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Punjabi University, Patiala

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Lesson No.

1.1 : PSYCHOSOMATIC DISORDERS : ETIOLOGY AND PREVENTION OF HYPERTENSION

1.2 : PSYCHOSOMATIC DISORDERS : ETIOLOGY AND PREVENTION OF ASTHMA AND ULCERS

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Department website : www.pbidde.org

LESSON NO. 1.1

PSYCHO-PHYSIOLOGICAL DISORDERS: ETIOLOGY AND PREVENTION OF HYPERTENSION

1.0 Objective

In this lesson, we will discuss how psychological factors can cause physical disorders. This is an important topic because psychological factors influence various serious physical disorders. Among these are heart attacks, high blood pressure, strokes, headaches, hypertension, asthma, muscle and joint pain, etc. the primary focus of this chapter would be on the etiology and prevention of Hypertension. Ulcers and asthma would be discussed in detail in the next lesson.

1.1 Introduction

Psycho-Physiological disorders are categorized under mental disturbance that arise from psychological problems which are manifested through physical symptoms. However, these physical symptoms cannot be traced back to any serious physical disease or any origin. Nor are they under the conscious control of the patient.

Psycho-Physiological disorder is a physical disease which is thought to be caused or made worse by psychological factors. Some physical diseases are thought to be particularly prone by some psychological conditions like stress and anxieties.

Psycho-Physiological disorders are also called 'Psychosomatic disorders', which means that the mind is adversely affecting the body. According to American Psychiatric Association, Psycho-Physiological disorders are characterized by physical symptoms that are caused by emotional factors and involve a single organ system, usually under the control of the autonomic nervous system.

1.2 A brief history of the disorders:

Physicians have been aware that people's mental and emotional states influence their physical well being since the time of Hippocrates (460-311 B.C.). Hein Rotn first used the word 'psychosomatic', applying it to problems of insomnia. In the twentieth century, the discoveries of psychologists have shed new light on how the mind and body interact to produce health and illness. Sigmund Freud introduced the idea that unconscious thought can be converted into physical symptoms. The formal study of psychosomatic illness began in Europe.

Cannon showed how different emotions produce pattern of physiological alternation, emphasizing the importance of the autonomic nervous system. It is also known that certain inherited traits respond differently to certain stimuli like stress and anxiety causing physical system break down. In the 3950's stress became the focus in psychosomatic, the main promoter of the idea being Hans Selye. Later on the environment and social models were combined with the one of the major life changes and social stress. It is a well known fact that psychological and social factors exert an influence over bowel and gastric dysfunctions, mainly peptic ulcers and irritable bowel syndrome, thus the bio-psychosocial model has been considered while understanding these diseases.

Sometime the term psychosomatic disorders is used when psychological factors cause physical symptoms, but where there is no real physical disease, these kinds of disorder should be called as somatoform disorders. Thus, we should distinguish between the Psycho-Physiological disorders and somatoform disorder. In somatoform disorders, psychological factors cause symptoms of physical disorders but there is no actual physical disorder (i.e. No tissue damage). On the other hand, in Psycho-Physiological disorders, psychological factors lead to real physical disorders. For example, prolonged psychological stress can cause the production of

excess acid in the stomach, and the acid in turn cause ulcer (holes in the walls of the stomach).

1.3 Three important points about Psycho-Physiological disorders

Three important points must be remembered about Psycho-Physiological disorders:

1. A Psycho-Physiological disorder is a real disease that harms the body. The fact that such disorders are believed to be due to emotional factors does not make the disease imaginary.
2. Psycho-Physiological disorders must be distinguished from somatoform or hysterical disorders. The difference has been mention in previous section.
3. We should stress that the disorders termed "Psycho-Physiological" are not always due to emotional distress. E.g. Asthma is called a Psycho-Physiological disorder, but psychological factors are thought to be the primary cause in only 34% of all cases (Rees, 3964). Thus, these diseases may also have physical origin, but can be an outcome of psychological processes.

We have been using terms "Psychosomatic or Psycho-Physiological disorders" for the physical diseases that are influenced by psychological factors, but the American Psychiatric Association's Diagnostic and Statistical manual of mental disorders (DSM-IV) labels psychosomatic illness as under "Psychological Factors Affecting Physical Conditions."

The realization that psychological factors contribute to many physical disorders has led to the development of the new area of health psychology, in which psychologists work to identify, prevent and treat the psychological factors that lead to physical illness.

The parts of the body most commonly affected by psychosomatic disorders are; gastrointestinal and respiratory systems, Gastric and duodenal ulcers, ulcerative colitis and irritable bowl syndrome. Respiratory problems caused or worsened by psychological factors include asthma and hyperventilation syndrome.

Cardiovascular complaints include coronary artery disease, hypertension and migraine headaches. Psychosomatic disorders also affect the skin (eczema, allergies and etc.) and genitourinary system (menstrual disorders and sexual dysfunction). All these complaints are attributed in part to the emotional state of the patient; the most obvious difference among them is the part of the body affected. In present chapter, we will focus on hypertension and how psychological factors influence this disorder.

1.4 Hypertension

It is one of the most serious psycho-physiological disorders Hypertension or high blood pressure occurs when the supply of blood through the vessels is putting excessive pressure on the vessel walls. When high blood pressure is a recurring pattern, it can cause hardening of the arteries' walls and deterioration of the cell tissue. Hypertension is a serious medical problem for several reasons. It is a risk

factor for other disorders such as coronary artery disease (Heart attacks), kidney failure and stroke. It may also produce some cognitive impairment.

Hypertension is a cardiovascular disease and it means high blood pressure. During states of calm, the beat of the heart is regular, the pulse is even, blood pressure is relatively low and internal organs are well supplied with blood. During stress, blood flows in greater quantity to the muscles of the trunk and limbs with increased heart beat we can feel. As it beats faster and with greater force, the pulse quickens and blood pressure mounts. Usually when the stress passes, the body resumes normal functioning and the blood pressure returns to normal. Under continuing emotional strain, however, high blood pressure may become chronic which we called hypertension.

1.4.3 Types of hypertension

1.4.3.1 Essential Hypertension

It is also called primary Hypertension. Essential hypertension is high blood pressure for which a physical cause has not been found and thus, it is assumed that the elevated pressure is due to psychological factors.

1.4.3.2 Secondary Hypertension

Secondary hypertension is high blood pressure that stems from known physiological causes such as excessive salt in the diet, kidney malfunction or arthrosclerosis. It is called secondary because the elevated blood pressure is a side effect of some other physical disorder.

In this chapter, we will be concerned mostly with essential hypertension as we are focusing on psycho-physiological disorders.

1.4.2 Measurement of Hypertension

Hypertension is determined by the levels of systolic and diastolic blood pressure as measured by a sphygmomanometer. The systolic blood pressure is the high level of pressure that occurs immediately after each heart beat, when blood is suddenly forced through the system. It is sensitive both to the volume of blood leaving the heart and to the arteries' ability to stretch to accommodate blood (their elasticity). Diastolic blood pressure is the low level of pressure that occurs just before each heart beat. It is the pressure in the arteries when the heart is relaxed. It is related to resistance of the blood vessels to blood flow.

Normal Systolic pressure is about 320 mm Hg (millimeters of mercury) and normal diastolic pressure is generally considered to be 20 mm. individuals are usually diagnosed as suffering from hypertension if they have sustained blood pressure reading of 340 mm of systolic and above 90 of diastolic blood pressure.

1.4.3 The etiology/development of essential hypertension:

1.4.3.1 Physiological Aspect:

Initially, stress results in a temporary increase in blood pressure, then the increased blood pressure cause the arteries to stretch and it is detected by a set of sensors called baro-receptors that send signals to the central nervous

system to reduce blood pressure. If the pressure is high for a prolonged period of time, the baro-receptors adjust to the higher level of pressure and signal to the central nervous system only when the pressure goes even higher. In other words, after an extended increase in pressure, the baro-receptors reset themselves, and high pressure becomes the norm.

1.4.3.2 Psychological Causes:

1.4.3.2.1 Psychoanalytic Interpretation:

The classical psychoanalytic interpretations of hypertension are that affected people suffer from "suppressed rage". There is high incidence of hypertension among those who suppress hostility and anger but this hypothesis can not be said to be firmly established in respect to all.

1.4.3.2.2. Stressful conditions

Various stressful conditions have been examined to determine their role in the etiology of essential hypertension. Stressful events, natural disasters, anger and anxiety have been found to produce short term elevations in blood pressure. Chronic psychological stress e.g. loss of employment has been accepted as an important factor in essential hypertension. Crowded high stress and noisy environment all produce higher rates of hypertension. The underlying explanation of stress and hypertension relationship is the excessive arousal of sympathetic nervous system activity during stressful times. The stressful events that require active adaptability may have greater role in the development of hypertension than do stressful events that require only passive acceptance with recurring or prolonged exposure to stress; the physiological changes produced by heightened reactivity may cause permanent damage, laying the ground work for chronic hypertension.

1.4.3.2.3 Personality and Hypertension

Hypertension, originally, was thought to be marked by personally traits, mainly by the tendency to suppress anger. Certain personality traits may be important in conjunction with other risk factors. The most researched trait is suppressed hostility. Another variable that is implicated in the development of hypertension as well as other cardiovascular disease is Type A Behaviour. Type A Behaviour Syndrome was originally formulated by Fredman & Rosenman (3914) as a behavioural and emotional style marked by an aggressive, increasing struggle to achieve more and more in less time, often in competition with other individuals. In particular Type A Syndrome is characterized by three components:

(i) Easily aroused hostility.
(ii) A sense of time urgency, and
(iii) Competitive achievement striving.

Thus, three main personality factors i.e. Type A Behaviour pattern, hostility and suppressed anger play an important role in the development of essential hypertension because these factors contribute to more frequent and more prolonged elevation in blood pressure.

1.4.4 Prevention & Treatment

Prevention of hypertension is usually focused on two factors: diet and stress management. First, attempt are made to change the person's diet and secondly, attempts are made to teach the person how to control or reduce stress in life because stress is a major contributor to cardiovascular diseases specifically hypertension.

Hypertension has been controlled in a variety of ways. Commonly, patients are put on low sodium diets to restrict their sodium intake. Reduction of alcohol is also recommended for hypertension patients. Weight reduction in overweight patients is strongly urged and exercise is recommended for all hypertensive patients. Caffeine restriction is often included as part of the dietary treatment of hypertension.

1.4.4.1 Drug Treatment

Most commonly, hypertension is treated with drugs like diuretics and beta-adrenergic blockers, but some anti hypertensive drugs have undesirable side effects, such as drowsiness, light headedness and erectile difficulties for men. Thus, many investigations have been undertaken on non-pharmacological treatment for essential hypertension. Efforts have been directed at weight reduction, restriction of salt intake, aerobic exercise, etc.

1.4.4.2 Psychological Interventions:

Psychological interventions have been applied to teach hypertensive individuals to lower sympathetic nervous system arousal. A variety of behavioural and cognitive behavioural methods have been evaluated for their potential success in lowering blood pressure. Some of the psychological interventions are as follows:

1.4.4.2.1 Stress management

The stress management condition is described as "teaching four methods of relaxation i.e. slow-breathing, progressive muscle relaxation, mental imagery and stretching, plus techniques to manage stress perception, reactions and situations. It is stressed here that role of stress management is more effective in preventing hypertension. Once hypertension is developed, other techniques must be used. There are several approaches under the rubric of stress management and more than one are typically followed in any given instance. The main objectives of these programs are to reduce aroused level, restructure cognitions and to train them for behavioural skills.

1.4.4.2.2 Relaxation Techniques

Method that draw on relaxation include bio-feed back, progressive muscle relaxation, hypnosis and meditation all of which are thought to reduce the blood pressure via the induction of a state of low arousal. Deep breathing and imagery are often added to accomplish this task. The relaxation therapy may be especially effective with patients who have elevated sympathetic tone and low left ventricular mass.

1.4.4.2.3 Self-management Training

Such training provides techniques to the people to identify their particular stress and to develop plans for dealing with them. The programs include training in self-reinforcement, self-calming task, goal setting and time management. These cognitive Behavioural techniques are thought to reduce blood pressure by helping people avert the anxiety they would otherwise develop in response to environmental stress. Beside this technique people to express anger might be useful as suppress of anger has been linked to hypertension. People can be trained either to reduce their anger through cognitive restructuring and relaxing procedure or they can be told the appropriate ways to express their anger.

Overall, it has been found that psychological interventions appear to be more successful than no-treatment with mild hypertension. Psychological therapy may actually substitute for pharmacological approach. However, with the severely hypertensive, both during treatment and psychological intervention should be used.

1.5 Summary

Psycho-Physiological disorders are characterized by physical symptoms that are caused by emotional factors. The formal study of psychosomatic illness began in Europe in the 3920's. In the 3950's stress became the focus in psychosomatic, the main promoter of the idea being Hans Selye. The realization that psychological factors contribute to many physical disorders has led to the development of the new area of health psychology, in which psychologists work to identify, prevent and treat the psychological factors that lead to physical illness. Hypertension is a cardiovascular disease and it means high blood pressure. It is one of the most serious psycho-physiological disorders Hypertension or high blood pressure occurs when the supply of blood through the vessels is putting excessive pressure on the vessel walls. Prevention of hypertension is usually focused on two factors: diet and stress management. First, attempt are made to change the person's diet and secondly, attempts are made to teach the person how to control or reduce stress in life because stress is a major contributor to cardiovascular diseases specifically hypertension.

1.6 Exercise

Q.3 With brief introduction of psycho-physiological disorders, describe various Psychological causes which may lead to development of hypertension.

Q.2 Critically examine different techniques that are used for treating hypertension.

1.7 Suggested Books

3. Taylor, S.E. (3993). Health Psychology. Los Angeles, CA: McGraw-Hill.
2. Carson, R.C. & Butcher, J.N. (3992). Abnormal Psychology and Modern Life (Ninth Edition). New York: HarperCollins.
3. Holmes, D. (3993). Abnormal psychology. New York: Harper Collins.

LESSON NO. 1.2

PSYCHO-PHYSIOLOGICAL DISORDERS: ETIOLOGY AND PREVENTION OF ASTHMA AND ULCERS

Lesson Structure

2.0 Objective

Psycho-Physiological disorder is a physical disease which is thought to be caused or made worse by psychological factors. In this lesson, two common psycho-

physiological disorders i.e. asthma and ulcers would be discussed. As basics of psycho-physiological disorders have been discussed in previous lesson, we will start directly from Asthma in which symptoms, types, and causes especially psychological ones would be the main concern. After mentioning treatment of asthma, we will shift our focus to ulcers. Discussing types, etiology and treatment of ulcers would be our primary concern

2.1 Introduction

In Psycho-Physiological disorders, psychological factors lead to real physical disorders. For example, prolonged psychological stress can cause the production of excess acid in the stomach, and the acid in turn cause ulcer (holes in the walls of the stomach). The parts of the body most commonly affected by psychosomatic disorders are; gastrointestinal and respiratory systems, Gastric and duodenal ulcers, ulcerative colitis and irritable bowl syndrome. Respiratory problems caused or worsened by psychological factors include asthma and hyperventilation syndrome. In present chapter, we will focus on asthma and ulcers and how psychological factors influence these disorders.

2.2 Asthma

A respiratory trouble causing impairment in breathing air by individual is characterized by this disorder. Wheezing while exhaling, coughing, tightness in the chest etc. are the features of the asthma. In Asthma, the air passages are narrowed, causing breathing to be extremely difficult (particularly exhalation). In addition, there is an inflammation of lung tissues mediated by the immune system. Numerous attempts have been made to define Asthma over the past two decades. National Heart, Lung and Blood Institute (1992) of the USA defined Asthma as "A lung disease manifested symptomatologically with airway obstruction that is reversible either spontaneously or with treatment; airway inflammation; and airway hyper-responsiveness.

People who have asthma have difficulty in breathing, feel constriction in the chest, gasping and apprehension. The asthma sufferer takes a longer time than normal to exhale and whistling sounds can be detected through the chest.

2.2.1 Types of Asthma

There are two types of Asthma:

2.2.4.1Extrinsic Asthma

It is also called allergic asthma. The causes of such disorders are dust, pollens, etc.

2.2.4.2 Intrinsic Asthma

Intrinsic Asthma: It is also called infective asthma. Infections rather than allergic noxious agents play a significant role in the etiology of this sort of asthma.

Most often, asthmatic attacks begin suddenly. The asthmatic individual has a sense of tightness in the chest and coughs. Subjective

reaction can include panic, fear, irritability and fatigue. A severe attack is a very frightening experience indeed. The asthma sufferer has immense difficulty getting air into and out of the lungs and feels as he or she is suffocating. The sufferer may become exhausted by the exertion and fall asleep as soon as breathing is more normal.

2.2.2 Etiology of Asthma:

Asthma is a disease with multiple causes. Medically, Asthma is viewed as an immunological disorder which interacts with psychosomatic medicine. Therefore, there are conflicting views on the precise role of the various emotional states responsible for eliciting an asthmatic response. On one extreme, asthma is considered entirely a psychosomatic disorder; others view it as a psychological disturbance stemming from the outcome of a pulmonary functional flare up.

While investigating the causes of asthma, Rees (1964) divided the various possible causes into three categories:

a) Allergic,
b) Infective,
c) Psychological.

Allergic agents like pollen, molds, fur and dust can predispose respiratory tract to bring Asthma. On the other hand, respiratory infections most often acute bronchitis can also make the respiratory system vulnerable to asthma. Among Psychological variables, anxiety, tension, frustration, anger, depression, are all may induce emotionally disturbance which inhibit the adequate functioning of the respiratory system and thus cause asthma.

It must be noted that the different causes of asthma varied in importance depending on the age of the individual. For younger than five years of age, the infective factor predominates. From ages six to sixteen the infective factor still predominates but psychological variables increased in importance. In the range from ages sixteen to sixty five, psychological factors decreased in importance until about the thirty fifty years thereafter becoming more consequential again (Rees, 1964).

Some cases of asthma have psychological factors as a primary cause. Even when asthma is originally induced by an infection or allergy, psychological stress can precipitate attacks. A study by Kleeman (1961), showed that 69% of the asthmatic attacks began with an emotional disturbance.

2.2.2.1 Psychological causes

2.2.2.1.1 Family Factor

The role of familial psychosocial factors in inducing asthmatic disorders has been observed among vulnerable children. Doctors have also noted certain asthmatic children whose symptoms improved markedly or remitted when isolated from a stressful familial environment. Parent-child relationship has found to be a significant predictor of Asthma. Although certain emotional factors in the home may be important in eliciting early asthmatic attacks in

some children, in other the illness may originally develop for non-familial reasons.

2.2.2.1.2 Personality and Asthma

It has been suggested that particular personality traits are linked to asthma. Person with neurotic symptoms such as dependency, sensitivity, anxiety, perfectionism are more prone to be asthmatic.

2.2.2.1.3 Stress and Anxiety:

The emotional overtone as during stress and anxiety can make individual vulnerable to asthmatic attacks because this heightened arousal brings bio-physical changes in respiratory function.

Besides all other causes, a diathesis-stress explanation should be kept in mind, which states that, if individual's respiratory system is predisposed to asthma, any psychological stresses can interact with the diathesis or weakness to produce the disease.

2.2.3 Prevention/Treatment

In order to deal effectively with negative consequences of asthma, two specialists should be involved in the management of this condition, the physician and the behavioural therapist or psychologist. As we are discussing psychological aspect of asthma, we will primarily focus on psychological therapies to deal with asthma.

The patients with physical symptoms and psychological disturbance due to psychosomatic diseases often have special therapeutic needs. Presently psychosomatic treatment uses psycho education, relaxation techniques, stress management and supportive therapy mainly cognitive-behavioural to deal with psycho-physiological disorders. Three distinct behavioural approaches are usually considered in management:

(i) Abnormal Pulmonary Function must be modified (Role of Physician).
(ii) Emotional disturbances must be changed (Role of Psychotherapist).
(iii) Maladaptive asthma related to inconsistent family behaviour and conditions must be altered (Family Interventions). A Psychotherapist can assist asthma patient with the help of five approaches:

2.2.3.1 Relaxation Training

There are various procedures to relax the patient so that their emotional arousal can be made to the optimal level. Herbert Benson is the promoter of relaxation techniques and considered these as strategic and preventive therapy approaches in psychosomatics.

Relaxation Techniques:-

(i) Edmund Jacobson's Progressive muscle relaxation therapy,
(ii) Deep breathing exercises improves the respiratory function and eliminate stress and tension.

(iii) Guided Imagery: It is a two component process: the first component implies deep relaxation and then imagination of restful mind and the body,

(iv) Biofeedback training: It is a combination of relaxation, visualization and cognitive method.

(v) Music therapy: It has indirect affect on psychosomatic disease, as it alleviates stress and anxiety which further leads to reduction in psychosomatic symptoms.

2.2.3.2 Systematic desensitization

Systematic desensitization involves Making the individual less sensitive to anxiety arousing situation by gradual approaching stressful situation in relaxed state of mind.

2.2.3.3 Self-management

Self-management: It is to educate clients to achieve self initiated skills and competence. It includes; 1) medical and behavioural knowledge 2) skill to control stressful events, 3) to cope positively with external stressors.

Since Psycho-Physiological disorders are the physical disturbances, sound psychotherapeutic practice requires close consultation with a physician.

2.3 Ulcers

The word ulcer refers to any abnormal break in the skin or a mucus membrane. The ulcers from which most people suffer are peptic ulcers which occur in the digestive system. In addition to causing considerable pain, ulcer can be dangerous because they lead to internal bleeding and can result in death. The term peptic is derived from pepsin, an important component of the acid stomach juices that aid in the early phases of digestion. This ulceration of the stomach or upper intestine (the duodenum) were found primarily in young women, but a shift occurred in the second half of the nineteenth century and in the twentieth century men became far more prone to peptic ulcers than women.

2.3.1 Types of Peptic Ulcers

Peptic ulcers are divided into two types, depending on where in the digestive system they occur.

2.3.1.1 Duodenal Ulcers:

These types of ulcers occur in the duodenum which is the first part of the small intestine where the food enters the intestine from the stomach. About 25% of such ulcers are caused by over production of gastric acid rather than by under protection of mucus.

2.3.1.2 Gastric Ulcers:

Gastric Ulcers occur in the stomach and in contrast to duodenal ulcers; they are usually the result of too little protective mucus rather than too much gastric acid. In many cases, individuals develop gastric ulcers because they

have ingested high levels of substance like aspirin or alcohol that reduce mucus, thus causing an acid-mucus imbalance.

2.3.2 Causes of Ulcer

2.3.2.1 Physiological Causes

Ulcers result from an imbalance between the level of gastric acid (primarily hydrochloride acid and pepsin) that is produced to break down food stuff and the level of mucus that is produced to neutralize the acid and thereby protect the walls of the intestinal tract. If the acid level gets too high because too much acid is being produced or because not enough mucus is being produced, the acid will create holes (ulcers) in the walls of the intestinal tract. The ulcers result in pain and vomiting (sometimes of blood).

2.3.2.2 Psychological Causes

A major reason for the overproduction of gastric acid is stress. Some types of stress are more likely to lead to ulcers than others. E.g. unpredictable stress is more likely to lead to ulcers than predictable stress. Another factor related with stress and ulcers is controllability as uncontrollable stress leads to more ulcers.

2.3.2.2.1 Prolonged Exposure to Anxiety

Intense anger or anxiety produced intense physiological reactions which can lead to development of ulcers as anxiety producing condition produce excessive secretion of hydrochloric acid.

2.3.2.2.2 Personality

Alexander (1950) developed a profile of the Ulcer-prone personality as someone whose disorder was caused primarily by excessive need for dependency and love. Repressed emotions resulting from frustrations, dependencies and love seeking needs are said to increase the secretion of acid in the stomach, eventually, eroding the stomach lining and producing ulcers.

2.3.2.2.3 Negative Attitude

Negative thinking and attitude induces immune-suppression and health endangering life style which may predispose toward peptic ulcer.

In general, the research consistently indicates that a predisposition to produce high level of gastric acid in combination with stress leads to the development of ulcers. Then, rather than talking about the stress-ulcer relationship, we should talk about the predisposition-stress-ulcer relationship.

2.3.3 Treatment and Preventions

Medical treatment for ulcers involves removing the ulcer or cutting the vagus nerve to lessen acid production or using anti-acid drugs but because it does not remove the underlying problems i.e. acid production and stress, the ulcers are very likely to return. Thus, the treatment of choice should involve various types of stress-

management training programs in which individual are taught to avoid or control stress. Following specific techniques can be used in management of ulcers.

(1) Learning better coping skills.
(2) Reappraisal of stressful situations and preserved ability of the self.
(3) Relaxation techniques (Breathing, progressive mustive relaxation, Bio-feed back).
(4) Psycho-educational techniques.

2.4 Summary

In Asthma, the air passages are narrowed, causing breathing to be extremely difficult (particularly exhalation). In addition, there is an inflammation of lung tissues mediated by the immune system. Asthma is a disease with multiple causes. Medically, Asthma is viewed as an immunological disorder which interacts with psychosomatic medicine. Therefore, there are conflicting views on the precise role of the various emotional states responsible for eliciting an asthmatic response. On one extreme, asthma is considered entirely a psychosomatic disorder; others view it as a psychological disturbance stemming from the outcome of a pulmonary functional flare up. Since Psycho-Physiological disorders are the physical disturbances, sound psychotherapeutic practice requires close consultation with a physician. The ulcers from which most people suffer are peptic ulcers which occur in the digestive system. In addition to causing considerable pain, ulcer can be dangerous because they lead to internal bleeding and can result in death. The treatment of ulcers should involve various types of stress-management training programs in which individual are taught to avoid or control stress.

2.5 Exercise

Q4: Describe various causes of Asthma with main emphasis on psychological ones.
Q2: Explain the role of physiological factors in Ulcers.
Q3: How can we prevent ulcers and asthma with the help og Psychological principals.

2.6 Suggested Books

1. Brannon, L.& Feist, J.(2000). Health Psychology: An Introduction to Behaviour and Health(4th edition) Brooks/Cole,USA.
2. Taylor, S.E. (1991). Health Psychology. Los Angeles, CA: McGraw-Hill.
3. Holmes, D. (1991). Abnormal psychology. New York: Harper Collins.
4. Davison, G.C., & Neale, J.M. (1996). Abnormal psychology (6th ed.) New York: Wiley.

LESSON No. 1.3 WRITER : GURMEET ANAND

SCHIZOPHRENIA—CLINICAL PICTURE AND TYPES

LESSON STRUCTURE

3.0 OBJECTIVE

The objective of this lesson is to understand the concept and clinical symptoms of schizophrenia. We shall be covering a brief introduction of schizophrenia and its types along with the symptoms. Also we shall focus some recent classification of this disorder along with the positive and negative symptoms of schizophrenia.

3.1 INTRODUCTION

Schizophrenia is the clinical syndrome that best corresponds to the layman's idea of "madness". According to Carson, Butcher and Mineka (1996), schizophrenia represents, "The ultimate in psychological breakdown".

Schizophrenia is a thought disorder. It is the most common form of insanity. Its characteristics and symptoms used to be generally placed under the term DEMENTIA PRAECOX. "DEMENTIA" means progressive mental deterioration and "PRAECOX" means early onset of the disease i.e., during puberty. It is a common term used for progressive degeneration or decline in mental functions such as inattention, memory, imagination, judgement, initiativeness, social aptitudes and adjustments. As the dementia progresses, such traits as dishonesty, cruelty, sexual deprivation, may be enhanced. Dementia accompanies many mental disorders, and there may be many types of degeneration.

The word "PRAECOX" means premature. Thus, dementia praecox means decline in mental functions which begins early in life, i.e., during youthful period.

3.2 MEANING AND DEFINITIONS OF SCHIZOPHRENIA

According to **COLEMAN,** "Schizophrenia is the descriptive term for the group of psychotic disorders characterized with gross distortions with reality, withdrawn from social interaction, disorganisation and fragmentation of perception, thoughts and emotions".

KRAPELIN gave the term Dementia Praecox to refer to a group of dissimilar conditions.

According to **PAGE,** "Schizophrenia is a general term referring to a group of severe mental disorder marked by a splitting or disorganization of personality".

According to **ROSEN AND GREGORY,** "Among psychiatric disorders, schizophrenia is one of the most common yet baffling disorder, manifesting in variety of sub-types and ever increasing variety of symptoms, within most of the sub-types".

According to **A.P.A. in (1988),** "Schizophrenia refers to one of the most baffling

mental illness, though it has a specific set of symptoms. This illness varies in its severity from individual to individual".

Though most of the modern thoughts agree on its severity and variety in symptoms, they further emphasize that it is a brain disease. Emphasizing this thought, TORREY says, "Schizophrenia is a brain disease, now definitely known to be such. It exhibits symptoms of a brain disease which include impairment in thinking, delusions, hallucinations, changes in emotions and behaviour."

According to **VIVE** : 'It is a brain disease, it is a real scientific and biological disease, it is not a split of personality but it means split within a single person of his thoughts and emotions."

Initially, schizophrenic disorders were attributed to mental deterioration early in life. *In 1860, a Belgian Psychiatrist, Morel, described the case of a 13 years old brilliant boy, who over a period of time lost interest in school, became withdrawn, reclusive, and appeared to have forgotten everything he had learnt. He talked of killing his father and showed stupid behaviour as his intellectual, moral, and physical functions deteriorated.* Morel used the term demence praecox, i.e., mental deterioration at an early age, to describe the condition. The Latin form of this term, dementia praecox was subsequently adopted by the German psychiatrist Krapelin, to refer to mental deterioration occurring early in life, typically in adolescence. He believed the cause of this disease was irreversible organic deterioration and paid no attention to psychological aspects.

It was the Swiss psychiatrist, Bleuler, who emphasized the psychological aspect of the disorder. He introduced the term *schizophrenia* in 1911, meaning thereby, *splitting of the mind/personality*, in the process broadening the concept of the disorder. Bleuler recognized that schizophrenia is a general category consisting of a variety of disorders, all of which do not begin early in life or are irreversible. He divided people with schizophrenia into those with chronic and acute symptoms, and held that acute cases had a good chance of recovery. In general, he summed up the primary characteristics of schizophrenic behaviour as the four A's —alteration in associations, affect, ambivalence and autism.

According to Carson and Butcher (1992), "The schizophrenias are a group of psychotic disorders characterized by gross distortions of reality, withdrawl from social interaction; and disorganization and fragmentation of perception, thought, and emotion". However, in a more recent tenth edition of their text, following Andreasen and Carpenter (1993), they hold that schizophrenia is a *provisional construct*, whose definition has changed over time, with substantial effects on incidence, diagnoses, and treatment. Consequently, they choose not to give a formal definition of term. In the eleventh edition published in 2000, they agree with APA (1997) that "it is likely that schizophrenia is the final common pathway for a group of disorders with a variety of etiologies, courses and outcomes".

3.3 Incidence :

Schizophrenia occurs in virtually all societies, from the inhabitants of jungles in

Malaysia to the technologically advanced Americans. Data from a WHO study (Sartorius et. al., 1986) shows very similar rates of schizophrenia across widely differing cultural contexts. About 1% of the total population is estimated to be schizophrenic, and this incidence has remained fairly stable over time. Due to the severity of the disease, almost half of the hospital population tends to be schizophrenic. Schizophrenia occurs primarily in youth, about 3/4 of all hospital admissions being between the ages of 15 and 45, the median age being in mid-twenties. There are no sex differences in overall rate of incidence, but males have earlier onsets and according to some researchers, tend to develop more severe forms of this disorder (Marcus et al., 1993; Tien and Eaton, 1992).

3.4 CLINICAL PICTURE

A. Symptoms :

The main symptoms in schizophrenia may be enlisted as follows :-

3.4.1. Disorganization of a previous level of functioning :

This is perhaps the cardinal sign of a schizophrenic breakdown. It distinguishes the schizophrenias from various developmental anomalies in which the person never attains a suitable degree of integrated behaviour functioning. Schizophrenia cannot be hidden. Impairment always occurs in areas of daily functioning, such as work, social relations and self-care so that observers note that the person is not himself or herself anymore. As Carson, Butcher, and Mineka (1996) hold, "the basic experience in schizophrenia seems to be disorganization in perception, thought, and emotion to the extent that the affected person is no longer able to perform customary social roles in an adequate social fashion".

3.4.2. Disturbance of formal thought (disorder in language and communication) :

Schizophrenia is often referred to as a formal thought disorder. This implies a failure to conform to the semantic and syntactic rules governing verbal communication that is not attributable to low intelligence, poor education, or cultural deprivation. The patient seems to be using words in combination that sound communicative, but gradually, the listener comes to know that he cannot understand what the patient is speaking.

Frude (1998) cites the example of a patient who made an observation regarding his surname -

Patient : Frude - fried foods - Frude is Fride. Your name is Fride.

Author : But it is spelled with a U!

Patient : But U and I are one.

Formal thought disorders are reflected in :

a. Incoherence: Disconnected images or fragments of thought, so that the patient cannot be understood. The patient may use 'neologisms' i.e., coin new words, which are meaningless to the listener.

b. Loosening of associations, a rapid shift of ideas from one topic to another.

Probably, its initial stage is incoherence.

c. Autistic speech: Thinking is so self-centred that it is clear only to themselves.

d. Poverty of speech : Amount of discourse is reduced.

e. Poverty of content: Amount is adequate but it conveys little information. It may just be a word salad.

f. Preservation : Words and ideas are persistently repeated.

g. Blocking : A train of speech is interrupted by silence and then the thought to be conveyed cannot be recalled.

3.4.3. Disturbance of content of thought (Delusions) :

Delusions are false beliefs. Many schizophrenics are subject to delusions, holding beliefs that the rest of the society would generally disagree with, or view as misinterpretations of reality. Delusions occur in other mental disorders as well, but they have a somewhat different content. In schizophrenia, the common delusions are : the belief that the person's thoughts are being broadcast into the external world so that everyone can hear them, the belief that others are inserting thoughts in the person's mind, the belief that the person's impulses and feelings are controlled by others, etc. In schizophrenia, delusions are very loosely organized and there is little or no connection between different delusions. However, they may result in violent behaviour.

3.4.4. Disturbance of attention

Schizophrenics appear to be *hypervigilant* i.e., they are acutely sensitive to extraneous sounds. Thus, they are in a state of sensory overload. They are unable to screen out distractions or to discriminate between relevant and irrelevant stimuli. They are also unable to integrate their sensations into a meaningful pattern. E.g., During an early phase, a schizophrenic reported. "I feel like I am too alert... everything seems to come pouring in at one I can't seem to keep anything out".

3.4.5. Disruption of perception (Hallucinations) :

The major symptom in schizophrenia is hallucination. Hallucinations are perceptions for which there are no discernible external stimuli. They can be associated with any sense modality, but in the schizophrenics, they occur generally in the auditory mode. Typically, the patient hears a voice (or voices) which keeps up a running commentary on his thoughts and behaviours. Some patients experience command—hallucinations—voices that compel them to do something.

3.4.6. Disturbance of affect :

Two affective abnormalities are found in many patients—*flat affect and inappropriate affect*. In *anhedonia* or flat affect, virtually no stimulus can elicit an emotional response. Even the most dramatic event produces at the most only an intellectual cold recognition of what is happening. Inappropriate affect is shown when the persons may show very strong affect, but the type of emotion is discordant with

the situation or the content of his thoughts e.g., the patient may laugh uproariously upon receiving the news of a parent's death.

3.4.7. Withdrawal from reality (autism) and retreat to an inner world :

Bleuler refers to schizophrenic withdrawal from the external world as *autism*. It implies a detachment from the external world and elaboration of an internal private world, which consists of illogical fantastic creations that interact with the person in various self-directed dramas.

3.4.8. Motor symptoms :

Disturbances in motor activity are obvious and bizarre. The patient shows strange facial or postural expressions, grimaces, actions, etc. Sometimes, there is an unusual increase in the overall level of activity and a great expenditure of energy similar to that seen in mania. Conversely, the patient may show catatonic immobility (unusual postures are adopted for very long periods of time). Indeed, this is the defining feature of catatonic schizophrenia in which the patient shows waxy flexibility—another person can move their limbs into strange positions which are then maintained for long periods of time.

3.4.9. Confused sense of self :

The schizophrenic often, has a loss of ego boundaries. He is perplexed about his own identity, including gender identity, and is confused about the boundaries separating his self from the environment. There is a fragmentation of the self and a sense of depersonalization. This may lead to intense panic. As one patient reports, "I didn't even seem to exist any more as a distinct person—just parts of me 'floating around' here and there in space it is sheer terror—like no other experience on earth".

3.4.10. Disrupted volition :

Goal-directed activity is almost universally disrupted in the schizophrenic, either due to intentiona1 flouting of external expectations or inability to carry out a course of acting. For e.g. The person may not want to take care of personal hygiene.

3.4.11. Lowered cognitive functioning :

The IQ level of 'a schizophrenic is generally below average, their mental age being 1 to 2 years below the general population. However, this impairment is not permanent with improvement in mental health, they recover their intelligence. Misra, Verma and Bhagat (1983) report that paranoid and chronic schizophrenics obtain significantly low IQ on Alexander' pass-a-long test than the general norm.

3.4.12. Bizarre behaviour :

Due to the disorganizations afore mentioned, the schizophrenic shows bizarre behaviour and his actions seem bizarre and unreal. An example is found in Hannah Green's novel—"I never promised you a rose garden" (1964) which describes how a young schizophrenic girl, burns herself repeatedly with cigarettes to "prove to herself whether or not she was truly made of human substance".

3.4.13. Lack of insight :

A schizophrenic does not realize he is ill or that he requires medical help.

Consequently, he is not amenable to treatment.

With regard to these symptoms, it is relevant to note that :-

1. All symptoms do not occur in a particular case.
2. The symptoms and their combinations are unique in each patient.
3. The symptom picture may be influenced by the person being labeled a schizophrenic and given a sick role.
4. The symptoms vary over time both episodically and over a long-range period.
5. Many symptoms are systematically linked together: one specific type of symptom may be closely associated with another because they arise from a common dysfunction; or one symptom may provoke another secondary symptom.

Bleuler maintained that primary symptoms are the direct result of an organic disorder, and that secondary symptoms reflect the person's attempts to cope with a problem in maintaining attention (a primary problem) by withdrawing from social interaction. Similarly, delusions may be secondary symptoms generated by conscious or unconscious attempts to make sense of complex and confusing situations.

An integrative model of schizophrenic symptomatology suggests that difficulties in coping with the level of the ambient stimulation produce disorientation; confusion, and thought disorder. As these effects become obvious in the person's speech, other people may avoid social contact with the person. Such avoidance might increase the potential for paranoid delusions. Any attempts by other people to normalize the person's behaviour may be regarded with suspicion, and may result in accusation of harassment and interference. Thus, a whole of collection of difficulties can arise from a single primary attention deficit. (Frude, 1988).

3.5 PHASES OF SCHIZOPHRENIA

Schizophrenia typically develops in late adolescence or early adulthood. In some cases, the onset of the disorder is acute and occurs suddenly with few signs of disturbance beforehand. In other cases, the disease is progressive and slow. It may take years before the actual psychotic behaviours emerge. This period deterioration is called the *prodormal* phase characterized by withdrawal. As behaviour becomes more bizarre, the *acute* phase begins with hallucinations, delusions, and bizarre behaviour. Following the acute episode, schizophrenics enter the *residual* phase, which is similar to the prodormal phase. Rarely does the person return to normalcy. More frequently, a *chronic* pattern develops with occasional recurrence of acute episodes.

DSM-IV classifies a person as schizophrenic only if he shows a majority of the aforementioned symptoms, and shows them for a period of more than 6 months. This 6-month period must include at least one week of active phase defined by the presence of at least 2 of the following: delusions, hallucinations, incoherence, catatonia, and flat or inappropriate affect. The remaining time can be either a prodormal (before active phase) or residual (after active phase) period consisting of social withdrawal, impaired role functioning, odd beliefs, lack of initiative, vague

speech and mannerisms etc."

3.6 SYNDROMES OF SCHIZOPHRENIA

The varieties of symptoms of schizophrenia are organized into syndromes identified by various clinicians in various ways. The ICD-10, used in India lists the various types of Schizophrenia as follows :-

1. Paranoid schizophrenia
2. Hebephrenic schizophrenia
3. Catatonic schizophrenia
4. Undifferentiated schizophrenia
5. Post-schizophrenic depression
6. Residual schizophrenia
7. Simple schizophrenia
8. Other schizophrenia
9. Schizophrenia, unspecified

Some other related disorders are :-

1. Schizotypal disorder
2. Acute polymorphic psychotic disorder with symptoms of schizophrenia
3. Acute schizophrenia-like psychotic disorder
4. Other acute and transient psychotic disorders
5. Acute and transient psychotic disorder, unspecified
6. Schizoaffective disorders

The DSM-IV lists the following types under Schizophrenia :-

3.6.1. Schizophrenia -paranoid type :

A symptom picture dominated by absurd, illogical, and changeable delusion frequently accompanied by vivid hallucination, with a resulting impairment of critical judgement and erratic, unpredictable, and occasionally dangerous behaviour. In chronic case, there is usually less disorganization of behaviour than in other types of schizophrenia, and less extreme withdrawal from social interaction. Paranoid schizophrenia is often not diagnosed until the fourth or fifth decade.

Case Profile :

At the age of 35 Mrs. M. G. developed angry feelings about her neighbours, claiming that they were spying on her and plotting to kill me by stealth She accused her family of conspiring with the neighbours, and of planting evil ideas, in her mind. She said repeatedly that she did not belong to the family: and complained of voices telling her to leave and return to her true life in an underground kingdom. Her description of this underground kingdom was at times highly detailed. When a doctor was called, she accused him of being 'the devil's agent', and she had to be forcibly moved to hospital. There, she claimed that she knew all about the nurses' private lives, she accused visitors of being spies and she identified patients as famous film stars and historical

character.

3.6.2. Schizophrenia -disorganized type :

It usually occurs at an early age than most other types of schizophrenia, and represents more severe disintegration of the personality. Emotional distortion and blunting are typically manifested in inappropriate laughter and silliness, peculiar mannerisms, and bizarre, often obscene, behaviour.

Case Profile:

Mr. PD., an 18 year-old student, had made few social contacts since entering university. He dressed in a somewhat strange way and made comments in tutorials, which were regarded by other students and his tutors as bizarre. One day, he disrupted a lecture by laughing repeatedly in a manic and rather threatening fashion. When asked to leave the lecture, he shouted odd disconnected phrases and seemed to hold a disjointed conversation with hallucinated voices. He was hospitalized, and after receiving major tranquillizers, his disturbed behaviour ceased. He sat in a trance-like state, constantly intertwining his fingers, and smiled for a long period. Occasionally, he would start crying or would burst out laughing.

3.6.3. Schizophrenia—catatonic type :

It is often characterized by alternating periods of extreme withdrawal and extreme excitement, although in some cases, one or the other reaction predominates. In the withdrawal reaction, there is a sudden loss of all animation and a tendency to remain motionless for hours or even days in a single position. The clinical picture may undergo an abrupt change, with excitement among on suddenly, wherein an individual may talk or shout incoherently, pace rapidly, and engage in uninhibited, impulsive, and frenzied behaviour. In this state, an individual may be dangerous.

Case profile :

Ms Y. F., 24-year old hairdresser, was admitted to hospital having been found at home in a state of 'rigidity', and resisting all attempts to rouse her. This state had persisted for several hours. In hospital, and after medication, she alternated between a catatonic state and a highly active state in which she ran about and performed exercise-like movements until collapsing back into a statue-like pose. She spoke rarely, and when asked a question, she would repeat it rather than providing an answer. At a later stage, she did the precise opposite of everything she was asked to do.

3.6.4. Schizophrenia—undifferentiated type :

It is a pattern of symptoms in which there is a rapidly changing mixture of all or most of the primary indicators of schizophrenia. Commonly observed are indications of perplexity, confusion, emotional turmoil, delusions of reference, excitement, dreamlike autism, depression, and fear. Most often, this picture is seen in the patients who are in the process of breaking down and becoming schizophrenic. It is also seen, however, when major changes are occurring in the adjustive demands impinging on a person with an already-established schizophrenic psychosis. In such cases, it frequently foreshadows an impending change to another primary schizophrenic subtype.

Case profile:

J.G., 24-year old man, had lived alone for a number of years apparently with very little social contact. He was caught stealing from a shop, and the policeman who interviewed him noticed a strangeness which made him wonder whether J. was mentally ill. A psychiatrist who later examined J. found him to be extremely apathetic, to have very little knowledge of the world around him, and to be obsessed with a science fiction world of his own creation. It was difficult to establish the degree to which J. actually believed in the strange things he described. He recounted things in a dreamy way and often, seemed to inhabit a world of his own.

3.6.5. Schizophrenia—residual type :

Mild indications of schizophrenia are shown by individuals in remission following a schizophrenic episode. It is a category used for people who have experienced an episode of schizophrenia from which they have recovered sufficiently so as not to show prominent psychotic symptoms. They nevertheless, still manifest some mild signs of their past disorder, such as odd beliefs, flat affect, or eccentric behaviour.

TYPES OF SCHIZOPHRENIA

Type	Characteristics
Undifferentiated type	A pattern of symptoms in which there is a rapidly changing mixture of all or most of the primary indicators of schizophrenia. Commonly observed are indications of perplexity, confusion, emotional turmoil, delusions of reference, excitement, dreamlike autism, depression, and fear. Most often, this picture is seen in patients who are in the process of breaking down and becoming schizophrenic. It is also seen, however, when major changes are occurring in the adjustive demands impinging on a person with an already-established schizophrenic psychosis. In such cases, it frequently fore-shadows an impending change to another primary schizophrenic subtype.
Paranoid type	A symptom picture dominated by absurd, illogical, and changeable delusions, frequently accompanied by vivid hallucinations, with a resulting impairment of critical judgement and erratic, unpredictable, and occasionally dangerous behaviour. In chronic cases, there is usually less disorganization of behaviour than in other types of schizophrenia, and less extreme withdrawal from social interaction.
Catatonic type	Often characterized by alternating periods of extreme withdrawal and extreme excitement, although in some cases one or the other reaction predominates. In the withdrawal reaction, there is a sudden loss of all

	animation and a tendency to remain motionless for hours or even days in a single position. The clinical picture may undergo an abrupt change, with excitement coming on suddenly, wherein an individual may talk or shout incoherently, pace rapidly, and engage in uninhibited, impulsive, and frenzied behaviour. In this state, an individual may be dangerous.
Disorganized type	Usually occurs at an earlier age than most other types of schizophrenia, and represents a more severe disintegration of the personality. Emotional distortion and blunting are typically manifested in inappropriate laughter and silliness, peculiar mannerisms, and bizarre, often obscene, behaviour.
Residual type	Mild indications of schizophrenia shown by individuals in remission following a schizophrenic episode.

3.7 Other closely linked syndromes

3.7.1 Schizophreniform disorder

It is schizophrenia-like psychoses of less than six months, often involving undifferentiated symptoms which do not justify the classification of established forms of schizophrenia. Vivid hallucinations are the main symptom. At present, all recent-onset cases must first receive a diagnosis of schizophreniform disorder. Due to the possibility of an early and lasting remission in the first episode of schizophrenic breakdown, prognosis for this disorder is more favorable than other established forms of schizophrenia.

3.7.2 Schizoaffective disorder

Symptoms of both schizophrenia and severe mood disorder are present. Thought processes are disorganized and extremes of moods are also shown. It is classified according to the prevailing mood, into the categories—bipolar type and depressive type. To receive this diagnosis, the patient must meet the criteria for a major mood disorder (unipolar or bipolar) and show at least two major symptoms of schizophrenia (such as hallucinations and delusions). A controversial category, some clinicians believe the patient to be primarily schizophrenic, others believe him to be basically mood disordered, and still others believe he has a distinct disorder. Highly episodic with periods of lucid intervals, the prognosis for schizoaffective disorders is better than schizophrenia, but considerably worse than mood disorders.

3.7.3. Schizoid personality disorder :

Such individuals show impaired social relationships and an inability as well as a lack of desire to form attachments with others. Loners, with solitary interests and occupations, they appear cold and aloof because they are not emotionally reactive. Current research has not established a clear, link with schizophrenia. (Siever, 1986)

3.8 Schizotypal personality disorder :

In addition to social isolation and withdrawal, they show cognitive and perceptual distortions, leading to eccentricities in their communication and behaviour. Highly personalized, superstitious thinking reveals oddities of thought, perception and speech. Under extreme stress they may experience *transient* psychotic symptoms.

THE PRINCIPLE PSYCHOTIC DISORDERS AND THEIR CHARACTERISTICS

Name	**Characteristics**
Schizophrenia	Six months or greater duration of disturbance. At least one month of active-phase usually including at least two of the positive symptoms listed in the next table or one positive and one negative symptom. A decline in social or occupational function must also occur. (Five subtypes include Paranoid, Disorganized, Catatonic, Undifferentiated, and Residual)
Schizophreniform Disorder	Same symptoms as schizophrenia except lasting less than six months. It is not necessary that there be a decline in function for this diagnosis.
Schizoaffective Disorder	The active phase symptoms of schizophrenic disorder occur together with an episode characteristic of a mood disorder. These are preceded or followed by at least two weeks of delusions or hallucinations.
Brief Psychotic Disorder	A psychotic disturbance lasting more than one day but less than one month.
Psychotic Disorder due to General Medical Condition	Psychotic symptoms thought to be physiological results of a general medical condition or illness.
Substance-Induced Psychotic Disorder	Psychotic symptoms thought to be the physiological result of toxin exposure, medication, or drug abuse.
Delusional Disorder	Non-bizarre delusions lasting at least one month without other symptoms that characterize the active phase of schizophrenia.

3.8 ADDITIONAL CLASSIFICATION OF SCHIZOPHRENIA

In recent years, researchers/clinicians have used the following additional classification to improve the diagnosis and treatment of schizophrenia :-

3.8.1. Process and Reactive schizophrenia :

Process schizophrenia develops over a period of time, not in response to obvious discrete stressors. It is a persistent impairment related to a less favourable outcome, primarily because the need for treatment is usually not recognized until the behaviour pattern is firmly entrenched. It is also called *Poor premorbid* or *chronic schizophrenia*. Reactive schizophrenia, which has a more sudden and dramatic onset, is marked by intense emotional turmoil and a nightmarish sense of confusion. Often associated with identifiable precipitating stressors, the symptoms may clear up within a few weeks. In a few cases, the acute episode is a prelude to a more chronic pattern. It is also called *good premorbid* or *acute schizophrenia*.

3.8.2. Positive and Negative symptom schizophrenia :

Crow (1980) proposed two Schizophrenic syndromes -Type I and Type II. Type I is characterized by positive symptoms, which represent the *presence* of excessive or distorted forms of behaviour e.g., hallucinations, delusions, disorganized behaviour etc. Something is *added* to normal repertoire of behaviour and experience. He held that this syndrome occurs due to a defect in dopamine transmission and shows a good response to neuroleptics. Type II is characterized by negative symptoms, which are the *absence* of normal behaviour or behavioural *deficit*, e.g., anhedonia, poverty of speech, social withdrawal, etc. It is related to structural brain changes and is resistant to treatment. Andreasen (1985) has developed rating scales for positive and negative symptoms. He was also the first one to name them. Though patients show both positive and negative symptoms, a preponderance of negative symptoms is related to more negative outcomes. (Fenton and McGlashan, 1993).

Positive and Negative Symptoms of Schizophrenic Disorders

Positive Symptoms	**Negative Symptoms**
Delusion	Flat affect
Hallucinations	Poverty of speech
Disorganized speech	Loss of directedness or motivation
Disorganized and bizarre behaviour	Loss of feelings of pleasure

A classic case in literature can be used to illustrate the complexity of the disorder. The Genain quadruplets-Nora, Iris, Myra, and Hester, all became schizophrenic by the time they reached adulthood. Born in the early 1930, the sisters were subjected to a good deal of publicity in their lives. The parents also encouraged them to appear together as a singing and dancing troupe. Otherwise however, the family led an isolated life, the father being particularly over-protective and over-involved with the daughters. It appears that he sexually abused at least two of the

girls. At 18 years of age, Hester became highly aggressive and dropped out of school. Her parents could hardly manage her. The others completed schooling and started working, though none of them was well-adjusted in this area. At the age of 20, Nora began to have a series of vague physical complaints and unusual nervousness. Quitting her job, she remained at home, deteriorating further, until she was hospitalized at 22 years of age. Within several months after her admission, Iris "Just went to pieces". She too, was diagnosed as schizophrenic. Myra broke down at the age of 24, but resisted hospitalization until the entire family was moved to the clinical center of NIMH. On arrival, she was impaired in thought and judgement, and severely autistic. The sisters remained at NIMH for three years. At the end, Myra was the only one capable of attaining a sustainable discharge. The other three sisters were transferred to a state hospital (Rosenthal, 1963).

3.9 SUMMARY

The schizophrenias are a group of psychotic disorders characterized by gross distortions of reality, withdrawal from social interaction; and disorganization and fragmentation of perception, thought, and emotion. The total thought disorientation leads to delusions, hallucinations and bizarre behavior. There are various types of schizophrenic disorders like schizo-paranoid type, schizo-catatonic type schizo-undifferentiated type, schizo-residual type, schizo-disorganized type. The symptoms are categorized into two main types ie positive and negative symptoms.

Check your progress

Q1 Explain the meaning of schizophrenia.

Q2 Write a detailed note on the symptoms of schizophrenia.

References

1. Carson and Butcher : Abnormal Psychology and Modern Life
2. Sarson and Sarson : Abnormal Psychology - The problems of aladaptive Behaviour.

LESSON No. 1.4 WRITER : GURMEET ANAND

CAUSES OF SCHIZOPHERNIA

LESSON STRUCTURE

4.0 OBJECTIVE

This chapter aims to explain the various causal factors underlying the schizophrenia. We shall furnish information on the role of biological, psychosocial and sociocultural factors, influencing the prevalence of schizophrenia. This lesson focuses on the intricate relationship of pathogenic family interactions and causation of schizophrenia.

4.1 INTRODUCTION

There are various view points regarding the causal factors underlying the schizophrenia. Apart from the theoretical perspectives, primary responsibility has been attributed variously to (1) Biological factors (2) Psychosocial factors, including pathogenic interpersonal and family patterns, and decompensation under excessive stress, and (3) Sociocultural factors, especially as influences on the types and local prevalence of schizophrenic disorders. We will discuss the theoretical perspective first in this lesson and then the biological, psychosocial and sociocultural factors as the underlying causes of schizophrenia.

4.2 THEORETICAL PERSPECTIVES :

4.2.1 Historical perspective :

This viewpoint indicates the conflict between biologically-oriented and psychologically-oriented researchers that continues to this day. Kraeplin paid no attention to the psychological aspects, and believed the disease was caused by irreversible organic deterioration. Bleuler emphasized the psychosocial etiology, believing that he was dealing with a group of disorders, of which only a few were irreversible. Dividing the symptoms into primary and secondary, he believed that the secondary symptoms could be relieved to a great extent.

4.2.2. Psychodynamic perspective :

Schizophrenia represents the overwhelming of the ego by the primitive sexual or aggressive impulses from the id. These impulses threaten the ego, giving rise to intense intrapsychic conflict. Thus, the person regresses to an early period in the oral stage called primary narcissism in which the infant has not yet learnt that he is distinct from the world. Thus, there is a loss of ego boundaries. Since the ego mediates the relationship between the self and the outer world, breakdown of ego also results in detachment from reality. Id, unconscious and out of touch with reality causes hallucinations and delusions. The Neo-Freudians placed more emphasis on interpersonal factors. For example, Sullivan emphasized the importance of impaired mother-child relations due to which the child takes refuge in a private fantasy world. A vicious circle of retreat and impaired social relations then ensue, finally culminating in schizophrenia.

4.2.3. Learning Perspectives :

Learning theories explain schizophrenia on the basis of reinforcement of maladaptive behaviour. Ullmann and Krasner (1975) held that schizophrenics might grow up in nonreinforcing environments due to disturbed family patterns or other environmental influences. Thus, they never learn to respond appropriately to social

stimuli. This view is supported by operant conditioning studies in which bizarre behaviour is shaped by reinforcement. For example, Haughton and Ayllon (1965) conditioned a 54 year old patient to cling to a broom to get a cigarette.

4.2.4. Social learning perspective :

This holds that schizophrenic behaviour results from modelling and reinforcement. Particularly hospitalizing a patient and labelling him as schizophrenic may lead him to behave in the role by observing others patients. Hospital staff may inadvertently reinforce schizophrenic behaviour by paying more attention to patients who exhibit more bizarre behaviour.

4.2.5. Interaction between stress and vulnerability :

With the increasing evidence for biological factors in schizophrenia, it has been realized that some people have a vulnerability to schizophrenia. Zubin et al. (1982) assume that schizophrenia is not a permanent disorder but rather a permanent vulnerability to a disorder, determined by genetic inheritence, prenatal and post-natal physical factors. This interacts with stressful events or conditions in a person's life. If the combination exceeds a certain critical level, schizophrenic behaviour will occur. As the stresses decrease, the disorder will abate, and the person will return to his/her earlier level of functioning. Thus, persons with markers (characteristics identifying vulnerable people) i.e., who are at high risk for schizophrenia, can be helped by teaching them better coping skills or putting them in a supportive environment.

4.3 CAUSES

4.3.1 Biological Factors :

In the recent years, the field has been dominated by research into biological factors. These are as follows :-

4.3.1.1 Heredity :

Schizophrenics often tend to have the disorder in the family. The following evidence is there :

a. Twin studies :

Gottesman and Shields (1972) revealed concordance rate of 42% for monozygotic twins and 9% for fraternal twins in a classic sixteen-year study. Gottesman's recent analysis (1991) of pooled data from four recent studies reveals concordance rates of 48% and "17% for monozygotic and dizygotic twins respectively. Torrey et al (1994) reduce these figures to 28% and 6% respectively basing their review only on eight adequately conducted studies. Case histories such as that of the Genain sisters seem to be compelling proof of genetic factors. However, if schizophrenia were exclusively a genetic disorder, the concordance rate would be 100%. In fact, there are more discordant than concordant twins, which suggests genetic predisposition rather than causation.

b. Adoption studies :

Children reared apart from schizophrenic parents: In this case, the concordance

rate is' studied for natural as well as adoptive parents of schizophrenics. Heston (1966) found that children born to schizophrenic mothers were more likely to become schizophrenic. They were also more likely to be mentally retarded, neurotic, or psychopathic. A large-scale adoption study in Denmark also found that biological relatives of schizophrenic adoptees are likely to suffer from many other difficulties, known as the *schizophrenic spectrum disorders*. The spectrum concept means that several disorders seem to be genetically related. The schizophrenic spectrum disorders include schizotypal personality, schizoaffective disorder and paranoid personality (Kety et al., 1994; Kendler et al., 1994). A continuing study by Tienari (1991) who incorporated an index of child-rearing adequacy of the adoptive families however, shows only a moderate genetic effect, that too, in interaction with the unfavourable family environment.

c. Family studies :

Rieder (1973) found that offspring of schizophrenic parents tend to develop schizophrenic spectrum disorders. This risk increases if both the parents have been diagnosed as schizophrenic (Kringlen, 1978) Thus, *assertive mating*, the tendency of people to mate with others who are similar to them, may lead to an increased risk for schizophrenia in children.

d. Studies of high-risk children :

This strategy of studying children born to schizophrenic parents actually intends to identify environmental factors that lead to actual breakdown or resistance to it. These studies have shown differences in the behaviour of these children, always favouring the control group children (Mirsky et al., 1985).

It is important to realize the data for the hereditary factor is :

(1) entirely correlational in nature; and

(2) extremely difficult to separate from environmental effects.

The studies suggest a genetic predisposition rather than causation. Based on the best available studies, the aggregate average risk of schizophrenia for first-degree (sharing 50% genes) relatives of index cases is 4.8%, approximately nine times the rate for control cases (Kendler and Diehl, 1993).

4.3.1.2. Biochemical factors :

The fact that the presence of some drugs in the bloodstream led to schizophrenic symptoms such as hallucinations (e.g., LSD) led researchers to look for *endogenous hallucinogens*, chemicals synthesized within the body might account for hallucinations, disorganization of thought, and other psychotic symptoms. However, they were unsuccessful in their endeavour. Instead, research revealed that schizophrenia is related to a biochemical disturbance of synaptic transmission in one or more important neural pathways in the brain. According to the *dopamine hypothesis* (Sacher et al.,. 1978; Snyder, 1978) schizophrenia is caused by an excess of dopamine activity at certain synaptic sites due to too many dopamine receptors or due to extra-sensitivity of some of these receptors. All early antischizophrenic drugs

(called *neuroleptics*) blocked dopamine-mediated neural transmission. However, the effects of such drugs are too general and quick (within hours) to be consistent with the clinical picture of gradual improvement in the patient. Thus, dopamine cannot be the only factor. Correlation does not imply a causal relationship, and the hypothesis is no longer widely accepted. The dopamine hypothesis has also been weakened by the emergence of second-generation antipsychotic drug *clozapine*. It effects those patients who do not respond to standard neuroleptic medication, and seems to be implicating different factors (Liebermann et al., 94).

4.3.1.3. Neurophysiological factors :

Neurophysiological disturbances in schizophrenia are thought to include an imbalance in excitatory or inhibitory processes and inappropriate autonomic arousal. These disrupt the normal attentional and information processing capabilities of the organism. For e.g. shizophrenics have been found to be deficient in their ability to track a moving target (Liebermann et al., 1993). People at risk for schizophrenia often experience difficulties in maintaining attention in processing information and other cognitive functions before the schizophrenic breakdown (Marcus et al., 1985, 1993) Anomalies in brain-waves have also been recorded with the EEG (Friedman and squires-'Wheeler, 1994). These abnormal neurophysiological processes could be genetic but they can also be due to other factors such as conditioning, difficulty in the birth process, etc.

4.3.1.4. Neuroanatomical factors :

New techniques like *Computerized Axial Tomography* (CAT) scanning that creates a three-dimensional picture of the brain with the help of a computer which combines X-rays at various locations (axes) of the brain; and *Magnetic Resonance Imaging* show that schizophrenia is associated with an enlargement of the ventricles and/or sulci. Brown et al. (1986) confirmed the same in post- mortem studies of schizophrenic individuals. Positron Emission Tomography (PET Scans) that measures metabolic activity at various sites in the brain has shown *hypofrontality* (abnormally low frontal lobe activation) in the schizophrenics (Andreasen et al., 1992). There is also. considerable evidence related to the involvement of temporolimbic structures in schizophrenia (Cannon, 1998). These centers have a particular role in the production of *positive* signs and symptoms.

4.3.1.5. Viral infections :

A significantly higher number of schizophrenics are born during winter months (Hare, 1979; DiLisi, Crow and Hirsch, 1986). This incidence increases if they are born in urban settings (Machon et al., 1983). Such studies have led researchers to hypothesize that a small number of schizophrenics could be suffering due to viral infection, just as prenatal Rubella leads to mental deficiency. However, this is just a hypothesis and no virus has as yet been firmly identified.

Conclusion :

Biological factors are not the primary cause of schizophrenia, rather they are

predisposing causes, which interact with other factors to produce schizophrenia. A model for this interaction has been given by Zubin et al. (1982). Unfortunately, researchers suffer .from a *tunnel vision* (Carson, 1991), adhering strictly to either a biological or a psychosocial perspective.

4.3.2 PSYCHOSOCIAL FACTORS

Many researchers hold that the primary cause of schizophrenia is to be found in the psychosocial context of the patient. Five major factors are particularly relevant to schizophrenia :-

4.3.2.1. Early psychic trauma :

Early psychic trauma due to negative events such as brutal attacks sexual abuse etc. leads the person to view the world as a dangerous and hostile place. Such experiences increase the incidence of schizophrenia among 'at risk' children (Parnas et al., 1985). Anthony (1978) suggests that early traumatic experiences may be less important than the overall continuing context in which they occur. It is the continuing consistency of trauma, which engenders schizophrenia.

4.3.2.2. Pathogenic family interactions :

Though the parent-child relationship is held to be most important factor, in recent years, the focus has shifted to total family interactions. Some factors are :-

a. Schizophrenogenic parents :

Studies of parents of schizophrenic patients have shown their peculiar characteristics. e.g., Roff and Knight (1981) found that schizophrenogenic mothers of male patients are rejecting, cold, dominating, overprotective and impervious to the feelings and needs of others. Though they have rigid moralistic attitude towards sex, in behaviour they are overtly seductive in physical contacts with the son. The father is inadequate, passive, and humourless. Often, he is also rejecting toward his son and seductive towards his daughter. Being contemptuous of his wife, he generates a conflict between mother and daughter. Though the concept of schizophrenogenic parents has been abandoned in the recent years, almost all studies (Carson, 1984) show emotional disturbance in the parents of schizophrenics, though the effects are most probably bi-directional.

b. Destructive marital interactions :

Lidz et al. (1965) have found that schizophrenic patients almost always come from disturbed families -showing marital schism or marital skew. Roft and Knight (1981) found that this also leads to a poorer outcome for patients as compared to those few patients who do not come from such families.

c. Pseudo-mutuality and role inflexibility :

Wynne et al. (1958) found that schizophrenic family relationships often, had the appearance of being mutual, understanding and open, but in fact were not—a condition they termed pseudo—mutuality. This is related to role inflexibility in these families. Each member has a simplified fixed character—good, evil, weak etc. The person is not viewed as a living changing entity that he actually is.

d. Faulty communication :

Bateson (1960) found an excess of *double-bind communication* in the families of schizophrenic patients Parents give mutually incompatible messages to the children through different media. Thus, the child does not know what he wants. Communication may be both *amorphous* and *fragmented*. Amorphous communication implies a failure of differentiation whereas, fragmented communication implies greater differentiation but lack of integration. *Communication deviance* is thus, one of the main causes of schizophrenia (Singer et al., 1978). Relapse into schizophrenia is also associated with a type of negative communication called *Expressed Emotion* (EE) directed at the patient by family members. Its two features are—emotional over involvement and excessive criticism (Milkowitz et al., 1986).

e. Undermining personal authenticity :

Buber (1957) points out that confirmation of authenticity is essential to normal inter-personal relationships. Such confirmation is denied to a schizophrenic. He is not respected or valued by his family members. Many a times, this is in the form of differential treatment as a child, such as scolding the elder child and loving the younger ones, no matter what they do.

It is important to realize that most children from pathogenic families do not become schizophrenic. Hence, pathogenic family interactions can not be the sole cause of schizophrenia.

4.3.2.3. Faulty learning and coping :

According to the behaviourist viewpoint, schizophrenia is learnt behaviour. Not only does the child acquire conditioned fears and Vulnerabilities, but also acquires irrationalities at the cognitive level from observation of pathological models. The faulty learning of the schizophrenic is reflected in :

(1) A deficient self structure shown as inaccurate assumptions regarding reality.

(2) Confused self-identity with basic feelings of inadequacy, insecurity etc.

(3) Personal immaturity (shown in overdependence and *good boy—good girl* orientation)

(4) Lack of needed competencies and ineffective coping patterns.

4.3.2.4. Exaggerated use of ego-defence mechanisms :

The schizophrenic relies excessively on ego-defence mechanisms rather than task-oriented coping strategies. Essentially, he withdraws from reality and distorts aversive experiences so that they are integrated within the self without further self-devaluation. Lidz (1978) proposed that the major effect of family disturbance is *egocentric cognitive regression*.

4.3.2.5. Social role problems :

Schizophrenics are inflexible in their own' role behaviour and uncomprehending of the role behaviour of others. Thus, they do not know how to interact with others.

Laing (1967), an existential philosopher, holds that a split arises between the false outer self and true inner self due to the harsh realities of the external world. When the split reaches a point where it can no longer be tolerated, psychotic breakdown results in the form of schizophrenia. Thus, the individual dons a mask of insanity as a social role and barricade, mostly unconsciously, but sometimes consciously.

4.3.2.6. Excessive stress and decompensation :

Schizophrenia is related to excessive stress typically centering on intimate personal relationships (Brown, 1972; Schwartz & Myers, 1977). In some cases, schizophrenia has a sudden onset while in others, it occurs in a slow, gradual manner. Decompensation may be partial or complete (Fenton & McGlashan, 1994).

4.3.3 SOCIOCULTURAL FACTORS

Though schizophrenia occurs throughout the world, cultural factors influence the type, symptom content, and incidence of schizophrenia. For example, Torrey et al. (1984) found a very high incidence of schizophrenia among Irish Catholics in Ireland as compared to Irish Catholics residing elsewhere. There are many other such examples. Apparently, some cultures, like some families, are schizophrenogenic.

Within a society, schizophrenia is more common among the lower socioeconomic classes in comparison to the upper classes. (Hollingshead and Redlich, 1959). Low socioeconomic status, however, may be a consequence rather than the cause of schizophrenia, because schizophrenics generally drift downwards in social status. Interestingly, there seems to be a reverse effect in India, where upper classes and castes experience higher rates of schizophrenia than the lower classes (Torrey, 1979). Researchers suspect that such factors as overcrowding, poor diet, lack of sanitation, and inadequate health care may contribute to an increased risk of schizophrenia, at least among those with genetic vulnerability (Kety, 1980).

Schizophrenia results from an interaction of biological, psychosocial, and sociocultural factors -their exact role varying according to the given case and clinical picture. Research on the causation of human behaviour is "fiendishly complex", in the words of Shakow (1969). Often, the interaction involves a vicious spiral in which life stress triggers metabolic changes that impair the functioning of a perhaps already compromised central nervous system; the latter, in turn, intensifying anxiety and panic as the individual realizes he is losing control, and so the spiral continues.

4.4 TREATMENT

Mainly, the treatment of schizophrenia involves chemotherapy with phenothiazine class of drugs popularly known as major tranquilizer. This permits a majority of cases to be treated as outpatients, though re-admission rates are quite high. For institutionalized patients, psychotherapy is not only helpful but also essential. Rigorous use of "token economies" has been most successful in the recent years. Psychodynamic therapy is also quite successful if done by experienced therapists. Recent approaches towards family intervention and training in social skills have also yielded fruit. The combination of all these approaches has been

demonstrated to have greater promise than either approach alone (Smith, Glass & Miller, 1980).

4.5 OUTCOME OR PROGNOSIS

Due to modern treatment methods, a schizophrenic patient admitted to the hospital for the first time has an 80-90% chance of discharge. However, the rate of readmission is extremely high, many patients showing the *revolving-door* pattern. Overall, 25% schizophrenic patients recover (i.e., they remain symptom-free for five years), 10% show deterioration and permanent disability, stabilizing at a low functioning level over a period of five years (Fenton and McGlashan, 1994). The rest (about 65%) show varying degree of personality impoverishment and episodic psychotic behaviour. Many of these become *street people* showing frequent relapses. Prognosis is less favourable for process (chronic) cases and when the onset of symptoms occurs at an early age (Roft, 1974).

4.6 SUMMARY

There are various view points regarding the causal factors underlying the schizophrenia. Apart from the theoretical perspectives, primary responsibility has been attributed variously to (1) Biological factors (2) Psychosocial factors, including pathogenic interpersonal and family patterns, and decompensation under excessive stress, and (3) Sociocultural factors, especially as influences on the types and local prevalence of schizophrenic disorders. Biological factors are not the primary cause of schizophrenia, rather they are predisposing causes, which interact with other factors to produce schizophrenia. Many researchers hold that the primary cause of schizophrenia is to be found in the psychosocial context of the patient. Sociocultural factors also contribute in the causation of schizophrenia. Chemotherapy along with the counseling are used as the treatment of schizophrenia.

Exercise

Q 1 Explain biological factor as the underlying cause of schizophrenia.

REFERENCES

1. Carson & Butcher : Abnormal Psychology and Modern Life.
2. Sarason & Sarason : Abnormal Psychology—The Problem of Maladaptive Behaviour.

LESSON No. 1.5 **WRITER : GURMEET ANAND**

MOOD DISORDERS

LESSON STUCTURE

5.0 OBJECTIVE

This lesson highlights the major forms of depression according to DSM IV classification and focuses on unipolar and bipolar disorders and their types. This lesson furnishes information on the symptoms of different kinds of depression and clearly differentiates the categories of mood disorders.

In this lesson you will learn about the causal factors in mood disorders under two major headings :-

(i) Causal factors in Unipolar Disorders; and
(ii) Causal factors in Bipolar Disorders.

The information will be imparted on the treatment for the manic depressive people.

5.1 INTRODUCTION:

Mood disorders have as their most prominent features disturbances of mood that are intense and persistent enough to be clearly maladaptive. To begin with, consider the following case :-

A prominent businesswoman in her middle years noted for her energy and productivity, was unexpectedly deserted by her husband for a younger woman. Following her initial shock and rage, she began to have uncontrollable weeping spells and doubts about her business. Decision making became an ordeal. Her spirits rapidly worsened, and she began to spend more and more time in bed, refusing to deal with anyone. Her alcohol consumption increased to the point that she was seldom entirely sober within a period of weeks. Serious financial losses were incurred owing to her inability or refusal to keep her affairs in order. She felt she was a "total failure" a self-attribution that was entirely resistant to alteration by a review of her considerable achievements indeed, her self-criticism gradually spread to all aspects of her life and her personal history. Finally, members of her family, having become alarmed essentially, forced her to accept an appointment with a clinical psychologist.

When significant mood change brings about behaviour that seriously endangers a person's welfare, psychologists and other mental health professionals conclude that the person has a mood disorder.

In the previous chapter you have learnt the various kinds of mood disorders and their symptoms respectively. This lesson will acquaint you about the possible causes of mood disorders. Both biological and psychosocial factors play a significant role in the causation of mood disorders. Although genetics is a predisposing factor but if an individual has an emotionally secure development then the genetic predisposition might remain suppressed. Apart from the biological factors an individuals life experiences also play a significant role eg; prolonged stress or deprived childhood may lead to mood disorder.

5.2 VARIETIES OF DEPRESSION ACCORDING TO DSM-IV

	Diagnosis	**Main Features**
Unipolar Disorders	**Dysthymia**	For at least the past two years, the person has been bothered for most of the day, for more days than not, by a depressed mood, and at least two other depressive symptoms, but not of sufficient persistence or severity to meet the criteria for major depression. The person cannot have had any manic or hypomanic episodes.

	Adjustment disorder with depressed mood	The person reacts with a maladaptively depressed mood to some identifiable stressor occurring within the past three months. Symptoms stemming from bereavement do not qualify. Once the stressor has terminated, the symptoms must remit within six months.
	Major depressive disorder	The person has one or More major depressive episodes in the absence of any manic or hypomanic episodes. Symptoms of a major depressive episode include prominent and persistent depressed mood or loss of pleasure for at least two weeks, accompanied by four or more symptoms, such as poor appetite, insomnia, Psychomotor retardation, fatigue, feelings of worthlessness or guilt, inability to concentrate, and thoughts of death or suicide.
Bipolar Disorders	**Cyclothymia, depressed**	At present or during the past two years, the person has experienced episodes resembling dysthymia, but also has had one or more periods of hypomania—characterized by elevated, expansive, or irritable mood not of psychotic proportions.
	Bipolar I disorder, depressed Bipolar II disorder, depressed	The person experiences a major depressive episode (as in major depressive disorder) and has had one or more manic episodes. The person experiences a major depressive episode and has had one or more hypomanic episodes.
Other Mood Disorders	**Mood disorder due to a general medical condition**	The person has notably depressed mood, including symptoms associated with major depression, whose primary causes is considered to be the direct physiological effects of a general medical condition. The medical conditions include degenerative neurological conditions such as Parkinson's disease, stroke, various metabolic and endocrine conditions, viral infections (including HIV), and certain cancers.

	Substance-induced mood disorder	The person has a prominent and persistent depression that is judged to be due to the direct physiological effects of some drug. The drug may be a drug of abuse, or a medication. The depression may occur is association with intoxication by the drug, or in association with withdrawal from the drug.

The two key states of mood disorder are **mania** Characterized by intense and unrealistic feelings of excitement and Euphoria; and **depression,** which involves feelings of extraordinary sadness and dejection. These states are often conceived to be at opposite ends of a mood continuum, with normal mood in the middle. Although this concept is accurate to a degree, it cannot explain every instance of mood disorder, because in rare cases, a patient may have symptoms of mania and depression at the same time. In these rare cases, the person experiences rapidly alternating moods such as sadness, euphoria and irritability all within the same episode of illness.

5.3 Major forms of mood disorders

Major forms of mood disorders are **Unipolar and Bipolar.** Unipolar, is more frequent the person experiences only depressive episodes. In **Bipolar,** the person experiences both manic and depressive episodes. This distinction is prominent in DSM-IV and although unipolar and bipolar forms of mood disorder may not be wholly separate and distinct. There are sufficient differences in symptoms, causal factors and treatments that is useful to make this distinction. Mood disorders may be differentiated by :-

(a) Severity :

The number of dysfunctions experienced in various areas of living and the relative degree of impairment evidenced in those areas.

(b) Duration :

Whether the disorder is acute, chronic or intermittent (with periods of) relatively normal functioning between the episodes of disorders. But major mood disorders also occur with alarming frequency -at least ten times more frequently than schizophrenia and at about the same rate as the anxiety disorder taken together. **Unipolar major** depression is much more frequent and its occurrence has increased in recent years (Lewinsohn et al., 1993). The most recent results (Kessler et al., 1994) found lifetime prevalence rates of major depression for males at nearly 13% and for females at 21%. It is a universal observation that unipolar depression is much more common in women. Depression is much more common in women than in men, this difference is similar to the sex differences for many anxiety disorders.

Although most mood disorder cases occur during early and middle adulthood, such reactions may occur anytime from early childhood to old age. Sorenson et at, (1991) found that about ¼ of adults reported the first onset of unipolar depression

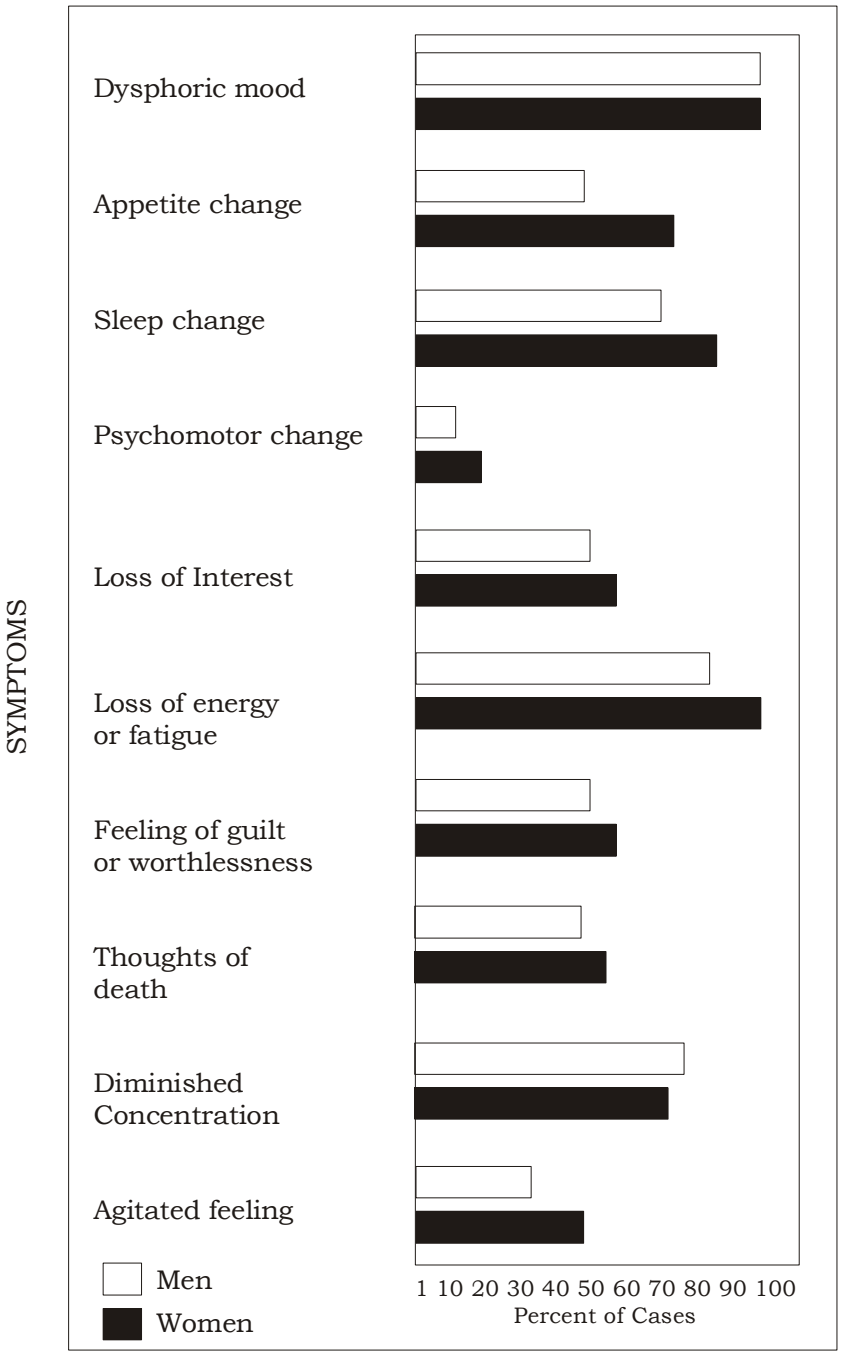


Figure 5.1 : Percent of all individuals diagonised as clinically depressed who report having each of these symptoms of depression.

in childhood or adolescence. Although rare, major depressions have been observed in preadolescent youngsters. (Puig-Antch et al., 1985, 1989). Even infants may experience a form of depression if they are separated for a prolonged period from their attachment figure (usually mothers) (Bowlby, 1973, 1980).

Suicide is a frequent outcome of both unipolar and bipolar disorder. Repressive episodes are undoubtedly the most common of the predisposing causes leading to suicide.

5.3.1 UNIPOLAR MOOD DISORDERS :

Sadness, discouragement, pessimism hopelessness about being able to improve matters and familiar feelings to most people. Depression is unpleasant when we are in it, but it usually does not last long. Sometimes, it seems almost to be self-limiting, turning off after a period or after it has reached a certain intensity level. Depressions would expect to occur in anyone undergoing painful but common life events, such as significant, personal, interpersonal or economic losses.

Normal Depression :

The term depression covers a variety of negative moods and behaviour changes. It is always the result of recent stress. Infact, some depression are considered adjustment disorder rather than mood disorder. Many depressions meeting criteria as "major" are also clearly related to the prior occurence of stress (Brown & Harris, 1978).

Example :

When we are grieving, it is a psychological process, say after the death of a loved one. This process is more damaging for men than women (Stroeke & Stroeke, 1983). Apart from death, there are many other situations which give rise to a similar state such a loss of status separation or divorce, financial loss, retirement, etc.

5.3.1.1 Other Normal Mood Variations :

Many situations other than obvious loss can provoke depressive feelings. Some people seem especially prone to develop depression. For e.g. some people get depressed after a difficult election campaign. A postpartum depression is seen in new mothers after the birth of the child (sometimes) in fathers also. Hormonal readjustments may play role in depression. Many students also experience mild or serious depression during their college years of supposed freedom and carefree personal growth. Normal depressions among college students were studied by Blatt et al. (1976). Depression was similar for males and females and it mainly involved three psychological variables :

(a) Dependency : the sense that one is in great need of help and support from others

(b) Self-criticism : the tendency to exaggerate one's faults and to engage in self-devaluation

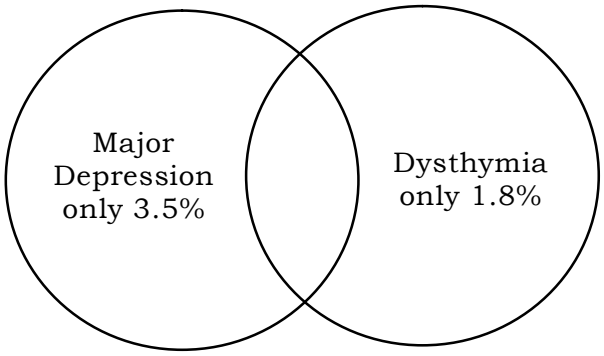
(c) Inefficacy : the sense that important events in the world are happening independent of -not dependent on one's own actions or efforts.

5.3.1.2 MILD TO MODERATE DEPRESSIVE DISORDERS :

Although severe mood disorders are obviously abnormal, a gray area exists where a distinction between normal and abnormal is difficult to establish. DSM-IV includes two main categories for depression of mild to moderate severity : dysthymia and adjustment disorder with depressed mood.

Dysthymia :

A person must have a persistently depressed mood for atleast two years with atleast two of the following six symptoms : poor appetite or overeating, sleep disturbance, low energy level, low self-esteem, difficulties in concentration or decision making and feelings of hopelessness. In between, there might be normal moods from a few days to a few weeks. Dysthymics do not really show less severe symptoms than do major depressive. The difference is simply that the dysthymics do not necessarily have the symptoms every day.



percentage of Individual's who had overlapping diagnoses of major depression and dysthymia over the lifetime.

Case Study:

A 28-year-old junior executive was referred by a senior psychoanalyst for "supportive" treatment. She had obtained a master's degree in business administration and moved to California a year and a half earlier to begin work in a large firm. She complained of being "depressed" about everything: her job, her husband, and her prospects for the future.

She had previously had extensive psychotherapy. She had seen an "analyst" twice a week for three years while in college, and a "behaviourist" for a year and a half while in graduate school. Her complaints were of persistent feelings of depressed mood, inferiority, and pessimism, which she claims to have had since she was 16 or 17 years old. Although she did reasonably well in college, she constantly ruminated about those students who were "genuinely intelligent". She dated during college and graduate school, but claimed that she would never go after a guy she thought was "special", always feeling inferior and intimidated. Whenever she saw or met such a man, she acted stiff and aloof, or actually walked away as quickly as possible, only to

berate herself afterward and then fantasize about him for many months. She claimed that her therapy had helped, although she still could not remember a time when she didn't feel somewhat depressed.

Just after graduation, she married the man she was going out with at that time. She thought of him as reasonably desirable, though not "special", and married him primarily because she felt she "needed a husband" for companionship. Shortly after their marriage, the couple started to bicker. She was very critical of his clothes, his job, and his parents; and he, in turn, found her rejecting, controlling, and moody. She began to feel that she had made a mistake in marrying him.

Recently, she has also been having difficulties at work. She is assigned the most menial tasks at the firm and is never given assignment of importance or responsibility. She admits that the she frequently does a "slipshod" job of what is given her, never does more than is require and never demonstrates any assertiveness or initiative to her supervisors. She views her boss as self-centered, unconcerned, and unfair, but nevertheless, admires his success. She feels that she will never go very far in her profession because she does not have. the right "connections" and neither does her husband, yet she dreams of money, status, and power.

Her social life with her husband involves several other couples. The man in these couples is usually a friend of her husband. She is sure that the women find her uninteresting and unimpressive, and that the people who seem to like her are probably no better off than she.

Under the burden of her dissatisfaction with her marriage, her job, and her social life, feeling tired and uninterested in "life", she now enters treatment for the third time. (Spitzer et al., 1994, pp. 110-111)

5.3.1.3 Adjustment Disorder with Depressed mood :

Basically, adjustment disorder with depressed mood is behaviourally indistinguishable from dysthymia. It differs from dysthymia in that it does not exceed six months in duration and requires the existence of an identifiable (presumably precipitating) psycho-social stressor in the patient's life within 3 months before the onset of depression. The difficulty here is because assessing the severity of a stressor is a highly subjective matter. Also, the diagnosis assumes that the person's problems will remit when the stressor ceases or when a new level and adjustment is achieved. Chronic cases of this sort would be rediagonsed as dysthymia.

5.3.1.4.MAJOR DEPRESSIVE DISORDER :

An affected person must experience either markedly depressed mood or marked loss of interest in pleasurable activities most of everyday for at least two weeks. In addition, **at least 4 more** of the following symptoms for the same period: fatigue or loss of energy, insomnia or too much sleep, decreased appetite and significant weight loss without dieting, psychomotor agitation or retardation (a slowdown of physical and mental activity), diminished ability to think or concentrate and recurrent thoughts of death and suicidal ideation.

Most of these symptoms must be present all day and nearly everyday for two

consecutive weeks before the diagnosis is applicable.

Psychotic :

Symptoms characterized by loss of contact with reality and including delusions or hallucinations may sometimes accompany' the other symptoms of major depression. In such. cases, a diagnosis of severe **major depressive episode with psychotic features is made.** Ordinarily, any delusion or hallucinations present are mood-congruent i.e., they seem in some' sense "appropriate" to serious depression because the content is negative in tone.

In addition to major depression with psychotic features, several other subcategories of major depression have been defined. One such subcategory in DSM-IV is major depression of the **melancholic type.** In addition to meeting the criteria for major depression, patient does not react to usually pleasurable stimuli or desired events. The patient must also experience early morning awakenings, depression being worse in the morning, marked psychomotor retardation or agitation, significant loss of appetite and weight etc.

Discriminating major depression from other forms of depressive disorder is not always easy. It may co-exist with dysthymia in some people, a condition given the designation "double depression" (Keller. et al., 1983). Double depressives are people who are moderately depressed on a chronic basis and who undergo increased problems from time to time during which they manifest "major" symptoms. Among dysthymics, the experience of double depression appears to be common.

When a diagnosis of major depression is made, it is usually also specified whether this is a single (initial) episode or a recurrent episode (one or more previous episodes have already occurred). This reflects the fact that depressive episodes are usually time limited (with an average duration of an untreated episode being about six months according to DSM-IV, but often re-occur following a period of .remission of symptoms for at least 2 months).

Some people who experience recurrent depressive episodes show a seasonal pattern, commonly known as **seasonal affective disorder.** To meet DSM-IV criteria for this type, the person must have had at least two episodes of depression in the past two years occurring at the same time of the year (mostly common in autumn or winter prevalence rates suggest that winter seasonal affective disorder is more common in people living at higher altitudes and in younger people).

5.3.2 BIPOLAR DISORDERS

Depression and mania—despite their seeming opposition—are sometimes closely related, and some people experience both states. As with the unipolar disorders, the severity of disturbance in bipolar disorder ranges from mild to moderate to severe. In the mild to moderate range, the disorder is known as **cyclothymia** and in the moderate to severe range, the disorder is known as **bipolar disorder.**

Cyclothymia :

Mania is in some ways the opposite of depression. It is a state involving excessive

levels of excitement, elation or euphoria often mixed with great self- esteems and feelings as if having great powers. In its milder forms, it is known **as hypomania.** Some people are subject to cyclical mood changes with relative excesses of hypomania and depression. These are symptoms of cyclothymia. But a cyclothymic does not however, experience enough of the symptoms or experience them persistently enough to qualify for diagnosis of major depression.

Symptoms of the hypomanic phase of cyclothymia are essentially the opposite of symptoms of dysthymia, except that there is decreased need for sleep. As in the case of bipolar disorder, no obvious precipitating circumstances may be evident, and an affected person may have significant periods between episodes in which the individual functions in a relatively adaptive manner.

In cyclothymia, however the diagnostic criteria for adults specify at least a 2 year span during which there are numerous periods with hypomanic and depressed symptoms (only 1 year is required for adolescents and children). Many clinicians feel that cyclothymia is a milder variant of bipolar disorder. In short, cyclothymia consists of mood swings, that at either extreme are clearly maladaptive but of insufficient intensity to merit the major disorder designation.

5.3.2.1 Bipolar Disorder I and II :

Kraeplin (1899) described the disorder as a series of attacks of elation and depression, with periods of relative normality in between and a generally favourable diagnosis. Today, DSM V calls this illness **bipolar disorder.**

Bipolar disorder is distinguished from major depression by atleast one episode of mania. Any given episode is classified as depressive, manic or mixed according to its predominant features. The depressed or manic classification is self-explanatory. A mixed episode is characterized by symptoms of both manic and major depressive episodes, the symptoms are either intermixed or alternate rapidly every few days. Such cases are rare.

Even though a patient may be exhibiting only manic symptoms, it is assumed that a bipolar disorder exists and that a depressive episode will eventually occur. Thus, there are no officially recognized "unipolar" manic or hypomanic counterparts to dysthymia as major depression. The assumption is that all mania—like behaviours must be part of a bipolar disorder, or perhaps exist along a continuum on which two conditions fall.

The features of the depressive form of bipolar disorder are usually clinically indistinguishable from those of major depression (Perris, 1982, DSM-IV, 1994). Although some studies do report higher rates of psychomotor retardation and hypersomnia in the depressed phase of bipolar disorder (Cassano et al., 1992), the essential difference is that these depressive episodes alternate with manic ones. In about 2/3 cased, the manic episodes either immediately precede or immediately follow a depressive episode; in other cases, the manic and depressive episodes are separated by intervals of relatively normal functioning (DSM IV, 1994) also identified a form of bipolar disorder called **Bipolar II** disorder, in which the person may not experience

full-blown manic episodes, but has experienced a clear-cut hypomanic episodes. That this is indeed a distinct disorder suggested by findings that Bipolar II disorder evolves into **Bipolar I** disorder (the type already described with full-blown manic episodes—usually simply called "bipolar disorder") in less than 5% of cases (Keller, 1987).

Manic symptoms in bipolar disorders tend to be extreme, and there is significant impairment of occupational and social functioning. A person who experiences a manic episode has a markedly elevated, euphoric and expansive mood, often interrupted by occasional outbursts of irritability or even violence. This mood must persist for atleast a week to qualify for a diagnosis. In addition, any of the 3 symptoms must also occur at the same time period: A notable increase in goal-directed activity may occur leading to restlessness and mental activity may also speed up, so that a person might experience "light of ideas" or thoughts that "race" through the brain. Distractability, high levels of verbal output in speech or in writing and a. severely decreased need for sleep may also occur. Inflated self-esteem is common. Personal and cultural inhibitions may loosen and a person may indulge in foolish ventures.

5.3.2.2 Differing Patterns in Manic and Depressive Behaviour Found in Bipolar Disorder

	Manic Behaviour	**Depressive Behaviour**
Emotional characteristics	Elated, Euphoric, very sociable, Impatient at any hinderance	Gloomy, Hopeless, socially withdrawn, Irritable.
Cognitive characteristics	Racing thoughts, flight of ideas, desire for action, impulsive behaviour, positive self image, delusions of grandeur	slowness of thought process, obsessive worrying, inability to make decisions, negative self-image, delusion of guilt and disease
Motor characteristics	Talkative, hyperactive, does not become tired, needs less sleep than usual, Increased sex drive, fluctuating appetite	Decreased motor activity, Tired, difficulty in sleeping decreased sex drive, Decreased appetite

Bipolar disorder, like major depression, is typically a recurrent disorder. As with unipolar major depression, the recurrences can be seasonal in nature, in this case **bipolar disorder with a seasonal** pattern is diagnosed.

A person who is depressed cannot be diagnosed as bipolar unless he/she has had atleast one manic episode in the past. This means that many people with 'C' bipolar disorder whose initial episode or episodes are depressive will be wrongly" diagnosed at first, and possibly throughout their lives or if they die before a manic

episode is experienced. But misdiagnosis is automatically prevented in a person who has manic symptoms.

People with bipolar disorder seem, in some way, to be even more fortunate than those who suffer from recurrent major depression. On an average they suffer from more episodes during their life times than do persons with unipolar disorder (although these episodes tend to be somewhat shorter). According to DSM-IV, more than 90% of those who have one manic episode will go on to have further episodes. About 5-10% of persons with bipolar disorder experience at least 4 or more episodes (either manic or depressive) every year, a pattern known as **rapid cycling.** See the following figure (Fig. 10.2) for clarity.

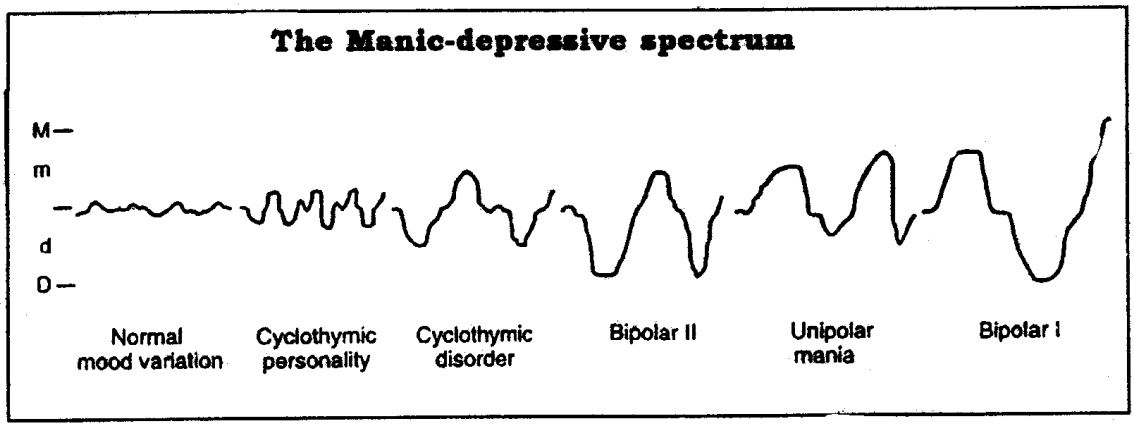


Figure 10.2 *There is a spectrum of bipolarity in moods. All of us have our ups and downs which we refer to as normal mood variation. People with a cyclothymic personality have more marked and regular mood swings, and people with cyclothymic disorder go through periods during which they meet the criteria for dysthymia (except for the two-year duration), and other periods when they meet criteria for hypomania. People with Bipolar II disorder have periods of major depression as well as periods of hypomania. Unipolar mania is an extremely rare condition. Finally, people with Bipolar I disorder have periods of major depression and periods of mania.*

Overall, the probabilities of "full recovery" for bipolar and unipolar disorder (i.e., being symptom-free for a period of 5 yr.) is about 40%.

5.3.2.3 SCHIZOAFFECTIVE DISORDER :

In major depressive or bipolar disorders, patients with mental and cognitive processes are so deranged as to suggest the presence of a schizophrenic psychosis—such cases are diagnosed as **schizoaffective disorder** in DSM-IV category. Such a person must have a period of illness during which he meets criteria for both a major mood disorder (unipolar or bipolar) and atleast two major symptoms of schizophrenia (such as hallucinations). During at least two weeks of the illness, they must

experience the schizophrenic symptoms in the absence of prominent mood symptoms, and they must meet criteria for a mood disorder for a substantial portion of the period of illness.

According to DSM-IV, the prognosis is probably better than that for schizophrenia but considerably worse than that for mood disorders.

5.4 CAUSAL FACTORS IN UNIPOLAR DISORDERS

This includes :-

(i) Biological causal factors;
(ii) Psychosocial factors.

5.4.I. BIOLOGICAL CAUSAL FACTORS

(1) HEREDITARY FACTORS :

The prevalence of mood disorders is higher among blood relatives of persons with clinically diagnosed mood disorders than in the population at large.

Perris (1992) reviewed 8 studies examining the risk for mood disorder in relatives of unipolar depressives and estimated that about 15% of first-degree relatives have also experienced unipolar depression, substantially higher would be expected in the general population.

Twin Studies:

They have also suggested that, there may be a moderate genetic contribution to unipolar depression.

Katz (1993) reviewed evidence from four studies showing that mono zygotic co-twins of a twin with unipolar major depression are about twice as likely to develop major depression as are dizgotic co-twins of a depressed twin.

KENDLER et al (1992), in a recent very large population based twin study of 1033 same sex female twin pairs, examined concordance rates using a variety of different definitions of "major depression" that have been used over the years by different investigators. They found that for most of the different definitions of depression hereditary estimates ranged from 33-45 percent.

In adopted subjects too, unipolar depression is detected.

2. BIO-CHEMICAL FACTORS :

Starting in the 1960's, the view that depression may arise from disruptions in the delicate balance of neurotransmitter substances that regulate and mediate the activity of the brain's nerve cells, or neurons have received a great deal of attention.

Early attention in the 1960's and 1970's focused primarily on 2 neuro-transmitter substances of the monoamine class, **norepinephrine** and serotonin because researchers observed that anti-depressant medications seemed to have the effect of increasing their availability at synaptic function.

SHELTON et al. (1991) found that antidepressant drugs, when administered for at least several weeks, decrease the number of and sensitivity of certain types of receptors and increase the responsiveness of others.

3. NEURO-ENDOCRINE AND NEURO PHYSIOLOGICAL FACTORS :

Ideas about hormonal influences on mood have a long history. One contemporary theory has focused on the hypothalamic pituitary adrenal axis, and. in particular, on the hormone cortisol, which is excreted by the outmost portion of the adrenal glands. Blood plasma levels of this substances are known to be elevated in from 50 to 60% of seriously depressed patients, [HOLSBOER, 1992], suggesting a possible clue of etiological significance. For e.g., people with low thyroid levels often become depressed. About 30% of depressed patient who have normal thyroid levels show dysregulation of this axis as evidenced through abnormal responses to thyrotropin releasing hormone.

4. SLEEP AND BIOLOGICAL RHYTHMS :

Although findings of sleep disturbances in depressed patients have existed as long as depression has been studied, only recently have some of these findings been linked to more general disturbances in biological rhythms.

Depressed patients, especially those with melancholic features, show a variety of sleep problems, ranging from early morning awakening, periodic awakening during the night, and for some, difficulty falling asleep. However, research using EEG recordings have found that many depressed patients also show a shorter-than-usual latency to the first period of REM sleep, as well as greater amount of REM sleep early in the night, than are seen in nondepressed persons. Because of this, in the period of the night when most deep sleep usually occurs, the depressed, person also receives a lower than normal amount of deep sleep. These findings suggest disturbance in both the overall sleep-wake cycle rhythms and the REM sleep rhythm (GOODWIN and JAMISON, 1990) (SHELTON et al., 1991).

Research has found some rhythmic abnormalities in all of rhythms in depressed patients, though not all patients show abnormalities in all rhythms.

Summary :

To summarize, although none of these approaches has established a definitive case for exactly how biological factors may be involved in causing major depression, biological causation, in general, remains a viable hypothesis.

5.4.2. PSYCHOSOCIAL FACTORS

Growing awareness of biological factors in the etiology of unipolar depressive disorders does not, of course imply that psychosocial factors are irrelevant. Indeed, evidence for important psychological causal factors in most mood disorders is at least as strong as evidence for biological factors.

STRESS AS A CAUSAL FACTOR :

Psychosocial stressors are known to be involved in the onset of a variety of disorders, ranging from some of the anxiety disorders to schizophrenia, but nowhere has their role been more carefully studied than in the case of unipolar depression; Indeed, many investigators have been impressed with the high incidence of stressful life events that apparently serve as precipitating factors for unipolar depression.

BECK (1967) provided a broad classification of the most frequently encountered precipitating circumstances in depression :-

(a) Situations that tend to lower self-esteem.
(b) The thwarting of an 'important' goal or the posing of an insoluble dilemma.
(c) A physical disease or abnormality that activates ideas of deterioration or death.
(d) Single stressors of over-whelming magnitude.
(e) Several stressors occurring in a series.
(f) Insidious stressors unrecognized as such by an affected person.

Research on stress and the onset of depression is complicated by the fact at depressed people have a distinctly negative view of themselves and the world around them. BROWN & HARRIS (1978, 1986, 1989) have concluded that depression often follows from one or more severely stressful events, usually involving some loss or exit from one's social sphere.

Interpersonal Effects of Mood Disorders :

Interpersonal problems and social skill deficits may well play a causal role in at least some cases of depression. In addition, depression creates many interpersonal difficulties—with strangers and friends as well as with family members (Hammen, 1991, 1995).

Brown and Harris (1978) have found that women without a close confiding relationship were more vulnerable to depression. Hammen (1992) reported that depressed individuals have smaller and less supportive social networks. Gottils and Hammen (1992) review evidence that depressives have social skills deficits. For e.g. they seem to speak more slowly and monotonously, and to maintain less eye contact. They are also poorer than nondepressed people at solving interpersonal problems. Infact, merely being around a depressed person may induce depressed feelings in others (Strack and Coyne, 1983).

In recent years, interpersonal aspects of depression have also been carefully studied in the context of marital and family relationships. Marital distress predicts a poor prognosis for a depressed spouse whose symptoms have remitted (Hooley and Teasdale, 1989). That is, a person whose depression clears up is likely to relapse if he or she has an unsatisfying marriage.

5.5 CAUSAL FACTORS IN BIPOLAR DISORDERS

5.5.1 BIOLOGICAL CAUSAL FACTORS

1. HEREDITARY FACTORS :

There is a significant genetic component to bipolar disorder, one that is stronger than that for unipolar disorder. A recent summary of studies using refined diagnostic procedures suggests that about 8 percent of the first-degree relatives of a person with bipolar illness can also be expected to have bipolar disorder, and another 11 percent can be expected to have unipolar disorder (Katz and McGuffin, 1993). This means that combined risk for unipolar or bipolar disorder in first-degree relatives of a person with

bipolar disorder is about 19 percent.

Although family studies cannot by themselves establish a genetic basis for the disorder, results from the twin studies also point to a genetic basis. Kallmann (1958) found the concordance rate for these disorders to be much higher for identical than for fraternal twins. Other studies have supported these earlier findings, particularly Bertelsen, Harvald, and Hanger (1977) estimated that monozygotic twins were 3½ times more likely to be concordant (69%) for a diagnosis of bipolar disorders than were dizygotic twins (19%). About three quarters of the affected co-twins had the same form of the disorder (bipolar), but nearly one-quarter had unipolar disorder. Thus, the results from both family and twin studies suggest that the risk for blood relatives of people with bipolar disorders includes an enhanced risk for unipolar disorder.

There appears to be only one adoption study focusing exclusively on people with bipolar disorder (Mendlewicz and Rainer, 1977). They found that 31 percent of the biological parents of the bipolar subjects had a mood disorder (both bipolar and unipolar), co pared with only 2% of the biological parents of controls.

Overall, no consistent support yet exists for any specific mode of genetic transmission of the bipolar disorders according to several recent comprehensive reviews (Gershon and Nurnberger, 1992).

In short, the role of heredity is not very clear as to be considered as an important factor in the total picture.

2. NEURO-PHYSIOLOGICAL FACTORS :

Pavlov was the one who expressed the possibility of imbalances in excitatory and inhibitory processes which may predispose the individual towards extreme moods swings. It is suggested that manic reactions may result from excessive excitation and weaker inhibition and depressive reaction from excessive inhibition and weaker excitation. Several investigators have found that in monkeys, who are supposed to be highly excitable animals, the process of excitation predominates over the process of inhibition. Such neuro-physiological disturbances could pre-dispose some individual to manic- depressive disorders under stress. The passive role of neurophysiological factors was also supported by ENGEL in 1962, who concluded that CNS is apparently organised to mediate 2 opposite patterns of amounting need. The first one is an active goal-oriented pattern directed towards the achievement from external sources. The second is in contrast, a defensive pattern which is aimed at reducing activity, conserving the energy and resources of the organism. Manic reactions appear to be an exaggerated form of the first reaction pattern, while the depressive appears to be an extreme form of the second pattern.

3. BIO-CHEMICAL FACTORS :

Kraepelin considered MDP to be toxic and a good deal of research has been directed towards finding the brain pathology and metabolic disturbances in the individual with this disorder. It has been observed that altered brain chemistry in both manic and depressive reactions have been there is addition to adrenal and pituitary changes. Functioning of glands is decreased is depression, and increased in mania. In assessing the role of neuro-physiological and bio-chemical factors, it is

relevant to note that prolonged disturbance in the metabolic process gives rise to schizophrenia also. The psycho-motor over- activity in the manic patients makes normal sleep impossible and in acute mania, the individual may get even less than an hour sleep. Similarly, sleep disturbances involving less total sleep, less REM (Rapid Eye Movement) and less deep sleep are the characteristic of depressive reactions also. The available evidence show the following results of different studies:-

(a) Genetic and constitutional factors may predispose a person to manic-depressive reactions.

(b) Neuro-physiological and bio-chemical factors appear to play an important inter—relational role in these disorders.

(c) Sleep disturbances appear to be a bi-product of these disorders and possibly an interesting factor in the total pattern. There is also considerable evidence regarding disturbances in biological rhythms in bipolar disorder. During manic episodes, bipolar patients tend to sleep very little (seemingly by choice, not because of insomnia). During depressive episodes, they tend toward hypersomnia (too much sleep).

5.5.2 PSYCHOLOGICAL FACTORS

Meyer considered manic depressive reactions as an attempt to deal with the threatening stress/situations. He emphasized the role of psychological factors causing the disease while dealing with psychological etiology, we come across 3 questions :-

(1) Are there any pre-disposing psychological factors in addition to biological factors?

(2) How manic depressive reactions can be explained as coping patterns?

(3) How they are maintained until they have seen their course?

These specific questions stress the importance of general role of psychological and inter-personal factors in the development of manic depressive reactions. These psychological factors include :-

1. Predisposing **family and personality** factors.
2. **Severe stress** like death of loved one, disappointment in love, financial losses, broken homes, marital stresses and so on.
3. **Feeling of helplessness** and loss of hope, stress by behaviouristic view.
4 **Extreme defences** that is flight from reality, escape mechanisms, fantasy and so on.
5. **Social Role and Communication:** The mental patient tends to play a social role, which is well-suited to make himself unique from others, while depression elicits their sympathy and support.

In 1970, Jnowsky, Leff & Epstein observed that acutely manic patients alienate themselves from family, friends and therapists. They are always on defensive attempting to justify their action (motivation). The manics apparently feel it threatening and unacceptable to rely on others and wish to be taken care of. He establishes a social role in a position in which he is able to control and manipulate people on whom he must rely on, whereas the depressive patient tends to adopt a

totally different social role in which he places others in position of supporting and caring for him. He generally obtains some secondary gains from the sympathetic and support from others, and places the depressed role in accordance with his own feelings and perceptions. Depressive reactions .can often be seen as attempt of the individual to cope with his feelings of discouragement and disappointment

5.5.3. SOCIOLOGICAL FACTORS

The incidents of MDP seems to consider differently in different societies. In some societies, manic reactions are more frequent, while in others, depressive reactions. According to Carothers—"Manic Reactions are more common among African natives and depressive reactions are relatively rare. They have incidents of depressive reactions to the fact that in traditional African culture, the individual is not responsible for his failure. In our society, the role of socio-cultural factors in MDP remains unclear but in all those conditions which include the stresses of life, leads to higher incidents of this disorder." The main factors are :-

1. Inflation
2. Unemployment
3. Restrictions imposed by society
4. Urban and Rural Communities

In a study in India by and Sethi & Gupta (1973), it was reported that the incidence of depression was much higher in urban areas as compared with rural areas, the ratio being 4:1.

5. Rapidly changing social values
6. Increased pace and complexity of life.

In the American society, the role of sociocultural factors in mood disorders is gradually becoming evident. Blazer et al. (1985) found roles of depression to be much higher in urban than in rural areas.

For unipolar disorder, there are suggestions that the poor have higher rates of depressive symptoms but not necessarily of diagnosable mood disorder (Hirschfeld and Cross, 1982). However, for bipolar disorder the findings are opposite, with a number of studies showing that bipolar disorder is more common in the higher socio-economic classes (Goodwin and Jamison, 1990).

Moreover, some studies show that bipolars tend to have more education, on an average, and come from families with higher SES status than do unipolar depressive.

Other interesting findings emerged from the ECA regarding the association of marital status to depression. In general, single and divorced persons tend to have higher rates of unipolar depression than those who are married, though it has been seen that distressed marriages are highly associated with depression. The same findings hold for bipolar disorder, with it being slightly more common in single and divorced persons (Boyd and Weissman, 1985).

5.6 TREATMENT OF MDP

For manic-depressive people, all types of drugs are used including tranquillizers, anti-anxiety and anti-depressive. New discoveries have found that anti-depressant drugs like MIRAMINE have proved very effective in treating depressive patients and

also for the prevention of relapse. About 60% of depressive patients are also anxious. So, tranquillizers and anti-anxiety drugs are commonly used in combination with the anti-depressants. Unfortunately, anti-depressant drugs require few days before their effects are observed. ECT (electro convulsive therapy) is often used with the patient who presents an immediate or suicidal risk (Fink, 1992).

It has been estimated that in about 6 to 8 ECT's, 90% of patients show favourable results. Many times, it does not prove so beneficial. In such cases, anti-depressants and anti-anxiety drugs are ordinarily used to maintain the treatment gain achieved by ECT. ECT is also used with patients who have not responded to other forms of pharmacological treatment, as well as for elderly.

Treatment is not ordinarily confined to drugs, but is usually confined with individual or group therapy.

A number of psycho-therapies have been developed in recent years, particularly in treatment of depressive patients. These therapies include behaviour therapy, play therapy and psycho drama. Even without formal therapy, the patient recovers in a year. With the modern method, hospitalized patients can be now discharged between 60 days. Relapse can occur in some cases but that can also be prevented by follow-up. The mortality rate for depressive patient appears to be twice as high as that for general population. In the overall picture, we can find at manic depressives recover slower than any other type of psychosis.

5.6.1 Lithium Therapy:

Lithium therapy has now become widely used in the treatment of both depressive and manic episodes of bipolar disorder. It is often effective in preventing cycling between manic and depressive episodes (although not necessarily for patients with rapid cycling), and bipolar patients are frequently maintained on lithium therapy over long time periods. Early studies indicated that lithium was considered an effective preventive for approximately 65% of patients suffering repeated bipolar attacks (Prien, 1992), but other studies present a more pessimistic picture with one large study finding only 33% of patients remaining free of episodes over a two year follow up (Prien et al, 1984).

Lithium therapy has some unpleasant side effects, such as lethargy, decreased motor co-ordination and gastrointestinal difficulties in some patients. Long term use of lithium has also been associated with kidney malfunction and some times, permanent kidney damage (Goodwin and Jamison, 1990).

More recently, there has also been emerging evidence for the usefulness of another category of drugs known as the anticonvulsants (such as carbamazepine) in the treatment of bipolar disorder (Post, 1992). These drugs may sometimes be effective in patients who do not respond well to the lithium or who have unacceptable side effects from it (Goodwin & Jamison, 1990).

5.6.2 Psychotherapy

Two of the best known of these depression specific psychotherapies are the cognitive-behavioural approach of Beck and colleagues (Bect et al., 1979) and the interpersonal therapy (IPT) programme developed by Klerman, Weissman and collegues (Klerman et al., 1984). Both are relatively brief approaches (10-20 sessions)

that focus on here and now problems rather than on the more remote causal issues. The interpersonal therapy (IPT) approach, being relatively new, has not yet been subjected to as extensive an evaluation. The efficacy of this psychological treatment for depression (and also of cognitive therapy), however, recently received strong support.

In any treatment programme, it is important to deal with unusual stressors in a patient's life because an unfavourable life situation may lead to a recurrence of the depression and may necessitate longer treatment. This point has been well established in studies that extended to the mood disorders, the well established finding that relapse in schizophrenia and bipolar disorder is co-related with certain noxious elements in the family life (Hooley, Orley and Teasdale, 1986). The marital therapy has the further advantage of also producing greater increases in marital satisfaction than did the cognitive therapy (O'leary and Beach, 1990).

5.7 SUMMARY

When significant mood change brings about behaviour that seriously endangers a person's welfare, psychologists and other mental health professionals conclude that the person has a mood disorder. Major forms of mood disorders are **Unipolar and Bipolar.** Unipolar, is more frequent the person experiences only depressive episodes. In **Bipolar,** the person experiences both manic and depressive episodes.

Depression and mania—despite their seeming opposition—are sometimes closely related, and some people experience both states. As with the unipolar disorders, the severity of disturbance in bipolar disorder ranges from mild to moderate to severe. In the mild to moderate range, the disorder is known as **cyclothymia** and in the moderate to severe range, the disorder is known as **bipolar disorder.**

Although the development of effective drugs and other new approaches to therapy have brought greatly improved outcomes for patients with mood disorders, the need clearly remains for still more effective treatment methods, both immediate and long term.

Exercise

Q1 Write a detailed note on the mood disorders

Q 2 Write a short note on the difference between unipolar and bipolar disorders.

Q 3 Ennumerate the causal factors in Bipolar Disorders.

Q 4 Write a note on the causal factors in Unipolar Disorder.

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