a threatening situation is transmitted to other similar situations, while the original fear is often repressed or forgotten. The excessive, unreasoning fear of water, for example, may be based on a childhood experience of almost drowning. The individual attempts to avoid that situation in the future, a response that, while reducing anxiety in the short term, reinforces the association of the situation with the onset of anxiety.

Some phobias are generated from the observation of a parent's or sibling's reaction. The observer then can take in the information and generate a fear of whatever they experienced.
Regions of the brain associated with phobias

Neurobiology

Phobias are generally caused by an event recorded by the amygdala and hippocampus and labeled as deadly or dangerous; thus whenever a specific situation is approached again the body reacts as if the event were happening repeatedly afterward. Treatment comes in some way or another as a replacing of the memory and reaction to the previous event perceived as deadly with something more realistic and based more rationally. In reality most phobias are irrational, in that the subconscious association causes far more fear than is warranted based on the actual danger of the stimulus; a person with a phobia of water may admit that their physiological arousal is irrational and over-reactive, but this alone does not cure the phobia.

Phobias are more often than not linked to the amygdala, an area of the brain located behind the pituitary gland in the limbic system. The amygdala may trigger secretion of hormones that affect fear and aggression. When the fear or aggression response is initiated, the amygdala may trigger the release of hormones into the body to put the human body into an "alert" state, in which they are ready to move, run, fight, etc. This defensive "alert" state and response is generally referred to in psychology as the fight-or-flight response.

Clinical phobias
Psychologists and psychiatrists classify most phobias into three categories and, according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), such phobias are considered to be sub-types of anxiety disorder. The three categories are:

- **Social phobia** - fears involving other people or social situations such as performance anxiety or fears of embarrassment by scrutiny of others, such as eating in public. Overcoming social phobia is often very difficult without the help of therapy or support groups. Social phobia may be further subdivided into
  - **generalized social phobia** (also known as social anxiety disorder or simply social anxiety) and
  - **specific social phobia**, in which anxiety is triggered only in specific situations. The symptoms may extend to psychosomatic manifestation of physical problems. For example, sufferers of paruresis find it difficult or impossible to urinate in reduced levels of privacy. This goes far beyond mere preference: when the condition triggers, the person physically cannot empty their bladder.

- **Specific phobias** - fear of a single specific panic trigger such as spiders, snakes, dogs, water, heights, flying, catching a specific illness, etc. Many people have these fears but to a lesser degree than those who suffer from specific phobias. People with the phobias specifically avoid the entity they fear.

- **Agoraphobia** - a generalized fear of leaving home or a small familiar 'safe' area, and of possible panic attacks that might follow. May also be caused by various specific phobias such as fear of open spaces, social embarrassment (social agoraphobia), fear of contamination (fear of germs, possibly complicated by obsessive-compulsive disorder) or PTSD (post traumatic stress disorder) related to a trauma that occurred out of doors.

Phobias vary in severity among individuals. Some individuals can simply avoid the subject of their fear and suffer relatively mild anxiety over that fear. Others suffer full-fledged panic attacks with all the associated disabling symptoms. Most individuals understand that they are suffering from an irrational fear, but they are powerless to override their initial panic reaction.
Treatments

Various methods are claimed to treat phobias. Their proposed benefits may vary from person to person.

Some therapists use virtual reality or imagery exercise to desensitize patients to the feared entity. These are parts of systematic desensitization therapy.

Cognitive behavioral therapy (CBT) can be beneficial. Cognitive behavioral therapy lets the patient understand the cycle of negative thought patterns, and ways to change these thought patterns. CBT may be conducted in a group setting. Gradual desensitisation treatment and CBT are often successful, provided the patient is willing to endure some discomfort. In one clinical trial, 90% of patients were observed with no longer having a phobic reaction after successful CBT treatment.

Eye Movement Desensitization and Reprocessing (EMDR) has been demonstrated in peer-reviewed clinical trials to be effective in treating some phobias. Mainly used to treat Post-traumatic stress disorder, EMDR has been demonstrated as effective in easing phobia symptoms following a specific trauma, such as a fear of dogs following a dog bite.

Hypnotherapy coupled with Neuro-linguistic programming can also be used to help remove the associations that trigger a phobic reaction. However, lack of research and scientific testing compromises its status as an effective treatment.

Antidepressant medications such SSRIs, MAOIs may be helpful in some cases of phobia. Benzodiazepines may be useful in acute treatment of severe symptoms but the risk benefit ratio is against their long-term use in phobic disorders.

There are also new pharmacological approaches, which target learning and memory processes that occur during psychotherapy. For example, it has been shown that glucocorticoids can enhance extinction-based psychotherapy.

Emotional Freedom Technique, a psychotherapeutic alternative medicine tool, also considered to be pseudoscience by the mainstream medicine, is allegedly useful.
These treatment options are not mutually exclusive. Often a therapist will suggest multiple treatments.

**Epidemiology**

Phobias are a common form of anxiety disorders. An American study by the National Institute of Mental Health (NIMH) found that between 8.7% and 18.1% of Americans suffer from phobias. Broken down by age and gender, the study found that phobias were the most common mental illness among women in all age groups and the second most common illness among men older than 25.

**Non-psychological conditions**

The word "phobia" may also signify conditions other than fear. For example, although the term *hydrophobia* means a fear of water, it may also mean inability to drink water due to an illness, or may be used to describe a chemical compound which repels water. It was also once used as a synonym for rabies, as an aversion to water is one of its symptoms. Likewise, the term photophobia may be used to define a physical complaint (i.e. aversion to light due to inflamed eyes or excessively dilated pupils) and does not necessarily indicate a fear of light.

**Non-clinical uses of the term**

It is possible for an individual to develop a phobia over virtually anything. The name of a phobia generally contains a Greek word for what the patient fears plus the suffix -*phobia*. Creating these terms is something of a word game. Few of these terms are found in medical literature. However, this does not necessarily make it a non-psychological condition.

**Terms for prejudice or discrimination**

A number of terms with the suffix -phobia are used non-clinically but have gained public acceptance, though they are often considered buzzwords. Such terms are primarily understood as negative attitudes towards certain categories of people or other things, used in an analogy with the medical usage of the term. Usually these
kinds of "phobias" are described as fear, dislike, disapproval, prejudice, hatred, discrimination, or hostility towards the object of the "phobia". Often this attitude is based on prejudices and is a particular case of most xenophobia. These non-clinical phobias are typically used as labels cast on someone by another person or some other group.

Below are some examples:

- Chemophobia – prejudice against artificial substances in favour of "natural" substances.
- Ephebiphobia – fear or dislike of youth or adolescents.
- Homophobia – fear or dislike of homosexuals or homosexuality.
- Xenophobia – fear or dislike of strangers or the unknown, sometimes used to describe nationalistic political beliefs and movements. It is also used in fictional work to describe the fear or dislike of space aliens.

Everyone, from the youngest child to the oldest adult, experiences anxieties and fears at one time or another. Feeling anxious in a particularly uncomfortable situation never feels very good. However, with kids, such feelings are not only normal, they're also necessary. Dealing with anxieties can prepare young people to handle the unsettling experiences and challenging situations of life.

**Many Anxieties and Fears Are Normal**

Anxiety is defined as "apprehension without apparent cause." It usually occurs when there's no immediate threat to a person's safety or well being, but the threat feels real.

Anxiety makes someone want to escape the situation — fast. The heart beats quickly, the body might begin to perspire, and "butterflies" in the stomach soon follow. However, a little bit of anxiety can actually help people stay alert and focused.

Having fears or anxieties about certain things can also be helpful because it makes kids behave in a safe way. For example, a kid with a fear of fire would avoid playing with matches.
The nature of anxieties and fears change as kids grow and develop:

Babies experience stranger anxiety, clinging to parents when confronted by people they don't recognize.

Toddlers around 10 to 18 months old experience separation anxiety, becoming emotionally distressed when one or both parents leave.

Kids ages 4 through 6 have anxiety about things that aren't based in reality, such as fears of monsters and ghosts.

Kids ages 7 through 12 often have fears that reflect real circumstances that may happen to them, such as bodily injury and natural disaster.

As kids grow, one fear may disappear or replace another. For example, a child who couldn't sleep with the light off at age 5 may enjoy a ghost story at a slumber party years later. And some fears may extend only to one particular kind of stimulus. In other words, a child may want to pet a lion at the zoo but wouldn't dream of going near the neighbor's dog.

**Signs of Anxiety**

Typical childhood fears change with age. They include fear of strangers, heights, darkness, animals, blood, insects, and being left alone. Kids often learn to fear a specific object or situation after having an unpleasant experience, such as a dog bite or an accident.

Separation anxiety is common when young children are starting school, whereas adolescents may experience anxiety related to social acceptance and academic achievement.

If anxious feelings persist, they can take a toll on a child's sense of well being. The anxiety associated with social avoidance can have long-term effects. For example, a child with fear of being rejected can fail to learn important social skills, causing social isolation.

Many adults are tormented by fears that stem from childhood experiences. An adult's fear of public speaking may be the result of embarrassment in front of peers many
years before. It's important for parents to recognize and identify the signs and symptoms of kids' anxieties so that fears don't get in the way of everyday life.

Some signs that a child may be anxious about something may include:

- becoming clingy, impulsive, or distracted
- nervous movements, such as temporary twitches
- problems getting to sleep and/or staying asleep longer than usual
- sweaty hands
- accelerated heart rate and breathing
- nausea
- headaches
- stomachaches

Apart from these signs, parents can usually tell when their child is feeling excessively uneasy about something. Lending a sympathetic ear is always helpful, and sometimes just talking about the fear can help a child move beyond it.

**Focusing on Anxieties, Fears, or Phobias**

Try to answer the following questions honestly:

Is your child's fear and behavior related to it typical for your child's age? If the answer to this question is yes, it's a good bet that your child's fears will resolve before they become a serious cause for concern. This isn't to say that the anxiety should be discounted or ignored; rather, it should be considered as a factor in your child's normal development.

Many kids experience age-appropriate fears, such as being afraid of the dark. Most, with some reassurance and perhaps a night-light, will overcome or outgrow it. However, if they continue to have trouble or there's anxiety about other things, the intervention may have to be more intensive.
What are the symptoms of the fear, and how do they affect your child's personal, social, and academic functioning? If symptoms can be identified and considered in light of your child's everyday activities, adjustments can be made to alleviate some of the stress factors.

Does the fear seem unreasonable in relation to the reality of the situation; and could it be a sign of a more serious problem? If your child's fear seems out of proportion to the cause of the stress, this may signal the need to seek outside help, such as a counselor, psychiatrist, or psychologist.

Parents should look for patterns. If an isolated incident is resolved, don't make it more significant than it is. But if a pattern emerges that's persistent or pervasive, you should take action. If you don't, the phobia is likely to continue to affect your child.

Contact your doctor and/or a mental health professional who has expertise in working with kids and adolescents.

**Helping Your Child**

Parents can help kids develop the skills and confidence to overcome fears so that they don't evolve into phobic reactions.

To help your child deal with fears and anxieties:

Recognize that the fear is real. As trivial as a fear may seem, it feels real to your child and it's causing him or her to feel anxious and afraid. Being able to talk about fears helps — words often take some of the power out of the negative feeling. If you talk about it, it can become less powerful.

Never belittle the fear as a way of forcing your child to overcome it. Saying, "Don't be ridiculous! There are no monsters in your closet!" may get your child to go to bed, but it won't make the fear go away.

Don't cater to fears, though. If your child doesn't like dogs, don't cross the street deliberately to avoid one. This will just reinforce that dogs should be feared and avoided. Provide support and gentle care as you approach the feared object or situation with your child.
Teach kids how to rate fear. A child who can visualize the intensity of the fear on a scale of 1 to 10, with 10 being the strongest, may be able to "see" the fear as less intense than first imagined. Younger kids can think about how "full of fear" they are, with being full "up to my knees" as not so scared, "up to my stomach" as more frightened, and "up to my head" as truly petrified.

Teach coping strategies. Try these easy-to-implement techniques. Using you as "home base," the child can venture out toward the feared object, and then return to you for safety before venturing out again. The child can also learn some positive self-statements, such as "I can do this" and "I will be OK" to say to himself or herself when feeling anxious. Relaxation techniques are helpful, including visualization (of floating on a cloud or lying on a beach, for example) and deep breathing (imagining that the lungs are balloons and letting them slowly deflate).

What is child anxiety?

All humans experience anxiety, it serves as a means of protection and can often enhance our performance in stressful situations. Children who are able to experience the slight rush of anxiety that often occurs prior to a math test or a big track race often can enhance their performance. However, experiencing too much anxiety or general nervousness, at inappropriate times, can be extremely distressing and interfering.

Although children have fears of specific objects, the feeling of anxiety is more general…children may feel constantly “keyed up” or extremely alert. Given the wide range of tasks children must accomplish throughout their childhood, it is important to be sure that their level of anxiety does not begin to interfere with their ability to function. If it does, it is important that they begin to learn some skills for coping more efficiently with their anxious feelings.

What are fears and phobias?

Children’s fears are often natural, and arise at specific times in their development. Children may develop fears from a traumatic experience (e.g. traumatic dog attack), but for some children, there is no clear event that causes the fear to arise. Some children become fearful simply by watching another child acting scared. Some children may refuse to sleep alone due to fears of creatures in their closet, while other children report feeling afraid of the dark. Children's fears are often associated with avoidance, discomfort, and physical complaints, such as rapid heart beat, stomach
distress, sweaty palms, or trembling. Researchers have found certain fears arise at
specific ages in all children, and these fears tend to disappear naturally with time, as
the child grows older. When children’s fears persist beyond the age when they are
appropriate, and begin to interfere with their daily functioning, they are called
phobias. Typically, children who are experiencing a phobia should be referred for
treatment by a psychologist.

Which of my child’s fears are normal?
Most children, when asked, are able to report having several fears at any given age.
Some research shows that 90% of children between the ages of 2-14 have at least one
specific fear. If your child’s fear is not interfering with his/her daily life (e.g., sleep,
school performance, social activities), or your family’s life, then most likely you will
not need to bring your child to a psychologist for help. Here are a list of fears that are
found to be VERY COMMON for children at specific ages:
INFANTS/TODDLERS (ages 0-2 years) loud noises, strangers, separation from
parents, large objects

PRESCHOOLERS (3-6 years) imaginary figures (e.g., ghosts, monsters, supernatural
beings, the dark, noises, sleeping alone, thunder, floods)

SCHOOL AGED CHILDREN/ADOLESCENTS (7-16 years) more realistic fears
(e.g., physical injury, health, school performance, death, thunderstorms, earthquakes,
floods.

WHAT DO CHILDREN FEAR?

The objects and situations that children fear vary a good deal. When very young
children show fear it can be hard to judge exactly what is causing it, and many parents
underestimate the number of things that frighten their children. In one study of ‘just-
fours’, parents reported that two-thirds of children had recurrent fears, and other
research points to a typical pattern and there are some fears such as as snakes, spiders
and heights that seem common to us as a species. Parents should always be aware that
some intense fears are quite a natural developmental stage and will ease naturally.
The following is a general list of normal fears:
Age 2-4: fear of animals, loud noises, being left alone, inconsistent discipline, toilet training, bath, bedtime, monsters and ghosts, bed wetting, disabled people, death and injury.

Age 4-6: fear of darkness and imaginary creatures. Also animals, bedtime, monsters and ghosts. Other fears, such as of strangers seem to be persistent. 'Stranger fear' would probably be called 'shyness', while fear of snakes tends not to decrease much, if at all, during this period. Children at this age may also fear loss of a parent, death, injury and divorce.

Beyond these ages, irrational fears tend to decline rapidly, though there may be further peaks to do with other situations, e.g. age 9-11: fear of school; fear of blood and injury.

Older children tend to worry more about death and related topics such as nuclear war. Up to age 11 boys and girls tend to be equally represented in the 'fear tables'; after 11 years boys lose their fears more rapidly than girls.

It has been suggested by some research that children between the ages of three and six; sometimes confuse reality, dreams and fantasy. This concept has been challenged in recent years, so it is not safe to believe that everything that the child of this age fears is just something they will grow out of. Young children may also sometimes believe that inanimate or non-living objects have lifelike qualities. They may too have inaccurate concepts of size relationships (monsters that can come up through plug-hole for example). They may also lack an accurate understanding of cause and effect and often perceive themselves as helpless and powerless, without effective means to control what is happening to them. 8 year-olds will probably have fragments of earlier fears but additional ones will tend to be more rationally based and will possibly include fear being late for school, social rejection, criticism, new situations, adoption, burglars, personal danger and war. 9 and 10 year-olds are also likely to fear divorce, personal danger and war and these three are very likely to continue as fear problems
into the mid teens. This age group might also fear blood and injury. 11 and 12 year-olds might fear animals, kidnapping, being alone in the dark and injections. Marks states that beyond this age boys lose their fears more readily than girls. 13 year-olds seem to fear heights as well as the three mentioned above.

14-16 year-olds will tend to have a wide range of rational or almost rational fears which might include: injury, kidnapping, being alone in the dark, injections, heights, terrorism, plane or car crashes, sexual relations, drug use, public speaking, school performance, crowds, gossip and divorce.

These childhood fears are not that different from those of adults. The most common adult fears are: public speaking, making mistakes, failure, disapproval, rejection, angry people, being alone, darkness, dentists, injections, hospitals, taking tests, open wounds and blood, police, dogs, spiders and deformed people.

As will be noted from the above, many childhood problems wax and wane as a normal part of development and a sensitivity in a certain area might be aggravated by a current problem so that this particular child temporarily ‘falls back’ into an earlier level of fear when faced with a trauma or severe family or school problems.

**WHAT ARE THE SYMPTOMS OF PHOBIA?**

In adults, phobias produce all the unpleasant physical symptoms of 'normal' fear:

* heart palpitations
* feeling sick
* chest pains
* difficulty breathing
* dizziness
* 'jelly legs'
* feeling 'unreal'
* intense sweating
* feeling faint
* dry throat
* restricted or 'fuzzy' vision or hearing.

In severe cases, people may feel certain that they are about to die, go mad, or lose control of themselves and injure someone, or do something disgusting and humiliating. Most of all they feel an overpowering urge to 'escape' from the situation they are in. Children are more likely to cry, shout or scream, or simply run away when confronted by the things they fear, though they may also be sick or go rigid. Paleness, perspiration and trembling are also signs of severe anxiety.

The level of symptoms that children with phobias experience varies a great deal, from very mild anxiety to very severe panic and terror. A mild degree of nervousness in particular situations is not usually a problem, but it is only a matter of degree, and at the other end of the scale there are children who have full-scale panic attacks when in the dreaded situation, and soon refuse to enter it altogether because of the terror that grips them at such times.

Phobias aren't just severe anxiety: the anxiety is turned into a phobia by avoidance. In the early stages of a phobia the child's parents sometimes try to tackle his or her fears head on by forcing him or her to enter the feared situation. If this works, the phobia can be overcome. If it doesn't, this is only likely to strengthen the fears and make the child want to avoid the phobic situation even more. It also risks destroying the child's confidence in its parents.

Avoidance is attractive because it brings a reduction of the tension; thus it rapidly becomes a habit. As with adults, avoiding the situations that make them feel frightened makes children more sensitive to those situations, and 'conditions' them to fear them even more.

This is why phobias can be such a big problem. Because we tend to avoid the things we fear, the fear can worsen very rapidly. To recover, we need to put that process into reverse, but the fear reaction is virtually automatic, and very difficult to control. It is a reaction inherited from our early history as a species, when we needed some instinctive protection to balance out our curiosity and tendency to flirt with danger. Fortunately, humans learn quickly and can train themselves to respond positively to threats, and not to react with terror to things which prove, with experience, to be harmless.
IT CAN'T JUST BE ANXIETY, CAN IT?

A child with severe phobic symptoms has an anxiety condition. This is much worse than just being nervous or 'a bit of a worrier'. Anxiety at this level can be as disabling as many physical diseases. However, because it seems unreasonable for someone to react so strongly to such ordinary situations, many parents may suspect a more 'logical' explanation - perhaps a serious physical or mental illness. Then the child may become a frequent visitor to the doctor's surgery and undergo a long series of medical tests, all of which draw a blank.

It often comes as a great relief to parents when they learn that the problem is not a brain tumour, psychosis etc., and that the nasty and frightening symptoms are in fact caused by anxiety. However, there is always the remote possibility that the child also has a medical condition, and this is one reason why we always recommend parents of phobic children to keep in touch with their GP.

HOW CAN CHILDREN'S FEARS BE TREATED?

The first thing to be considered is whether or not the phobia impacts strongly on the child's life. If it does not interfere with day-to-day functioning then it might be worth considering allowing nature to take its course. If there is a level of handicap or severe distress, then treatment is indicated.

Persistent fears in children can be treated in much the same way as they are in adults; that is by desensitisation through being exposed to the feared situation. However, as children's fears are often volatile and transitory the child's previous record with fears should be considered before launching into an elaborate treatment programme. As already said, most fears will cease to be a problem without any need for treatment, and there is always the risk of teaching the child a new way of getting attention if every expression of fear brings a dramatic response from a parent. (Of course, if a child feels the need to use 'fears' as a way to be noticed, this might indicate different kinds of problem within the family.)

Nobody with a phobia responds to punishment or obtains the slightest improvement from being 'talked out of it'. Children in particular seem to respond best to being helped to increase their skill and competence, and being encouraged to take part in
activities that will involve the thing they fear. With young children especially, practical activities that involve exposure could also be turned into a game, since most children respond better to play than to work. With a fear of bees, for instance:

**first the bee is shown in a sealed bottle, some distance away**

then it is brought closer; then closer (the child can be rewarded with a small treat for every shoe's length closer he or she is prepared to approach the bottle - or allows the bottle to approach, if that is less stressful). Eventually the child can be helped to touch the bottle, with a grand prize for this. Other exposure 'steps' could include walking in the garden (accompanied at first) when bees are about, with an escape route clearly established to build confidence. If the parent is feeling brave, further exposure could be undertaken by 'modelling', i.e. doing the feared thing and showing the child in practice that there is no need to be afraid. In the case of a bee this might involve letting the bee alight on their clothing, with the child safely distant. In extreme cases of phobia in children a therapist might use relaxation, videos and 'fantasy exposure' (helping the child to face the dreaded situation in his or her imagination) before attempting live exposure work.

**Talking help**

Most children do not want to upset their parents and may be resistant to talking about the intensity of their feelings. If this is the case, one technique suggested by Anxiety Care is to ask the child what he or she thinks a close friend would be feeling in this situation. This doesn’t work, of course, if the friend is perceived to be tough, but if the child can be helped to explore this cared-for person’s possible responses in similar situations, where he or she was afraid, this can establish the level of fear that the phobic child accepts as ‘normal’. Parents can sometimes be horrified at the fear levels uncovered in this way and it is important that an over reaction that involves shame and feelings of worthlessness as a parent do not become involved. If it does, this will only cloud the issue and unbalance the necessary socialising and discipline that the child needs in the rest of his or her daily life. When the child resists support, it can become very difficult. Where very negative thinking is involved, the parent can try to help by gently challenging the child’s
thought processes. This is described in ‘Poor Thinking’ on this site. Obviously a heavy challenge is rarely likely to work with a very young child and the parent needs to work out the best way to approach the problem: in some way helping the child to look at his or her thoughts and beliefs in a way that is challenging, not threatening. If the child refuses all help then the parent could usefully talk to a doctor or therapist without the child being present in order to learn ways to apply help at such time that the child is willing to accept it.

**Depression**

Sometimes depression occurs alongside a severe phobia. The problem here is that depression undermines: it takes away the will to try to overcome the phobia and may even make the sufferer feel that he or she is helpless against it. Where depression is suspected the GP must become involved. If the depression is mild or moderate, the child will probably receive help focused on the anxiety with concurrent support for the depression. If the depression is judged to be severe, the focus will be on treating the depression.

**Medication**

Drugs are rarely the first treatment of choice for young children. In the developing brain the neurotransmitting system seems to be particularly sensitive to medication so it is unlikely that a doctor would suggest medication early on in treatment for a very young child. If it is considered, the dosages would have to be very carefully monitored.

**SCHOOL PHOBIA (SCHOOL REFUSING)**

The number of children who dislike school and avoid it whenever possible is probably more than 5% of the school-age population, but less than 1% could genuinely be called 'school phobic'. School phobia, also called 'school refusal' is commoner among boys, and the peak onset in Britain is at the age of 11-12 years. This is perhaps not surprising, since this is the age when most children move from primary to secondary school, and therefore experience great changes in their lives. There are also smaller peaks at the age of 5-7 years old, where separation from the mother may be a primary cause (See the article on separation anxiety on this site); and
at 14, where it is more likely to be associated with a psychiatric disorder such as depression.

Some older adolescents and young adults may experience fears of college or work that resemble school phobia; most of these will have been school refusers when children.

Sometimes school refusing begins suddenly, for instance after a prolonged absence from school due to illness; following an abrupt change of school or class; after school holidays - or even after a weekend. However, the actual event immediately before school refusal is unlikely to be the sole cause of the problem, though it might have been the last straw on top of a lot of other things. These additional situations could include family problems; difficulties at school; anxiety about puberty; other sexual matters; general difficulty with social situations; anxiety about being separated from the parents (mainly the mother); bereavement; or depression. However, most cases of school refusal seem to develop slowly. Reluctance to attend gradually increases, with visible signs of anxiety that grow more obvious as the child is pressured to go. Sometimes the child will deny that he or she is afraid, but signs such as paleness, trembling and frequent urination may be very obvious to the parent. Typically the child will complain of bodily pains, stomach trouble or nausea in the early morning. These problems usually cease abruptly if the child is allowed to stay at home, and re-appear when he or she is once again pressured to go to school. Some children will simply refuse to go to school, offering no reason. Others might complain of bullying, or of being unable to get on with teachers or do the school work. Some may express fears about undressing in front of other children, or of making a spectacle of themselves by fainting, vomiting or losing control of their bowels. Less often they may mention fears of something happening to one or both of their parents while they are at school, or simply of feeling 'unsafe' when far from home.

Children deal with their fear of attending school in many ways. Some may go through the morning ritual almost normally, but are then unable to leave the house, or turn back before reaching school. Others may flatly refuse to get out of bed, or lock themselves in somewhere, or run off until they feel it is safe to return home. Some
will gladly put up with punishment as the price of not going, and many will promise (and mean it at the time) to go 'this afternoon' or 'tomorrow' if they are only allowed to stay at home now. Some children have been known to threaten, or even attempt, suicide when they felt totally trapped by the situation.

**PHOBIA OR TRUANCY?**

School phobia is sometimes confused with truancy - even by teachers and educational workers. However, truants do not usually express or display such high levels of anxiety, and nor do they flatly refuse to attend school. It is just that there are other things they would rather be doing. They are more likely to pretend to set off for school, and then disappear on the way, or during the day, returning home at the normal time, so that parents are often the last to find out what is happening. Truants also tend to become involved in other delinquent behaviour. They may also come from disadvantaged areas and homes where there is not enough discipline, caring, or simple parental interest. Their school work is likely to be rather poor and they will probably show little interest in what the school thinks of them.

This is in sharp contrast to the typical school refuser, who comes from a stable home with both parents present and caring (if sometimes over-protective) and who is often described as "always such a good boy/girl - never any trouble before this". Typical refusers may also be sensitive to the point of timidity, being unduly wounded by adverse comments from teachers, and have unrealistically high goals for themselves; they may then become excessively upset at their perceived failures.

**TREATMENT FOR SCHOOL REFUSAL**

Anxiety Care receives many letters and phone calls from parents of school refusers. Besides the anxiety and confusion, many share a feeling of guilt. They have been told, or have read, that it is "all their fault" for making a "mummy's boy (or girl)" out of the child. In our culture, that usually means 'wimpish' and 'inadequate'. Parental reactions can then be deep shame or anger and a closing of family ranks. None of this is conducive to helping the child out of the problem.

Although 'separation anxiety' (difficulty in leaving mother) can be a major factor in school refusal for 5 to 7 year-olds, it is not necessarily significant for older children.
'Real' fears of such things as being bullied, PE and games, unfriendly teachers, the size of the school, and other personal and family difficulties, might be the dominant factors. Several cases brought to Anxiety Care have been triggered (or 'last-strawed') by a death in the family. Sometimes it was not a close relative, or even a human being that died; but for an 11 or 12 year-old this may have been the first time that the finality of death came home to them; and this can be a shock. Even if the experience wasn't particularly traumatic, it is never safe to assume that children will deal with such a loss as an adult would.

Children may also react to loss of friends through moving to a new school or area in the same way that they would to a bereavement. A good therapist would not jump to conclusions about reasons, but would make a systematic investigation of all the possible factors - child, family and school.

PROFESSIONAL THERAPY FOR SCHOOL REFUSING

Parents cannot afford to allow school refusal to be ignored or treated in a haphazard and ineffectual manner. The law requires a child to be educated, and most parents are not able to pick and choose where this takes place. If children do not go to school, parents may be taken to court, and there is even the (very slight) risk of the child being taken into care. Nobody wants this to happen, so professional help is usually readily available, and it is vital for parents to make the best use of it.

Most current treatments for school refusing are carried out around the home and the school by clinical child psychologists. They will involve helping the child to deal with anxiety symptoms in the situation where they developed, while getting the child back to school as quickly as possible. Inpatient treatment compares poorly with this kind of 'live' support, though a small minority of children do fare better away from home.

Some parents may be tempted to take their child out of the school system altogether, but research shows that temporary home tuition is not a useful road to recovery, and works against the child's early return to school. Permanent withdrawal, even if some children do better academically, and feel more content outside the school system, has some dangers. The child with low social skills may not learn how to relate to the peer group, which can become a major problem. The child may also never resolve the underlying problems that generated, or were part of, the school phobia.
They may thus become prime candidates for a similar anxiety disorder later in life when faced with going to college, or to work. They may also be so handicapped by lack of the social and 'peer' learning gained at school that character traits such as timidity, over-sensitivity, and the tendency to have unrealistic expectations of themselves and others, may become a permanent barrier between the young adult and the rest of the world. The problem with setting a goal of 'the child returning to school as quickly as possible' is deciding how soon to aim for. The therapist's personal beliefs and the extent of the child's anxiety will be the main factors here. However, whether the period is short or long, all therapists will have a series of priorities. They will: work at establishing a good, trusting relationship with the child and the family clarify the situations that actually create anxiety desensitize the child to these situations by getting the child to imagine the dreaded events, with relaxation techniques, and simply by talking about it lastly, they will help the child to confront the situations 'live'.

THERAPISTS AND PARENTS
Therapists are well aware that they need the full support of the child's family, and that there can be much confusion, anger, guilt and plain misconception to work through before therapy proper can begin. They would spend time with the parents, trying to assess how much bearing their behaviour and reactions have on the school refusal problem. They would probably meet with the parents alone, so that other problems which could be affecting the child might be resolved without the child being drawn into them (or feeling to blame for them). They would also talk through worries such as parents feeling cruel and guilty about forcing the child to go to school. Where parents are uneasy about seeming to criticise teachers, or staff feel threatened or irritated by the idea that their school is a 'dreaded place', they would also act as go-between.

The therapist would also help the parents find the best ways to deal with: the child's tantrums, complaints about illness, refusal to talk about the problem (or insistence on doing so) redressing the balance if the child had begun to dominate the family through
the phobia ways to avoid escalating threats and/or polarising into 'protecting mother' and 'threatening father' that can be so damaging in the families of school refusers.

Towards the end of the treatment, with the child ready to attend school, the therapist would also discuss the best times to return, such as after a weekend or a holiday, rather than in midweek, which might arouse more comment from other children. And they would work out, perhaps using role play, the responses the child might use to those making fun of his or her absence. After the child has returned to school, they would go on to help the parents recognise danger points in the future, and encourage them to use the 'management' techniques they have learned. Live exposure to the dreaded situation is part of overcoming all phobias. However, simply dragging a child to school would not be appropriate in most cases. While school may be the focus of fear, most school refusers get to that point via a number of 'stressor' situations working together. So before the journey to school is attempted, the various fears already mentioned have to be faced. Nevertheless, the journey to school has to be undertaken sooner or later, and this can be a very dramatic time, when the parents' anxiety is almost as high as the child's. Parent and therapist have to be clear how to deal with this. A good therapist will have explained that all 'exposure work' is built round the child's actual anxiety level, not what it should be or could be. This will ease parents' fears of the child experiencing a total collapse or breakdown. A strategy would be worked out in advance for certain situations, for example: with a young child, the parents would not linger within sight of the classroom, fuelling the child's anxiety as well as their own if the child was to be physically restrained from escaping, the parents wouldn't let the child think that a little more hysteria might bring them leaping to the defence there would be a planned response if the child should run home. It is extraordinarily hard for parents to stand by while their children suffer, even when they know it is necessary and temporary. Therapists work closely with parents, and they understand how important it is for the family to be able to support the child as he or she gradually comes to terms with school life.

Most children experience some nervousness at the beginning of a new school year. New teachers, new classes and a whole new routine can leave even the most even-
tempered child frazzled and exhausted in the first few weeks. Most of the time, children settle into a routine and quickly work through their early jitters.

For some children, however, normal anxiety gives way to more serious fears. Phobias are common in children. In fact, the majority of specific phobias appear by the time the sufferer is seven years old. Fortunately, most childhood phobias respond well to treatment. Children may not share their fears, so it often falls to parents to monitor their kids. Here are some things to look for in children of various ages.

**Elementary School**

According to developmental psychologist Jean Piaget, children are in the "concrete operational stage" of cognitive development from the ages of approximately seven to eleven. Their fears tend to reflect the concrete way in which they see their environment. Common phobias in elementary school aged children include fears of thunderstorms, animals, and the dark. School-related phobias may also develop, such as a fear of bigger kids or a fear of a teacher that is perceived as “mean.”

Children of this age often demonstrate their anxiety by regressing. They may become clingy, refuse to go into the classroom without a parent and cry or throw tantrums. They may also freeze or run when confronted with the feared situation. Physical complaints such as stomach aches are also common, and usually follow a pattern.

**Middle School**

Again, according to Piaget, most children enter the "formal operational stage" of development near the beginning of their middle school years. Pre-teens begin to understand abstract topics such as love, and begin to explore "shades of gray." It's also a time of immense pressure for many kids, as they struggle to establish their identities, forge more adult friendships and begin to plan for their futures.

The most common phobias in this age group tend to focus on school-related topics. "School phobia" is a general term that may apply to any fears that make the child reluctant to go to school. School phobia is thought to be related to separation anxiety, but may also stem from bullying or humiliation, or a simple reaction to new pressures.
Many kids of this age react to their fears through defiance. They may become argumentative or withdrawn, develop friendships with troublemakers, skip school or even turn to alcohol or drugs. Some children regress instead, becoming clingy and overly dependent on the parent.

**High School**

High school is a whirlwind time of changes and pressures. Kids of this age are torn between wanting to become adults and wanting to extend their childhoods. They worry about their grades, wonder if they will get into good colleges and struggle to develop adult relationships with their friends and dating partners.

Agoraphobia and social phobia are most common among this age group. Social phobia can be related to the body image issues that plague many teens. It may be restricted to a single situation, such as a fear of speaking in front of the class, or may be all-encompassing, making teens scared to be seen in public. Agoraphobia may develop out of an untreated social phobia or another disorder, or may appear alone. Agoraphobic teens may severely restrict their activities out of a fear of losing control in public.

Teens generally display many of the same phobia symptoms as adults. They may refuse to participate in certain activities. They may shake, sweat or show signs of illness before or during a confrontation with the feared activity. Teens may also turn to alcohol or drugs as an escape. They may spend a great deal of time alone, and may gradually develop depression or other disorders.

**Helping Your Child Confront a Phobia**

Although some phobias spontaneously go away without treatment, others will gradually worsen until treatment is obtained. However, it can be difficult for parents to know how to help, especially if the child is reluctant to discuss the situation.

If you notice a change in your child’s behavior, talk to him or her about your concerns. Keep your tone light and friendly, as kids are extremely perceptive to the moods of others. Ask him directly about his fears, but avoid making accusations.
Be supportive - within reason. Many parents’ first reaction is to force the child to confront the fear. While flooding can be an effective professional technique, it should not be tried by anyone who is not trained in its use. Forcing your child into a feared situation could cause psychological damage.

Yet, on the other hand, don’t be too supportive. Some parents go to the opposite extreme, shielding their children from any possibility of confronting the feared situation. This can reinforce the phobia, making it much more difficult to treat.

Whether to seek treatment can be a difficult call for parents. If your child has a specific phobia that is not greatly impacting his or her life, you might want to wait it out. Specific phobias in children are generally not diagnosed until they have been present for at least six months. In the meantime, be calm and reassuring with your child, and help him or her talk through the fear.

Social phobia and agoraphobia should be treated more aggressively, as should persistent specific phobias. The family doctor is a great place to start. He or she can ensure that there is nothing medically wrong with the child, and provide a reference to a trusted therapist.

Treatment may take many forms, depending on your child’s needs. Play therapy for younger children and medication are especially common. Look for a therapist that makes both you and your child comfortable. You will be an important part of your child’s phobia treatment.

When a child doesn't want to go to school, it is often assumed by school professionals the reason lies at home. Perhaps the child is afraid to leave home out of an unrealistic belief he or she must stay behind to mind the store, or to guard against some danger. The hypothesis is the child feels unbearably anxious unless he or she stays home, where the parents' well-being may be confirmed. The child's parents, on the other hand, may search for something in school that has intimidated their child. A school psychologist understands that school avoidance is probably the result of many factors, and the child may be reacting to both home and school stressors.
Current thinking about school phobia suggests there are some children who refuse to attend school because of separation anxiety. These are mostly younger children who are less accustomed to being away from home.

The majority of children who refuse school, however, are between eight and thirteen years old. Some are trying to avoid uncomfortable feelings associated with school. They tend to be sensitive, overactive boys and girls who don't know how to deal with their emotions. They may fear being criticized or evaluated. A few are truly frightened by a particular activity, such as riding the school bus or attending an assembly.

Many of these children do attend school but with great discomfort. They tend to be highly anxious and lack the skills needed to handle social interactions. Perhaps they have had negative experiences in the past and are afraid something else will happen.

Research indicates many children experience school events as stressful enough to produce such symptoms as withdrawal, aggression, moodiness or anxiety. Studies conducted at the National Center for the Study of Corporal Punishment (reported in the Monitor, the newspaper of the American Psychological Association) indicates many of these events involve disciplinary methods which are punitive in nature and attack the child's self esteem. A child's behavior may even resemble symptoms of post-traumatic stress disorder. In this condition, memories of a traumatic event continue to interfere with daily functioning, long after the actual event took place.

While severe stress responses may be unusual, any child who does not want to go to school is experiencing stress, and an important part of solving the problem is for the adults involved to assess what may have gone wrong. When a child seeks to avoid school, the parents are advised to quickly request consultation with both the classroom teacher and the school psychologist. If this is done, parents, teacher and psychologist may explore clues from both home and school to determine how the child's needs are not being met. While most children are adaptive and resourceful and able to adjust to a certain amount of challenge, there are limits to adaptation. Children
whose skills are weak in areas needed for school success may encounter demands beyond their abilities. Sensitive children who are highly in tune with others may encounter an experience which overloads their finely-tuned empathies. Whatever the cause, the parents need to see themselves as part of a professional team working to solve the problem.

But first of all, parents must bring the child to school. They will probably be strongly ambivalent about subjecting the child to what seems like a piece of unbearable stress. However, by working with the school psychologist to find ways to modify school and home environments for the child's benefit, some of the discomfort will be resolved. Sometimes simple interventions, such as a planned focus on the child's positive behaviors, or special time with an important person in the child's life, may help the child comfortably resume going to school. At school, short-term counseling, opportunities to engage in favorite activities, or a chance to earn a privilege could be options. If necessary, the psychologist will also help find a therapist to work with both the child and the family.

The experience of joining with school personnel to successfully reintegrate a phobic child into the school will allow parents to learn what works and what doesn't for their boy or girl. They will have an ally in the school psychologist, who will act as a liaison among the various people involved. If the child has other difficulties beyond school refusal, they will be addressed. Intervention will give the child a chance to benefit from the educational environment and to master academic tasks in a supportive and encouraging setting where the child may thrive.

Avoidant personality disorder

Avoidant personality disorder (or anxious personality disorder) is a personality disorder recognized in the Diagnostic and Statistical Manual of Mental Disorders handbook in a person characterized by a pervasive pattern of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluation, and avoidance of social interaction.
People with Avoidant personality disorder often consider themselves to be socially inept or personally unappealing, and avoid social interaction for fear of being ridiculed, humiliated, rejected, or disliked.

Avoidant personality disorder is usually first noticed in early adulthood. Childhood emotional neglect and peer group rejection are both associated with an increased risk for the development of AvPD.

There is controversy as to whether Avoidant personality disorder is a distinct disorder from generalized social phobia and it is contended by some that they are merely different conceptualisations of the same disorder, where Avoidant personality disorder may represent the more severe form. This is argued as generalized social phobia and Avoidant personality disorder have a similar diagnostic criteria and may share a similar causation, subjective experience, course, treatment, and identical underlying personality features, such as shyness.

**Signs and symptoms**

People with Avoidant personality disorder are preoccupied with their own shortcomings and form relationships with others only if they believe they will not be rejected. Loss and rejection are so painful that these individuals will choose to be lonely rather than risk trying to connect with others.

- Hypersensitivity to rejection/criticism
- Self-imposed social isolation
- Extreme shyness or anxiety in social situations, though the person feels a strong desire for close relationships
- Avoids physical contact because it has been associated with an unpleasant or painful stimulus
- Avoids interpersonal relationships
- Feelings of inadequacy
- Severe low self-esteem
- Self-loathing
- Mistrust of others
- Emotional distancing related to intimacy
- Highly self-conscious
- Self-critical about their problems relating to others
- Problems in occupational functioning
- Lonely self-perception, although others may find the relationship with them meaningful
- Feeling inferior to others
- In some more extreme cases — agoraphobia
- Utilizes fantasy as a form of escapism and to interrupt painful thoughts

**Causes**

Apart from the above, other causes of Avoidant personality disorder are not clearly defined, and may be influenced by a combination of social, genetic, and psychological factors. The disorder may be related to temperamental factors that are inherited. Specifically, various anxiety disorders in childhood and adolescence have been associated with a temperament characterized by behavioral inhibition, including features of being shy, fearful, and withdrawn in new situations. These inherited characteristics may give an individual a genetic predisposition towards AvPD. Childhood emotional neglect and peer group rejection are both associated with an increased risk for the development of AvPD.

Psychologist Theodore Millon identified four subtypes of avoidant personality disorder. Any individual avoidant may exhibit none or one of the following:

- conflicted avoidant - including negativistic features

  The conflicted avoidant feels ambivalent towards themselves and others. They can idealize those close to them but under stress they may feel under-appreciated or misunderstood and wish to hurt others in revenge. They may be perceived as petulant or to be sulking

- hypersensitive avoidant - including paranoid features
The hypersensitive avoidant experiences paranoia, mistrustfulness and fear, but to a lesser extent than an individual with paranoid personality disorder.[20] They may be perceived as petulant or "high-strung".

- phobic avoidant - including dependent features
- self-deserting avoidant - including depressive features

Differential diagnosis

Research suggests that people with Avoidant personality disorder, in common with sufferers of chronic social anxiety disorder (also called social phobia), excessively monitor their own internal reactions when they are involved in social interaction. However, unlike social phobics, people with Avoidant personality disorder may also excessively monitor the reactions of the people with whom they are interacting.

The extreme tension created by this monitoring may account for the hesitant speech and taciturnity of many people with Avoidant personality disorder; they are so preoccupied with monitoring themselves and others that producing fluent speech is difficult.

Avoidant personality disorder is reported to be especially prevalent in people with anxiety disorders, although estimates of comorbidity vary widely due to differences in (among others) diagnostic instruments. Research suggests that approximately 10–50% of people who have panic disorder with agoraphobia have Avoidant personality disorder, as well as about 20–40% of people who have social phobia (social anxiety disorder).

Some studies report prevalence rates of up to 45% among people with generalized anxiety disorder and up to 56% of those with obsessive-compulsive disorder. Although it is not mentioned in the DSM-IV, earlier theorists have proposed a personality disorder which has a combination of features from borderline personality disorder and Avoidant personality disorder, called "avoidant-borderline mixed personality" (AvPD/BPD).
Treatment

Treatment of Avoidant personality disorder can employ various techniques, such as social skills training, cognitive therapy, exposure treatment to gradually increase social contacts, group therapy for practicing social skills, and sometimes drug therapy. A key issue in treatment is gaining and keeping the patient's trust, since people with Avoidant personality disorder will often start to avoid treatment sessions if they distrust the therapist or fear rejection. The primary purpose of both individual therapy and social skills group training is for individuals with Avoidant personality disorder to begin challenging their exaggerated negative beliefs about themselves.

Epidemiology

According to the DSM-IV-TR, Avoidant personality disorder occurs in approximately 0.5% to 1% of the general population. However, data from the 2001-02 National Epidemiologic Survey on Alcohol and Related Conditions indicates a prevalence rate of the disorder of 2.36% in the American general population. It is seen in about 10% of psychiatric outpatients.

History

The avoidant personality has been described in several sources as far back as the early 1900s, although it was not so named for some time. Swiss psychiatrist Eugen Bleuler described patients who exhibited signs of Avoidant personality disorder in his 1911 work *Dementia Praecox: Or the Group of Schizophrenias*. Avoidant and schizoid patterns were frequently confused or referred to synonymously until Kretschmer (1921), in providing the first relatively complete description, developed a distinction.

Treating Childhood Phobias - Phobia Treatments

Childhood Phobias Lead to Anxious Behavior in Adulthood

“Children who are not cured of their phobias run a great risk of developing other areas of anxiety later on,” says Lena Reuterskiöld, of The Swedish Research Council.
“It’s therefore important to find effective forms of treatment that can reduce this risk.” She explains that certain one-session therapy treatment sessions are effective for various types of phobias.

The Research on Treatments for Phobias in Children

Reutersköld’s research involved children and adolescents with various specific phobias in Stockholm, Sweden, and in Virginia in the United States. The treatment studied was a “one-session treatment” that was three hours long.

This phobia research showed that 55% of children who voluntarily signed up for this phobia treatment successfully overcame their anxiety attacks.

The “One-Session” Treatment for Kids With Phobias

This phobia treatment for children is accomplished in one session with a therapist. It isn’t expensive (but the cost may fluctuate with different psychologists or counselors). Unlike anxiety medication, this one-session therapy treatment for adolescents doesn’t have side effects. Further, it’s not associated with a specific culture, so doesn’t need to be changed to fit a certain country or region.

In the session, a child slowly approaches whatever he/she is afraid of (alongside the therapist). This safe, controlled environment helps reduce anxiety attacks and feelings of fear. After the therapist interacts with the object of fear, the child is encouraged to do the same.

The theory behind this phobia for children is that they’ll experience decreased anxiety, and learn that what they most fear will not occur (in psychology, this is exposure therapy or systematic desensitization). To reduce anxious behavior, it’s important for children to spend an extended amount of time with the object they fear.

One-Session Therapy Treatment Works for Adults With Phobias

“One-session treatments have also proven to be effective over time,” says Reutersköld. “Adults who have been treated with this method notice the effects of the
treatment more than a year after the session. And nothing indicates that the effect would taper off sooner in children, which we assume will soon be confirmed by a follow-up study.”

PERSONALITY DEVELOPMENT OF CHILDREN

Children are not just little adults. They go through typical characteristics of growth—intellectually, emotionally, and socially—on their way to becoming adults. When parents realize these things, there is less strain on both parents and children.

The following chart lists some common characteristics of children's behavior, arranged by broad age groupings, with reasons for that behavior and the implications that behavior may have on planning enjoyable and productive family home evenings. However, when considering any growth or behavior chart, remember that not every child will necessarily fit into described patterns. Individual children grow and develop differently and at different speeds. For instance, all children in one family will not walk or talk at the same age. Each child should be respected as an individual. The descriptions in this chart identify general behavior only, and you will note that the age groupings overlap.

Birth to 3 years of age

Characteristics

1. A child likes affection, being held and cuddled. He especially likes motion—being carried, tossed, and sitting on a lap.
2. He loses interest quickly and will interrupt conversations, stories, or activities with cries, noises, and wiggling. He enjoys simple, repeated gestures and touches, playing with objects, putting them in his mouth and throwing them.
3. A child stops "naughty" behavior when you tell him to, but he soon goes back to it as though he doesn't care what you want.
**Reasons**

1. Infants and young children learn trust and love first through touch. They are absorbed in exploring the world through their senses and movements, and they are gradually getting more control over their muscles.
2. Children at this age are only aware of their own viewpoint, wants, and experiences. Doing things over and over helps them learn about things.
3. Children have no understanding of rules and cannot understand how one situation has any relationship to another. They lack the ability to foresee consequences.

**Implications**

1. Give lots of affection, holding, cuddling, talking and listening. He is unable to understand rules, so correct his behavior with patience and love. He has a limited attention span. He will listen only to those things that interest him.
2. Provide short, vivid stories and games (peek-a-boo, patty-cake) that challenge his mental and sensory abilities. Provide repetition and practice short behaviors. Talk about Heavenly Father and Jesus and how to please them.
3. Do not try to teach concepts or rules; he cannot understand them. But do have rules and be consistent in applying them. Respond to him in positive ways to help him feel good about himself.

**2 to 7 years of age**

**Characteristics**

1. A child will display affection at odd moments. He may run to you for a quick hug and then go on with his play. He likes affection but only in brief doses. He may sometimes push unsought affection aside when his attention is elsewhere. He rejects your help even though there are many things he cannot do for himself, like drawing and other tasks requiring good finger and hand coordination.
2. A child may seem selfish, not sharing. He wants things others are using and does
not play with children so much as along side them. Disagreements and frustrations are common. He interrupts others and cannot stay long with one activity if others are not doing it. He likes stories and imitates others.

3. A child may seem willful and disobedient and unable to justify "naughty" behavior. His reasons may be illogical: "Jimmy (an imaginary friend) made me." He is often slow to obey and must be reminded.

Reasons

1. Parents meet most of a child's needs and satisfactions. As a child begins to conquer his world, he needs to know that this source of security is still there. He has an equally important need to do things, to be active, and to explore his world as his control over his body improves.

2. A child still thinks the world is the way he sees it, not understanding that there can be more than one reason for anything. He cannot understand others' needs. He cannot keep a lot of ideas in his head for very long, so he turns to other things when his attention lags or he gets bored.

3. "Good" means "satisfying" to him; he still doesn't understand that rules apply to many situations. He doesn't reason the same way adults do. He learns by testing the limits imposed upon him.

Implications

1. Give him simple things to do--holding pictures, leading songs. Increase these and add talks as he gets older. Let him feel he is an important part of family home evening. Give affection and praise. Practice "good" behaviors like folding arms and bowing heads, kneeling for prayers, drinking from a sacrament cup, and sitting still. Teach him about Jesus Christ and the gospel and how you feel about them.

3. Read or tell scripture stories. Explain the "hard" parts. Choose stories that give "good" behavior to copy. Explain in concrete terms, not in abstract principles. Define gospel words like repentance, faith, and forgiveness with familiar examples. Use examples, simply told, from your own or other family members' lives.
3. Introduce rules but keep them simple. Be firm and consistent. Help your child to be successful so he can develop self-confidence. Show how obedience will help him grow.

7 to 12 years of age

Characteristics

1. Boys may appear less open to affection than girls, particularly around others, but may accept it more willingly when hurt or frustrated. Both are active, like games, and prefer the company of their own sex.
2. They like games and may spend much time discussing rules, fairness, and cheating. Some are aggressive while others lack self-confidence. In school, girls may be more successful, obedient, and more interested than boys. A child might be interested in clubs, cliques, or neighborhood gangs, seeking friends outside the home.
3. He questions parents' decisions, wanting to know "why." When your explanations are fair or logical, he will accept them; if arbitrary or inconsistent, he will question them, but usually obey.

Reasons

1. Boys and girls are learning what they are all about. They play at the roles set for them much of the time. Although they look to each other for examples, parental love and approval are very important.
2. Games and clubs help the child learn about himself and how rules apply to his life. He is very aware of competition and concerned about his performance. Because girls are usually more adept at language and social skills at this age, they may do better than boys who may feel inferior or rejected.
3. A child has discovered that things that happen are governed by or explained by rules. Knowing the rules and how they apply is extremely important because it helps him predict consequences.
Implications

1. Be ready to listen. Give each child some personal time. Support your child in his problems. Provide real-life examples (stories and short examples) of good role models.
2. Provide challenging games that teach sportsmanship, honesty, and cooperation. Help boys get ready for priesthood service. Teach the commandments and obligations as children of our Father in Heaven. Choose activities that build family unity.
3. If your child questions decisions, do not become angry. Explain and then allow him to respond. Be fair and impartial in applying rules, helping him understand how Heavenly Father's rules are for our good.

11 to adulthood

Characteristics

1. A boy may become awkward and clumsy, while a girl may become silly and self-centered. Both may seem irresponsible.
2. Youth may enjoy sports, group activities, and discussions about "life," values, and principles (justice, equality, peace). But they may show great intolerance for others' opinions. They may want to escape the family but be afraid to do so.
3. Youth often question values and come to distrust rules, especially rules without any strong ethical or moral basis. They may insist upon their "rights" to be independent. They may seem uncertain of what is meant by "right" and "wrong" for a time. They often reject authority as a reason to approve or disapprove of a behavior.

Reasons

1. Physical growth and changes are emotionally upsetting; the youth feels that things are happening faster than he is ready for them. He feels more socially than physically
awkward.

2. Sports and play are no longer ways of exploring rules. They reassure youth about their abilities as they watch and copy others while establishing their own adult identities. Youth are especially concerned about relationships with each other. They may be insecure and uncertain about what society expects.

3. Youth have found by now that rules are not infallible. They are now able to handle abstract concepts and are busy building their own guiding philosophy of life. They now look behind the rules for the principles.

**Implications**

1. Discuss gospel and life principles with your child. Avoid arguing over his different views; rather teach by sharing your own faith, experiences, uncertainty. Be supportive, encouraging, and accepting. Be consistent in applying rules and explain them in terms of principles.

2. Encourage family support for your children's activities. Be friendly and open to their friends. Discuss marriage goals and how priesthood and service activities express the principles of love, brotherhood, and forgiveness. Find ways to bring their friends into family activities rather than competing for time and loyalty.

3. Teach the idea of baptism, priesthood, and marriage covenants. Help your children see scripture as a record of people trying to cope with problems. Give them opportunities to become involved in challenging discussions of ethical problems and gospel applications. These discussions are practice for making decisions on their own later.