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Analysis

Psychological Disorder in Children and Adolescents: A Critical Analysis

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ABSTRACT

The important role of psychosocial disorders in psychology has attracted the attention of scholars. In 1894, Freud presented a research paper in which he separated it from mental depression and gave it an independent identity. Freud once believed that disorder is present in every person, whether more or less. In fact, there is no person who can be explained without some degree of disorder inherent in him. In particular, mental and social disorders play an important role in psycho-neuropathies. Psychosocial disorder refers to a condition in which unexplained emotional stress and open anxiety are prominent while other symptoms are incidental. The present paper tries to produce a critical analysis on Psychological Disorder in Adolescents.

Keywords: *Psychological disorder, Environment, Symptoms, Causes*

Psychosocial disorder is a very common disease. The percentage of psychosocial disorders in all psycho-neuropathies ranges from 30 to 40. Its victims are children and adolescents of any age, group and economic status. On the basis of surveys, it can be said that five percent of the total population lives in its clutches.

Dangerousness and uncertainty are the main features of psychosocial disorder. Under the actual situation, nothing remains to prevent its eruption, so no meaningful step can be taken to stop it. The person keeps sniffing the danger like a cockroach. He feels that something untoward is about to happen, something is about to happen in which he will be in danger. He remains engrossed in a wave of unknown fear.

The second main feature of psychosocial disorder is that this disorder, being objectless, keeps on shifting from one object to another. Freud called this a free-flowing disorder because the disruptive stimuli are mysterious, complex and widespread. The individual remains ignorant of the causes of the disorder and attempts to name this unnamed fear by looking for possible factors and trying to link it. In fact, the cause of disorder is sometimes associated with one thing and sometimes with another.[1]

In general, the state of disorder is helpful and beneficial for the person because it activates the person and makes him aware and conscious of the environment. The disorder

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overpowers the person in such a way that he is not able to do even normal routine. Disorder becomes part of his habit and behavior. His perception starts getting affected and he is not able to get pleasure even with the materials of entertainment. In short the disorder becomes a part of his person.

Disorders in the child

(a) Low-risk

Numerous studies have shown that most normal children go through phases of difficult behavior, so that little importance should be attached to isolated and transient emotional and behavioral difficulties of any kind. Further- more, some so-called 'symptoms', even when persistent, show so little association with psychiatric disorder that they are of negligible predictive value. Nail-biting and thumb-sucking fall into this category. Their association with emotional disturbance as measured in other ways is so low that they are of little use as indicators of mental health or ill-health, either present or future. Neurotic disorder in children (i.e. a disorder characterized by unhappiness, misery, anxiety, fears, obsessions, and the like) can be very distressing and handicapping. If at all severe or persistent, neuroses undoubtedly Warrant treatment. However, perhaps surprisingly, child neurosis is not usually a precursor of adult neurosis. Indeed, it may be that to some extent they constitute different sorts of disorder in spite of rather similar symptomatology. The prognosis for most neuroses in childhood is very good. The great majority of neurotic children become normal adults and, contrary to what one might expect, the risk of manic-depressive disorder or anxiety neurosis in adult life appears to be no different in neurotic children from that in the general population. At present, little is known on how to distinguish the small minority of child neuroses that become chronic.[2]

(b) High-risk

In very sharp contrast to the prognosis for neurotic children, the outlook for children with antisocial and aggressive disorders is poor. Children referred to the clinic for antisocial behavior included high proportions that were still antisocial as adults. More striking was the finding that the anti- social children, when adult, had more marital difficulties, poorer work records, worse social relationships, more psychiatric disorder and, to some extent, even poorer physical health. These findings referred to children with persistent and general antisocial problems and not to the many normal children who commit an isolated delinquent act. Nevertheless, the proportion of children with serious antisocial disorder is high, and many of the delinquents of today become the psychopaths of tomorrow. Antisocial disorders are peculiarly difficult to treat, but the challenge is unavoidable. If the rate of disabling psycho-social disorders in adults is to be reduced we must devise and evaluate new methods of treatment for the antisocial child. Severe reading retardation is another high-risk disorder, both in its own right and through its strong association with delinquency. A third of children with specific reading difficulties show antisocial problems and a third of anti- social children are seriously retarded in their reading. The nature of the associations between reading retardation and antisocial disorder is not entirely clear but the evidence suggests that, at least in some cases, the reading difficulties may lead to the development of antisocial and aggressive problems. Effective early treatment of reading retardation might lead to a reduction in the rate of later delinquency. When untreated, reading retardation is a remarkably persistent disability even in children of average or above average intelligence. It also has wide- spread effects on children's educational progress in other subjects and on the later possibilities of training for a job. Among ten-year-olds on the Isle of Wight, one child in 25 was at least 28 months retarded in his reading skills. When re-examined 28 months later the children had made, on average, only ten months' progress; relatively, they had

fallen even further behind, and not one of the children had caught up in his reading. It is not known to what extent early treatment can prevent the generally poor outcome in children with reading difficulties.[3]

All too often, reading retardation remains undiagnosed until late in child- hood, when the child's (and teacher's) feelings of failure and hopelessness make remedial action difficult. Early diagnosis depends to a large extent on the teacher's knowledge of each child's progress and of his willingness to refer children for psychological and medical investigation when they are experiencing educational difficulties. Doctors, especially pediatricians and school medical officers, also have an important role in early detection through their knowledge of disorders associated with later reading difficulties. Developmental problems of speech, language, coordination, and perception are of great importance in this respect. Doctors are very prone to reassure mothers of children who are late in talking or in walking that all will be well in the end. It is, of course, true that most children who are late talkers eventually learn to talk normally but a delay in talking may well be followed by difficulties in learning to read. A reorganization of the medical examination at school entry to place a greater emphasis on developmental assessment might help to pick out those children likely to need special help in reading. Hospital doctors, to whom late speakers are often referred, need to be aware of the educational implications of these developmental disorders. Similar issues apply to chronic physical disorders, especially neuro epileptic conditions. There is a greatly increased rate of psychiatric disorder and severe reading difficulties in children with cerebral palsy, epilepsy, and other chronic brain diseases, even when the children are of average intelligence. To what extent these i Psychiatric and educational complications lead to handicaps in adult life is uncertain, but if handicaps are to be prevented, pediatric care must go beyond mere medical management to include consideration of the wider implications of cerebral disorders. Infantile psychosis or infantile autism (two terms referring to much the same condition) must also be included among the high-risk disorders, as they generally carry a rather gloomy prognosis. However, it is important to emphasize that some autistic children, especially those of normal intelligence, can improve so much that they can eve a reasonable social adjustment and eventually hold a regular job. Moreover, there is some suggestion that modern methods of treatment may increase the proportion of patients who improve. In spite of the term 'psy-chosis' the condition probably has nothing to do with schizophrenia as seen in adults. The cause of infantile autism is still unknown, but the balance of the evidence suggests that its basis is a developmental disorder which particularly involves a defect in the comprehension of language.[4]

Disorders of the environment

a) Low-risk

A Traditionally, much emphasis has been placed on the effects of infant care practices such as breast or bottle feeding, schedule or demand feeding, and the timing of weaning and toilet training. It now seems that this emphasis has been largely misplaced. There is no evidence that the timing or type of any of these infant care practices has any significant association with psychological development in either childhood or adult life. The interpersonal context in which training occurs appears to be more influential than either the timing of the training or the methods used. Much the same may be said about methods of discipline. Within surprisingly broad limits the techniques of discipline employed by parents have little effect on the pattern of the child's development. The purpose of the discipline, that is what type of behavior is praised and what type of behavior is punished, is important. The quality of the parent-child relationship is also influential. But otherwise there is no clear evidence that one method of discipline is any more effective than another. It is only possible to draw the banal

conclusion that extremes of any kind (extreme punitiveness or complete laissez-faire) are undesirable and that marked inconsistency of discipline is often harmful. In 1951, Bowlby drew attention to the distress and unhappiness of children that often followed when they were separated from parents, especially when this was associated with admission to a strange environment such as a hospital. Later work has shown that this distress may be greatly reduced by enlightened hospital practice such as allowing mothers to stay with their children, by providing proper opportunities and facilities for the children to play, and by keeping unpleasant procedures such as enemas and venipunctures to a minimum. Despite the importance of these findings, parent-child separation, as such, must be classed as a low-risk factor so far as long-term consequences are concerned. The evidence from Bowlby's own studies and those of Yarrow shows that if children are given adequate care following separation (this is a crucial proviso) most children do not show long-term damage. A stable parent-child relationship is important but this is not necessarily incompatible with separation. Furthermore, both animal and human studies suggest that peer-relationships, as well as parent-child relationships, play an important role in development. The last low-risk factor to be mentioned is that of the mother who goes out to work. Working mothers have come under criticism at various times in the past, but it is now evident from numerous studies that children in such families suffer no psychological disadvantage. Of course, there must be good quality stable arrangements for the care of the children while the mother is at work, but, given these, the children may be expected to develop normally.[5]

(b) High-risk

Whereas various patterns of child-rearing and parent-child separation are classed as low-risk factors, a child's family background is nevertheless a most important influence on his development. Of all the family variables that have been studied, discord, quarreling, tension and disruption have been most consistently associated with disorder in the child. Children reared in homes characterized by strained relationships and hostility have a strong likelihood of developing antisocial aggressive behavior or frank delinquency. Interestingly enough, they are not particularly likely to become neurotic. The confidence with which family discord can be identified as a high risk factor is much increased by the fact that the association has been shown repeatedly in longitudinal as well as cross-sectional studies. In cross sectional studies it is difficult to determine whether the family discord led to delinquency or whether the disruptive behavior of the child led to family tensions. However, several longitudinal studies have now shown that family discord measured when the children were young can predict the development of delinquency when they are older. Furthermore, the presence of family discord and disruption measured at the time boys first come before the courts for a delinquent act has been shown to predict whether or not the delinquency continues. These findings leave little doubt that it is the family situation that leads to the antisocial behavior of the children but it is not known how it does so, nor is it known to what extent a good relationship with one parent can compensate for a bad one with the other. Another Indication of high-risk may be the mother's application for therapeutic abortion. A Swedish follow-up study of children born after application for therapeutic abortion had been refused showed that the children had a higher rate of psychiatric, social, and educational disabilities than other children. The very fact that a woman applied for legal abortion meant that the prospective child was at risk, even when the grounds for the application were so slight that it was refused. Parents with severe personality defects often tend to sink to the lower strata of society so that psycho-social difficulties are generally more common in the families of the unskilled. However, as in the middle class, family discord is conducive to delinquency, not the fact that the father is a laborer. On the other hand, there is no doubt that the working-class child is at a considerable educational

disadvantage. Although genetic factors play an important part in this, a lack of appropriate verbal and perceptual experience, as present in many lower-class homes and even more so in many institutions, can seriously retard intellectual and educational growth Children in very large families are particularly at risk educationally, probably because they have limited opportunities for conversation with adults. The last high-risk factor to be mentioned is parental mental disorder. Chronic depression, neurosis or personality disorder in a parent is associated with an appreciably increased risk of psychiatric disorder, particularly of an antisocial type, in the children. Genetic factors may play some part in this but the family disruption associated with mental disorder is a powerful pathogenic influence. The child from a happy united family in which one parent happens to have some mental disorder probably has only a low risk of developing in a deviant direction.[6]

Mental disorder differs from social disorder in many respects. Social disorder is associated with a car while mental disorder is associated with psychosis. Social disorder because of the association with a factor; Therefore, as soon as the factor is removed, the disorder also ends, but the mental disorder is endogenous and as a result it remains constant. In addition, the proportion of social disorder is displayed. If the factor of disorder is negligible, then the disorder is also radical and among the major factors, the disorder is also big, but in case of mental disorder there is no such ratio. The person constantly expresses the disorder in an exaggerated way. Social disorder is more related to the present whereas mental disorder is mostly related to the future.

The symptoms of mental disorder

The symptoms of mental disorder are divided into two parts:

Psychotic symptoms: Agitation, apprehension, alertness, apprehension and subjective feelings of impending disaster are prominent among the mental symptoms of mental disorder. The patient feels that the time to come will be catastrophic for him. His heart or mind will explode, he will die whatever he wishes for, otherwise the sky will fall, but something will definitely happen. But even after thinking so much, he is not able to guess the nature of the calamity. He is helpless like a puppet in the hands of circumstance and has no option but to wait for the calamity to pass. He is fearful, intolerant and anxious and feels that he will go mad.

Physical Symptoms: Many physical symptoms are also seen in this. The patient's mouth becomes dry, the face becomes red, the throat becomes blocked and he bathes with sweat. Abdominal disturbances, muscle tension, pain, fatigue and restlessness are also seen. In addition, the patients exhibit neurasthenia, headache, difficulty in breathing, clammy hands and increased palpitations.

Attacks of mental disorder are sudden and also gradual. In both cases, the long-term state of fear of mental disorder produces the disorder. In the case of mental disorder, the disorder suddenly rises to the top and descends in the same way. In chronic mental disorder, the disorder develops gradually and persists for a long time. There is individual variation regarding the status of mental disorder. In some people it lasts for a few seconds, while in some cases it lasts for a few hours. Similarly, in some people it persists for months. In mental disorder, the person gets engulfed in the flood of fear and terror. His sympathetic nervous system becomes overactive and he is drenched with sweat. His heart starts beating fast and feels restless due to the blockage of breath. In some situations, a person hears a 'silent shriek' in the brain. Sometimes a person also feels that the ground is slipping under his feet or there is a crack in which he will get drowned. His mouth becomes dry and starts

trembling. Symptoms of diarrhea and frequent urination are also found in it. He gets confused and feels as if he is going crazy. In some situations, hunger leads to a complete distaste, and vice versa, sometimes there is intense hunger. Blurred vision, pain and stiffness in the body, sleeplessness, sudden awakenings at night, numbness, tremor of hands, dilation of the pupil are also common symptoms. On waking up in the morning, instead of freshness, the patient feels tired. The patient tries to escape but cannot find a rescue or a place. At the end of mental disorder, he becomes restless and limp. He is squeezed both in terms of physical strength and momentum.[7]

Causes of mental disorders

There are many causes of mental disorders, the main ones being:

(1) Early Childhood Training: Some parents, in a way, put some burden on their children. Many unusual situations in which children are brought up make them prone to mental disorders.

a) *Overprotection*: Some parents provide their children to feed their children from sunlight, wind, water etc. like delicate plants, but they forget that plants also need them. Overprotective parents constantly warn their children of dangers. Even minor problems are presented in exaggeration. Horror tales and stories of destruction make the children even more terrified. In this way, even before knowing and understanding the danger, fear is imprinted on their child and they start seeing everything from the same perspective.

   Sometimes children are inspired to imagine hidden dangers. They are always taught to think in terms of the future, but not to believe in reality. The personality structure of such children is uncomfortable, stressed and vulnerable. They start to think of the external world as frightening and cruel and start doubting their ability even in the face of mild stress.

   Some parents make the mistake of imposing social maturity on their children. They constantly present adult problems, uncertainties and disillusionment to the children. Doubts regarding essential necessities of life, economic and occupational problems, adult social enterprise and distrust in parents create a feeling of insecurity in children. Children also have personal problems of their own age and want the safety and protection of an adult. In the absence of this, they are laden with problems and remain immature.

b) *Perfectionist Demands*: The childhood of patients with mental disorders is filled with perfectionist demands of the parent. Even when a child does well, better is expected from him. High goals are set before him in which he is neither interested nor special ability. As a result, he fails to fulfill them. Jenkins (1969) also found in his study that the parents of the patient tend to have high aspirations and disapprove of the children's achievement of low level. In a state of doubt, the child does not know which of his behavior will be acceptable and which is punishable. When parents always put demands in front of children, which are not in their power to fulfill, then they adopt unrealistic criteria and become self-critical.

c) *Rejection*: Some parents reject their children as unwanted. They have an authoritarian attitude towards children. According to psychologists, such parents adapt their children to mental disorders. For example, punishing children, when they try to satisfy their needs, especially sensuality or by always showing displeasure towards their overall behavior, they create mental disorder in them. If the child does not understand the behavior of the parent, then he starts to feel that his needs are

wrong or immoral and in the eyes of the parent he is negative. Parents who are too rigid and for whom there is no room for failures, they push their children towards mental disorder. A child wants to please his parents. When they are unhappy, he understands that he has failed somewhere and deserves punishment. If parents punish children excessively in order to determine whether good or bad, then the child starts worrying about his own actions. He understands that he is different and worse than others and may lose the affection and protection of the parent. As a result, he becomes a victim of mental disorder without knowing the reason.

d) *Permissive parenting*: In contrast to the authoritarian parent, some parents are highly permissive and do not impose any restrictions on the children. Children have an arbitrariness to do everything. This relaxation has a bad effect on the children and they not only become disordered but also unable to establish the criteria of self-evaluation. Every child during the process of socialization keeps on doing self-examination by establishing criteria for assessing his/her behaviors. It is necessary. In the absence of this, there is a lack of this ability in the child, as a result of which he suffers from mental disorder.

e) *Symbiotic mother child unit:* The closest contact of the infant is with its mother and due to the identification; it establishes partial integration or merger with the mother image. The child imbibes the feelings and qualities of his mother. Thus, the child unconsciously adopts the mother's attitudes, character qualities and behaviors just because of identification.

(2) Inability to control dangerous impulses: A person becomes a victim of mental disorder under situations that arouse fearful feelings, such as those that destroy his self-image or endanger his relationship with others. Sometimes the feeling of aggression and hostility presents a danger of tearing through a person's defenses and manifesting in behavior that challenges his moral values, economic and social status. This danger is so real for those who are vulnerable that they are forced to adopt a compliant, submissive and self-compensating role so that they can seek protection, love and acceptance of others. This inhibition of striving to be one inevitably generates feelings of strong aggression and hostility, although any condition of this must be controlled and denied so that he can maintain his image of a worthy person and avoid rejection by others. Often these repressed feelings are expressed in indirect ways, such as by imagining killing and harming others. But since such persons depend so much on the approval of others that they become afraid and unable to accept their aggressive feelings and become victims of mental disorder. Whenever implicit impulses make their presence felt, even if it is in the imagination, one gets worried without any reason. A woman did not keep a knife in her kitchen lest she might attack her husband. Similarly, a husband would not go swimming with his wife because he was afraid that her repressed aggression might manifest in the conscious.

(3) Erotic delusions: Freud claims that the basis of mental development always lies in the work life of the individual. The mental disorder the patient suffers from depends on the difference between sensual arousal and sensual gratification. In a situation where job satisfaction is not sufficient, excess arousal manifests itself in physical symptoms such as heart palpitations, and on a mental level it manifests itself in the form of fear and anxiety which may remain fixed or vague. There can be many sources for this. During adolescence, the first interview or sexual intercourse due to menstruation or other sex problems etc. can

make them a victim of mental disorder and abnormal work experience can cause mental disorder in them.[8]

According to Freud, sexual desires are mostly repressed and stored in the unconscious. Due to social restrictions and prohibitions, they are not able to satisfy their sexual desires in a less desired way and suppress them. Some people become victims of mental disorders due to their lustful desires. The conflict between biologically determined sexuality and social consciousness produces mental disorder. Desires are repressed but their effect is painful.

Repressed libidos pose a risk of breaching the existing defenses and resulting in acute psychotic disorder. For example, a person tries to suppress his homosexuality by considering his tendency to be grossly immoral and opposing his self-concept. For some time, this repression protects it, but the process of repression is rarely complete. Due to faulty repression, a person experiences acute mental disorder from time to time, even though he cannot understand the reason. Apart from this, some changes in the circumstances of life such as friendship with a feminine man, give rise to his tendency towards homosexuality and the safety of the person is endangered, as a result he becomes a victim of mental disorder without knowing the reason. Kiskar has given an example in which a man becomes a victim of mental disorder while watching a ballet dance because he has experienced attraction towards a male dancer and there is a danger that his repressed homosexual tendencies may become apparent.[9]

***(4) Feelings of incapacity and insecurity*:** It is an expression of the inability of a person with mental disorder to respond to internal and external stress. The person senses his inability in difficult situations and somehow maintains a balance. But whenever the situation changes, and new prosecution is needed, it presents the risk of infection imbalance. In youth, when there is a need to adopt new responsibilities, it becomes a victim of mental disorder due to its inability. In this way the change of external environment begins to challenge their organized balanced ego. They take every new change as a threat. Mental disorder reactions are the first danger signal that the situation is getting out of the person's control.

Patients with psychotic disorders display a history of underlying insecurities. Freud considered a mental disorder to be an ambiguous reaction that dates back to the period of childhood when the euphoric relationship is not established. In infancy, the child cries when he is hungry and he becomes a victim of mental disorder whether his initial needs will be met or not. When there is a delay in getting food, its basic security is at risk. But the fear of not getting food is more deadly than the real conundrum. Therefore, mental disorder is the regression of the mind towards infancy where the object relation is not established. The actions of the child at that time are very generalized, very vague and the sexual energy is not related to any specific area. He does not have basic faith and trust in the object. Similarly, when they grow up, any dangerous situation starts to shake their safety. Freud mentions security-challenging events at several specific periods of life. For example, separation from a loved object or an order to take away dependency etc. In the early development of the child, it is the mother who fulfills his needs and he is dependent on her. Loss of this shelter due to death or divorce or fear of it gives rise to mental disorder.

Due to the feeling of insecurity, any apprehension of harm in the person's situation or obstruction in the fulfillment of goals makes the person a victim of mental disorder. To the slightest fear of failure, they engage in frantic double-blind attempts. This tends to constrain their way of life and consequently the overall stress pattern increases.[10]

(5) Guilt: In most mental disorders, guilt or guilt plays an important role. Sometimes it is experienced in the conscious, as being done wrong, as having a bad conscience or as being inferior and unworthy. In the most powerful form, guilt acts on an unconscious level, that is, in the form of a growing mental disorder between the ego and the parahan system. The ego defenses protect the individual from the full effects of Parahan's aggression. The person feels only social and mental disorder, without knowing that the parahan puts pressure on the ego because what he is doing, speaking or thinking is wrong. Darling mentions a man who beat an innocent child with his motor, and this guilt later manifested itself as a mental disorder. There are several sources which can instead lead to a child suffering from chronic mental disorder:

a) One is that the child establishes identification with the defected parent in early life, which is called parahan identification. It is also normal and necessary to establish a mutual identification with the parent, but when they are the culprit then this identification will be called misfortune.

b) Another way in which a child can commit guilt is by excessively punishing, demanding and degrading. The child understands that punished children are bad children, instead of understanding that children are punished because they have done wrong. Similarly, they believe that neglect means their incompetence, not parental irresponsibility. Parental devaluation leads to self-evaluation and it generates inferiority, negativity and long-term guilt.

c) Guilt also arises because of the tempting parent. The seductive parent unconsciously tempts the child and when he reacts, they stop and punish him. The child thinks that he is bad so he has been punished and this repeated thought gives rise to mental disorder.

d) Teaching of rigid morals is also a source of mental disorder. Some parents take utmost care of work related perfection. They see their children as selfless and innocent and cannot digest any immorality. This feeling is also seen later in those children where even a little sexuality causes mental disorder.

(6) Re-induction of past traumas: Sometimes some events cause deep wounds in the person. This wound found in early life turns green when such a situation is present in front of the person. Coleman mentions a patient who had to run away from coming to work. After psychoanalysis it was found that his father was cruel to him and this sentiment was transferred to the new supervisor symbolizing the father who was critical of his work. The latter circumstance had punctured the old wound and he became a victim of mental disorder.

(7) Primary benefit and secondary benefit: The primary benefit is helpful in reducing the mental disorder which helps the patient to maintain most of his integration. In mental disorders, stress occurs in the form of direct release through simple physical and emotional methods. Thus the physical symptoms of the patient act like a safety valve through which the excess stress is automatically released and the personality is saved from disintegration. This remedy is only partially successful because the patient's protective structure itself remains flawed and protective release tends to exacerbate rather than reduce mental disorder. Therefore, the primary benefit cannot be considered as a permanent solution to the mental disorder.

Under the secondary benefit, all the benefits that the patient is able to get from the disease, they all come. Being sick proves beneficial for the patient because he remains the center of attraction. He escapes from all the responsibilities and gets the comforts lying around. It also has some role in mental disorders. Through mental disorder, he attracts the attention of people to himself.[11]

(8) Faulty defense mechanisms: Mental disorder is an indicator of partial failure of a person to have adequate defense mechanisms. Part of the security remains intact. The archaic defenses of childhood and adult security are not completely disconnected, but what does happen is that some degree of the disorder escapes control by breaking through the defenses and knocking on the brain. The person gets nervous and becomes a victim of mental disorder without knowing the reason.

According to Eolman, "Psychosocial disorder is a sign of weakness of the ego. When the ego is suppressed by truths, it turns into a real disorder. When its pressure increases, disorder develops which can be divided into the following parts:

- **Actual Disorder:** It is natural to develop disorder towards a previously anticipated threat, in which either a past experience indicates danger or the human himself is involved in an actual fight or the perception of the old danger paralyzes him so that he can become a victim of the present danger unable to establish harmony in the face of it.
- **Nervous disorders:** Nervous disorders can be experienced in many ways. Sometimes it is experienced only as discomfort. When there is excessive pressure of disorder, there is no release of sensual energy, and then nervous disorder develops.
- **Moral disorder:** Moral disorder occurs when the super ego is suppressed. Moral disorder is found in the form of inferiority complex and guilt. As a result, there are many facts of disorder. The disorder arises at that time when man does not agree with himself. If it is to be defined in simple words, then it can be said that it is a stable psychological condition which arises from our internal contradiction. Because of this, countless unnamed feelings like fear, anger, restlessness, irritation and depression etc. arise and when the disorder crosses its limit, it affects the harmony.12

The disorder has a physical side (irregular respiration, increased heart rate, nervous system irregularities such as palpitations and paralysis, excessive sweating, etc.) and a psychological side. The main features of the psychological side are: a special conscious attitude and (1) A painful consciousness of being physically and mentally powerless in a personal matter, (2) Foreshadowing of an inevitable and existing danger, (3) A pressured and Physically fatigued consciousness as if facing an emergency, (4) A fearful diagnosis of the actual problem, and (5) An inconclusive state of oneself that creates an effective barrier to the nature of the potential apprehension; genuine fear. In relation to the possibility of the presence of, in relation to, the best measures to reduce or eliminate the harm, the effective use of those measures by any person whenever there is an emergency. To see disorder as distinct from a fear that has no symptoms, a fearful diagnosis of the real problem and an inconclusive state of its own. Social disorder is a response to a real and frightening threat whereas mental disorder is a more typical response to an unreal or imaginary threat. It is clear that disorder is an unpleasant emotion characterized by fear or a feeling of dread, but looking at this initial idea in detail, the situation is completely different. This is because the disorder is neither an isolated reaction that occurs in the same way in each individual situation, nor is it a concrete visible event.[13]

CONCLUSION

In the disorder, the patient feels fearful, stressed, disorganized, unpleasantly scared and nervous; he is naturally concerned about the particular circumstances that lead to the condition of the disorder. He is in a state of vain and irrational fear with an unhealthy awareness of himself. In this there is an unknown and hidden fear for no apparent reason, which keeps the patient in an automatic mental and social preparation of defense against that hidden fear.

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