DELUSIONAL (PARANOID) DISORDER

The term paranoia has been in use a long time. The ancient Greeks & Romans used it to refer more or less indiscriminately to any mental disorder. Our present, more limited use of the term stems from the work of Kraepelin, who reserved it for cases showing delusions & impaired contact with reality but without the bizarreness, fragmentation & severe personality disorganization characteristic of schizophrenia.

Currently two main types of psychoses are included under the DSM IV headings relating to (nonschizophrenic) paranoid disorders: delusional disorder, formerly called paranoia or paranoid disorder & shared psychotic disorder, in which two or more people develop persistent, interlocking delusional ideas.

DSM-IV requires that diagnoses of delusional disorder be specified by type, based on the predominant theme of the delusions present. These types are as follows:

Persecutory type. The predominant delusional theme is that one (or someone to whome one is closely related) is being subjected to some kind of malevolent treatment, such as spying, stalking or the spreading of false rumors of illegal or immoral behavior. Legal actions of one sort or another are often instituted to redress the alleged injustice, & in extreme cases more direct & dangerous modes of counteraction are employed such as attempted (and sometimes completed) murder.

Jealous type: The predominant theme is that one's sexual

partner is being unfaithful.

Erotomanic type : The predominant theme is that some other person of higher status, frequently some one of considerable prominence, is in love with one & wants to start a sexual liaison.

Somatic type : The predominant theme is an shakable belief in having some physical illness or disorder, often esoteric or exotic in nature.

Grandiose type, The predominant themes is that one is a person of extraordinary status, power, ability, talent, beauty etc, or that one has a special relationship with someone having such attributes, usually someone of celebrity status.

Mixed, This diagnosis is used where there are combinations of the above, but when no single theme predominates.

Of these types, the persecutory is by far the most common & our discussion will focus on this form of the disorder.

Although the formal diagnosis of delusional disorder is rare in clinic and mental hospital populations, This observation provides a somewhat misleading picture of its actual occurrence. Many exploited inventors, fanatical reformers, self-styled prophets, morbidly jealous spouses, persecuted teachers, business executives or other professionals fall into this category. Unless they become a

Although the evidence that paranoid people advance to justify their claims may be tenuous & inconclusive, they are unwilling to accept any other possible explanation and are impervious to reason. A husband may be convinced of his spouse's unfaithfulness because on two separate occasions when he answered the phone the party at the other end hung up. Argument and logic are futile. In fact any questioning of his delusions only convinces him that his interrogator has sold out to his enemies.

Although ideas of persecution predominate many paranoid individuals develop delusions of grandeur in which they endow themselves with superior or unique abilities. Such "exalted" ideas usually center on messianic missions, political or social reforms, or remarkable inventions. Paranoid people who are religious may consider themselves appointed by God to save the world & may spend most of their time "preaching" and "crusading".

Aside from the delusional system, such an individual may appear perfectly normal in conversation, emotionality & conduct. Hallucinations & the other obvious signs of psychopathology are rarely found. This normal appearance, together with the logical & coherent way in which the delusional ideas are presented may make the individual most convincing, perhaps especially to persons awash in their own uncertainties.

Paranoid individuals are not always as dangerous as

serious nuisance, these people are usually able to ma
n themselves in the community & do not recognize their
paranoid condition nor seek help to alleviate it. In se
instances, however they are potentially dangerous & in
virtually all instances they are inveterate "injustice-dete
rs" inclined to undertake retributive actions of one sor
or another against their supposed tormenters.

The Clinical Picture in Delusional Disorder:

A paranoid or delusional, individual feels singled o
& taken advantage of, mistreated, plotted against, stole
from, spied on, ignored, or otherwise mistreated by
"enemies". The delusional system usually centers on on
major theme, such as financial matters, a job, an inventio
an unfaithful spouse, or another life affair. Eg. a wome
who is failing on the job may insist that her fellow work
and superiors have it in for her because they are jealou
her great ability & efficiency. As a result, she may qui
job & go to work elsewhere, only to find friction develop
again & her new job in jeopardy. Now she may become co
vinced that the first company has written to her present
employer and has Turned every one against her so that s
has not been given a fair chance. With time more & mor
of the environment is integrated into her delusional
system as each additional experience is misconstrue
& interpreted in the light of her delusional ideas.

popular fiction & drama suggest, but the chance always exists that they will decide to take matters into their own hands and deal with their enemies in the only way that seems effective. The number of husbands and wives who have been killed or seriously injured by suspicious, paranoid mates is extremely large worldwide (DeKay & Buss 1992).

Causal Factors in Delusional Disorder

Most of us on various occasions may wonder if we are not jinxed. When it seems as if everything we do goes wrong and the cards seem to be stacked against us. Many people go through life feeling underrated & frustrated, brooding over fancied & real injustices. Meissner (1978) regards such attitudes as a normal & essential phase of personality development, a necessary component in the achievement of personal identity & autonomy. Most people, according to this view, are able to grow beyond this phase, whose central feature is the need for an enemy. Some few are not however, in which case they chronically entertain paranoid explanations of what ever problems they may have.

Most delusionally disordered persons seem as children to have been aloof, suspicious, seclusive, secretive, stubborn and resentful of punishment. When crossed, they became sullen and morose. Rarely do these pre-paranoid individuals show a history of normal play with other children or good socialization in terms of warm affectionate relationships (Sarvis 1963, Schwartz 1963). The seeds may thus be sown quite early for

a stand-offish & relatively unfriendly interpersonal style. Such a child may understandably be unpopular with peers - in effect an aversive stimulus. Thus as Lemert (1962) has noted an unduly suspicious or coldly rejecting person frequently becomes a target of actual discrimination & mistreatment. Ever alert to injustices, both imagined & real such individuals find abundant "proof" of persecution.

In this context, Grunebaum and Perlman (1973) have pointed to the naivete of a pre-paranoid person in assessing the interpersonal world - in terms of who can be trusted & who cannot - as a fertile source of hurtful interactions. As they express it, "The ability to trust others realistically requires that the individual be able to tolerate minor & major violations of trust that are part of normal human relationships". The pre-paranoid individual is unprepared for the 'facts of life", however tending to both trust & mistrust inappropriately & to overreact when others are perceived, accurately or not, as betraying the trust.

Where delusional disorder develops, it usually does so gradually, as mounting failures & seeming betrayals force these individuals to an elaboration of their defensive structures. To avoid self devaluation, they search for "logical" reasons for their lack of success. They become more vigilant, begin to scrutinize the environment, search for hidden meanings, & ask leading questions. They ponder like a detective over the 'clues", they pick up trying to

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them into some sort of meaningful picture.

Gradually the picture begins to crystallize - a p
ss commonly referred to as "paranoid illumination". It b
es apparent that they are being singled out for so
obscure reason, that other people are working agains
them, that they are being interfered with. In essen
they protect themselves against the intolerable assump
"There is something wrong with me", with the defensiv
transformation, "They are doing something to me". Th
have failed not because of any inferiority or lack of
their part, but because others are working agains
them. They are on the side of good and the progress
humankind, while their enemies are allied with the
of evil. With this as their fundamental defensive p
they, proceed to distort & falsify the facts to fit i
gradually develop a logical, fixed delusional sy

The role of highly selective information proces
in the development of these delusional systems shou
be emphasized. Once these individuals begin to susp
that others are working against them, they start ca
nothing the slightest signs pointing in the direction
their suspicions and ignore all evidence to the contr
(Swanson etal 1970)

With this frame of reference it is quite eas
our highly competitive & sometimes ruthless world,
paranoid persons to find ample evidence that o

SCHIZOPHRENIA

Schizophrenia is a mental disorder marked by nagative serious disterbances of thought. Though there is no universally agreed upon definition of schizophrenia but the term can be used to refer to a group of disorders charecterised by gross distortion of reality, withdrawal from social interaction & disorganisation of thoughts & emotions.

Clinical Picture:—

When the disorder develops gradually over a period of time & not in response to obvious discrete stressors & tend to be long lasting it is referred to as "Process schizophrenia". The Process schizophrenia is generally considered as unfavourable. because the need for treatment is usually not recognized until the behavior pattern has become firmly entrenched. It also called as "chronic schizophrenia"

In Reactive schizophrenia the onset of the symptoms is sudden & dramatic and is marked by intense emotional turmoil & nightmarish sense of confusion. This pattern is often associated with identifiable precipitating stressors. The symptoms may clear in matter of weeks though in some cases they may serve as a signal for development of chronic pattern.

Mental health workers typically distinguish between positive & nagative symptoms of schizophrenia. Recently the third category of symptoms has been added which is called as Disorganized category. Though there is no

universal agreement about which symptoms should be included in these categories, positive symptoms would include more active manifestation of abnormal behavior and distortion of normal behavior. Hallucination + delusion are included here.

Nagative symptoms involve deficits in normal behavior. In such areas as speech or motivation.

The disorganized symptoms include disorganized speech, erratic behavior, inappropriate affect.

The diagnosis of schizophrenia requires that [illegible] or more positive, negative

Positive Symptoms :-

Disturbances of thought content - delusions are irrational beliefs that the individual defends vigourously despite their logical absurdity + despite the objective evidence showing them to be untrue. It is the basic characteristic of madness. A common delusion in the people with schizophrenia is that others are 'out to get them". In other words delusions of persecution are the main common delusion.

Other common delusions in schizophrenia are:-

(a) Delusion of grandeur.

(b) Delusion of reference (feeling that others are talking about

Disruption of Perception (Hallucination):-

The patient is not able to sort out + process the great mass of sensory information to which he is exposed. There a massive breakdown of perceptual filtering through

person into turmoil. Hallucinations particularly auditory hallucinations are experienced.

Nagative Symptoms:-

Avolition:- without will

Inability to persist & initiate activities. The goal directed behavior is almost universally disrupted in schizophrenic individuals. They show little interest in performing the most basic day to day activities, including those associated with personal hygine.

i) Alogia:- without speech.

It reffers to relative absence of speech. The person is uninterested in communication & gives only brief replies.

ii) Anhedonia:-

The patient is indifferent to the activities that provide pleasure.

iii) Affective flattering:-

By flat affect we mean that the person does not show emotions that is shown by most normal people. Schizophrenics stare at others vacantly & speak in a flat & toneless manner & seem to be uneffected by the things around them.

iv) Retreat to inner world:-

Ties with the external world are loosened in schizophrenia & there is a withdrawal from reality which is often accompanied by claboration of the inner world in which the person develops illogical fantastic ideas.

v) Confused sense of self:-

The patient may feel confused about their identity to the point of loss of subjective sense of self.

Disorganised sumptoms :-

Disorganised speech :-

communication disturbance is usually considered as prime indicator of schizophrenia. The communication is fragmented & there is loosening of associations.

Disorganised behavior :-

Various peculiarities of movement are sometimes observed in the patients. The motor disturbances may range from hyperactivity to marked decrease in movement

Types :-

) Catatonic
) Paranoid
) Disorganised type
:) Undifferentiated type
:) Residual type.
) Undifferentiated type :-

Symptoms :- It is something of a waste basket category. A person diagnosed meets the usual criteria of schizophrenia including hallucinations, delusions, disorganized thoughts & bizarre behavior, but does not fit into one or other type because of mixed symptoms, picture commonly observed are the indications of perplexity, confusion, emotional turmoil, delusions of reference, excitement, depression, dream like dissociation, fear & Most often this picture is seen in the patients who are in process of becoming schizophrenics. This disorder is also seen when major changes are occuring in the adjustive

distortions are manifested in an inappropriate laughter. peculiar mannerisms + bizarre + often obscene behaviour. Hallucinations particularly auditory are common. In occasional cases the patient can become aggressive + hostile. Incoherent speach, emotional outbursts + silly behaviour are also characteristic.

Residual schizophrenia :-

Mild indication of schizophrenia shown by individuals in remission following a schizophrenic episode.

Schizoaffective type disorder :-

finds no mention in DSM IV.

It is applied to individuals who show symptoms of both schizophrenias + serious affective disorders.

Causes :-

Biological factors are as important as social causes.

Biological causes :-

(a) Genetic or Hereditary factors :-

In view of disproportionate incidence of schizophrenia in family background of schzophrenics, researchers have concluded genetic factors play a role in this disorder. No specific gene for schzophrenia has been identified + no chromosomal gene locus has been identified. Most researchers agree that the disorder has polygenic involvement.

(b) Twin studies :

Kallmann found that concordance rate among identical twins for schizophrenia was 86.2% + between fraternal twins was 14.5 %

impinging on a person with already established schizophr
symptoms.

Undifferentiated disorder frequently foreshadows
such cases an impending change from one primary
to another subtype.

2) Paranoid schizophrenia :-

Symptom picture is dominated by absurd, illogic
& changeable delusions, frequently accompanied by
hallucinatics with resulting impairment of critical
ment & erratic unpredictable & occassionally danger
behavior. In chronic cases there is less disorganise
behaviour & there is less extreme withdrawl from so
interaction.

3) Catatonic schizophrenia :-

Characterised by alternating periods of extreme
drawal & excitement although in most cases one or
other reaction predominates. In withdrawl reaction,
is sudden loss of all animation & the tendency to
motionless for hours & days in a stereotyped positio
clinical picture may undergo abrupt change with
excitement coming on. The individual suddenly beg
shout incoherently, take rapidly, pace rapidly &
display variety uninhibited impulsive behavior.

4) Disorganized schizophrenia :-

It usually occurs at an earlier age than
other types of schizophrenia & it represents a
severe disintegration of personality. Emotional

Torrey et al (1994) reviewed 8 most adequately conducted twin studies & concluded that overall pair wise concordance rate for schizophrenia in MZ. twins 28% & in DZ. twins was 6%.

Adoption studies :-

Twin studies at times lack control, therefore many experts advocate use of adoption studies.

Heston (1966) was the first to use adoption method. In a follow up study of 47 people who were born to schizophrenic mothers in state mental hospitals, but had been placed with relatives or foster homes shortly after birth. Heston found 16.6% of these subjects were diagnosed as schizophrenics. In contrast none of the 50 control subjects selected from among residents of same foster homes whose biological mothers were schizophrenics later became schizophrenics.

Heston concluded that children born to schizophrenic mothers are not only more likely to become schizophrenic but also suffer from wide spectrum of disorders.

Family studies :-

Heston after review of literature reported that 45% of children who have one schizophenic parent would later become schizoid or actually schizophenic. The corresponding statistics for children with two schizophenic parents approached 66%

But genetic factors cannot be sole cause because :-
Concordance rate for MZ twins is higher than that for

DZ twins but never approaches 100%.

2) In some studies the discordance rate for schiz... in MZ twins has been found to be greater than concord... rate.

3) The higher concordance rate in MZ twins than DZ t... might be consequence at least in part of a higher ... of shared pathogenic factors. other than the tained gen...

1) Biochemical factors:

More & more researchers now agree that schizophrenia ... be caused due to chemical imbalance in brain. Perhaps t... most exciting early study was made by Heath et al in wh... they found that schizophrenia might be caused because ... metabolic defect which is perhaps inherited & activ... by severe stress.

The recent findings have thrown up Dopamine Hypothesis based on the observation that all the anti-schizophrenic drugs had the common property of blocking Dopamine mediated neural transmission. According to this hypothesis schizophrenia is the product of excess of dopamine activity certain synaptic si...

ii) Neurophysiological factors:-

Much of recent research has focussed on ne... physiological disturbances such as imbalance in various neuro-physiological processes & inappropria... autonomic arousal. Such disordered physiology ... disrupt normal attentional information processing capaci...

There seems to be a growing consensus that disturban...

threatened.

Lidz etal from their studies as well as the review of number of other studies concluded male schizophrenics came from the families with passive ineffectual father & disturbed engulfing father. In over half of the families that they studied, one of the parents was seriously emotionally disturbed. There was a great deal of reality distortion in family. The net result was that the child got training in irrationality & maladaptive behavior.

Kaufman found that in most families having schizophrenic children parents are themselves emotionally disturbed.

Faulty communication:-

Gregory Bateson was the first psychologist to emphasize upon conflicting & confusing nature of communication among the members of schizophrenic families. He used to term 'double bind" to describe such pattern. Double binds are mutually incompatible behavior or demands by parents.

Singer & Wynne have defined the communication & thinking pattern in schizophrenic families as amorphus & fragmented.

Psuedo Mutuality & Role Inflexibility:-

Wynne etal. found that family relationship had an appearance of mutual understanding but were not so actually a condition termed as Psuedo Mutuality.

They also found that rigidity in family role structure tended a depersonalize the child, blocking his growth towards maturity.

of this type underlie cognitive & perceptual distortions characteristic of schizophrenia.

(iv) Neuroanatomical Evidance:-

Researchers on structural properties of brain have found that in most cases of schizophrenia there is abnormal enlargement of brain's ventricles.

(2) Psychological & Interpersonal factors:-

(i) Early psychic trauma increased vulnerability:-

Karl Menninger found that deep hurts that the individual has suffered during his childhood or adolescence make the individual tense & bitter. He comes to realize the world as hostile, withdrawn from it & start hallucinating.

(ii) Schizophrenogic parenting:-

Many studies have examined the parents of schizophrenogenic; mothers of male patients; termed as schizophrenogenic, these mothers were found to be rejecting, dominating, cold, overprotective & impervious to the feelings & needs of others.

Fromm-Reichmann found that such mothers while on one hand rejected the child on the other hand tended to dominate & over protect the child making the child dependent.

(iii) Destructive family interaction:-

Lidz et al in their study studied 14 families with schizophrenic off springs & they failed to find even a single family that was well integrated. In about 8 of 14 families couples lived in a state of chronic discord where the continuation of marriage was constantly

privations that people of low social economic leves.

tement :-
community oriented treatment facilities appear to
nducting two parall programs. first concerns
admitted, acutely disturbed schizophrenics
e family & community ties & intact. Most of
patients respond favourably to Treatment &
be discharged with in 20 to 60 days provided they
ive adequate after care.

The second program is devoted for more savere
chronic cases involving the patients whose family &
mmunity ties have been disrupted. They respond more
owly to the treatment & usually their complete recovery
not possible. However their hallucinations & delu-
ions can be reduced to a point that they are no
longer threatening.

Drug treatment :-

The invention of tranquilizers has truly revoluti-
nized the treatment of schizophrenics patients. Major
tranquilizers are given to control excitement &
thought disturbances whereas minor ones are used to
decrease apprehension & promote sleep. Antidepress-
ants to alleviate mood & to increase alertness is
also used. But sole reliance on tranquilizers is not
recommended as there are number of side effects &
also the risk of dependence.

(vi) Excessive life stress & Decompensation :-

Brown found a marked increase in the severity life stress during the ten week period prior to perso schizophrenic breakdown. Their problems typically centred around interpersonal relationship.

(vii) Faulty learning :-

(a) Conditioning - early psychic trauma & increased ulnera bility.

(b) Observation learning - faulty parental model.

(3). Socio-cultural factors :-

Empirical researches & investigations have report the existance of schizophrenia in all cultures & soci But there is systematic difference in the form & con of schizophrenia between cultures & even in sub-c res. Carothers (1953) found that disorganised type schizophrenia as the most common type among Afr tribal groups. He attributed this to the lack of well developed defence mechanisms.

Kinzie & Bolton (1973 found acute types of schizop renia to be the most common sub type among Malay tribals.

Levy & Rowitz found higher incidence of schizophr & greater likelihood of relapse among people belongi to low SES. Its because these people are exposed to rapid & drastic social change which produce anxi & insecurity. This anxiety further intensifies becau of harsh & impersonal environment & various type

ANXIETY- DISORDERS (ADs)

Categories of Anxiety Disorders:-

Generalized anxiety disorder.
Phobic disorder.
Panic disorder with or without Agoraphobia.
Obsessive Compulsive Disorder.
Post traumatic stress Disorder.
Acute stress Disorder
Substance Induced Anxiety disorder.
Anxiety disorder due to general medical condition.

Generalized anxiety disorder:-

It is characterized by chronic excessive worry about a number of events or activities. The patient reports free floating anxiety, because it is not anchored to a specific object or situation as with phobias.

DSM IV (1994) criteria specify that the worry must occur for atleast six months and must be experienced as difficult to control. The subjective experience of excessive worry must be accompanied by atleast three of the following six symptoms.

Restlessness or the feeling of being on the edge.
Mind going blank and difficulty in concentration.
Irritability.
Sense of being easily fatigued.
Muscle tension.
Sleep disturbance.

The generalized anxiety disorder patients live in a state of tension, worry and diffussed uneasiness

Psychotherapy:-

The aim of psycholtherapy is to reestablish the bond of human relatedness & correct attitudes, remove spec psycholic symptoms & develop interpersonal competen es for coping with the stresses of life. Group psy cholterapy has given better results than individual psycholterapy.

Among behaviour therapy techniques, token econ has been found to be useful. CBTs which emphasize on coguitive restructuring are also used as schizophenia is primarily a th disorder. Milieu Therapy where the emphasis is given on the development of meaningful & constructive environme has also been found to be effective.

Socio therapy is effective in schizophrenia as it directed towards working out family crises & alleviat pathogenic family conditions & helping the patient ma adequate adjustments in the community. Because the relapse rate is very high, therefore special care is needed for the patient after he has received psycholterapeutic treatment. After care progress therefore assumes importa ce in any therapeutic treatment.

are not adequately dealt with because the person's
ense mechanisms have broken down. The principal
rence between generalized anxiety disorder and
ic disorders is that while in phobias
of repression and displacement are operational,
are absent in generalized anxiety disorde. Persons
generalized anxiety disorder have not displaced
onto some external object and they are anxious all
time and unaware of the real source of anxiety.

Behavioristic Explanation

The behavioural formulations of generalized
xiety stem from classical conditioning of anxiety to many environ-
ental cues in the same general way that phobias
re conditioned. Thus generalized anxiety disorder in-
olves phobic like responses to many aspects of external
nvironment. The primary difference between the two
is simply in the number and kind of environmental
cues that have become sources of anxiety.

Cognitive Approach :-

Researches by Mineka (1985) and Barlow (1991)
have shown that the experience with uncontrollable,
unpredictible life events may promote both the current
anxiety as well as the vulnerability to anxiety in
the presence of future stressors. People with G.A.D
may have a history of experiencing many important
events their lives as unpredictable & uncontrollable and
it contributes to their inability to control their worries.

Barlow has described the fundamental process as one of anxious apprehension which is defined as- "Future oriented mood state in which a person attempts to be constantly ready to deal with upcoming negative events". The mood state is characterized by negative affect- chronic over arousal and a sense of uncontrollability

Anxious apprehension might be the feature of other anxiety disorders as well but it is the basic feature of generalized anxiety disorders.

Generalized anxiety disorder is a fairly common disorder with nearly 4% of the patients of mental disorders in each nation belong to this category.

GAD cooccurs with other anxiety and mood disorders especially panic disorders with agoraphobia. People with GAD often also report mild depression and difficulties in interpersonal relationships.

Generalized anxiety disorder, because it is characterized by anxiety which has a lifelong therefore some experts are of the opinion that it should be reconceptualized as personality disorder.

Causes of generalized anxiety disorder:-

Psycho-social causal factors:-

Psychoanalytical Explanation:-

According to psychoanalytical viewpoint generalized or free floating anxiety results from unconscious conflict between id and ego impul

Evidence regarding the genetic factors in GAD is mixed and it seems that there is a modest heritability for other anxiety disorders.

Socio-Cultural factors:-

The extent of insecurity that is produced by a given culture in its members and the degree of uncontrollability and unpredictibility that is associated with that insecurity influences the extent to which GAD will be prevalant in a given society. In the cultures, where the religion offers mechanisms for coping with stress it is likely that individual will be less stressed and the disorder will be less prevalent.

Treatment of Generalized Anxiety Disorder:-

Biological Treatment:- will involve tranquilizers, anti-anxiety drugs, and anti depressants.

Problems:-

Short-term effect.

Side effect.

Psychological and physiological dependence.

Psychological Treatment:-

It involves cognitive therapy which aims at bringing about cognitive restructuring by helping clients focus upon what is really threatening and by helping them to confront their irrational beliefs and cognitions which cause them anxiety.

In addition the schemas that the people develop early life about how to cope with strange and dangerous situations may leave them prone to automatic thoughts focussed on possible threats and contents of those thoughts help to maintain anxiety. They are likely to process threatening information in a way that they pay attention automatically to threatening cues in environment. Moreover they are prone to interpret ambiguous information in a threatening manner.

(ii) Biological factors:-

GAD is a diffussed emotional state involving arousal and preparation for possible impending threat and the brain areas (Limbic System) and neurotransmitters. GABA which is seen to be most strongly implicated Limbic System and GABA -> Gama Amino bulyric acid -> which plays an important role in the way our brain inhibits anxiety in stressfull situations.

Neurobiological researches have shown that highly anxious people have some kind of functional deficiency in GABA and this might be the cause of anxiety.

But it is not very clear whether the anxiety is caused by or it causes functional deficiency in GABA. But GABA definitely promotes the maintainence of anxiety.

Most CBT programmes are accompanied by relaxation training to reduce excessive physiological arousal, Because the patients practise avoidance of the feelings of anxiety and the negative effect associated with the images, the emphasis in CBT is on making the patient directly confront anxiety. Provoking images so that they can be desensitized to them.

POST TRAUMATIC STRESS DISORDER (PTSD)
ACUTE STRESS DISORDER (ASD)

Post Traumatic Stress Disorder :-

In DSM IV, ASD & PTSD find mention under the category of anxiety disorders and the difference between the two is of duration. ASD occurs within four weeks of traumatic event and lasts for minimum of two days and maximum of four weeks. If the symptoms last longer the diagnosis is for PTSD. The diagnosis of PTSD is not given until an unless the symptoms last for atleast one month.

If the symptoms begin within six months of trauma event then the reaction is considered to be acute if after six months, then the reaction is considered to be delayed. further if the duration of symptoms is between 1- to 3 months it is acute & if its more than three months its cronic.

Symptoms :-

(a) Frequent reexperiencing of the event through intrusive thoughts, flashbacks, nightmares, and dreams.

(b) Persistant avoidance of situation associated with trauma and a general, numbing and deadening of emotional feelings.

(c) Increased physiological arousal resulting from exaggerated startle responses or difficulty in sleeping.

(d) The individual experiences impaired concentration disturbances in memory.

(e) Person experiences feeling of depression.

PTSD is the only anxiety disorder in which specific causal agent that is trauma serves as a diagnostic criterion. Although trauma is the necessary cause of PTSD, its occurance does not tell the whole story. Among other factors that contribute to symptom development are characteristics of trauma itself. What happens to the victim after trauma and the personality & coping style of the trauma victim.

Traumatic Experiences:-

Resnick et al (1993) found that 26% of males whose trauma was crime related develop PTSD whereas only 9% of the noncriminal trauma victims develop PTSD.

The extent of injury during trauma also predicts subsequent symptom development. Resnick et al found that males who were injured by a trauma appear to be more likely to develop PTSD symptoms than those who were not injured.

Green et al in their study found that victims perception of trauma can also increase their likelihood of PTSD. The belief that victim's life is in danger and that he/she has no control over the trauma appears to contribute the PTSD symptoms.

(2) Post trauma events :-

Several studies have shown that risk of develop ment of PTSD is inversely related to the amount of support that trauma victims have.

Social support is likely to make the person fe that the stressor can be managed and he is less lik to believe that the world is a dangerous place. O the other hand, absence of such support is not o likely to increase such feelings but also make th individual generalize these feelings to other simi situations.

(3) Individual Differences :-

Individual differ in their stress coping abiliti Those with super coping strategies are less likely show extreme reaction to the traumatic episode Schnurr et al have found that the people who ar more likely to develop PTSD symptoms are the ones who are :-

(i) Overly concerned with bodily fuctions such as stomach or head problems.
(ii) Exhibit social maladjustments.
(iii) are more passive, inner directed and inhibited
(iv) are highly sensitive to criticism and are high suspicious.

Williams & Yule (1995) found that people who ha depressive tendencies, have tendency for social withdrawal and lack confidence in their capaciti

to control stressor are more prone to develop PTSD.

Biological factors! —

Morgan et al have reported high concordance rate for MZ twins compared to DZ twins.

~~Neurotransmitter~~ - There have been some studies which have associated PTSD reactions with the excessive sugers in neurotransmitters such as nor-epinephrine.

Researches have also associated hypersensitivity in certain brain structures such as Locus coeruleus ~~coeruleus~~ with PTSD.

Cognitive Behavioral factors! —

Behavioral and cognitive theorists have tried to explain the causation of the disorder with the help of two factor

According to behaviorist the neutral ~~situation~~ stimulus when associated with traumatic experience becomes conditioned emotional ~~situation~~ stimulus. Later the conditioned ~~situation~~ stimulus can elicit the same frightening reaction as that associated with the unconditioned stimulus.

Later through the process of generalization it can spread to other ~~situations~~ stimuli as well. Once these emotional responses have become conditioned to the array of ~~situation~~ stimuli the person may exhibit various behaviors intended to avoid the ~~situation~~ stimuli. these behaviors are reinforced through the process of instrumental conditioning.

In the recent years work by Foa et al has increasingly emphasized on the concept of fear network for PTSD. They propose that following a traumatic event, a memory network is set that interconnects all fear stimuli and response elements associated with the trauma. The network contains the information about trauma related stimuli and responses along with the information about the meaning of the event to the person. These fear net-works also include escape and Avoidance programs designed to protect the people from harm in the situation similar to those in which they experienced life-threatening trauma. When any part of fear ⟹ network is processed & activated, escape & avoidance programs are set in motion to remove the person from danger.

Treatment – (1) Drugs –

- anti anxiety drugs are helpful in alleviating anxiety.
- antidepressants to remove depression etc.

(2) Psychological Treatment :—

Cognitive Behavioral Treatment has been found to be useful. Direct Exposure treatment similar to that used for phobias has been found to be effective.

Of cognitive therapies; Cognitive Processing therapy has given good results. The general approach of all cognitive therapies appears to be

(I) To activate fear memory network.

(II) To provide experiences that are incompatible with the information stored in it.

PANIC DISORDER (PD)

Panic Disorder is defined and characterized by the presence of unexpected panic attacks that often seem to come "out of the blue". The hallmark of PD is the sporadic & unexpected attacks of intense terrifying anxieties that leave victims feeling as if they are going to die. These attacks reach peak intensity with in few minutes & may last for few minuts to few hours.

The person then develops persistant anxiety that another attack will occur. According to DSM IV, the person is labelled as having panic disorder must have experienced recurrent unexpected attacks and must have persistant concern about having another attack or be worried about the consequences of having an attack for atleast a month. The person to qualify as a patient having full blown panic attack must show the presence of atleast four out of 15 symptoms that are identified for this disorder:-

(i) Accelerated heart rate or pounding heart.
(ii) Profuse sweating.
(iii) Trembling or shaking.
(iv) Sensations of shortness of breath.
(v) Feeling of choking.
(vi) Chest pain or discomfort.
(vii) Nausea or abdominal distress.
(viii) Feeling dizzy or unsteady.
(ix) Derealization (feeling of unreality)
(x) Depersonalization (being detached from oneself.
(xi) Fear of losing control.

(i) Chills and hot flushes.
(ii) Paresthesia : numbness or tingling sensation.
(iii) Loss of self control : Reduced inhibitions.
Mild depression.

Such attacks are normally unexpected and a
to be provoked by the aspects of immediate situa
However they may occur in the situations in whi
They are least expected, such as during relaxati
or sleep. The two features that dislinguish panic d
orders from other types of anxiety are—
Brevity.
Intensity.

The age of onset is between adolesence and mid th
and the course of the untreated panic disorder is varia
and individual may go months or even years without
an attack and then occur on its own, but in majority
of cases it is accompanied with agoraphobia.
Persons with agoraphobia fear leaving home, being
public, and travelling. Their most basic fear is havin
a panic attack while being away from the place
they consider safe. Such patients are likely to
develop addiction for alcohol and are also prone to
ward using various self prescribed anxiety medicat
to obtain relief & this places them at a risk of
substance abuse.

Panic disorders or agoraphobi

gether because accumulating evidence suggests that y share some basic properties including genetic rage. Researches also suggest that in most cases raphobia develops as a secondary reaction to the perience of panic ie after having experienced few nic attacks the person begins to develop ~~to dev~~ p a fear of situations in which attacks have occured d this gradually spreads to involve fear of other tuations where attacks might occur. Thus the person xperiences anticipatory anxiety most of the time.

Cases of agoraphobia without panic are extremely rare in inical settings and even when they are seen there is a story of limited symptom attacks (fewer than four symptoms) some unpredictable somatic ailment.

auses :-

Psychodynamic causes :-

Freud theorized that agoraphobia has its roots in fears tied to unresolved odipal complex. He believed that anxiety generated by being alone and away from home derived from an unconscious temptation to act out sexual impulses in public. The more satisfactory explanation comes from object relation theory which claims that Agoraphobia has its origins in unresolved separation anxiety. The fear of losing or being separated from a protective or nurturant parent usually the mother is first seen around four months of age and is a perfectly normal

attached to a parent and feels distressed when sep from the parent.

In some cases, however, parents may not have equately filled an infant's need for physical security emotional closeness. This problem may arise from physical loss or separation of from parent or when parents are emotionally distant or unresponsiveness to the infant. In such cases child is likely to develop long lasting fears of being abandoned. The feeling of seperation is likely to make the child unsure of exploring the new environment- espec the public places which are unpredictable and where the events are uncontrollable.

Biological Factors:-

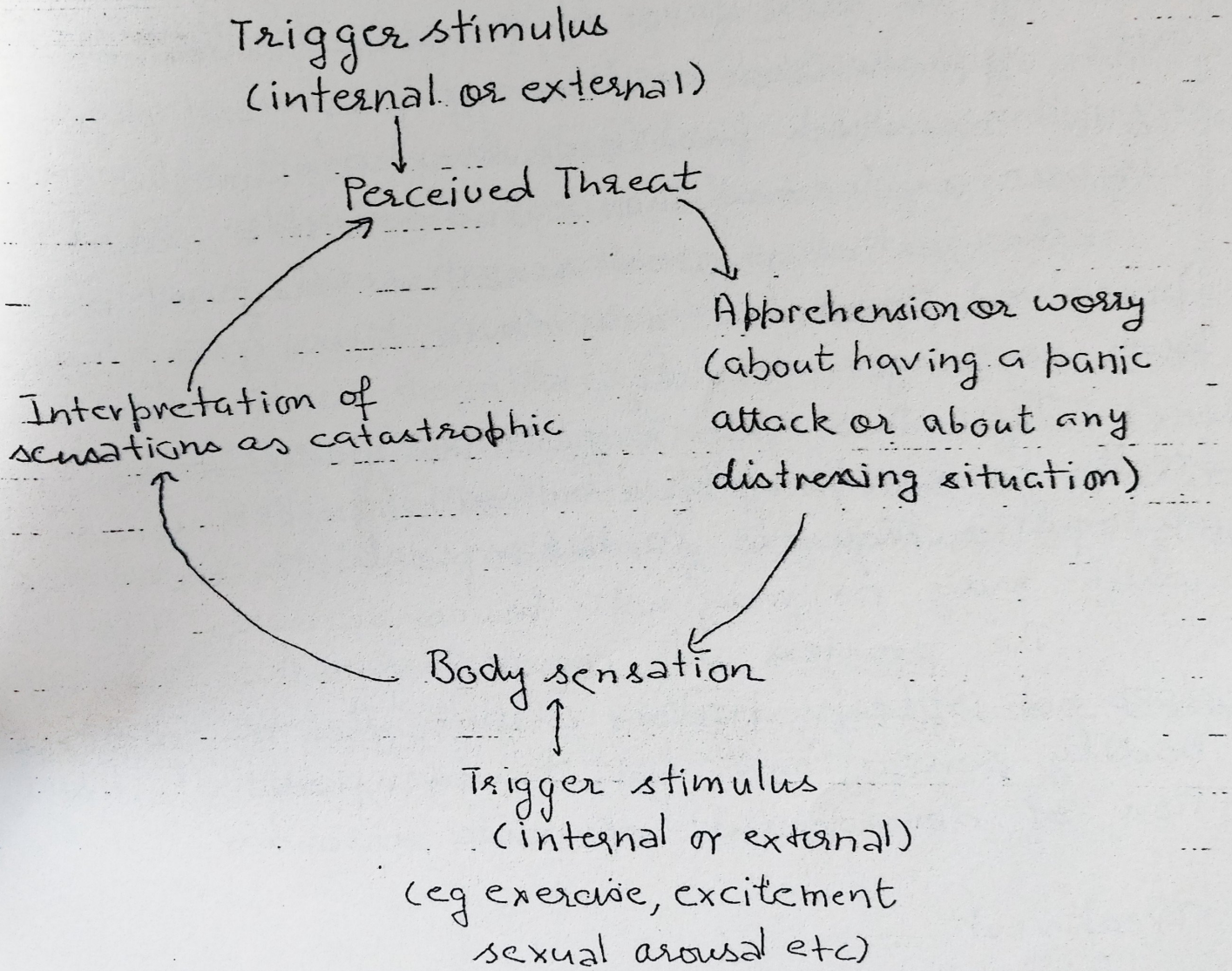
Panic disorder and agoraphobia tend to run in families. Kendler et al (1992) reported greater concordance between monozygotic twins than dizygotic twins Torgersen (1983) also reported that the concordance rate for panic disorder and agoraphobia is greater monozygotic than dizygotic twins.

Most researchers today acknowledge the genetic contribution to panic disorder + agoraphobia.

Neurobiological researches by Gorman et al (1989) have proposed that different brain areas are involved in different aspects of panic disorders. The panic attacks themselves arise from the activity in the locus Coeruleus in the brain stem involve

autonomic nervous activity. for those people who de-
anticipatory anxiety, the limbic system is involved
the phobic avoidance seen in agoraphobia is
a learned act that is controlled by Prefrontal
ex which is a part of brain involved in learning.

The Panic Circle



BECK & EMERY (1985), & CLARK (1986) have proposed
cognitive model of panic. According to this model

Panic patients are hypersensitive to their bodily sensations and are prone to giving them direct possible interpretation. Clark refers to this tendency to catastrophise about the meaning of their bodily sensations as 'catastrophizing'. Any kind of perceived threat may lead to apprehension or worry which is accompanied by various bodily sensations. If a person catastrophises about the meaning of his/her bodily sensations it is likely to raise level of perceived threat creating more apprehension and worry plus more physical symptoms which fuel catastrophic thoughts. The vicious cycle may then culminate in a panic attack.

The initial physical sensations may not arise from perceived threat but may come from other sources such as anger or drugs etc.

Thus this model suggests that panic attacks don't really come out of blue but rather are triggered by automatic thoughts (catastrophic interpretations) which may or may not be conscious.

The problem with cognitive model is that it does not specify factors which lead a person to catastrophise bodily sensations, yet its an effective explanation of development of panic

Treat

Cognitive Behavioral Treatment:-

The essential feature of any cognitive Behavioral intervention includes three basic elements.

Breathing retraining which teaches clients to reduce breathing rate and thus promole relaxation.

Interoceptive Exposure to somatic cues that often trigger an attack. This exposure is intended to reduce anxiety about physical sensations.

Cognitive Restructuring which is geared to correct clients chronic misinterpretation about bodily sensations.

Cognitive Behavioral treatment package have been reported to eliminate panic attacks in 80-90% of clients and these procedures are effective both in group and individual therapy.

A specific cognitive Behavioral intervention known as Panic Control treatment has a good track record in not only relieving symptoms of panic disorder but also reducing symptoms of other anxiety.

Drug treatment:-

Anti anxiety and anti depressants have been.