Psychiatric disorders

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Psychiatric disorders | Type, Cause and Remedy

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So much so that psychiatric conditions are not recognized as diseases and disorders. Psychiatric specialists and psychologists are therefore low in number in our country.

In general, psychiatric illness exists when these conventional bounds of normality of inner experience or of behavior are exceeded, and when definite inconvenience is thereby caused, or seems likely to be caused, to either the person concerned or to those around him.

For example, inner experiences such as fear before a possible car smash, or apprehension before a dental appointment, are common and accepted as normal. Fear and apprehension without a conventionally acceptable cause or with a cause too trifling for the intensity of feeling, may prompt the sufferer to seek medical advice.

For example, to be suspicious of strange men is at times a wise precaution for females. To be suspicious of all men all the time is excessive but the inconvenience may be balanced by the pleasure of feeling such a centre of attraction. However, if public accusations follow that all the men around her have designs on her virtue, and then the neighbors of such a lady are likely to press her to seek medical advice.

The study and treatment of all such personally or socially inconvenient forms of experience or behavior is termed psychiatry. Stress of modern life, addictions drugs and other non-drug substances, mental handicaps due to genetic reasons, are all part of the psychiatric disorder scenario.

The Stethoscope has chosen this week's Cover Story on Psychiatric illness to focus on the causes, treatment, care, and preventive measures needed to combat these socially and medically significant disorders and to take help of the innovative remedies and resources within the country and in the advanced nations.

{mospagebreak title=The Causes of Psychiatric Illness & heading=Psychiatric disorders}The Causes of Psychiatric Illness

Illness is generally the result of a number of different factors operating together rather than of a single cause. For example, an illness such as pneumonia may be regarded as an infection of the lungs by bacteria, but mere contact with such organisms does not necessarily lead to pneumonia. A person's inherited susceptibility to chest infection, his own acquired resistance to the bacteria and his general state of bodily health may all influence the result. In addition, his body's reaction to the infection may modify the severity of the illness.

Similarly, the causes of a psychiatric illness may include an immediate precipitating cause, emotional or physical, an inherited liability to emotional disorder, and the susceptibility which a person may develop in his own lifetime. The nature of the illness will depend on all these factors and also on the individual personality.Inherited Influences

These are transmitted through certain structures in the germ cells of the mother and father. They are independent of the parents' influence on the developing child. The inherited characteristics may be tendencies to develop particular illnesses or a general greater-than-average liability to emotional disorder. In very few conditions is the inherited factor the chief cause, and types of psychiatric illness in which all blood-relatives are affected are very rare. Unaffected persons from an affected family may sometimes transmit the tendency to their children.

The majority of psychiatric illnesses occur without any pronounced inherited contribution and most children born of psychiatrically ill parents do not inherit the condition.Influence of Personality and Psychological Development

Everyone knows that members of any given family may have similar personalities and temperaments, and that in some families there is a common tendency to be ‘highly strung’. This can be partly accounted for by truly inherited traits, as above. But perhaps even more important is the influence which members of the family have on each other's development. The effects on developing personality of family relationships and, later, of wider social contacts, have been described.

Varying Responses. Different people respond to the same situation in different ways. They show tendencies to react

quickly or slowly, aggressively or submissively, in a hostile or friendly manner, suspiciously or trustingly according to their inherited qualities and the ways in which they have learned from their experience. Most people will respond at different times in each of these and many other ways. Often the personality and the way it has developed will decide the nature of the response as much as the person or incident arousing it. Often a person's responses will be consistent in that he will react similarly to a particular type of situation as it recurs. For example, he may show particular respect or particular rebelliousness in the face of authority. He may show undue aggressiveness or undue submissiveness when he feels uncertain of himself.

Recurring Difficulties. Everyone meets situations which for him are peculiarly difficult to deal with. Often he will not be fully aware of the nature of the difficulty and, in that case, the difficulty will tend to recur with unpleasant emotional accompaniments, the source of which is unrecognized. If this experience is severe or prolonged or leads to difficulty in managing his life, he will be said to be suffering from an emotional disorder. He will be aware of repeated and apparently unfounded feelings of anxiety, fear, guilt or depression. Such difficulties may begin in early life, and persist unrecognized and unsolved only to be encountered once more in later years when the individual concerned is under stress.Immediate Emotional Causes

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Causes. Most people have experienced anxiety in some degree, though not everyone is equally prone to it. It is not known for certain why this is so. Genetic factors may have a bearing, and it seems fairly well-established that certain events in childhood play a significant part. It is possible that these two factors are complementary. Whatever it’s more distant origins, anxiety is often precipitated by some form of current stress. In some cases, the stress will be self-evident, as in loss of one's home through fire or flood, serious physical illness, financial catastrophe, difficulties in marriage, threatened or actual loss of employment and indeed in all circumstances where the individual feels threatened or insecure. In other cases the stress will be less obvious, and the significance of unconscious factors altogether greater.

Clinical Features. Anxiety may be acute (may begin suddenly) or chronic (prolonged). It may also start gradually. Often it is very short-lived, though it can and does recur. It may produce certain secondary effects, although these are not pronounced in the milder forms. Restlessness is an example, and varies considerably. The same is true of impaired concentration and disturbed sleep.

Physical changes, when they occur, are temporary and reversible. Thus, the pulse rate may rise and is sometimes experienced as palpitations. The blood pressure may increase. Occasionally, there is a tendency to diarrhoea or to the frequent passing of urine. Other bodily changes are often present, but clinically they are not of any great importance.

Treatment. Short-lived anxiety, unless severe, rarely calls for treatment. But longstanding anxiety often brings a patient to his doctor. The doctor may prescribe a sedative or a tranquillizer, or may discuss with the patient whatever difficulties may seem to underlie the condition. Sometimes he may refer the patient to a specialist for more detailed psychotherapy.

Simple uncomplicated anxiety of any considerable duration, however, is not often seen by the psychiatrist. It is almost always complicated by further symptoms, usually of an hysterical or obsessional kind.Hysteria

There are two main clinical kinds of hysteria: anxiety hysteria, in which the patient develops phobias; and conversion hysteria, in which the patient develops bodily symptoms. In addition, there are certain striking disturbances of consciousness which are more difficult to classify. They are described under the heading of ‘dissociation hysteria’.Anxiety Hysteria

In this condition the anxiety relates to an external situation, object or person. But unlike the anxiety present in the face of a very real danger, the fear in anxiety hysteria seems irrational. Thus there may be fear of open spaces, streets, lifts, tube-trains, water, spiders, or children, to name only a few examples. Such irrational fears are termed ‘phobias’.

The apparently irrational nature of these fears springs from the fact that the sources of the anxiety remain unconscious, while the fear is displaced from the original object or objects on to a relatively harmless substitute. But the choice of object or situation is itself significant since it represents, in a symbolic form, the original dangerous object or person.

Causes. A man afraid of a crowded tubetrain may be unable to face his fear of a tangled domestic situation from which he can see no escape. A modest girl of strict upbringing may be unable to allow herself to recognize the temptations which strangers represent for her, and thus be confined to her home by an apparently irrational fear of streets. These are simplified examples; as a rule, the determinants of the phobia are rather more complicated.

A dangerous internal impulse is sometimes symbolized by a phobia. A man who is afraid of knives may, in this way, be expressing his alarm at his own destructive feelings.

But whatever the phobia symbolically represents, its success as a defense rests in the opportunity it gives the patient to avoid the apparently threatening situation and so maintain some peace of mind. But the price the patient pays may be heavy. For while a patient with a fear of tube-trains may manage perfectly well as long as he travels by bus, a patient with a severe street phobia may be seriously incapacitated.Conversion Hysteria

Just as in anxiety hysteria inadmissible unconscious factors are symbolized by a phobia, so, in conversion hysteria, they are symbolized by bodily symptoms. The anxiety is now said to be `converted', that is, its sources are represented by the bodily change. Usually, this form of hysteria is a more successful defense against anxiety than the phobia; indeed, in some cases of conversion obvious anxiety may be entirely absent.

Clinical Features. The forms which conversion may take are as limitless as the varieties of phobia. Very striking disabilities such as blindness, deafness or paralysis are less common than they were fifty years ago, but they still occur from time to time. On the other hand, hysterical loss of voice, muscle weakness, pains of all kinds, headaches and disturbances of sensation such as numbness still occur with the greatest frequency. An inevitable result of this is that some patients are referred to general hospitals for specialist medical and surgical advice, where investigations fail to reveal a physical basis for the disorder.

It used to be thought that hysteria of this kind occurred almost entirely in women. This idea originated from the notion of

the ancient Greeks that the symptoms of hysteria were due to a wandering of the womb or ‘hysteros’. Nowadays it is recognized that hysteria is common in men.

Symbolic Paralysis. A hypothetical example may help to demonstrate some of the symbolism to be found in conversion hysteria.

An attractive young woman whose mother had recently died had to cope unaided with a tyrannical and bedridden father. Her sense of duty allows her no protest in spite of an intense longing for a young man whom she often meets during the course of her daily shopping. One morning she wakes to find both legs paralyzed. The unconscious conflict between desire and hostility has been converted into a bodily symptom which has three immediate results. First, she can no longer meet the young man she admires. Secondly, she can no longer care for her father since she is now unable to climb the stairs. Thirdly, her sexual conflict is symbolized by the paralysis.

This case is oversimplified, but it may serve to illustrate not only the process of symbolization but also the gain from the illness which results from the production of symptoms. This so-called 'secondary gain' explains why conversion hysteria is not always easy to cure.Dissociation Hysteria

This group of conditions is closely allied to conversion hysteria. The main difference is that, in dissociation, the disturbance is one of consciousness while in conversion the disturbance is bodily.

To this category belong certain ‘dream states', somnambulism or sleep-walking, massive loss of memory, wandering from one town to another with no recollection (fugues) of the journey, and the very rare cases of ‘multiple personality'. In these remarkable, rare cases a man may live part of his life in an apparently ordered way, without any knowledge on his part that he lives the rest of his life in an entirely different way, perhaps in a different place and under a different name. In fiction the best-known example is Stevenson's ‘Dr. Jekyll and Mr. Hyde', but there are a number of startling though authentic cases on record.

In all forms of dissociation a whole area of the patient's mental life which he does not wish to recognize is excluded from consciousness.The Hysterical Personality

A large number of people, who cannot necessarily be regarded as psychiatrically ill and who may never develop hysterical symptoms, show certain personality traits which together constitute what is known as the ‘hysterical personality’.

These people are often said to be emotionally shallow, able to form impulsive and fickle relationships but rarely ones of a lasting or deeply felt kind. They are often sexually capricious or frigid. They are said to be fond of the limelight and tend to dramatize their actions and relationships. Where these traits are sufficiently pronounced to interfere seriously with the patient's life, treatment may be called for.The Obsessional Neurosis

Unlike hysteria, the major disturbance in obsessional neurosis is of thought, word or deed, so that the patient feels compelled repeatedly to think certain thoughts or perform certain actions. In each case the symptom is determined by unconscious factors, and often seems perverse, alien or absurd to the conscious mind.

The obsessional symptom is characteristically recurrent, occurs against the patient's conscious wishes, and cannot be dismissed by an act of will. These features distinguish the obsession from all other forms of pre-occupation.

Obsessional Thoughts. There are countless varieties of obsessional thoughts. There may be disturbing ruminations of killing a loved one, or of spreading infection or poisoning people. Such thoughts occasion a great deal of guilt. Elaborate defenses may be involved in a constant fight to prevent any such thought from being translated into action. But sometimes the thoughts concerned seem trivial or even meaningless. In such cases the trivial thoughts may sometimes occupy the patient more and more until, occasionally, more important thoughts are virtually excluded. In some cases the thoughts take the form of unwanted philosophical speculations, such as ‘Why am I?’ or ‘What is God?’ Sometimes thoughts appear in flagrant contradiction of the patient's conscious attitudes. A religious man, for example, may feel plagued by blasphemous ideas, and a woman who prides herself on her purity may find herself preoccupied with obscene thoughts.

Sometimes the thoughts refer to recent actions. The patient may find himself constantly wondering whether or not he has turned off a gas tap, locked a door or switched off a light, even when he knows perfectly well that he has done so. In other cases the thought of doing some definite and purposeful act may be followed immediately by the thought of doing its opposite. Such a condition may be characterized by extreme indecision.

Obsessional Speech. Some people are obsessed by words rather than by thoughts. A man may find himself compelled to mutter an obscene, trivial or frightening word, and then feel very embarrassed in case he has been overheard. More rarely, he may shout. As with all obsessions, a conscious fight against these activities results in anxiety which may be very considerable.

Compulsive Actions. When we consider compulsive actions, we find them equally varied. The patient may feel compelled to remember every single event of the day and to record it in a diary, even when he feels the task overwhelmingly beyond him and stays up half the night in a vain endeavor to complete his notes. Or he may find himself compelled to write on lavatory walls, to his continued astonishment, guilt and disapproval. Sometimes he has to touch a series of objects, often in a carefully organized manner and order. Such activities may become so involved and elaborate that his life is seriously dislocated by them.

Although such compulsive actions may remain isolated they are often built up into complicated rituals. A woman may have to dress in a certain order, have everything `just so', and may take several hours to get the seam of her nylons straight.

Guilt is a striking feature of obsessional neurosis. It explains the constant need to eliminate objectionable thoughts, to check and recheck whether or not one has done any damage. Ambivalence-in this case the coexistence of destructive and reparative tendencies-is more pronounced in this disturbance than in any other neurosis.

Many defenses are employed by the obsessional subject to allay his anxiety. A return is often made to earlier levels of development when magical devices, such as crossing one's fingers, touching wood, walking round ladders and stepping between cracks on the pavement, were used for supposed self-protection (as in young children). Another defense is displacement. In obsessional neuroses, the fight against unconscious forces takes the most devious routes.The Obsessional Personality

As with the hysterical personality, the obsessional personality shows a number of traits which are shared by many people who cannot be considered psychiatrically ill, unless these traits are so pronounced that everyday life are seriously interfered with.

illness such as hysteria or the obsessional neuroses. It is also very common in depression and other psychoses.The Sexual Perversions

Human sexual behavior varies so widely that it is not always easy to say what is normal and what is perverse. Indeed, the concept of sexual `normality' is often a social one. Male homosexuality, for example, was entirely accepted in the Greek City State but is not tolerated in most countries today. On the other hand, female homosexuality, which can hardly be regarded as less `perverse', rarely arouses so much condemnation.

It is difficult to give a satisfactory psychological definition of sexual perversion. In general, however, the perverse sexual act tends either to exclude or replace heterosexual genital intercourse, or to relegate it to a subordinate role. Thus the exhibitionist or the peeping Tom gets sexual satisfaction without indulgence in intercourse; the homosexual may never have sexual relations with women or, if he does, he will find relations less satisfying than those with men; and the fetishist finds the excitement he gets from the article of clothing concerned of primary importance, even when intercourse takes place.

Homosexuality in either sex may be active or passive and both forms may be practiced at different times by the same person. The partners may be of any age. Some male homosexuals (probably a fairly small percentage) show a preference for children. Some homosexual attachments are very constant and the partners may live together, sometimes in great affection. Other homosexuals are promiscuous.

Fetishism. In fetishism the subject, invariably a male, is excited by some particular article of female clothing such as a stocking, a piece of underwear or a shoe. Not all fetishists require a partner to wear these items to get sexual satisfaction, but when they do the article itself is sexually more important than the person who wears it.

Exhibitionism. The man or woman concerned gets satisfaction from exposing the body, while in `voyeurism' the voyeur gets his sexual enjoyment from spying on couples making love.

Sadism and Masochism. In sadism the sadist derives sexual pleasure from inflicting pain, while in masochism the reverse is the case.

These are the commonest perversions met with in clinical practice, though only a small proportion of perverts seek treatment.

Causes: In some adolescents perversions are merely forms of sexual experiment and have no special significance. In some homosexuals genetic factors seem to be important, especially in men with pronounced feminine physical characteristics and, equally, women of masculine build and appearance. But psychological factors can rarely be excluded.

The growing child passes through important stages where his relationship with parents, brothers and sisters make him aware of the fundamental sex differences. During these stages, attitudes of passivity or assertion, and feelings about masculinity and femininity are encountered and dealt with. Failure to negotiate these stages satisfactorily has important consequences in later sexual development. In perversions, such early difficulties have been pronounced. In addition, problems at these stages are reinforced by pathological attitudes developed even earlier in childhood.

Treatment: The majority of people with perversions never come to treatment. The fact that the symptom is in itself pleasurable tends to weaken the incentive to seek help. If, in addition, the pervert has a fairly stable and well-adjusted private life he may only wish to be left in peace.

Psychotherapy offers the best, if not the only, hope of resolving the mental conflicts behind the perversion, though its use is limited. Sometimes, especially in fetishism, a form of `deconditioning' has been used. In some male perversions, where the urge to practice the perversion is particularly strong, synthetic hormones have been used to damp down the sexual drives.

{mospagebreak title=Anxiety Neurosis & heading=The Types of Psychiatric Illness} Anxiety Neurosis

All people experience fear and anxiety. Fear is an emotional, physiologic, and behavioral reaction to a recognized external threat. Anxiety is an unpleasant emotional state that has a less clear source. Anxiety is a response to stress, such as the break-up of an important relationship or exposure to a life-threatening disaster. One theory holds that anxiety may also be a reaction to a repressed sexual or aggressive impulse that's threatening to override the psychological defenses that normally keep such drives in check. As such anxiety indicates the presence of psychological conflict. This is the commonest form of psychoneurosis characterized by lack of concentration, loss of interest and unforeseen fears due to adaptation to environmental stress. It may thus be said that anxiety is often accompanied by physiologic and behavioral changes similar to those caused by fear. Because of these similarities, people often use the terms anxiety and fear interchangeably. Anxiety can arise suddenly, as in panic, or gradually over minutes, hours or days. The anxiety itself can last for any length of time, from a few seconds to years. It ranges in intensity from barely noticeable qualms to full blown panic. In fact anxiety serves as one element in a wide range of flexible responses that are essential for people to

survive in a dangerous world. A certain amount of anxiety introduces an appropriate element of caution in potentially dangerous situations. Most of the time, a person's level of anxiety makes appropriate and imperceptible shifts along a spectrum of consciousness from sleep through alertness to anxiety and fear and back again. Sometimes, however, a person's anxiety response system operates improperly or is overwhelmed by events; in this case, an anxiety disorder can arise. People react differently to situations. The ability to tolerate anxiety varies among people, and determining what constitutes abnormal anxiety can be difficult. However, when anxiety occurs at inappropriate times or is so intense and long-lasting that it interferes with a person's normal activities then it is properly considered a disorder. Anxiety disorders can be so distressing and interfere so much with a person's life that they can lead to depression at the same time. Others develop depression first and then anxiety disorder later. Anxiety disorders, as told earlier, are the most common type of psychiatric disorder. The diagnosis of an anxiety disorder is based largely on its symptoms. Depression and anxiety neurosis are most common anxiety disorders.Depression and anxiety neurosis: Depression

Depression is an affective disorder with disturbance of mood. It like anxiety (with which it is associated), is ubiquitous and is a reality of everyday life. It frequently presents in the form of somatic complaints with negative medical workup. It can be a normal reaction to a wide variety of events and must be evaluated as such. Depression may occur alone or combined or in cycle with mania.

Depression usually presents with misery and malaise associated with poor self-consciousness and self-abnegation without hope.

Aetiolog: Not clearly known.Predisposing causes :
- Heredity is an important factor.
- Constitution: These patients are of pyknic built, obese and muscular development is poor.
- Exposure to stress is important.
- Organic diseases depressing the vital powers may play some role e.g. various viral diseases, candiova scular diseases, anemia, myxoedema, cardinoma etc.Clinical Features:

Manic depression may be present. Besides, various somatic manifestations are-loss of appetite, loss of weight, amenorrhoea, pressure headache, backache, constipation, retardation of physical activity etc.Anxiety Neurosis

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Antiology:
- Many patients appear to have personality traits of high anxiety and poor tolerance of stress.
- Unexpected life events which the patient cannot handle.
- Unexpected disasters such as floods, accidents and terrorist activities.
- Sexual background

Clinical features:

These are divided into 2 groups- psychological and somatic. If somatic symptoms predominate the patient is likely to regard himself as physically ill.Prevention:
- Explanation and reassurance.
- Specific relaxation techniques should be taught.
- Change of place may be effective.