# CHAPTER - I
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In the current world scenario of competition, the society is in a constant state of transition. Life today seems to be burdened by various kinds of stresses and anxieties. People are always on the move and have lesser or no time left to spend with their families, friends, or leisure activities with such busy life styles an individual tends to be emotionally and physically drained, sometimes even alienated or isolated. As a result problems related to the affect arise Besides this, they are prone to developing different psychosomatic disorders

The world of psychosomatic disorders again is an area comprising of an array of disorders. However, despite being classified under a common category of psychosomatic disorders, two disorders are observed to differ in characteristics Therefore, development of appropriate therapeutic packages will have to be founded on crucial understanding of the association between the disorder and various psychological variables affecting the same.

The present study attempts to highlight these differences Psychological stress or emotional responses to life stress can influence gastro-intestinal functioning in anyone and can create symptoms like ulceration, pain, altered bowel function etc. Associated with this are psychological disorders like anxiety, panic depression.

A major factor affecting such gastrointestinal and psychological disorders is 'affect'. The inability to verbalize emotions (affect), feelings and concerns can lead to increased symptoms and illness, resulting in reduction of the person's ability to cope. In today's world, the individual is torn between a busy life style on one hand and to communicate, relate, to others effectively, on the other. This has resulted in an increasing withdrawal of the individual in a shell, wherein it becomes difficult for him to express his emotions or feelings. This phenomenon is known as "Alexithymia".

Alexithymia, can lead to increased symptoms and illness, resulting in reduction of the person's ability to cope Besides this psycho-social consequences such as reduced sense of health and well being, constant concerns related to the symptoms and how to control them, problems with daily activities, inter personal relationship with family, friends and co-workers emerge.

In this study the psychosomatic disorders considered are gastro-intestinal in nature. The individuals afflicted by a gastro-intestinal disorder may differ in terms of the type of disease. One individual may be suffering from the acid-peptic disease while another may be suffering from irritable bowel syndrome. Both, these individuals might again be different in terms of their ability to verbalize emotions. There may be variations in terms of their personality anxiety levels and depression levels. Besides these, they may be different in their coping patterns at Physiological, Psychological and interpersonal level and also at socio-cultural level. Failures of coping effort will again be an obstacle in the individual's adjustment mechanisms

Having made these observations, it become imperative to understand the differences between the gastro–intestinal disorders falling in the same category. Why does one individual get afflicted by acid – peptic disease while the other suffers from irritable bowel syndrome ? Along with this it is also vital to understand these difference in terms of their association with various psychological variables that play major role in their causation and are also a consequence of the diseases.

The present research thereby becomes very relevant as it encompasses two major gastro-intestinal disorders quite commonly found and compares them on prominent psychological factors. This research does not delve into a cause – effect relationship as, all the variables are intertwined and overlap each other in some or the other manner. This research is a sincere attempt to understand how are Acid – Peptic Disease and Irritable Bowel Syndrome different. This, difference is studied on the basis of five major variables, viz., alexithymia (the inability to verbalize emotions), personality (Introversion-Extraversion, neuroticism dimensions), adjustment, anxiety and depression

# PSYCHOSOMATIC DISORDERS

The term "Psychosomatic", in a general way is used to refer to organic (somatic) diseases which are partly "non –organic" in the sense that in their etiology emotional factors are held to play a significant role. Sometimes, "Psychosomatic" is also used more loosely to refer to chronic organic diseases with a complex psychic overlay e.g. Tuberculosis. The etiology of such diseases is not very distinctly affected by psychic factors, however, the progress of which may be affected.

Traditionally, the medical profession has been concerned with physical illness and has concentrated research efforts on understanding and controlling the organic factors in disease In psychopathology, on the other hand, interest has centered primarily on uncovering the psychological and emotional factors that lead to the development of mental disorders. Today, it has been proved that both of these approaches are limited; although an illness may be primarily physical or psychological it is always a disorder of the whole person – not just of lungs or psyche, for example the individual is a psychobiological unit in continual interaction with the environment. An important part of this intersectional view is the emphasis given to the socio-cultural influence. The interdisciplinary approach to all disorders which fits relevant biological, psychosocial and socio-cultural data into a coherent picture is also referred to as psychosomatic approach.

Psychosomatic medicine emphasizes the unity of mind and body and the interaction between them. In general the conviction is that psychological factors are important in the development of all diseases whether that role is in the initiation, the progression, the aggravation or the exacerbation of a disease

or in the predisposition or the reaction to a disease is open to debate and varies from disorder to disorder. The term "psychosomatic" has become a part of the concept of behavioral medicine, which was defined in 1978 by the National Academy of Science as "The interdisciplinary field concerned with the development and integration of behavioral and biomedical science knowledge and techniques relevant to health and illness and the application of this knowledge and these techniques to prevention, diagnosis and the rehabilitation. Behavioral medicine, thus, is an inclusive term for the field of psychosomatic medicine.

In the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the term "Psychosomatic" has been replaced with the diagnostic category of "psychological factors affecting medical condition", earlier in the revised third edition i.e. DSM-III-R, it was called, psychological factors affecting physical condition

**A brief history of the concept of psychosomatic disorders :**

The history of psychosomatic medicine parallels the history of humankind. Representatives from both psychiatry and medicine have agreed for more than 100 years, that, in some disorders, emotional and somatic activities overlap Those disorders were first called psychosomatic by Johann Christin Heinroth (1818) when he used the term in regard to insomnia the work was later popularized by Maximilian Jacobi a German Psychiatrist. The number of disorders identified as psychosomatic gradually grew to include ulcerative colitis, peptic ulcer, migraine headache, bronchial asthma and rheumatoid arthritis.

**Classification of psychosomatic disorders :**

Psychosomatic disorders are classified according to the organ system affected and it seems that no part of the body is immune. In the APA, classification, ten categories of psychosomatic disorders have been listed. They are as follows :

***1) Psychophysiologic skin disorders :***

These include diseases related to the skin e.g. Neurodermatosis, Atopic dermatisis, eczema, Acne etc.

***2) Psychophysiologic musculoskeletal disorders :***

These include disorders related to the muscles and bones e.g Backache, muscle cramps, tension, headache etc

***3) Psychophysiologic respiratory disorders :***

These include disorders related to the respiratory system e.g. Bronchial Asthama, Hyperventilation Syndrome, Asthamatic whizzing etc.

***4) Psychophysiologic cardiovascular disorders :***

These include diseases related to the cardiac system (heart) e g. Hypertension, coronary Artery disease, congestive heart failure, cardiac Arrhythymia, Tachycardia, Migraine headaches etc

***5) Psychophysiologic haemic and symphonic disorders :***

These include the diseases or disorders occurring due to disturbances in the blood and lymphatic system.

6) ***Psychophysiologic gastrointestinal disorders :***

These include disorders of the gastric system e.g Peptic Ulcers (Acid Peptic Disease), Chronic Gastritis ulcerative colitis, irritable Bowel syndrome, Mucous colitis etc.

7) ***Psychophysiologic gentio–urinary disorders:*** These include disorders related to the urinary and reproductive systems e.g. painful menstruation disturbances in menstruation and urination.

8) ***Psychophysiologic endocrine disorders :***

These include the disorders related to the endocrine glandular system, e.g., Hyperthyroidism, Diabetes meltitus etc.

9) ***Psychophysiologic disorders of special sense :***

These include the disorders related to the sense organs, e g., chronic conjunctivitis etc

10) ***Psychophysiologic disorders of other types :***

These include the disturbances in the nervous system where in emotional factors play a significant role, e.g , multiple sclerosis.

The present research, however, does not delve into all types of psychosomatic disorders. It concentrates on having a comparison between two gastrointestinal disorders, viz, Acid Peptic Disease (Peptic Ulcer) and Irritable Bowel Syndrome. This comparison is based on various psychological aspects, viz, Alexithymia adjustment, personality, anxiety and depression

**Psychosomatic considerations in gastrointestinal disease:**

The term psychosomatic identifies a mind-body relationship, on emotional, conscious or self willed state accompanied by changes in visceral function. The latter are readily displayed in animals in situations of fear and anger and in association with food seeking and food consuming activities. In human beings, similar relationships occur, as exemplified by the diarrohea accompanying fright or the nausea and vomiting that may occur with the sight and smell of odious or offensive phenomena.

The neurophysiological basis of the visceral response lies in the visceral nervous system Historically, the efferent or motor nerves originating in the paravertebral ganglia and the cranial nerves were designated as the autonomic nervous system, which was further divided into a craniosacral (parasympathetic) and thoracicolumbar (sympathetic) division. Afferent or sensory fibres from the viscera are an integral part of the system, however, and evidence gathered during the last 50 years has shown that the hypothalamus and limbic system play important roles in coordinating afferent and efferent activity. (Fig. A).

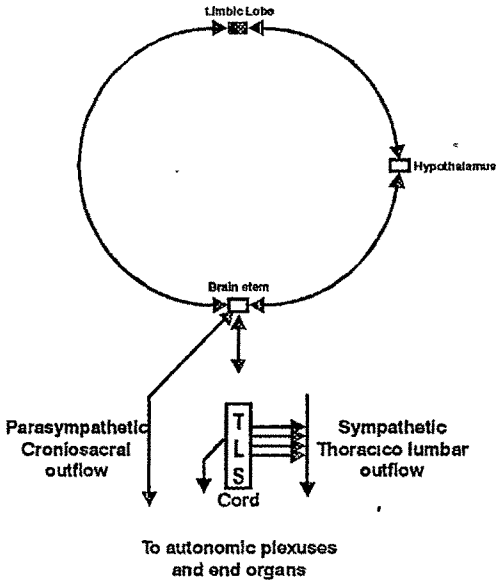


Fig. A. : A Diagrammatic representation of the visceral system showing the coordination between the limbic system and hypothalamus.

As shown in figure – A, the major issue involved is that of the choice of illness and choice of organ Why is it that some people cope with stress, conflict, anxiety, etc., by means of neurotic reactions while others, under similar circumstances develop psychosomatic symptoms? Even within psychosomatic symptoms individuals differ in the nature of disorders, depending on the type of organ, e.g One individual develops a psychosomatic cardiological disorder while the other develops a gastrointestinal disorder. Among gastrointestinal disorders again, individuals tend to differ in the type of gastrointestinal disorder. Hence this study becomes relevant in order to understand the differences between two psychosomatic disorders falling in the same category.

## ACID – PEPTIC DISEASE (APD)

Acid Peptic disease is commonly known as peptic ulcer disease A number of references to gastric ulcer existed for thousands of years, but duodenal ulcer seems to be a disease of the 20th century. In the first half of the 20th century, the understanding of Acid Peptic Disease was not very even and the diagnosis was largely either clinical or radiological. However, with the occurance of endoscopy in early 1970's, and the feasibility of target biopsy of the gastroduodenal mucosa, great strides were made in the accurate diagnosis of Gastric Ulcer and Duodenal ulcer, as well as the description of mucosal histological changes The focus of attention, however, was to understand the hormonal (gastrin) and neuronal control of acid secretion in the stomach.

Thompson (1996) has given very useful historical data regarding acid-peptic disease in his monogram, *"Ulcer story".*

Acid-Peptic disease is characterized by ulcers of the stomach (Gastric ulcers) and Duodenum (Duodenal ulcers). These ulcers are also known as peptic ulcers.

**Definition :**

***Peptic Ulcer:*** "Peptic Ulcers are circumscribed breaks in the surface of the gastrointestinal mucosa occuring in the areas bathed of acid-pepsin." (Thompson, 1996).

Acid and Pepsin indicated by the definition are the prerequisites for the development of Acid-Peptic Disease Hypersecretion of acid-pepsin leads to

greater risk for development of duodenal ulcer. However, sometimes it was observed that Gastric ulcer develops in individuals in whom acid-pepsin secretion was lesser than the mean value for normal subjects

Acute ulcers have not fibrous tissue reaction at the base of the ulcer. They may be superficial or deep. Basically, breaks in the Mucosa not penetrating below the muscularis mucosae are expressions, not ulcers. Chronic ulcers, on the other hand, consist of areas of fibrous connective tissue at the margins or base. This is explained diagrammatically below . (Fig. B)

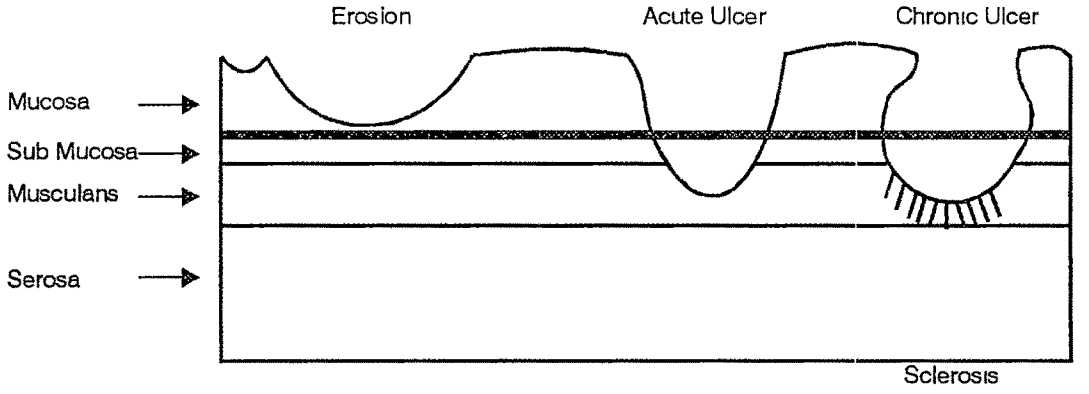


Fig B : Diagrammatic Illustration of acute and chronic gastric mucosal lesions. Modified from Sava, G. (1967) Franc Medicale, 30, 274.

Peptic ulcers can also be classified on the basis of the site where they occur : gastric, duodenal, jejunal (Occurring usually distal to the site of an anastomosis between the stomach and jejunum created surgically) or esophageal (occurring at the lower end of the esophagus). Rarely, Peptic ulcers also occur in the ileum, associated with acid-pepisn secreting mucosa in a Meckel's diverticulum The rapidly progressive and severe ulcer syndrome

associated with marked hyper gastrinemia (Zolinger – Ellison Syndrome) is a unique example of the corrosive action of excessive acid – pepsin.

***Symptoms and signs of Acid Peptic Diseases*** :

Acute Peptic ulcers become manifest in 85% of patients through gastrointestinal bleeding. While in others the manifestation of ulcers occurs through free perforation into the peritoneal cavity. The bleeding is observed as red blood or coffee ground material in Vomitus; or black or dark red stools. Perforation is accompanied by severe abdominal pain, vascular manifestations of shock and collapse, board like rigidity of the abdomen and loss of liver dullness The bleeding may be from one or multiple acute superficial erosions in the stomach or duodenum or an artery at the base of an acute duodenal ulcer.

Chronic gastric ulcers usually occur at the junction between pyloric and acid secreting mucosa (Oi, et al, 1959) Some kind of upper abdominal distress, often not described as pain by the patient, is usually present. The relation of pain to meals is not constant, but the pain may be aggravated by food or can occur shortly after eating. Relief is usually achieved by Alkalis. Pain that awakens the patient from sleep or radiates in the back often is an indication of a deep ulcer which penetrates into the adjacent organs. The cause of the pain is not known completely. Acid Pepsin must bathe the ulcer exposure of nerve endings to acid in the presence of inflammation results in the sensation of pain (Wolf, 1965) Bleeding and perforations may occur as in acute ulcers.

Chronic duodenal ulcer is characterized by epigastric pain when the stomach is empty, relief with food and alkali, and pain occuring in a cycle of days or weeks interspersed with months of freedom from pain. The latter are particularly common in the summer (Hall, et al, 1972). Failure of the pain to be relieved by food and alkali usually signals a complication such as posterior penetration into the pancreas (especially with radiation of the pain to the back) (Haubrich, et al, 1953) or stenois at the outlet to the stomach secondary to scar tissue or edema. Under the latter circumstances, the patient may resort to self – induced vomiting for relief Free perforation with diffused abdominal pain and abdominal rigidity occurs in about 3-13% of patients with peptic ulcer, whereas hemorrhage wit hematemesis and melena occurs in about 25% (Ivy, Grossman and Bachrach, 1950). Stenosis at the outlet of the stomach, known by the misleading term pylori stenosis, occurs in 2-7% (Haubrich, 1963) Visible peristaltic waves may be seen crossing the epigastrium from left to right in this complication. Shaking the abdominal or ballottement of the left upper quadrant, may elicit a succussion splash. The vomitus may contain undigested food recognizable as having been consumed the day before

The symptoms of peptic ulcers of the oesophagus differ from those described for the ulcers of the stomach and the duodenum Patients complain of dysphagia and heartburn as a result of reflux peptic esophagitis and stricture formation. In jejunal ulcer, the pain is often in the left upper guadrant of the abdomen, and there is little relief with food The ulcers of the Zollinger – Ellison syndrome are sometimes multiple, they may occur distal to the duodenal bulb and often appear shortly after gastric surgery for ulcer

Pain appears to be related to the bathing of the ulcer bed with acid pepsin and to contraction of smooth muscle. Anticholinergic medication inhibits secretion of acid-pepsin and relaxes smooth muscle while relieving pain.

In patients with uncomplicated duodenal ulcer, the physical examination shows only mild to moderate epigastric tenderness

**Etiology of peptic ulcer in humans :**

Acute peptic ulcers usually occur under circumstances of severe stress, such as after major surgical procedures, respiratory failure, severe burns etc. This also led to the coining of the term "Stress Ulcer" (Brooks, 1966). The ulcers are often multiple and occur in the stomach and duodenum with equal frequency Similar lesions occur after the ingestion of medications like acetylsolicylic acid or adrenocortico steroids in high doses. Sepsis may be an important factor (David, et al, 1971). Etiological factors demonstrated in human beings include :

1) Hyper-secretion of acid – pepsin.
2) Usage of pain medications such as aspirin or non-steroidal anti-inflammatory agents.
3) Anatomical predisposition of acid peptic disease in areas of junctional epithelium
4) Mucosal blood flow and hypoxia (Poor blood supply).
5) Defects in the normal gastric mucosal barrier which prevents the back diffusion of hydrogen on from the gastric lumen and permits the entrance of sodium from extra cellular fluid (Ivy, 1971)
6) Reflux of bile: An incompetent pyloric sphincter allows reflux of bile to occur into the stomach, this causes gastic ulcer.

7) Salivary secretion : The bicarbonate content and acid neutralizing capacity of saliva serves as a protection against acid- peptic disease.

8) Sex hormones : There is a relatively low incidence of acid – peptic in women especially prior to menopause or during pregnancy. It is also rare for a premenopausal woman with acid-peptic disease to sustain a perforation (Welsh, et al, 1960).

9) Socioeconomic influences : The incidence of ulcers is noted to be high in large modern cities. The incidence of ulcer is low in primitive races. Occupations also seem to affect the causation of ulcer. On the basis of general observations it can be said that there is few cases of ulcers in India villages or tribal areas.

10) Ulcers are Seasonal · They are more in spring than in summer or perhaps in winter

11) Diet· Law fibre diet and a spicy diet also causes ulcers.

12) Emotional changes : According to Spiro (1970) "The susceptible person with strong emotions and ardent feelings may not develop an ulcer unless he has had earlier ingrained in him some certain reaction pattern to specific emotions, or unless he less been trained at an early age to react to outside pressures and inside feelings with what his society regards as an appropriate manner" Urbanization and industrialization also lead to development of duodenal ulcers owing to the demands they make on the individuals. Ulcers also develop when the individuals as a group repress their emotions or tend at least to inhibit outward expression of strongly held feelings.

**Psychologic aspects associated with acid peptic disease :**

The relationship between physical disorders and psychological states has been an intriguing area of research for clinicians since a very long time. Psychosomatic disorders, hence were studied, as they seem to be affected directly by psychosocial factors. Advances in biological researches have led to a better understanding of the acid peptic disease. Various models have been developed to understand. The various aspects associated with acid peptic diseases.

***Psychosomatic Model :***

Franz Alexander (1931) was the first person to investigate carefully the role of psychological factors in patients with acid–peptic disease, Earlier, acid-peptic disease was known to develop in individuals with certain personality types, but there was no consensus about their characteristics.

Hartman (1932) observed that peptic ulcer type individuals feel compelled to overcome every obstacle. Unambiguous, apathetic, stoic men never had ulcers.

Draper and Touraine (1932) found in peptic ulcer patients a rejection of "Unconscious female tendencies" and classified them anatomically as asthenic or longitudinal in build.

Alexander (1950) and his colleagues observed that peptic ulcers as well as non specific gastric symptoms developed more frequently in particular personality types, however there were a large number of exceptions, so they did not make any generalization. It was found that there was a wish to be

dependent and cared for which clashed with the individual's pride and aspiration for independence and accomplishment. These opposing tendencies led to development of internal conflict, which become apparent. Many individuals had an exaggerated aggressive, ambitious and confident attitude. They denied taking help, and burdened themselves with too many responsibilities. However, on a deeper level, they wished to have passive, sheltered existence of a little child. Once severe ulcer symptoms developed, patients could acknowledge their wish to withdraw from the responsibilities.

Alexander (1950), further explained the mechanism by which the Psyche finds a somatic, physiologic outlet in the form of peptic ulcer He suggested that individuals regress psychologically to cope with the distress when they find the wish to depend on others unacceptable inherently, or when they get frustrated by external circumstances. Similar to the infants experience of hunger, which is eliminated by maternal feeding a wish to be fed becomes a symbolic substitute for the wish to be dependent and to be loved. This produces the essential psychosomatic transformation. "Psychic" hunger mobilizes the stomach into production of gastric acids. The stomach functions continuously as if the food is being taken in or about to be taken in This causes hypersectretion of gastric acid and hyper mobility and may lead to ulcer formation

Wolf and Wolff (1943) attributed the findings of hyperemia, hypermotility and hypersecretion in a patient with a permanent gastric fistual to hostile feelings which the patients were unable to express.

***Psychophysiologic Model :***

Weiner, et al (1957) conducted research on gastric acid hypersecretors and hyposecretors. They observed that it was possible to classify majority of hypersecretors and hyposecretors on the basis of their psychological profile.

Hypersecretors seemed to be more dependent in relationships, especially with authority figures. They were compliant, had a passive attitude, childish affect, greater need for tactile contact with others and more immature body images on human drawing tests. Hypersecretors an the other hand were more depressed and they somaticized less than hyposecretors who were more comfortable in expressing resentment and hostility.

However, Weiner and his group (1957) did not find support for the theory that specific personality characteristics of the patients who develop peptic ulcer disease cause gastric acid hypersecretion.

***Somatopsychic Model :***

Engel (1975) classified peptic ulcer patients into three types :-

a) Pseudo independent

b) Passive dependent

c) Acting out type

**Pseudo independent Person :**

The Pseudo independent person typically denies his underlying dependent needs and presents an opposite façade. He dominates or controls others and forces them to provide for his needs. His spouse is often a long suffering, self – denying provider. Thus he is successful in keeping his dependent needs out of conscious awareness.

**The passive dependent individual:**

He expresses his dependent needs directly and is aware of it Often he is fairly successful, outwardly passive, compliant and eager to please. But, he is also clinging and demanding. Hence he finds a nurturing parental figure or a supportive social organization.

**The acting out type**

This type of individual is insistent, demanding and immature He disregards everyone else Such as person's needs are paramount, often antisocial and irresponsible. He is prone to substance abuse and often is a drifter.

Engel (1975) has described these broad character types as vulnerable in their tendency to develop acid – peptic disease. However, he has also cautioned against overgeneralization. He has postulated that it is the somatic factor that influences the psychic development. While, the psychological factors define the social circumstances that prove stressful and activate organize process and ulcer formation However, timely corrective action and compensatory social circumstances may prevent the development of a vulnerable personality. Thus, the somatic factor, the psychological characteristics and the peculiar social stressors form the biopsychosocial substrate of peptic ulcer disease

***Biopsychosocial model*** *:*

Studies conducted by various researchers indicate that peptic duodenal ulcer is a heterogeneous illness Attempts to delineate the psychogenic factors

in the etiology of acid peptic disease have used advanced behavioral methodology.

Three major areas of research developed out of this

1) Personality and Psychological factors
2) Stressful Life Events
3) Biopsychologic interaction

1 ***Personality and Psychological Factors***:

According to many psychoanalytically oriented researchers, the psychosomatic individual's personality structure is very distinct from neurotic or psychotic patterns. As observed by Sifneos (1950) such individuals have difficulty in verbalizing feelings and have a decreased capacity to fantasize. They lack imagination and are poor in interpreting functions and symbolization. There is emotional rigidity and a tendency to introversion. Besides this the individual has a overt wish to be independent and covertly he needs to be passive. These characteristics are indicative of the "alexithymic" individual who is more prone to psychosomatic disorders (Nemiah J. C. and Sifneos P. E , 1970). Some investigators have attempted to link acid peptic disease with dependence, depression, hypochondriasis etc. However, it is not clear whether these psychological findings are the cause or the effect of the acid-peptic disease process

2. ***Stressful Life Events*** :

The role of stress in the pathogenesis and course of acute somatic illness has been studied in several psychosomatic diseases with both animal and human models Stressful life events in humans, usually assessed by

Holmes and Rahe's Schedule of Recent Life Events (Holmes, et al. 1967) have been correlated with increased physical morbidity. Besides this, while studying the role of stress in illness one should consider the patient's premorbid personality or coping style, his perception of the stressful event(s), and the availability of social supports, all of which may exacerbate or mitigate the physiologic response to stress.

Researches done in psychoneuro-immunology and psychoneuro physiology have shown the mediating mechanisms, that connect the psyche and soma, particularly the effect of stressful events in the evolution of physical illness Interactions and feedback loops (both direct and indirect) between the immune systems and the central nervous system have been found. Walker et al. (1957) found that in acid – peptic disease, catecholamines, carticosteroids, pepsinogen I and II, as well as direct vagal stimulation often acted as mediators between stressful events and ulcer formation Despite the inherent difficulty in measuring stress, the relationship of stressful life events with ulcer formation and gastric hyperacidity have also been studied. Thus, the earlier psychodynamic explanations of the role of personality factors in evolution of acid peptic disease are further supported by more scientifically based researches on the role of stress and coping ability.

3 ***Biopsychologic Interaction***:

After Weiner's (1957) original contributions, several other studies have focused o the role of biopsychologic interactions in acid peptic disease

Gundry et al, (1967) found that patients of duodenal ulcer could be classified into two groups:

a) Those individuals with low acid output who tend to be depressed.

b) Those individuals with high acid output and who tend to be anxious

Several other studies also support these findings and have also correlated Gastrin levels with personality factors like strivings for independence, achievement, expressively etc some studies done gastric emptying and gastric motility and their association with psychological characteristics have been less fruitful.

# IRRITABLE BOWEL SYNDROME

Irritable bowel syndrome is a major public health topic and receives much media attention in newspapers, magazines, radio and television. It is the most common functional Gastrointestinal disorder. Functional Gastrointestinal disorders are "Variable combinations of chronic or recurrent gastrointestinal symptoms not explained by structural or biochemical abnormalities In other words, these are the disorders for which a cause cannot be found even after performing blood tests, taking X-rays and examining the digestive tract with endoscopes. IBS is a functional disorder of the digestive tract. The term "Functional disorder is widely misused as a synonym for "imaginary disorder" Hence, patients with such disorders are often considered to be hypochondriacs, psychoneurotic or malingerous However, this is not the truth In fact, " functional disorder" means no more than a disorder of (physiologic) function, which is a normal manifestation of illness. The term is used to describe disorders of functions in which the pathophysiology and the underlying pathology remain unidentified When the cause of a "Functional disorder" is identified the name usually changes to reflect identification of pathology.

As the underlying pathophysiology of IBS is unknown. There are no specific diagnostic procedures for its identification. The diagnosis is mainly dependent on the symptoms. These include altered bowel function, abdominal pain, stool mucus distention and so on. Clinical impressions of psychoneuosis or at least unhappiness and dissatisfaction in patients with IBS were reinforced by a study that appeared to confirm a high incidence of psychiatric disorders in patients with IBS, leading, physicians to use the diagnosis in cases with a

combination of vague abdominal symptoms, minor psychiatric symptoms and an apparent absence of organic diseases

**Definition**

Irritable Bowel Syndrome is defined as "a condition of abnormally increased spontaneous movement (motility) of the small and large intestine, generally exacerbated by emotional stress".

IBS is a common disorder of the intestines, leading to crampy pain, gassiness, bloating and changes in bowel habits. Some people with IBS have constipation (difficult or infrequent bowel movements) others have diarrhea (frequent loose stools, often with an urgent need to move the bowels) and some people experience both. Sometimes the individual with IBS has a crampy urge to move the bowels but can not do so

IBS is also known by many names – Pylorospasm, spastic colitis, nervous, indigestion spastic color, intestinal neurosis, functional colitis, irritable color; mucous colitis, laxative colitis and functional dyspepsia.

Irritable Bowel Syndrome is usually diagnosed on the basis of altered bowel habits, abdominal pain, and the absence of detectable pathology painless (or Nervous) diarrhea affects nearly 10% of IBS patients and may be a separate variant because the patients seem to have different patterns of motility different personality types and the course of illness seems to be more directly affected by emotional stress The symptoms of IBS usually begin in the teenage years or in the early twenties, sometimes abdominal pain in childhood may also be related to later appearance of Irritable Bowel Syndrome. Nearly

half of the adults with irritable bowel syndrome have in onset of symptoms before the age of 35

It is found that there can be a history of disordered bowel habits in a close relative of patient with irritable Bowel Syndrome. Recurrent abdominal pain of childhood is commonly found in children whose parents have a history of bowel disorders. However, it is not clear whether this is caused by environmental or genetic factors.

**Symptomatic signs of irritable Bowel Syndrome**

Normal bowel function varies from person to person Normal bowel movement is one that is formed but not hard It does not contain blood and is passed without cramps or pain.

People with irritable bowel syndromes, on the other hand, usually have crampy abdominal pain with painful constipation or diarrhea. In some people, constipation and diarrhea occur alternately. Sometimes people with irritable bowel syndrome pass mucus with their bowel movements Bleeding, fever, weight loss and persistent severe pain are not symptoms of IBS but may indicate other problems.

There is diarrhea alternating with constipation for six months or more. The abdominal pain occurs after meals and is relieved by intermittent bowel movement. Along with this there is abdominal tenderness, fullness, bloating and swelling, abdominal distention. Besides these there is nausea, chest pain, vomiting, loss of appetite, pain in the pelvis, rectum or anus There may be Heartburn or Indigestion leading to formation of gas. The individual has trouble

in swallowing or there is a lump in the throat the individual has emotional distress and may be depressed.

The individuals having irritable bowel syndrome usually show a characteristic history of the disease. Various tests done do not reveal any abnormalities.

**Etiology of Irritable Bowel Syndrome**

Irritable Bowel Syndrome is not caused by infection, inflammation or blockage. Evaluation with X-rays, endoscopy, and blood testing usually fails to show any abnormally. However, various reasons seem to be causing this disorder.

1. ***Disturbances of the normal activity and function of the digestive tract:***

The normal movement of food contents through the digestive tract depends upon motility or peristalisis which is the rhythmic and orderly contraction of the muscles of the gut A disturbance in normal motility and peristalsis creates symptoms like cramping abdominal pain, diarrhea, constipation, and relief of pain with the passage of loose bowel movements

***2. Increased sensitivity to what is happening in the gut and abdomen:***

Many people with irritable bowel syndrome have enhanced sensation and perception of bowel function. They can feel things in their gastrointestinal tract, chest, abdomen and rectum that people without irritable bowel syndrome cannot. In other words, patients with irritable bowel syndrome have lower internal pain thresholds for reasons which are not understood.

3. ***Gut reaction to "triggers":***

The people with irritable bowel syndrome have a sensitive gastrointestinal tract, which can have a hyper reaction to things that activate or "trigger" pain and symptoms. These triggers may be in the form of foods, inflamation and infection seasonal changers, dietary substances caffeine, Drugs and Medications stress, Hormones (menstrual cycle and psychological problems.)

4. ***Problems related to the Brain Gut. Connection:***

The mind Body / Brain-Gut connection is a major factor affecting the irritable bowel syndrome there is a powerful "connection between the mind and the body/gut Gut sensations reach the brain the large circuit of nerves in the wall of the intestine, then to the spinal cord and finally the brain This transmission is bi-directional just like a two away street. The gut affects the brain, and the brain affects the gut.

5. ***Stress:***

Psychological stress or emotional responses to life stress can influence gastrointestinal function in anyone through the Brain-Gut connection and produce gastrointestinal symptoms such as pain and altered bowel function. But people with irritable bowel syndrome are more susceptible to experience symptoms which are more severe and occur more frequently. In brief, stress stimulates colonic spasm in people with irritable bowel syndrome.

6. ***Psychological disorders:***

Various studies conducted on Irritable bowel syndrome, have shown that people with irritable bowel syndrome who consult doctors for the symptoms are

more likely to have psychological problems than the people with symptoms who do not consult a doctor about them Thus, psychological disorders such as anxiety, panic, depression, somatoform disorders (unexplained bodily symptoms), a history of abuse (mental, emotional, physical or sexual), alcohol or substance abuse, or an eating disorder can lead to increased symptoms and illness thereby reducing the person's ability to cope

***7. "The Irritable Body" and Somatization:***

The Gastrointestinal tract is unusually sensitive and irritable in many people with irritable bowel syndrome Similar to this is the fact that these people have a sensitive "irritable body". In other words, what the doctors call "Somatization symptoms like painful tender muscles (Fibromyalgia) pain in the jaw, Pelvic pain, Fatigue and low energy, Dizziness, Chest pain, painful menstrual periods, insomnia, feeling faint, abdominal pain headaches, difficulty in concentrating, back pain, decreased sex drive, bladder problems etc. occur. These symptoms are associated with normal test results and cannot be explained by any specific disease process.

***8. Diet:***

Many people have reported that their symptoms occur following a meal eating causes contractions of the colon Normally, this response may cause an urge to have a bowel movement within 30 to 60 minutes after a meal. In people with irritable bowel syndrome, the urge may come sooner with cramps and diarrhea. The strength of the response is often related to the number of calories in a meal and especially the amount of fat in a meal. Fat in any form (animal or vegetable) is a strong stimulus of colonic contractions after a meal. Certain

medicines and foods like chocolate, during products, (cream, cheese, butter), vegetable oil, margarine etc. may also trigger spasms in some people.

**Psychological aspects of Irritable Bowel Syndrome:**

(Psychological symptoms and personality Traits in IBS).

Among the persons seeking treatment for irritable bowel syndrome, the symptoms of psychological distress are observed commonly. More than half of these patients are found to have a psychiatric diagnosis in addition to bowel dysfunction. Although a large number of patients with IBS have elevated scores on psychometric inventories, no specific pattern of psychological symptoms is found to be unique to the person Elevated scores of IBS patients were found from a medical clinic on the factors including somatization, depression, anxiety, interpersonal sensitivity and hostility.

IBS patients have been found to be significantly elevated on the Eysenck personality inventory. Studies have also indicated that psychiatric symptoms do not cause IBS but predispose persons with bowel symptoms to consult a physician

It was suggested by Lydiard, et al. (1986) that panic attacks are involved in the origin of the symptoms in certain people. This can not be true for a large number of people with irritable bowel syndrome because panic attacks are so frightening to the people when they occur that those are the symptoms usually emphasized by the person when they consult a doctor for treatment. Irritable bowel syndrome would therefore not be diagnosed if it occurred only in association with panic attacks

**Learned illness behavior:**

People with irritable bowel syndrome tend to report multiple somatic complaints. They have a tendency to score in the abnormal range on measures of somatization and hypochondriasis. Such people overutilize medical services, and also consult doctors more often for non-gastronitestinal complaints This pattern of multiple somatic complaints and overutilization of healthcare services is collectively known as illness behavior what causes the illness behavior? Studies have shown that the tendency to be preoccupied by several somatic complaints and to overutilize health care services is learned during childhood, as a result of the way parents behave in response to symptoms and as a result of the modeling that occurs when parents are ill themselves

Towards the end of the first year of life, the child can experience gratification with the act of defecation. Later on, how he views that process, will depend on the values his family and culture have imposed As he matures, the child learns to control his bodily processes. He also learns to differentiate himself from the world around him and can utilize this developing ability to withhold or expel stool to achieve this. He eventually develops a sense of right and wrong, learns to discipline his impulses and comes out of this period with a sense of autonomy If these tasks are not achieved, then he grows up to be more susceptible to those stresses with whom he is more likely to deal with by "letting go" or "holding back" of his stool. The presence of constipation or diarrhea may become unconscious modes of expressing forbidden impulses.

Thus, a pattern of childhood social learning contributes to the development of illness behavior in general and preoccupation with

gastrointestinal symptoms such as those involved in functional bowel disorders. These may be learned when parents respond specifically to bowel complaints to a greater extent than they respond to other types of somatic complaints

# ALEXITHYMIA

## Introduction

The term "Alexithymia' coined by Sifneos (1972) has been derived from the Greek language 'a' = Lack, 'Lexis = word and 'thymos' = emotion 'Alexithymia' thereby refers to a specific disturbance in psychic functioning characterized by difficulties in the capacity to verbalize affect and to elaborate fantasies. Psychoanalysts and psychotherapists depend upon affects and fantasies to understand the intra psychic lives of their clients, hence alexithymic individuals are poor candidates for insight – oriented psychotherapies Individuals with reduced emotion expressiveness and a limited fantasizing ability were described by psychotherapists long before the alexithymia concept was introduced and were referred to as people who are "not psychologically minded". However, very little though was given to know why they had this state of mind. It has been observed from psychoanalytic and neurobiological researches that developmental experiences and neurophysiological factors play a role in the etiology of alexithymia. (Taylor, 1984, 1986) Since style of communication are learned within a social context and as some languages cost limitations on the expression of emotion (Leff. 1973) it is vital to consider the socio-cultural factors also while evaluating the alexithymia construct.

## Definition :

Alexithymia refers to affective deficits in, differentiating, identifying and communicating one's feelings and to a cognitive style marked by concrete, utilization, externally focused thought rather than introspection, fantasy and day dreaming It is observed that the prevalence of alexithymia is substantially

higher among the patients who suffer from various pain, psychological and psychiatric disorders as compared to healthy control group individuals Besides this unlike the patients with obvious emotional distress and elaborate physical and psychological symptom, people with alexithymia have been described as "Pseudonormal" as they often seem to be conforming, complaint and rational. Also the interpersonal relationships of patients with alexithymic characteristics tend to be either overly dependent or aloof.

Sifneos (1970) used the term 'Alexithymia' to describe certain clinical observations on a variety of patients suffering from various psychosomatic diseases, but also occurring occasionally in normal individual's who are not sick Although the term was criticized by classicists, it was internationally accepted and presently very widely used

These observations were first made by Sifneos at the Massachusetts General Hospital of Harvard Medical school during the 1960's

**Clinical features of alexithymia**

As compared to neurotic patients, alexithymic individuals have no appropriate words to describe their feelings, and actually give the impression that they are devoid of them. They show a paucity of fantasy life, tend to describe endlessly symptoms or details surrounding a casual event, instead of the feelings which generally are anticipated to have been around to by French psychoanalysts as "Pensee operatorire". The alexithymic individuals tend to rush into action, cry copiously, assume rigid postures and have difficulty in communicating with people in general and with their interviewer in particular

These characteristics, howsoever, are not related to the social, educational or cultural background of alexithymic people

In case when someone insists to interview alexithymic individuals and asks them to describe their feelings, these individual's tend to become confused, irritable and defensive. They usually portray that they do not know what the interviewer means when he is persistent and keeps on questioning them about their fantasies and feelings sometimes they also are unable to distinguish between feelings such as sadness, anger, fear or joy and have difficulty locating in their body the sensations experienced by them

Besides this, such alexithymic individuals tend to parrot the words which are offered to them by the interviewers to describe feelings, but clearly they are not convincing in conveying the message that indeed such words are meaningful to than

**Table 1: Differences between Patients with Alexithymic and Neurotic defects**

| Alexithymic Individuals | Neurotics |
|---|---|
| 1. Presenting complaints<br>a) Endless description of physical symptoms, at times not related to an underlying medical illness | a) Less emphasis on physical complaints<br>b) Elaborate description of psychological difficulties (symptoms and/or interpersonal problems) |
| 2 Other complaints<br>a) Tension, irritability, frustration, pain, boredom, void, restlessness, agitation nervousness | a) Anxiety described in terms of fantasies and thoughts rather than in physical sensations<br>b) Depression described in terms of feelings of worthlessness, guilt, sleepless nights etc |

| Alexithymic Individuals | Neurotics |
|---|---|
| 3 Thought content<br>a) Striking absence of fantasies and elaborate description of trivial environmental details. | a) Rich fantasy life<br>b) Marked ability to describe feelings in eloquent terms |
| 4 Language<br>a) Marked difficulty in finding appropriate words to describe feelings | a) Appropriate in describing feelings. |
| 5. Crying<br>a) Rare<br>b) At times they cry copiously but crying does not seem to be related to an appropriate feeling such as sadness or anger | a) Appropriate to specific feeling |
| 6. Dreaming<br>a) Rare | a) Often |
| 7. Affect<br>a) Inappropriate | a) Appropriate |
| 8 Activity<br>a) Tendency to take action impulsively.<br>b) Action seems to be a predominant way of life | a ) Appropriate to situation. |
| 9 Interpersonal relations<br>a) Usually poor with a tendency of marked dependency or preference for being alone, avoiding people | a) Specific conflicts with people at generally good interpersonal relation. |
| 10. Personality make-up<br>a) Narcissistic, withdrawn, passive-aggressive, or passive- dependent, psychopathic | a) Flexible |
| 11. Posture<br>a) Rigid | a) Flexible |
| 12 Counter transference<br>a) The interviewer or the therapist is usually bored by the patient whom they find frightfully 'dull'. | a) Easy communication with patient whom the interviewer or therapist finds 'interesting'. |
| 13 Relation to social, educational, economic or cultural background<br>a) None | a) Considerable |

**Etiological theories :**

The purpose of these theories is to explain the etiology of the disease

The etiological theories related to alexithymia include :-

1) Genetic theories
2) Neuoanatomical – Neuorophysiological theories.
3) Developmental and/or socio-cultural theories
4) Psychodynamic theories

1) ***Genetic Theory***

It assumes that there is a strong hereditary predisposition to alexithymia and that genetic defects play an important role in the process of occurrence of alexithymia. Researches conducted by Heiberg and Heiberg (1977) in Norway give ample evidence regarding this. It was seen that monozygotic twins had higher concordance for alexithymic characteristics while the dizygotic twins did not share this finding

2) ***Neuroanatomical / Neurophysiological Theories***.

Researchers conducted by Mclean (1958) and other investigators as well as a further systematic elaboration by Nemiah (1977) suggested that due to deficits in the connections between the neocortex and the limbic system, emotions are expressed through the autonomic nervous system, and a discontinuity may take place in the functions of both systems.

The term of 'Functional Commissurotomy' was proposed by Hoppy and Bogen (1977). Their proposition was based on observations of patients with severe psychosomatic disturbances

Sifneos proposed that due to interruptions in limbic systems and neo-cortical connections, two things must occur (a) a hyperactivity of the autonomic nervous system and (b) presence of defects in the peripheral organs. As a result lesions and psychosomatic symptoms develop in alexithymic individuals Even if peripheral organ deficits do not exist individuals can exhibit alexithymic characteristics without suffering from psychosomatic illness.

3) ***Development and/or socio-cultural Theories***

Socio-cultural environmental or factors within a family system may play an important role in the development of an inability to learn to associate and to verbalize emotions with fantasies and thoughts. Thereby leading to occurrence of alexithymic characteristics, which later on predispose such individual's to the development of psychosomatic diseases.

4) ***Psychodynamic Theories***:

Alexander (1950) and McDougal (1974) and other psychoanalysts proposed that the specificity of psychological conflicts resulted from interactions between mother and child, and predisposed psychosomatic patients to using defensive mechanisms like excessive denial and regression. This led to their inability to fantasize and forced them to use, in a compensatory way, a concrete way of thinking, which Marty, et al (1963) called a *'Pensee Operatoire'*.

Krystal (1979) emphasized the importance of massive regression and proposed that it head to a primate state of functioning and played a significant role in the development of alexithymic characteristics.

Besides all these etiological theories, an important aspect was given by Freyberger (1977). This was the distinction of 'primary' and 'secondary' alexithymia. Primary alexithymia may occur due to a genetic, anatomical or bio-physiological defects which cannot be altered by therapeutic interventions. While secondary alexithymia may occur due to development, socio-cultural or psychodynamic factors.

**Therapeutic Implications:**

It is essential for a therapist to understand the nature and level of development of the individual's character along with the psychopathology underlying his difficulties. So, the psychotherapeutic interventions that can be given have to be divided into two major categories.

1) Supportive therapies, and
2) Dynamic therapies

Supportive therapies are most effective in cases where the individuals due to genetics, physiological and environmental limitations have failed to develop a mature character structure and do not possess adequate strength of character to face the vicissitudes of every day realities. The individual or group supportive interventions are basically anxiety suppressing and involve techniques like active reassurance, behavioral modification, environmental manipulation, meditation or use of psychotropic medication. Such type of intervention does not put stress on the underlying autonomic and peripheral defects and is ideal for treating primary alexithymic patients.

Dynamic therapies are based on psychoanalytic principles. They try to deal systematically with the psychological conflicts underlying the patients mechanisms which are used to handle them They instruct the patient to learn new ways to deal with their feelings. Transference interpretations are used as the main therapeutic tool within the context of therapeutic interaction. It is observed in follow-up interviews that insight and problem solving occur, this clearly shows that these individuals are just aware of their own psychodynamics' as their therapists have been These types of interventions are helpful with patients with secondary alexithymia.

**Therapeutic Research Findings :**

1) Individual or group supportive therapies in conjunction with psychotropic medication, environmental manipulations, behavior modification, techniques, relation and meditation were ideal for patients with alexithymic traits – Salminen J. K. et al (1980), Sifneos P.E. (1975).
2) Specific Techniques like guided teaching, concrete visual feedback and meditation along with group therapy are recommended for psychosomatic patients.
3) Another aspect of treatment to observe their feelings during the psychotherapy sessions and then to learn to tolerate, manage and finally verbalize their affects
4) There are many other viewpoints in dealing with the treatment of alexithymic psychosomatic patients However, one can conclude that any type of psychotherapeutic technique that is used for treating psychosomatic alexithymic patients should have a clear-cut description of criteria for selection specification of the technical interventions which have been

utilized and a systematic investigation of the therapeutic outcome in the long term follow-up studies.

The two decades between Horney's (1952) paper "The paucity of inner experiences" and the coining of the term "alexithymia" by Sifneos (1973) represent the evolution of a concept into a usable construct In the following two decades, the construct was refined and developed, notably by Taylor and colleagues (1992), with the construction of a valid reliable scale, that has gained widespread use. It is interesting that high alexithymia scores were found in patients diagnosed with sleep state misperception and the apparent paucity of REM sleep in some patients characterized as having alexithymia, but the relationship between REM sleep and TAS score is yet incomplete and such studies may add evidence to support a categories rather than dimensional approach to alexithymia A 5½ year follow-up study from Finland shows an increased death rate, particularly as a result of suicide or homicide, among middle aged men with high alexithymia There may be a considerable debate about whether alexithymia mediates the expression of physical illness or in some way contributes to the cause of some physical illnesses.

**Alexithymia and Physical Illness.**

Numerous studies document that alexithymia and physical illness are linked, although it is tempting to conclude that alexithymia causes or exacerbates physical illness, these studies demonstrate only a reliable association, there are in fact, several pathways potentially accounting for the relationship between alexithymia and physical illness.

Figure (A) presents a model of these pathways We view physical illness as a global concept comprised of two partially overlapping components organic disease and illness behavior. Organic disease includes the etiology, progression, exacerbation, and remission of tissue pathology, which is documented by laboratory tests or observable clinical signs. In contrast, illness behavior encompasses the subjective report of physical symptoms, behavioral expression of pain and disability and the seeking of medical care. Most somatic disorders include both organic disease and illness behavior. Many disorders, however, manifest illness behavior which is disproportionately greater than the extent of detected organic dysfunction (e g headaches, irritable bowel syndrome, fibromyaglia) and a few disorders are primarily organic without symptoms or disability (e g. silent cardiac disease, hypertension)

Alexithymia may influence organic disease and/or illness behavior through for mediating pathways : physiological; behavioral; cognitive or social. (Fig C)

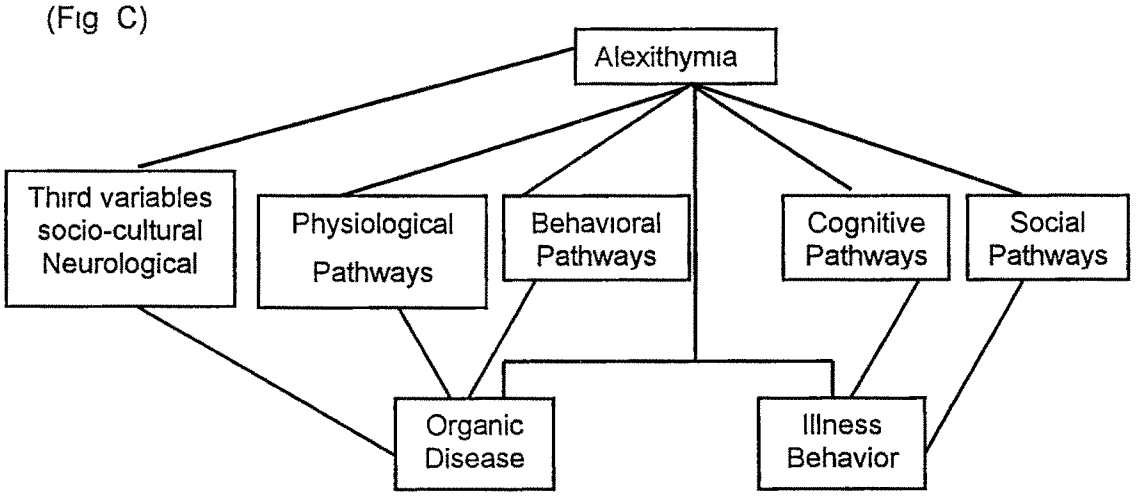


**Fig. C. Overview of various pathways linking alexithymia and physical illness adapted from Cohen and Rodriguez (1995).**

- The absence of arrows between parts of the model (e g from organic Disease to illness behavior) does not imply a lack of relationship

Physiological and behavioral paths affect organic disease, whereas cognitive and social paths affect primarily organic disease through physiological or behavioral paths. An alternative path views alexithymia as caused by physical illness The "third variables" are paths that view alexithymia and physical illness as related by the causal – influence of socio-cultural or biological factors These paths however are not necessarily mutually exclusive; each may be valid, and each should be evaluated for the role it may play in the link between alexithymia and physical illness

Researchers have attempted to assess alexithymia with numerous measures, which vary greatly in the degree to which they are supported by reliability and validity data In a comprehensive and critical review of most of these measures Linden et al (1995) concluded that the Toronto Alexithymia Scale (TAS) and the Beth Israel Hospital Questionnaire (BIHQ) are psychometrically the best alexithymia measures.

**Alexithymia Influences Organic Disease as under :**

1) ***Physiological Pathways:***

It has been hypothesized that alexithymic people have undifferentiated affect which is accompanied by physiological arousal. Because affect differentiation, elaboration, and regulation is impaired, the arousal remains active, potentially disturbing the autonomic, pituitary–adrenal, and/or immune systems, and eventuating in tissue pathology.

2) ***Behavioral pathway:***

Alexithymia may lead to organic disease, by prompting unhealthy behaviors such as smoking, substance abuse, poor nutrition, disordered sex, sleep loss, and nonadherence to medical regimens. It has been hypothesized that alexithymia may lead to addictive or compulsive behaviors because of the failure to regulate undifferentiated affect via healthy psychological strategies Also, disturbed self-object development may hinder viewing one's body as an integral part of one self, thus leading to a lack of self-care behavior.

There is a consistent evidence that alexithymia is related to some unhealthy behaviors, especially substance abuse and disordered eating preliminary evidence also suggests that alexithymia is associated with less use of psychological affect regulation methods in favor of engaging in active behaviors Yet it is not known whether compulsive, unhealthy behaviors result from failure to regulate affect psychologically, or whether alexithymia associated unhealthy behavior leads to organic disease

**Alexithymia Influences Illness Behavior as under:**

1) ***Cognitive Pathways***:

Several cognitive mechanisms can be hypothesized by which alexithyma may influence illness behavior People with alexithymia may be excessively aware of or attuned to their bodies, such that they notice otherwise common and benign sensations; or, the undifferentiated arousal that accompanies alexithymia which may generate somatic sensations In either case, alexithymic people may focus on and amplify those sensations, thereby increasing sensation magnitude through a positive, autonomic feedback loop. Amplified

sensations may be experienced as symptoms of physical illness, perhaps because of an attribution of sensations to biological rather than psychological or benign causes. Also, alexithymia may overlap with neuroticism or negative affectivity, which is the disposition to notice and complain about negative emotional and physical experiences, which would result in a response bias of excessive symptom reporting Finally, alexithymia may be associated with beliefs that encourage seeking of medical care.

Thus, there is evidence that alexithymia is associated with : a) neuroticism and related negative affect states, which increases the likelihood of somatic complaints (and perhaps of psychological attributes for physical symptoms,) of somatic functioning, which is manifest in discordance between physiological arousal and subjective reports

2) ***Social Pathways***:

Clinical observations of alexithymic patients suggest that they are boring, difficult to ally with therapeutically, and either overly dependent or aloof. If alexithymic patients do not indeed have impaired social functioning or deficient social support, then these deficits could influence disease indirectly, through physiological pathways (e g a lock of interpersonal emotion regulation opportunities or behavioral pathways, alcohol abuse, poor diet, or avoidance of care when one lacks a partner). More likely, however, is that disturbed social relationships directly influence illness behavior, by promoting complaints or disability, and/or altering health care behavior.

**Alexithymia is a product of disease :**

A different conceptualization of the alexithymia / physical illness link is that illness predates and leads to alexithymia. Physical illness clearly influences psychological functioning. Some organic conditions induce or mimic depression or anxiety, as do some medications or treatments. Similarly, some disorders cause disrupted activities, loss of control, social stigma, disfigurement, and/or loss of self-esteem, which singly or in combination can cause negative affective reactions

**Third variables causing alexithymia and physical illness**:

Associations between alexithymia and illness may be due to a third factor, or a confounder, which causes both Here, we are mainly dealing with socio-cultural and biological/genetic factors as potential third variables.

a) ***Socio-cultural factors***.

It has been suggested that cultures that do not value or teach introspection and emotional awareness lead to the development of alexithymia In particular, alexithymia may be more prevalent among the less educated or poor because cultural expectations, or exigencies of surviving daily life, discourage affective processing in favor of rational, externally oriented, problem – focused thought Because low economic status (SES) has known health risks (presumably due to poor nutrition, lack of medical care, the stress of poverty, increased conflict, etc). Low SES may create both alexithymia and illness. Although some of the variation in alexithmia may be due to socioeconomic factors, and low SES probably leads to poor health, there is as yet, no conclusive evidence that SES accounts for the relation ship between alexithymia and physical illness

b) ***Biological Factors:***

This pathway proposes that both alexithymia and physical illness are manifestations of some physiologically based abnormality. Alexithymia then, would result from an inborn biological source, and this factor would also give rise to physical illness. There is some evidence of altered hemispheric laterality and/or interhemispheric transfer associated with alexithymia; yet, for this pathway to be valid it would require that this same neuralgic condition creates physical illness, which is not likely. Thus, this pathway remains largely untested and probably implausible

The present study is an attempt to compare normal individuals with those having psychosomatic gastrointestinal disorders, specifically Acid Peptic Disease and Irritable Bowel Syndrome. Hence it becomes imperative for the researcher to discuss the nature and meaning of psychosomatic disorders Psychological variables, viz, Neuroticism, Extraversion introversion dimensions of personality, adjustment, anxiety and depression are also taken into consideration

# ADJUSTMENT

**The concept of adjustment :**

The concept of adjustment has its roots in biology. In biology, the term usually employed is "adaptation". Darwin's theory of evolution (1859) explains the process of 'adaptation' in an extensive manner. According to Darwin, only those species most fitted to adapt to the hazards of the physical world survived.

Biologists and Physiologists are still concerned with adaptation and many human illnesses are considered to be a result of Physiological process of adaptation to stress life. (Selye, 1956)

The biological concept of 'Adaptation' has been borrowed by Psychologists and renamed 'Adjustment' Adaptation and Adjustment together represent a functional perspective for viewing and understanding human behavior Among the various concepts that suggest themselves in a description of the vital phenomenon of adjustment, some concepts like 'regulation', 'co-ordination' and 'adaptation' are well established in most life sciences However, a major question encountered by psychologists is whether to follow the Newtonian or the Darwinian Paradigm or to follow the General Systems theory of Bertelanffy (1968)

In a general way, adjustment is a concept known to most of us There are however, different ways of adjusting, most of which a healthy body does for us automatically We must be more active in order to make a good adjustment to other people and to ourselves But what constitutes good adjustment is a matter on which people, including psychologists, differ. So, the main issue is

that, what constitutes good adjustment? The well-adjusted person is one whose responses are mature, efficient, satisfying and healthy The term "healthy" implies that the response is wholesome. To respond in totality is the most striking feature of good adjustment.

The well-adjusted individual reacts in an efficient manner to various situations and resolve conflicts, frustrations, special or marital problems and various other kinds of difficulties without the use of symptomatic behavior Hence, he is virtually bereft of disabling symptoms as chronic anxiety, obsession, indecision or Psychosomatic disturbances, that interfere with his moral, social, religious or vocational aims. Such a person thereby lives in or helps to construct an environment of interpersonal relations & mutual enjoyments which promotes continuous growth of the personality

**Definition of Adjustment :**

Different psychologists, biologists, mental hygienists and other behavioral scientists have described the word 'Adjustment' in many ways Some definitions are discussed below :

In a broad sense, Adjustment is defined as "the process of interaction between the individual and his environment for the sake of bringing harmony between them

According to Schneider (1955), "Adjustment is a process by which the internal demands of motivation are brought into harmonious relation with the external demands of reality". In other words adjustment is a process, involving both mental and behavioral responses, by which an individual strives to cope

successfully with inner needs, tensions, frustrations, and conflicts, and to effect a degree of harmony between these inner demands and those imposed on him by the objective world in which he lives.

Adjustment has also been explained in terms of the ways of getting along satisfying ones internal demands Adjustment, thereby is viewed not as a condition but a process in which changing forces call on the adaptive reactions which have certain elements of consistency that lead to stability in behavior

As defined by Symonds (1947) "Adjustment is a satisfying relation of an organism to its environment".

According to Lazarus (1976) Adjustment consists of "the psychological processes by means of which the individual manages or copes with various demands and pressures".

Another view on adjustment lays stress on the achievement of self acceptance, on freedom from internal conflicts, on self realization and on developing a unifying set of values which give life purpose and meaning Rogers (1961), has emphasized on the need for person's adjusting to himself, understanding his strengths and weaknesses, facing up to reality and achieving a harmony within himself.

Erich Fromm (1941) opined that there is also a social aspect of adjustment which requires the individual to achieve a reasonable compromise between his drive for self realization and the demands of society

According to Kaplan (1950) "A well adjusted person is one whose needs and satisfaction in life are integrated with a sense of social feelings and acceptance of social responsibility.

Thereby, 'adjustment' constitutes that process of life wherein the individual strives to attain an equilibrium between the demands of the inner self and the social culture to which he is exposed. This leads to the growth of the person's interpersonal, intrapersonal relationships and emotional health which in turn promotes effective adjustment.

When the individual makes the necessary changes to experience, the outcome is success, and satisfaction Thereby he makes a satisfactory positive adjustment. However, psychologists take into account both the overt and covert changes experienced by the person in their formative years Adjustment constitutes of social as well as personal experiences of the individual. These changes occur within the confines of the external environmental influences. Eventually these patterns of behavior make the person a well-adjusted individual or a maladjusted individual.

**Adjustment and Maladjustment :**

The desire to succeed in various aspects of life such as marriage, home, school, work place etc. motivates most of the people. When these efforts lead to a balanced relationship between the individual's wants and the environmental demands, thereby propelling him towards wholesome, constructive attitudes and behavior, the individual is believed to have gained good adjustment to life experiences. However, if the efforts are inefficient and not desirable, they will cause dissatisfaction and behavioral maladjustment.

Since adjustment may be good and bad, ineffective or damaging, the terms "good adjustment" and maladjustment are used. It is not the kind of behavior that determines whether we are dealing with adjustment processes, but the way in which behavior is used.

The concept of adjustment can be applied as long as the response serves to reduce or to mitigate the demands made of the person. When such responses are inefficient unwholesome that is detrimental to personal well-being or pathological, they are designated as "maladjustment".

Thus, adjustment by itself is neither good nor bad it is simply an organism's individual way of reacting to inner demands or external situations. In some instances the adjustment is efficient, wholesome or satisfying such adjustment is "good adjustment" While in those instances where the reaction is disabling ineffective or pathological it is termed as maladjustment.

**The concept of Good adjustment :**

Adjustment requires meeting personal or environmental demands in an efficient and wholesome manner. Thereby making wholesomeness the most characteristic feature of good adjustment. Adjustment may be viewed as good or poor depending upon the response given to the problem according to the level of development Adjustive responses are suited to man's nature, to his relations with his fellow given to the problem according to the level of development. Adjustment responses are suited to man's nature, to his relations with his fellowmen, and to his relations with god.

It is vital to understand that adjustment is relative and not absolute in character. It must be judged or evaluated in terms of meeting the problem appropriate to the level of development what is good adjustment at one age level may be poor adjustment at another. Thus growing up is a process of meeting stresses and strains in succession and thus building the capacity to meet the problems that are beyond the scope of adjective powers.

Another reason for adjustment being relative is that it differs upto a certain extent with the social and cultural norms. Besides this there are individual variations in behavior. There are many instances wherein even a well adjusted individual finds himself in situations or problems beyond his adjective powers, and when his responses may be unwholesome and inefficient The individual's needs are satisfied by interaction with the environment. The individual tries to obtain a harmonious relationship with the environment by getting along with its demands satisfactorily However an adjustment problem arises when the person is confronted by demands of the environment which he cannot fulfill or, when an environmental demand comes in the way of immediate or early satisfaction of his need Thus, adjustment comprises of the efforts of a person to satisfy the demands of his environmental situations along with fulfilling his personal needs To create a harmonious relation with the environment, the individual may use modes like adoption, mastery and conformity.

**The Adjustment Process :**

An individual is constantly affected by animate and inanimate factors in his environment. This phenomena is not a static one it begins right from

childhood The individual strives to attain self-realization security and self expression throughout his life His needs desires, feelings and ambitions are manifested through his overt behavior. These internal forces (needs, motives feelings and emotions) cause tension and disequilibrium within the individual. Thereby the individual is driven to explore various avenues to secure relief from tension. If these response are not in consonance with the environment then discontent resentment and maladjustment occurs.

The process of adjustment occurs when the individual's have needs or requirement and when they seek various modes to satisfy or fulfill these needs. When viewed from the angle of satisfaction of needs, the adjustment if considered to be a process of need satisfaction or need reduction while if seen from the angle of getting along with the environment in various ways then adjustment is considered to be the process of adaptation, conformity and problem solving

The term "Process of Adjustment" refers to the entire sequence from the time a need, tension or drive is aroused till the need is satisfied, there is reduction in tension or the drive is extinguished. According to this definition, the time span involved in the process of adjustment is not specified this time span way be either very short or long Besides, this the areas of behavior have not been given any significant. Thereby, the person's major need may be involved or it may be any insignificant area also.

An adjustment is process of interaction between ourselves and our environment This process may involve adoption or alteration of the environment The process of adjustment is also continuous. Neither the

individual his world is constant or static. Both are being acted upon and modified continually. Recognition of this process of continuous interactions emphasis that no human adjustment is ever complete or ideal. Besides this is a process of cause and effect relationships.

As explained earlier the process of adjustment has been explained through various viewpoints. Some view points emphasize internal adjustment, and self-realization, while others have stressed on the socio-cultural aspects In brief, each individual faces a continuous emergence of new requirements within himself and the environment Hence, he has to exert constant effort to maintain an equilibrium among these forces. Thereby the process of adjustment is never ending while life goes on

The process of adjustment has different phases Some authors have identified a few phases in this process, beginning when a need is felt and ending when the need is satisfied. The first phase consists of the drive or instigation factors. Here the individual is thwarted by some obstacle or circumstances, which prevents the fulfillment of his need. The second phase is the behavior of seeking effective solutions. Here the individual makes varied exploratory responses The third phase is that of attaining the goal and the fourth is that of the reduction of tension or the period of satisfaction However, these phases many a times cannot be distinguished clearly. Another aspect of these phases is that the needs of the individual may not be satisfied always and may lead to maladjustment.

Thus, adjustment is not a condition of happiness or contentment which can be earned and once earned, retained for life, like a college degree.

Adjustment is a dynamic process involving interactions between ourselves and the environment and has various other facts also

**Areas/Varieties of Adjustment :**

As we already know adjustment is process of continuous interaction with the external environment. Individuals react differently to their personal conflicts and frustrations and to the demands of the environment. Another aspect of the adjustment process is the situational context of the response How does the individual respond to his home and family ? to school? To himself? To his social environment?. These varieties of adjustment can be categorized into various areas such as home and family adjustment, social adjustment, emotional adjustment, Religious adjustment, marital adjustment etc Among all forms of adjustments there are important internal relations that mutually affect each other so that the process of adjustment is integral and total in nature. The major areas of adjustment are discussed here.

**Home and family adjustment :**

The home and family play a pivotal role in the life of all the family members The home and family involve a special group of relationships and situations which make them different from the social adjustment The family has to meet many cultural and personal needs of its members In order to help the individual attain his goals the family also has to maintain a congenial atmosphere. Adequate home and family adjustment is based on certain important requirements which also interact with others.

1 Wholesome relations among the members of the family group : Bad feelings between parents and children or between siblings make parental

adjustment to the home situation difficult. Negative feelings like favoritism, nagging, rejection hostility etc. should be avoided in order to meet the demands of family life.

2. The willingness to accept parental authority : Some parental authority is necessary for the stability of the family; to satisfy the demands of family life, children, must learn that parental authority and discipline are not only necessary but also desirable. Many empirical studies indicate that most adequately adjusted children have a sound attitude towards parental discipline

3. The capacity to assume responsibility and accept restrictions . Family members must take responsibility and accept the restrictions or limitations imposed by the home, so as to lead wholesome family life These restrictions and responsibilities are realistic aspects of normal family living thereby adjustments made to them should be in the interest of individual members as well as the family group.

4. Provision for self-expression : The family must provide opportunity for developing and strengthening the feelings of individual members. This can be done by developing mutual interest, cooperation, providing security and ample positive chances to utilize the abilities of individual members The family should develop the feelings of acceptance and also provide opportunity for close personal contact.

5. Gradual emancipation from the home and independence : A certain amount of family affection, warmth, acceptance and feelings of belongingness are

needed for a wholesome family life. However when these become too much emotional strangulation occurs. Thereby making it difficult for the persons involved to adjust effectively. Thus, parents too must emancipate themselves from the emotional bond with the children and allow them to be independent

**Social Adjustment :**

Social adjustment signifies the capacity to react effectively and wholesomely to social realities situations and relations, so that the requirements for social living are fulfilled in an acceptable and satisfactory manner

In other words "social adjustment" refers to the extent to which an individual and his associates are satisfied with the nature and amount of his social participation It involves maintaining harmony with one's social environment, by modifying the demands and the behavior of individuals interacting with each other. It also comprises of the need to recognize and respect the rights of other people in society. Besides this it is important to get along with other people and foster the development of lasting friendships in order to have effective social adjustment.

Interest in and sympathy for the welfare of other people also is an important aspect of social adjustment. Along with these one has to develop the capacity to respect the rights of others and to confirm to the laws, traditions and customs of the society.

This however does not mean that social adjustment is blind conformity. There are instances when social demands are not correct and the individual resists them with all the moral strength. Finally, if the basic principles and practices of the society in general are adhered to social adjustment is assured.

**Emotional Adjustment :**

An individual is pressurized by situations involving conflicts. Such situations lead to the building up of drives to resolve the tension. When the path to resolution is blocked, an emotional state develops. This emotional or internal stimuli involves widespread bodily changes, the sensations of which form a background against which the object or mental process causing the emotional state projects itself.

The emotional development of an individual is both affected by and affects the physical, mental and social growth. Besides these, glandular disturbances, excessive fatigue, organic illness and pathology, also are found to affect the emotional growth of the individual.

Emotional adjustment involves emotional adequacy, emotional maturity and emotional control. Emotional adequacy refers to the content and range of emotional responses When either of these aspects is distorted or inadequate emotional maladjustment will occur *Emotional maturity* implies the capacity to react emotionally with reference to the demands imposed by different situations. To react like a child in an adult situation indicates immaturity. *Emotional control* is that aspect of maturity, which requires self-control. It involves the regulation of feelings and emotions in terms of external and internal demands Lack of control indicates faculty, training, conflict, frustration

and psychological immaturity and tends to destroy emotional stability However excessive control does not mean rigidity of emotions.

Emotions that are very frequent, strong and persistent may lead to cardiac disorders, digestive disorders, and disorders affecting the bones, skin, muscle, sensory organs and respiratory system. It is also observed that emotional stress causes sleep disturbances, fatigue, constipation, diarrhea, ulcers and headache Besides these weight loss, and reduction of appetite are also found.

Emotional tensions cause inefficient behavior, instability mood swings and unpredictable, inconsistent performance. Despite the fact that strong emotions affect the growth of the individual and his social adjustments, their presence cannot be avoided from life They thereby form an inevitable and unseparable aspect of every individual's life.

**Theories of Adjustment :**

Human beings strive to adjust to their external environment and also to one another constantly. Glancing through history the process of adjustment has been explained and interpreted through various theories. The base for all these theories differs but all of them agree that the main goal of the adjustment process is the achievement of security adequacy and satisfaction.

**Psychoanalytic Theory :**

Foremost among the various theories of adjustment is the psychoanalytic theory. According to this theory all behavior mental processes, symptoms and adjustment mechanisms are determined mainly by psychic

factors instinctual drives, repressed wishes, complexes, of which the individual is unaware. Another important aspect is that of psychological dynamics. According to this the unconscious psychic factors function as powerful forces that demand expression in behavior or response of some kind. The responses occurring out of the unconscious drives are influenced by social or moral conditions and are manifested in the form of dreams, symbolic acts, neurotic symptoms or adjustment mechanisms like sublimation projection and rationalization. This is known as psychic determinism are further complemented by the theory of psychosexual development the psychoanalytic theory has various views as given by different psychoanalyst, right from Freud, Carl Jung, Alfred Adler, Otto Rank, Karen Horney and Eric Fromm.

**Behavior Theory :**

John Watson founded the school of behaviorism. This theory does not accept the psychoanalytic concepts of consciousness mind, the unconscious morality and free will according to behaviorism, all human responses are similar in nature. All the response are habitual There by adjustment is the process of adapting acquired behavior responses to the needs of the moment maladjustment occurs with the habits formed do not suit these requirements. Maladjustment is caused due to bad habits Thus for effective living and good adjustment it is essential to have proper conditioning from infancy. This approach has been largely rejected by contemporary psychologists for being unrealistic. However, this approach led to the better understanding of the role of environmental factors and conditioning in the process of adjustment.

Many other theories based on superstitions also evolved out of the individual's effort to attain security adequacy and satisfaction. Some of these are described as follows :

**The spirit theory :**

The primitive age of human development regarded the existence of spirits as the causing factor for every unexplainable natural phenomena According to the ancient man behavior was affected by the spirits. If the evil spirits were dominant then the behavior became strong, bizzare and unacceptable

The individual was guided by oracles in solving their problems. The responsibility of carving out his own future thereby, was not developed in the ancient era. This theory in the modern context seems highly vague, unacceptable and unrealistic

**The theory of Religion :**

According to this theory religion was the mode of explaining the various natural or supernatural phenomena The explanations for the various phenomena revolved around various deities or Gods

The individuals tried to please their Gods for solving various problems Such methods or rituals of propriating the Gods led to the feelings of security, adequacy and satisfaction Religion thereby has been more acceptable to the modern individual. Many people have made good and satisfactory adjustment to life on the basis of their religious beliefs However, such beliefs cannot be verified scientifically.

**Astrological Theory :**

During the middle ages astrological theories were derived from Astronomy. The astrological theory emphasized the effect of the sun, moon, stars and planets on the human adjustment behavior and personality the universe according to astrology is divided into twelve houses. The son the moon and the stars pass through these houses every twenty four hours. All this affected the individual's character, personality, behavior and especially his zodiac sign. Currently astrologers are seen to predict various things from the neurological, physiological or psychological terms (Medical Astrology). Millions of people take advise of astrologers in resolving adjustment problems even today

**Popular superstitions theory :**

According to this theory the occurrence of any phenomenon is affected by omens, signs etc.

A superstition is the belief that omens, signs or certain types of activity, can produce magical effect and can help an individual to adjust satisfactorily. Thereby, there is some magical power which helps an individual to satisfy his needs and solve his problems without his own efforts. Many times the existing situation is attributed to "good or bad luck" There are several instances even today when individual's wear special charms (Taviz) lockets or make some specific gestures to ward off "bad luck".

Thus, all the theories discussed above have made their own contributions into understanding the process of adjustment. But, none of them can individually explain adjustment process

**Feelings and emotions in relation to adjustment :**

In order to understand the dynamics of adjustment it is vital to know the relation between affective states adjustment and mental health. The important affective states or feelings comprise of the following feelings.

1 Feelings of inferiority and inadequacy

2. Feelings of guilt

3. Feelings of rejection, worthlessness and not being wanted.

4. Feelings of insecurity.

5. Feelings of resentment, hostility and hatred.

6 Feelings of anxiety

7. Feelings of dependence

8. Feelings of frustration

Every feelings mentioned above plays on important role in the process of adjustment and mental health. When the needs and desires of an individual are blocked feelings of various kinds emerge. These feelings, act as intermediary dynamic forces in the development of inadequate adjustive reactions, restrictive personality characteristics, or mental instability.

Emotional disturbance has similar effects due to the disruptive influence of emotions on mental processes and behavior Emotions are psychophysical in nature They are hence prone to influence physical processes and to disturb the mental stability of the individual.

The individual's mental processes are disrupted by the intense emotional reactions Attention perception, judgement and reasoning capacities are adversely hit and disorders of association, delusions, hallucinations and

illusions may develop Besides, these disruptive effects are carried over into the behavior of the person and impair his adjustment to reality.

Intense emotional reactions are those that fail to find adequate lead to the development of psychosomatic disorders. Peptic ulcer, high blood pressure and gastro intestinal disturbances are typical symptoms of emotional disturbance. The emotions have deep in the glandular and autonomic nervous systems When, they are not allowed to have a normal outlet they lead to severe physiological disturbances. Hence, psychosomatic symptoms develop. But, this is true for excessive abnormal or pathological emotions and not to normal emotions.

The emotional adjustment is equally dependent on the capacity for normal expression as on the control or inhibition. The total suppression of emotion in itself also is pathological. Thus, whether normal or pathological, emotions play a dominant role in reinforcing the dynamics of behavior

**Characteristics of the well-adjusted person :**

Adjustment is a dynamic and continuous process. Every individual is faced by a different demand either internal or external at varying times. He tries to resolve and satisfy them in different ways, depending upon his abilities There are a few basic characteristics that identify a well-adjusted person. These have been discussed below :

1. ***A sense of individuality :***

A well- adjusted person has the capacity to conform to the norms of the society However, he also has a sense of individuality. He is capable of deciding when it is undesirable for him to confirm.

2. ***Self-knowledge and Acceptance :***

The well adjusted individual knows his capabilities and limitations. This is necessary to meet the demands made on the individual, to resolve conflicts and frustrations and to deal effectively with problems and situations so as to achieve or promote good adjustment. The individual also has an awareness regarding his basic motivations.

3. ***Confidence :***

Lack of confidence for one's own self hampers the individual's development. Besides this the social relationships are affected. In order to share warm and congenial relationships one must have confidence in both others and own self.

4. ***Sense of security & responsibility :***

A strong sense of security arises when an individual receives love and acceptance in proper amounts. An insecure individual is full of self-doubts, apprehension and distrust. On the other hand, the secure person is confident and able to satisfy his emotional needs

A well – adjusted individual takes responsibility for himself & others as well

5. ***Well-defined goals and goal orientation :***

A well-adjusted individual has realistic goals. Such a person acts with direction, purpose and organized effort. A realistic goal, leads to the development of the hope of attaining it. This causes reduction of tension

6. ***Values and philosophy of life :***

The philosophy of life or valves refer to a set of ideas, truths, beliefs and principles that guide the person in his thinking, attitudes and relations to himself and others, in his perspective regarding reality and his social, moral and religious behavior. A persons philosophy of life determines how he evaluations his obligations and privileges with respect to himself, society and God.

7. ***Adaptability :***

An individual having good adjustment is adaptable. He has the capacity for change according to the demands made upon him.

8. ***Adequate orientation to reality :***

A well – adjusted individual has a realistic attitude. Thereby he accepts reality as it is rather than in terms of what he wishes or fears.

9. ***Orientation to time :***

For some people the only worth-while aspects of life are those that are a part of the past. For them the present and future are not pleasant while there are some other people for whom the present is most important. Some individuals on the other hand hold future as the most important reality Such excessive dwelling on one point causes maladjustment An well-adjusted individual hence does not stagnate at one point

10. ***A problem solving attitude :***

A well-adjusted person solves his problem very scientifically. He is able to define and analyze the problem. He can evaluate different modes to solve the problem. Finally he can select the best chance of solving the problem.

# PERSONALITY

Individuality is an outstanding characteristic of man Every person is a unique creation of forces of nature separated spatially from all other men. He behaves throughout his own particular span of life in his own distinctive fashion.

The word "Personality" is used both by laymen and professionals. Everywhere it is used with a different meaning. In common speech it usually refers to one's public image. Sometimes if a person seems to be quite impressive then he is said to be having a good personality We all tend to make personality judgements about the people we know. Often we make personality judgement and impressions about the personality of people we do not know, but have only read about the term 'Personality' many a times indicates that the person is unusual. Others might use the term personality to refer to public figures, 'as in a major television personality' or to compliment or insult someone, as in 'she has lots of (or absolutely no) personality. "These everyday usages of the term personality are quite different from the meaning attributed to it by psychologists even, within the realms of psychology, the task of defining personality is not very easy. Various definitions of 'Personality' therefore are found to exist

**The definition of Personality :**

The terms 'Personality' in English, 'Personnalité' in French and 'Personalichkeit' in German closely resemble the 'Personalitas' of medieval Latin. The word 'Personality' is derived from the Latin work 'Persona' which refers to the masks that actors wore in ancient Greek plays

There is little common agreement among personality theorists on appropriate use of the term personality.

According to C.G. Jung (1939) 'Personality is the integration of the ego, the personal unconscious, the collective unconscious, the complexes and the archetypes.

Alfred Adler has described personality as the 'Individual's style of life, or characteristic manner of responding to life's problems, including life goals. (Ansbacher, 1984).

As defined by Murray (138) personality is 'the continuity of functional forms and forces manifested through sequences of organized regnant processes and overt behaviors from birth to death".

According to Raymond Cattell (1950), "Personality is that which permits a prediction of what a person will do in a given situation".

Freud (1923) has defined personality as 'the integration of the Id, the Ego, and the Superego."

Skinner (1953) the leading heir of behaviorist position, believed that the term "Personality" was ultimately superfluous, as overt behavior can be completely comprehended in terms of responses to factors in the environment theorists like Sheldon (1944) have emphasized temperament as the core of personality.

Hans Eysenck (1970) has defined personality as "a more or less stable and enduring organization of a person's character, temperament, intellect and physique which determines his unique adjustment to the environment".

Walter Mischel (1986) has mentioned both inner process and behavior in explaining personality. According to him personality consists of "the distinctive pattern of behavior (including thoughts and emotion) that characterize each individual's adaption to the situations to the situations of his or her life".

The most widely accepted and popular definition of personality was given by psychologist Gordon Allport (1937) According to Allport 'Personality is the dynamic organization within an individual of those psychophysical system that determine his unique adjustment to his environment'.

Regardless of the differences in defining Personality, there is a certain degree of agreement among the psychologists in considering personality as an integration of traits that can be investigated and described in order to render an account of the unique quality of the individual

Personality has been studied in a number of different ways. Some have developed broad theories to explain the origins and make – up of personality Others have focused only on issues like influence of heredity on personality

**Theories of Personality:**

The approach of theory construction, was popular for many years. As an outcome of that a variety of personality are found to be existing Most of these broad theories can be grouped into the following categories.

a Type and Trait Theories

b. Dynamic theories (Psychoanalytic and Neo Psychoanalytic)

c. Learning and Behavioral theories

d. Humanistic theories

e. Cognitive theories

f. Existential and eastern theories

a **Type and Trait theories of personality**:

Type and Trait theories of personality both focus on people's personal characteristics However, various type and trait theorists differ in the ways they use those characteristics to describe people

***Type Theories***:

The very nation of classifying people into types is one of the oldest ideas about personality. One of the earliest efforts to describe personality in terms of disposition was made by the Greek physician Hippocrates in 400 B. C He suggested that personalities could be classified according to a predominance of certain body fluids or humors. A predominance of blood led to sanguine temperament cheerful, vigorous, confident, optimistic. A predominance of mucous led to the phlegmatic personality–slow moving, calm and unexcitable. A predominance of black bile led to melancholic or depressed personality, whereas yellow bile caused volatile or not tempered choleric personality. A type is simply a class of individuals said to share a common collection on of characteristics. The groupings or sets of types are known as typologies

Neuroticism stability, Introversion and extraversion are the dimensions of personality and these tendencies are found in the persons who are neurotic,

introverted and extroverts respectively. Carl Jung (1933) tried to explain behavior on the basis of two basic attitudes four functions, or ways of perceiving the environment and orienting experience. The two basic attitudes described by him were introversion and extraversion. The four functions were grouped into opposite pairs. These functions are as follows

***Sensation and intution***:

These functions refer to how we gather data and information. The sensor is more comfortable when using the five senses and dealing with facts and reality The intuitor looks for relationships and meanings or possibilities about past or future events

***Thinking and feeling***:

These functions refer to the manner in which we use logic and impersonal analysis. The feeler is more concerned with personal values, attitudes and beliefs.

Extraversion, according to Jung is an attitude wherein the psyche is oriented outward to the objective world. The extravert tends to be more comfortable with the outer world of people and things.

Introversion is an attitude in which the psyche is oriented inwards to the subjective world. The introvert is more comfortable with the inner world of concepts and ideas.

Jung believed that medical experiences have taught us that there are two large groups of functional nervous disorders. One group comprises of all those forms of disease which are designated as hysteria, while the other group

comprises of all those forms of disease which the French school designated as psychasthenia The hysteric belongs to the type of extraversion and the psychasthenic to the type of introversion.

He further says about the nature of extraversion and introversion, "When orientation to the object and the objective facts is so predominant that the most frequent and essential decisions as well as actions are determined, not by subjective values, but by objective relations, one speaks of the extroverted attitude When this becomes habitual one speaks of the extroverted type." "Unlike the extraverted type the introverted type is prevailingly oriented by subjective factors Introverted consciousness doubtless views the external conditions, but it selects the subjective determinants as the decisive ones.' (Jung, 1933).

**Introversion – Extraversion Dimension and the thought process:**

There exists among the introverts, a tendency of exaggeration of thought processes. This is in associated with directly observable social behavior. Besides this the tendency to withdraw from social contacts also exists While among the extroverts there is a diminution of the thought processes in relation to directly observable social behavior with an accompanying tendency to make social contacts. The essential sign of the extreme introvert is

(i) The internal activity of the brain.

(ii) The control and modification of urge by cerebral processes of the highest level.

In introversion a delayed response pattern, inhibition of overt emotional expression and withdrawal from social contacts, is found. The introvert has a more subjective outlook while the extravert has a more objective outlook

The introvert shows a tendency to self-control (inhibition), while the extrovert shows a tendency to lack of such control. There is heightened degree of cerebral activity in introverts while the extrovert demonstrates a higher degree of behavioral activity.

**The Extraverted and introverted Types :**

Jung had combined the attitudes of introversion and extraversion and the four functions, to form eight psychological types These are described as follows:

I) **The Extraverted Types**: Four of the types are extroverted These include :

(i) ***Thinking:*** Such individuals tend to live according to fixed rules. They repress feelings and try to be objective but are sometimes dogmatic in their thinking.

(ii) ***Feeling :*** Such individuals are sociable people who seek harmony with the world. They respect tradition and authority. They also are emotional, as the thinking is repressed

(iii) ***Sensing:*** Such individuals seek pleasure and enjoy new sensory experiences. They are strongly oriented toward reality and repress intution.

(iv) ***Intutive:*** Such individuals are very creative and find new ideas appealing. They tend to make decisions based on intutions

(hunches) rather than facts and are in constant touch with their unconscious wisdom They repress sensation.

II) **The Introverted Types:** The other four types, that are introverted include :

(i) ***Thinking:*** Such individuals have a strong need for privacy. They tend to be theoretical, intellectual and somewhat impractical These individuals repress feelings and may have trouble getting along with other people

(ii) ***Feeling:*** Such individuals tend to be quiet, thoughtful and hypersensitive. They repress thinking and may also seem to be mysterious or indifferent to others.

(iii) ***Sensing:*** Such individuals tend to be passive, calm and artistic They focus an objective sensory events and repress intution.

(iv) ***Intution:*** Such individuals seem to be mystic dreamers who come up with unusual new ideas and are seldom understood by others sensing is repressed in them.

Jung opined that the types as cited above rarely occur in a pure form. There may be a wide range of variation with each type. People with specific type may also change as changes occur in the collective unconscious However, they will not change to another type.

**Myers-Briggs Type Indicator (MBTI)**

The Myers-Briggs Type Indicator (MBTI) was developed by Katherin C. Briggs (1961). It was especially designed to make it possible to test Jung's theory of psychological types (Jung 1921/1971). The essence of the theory

states that much seemingly random variation in behavior is in reality quite orderly and consistent. It is due to the basic differences in the way individuals prefer to use their perception and judgement. It is assumed, that if people differ systematically in what they perceive and in how they reach conclusion, then it is quite natural for them to differ correspondingly in their reactions, various skills, etc

The MBTI is based on Jung's ideas about the perception and judgement and the attitudes in which these are used.

**Identifying the MBTI Preferences**

The main objective of the MBTI is to identify four basic preferences The indices Extraversion-Introversion (EI), Sensing-Intuition (SN), Thinking-Feeling (TF) and Judgement-Perception (JP) are not designed as scales for measurement of traits or behaviors. Every individual is assumed to use both poles of each of the four preferences However, they respond first or most often with preferred functions or attitudes.

Since people do not fall naturally into distinct personality types, psychologists developing type theories have to take special steps. One such approach has been to develop theories about specific types by treating each type as a personality dimension Individuals can then be scored or rated to known their position on each dimension. This approach has been used by H. J. Eysenck to establish his hierarchical theory Eysenck (1967) identified two main dimensions of personality viz. Extraversion introversion emotionality stability vs neuroticism. The extraversion introversion dimensions are specifically discussed in the later portion of this chapter.

A second general approach to personality types involves specifying certain key characteristics or extreme scores that must be manifest before any individual is said to fit the type. The people who do not fit the type are simply ignored and attention is focused on the relatively "pure" cases who fit the criteria for the particular type or "strike zone". This approach is commonly used in diagnosing psychological disorders

**Trait theories**:

A trait is a tendency to behave in a relatively consistent and distinctive way across situations. Gordon Allport (1937) described that the English language comprised of about 18,000 trait like terms – terms that designed "distinctive and personal forms of behavior". Some of these terms reflect personality traits. Allport (1961) believed that those 'Traits' or 'dispositions' could describe an individual's uniqueness at three levels of generality.

Allport judged people's traits as being Cardinal, central or secondary by examining their personal documents such as letters and diaries. Allport by using traits to described the uniqueness of individual's had subscribed to the idiographic approach. This approach comprises of the psychological study of the individual This is done to understand the varied aspects of an individual's behavior This approach involves a search for consistencies within particular individuals

Allport differentiated between closed systems and open systems of personality. The closed systems are continuous and admit little change. While the open systems are discontinuous and give ample opportunities for extensive growth He coined the term 'Proprium' which referred to the central experience

of self awareness that a person has in growing and moving forward Closely, associated to the concept of proprium is his concept of functional autonomy. It implies that adult motivation is not necessarily attached to the past experiences He described two levels of functional autonomy. Perseverative and propriate.

Allport, found that the neurotic and healthy personalities had a severe discontinuity between them. While describing the healthy personality he explained six criteria of maturity (1961) these are,

1. Extension of the sense of self
2. Warm relating of self to others
3 Emotional security (self – acceptance)
4 Realistic perception, skills and assignments
5 Self objectification (Insight and Humor)
6. Unifying philosophy of life.

Thus for Allport personality is dynamic, organized psychophysical, determined and characteristic

Henry Murray (1938) made a significant contribution to the study of personality he constructed a thorough list of twenty basic human needs. He also developed several techniques for assessing personality. The best known and widely used is the thematic apperception test (TAT). Murray has also gave the concept of press, which is a force from the environment either helping or hindering an individual in reaching goals.

William Sheldon (1954) used extensive correlational studies to classify people by body types that were thought to the closely linked to temperament

types He developed the "Psychometric Trait Theory". According to which, the plump "endomorphs" tend to be relaxed and easy going the muscular "mesomorphs" are more energetic and aggressive and the thin "ectomorphs" are high strong and solitary. Although Sheldon's research yielded strong positive associations between body and temperament types, other reserachers have found merely positive but weak associations suggesting that such temperament types tend to be stereotypes that exaggerate a kernel of truth (Tucker, 1983)

Raymond Cattell, (1950) employed more sophisticated, quantitative and mathematical analysis and established a completely different theory Cattell gathered a lot of data on the behavior of large number of individual's. This data was collected by using a variety of techniques, such as life records, self-report questionnaires or projective tests and then was subjected to the complex statistical technique of factor analysis Based on the results he suggested two kinds of traits a) Surface Traits b) Source traits and classified them into traits of ability, traits of temperament and dynamic traits.

Despite the fact that trait theories and type theories have enhanced our knowledge regarding human behavior, criticisms regarding the adequacy of a trait and type assessment arise This is because people's behaviours often vary with the situation in which they occur. Besides, the performance of individuals on various measures can be influenced by response sets, including the desire to make a certain impression.

b **Psychodynamic personality Theories** (Psychoanalytic and Neopsychoanalytic theories) :

Type and trait theories comprise of search for the separate components of personality and for the modes to fit together those components to form a personality structure. On the other hand the psychodynamic theories view personality and behavior in terms of dynamics or interaction, of the driving forces of personality such as desires, anxieties, conflicts and defenses. According to this viewpoint, individuals are inevitably entangled in the clash between conflicting forces of life, such as between impulses and inhibitions or between individuals and the society. Although various psychodynamic theories emphasize different aspects of personality most agree that the basic dynamics of personality include conflict between anxiety and defenses.

Among the various psychodynamic theories of personality, the most dynamic theory is Freud's psychoanalytic theory.

**Freud's Psychoanalytic Theory**:

Sigmund Freud (1965) has compared personality to an iceberg in which only the surface tip is visible Most of the Psychic activity remains unconscious. Every aspect of behavior, whether human, dreams or works of art, can be interpreted in terms of its surface meaning or of its true, unconscious meaning. Freud characteristically interpreted various human behaviors in terms of their deeper unconscious meanings. His psychoanalytic theory includes three major parts 1) a theory of personality structure 2) a theory of personality dynamics, in which conscious and unconscious motivation and ego defense mechanisms

are the main aspects 3) a theory of psychosexual development. Which comprises of three main process, viz. The id, ego and superego.

1) ***Personality Structure***.

According to Freud the personality comprises of three interacting processes, viz, the Id, the Ego and the Superego. The Id is the unconscious reservoir of psychic energy. (derives and impulses). All the drives that make up the id have their source from two basic instincts viz. Eros (life instinct) and Thanatos (death instinct) Freud believed that sex drive was the major source of psychic energy affecting the entire personality, including the need for affection love of family – friends the urge towards creatively and the need for erotic behavior The sexual energy underlying the various urges is called the libido

The id operates entirely on the pleasure principle, without considering rules, reason, reality or morality.

The ego acts as a mediator by balancing the pressures of the id and superego. It consists of elaborate ways of behaving and thinking which constitute the 'executive function' of he person. The ego operates on the basis of the reality principle and its main concern is the well being of the person The ego delays satisfying the desires from the id and propels behavior into a socially acceptable manner.

The superego or the conscience is shaped by the moral standards of society mainly learnt form the parents and other authorities. The superego does not give a consideration to reality than the id, instead it acts in accordance with

the principles of perfection. Much of the repression of unacceptable impulses is carried out directly by the ego or the urging of the superego.

2) ***Personality Dynamics***

According to Freud's view of personality dynamics, the id, ego and superego are often in conflict. When this happens, the ego experience, anxiety Freud has described three types of anxiety viz reality anxiety Neurotic anxiety and Moral anxiety

Freud in his theory has proposed three levels of awareness. The conscious, the preconscious and the unconscious Defense mechanisms (chiefly repression) which are the unconscious reactions to reduce the level of anxiety were also discussed by Freud

3) ***Stages of Psycho-sexual Development:***

According to Freud personality develops through a sequential process, and the manner in which the child handle the characteristic developmental conflict has a decisive influence on his or her adult personality Freud had described personality in terms of various stages revolving around body zones. These stages of psycho-sexual development were the oral stage, the anal stage, the phallic stage with electra and oedipus complex). The latency stage and the genital stage.

The Neo-psychoanalytic approach is described by many of Freud's followers who were original thinkers in their own right. They modified and expanded his views. Among them the prominent were C.G. Jung Alfred Adler (1929, 1931) and Karen Horney (1937).

Carl Jung's (1939) analytical psychology

Carl Jung's (1939) analytical psychology, considers the structure of personality as a complex network of interacting systems that strive towards eventual harmony. The primary systems are the ego, the personal unconscious with its complexes and the collective unconscious and its archetypes. The ego is the conscious perception of self according to Jung. The personal unconscious includes experiences that have been repressed or forgotten. These are organized into complexes. The collective unconscious consists of potential ways of being that all humans share. Archetypes are universal thought forms of the collective unconscious and predispositions to perceive the world in certain ways The more well known archetypes include the anima and the animus. Two basic attitudes (introversion and extraversion) and four functions (sensation, thinking, feeling and intution) are described by Jung In every individual, one of the attitudes and functions is more dominant and its opposite is weaker.

Alfred Adler's Individual Psychology (1929, 1931):

Adler's individual psychology emphasized interpsychic (interpersonal) phenomena. According to him behavior is guided by the principle of finalism. According to him, the primary objective of the psyche is the goal of superiority. Feelings of inferiority lead the individual to find ways to compensate for his weaknesses Adler emphasized the concepts of compensation and overcompensation. Another distinct concept given by Adler is the style of life. The style of life is influenced by factors such as family constellation and family atmosphere

Karen Horney's Psychoanalytic Interpersonal Theory

The two major aspects of Horney's theory were the twin notions of basic anxiety and basic hostility (1937). According to her basic anxiety is reflected in ten neurotic needs which lead to three ways of relating to others (moving toward, moving against and moving away) and to three basic orientations towards life (the self-effacing solution, the self-expansive solution, and the resignation solution). Other major concepts described by Horney are the Real self representing that which a person actually is and the idealized self representing that which a person thinks he or she should be. Another distinct concept suggested by Horney is "Feminine Psychology" wherein she has dealt with the phenomena of 'womb envy'.

Erikson's theory of Psycho-social Development

According to Erikson "In each stage of life a given strength is added to a widening ensemble and reintegrated at each later stage in order to play its part in a full cycle" (1969). He has described the stages as epigenetics and that they are centered around an emotional conflict the people encounter at certain critical periods. The main stages are Trust vs. Mistrust, Autonomy vs. Shame and Doubt, Initiative vs. Guilt. Industry vs. Inferiority, Ego Identity vs. Role confusion, Intimacy vs Isolation, Generality vs Stagnation and Ego integrity vs Despair

Many other researcher have modified the original notions of psychoanalysis to make them applicable in the contemporary society. Although influential, the dynamic theories are limited. Many of the psychodynamic concepts and interpretations are not easy to prove or disprove. Thus the

dynamic approach in general is rich in ideas but poor in experimental tests of these ideas

c. **Learning and Behavioral Theories:**

Learning theorists de-emphasize the biological basis of behavior and instead focus on how behavior is learned through interaction with the environment. They believe that most of our personality and behavior are acquired through processes such as observational learning, with or without reinforcement. Learning and conditioning in classical, instrumental or cognitive forms – are highly relevant to personality and its development.

Dollard and Miller (1950) using animal experiments described the structure of personality in terms of habits. They distinguished between primary and secondary drives and reinforces as the primary motivating forces of personality. Dollard and Miller have adopted many freudian concepts and integrated them into learning theory terms. Unconscious processes are reconceived as unlabeled drives and cues The defense mechanisms and stages of development are also reconceived in terms of the learning process Thus the theory of personality seeks to emulate a scientific model and emphasizes empirical research

B.F Skinner's (1969) radical behaviorism uses instrumental conditioning principals to explain the way in which environmental conditions influence people's behavior. Skinner (1969) describes variables and forces in the environment that shape overt behavior rather than developing a personality theory. According to him the term "Personality" and concepts of internal

structure are ultimately superficial. Behavior is best understood in terms of responses to the environment.

Bandura and Walters (1963) extended social learning theory into the domain of observational learning. Bandura (1978) has characterized the mutual interaction among the various components of learning. Personal–cognitive variables, environment and behavior as reciprocal determinism. According to this view individuals have a tremendous capacity to learn and change, especially when they make full use of their minds and maximize their competencies in interacting with the environment. According to Bandura most human behavior is learned through the process of observational learning, by following a model. The major factors influencing modeling are (I) characteristics of the model, (ii) attributes of the observer and (iii) the reward consequences associated wit the behavior.

The four processes involved in observational learning are

(i) Attention processes

(ii) Retention processes

(iii) Motor reproduction processes and

(iv) Motivational processes

Bandura, unlike Skinner opines that direct reinforcement is not necessary for learning to occur. Extrinsic, Intrinsic, vicarious reinforcement and self-reinforcement all play a role in observational learning.

Julian Rotter's theory (1966) integrates two major trends in personality research learning theory and cognitive theory The four major concepts in his social learning approach are

(i) Behavior potential

(ii) Expectancy

(iii) Reinforcement value

(iv) Psychological situations

These four variables can be measured and related in a specific formula, in order to predict an individual's behavior in a given situation. He had developed the I-E Scale, a significant assessment tool to measure an individual's perception of locus of control. According to Rotter the concepts of need and minimum goal level also assist in predicting behavior and understand personality adjustment

Learning and behavioral theories have been criticized for diminishing the person in personality however the clarity and experimental 'testability' of the behavioral and learning theories have lead to increase in their value.

d **Humanistic Theories of Personality** :

Humanistic psychology achieved a lot of importance during the 1950s' and 1960s, when many thinkers became concerned about modern technology's threat to human values. Humanistic psychology became an alternative to the deterministic out look of psychodynamic and behavioral psychology. Thereby emerging as the "Third Force" in psychology Humanistic theories emphasize the values of human freedom and the individual. Importance is given to the people's subjective attitude, feelings and beliefs especially with regard to the self Two major theories were given by Carl Rogers and Abraham Maslow

Roger's Humanistic Theory :

Roger's (1959) humanistic theory is influenced by phenomenology, which emphasized that the object, or event in itself is not important. It is the perception of these events or objects which actually matters. The phenomenal field refers to the total sum of experiences an organism has the organism is the individual as a process, and the self is a concept of who one is. According to Rogers in mature, adjusted people there is a congruence between the person and the self. When denial or distortion is present in the symbolization of experience then a state of incongruence develops.

While explaining the development of personality, Rogers believed that the young child has strong need for positive, regard by others and need for positive self-regard Parents and others react to the child's behavior sometimes in a positive way and sometimes with disapproval. The child thereby learns to regard some of his actions, thoughts and feelings as unworthy and may often react by distorting or denying these unworthy aspects of self. In an ideal situation, positive regard in unconditional and not contingent on any specific behaviors. If it becomes contingent upon specific behaviors them it is known as conditional positive regard. In such situations the child feels that his parents will not love him unless he thinks, feels and acts as per their wishes This results in interjection of values of others by the child Hence, discrepancy between the self-concept and the experiences of the organisms. Inadequate self-concepts such as feelings of inferiority or stupidity, frequently arise because a person has not received adequate positive regard from others. A full functioning person as described by Rogers (1959) has the characteristics of (I) Openness to

experience (ii) Existential living (iii) organismic trust (iv) Experiential freedom (v) creativity.

The people are born with a capacity to direct themselves in the healthiest way, toward a level of completeness called self-actualization. Thus, Rogers viewed personality not only as a static entity composed of traits and patterns but as a dynamic phenomenon comprising of ever-changing communications relationship and self-concepts

Abraham Maslow's Theory of Personality:

Abraham Maslow in his widely acclaimed work "Motivation and Personality" (1970), has presented his theory of personality and described in detail his concepts of the hierarchy of needs and self-actualization.

Maslow believed that human beings are interested in growing rather than simply restoring balance or avoiding frustration. Each person has an inherent need to actualize his or her potentialities. However for him the core of such growth needs functions in relation to a hierarchy of needs.

Maslow distinguished between motivation and metamotivation which consist of D-needs and B-needs respectively The D-needs or deficiency needs, arise out of the organism's requirement for physiological survival or safety e.g. the need for food motivates the person to perform activities that reduce these drives. On the other hand metamotivation refers to growth tendencies. It comprises of B-needs or being needs, which arise out of the person's drive to self actualize and fulfill its inherent potential motivation and the D-needs take precedence over metamotivation and the B-needs.

In his hierarchy of needs Maslow has described five basic needs, these are physiological needs safety needs belonging and love needs self esteem needs and self – actualization needs. Each lower need must be satisfied before the individual can become aware of or develop the capacity to fulfill the needs of the levels above it. Fig D

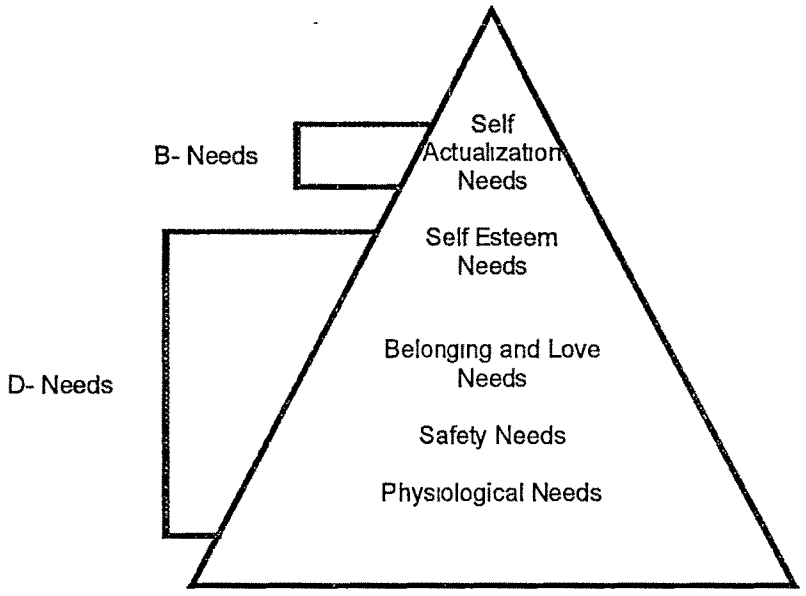


**Fig. D : Maslow's Hierarchy of Needs**

Maslow was of the opinion that 'peak experience' frequently found in self-actualized individuals is an episodic, brief occurrence wherein the person suddenly experiences a powerful transcendental state of consciousness. During this state, the person experiences a sense of heightened understanding, an intense euphoria an integrated nature, unity with the universe, and an altered perception of time and space. Such experiences occur more frequently in psychologically healthy people and may produce long lasting beneficial effects

All the humanistic theories share a common view point that personality is focused on individual's internal perceptions or introspections However, the primary criticism attributed to humanistic theories is that they are unscientific Critics feel that lot of information is gained from humanistic therapy and from studies based on self-reports, resulting in formulations which are incomplete, lacking scientific precision and a elaborate analysis of the causes of behavior.

e. **Cognitive Theories of Personality**:

Cognitive theories of personality, exemplified here by George Kelly, stress on the processes by which an individual becomes aware of the world and makes judgement about it Cognitive theories emphasize that an individual's behavior is determined not just by the environmental factors but also, and primarily, by his or her attitudes, expectations and beliefs. Other theories of personality have recognized cognition as an important factors but none of them have made it the focus of their theory.

Kelly's cognitive theory (1955) regards cognition as the primary factor determining personality and behavior his theory of personality is based on his philosophical position of constructive alternativism the assumption that any one event is open to a variety of interpretations Kelly (1955) explained his theory on the basis of one fundamental postulate which is as follows :-

"A person's process are psychologically channelized by the ways in which he anticipates events". Kelly later on elaborated this postulate with eleven corollaries which focused on a primary word viz Construction, individuality, organization, dichotomy, choice, range, experience, modulation, fragmentation, communality and sociality. (Kelly, 1955).

Kelly interpreted many traditional concepts in personality theorizing in a new way He re-defined the concepts of self-construct, role, learning, motivation and emotion in his theory. According to him self-construct is the core or basic role structure by which one conceives of one self as an integral individual in relation to other people. The role, is defined by the individual in an effort to understand the behavior of other people and related to them.

Kelly believed that the individual is a process and is in a state of continuous activity his behavior is governed by a system of personal constructs. According to Kelly learning and motivation are built into the very structure of the system and no special inner factors like drives, needs, motives or instincts are required to explain human motivation

The constructs may be verbal or preverbal. The conscious and unconscious processes may be explained by an individual's capacity to from constructs that cannot be verbalized Emotions, arise when the constructs are in a state change. Kelly also explained the basic psychological concepts of anxiety, guilt and aggression in accordance with his theory of personal constructs (Kelly, 1955). According to him, anxiety, is the recognition that the events with which once is confronted lie outside the range of one's construct system. Guilt is a "Perception of one's apparent dislodgment from his core role structure". While hostility is the "continued effort to extort validational evidence in favor of a type of social prediction which has already proven itself a failure".

Kelly (1958) developed the Role construct repertory test (Rep Test) This test allows a person to reveal his or her constructs by comparing and contrasting a number of different persons in his or her life.

Kelly has been criticized for being too intellectual and for failing to deal with the whole of personality or the emotions

f. **Existential Theories** :

During the past century a lot of progress has been made in the area of human nature and personality. Yet, the understanding of what it means to be human is inadequate There has been a growing feeling that the dominant concerns of the Western Science and Psychology have ignored the spiritual side of the person. Many people nowadays have turned to existential philosophy or the East in the hope to find something that can humanize the thrust of modern technology that threatens to destroy the very civilization that developed it. The 'Existentialism" movement in contemporary philosophy and psychology arose in various parts of Europe and among different schools of thought. Its foundations are to be seen in the resistance movements during world war II and in the philosophies of Soren Kierkegaard (1813-1855), Martin Heidegger (1889-1976), and Jean Paul Sartere (1905-1980). The word 'Existentialism' is derived from the Latin 'exsistere' which means to 'to stand out' or 'to emerge' and the existential approach focuses upon the human being as he or she is emerging and becoming.

According to Rollo May (1967), the main problem faced by an individual in the second half of the twentieth century, is a feeling of powerlessness in the face of nuclear war. May defined anxiety as the apprehension cued off by a threat to an essential value It is intensified in contemporary culture by the interpersonal isolation and alienation arising due to the way in which we see ourselves He stressed on the fact that the current scenario of the society is

that values are lost. Hence the need today is to discover and affirm a new set of values. May has described fair stages of consciousness viz. Innocence, Rebellion, Ordinary consciousness of self and the creative consciousness of self. He has explained the major issues in personality in ways that avoid abstraction and encourage the confronting of paradoxes. He suggested three basic changes in psychological methods of research on personality.

1) We must know what we are talking about.
2) We must recognize that all ways of understanding what it means to be a human being are based on philosophical assumptions
3) We must ask the question of the nature of person as person, the ontological question of what it means to be.

May (1983) suggested that it would be more scientific to first try to see clearly what we are talking about and then try to find symbols to describe what we see with a minimum of distortion

May's theory is not a scientific theory of personality. It does not consist of a series of hypothesis that could be checked by empirical methods.

Since this study focuses on the introversion – extroversion and neuroticism stability dimensions of personality, these have been studied in detail

**Dimensions of Personality : neuroticism, Introversion and Extraversion : Neuroticism .**

According to Jung when one complex bipolar relationship to another - particularly the ego becomes extreme, then there is an incompatibility in consciousness that ensues. In other words, the emotional suffering generated by this conflict becomes in tolerable and anxiety cannot be contained and anxiety cannot be contained. This splitting leads to the impossibility of affirming the totality of one's nature. Hence neurotic dissociation and possible illness evolve, especially if the condition becomes fixed.

Thus neurosis is defined as a dissociation of the personality due to the existence of complexes. The individuals maintain their psychic equilibrium by living out two incompatible complexes, one more ego – identified and the other more ego alien, usually found in projection. When an individual lacks the ability to cope with everyday problems and feels threatened and anxious so much so that his ego defense mechanisms also prove inadequate for the coping ability, he shows neurotic pattern of behavior. It is a maladaptive behavior. Commencement of such a behavior is known as 'Neuroticism', which is a minor maladjustment and may not aggravate. However, if it aggravates then it may lead to neurosis

There are two basic views regarding the nature of "Neuroticism". These are as follows:

1. The traditional German view
2. The Modern view of Mental defect

*1.* ***The Traditional German View :***

The traditional, German, view of neurosis was presented by Henderson and Gillespie (1943) According to this view, the neuroses as compared with the Psychoses, indicate totally different modes of reaction., "the distinction between psychoneuroses in general and psychoses are symptomatic, psychopathological and therapeutic. While explaining biologically, that is as types of reaction to environment, the psychoneuroses are distinct in several ways. In psychoneuroses only a part of the personality is affected while in psychosis there is a total change of the individuals personality. Besides this in Psychoneuroses reality remains unchanged qualitatively, although its value may be quantitatively altered (diminished). While in Psychosis reality is considered in a way very different from the normal. Besides this the patient also behaves accordingly. Thus, the conception of qualitative differences between neuroses and psychoses is disputed in the realm of the affective disorders.

2. ***The modern view of Mental Defect*** :

According to this view, "the genetic background of intellectual defect is multifactorial, when the special clinical types are excluded" (Penrose, 1944) This view holds that, "The word "neurotic" is used exclusively for the person who occupies the lower end of the distribution of "general adoptedness" or "personality organization" or whatever we conceive to constitute the essence of this trait.

Thus, the basic issue between these two opposing views is whether or not certain types of abnormality are to be included in the normal distribution, as

mere extreme cases occurring towards the lower end, or whether these types constitute pathological variants, super imposed on that curve.

**Theories of Neuroticism**

There are three main classes of theories which clarify the term "Neuroticism". These are classified as follows :-

1. Environmental Stress Theory
2. Hereditary Predisposition Theory
3. Multiple Causation Theory

1. ***Environmental Stress Theory***:

This class of theories comprises of the theories which regard neurotic phenomena as types of response to which all human beings are equally liable. The severity and type of neurosis, according to this theory is dependent mainly due to environmental stress.

2. ***Hereditary Predisposition theory***:

According to this class of theories neuroticism is regarded as being of a unitary kind, and dependent or genetic factors The genetic basis of the disorder might be found in a single abnormal gene, whose variations in expression could be accounted for by environmental differences and by differences in the genotypic milieu. Besides this, the genetic basis may also be found in a large number of separate genes of small but similar effect.

3. ***Multiple Causation Theory:***

According to this theory neurotic constitution is caused to more than one genetic factor, with dissimilar effects. These genetic factors on one hand may be conceived to be specific to a particular type of neurosis on the other hand

they may be thought of as overlapping in their effects, and producing predispositions to more than one type of neurosis.

Thus, all the three types of theories agree that environmental stress plays some role in the causation of neurosis.

**Introversion – Extraversion** :

According to Carl Jung (1939) "Medical experience has taught us that there are two large groups of functional nervous disorders – the one embraces all those forms of disease which are designated hysteria, the other all those forms which the French school has designated psychasthenia... The hysteric belongs to the type of Extraversion, the psychasthenic to the type of Introversion".

Freud (1920) identified "Introversion" with incipient neuroticism. According to him "an introvert is not yet a neurotic, but he finds himself in a liable condition; he must develop symptoms at the next dislocation of forces, if he does not find other outlets for his pent-up libido Jung, (1923) on the other hand considered it a mistake to believe that introversion was more as less the some as neurosis.

According to Freud (1924) extravert is "an individual in whom exists a diminution of the thought processes in relation to directly observable social behavior with an accompanying tendency to make social contacts". Researchers have indicated that a decrease in social contacts was the circumstance most commonly associated with neurosis. Hence the lack of

"sociability" must be regarded as an index of neuroticism, not as a sign of introversion.

**Theories of Introversion – Extraversion :**

Various theories have been proposed by different researchers to explain the dipolar dimension of Introversion–Extraversion. Jung (1939) opines "When orientation to the object and the objective facts is so predominant that the must frequent and essential decisions and actions are determined, not by subjective values, but by objective relations, one speaks of an extraverted attitude. When this becomes habitual, one speaks of the extraverted type. The introverted type is prevailingly oriented by subjective factors Introverted consciousness doubtless views the external conditions, but it selects the subjective determinants as the decisive ones "

Conklin (1922) defines extraversion "as a more a less prolonged condition in which attention is controlled by the objective conditions of attention more than by the subjective, and in which the content of the subjective conditions is most closely related to the objective" The reverse of this phenomena is defined as "Introversion".

Freud (1924) defined introvert as "an individual in whom exists an exaggeration of the thought process in relation to directly observable social behavior, with an accompanying tendency to withdraw from social contacts. "On the other hand the extravert is" an individual in whom exists a dimunition of the thought process in relation to directly observable social behavior with an accompanying tendency to make social contacts".

McDougall (1926) has explained introversion-extraversion in physiological terms. According to him "the essential mark of the extreme introvert is the tendency to interval activity of the brain, especially to an excess of those activities of the highest level in which self conscious reflection and control of lower level processes bulk so largely. The essential mark of the extravert is the ready passing over of the effective urge into action of the effective urge into action and expression, without the modification and control of it by cerebral processes of the highest level."

White (1926) considers introversion a return to a less clearly defined individuality and a return to a phylogenetically older and more diffuse form of contact with reality. Tansley (1925) has described extraversion as a primitive biological function of the mind. Bingham (1925) has stated that "(in) introversion (we) stress the exaggerated tendencies to delay response, to inhibit overt emotional expression, and to withdraw from social contacts".

Kempf (1921) believed that the introvert has a more highly developed and a more dominant central nervous system, and hence is more subject to inhibitions and delayed responses of a directly adaptive nature.

Marston (1925) believed that extraversion could be identified with a tendency towards skeletal expression of emotion, while introversion is identified with the dissipation of emotionally aroused energy within the organisms rather than with the adequate discharge of this energy through skeletal channels upon the environment

Among all the theories that have been proposed there seems to be some agreement on the following points .-

a) The introvert has a more subjective outlook, while the extravert has a more objective outlook.
b) The introvert shows a higher degree of cerebral activity, while the extravert a higher degree of behavioral activity.
c) The introvert shows a tendency to self-control (inhibition) while the extravert shows a tendency to lack of such control

**Extraversion-Introversion, Neuroticism Dimensions and Eysenck's Theory:**

Eysenck (1970) views personality as a hierarchy At the bottom of the hierarchy are specific response behaviors that we can actually observe, such as someone answering a phone. The next level comprises of habitual responses, which are clusters of specific behaviors that characteristically recur in similar circumstances, such as buying groceries or giving parties. Above this are more generalized traits, clusters of related habitual responses such as the source traits. At the top of the hierarchy related clusters of traits make up broad general dimensions or basic types, such as someone answering a phone. The next level comprises of habitual responses, which are clusters of specific behaviors that characteristically recur in similar circumstances, such as buying groceries or giving parties. Above this are more generalized traits, clusters of related habitual responses such as the source traits. At the top of the hierarchy related clusters of traits make up broad general dimensions or basic types, such as introversion or extraversion.

This hierarchical structure of personality is depicted below

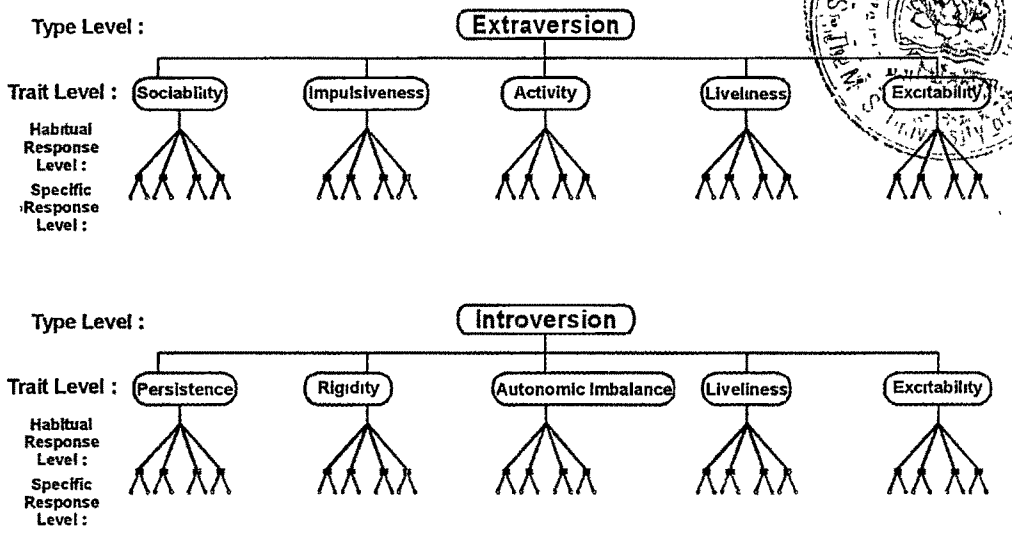


Fig E Eysenck's Hierarchical Model of Personality Development

Eysenck, H J. (1967).*The Biological Basis of Personality.* Springfield : Illinois

The emotionality versus stability dimension as described by Eysenck refers to an individual's adjustment to the environment and the stability of his or her behavior over time. Some people tend to be well integrated and emotionally stable, while others tend to be poorly integrated, emotionally unpredictable, and neurotic In Eysenck and Rochman's (1965) words "At the one end we have people whose emotions are labile, strong and easily aroused, they are moody, touchy, anxious, restless and so forth. At the other end we have the people whose emotions are stable, less easily aroused, people who are calm, even tempered, carefree, and reliable." In both dimensions, most people fall somewhere in the middle of the two extremes

The basic dimensions of personality may be depicted as shown in the following diagram. The inner circle shows Hippocrate's four temperaments. The outer ring shows the results of factor analysis studies of the inter co-relations among traits. The traits, which are on a continuum, clearly reflect the two

dimensions of emotional security versus neuroticism and introversion versus extraversion

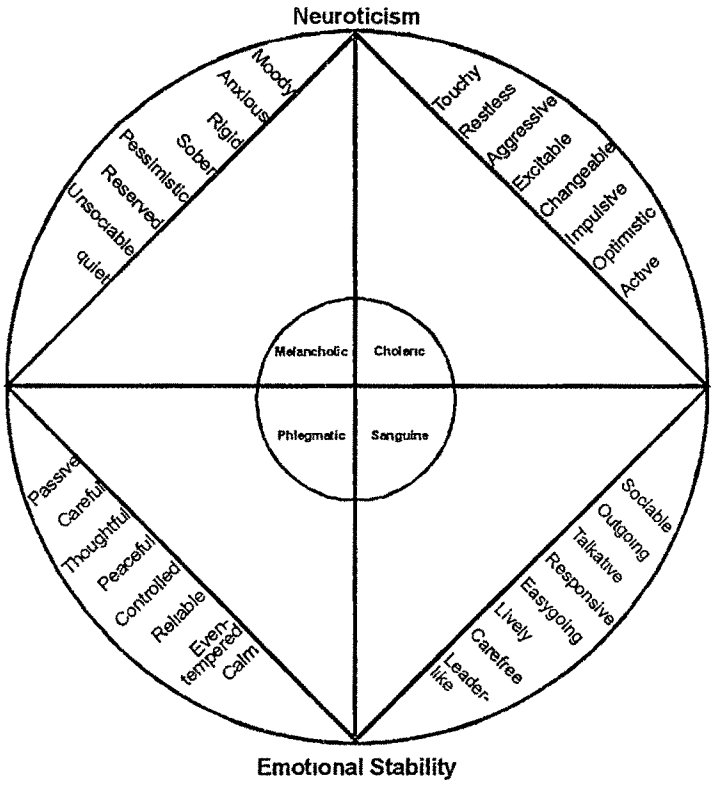


Fig. F : The inter-correlation of Traits

As shown in figure-F, the inner circle shows Hippocratic four temperaments. The outer circle shows the results of factor analysis studies of inter co-relations between traits done by Eysenck and others. According to Eysenck (1957) individuals differ in the reactivity of their brains and central nervous systems and in the speed with which they develop conditioned responses. These differences correlate with the dimensions of emotional stability / neuroticism and introversion / extraversion. He suggests in his theory of excitation inhibition that introversion / extraversion is related to arousal thresholds in the ascending reticular activating system (RAS) of the brain and

emotional stability / neuroticism is related to differences in visceral brain (VB) activation.

Eysenck believes that introverts may have higher levels of RAS reactivity than extraverts. Thus, given identical stimulating conditions, the state of arousal would be higher in introverts than in extraverts. The high level of arousal may create a constraint on their behavior and contribute to the specific traits, such as reserved and careful, that generally characterize introverts. Similarly, the low levels of arousal experienced by extraverts may lead to and absence of constraints and a predominance of impulsive and outgoing behavior normally associated with extraversion.

Eysenck has also suggested that there is a causal connection between biological functions of the brain and the basic personality dimensions of emotional stability / neuroticism and introversion / extraversion Another aspect stressed upon by Eysenck is that of genotype and phenotype. The genotype refers to the genetic make up of an individual and the phenotype refers to the individual's observable appearance and behavior that arise out of the interaction of the genotype with the environment. Difference in the genotype lead to the development of different habitual levels of arousal and thresholds for emotional response Through interactions with a particular environment, these tendencies lead to the various emotionally stable or unstable, introverted or extraverted phenotypic patterns of behavior and primary traits that have been identified through factor analysis (1970).

Eysenck has constructed a number of paper-pencil tests and self-report inventories to measure the dimension of introversion / extraversion and

neuroticism. Among them are the Maudsley Personality Inventory, the Eysenck Personality Inventory, and the Eysenck Personality Questionnaire.

Thus the neuroticism, introversion – extraversion dimensions have been a topic of research for many years. They have been linked with various other factors such as psychosomatic disorders, leadership behavior, adjustment patterns etc. in the present study, these dimensions have been studied in the psychosomatic gastrointestinal disorders viz. Acid-peptic disease and irritable Bowel syndrome. Various other variables have also been associated, with these dimensions

# ANXIETY

Anxiety–an uneasy, fearful feeling – is the hallmark of many psychological disorders. It is often concealed and reduced by defensive behaviors such as avoidance or ritualistic action.

The literature about anxiety is very large but most of it is of clinical theoretical nature. This is due to the fact that anxiety has been the main area of interest of clinicians and other professionals who are primarily concerned with the problems of amelioration. A much agreed upon view holds anxiety as an extremely unpleasant, painful affect which the instinctive hedonism of most normal and neurotic people suffers with poor grace and tries to circumvent at almost any price Even normal persons may invest a great deal of psychic energy in various psychological maneuvers, the major function of which is to prevent the outbreak of anxiety openly in their lives.

Anxiety occurs in all degrees of intensity and is manifested as a diffused feeling of physical tenseness, through innumerable intermediate gradations marked by increasingly severe somatic and psychic symptoms, to the shattering paroxysm of annihilating panic

**The nature of Anxiety**

The sensation of anxiety is commonly experienced by virtually all human beings. The feeling is characterized by a diffused, unpleasant, vague sense of apprehension, often accompanied by autonomic symptoms, such as headache, perspiration, palpitations, tightness in the chest, and mild stomach discomfort.

As expressed by Carrol (1955), "In the atmosphere of security some anxiety is present, to be sure, but mild anxiety is not inhibitory, actually it spurs the person on to new achievements Every individual has a drive to drive to growth. If this drive is rewarded by a number of successes he can tolerate a few failures. While, repeated failures create an anxiety which always holds him back " The basic conflict here is the desire to go ahead versus fear of doing so.

Spielberger (1966) believed that anxiety is a dominant fact and it threaten to become the dominant cliché of modern life Anxiety is the most prominent mental characteristic of accidental civilization.

Sinha (1962) has stated that "Observation of the behavior of normal college going population in this country points to the fact that anxiety is fast becoming as much a characteristic of the contemporary Indian Scene".

**The Concept of Anxiety:**

The term anxiety has been derived from the Latin word 'Angustus' meaning narrow or constricted and 'Ango anxi' meaning to bind, draw, throttle or strangle. Since the 17$^{th}$ century, it means a state of agitation or depression with feelings of distress. Nearly a century ago, Sigmund Freud (1894) coined the term "Anxiety neurosis" and identified two forms of anxiety. One type of anxiety resulted from dammed – up libido. The conditions of heightened anxiety related to libidinal blockage include neurasthenia, hyprochondriasis, and anxiety neuroses, all of which according to Freud have a biological basis. The other form of anxiety is best characterized as a diffused sense of worry or dread that originates in a repressed thought or wish. Such, form of anxiety is responsible for the psychoneuroses hysteria, Phobias and obsessional

neuroses. Freud described these conditions and the anxiety associated with them to be primarily related to psychological factors, rather than physiological factors.

The publication of 'Inhibitions, Symptoms, and Anxiety' by Freud (1926) created a new theory of anxiety that accounted for both real external anxiety and neurotic internal anxiety as a response to a dangerous situation. One situation comprises overwhelming instinctual stimulation, the prototype of which is the experience of birth. In such situations, increased amount of drive pressure, penetrates the protective barriers of the ego, producing a state of helplessness and Trauma. The second form of anxiety is more common and comprises of the anxiety that develops in anticipation of danger, rather than as a result of danger.

Such type of warning given to the organism is known as signal anxiety It warns of an external or internal threat, and has life saving qualities. This form of anxiety operates at the unconscious level and serves to mobilize the ego's resources to avert the danger.

**Definition**

Anxiety as a psychological concept has an ambiguous status because of the fact that it has been attributed different meanings by various investigators. Besides its nuclear meaning, probably accepted to everyone, that anxiety is a fearful unpleasant feeling-state with some physiological concomitants (Krause, 1961), there are many nuances and differences in the usage of the term.

Anxiety in general is a feeling of mingled dread and apprehension about the future without specific cause for the fear As defined by Drever (1958) anxiety is "a chronic complex emotional state with apprehension or dread as its most prominent component, characteristic of various nervous and mental disorders."

According to May (1950), anxiety is "the apprehension cued off by a threat to some value which the individual holds essential to his existence as a personality."

According to George Kelly (1955) anxiety is "the recognition that the events with which one is confronted lie outside the range of one's construct system".

Freud (1949) defined anxiety, in terms of three characteristic namely (i) "Specific unpleasurable quality". When It involves (ii) "Efferent or discharge phenomena", and It (iii) consists of the perception of these.

Cattell (1966) has stated that "anxiety arises from a threatened deprivation of an anticipated satisfaction when the threat does not carry complete cognitive certainty"

Sullivan (1955) in his definition of anxiety, more or less confirmed to Freud's view but he emphasised the need for security.

Karen Horney (1945) has suggested that anxiety is the basic human condition with which we have to deal. However, unlike Freud, Horney does not see anxiety as an inevitable part of the human condition. She has suggested

that anxiety is created by social forces rather than by the human predicament itself.

Anxiety can be identified as an affect in interpersonal behavior that is objectively experienced by the subject and communicated by him to an observer. (Grinker, 1959). Thus, inspite of in-depth study into the subject of anxiety, no one particular or precise definition has been agreed upon.

**Types of Anxiety**

Anxiety has been categorized into different types in various ways. The psychiatrists, psychoanalysts and psychologists differ in their ways of classifying anxiety Psychiatrists have classified anxiety as either "free-floating" or "bound anxiety", "acute" or "chronic" while psychoanalysts have labelled it "conscious or unconscious" anxiety. Anxiety has been classified as either "trait" or "state" anxiety by psychologists.

When evaluating a patient with anxiety, the clinician has to differentiate between normal and pathological types of anxiety also.

1. Free-Floating and Bound Anxiety:

The anxiety which occurs in specific situations or involves only a specific response is known as "bound" anxiety It is also called situational anxiety. While the general anxiety which is of a pervading type of influences all the activities of an individual without being tied or bound to one specific situation is called "Free-Floating" anxiety.

2 Acute and Chronic Anxiety

"Acute" anxiety is a sudden and intense form of anxiety It appears all of a sudden in the form of an attack. While "Chronic" anxiety is an elevated state of anxiety persisting over a long period.

3. Objective, or Conscious Anxiety:

Objective anxiety is an emotional reaction to a perception of danger in the external world, where danger is as an external condition which is remembered as a traumatic effect in the past. This traumatic effect paralyses the person so that he is not able to make a coping response to a source of intense, recessive excitation

As considered by Freud (1926) objective anxiety is a syndrome with fear He has defined it as reality anxiety–It refers to fear of a real danger in the external world. It can also be called "Conscious " anxiety

4. Neurotic Anxiety

It refers to the fear that one's inner impulses cannot be controlled (Freud 1926) it is an affective reaction to a perception of danger in the internal world It is a derivative of reality anxiety, since fear of the id is basically a fear what the id may cause The person to do It can also be known as "Unconscious Anxiety".

5. Moral Anxiety:

Moral anxiety also has its base in reality anxiety. It is a fear of the retributions of one's own super-ego or conscience (Freud 1926) Here, the ego considers itself to be in danger when the super-ego is angry with it or threatens

to punish it or stops loving it. Moral anxiety expresses itself as feelings of shame and guilt.

6. State and Trait Anxiety:

When a person is referred to as "anxious" it has two connotations one that he is anxious at the moment and the other that he is an anxious person

Being anxious at a moment is a transitory phase of anxiety which is caused functioning of a particular stimulus condition. This has been described as "state anxiety"

Predisposition or proneness to anxiety describes to behavioral category as anxiousness. This is known as "trait anxiety".

Krause (1961) concluded that for defining transitory or state anxiety the most widely accepted criterion was introspective reports. Usually, the transitory anxiety was guaged by physiological signs – restlessness, speech disturbances, bodily tensions gestures and task performance, clinical intuition and the response to stress.

7 Active and Passive Anxiety :

Roubieck (1970) has differentiated between active and passive type of anxiety depending on the response, defense or attack respectively.

"Active anxiety" is accompanied by increased muscle tension, techycardia and acceleration of breathing and helps to defend the individual by way of attack or flight. It can also cause panic reaction with purposeless psychomotor restlessness.

"Passive anxiety" is accompanied by a temporary cessation of respiration, bradycardia and sometimes by a transitory paralysis of movement Phylogenetically this condition corresponds to a primitive defence reflex, "Stimulating death".

8 Normal and Pathological Anxiety:

Normal anxiety is a fear reaction to threats to personal values that are regarded as essential to his existence by an individual Anxiety is considered normal if the fear reaction is proportionate to the situational threat and the danger can be handled on a conscious level Here, the anxiety creating experiences are temporary and lend themselves to successful handling.

Pathological or abnormal anxiety involves fear reaction which is highly disproportionate to the actual danger. It is manifested at an unconscious level as the cause for anxiety is hidden from the individual. The conflicts or frustrations underlying anxiety are buried in the unconscious

**Anxiety Disorders**:

Anxiety disorders are the disorders most affected by the diagnostic criteria in the third edition of Diagnostic and statistical manual of mental Disorders (DSM – III), the revised third edition (DSM –III – R), the fourth edition (DSM-IV) and by growing knowledge of the biology of anxiety Gradually anxiety disorders have moved away from a conceptualization based on psychodynamic formulations of neuroses". As a result the word "Neurosis" has been dropped from the official nomenclature, and the divisions among the

various anxiety disorders have been made on the basis of valid and reliably recognized clinical criteria

**Table** 2 : **DSM - IV Classification of Anxiety Disorders**

DSM – IV lists the following anxiety disorders :-

1. Generalized Anxiety Disorder
2. Panic Disorder (with without agoraphobia)
3 Agoraphobia without a history of panic disorder.
4 Specific and social phobias.
5 Obsessive compulsive disorder.
6 Post – traumatic stress disorder.
7 Acute stress disorder.
8 Anxiety disorder due to a general medical condition
9. Substance induced anxiety disorder .
10 Anxiety disorder and otherwise specified.

These disorders as classified in DSM-IV are briefly described below :

***1. Generalized Anxiety Disorder :***

In generalized anxiety disorder, distress and uneasiness are persistent and spread across various situations Primary symptoms of generalized anxiety disorder are anxiety, motor tension, autonomic hyperactivity and cognitive vigilance. The anxiety is excessive and interferes with the other aspects of the patient's life. The motor tension is most commonly manifested as shakiness, restlessness, and headache. The autonomic hyperactivity is commonly manifested by shortness of breath, excessive sweating palpitations and various

gastrointestinal symptoms. The cognitive vigilance is seen in the patient's irritability and the case with which the patient is startled.

The individual may also have a sense of foreboding apprehension and a feeling of impending doom, mixed with the physical symptoms. Usually, the individual with generalized anxiety disorder seek out a general practitioner for help with some somatic symptom. Alternatively, the individual goes to a specialist for a specific symptom The age of onset is not very specific for this disorder. It is found that individual's usually come to the clinician in their 20s although the first contact with the clinician can occur at any age

***2. Panic Disorder with and without Agoraphobia :***

Panic disorders involve specific, focused, time-bound attacks of intense fear, eve terror. The panic attacks, lasting from a few minutes up to on hour or more may include intense versions of the generalized anxiety characteristics but may also include symptoms like choking or smothering sensations

In panic disorder with agoraphobia, the above mentioned symptoms are accompanied with agoraphobia. Agoraphobic fears typically involve clusters of situations such as being in a crowd, being outside the home, travelling in a bus or train etc While in the panic disorder without agoraphobia the symptoms of panic attack as mentioned above occur, but agoraphobia is absent.

***3. Agoraphobia without the history of panic disorder:***

This type of disorder is characterized by symptoms of extreme fear and a sense of impending death and doom Patients are unable to find the source of their fear. They feel confused and have difficulties in concentrating. The

physical symptoms include tachycardia palpitations, dysphea and sweating. The individuals avoid situations in which it would be difficult to obtain help. They may insist that they be accompanied wherever they go.

### *4. Specific Phobia and Social Phobia:*

Phobias are characterized by arousal of severe anxiety when the individual is exposed to a specific situation on object or when the individual even anticipates exposure to the situation or object. The fear is in intense, persistent and irrational for something specific. Specific Phobias include fear for animals, insects, heights, water, Blood, injection, situations, dark etc.

Social Phobia is characterized by marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by other. The individual fears that he or she will act in a way that will be humiliating or embrassing. The person knows that the fear is excessive on unreasonable. But, the feared social situations or performance situations are avoided or else endured with intense anxiety or distress This interferes significantly with the person's normal routine, occupational functioning, social activities or relationships.

### *5. Obsessive – compulsive Disorder :*

An obsession is a recurrent and intrusive thought, feeling idea or sensation. A compulsion is a conscious, standardized, recurrent thought or behavior obsessions and compulsions tend to go together, however some individual's have only obsessive thoughts and no compulsions

Obsession involves recurrent and persistent thoughts, impulses or image that are experienced at some time during the disturbance. They are intrusive and inappropriate and cause marked anxiety or distress While compulsions involve repetitive behaviors or mental acts e g. handwashing, ordering, checking, counting, praying etc. The individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

Obsessive – compulsive people may be almost incapacitated by the rituals they have to perform. Besides this they are likely to be very inhibited, unemotional and detached. They keep their lives under tight control

### *6. Post – Traumatic Stress Disorder (PTSD) :*

Post traumatic stress disorder occurs when an individual has experienced an emotional stress that was of a magnitude which could be traumatic for almost anyone. Such traumas include combat experience natural catastrophe, assault, rape and serious accidents, etc. This disorder consist of :

(1) The re-experiencing of the trauma through dreams and waking thoughts,

(2) Persistent avoidance or reminders of the trauma and numbing of responsiveness to them, and

(3) Persistent hyper-arousal

Some common symptoms associated with it are depression, anxiety and cognitive difficulties.

### *7. Acute Stress Disorder :*

In acute stress disorder the person has been exposed to a traumatic event wherein the person experienced, witnessed or was confronted with an

event (s) that involved actual or threatened death serious injury or a threat to the physical integrity of self or others. The person responded to the event with intense fear, helplessness or horror. Along with these dissociative symptoms like subjective sense of numbing, detachment, absence of emotional responsiveness, reduced awareness de-realization, depersonalization, etc., may also be present

The traumatic event is persistently re-experienced in various forms (e g recurrent thoughts, dreams, illusions etc.). The individual tends to avoid the stimuli that evoke recollections of the trauma Besides these symptoms of anxiety or increased arousal also are found All these cause significant distress to the individual and cause distress or impairment in all areas of life

***8. Anxiety Disorder due to a General Medical condition :***

The Symptoms of anxiety disorder due to a general medical condition can be identical to those of the primary anxiety disorders. A syndrome which is similar to panic disorder in the common clinical features and most uncommon to Phobia. This disorder is characterized by prominent anxiety, panic attacks, obsessions or compulsions These disturbances are the direct physiological consequence of a general medical condition. The disturbance does not occur exclusively during the course of delirium.

It causes clinically significant distress or impairment in all areas of functioning.

### *9. Substance induced Anxiety Disorder :*

Substance induced anxiety disorder involve prominent anxiety, panic attacks, obsessions or compulsions. These symptoms develop within or during a month of substance intoxication or withdrawal. Medication use is etiologically related to the disturbance. Some commonly used substances that induce anxiety include many serotonogenic drugs (e.g LSD), Caffein amphetamines, Cocaine, a wide range of prescription medications etc.

The symptoms vary, however, with the particular substance involved. Infrequent use of psycho-stimulants also cause anxiety disorder.

### *10. Anxiety Disorder not otherwise specified :*

Some individuals has symptoms of anxiety disorders that do not meet the criteria for any specific DSM-IV anxiety disorder, or Phobic disorder or adjustment disorder with anxiety or mixed anxiety and depressed mood. Such people are classified as having anxiety disorder not otherwise specified.

## Etiological Theories of Anxiety Disorders

Interpretations of and explanations for anxiety disorders vary according to one's theoretical standpoint and inclinations. The major viewpoints/theories explaining anxiety disorders are as follows

A. Psychoanalystic/Psychodynamic Theories,

B. Behavioral Theories,

C. Cognitive Theories,

D Existential Theories and

E. Biological Theories,

***A. Psychoanalystic/Psychodynamic Theories :***

In most psychodynamic theories anxiety disorders are attributed to inner conflict and unconscious impulses.

Freud (1926) in his book 'Inhibitions, Symptoms and Anxiety' proposed that anxiety is a signal to the ego that an unacceptable drive is pressurizing to be represented and discharged consciously Acting as a signal anxiety propels the ego to take defensive action against the pressures from within. If anxiety goes beyond the low level of intensity characteristic of its role as a signal. It may strike back with all the features of a panic attack. Anxiety thereby is a kind of psychic overflow which is in excess and cannot be deflected with the use of defense mechanism Such an overflow may be expressed in the form of anxiety disorders.

Within psychoanalytic theory, anxiety is divided into four categories depending on the nature of the feared consequences These are as given below

(i) Id or impulse anxiety.

(ii) Separation anxiety

(iii) Castration anxiety

(iv) Superego anxiety

(i) Id or impulse anxiety .

This type of anxiety is related to the early stages of development. The event which is the prototype for this source of anxiety is birth when the infants are likely to be overwhelmed with needs and stimuli over which their helpless state provides no control.

(ii) Separation anxiety

This type of anxiety occurs in somewhat older but still pre-oedipal children, who are afraid that they may lose the love of their parents or even get abandoned by them, if they are unable to control and direct their impulses.

(iii) Castration anxiety

This type of anxiety consists of fantasies of castration that characterize the oedipal child. These fantasies particularly in association to the child' developing sexual impulses are magnified in the castration anxiety of the adult

(iv) Superego anxiety.

It occurs as an outcome of the final development of the superego that indicates the passing of the Oedipus complex and the advent of the pre-pubertal period of latency.

Until 1926, Freud believed that anxiety was a consequence of the damning up of energy by repression later on he reversed himself and proposed that anxiety is the cause of repression and not its effect. He explained that "It was not the repression that created the anxiety; the anxiety was there earlier, it was the anxiety that made the repression" (Freud, 1933) According to Freud the division of personality into Id, Ego and Superego forced him to adopt this new position on anxiety.

Psychoanalysts differ in explaining the sources and nature of anxiety. Sullivan (1954) emphasized the early relationship between the mother and the child and the transmission of the mother's anxiety to her infant. Horney (1945) described basic anxiety as an insidiously increasing, all-pervading feeling of

being lonely and helpless in a hostile world He proposed that anxiety resulted from feelings of insecurity in interpersonal relations. Unlike Freud, she did not believe that anxiety is an inevitable part of the human condition

B. Behavioral Theories .

Behavioral or learning theories of anxiety consider anxiety to be a conditioned response to specific environmental stimuli. According to Pavlov (1960) the phobic disorders may be acquired through the association of painful or unpleasant events with particular situations in the life histories of individuals having severe phobias which often comprise of especially threatening or traumatic events These events may have triggered specific phobias by the process of classical conditioning and may recur periodically. Behavioral theories assume that anxiety is a learned response either from modeling parental behavior or through the process of conditioning.

As proposed in the instrumental or operant conditioning theory of Skinner (1953, 1971) phobias may be reinforced Anxiety is a drive that motivates the organism to do what it can to eliminate the painful affect. Those avoidance patterns remain stable for a long time as a result of the reinforcement from their anxiety capacity to diminish activity. This can be explained through the classical conditioning and instrumental or operant conditioning models. However, these models based on animal derived principles seemed too limited to explain for many aspects of real human behavior.

Albert Bandura and Richard Walters (1963) proposed the observational learning model According to their view, anxiety can be explained on the basis of fearful models and observational learning opportunities. The classical

conditioning, instrumental or operant conditioning and observational learning theories are used effectively for therapeutic purposes also.

In recent years, however, behavioral theorists have demonstrated much interest in cognitive approach to conceptualize and treat anxiety disorders.

C Cognitive Theories:

Cognitive theories believe that an individual's behavior is determined not only by the environment but also by his or her attitudes, expectations and beliefs. According to George Kelly (1955), "a person's processes are psychologically channelized by the ways in which he anticipates events" Kelly assumed that the future, rather than the past, is the primary impetus of behavior In accordance of his theory of personal construct, Kelly (1955) described anxiety as, "The recognition that the events with which one is confronted lies outside the range of one's construct system". In other words, we feel anxious when we cannot understand ourselves and the events of out lives in terms of our past experiences such discrepancy can lead to construct change. If a change is merely incidental the individual may experience some fear, but it the change is comprehensive, the individual will feel deeply threatened. Many behaviorists in explaining anxiety hold the view that maladaptive or irrational ideas can stimulate undesired behavior This view is also assumed by Donald Meichenbaum (1977) He uses self – instructional training to treat individual's in whom high anxiety of poor self control interfering with coping.

D Existential Theories:

Existential theories of anxiety provide models for generalized anxiety disorder, where there is no specific stimulus causing a chronically anxious feeling. The main concept of existential theory is that persons become aware of a profound nothingness in their lives, feelings that may be even more discomforting than an acceptance of their inevitable death. Anxiety thereby is the person's response to that wide gap of existence and meaning. According to Rollo May (1977), anxiety is distinctly bound up with consciousness and subjectivity He proposes that anxiety is an inevitable characteristic of being human (May, 1983). When, the distinction between the self and object breaks down, anxiety occurs. Although the particular events that may become threatening are learned.

E. Biological Theories:

No specific biological cause has been identified for the anxiety disorders However, evidences have shown that biology plays an important role in anxiety. It is found that tranquilizing drugs help to alleviate anxiety. Investigators are now exploring how these drugs help and which sites of the brain they affect. This may help in understanding the body's "anxiety system". Carey and Gottesman (1981) have found that heredity plays at least some role in the anxiety disorders

Biological theories regarding anxiety have developed out of pre-clinical studies with animal models of anxiety. The study of patients in whom biological factors were ascertained, the growing knowledge regarding basic neuroscience, and the actions of psychotherapeutic drugs. Some researches point out that biological changes result due to the psychological conflicts

existing in an anxiety hidden individual, while other studies point out that biological events precede the psychological conflicts.

**Autonomic Nervous System :**

The Autonomic nervous system plays a major role in the phenomena of anxiety. The James-Lange theory states that subjective anxiety is a response to peripheral phenomena It is now generally thought that central nervous system (CNS) anxiety preceeds the peripheral manifestations of anxiety.

**Neurotransmitters:**

Three major neurotransmitters are associated with anxiety viz. Norepinephrine Seratonin and Y – aminobutyric acid (GABA)

**Brain – Imaging studies :**

A variety of Brain – imaging studies conducted with specific anxiety disorder, have revealed many factors in understanding anxiety disorders. Computed Tomography (CT), Magnetic resonance imaging (MRI) and computerized Axial Tomography (CAT) have occasionally found some increase in the size of cerebral ventricles Several studies have found abnormal leisons in the right hemisphere but not in the left hemisphere. Functional brain-imaging studies e g. positron emission tomography (PET), single photon emission tomography (SPECT) and electro-encephalography (EEG) of anxiety patients have shown abnormalities in the frontal cortex, the occipital and temporal areas.

**Genetic studies:**

Data for anxiety disorders, indicates a higher frequency of the illness in first degree relatives of the anxiety patient, than in non-relations.

# DEPRESSION

All of us, at some point of time in our lives, have experienced depression. We show occasional changes in affect or mood. The people talk of the depressive feelings in different words. Words like grief, sadness, pessimism, unhappiness, loneliness, etc., are used to convey depressive feelings. Sometimes we feel sad or let down, at other times we tend to be happy and elated. However, in some people these mood swings go beyond their control. Gradually they become extreme in degree or duration thereby creating a major problem for themselves. Such extreme moods along with particular patterns of maladaptive thinking and behavior are diagnosed as 'affective disorders'. And depression is a disorder of affect.

The history of depression is as old as that of human existence. Literature is full of instances depicting the phenomena of depression. The description of depression can be found in many ancient scriptures also The old Testament story of King Saul describes the depressive episode So does the story of Ajax's suicide in Homer's Illiad.

The concept of depression is dynamic and has its psychoanalytic foundations in Freud's seminal work – "Mourning and Melancholia" (Freud, 1917).

Depression has been the focus of attention of laymen and medical professionals alike. There is a tremendous amount of recorded history about depression (Grinker, 1961).

Depression is a universal experience, the emotions of sadness and grief and intrinsic facets of the human condition (Mendels, 1970) It is an extremely common problem and can be extremely painful one, regardless of the individual's age or life circumstances.

In this modern era of technological advances, the society is undergoing a major transition. The people are facing problems is every aspect of their lives. These pressures may be in form of economic or financial constraints, instability in personal relationships, jobs etc. Feelings of alienation and stress due to faulty life styles also work as catalysts in occurrence of depression. Breaking of traditional values and blind aping of the Western culture also has affected the Indian society adversely Under such circumstances, anyone can fall an easy prey to depression.

**The Definition of Depression :**

Depression is defined as an emotional state marked by sadness, inactivity and self-depreciation. It is not necessarily an illness, but certainly associated by many mental and physical disorders.

Coleman (1981) has defined depression as "an emotional state characterized by extreme dejection, gloomy rumination, feelings of worthlessness, loss of hope and often apprehension".

Depression in the normal individual is, "a state of despondency characterized by feelings of inadequacy, lowered activity and pessimism about the future." In pathological cases, it is an extreme state of unresponsiveness to

stimuli, together with self-depreciation, delusions of inadequacy and hopelessness.

The condition labeled as depression, has been described as 'Melancholia' in the ancient times. Hippocrates made the first clinical description of Melancholia in the 4th century B C. He also has described mania and depression In the 2nd century AD, Aretaeus, a physician, discussed melancholia and mania as alternate phases of the same disorder.

**Symptomology of Depression :**

Low mood, pessimism, self-criticism and retardation or agitation are accepted as symptoms of depression everywhere. The most conspicuous symptoms of depression are the feelings of worthlessness, hopelessness and suicidal urges. In some persons, these moods of depression alternate with brief periods of undue elation Some signs and symptoms that have been considered to be intrinsic to the depressive syndrome, include, autonomic symptoms, constipation, slow thinking and anxiety (Beck, 1967).

Aaron T. Beck (1967), has classified the symptoms of depression under four categories. These are as follows :

***1. Emotional Manifestations :***

These include dejected mood, Negative feelings towards self, Reduction in gratification, Loss of emotional attachments, crying spells.

***2. Cognitive Manifestations :***

These include, self-evaluation, Negative Expectations, self-blame and criticism, Indecisiveness and distortion of body image

### *3. Motivational Manifestations :*

These include Paralysis of will, Avoidance, Escapist and withdrawal wishes, Suicidal Wishes and increased dependency.

### *4. Vegetative & Physical Manifestations :*

These include, Loss of appetite, sleep disturbances, Loss of libido, Fatigability, Delusions of worthlessness, Crime & Punishment, Nihilistic, somatic and delusions of poverty and hallucinations.

Beck (1967), described that the individual prone to depression; acquires certain negative attitudes about himself, the outside world and his future during the development period. He becomes specifically sensitive to certain items like deprivation, being thwarted or rejected. Exposure to such stresses leads him to respond disproportionately with ideas of personal deficiency with self-blame and pessimism.

Based on idiosyncratic attitudes, schemes are formed These schemas enable the individuals to orient himself to a situation, recognise and label the salient features and finally conceptualise the experience In depression, these schemes create typical depressive feelings of sadness, guilt, lonelines and pessimism As the depression deepens, these schemes increasingly dominate the cognitive processes involved in attaining self-objectivity and reality testing (Beck, 1967).

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) identifies two basic symptom patterns in mood disorders-one for depressions and one for mania Depressive episodes can occur both in

major depression and bipolar disorders To be suffering from major depression, a person must have had one or more major depressive episode-periods that involved more than just 'sadness' While in Bipolar disorder, the individual tends to oscillate between two mood states, viz, depression and mania

**Characteristics of a Major Depressive Episode :**

A major Depressive episode is characterized by feelings of sadness accompanied by persistent problems in other areas of life-such as appetite change, alteration in sleep patterns, loss of interest or pleasure in usual activities including sex, loss of energy, diminished ability to think of concentrate, feelings of worthlessness or self-reproach or suicidal thoughts or acts

The depressed person seems to be lost, vulnerable, detached, unable to find joy in any aspect of daily life and has a totally negative thought pattern. Often the person is constantly on the verge of tears His thoughts about himself are negative and he sees the future as completely hopeless. As a result, he is prone to suicidal tendencies.

In the present state, depression can be defined in terms of the following features :

1 A specific alteration in mood, sadness, loneliness, apathy.
2. A negative self concept associated with self reproach and self blame.
3 Regressive and self punitive wishes, desires to escape, hide or die
4 Vegetative changes : anorexia, insomnia, loss of libido.
5. Change of activity level · retardation or agitation.

**Extent of depression :**

Depression usually affects the sophisticated, mature and intellectual classes of the society. In children, its onset is mostly from puberty. Creative individuals like authors, poets, musicians, painters are found to be more prone to depression.

**Types of Depression :**

***1. Simple Depression :***

In Simple depression, the individual's mental and physical activities slow down. He feels sad, dejected and gloomy. The thinking process becomes sluggish and he speaks in a monotone. Feelings of worthlessness, incompetence and lack of interest develop He becomes irritable and sensitive and cries easily. He may have suicidal thoughts and may plan for such actions The individual neither sleeps well nor eats well Complaints of complete exhaustion are observed.

***2. Marked Depression :***

In Marked Depression, the attitude of the person is of total helplessness and worthlessness His speech is slow and monotonous. He has slow and monotonous speech He feels dejected and is in a state of despair Suicidal thoughts occur and attempts to commit suicide are also made. Sometimes these attempts may prove fatal also. Some individuals feel so guilty and unworthy that they do not eat, while others feel so dependent that they never speak even when spoken to; they mutter unintelligently. The individuals become sluggish and some people show delusional trends.

### *3. Stuporous Depression :*

Stuporous depression is the most severe degree of depression. It is accompanied by morbidity, dearth of ideas, abulia stupor and clouding of conciousness. The individual is in a state of stupor He is unresponsive to everything and has to tube feed and cared for all other needs. He may remain motionless for long time periods until moved or disturbed. Hallucinations are frequently found while delusions occur occasionally. Physical symptoms like stomach disorders, loss of weight, sleepiness, constipation, weakness and fatigue are also found.

### *4. Delusional Depression :*

Delusional Depression is predominantly characterized by delusions-mostly of persecution Other delusions include hypochondriacal ideas, ideas of ruin, ideas of humility and ideas of guilt. In some people, these delusions are accompanied by hallucinations and illusions. The individual's speech becomes slow and monotonous

### *5. Agitated Depression :*

In Agitated Depression, the individuals become apprehensive Melancholia and motor restlessness usually seen as hand rubbing, face rubbing or pacing the floor accompany this apprehension. The individual becomes irritable and overactive. He shows hypochondriacal trends as well as ideas of self-accusation. Since, the individual is unable to eat or sleep property; he loses weight and develops malnutrition. Some persons even attempt suicide

### *6. Reactive Vs Endogenous Depression :*

The reactive depression is caused due to psychological factors found within the person. While endogenous depression is caused more due to biological reason.

### *7. Neurotic Vs Psychotic Depression :*

Severe depression with symptoms of chronic retardation, autonomic disturbances, hallucinations, delusions and suicidal thoughts is known as Psychotic depression While the milder disorders are known as Neurotic depression. The Neurotic depressive feels sad, dejected and discouraged He is tense and restless, shows disinterest, is pessimistic about the future Suicidal thoughts also occur and suicidal attempts also are made

Depression may not always end in Suicide However, even then the individual endures intense pain and suffering. The intensely painful nature of depression, its high incidence has always led researches to study its cause Different causal theories have been formulated to explain depression. These are described as follows :

### Theoretical Background of Depression

The Causal factors of depression have been explained chiefly though five major sources viz.,

A Ancient Theories

B. German Descriptive and Nosological theories

C. Psychoanalytic Theories

D Behaviouristic Theories

E Cognitive Theories

F Biological / Genetic Theories

**A. Ancient Theories :**

More than 2500 years ago, Hippocrates had postulated that depression was caused by the movement of black bile. The Ancient theories classified mental illness into broad categories of mania, epilepsy, paranoia and melancholia; where melancholia consisted of description of patients with abnormal depression.

The word "Melancholia" is derived from the greek word 'MELAGKHOLIA', meaning black bile; (Melas = Black, Khole = Bile). It was believed that a sudden flow of bile of the brain caused unpleasant dreams and anxiety. Excessive flow of black bile caused melancholia. However, this view was questioned by Caelius Aurelianus. He believed that depression was mainly caused due to indigestion, use of drugs, grief and fear. The onset of melancholia was described by symptoms like mental anguish, distress, dejection, silence, wish to die, unexplained weeping, meaningless mutterings, distension and other symptoms (Grinker, 1961).

In the second century AD, Aretaeus had differentiated Melancholia and Mania as alternate phases of the same disorder (Munsinger,1983). This differentiation resembles the concept of manic-depressive disorder developed by Kraeplin, (1921).

Thus ancient researches also had knowledge related to some etiological factors of depression.

**B. German descriptive and Nosological Theories:**

The 19th century, under the leadership of Kraeplin (1921), ushered in a new era in the realms of psychology and psychiatry. Kraeplin attempted to establish a proper history of the various entities included in classification of mental illnesses. He laid emphasis on etiology and diagnosis, however, the final stages of an illness determined the prognosis.

According to Kraeplin, depression developed gradually. Symptoms like preliminary sadness, dejection, lack of enjoyment in work or family life, complaints of dullness, confusion, apprehensiveness, delusions etc , become visible long before the actual onset of depression He has observed that depressed individuals often suffered from delusions of hypochondriasis and guilt. Along with these auditory hallucinations, Kraeplin had also highlighted the role of premorbid personality and heredity in depression. Thus, he had observed and described all the types of depression and most of the symptoms of depression known today.

Bleuler (1924) has described depression as "a flat colourless affective state wherein the patients complain that they have no emotions". The expression of emotion is painful, desperate, anxious usually with very little mobility However, the rigidity of affect as seen in Schizophrenia is absent. The thoughts are difficult and create an internal psychic pain. Bleuler (1924) has also discussed delusions of ruin (economic, bodily and spiritual) that take different forms on the basis of the individual's personality. He has described three cardinal symptoms that are to be found in all depressive individuals :

- Depressed Mood
- Mental Retardardation
- Inhibition of Will

The earliest attempts comprising Psychological explanation of grief and depression were made by Sigmeund Freud in his paper "Mourning and Melancholia" (1917) In the paper, he had described on the basis of some case studies, the distinguishing characteristics between mourning and abnormal depression According to him melancholia was symptomised by "painful dejection, abrogation of interest in the outside world, loss of the capacity to love, inhibition of all activities, self-reproach and delusional expectations of punishment" (Freud 1917). Freud differentiated melancholia or depression from normal grief on the basis that the depressed person feels profound self-depreciation in association with guild and self-reproach, while the mourner does not.

In the theory of ambivalence, Freud (1922) explained the phenomena of depression in context of bereavement and self-recrimination. He postulated a relation between object loss and melancholia He proposed that at an unconscious level, loss of a loved object leads to depression. His other viewpoint was that due to oral fixation, an individual tends to become dependent on others for self-evaluation. Thus, when there was a combination of a dependent personality and loss of a loved one, the depression grew more serious. He suggested that the depressed person's rage is internally directed because of the identification with the loved object The person feels abandoned, angry and frustrated. But the depression is not expressed as hostility. The object loss gradually is converted into an ego-loss, thereby setting

in motion a prolonged and exaggerated grief reaction-which includes feelings of guilt, blame and loss of self-esteem This, in turn, can set the stage for the development of depression when the child enters adulthood Thus, the sadistic side of the ambivalence targeting the lost object becomes united with the ego. Every struggle of ambivalence loosens the fixation of the libido to the object by disparaging and disintegrating it (Grinker, 1961).

He found that in majority of the depression cases, onset of the first attack was between the age of 15-30 years As the age increased the frequency of melancholia episodes also increased

Fredrick Albert Lange (1928) made this observation that researches of later German psychiatrists, laid great emphasis on the personality of individuals prone to the manic-depressive psychoses. He found that the Germans gave much importance to heredity, particularly the constitutional defects The depressive individual, thereby was characterized by pyknic body build, short stature and stocky body. In such people, depression was preceded by hypochondriacal attitude towards the self and a compulsive sensitive attitude towards others.

Thus, during this period before the First World War, techniques of observation and description of the clinical manifestations of depression and the classification of the depressive syndrome into various categories reached its pinnacle with the works of the German Psychiatrists.

In the period between the two world wars, mostly emphasizing heredity and constitutional factors depicted etiology of melancholia. These works laid

the foundation for the etiology of depression and greatly influenced the psychoanalytic movement.

**C. Psychoanalytic Theories :**

The 20th century was characterized by the works of Freud and the development of the Psychoanalytic theories, explaining mental illness. This created "The Second Psychiatric Revolution" Emphasis was laid on explaining mental illness through individual psychodynamics.

Earlier, Karl Abraham (1953) was of the opinion that depression is caused by a special fixation of the libido at the oral (cannibalistic) stage, as found in the introjection and incorporation of the lost love object (Grinker 1961).

Melanie Klein (1948) linked depression to the depressive position She explained depression in terms of the mechanisms of projection and introjection, operative at or near birth. According to her, depressed individuals suffer from the concern that they may have destroyed loving objects through their own destructiveness and greed. As a result of that fantasized destruction, they experience persecution by the remaining hated objects. The feelings of worthlessness occur due to the sense that their good internal objects have been transformed into persecutors because of their own destructive fantasies and impulses (Kaplan et al, 1994)

Heinz Kohut (1971) redefined depression in terms of self-Psychology According to him, the depressed individual feels a sense of incompleteness and despair at not receiving the longed for response These responses from

the environment are necessary to sustain self-esteem and a feeling of wholeness

Thus, extensive psychoanalytic literature on depression elaborates the concept of loss and presence of aggressive feelings intertwined with melancholy as postulated by Freud (Mendelson, 1974).

**D. Behavioristic Theories :**

The Behaviouristic theories of depression emphasized the mentalistic concepts and held that it had no role in the occurrence of illness.

They attributed depression to the process of reinforcement and social interaction. Peter Lewinsohn and his research team (1979) found that depressed people often have had especially high frequencies of unpleasant, unrewarding events in their lives. These people, due to the low level of reinforcement received, tend to invest less hope and energy in social interactions and other activities. They thereby do not seem to be very useful to others. Hence, others tend to avoid depressed people. Consequently, their depression deepens further (Lewinsohn & Arconad 1981). Eventually, the individual is entangled in a vicious circle of learned helplessness and hopelessness

Seligman (1975) proposed the "learned helplessness theory of depression". This theory assumes that the main cause of depression is a person's belief that control over environment is impossible. According to this theory, depression can improve if the clinician instills in the depressed patient a sense of control and mastery of the environment.

Coyne (1976) described the negative impact depressed people can have on others. Later on, Coyne (1982) found that depressed people tried to cope with stressful situations by seeking emotional support from others, a dependent style that may contribute to the discomfort others feel around them. However, when inspite of the support or aid offered by others, the depressed individual does not improve, irritation occurs. Other people at such times give reassurance and statements of support along with increasing avoidance of the depressed person. As a result, the person gets confused and depressed. This theory has been quite useful by helping to stimulate new ideas on how to help depressed people recover

**E. Cognitive Theories :**

One prominent model proposed by Abramson (1978) assumes that depression involves a kind of 'giving up' or learned helplessness. According to this model, depression can occur when people expect bad things to happen to them and assume that they will not be able to prevent or control them. If people attribute this lack of control of personal causes, their self-esteem will be impaired. If they believe the causes are stable, then their depression will be long lasting. If they believe their lack of control extends to many situations, then their depression will be generalized across situations Thus, the depression is affected by cognitions

Aaron Beck (1974, 1976) stressed the Cognitive aspects of depression. According to him, depression is primarily a disorder of thought and secondarily a mood disorder. Beck's model of cognitive depression is based on systematic observations and experimental testing (Beck, 1983). His view is that individuals

become depressed as they have distorted cognitive beliefs These beliefs constitute the "cognitive triad" (Beck, 1983) The depressed persons as explained by him, are dominated by negative views of self, the outside world and the future. Beck (1974) described that depressed people experience major distortions of logical thought. These consist of,

1. ***Arbitrary Inference*** : Drawing a conclusions based on very little or no proof at all.
2. ***Selective Abstraction*** : Drawing a conclusion by concentrating on one detailed aspect of a situation.
3. ***Overgeneralization*** : Unjustified generalizing from limited proof
4. ***Magnification and Minimisation*** : Exaggerating or limiting the significance of information.

According to Beck, the other signs and symptoms of the depressive syndrome may be viewed as consequences of the activation of the negative cognitive patterns (Beck, 1983). He has classified the symptoms of depressions into four categories, viz , Emotional, physical, cognitive and motivational manifestations.

**Classification of depression (Beck, 1967):**

***Emotional Manifestations :***

These consist of the changes in the patients feelings or his overt behavior directly attributable to his feeling states e.g. Symptoms like dejected mood, self-dislike, crying spells, loss of gratification and attachment.

***Physical Manifestations :***

These consist of physical symptoms like loss of appetite, disturbed sleep, loss of libido and fatigability.

**Cognitive Manifestations :**

These were classified into three categories viz. mild, moderate and severe. The cognitive manifestations are low self-evaluation, distorted body image, negative expectations, self blame, self-criticism and indecisiveness.

***Motivational Manifestations :***

These include consciously experienced strivings, desires and impulses that are prominent in depression.

**Personality & depression (Beck 1976, 1983) :**

In the years following the classification of depression, Beck (1976) tried to determine whether particular clusters of personality attributes or cognitive structures were specifically related to the types of emotions that were aroused in a given situation He observed that, for a given individual, specific stressors are linked to specific emotional reactions. He found that depression was related to two personality types :

- *The Social-Dependant Type*
- *The Autonomous Type*

Although these personality types referred to the individual's mode of functioning and dominant personality patterns at a given time rather than a fixed immutable personality structure (Beck, 1983). Beck noticed that autonomous depression is permeated with the theme of defect or failure. On the other hand, in "reactive depression" (socially dependent type) the

individuals are preoccupied with the theme of deprivation. The precipitating factor for depression among individuals with autonomous personality are impediments in their goal-seeking behavior and among depressed individuals with social-dependent personality is actual or perceived interruption in the "pipeline" of social supplies.

In contrast to Beck's view, certain other researches have suggested that depressed people may actually make more accurate assessments of themselves and certain situations than non-depressed people. Another finding was that, reduced depression might go hand-in-hand with exaggerated self-perception. One way of warding away depression thus is to be a bit unrealistic about ourselves-adopting a "warm glow" (Lewinsohn et al, 1980) that keeps us focused on our weaknesses and failurers.

A careful review of the research on the cognitive processes (Coyne & Gotlib, 1983) showed that each of the major models have some scientific support but none has strong support

**F. Biological / Genetic Theories :**

Many investigators believe that biological factors play an important role in depression. Some physiological deficit, either inherited or acquired in other ways, is considered to make some individuals more vulnerable to depressive episodes.

Hereditary / Genetic factors play a significant role in depression. Concordance rates for depression are found to be higher in identical (monozygotic) twins than for fraternal (dizygotic) twins.

Another mechanism underlying depression is the role of neuro-transmitters. Depression according to this idea is caused not only by low levels of nor-epinephrine in the system but more specifically, by low levels of nor-epinephrine or other similar substances available for transmission of information (Sulser, 1979). A large number of studies have associated the biogenic amines nor-epinephrine and serotonin with the patho-physiology of depression. Data reveals that dopamine also plays an important role in depression.

Abnormal regulation of the thyroid and adrenal glands caused by the abnormal functioning of biogenic amine containing neurons also leads to depression

**The Phenomena of Depression in Indian Context :**

Depression, as in other cultures is a phenomenon that has found an important place in the Indian literature. It has been mentioned in the Ramayan and Mahabharat, various folk stories, ancient medical monographs and compendia

In Ramayan, depression affected 'Ram' when he was fifteen years of age. He was found to be deeply in pensive thought, he forgot to perform daily activities of life allotted to him, his mind grew despondent. The author's description of Ram indicate the characteristics of depression which are explained to the modern clinicians and psychiatrists as psychomotor retardation, withdrawal, depressed, faced etc

In Mahabharat, Arjun, anticipating the destruction of his kith and kin in the battle of Kurukshetra, gets depressed At that time, Lord Krishna lifts him out of the depression by admonishing and counselling him This, created the 'Gita', which till date, is a source of inspiration to a large number of individuals.

Ayurveda has talked health, in terms of the stability of various bodily and mental humors. Disease occurred when there was an imbalance of these 'doshas' (i.e. Vata, Pitta & Kaph). Imbalances of doshas caused diseases. 'Unmad' or inanities resulted from the disorders of these 'doshas'. This is very similar to Hippocrates's explanation of melancholia, as caused by black bile

The researches on depression in the general population indicate that it is more in Northern and Eastern India as compared to Western and Southern India. Effects of Urbanisation like pollution, stress, competition etc have led to development of depression in urban areas Rural areas also have recorded depressions, but in lesser proportions (Sethi & Gupta 1973).

Other factors related with depression, included–social classes, unemployment, educational levels, family structure, gender etc