Chapter One

Introduction

One's own body and its well-being is one of the many areas in which a significant amount of interest has been shown. Since the etiology of peptic ulcer and ulcerative colitis has been one of the great riddles of internal medicine, an area of clinical research which has immediate practical implications for the medical practice as a whole is that of psychosomatic medicine. The term "psychosomatic" can be traced in Heinroth's use of the term as early as 1818. An interest in the psychosomatic approach was in fact the aftermath of World War II having become too explicit through observation that thousands of soldiers were debilitated by symptoms of physiological disturbances as a result of psychological stress, began to be established. The need for psychosomatic approach lies in the fact that somatic medicine has no clear answer to the causes of some diseases. The economic cost of peptic ulcer and ulcerative colitis in terms of lost income due to disability, of expected income fulfilled due to premature death, and of medical expenses, may be as much as a billion dollars each year (Lachman, 1972).

It is obvious that gastrointestinal disorders open up a meaningful area of investigation in clinical psychology where our knowledge about man's mental processes in health or disease on a scientifically firmer basis can lend support to
some psychological hypotheses. The main thrust of the study is to focus on peptic ulcer and ulcerative colitis with all their physical symptoms that are usually the consequences of sustained emotional tension, such as alienation and health locus of control. In other words, the purpose of the study is to extend the line of research and to establish relationship between peptic ulcer and ulcerative colitis on the one hand, and between alienation and health locus of control on the other.

Psychosomatic Disorders:

The term psychosomatic is derived from the Greek words psyche and soma. Psyche, in ancient times, meant soul or mind and more recently has come to mean behaviour, soma typically refers to the physical organism of the body. The term Psychosomatic, therefore, indicates relationships between psychological processes or behaviour on the one hand, and somatic structures or bodily organs, on the other (Mora, 1967). Psychosomatic disorders are physiological dysfunction and structural aberration that results primary from psychological processes rather than from immediate physical agents. Prolonged emotional tension, with over-stimulation of the autonomic nervous system and alterations in blood supply, can produce tissue change and may result in destruction of tissue and organic disease, which is considered to be caused by social or psychological events (Kaplan, 1967). It should be
emphasized, however, that a given case of ulceration should not be diagnosed as psychosomatic until a thorough medical examination has ruled out organic factors as the primary cause.

The sequence of appearance and disappearance of psychosomatic disorders appears to be directly related to the amount of stress in the individual's life situation. In general, the development of psychosomatic disorders involves the following sequence of events: (a) the arousal of negative or positive emotions, (b) the failures of these emotions to be dealt with adequately, and (c) response stereotype in specific organ system (Coleman, 1976).

In fact, Matarazzo, Matarazzo and Saslow (1961) concluded that the incidence of physical illness in a population is a good predictor of mental disturbances, and vice-versa. It is well-known that at least half of the patients who seek medical aid and visit doctors with physical complaints have emotional problems that partly or wholly account for these complaints. Interestingly enough, people are defensive in admitting that the nature of their disease is psychological and feel uneasy on being perceived as pretending and projecting the symptoms for some conscious reason, although what the doctor means is that emotional or nervous tension is the cause of discomfort (Coleman, 1976). Neki (1976) has advocated the use of somatic and
psychological approaches as complementary strategies in these cases. Perhaps holism may be considered as a kind of psychosomatic integration. The organism reacts to stress as a psychobiological unit - that although a disorder may be primarily physical or psychological in nature, it is always a disorder of the whole person (Lachman, 1972).

A true prospective on psychosomatics may be possible only through our knowledge about the interacting role of biological, psychological and sociocultural determinants in predisposing an individual to disorders as well as in precipitating and maintaining them. A number of biological factors have been known to be implied in psychosomatic disorders. Research on genetic factors particularly on peptic ulcer and ulcerative colitis, has shown that the brothers of ulcer patients are about twice as likely to have ulcers as comparable members of the general population, (Gregory and Rosen, 1965). Burton and Harris (1947) found that twins to be suffering from ulcerative colitis soon after birth. It has been discovered that people with group O are slightly more likely to get ulcer complications of bleeding and perforation (Martin and Stiel, 1982). Most individuals who develop peptic ulcer may be linked with the presence of high serum pepsinogen levels from infancy (Mirsky, 1958). Working on differences in autonomic reactivity, Wolff (1950) suggested
that some people can be classified as "stomach reactors", depending on what kind of physical changes that stress characteristically triggers in them. Heredity may produce somatic weakness in a particular organ system, making it more vulnerable to stress than others. The person who has inherited or developed a "weak" stomach presumably will be prone to gastrointestinal upsets during anger or anxiety, (Rees, 1964). Activation of the colon is an outlet for autonomic excitation which leads to ulcerative colitis (Karush, Hiatt, and Daniels, 1955). Presumably, corticovisceral control mechanism may fail in their homeostatic functions, so that the individual's emotional response is exaggerated in intensity and he does not regain physiological equilibrium within normal time (Halberstam, 1972; Lebedev, 1967).

The role of psychological factors in psychosomatic disorders has been found in personality characteristics and inadequate coping patterns. Dunber (1943) concluded that it is "more important to know what kind of patient has the disease than what kind of disease the patient has". Alexander et al., (1968) found relationship between personality and certain psychosomatic gastrointestinal disorders. Many individuals suffering from psychosomatic disorders also appear unable to express their emotions adequately by verbal
means, nor have they learned to use various ego-defense mechanisms (Hokanson and Burgass, 1962). Peptic ulcer and ulcerative colitis occur especially among individual who are "tense" (Groen, 1947). It was hypothesized by Alexander (1950) that each type of psychosomatic disorder could be associated with a particular kind of stress. For example, peptic ulcer is typically associated with frustration of the needs for love and protection, ulcerative colitis is associated with loss of emotional support from a key figure. Stressful interpersonal relationships — including marital unhappiness, divorce and bereavement — may have destructive effects on personality adjustment. Such patterns may also influence physiological functioning (Parkes, Benjamin, and Fitzgerald, 1969). Some psychosomatic disorders may be acquired and maintained in much the same way as other behaviour patterns. An individual who is repeatedly allowed to stay home from job when he has an upset stomach may be learning the visceral response of chronic indigestion (Lang, 1970).

The incidence of specific disorders, both physical and mental, varies in different societies, in different strata of the same society, and over the time. Psychosomatic disorders, including peptic ulcer and ulcerative colitis occur among all major groups. On the other hand, such disorders appear to be
extremely rare among primitive societies (Kidson and Jones, 1968; Stein, 1970). A number of studies found a disproportionately high incidence of psychosomatic disorders at the two extremes of the socio-economic scale (Faris and Dunham, 1939; Pasamanick, 1962; Rennie and Srole, 1956). For example, ulcerative colitis was most commonly found on lower socio-economic levels, while peptic ulcer was believed most common among executives. In general, it would appear that any sociocultural conditions that increase stressfulness of life may tend to play an important role with the human organism and lead to an increase in psychosomatic disorders as well as other physical and mental problems.

Psychosomatic disorders are classified according to the organ system affected, extending the view that no part of the body is immune. Each system preceded by the word psychophysiologic is to emphasize that we are dealing with disorders caused and maintained primarily by psychological and emotional factors rather than organic ones. The physical symptoms of peptic ulcer and ulcerative colitis are usually brought in large part by sustained emotional tension. In these disorders there is a tendency for a single organ system to be involved, such as gastrointestinal system (Coleman, 1976).
Gastrointestinal Ailment as Psychosomatic Disorders:

Psychosomatic disorders are physiological dysfunction and structural aberration that result primarily from psychological processes rather than from immediate physical agents (Kaplan, 1967). The gastrointestinal tract is extraordinarily responsive to emotional stimuli, and this category, therefore, includes a wide variety of disorders, such as peptic ulcer and ulcerative colitis. Both disorders may occur as complications of adrenal steroid or ACTH administration (Prugh, 1950).

Desires and their gratification and the experiencing of pleasure and unpleasure during the early years of life are largely centered in the gastrointestinal tract. The gastrointestinal system is vegetative and visceral system par excellence. It is of the greatest importance to the human being in earliest infancy, not only as the conduct for bodybuilding nourishment but also as one of the earliest modalities available to him by any means through which he can establish and maintain contact with the world around him. Gastrointestinal function is, indeed, vital to health throughout life, even in the later stages after maximum growth has been achieved. Basically, the functions of gastrointestinal tract are ingesting and digesting food in order that it can be absorbed into the circulatory system for
distribution throughout the body. The processes involved are both mechanical and chemical. The mastication of food, the swallowing of it, and the movement of it by the stomach and intestines are mechanical processes. A wide variety of chemical processes are also involved in modifying the chemical and physical nature of the original food substances. For example, the secretion of the salivary glands contains ptyalin, the secretion of the gastric glands contains pepsin, and the secretion of the pancreas contains trypsin. These substances are enzymes, a word meaning biological catalyst. A catalyst is a substance that increases the velocity of a chemical reaction but is itself not chemically changed by the reaction (Lachman, 1972).

When most people hear the term psychosomatic gastrointestinal disorders, they probably think of such things as ulcers and colitis. The interaction between the digestive and nervous system is more elaborate than this, however, and we would again be mistaken if we were to allow the dysfunctions of the gastrointestinal system to overshadow its amazing efficiency. From its entry into the mouth until its expulsion in a transformed state from the anus, a piece of food travels on around 30-foot journey which usually takes about 24 hours. Contrary to the popular assumption, very little digestion takes place in the stomach. Over 95 per cent
of all food is broken down and absorbed by the small intestine (Mahoney, 1980).

Gastrointestinal Disorders Stemming from Improper Diet:
A person's diet can be "improper" either because it lacks essential nutrients or because it is excessive to the point of endangering his or her health (Mayer, 1976). At least 45 and possibly as many as 50 dietary compounds are recognized as essential for human being to live a full healthy life, (Scrimshaw and Young, 1976).

Plesset and Shipman (1963) studied the problem of the effect of dieting in provoking anxiety or depression in obese people. Obese persons with high scores in anxiety and depression were unsuccessful dieters, suggesting that high anxiety and depression in the obese person were signs of an inability to overcome unconscious factors against weight maintenance.

Gastrointestinal Disorders Associated with Digestive Dysfunction:
Rare is the individual who has not at some time or another experienced digestive problem in response to stress. Major life changes - a wedding, a vacation, military service, moving to a new town - each may be associated with the symptoms of an 'upset stomach' for something. Digestive
dysfunction in stress has strong support in medical research (Lachman, 1972).

In times of stress, the balance of digestive enzymes and acid may be seriously altered (Khosla, 1982), and most of us are familiar with its unwelcome consequences:

**Peptic Ulcer**: A wound or lesion on the wall of the stomach or duodenum.

**Ulcerative Colitis**: Inflammation of the colon (the large intestine) resulting in diarrhea, pain, constipation, and sometimes bleeding and anemia.

**Constipation**: Lack of regular bowel movement, infrequent and occasionally painful bowel movement.

**Diarrhea**: Frequent liquid and loose bowel movement.

**Gastritis**: Inflammation of the lining of the stomach, associated with excess stomach acid, gas, nausea and burning sensation.

**Heartburn**: Burning feeling in the stomach or esophagus.
Nausea: Loss of hunger and feeling of imminent vomiting.


Gastrointestinal Disorders Associated with Structural Damage:

If the stomach and intestines are exposed to long-term dysfunction, their structural integrity may eventually break down. This is particularly apparent in the conditions of gastrointestinal ulcer and colitis. In the former, the protective mucous membrane of the stomach or small intestine may be worn through over-activity and excessive secretion of digestive acids. These acids eventually eat their way into the tissue itself and produce a lesion which may become progressively larger - causing great discomfort and serious blood loss due to internal hemorrhage. Colitis is a condition marked by inflammation of the colon. Its first sign is often the presence of mucus in the stool. If the inflammation continues over a long period of time, the colon may suffer structural damage in the form of lesion and the condition of ulcerative colitis may develop. Positive correlations between psychological factors and gastrointestinal disturbances have been reported in numerous studies (Alexander and Menninger, 1963).
Peptic Ulcer:

Perhaps the most frequently mentioned example of a gastrointestinal disorder believed to be of psychosomatic origin is peptic ulcer. It results from an excessive flow of the stomach's acid containing digestive juices, which eat away the mucous membrane that lines the stomach or duodenum, leaving a crater like wound. The gastric secretions contain three major components mucus, pepsin, and hydrochloric acid. Acid secretion may occur in response to emotional factors. Pickford (1952) has conceptualized the peptic ulcer as "a self inflicted digestive bite".

Peptic ulcers of the stomach or duodenum are called, respectively, gastric and duodenal. It is generally present for weeks or months and may become quite deep, perhaps one half or one centimeter in depth. As the mucosa - are thin membrane coated with a slightly liquid called mucus - is destroyed, the top of the ulcer becomes made up of dead cells and is whitish-yellow in colour; this is called ulcer slough. The deeper layer of the ulcer is made up of scar tissue that forms as the tissue tries to repair itself, (Martin and Stiel, 1982).

Among the theories concerning psychological circumstances related to the development of gastrointestinal ulcer are the following:
(1) An ulcer results from conflicts relating to dependence and independence, (Alexander, 1934).
(2) An ulcer results from resentment, hostility, and anger reaction (Wolf and Wolff, 1947).
(3) An ulcer develops in an ambitious person who works under high pressure, (Dunber, 1943; Hartman, 1933).

There have been an exhaustive efforts to find the link between ulcers and life stress. Air traffic controllers, foremen and businessmen have higher rates of ulcers. Ulcer symptoms are supposed to be related to conflicts over dependence or to vacillation between active and passive behaviour in order to obtain care and love (Wolff, 1950).

**Gastric Function and Peptic Ulcer:**

The gastric mucosa secretes pepsin and hydrochloric acid and under normal circumstances, the mucosa resist the proteolytic activity of these substances. It seems probable that peptic ulceration occurs either when proteolytic activity increases or when the resistance of the mucosa is diminished, for one reason or another. Thus, the concept of ulcer etiology may be written as 'acid plus pepsin versus mucosal resistance'.

The rate of secretion of hydrochloric acid appears to be under vagal and abnormal control, whereas the secretion of
pepsin appears to be primarily under vagal control. It is
possibly that ACTH may render the gastric mucosa more
sensitive to these physiological stimuli. A thin piece of
razor blade left in this acid will get dissolved overnight.
So also a piece of meat can be completely destroyed during
this period. That is, therefore, why the muscles of the
stomach themselves do not get destroyed by the gastric juice
of acid and pepsin secreted. The answer to this question is
usually that the gastric mucosa, ordinarily resistant to acid
and pepsin digestion and also capable of rapid regeneration,
protects itself by the secretion of mucin. This secretion is
stimulated by mechanical means or by vagal impulses. Several
mechanisms protect the gastric mucosa from hydrogen ions
secreted into the lumen of the stomach. The surface
epithelial cells secrete biocarbonate which creates an
alkaline milieu at the surface of the mucosa; this
biocarbonate secretion is under the influence of mucosal
prostaglandins. The tight junctions between the epithelial
cells, and their surface lipoprotein layer provide a
mechanical barrier. These mechanisms can be described as the
'gastric mucosal barrier', (Dash, 1987; Martin and Stiel,
1982).

There is a considerable body of evidence indicating
that gastric functions are sensitive to emotional tension,
that increased secretion of acid and pepsin may occur in certain people of emotional stress (Lipton, et al., 1966).

Ulcer in the stomach or duodenum has got a very specific pattern and the pain has a specific relationship with food. In fact, food relieves pain immediately after eating, when the stomach is empty, the patient complains of pain which is relieved by taking food. Pain varies from a slight hunger pain, or a feeling of bloatedness, to severe pain like a cut with knife. In any case, a small snack or milk often relieve the pain a great deal, and this has led to the term 'feeding an ulcer'. The main aim of a milk diet has been to reduce gastric acidity, suppress gastric motor activity and maintain mucosal resistance (Khosla, 1982; Martin and Stiel, 1982).

It has been demonstrated by Kirsner (1961) that pain can be induced in an ulcer patients by instilling hydrochloric acid and can be promptly relieved by neutralizing the acid. In many patients the pain is worst at night, several hours after the last meal of the day.

**Ulcerative Colitis:**

Another major disorder of the gastrointestinal system frequently regarded as psychosomatic disorder is ulcerative colitis. That the lower and the upper part of the gastrointestinal tract is quite responsive to emotional
stimulation, that bowel movements may increase in frequency during conditions of emotional conflict, or may be a decrease in frequency of bowel movements, can result in a constipation condition. The passing of mucus in the stools often shows the beginning of the inflammation of the colon (Lachman, 1969).

Ulcerative colitis is a potential severe, life-threatening disorder. It usually takes place in circumstances of actual or threatened loss of emotional support from a key figure, father or mother. Exacerbations are related to some family crisis or to other intensifications of emotional stress. These families exhibit problems in communication, particularly on negative feeling (Prugh, 1950). The important psychological condition leading to the development of ulcerative colitis is that of an affective state characterized by despair and helplessness (Engel, 1958). Thus, fear related to conflict over dependent attitudes leads to frustration or insecurity and provokes intense anxiety which produces persistent autonomic excitation which activates the colon (Karush, Hiatt, and Daniels, 1955).

Groen (1947) has viewed ulcerative colitis as the result of chronic anxiety which causes a motility imbalance, secondarily, leading to ulceration, due to inability of
taking action in life. Ulcerative colitis patients have ambitious parents who wanted to realize their goals through the members of their family. When the patients senses failure and worthlessness in spite of all efforts to fulfil the wishes of the parents, his self-confidence and self-reliance are replaced by futility, desperation and feeling of hopelessness. A loneliness period may develop, followed by the onset of colitis symptoms (Paulley, 1956).

Psychologically, ulcerative colitis patients have been characterized as obsessional, compulsive, and rigid people who wish to maintain strong control over their impulses, are book keeping and involved in library work (Sarason, 1972). Colitis has been viewed by White, Cobb and Jones (1939) as a dysfunction of the colon resulting from an overactive parasympathetic nervous system due to emotional conflicts. Dependency, anxiety, resentment, sensitivity and guilt are the common emotional characteristics found in patients suffering from colitis. These patients are overdependent, inhibited, passive, timid in nature, cold and do not develop warm relationships with others (McDermott, 1967; Khosla, 1982). Two types of ulcerative colitis patients have been identified by Karush et al., (1968) as an active group who are relatively independent and controlling, and a passive group who feel themselves as helpless victim of others.
The psychosomatic theory of the etiology of ulcerative colitis (Groen and Van Valk, 1956) is as follows:

(1) In their personality structure, some individuals possess a "core" of characteristics (either inherited or developed under influence of certain situations), which make them more vulnerable than others to certain kinds of interhuman conflicts which threaten their emotional security, particularly if these conflicts occur with "key figure", in their close environment, such as parents, step-parents, sisters, or brothers, employers, neighbours, marriage partners, colleagues and teachers, etc.

(2) In the acute condition of the disorder breaks out after a later period of not more than twenty-four or forty-eight hours after such patient has met a conflict, that is characterized by a coarse, unusually humiliation, verbal offence, often in front of others, which hurts the individual's self-respect and keep him or her defeated and humiliated. This leads to inferiority of the function of the individual as a male or female, occurring in a life situation from which the individual can not free himself or herself.

(3) Whether the feeling of defeat and humiliation are conscious or not, the emotional conflict is not discharged in weeping, speech or action, fighting. The inhibition of a
behavioural discharge changes the external interhuman emotional trauma into an internal conflict situation. It is, then, this emotional conflict within the individual which, through mechanisms in the central nervous system, creates the changes in the colonic mucosa that are responsible for clinical and pathological signs of the disease.

Sullivan and Chandler (1932) emphasized the effects of the liquid contents of the small intestine that carried down into the colon as a result of emotionally induced hypermotility of the bowel. This liquid contains enzymes of a higher digestive power than the normal, or the natural protective power of the mucosa of the colon may lowered, producing a digestion of the mucosal surface of the colon, and thus facilitating bacterial attacks and ulceration.

Ulcerative colitis is a case marked by inflammation of the colon. The presence of the mucus in the stool is often its first sign. If the inflammation continues for a long time, the colon may suffer structural damage in the form of wounds and ulcerative colitis condition may develop. Hemorrhaging and perforation of the colon are sometimes prompting surgical removal of the affected part (Mahoney, 1980). The symptoms may range from the passage of small amount of stools with rectal bleeding or there may be diarrhea accompanied by considerable colonic bleeding,
anaemia, toxaemia, tachycardia and weight loss (Khosla, 1982). Engel (1954a; 1954b) has emphasized that bleeding rather than constipation or diarrhea is the first symptom of ulcerative colitis in sixty per cent of the cases. Engel (1956) described headache as the most common symptom experienced by ulcerative colitis patients.

The physiological changes in the colon are the result of parasympathetic influences on the wall of the colon, thus, implicated in this disease is the parasympathetic nervous system, that facilitates activities of the intestinal canal, promoting blood flow, mucous secretion, peristalsis, and other important activities of digestive process (Lachman, 1972; Sarason, 1972).

There could have been quite a few personality variables that might be related to gastrointestinal disturbances and be taken up for investigation, but in view of the literature available in the area, a better way was to look for the relevant personality variables that have been ignored or not much used in the psychological inquiry of the present kind. Two such personality variables, namely, alienation and health locus of control seemed to hold promise of being meaningfully related to gastrointestinal disorders of peptic ulcer and ulcerative colitis.
Alienation:

The one personality variable presumed to be related to peptic ulcer and ulcerative colitis is alienation. The meaning of alienation was popularized in early theological writings. Calvin (1954) used the term alienation on spiritual death. According to him, "spiritual death is nothing else than alienation of the soul from God". The term alienation is a good example of 'panchreston' - a term coined by Hardin (1956) to indicate to scientific concepts which in attempting to explain all, essentially explain nothing. Seeman (1971) has pointed out that the concept of alienation has been popularly adopted as the signature of the present epoch. Johnson (1973) characterized the concept of alienation as being capable of carrying a great deal of feeling in perplexing, inexplicit, and deeply annoying manner. Schacht (1970) has reported about the semantic meaning of alienation. The word signifies separation or distance between two entities. The English term of alienation was derived from the original Latin noun alienatio which in turn was derived from Latin verb alienare, meaning to 'take away' or 'remove', (Klein, 1966).

In the presence of numerous concepts and definitions of the phenomenon, one finds it difficult to decide for a suitable definition of alienation. Alienation as a psychological characteristic allows for the persistence of
the idea that the use of alienation concepts involves insensitivity to structure and implies irrationality, frustration-aggression, impulsiveness, or otherwise unrealistic response, (Oberschall, 1973). The term of anomie indicates to a state of societal disregulation or disorganization as the consequence of the perceived lack of socially approved means and values to direct one's behaviour for the purpose of achieving culturally prescribed goals (Blauner, 1964). Many subjects do seem alienated in varying degree from themselves, from others and from the society as a whole. They seem unable to find a truly authentic, meaningful and fulfilling way of life. Being unloved and lonely has been called 'the greatest poverty' is the outcome of conditions out of his/her control, that no body cares what happens to him/her and no one can be trusted (Shepard, 1971).

Alienation is reflected in a lack of authentic relationship with others, inability to find satisfying values and meanings, rootlessness and a belief that one is powerless to do anything that will have any effect and significant to him/her. Hence, the lesser the confidence a person has in himself, the greater will be the sense of alienation, (Gould, 1969). Alienation refers to the presence of distrust and estrangement in one's attitude toward those representing authority.
Seeman (1959, 1971) has distinguished five types of alienation: –

(1) Powerlessness: refers to the sense of control over events (or lack of it). It is the expectancy or probability held by the individual that his/her own behaviour cannot determine the occurrence of the outcomes or reinforcements, person seek.

(2) Meaninglessness: is indicated to the state when the individual is unclear as to what he ought to believe, or inability to understand one's complex environment.

(3) Normlessness: as a condition in which there is a high expectancy that socially unapproved behaviours are required to achieve given goals. The individual may develop norms of his/her own to guide behaviour.

(4) Isolation: is defined in terms of rewards values; the alienated in the isolation sense are those such as intellectual, assign low reward value to goals or beliefs, that are highly valued in the given society.

(5) Self-estrangement: means to be something less than one might ideally be if the circumstances in society were otherwise.

In recent years, a great deal of interest has been focused on alienation, (e.g., Kureshi and Husain, 1982;
Sastry, 1985; Sahar, Rahman and Kureshi, 1990; Sathyarathi and Thomas, 1984; Mohonty, 1984; Rai, 1985; Bhattacharya and Sen, 1986; Verghese, 1973; Srivastava et. al., 1971). According to Singh (1971) alienation in combination with certain psychological characteristics can make positive contribution toward modernization of the Indian society. He observed alienation combined with a perception of change in the society and a sense of optimism, increased socio-political modernity and aspirations are probably the most important factors of social change in India.

Gurin, Gurin and Morrison (1978) have suggested that structural changes in the social system, leading to increased opportunities for experiencing success, provide a means of raising the expectancies of low-expectancy persons. They analyzed the culture of poverty of alienation, and stressed that society must give opportunities for the poor people to have achieved statuses, that permit the experience of social praise, the exercise of the choice and the development of high self esteem. Aronson (1972) has reported that high-esteem people will be in need to justify their behaviour when its consequences threaten the integrity of their self-concept or respect.

Working on alienation, Aberbach and Walker (1967) have found that both whites and blacks gave a variety of different
definitions when asked to describe the best possible life. Both racial groups were strongly optimistic about the future. Agger et al., (1961); Dean, (1961); Eckhardt and Hendershot (1967); Hughes (1967); Milbrath (1965); Olsen (1969) and Wright (1975b) have established correlation between alienation and age. Some of them stated that alienation should increase monotonically with age. Explanatory factors of alienation investigated in other socialization studies such as family unit, sex, social class, school curriculum, peer groups, intelligence and the mass media (Lyons, 1970).

Alienation may be of the technical or organisational character of an industry or the structure of the bureaucracy; in the case of anomie, it may be combination of personal affluence and a breakdown, conflict or rejection of norms of authority at home, at work or at school. The nature and extent of social stratification, the character of the political system, the structure of the economy, the degree of pluralism, the pace of industrialization, the nature and pattern of the predominant social values which have influence on the nature and distribution of alienation (Klein, 1966).

Historical and sociological analysis focus on social-structural factors seem to be related to conditions of widespread alienation within the society (Blauner, 1964;
Within analyses of philosophical and psychological aspects of alienation, disillusionment process is reflected in the existentialist's feeling of abandonment, and the experience of 'pyrrhic victory' and 'loss of Eden' among alienated college students, as described by Keniston (1965). Psychological and philosophical approaches generally examine the individual's experience in relation to other persons.

In the field of mental health, a work of Seligman's on helplessness (1975), found that the sense of low control plays in the development of anxiety and depression, in personality disorders and even in psychosomatic death. Seligman concluded that helplessness appear to keep people more vulnerable to pathogens. Alienation has also been investigated as a key variable in the expanding field of medical sociology. Antonovsky (1979) has proposed that the sense of coherence in social welfare is an important variable in sustaining a healthful life-style.

In psychology and psychiatry, alienation is considered as a state of psychological isolation, lack of feeling of competence, interpersonal distrust, uncrystallized sense of identity and the feeling that individual lacks meaning and authenticity in his/her life (Daly, 1968). Recent research in social psychology of stress (Lazarus, 1966; Lavine and
Scotch, 1970; McGrath, 1970) finds that when a person is unable to alleviate his experience of alienation, and if this experience extends for a long period of time, two general syndromes of stress may find: psychophysiological stress as reflected in certain physical disorders, and self-destructive or anti-social behaviour as manifested in individual's self-disparagement or aggression toward others (Durkheim, 1897/1951).

Selection of the variable of alienation has been guided by the consideration that it has the probability of being related to the psychological accomplishments of gastrointestinal disorders. Of the many conceptions of alienation, the one used in this study is some kind of an assortment of the existing concepts in social sciences, particularly in psychology. For the present investigation, a definition of alienation had to be worked out which incorporated the various shades of the dimension. This was available in the form of the construct being factorized in terms of certain components which were basically psychological in nature (Kureshi and Dutt, 1979). There are five subdimensions which have been claimed to tap alienation in all its entirety for "despair", "disillusionment", "unstructured universe", "psychological vacuum", and "narcissism", (Kureshi and Dutt, 1979).
"Despair" refers to a feeling of hopelessness, of being dishearted and pessimistic combining the general feeling of anxiety, a vague uneasiness and distress of mind. A tendency to resignation and escape, at times expressing itself in aggressiveness and indignation to others. A heightened state of despair goes with a loss of faith in others and general distress.

"Disillusionment" is indicative of the feelings of being thrown to reality from the world of make-believe with realization that what is apparent is not essentially real. It suggests detachment and bitterness experienced by the individual subverting his/her hopes and ideals. The dawn of truth puts him/her in a state where he/she reprimands himself/herself and develops feeling of discern and disdain against his/her own self.

An experience of emptiness, an extinction of meaning and purpose on life, a feeling that the corporal needs are all in all and that human values are of no consequences, are what the factor "Psychological vacuum" conveys. Inability to cope with one's level of aspiration and dissatisfaction even with the best accomplishment are contained in this facet of alienation.

The feeling that people and nature are governed by regular laws is an illusion, expresses the aspect of "unstructured universe".
An excessive preoccupation with one's own self and unrealistic view of one's own worth is what is meant by "narcissism". Psychoanalytically, this factor is close, to the stance that the libido is withdrawn from other objects and persons and is invested in one's self, resulting in a loss of contact within reality.

Health Locus of Control

It is another personality variable that seemed to have to do with peptic ulcer and ulcerative colitis. The dimension of internal-external control is an offshoot of social learning theory of Rotter (1954), according to which the effect of reinforcement depends on the subject's perception of relationship between action and its outcomes. Rotter (1966) has reported that on the basis of their experience people develop generalized expectancies for internal versus external control of reinforcement. As a general principle, "Internal control" refers to the perception of positive and/or negative events as being a consequence of one's own actions and thereby under personal control; "external control" refers to the perception of positive and negative event as being unrelated to one's own behaviour in certain situations and, therefore, beyond personal control, (Lefcourt, 1966).

People who score more toward the "Internal" direction seem to be more achievement-oriented and less conforming and
compliant, more intelligent, to support political positions that stress individual responsibility and to take more reasonable risks (Strickland, 1977). People who are more internally-oriented handle threatening situations effectively. On the other hand, externally-oriented people may be more sensitive to factors in a situation that might interfere or block their efforts. Such people may be first to perceive obstacle and may be better able to cope effectively with them (Phares, 1976).

MacDonald (1971) found that internals described their mothers as having been more predictable standards for behaviour, having more nurturant and loving, and exerted more pressure to achieve. Their fathers were described as more nurturant and loving, as having more physical punishment as opposed to withdrawal of love. Externals were more likely to describe their mothers as protective and inclined to use deprivation of privileges as a punishment. Tolor and Jalowiec (1968) have reported that externals perceive their mothers as authoritarian and rejecting. Joe (1971) observed that the parent who is perceived as warm, permissive, flexible, supportive, approving and consistent in discipline and who expects early independence behaviour from his child, is more likely to encourage his child's belief in internal control than is the parents who is dominating, punitive, rejective and critical. Internals are more likely to take the
initiative steps in attaining goals and in controlling the environment. Straists and Sechrest (1963) and James, Woodruff, and Werner (1955) have found that smokers seem to be more external than nonsmokers, and persons who quit smoking appeared to be more internal than those who did not stop smoking.

Davis and Phares (1967) found that when individuals want to change the attitude of another subject, internals actively get more information about the other person in order to be better influenced. Phares (1968) found that in utilization of information in solving a problem, internals are superior to externals, even when both of them have learned the information equally. Phares, Ritchie, and Davis (1968) have reported that when subjects were given threatening feedback regarding their personality, internals were more disturbed than were externals. Interestingly to take a remedial step to deal with their personality problems. Taken as a whole, the internals more actively seek, acquire, utilize, and process information that is relevant to their controlling and manipulation over the environment.

Many people are of the opinion that success is a matter of 'being in the right place at the right time'. Such people have an external orientation toward control. They appear to observe chance or fate as an essential factor. They are the
owners of lucky charms, the readers of horoscopes, the buyers of the lottery tickets. They consider promotions as going to whomever the boss happens to like, marriage as depending on chances with whom you fall in love, and they regarded life in general as governed by 'whatever will be, will be'. Internal people seem to perceive themselves as masters of their own fate, of their reinforcements and rewards, rather than buying of lottery tickets, they buy self improvement books. They regard promotions as depends on hard work on what you know and have rather than who you know, (Strickland, 1977).

One of the important aspects of the environment is one's own body and its well-being. Strickland (1974) has reported on significant implications of locus of control in both physical and emotional well-being. Seeman and Evans (1962) reported that hospitalized patients with internal locus of control orientation possessed more information about their physical condition, asking both doctors and nurses more, and showing less satisfaction with amount of information they are getting about their condition from the hospital personnel than do the external patients. Research by Ducette (1974), and Lowery and Ducette, (1976) showed that among newly diagnosed diabetics, internals knew more about their condition than did externals. Strickland observed that I-E seems to be linked to prophylactic dental behaviour,
participation in physical fitness activity, preventive medical shots, use of seat belts in autos, ability to influence post-operative care, and patient behaviour in a variety of kidney, ulcers and cardiovascular conditions. The role of I-E in the control over self has been found in weight reduction programmes (Balch and Ross, 1975). Furthermore, Lundy (1972) and MacDonald (1970) have demonstrated that external females are less likely to practice effective birth control than are internals.

Encountering failures or other negative outcomes could lead internals to strong feelings of personal responsibility, and helplessness (Phares, 1972). It has been found by Berzins and Ross (1973) that users of narcotics are more internals than those nonusers. Nowicki and Hopper (1974) and Plamer (1971) have reported that externals are heavy drinkers. Erfan (1963) noted that internal persons are more in number than externals in forgetting the failure; thus externals have less need to repress threatening or unfavourable information, internal seem to use the defense of repression. Externals may be more frank about their disturbances or anxieties, (Byrne, 1964). Penk (1969) and Crandall et. al., (1965) have found that belief in internal control may be expected with increasing age.
The concept of locus of control came from speculations about the unusual behaviour of a patient in psychotherapy. Both the improvement of the patient and the force of accumulated research on locus of control have shown that I-E can be useful clinical tool. However, research in health, using I-E seems to be the simple recognition that individual differences in interpretation of reinforcement highly contribute to behaviour (Balch and Ross, 1975).

Health is one of many areas in which there has been a significant amount of interest in relating locus of control (LOC) beliefs to a variety of relevant behaviours, (Strickland, 1978; Wallston and Wallston, 1978; Cromwell, Butterfield, Brayfield and Curry, 1977). Using their own scale, Dabbs and Kirscht (1971) found that college students with internality were more likely to be inoculated against influenza than those with externality. Kirscht (1972) reported expectancy for control for health to be positively related to having in the past made medical and dental visits, controlled diet, cared for teeth, and to the intention of doing these activities in the future, Kirscht, therefore, concluded that motivation for control tended to account for relationships to perception of vulnerability to specific diseases whereas expectancy was more related as a belief that health can be determined by personal actions.
Wallston and Wallston (1973) observed locus of control orientation as an individual difference variable that could be related to information exchanges between patients and health care professionals. They conceptualized the intent of many health education efforts as internality training programmes, by means of the health-related measures of locus of control beliefs. They referred to Rotter's writings (Rotter, 1960, 1966) in which he advocated taking the situation into account when they devised measures of expectancy for their rationale in developing a health-specific measure.

Wallston, Maides, and Wallston (1976) reported three important uses of health locus of control (a) as an independent variable to predict health behaviour, either alone or in combination with other relevant belief and attitude variable (Wallston, Wallston, Kaplan, and Maides, 1976; Krantz, Baum, and Wideman, 1980; Toner and Manuck, 1979; Sproles, 1977). (b) as an independent variable, in combination with different treatment conditions, such that treatment outcome may vary with locus of control belief; Saltzer, 1978; Key, 1975; Wallston and McLeod, 1979); and (c) as dependent variable to measure treatment outcome (Wallston and Wallston, 1973; Bloom, 1979; Tolor, 1978; Dishman et. al., 1980).
The social variables of the study used as the probable source of variation in the occurrence of peptic ulcer and ulcerative colitis included locale and sex. The relevance of the variable of locale may be gauged from the fact that climatic conditions, patterns of eating habits, attitudes, likes and dislikes for certain foods, play an important role in causing peptic ulcer and ulcerative colitis. Inclusion of two geographically distant samples (Srinagar and Aligarh) has mainly been guided by this consideration.

The variable of sex is not merely a demographic consideration, but it has been used here, as a variable of some consequence in view of the fact that sex role stereotypes and cultural conditioning predispose members of the two sex rather differently so that they are not equally sensitive-insensitive to the stimuli they are exposed to, nor do the same conditions contribute to the like extent in determining alienation among the two.

To sum up, it may be restated that the present study has the main objective of studying ulcer and colitis as ailments of psychosomatic-gastrointestinal nature, prone to variations in respect of certain social variables, bearing resemblance to and to be explained in terms of such personality variables as alienation and health locus of control.
Having discussed the psychology and physiology of peptic ulcer and ulcerative colitis, their various patterns and dysfunctions given an exposition of the personality variables assumed to be related to these disorders, it is now time to proceed to presenting a review of the relevant studies in the following chapter.