INTRODUCTION
CHAPTER 1
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INTRODUCTION

Man has been interested always in knowing about himself and understanding others. That is why it is said that though psychology as a scientific branch of study of recent origin, as a subject to understand human nature is as old as that of human history.

The term "Psychology" comprises of two Greek words namely, "Psyche" and "Logos". The former word refers to the "soul" and latter word means "the study of the soul". In the beginning psychology was the study of soul.

Later on, the word "Psychology" was referred to the study of the mind. Currently it is defined as a science that studies the behaviour of man and other living beings. The word behaviour refers to the activities of the organism that can either be observed by another person or by a study of such activities by using certain instruments or tools.

Man is essentially a living organism. Psychology is primarily concerned with the responses of these organisms to their outside world. The organism takes stimuli from the environment which interact with its mind and organic system and which in turn, respond to these stimuli. Hence psychology may be considered to be a biological science if we describe it in terms of stimulus, organism and response.
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1.1 THE FIELD OF PSYCHOLOGY

Psychology is interested in understanding the behaviour of people in different situations and contexts and also in applying the general psychological principle in different fields of human life. The different fields of psychology are:

1. Clinical Psychology
2. Counselling Psychology
3. Community Psychology
4. Developmental Psychology
5. Experimental Psychology
6. Educational Psychology
7. Industrial Psychology
8. Psychometric Psychology
9. Health Psychology
10. Social Psychology
11. Environmental Psychology
12. Organizational Psychology

1.2 NORMAL AND ABNORMAL

Normal: Normal people exhibit satisfactory work capacity and earn adequate to how they need more. They are capable of establishing satisfying
and acceptable relationship with other people and their emotional reactions are basically appropriate to different situations. Such people manage to control their emotions. Their emotional experiences do not affect their personality adjustment, though they experience occasional frustrations and conflict. The people who adjust well with themselves, their surroundings and their associates constitute the normal group.

Normal behaviour will represent the optimal development and functioning of the individual consistent with the long-term well-being and progress of the group.

So we can say that people have average amount of intelligence, personality, and stability social adaptability are considered as normal.

**Abnormal:** Freud’s view that nobody is fully normal though held by some as an exaggeration, it should be accepted beyond doubt that abnormality is perhaps the major problem of a modern society.

The unusual or maladaptive behaviour of many persons that do not fit into our common forms of behaviour is known as abnormal behaviour. Abnormality refers to maladjustment to one’s society culture and surroundings.

The word abnormal literally means “away from the normal,” In the case of physical illness abnormal behaviour is behaviour that deviates from society’s norms. According to the other view, that behaviour is abnormal if it
interferes with the well being of the individual and or the group. Social
scientists have argued for the concept of "abnormal" as deviation from
society norms.

According to Ullman And Krasner (1969), "abnormal is simply a level
given to behaviour that is deviant from social expectation."

Abnormal behaviour includes the more traditional categories of mental
disorders, alcoholism, neuroses and psychoses. All represent maladaptive
behaviour to personal distress, and often they bring destructive group
conflict.

Thus mental health personal are adopting the concept of abnormal as
maladaptive, and in assessing, treating and preventing abnormal behaviour
on both individual and group levels, they are concerned not only with the
individual but also with the family, community and general societal setting.

The term maladaptive itself has an advantage over the term abnormal. A
person once seen as "abnormal" may forever be seen that way, whereas
maladaptive behaviour can usually be changed.

1.3 THE PROBLEM OF CLASSIFICATION

Classification has been carried out in different ways of abnormal behaviour.

In 1952 the APA (American Psychiatric Association) adopted a
classification of mental disorders that was based largely on a scheme worked
out by the United States Army during World War II. In 1968 the APA adopted a modified classification worked out in the World Health Organization. This international classification permits mental health workers to compare incidence, types of disorders, treatment procedures, and other relevant data concerning mental disorders throughout the world.

1.4 CURRENT CLASSIFICATION OF MENTAL DISORDERS

The widely used classification schemes for mental disorders are the Diagnostic and Statistical Manual of Mental Disorder (Fourth Edition) devised by the American Psychiatric Association, DSM IV. There also exists a worldwide classification system, called the international classification of Diseases, 9th Edition (World Health Organization) ICD-10, which covers all diseases and disorders, both physical and mental. Both APA and WHO have worked closely over the years to ensure compatibility between their two-classification systems. The mental disorders were classified in 10 categories or Axes:

1.4.1 MENTAL RETARDATION

Borderline Mental Retardation

Mild Mental Retardation

Moderate Mental Retardation
Severe Mental Retardation

Profound Mental Retardation

1.4.2 ORGANIC BRAIN SYNDROMES

Senile and pre-senile dementia

Alcoholic psychosis

Psychosis associated with intercranial infection

Psychosis associated with other cerebral condition

Psychosis associated with other physical condition (e.g. endocrine disorders metabolic or nutritional disorder).

1.4.3 PSYCHOSES

Schizophrenia (Simple, Hebephrenic, Catatonic, Paranoid).

Major affective disorders

Involution melancholia

Manic-depressive illness manic type

Manic-depressive illness depressive type

Manic-depressive illness circular type

Paranoid states

1.4.4 NEUROSES

Anxiety Neuroses

Hysterical neuroses (conversion and dissociative type)

Phobia neuroses
Obsessive Compulsive neuroses

Neurasthenic neuroses

Depersonalization neuroses

Hypochondriacal neuroses

1.4.5 PERSONALITY DISORDERS AND CERTAIN OTHER

NONPSYCHOTIC MENTAL DISORDERS

**Personality Disorders**

Paranoid personality

Cyclothymic's personality

Schizoid personality

Explosive personality

Obsessive-compulsive personality

Hysterical personality

Aesthetic personality

Antisocial personality

Passive aggressive personality

Inadequate personality

**Sexual Deviations**

Fetishism

Pedophilia

Transvestitism
Exhibitionism
Voyeurism
Sadism
Masochism
Other unspecified deviation

**Alcoholism**
Episodic excessive drinking
Habitual excessive drinking
Alcohol addiction

**Drug Dependence**
Opium, opium alkaloids and their derivatives
Synthetic analgesic with morphine
Barbiturates
Other hypnotics and sedatives tranquilizers
Cocaine
Marijuana
Other drug dependence

1.4.6 **PSYCHOPHYSIOLOGICAL DISORDERS**
Psycho physiologic skin disorders
Psycho physiologic musculoskeletal disorder
Psycho physiologic respiratory disorder
Psycho physiologic cardiovascular disorder
Psycho physiologic hemic and lymphatic disorder
Psycho physiologic gastrointestinal disorder
Psycho physiologic genito-urinary disorder
Psycho physiologic endocrine disorder
Psycho physiologic disorder of organ of special special sense
Psycho physiologic disorder of other type

1.4.7 SPECIAL SYMPTOMS

This category includes speech disturbance, specific learning disturbance, other psychomotor disorder, disorder of sleep, feeding disturbance and enuresis.

1.4.8 TRANSIENT SITUATIONAL DISTURBANCES

This category includes emotional disturbances of a transient nature referred to as adjustment reaction of infancy, of childhood, of adolescence, of adult life, and of late life.

1.4.9 BEHAVIOUR DISORDERS OF CHILDHOOD AND ADOLESCENCE

Hyper kinetic reaction
Withdrawing reaction
Overanxious reaction
Runaway reaction

Unsocialized aggressive reaction

Group delinquent reaction

Other reaction of childhood (or adolescence)

1.4.10 CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NONSPECIFIC CONDITIONS

This category includes marital, social and occupational maladjustment, social behaviour and other social maladjustment.

1.5 ASSESSING AND TREATING MALADAPTIVE BEHAVIOUR

Maladaptive behaviour can be treated, they must first be identified, sometimes assessment is undertaken at the individual’s own request because of feelings of anxiety, depressions and personal distress, many assessment methods are available to the clinician, including medical, psychological, and sociological procedures. On a psychological level the clinician can use interviews, psychological tests, rating scales, observations of the individual’s behaviour in actual situations, and a variety of other techniques to assess the maladaptive behaviour.

The clinical psychologist makes an overall evaluation of the patient’s behaviour in terms of such factors as daily demands, overall needs, and social responsibility.
1.6 HELPING FIELDS AND PERSON

At the present time, there are several distinct related professional fields with the study of abnormal behaviour and with mental health. The related fields concerned with emotional problems and psychotherapy the professional field broadly concerned with the study, assessment, treatment and prevention of abnormal behaviour.

Abnormal Psychology has long been referred to as part of the field of psychology, viz; clinical. The field of clinical psychology is broadly concerned with the study, assessment, treatment and prevention of abnormal behaviour.

As in the case of assessment, the individual may come for treatment. Some procedures range from the use of drugs through individual or group psychotherapy modifying adverse conditions in the patient's life situation.

1.7 PERSONALITY

Personality has been regarded as a practical force in determining success or failure in life. Some of the symbols most commonly used to judge personality are analyzed. These include such important symbols of self as clothing, speech, names, use of leisure time, and reputation. Many traditional beliefs show that the kind of personality a person develops as well as the outstanding traits in his personality patterns are determined by his genetic
make up. It also weakens the motivation of parents and teachers try to guide and direct the development of personality in children during the early formative years of their lives. Some personality changes in the environment and in the person's general health condition at times other than puberty and middle or old age.

1.7.1 WHAT IS PERSONALITY

The importance of personality increases as social life becomes more complex. A 'pleasing' personality in a complex society, simple cultures, where the scale of social relations is low and behaviour is regulated by old-age customs, personality is of less concern. Today all these conditions are changed, and practically in every life role, personality has a major significance.

1.7.2 RECOGNIZING THE SOCIAL VALUE OF PERSONALITY

A good personality is believed to be a symbol of happiness and success in life. Developing the personality is a major goal for many people, they try to develop a wholly new personality pattern and they try to discover some easy way to do it by reading books or newspaper on personality improvement. But the basic structure of personality cannot be changed. Therefore, we should try to develop a fully functioning personality.
1.7.3 THE MEANING OF PERSONALITY

The term 'Personality' is derived from the Latin word Persona, which means 'Mask'. Allport (1937) define "Personality is the dynamic organization within the individual of those psychophysical systems that determine the characteristic, behaviour and thought." ‘Dynamic’ refers to the constantly involving or changing nature of personality. Not only the personality become more complex in structure as the individual’s physical and psychological characteristics develop, but also from time to time and from situation, there are changes in the structural situations.

A psychophysical system is composed of habits, attitudes, emotional states, sentiments, motives and believes, all of which are psychological but have a physical basis in the individual’s neural, glandular or general bodily states. Personality is neither exclusively mental nor exclusively neural (physical). It originates the functioning of both ‘mind’ and ‘body’.

1.8 HEALTHY PERSONALITY

A Person with a healthy personality as one who is able to gratify his needs through behaviour that confirms to both the norms of his society and the requirements of his conscience. The second essential to a healthy personality is that the person takes interest in life to the satisfaction of others.
The studies of people in different social and cultural background characteristics, which are almost universal in those whom they regard as well adjusted, or as having healthy personality. The most important characteristics are the ability to appraise them realistically and to the ability to evaluate their achievements, acceptable emotional control, goal orientation and outer-orientation, the ability to gain social acceptance. These characteristics are regarded by personologists as the healthy personality syndrome.

No one born with a sick or healthy personality. The kind of personality pattern the person develops dependent largely upon his life experience. In a healthy personality, physical, psychological and self-concept factors play a major role.

1.8.1 PHYSICAL CAUSES

A person who suffers from only minor illness is far more likely to have a healthy attitude toward life in general than the person who suffers from chronic illness, whose homeostasis is upset by glandular imbalance or other physiological conditions.

1.8.2 PSYCHOLOGICAL CAUSES

Psychologically the major factor contributing to a healthy personality is self-concept. If the self-concept is reasonably favorable, the person will accept himself, if the self-concept is unfavorable, he will reject himself.
1.8.3 SELF-ACCEPTANCE

The conditions which contribute to the development of favourable self-concept are self-understanding, realistic expectations, absence of environmental obstacles, favorable social attitudes, absence of severe emotional stress, identification with well adjusted people, self-perspective, good childhood training.

Since a healthy personality is not a part of the person's hereditary involvement it developed through learning and life experiences. Life is more enjoyable and people are happier when they are physically and mentally healthy. Medical science devotes considerable time to disseminating information about how to prevent physical illness and to promote good health. This is done through the schools, colleges and mass media.

1.9 PERSONALITY DISORDERS

The behavior which is maladaptive and which causes significant harm to the individual is called personality disorders. Personality disorders are described as below:

1.9.1 ANTISOCIAL PERSONALITY

Also known as psychopathic personality this refers to recurrent delinquent behavior, aggression, impulsiveness and lack of feelings for other people.
1.9.2 PARANOID PERSONALITY

These individuals are very sensitive to criticism. They are excessively establishing what they want and regard as their personal rights forcefully. If things go wrong for them they blame other people.

1.9.3 DEPENDENT PERSONALITY

These people face many difficulties in their daily responsibilities. They need constant support from other people and may enter into unsuitable relationships.

1.9.4 HYSTRIONIC PERSONALITY

It's also called hysterical personality usually applies to women who display traits of emotional shallowness, vanity and dramatization. Most patients with hysteria have normal personalities. Hysteria patient doesn’t know what type of activity he does.

1.9.5 SCHIZOID PERSONALITY

People with this type of personality are socially withdrawn, and prefer loneliness, they don’t contact with other people because of social phobia.

1.9.6 OBSESSIOINAL PERSONALITY

Obsessional traits are orderliness and cleanliness. These people are often insecure and like their lives to be as routine and predictable as possible. They may develop obsessional neurosis under stress and are also develop
depressive illness during which their obsessional traits become more pronounced.

1.10 PSYCHOSES

A psychosis is a severe form of mental disease. The main symptoms of a psychotic involve extreme personality disorganization and loss of contact with reality. A psychotic patient is different from normal individual by the bizarreness of his actions, the incoherence of his speech, hallucinations and his general mental confusion. Hallucinations may be of different types such as taste and smell, sound and touch. Psychotic patient shows the characteristics of the infant, who has not been able to distinguish between the inner and the outer world, his behavior is too unreasonable and inappropriate to be understood by normal man.

A psychotic patient distorts reality and become disoriented towards persons and things in the external world. He has no proper idea or knowledge of time and place, which make his personality more and more disordered. With out any apparent cause, they become suddenly excited, depressed, violent and irritable. His memory fails and he cannot grasp and understand new materials.

This category of mental abnormality includes affective reaction, Paranoid reactions and Schizophrenic reaction. All the psychological functions like perception, Learning, Memory, and Imagination become affected.
Thus, in short a psychosis refers to severe mental disorders that disintegrated the personality and disrupt the individual’s interpersonal as well as social relationship. There is permanent impairment of total personality. A psychotic lives in his own world. The rules; regulations standards and norms have no implications, no value for him. A psychotic takes his dreams, imaginations and delusions as real, and strangely enough strongly believes that they are real.

1.11 PSYCHONEUROSES

Psychoneuroses are relatively mild personality disorders that distress and inconvenience the patient, but do not disrupt his social adjustment and interfere with his every day activities to the point of necessary supervision in a mental hospital. The patient does not loose contact with others. Psychoneurotic patients are aware of what they are doing; they also understand their mental troubles and difficulties. Their behavior is not a source of danger to others.

In the neuroses we find faulty learning, often in early development, leading to persistent feelings of threat and anxiety in facing the everyday problem. The individual is said to exhibit neurotic behavior if he frequently misevaluates adjutive demands, becomes anxious in situations. Although neurotic behaviour is maladaptive, it does not involve gross distortion of reality or marked personality disorganization, nor is it likely to result in
violence to the individual or to others. Rather neurotics are typically anxious, ineffective, unhappy, and often guilt-ridden individual, who do not ordinarily require hospitalization but nevertheless are in need of therapy. Anxiety, Phobia, Hysteria, Obsessive-compulsive neuroses etc. are the main psychoneurotic disorder.

1.12 ANXIETY

Anxiety disorders, is a most prevalent psychiatric illness in the general community. Anxiety is not caused by organic disease of the brain and not also involves hallucination and delusions. Anxiety has long been recognized as a prominent symptom of many psychiatric disorders. It has been particularly associated with the symptoms of depression. Freud (1895) who first suggested that cases with mainly anxiety symptoms should be separated from neurasthenia under the name of anxiety neurosis. According to Freud original anxiety neurosis includes phobias and panic attacks, and he originally proposed that the causes of anxiety neurosis and anxiety hysteria were related to sexual conflicts. Anxiety neurosis is the most common of the various neurotic patterns, constituting 30 to 40% of all neurotic disorders. Adolf Meyer considered that a stressful situation in person’s life could cause anxiety neurosis.

Anxiety disorders and depression may be overlooked because individuals experiencing these problems are less difficult for caretakers to deal with than
individuals who are aggressive or noncompliant. Another factor that may have contributed to a lack of attention to anxiety disorders and depression is that it is
an unpleasant emotional state with characteristic cognitive behavioural, and physiological component. Anxiety may involve feelings of worry and apprehension and may be accompanied by increased pulse and respiration, sweaty palms, or dry mouth, and by avoiding situations in which anxiety occurs.

1.12.1 CLASSIFICATION OF ANXIETY DISORDERS

DSM IV and ICD 10 adopt the same general criteria. The main differences are that in ICD 10 the disorders are divided into (a) Phobic anxiety disorders and (b) other kind of anxiety disorders, which include panic disorders and generalized anxiety disorders. The classifications are as follows:

<table>
<thead>
<tr>
<th>ANXIETY DISORDERS CLASSIFY IN ICD10</th>
<th>ANXIETY DISORDERS CLASSIFY IN DSM IV</th>
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<tbody>
<tr>
<td>(A) PHOBIC ANXIETY DISORDERS</td>
<td>(i) Agoraphobia</td>
</tr>
<tr>
<td>(i) Agoraphobia</td>
<td>Without a history of panic</td>
</tr>
<tr>
<td>Without panic disorder</td>
<td>Disorder</td>
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<tr>
<td>With panic disorder</td>
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<tr>
<td>(ii) Social phobia</td>
<td>(ii) Social phobia</td>
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<tr>
<td>(iii) Specific phobia</td>
<td>(iii) Specific phobia</td>
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(B) OTHER ANXIETY DISORDERS PANIC DISORDERS

(i) Generalized anxiety disorders
(ii) Mixed anxiety and depressive disorders

(i) Panic disorders without agoraphobia
(ii) Generalized anxiety disorders

Anxiety disorders are abnormal states in which the most striking features are mental and physical symptoms, which are not caused by organic brain disease or any other psychiatric disorder. Anxiety disorders are divided as follows:

(i) Generalized anxiety disorders in which anxiety is unvarying and persistent;

(ii) Phobic anxiety disorders in which anxiety is intermittent and arises in particular circumstances;

(iii) Panic disorder in which anxiety is intermittent and unrelated to particular circumstances;

1.12.2 SYMPTOMS OF GENERALIZED ANXIETY DISORDERS

The symptoms of generalized anxiety disorder are persistent and are not restricted to or strongly predominating in any particular set of circumstances. There are three characteristic features in generalized anxiety disorders:

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(a) **Worry and apprehensions**: difficult to control, more prolonged than the ordinary worries and concerns of healthy people. Worries are widespread and not focused on a specific issue.

(b) **Motor tension**: which may be experienced as restlessness, trembling, inability to relax, and headache, which is usually frontal or occipital.

(c) **Autonomic hyperactivity**: which may be experienced as sweating, palpitations, dry mouth, epigastric discomfort, and dizziness.

Other psychological symptoms of generalized anxiety disorder are *irritability, poor concentration, and sensitivity to noise*. Some patients complain of poor memory when they are experiencing the effects of failure to concentrate. Other motor symptoms include aching and stiffness in muscles.

There are autonomic symptoms of anxiety, which can be grouped as follows according to systems of the body:

(a) **Gastro-intestinal**: dry mouth, difficulty in swallowing, epigastric discomfort, excessive wind, and frequent loose motion.

(b) **Respiratory**: feeling of constriction in the chest, difficulty in inhaling as in asthma and consequences of hyperventilation.

(c) **Cardiovascular**: feeling of discomfort over the heart, palpitation, and awareness of missed beats and throbbing in the neck.
(d) **Genitourinary**: frequency and urgency of micturition, failure of erection, and lack of libido, and among women menstrual discomfort and at times amenorrhoea.

(e) **Nervous system**: tinnitus, feeling of blurring of vision, dizziness that is not rotational, prickling sensations.

The appearance of a person with generalized anxiety disorder is characteristic. His face looks strained, with a furrowed brow, his posture is tense, and he is restless and often tremulous. The skin looks pale and sweating is common, especially from the hands, feet and axillae. Other symptoms of generalized anxiety disorder include tiredness, depressive symptoms, obsessional symptoms and depersonalization.

1.12.3 **DIFFERENTIAL DIAGNOSIS**

In order to arrive at a conclusion that whether the patient is suffering from anxiety we have to make a differential diagnosis.

Generalized anxiety disorders have to be distinguished from certain other psychiatric and physical disorders. Anxiety symptoms may occur in any psychiatric disorder, the most frequent problem is the distinction between anxiety and depressive disorder. Anxiety is a common symptom in depressive disorder, and generalized anxiety disorder often includes some depressive symptoms.
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In generalized anxiety disorders information on these two points should be obtained from relatives or other sources as well as from the patient. The symptom appeared first and is more severe is considered to be primary. Some physical illnesses may also be present with anxiety symptoms. This possibility should be considered especially when no obvious psychological causes can be found and when the personality is normal. An important differential diagnosis is from thyrotoxicosis, in which the patient may be irritable and restless with tremor and tachycardia. Sometimes anxiety is the presenting symptoms of other physical illness because the patient fears that the early symptoms reported a fatal illness such as cancer.

The opposite diagnostic error can also be made. Thus, generalized anxiety disorder with prominent physical symptoms may be mistaken for physical disease, when this happens, patients may then undergo unnecessary investigations that may increase anxiety. Correct diagnosis is more likely if the doctor remembers the diversity of the anxiety symptoms: palpitation, headache, and frequency of micturition, and abdominal discomfort can all be the primary complaint of an anxious patient.

On the basis of above discussion we can summarize that the appearance of a person with anxiety disorders is characterized by the following physical and psychological symptoms.
(1) **PSYCHOLOGICAL SYMPTOMS**  
- Fearful anticipation  
- Irritability  
- Sensitivity to noise  
- Restlessness  
- Poor concentration  
- Worrying thoughts  

(2) **PHYSICAL SYMPTOMS**  
**GASTROINTESTINAL**  
- Dry mouth  
- Difficulty in swallowing  
- Epigastric discomfort  
- Excessive wind  
- Frequent or loose motion  
**RESPIRATORY**  
- Constriction in the chest  
- Difficulty inhaling  
- Over breathing  
**CARDIOVASCULAR**  
- Palpitations  
- Discomfort in chest  
- Awareness of missed beats  
**GENITOURINARY**  
- Frequent or urgent micturition  
- Failure of erection  
- Menstrual discomfort  
- Amenorrhea  
**NEUROMUSCULAR SYSTEM**  
- Tremor  
- Prickling sensations
Tinnitus
Dizziness
Headache
Aching muscles

(3) SLEEP DISTURBANCE
Insomnia
Night terror

(4) OTHER SYMPTOMS
Depression
Obsessions
Depersonalization

Other psychological symptoms of anxiety are irritability, poor concentration and sensitivity to noise. Some patients also complain of poor memory when they are experiencing the effects of failure to concentrate.

CAUSAL FACTORS

Anxiety reactions reflect the individual’s acute feelings of inadequacy in the face of inner and outer stresses. Some reactions are considered normal when the stress situation is sufficiently severe or justify them. Many patients feel uneasy a good deal of the time and occasional mild anxiety attacks. The anxiety occurs, severe financial reverses, loss of employment, and other unusual stresses may activate rather severe but perfectly normal feeling of anxiety.
Jenkins (1968, 1969) pointed out that anxiety neurotic often come from families in which parents have high expectations for their child while at the same time rejecting his actual accomplishments as substandard. Anxiety neurotics tend to have difficulty in making decision, under certain conditions such as conflicts involving moral values of possible loss of security and status. Although we have emphasized the inadequacy, over sensitivity and low stress tolerance of the anxiety.

1.13 PHOBIA (PHOBIC ANXIETY DISORDER)

A Phobia is a persistent fear of some object or situation that presents no actual danger to the person. Phobic disorders have been recognized since antiquity but the first systematic medical study of these conditions was probably that of Le Camus in the 18th century (Errera 1962) In the 19th century the psychiatric classifications included phobias with the monomania's, which were disorders of thinking rather that emotion. Phobias may be defined as 'a fear of particular object or situation'. Normal fears for water harmless animals, closed places, dark rooms are established due to childhood conditions. Many people developed specific phobias, which are not part of a neurotic pattern as THE CASE OF snake phobia. In phobic neurosis the phobia is characterized by irrational fears and avoidance behaviours. This neurotic pattern occurs more commonly among adolescents and young adults than older people and also it is more common.
among females than males. In phobic reactions such fears are intense and interfere with everyday activities. Phobic neurotic usually shows a wide range of other symptoms in addition to their phobias such as tension, headache, back pains, stomach upsets, dizzy spells and fear of cracking up. Phobic anxiety disorders also have same core symptoms as generalized anxiety disorders, but in some phobic disorders these symptoms are mild and the patients is free from anxiety for most of the time; in other phobic disorder many circumstances provoke anxiety with the result that it is more frequent. There are some phobic situations in which no anxiety is experienced. There are two other features, which characterize phobic disorders: (i) The person avoids circumstances that provoke anxiety, when there are the prospects of encountering these circumstances. (ii) The circumstances provoking anxiety includes situations (e.g. crowded places), ‘objects’ (e.g. spiders), and natural phenomena (e.g. thunder).

1.13.1 TYPES OF PHOBIA

In 1895 Freud proposed that two groups of phobias could be recognized.

(1) Common phobias with an exaggerated fear of things that are commonly feared such as darkness and solitude.

(1) Specific phobias the fear of situation not feared by healthy people such as open places.
The following list of the common phobias and their objects will give some hint of the variety of situations and events around which phobias may be centered.

Acrophobia : High places
Agoraphobia : Open places
Algophobia : Pain
Astraphobia : Storms, thunder and lightening
Claustrophobia : Closed places
Hematophobia : Blood
Mysophobia : Contamination or germs
Monophobia : Being alone
Nyctophobia : Darkness
Ochlophobia : Crowds
Pathophobia : Disease
Pyrophobia : Fire
Syphilophobia : Syphilis
Zoophobia : Animals or some particular animal

This classification of phobias was accepted widely until the 1960's when the use of behaviour therapy to treat the condition led to an increase interest in classification. Phobic disorders are classified in slightly different ways in DSM IV and ICD10. In both systems phobic disorders are divided into
Simple, Social and Agoraphobia depending on the age of its onset. The
different responses of various phobias to behavioural methods suggested a
group into:

Simple phobias (begins in childhood)

Social phobias (begins in late adolescence)

Agoraphobias (begins in early adult life).

1.13.2 SIMPLE PHOBIA

In this phobia a person is anxious in the presence of one or more particular
objects or situations. Simple phobias may be characterized by adding the
name of stimulus, e.g. Spider phobia of flying anxiety during aeroplane
travel. A few people have such intense fear that they are unable to travel in
an aeroplane. In Phobia of illness, patient experience repeated fearful
thought that they might have cancer, venereal disease, or some other serious
illness. Such fears may be associated with avoidance of hospitals. Most
simple phobias of adult life are a continuation of childhood phobias. Simple
phobias are common in childhood. By early teenage years most of these
childhood fears have been lost, but a few persist in adult life. (Kendler et al;
1992) The psychoanalytic explanation is that phobias persist because they
are not related to obvious stimulus but to a hidden source of anxiety.
Clinical experiences suggest that simple phobias originate in childhood continue for many years, while those starting in adult life after stressful event have a better prognosis.

1.13.3 SOCIAL PHOBIA

Social Phobia is experienced in situations in which the person is likely to be observed and criticized. Socially phobic people tend to avoid such situations and do not get themselves engaged in them fully, e.g. they avoid making conversation, or they sit in a place where they are least conspicuous. Socially phobic people are often preoccupied with the idea of being observed critically. Some patients become anxious in wide range of social situations others are anxious only in specific situations such as public speaking.

According to Davidson et al; (1993),Kessler et al; (1994) Social phobias are about equally frequent in men and women. The one-year prevalence of social phobia has been estimated 7% for men and 9% of women.

Social phobia has to be distinguished from avoidant personality disorders characterized by life long shyness and lack of self-confidence.

(Fyer et al; 1993) Genetic vectors are suggested by the finding that social phobias are more common among the relatives of social phobics than in the population. Social phobia usually begins in late adolescence, when young
people are expanding their social contacts and impression that they are making on other people.

1.13.4 AGORAPHOBIA

Agoraphobic patients are anxious when they are away from home, in crowds or in situations that they cannot leave easily. In these circumstances the symptoms are similar to those of other phobic disorders, but other symptoms such as depression, depersonalization, and obsessional thoughts are more frequent in agoraphobia than in other phobic disorders. Many situation that provoke agoraphobia include buses and trains, shops and supermarkets, and places that cannot be left suddenly without attracting attention. The onset and course of agoraphobia differ in several ways from those of other phobic disorders. While most patients associated the onset of agoraphobic symptoms with a panic attack, some describe an onset without such an attack. As the condition progress, agoraphobic patients become increasingly dependant on the spouse or other relatives for help with activities, such as shopping that provoke anxiety.

Agoraphobia patients feel anxious in social situations, while some social phobics avoid crowded, buses and shops where they feel insecure.

Buglass et al; (1977) found no evidence that agoraphobics had more family problems than controls. Clinical observation suggests that symptoms are
sometimes prolonged by over-protective attitudes of other family members, but this feature is not found in all cases.

Most of us have minor irrational fears, but in phobic reactions such fears are intense and interfere with everyday activities. Phobic neurotics usually show a wide range of other symptoms in addition to their phobia, such as tension, headaches, back pains, stomach upsets, dizzy spells, and fear of cracking up. More acute chronic disorders such individuals often complain feeling of unreality of strangeness, and of not being themselves.

In some instances, phobic neurotics also have serious difficulty in making decision. Neurotics usually admit that they have no real cause to be afraid of the object or situation, but say that they cannot help themselves.

1.13.5 CAUSAL FACTORS

Phobias may accrue in a wide range of personality patterns and abnormal syndromes. In general phobias have been attempts to cope with specific internal or external dangers by carefully avoiding situations.

The phobia may represent a defensive reaction that protects the individual from situations in which his repressed aggressive or sexual impulses might become dangerous. A phobia may represent a displacement of anxiety from some external cause elicited it to some other object or situation.

Phobic behavior tends to be reinforced by the reduction in anxiety that occurs when the individual avoids the feared situations or stress. In addition,
phobias may be maintained in part by secondary gains, such as increased attention, sympathy, and some control over the behavior of others.

1.14 PANIC DISORDERS

The diagnosis of panic disorder was not used until it was introduced in DSM III in 1980, the central feature is the occurrence of panic attacks, i.e. sudden attack of anxiety in which physical symptoms predominate and accompanied by fear of a serious consequence such as a heart attack. In the past, these symptoms have been variously referred to as irritable heart, Da Costa’s syndrome, neurocirculatory asthenia, disorderly action of the heart, and effort syndrome. These early terms assume that patients were correct in fearing a disorder of cardiac function.

In 1980 the authors of DSM III introduced a new diagnostic category panic disorders, which included patients whose panic attacks occurred with or without generalized anxiety, but excluded those whose panic attacks appeared in the favour of agoraphobia. In DSM IV, all patients with frequent panic attacks are classified together.

1.14.1 SYMPTOMS OF A PANIC ATTACK

In DSM IV the following symptoms of Panic Disorder has been specified:

- Shortness of breath and smothering sensations.
- Choking.
• Palpitations and accelerated heart rate.

• Sweating.

• Dizziness, Unsteady feelings or faintness.

• Nausea or abdominal distress.

• Depersonalization or derealization.

• Numbness or tingling sensation.

• Flushes or chills.

• Trembling or shaking.

• Fear of dying.

• Fears of going crazy or doing something uncontrolled.

1.14.2 CLINICAL FEATURES OF PANIC DISORDER

Important features of panic attacks are that anxiety builds up quickly, the response is severe, and there is a fear of catastrophic outcome. DSM IV the diagnosis is made when panic attacks occur unexpectedly and when more than four attacks have occurred in four weeks or one attack has been followed by four weeks of persistent fear of another attack. Some patients with panic disorder are hyperventilatine.

Hyperventilation is breathing in a rapid and shallow way with a resultant fall in the concentration of carbon dioxide in the blood. The resulting hypnocapnoea may cause dizziness, tinnitus, headache, a feeling of
weakness, faintness, numbness and tingling in the hands, feet and face, carpopedal spasms, and precordial discomfort. There is also a feeling of breathlessness, which may prolong the condition if the patient concludes from this feeling that he should breathe even more vigorously, when a patient has unexplained bodily symptoms, the possibility of persistent over breathing should always be born in mind. Watching the pattern of breathing can make the diagnosis easy.

1.14.3 DIFFERENTIAL DIAGNOSIS

Panic attacks occur in generalized anxiety disorders, phobic anxiety disorders (most often agoraphobia), depressive disorders, and acute organic disorders.

1.14.4 AETIOLOGY

There are three main hypotheses about the origin of panic disorder. The first proposes the biochemical abnormality, the second hyperventilation, and the third a cognitive abnormality.

1. The biochemical hypothesis is reflected in the term, ‘endogenous anxiety’ which has been proposed for these cases. The hypotheses is based on three sets of observation:
First, chemical agents such as sodium lactate and yohimbine can induce panic attacks more readily in patients with panic disorder than in healthy people.
Second, panic attacks are reduced by certain drugs.

Third, there is some evidence for a genetic basis for the disorders. In panic disorder patients make it difficult to identify a single common mechanism. It is possible that panic disorder occurs more often among relatives, suggesting a genetic and therefore possibly a biochemical basis for the disorder (Crowe et. al.1983), Twin studies support this idea, but the number of pairs studied are too small for a definitive conclusion.

2. The hyperventilation hypotheses are based on the observation that in some people voluntary over breathing produced symptoms like those of a panic attack (Hibbert 1984). Panic disorder is caused by hypersensitivity of a biological system that responds to feelings. It is suggested that this response is set off in panic patients by minimal cues for suffocation (Klein 1963).

3. The cognitive hypotheses are based on the observation that fears about serious physical or mental illness are more frequent among patients with panic attacks than among anxious patients, without panic attacks there is a spiral of anxiety in panic disorder as the physical symptoms of anxiety activates fears of illness and thereby generate more anxiety (Clark 1986).

1.14.5 TREATMENT

In Panic attacks apart from supportive measures and attention to any personal or social problem, treatment is mainly with either drugs or cognitive therapy. Benzodiazepines control panic attacks when given in high
doses. Alprazolam a high potency benzodiazepine, can be given in such doses without marked sedation, although it is probably no more effective in reducing panic attacks than an equivalent dose of diazepam (Dunner et. al. 1986). Benzodiazepines should be withdrawn very gradually to avoid withdrawal symptoms. The antidepressant drug imipramine also controls panic attacks (Klein 1964). The first effect of the drug is often to produce an unpleasant feeling of apprehension, sleeplessness and palpitations.

Recently, a technique of cognitive therapy has been used to reduce fears of the physical effects of anxiety, on the assumptions that fears prolong the disorders. Common fears are that palpitations indicate an impending heart attack, or that dizziness indicates impending loss of consciousness. The relevant symptoms are induced by exercise. Studies have confirmed that cognitive therapy is at least as effective as imipramine given in high doses of 225 mg. (Clark et. al. 1994).

1.14.6 MIXED ANXIETY AND DEPRESSIVE DISORDER

There are several reasons, why anxiety and depression may occur together. First, the antecedent causes may be similar. Brown et. al. (1993) found that childhood adversity is associated with both anxiety and depressive disorder in adult life. A second reason is that many stressful events combined elements of loss (which is known to be associated with depression) and danger (which is associated with anxiety). A possible third, reason for the
association is that persistent anxiety can lead to secondary depression of mood.

The prognosis of these mixed cases is not clear. It is generally treated with a try cyclic antidepressant or monoamine oxidize inhibition, both of which have anxiolytic as well as antidepressant effects (Rickets et. al. 1974; Davidson et. al. 1980; Johnston et. al.1980).

1.15 DISSOCIATIVE DISORDERS (HYSTERICAL NEUROSES)

Neurotic disorders include anxiety, obsessional and dissociative disorders. These disorders are not caused by organic disease of the brain and do not involve hallucinations and delusions. These neurotic disorders are classified in DSM IV and ICD 10, In DSM IV Obsessive compulsive disorders are regarded as a type of anxiety disorder, while in ICD 10 they are classified separately.

1.15.1 DSM IV CLASSIFICATION

In the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM IV) the essential feature of the dissociative disorder is defined as a state of disrupted consciousness, memory, identity or perception of the environment. DSM IV offers specific diagnostic criteria of 4 dissociative disorders.
1. DISOCIATIVE AMNESIA (Once called psychogenic amnesia)

2. DISOCIATIVE FUGUE (Once called psychogenic fugue)

3. DISOCIATIVE IDENTITY DISORDER (Once called multiple personality disorders)

4. DEPERSONALIZATION DISORDER

1.15.2 DISOCIATIVE AMNESIA

This is characterized by an ability to remember information, usually related to a stressful or traumatic event that cannot be explained by ordinary forgetfulness, or as a general medical condition.

1.15.3 DISOCIATIVE FUGUE

Associated with an ability to recall the past and with confusion about a person’s personal identity or with the adoption of a new identity.

1.15.4 DISOCIATIVE IDENTITY DISORDER

Generally considered to be the most severe chronic, dissociative disorder characterized by the presence of two or more distinct personalities within a single person.

1.15.5 DEPERSONALIZATION DISORDER

This is characterized by recurrent or persistent feelings of detachment from the body or mind. People with dissociative disorders, however have lost the sense of having consciousness. They feel as though they have no identity, or they are confused about who they are or they expense multiple identities. All
these disorders were once known as hysterical neuroses of the dissociative type.

1.16 ICD-10 CLASSIFICATION

The 10th revision of international statistical classification of disease and related health problem (ICD-10) organizes dissociative (conversion) disorders somewhat differently than DSM IV.

The dissociative disorders in ICD-10 include dissociative amnesia, dissociative fugue, dissociative stupor, trance and possession disorders, dissociative motor disorders, dissociative convulsions, dissociative anesthesia and sensory loss, mixed dissociative disorders.

These disorders usually are connected with trauma, personal conflicts, and poor relationship with others. ICD -10 adds the term conversion to indicate that the effects of the unsolvable problems are transformed into symptoms. These disorders tend to see their problem as connected with the dissociative symptoms not with the disorders.

Previously used term hysteria has been replaced in the ICD -10 classification by dissosiative disorders but many clinicians still prefer hysteria as a diagnostic category.
1.16.1 CONVERSION TYPE

Dissociative disorder is defined as a syndrome, characterized by a loss of neurological functions without any underlying organic pathology.

Clinical Features categorizes into three groups of symptoms. Sensory, Motor and visceral.

i. Sensory Symptoms: Most common forms of these reactions loss of sensitivity (Anesthesia), excessive sensitivity (Hyperesthesia), loss of sensitivity to pain (Analgesia), abnormal sensations (Paresthesia) such as tingling. Rarely loss of vision or hearing may also present.

ii. Motor Symptoms: Hysterical Motor disorders also cover a wide range of symptoms. Hysterical paralysis are usually confine to a single limb such as an arm or a leg, and loss of functions usually selective. Tremors (Muscular shaking) and tics (Localized muscular twitches) are common. Occasionally there are flexion contractures of toes and fingers or rigidity of larger joints (Elbows and knees) which produce walking disturbances. Most common hysterical disturbances of speech are aphonea in which the individual is able to talk in whisper and mutism in which he can not speak at all. These persons are usually cough in a normal manner, while in laryngral paralysis both the cough and the voice are affected.

iii. Visceral Symptoms: These symptoms includes headache, obstruction in throat, shocking sensations, difficulty in breathing cold and calmly
extremities, nausea and occasionally hiccough. These are several criteria to distinguish between hysterical and organic disturbances.

1.16.2 AETIOLOGY (CAUSAL FACTORS)

This disorder is more commonly diagnosed in women and children. In the development of conversion patterns there are usually following events.

a. A desire to escape from unpleasant situation or avoiding everyday responsibilities.

b. To obtain sympathy and attention from others.

c. Under continued stress.

1.16.3 DISSOCIATIVE TYPE

Dissociative type of hysteria is a way of avoiding stress with gratifying needs. Dissociative pattern include amnesia and fugue status.

DISSOCIATIVE AMNESIA

The characteristic feature of dissociative amnesia is a loss of personal identity, so that the patient is unable to recall his/her name, address or other personal and family details. It may occur in neurosis, psychoses or brain pathology; where it generally involves an actual loss (not retained in storage) of memory. While in psychogenic amnesia, the forgotten material is still there beneath the level of consciousness. The basic habit pattern of patient, such as ability to talk and so on remain intact.
DISSOCIATIVE FUGUE

In this amnesia state the individual travel aimlessly many miles from familiar surroundings, this known as ‘fugue state’ and then days, weeks or sometimes even years later suddenly finds himself in a strange place, not knowing how they got there. During such dissociative reactions the individual appears normal and able to engage in complex activities.

DISSOCIATIVE IDENTITY DISORDER

Dissociative identity disorder commonly known as multiple personality disorder, its cause typically involves a traumatic event, usually during childhood physical or sexual abuse. People with Dissociative identity disorder have two or more distinct personalities, each personality conveys the sense of an integration of the way people think, feel, behave and appreciate of themselves.

DEPERSONALIZATION DISORDER

DSM-IV characterizes depersonalization disorders as a persistent. In this disorder person feels that his/her ‘self’ and reality is temporarily lost. Patients with depersonalization disorder feel that they are detached from their bodies and realize the unreality of the symptoms depersonalization is the feelings that the body or the personal self is strange and unreal.
DISSOCIATIVE TRANCE DISORDER

Trance disorders are altered states of consciousness. In this disorder patients lose usual sense of personal identity and awareness of their immediate surroundings on environmental stimuli, they have limitations in movements, postures and speech.

1.17 MANAGEMENT

Completing the physical and psychiatric assessment to rule out other organic disease initial management should concentrate on simple explanation and reassurance that the symptoms will go off with treatment. This involves identifying those factors, which precipitated the symptoms, and helping the patient to cope with them more adoptively. Reinforcing factors must be corrected in patients social network and modify the basic life style of the hysterical personality. Acute conversion symptoms can usually remove by hypnosis.

1.18 OBSESSIVE-COMPULSIVE DISORDERS

Obsessive-compulsive disorder is a type of neurotic disorder. It forms about 12-20 percent of the neurotic population.

Obsessional thinking, compulsive behaviour and varying degrees of anxiety, depression and depersonalization characterize obsessive-compulsive disorders.
Obsessive thoughts may center around a wide variety of topics such as concern over bodily function (to perform acts) attempting suicide, commenting some immoral activity. They are usually unpleasant violent and not carried out in action, they remain a source of torment to the individual.

Example 1. A farmer thought of hitting his son over the head with a hammer, though he loved his son very much.

Example 2. A prisoner thought about killing a hated guard and persistently think about brotherly love.

Obsessional rituals include both mental activities, such as counting repeatedly in a special way or repeating a certain form of words, and repeated senseless behaviour, such as washing the hands 20 or more times a day, and frequent returns to some act already performed to reassure that the act have been done right such as turning of the gate or water. Obsessional thoughts with fearful content (such as thoughts about knives) have been called obsessional phobias, so patient avoid to go in the kitchen. Anxiety is an important component of obsessive-compulsive disorders and obsessional patients are often depressed.

Obsessive-compulsive disorders must be distinguished from other disorders in which obsessional symptoms occur. The distinction from generalized anxiety disorder, panic disorder or phobic disorder should seldom be difficult provided when a careful history is taken. A strict routine of work
can be temporarily adaptive in a particularly difficulty stress situation this rigid pattern of behavior help to prevent anything from going wrong and hence provide some security and predictability. If slightest detail gets out of order, the individual feels threatened and anxious.

1.18.1 TREATMENT

Obsessive-compulsive disorder often runs a fluctuating course with long periods of remission. Depression disorder often accompanies obsessive-compulsive disorder and in such cases effective treatment of the depressive disorder often leads to improvement. This disorder can also be treated by the use of drugs.

Anxiety drugs give some short-term symptomatic relief. Antidepressant (clomipramine, fluoxetine) are effective in reducing obsessional symptoms. Drug treatment is indicated in obsessional thoughts without rituals.

1.18.2 BEHAVIORAL THERAPY

Obsessional rituals usually improve with desensitization technique and exposure to any environmental cues that increase them.

1.18.3 PSYCHOTHERAPY

Supportive interviews can benefit patients by providing continuing hope. Joint interviews with the spouse are indicated where marital problems are aggravating the symptoms.
1.19 TREATMENT

The treatment of neurotic disorder such as Anxiety, Phobia and Dissociative reactions is carried out with the systematic procedure of behaviour therapy. The procedure involves training in deep muscular relaxation, desensitization and cognitive therapy. The therapy has been described here under.

1.19.1 BEHAVIOR THERAPY

Behavioral therapy can be traced to Janet's (1925) methods of re-education which were used for disorders with a behavioral elements. It was well-known experiments on conditioning by Pavlov and on reward learning by Thorndike and others (Thorndike 1913) that provided a theoretical basis for a treatment based on experimental psychology. In the United Kingdom, Psychologist working at the Maudsley hospital applied learning principle to the treatment of individual patient's specially those with phobic disorders. In South Africa, Wolpe developed a treatment based on his experimental work with animals. He subsequently described it an influential book Psychotherapy By Reciprocal Inhibition (Wolpe 1958). This book was a landmark because for the first time, the clinician was offered a practical and widely applicable behavioral treatment procedure backed by a reasonably convincing theory, supported by results.
Behavior therapy is based on the principles of learning theory, particularly operant and classical conditioning. This therapy is most often directed at specific, delineated habits of reacting with anxiety to objectively non-dangerous stimuli such as phobias, compulsions, psycho physiological reactions and sexual dysfunctions and also consists of a number of treatment methods derived from research in experimental and social psychology. These techniques constitute a break with traditional insight therapy, emphasizing behavior rather than personality review and change.

Wolpe (1958) defined neurosis as learned behavior that is persistent and unadaptive and which is acquired in anxiety-generating situations. Historically, symptoms arise by training or trauma by purpose or accident during the life span of the individual who is more or less predisposed towards them. Behavior therapy emerge as a systematic and comprehensive approach to psychiatric (behavioral) disorders. Joseph Wolpe and his colleagues in Johannesburg, South Africa used Pavlovian techniques to produce and eliminate experimental neurosis in cats. From this research Wolpe developed systematic desensitization, the prototype of many current behavioral procedures for the treatment of maladaptive anxiety produced by identifiable stimuli in the environment. At about the same time a group at the institute of psychiatry of the University of London, particularly Hans Jürgen Eysenck and M.B. Shapiro stressed the importance of an imperical
experimental approach in understanding and treating individual patients using own control, single-case experimental paradigms and modern learning theory. The third origin of behavior therapy was the work inspired by the research of Harvard psychologist B.F. Skinner. Skinner’s students began to apply his operant-conditioning technology developed in animal-conditioning laboratories to human beings in clinical settings.

1.19.2 Cognitive Therapy

Cognitive Therapy—according to its originator, Aaron Beck—is “based on an underlying theoretical rationale than an individual’s affect and behavior are largely determined by the way in which he structures the world”. A person’s structuring of the world is based on cognitions (Verbal or Pictorial ideas available to consciousness), which are based on assumptions (Schemas developed from previous experiences).

According to Beck, if a person interprets all his experiences in terms of whether he is component and adequate his thinking may be dominated by the schema. “Unless I do everything perfectly, I’m a failure”. Consequently, he reacts to situations in terms of adequacy even when they are unrelated to whether or not he is personally competent.

Cognitive therapy is a short-term structure therapy that uses active collaboration between patient and therapist to achieve its therapeutic goals, which are oriented toward current problems and their resolutions.
Depressive disorders (With or without suicidal ideation) have been the main focus of cognitive therapy; however, cognitive therapy is also used to treat other disorders, such as panic disorder, obsessive-compulsive disorder, paranoid personality disorder and somatoform disorders.

1.19.3 Cognitive Techniques

Therapy is relatively short and lasts up to about 25 weeks. If a patient does not improve in this time, the diagnosis should be reevaluated. The cognitive therapy's approach includes four processes: eliciting automatic thoughts, testing automatic thoughts, identifying maladaptive underlying assumptions and testing the validity of maladaptive assumptions.

Eliciting Automatic Thoughts

Automatic thoughts also called cognitive distortions are cognitions that intervene between external events and a person's emotional reaction to the event. Every psychopathological disorder has its own specific cognitive profile of distorted thought, which if known, provides a framework for specific cognitive interventions.

Testing Automatic Thoughts

Acting as a teacher, a therapist helps a patient test the validity of automatic thoughts. The goal is to encourage the patient to reject inaccurate or exaggerated automatic thoughts after careful examination. The therapist
reviews the entire situation with the patient and helps reattribute the blame or cause of the unpleasant events.

**Identifying Maladaptive Assumptions**

As patient and therapist continue to identify automatic thoughts, there patterns usually become apparent. The patterns represents rules or maladaptive general assumptions that guide a patient’s life.

**Testing the validity of Maladaptive Assumptions**

Similar to testing the validity of automatic thoughts is testing the accuracy of maladaptive assumptions. Though cognitive therapy can be used alone in the treatment of mild to moderate depressive disorders or in conjunction with antidepressant medication for major depressive disorder. Studies have clearly shown that cognitive therapy is effective superior or equal to medication alone. It is one of the most useful psychotherapeutic interventions currently available for depressive disorders and shows promise in the treatment of other disorders.

**1.19.4 Systematic Desensitization**

Developed by Joseph Wolpe, systematic desensitization is based on the behavior principle of counter conditioning. Whereby a person overcomes maladaptive anxiety elicited by a situation or an object by approaching the
feared situation gradually and in a psycho physiological state that inhibits anxiety. In systematic desensitization patients first attain a state of complete relaxation and then exposed to the stimulus that elicits the anxiety response. Systematic desensitization is a method for breaking down neurotic anxiety in piecemeal fashion. In relaxation state the patient is exposed top a weak anxiety-producing stimulus for a few seconds. If the exposure is repeated several times the stimulus loses its intensity evoke anxiety. Later on ‘stronger’ stimuli are introduced with similar treatment. For example, when a child is afraid of pathing the sea, the parent will take him near the approaching waves and lift him up when a wave approaches then when the child has became comfortable about this, the parent encourages him to dip his foot into a wave and later his ankle and so on. During whole process the child is given his favourable eatables. Ultimately the child becomes able to play in the sea with pleasure. The systematic desensitization consists four steps:

1. Training of deep muscle relaxation

   The patient is asked to practice at home for 15 minutes twice a day. There is no necessary sequence for training the various muscle groups in relaxation but the sequence adopted should be orderly.
2. The construction of Hierarchies

An anxiety hierarchy is a list of stimuli on a theme ranked according to the amount of anxiety they evoke. The stimulus evoking greatest anxiety should be at the top of the list. Hierarchy construction usually begins at about the same time as relaxation training and is subject to alterations or addition at any time. The raw data from which hierarchies are constructed come from four main sources:

(a) The patients history
(b) Response to the willough by questionnaire
(c) A fear survey schedule
(d) Special proving into situations in which the patient feels unadaptive anxiety.

3. The subjective anxiety scale

Knowledge of the magnitude of the patient’s anxiety responses to specific stimuli is being indispensable to desensitization is introduced to the patients by addressing him as follows:

Think of the least anxiety provoking situation that you have ever experienced and assign to this the number 100. The unit is the sud (Subjective unit of disturbance). Use the scale after rating the items of the hierarchy according to the amount of anxiety exposed on the patient.
4. Desensitization Procedure: Counteracting anxiety by relaxation

The patient has attained a capacity to calm himself by relaxation using establishing hierarchies. Many of them are adequately calm when relaxation training has gone halfway or less. Desensitization programme makes it highly desirable for the patient to achieve a positive feeling of calm, i.e. a negative of anxiety.

Systematic desensitization works best when there is a clearly identifiable anxiety-provoking stimulus. Phobias, obsession, compulsions and certain sexual disorders have been successfully treated with the technique.

1.19.5 Jacobson's Progressive Muscular Relaxation Techniques

Relaxation means anything from engaging in sporting activities, watching television, to going on a holiday. In like manners anxiety can refer to hostile atmospheres, aversive feelings within the individual. However, from a scientific point of view, relaxation refers to the lengthening of skeleton muscle fibres, while tension refers to the contraction or shortening of muscle fibres. During muscular contraction glycogen, a form of sugar is broken down, heat is produced and fatigue products mostly lactic acid are formed the especially when the muscles are relaxed. However, if the muscles are held in a state of contraction for a long interval, the circulation is impeded.
and the fatigue products build up rapidly. Most people given regular practice can reverse long-standing maladaptive muscular habits.

1.19.6 Historical Aspects of Progressive Relaxation Training

It is generally recognized that there are two distinct phases in the history of relaxation technique.

The first phase began with the work of Dr. Edmund Jacobson in the field of relaxation therapy. His investigations began in 1908 in the laboratory at Harvard University. Further studies were carried out in Chicago at the university there and at the laboratory for Clinical Physiology. Jacobson’s results appeared in scientific journals and in 1938 he published a book entitled "Progressive Relaxation". Relaxation is the direct physiological opposite of tension or excitement; it is the best absence of nerve muscle impulses. Jacobson trained his clients to systematically contract and relax groups of muscles; by having them pay attention to and discriminate the subsequent sensations and relaxation they were able to almost totally eliminate muscular tension and to experience feelings of profound relaxation.

In the second phase Joseph Wolpe found that the generalized fears of the animals showed strong anxiety on the floor of laboratory. Wolpe compared these patterns of behavior with human neurotic patterns and realized that in
humans deep relaxation could be used to inhibit anxiety evoked by fear-arousing stimuli. The autonomic effects accompanying deep relaxation are diametrically opposed to characteristic of anxiety.

1.19.7 Benefits of Deep Relaxation

The potential advantages of relaxation are numerous. Burns (1981) has listed a number of these advantages. Some of which are briefly summarized below:

1. The general effects of stress may be dealt with more competently.

2. Stress-related problems such as hypertension, tension, headaches, insomnia may be eliminated.

3. Anxiety levels may be significantly reduced. There is evidence to show that individuals with high levels of anxiety will demonstrate the greatest positive physiological effect of relaxation training.

4. Preventive aspects of relaxation training are important, in the control of anticipating anxiety before anxiety-provoking situations, such as an important board meeting, a significant interview etc.

5. Relaxation should help to diminish the need to depend on stress inhibitors.

6. Vocational, Social and Physical skills may occur as a result of reduced levels of tension.
7. Fatigue due to prolonged mental activity and or physical exercise may be overcome more rapidly by using relaxation skills.

8. Self-awareness of one’s physiological state may be increased as a result of relaxation training.

9. Relaxation can be an aid to recovery after certain illness and surgery, it can raise the threshold of tolerance to pain.

10. Interpersonal relationships may be expected to improve, relaxed person in difficult interpersonal situations will think more rationally.

1.19.8 Relaxation Training

- Relaxation is a self-control method. It is an active coping skill to be practiced and applied to daily life.

- Relaxation is an active process, the individual gains control over himself by letting go. Stressful situations generally result in tightening the reins of control.

- During the basic stage relaxation should be practiced for at least 30 minutes each day; during the intermediate and advanced stages, it should be practiced for 15/20 minutes. Thereafter the skill should be maintained by practicing for 15/20 minutes, two or three times each week although the number of sessions will depend on the individual and the stressors encountered in everyday life.
• Relaxation may in some cases, serves as a part of a therapeutic programme which might also include cognitive restructuring, desensitization, biofeedback etc.

• In relaxation there may be a feeling of calmness and a less critical or demanding attitude and also used specifically to overcome a problem of insomnia.

• The setting where the relaxation is to take place is important, it will be difficult to learn to relax is an environment with extraneous noise. Although the eyes should be kept closed during relaxation the process may be facilitated if the illumination is kept low.

• High levels of tension can lead to rigid control. The over tense individual may have developed a pathological over awareness of anxiety-producing internal and external cues. Individual may have fears of losing control while learning to relax; this may manifest itself by the individual being able to relax to a certain stage and being unable to proceed beyond.

• While the muscles are beginning to unwind a number of unusual feelings may be experienced such as, heaviness in parts of the body, floating in the air, tingling sensations, sudden muscular contractions in relaxation process. They may be effectively overcome by opening the eyes, by breathing somewhat more deeply and by slowly contracting the muscles throughout the body.
• Concentration is a problem about which most people make comment. It is not possible to focus one’s mind on relaxation for a long period of time.

• When reading the instructions for the relaxation procedures it should will be observed that various groups of muscles are systematically tensed and relaxed; the tension should be released immediately and not be allowed to dissipate slowly.

• A valuable aspects of relaxation training process is to have the individual discriminate feelings of tension and relaxation in his muscles.

• The goal of relaxation is to remove excessive stress which may be interfering with the normal functioning of the individual.
Often the individuals may experience accession tension as the consequence of prolonged, unremitting stress over many years. More time and effort must be spent in relaxing these particular groups. Given adequate attention and patience the signs of tension should gradually dissipate.