

Life events and psychiatric disorders essay sample



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Life Events

Researchers have long been interested in understanding how individuals and environments affect each other, primarily so as to describe and explain age – related behaviour and individual differences. One focus has been to study life events. A life event is indicative of or requires a significant change in the ongoing life patterns of the individual. According to Settersten and Mayer (1997), “ A life event is a significant occurrence involving a relatively abrupt change that may produce serious and long lasting effects”. It refers to the happening itself and not to the transitions that will occur because of the happenings. Life events can occur in a variety of domains (family, health, and work) and may be age graded (School, marriage and retirement), history graded (war and depression), or non-normative (illness and divorce). Most of the adolescent and adult literature reflects a sociological tradition of assessing the impact of life events as transitions between major roles, age grades, status gains and losses, and so forth. Turning Points

A turning point is a special life event that produces a lasting shift in the life course trajectory. It must lead to more than a temporary detour. As significant as they are to individual’s lives, turning points usually become obvious only as time passes (Wheaton and Gotlib, 1997). Three types of life events can serve as turning points (Rutter, 1996): * Life events that either close or open opportunities.

* Life events that make a lasting change on the person’s environment. * Life events that change a person’s self-concept, beliefs and expectations.

However, it must be remembered that the same type of life events may be a turning point for one individual, family, or other collectivity, but not for

another. Also, less dramatic transitions may become turning points depending upon the individual's assessment of its importance.

Life Event Stress

The Encyclopedia of stress defines stress as “ real or an interpreted threat to physiological or psychological integrity of an individual that results in physiological and/or behavioural response.” Stress involves a process in which environmental demands tax or exceed the adaptive capacity of an organism resulting in psychological and biological changes that may place persons at risk for disease. Three broad traditions of assessing the role of stress in disease risk may be distinguished: * The environmental tradition focuses on assessment of environmental events or experiences that are normatively (objectively) associated with substantial adaptive demands. * The psychological tradition focuses on individuals' subjective evaluations of their abilities to cope with the demands posed by specific events or experiences. * The biological tradition focuses on activation of specific physiological systems that have been repeatedly shown to be modulated by both psychologically and physically demanding conditions.

Life event stresses thus essentially follow the environmental tradition, and are concerned with situational encounters and the meaning a person may attach to such events. Stressful life events are causally implicated in a variety of undesirable effects on our performance and health (Dohrenwend and Dohrenwend, 1997). Such observation is based on two assumptions. Firstly, life changes require adaptation on the part of the individual and are stressful. Secondly, persons experiencing marked life changes in the recent past are susceptible to physical and psychiatric problems. All life events

require adaptation, but all life events are not necessarily unpleasant. Life events can either be pleasant in nature where the stress is called 'Eustress' or unpleasant in nature where the stress is called 'Dystress' (Selye, 1974). There may also be some life events which simply act to help maintain the internal steady state or to keep the individual interested in undertaking appropriate activities. Such stress may be called 'Neustress' (Joseph P. Auto, 1995)

ORIGIN OF LIFE EVENTS RESEARCH

The hypothesis that emotional conflicts related to external events can precipitate mental illnesses was first formally suggested by Heinroth in 1818 in his designation of the term 'psychosomatic'. Later in early part of the 20th century, Adolf Meyer, popularized the 'life chart' methodology. This approach emphasized the importance of dynamic interplay among biological, psychological and social factors such that important life events within the person's biography became foci of attention for studying health and disease. However, no formal scale or schedule for assessing life events or their impact on health was as yet available. In the early 1960s, Rahe and Holmes began developing a life events schedule based upon findings over 5, 000 of Meyer's "life charts" taken on patients at the University of Washington. Each item selected for their schedule of Recent Experience was included because it was found to have occurred in a large number of patients preceding the onset of their illness. Holmes and Rahe (1967) also developed the Social Readjustment Rating Scale (SRRS) by assigning weights for events of different judged severity from the Schedule of Recent Experience.

These weights were called "life change units" (LCU). Elevated scores on the SRRS have been associated with the onset of numerous medical disorders

(Rahe and Arthur, 1978). It has also been used extensively in studies of onset of psychiatric disorders including schizophrenia, depression and suicide attempts. The SRRS had an enormous impact on research on the relations between life events and illness. It also brought forward and strengthened the notion that the effects of stressors operate largely through the creation of excessive adaptive demands. This led users of SRRS to be more concerned with the magnitude of life change than with whether the change was positive (e. g., promotion) or negative (e. g., or job loss). Beginning in the 1970s, a new generation of stressful life event researchers began to challenge many of the basic assumptions involved in the construction and scoring of the SRRS. The following new ideas were advanced: * Individuals to estimate the stressfulness of their own experiences as a way of generating measures rather than judge's ratings. (e. g., Sarason et. al., 1978). * Development of a life event interview in which investigators rate the importance of events while taking into account the context in which they occur. (Brown & Harris, 1978).

* Development of newer checklists to expand the range of experiences evaluated. (Dohrenwend et al., 1978). * Development of scales to assess stressful life events in specific populations whose experiences might be different from those represented on the more general SRRS. These included scales for children (e. g., Sandler & Ramsay, 1980, Monaghan et al, 1978) adolescents (e. g. Murrell et al., 1984) and scales for different cultures (Singh et. al., 1983; Sanjam, 1987). * Development of life event scales based on a multidimensional conception of stressors that separately assessed the extent of threat, loss, danger and other aspects of stressful events (Brown & Harris,

1978). Apart from these new developments, there have been continuations of what has already been established: * A continuation of basic research to document the effects of stressful events on a variety of physical and mental health outcomes using newer stressful life event measures. * An interest in studying the cumulative effects of experiencing two or more stressful life events in the same short interval of time. (Mc Gonagle & Kessler, 1990). * An interest in studying the joint effects of experiencing a stressful event in the context of an ongoing chronic stressor in the same life domain (Wheaton, 1990). * A considerable interest in studying vulnerability factors, i. e., characteristics that make people more or less susceptible to stressor induced disease.

* A movement away from an earlier tradition of focusing exclusively on the acute health damaging effects of discrete life events towards an investigation of the long term health-damaging effects of chronic stressors. A new interest in the cumulative effects of minor daily stressors on both emotional health (Bolger et al, 1989) and physical health (Stone et al., 1987). THEORETICAL ISSUES

The nature of causal relationship between psychosocial stress and functional mental disorders has been conceptualized by various theories or models. Although these models have differed in their emphasis on the role of stress in the etiology of psychiatric illness, they have unanimously taken into consideration the impact of stress in both physiological and psychological spheres. Crisis Theory

The crisis theory of stress was initially proposed by Lindemann (1944); and was further elaborated by Sating (1973). The theory maintains that when an individual is faced with a new situation (life event) he goes into a period of disequilibrium (crisis). The outcome of crisis may either be adaptive or maladaptive. In the latter condition, it will lead to physical or psychological illness or reduced functional capacity. The Crisis Model has been best used to explain the experiences of healthy individuals with relatively intact personalities and relatively enduring coherent human relationships (Beck & Worthen, 1972).

Principle of Optics

Rahe et al (1974) proposed that one's past experience may alter the significance of his recent life change and often defense mechanisms are employed which diffract away some of the life change events. Those which are not diffracted away, stimulate a multitude of physiological processes. Prolonged unabsorbed psycho-physiological activities eventually lead to organ system dysfunction or variety of psychological disturbances.

Differential Effect

Brown and co workers (1973) have opined that the effect of stress varies for each individual. Stress may have both triggering and formative effects on mental illness. Triggering and formative effects are opposite ends of the same continuing rather than qualitatively different processes. Triggering events at the most trigger an illness, i. e, they may at the most bring the onset forward by a short period of time and perhaps make it more abrupt. Formative events on the other hand, play a formative role and the onset of the illness may be either substantially advanced in time by the event or brought about by it altogether. Brrown et al (1973) have also given the

concept of “brought forward time”, i. e., the estimate of the average time from an onset produced by an event to the time when a spontaneous onset would have occurred, had not the events intervened. If the brought forward time is more (i. e. > 12 months), the effect is formative, if it is less, the effect is triggering. (Brown et al. 1973) Cybernetic Model

Cybernetics is a study of systemic regulatory mechanisms that operate via feedback loops. Kagan and Levi (1974) proposed that the combined effect of psychosocial stress and psychobiological programme determines the psychological or physiological reactions which may lead to precursor of an illness or the illness itself. Diathesis or Vulnerability Models

Several vulnerability models have been proposed, but the initial one was proposed by Meehl (1962) and it was later modified by Rosenthal (1970). These models assume that people have varying degrees of vulnerability to the development of a mental disorder and that the likelihood to develop an illness is a function of both the extent of the biologically influenced vulnerability and the magnitude of stress that the individual is encountering. Vulnerability approach postulated that a balance and counter balance is maintained between vulnerability and the amount of stress that can be tolerated before the symptoms appear. This model is used essentially to explain schizophrenia (Zubin & Spring, 1977). Psychodynamic Theories

According to the theories of Freud, Jung and Sullivan, psychological stress results in regression. This overburdens already strained coping mechanisms, and triggers a sequence of internal changes whose outward expression is the development of psychotic symptoms. The stress itself may be more of

prolonged conflict than a single disturbing experience or it may be objectively minor but have special psychological implications for the individual or it might exert its effect by virtue of acting on an already abnormal personality structure. Although these theories lack the support of any credible scientific research, they have been widely and uncritically accepted for long, and they are useful in that they help clinician to understand and anticipate the impact of life events on the patient's course of illness. TYPES OF LIFE EVENTS

Life events have been classified in different ways. Some of the dichotomous classifications of life events, which are useful in explaining the results of life events research, are described below: Personal Vs Impersonal Events

Personal events are the events in which the individual is an active participant and partly or fully responsible for the event. This includes marital or family conflicts, broken engagement or love affair, construction of a house, getting married and so on. Whereas, in impersonal events, the individual is not directly responsible for the events. Examples include death of a friend, illness of family members, property damage, birth of a daughter and so on (Singh et al., 1983).

Desirable Vs Undesirable Events

The events which are consistent with the favour or desire of the individual, such as getting married, becoming an officer, etc are desirable ones.

Contrarily, undesirable events imply the unwanted occurrence of events such as death of spouse, theft or robbery, divorce, etc. (Singh et al., 1983).

Pleasant Vs Unpleasant Events

Pleasant events are enjoyable events such as going on pleasure trip, educational or occupational achievement, etc. The events which are experienced by the person as noxious, aversive, or dangerous are unpleasant events. It is noted that all pleasant events may not be desirable and all the desirable events are not pleasant. Major Vs Minor Events

The events over which the individual attaches importance or values are major events while the events which are, according to the individual, negligible or inconsiderable are minor events. Interestingly, a major event for one individual may be minor for another and vice-versa. (cf : Kamaranjan, 1996) Chronic Vs Acute Events

Chronic events are stresses associated with everyday living, such as family, work, poverty, physical disability and mental deficit, while acute events are stresses associated with largely external or unusual changes that are unanticipated, undesired, and uncontrolled. (Mc Glashan and Hoffman, 2000)

Severe and Non-severe Events

Severe events are experiences of long-term or moderate long term threat to an individual (e. g. death of spouse). Non severe events were experiences that are threatening only in the short term, usually less than a week (e. g., a child nearly hit by a car) (Brown & Harris, 1978). MEASUREMENT OF LIFE EVENTS

It is unanimously accepted today that exposure to daily or life time stressors may have an important bearing on health and well being. Much of research in this area has had focused in the role of stressful life events in the etiology of various psychiatric illness. The main consideration among researchers on

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life events are: * What type of life events influence psychological disturbance? * What is the differential influence of life events in various mental disorders? * How do life events affect mental health, directly, indirectly and interactively? Relationship between personality factors and life events has also been studied by various researchers. (Bhatti and Channabaravanna, 1985).

According to Wethington (2000), assessment of life events is one of four types of naturalistic stressor assessments, the other three assessments being that of stress appraisals, chronic stressors and daily events (or hassles). The differences are pointed out below: * Life events: These are exposure to out-of-the-ordinary, demanding events, such as divorce, that have the capacity to change the patterns of life or arouse very unpleasant feelings. * Stress appraisals: These are self reports of perceived stressfulness and appraisals of threat posed by events. Measures of appraisal focus on the degree to which an event threatens well-being or threatens to overwhelm resources to cope. Life event scales may or may not include appraisal as a component.

* Chronic stressors: These are enduring or recurrent difficulties and strains in an area of life. Recent research on stress and illness has turned toward emphasizing the role of persistent, continuous, or regular exposure to stressors as important risk factors for the development of disease. * Hassles: These are exposure to smaller, relatively minor, universal and normally less emotionally arousing events whose effects disperse in a day or two. The hassles paradigm focuses attention of the potentially deleterious ways in which minor stressors, even those whose effects are relatively fleeting, can

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have long-term negative effects on health. There are two contrasting methods of measuring life events, which have developed over time, namely,

- * Checklist Measures

- * Personal Interview Measures

Checklists are easy to administer and are useful in conducting large amount of exploratory health research. Checklist method was derived from an environmental perspective on stress, proposing that the basis of experienced stress is an event that brings about a need for social, physical, or psychological readjustment. The earliest of these perspectives was the life change readjustment paradigm developed by Holmes and Rahe (1967). Other theoretical paradigms on stress, such as those developed by Lazarus (1984), Dohrenwend (1993), and Brown (1987) have augmented their approach in significant ways. Some checklists measure timing and severity of checked event, by asking respondent to report date of occurrence, by asking for a brief written description, or by asking respondent to rate the relative stressfulness of the event. Despite their popularity, checklist measures have been criticized on their reliability and validity as measures of stressor exposure. These criticisms include:

- * Vagueness and generality of the questions,
- * Inclusion of events that are confounded with feeling states of psychiatric illness.
- * Recency biases, i. e. respondents are more likely to recall events that occur in the last few months than those that occurred a year ago.

The Personal interview measures use qualitative probes in order to specify more precisely the characteristics of life events believed to produce the

actual risk of illness and timings of life events in relationship to the outcomes. The early development of personal interview methods for assessing life events initialized a theoretical perspective distinct from the change readjustment paradigm, which informed life event checklist. The major developer of interview methods (George W. Brown) proposed that social and environmental changes (and anticipation of those changes) that threaten the most strongly held emotional commitments are basis for experienced severe stress. This perspective also holds that severe stressors, rather than minor, threaten health, distinguishing it from both change readjustment and hassles paradigms. Interview measures are not used commonly, primarily because of their greater expense and complexity. Investigators tend to use them under the following circumstances: * Where more precise severity ratings are required.

* Where the relative timing of stressor exposure and disease onset is critical to a study. * When the occurrence of an event, or series of events, may be related to respondent illness or behaviour. * Promoters of interview measures claim that they are more comprehensive, reliable and valid than checklist measures, although there is considerable debate on this point.

TOOLS FOR MEASURING LIFE EVENTS

Social Readjustment Rating Scale (SRRS): Developed by Holmes and Rahe(1967), this scale is a milestone of life events research. This scale has 43 events which have been taken from the Schedule of Recent Experience, and have been assigned weights in terms of their judged severity. Each item has a “ life change unit” (LCU). The more severe the item, the greater change it calls for, and so the greater is its LCU. Schedule for Life Events:

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Developed by Paykel et al. (1975) this covers 64 defined life events, which are again divided into nine categories – work, education, finance, health, bereavement, migration, family and social relationship.

It is administered in the form of a semi-structured interview, where each event is enquired for until it clearly does not apply covering a period of one year prior to the interview. Presumptive Stressful Life Events Scale (PSLE): Developed by Gurmeet Singh et al. (1983), it was constructed and standardized for use in the Indian population. It is a standardization of the SRRS. It is in the form of an inventory of 51 items, each item having a weighted stress score. For example, death of spouse = 100; conflict over dowry = 51; going on pleasure trip = 20. The items are further categorized as (i) personal or impersonal events. (ii) desirable, undesirable, or ambiguous events. It is administered in the form of a semi structured interview, wherein the events are assessed to be either present or absent.

British Life Events Inventory for Children: Developed by Monaghan et al (1978), this inventory is specially designed to assess life events of children. Life Events Inventory for Indian Children: Developed by Sanjam (1987), this is an Indian adaptation of the British Life Events Inventory for Children. It comprises of 50 items with assessment of stress on two time frame parameters i. e. “ last one year” and “ ever in life prior to last one year”.

Bedford College Life Events and Difficulties Schedule (LEDS): Developed by Brown and Harris (1978), this is the most widely used personal interview method. It is a semi structured survey instrument, appropriate for use in a community sample as well as with patients, assessing a wide variety of stressors. The interview consists of a series of questions asking whether

certain types of events had occurred over the past 12 months (or larger) and a set of guidelines for probing positive responses. Structured Event Probe and Narrative Rating Method (SEPRATE): Developed by Dohrenwend and colleagues, et al. (1993), this is an alternative life events interview and rating system using a magnitude of “ life change” rating system. It consists of a series of yes/no questions regarding 84 types of events or difficulties that may have occurred and been severely stressful. NEUROBIOLOGY OF LIFE EVENT STRESS

The biology of life events is subsumed in the biology of stress. Several physiological systems have been implicated in active and passive coping with stress. These include the central nervous system, catecholamines, immune, endorphin – enkephalin, hypothalamico-pituitary-adrenocortical and the sympatho-adrenomedullary systems (Baum et al., 1982). The physiological stress responses include primarily the activation of autonomic nervous system and hypothalamus-pituitary-adrenal axis leading to increased blood pressure and tissue levels of catecholamines and glucocorticoids. Elevations of epinephrine, norepinephrine and cortisol have repeatedly been found among persons experiencing chronic and acutely stressful events (Hlastala and Frank, 2000). Stressors also activate serotonergic systems in the brain as evidenced by increased serotonic turn over (Kaplan and Sadock, 2000).

Amino acid and peptidergic neurotransmitters are also found to be intricately involved in the stress response. Studies have shown that corticotrophin releasing factor (CRF), Glutamate, and Gamma aminobutyric acid (GABA) – all play important roles in the generation of the stress response or in

modulation of other stress responsive systems such as dopaminergic and noradrenergic brain circuits (Kaplan and Sadock, 2000). The sympatho-adrenomedullary system (SAS) is activated during active coping (fight or flight), which generally, but not always, involves physical exertion. This system increases metabolic activity in response to stressful situations. Measures of norepinephrine and epinephrine are typically used to indicate the activity of the SAS.

There are two important features of physiological stress response. The first involves turning it on in amount that are adequate to the challenge. The second is turning off the response when it is no longer needed. Physiological mediations of the stress response, namely the catecholamines and the glucocorticoids from the adrenal cortex, initiate cellular events that promote adaptive changes in cells and tissues throughout the body, which in turn protect the organism and promote survival. However, too much stress or inefficient operations of the acute responses to stress can cause wear and tear and exacerbate disease process. There are however, enormous individual differences in interpreting and responding to what is stressful, as well as individual differences in susceptibility to diseases, in which stress may play a role. LIFE EVENTS AND PSYCHIATRIC ILLNESS

Extensive empirical research on life events and illnesses has demonstrated that life events stress may result in problems in both physical and mental health (Cohen, 1980). There is growing body of literature on the role of life events in producing variety of mental disorders. However, majority of individuals undergoing serious life events do not develop psychological impairment. Hence, the focus of current life events research has been to

understand the conditions under which life events produce psychological dysfunction and to identify those persons who are at risk.

The notions of ‘vulnerability’ and ‘diathesis’ are of particular importance in understanding the impact of life events on mental health. ‘Diathesis’ as described by Meehl (1962) refers primarily to inherited predispositional factors, and ‘vulnerability’ has been expanded to include predispositional environmental factors (Zubin and Spring, 1977; Spring & Coons, 1982). An individual with a high predisposition is at high risk of developing illness symptoms, in the face of stressful life events. Again, perception of stress is a subjective phenomenon, as the same life event may be stressful to one individual but not to another. Individual’s personality makeup influences his perception and appraisal of the situation and this in turn determines his reaction to the same (Sejwal, 1984). Life Events and Schizophrenia

The influence of life events on the etiology and course of schizophrenia has been a controversial issue. Research examining the relationship between life events and the onset of schizophrenic episodes can be divided into three groups: Type I: Some studies have found a significant increase in “independent” life events preceding the onset of psychotic symptoms suggesting that they may play a major triggering role for episodes. “Independent events” are those events which are not influenced or caused by patient’s own behaviour (e. g. death of loved one). Bleuler (1911) considered life situations and emotional conflicts as causal factors in the onset of at least some cases of schizophrenia. Valliant (1964) observed that 60% of their schizophrenic patients had life events 3 weeks prior to onset of illness. Lukoff et al. (1984) and Brown & Birley (1968) had also found an increase in the

frequency of life events 3 weeks before the onset of schizophrenia. Type II: Other studies have found an increase in life events before onset, but the occurrence of the life events was not independent of the influence of the patient's behaviour.

Non-independent life events such as being fired from a job, divorce, failing in an exam, may reflect the prodromal period of the illness or an ongoing schizophrenic process. Zubin and Spring (1977) have labeled the processes by which schizophrenic patients often bring an excess of life events upon themselves as " stress prone patterns of living". Although both onset as well as relapse in schizophrenia has been associated with an increased report of life events, these events are mostly of the non-independent types. This increases an already inflated stress level and so influences the timing if not probability of illness onset (Rabkin, 1980). Beck and Worthen (1972) had also reported that apparently trivial events are idiosyncratically interpreted by these patients so that they are subjectively but not objectively stressful. A study by Serban (1975) found that chronic schizophrenics experienced maximum stress, while acute schizophrenics experienced medium stress, compared to the normal population.

Das et al. (1997) had reported higher number of life events in the one year preceding relapse in relapsed schizophrenics as compared to stable schizophrenics. The latter two studies are thus, again indicative of the role of a schizophrenic process in the patients' experience of stressful life events. Ventura et al. (1989) reviewed the studies on life events and concluded that both vulnerability and stress factors, and not just the latter, contribute to the onset and course of schizophrenia. Type III: The third set of studies in the

literature report no relationship between life events and the onset of schizophrenic episodes. (e. g. Leff et al., 1973; Leff & Vaughan, 1980).

Comparative studies of schizophrenic patients with other groups of psychiatric patients reveal that undesirable life events were more common in depression than in schizophrenia (Beck and Worthen, 1972; Jacobs et al., 1974; Martin et al., 1995) Life Events and Mania

Meynert (1890) and Westphal (1911) had initially suggested that exogenous factors (romantic and psycho-reactive factors) can play a part in precipitation of mania. Ambelas (1979) found 28% of patients experiencing life events before a manic episode, which was 5 times more than in control group. Similarly, Leff et al. (1976) reported that independent events occurred soon before an attack in 28% of their cases. Singhal et al. (1984) reported 60% of manic patients as experiencing stressful life events of various kinds, compared to only 13% of the controls. Lakhera et al. (1995) reported life events in 54% of their manic patients in the month preceding their manic episodes.

Kennedy et al. (1983) used manic patients as their own controls and observed a far higher frequency of life events in a period prior to the manic episode than during an equal subsequent period of time. With regards to the type of life events that precede the manic episode, the more commonly reported ones are work & interpersonal difficulties (Patrick et al., 1978; Dunner et al., 1979; Joseph P. Auto, 1995); death of first degree relative, economic crises, failure in achievement (Singhal et al., 1984); and financial problems, large loans, marital and family conflicts, damage to property or crops (Lakhera et al., 1995). Joseph P. Auto (1995) studied life events in

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schizophrenics, depressives and manics and concluded that life events preceding mania were more related in time. Life Events and Depression

In an early study, Arieti (1959) concluded that typical precipitating stresses in severe depressive reactions fall into three general categories – death of loved one, failure in an important interpersonal relationship (usually with one's spouse) and a severe set back or disappointment in the work or other goals to which an individual has been devoted.

A large body of research has documented an increase in occurrence of life stress before the onset of major depression. (Paykel et al., 1969, 1994; Rao and Nammalvar, 1976; Brown and Harris, 1978, 1989; Chatterjee et al., 1981; Rao, 1986; Monroe and Depne 1991; Miller et al, 1989; Paykel and Cooper, 1992; Bebbington et al., 1993; Mazure, 1998). Many investigators have documented that bereavement has a role in the causation of depression. Loss of spouse has been reported as a significant life event that precipitates depressive illness. (Parkes 1964; Clayton et. al., 1968). Parkes (1964) observed that the number of patients whose illness followed the loss of spouse was six times greater than expected. Events involving ' loss', ' separation' or ' hazard' (Beck et. al., 1972) exits and interpersonal arguments (Jacobs et. al., 1974) have been found to precede depressive illness.

Rao and Nammalvar (1976) identified bereavement as a critical precursor of depression. Benjaminson (1981) reported that multiple events were more common in non endogenous depression compared to endogenous depression. Leff et al., (1970) and Thomson & Henrie (1972) did not find any

difference between endogenous and neurotic depression in relation to life events. Satija et al., (1982) reported that recent life events were found to be more responsible than chronic history of life events for the onset of a depressive episode. Williamson et al., (1995) found that depressed adolescents had significantly more independent stressful life events during the previous year than did the normal controls. Similar association between stressful life events and level of depression had been found in University students by O’Niel et al (1986). Mundt et al. (2000) reconfirmed the role of life events for the timing of depressive episodes in a two year prospective follow up study. Life Events and Anxiety Disorders

The effects of life events either on the etiology or precipitation of neurotic disorders are unclear. Previous studies of life events or specific stressors related to phobic behaviour suggest that such events may trigger neurotic disorder but only in few of the patients studied (Myers et al., 1971; Cooper and Sylph, 1973). A significant relationship between stressful events and onset of anxiety symptoms was reported by Ram and Sharma (1988). Similarly, Takeuchi et al., (1986) has reported life events as playing an important role in the inception of anxiety disorder in 118 patients with the disorder. Servant and Parquet (1994b) found that early and recent life events, especially loss and separation may be a risk factor for secondary depression in anxiety disorder. Sharma and Ram (1986) observed academic failure in examination and appearing for interview to be significantly more in anxiety neurotics than in controls, during the 6 months prior to the onset of illness. Recently, Sharma and Ram (1987) investigated the relationship

between life events, social and family support, and magnitude of illness in 87 patients of anxiety neurosis and 47 controls.

In comparison to controls, anxiety neurotics had less social and family support. One study found a significant relationship between life events and panic disorder (Fravelli et al, 1989). Epidemiological and clinical data are consistent with the view that panic disorder is significantly and strongly associated with both parental death and separation in childhood (Servant and Parquet, 1994b). In an investigation of 157 patients with panic disorder, Servant and Parquet (1994a) found that 53 patients (33. 7%) had experienced a major loss or separation before the age of 15 years, and it was also noticed that the panic group with early life events showed a significantly higher life time prevalence of major depression than panic group who did not experience early life events. Savoia and Bernik (2004) reported that the type of event and the coping skills used in response to them, more than the occurrence of stressful events itself, may be associated with the onset of panic disorder. Loss of social support was a more common life event in panic patients compared to normal, and they tended to use coping skills judged as ineffective.

Friedman et al., (2002) found in their group of panic disorder patients, that a history of childhood physical or sexual abuse was positively correlated to clinical severity. Khanna et al., (1988) reported an excess of life events in the preceding to months in the OCD sample. They identified these events to be more independent, to have significantly higher negative impact and to be more uncontrolled. Both Khanna et al. (1988) and Mc Keon et al., (1984) reported a delay between peak time of occurrence of events and the onset of

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OCD. Mc Keon et al. (1984) took this delayed impact of life events to imply that a certain level of emotional arousal is necessary before obsessions intervene. De Loof et al. (1989) compared the life events of patients with obsessive compulsive disorder and panic disorders and found that the former group did not differ from the latter in terms of number of life events they experience during the one year prior to the onset of their disorder. However, over the total life course, panic disorder patients experience more life events than obsessive compulsive disorder patients. Newman and Bland (1994) compared the life events experienced by the patients with major depression, anxiety disorder and panic disorders and reported significant associations between stressful events and these disorders.

Apart from all these studies importance has been given to life events in ICD-10 and DSM – IV in the etiology of majority of mental illnesses, for e. g. Acute and transient psychotic disorder, Brief reactive psychosis, PTSD, Dissociative disorders, Adjustment disorder etc. Prolonged exposure to life threatening circumstances have been found to bring about enduring personality changes. Special emphasis has been given to life events for considering it as a precipitating factor in the onset of these mental illnesses. GENDER

DIFFERENCES IN THE RATES OF EXPOSURE TO STRESSFUL LIFE EVENTS

Three patterns of association between gender and life event exposure are most commonly seen in the literature: * Women have a broadly higher risk for most or all categories of stressful life events. * Women are at greater risk for a subset of events (e. g. Network, Interpersonal). * No major differences are seen between the genders in event exposure. Previous studies have also produced a range of findings about gender differences in sensitivity to

stressful life events. Most, but not all of these studies have employed self report measures of “ depression” or “ distress” rather than syndromal diagnoses of major depression.

CONCLUSION

Life events research has thus been an area of immense interest since the 1960s. The problems defined and the hypotheses generated are so varied in this area, that there is very little scope of exhaustion. Although literature suggests that life events play an important role in the precipitation and relapse of psychiatric disorders, the relationship is not all that straight forward. The relationship between stress and illness varies with pre existing vulnerability factors. That is, differences in social support system, skills, attitudes, beliefs, and personality characteristics render some persons relatively immune to stress induced illness & other relatively susceptible. Hence, future research should focus on identifying these intervening variables and understanding their effect on stress – illness relationship.